

A FEMINIST ANALYSIS OF CONTEMPORARY WOMEN'S HEALTH: BRINGING
MARGINALIZED WOMEN TO THE CENTER

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ABSTRACT

Amanda J. Grigg: A Feminist Analysis of Contemporary Women's Health: Bringing Marginalized Women to the Center
(Under the direction of Susan Bickford)

What does it mean for women's health to be a national priority, particularly for socioeconomically disadvantaged women and women of color for whom state intervention has historically taken the form of oppression, regulation, and punishment, and who often suffer disproportionately worse health outcomes than their more privileged peers? As this question suggests, contemporary women's health is fraught with contradictions. Drawing attention to marginalized women's health issues is at once risky and necessary. This work attempts to answer this question and navigate these contradictions by employing two central insights drawn from feminist bioethicists, feminist health activists, and sociologists of medicine. First, that health cannot be understood simply as a good in need of more equitable distribution. Health is a contested concept whose meaning has been profoundly shaped by social realities. As a result, health and medicine have been sites of troubling normalization and regulation. Second, that poor women and women of color have seen their health issues obscured, even within the feminist women's health movement, and continue to suffer worse health outcomes than their more privileged peers. Attention to these two contradictory insights is essential to any effort to address marginalized women's health needs without incurring the kinds of problems long associated with institutional intervention in the lives of poor women and women of color.

This work outlines the principles of a feminist analysis of women's health. A feminist analysis considers the roles played by 1) the social construction of health, 2) new paradigms of

health, 3) structural variables, and 4) political power in determining how and for whom contemporary women's health works. Applying these factors, it analyzes several issues: drug use during pregnancy, food stamp soda bans, the occupational health of domestic workers, and postpartum depression. In analyzing these issues, it considers the possibilities for an empowering and inclusive understanding of women's health.

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INTRODUCTION:

Everyone wants health. To have it, to maintain it, to improve it, to return to it. The popularity of fitness culture, clean-eating, workplace wellness campaigns, genetic screenings and preventative surgeries confirm as much. Of course these activities all have motives in addition to health, from achieving the perfect body to lowering healthcare costs for employers and increasing revenues for pharmaceutical companies. Critics argue that prevailing ideas and practices of health individualize responsibility for social problems, expand the scope of health to reach almost all areas of life, and require responsible citizens to nearly constantly engage in health promoting behaviors. These critics also worry that pressures to achieve an increasingly unattainable standard of health have been internalized. In light of all this, it is ironic that a pejorative scholarly term for this trend, “healthism” has been adopted by those who see these shifts as empowering and embrace the growing cultural obsession with health.

Women’s health has seen similar growth in attention.¹ The women’s health movement of the 1970s revolutionized women’s health care, including birth control and childbirth, and spawned the breast cancer movement. The past two decades alone have seen the creation of several federal offices devoted specifically to women's health, dramatic increases in funding for women’s cancers, and the adoption of federal policies requiring the inclusion of women and

¹ When I suggest that women’s health receives increased attention, of course I do not mean simply that a state of well being among women has received increased attention (though it has, in a sense). Instead I mean that there has been an increase in attention to issues of women’s health (including issues that threaten women’s mental and physical well-being, means of improving women’s mental-and physical well-being, policies, programs, and organizations aimed at addressing women’s mental and physical well-being) from politicians, researchers, non-profit organizations, health professionals, the media, the general public, and women themselves.

minorities in federally funded medical research.² In 2002 the Department of Health and Human Services spent almost \$70 billion on women's health, and the Office of Public Health and Science budgeted an additional \$68 billion for women's health research and programming.³ In 2014, the federal government provided \$682 million in funding for breast cancer research alone.⁴

In light of all of this it should be no surprise that, writing in the *New York Times* in 2006, Roni Rabin declared that women's health had become "a national priority."⁵ At the same time, a robust literature has emerged documenting continued (and in some cases increasing) racial disparities in health outcomes. These disparities include significant differences in health outcomes between white and racial minority women, and between middle- and upper-income women and poor women.⁶ Further, since the origins of the modern women's health movement in the 1970s, activists and policymakers have been criticized for defining women's health needs based largely on the experiences of middle- and upper-income white women. In recent years, scholars have argued that contemporary understandings of women's health have been profoundly

² Karen L. Baird, Dana-Ain Davis, and Kimberly Christensen, *Beyond Reproduction: Women's Health Activism, and Public Policy*, 9-28.

³ *Ibid.*, 9

⁴ "Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)," National Institutes of Health, February 5, 2015.

⁵ Roni Rabin, "Health Disparities Persist for Men, and Doctors Ask Why." *The New York Times*, November 14, 2006, http://www.nytimes.com/2006/11/14/health/14men.html?_r=2&.

⁶ For example, racial disparities in breast cancer mortality rates are well-documented. See: Christopher I. Li, Kathleen E. Malone, and Janet R. Daling, "Differences in Breast Cancer Stage, Treatment, and Survival by Race and Ethnicity," *Archives of Internal Medicine* 163, no. 1 (2003); Alan R Nelson, Brian D Smedley, and Adrienne Y Stith, *Unequal Treatment:: Confronting Racial and Ethnic Disparities in Health Care*, vol. 1 (National Academies Press, 2009); Brian D Smedley, "The Lived Experience of Race and Its Health Consequences," *American Journal of Public Health* 102, no. 5 (2012).

influenced by postfeminist, neoliberal, colonial, and biomedical views of health in ways that can exclude women who do not conform to race, gender, and class ideals.⁷

This work asks what it means for women's health to be a national priority, particularly for marginalized women for whom state intervention and attention has historically taken the form of oppression, regulation, and punishment, whose health issues have often been obscured even within feminist women's health activism, and who often suffer disproportionately worse health outcomes than their more privileged peers.

My efforts to answer this question are premised on two central notions. First, health is not always, or only, a good. In a first sense, health is not a discrete good separated from social context and variables. That is, there is no simple way to better distribute good health outcomes. One cannot address persistent health disparities merely by improving access to health care, but must address problems ranging from gender roles to homelessness. Though many medical and public health professionals have recognized the complexity of improving health outcomes (see discussion below), it is often neglected in policy interventions and media discussions. Secondly, what is less recognized is that health can refer to health outcomes (physical well-being or illness), but it can also refer to health as a concept that can be called upon to make claims and which, because of its cultural significance and authority, can be invoked to coerce, to reinforce norms and inequalities, and to penalize. This latter view has been central to feminist perspectives of health. As a concept, health is often used to make claims with a tenuous relationship to physical and mental well-being, and/or to mask claims that would better be understood as

⁷ Tasha N. Dubriwny, *The Vulnerable Empowered Woman: Feminism, Postfeminism, and Women's Health* (New Brunswick: Rutgers University Press, 2013); Paula Gardner, "Re-Gendering Depression: Risk, Web Health Campaigns, and the Feminized Pharmaco-Subject," *Canadian Journal of Communication* 32, no. 3 (2007); Sarah E.H. Moore, "Is the Healthy Body Gendered? Toward a Feminist Critique of the New Paradigm of Health," *Body & Society* 16, no. 2 (2010); Jan E. Thomas and Mary K. Zimmerman, "Feminism and Profit in American Hospitals the Corporate Construction of Women's Health Centers," *Gender & Society* 21, no. 3 (2007).

something other than (and perhaps less compelling than) health. Here we might think of Jonathan Metzl's explanation of his collection's title *Against Health*, which notes that women's and men's health magazines might better be understood through the frame of sexism or cultural narcissism than health, that certain anti-smoking campaigns might better be understood as a kind of moralism than as health, and that erectile dysfunction advertisements might better be understood through the lens of phallocentrism than health. In this work I argue that similar uses of "health" are at play in the discourse surrounding bans on the purchase of soda with food stamp benefits. In that case we might recognize some such claims as based more in raced beliefs about the entitlement of the poor than in concerns about health. Thus the first premise leads us to the conclusion that though women's health outcomes are and should be of great concern, we should not view health or health care merely as something that must or can simply be more broadly distributed.

Second, though support for women's health is perhaps greater in scope and scale than ever before, it remains exclusionary. The recent wave of attention to women's health has resulted in some issues receiving unprecedented funding while others are ignored, and some women receiving more screening and more aggressive treatment than ever before while others lack access to care entirely. The combination of these two insights is essential. Without a critical view of the disciplinary aspects of health, we might simply advocate for more universal access to health care or more Congressional hearings and legislation on marginalized women's health issues. Without attention to exclusions, we might focus our critiques of ideas and practices of health on the most prominent issues, which tend to be those facing relatively privileged white women. We might have a thousand volumes on the commercialization of the breast cancer

movement and nothing written on the struggles of incarcerated women to receive adequate health care.

Breast cancer has come under particular scrutiny from critics of contemporary ideas of health. According to feminist critics, the movement exhibits flaws common to contemporary women's health discourse, including an emphasis on individual biology that depoliticizes the issue and obscures the roles of identity and context in breast cancer discourse, activism, and treatment. In fact, those involved in some of the most well-known and well-funded organizations in the breast cancer movement, including the Susan G. Komen Foundation, often actively reject the notion that they are engaging in politics.⁸ Generally the movement avoids critiques of the pharmaceutical or medical industry or of the profit-incentives inherent in the cancer industry.⁹ It also largely fails to acknowledge the extent to which gendered context, including cultural emphasis on breasts and female body image, influence breast cancer discourse, activism, and even treatment.¹⁰ In her work on the subject, Gayle Sulik argues that to render the issue of breast cancer palpable to the public, pink ribbon culture has transformed breast cancer from "an important social problem that requires complicated social and medical solutions" to a popular issue (and often an actual item) for public consumption.¹¹ Similarly, Barbara Katz Rothman has argued that breast cancer is framed as a "disease of innocence" and is centrally linked to

⁸ Amy Blackstone, "'It's Just About Being Fair': Activism and the Politics of Volunteering in the Breast Cancer Movement," *Gender & Society* 18, no. 3 (2004), 357-360.

⁹ Gayle Sulik, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health* (New York: Oxford University Press, 2011), 202-210.

¹⁰ *Ibid.*, 73-101.; Sue Wilkinson and Celia Kitzinger, "Whose Breast Is It Anyway?: A Feminist Consideration of Advice and 'Treatment' for Breast Cancer," *Women's Studies International Forum* 16, no. 3 (1993), 230-231.

¹¹ Sulik, *Pink Ribbon Blues*, 9.

women's identities as mothers, grandmothers, aunts and sisters, creating an image of breast cancer that is as uncomplicated and sympathetic as possible.¹²

These critiques around breast cancer are not new. As they suggest, attention to women's health is not always a good thing, and women's health activism can unintentionally work to undermine women's health politics (or even the health of particular women). They also suggest that the identity of the women associated with a health issue shapes how an issue is understood and the extent to which the public embraces that issue. And while critics have frequently questioned the substance of the now-ubiquitous breast cancer movement, far fewer questions have been posed about why some women's health issues receive no attention at all.¹³ More broadly we might ask whether issues associated with less privileged, less gender-ideal-conforming, less sympathetic women benefit from the outpouring of attention to women's health. We might ask whether the same ideas about health and gender that make breast cancer such a popular issue exclude conditions facing marginalized women from the same kind of recognition, whatever the consequences of that recognition. In this project I address all of these questions and argue that efforts to incorporate such excluded issues force us to rethink many of the problematic aspects of dominant women's health discourses and practices, to confront contradictions in women's health politics, and to develop a more complete, empowering, and inclusive understanding of women's health.

In this dissertation, I present a view of health claimsmaking as something that has great potential to improve lives but which often harms women, that improves the lives of some women

¹² Barbara Katz Rothman, "Genetic Technology and Women," in *Women, Gender, and Technology*, ed. D.G. Johnson and S.V. Rosser (Urbana: University of Illinois Press, 2006), 95.

¹³ In the case of breast cancer, the movement has done little to address disparities in mortality, despite the fact that black women are in some cities three times more likely to die of breast cancer than white women. This should not be surprising in light of its failure to address contextual, structural variables.

while harming others, and that improves women's lives in some ways while simultaneously making them worse in other ways.¹⁴ With this in mind I do not argue simply for more health – that is, for recognition of a broader set of health problems or for a reframing of marginalized women as health-endangered – but for an improved and specifically political understanding of health that recognizes the dangers health discourses and practices pose in addition to the benefits they can bring, and that acknowledges the health problems facing marginalized women.

Exploring health problems that go ignored, specifically those faced predominantly by marginalized women, makes the normative complexity of health particularly salient. While it is easy to reject the use of health discourses and practices to regulate marginalized women – here we might think of the forced sterilizations of women of color throughout American history – it is much harder to reject health discourses and practices that are flawed in their insufficiency rather than in their intent – here we might think of poor women of color in Chicago who face barriers to advanced breast cancer screening. Or, turning to case studies presented here, we might argue for greater occupational safety for domestic workers, while still challenging efforts to improve their safety that place full responsibility on the workers themselves. Or we might argue for better nutrition for poor women, while challenging some efforts to improve their health by excluding items eligible for purchase with SNAP benefits.

Problems with how we understand and operationalize women's health are tied to several much larger issues. Our understanding of women's health influences which issues receive attention and funding and which issues are seen through the sympathetic lens of disease (as opposed to, for example, vice). Our understanding of women's health is fundamentally tied to our understanding of what causes health problems and what kinds of solutions health problems

¹⁴ In this use health refers not to the state of being without illness but to ideas, arguments, and legislation, about health, as well as practices and policies aimed at improving or ensuring health.

require. It also determines which issues are *not* issues of health and thus *do not* require the treatment available to health issues.

How we understand women's health shapes how and whether we respond to disparities in health. Thus, conceptualizing women's health is tied to ideas about the proper role of government and the extent to which individuals are responsible for their own fate; to arguments about what health looks like and requires, what causes good or ill health, and the value of good health; and all of these are profoundly influenced by implicit beliefs about gender, race, and class. The substance and boundaries of the women's health should be of interest to anyone concerned with social justice, inequality, women's agency, ideas of health, or arguments about government and individual responsibility. The difficulty is that concerns about women's health are now so ubiquitous that it can seem unnecessary to ask what women's health entails, or what it is, or what it means to identify an issue as one of women's health. As I will demonstrate, however, these questions are essential to a feminist of understanding of contemporary women's health.

A Feminist Analysis of Women's Health

This work brings together two insights vital to understanding women's health generally, and marginalized women's health in particular. First, it applies a critical view of discourses and practices of health, recognizing that "health" is not always or solely a good. Second, it acknowledges that despite the expansion in the scope and scale of women's health care, significant disparities in attention, access, and outcomes persist. These insights are better understood in the context of a feminist analysis of women's health, which explores how and why

one should be critical of discourses and practices of health, as well as how and why women's health can be exclusionary.¹⁵

As detailed in chapter 1, I do not subscribe to a specific school of feminist thought, though the insights of feminists of color who theorize the interrelated axis of race, class, and gender, including the work of Kimberlé Crenshaw, Patricia Hill Collins, and Cherríe Moraga, are a central influence on my work. I draw on work from a range of disciplines, including historical accounts and criticisms of the women's health movement by feminist scholars such as Sandra Morgen, Sheryl Burt Ruzek, and Michelle Murphy, in addition to work by feminist scholars of bioethics, communication, and critical race studies, including Adele Clarke, Virginia Olesen, Tasha Dubriwny, and Dorothy Roberts. The feminist analysis I apply highlights the roles identity, politics, and culture play in shaping how we think about women's health and in shaping women's health outcomes. Specifically, it recognizes that ideas about what health looks like and requires are shaped by the cultures from which they emerge, that social and political inequalities influence health outcomes, and that making claims based on health can be used as a strategy for employing social and political power (particularly, but not exclusively in terms of exerting power over women in ways that limit their agency).

Methodologically, a feminist analysis is intersectional, both in understanding oppressions as overlapping and interlocking, and in centering the analysis of health on the health of marginalized women.¹⁶ By bringing multiply marginalized women to the center of our analysis, we gain a more complete understanding of women's health, of the insufficiency of contemporary

¹⁵ See Chapter 1 for a full explanation.

¹⁶ The theory of intersectionality posits that multiple forms of discrimination (based on race, gender, class, ability, s sexuality, etc.) operate interdependently and simultaneously to produce systemic injustice and social inequalities. It also suggests that oppressive institutions, those supporting sexism, homophobia, racism, etc., operate dependently and cannot be understood in isolation from one another. We cannot understand sexism, either as experienced by an individual woman, or as it functions to produce systemic injustice, without understanding how it interacts with, supports, and is supported by other forms of discrimination. See Crenshaw, Kimberlé. "Mapping the margins: Intersectionality, identity politics, and violence against women of color." *Stanford law review* (1991): 1241-1299.

understandings of women's health, and of the roles played by identity, power, and inequalities in shaping discourses and practices of health as well as health outcomes. A feminist analysis of health also draws on the first-hand experiences and knowledge of women wherever possible. Here I draw on the practice of consciousness raising and to a lesser extent on arguments about feminist standpoint that emerged from it, including those made by Catherine MacKinnon.¹⁷ Drawing on critiques of standpoint theory in woman of color feminisms, I do not assume that there can be a unified feminist standpoint (an assumption which has historically focused on the standpoint of relatively privileged women).¹⁸ Instead, I aim to incorporate the voices of women affected by particular health issues as sources of knowledge, focusing on some of the least privileged women in the world of women's health without assuming that their experience is comprehensive or conclusive. This woman-produced knowledge often works to challenge biomedicalization and depoliticization, reveal the use of health as a strategy for exerting social and political power, and identify ways in which systematic inequalities have shaped women's experiences of health. Just as the theoretical framework of my analysis highlights identity and power, so too does its substantive focus, by focusing on the most vulnerable women and attending to their unique experiences of health.

Overview of Chapters

Women's health has been a central concern to feminists since the earliest days of the second wave of the feminist movement. Those early efforts to address health have in turn been critiqued and advanced by feminists in the ensuing decades, resulting in a rich body of theorizing

¹⁷ Catharine A. MacKinnon, *Toward a feminist theory of the state*. Harvard University Press, 1989.

¹⁸ For critiques of standpoint theory by women of color feminists see: Maria C. Lugones and Elizabeth V. Spelman. "Have we got a theory for you! Feminist theory, cultural imperialism and the demand for 'the woman's voice'." In *Women's Studies International Forum*, vol. 6, no. 6, pp. 573-581. Pergamon, 1983.

about health by academics and activists from all schools of feminist thought. It is to this work that I turn in Chapter 1. My purpose in this chapter is to offer readers – particularly those unfamiliar with feminist approaches to health - an overview of the key theories and ideas that guide my analysis in the following chapters. I begin with a brief history of feminist activism and theorizing around health in the 1970s. This history is followed by a discussion of the shifts that have occurred in women’s health activism and scholarship since the feminist movement, and of the valuable work that marginalized women’s groups have done to complicate and expand our understanding of health. The chapter concludes with a detailed description of how feminist theory can provide an approach to women’s health, which will guide my analysis of health issues in the chapters that follow.

The analysis begins in Chapter 2, with the issue of drug use during pregnancy. I begin with a brief overview of efforts to criminalize drug use during pregnancy, from efforts to address so-called “crack babies” in the 1980s to Tennessee’s unprecedented 2014 decision to categorize prenatal drug use as assault. Exploring drug use during pregnancy demonstrates the great complexity of marginalized women’s health. In this case, many women lack access to treatment but are reported to law enforcement for punishment as a result of interaction with medical professionals. This occurs despite the fact that punishment goes against recommended medical treatment for addiction. Such practices are often established in the name of health, though they focus on the health of unborn children rather than their mothers. Thus while marginalized women are not necessarily ignored in the context of growing concern about women’s health, the attention that is devoted to their health is distinctly different from that devoted to privileged women’s health. To understand their position we must both recognize the ways in which they are

excluded from health (discourse and care) and critically examine where and how they are included.

Applying a critical analysis to the deployment of health in the context of maternal drug use, I argue that proponents of criminalization present an understanding of health that obscures its structural and political aspects, and that emphasizes concerns about the health of drug-exposed infants as part of efforts to establish fetal personhood. This view of health makes the regulation and punishment of pregnant drug users in the name of health both possible and appealing. Attention to this situation reveals that pregnant drug users are doubly harmed in the context of health, subject to punishment based on arguments about health and suffering from a serious lack of access to treatment that is only exacerbated by the punitive approach to addiction. I conclude by exploring what kinds of solutions a feminist analysis supports, and how the insights of a feminist analysis are essential to preventing further harm.

In Chapter 3 I analyze legislators' proposals to further limit the items eligible for purchase with SNAP benefits. Again I begin with a summary of the policies surrounding such proposals, which are linked to concerns over rising obesity rates and a perceived "obesity epidemic." While the health of pregnant drug users is largely ignored, women who use food stamps are very much the focus of concerns about health. My analysis of SNAP bans offers examples of the failures of health discourse and policy that targets marginalized women. Again I find that the view of health guiding legislation and media coverage obscures structural causes of ill health and the extent to which cultural context shapes our ideas about health. Here again the combination of a critical view and attention to exclusions and disparities proves vital to understanding the challenges of food insecurity. Limitations on SNAP purchases remind us that including marginalized women in conversations about health without fundamentally altering the

substance of those conversations does little to improve their lives, and much to limit their agency.

In Chapter 4 I turn to the case of the health risks involved in domestic work, focusing on cleaning women. Though occupational health regulations and workplace wellness campaigns have gained momentum in recent decades, domestic workers remain unprotected by much of the existing legislation. Furthermore, the private and often isolated nature of their work makes them particularly vulnerable to exploitation. As this chapter demonstrates, cultural norms and biases, together with systemic inequalities are central forces shaping health outcomes and one's ability to take action to address health problems. I argue that efforts to engage domestic workers in monitoring their own health, along with biomedical efforts to simply address the symptoms of their working conditions are insufficient. As the case of domestic workers' health demonstrates, some health problems require significant institutional, cultural, and/or political change in order to be adequately addressed. Access to medical care after problems arise, or inclusion in a culture of wellness and healthism, will not suffice. Thus exclusion from the benefits of increased attention to women's health cannot be addressed by applying existing understandings of health. Here again the combination of attention to exclusion and a critical feminist view of health care provision are vital to understanding the issue at hand, and how it might best be addressed.

The fifth chapter takes a somewhat different approach. In this chapter I focus on an issue that is not predominantly associated with marginalized women, but instead with privileged white women, exploring the efforts of postpartum depression advocates to acquire medical recognition and state and federal funding for research and screening. As this chapter demonstrates, the insights of a feminist theory of health are valuable for women in a variety of positions, not solely those on the margins. The case of postpartum depression offers a powerful example of what we

might think of as the upper tier of medicalization, of women whose health is of deep concern to legislators and medical professionals, and for whom prenatal and postnatal screening means increased medical care (and increased medical authority over their lives) rather than criminalization. However both a critical view of discourses and practices of women's health and attention to exclusion remain relevant. As my analysis demonstrates, efforts to address postpartum depression focus largely on biology, ignoring the role cultural norms, gender roles, and work and family leave policies play in shaping maternal stress and mental health. This exploration also demonstrates the ways that recognized health issues, when they are defined by and for privileged women, can exclude marginalized women. This example highlights similarities and differences in how women experience increased attention to their health, problematizing the biomedical, depoliticized view of health and the extent to which health continues to be used to limit women's agency. Chapter 5 demonstrates that popular views of health as individual and biological fail all women, but through very different means.

CHAPTER 1: A FEMINIST ANALYSIS OF WOMEN'S HEALTH

In the late 1960s and throughout the 1970s, feminists (sometimes literally) took their health into their own hands. As part of the women's health movement women diagnosed and treated their own yeast infections, fit one another for diaphragms, identified early pregnancy, embraced home birthing and midwives, and performed abortions.¹ Activists also demanded greater access to knowledge about their own bodies and began producing that knowledge themselves in consciousness raising groups. The most famous example of such efforts is the renowned *Our Bodies Ourselves*, which was written and self-published by a group of feminists who began meeting to discuss their dissatisfaction with their medical providers.² Work by women's health activists resulted in the inclusion of warning labels about side effects and risks of birth control pills in the 1970s, new public health standards for breast self-examinations and mammograms in the 1980s, and the passage of the National Institute of Health Revitalization Act mandating that women and minorities be included in federally funded medical research in the 1990s.

More recently, the passage of the Patient Protection and Affordable Care Act (ACA) was much lauded by women's health activists. As a result of the ACA, women's preventative care services (including mammograms, cervical exams, HIV screening, domestic violence

¹ Together these kinds of efforts by women to take their health into their own hands formed the women's self-help movement, a subset and foundation of what is more broadly referred to as the women's health movement. See Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger, 1978), 53-64; Sandra Morgen, "The Dynamics of Cooptation in a Feminist Health Clinic," *Social Science and Medicine* 23 (1986); Karen L. Baird, Dana-Ain Davis, and Kimberly Christensen, *Beyond Reproduction: Women's Health Activism, and Public Policy* (Madison, NJ: Fairleigh Dickinson University Press, 2009), 20.

² Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990* (New Brunswick: Rutgers University Press, 2002), 16-21.

screening and counseling, breastfeeding support and supplies, and contraceptives) are now covered at no cost. The Department of Health and Human Services' decision to include contraceptives in preventative care services produced surprising controversy over the right to contraceptives and debates between those who framed the mandate as an issue of women's health and those who framed it as an issue of religious liberty. The ACA outlawed the denial of insurance for gender-related "pre-existing conditions" including having had a Cesarean section, or being a victim of sexual assault or domestic violence. Also outlawed was the practice known as "gender rating" through which insurers charged women higher premiums than men. The ACA requires HHS to improve its data collection, including data about the health of LGBT individuals. In response to this requirement, the HHS has added sexual orientation and gender identity questions to federal population health surveys in an effort to advance knowledge of LGBT health outcomes and needs. As evidenced by the attention to women's health in the landmark ACA, the issues encompassed in women's health have expanded dramatically in scope since the 1960s, and women's health has become an issue of national concern. In this sense the women's health movement seems to have been profoundly successful.

Of course feminist success is never quite so simple. The increasing interest in women's health, like feminism itself, is, as Gloria Steinem once said, "not an unmixed blessing."³ Particularly in its early years, the women's health movement tended to exclude the voices and needs of marginalized women. As women's health has become a national priority and buzzword, the content of women's health discourse and activism have moved away from its feminist roots. As its popularity has grown, feminist language and practices of women's health have been employed in ways that are far from feminist. For example, Jan Thomas and Mary Zimmerman

³ From an early film on the feminist movement, cited in Adele E. Clarke and Virginia L. Olesen, "Revising, Diffracting, Acting," in *Revisioning Women, Health, and Healing: Feminist, Cultural, and Technoscience Perspectives*, ed. Adele E. Clarke and Virginia L. Olesen (New York: Routledge, 1999), 4.

have argued that hospital-sponsored women's health centers have co-opted the concept of women's health centers originated by grassroots feminist organizers in the 1970s.⁴ As a result, women's centered care no longer means educating and involving women in their care, nor does it entail providing care to a range of women. In hospital-sponsored women's health centers, women-centered care is profit-driven care, providing expert attention and the latest medical technology to insured women with disposable incomes, with no changes to hierarchies or treatment methods. As a result of such cooptation and dilution, despite the many touted successes of the women's health movement, women's lives are increasingly biomedicalized and the movement for women's health continues to be stripped of its potential to disrupt and empower. At the same time, many women remain excluded not just from the expanding scope of the conceptual boundaries of women's health but also from health care itself. The popular view of women's health has lost much of its feminist potential, and the boundaries of women's health continue to exclude already marginalized women.

One of the central premises of this work is that when seen from a feminist perspective, the discourses, policies, and practices of women's health are not only complex but often contradictory. This is exemplified in this work's combination of a critical view of women's health and an emphasis on the exclusion of marginalized women from (admittedly problematic) health care. In making this argument, I rely on a number of feminist scholars whose work has articulated the complexity of women's health. In their volume on feminist, cultural, and technoscientific approaches to women's health, Adele Clarke and Virginia Olesen characterize contemporary women's health as "beset by dilemmas, paradoxes, and contradictions – in both

⁴ Thomas and Zimmerman, "Feminism and Profit in American Hospitals."

feminist theorizing and women's health situations."⁵ Similarly, Michelle Murphy's account of feminist reproductive health politics in the 1970s employs the language of entanglements, or "attachments of material, technical, and social relations across divergent and even antagonistic terrains of politics."⁶ As a result of such entanglements, she argues, the tools created by feminist self-help activists to empower women have been caught up in neoliberal population control efforts, and have even helped to make the constituent elements of neoliberal public health appear ethical.⁷ In her critique of contemporary women's health, Tasha Dubriwny argues that in the current context individuals are increasingly held responsible for ensuring their own health, consumption of medical services has replaced political action, and equality is lauded but policies continue to reinforce and expand economic, political, and health disparities.⁸ The language of feminist health has been co-opted, leaving women to find "empowerment" through focus on the self (rather than through changing culture or policy) and through the consumption of existing medical treatments. Recognizing the normative and empirical complexity of women's health, as these scholars do, allows us to identify entanglements, contradictions, and co-optations, to see the promise in the problematic, and the oppressive in the empowering.

⁵ Clarke and Olesen, "Revisioning Women, Health, and Healing," 4.

⁶ Michelle Murphy, *Seizing the Means of Reproduction: Entanglements of Feminism, Health, and Technoscience* (Duke University Press, 2012), 12.

⁷ *Ibid.*, 175; Lisa Duggan, *The Twilight of Equality?: Neoliberalism, Cultural Politics, and the Attack on Democracy* (Beacon Press, 2012). The term neoliberal has undergone significant conceptual stretching, and is now used to refer to a great number of policies and government priorities. American studies scholar Lisa Duggan has described neoliberalism as the "brand name" for a variety of economic policies that favor the free-market, corporations, and significant cuts to social welfare programs, and are anti-big government. It is also used to describe a related cultural phenomenon in which personal responsibility and privatization are increasingly valued (mindsets that support the cuts to social services associated with neoliberal economic policies) and in which terms like empowerment are appropriated to refer to consuming goods, or taking personal responsibility for problems that are no longer addressed by social welfare programs. In the case of women's health both of these definitions of neoliberalism are employed, as in Dubriwny's work which explores how the economic policies and cultural values of neoliberalism are reflected in medical practices and subjectivities.

⁸ Dubriwny, *The Vulnerable Empowered Woman*.

Though the women's health movement emerged in an era in which feminists aligned themselves with a particular version of feminism (i.e., liberal feminism, radical, socialist, or Marxist feminism, womanism) feminism and feminist theories of women's health have moved beyond this. Many feminist activist and scholars now claim the label without aligning themselves to a particular brand of feminism, though there continue to be productive disagreements about the nature of feminism and feminist theory. At the same time, aspects of feminist thinking and practice that emerged in specific feminist camps, including the insights about intersectionality developed by women of color feminists, have been widely embraced. In this work I draw on the work of feminists from a range of disciplines and ideologies, including work by feminists who do not align themselves with a specific brand of feminism. Most frequently, I draw on the work of feminist bioethicists and woman of color feminists that together form the basis for my own feminist theory of health, detailed in this chapter.

Some of the most powerful work done to expand and complicate our understanding of women's health has come from marginalized women. Women of color in particular have drawn attention to the many material conditions beyond access to care that are necessary to improve the health of the least privileged.⁹ For example, scholars and activists of color, including Loretta Ross and the SisterSong Collective, led the shift from thinking in terms of reproductive rights to the broader, deeper concept of reproductive justice that calls not just for the right to reproductive agency, but for the conditions required to make that agency meaningful.¹⁰ Feminist disability

⁹ Tania Ketenjian, "Byllye Avery, Interview by Tania Ketenjian," in *Voices of the Women's Health Movement*, ed. Barbara Seaman and Laura Eldridge (New York: Seven Stories Press, 2012); "Helen Rodriguez-Trias, Interview by Tania Ketenjian," in *Voices of the Women's Health Movement*, ed. Barbara Seaman and Laura Eldridge (New York: Seven Stories Press, 2012).

¹⁰ Asian Communities for Reproductive Justice, *A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice*, (2005), <http://strongfamiliesmovement.org/assets/docs/ACRJ-A-New-Vision.pdf>; Kimala Price, "What Is Reproductive Justice? How Women of Color Activists Are Redefining the Pro-Choice Paradigm," *Meridians* 10, no. 2 (2010); Jael

scholars such as Adrienne Asch, Rosemarie Garland-Thomson, and Susan Wendell, have challenged the valorization of the normal and the healthy.¹¹ In so doing their work challenges views of women's health that aim to make women healthier with existing tools and according to existing definitions of health. In their efforts to eliminate the American Psychiatric Association's diagnoses for homosexuality and gender nonconformity, LGBT activists and scholars have highlighted the extent to which notions of health are shaped by social and cultural norms, and the extent to which the language and authority of health can be used to justify and reinforce those norms.¹² Similarly, critical race scholars, including Dorothy Roberts, have drawn attention to the ways in which differences in the application of medical advancements can reinforce existing disparities, particularly between privileged white women and poor women of color.¹³ All of these groups push us beyond a view of health as simply a good to be more broadly distributed among women.

My work aims to contribute to this conversation with a feminist view of health that is equally attentive to problems with how health is conceived of and practiced, and to the exclusion of marginalized women from many of the benefits (complex as they might be) of increased

Silliman et al., *Undivided Rights: Women of Color Organizing for Reproductive Justice* (Boston: South End Press, 2004).

¹¹ Adrienne Asch and Michelle Fine, eds., *Women with Disabilities: Essays in Psychology, Culture, and Politics* (Philadelphia: Temple University Press, 1988); Rosemarie Garland-Thomson, "Feminist Disability Studies," *Signs* 30, no. 2 (2005); Susan Wendell, "Toward a Feminist Theory of Disability," *Hypatia* 4, no. 2 (1989); *The Rejected Body: Feminist Philosophical Reflections on Disability* (New York: Routledge, 2013).

¹² Ronald Bayer, "Politics, Science, and the Problem of Psychiatric Nomenclature: A Case Study of the American Psychiatric Association Referendum on Homosexuality," *Scientific controversies: Case studies in the resolution and closure of disputes in science and technology* (1987); David F Greenberg, *The Construction of Homosexuality* (University of Chicago Press, 1990).

¹³ Dorothy Roberts, *Shattered Bonds: The Color of Child Welfare* (New York: Basic Books/Civitas, 2001); *Fatal Invention: How Science, Politics, and Big Business Re-Crete Race in the Twenty-First Century* (New York: The New Press, 2011); "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy," *Harvard Law Review* (1991); "Race, Gender, and Genetic Technologies: A New Reproductive Dystopia?," *Signs* 34, no. 4 (2009).

attention to women's health. In this sense it represents both a tool for critique and a guide for developing less problematic discourses and practices of health. Viewing contemporary women's health as complex and contradictory, and through the eyes of marginalized women, allows us to identify what contemporary views of women's health miss, and to draw attention to the political nature of concepts of health and health care provision. This work demonstrates that the consequences of the women's health movement have not been universally positive, and have varied dramatically across race and class. Marginalized women's health in particular has been ignored or, where attended to, has been attended to indirectly, in ways that reject medical expertise, and in ways that are repressive or punitive. However, even privileged women whose experiences have been at the center of women's health have at times suffered under certain visions or practices of health. I do not conclude that discourses of health are inevitably oppressive. My analysis demonstrates that a more inclusive, nuanced, feminist understanding of women's health retains the potential to empower. Drawing on women of color feminists, critical race scholars, feminist anthropologists, and bioethicists, I articulate a feminist theory of women's health driven by two central premises – a critical view of women's health, and attention to exclusions and disparities in women's health care and health outcomes – and four related insights about the nature of contemporary health: the social construction of health and illness, the dominance of biomedicalization, the role of structural variables in shaping health outcomes, and health as power.

The Social Construction of Health and Illness

A feminist analysis first recognizes that ideas about health and illness are context-dependent. How we define health and illness, including what we think of as an issue of health and what we think of as not health and instead some other kind of issue (of morality, for example) vary across

time and culture. This insight is indebted to the work of medical anthropologists, medical sociologists, and other feminist scholars of health and medicine.¹⁴ Feminist scholars, including Sue Fisher, Judith Lorber, Lisa Jean Moore, Barbara Ehrenreich, and Deirdre English have criticized the supposed universality and objectivity of medical knowledge, highlighting evidence of gender bias in Western medicine.¹⁵ More recent work by feminist scholars has begun to demonstrate how definitions of health and illness are influenced by gender in conjunction with race and other markers of status and privilege.¹⁶

Medical sociologists, most notably Eliot Friedson and Irving Zola, have long argued that social forces shape our understanding of and actions toward health and illness.¹⁷ Similarly medical anthropologists such as Andrea Wiley and John Allen have argued that cultural variables influence how health is defined and that these definitions vary across time and culture.¹⁸

Particularly relevant for this work is the notion, described by Schneider and Ingram, that the

¹⁴ Marjorie Kagawa-Singer, "Redefining Health: Living with Cancer," *Social Science & Medicine* 37, no. 3 (1993), 302-303; Andrea S Wiley and John Scott Allen, *Medical Anthropology: A Biocultural Approach* (Oxford University Press Oxford, 2009). For medical sociologists see: Phil Brown, "Naming and Framing: The Social Construction of Diagnosis and Illness," *Journal of Health and Social Behavior* (1995); Peter Conrad and Kristin K Barker, "The Social Construction of Illness Key Insights and Policy Implications," *ibid.* 51, no. 1 suppl (2010). Medical anthropologists argue for example, that cultural variables influence health (including along gender lines), that the definition of good health varies across time and cultures, and that vulnerability to disease is closely tied to social inequalities.

¹⁵ Elizabeth J Adams, Laurence Grummer-Strawn, and Gilberto Chavez, "Food Insecurity Is Associated with Increased Risk of Obesity in California Women," *The Journal of Nutrition* 133, no. 4 (2003); Barbara Ehrenreich and Deirdre English, "Complaints and Disorders: The Sexual Politics of Sickness," ed. Glass Mountain (Old Westbury, NY: The Feminist Press, 1972); Sue Fisher, *In the Patient's Best Interest: Women and the Politics of Medical Decisions* (Rutgers University Press, 1986); Judith Lorber and Lisa Jean Moore, "Gender and the Social Construction of Illness," in *Gender and the Social Construction of Illness*, ed. Judith Lorber and Lisa Jean Moore (Lanham, MD: AltaMira Press, 2002).

¹⁶ "Gender and the Social Construction of Illness.,"; Roberts, *Fatal Invention*; "Reconstructing the Patient: Starting with Women of Color," in *Feminism in Bioethics*, ed. Susan M. Wolf (New York: Oxford University Press, 1996).

¹⁷ Brown, "Naming and Framing: The Social Construction of Diagnosis and Illness.,"; Peter Conrad and Kristin K Barker, "The Social Construction of Illness Key Insights and Policy Implications," *ibid.* 51, no. 1 suppl (2010); Eliot Friedson, "Profession of Medicine: A Study of the Sociology of Applied Knowledge," *New York: Dodd, Mead* 81 (1970); Bryan S Turner, *Medical Power and Social Knowledge* (Sage, 1995); Irving Kenneth Zola, "Medicine as an Institution of Social Control," *Sociological Review* 20, no. 4 (1972).

¹⁸ Wiley and Allen, *Medical Anthropology*.

identities (and values, symbols, and images attributed to those identities) of the groups most associated with a health condition shape how it is viewed and the policies that are proposed to address it.¹⁹ We see the role of identity whenever a group of women with a yet-undiagnosed condition are dubbed hysteric, or when male sexual dysfunction receives infinitely more attention than that of females, despite being less common.²⁰ Rather than assuming that diseases are universal across time and space, these perspectives recognize that cultural and social systems shape our understanding of health and illness.

For example, the medical understanding of conception has long been influenced by cultural ideas about gender roles. The female role in the reproductive process has historically been described as passive while the male reproductive process has been described as active and even awe-inducing, both mirroring the cultural ideals associated with their respective gender. One classic medical textbook describes the female as “shedding” gametes while the male “produces” them.²¹ Another describes menstruation as failed production and the maturation of sperm as “remarkable” and “amazing” in its “sheer magnitude.”²² According to medical textbooks the journey of sperm is perilous, with sperm propelling themselves towards the egg, which passively

¹⁹ Anne Schneider and Helen Ingram, "Social Construction of Target Populations: Implications for Politics and Policy," *American political science review* 87, no. 02 (1993). See also Baumgartner and Rose's application of this argument to U.S. poverty policy Max Rose and Frank R Baumgartner, "Framing the Poor: Media Coverage and Us Poverty Policy, 1960–2008," *Policy Studies Journal* 41, no. 1 (2013). Schneider and Ingram make this argument in relation to policy generally, here I apply it to health policy in particular.

²⁰ See discussion of Michelle Murphy's work on assumptions of hysteria in Chapter 4. For work on the disparate attention to male sexual dysfunction, and critiques of increasing biomedical attention to female dysfunction see: Heather Hartley and Leonore Tiefer, "Taking a Biological Turn: The Push for a" Female Viagra" and the Medicalization of Women's Sexual Problems," *Women's Studies Quarterly* (2003); Leonore Tiefer, "A New View of Women's Sexual Problems: Why New? Why Now?," *The Journal of Sex Research* (2001).

²¹ Vernon B. Mountcastle, *Medical Physiology*, 14th ed. (London: Mosby, 1980), 134.

²² Arthur J. Vander, James H. Sherman, and Dorothy S. Luciano, *Human Physiology: The Mechanisms of Body Function*, 3rd ed. (New York: McGraw Hill, 1980), 483-84.

drifts through the fallopian tubes to await penetration by forceful, active sperm.²³ In fact, recent research has found that the forward motion of sperm is extremely weak and that the egg's surface effectively captures the sperm, allowing its digestive enzymes and side-to-side motions to work towards penetrating the egg. Contradicting centuries of medical knowledge, researchers now believe that the sperm and egg are "mutually active partners."²⁴

Further demonstrating the subjective nature of medical knowledge, medical sociologists have documented the social and political processes through which definitions of biological disease are negotiated.²⁵ In *The Politics of Difference*, Stephen Epstein outlines how bureaucrats and activists have pushed for the inclusion of women and minorities in federally funded medical research.²⁶ As Epstein's account demonstrates, major shifts in medical knowledge often come not from objective, scientific observation of nature but from conflicts and negotiations between political actors. Social and cultural variables can also influence the process through which conditions are medically recognized, as they did when bias against gays delayed the recognition of AIDS.²⁷ Or (as we will see in Chapter 5) when sympathetic white middle- and upper-income mothers successfully lobbied for recognition of postpartum depression.

The process through which human experiences come to be labeled as "medical" problems is referred to as medicalization. While the term medicalization is value neutral, it is often used to

²³ See Emily Martin, "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles," *Signs* (1991).

²⁴ Gerald Schatten and Heide Schatten, "The Energetic Egg," *The Sciences* 23, no. 5 (1983), 51.

²⁵ Steven Epstein, *Inclusion: The Politics of Difference in Medical Research* (Chicago: The University of Chicago Press, 2007); Kelly Ann Joyce, *Magnetic Appeal: MRI and the Myth of Transparency* (Cornell University Press, 2008); Stefan Timmermans, *Postmortem: How Medical Examiners Explain Suspicious Deaths* (University of Chicago Press, 2007).

²⁶ Epstein, *Inclusion: The Politics of Difference in Medical Research*, 53-93.

²⁷ Brown, "Naming and Framing: The Social Construction of Diagnosis and Illness"; Paula A. Treichler, "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification." *October* 31 (1987): 35-47.

critique expanding medical authority by critics who argue that it represents a form of social control and that it detracts attention away from the non-biological causes of human suffering. And though feminists have been critical of expanding medical authority, women (and particularly privileged women) have also been involved in the process of medicalization, demanding medical recognition for their experiences.²⁸ As Catherine Riesmann argues, by recognizing the processes through which medical knowledge is produced, the concept of medicalization highlights that medicine is a social, not merely scientific, project.²⁹

One of the central insights of this line of research, particularly among feminists, is that insofar as it is shaped by its social and political context, medical knowledge can reflect and reproduce existing social norms and inequalities. Feminist critics argue that it is no accident that health is often aligned with behaviors that are socially, economically, or morally valued, while illness is aligned with behaviors that are discouraged.³⁰ Feminist scholars, including bioethicist Susan Sherwin, have argued that the social meaning of gender has been adopted and reinforced by medical discourse and practice, naturalizing gender inequality and encouraging women to enact dominant cultural ideals of femininity.³¹ Medical knowledge about pregnancy,

²⁸ Catherine Kohler Riesmann, "Women and Medicalization: A New Perspective," in *The Politics of Women's Bodies: Sexuality, Appearance, and Behavior*, ed. Rose Weitz (New York: Oxford University Press, 1998): 53-57; Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger, 1978); Verta Taylor, *Rock-a-by-Baby: Feminism, Self-Help and Postpartum Depression* (New York: Routledge, 1996): 59-94.

²⁹ Riesmann, "Women and Medicalization," 52.

³⁰ Rutledge M Dennis, "Social Darwinism, Scientific Racism, and the Metaphysics of Race," *Journal of Negro Education* (1995); Reginald Horsman, "Scientific Racism and the American Indian in the Mid-Nineteenth Century," *American Quarterly* (1975); Louis Menand, "Morton, Agassiz, and the Origins of Scientific Racism in the United States," *Journal of Blacks in Higher Education* (2001); Roberts, *Fatal Invention*; William Stanton, *The Leopard's Spots: Scientific Attitudes toward Race in America, 1815-59*, vol. 1965 (University of Chicago Press Chicago, IL, 1960). We frequently see the influence of social and political context on medical knowledge in the history of scientific racism in the United States, beginning in earnest with the publication of Darwin's *Origin of Species* in 1859 and continuing – albeit in less explicit forms – to this day.

³¹ Adele Clarke, *Disciplining Reproduction: Modernity, American Life Sciences, and 'the Problems of Sex'* (Univ of California Press, 1998); Barbara Ehrenreich and Deirdre English, *For Her Own Good: Two Centuries of the Experts'*

premenstrual syndrome, childbirth, and menopause, all contain clear notions about women's "proper" place in society, and more general assumptions about women's sexuality and femininity. For example, because many of the symptoms of PMS, including anger and aggression, defy gender norms and ideas about how women "naturally" or "normally" behave, they are considered clear evidence of a disorder.³²

Biomedicalization and the New Paradigm of Health

The context in which ideas about health and health practices emerge has changed dramatically in the past few decades, enough to constitute a "new paradigm" according to many scholars of health. This new paradigm is characterized in part by biomedicalization.

Biomedicalization refers to the increasingly complex, multi-sited, and technological processes of medicalization.³³ The "biomedical" in biomedicalization refers to a particular model of health and illness. As Elliot Mischler explains:

The biomedical model of illness assumes that disease is a deviation from normal physiological functioning, that diseases have specific causes that can be located in the ill person's body, that illnesses have the same symptoms and outcome in any social situation, and that medicine is a socially neutral application of scientific research to individual cases.³⁴

Clearly this biomedical view undermines feminist insights about the social construction of health and illness. As Mischler's account suggests, current views of health and illness also tend to individualize.

Advice to Women (New York: Anchor Press, 1978); Lorber and Moore, "Gender and the Social Construction of Illness," 1-12, 71-92.

³² Susan Markens, "The Problematic of 'Experience' a Political and Cultural Critique of PMS," *Gender & Society* 10, no. 1 (1996), 44-49.

³³ Clarke et al., "Biomedicalization," 162.

³⁴ Elliot G Mischler, "Viewpoint: Critical Perspectives on the Biomedical Model," *Social contexts of health, illness, and patient care* (1981): 14.

In the 1980s Robert Crawford coined the term “healthism” to describe the shift toward locating health and disease at the level of the individual, and the growing pressure on individuals to ensure their own health.³⁵ In the decades following the coining of healthism, the once pejorative term has been embraced by a growing number of people who idealize health and find health-promoting activities empowering. Sociologist and social theorist Nikolas Rose has since argued that the public has internalized the message of healthism, rendering state intervention unnecessary. Rose describes this internalized healthism as “responsibilization,” in which the burden of ensuring health is transferred from the government to individuals, who are assumed to be to blame if they become sick.³⁶ The 2000s in particular saw the emergence of health (more specifically encouraging health-promoting behaviors) as a guiding principle of governments and individuals.

The biomedical era has also seen changes in the standards for health, which expand the range of activities required of healthy subjects. Thanks in part to technological advancement, and in part to the eradication of many major diseases, health is increasingly understood not as the absence of illness but as the presence of wellness, active prevention of illness, and achievement of near-perfect physical condition. Accordingly, governments of industrialized Western nations have encouraged their citizens to view health as a way of life rather than something to be focused on only in times of illness. Public health efforts of the World Health Organization as well as those of many economically advanced countries have undergone a shift from focusing on curing

³⁵ Robert Crawford, "Healthism and the Medicalization of Everyday Life," *International Journal of Health Services* 10, no. 3 (1980).

³⁶ Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century* (Princeton: Princeton University Press, 2007), 4.

illness to focusing on preventing illness and promoting health.³⁷ The realm of medicine has expanded beyond the treatment of illness to encompass the enhancement or optimization of the body in ways that are framed as improving or maximizing health (i.e. anti-aging treatments, erectile dysfunction medicines, cosmetic surgery). To maintain the increasingly high standard for health, individuals must vigilantly monitor themselves, engage in a range of health promoting behaviors, identify risk factors, and take actions to mitigate risk of illness. As Adele Clarke and Janet Shim explain, under the new paradigm of biomedicalization, “health becomes an individual goal, a social and moral responsibility, and a site for routine biomedical intervention.”³⁸ Similarly scholars who characterize the new paradigm as one of “health promotion” argue that health promotion broadens the scope of public health efforts to dissolve the difference between unhealthy and healthy populations, self-consciously involve itself in their health, develop techniques to monitor and maintain their status, and bring health promotion specialists into previously unmonitored areas of subject’s lives.³⁹

Much of the shift in the standard of health is made possible by biomedical advances that make it easier to identify illness and susceptibility to illness at the genetic, molecular, and submolecular level. This expands the scope of medical authority to include those at risk of disease in addition to those who are actually ill. The emergence of this kind of technology helped give rise to what David Armstrong terms “surveillance medicine,” which consists not only of

³⁷ Robin Bunton, Roger Burrows, and Sarah Nettleton, *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk* (Routledge, 2003); Michael Bury, *Health and Illness in a Changing Society* (Psychology Press, 1997); Robert Crawford, "The Ritual of Health Promotion," *Health, medicine and society: Key theories, future agendas* (2000); Sarah Nettleton, *The Sociology of Health and Illness* (Polity, 2006).

³⁸ Clarke et al., "Biomedicalization," 171.

³⁹ Robin Bunton. "More than a woolly jumper: health promotion as social regulation." *Critical Public Health* 3, no. 2 (1992): 4-11.

treatment but of regularly identifying and mitigating risk.⁴⁰ Critics such as Tasha Dubriwny also link biomedicalization to neoliberal beliefs about personal responsibility. Under biomedicalization, once a health risk is identified, individuals are expected to and often wish to take action to minimize their risk. For example, the development of tests for the BRCA1 and BRCA2 genes has been associated with a rise in preventative double mastectomies.⁴¹ When surveillance medicine is combined with the imperative to monitor and minimize risk, everyone becomes implicated in the process of (eventually) becoming ill.⁴² Thus critics argue that in the era of biomedicalization even the healthy are at best the “worried well,” made “ready subjects for health-related discourses, commodities, services, procedures, and technologies.”⁴³

To better understand the relationship between biomedicalization, individualization, and depoliticization, we might consider the example of breast cancer. Of course, a woman does not develop breast cancer as a result of sexism, and it is not a political or collective problem in that sense. But she might develop breast cancer as a result of exposure to environmental pollutants. She might only have certain treatment options available to her as a result of the structuring of insurance or because of the incentives driving the pharmaceutical industry, which can privilege more profitable treatments. She might be pressured to undergo unnecessarily invasive surgery because she lacks agency in her relationship with her doctor, or because of cultural ideas about

⁴⁰ David Armstrong, "The Rise of Surveillance Medicine," *Sociology of Health and Illness* 17, no. 3 (1995): 403.

⁴¹ Katharine Yao, Andrew K. Stewart, David J. Winchester, and David P. Winchester. "Trends in contralateral prophylactic mastectomy for unilateral cancer: a report from the National Cancer Data Base, 1998–2007." *Annals of surgical oncology* 17, no. 10 (2010): 2554-2562; Min Yi, Kelly K. Hunt, Banu K. Arun, Isabelle Bedrosian, Angelica Gutierrez Barrera, Kim-Anh Do, Henry M. Kuerer et al. "Factors affecting the decision of breast cancer patients to undergo contralateral prophylactic mastectomy." *Cancer Prevention Research* 3, no. 8 (2010): 1026-1034.

⁴² Clarke et al., "Biomedicalization."; Alan Petersen, "Risk, Governance, and the New Public Health," in *Foucault, Health, and Medicine*, ed. Alan Petersen and R. Bunton (New York: Routledge, 1997); Roland L Weinsier et al., "Hospital Malnutrition. A Prospective Evaluation of General Medical Patients During the Course of Hospitalization," *The American journal of clinical nutrition* 32, no. 2 (1979).

⁴³ Clarke et al., "Biomedicalization," 172.

health and risk and personal responsibility. She might feel the need to pursue reconstructive surgery as a result of the ever-present ideals about female bodies, and the cultural importance of a woman's physical appearance. In treatment and remission she will likely feel pressured to enact the narratives of a breast cancer patient and survivor, which are gendered.⁴⁴ If she is a black woman she will be more likely to die of breast cancer than if she were a white woman, a disparity that medical researchers have tied in part to socioeconomic factors and poorer health at diagnosis, as well as disparities in quality of previous primary care, access to quality screening, and cancer treatment and differences in rates of mammogram follow-up.⁴⁵ All of this suggests that breast cancer – its origins, the treatments associated with it, the experiences of women who develop it – is profoundly influenced by cultural and social norms, by conditions of inequality, by government regulations, and by institutions and profit incentives. In sum, it is deeply political.

However, a biomedical view would urge us to understand breast cancer at an individual level, as the failure of a biological system in an individual body. It would encourage us to view the risk of breast cancer as something to be monitored and minimized by the individual, and to view medical technologies as something to be consumed, often without questioning their value or the motives of those who own and operate them. All of these impulses work directly against the recognition of the role of political variables outlined above. A focus on the individual obscures environmental variables, and a focus on biology and medical technology obscures the social and political forces that shape the kinds of technology available, who they are available to,

⁴⁴ Sulik, *Pink Ribbon Blues*, 101-110.

⁴⁵ Much of the same medical research also suggests that biological differences (in estrogen receptor status or obesity for example) may play a role in mortality disparities, noting that such biological differences may be the result of exposure to less favorable environmental conditions. K. A. Dookeran, "Racial and Ethnic Differences in Breast Cancer Survival: How Much Is Explained by Screening, Tumor Severity, Biology, Treatment, Comorbidities, and Demographics?." *Breast Diseases: A Year Book Quarterly* 19, no. 2 (2008): 133-135; Jeffrey H. Silber, Paul R. Rosenbaum, Amy S. Clark, Bruce J. Giantonio, Richard N. Ross, Yun Teng, Min Wang et al. "Characteristics associated with differences in survival among black and white women with breast cancer." *Journal of the American Medical Association* 310, no. 4 (2013): 389-397.

and how and why individuals consume them. It is easy to overlook the political elements of health in light of a supposedly objective scientific explanation for health problems, in light of a cultural obsession with ensuring health through medical technology, and in light of the increasing availability of biomedical tools with which the privileged can monitor their health.

The key characteristics of the era of biomedicalization tend to encourage the individualization and depoliticization of health problems. Most obviously, individualization and depoliticization occur when health problems are viewed as having exclusively or overwhelmingly biological causes (see Chapter 5). Even when an issue is not viewed primarily as having biological causes, the biomedical era's characteristic emphasis on individuals taking responsibility for their health can support individualization and depoliticization (see Chapter 2 and 4). In addition, the immense value accorded to health can allow arguments about health to be used to justify policies that blame and punish women for their health problems, and to obscure more contentious and troubling justifications (see Chapter 2 and 4). Though the shifts in thinking about health that are associated with the biomedical era lend themselves to such uses, not all contemporary medical knowledge and practices individualize and depoliticize, nor do they inherently ignore structural variables, as evidenced by the many medical and public health professionals working on social determinants of health.

The era of biomedicalization is also characterized by immense disparities in health outcomes and in access to health care and medical advancements. Scholars of biomedicalization, most notably Adele Clarke and Virginia Olesen, refer to this in terms of stratification or stratified biomedicalization.⁴⁶ Though medical technology has seen an unprecedented expansion in reach,

⁴⁶ Adele E Clarke and Janet Shim, "Medicalization and Biomedicalization Revisited: Technoscience and Transformations of Health, Illness and American Medicine," in *Handbook of the Sociology of Health, Illness, and Healing* (Springer, 2011); Clarke et al., "Biomedicalization."

there are still individuals and groups who are aided less or left out completely.⁴⁷ There is at once problematic abundance and problematic scarcity; in other words, some women fight against excessive biomedical interventions in their lives while others lack the most basic forms of care. Some women, particularly poor women of color, experience both biomedicalization and barriers to care. As discussed in Chapter 2, poor women of color who use drugs during pregnancy find themselves fighting against punitive state-sponsored biomedical interventions, while also lacking access to basic prenatal care and addiction treatment. As a result of the stratified nature of biomedicalization, women may have very different experiences with medicine, and even different health problems, depending on their identity and position in society.

Medical care and health outcomes are stratified within and across national borders. In the United States, white women and women of color can have divergent relationships to reproductive technologies. For example, feminist scholars have critiqued new reproduction-assisting technologies for reinforcing a system in which white women's reproduction is valued while black women's reproduction is devalued and discouraged (if not simply made impossible).⁴⁸ As Dorothy Roberts has argued:

At a time when wealthy white women have access to technologies that assist them in having children who not only are genetically related to them or their partners but have also been genetically screened, various laws and policies discourage women of color from having children at all.⁴⁹

Others, including Faye D. Ginsberg, Rayna Rapp, Marcia Inhorn, France Twine, Wendy Chavkin, and JaneMaree Maher, highlight stratification at the global level, arguing that globalization has allowed reproductive technologies to cross borders, and stratified access to

⁴⁷ "Biomedicalization," 170.

⁴⁸ Rayna Rapp, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* (New York: Routledge, 1999); Dorothy E Roberts, "Privatization and Punishment in the New Age of Reprogenetics," *Emory LJ* 54 (2005); "Race, Gender, and Genetic Technologies."

⁴⁹ "Race, Gender, and Genetic Technologies," 784.

technologies has traveled along with them.⁵⁰ As a result of the spread of such technologies, medical tourists travel from countries in the Global North to countries in the Global South for services that citizens of those countries cannot afford, sometimes paying those very women for use of their eggs or wombs.⁵¹

As Chapter 2 (and to a lesser extent Chapter 4) demonstrates, marginalized women lack access to screening and treatment for recognized medical conditions. Moreover, stratified biomedicalization means that health problems affecting marginalized women can go ignored by the same medical professionals, media outlets, and legislators who zealously work to address conditions associated with privileged women. In some cases medical professionals recognize marginalized women's health problems, but legislators ignore the medical view in favor of an understanding that blames health outcomes on poor individual choices, and consequently advocate for punitive solutions. The stratification of medical recognition also highlights the complexity of women's health. Though biomedicalization in women's lives has been harshly criticized by feminists, some women have demanded medical recognition of their condition in the hopes of benefitting from better treatment and destigmatization. As the lives of marginalized women demonstrate, the current alternatives to a biomedical view of one's condition (lack of protection or punitive treatment) are, if possible, even less appealing.

Attention to disparities in access to care, health outcomes, and recognition of health issues represents one significant way that a feminist analysis illuminates the complexity and contradictions of women's health. Of course the very nature of biomedicalization distracts us

⁵⁰ Wendy Chavkin and JaneMaree Maher, *The Globalization of Motherhood: Deconstructions and Reconstructions of Biology and Care* (Routledge, 2010); Faye D Ginsburg and Rayna Rapp, *Conceiving the New World Order: The Global Politics of Reproduction* (Univ of California Press, 1995); Marcia Claire Inhorn, *Local Babies, Global Science: Gender, Religion, and in Vitro Fertilization in Egypt* (Psychology Press, 2003); France Winddance Twine, *Outsourcing the Womb: Race, Class and Gestational Surrogacy in a Global Market* (Routledge, 2015).

⁵¹ For example, women in India, as a group, now earn more than \$450 million per year for gestational surrogacy Chavkin and Maher, *The Globalization of Motherhood*, 136.

from the political elements of disparities, guiding us toward biological explanations for systematic differences in health outcomes. My analysis is thus attentive to the influence of biomedicalization and critical of it insofar as it undermines a view of health as shaped by culture and context, as political, and as unequal in ways that biological differences cannot justify.

Structural Variables and Health Outcomes

The dominance of a biomedical view is particularly problematic in light of the immense role structural variables play in shaping health. My analysis highlights the way structural variables, including poverty, exposure to stress, violence, and pollution, influence health outcomes. Broadly, one might think of structural variables as contextual or external variables (in opposition to internal or biological variables) and as systematic (in opposition to forces that affect individuals at random rates). Though structural variables originate externally they act on the internal directly and indirectly. Structural variables can also interact with internal forces and together result in poorer health outcomes, as when environmental forces activate certain genes, or when environmental pollutants exacerbate pre-existing asthma. Structural variables disproportionately affect certain groups as a result of systemic inequalities. For example, a broken arm is not a structural variable in drug use, but systematically higher rates of exposure to violence and sexual abuse among women of color are important structural variables. Central to this understanding of structural variables is the recognition that non-biological variables disproportionately affect certain groups in certain ways, and that they do not do so by happenstance.⁵² This understanding of structural variables encompasses the web of implicit and explicit biases, and policies based on and reinforcing those biases, that function to uphold persistent inequalities.

⁵² Here again we can think of such variable as purely non-biological or external, and as interacting with biological or internal variables to together produce a poor health outcome.

Women of color working in the women's health and reproductive justice movements have played a vital role in bringing a structural view of health to light. Dr. Helen Rodriguez Trías, a founding member of the Committee to End Sterilization Abuse, exemplifies this role in her description of Puerto Rican women's health as explicitly encompassing contextual factors:

I try not to talk just in terms of narrow health issues or, just about health care and lack of access to health care. I try to emphasize the need to improve health conditions: where we work, where we live, what our environment is like, what are the chances of you or someone in your family being victimized by violence, traumatized by violence?⁵³

Similarly Byllye Avery, the founder of the National Black Women's Health Project, has explained that the group very quickly recognized the importance of psychological well being for overall health. They found that many women were living with "psychological distress" resulting from exposure to violence, rape and incest. These issues needed to be addressed, a woman needed to "get the message that you are a good and whole person" before she could be engaged to address problems with cardiovascular disease, hypertension, or diabetes.⁵⁴

Though they have not always done so, today most medical professionals and public health scholars recognize the importance of structural variables, referred to in the literature as social determinants of health. In 2002, The Institute of Medicine's Committee on the Quality of Health Care in America featured social determinants of health prominently in its final report on the future of the American health system.⁵⁵ In 2008 the World Health Organization (WHO)'s Commission on Social Determinants of Health released a comprehensive report on the role of structural variables in shaping health, which began by stating, "social justice is a matter of life

⁵³ Ketenjian, "Helen Rodriguez-Trías," 91.

⁵⁴ "Byllye Avery, Interview by Tania Ketenjian," 98.

⁵⁵ Bloom, Bernard S. "Crossing the quality chasm: a new health system for the 21st century." *JAMA: The Journal of the American Medical Association* 287, no. 5 (2002): 646-647.

and death.”⁵⁶ In the vein of critics of biomedicalization, WHO defines social determinants of health quite broadly as:

the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.⁵⁷

In an effort to address social determinants, the World Health Organization operates a Social Determinants of Health Unit and a Public Health Program on Environmental and Social Determinants of Health.⁵⁸ Articles in the *Journal of the American Medical Association* and *New England Journal of Medicine* now draw attention to problems of bias in the provision of health care, health disparities, and the role of social determinants of health.⁵⁹ There are powerful arguments for the recognition of social determinants of health coming from the medical establishment, as evidenced by the following excerpt from an editorial featured in the *New England Journal of Medicine*:

If we are to break the vicious cycle of inequality and uphold the tradition of physicians as champions of social justice in the global arena, we must widen our perspective beyond the individual to confront the “causes of the causes” at multiple levels, so as to help create social and physical environments that promote good health for all.⁶⁰

⁵⁶ Commission on Social Determinants of Health. "Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health." (2008).

⁵⁷ World Health Organization, “Social Determinants of Health” available at http://www.who.int/social_determinants/en/

⁵⁸ Ibid; World Health Organization, “Public health, environmental and social determinants of health (PHE): Health and Climate Change: Road to COP21” available at <http://www.who.int.libproxy.lib.unc.edu/phe/en/>

⁵⁹ Michael G. Marmot and Ruth Bell. "Action on health disparities in the United States: commission on social determinants of health." *JAMA* 301, no. 11 (2009): 1169-1171. Hilary K. Seligman and Dean Schillinger. "Hunger and socioeconomic disparities in chronic disease." *New England Journal of Medicine* 363, no. 1 (2010): 6-9. David R. Williams and Ronald Wyatt. "Racial Bias in Health Care and Health: Challenges and Opportunities." *JAMA* 314, no. 6 (2015): 555-556. Edward Patridge and Mona Fouad. "Community-driven approaches for reducing health disparities in cancer." *JAMA* 303, no. 11 (2010): 1090-1091.

⁶⁰ Jennifer K. Cheng. "Confronting the Social Determinants of Health—Obesity, Neglect, and Inequity." *New England Journal of Medicine* 367, no. 21 (2012): 1976-1977.

Unfortunately this more nuanced understanding of health outcomes is far less frequently adopted by people discussing, reporting on, or creating policy about health. In fact, a 2010 study of media coverage of racial and ethnic disparities in health found that not only had attention to disparities peaked in 1998 before declining, but that behavioral explanations for health disparities were twice as common as societal-level explanations, and that just 4% of articles referenced social justice.⁶¹

Structural variables can operate within or outside of the health system to demote health. As an example of the latter, a review of the literature on lesbian health care concluded that many care givers hold condemnatory views of lesbian clients and that lesbians frequently find that upon disclosure of their sexuality health care providers become hostile, resulting in patients fearing for their safety in health care interactions and delaying care.⁶² Though here bias operates within the health care system, it likely originates outside of it. As an example of structural variables operating outside of the health care system, recent studies have identified high levels of stress among lesbians resulting from negative societal attitudes toward homosexuality.⁶³ One study found that two thirds of those surveyed reported that their stress was severe enough to affect their health.⁶⁴

Viewing health as an individual or biological issue distracts from the extent to which health is an outcome of inequalities and larger social and political structures. It also distracts

⁶¹ Daniel Shive and Uzy Igweatu. "Coverage and framing of racial and ethnic health disparities in US newspapers, 1996-2005." *American Journal of Public Health* 100, no. S1 (2010): S224.

⁶² Patricia E Stevens, "Lesbian Health Care Research: A Review of the Literature from 1970 to 1990," *Health Care for Women International* 13, no. 2 (1992): 98-111.

⁶³ J. Bradford and C. Ryan, "The National Health Care Survey: Final Report," (Washington, D.C.: National Lesbian and Gay Health Foundation, 1988); K.E. Gillow and L.L. Davis, "Lesbian Stress and Coping Methods," *Journal of Psychosocial Nursing* 25 (1987).

⁶⁴ Bradford and Ryan, "The National Health Care Survey: Final Report."; "Who We Are: Health Concerns of Middle-Aged Lesbians," in *Lesbians at Midlife: The Creative Transition*, ed. B. Sang, J. Warshow, and A.J. Smith (San Francisco: Spinsters Book Co., 1991).

from the fact that health problems might require social or political changes in addition to medical treatment. As Evan Stark and Anne Flitcraft argue in their 1982 work on physicians' failure to recognize that female patients suffer from domestic violence:

Medicine...often categorizes problems fundamentally social in origin as biological or personal deficits, and in so doing smothers the impulse for social change which could offer the only serious resolution.⁶⁵

This view is not unique to medical professionals, and in fact the medical community has made enormous strides in recognizing and later drawing attention to structural variables, which are often referred to in the literature as social determinants of health. However the biomedical view is still frequently adopted by laypeople, including lawmakers. A recent article in *Health Affairs* suggested that policymakers tend to medicalize health problems, focusing on increasing access to health services despite the fact that “concerted policy action in income security, education, housing, nutrition/food security, and the environment,” is “critical” to efforts to improve health among the socially disadvantaged.⁶⁶

Often several structural variables intersect to produce health problems. For example, child asthma rates are drastically higher among children living in poverty, a disproportionate number of whom are racial minorities. Increased rates of asthma have been directly linked to heightened exposure to environmental pollutants in poor neighborhoods resulting from greater proximity to industrial polluters, high traffic areas, and the substandard quality of much public housing.⁶⁷ The disparate rates of pollution in poor neighborhoods, and the fact that

⁶⁵ Evan Stark and Anne Flitcraft, "Medical Therapy as Repression: The Case of Battered Women," *Health and Medicine* 1 (1982): 32.

⁶⁶ Paula M. Lantz, Richard L. Lichtenstein, and Harold A. Pollack, "Health Policy Approaches to Population Health: The Limits of Medicalization," *Health Affairs* 26, no. 5 (2007): 1253.

⁶⁷ N. Halfon and P.W. Newacheck, "Childhood Asthma and Poverty: Differential Impacts and Utilization of Health Services," *Pediatrics* 91, no. 1 (1993); James W. Krieger et al., "Asthma and the Home Environment of Low-

neighborhoods are segregated by race and class are the result of a host of variables including housing policies, environmental policies, and social welfare policies, all of which have been shaped by a legacy of racism, and made possible in part by the limited political influence of the poor and racial minorities. A recognition of the structural variables related to childhood asthma suggests that addressing it, particularly among poor minority children, will require solutions beyond individual medical treatment, whether that means improving public housing, providing more generous social support for low-income families, or creating stricter environmental laws (or, as is likely, all of the above). The balance of influence between structural variables and individual biology may vary between conditions or between individuals, but we cannot understand health in any comprehensive sense without understanding that structural forces play a role in shaping it.

Health and Power

Health is inextricably tied up with power relations in ways that defy simple explanation. Feminist activists of the 1970s described the doctor/patient relationship as one with a troubling power imbalance, contrasting doctors' tendency to give patients unequivocal orders and hoard medical knowledge with their own efforts to take back control over their health by becoming informed decision-makers, challenging their doctors' opinions, gathering and producing their own medical knowledge, and engaging in some self-help health care. Thus activists wrested control over decision-making, knowledge production, and health care provision out of the hands of medical professionals. Under this view, power was something held (by doctors) and in need of redistribution (to patients), and power inequalities shaped practices of health care and the production of medical knowledge. In this sense the work of feminist health advocates echo

Income Urban Children: Preliminary Findings from the Seattle-King County Healthy Homes Project," *Journal of Urban Health* 77, no. 1 (2000).

several ways of thinking about power that have been central to the work of political theorists and feminist scholars.

Political theorists, including many feminist theorists have developed a number of ways of thinking about how power works, many of which can be identified in discourses of health and practices of health care. Liberal feminists have understood power as something held by particular individuals or groups, and have highlighted power relations between individuals who might formally be recognized as equals but whose relationships involve coercion, discrimination, or manipulation.⁶⁸ Similarly in Robert Dahl's influential work on power, he argued "A has power over B to the extent that he can get B to do something that B would not otherwise do."⁶⁹ We can also find this form of power in Foucault's work, though it is certainly not his focus. According to Foucault, juridical power is made up of formal prohibitions and punishments and located in official institutions. It is exerted by those official institutions, through the creation of laws, the actions of police officers, and government agencies.⁷⁰

In the realm of health we find these kinds of overt, asymmetric power relations between patients and doctors, particularly in the years before women's health and patients' rights movements. As Belita Cowen, founder of the National Women's Health Network recounted, "In 1974, women had very little say when it came to making medical care decisions. Everyone but

⁶⁸ Such as John Stuart Mill, "The Subjection of Women," in *Essays on Sex Equality*, ed. Alice Rossi (Chicago: University of Chicago Press: 1970); Susan Moller Okin, *Justice, Gender and the Family* (New York: Basic Books, 1989).

⁶⁹ Robert Dahl, "Decision-making in a democracy: The supreme court as a national policy-maker," *Journal of Public Law* 6 (1957): 202. Nelson W. Polsby offered a similar conceptualization of power. Nelson W. Polsby, *Community Power and Political Theory*, (New Haven: Yale University Press, 1963).

⁷⁰ Michel Foucault, *The History of Sexuality*, Volume 1: An Introduction, trans., Robert Hurley (New York: Vintage, 1979).

the patient herself made decisions – doctors, drug companies, hospitals, law makers.”⁷¹ Women’s bodies are still the site of formal punishments and prohibitions, as in the case of abortion bans and recent statutes increasing the punishment for drug use during pregnancy. In the case of drug use during pregnancy such overt power has been exercised by a web of authority figures including doctors (who report women to social service agencies), social service workers (who evaluate women and report them to law enforcement), police officers (who arrest women), prosecutors (who charge and try women), and legislators (who create the laws increasing or formalizing punishment for drug use during pregnancy). Under the liberal feminist view of power, the solution to oppression is more equitable distribution of power. In the case of women’s health, redistributing power has mean educating patients and empowering them to make informed decisions about their care, as well as urging the medical profession to reconsider the role patients, particularly women, can and should play in their own care.

Feminist critics of understandings of power as overt control have argued that they fail to address the broader social, institutional, and structural contexts that shape the individual relations of power.⁷² Here we might think of Helen Marieskind’s 1975 account of the Women’s Health Movement, in which she argued that within the health care system women were treated “according to the doctor’s traditional concept of an authoritative doctor-patient relationship” and “according to prevailing social norms of male-female relationships,” both of which were characterized by condescension towards women.⁷³ Thus feminists could not have fully understood the relationships of power and powerlessness between (predominantly) male doctors

⁷¹ Tania Ketenjian, "Belita Cowan, Interview by Tania Ketenjian," in *Voices of the Women's Health Movement*, ed. Barbara Seaman and Laura Eldridge (New York: Seven Stories Press, 2012), 84.

⁷² Iris Marion Young, *Justice and the Politics of Difference* (Princeton: Princeton University Press, 1990).

⁷³ Helen Marieskind, "The Women's Health Movement," *International Journal of Health Services* 5:2 (1975), 219.

and female patients without attending to the ways that prevailing gender roles shaped those interactions.

Critics have also challenged the view of power as the possession of an individual or group. For example, Iris Marion Young draws our attention to the “larger structure of agents and actions” that make the exertion of power possible.⁷⁴ Young offers the example of a judge with the power to sentence someone to jail who relies on “a network of practices” performed by wardens, guards, record-keepers, administrators, parole officers, and lawyers to carry out her order.⁷⁵ Similarly, the doctor who orders a pregnant woman to undergo substance abuse treatment sees orders carried out by social service workers, police officers, judges, wardens etc. Young, along with other critics, has also argued that power is increasingly exerted not within dyadic relationships between powerful and powerless, but by more impersonal structural mechanisms including cultural norms and social practices.⁷⁶

Just as feminists have critiqued the liberal feminist view of power, political scientists have critiqued Dahl’s pluralist model of power. Dahl’s work on power was challenged by Peter Bachrach and Morton Baratz for focusing on what happens in decision-making settings, and inadequately attending to those issues that are left off of the agenda entirely.⁷⁷ Bachrach and Baratz argued for an expansion of power to include instances in which someone controls which issues are neglected or consciously excluded from the public agenda.⁷⁸ In this sense power is

⁷⁴ Young, *Justice and The Politics of Difference* 32

⁷⁵ Ibid.

⁷⁶ Young, *Justice and the Politics of Difference*; Nancy Fraser, “Beyond the Master/Subject Model: Reflections on Carole Pateman's Sexual Contract,” *Social Text*, 37: 173–181 (1993).

⁷⁷ Peter Bachrach and Morton S. Baratz. "Two faces of power." *American Political Science Review* 56, no. 04 (1962): 947-952

⁷⁸ Ibid.

exercised by limiting the scope of decision-making to issues that favor those in power.⁷⁹ Or, in A/B terms, power is exercised “when A devotes his energies to creating or reinforcing social and political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A.”⁸⁰ To the extent that A is successful, B is prevented from bringing up any issues whose resolution might run counter to A’s interests. Thus power is exerted when an individual or group consciously or unconsciously “creates or reinforces barriers to the public airing of policy conflicts.”⁸¹ Looking ahead to the work of Steven Lukes and Michel Foucault, we should also note that Bachrach and Bartatz suggest that these barriers can form a kind of false consensus in which broad sections of the community are manipulated into self-imposing adherence to the norms and goals of the elite.⁸²

This understanding of the agenda-setting dimension of power is crucial to understanding women’s health, and particularly to recognizing the ways in which attention to women’s health issues has been exclusionary. To the extent that the definition and boundaries of health are up for debate, as discussed in the previous section on the social construction of health, power plays a role in determining whose issues receive attention, legitimacy, hearings, funding, and legislation. Those with more power are more likely to have their issues recognized, while those without are more likely to be ignored, or have their issues addressed in ways that are punitive. We see an example of this in my analysis of the success of predominantly white, well-educated, middle- and upper-income postpartum depression advocates, compared to the relative inattention to the

⁷⁹ Ibid.

⁸⁰ Ibid, 948.

⁸¹ Ibid, 949.

⁸² Ibid citing E.E. Schattschneider, *The Semi-Sovereign People* (Boston, MA: Wadsworth, 1960), 71.

health of domestic workers, and the stigmatizing and punitive attention to SNAP beneficiaries and women who use drugs while pregnant. In order to understand the dynamic through which issues reach the decision-making arena, but are addressed in ways that are punitive or that reject the frame of health, we must turn to yet more work on power.

Steven Lukes adopted Bachrach and Baratz's insight in his influential efforts to expand the academic conceptualization of power.⁸³ Beginning with 1962's *Power: A Radical View* Lukes identified three dimensions of power. The first, drawing on Dahl, is overt, a visible form of power exerted in conflict over decision-making, in which power consists of winning. This face is joined by a second face, a power that determines which issues are on the public agenda (drawing on Bachrach and Baratz). Here power means controlling not how something is decided but which issues reach the decision-making arena and which are ignored. Like the first face of power, this face is active and deliberate, intentionally suppressing observable interests. Lukes' central contribution is the insidious third face of power, power as domination. The third face of power is constituted by the shaping of beliefs and desires. Drawing on Gramsci, Lukes argues that power can also mean securing consent to dominant power relations through shaping the desires and beliefs of the dominated. Power as domination is ensured through political socialization, which leads actors to comply with the dictates of the powerful even if they go against their own interest. Through exertion of the third face of power, those without power internalize their powerlessness, accept it, and are unaware of and thus do not act on their interests.⁸⁴ In this sense, power can create a kind of false consciousness.⁸⁵ Power does not appear to work against the interest of those it dominates because it shapes their preferences and

⁸³ Steven Lukes. *Power: A radical view*. Vol. 1. (London: MacMillan, 1974).

⁸⁴ Ibid

⁸⁵ Lukes draws here on Gramsci, Herbert Marcuse and the shaping of consciousness or preferences.

suppresses their grievances.⁸⁶ Thus as Lukes argues, observable conflict can disappear and the mechanisms of power may no longer be intentional or active.⁸⁷ This third face of power goes beyond decision-making and agenda setting to recognize the deeper, less visible level at which power can operate.

Feminists have similarly drawn attention to domination as a key way in which power manifests itself, particularly in relation to women. Radical feminists including Marilyn Frye and Catharine MacKinnon have conceptualized power in terms of relationships of dominance and subordination between a ruling and ruled class.⁸⁸ MacKinnon describes maleness as an “omnipotent” and “pervasive” form of power that renders women powerless.⁸⁹ Under her view, gender difference is a function of male domination over women and heterosexual sex is the paradigm of male dominance.⁹⁰ As MacKinnon explains, sexuality is a central dimension along which gender is socially constituted. Male sexuality is defined by “eroticized domination” and “aggressive intrusion on those with less power” while female sexuality is defined by “submission eroticized.”⁹¹ MacKinnon has been criticized for treating gender as the only axis of domination, and feminists have since developed conceptions of structural domination that account for multiple interacting hierarchies. Moving beyond a dual-systems analysis, Iris Marion Young

⁸⁶ Steven Lukes, “Power,” *Contexts* 6:3 (2007): 59-61.

⁸⁷ *Ibid.*

⁸⁸ Marilyn Frye, *The Politics of Reality: Essays in Feminist Theory* (Freedom, CA: The Crossing Press, 1983); Catharine MacKinnon, *Toward a Feminist Theory of the State* (Cambridge, MA: Harvard University Press, 1989). Similarly, Marxist feminists have focused on power’s dominating effects arguing that the combined forces of class and gender domination cause women’s oppression. Zilla Eisenstein, “Developing a Theory of Capitalist Patriarchy,” in Eisenstein (ed.), *Capitalist Patriarchy and the Case for Socialist Feminism* (New York: Monthly Review Press, 1979); Heidi Hartmann, “The Unhappy Marriage of Marxism and Feminism: Toward a More Progressive Union,” in Lydia Sargent (ed.), *Women and Revolution* (Boston: South End Press, 1980).

⁸⁹ *Toward a Feminist Theory of the State* 125, 105

⁹⁰ *Ibid* 128-134

⁹¹ *Ibid* 130, 125

identifies five faces of oppression – exploitation, cultural imperialism, systemic violence, powerlessness, and marginalization - each of which enact relations of power and inequality that in turn constitute oppression.⁹² Though Young’s focus in *Justice and the Politics of Difference* is on justice, her efforts to move beyond the distributive paradigm involve directing our attention to power relations (in place of the distribution of goods) and to an understanding of power as relational and oppression and domination as structural.⁹³ As Young argues, oppression in the United States is not the result of a tyrannical power intending to keep a group down but of “the everyday practices of a well-intentioned liberal society.”⁹⁴

Returning to women’s health, we can see how Lukes’ version of power as domination might emerge. If women are discouraged from challenging authority figures throughout their lives, ignored by their doctors when they ask questions, excluded from legislative discussions of women’s health, and barred from medical school, they could quite feasibly come to accept their powerlessness and accept that doctors, legislators, and pharmaceutical executives recognize and are promoting their best interests. In John Gaventa’s work on three dimensional power in Appalachian mining communities, he finds that violence (real or imagined), social isolation, and economic vulnerability were effective in keeping miners from engaging in conflict with their employers even after community efforts to draw attention to the power dynamics at work and to organize to change them.⁹⁵ These conditions echo several of the faces of oppression identified by Iris Marion Young. We find marginalized women in quite similar positions in my exploration of drug use during pregnancy, SNAP regulations, and domestic work.

⁹² Iris Marion Young, *Justice and the Politics of Difference*.

⁹³ Ibid, 31-32.

⁹⁴ Ibid.

⁹⁵ John Gaventa, *Power and Powerlessness: Quiescence and Rebellion in an Appalachian Valley* (Champaign, IL: University of Illinois Press, 1980).

In 2005 Steven Lukes published an expanded edition of *Power: A Radical View*, in which he significantly updated his thinking on power. Discussing the republication, Lukes explained that it was motivated in part by Foucault's influence on theories of power since the book's initial publication.⁹⁶ Lukes and Foucault share much in common in their understanding of power, including an attention to its ability to shape desires and beliefs in the absence of overt conflict. They also share recognition of power's persuasive effects and an understanding of the role of everyday practices, norms, and socialization in securing compliance. However, according to Lukes, Foucault carries this view of power to "its ultra-radical extreme" concluding that there is no liberation from power.⁹⁷ Lukes takes particular issue with Foucault's assertion that we are "constituted by" power or are the "effect" of power.⁹⁸ According to Lukes, "to follow Foucault down this path, seeing power as existing "everywhere" and as "constituting" its subjects, is to abandon social science and the project of studying power empirically."⁹⁹

Foucault's work has been particularly influential in feminist efforts to conceptualize power. Foucault argued that the liberal view of power is too focused on formal, explicit assertions of power, while power is increasingly exerted through much subtler, more pervasive means. He also criticized radical views of power for conceiving of power as something exerted

⁹⁶ Steven Lukes, and I. Kearns. "In conversation with... Steven Lukes." *Public Policy Research* 13 (2006): 271-5. Peter Morris similarly acknowledged the influence of Foucault in *Power: A Philosophical Analysis*, 2nd edition, (Manchester: Manchester University Press, 1987).

⁹⁷ Lukes and Kearns, "In conversation," 274. Lukes' interpretation of Foucault is somewhat misleading for its emphasis on his early work and "rhetorical extravagances." In fact, Foucault argued that language and the body are indeterminate and contingent, which allows for transgression and creates opportunities to create new understandings. Things such as avant-garde writing can demonstrate, in Johanna Oksala's words "the instability of the order of things we take for granted" and create the potential for resistance, transgression, and transformation. See Johanna Oksala, *Foucault On Freedom* (New York: Cambridge University Press, 2005). Though Foucault does not provide much information about how such transgression occurs, feminists, including Judith Butler, have built extensively on this understanding of freedom within a context of Foucaultian power. Judith Butler, *Gender Trouble* (New York: Routledge, 1990).

⁹⁸ Lukes and Kearns, "In Conversation."

⁹⁹ Lukes, "Power," *Contexts* 6:3 (2007): 61.

by a discrete ruling class on a discrete ruled class and for viewing it as inherently repressive. In place of these views, Foucault proposed an understanding of “disciplinary power,” that saw power exerted through means such as social norms, surveillance, and approbation, and power relations as forming a dense web that crisscrosses society.¹⁰⁰ Thus Foucault recognized the first and second (overt) faces of power while drawing attention to a form of power much like that outlined by Lukes. Notably, unlike Lukes, who focused on power as domination, Foucault viewed power as productive as well. Specifically, Foucault rejected the view of power as primarily repressive or prohibitive, forcing us to do things against our wishes. Instead, he argued that power often functions productively, producing practices, rituals, and subjectivities and in so doing producing “reality” itself.¹⁰¹

In *Discipline and Punish* Foucault argues that a new form of power emerged in the eighteenth century that functioned by acting upon the body. Disciplinary power operates by training the body to produce specific gestures, habits, and skills. The “rules” of disciplinary practices are internalized and often the practices are embraced and even seen as a source of power by those engaging in them. Together, these habits not only shape behaviors, but also construct identities. In this sense power is productive. As Amy Allen explains, disciplinary power “both constrains individuals by subjecting them to regulation, control, and normalization and, at the same time, enables or empowers individuals by positioning them as subjects who are endowed with the capacity to act.”¹⁰² Power works not only by subjugating or repressing, but by forming the grid of intelligibility for our actions and desires and determining the forms that

¹⁰⁰ In the second edition of *Power*, Luke divides Foucault’s work into two phases, arguing that in the latter Foucault employs a less pervasive view of power. The first phase covers Foucault’s early work on discipline and first volumes on sexuality. The second phase covers Foucault’s writings from 1978 to his death in 1984.

¹⁰¹ Foucault, *Discipline and Punish*, 194.

¹⁰² Amy Allen, *The Power of Feminist Theory: Domination, Resistance, Solidarity* (Boulder, CO: Westview Press, 1999), 51.

modern subjectivities take. For Foucault, key sites of such discipline were the military, schools, hospitals, prisons, and factories.

Feminists, incorporating an awareness of gender absent in Foucault's work, have applied his concepts far beyond his initial case studies, to analyze diet and beauty regimens and bodily comportment. According to Sandra Bartky, such disciplines produce "a modality of embodiment that is peculiarly feminine."¹⁰³ Returning to the hospitals of Foucault's original work, a feminist analysis might explore how gynecological visits involve practices and positions unique to women, which render them vulnerable, uninformed and submissive. In fact, self-help activists made similar critiques in support of women-run health centers, challenging the use of uncomfortable and revealing medical gowns in routine care, the position women were forced to take during pelvic exams and the use of a drape to conceal the doctor's activity.¹⁰⁴

The work of Foucault and the feminists who have taken him up is essential to an understanding of how power operates in the realm of health. Particularly useful is Foucault's recognition of the way medical knowledge constitutes a kind of power. Foucault saw power and knowledge as fundamentally connected (in fact he often used the single term power/knowledge). According to Foucault, specific forms of power including medical power require specific forms of knowledge. Medical institutions exert power over individuals not through force or coercion, but through the authority associated with their expert ability to recognize illness, explain medical

¹⁰³ Sandra Lee Bartky. "Foucault, femininity, and the modernization of patriarchal power," in *Feminism and Foucault: Reflections on Resistance*, ed. Irene Diamond and Lee Quinby (Boston: Northeastern University Press, 1988), 27. Foucault's tools for attending to these "micro-physics of power" have been enormously helpful to feminists in efforts to illuminate the subtle, and pervasive mechanisms of power. However feminists have also criticized Foucault's work for its tendency to obscure structural mechanisms of power and structural inequalities, what we might think of as "macro" rather than "micro" structures of domination. Amy Allen, for example, has argued that an adequate feminist theory of power requires micro- and macro-level analysis, which together allow us to recognize that everyday power relations are part of a larger system of domination such as racism, sexism, and classism. Allen, *The Power of Feminist Theory*, 196, 267.

¹⁰⁴ Sandra Morgen. *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990* (New Brunswick, NJ: Rutgers University Press, 2002).

problems, and present solutions. Of course, as Foucault recognized, the existence of disciplinary power does not preclude the presence of juridical power. In the realm of medicine we find ample use of both forms of power.

Turning to a related but distinct literature, scholarship on social control is also essential for understanding power and women's health. Social control, much like Foucault's disciplinary power, discourages deviance – behaviors that violate social rules and norms – and encourages conformity to norms. It can be exerted informally, through socialization, the internalization of norms, self-surveillance, shame, disapproval and even discrimination and exclusion (mirroring the power described by Foucault and Lukes). Alternately, social control can be exerted formally through explicit sanctions enforced by authorities or their representatives (more closely reflecting the kind of power described by Dahl and liberal feminists). Medical social control can be accomplished through informal forms of control outside of medical institutions (shame, socialization), formal activities outside of medical institutions (laws, punishments targeting health), and informal and formal activities within medical institutions (shaming by medical professionals, recommended treatments, diagnosis, reporting to authorities).

In scholarship on social control we find attention to the macro effects of power in addition to its micro-mechanisms, as well as attention to health and medicine as key sites of the exertion of such power. Central to social control is the notion that medical knowledge and ideas of health are socially constructed and culturally and historically dependent. Because medical knowledge closely adheres to existing social and cultural norms, it tends to encourage behaviors that are socially desirable and discourage undesirable behaviors. Eliot Freidson was one of the first scholars to present a social construction theory of illness. In 1970's *Profession of Medicine* he argued that illness and disease are social constructions like deviance, evaluative

classifications based on social ideas about what is *not* “acceptable” or “desirable.”¹⁰⁵ Here we can think about the shift from viewing homosexuality primarily as a sin (sodomy) to viewing it as a mental illness.¹⁰⁶ Similarly, in her work on women and medicalization, Catherine Kohler Riessman argues that “medical practices become a vehicle for eliminating or controlling problematic experiences that are defined as deviant” in order to ensure obedience to social norms.¹⁰⁷ As an example, Riesmann argues that the use of scientific rationales such as “bonding” and “attachment” to justify mothers being near their babies after birth reaffirms the social norms of parenting. Janet Stoppard has argued that the creation of a medical diagnosis for pre menstrual syndrome (PMS) allows any behavior inconsistent with traditional femininity (i.e. passivity, compliance, accommodation) to be attributed to illness.¹⁰⁸ As a result, real feelings or complaints can be written off as temporary hormonal reactions, and the role of external forces in causing women emotional and physical discomfort can be ignored.

Robin Bunton has argued that government health promotion efforts are a vital form of social control in contemporary society. Further, she suggests that they can be subject to manipulation, “allowing governments to lend symbolic rather than actual support to necessary

¹⁰⁵ Elliot Freidson, “Profession of Medicine”; Michel Foucault, *Discipline and Punish: The Birth of the Prison*. Foucault made similar arguments regarding expert knowledge about what was “normal” or “abnormal” for humans, which he argued was not objective science but did constitute a key form of power in modern society.

¹⁰⁶ Jack Drescher, “The Removal of Homosexuality from the DSM: Its Impact on Today’s Marriage Equality Debate,” *Journal of Gay & Lesbian Mental Health* 16 (2012): 124-135.

¹⁰⁷ Catherine Kohler Riessman, “Women and Medicalization: A New Perspective,” in *The Politics of Women’s Bodies: Sexuality, Appearance, and Behavior*, ed. Rose Weitz (New York: Oxford University Press, 1998): 51.

¹⁰⁸ Janet M. Stoppard, “A Suitable Case for Treatment? Premenstrual Syndrome and the Medicalization of Women’s Bodies,” in *Anatomy of Gender: Women’s Struggle for the Body*, ed. Dawn H. Currie and Valerie Raoul (Ottawa: Carleton University Press, 1992), p. 119-129.

environmental change for health” and to exploit “this new and more ambitious rhetoric to justify a range of actions (and non-actions).”¹⁰⁹ As Bunton argues,

The broad, abstract, and on occasions, vacuous statements on health promotion and healthy public policy allow national and local governments to effect a crusading zeal with little actual risk or commitment...Perhaps as worrying as this, however, is the ability of this more confident health promotion to promote not only health but particular types of society.¹¹⁰

Further, policies purportedly aiming to improve health can serve additional or alternative motives. We see an example of this in my analysis of state legislators’ efforts to place new restrictions on the use of SNAP benefits and the links between anti-abortion efforts and efforts to criminalize drug use during pregnancy.

This brings us, finally, to a discussion of the ways in which health is powerful in itself. In 1972 Ivan Illich famously argued that medicine was replacing religion and law as a major institution of social control, becoming “the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts”¹¹¹ Medical sociologists have pointed to increasing secularization as a central factor encouraging the growing authority of medicine, suggesting that medical authority came to replace religion as the dominant moral ideology and social control institution in modern society.¹¹² Feminist scholars in particular, including Barbara Ehrenreich and Deirdre English, have documented the historical

¹⁰⁹ Robin Bunton, "More than a woolly jumper: health promotion as social regulation." *Critical Public Health* 3:2 (1992): 4.

¹¹⁰ Ibid, 4-5.

¹¹¹ Irving Kenneth Zola, "Medicine as an Institution of Social Control," *Sociological Review* 20:4 (1972): 487.

¹¹² Ibid; Bryan S. Turner, *The Body and Society: Explorations in social theory*. (Thousand Oaks, CA: Sage, 2008); Bryan S. Turner, *Medical Power and Social Knowledge*. (Thousand Oaks, CA: Sage, 1995).

transformation of religious justifications for patriarchy into scientific justifications.¹¹³ As discussed in the previous section, in the biomedical era health is perhaps more valued than ever before. Maintaining one's health has become a moral obligation, and healthiness is a deeply desired commodity and mark of self worth.¹¹⁴ Health is, as Jonathan Metzl and Anna Kirkland argue in *Against Health*, "the new morality."¹¹⁵ As a result, arguments based on health have become unprecedentedly powerful, often regardless of their actual relationship to the promotion of health.

Further, the "new paradigm" of health means that "health" includes more events, experiences, and issues than ever before. Thus the power of deploying the label of health can be increasingly widely applied. Medicalization has been central to arguments about medicine and public health as social control. Scholars have argued that in order for issues to be subject to medical social control, they must be recognized by medical professionals as issues of medicine and come under medical authority, or in academic terms be "medicalized."¹¹⁶ In recent years Peter Conrad has argued that medicalization no longer requires that an issue move into the jurisdiction of the medical profession.¹¹⁷ According to Conrad, the medical profession can be

¹¹³ Barbara Ehrenreich and Deirdre English, *Complaints and Disorders: The Sexual Politics of Sickness* (Old Westbury, NY: The Feminist Press, 1972), 6-9, 83.

¹¹⁴ Robert Crawford, "Healthism and the Medicalization of Everyday Life." *International Journal of Health Services* 10(3): 365-388; Richard Klein, "What Is Health and How Do You Get It," in *Against health: How health became the new morality*, ed. Jonathan M. Metzl and Anna Kirkland (New York: New York University Press, 2010).

¹¹⁵ Jonathan M. Metzl and Anna Kirkland, eds., *Against Health: How Health Became the New Morality* (New York: New York University Press, 2010).

¹¹⁶ See note 20.

¹¹⁷ Conrad argues that that medical social control is made up of medical ideology (the imposition of a medical view of the world); collaboration (through which doctors act as the gatekeepers of medical knowledge and technicians); technology (the use of innovations including surgery and genetic screening); medical excusing (including doctors notes for missing school, disability benefits, and the insanity defense) and, drawing on the work of Foucault, surveillance (including the internalization of the "medical gaze") Peter Conrad, "Medicalization and Social Control." *Annual Review of Sociology* 18 (1992): 209-232; Peter Conrad, "Types of Medical Social Control," *Sociology of Health and Illness* 1:1 (1979): 1-11.

marginally involved or even uninvolved in an issue coming to be seen as one of medicine or health. Instead, he argues:

Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to “treat” it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession.¹¹⁸

Conrad argues that medicalization has changed, thanks to the advent of biomedicine (particularly the pharmaceutical industry and genetics), consumer medicine, and managed care. As a result, professional claims makers no longer drive medicalization. In their place, commercial and market interests instigate the spread of the labels of health and medicine.¹¹⁹

In light of the power of health and the rise of biomedicalization, it is even more important to recognize that our understanding of what health looks like and requires is socially constructed. It is also at times vague and contested, and hence moralism, paternalism, racism, and sexism can masquerade as health concerns. As Jonathan Metzl argues, framing an argument as one of health rather than some other concern (i.e. moralism or racism) allows one to be much more cavalier in making assumptions about the group in question, to oversimplify (focusing on health to the detriment of other issues at play), and to position oneself as well-meaning and on the side of decency. For example, Metzl argues that Coca Cola’s framing the marketing of its snack foods to urban minorities as health promotion rather than racism or capitalism allows for “a language of betterment that skillfully glosses over the structural violence done to minority and lower-income Americans, while at the same time suggesting that social and economic misfortune results from

¹¹⁸ Peter Conrad, "Medicalization and social control."

¹¹⁹ Peter Conrad, "The Shifting Engines of Medicalization," *Journal of Health and Social Behavior* 46:1 (2005): 3-14.

poor food choices.”¹²⁰ Together, understanding of health as an uncomplicated, universal good, and the spread of the health, wellness, and medical frames mean that arguments based on health can have immense influence. Current views of health mean that linking actions, policies, or arguments with health can make them more influential, and the contested and ever-expanding boundaries of health mean that one can cite health to support arguments unrelated to, tangentially related to, or related to but not motivated by health.

As Dahl, liberal feminists, radical feminists, and second face of power scholars would all recognize, there is power in the realm of health. There is power exerted by doctors and legislators, often with the aid of institutional authority and intermediary actors. There is also, as Lukes and Foucault would argue, power present in social norms, practices, and pressures surrounding health. There is also power in the idea of health. Arguments framed as or citing health can persuade where other arguments could not, justify actions that other arguments could not, and obscure potential critiques in ways that other arguments could not. This final sense of health’s power -- of power in deploying the concept of health and of health’s consequent political value -- is further evidence that health is not merely a good to be more broadly distributed. Because of the consequences of framing something as an issue of health, arguments about health can be and are deployed for aims unrelated to health, as we will see in the case of food stamp bans. Arguments about health can also be deployed in ways that undermine physical and mental well being, as we will see in the case of drug use during pregnancy. As we now know, the realm of health has been a site of significant social control and problematic disciplinary practices, and the label of health can be manipulated and misused for motives beyond and even counter to health.

¹²⁰ Jonathan M. Metzl, “Introduction: Why Against Health?” in *Against Health: How Health Became the New Morality* eds. Anna Kirkland and Jonathan M. Metzl (New York: NYU Press, 2010) 4.

Applying a Feminist Analysis of Women's Health

The insights of a feminist analysis are all closely related and in many ways overlapping. The dominance of the biomedical view of health lends arguments about health a particularly potent power to control and regulate. The biomedical view also undermines recognition of health as socially constructed and of the structural variables shaping health outcomes. And the knowledge produced by women about their own health, which has been used to counter the repressive tendencies of health and expand women's agency, also highlights health as socially constructed and health outcomes as structural. The disparities in access to health care and in health outcomes that are characteristic of the biomedical era are in great part a result of structural variables shaping health care and health outcomes. Together, the knowledge that health can operate as a form of power and a tool of regulation and the recognition that ideas of health are socially constructed are much more powerful than they might be alone. They tell us that contextually dependent ideas about health and illness both draw from and reinforce existing inequalities.

Together, the insights of this analysis demonstrate the political nature of health. As I have argued, health is shaped by social and political context, which determine how we conceptualize health, how we practice health, and how we evaluate health outcomes for individuals and groups. Recognizing the political nature of health allows us to move beyond a view of medicine as objective truth, and of health as an uncomplicated good that only needs to be more broadly distributed. Under this view we can challenge what health looks like and requires, and we can search for solutions to health problems, including disparities in health outcomes, beyond individual medical treatment. Finally, this view of health highlights the extent to which one's identity shapes one's access to care, experiences of care, and health outcomes. Historically the

political nature of health has meant that women, and particularly marginalized women, have found medicine to be punitive, have had poorer health, and have seen health defined in ways that excluded them or demanded that they conform to a white, male (and later white female) standard.

Finally, I want to add a brief note on the use of medical research. A feminist analysis does not reject medical research on health and illness, but it does challenge its objectivity, resist the dominating tendencies of the biomedical view, and draw attention to structural variables shaping health outcomes (including those identified by medical researchers, as we will see in Chapter 3). As discussed earlier in this chapter, a feminist analysis recognizes that ideas about health and about what causes health problems are the result of conflicts and negotiations between political actors, including between medical experts with competing perspectives. It also recognizes that media outlets and legislators choose which expert knowledge to emphasize (and exaggerate), and which to ignore. Thus it is attentive to situations in which medical knowledge that contradicts problematic portrayals of marginalized women's health issues, or discourages punitive policies aimed at marginalized women, is overlooked by the media and policymakers (as in Chapters 2 and 3). In light of the above criticisms of biomedicalization and medical knowledge as socially constructed, it may seem counterintuitive for my analysis to draw attention to medical findings as a corrective to current policy. However, cases in which medical knowledge is ignored in favor of a moralistic or otherwise amedical view challenge the tendency to view biomedicalization solely through the lens of the privileged, and highlight the extent to which marginalized women are excluded from the benefits of biomedical advances (while also suffering unique harms as a result of biomedicalization).

CHAPTER 2: CRIMINALIZING DRUG USE DURING PREGNANCY

In 2013, Alicia Beltran was arrested in Wisconsin for declining unnecessary medical treatment while pregnant. During a prenatal appointment, Ms. Beltran admitted to having had an addiction to Percocet, an opioid or painkiller, the previous year.¹ She explained to her doctor that she had sought treatment but lacked health insurance, and was unable to pay for anti-addiction drugs. Instead, she borrowed pills from friends and successfully self-administered decreasing doses of the drug. After testing negative for opiates, Ms. Beltran declined her doctor's suggestion to re-administer the anti-addiction drug under supervision. Not convinced of her sobriety, the doctor consulted a social worker who visited Ms. Beltran's home to encourage her to continue anti-addiction medication and threatened her with a court order if she refused. Ms. Beltran again declined and was reported for child endangerment. On July 18, police surrounded her home, handcuffed her and took her to a hospital where she was forced to undergo a medical exam. The examining doctor found no evidence of continued opiate use and later testified that Ms. Beltran did not require inpatient treatment.² When she arrived at her family court hearing in shackles, Ms. Beltran discovered that her fetus had been appointed a legal guardian, though her requests

¹ Erik Eckholm, "Case Explores Rights of Fetus Versus Mother," *The New York Times*, October 23, 2013. <http://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html>.

² Sarah Blaskey and Benjamin Ratliffe, November 14, 2013, comment on Socialist Worker, "The Myth of the 'Cocaine Mom,'" *Socialist Worker*. <http://socialistworker.org/2013/11/14/the-myth-of-the-cocaine-mom>

for a lawyer were repeatedly denied.³ A judge ordered Alicia Beltran to complete a 78-day stay at a drug treatment center under a Wisconsin law known as the “cocaine mom” act.⁴

Alicia Beltran is just one of hundreds of women who have been arrested, prosecuted, incarcerated, or involuntarily committed to treatment under suspicion of drug use during pregnancy. Though medical professionals have come to recognize drug use as a public health problem requiring medical treatment, drug policy in the United States continues to rely predominantly on the tools of the criminal justice system. In recent years drug use among pregnant women in particular has come under scrutiny with poor women and women of color bearing the brunt of efforts to criminalize drug use during pregnancy. Such efforts began in earnest during nationwide panic over children born exposed to crack cocaine, whom the media quickly dubbed “crack babies.”⁵ Though the crack baby myth has been disproven, prosecutions of pregnant drug users have continued unabated and expanded to include children born exposed to opioids or painkillers. The National Advocates for Pregnant Women have conservatively identified 413 cases of women arrested on criminal charges as a result of activity during their pregnancy or forced to undergo medical interventions on behalf of their unborn child between 1973 and 2005.⁶ The majority of these cases (84 percent) involved women who were accused of

³ Daniella Silva, "Shackled and Pregnant: Wis. Case Challenges 'Fetal Protection' Law," *NBC News*, October 24, 2013, http://usnews.nbcnews.com/_news/2013/10/24/21117142-shackled-and-pregnant-wis-case-challenges-fetal-protection-law?lite.

⁴ Eckholm, "Case Explores Rights of Fetus Versus Mother." As a result of her time away, Beltran lost her job as a waitress. After lawyers from the National Advocates for Pregnant Women initiated a suit challenging the “cocaine mom” act, Beltran’s trial was cancelled. Had she been found guilty, she could have been required to undergo additional counseling or social services supervision or had her parental rights terminated upon giving birth.

⁵ See notes 15-17.

⁶ Lynn M Paltrow and Jeanne Flavan, "The Policy and Politics of Reproductive Health: Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health," *Journal of Health Politics, Policy and Law* 38, no. 2 (2013). Though the majority of these prosecutions involve illegal drug use, pregnant women have also been prosecuted for engaging in legal activity during pregnancy, most notably for consuming alcohol or failing to observe recommended medical care.

using illegal drugs while pregnant. There has been a dramatic increase in cases of arrest or forced intervention since 2005.⁷ There are clear racial and class disparities in arrests and forced interventions, with over half of all cases brought against African Americans and the majority of defendants qualifying for indigent defense.⁸

Efforts to criminalize drug use have continued despite medical and public health experts arguing for a reframing of drug use as a problem of public health. Medical experts have long recognized drug addiction as a medical condition that is treatable (but thus far not curable).⁹ The medical profession now identifies addiction as a chronic brain disease with “a strong genetic component.”¹⁰ Advances in molecular science and neurobiology have suggested that genetic factors play a role in determining an individual’s vulnerability to addiction.¹¹ Research has also found that neurobiological factors (specifically the effects of drugs on brain chemistry and circuits) explain much of addictive behavior, including repeated use of drugs, difficulty inhibiting behavior and controlling strong desires, difficulty recognizing potential negative

⁷ Lynn M. Paltrow and Jeanne Flavin, "Pregnant, and No Civil Rights," *The New York Times*, November 8 2014, <http://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html>. The National Advocates for Pregnant Women have identified an additional 380 cases since 2005, though they have not released information about what percentage of those cases are associated with illegal drug use.

⁸ Paltrow and Flavin, "The Policy and Politics of Reproductive Health."

⁹ American Medical Association Committee on Alcoholism, "Hospitalization of Patients with Alcoholism. (Reports of Officers)." *Journal of the American Medical Association* 162 (1956); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders DSM-II* (Washington, DC1952); World Health Organization: Expert committee on mental health, "Report of the First Session of the Alcoholism Subcommittee," in *WHO Technical Report Series* (Geneva1951). The American Medical Association, American Psychiatric Association, and World Health Organization, all recognize addiction as a medical condition and health problem.

¹⁰ Redonna K. Chandler, Bennett W. Fletcher, and Nora D. Volkow, "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," *Journal of the American Medical Association* 301, no. 2 (2009): 183.

¹¹ George R. Uhl and Robert W. Grow, "The Burden of Complex Genetics in Brain Disorders," *Archives of General Psychiatry* 61, no. 3 (2004), 224.

consequences, and difficulty delaying gratification.¹² In light of these findings, medical professionals now argue that biological determinants, and not moral weakness, are to blame for many of the behaviors associated with drug use.

According to national and international experts (including the American Medical Association and World Health organization) drug use is not a “bad habit”, a moral failing, or a personal choice. These experts argue that framing it as such encourages treatments that emphasize punishment.¹³ Further, research suggests that public health approaches are less expensive and more effective than criminalization at reducing the disease, crime, suffering and death associated with drug abuse.¹⁴ Medical experts have also explicitly opposed the criminalization of drug use in pregnant women, warning that punitive drug testing policies deter women from seeking vital prenatal care.¹⁵ Medical research has also roundly discredited the myth of crack babies.¹⁶ Researchers who followed the development of children born exposed to

¹² Peter W Kalivas and Nora D. Volkow, "The Neural Basis of Addiction: A Pathology of Motivation and Choice," *American Journal of Psychiatry* (2014): 1407-1409; Nora Volkow and Ting-Kai Li, "The Neuroscience of Addiction," *Nature neuroscience* 8, no. 11 (2005): 1429-1430; Catharine A Winstanley, "The Orbitofrontal Cortex, Impulsivity, and Addiction," *Annals of the New York Academy of Sciences* 1121, no. 1 (2007).

¹³ Ron Abrahams et al., "Open Letter to Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opioid Use by Pregnant Women," news release, March 11, 2013, <http://advocatesforpregnantwomen.org/Opioid%20Open%20Letter%20-%20March%202013%20-%20FINAL.pdf>.

¹⁴ William S. Cartwright, "Cost–Benefit Analysis of Drug Treatment Services: Review of the Literature," *The Journal of Mental Health Policy and Economics* 3, no. 1 (2000): 21-22; Substance Abuse and Mental Health Services Administration, "National Expenditures for Mental Health Services and Substance Abuse Treatment 1991-2001," (Rockville, MD2008): 24-42.

¹⁵ Maureen A Norton Hawk, "How Social Policies Make Matters Worse: The Case of Maternal Substance Abuse," *Journal of Drug Issues* (1994): 518-519; National Advocates for Pregnant Women, "Medical and Public Health Statements Addressing Prosecution and Punishment of Pregnant Women," <http://perma.cc/EQW5-94U8>. American Medical Association The Board of Trustees, "Legal Interventions During Pregnancy-Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *Journal of the American Medical Association* 264, no. 20 (1990): 2666. American College of Obstetricians, Gynecologists, and Committee on Health Care for Underserved Women, "Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist," *Committee Opinion*, no. 473 (2011): 1-2.

¹⁶ Laura M. Betancourt et al., "Adolescents with and without Gestational Cocaine Exposure: Longitudinal Analysis of Inhibitory Control, Memory and Receptive Language," *Neurotoxicology and Teratology* 33, no. 1 (2011); Deborah A. Frank et al., "Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine

crack cocaine have found that the effects are less severe than those of alcohol exposure and comparable to those of tobacco, both of which are used more frequently by pregnant women than are illegal drugs.¹⁷ Despite all of this, criminalization persists.

In this chapter I approach the problem of drug use during pregnancy using a feminist analysis. This analysis entails several assumptions about how to think about health, as well as identifying several ways of thinking or talking about which feminists should be wary. Central to all of these assumptions is the recognition that women's health is political and contextual.¹⁸ That is, that our ideas and practices of health as well as health outcomes are shaped by the cultural, social, and political context in which they occur, including by systemic disparities in power along lines of gender race, and class. As the case of the criminalization of drug use during pregnancy demonstrates, marginalized women are excluded from health (by policies that actively reject medical views and treatment of their problems, and through a lack of access to treatment facilities), and harmed by health (by policies that cite the health of their infants to justify punishment and by medical professionals who function as part of the system of criminalization).

Exploring the criminalization of drug use during pregnancy illustrates the enormous disparities in how differently positioned women experience the health care system. It also reveals the extent to which marginalized women are excluded from the benefits of the nation's increased concern for, research into, and attention to women's health. Drug use among pregnant women

Exposure: A Systematic Review," *Journal of the American Medical Association* 285, no. 12 (2001). Lily Alvarez et al., "Physicians, Scientists to Media: Stop Using the Term 'Crack Baby'," news release, 2004, <http://perma.cc/95LL-MDSE>. In 2004, 30 leading doctors and researchers in prenatal exposure to drugs signed an open letter dispelling the myth of the "crack baby." As the letter explained, not only had none of them identified "a recognizable condition, syndrome, or disorder that should be termed 'crack baby,'" but that by definition, infants could not be addicted to any substance.

¹⁷ Substance Abuse and Mental Health Services and Administration, "Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings," in *NSDUH Series H-48* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014): 26.

¹⁸ Roberts, "Reconstructing the Patient," 121. As Dorothy Roberts argues, a feminist approach to medicine and health acknowledges "the politics of the relationship between the practice of medicine and the social order."

draws our attention to several considerations that are central to a critical feminist understanding of health, including: 1) that subjective, cultural and political variables shape our understanding of health, 2) the disparate impact of biomedicalization 3) the structural causes of and solutions to health problems, and 4) the ways in which discourse about health can be strategically deployed to regulate and oppress women. The criminalization of drug use by pregnant women demonstrates the centrality of power to our conceptions and practices of health and medicine, and illuminates the ways in which health can harm, as well as help.

The Criminalization of Drug Use During Pregnancy

In 1985, amidst record-level public attention to drug use, *The New England Journal of Medicine* published an article identifying possible birth defects resulting from prenatal exposure to cocaine, and estimating that “a large number of women have used cocaine while pregnant.”¹⁹ The “crack baby” story quickly received national coverage, with journalists reporting that prenatal exposure to crack was more dangerous than exposure to other drugs, including the pure form of cocaine. Exposed children, they suggested, would be irreparably damaged. A 1989 *Washington Post* column by Charles Krauthammer epitomized the hysteria that characterized the national conversation about drugs, and crack babies in particular. Krauthammer described the children of crack users as “a bio underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth.”²⁰ They would lead lives, he explained “of certain suffering, of probable deviance, of permanent inferiority... And all this is biologically determined from birth.”²¹ Krauthammer was far from alone. Media coverage of the crack baby

¹⁹ Ira Chasnoff et al., "Cocaine Use in Pregnancy," *New England Journal of Medicine* 313 (1985), 668.

²⁰ Charles Krauthammer, "Children of Cocaine," *The Washington Post*, July 30 1989; *ibid.*

²¹ *Ibid.*

scare emphasized the biological “inferiority” of crack babies and the threat and cost they posed to society.²² Media narratives also villainized mothers, suggesting they had no concern for their children, since crack made a mother “indifferent to her child or abusive when its cries irritate her.”²³

In response to the perceived crack baby epidemic, prosecutors across the country began charging women whose newborns tested positive for drugs with child abuse, neglect, and even manslaughter.²⁴ In the following years, states began to consider laws specifically targeting women who used drugs while pregnant. In 1998, almost a decade after the height of the war on cocaine and well after the existence of “crack babies” had been disproven, Wisconsin, South Dakota, and South Carolina all enacted laws allowing pregnant women to be imprisoned for

²² In the December following Krauthammer’s article, The Washington Post published an article featuring a black woman, pregnant and addicted to crack, with a headline declaring “For Pregnant Addict, Crack Comes First.” Duke Lynne, “For Pregnant Addicts, Crack Comes First,” *The Washington Post*, December 18 1989. Other outlets focused on the cost to the state or the victimhood of exposed infants. The New York Times discussed “Cracks Smallest, Costliest Victims” and the Atlanta Journal cautioned, “Crack Babies Cost Us a Lot More Than \$504 Million.” “Crack’s Smallest, Costliest Victims,” *The New York Times*, August 7 1989. Jeff Dickerson, “Crack Babies Cost Us a Lot More Than \$504 Million,” *The Atlanta Journal*, September 20 1991.

²³ C. Estes et al., “Crack Babies,” *Economist*, April 1 1989.

²⁴ Lynn Paltrow, “Winning Strategies: Defending the Rights of Pregnant Addicts,” *Champion* (1993): 19; Roberts, “Punishing Drug Addicts Who Have Babies”; Jacqueline Berrien, “Pregnancy and Drug Use: The Dangerous and Unequal Use of Punitive Measures,” *Yale Journal of Law & Feminism* 2, no. 2 (1990): 240-243. In 1987, for the first time in U.S. history, a woman was charged with criminal liability for actions during pregnancy that allegedly contributed to her infant’s death. A California judge dismissed the charges declaring that the law under which the woman had been charged did not apply to pregnant women, but noting that if a more narrowly tailored law passed he would uphold it.

endangering their fetus by using drugs or alcohol.²⁵ In the same year, similar legislation was introduced in ten other states.²⁶

The crack baby epidemic has been succeeded by similar fears about other drugs, including methamphetamines and prescription opiates.²⁷ By 2005, news outlets had begun referring to children born to mothers addicted to methamphetamines as “ice babies” and “meth babies,” despite medical professionals openly criticizing the terms.²⁸ More recently, there has been widespread concern about children born to mothers addicted to illegal narcotics or prescription opioids, who can suffer from symptoms of withdrawal at birth.²⁹ This condition is known as Neonatal Abstinence Syndrome (NAS). Echoing the moniker of “crack babies,” Fox News began calling children born exposed to opioids “Oxytots.”³⁰

Despite the debunking of a “crack baby” syndrome and mounting medical critiques of criminalization, legislators and prosecutors have actually increased efforts to penalize pregnant

²⁵ Cynthia Dailard and Elizabeth Nash, "State Responses to Substance Abuse among Pregnant Women," *The Guttmacher Report on Public Policy* 3, no. 6 (2000). <https://www.guttmacher.org/pubs/tgr/03/6/gr030603.html>; Loretta P Finnegan and Stephen R Kandall, *Women, Children, and Addiction* (Routledge, 2014), 123. In 1999 Regina McKnight became the first woman convicted under the South Carolina law. McKnight was found guilty of homicide by child abuse for suffering an unintentional stillbirth after using cocaine during her pregnancy. Her conviction was overturned by the South Carolina Supreme Court in 2008 and she was released after serving almost eight years of a twelve year sentence.

²⁶ *Women, Children, and Addiction*, 123-124.

²⁷ Erich Goode and Nachman Ben-Yehuda, *Moral Panics: The Social Construction of Deviance* (John Wiley & Sons, 2010): 207-213. During the height of meth coverage, the media compared meth to crack cocaine, suggesting (as they had with crack cocaine) that it was unprecedentedly popular and addicting.

²⁸ Alvarez et al., "Physicians, Scientists to Media: Stop Using the Term 'Crack Baby'." Doctors and researchers wrote a public letter to numerous news outlets discouraging use of the term which they argued lacked scientific validity.

²⁹ A much-covered 2012 report in the *Journal of the American Medical Association* found that the rates at which newborns in the United States were diagnosed with neonatal abstinence syndrome (NAS) had almost tripled between 2000 and 2009. Stephen W Patrick et al., "Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000-2009," *Journal of the American Medical Association* 307, no. 18 (2012): 1937.

³⁰ Fox News, *'Oxytots' Victims of Prescription Drug Abuse* (2011). <http://video.foxnews.com/v/1247046209001/oxytots-victims-of-prescription-drug-abuse/>.

drug users since the 1980s.³¹ The National Advocates for Pregnant women have identified almost as many arrests and interventions between 2005 and 2014 as occurred in the preceding three decades.³² Existing laws have been drawn on (and in some cases been reinterpreted) to allow for the prosecution of pregnant drug users. This was the case in 2003 and 2004, when a Texas District Attorney attempted to extend new child abuse legislation to the unborn in order to require doctors to report signs that pregnant patients were using drugs.³³ Similarly in 2005, a fetal protection law directed at violence against pregnant women was used to prosecute pregnant drug users in Northern Texas. According to reporting by Kathy Lohr of NPR's Morning Edition, Texas Right to Life "worked for years to get the law passed."³⁴ In 2006, Alabama passed a chemical endangerment law aimed at deterring adults from bringing children to places where controlled substances are made or distributed. The law, which aimed to protect children from the state's growing methamphetamine laboratories, was quickly used to prosecute women whose infants tested positive for drugs. By 2014, one hundred women had been prosecuted under the law.³⁵ In 2014, the state's supreme court upheld the prosecutions, holding that the term "child" in

³¹ Linda C Fentiman, "In the Name of Fetal Protection: Why American Prosecutors Pursue Pregnant Drug Users (and Other Countries Don't)," *Colum. J. Gender & L.* 18 (2008): 10-16; Paltrow and Flavan, "The Policy and Politics of Reproductive Health."

³² "The Policy and Politics of Reproductive Health." Guttmacher Institute, "Substance Abuse During Pregnancy," in *State Policies in Brief* (2015); Thomson-DeVeaux, "The New Moral Panic over Drug-Dependent Babies," *The American Prospect* 2014. There have been 380 arrests and forced interventions since 2005 compared to 413 between 1973 and 2005. At least five states now require hospitals to report NAS diagnoses to the Department of Health, fifteen require reporting suspected prenatal drug use, and four require drug testing if prenatal use is suspected. Drug use during pregnancy remains grounds for civil commitment in Minnesota, South Dakota, and Wisconsin. Today eighteen states consider drug use during pregnancy to be child abuse under civil child-welfare laws, and it is increasingly common for states to allow custody of children to be revoked based on a single positive drug test.

³³ Tanya Albert, "Texas Fetus Abuse Law Could Spell Legal Trouble for Doctors," *American Medical News*, February 2 2004. <http://www.amednews.com/article/20040202/government/302029979/6/>.

³⁴ "Texas Makes Landmark Use of Fetal Protection Law." Narrated by Kathy Lohr. Morning Edition. *NPR*, July 9, 2005. <http://www.npr.org/templates/story/story.php?storyId=4695866>.

³⁵ Ada Calhoun, "The Criminalization of Bad Mothers," *The New York Times*, April 25 2012. <http://www.nytimes.com/2012/04/29/magazine/the-criminalization-of-bad-mothers.html>.

the chemical endangerment law included fertilized eggs, embryos, and fetuses, and offering no exemption for women using drugs as prescribed by a physician.³⁶

In addition to the application of existing laws, new laws are emerging specifically targeting drug use during pregnancy. In 2000, Oklahoma joined South Dakota and Wisconsin as the third state with a fetal abuse law targeting pregnant women.³⁷ In 2014 Tennessee prosecutors, frustrated by their inability to crack down on drug use during pregnancy, proposed a first-of-its-kind law defining drug use during pregnancy as assault.³⁸ It passed despite vocal opposition from medical groups who argued that the law would deter pregnant women from seeking necessary prenatal care and addiction treatment.³⁹ The law replaced a 2013 law known as the Safe Harbor Act, which focused on increasing access to treatment and shielding pregnant drug users from a loss of parental rights. The Safe Harbor Act was particularly relevant to pregnant drug users in Tennessee, who face significant barriers to treatment. Tennessee is home to 177 addiction treatment facilities, just two of which provide prenatal care on site and allow older children to stay with their mothers, and only nineteen of which provide addiction care for pregnant

³⁶ *Ex Parte Hope Elisabeth Ankrom v. State of Alabama*, WL 135748 (Ala.) (S.C. AL 2013).

³⁷ The “Oklahoma Prenatal Addiction and Treatment Act” made it a misdemeanor for pregnant drug users to fail to obtain substance-abuse treatment. The bill also created a task force to study substance abuse and treatment during pregnancy.. *Oklahoma Prenatal Addiction Act*, 63 OK Stat § 63-1-546.1

³⁸ Tennessee has one of the highest rates of NAS in the nation. From 2000 to 2009, the incidence rate of NAS in Tennessee increased from 0.7 to 5.1 per 1,000 births, surpassing the national average, which increased from 1.2 to 3.4 per 1,000 births. Patrick et al., "Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000-2009."

³⁹ While a representative of the Tennessee Medical Association expressed some support for the law saying “right or wrong, at least we are doing something” he also expressed concern that the law might have “unintended consequences” including discouraging women from seeking prenatal care. Douglas Springer, "Drug-Addicted Mothers Need Access to Treatment," *The Chattanooga*, May 8 2014. Leading medical organizations oppose criminalization and medical and public health experts have called for the law to be repealed. National Advocates for Pregnant Women, "Open Letter to the Tennessee Medical Association," news release, 2014, <http://advocatesforpregnantwomen.org/Open%20Letter%20to%20the%20TMA%20-%202014.pdf>.

women.⁴⁰ It is particularly difficult for poor women to receive treatment in Tennessee, which has one of the nation's most restrictive Medicaid programs and fewer than fifty beds available that accept Medicaid.⁴¹ Though the new Tennessee law allows women to use participation in a drug treatment program as an affirmative defense, it does nothing to make treatment more accessible for pregnant women, while simultaneously making encounters with medical professionals more threatening.⁴²

Proponents of Tennessee's criminalization law have regularly misrepresented medical knowledge about addiction and neonatal abstinence syndrome. The bill's sponsor, Representative Terri Weaver, criticized opponents, saying "to allow women to not have any accountability and *to continue to choose* – we all make choices in our life, some are good and some are bad."⁴³ Speaking to his fellow legislators, Tennessee Representative Tony Shipley explained (incorrectly) that "[t]he doctors say that the best place to detox a baby is in utero."⁴⁴ A drug court judge in Shelby County Tennessee requires participation in an abstinence-only twelve-step program despite the fact that the use of anti-addiction medication is the standard of care for

⁴⁰ RH Reality Check, "Veto the Pregnancy Criminalization Law, Sb1391," <http://action.rhrealitycheck.org/page/s/gov-haslam-veto-pregnancy-criminalization-sb-1391>.

⁴¹ Rosa Goldensohn and Rachael Levy, "The State Where Giving Birth Can Be Criminal," *The Nation* 2014. <http://www.thenation.com/article/state-where-giving-birth-can-be-criminal/>.

⁴² An affirmative defense allows a defendant to present a defense that defeats a claim even if the facts supporting the claim are true. In the case of the Tennessee law, women who give birth to children who test positive for or are harmed by narcotic drugs can avoid punishment if they have been enrolled in a long term treatment program since before the child's birth and successfully completed the program.

⁴³ *Tennessee House Floor Debate on Sb1391/Hb1295*, 108th, April 9 2014.

⁴⁴ *Ibid.*

opioid-addicted pregnant women.⁴⁵ In his own words, the aforementioned Shelby County Drug Court Judge is “trying to keep women from having crack babies.”⁴⁶

Applying a Feminist Analysis

1. Raced Motherhood and Conceptions of Health

The ways the public, media, and legislators respond to health problems, and the kinds of solutions they propose, are the result of a host of social, cultural, and political considerations. In the case of drug use during pregnancy, these considerations include cultural beliefs about motherhood and femininity, the social position of poor women and women of color, as well as the long-standing stigmatization of drug users. As we will see, it is possible (and for some appealing) to treat the predominantly poor women of color who use drugs during pregnancy harshly – and in ways that contradict the recommendations of health experts - because they are already deeply stigmatized.

In part, drug use during pregnancy is treated particularly harshly because it represents the violation of multiple social norms. As one obstetrician specializing in drug use during pregnancy theorized, the issue receives far more attention than equally dangerous and preventable conditions because "this is an easy group to pick on because addiction has such a stigma."⁴⁷ In her ethnography of female crack users in Atlanta, Claire Sterk noted that women experienced more severe social disapproval than male drug users because drug use is seen as inherently

⁴⁵ Lori Whitten, “A multisite clinical trial lays groundwork for improving care for mothers and babies affected by opioid dependence,” *National Institute on Drug Abuse Notes*, July 6, 2012. <http://www.drugabuse.gov/news-events/nida-notes/2012/07/buprenorphine-during-pregnancy-reduces-neonate-distress>; Richard A. Rettig and Adam Yarmolinsky, "Federal Regulation of Methadone Treatment," (Washington, D.C.: National Academy Press, 1995). Withdrawal can cause uterine contractions, early labor, and miscarriage. With regard to safety of methadone during pregnancy, the National Institute of Medicine has reported that “[t]here is no reported evidence of any toxic effects of methadone in the woman, fetus or child, although such evidence has been sought.”

⁴⁶ Goldensohn and Levy, "The State Where Giving Birth Can Be Criminal."

⁴⁷ “Tennessee Bill Could Send Addicted Moms To Jail.” Narrated by Blake Farmer. Shots. *NPR*, April 21, 2014. <http://www.npr.org/blogs/health/2014/04/17/304173789/tennessee-bill-could-send-addicted-moms-to-jail>.

masculine.⁴⁸ In addition, the use of drugs during pregnancy violates deeply held beliefs about motherhood. The expectation for pregnant women to minimize risks to their fetus is so strong that even those who engage in safe, legal activities such as drinking a single glass of wine face social stigma and openly expressed reproach.⁴⁹ In fact, women who use drugs are far more likely to encounter condemnation than those who use tobacco or alcohol, two substances whose harms are far better documented than those of drugs.⁵⁰ The combined effects of the stigmatization of drug use and of women who engage in activities that pose a potential harm to their fetuses are severe. The intensity of this stigmatization is evident in media coverage referring to infants with NAS as “innocent victims” and in Tennessee bill sponsor Terri Weaver’s repeated reference to pregnant drug users as “the worst of the worst.”⁵¹

Medical experts have criticized the tendency to blame and vilify mothers without recognizing the nature of addiction. Pregnant drug users are regularly blamed for their poor “choices,” or portrayed as perpetrators or victimizers who actively choose to harm their children.⁵² These characterizations are implicit in coverage that frames newborns with NAS as

⁴⁸ Claire Sterk, *Fast Lives: Women Who Use Crack Cocaine* (Temple University Press, 2011), 3-4.

⁴⁹ Elizabeth Armstrong’s work offers a comprehensive account of the social stigma associated with pregnancy. Elizabeth M Armstrong, *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome & the Diagnosis of Moral Disorder* (JHU Press, 2003). In a contemporary example the etiquette expert for The New York Times received a question from a reader who had publicly admonished a stranger for ordering a glass of wine while pregnant. Steven Petrow, "Is It Okay to Tell a Pregnant Woman to Stop Drinking Alcohol?," <http://www.everydayhealth.com/columns/steven-petrow-medical-manners/is-it-okay-to-tell-a-pregnant-woman-to-stop-drinking-alcohol/>. CBS News coverage of a study reporting that one in thirteen pregnant women drink alcohol featured a stock image of a pregnant woman, her stomach emblazoned with the hazard symbol for poison, a skull and crossbones. Ryan Jaslow, "1 in 13 Pregnant Women Drink Alcohol, Cdc Says," *CBS News*, July 19 2012.

⁵⁰ Kristen W Springer, "The Race and Class Privilege of Motherhood: The New York Times Presentations of Pregnant Drug-Using Women." *Sociological Forum* 25, no. 3 (2010): 495.

⁵¹ *Tennessee House Floor Debate on Sb1391/Hb1295*; Arian Campo-Flores, "Pain Pill's Littlest Victims," *The Wall Street Journal*, December 28 2012; Catherine Oilan, "Prescription Drug Addiction among Pregnant Women Becoming 'Monstrous Tidal Wave'," in *Rock Center with Brian Williams* (NBC 2012).

⁵² M. McNeil and J. Litt, "More Medicalizing of Mothers: Foetal Alcohol Syndrome in the USA and Related Developments," in *Private Risks and Public Dangers*, ed. S. Scott, et al. (Ashgate, VT: Ashgate, 1992).

“victims.”⁵³ Representative Weaver has expressed similar sentiments, arguing that “these defenseless children deserve some protection.”⁵⁴ Experts have called for more objective reporting, insisting that infants can experience the symptoms of withdrawal but cannot exhibit addiction, which is characterized by compulsive behavior despite adverse consequences.⁵⁵ These same experts have urged the media to acknowledge that neonatal abstinence syndrome is treatable. Despite this, the media regularly refer to newborns with NAS as drug-addicted and facing long-term harm, and suggest that NAS is difficult or impossible to treat.⁵⁶ The consequences of NAS are also frequently exaggerated, as when Representative Weaver explained that “[t]hese babies are born addicted and their lives are totally destroyed.”⁵⁷ According to Weaver, newborns with NAS are “twisted” and will “never be the same.”⁵⁸

The discourse surrounding drug use during pregnancy is profoundly tied up with assumptions about race and class, so much so that we cannot understand the public or legislative response without acknowledging the ways in which the identities, values, and images associated with pregnant drug users shape the discourse and policy surrounding pregnant drug use. In her analysis of media coverage of crack mothers, Marian Meyers finds that in media narratives these

⁵³ Arian Campo-Flores, “Pain Pills’ Littlest Victims,” *Wall Street Journal*, Dec. 28, 2012, <http://www.wsj.com/articles/SB10001424127887324731304578193642361543484>; Laura Ungar, “Kentucky Sees Surge in Addicted Infants,” *USA Today*, Aug. 27, 2012, <http://www.wsj.com/articles/SB10001424127887324731304578193642361543484>

⁵⁴ *Tennessee House Floor Debate on Sb1391/Hb1295*.

⁵⁵ Alvarez et al., “Physicians, Scientists to Media: Stop Using the Term ‘Crack Baby’.”

⁵⁶ Stephen Davis and Meghan Dwyer, “The Tiniest Addicts: More Babies Born Dependent on Drugs,” *Fox6 Milwaukee*, November 27, 2013, <http://fox6now.com/2013/11/27/the-tiniest-addicts-more-babies-born-addicted-to-drugs/>; Mark Lallanilla, “Epidemic of Painkiller Addiction Strikes Newborns,” <http://perma.cc/46ZH-XR6P>; Liz Szabo, “Number of Painkiller-Addicted Newborns Triples in 10 Years,” *USA Today*, May 1 2012, <http://usatoday30.usatoday.com/news/health/story/2012-04-29/durg-addicted-painkiller-babies/54646654/1>.

⁵⁷ “TN Bill Would Charge Moms Whose Babies Are Born Addicted,” *WSMV Nashville*, February 26 2014, <http://perma.cc/9MH7-TUB6>.

⁵⁸ Marika Seigel, “Tennessee Criminalizes Drug-Related Pregnancy Complications,” *Al Jazeera America*, April 30 2014, <http://america.aljazeera.com/opinions/2014/4/tennessee-prenatalcarematernaldrugusebillhaslam.html>.

mothers – who were predominantly black – were portrayed as having “no intrinsic value.”⁵⁹ As an example, she quotes a proponent of the “tough-love” criminalization approach who says it is “designed to force women into treatment, for the sake of their children.”⁶⁰ Returning to the debate over Tennessee’s criminalization law, we find that Representative Weaver advocated for the policy by citing “ladies that are in Memphis Tennessee who are having eight and nine babies addicted to coke and heroin.”⁶¹ Though Weaver did not specifically mention race, her reference to Memphis – the only majority-black city in a predominantly white state – and to over-fertile inner-city women, left the comments deeply raced.⁶² Another scholar’s analysis of news coverage found that women who used drugs while pregnant were frequently described as such bad mothers that “it would be best for the children and society if the women were sterilized or shot.”⁶³

These arguments are tied to the association of pregnant drug use with poor women of color, whose role as mothers has been devalued since slavery.⁶⁴ The disproportionate punishment of black women of color for drug use during pregnancy and the tendency to place the blame for poor infant health on black women share roots with forced sterilization and welfare reform, as

⁵⁹ Marian Meyers, "Crack Mothers in the News: A Narrative of Paternalistic Racism," *Journal of Communication Inquiry* 28, no. 3 (2004): 210.

⁶⁰ *Ibid.*, 207.

⁶¹ *Tennessee House Floor Debate on Sb1391/Hb1295*.

⁶² U.S. Census Bureau, "State and County Quickfacts: Memphis, TN," (2015), <http://quickfacts.census.gov/qfd/states/47/4748000.html>.

⁶³ Springer, "The Race and Class Privilege of Motherhood: The New York Times Presentations of Pregnant Drug-Using Women," 495.

⁶⁴ Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (New York: Routledge, 1999): 78-81; Beth E. Richie, "The Social Construction of the "Immoral" Black Mother," in *Revisioning Women, Health and Healing: Feminist, Cultural, and Technoscience Perspectives*, ed. Adele E Clarke and Virginia L Olesen (New York: Routledge, 1999); Dorothy Roberts, "Unshackling Black Motherhood," *Michigan Law Review* 95, no. 4 (1997): 949-951; Dorothy Roberts, "Racism and Patriarchy in the Meaning of Motherhood," *American University Journal of Gender & The Law* 1, no. 1 (1993): 7-33.

evidenced by the work of Ange-Marie Hancock and Dorothy Roberts.⁶⁵ In fact, Weaver's comments echo those of critics of welfare who described urban (implicitly) black "welfare queens" as overly fertile – a discourse that similarly placed the blame for social problems on the personal choices of poor women of color.⁶⁶ All of these efforts have drawn on the notion that black women are unfit mothers in order to justify policies that disproportionately discourage or punish reproduction among black women. This devaluation has been closely linked with the scapegoating of black mothers, whose incompetent mothering is blamed for the problems facing black families.⁶⁷ In fact, Kristen Springer's analysis of the *New York Times* coverage of drug use during pregnancy has found that women of color are twice as likely as white women to be blamed for social problems associated with drug use, including crime, health care costs, and adoption burdens, than are white women.⁶⁸ Poor women are also significantly more likely than women of higher socioeconomic status to be blamed for social problems resulting from substance use.⁶⁹

The case of drug use during pregnancy demonstrates the extent to which subjective variables (including biases against drug users and raced and gendered ideas about motherhood) shape our ideas of what counts as health, where the blame lies for health problems, and the kinds

⁶⁵ Ange-Marie Hancock, *The Politics of Disgust: The Public Identity of the Welfare Queen* (New York: New York University Press, 2004); Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Pantheon Books, 1997).

⁶⁶ Hancock, *The Politics of Disgust*, 23-64. *Tennessee House Floor Debate on Sb1391/Hb1295*. The implication of these comments were not lost on representative Gilmore, a black woman from Memphis who called Weaver's emphasis on pregnant drug users in urban areas "very offensive." And in fact the first two women charged under Tennessee's law were black women from Memphis. <http://www.myfoxmemphis.com/story/27913673/mom-arrested-drug-addicted-baby-case>

⁶⁷ Roberts, "Unshackling Black Motherhood."; Roberts, "Punishing Drug Addicts Who Have Babies."

⁶⁸ Kristen W. Springer, "The Race and Class Privilege of Motherhood: The New York Times Presentation of Pregnant Drug-Using Women," *Sociological Forum* 25, no. 3 (2010): 488-489.

⁶⁹ Ibid.

of solutions required for them. The stigmatization of drug use, the devaluation of poor women and women of color, and the cultural abhorrence for women who are perceived to be harming their children make punishment of pregnant drug users a viable option despite the calls of medical and public health professionals for alternative solutions.

2. Women, Children and Selective Biomedicalization

Scholars of medicine often refer to the dominant understanding of health – as primarily biological and best addressed by biomedical products and treatments – as a “biomedical” view. The biomedical view is problematic because in emphasizing biological causes of illness, it can obscure structural causes of ill health. Historically, white feminists have criticized biomedicalization for its tendency to expand the reach of medical authority into new areas of women’s lives. The effects of the biomedical view on pregnant drug users are more complex. Proponents of criminalization reject the medical profession’s recognition of drug use as a health problem, rendering both structural and biological explanations irrelevant and discouraging medicalization. Instead drug use is seen as a personal or moral failure, a poor choice rather than a health problem. Though it is not biomedical, this individualizing or moralizing view leaves structural causes similarly (and troublingly) ignored. At the same time, the lack of medical recognition leaves little room for the destigmatization of drug use during pregnancy, let alone efforts to expand access to treatment, both frequently cited benefits of a biomedical view.⁷⁰

As we have seen, the absence of a biomedical view of drug use during pregnancy does not mean less medical or state intervention in women’s lives. Though the use of drugs itself is not biomedicalized, the effects of drug exposure on the fetus and infant are. Biomedicalization

⁷⁰ Tasha N. Dubriwny, "Television News Coverage of Postpartum Disorders and the Politics of Medicalization," *Feminist Media Studies* 10, no. 3 (2010): 288; Taylor, *Rock-a-by-Baby: Feminism, Self-Help and Postpartum Depression*, 72-88.

plays a significant role in how drug use during pregnancy is addressed because it is central to the understanding of the effects of that drug use on infants. And as is often the case when an issue is biomedicalized, discourse surrounding prenatal drug exposure regularly obscures structural causes of poor infant health in favor of an individual, biological cause (drug exposure).⁷¹ Thus the health problems of drug-exposed infants are linked directly to drug exposure with no recognition of alternative causes, and in the absence of a biomedical or structural view of drug use, individual women are found personally to blame for that drug exposure. Together, the rejection of biomedical views of drug addiction and adoption of biomedical views of poor fetal health work to focus the blame for poor infant health on individual women.

The moral view of drug use employed by criminalization proponents rejects considering it as an issue of health and medicine while also obscuring the influence of external forces. Though responses to drug use during pregnancy are not impaired by an overemphasis on biological causes, they are impaired by an overemphasis on the biological causes of the health problems of infants. Though medical experts increasingly recognize the role of poverty, insufficient nutrition, and other contextual variables in shaping newborn health, legislators and the media largely disregard these variables, drawing direct connections between drug use and a host of infant health problems. Despite what policy and public discourse might suggest, structural variables play an important role in shaping both drug use during pregnancy and health problems among children of poor mothers.

As is often the case with marginalized women, the harms experienced by pregnant drug users are not generally those resulting from expanding medical authority, but those associated with the absence of medical recognition and barriers to medical care. The treatment of pregnant

⁷¹ Prenatal drug exposure may not be viewed purely in biomedical terms insofar as the condition originates outside of the individual. Though it does reflect the biomedical view insofar as contextual variables are not considered and solutions are aimed at treating individual bodies.

drug users fits the pattern described as stratified biomedicalization, the notion that the U.S. medical system is stratified along lines of race, gender, and class, resulting in drastically different experiences, benefits, and burdens depending on one's identity. Medicalization applied to the privileged is often co-optative, expanding medical authority and surveillance, and encouraging the constant monitoring of one's health and consumption of medical products and treatments. This form of medicalization also comes with benefits: it can result in the destigmatization of experiences as they come to be understood as blameless biological processes or diseases. Medical recognition and destigmatization can mean increased popular attention and funding for research and new forms of treatment.⁷² Adele Olesen and Virginia Clarke characterize medicalization applied to the marginalized as exclusionary/disciplining, which consists of barriers to access to medicine and the use of medical authority and treatments in ways that are punitive or disciplinary.⁷³ We can find stratified medicalization when, as is often the case in the case studies cited here, problems associated with marginalized women are ignored or not recognized as issues of health. Stratified medicalization is also present when, as has been the case with reproductive technologies, women have drastically different experiences with health care based on their identity and social position.⁷⁴

We can view the criminalization of drug use during pregnancy as an example of the stratified nature of medicine in both of these senses. First, as an issue associated with marginalized women, criminalization clearly fits the model of exclusionary/disciplining biomedicalization. There are significant barriers to treatment, enormous stigmatization, and

⁷² See Chapter 5.

⁷³ Clarke et al., "Biomedicalization," 170.

⁷⁴ For example, scholars have problematized the simultaneous expansion of new reproductive technologies that encourage privileged white women to reproduce at any cost, and social programs that discourage reproduction among poor women and women of color. See: Roberts, *Killing the Black Body*.

increasingly formalized procedures of punishment for women who use drugs while pregnant. In addition, even on the issue of drug use during pregnancy, experiences are stratified according to identity. Poor women and women of color are disproportionately punished for drug use during pregnancy. White middle- and upper-income women with private insurance and a regular care provider are more likely to avoid legal punishment.

A study by NAPW of the arrests and prosecutions of pregnant women from 1973 to 2005 found that black women were significantly more likely to be arrested, reported to state authorities by hospital staff, and subjected to felony charges.⁷⁵ Part of what influences this bias is the fact that there is no consistent policy regarding drug testing of pregnant women, which means testing and reporting are left up to the discretion of hospital personnel. In its nationwide survey of treatment methods for prenatal drug exposure, the Department of Health and Human Services reported that hospital policies for testing newborns “vary widely,” with “most conducting testing that is based on somewhat subjective criteria.”⁷⁶ Often the triggers for testing are complications with birth, low infant birth weight, or premature delivery, complications for which women of color, particularly black women, are already at higher risk. In addition, the implementation of drug tests vary by hospital, with more public hospitals with indigent minority clients engaging in testing than facilities with predominantly white, affluent clients.⁷⁷ Finally, research has shown that providers who are not familiar with their patients are more likely to rely on stereotypes and personal beliefs that do not accurately characterize their patients and which may negatively

⁷⁵ Paltrow and Flavan, "The Policy and Politics of Reproductive Health," 333.

⁷⁶ N.K. Young et al., "Substance-Exposed Infants: State Responses to the Problem," (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009): 4.

⁷⁷ Edith S Lisansky Gomberg, "Gender Issues," in *Recent Developments in Alcoholism* (Springer, 1993); Goldensohn and Levy, "The State Where Giving Birth Can Be Criminal."

impact their care.⁷⁸ This finding suggests that women without access to insurance or regular care, and whose identities are associated with negative stereotypes are at greater risk of having their identity negatively impact their care.⁷⁹ As a result, black women in particular face higher levels of scrutiny than white women—leading to more prosecutions under these types of laws.

In one prominent example, a South Carolina hospital initiated a policy of nonconsensual drug testing of pregnant women. The hospital chose to test for cocaine only (a drug much more prevalent among black than white women), and to allow tests to be conducted at providers' discretion when women exhibited certain characteristics, including inadequate prenatal care, or having a history of drug or alcohol abuse. Hospital employees reported positive tests to the Police Department and county prosecutor, resulting in the arrests and prosecutions of thirty women.⁸⁰ The policy was so aggressive that some women were arrested within hours of delivery and still bleeding when they arrived at the jail.⁸¹ The subjective standards for testing, the exclusive focus on cocaine, and the hospital's predominantly indigent minority clientele ensured that the policy would disproportionately affect black women. Though black women made up just

⁷⁸ Alexander R. Green et al. "Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients," *Journal of general internal medicine* 22, no. 9 (2007): 1231-1238; James Miner et al., "Patient and Physician Perceptions as Risk Factors for Oligoanalgesia: A Prospective Observational Study of the Relief of Pain in the Emergency Department," *Academic Emergency Medicine* 13, no. 2 (2006): 144-145; Alan R. Nelson, Brian D. Smedley, and Adrienne Y. Stith, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*. (Washington, D.C.: National Academies Press, 2002).

⁷⁹ There is an extensive body of scholarship documenting the association of good motherhood with white women and the association of people of color with negative stereotypes including criminality and uncooperativeness, particularly with medical professionals. Such work can be found in critical race scholarship, criminology, political science, sociology, communication studies, and feminist scholarship. See for example Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (New York: Routledge, 2000); Jennifer L Eberhardt et al., "Seeing Black: Race, Crime, and Visual Processing," *Journal of personality and social psychology* 87, no. 6 (2004); Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare* (Free Press New York, 1994); Roberts, "Racism and Patriarchy in the Meaning of Motherhood."; Samuel R Sommers and Phoebe C Ellsworth, "Race in the Courtroom: Perceptions of Guilt and Dispositional Attributions," *Personality and Social Psychology Bulletin* 26, no. 11 (2000).

⁸⁰ Kimani Paul-Emile, "The Charleston Policy: Substance or Abuse," *Michigan Journal of Race & Law*. 4 (1989): 349-353; Roberts, "Unshackling Black Motherhood."

⁸¹ "Unshackling Black Motherhood," 943.

thirty-three percent of the area's general population, all but one of the thirty women arrested under the policy were black.⁸² Similarly, a study of women who enrolled for prenatal care at public health clinics in a single county in Florida found that black and white women had similar rates of substance abuse, but that black women were reported at almost ten times the rate of white women.⁸³

In Tennessee, the implementation of a new law defining drug use during pregnancy as assault, has resulted in significant discrepancies in drug testing between different hospitals, including disparities along race and class lines. According to doctors in Nashville, some hospitals test all pregnant women, while others “test based on appearance and behavior;” some hospitals in poor neighborhoods “test everyone,” while hospitals in rich neighborhoods “not so much.”⁸⁴ The gap between NAS cases and NAS arrests confirms as much. Discrepancies were particularly prevalent in Memphis, one of the poorest cities in the nation and, as previously noted, the only Tennessee city with a majority-black population.⁸⁵ Four percent of Tennessee's NAS cases occurred in Memphis, but two thirds of their NAS arrests took place there.⁸⁶

We can return to the case of Alicia Beltran to understand the extent to which race and class determine whether pregnant drug users will be subjected to the exclusionary disciplining arm of medicalization and suffer criminal punishment. If Alicia Beltran did not work as a

⁸² Paul-Emile, "The Charleston Policy: Substance or Abuse," Only one white woman was arrested under the policy and her medical charts unnecessarily noted that she had a “Negro boyfriend,” 326.

⁸³ Ira J Chasnoff, Harvey J Landress, and Mark E Barrett, "The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida," *New England Journal of Medicine* 322, no. 17 (1990): 1204.

⁸⁴ Goldensohn and Levy, "The State Where Giving Birth Can Be Criminal."

⁸⁵ Elena Delavega, "2013 Memphis Poverty Fact Sheet," (Memphis, TN: The University of Memphis Department of Social Work, 2013). In 2011 census data indicated that Memphis was the poorest metro area in the nation. In 2012 it had the highest overall and child poverty rates. Since then it has continually been among the poorest if not the poorest city in the United States.

⁸⁶ Goldensohn and Levy, "The State Where Giving Birth Can Be Criminal."

waitress, but in a job that provided her with health insurance, she would not have needed to self-administer the anti-addiction drug. With health insurance she would have had documentation of having completed treatment, and might have had a regular provider who could have spoken on her behalf. In addition, she might have had a regular pre-natal care provider who, as the research discussed above suggests, would have been more likely to trust her insistence that she had ended her addiction and less likely to rely on stereotypes in evaluating her case. Even without a regular provider, if Beltran had been white and middle-class and unfamiliar providers had implicitly used stereotypes in evaluating her, the stereotypes of a white middle-class woman would not have linked her with chronic drug use or suggested that she was an unreliable mother. Research has also shown that practitioners are more likely to dominate conversations with racial minorities, and to make them feel less involved in decision-making regarding their health.⁸⁷ If Beltran were white rather than Latina, her doctor may have listened more closely to her account of ending her addiction and granted her the agency to participate in her care by declining Suboxene treatment. Research on reporting of drug use during pregnancy suggests that if Beltran had been white, even if she *had* tested positive, the doctor and social worker would have been less likely to report her to authorities.⁸⁸

3. Structural Variables in Drug Use Among Women

Drug use among women is profoundly influenced by structural variables, most notably experiences of gendered violence. Among women, assault is associated with an increased

⁸⁷ Laura A. Siminoff, Gregory C. Graham, and Nahida H. Gordon. "Cancer communication patterns and the influence of patient characteristics: disparities in information-giving and affective behaviors," *Patient Education and Counseling* 62, no. 3 (2006): 355-360; Gregory B. Diette, and Cynthia Rand. "The contributing role of health-care communication to health disparities for minority patients with asthma," *CHEST Journal* 132, no. 5 (2007): 802S-809S.

⁸⁸ Lisa Cooper et al., "The Associations of Clinician's Implicit Attitudes About Race with Medical Visit Communication and Patient Ratings of Interpersonal Care," *American Journal of Public Health* 102, no. 5 (2012).

likelihood of using drugs, even for those who have never used drugs.⁸⁹ Research suggests a majority of female drug users have experienced sexual assault, sexual/physical abuse, or other forms of violence.⁹⁰ Female drug users are also more likely than males to present a range of psychological variables predicting relapse, including depression, anxiety, and suicidal thoughts.⁹¹ Research in public health and family violence suggests that childhood sexual abuse is present among 48 percent to 66 percent of women receiving treatment for substance abuse, and that between 47 percent and 90 percent of women receiving treatment have experienced intimate partner violence.⁹² Women in substance abuse programs also exhibit high rates of post-traumatic stress disorder, and substance abuse as self-medication for such conditions is common.⁹³

⁸⁹ Dean G Kilpatrick et al., "A 2-Year Longitudinal Analysis of the Relationships between Violent Assault and Substance Use in Women," *Journal of Consulting and Clinical Psychology* 65, no. 5 (1997).

⁹⁰ Malitta Engstrom et al., "Childhood Sexual Abuse and Intimate Partner Violence among Women in Methadone Treatment: A Direct or Mediated Relationship?," *Journal of Family Violence* 23, no. 7 (2008); Jeffrey Fagan, "Women's Careers in Drug Use and Drug Selling," *Current Perspectives on Aging and the Life Cycle* 4, no. 1 (1995); Virginia Gil-Rivas, Robert Fiorentine, and M Douglas Anglin, "Sexual Abuse, Physical Abuse, and Posttraumatic Stress Disorder among Women Participating in Outpatient Drug Abuse Treatment," *Journal of Psychoactive Drugs* 28, no. 1 (1996); Brenda A Miller, William R Downs, and Maria Testa, "Interrelationships between Victimization Experiences and Women's Alcohol Use," *Journal of Studies on Alcohol and Drugs*, no. 11 (1993).

⁹¹ Gil-Rivas, Fiorentine, and Anglin, "Sexual Abuse, Physical Abuse, and Posttraumatic Stress Disorder among Women Participating in Outpatient Drug Abuse Treatment."; Denise A Hien et al., "Do Treatment Improvements in PTSD Severity Affect Substance Use Outcomes? A Secondary Analysis from a Randomized Clinical Trial in NIDA's Clinical Trials Network," *The American Journal of Psychiatry* 167, no. 1 (2009).

⁹² Nabila El-Bassel et al., "Drug Abuse and Partner Violence among Women in Methadone Treatment," *Journal of Family Violence* 15, no. 3 (2000); Nabila El-Bassel et al., "Relationship between Drug Abuse and Intimate Partner Violence: A Longitudinal Study among Women Receiving Methadone," *American Journal of Public Health* 95, no. 3 (2005); Gil-Rivas, Fiorentine, and Anglin, "Sexual Abuse, Physical Abuse, and Posttraumatic Stress Disorder among Women Participating in Outpatient Drug Abuse Treatment."; Louisa Gilbert et al., "Childhood Abuse as a Risk for Partner Abuse among Women in Methadone Maintenance," *The American journal of drug and alcohol abuse* 23, no. 4 (1997); Miller, Downs, and Testa, "Interrelationships between Victimization Experiences and Women's Alcohol Use."; Renee Schneider et al., "Prevalence and Correlates of Intimate Partner Violence Victimization among Men and Women Entering Substance Use Disorder Treatment," *Violence and Victims* 24, no. 6 (2009): 747.

⁹³ Denise A Hien et al., "Promising Treatments for Women with Comorbid Ptsd and Substance Use Disorders," *American journal of Psychiatry* 161, no. 8 (2004); Hien et al., "Do Treatment Improvements in Ptsd Severity Affect Substance Use Outcomes? A Secondary Analysis from a Randomized Clinical Trial in NIDA's Clinical Trials Network."; Lisa M Najavits, Roger D Weiss, and Sarah R Shaw, "The Link between Substance Abuse and Posttraumatic Stress Disorder in Women," *The American journal on addictions* 6, no. 4 (1997). Between 26% and

Research has found that drug use also increases risk of assault and intimate partner violence, suggesting a cyclical relationship in which violence increases risk of substance abuse, which in turn increases likelihood of victimization.⁹⁴ Studies focusing on violence during pregnancy confirm this finding, linking violence with significantly higher use of alcohol, tobacco, and illegal drugs during pregnancy.⁹⁵ Notably, the same body of work links experiences of violence during pregnancy with fetal health problems, including low birth weight.

Attention to structural variables is equally important to understanding the health of drug exposed infants. In the case of the children of pregnant drug users, it is generally impossible to separate out structural variables from the effects of drug exposure. As a lawyer defending mothers of “crack babies” argued, “[t]hese are *poverty* babies, and *nobody wants to address that. So we call them crack babies.*”⁹⁶ Well after the crack baby scare, a twenty five-year study confirmed that conditions associated with poverty are actually more harmful to children than gestational crack use.⁹⁷ These conditions include insufficient maternal nutrition, which is associated with increased risk of pregnancy complications and health complications for infants,

59% of women receiving treatment for substance abuse suffer from PTSD, compared to 10%-12% in the general population

⁹⁴ El-Bassel et al., "Relationship between Drug Abuse and Intimate Partner Violence: A Longitudinal Study among Women Receiving Methadone," 465-470; Kilpatrick et al., " 841-845."

⁹⁵ Hortensia Amaro et al., "Violence During Pregnancy and Substance Use," *American journal of public health* 80, no. 5 (1990); Judith McFarlane, Barbara Parker, and Karen Soeken, "Physical Abuse, Smoking, and Substance Use During Pregnancy: Prevalence, Interrelationships, and Effects on Birth Weight," *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 25, no. 4 (1996): 317.

⁹⁶ Janine Jackson, "The Crack Baby Myth, Now They Tell Us," *Fairness & Accuracy in Reporting*, January 30 2009, <http://www.fair.org/blog/2009/01/30/the-crack-baby-myth-now-they-tell-us/>.

⁹⁷ Susan Fitzgerald, "'Crack Baby' Development Issue Not Side-Effect of Drug, but Poverty," *The Philadelphia Inquirer*, July 25, 2013, <http://www.csmonitor.com/The-Culture/Family/2013/0725/Crack-baby-development-issues-not-side-effect-of-drug-but-poverty>.

as well as neurological problems and sudden infant death syndrome.⁹⁸ More recent research has found that the stress associated with poverty in pregnant women can alter the structure of a child's brain.⁹⁹ In addition, a robust literature exists documenting the negative health impact of intimate partner violence on pregnant women and infants, violence to which young women, poor women, women of color, and drug users are more frequently exposed.¹⁰⁰ The frequent coexistence of drug use during pregnancy with contexts of stress, poverty, violence, and inadequate nutrition make it extremely difficult to isolate the effect of exposure to drugs. Even if it were possible to isolate these effects, experts suggest that they would pale in comparison to the consequences of contextual variables.¹⁰¹

The denial of structural variables is a key element in the logic of criminalization, which places the blame for poor infant health on the "bad choices" of individual (predominantly poor, black) women in two key ways.¹⁰² First, proponents of criminalization do not present drug use as a health problem shaped by context, but as poor individual choice. Under this view, the effects of

⁹⁸ Tore Henriksen, "Foetal Nutrition, Foetal Growth Restriction and Health Later in Life," *Acta Paediatrica* 88, no. s429 (1999); Barbara A Laraia, Anna Maria Siega-Riz, and Craig Gundersen, "Household Food Insecurity Is Associated with Self-Reported Pregravid Weight Status, Gestational Weight Gain, and Pregnancy Complications," *Journal of the American Dietetic Association* 110, no. 5 (2010); Nina Øyen et al., "Fetal Growth Retardation in Sudden Infant Death Syndrome (Sids) Babies and Their Siblings," *American journal of epidemiology* 142, no. 1 (1995).

⁹⁹ Kimberly G Noble et al., "Family Income, Parental Education and Brain Structure in Children and Adolescents," *Nature neuroscience* 18 (2015): 775-777.

¹⁰⁰ Kathryn M Nowotny and Jennifer L Graves, "Substance Use and Intimate Partner Violence Victimization among White, African American, and Latina Women," *Journal of interpersonal violence* (2013); Phyllis W Sharps, Kathryn Laughon, and Sandra K Giangrande, "Intimate Partner Violence and the Childbearing Year Maternal and Infant Health Consequences," *Trauma, Violence, & Abuse* 8, no. 2 (2007).

¹⁰¹ Micah Lewis, professor of pediatrics and psychiatry at the Robert Wood Johnson Medical School has suggested that such contextual variables are "far more likely to damage a child's intellectual and emotional development" than exposure to drugs before birth.

¹⁰² See Dorothy Dorothy Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy," *Harvard Law Review* 104, no. 7 (1991): 1436. In which she argues, "[T]he prosecution of crack-addicted mothers diverts public attention from social ills such as poverty, racism, and a misguided national health policy and implies instead that shamefully high Black infant death rates are caused by the bad acts of individual mothers. Poor Black mothers thus become the scapegoats for the cause of the Black community's ill health."

drug use are purely the fault of individuals rather than the fault of biology or structural variables such as exposure to violence. Second, the logic of criminalization asserts that poor infant health is a direct result of drug exposure, disregarding the significant role of contextual variables. The consistent misrepresentation of the health consequences of perinatal drug exposure – as long-lasting, as addiction, as untreatable – enhances the gravity of this supposedly direct connection. Together, these assumptions allow proponents of criminalization to argue that individual women are responsible for poor infant health. This conclusion is made more palatable by the fact that the women in question are already marginalized and stigmatized in society; they are easy targets for blame.

4. The Power of Health: Agency, Oppression and Knowledge Production

In light of the immense value our culture places on health, it should not be surprising that arguments about health can be very powerful. And in light of the extent to which health is contextual and socially constructed, it should not be surprising that those arguments can be deployed for strategic political purposes beyond those of promoting health. Feminists such as Ehrenreich and English have, for example, argued that for women, health has historically looked very much like fulfilling gender roles and norms, and thus those who violated norms could justifiably be treated until they conformed.¹⁰³ Exploring the health problems facing marginalized women demonstrates that arguments about health can be used to control even those women whose issues are excluded from the domain of health, and that the most vulnerable women can be targeted with policies that harm all women. Though the health of pregnant drug users is not emphasized in debates over the issue, the health of their children is. And concern over the health

¹⁰³ Ehrenreich and English, "Complaints and Disorders," 18-25.

of children, rather than that of pregnant women, is used to justify a host of policies that severely limit the agency of women, and of women of color in particular.

The national conversation surrounding drug use among pregnant women is fundamentally tied to an even more controversial conversation about fetal rights. Concurring with the application of Alabama's Chemical Endangerment Law to pregnant drug users, Alabama Supreme Court Justices Roy Moore and Tom Parker emphasized that "the inalienable right to life is a gift of God" which requires that *Roe v. Wade* be overturned and that women seeking abortions be prosecuted, equating women seeking abortions with killers.¹⁰⁴ This ruling is just one of many instances in which criminalization efforts have been linked to and used to further anti-abortion efforts. The National Advocates for Pregnant Women described the chemical endangerment ruling as a "Personhood Measure in disguise."¹⁰⁵ Unsurprisingly Personhood USA, the leading organization working to establish fetal rights, has praised criminalization efforts.¹⁰⁶ The links between efforts to criminalize prenatal drug use and efforts to establish fetal rights bring together two key insights. First, these links illustrate the way claims about health can be used to strengthen less politically popular (or particularly contentious) arguments and actions. Second, they reaffirm long-standing concerns that health is a space in which women's agency is particularly at risk.

Since *Roe v. Wade*, opponents have fought to undermine abortion by establishing rights for the fetus in both public opinion and the law. Strategically, they often have done so through efforts that purportedly aim to address other problems, including crime. The Unborn Victims of

¹⁰⁴ *Ex Parte Hope Elisabeth Ankrom*. Justice Moore and Parker, concurring.

¹⁰⁵ Lynn M Paltrow, "National Advocates for Pregnant Women's Lynn Paltrow on Alabama Supreme Court's Decision in "Personhood" Measure in Disguise Case," news release, 2013, <http://perma.cc/QVF9-MCQ3>.

¹⁰⁶ "Tennessee Passes Law against Prenatal Child Abuse," Personhood USA, <http://perma.cc/7JJ7-CXGG>.

Violence Act, introduced in 1999, represented one such effort. The act would have created separate penalties for individuals who harm an “unborn child” in the process of committing a federal crime, establishing federal recognition for an embryo or fetus as a person with rights separate from that of a pregnant woman. In light of these motivations, we might understand the enthusiasm with which Wisconsin, South Dakota, and South Carolina all passed “crack baby” laws almost a decade after the height of the war on cocaine and well after the existence of “crack babies” had been disproven. Critics of criminalization argue that abortion opponents have seized upon the issue as one that produces particularly sympathetic responses to fetal rights.¹⁰⁷

Criminalization efforts consistently promote the notion that the rights accorded to children should extend to embryos and fetuses. Alabama prosecutors interpreted the state’s chemical endangerment law’s use of the term “child” to include embryos and fetuses, justifying the arrest of women whose children tested positive for drugs. And the state’s supreme court upheld this interpretation, establishing a legal precedent for fetal rights. Media accounts of criminalization frequently describe pregnant drug users as perpetrators, portraying them as adversaries of their fetus.¹⁰⁸ Similar language is present in debates over legislation, as when Tennessee Representative Weaver demanded “protection” for “these defenseless children.”¹⁰⁹ This model is central to the movement for fetal rights, which portrays pregnancy as involving “a conflict of rights between a woman and her fetus.”¹¹⁰ Sara Zeigler, a feminist scholar, has argued that this strategy for establishing fetal rights is clever because it focuses on individuals to whom

¹⁰⁷ Calhoun, “The Criminalization of Bad Mothers.”

¹⁰⁸ Giovanna Breu, “Cocaine Claims Its Tiniest Victims: Babies Born Addicted,” *People*, September 8 1986.

¹⁰⁹ *Tennessee House Floor Debate on Sb1391/Hb1295*.

¹¹⁰ Katherine Beckett, “Fetal Rights and Crack Moms: Pregnant Women in the War on Drugs,” *Contemporary Drug Problems* 22 (1995): 593.

“the average person is not going to be at all sympathetic.”¹¹¹ These efforts help to establish the idea that the fetus and the pregnant woman have divergent rights without invoking the controversial issue of personhood, and by targeting disempowered individuals for whom society feels little sympathy.

State actions to begin recognizing drug use by pregnant women in child abuse statutes are often accompanied by similar changes in public understanding and legal interpretation of the relationship between pregnant women and their fetuses. Using statutes to equate drug use by a pregnant woman and child abuse is particularly problematic to those concerned about the agency of pregnant women.¹¹² To understand the problematic precedent these statutes sets, we can dissect the considerations the state makes in making decisions about child welfare. In making decisions about parental rights, the state typically weighs the well being of a child against the right of the guardian to raise that child. While the guardian might have a right to parental authority, that right is far less compelling than the child’s right to safety and well being. Therefore, the state can easily justify revoking parental authority on behalf of child welfare. The consequences of the same kind of state intervention in child abuse cases change drastically when the child is in utero. When prenatal drug use is framed as child abuse, state intervention to protect the child can take the form of arrest, mandatory treatment, or involuntary commitment, which inherently infringe on a pregnant woman’s fundamental rights. As previously noted, the right a parent generally forfeits in a child abuse case is the right to parental authority. However, when a pregnant woman is concerned, the “guardian’s” right to individual liberty and bodily autonomy are also in jeopardy. Instead of robustly evaluating the worth of these rights, the child abuse model

¹¹¹ Nina Martin, "This Alabama Judge Has Figured out How to Dismantle Roe v. Wade," *Pro Publica*, October 10 2014.

¹¹² For more on this argument see Kenneth A Ville and Loretta M Kopelman, "Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy," *The Journal of Law, Medicine & Ethics* 27, no. 4 (1999).

continues to privilege the well being of the child. Yet the nature and consequences of state intervention have shifted dramatically. The state is now determining intervention that affects fundamental rights under a rubric created to only evaluate the right to parental authority. The application of child abuse statutes to pregnant women is significant because the standards of proof required to justify state intervention in child well being are much lower than those required to deprive individuals of fundamental rights in other situations. These lower standards of proof make it possible for questionable claims about the relationship between drug use and infant health and long-repudiated science to be used to incarcerate and involuntarily commit pregnant women.

Though criminalization efforts are generally not linked explicitly to anti-abortion efforts, they are consistently promoted and sponsored by pro-life advocates and legislators, and draw on the language of the anti-abortion movement. During floor debate over the Tennessee's act, avowedly pro-life sponsor Weaver referred to unborn children in the following terms: "really and truly we have a life inside of a belly," "the life that is inside your womb," "life in their belly," "the life that is within them," and "those little guys" who "don't have a voice."¹¹³ She told fellow legislators, "we are saving babies" and called on them to "answer for those who do not have a voice," a common rallying cry in the pro-life movement.¹¹⁴ She went on to describe the proposed law as "another tool in the toolbox to work with Safe Harbor, to work with Right to Life to work with these different facilities that offer help to these ladies."¹¹⁵

¹¹³ "About Me" Terry Lynn Weaver, <http://perma.cc/EN7G-D6KU>; *Tennessee House Floor Debate on Sb1391/Hb1295*.

¹¹⁴ "Be a Voice for the Voiceless," Heroic Media, <https://www.heroicmedia.org/20weeks>; "Melissa Oden: Abortion Attempt Survivor. A Voice for the Voiceless," Melissa Oden, <http://perma.cc/C99D-U4BC>.

¹¹⁵ *Tennessee House Floor Debate on Sb1391/Hb1295*.

The consequences of criminalization on women's agency cannot be overstated. When rights are granted to the fetus, there is a drastic increase in the potential infringement on women's agency and autonomy. Any actions aimed at protecting the now-rights-bearing fetus must be performed upon the pregnant women. As a result of criminalization, pregnant women are surveilled and pressured by medical professionals, arrested, involuntarily committed to treatment, forcibly separated from their children, and incarcerated. In at least three cases in Nashville, women whose children tested positive for drugs were offered a plea deal in exchange for being sterilized.¹¹⁶ Women who already face enormous barriers to health care and meaningful reproductive choice are discouraged from seeking necessary medical care, discouraged from continuing pregnancies for fear of punishment, and even incentivized to undergo permanent sterilization.¹¹⁷ Thus, through criminalization, women are deprived not only of their right to raise their child, but of their rights to bodily autonomy, to free movement, to free association, to individual liberty, and to reproductive justice.¹¹⁸

Views of pregnant drug users as inherently bad mothers deserving of blame are common in efforts to criminalize drug use during pregnancy.¹¹⁹ Women who use drugs during pregnancy

¹¹⁶ Associated Press, "Nashville Assistant DA Fired Amid Reports of Sterilization in Plea Deals," *CBS News*, April 1 2015. In 2015, reports surfaced that there had been at least five such cases in the past five years, three of which involved drug-exposed infants.

¹¹⁷ Katha Pollitt, "Fetal Rights: A New Assault on Feminism," *Nation (New York, NY: 1865)* 250, no. 12 (1990): 410-11.

¹¹⁸ Helene M. Cole, "Law and Medicine/Board of Trustees Report: Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *Journal of the American Medical Association* 264, no. 20 (1990).

¹¹⁹ Drew Humphries, *Crack Mothers: Pregnancy, Drugs, and the Media* (Ohio State University Press Columbus, 1999); Roberts, "Punishing Drug Addicts Who Have Babies.," "Motherhood and Crime," *Iowa L. Rev.* 79 (1993); Springer, "The Race and Class Privilege of Motherhood: The New York Times Presentations of Pregnant Drug-Using Women." Defending Tennessee's criminalization bill against claims that it would deter women from seeking prenatal care, Representative Terri Weaver repeatedly asserted the indifference pregnant drug users feel for their children, explaining that "these ladies are not those who would consider prenatal care...their only next decision is how to get their next fix" and "these ladies are not thinking about prenatal care. Again I want to emphasize what

are regularly described as choosing drugs over their children and as indifferent to the dangers drug pose to their fetus.¹²⁰ News coverage of the first Tennessee mother charged with misdemeanor assault for drug use during pregnancy explained that “in the multiple choice game that makes up life, it appears she has again failed to pick the right answer.”¹²¹ Similarly Florida’s NAS task force recommended public educational campaigns that frame drug use during pregnancy as a matter of “choice.”¹²² In fact, women who use drugs during pregnancy often describe it as a way to cope with the pressures of their lives. Edith, a thirty-four year old mother of two explained that pain pills allowed her to keep up with her responsibilities at home: “A lot of the reason I used was to deal with my kids. Single parenting is like the hardest job in the world.”¹²³ Others used drugs in order to cope with abusive partners or other stressful life situations, including threats by social service and legal systems. The experiences of all of these women reaffirm research suggesting that drug addicts often use substances in order to self-medicate to address overwhelmingly painful or stressful experiences.¹²⁴

Researchers working with pregnant drug users have consistently found that they define good mothering in the same ways as non-drug using women, and attempt to be good mothers

they’re thinking about and that is just money for the next high.” The indifference of pregnant drug users was a near constant refrain for Weaver, who also argued that drug users “are not even considering the life that is within them.” *Tennessee House Floor Debate on Sb1391/Hb1295*.

¹²⁰ Humphries, *Crack Mothers: Pregnancy, Drugs, and the Media*; Springer, "The Race and Class Privilege of Motherhood: The New York Times Presentations of Pregnant Drug-Using Women."

¹²¹ Les Smith, "Mother of Drug-Addicted Baby Fails at Last Chance," *My Fox Memphis* 2015.

¹²² Statewide Task Force on Prescription Drug Abuse & Newborns, "Final Report," (Florida Office of the Attorney General, 2013).

¹²³ Phyllis L Baker and Amy Carson, "“I Take Care of My Kids” Mothering Practices of Substance-Abusing Women," *Gender & society* 13, no. 3 (1999): 353.

¹²⁴ *Ibid.*, 359.

despite their drug use.¹²⁵ This often begins with efforts to have a healthy pregnancy.

Ethnographic interviews with over 100 pregnant drug users revealed that they are “active agents who show concern for fetal well-being and strive for positive fetal outcomes as best they can.”¹²⁶

Other studies have found that most pregnant drug users continued to use drugs, but made behavioral changes aimed at minimizing harm, including minimizing or eliminating drug consumption, switching to drugs they perceived to be less dangerous, eating better, sleeping more, taking prenatal vitamins, and seeking prenatal care.¹²⁷ Pregnant women who continued to use drugs “anguished” over the consequences of their drug use, and those who did not seek institutional care or support expressed fear of punitive institutional interventions.¹²⁸

Interviews with mothers at a residential substance abuse treatment program for women revealed that they viewed motherhood as “a fundamental part of their lives,” and understood their role as mothers to be one of protecting their children and helping them fulfill their needs.¹²⁹ Contrary to what proponents of criminalization have argued, women who had used drugs while pregnant felt guilty about actions that they saw as “bad mothering.” Notably, some of their perceived mothering failures included being subjected to the kinds of violence that are associated with an increased risk of drug use. Carol, a 31-year-old mother of five, identified enduring her husband’s abuse as one way in which she failed to provide a safe environment for her children,

¹²⁵ Ville and Kopelman, "Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy."

¹²⁶ Katherine Irwin, "Ideology, Pregnancy and Drugs: Differences between Crack-Cocaine, Heroin, and Methamphetamine Users," *Contemporary Drug Problems* 22 (1995): n.p.

¹²⁷ Baker and Carson, "'I Take Care of My Kids' Mothering Practices of Substance-Abusing Women."; Mary Ellen Colten, "Attitudes, Experiences, and Self-Perceptions of Heroin Addicted Mothers," *Journal of Social Issues* 38, no. 2 (1982); Irwin, "Ideology, Pregnancy and Drugs: Differences between Crack-Cocaine, Heroin, and Methamphetamine Users,"); Sheigla Murphy and Marsha Rosenbaum, *Pregnant Women on Drugs: Combating Stereotypes and Stigma* (Rutgers University Press, 1999).

¹²⁸ Baker and Carson, "'I Take Care of My Kids' Mothering Practices of Substance-Abusing Women," 77; Murphy and Rosenbaum, *Pregnant Women on Drugs: Combating Stereotypes and Stigma*.

¹²⁹ *Pregnant Women on Drugs: Combating Stereotypes and Stigma*.

who had seen him run her over with a car and kick her “up and down the hallways of our house.”¹³⁰ Asked about ways in which they felt they were good mothers, the women spoke about abstaining from drugs while pregnant, ensuring that their children were fed, bathed, clothed, well-rested, and at school on time, and abstaining from drug use in front of them.

Looking to the experiences of pregnant drug users confirms something that feminist health activists have long known: experiential knowledge is essential to understanding health, and particularly to understanding the health issues of marginalized groups. Contrary to what advocates of criminalization might have us believe, research suggests that pregnant drug users are rarely indifferent to the health of their pregnancy. Many use drugs while unaware of their pregnancy, or engage in a number of behaviors to minimize the risk of harm to the fetus. Nor do they simply wake up one day interested in drugs, or “choose” drugs over their children. The insights gained by exploring the experiences of pregnant drug users suggest that criminalization not only discourages important harm-minimizing behaviors (predominantly seeking prenatal care), but also fails to address many of the issues leading to drug use. Here we can recall the many structural variables of both prenatal drug use and poor infant health. The presence of these structural variables and the accounts of pregnant drug users both indicate that much broader efforts, including anti-violence and anti-poverty efforts and improved access to counseling and treatment, are vital to addressing the problem of drug use during pregnancy.

Implications and Conclusion

The criminalization of drug use during pregnancy demonstrates the value of attending to exclusions from health care, while also employing a critical view of women’s health. Thinking back to the two premises driving this work, we find that women who use drugs while pregnant

¹³⁰ Baker and Carson, “I Take Care of My Kids” Mothering Practices of Substance-Abusing Women.”

have largely been excluded from the benefits of increased attention to women's health. They tend to lack access to health care, including vital addiction treatment and prenatal care. They are denied the application of a sympathetic, less punitive health-based approach to their addiction by legislators despite formal medical recognition. With this exclusion alone in mind we might call for an end to punitive responses to drug use and increased attention to drug use as a medical problem. Addressing exclusion might mean improving access to prenatal care and addiction treatment for pregnant drug users, establishing more treatment facilities that accommodate women with children, and improving training and expanding screening to recognize the signs of drug use during pregnancy.

However, if we also recognize that health is not a good that can be easily redistributed, it becomes clear that the above measures would do little to address the problems of poverty, violence, stress, and abuse associated with drug use. Addiction treatment alone will not adequately address drug use, nor will it address the many causes of poor health among infants born to drug-using mothers. Further, when we acknowledge that health is not always a good, we recognize that the above measures could in fact produce their own harms. Attending to a critical view of health, we can recall the case of Alicia Beltran, who was incarcerated by order of a medical professional. In fact Beltran's experience could become the model for a medical alternative to criminalization, encouraging health care providers to aggressively screen for drug use and be overly cautious, calling in the state if necessary to ensure that women adhere to their recommendations. Under such a regime, pregnant drug users would likely continue to avoid care for fear of invasive or oppressive medical treatment.

We can look to medical interventions on privileged, non-drug using women as evidence of the plausibility of such invasive uses of medicine. In January of 1996, Laura Pemberton, a

white woman, attempted to deliver her second child vaginally in her home.¹³¹ Doctors recommended against a vaginal birth because Pemberton had previously had a somewhat unusual cesarean. After a day of labor at her home in Tallahassee Florida, Pemberton became dehydrated and visited an emergency room requesting an intravenous infusion of fluids. Doctors there recommended a cesarean and when Pemberton and her husband declined, sought a court order to force her to undergo the procedure. As a result, a sheriff visited Pemberton's home and took her into custody, strapping her legs together and forcing her to go to a local hospital where an emergency hearing was underway to determine the state's interest in protecting her fetus. A judge compelled Pemberton to undergo the operation. She subsequently safely birthed three children vaginally. In 2009, a doctor at the same hospital ordered a pregnant patient to bed rest and refused to allow her to leave the hospital for a second opinion, attaining a court order requiring the patient to undergo "any and all medical treatments" that the physician, acting in the interest of the fetus, deemed necessary.¹³² As evidenced by these cases, medical attention does not preclude invasive or punitive treatment. Although I agree that greater access to treatment and care are necessary, I also argue that attention to health without critical analysis of how health and medicine operate does an immense disservice to women patients.

Instead, if we hold these two insights simultaneously and work from within the tensions of women's health -- if we base our analysis of the issue on a view of women's health in all of its complexities -- we are left with a better understanding of drug use during pregnancy, and a better guide for moving forward. Efforts to increase access to care or screening must be coupled with a critical view of health, recognition of the strategies of personhood advocates, and the punitive potential of health care interventions. Solutions should draw on the insights of women suffering

¹³¹ Paltrow and Flavan, "The Policy and Politics of Reproductive Health," 306-307.

¹³² *Burton v. State of Florida* 49 So. 3d 263 (Fla. Dist. Ct. App. 2010).

from addiction, and aim not merely to treat addiction (or drug-exposed children), but to address the many structural variables, from gender violence to poverty, associated with drug use. Efforts to improve the health of children born to women who use drugs must similarly recognize and aim to address the many variables associated with their poor health outcomes, beyond exposure to substances. This brings us back to the need for programs aiming to improve the living conditions of poor pregnant women. In addition to eliminating punitive responses and improving access to care, race and class biases and stigma among medical professionals must be addressed if drug-using women are expected to trust and regularly visit health care providers.

Embracing these seemingly at-odds insights also leave us with a better understanding of women's health more broadly. This analysis demonstrates that health is inherently political in a number of complicated ways: in its substance (insofar as our understanding of health is shaped by social norms that tend to serve those in power), in its application (insofar as access to care and quality of care varies depending on one's social position and because arguments about health can be deployed strategically for political purposes), and in its outcomes (insofar as health outcomes are shaped by structural variables including those related to social, economic, and political inequalities). It also reaffirms a critical view of proposed conceptions of health and of proposed solutions to health problems, and alertness to the influence of inequality, identity, bias, and ulterior motives in how we conceptualize both. This analysis also requires us to recognize that certain conceptualizations of health can help to uphold existing power structures. For example, viewing drug use as a personal failing rather than as a health problem resulting from poverty, inequality, and gender violence, supports the continued withdrawal of social support programs and precludes the need for a shift in government priorities.

Attention to exclusion and critiques of health urge us to question any understandings of health that posit themselves as apolitical or objective, or that suggest that health outcomes are purely biological. Exploring pregnant drug users' health also encourages us to seek out similarities or shared concerns in women's health across differences. For example, criminalization efforts that seek to establish personhood impact all women. Similarly, individualization and depoliticization are present in women's health across race and social class, though they are achieved in different ways. Together, these insights suggest that we must move beyond calls for more equitable distribution of health (or health care) and critiques of how well-known women's health issues are conceptualized to challenge the very meaning of women's health.

CHAPTER 3: FOOD STAMPS & SODA BANS

Though food stamps have not historically been framed as an issue of health, they have recently come to be seen through the lens of health in two significant ways. First, food stamps have been discussed in relation to rising rates of obesity in the United States and in response to fears of an “obesity epidemic” concentrated among the poor. Specifically, critics have recommended banning the purchase of non-staple foods, such as soft drinks, with food stamps as part of an effort to fight obesity.¹ Second, recent discussions of food stamps have focused on the extent to which they provide access to fresh, healthy foods. Here the emphasis is on making healthy foods more accessible rather than making unhealthy foods less accessible. In these conversations, access to fresh produce in particular is described as good for the health of food stamp recipients, as a way to lower health costs for the country, and as a means of increasing local food sales for family farmers.²

Of course food stamps, now known as the Supplemental Nutrition Assistance Program (SNAP) are not purely a women’s issue.³ However SNAP, like most anti-poverty programs, is more likely to be used by women than men. Families headed by working mothers are

¹ Associated Press, "Limit Food Stamps for Sodas, 18 Mayors Ask Government," <http://www.cbsnews.com/news/limit-food-stamps-for-sodas-18-mayors-ask-government/>; Jennifer Liberto, “Food Stamp Soda Ban Can Save 140,100 Children From Obesity,” *CNN Money*, June 5, 2014, <http://money.cnn.com/2014/06/05/news/economy/food-stamps-soda/>.

² USDA Food and Nutrition Service, "USDA Announces up to \$31 Million to Empower People to Make Healthy Eating Choices," (2014).

³ The food stamp program was renamed SNAP during under George W. Bush in an effort to reduce stigma associated with the program’s original name, though it continues to be referred to in popular discourse as food stamps. In this chapter I use the terms interchangeably.

disproportionately likely to be poor, compared to families headed by fathers.⁴ In recent years, 30 percent of households headed by single women have lived in poverty, compared to 16.4 percent of households headed by single fathers.⁵ Rates of food insecurity for single parent households headed by women are more than double the national average.⁶ Socioeconomic status is also deeply raced, with black and Latina women at least twice as likely as white women to live in poverty.⁷ Just as poverty is “feminized” (more common among women), so too is participation in anti-poverty programs. Research by the Pew Foundation confirms that women are about twice as likely as men to have used food stamps at some point in their lives, and that minority women are far more likely than either white women or minority men to have used food stamps.⁸ In addition, the SNAP program is often linked to problems of obesity based on longitudinal studies that find that women (but not men) are more likely to become obese the longer they participate in SNAP programs.⁹

In this chapter I apply a feminist analysis to policies aimed at improving the health of food stamp recipients. As this chapter will demonstrate, much of the health discourse surrounding food stamps is deeply problematic, both in its content and insofar as it obscures

⁴ Deborah Povich, Brandon Roberts, and Mark Mather, "Low-Income Working Mothers and State Policy: Investing for a Better Economic Future," *The Working Poor Families Project Policy Brief* Winter 2013-2014 (2013).

⁵ National Poverty Center, "Poverty in the United States," <http://www.npc.umich.edu/poverty/>.

⁶ Alisha Coleman-Jensen, Christian Gregory, and Anita Singh, "Household Food Security in the United States in 2013," (Washington, DC: Department of Agriculture, Economic Research Service, 2014). In 2013 14% of all American households were food insecure, 19.5% of all households with children were food insecure, and 34% of households headed by single women were food insecure.

⁷ Alexandra Cawthorne, "The Straight Facts on Women in Poverty," (Center for American Progress, 2008).

⁸ Almost 40% of black women have received SNAP benefits compared to 21% of black men and 19% of white women. Rich Morin to PewResearchCenter: Fact Tank, 2013, <http://www.pewresearch.org/fact-tank/2013/07/12/the-politics-and-demographics-of-food-stamp-recipients/>.

⁹ CL. Baum, "The Effects of Food Stamps on Obesity," *Southern Economics Journal* 77 (2011); D. Gibson, "Food Stamp Program Participation Is Positively Related to Obesity in Low Income Women," *Journal of Nutrition* 133 (2003); CD Meyerhoefer and Y. Pylypchuk, "Does Participation in the Food Stamp Program Increase the Prevalence of Obesity and Health Care Spending?," *American Journal of Agricultural Economics* 90 (2008).

ulterior motives and biased claims and assumptions. Exploring food stamps through a feminist lens also highlights the importance of structural variables in shaping health outcomes. A related discussion of alarm over the “obesity epidemic” demonstrates how medicine is shaped by and shapes our social and political worlds. Finally, exploration of food stamps demonstrates that the insights of feminist scholarship on health can be applied to issues that are not solely or traditionally viewed as issues of women’s health.

Health in Food Stamp Policy and Discourse

According to the US Department of Agriculture, in 2013, 14.3 percent of Americans, or 17.5 million households, had difficulty providing enough food for their family members due to lack of resources – a condition referred to as “food insecurity.”¹⁰ In the same year, 5.6 percent of U.S. households, almost 7 million households, had very low food security, meaning that food intake of household members was reduced and normal eating patterns were disrupted due to limited resources.¹¹ Notably, food insecurity results not only in inadequate access to food (malnutrition), but also in inadequate access to healthy foods (poor nutrition), and in unpredictable and frequently disrupted nutrition patterns, all of which have negative effects on health outcomes.

Food stamps are increasingly discussed in the context of concerns about an obesity epidemic. An association between hunger and obesity might seem paradoxical – food insecurity results from insufficient resources to purchase food, while obesity is associated with overconsumption. However, since medical researchers first proposed an association between the two in 1995, there has been a growing conversation about the correlation between food

¹⁰ Coleman-Jensen, Gregory, and Singh, "Household Food Security in the United States in 2013."

¹¹ Ibid.

insecurity and weight. And, because many if not most households experiencing food-insecurity participate in the SNAP program, there has been speculation that the food stamp program might play a role in what is now referred to as “the obesity-food insecurity paradox.”¹² A quick analysis of news coverage confirms that attention to this relationship has grown considerably. A LexisNexis search for news articles linking obesity to the food stamp program identifies just 25 articles from the years 1995-2000. Four times that number of articles appeared in the following five years, a number that more than quadrupled in the five years after that (from 110 articles to 575 articles). In the past four years, there have been over 850 articles linking food stamps to obesity. These increases in media coverage reflect growing interest among policymakers and the public in the relationship between food stamps and obesity.

In 2003, Minnesota Governor Tim Pawlenty discussed placing a limit on SNAP purchases while proposing stricter rules for welfare. A request for USDA approval of the new restrictions described the limits as part of a broader effort to fight obesity.¹³ The Department of Agriculture denied Minnesota’s waiver request to ban the purchase of candy and soft drinks with food stamps, citing its “questionable merits,” while explaining that such a policy would lead to “confusion and embarrassment” among recipients and perpetuate the myth that SNAP recipients make poor shopping decisions.¹⁴ Discussing the denial, a spokesperson for the governor said “[t]he food stamp program is designed to be a nutrition program and not ‘a free Kit Kat for

¹² William H Dietz, "Does Hunger Cause Obesity?," *Pediatrics* 95, no. 5 (1995); Lauren M Dinour, Dara Bergen, and Ming-Chin Yeh, "The Food Insecurity–Obesity Paradox: A Review of the Literature and the Role Food Stamps May Play," *Journal of the American Dietetic Association* 107, no. 11 (2007); Holly C Gooding, Courtney E Walls, and Tracy K Richmond, "Food Insecurity and Increased Bmi in Young Adult Women," *Obesity* 20, no. 9 (2012); Marilyn S Townsend et al., "Food Insecurity Is Positively Related to Overweight in Women," *The Journal of Nutrition* 131, no. 6 (2001).

¹³ Terry Collins, "USDA: Food Stamps Can Buy Candy," *Minneapolis Star Tribune*, May 8 2004.

¹⁴ They also noted that it would be nearly impossible to categorize and monitor the enormous number of existing foods and regularly introduced new items and that there was no clear standard for what constitutes healthy vs. unhealthy foods. AP, USDA Rejects Ban on Buying Junk Food with Food Stamps, May 8, 2004
Anemona Hartocollis, Food Stamps As New Front In Soda Wars, NYT Oct 7, 2010 Section A P1

everybody program.”¹⁵ State Human Services Commissioner Kevin Goodno told the Associated Press that the state had simply wanted to “stop using taxpayers’ dollars for low income people to purchase candy bars and soda pop” which did not provide the nutrition for which food assistance is intended.¹⁶ This initial effort to ban certain foods from the SNAP program exhibits many of the traits common to the debate over health and food stamp policy. Though obesity is claimed to be the reason for policy change, the real reasons are concerns about overly generous welfare programs and excessive entitlements, as well as flawed assumptions about the purchasing habits, needs, and motives of SNAP recipients.

The Minnesota proposal was just the first of in a flurry of efforts to create new restrictions on SNAP purchases. Four years later in 2008, Congress debated and eventually rejected a change to the Farm Bill that would have limited the purchase of sugared drinks with food stamps.¹⁷ In 2009, Maine’s Legislature considered requesting a waiver to prohibit the purchase of soft drinks and snack foods with SNAP benefits.¹⁸ The bill’s sponsor, Representative Peggy Pendleton, told a public forum that taxpayer’s money should not be spent on items that contribute to “dental decay, diabetes, and obesity.”¹⁹ In 2010 New York City Mayor Michael Bloomberg requested permission from the Department of Agriculture to bar SNAP recipients from using benefits to buy soft drinks or sugared drinks for two years, in order to assess the

¹⁵ Collins, "USDA: Food Stamps Can Buy Candy."

¹⁶ Associated Press, "USDA Rejects Ban on Buying Junk Food with Food Stamps," *Los Angeles Times* 2004.

¹⁷ Anemona Hartocollis, "Food Stamps as New Front in Soda Wars," *New York Times*, October 7 2010.

¹⁸ *Resolve, to Require the Department of Health and Human Services to Request a Waiver to Prohibit the Use of Food Stamps for the Purchase of Soft Drinks*, 124. A similar ban was proposed again in 2015, this time limiting the use of SNAP benefits for soda, candy, and chips. A.J. Higgins, "Effort to Ban Junk Food Buys with Food Stamps Reignated," *Bangor Daily News*, April 24 2015.

¹⁹ Meg Haskell, "State Rejects Food Stamp Restrictions," *ibid.* 2009.

positive impact of such a policy. Bloomberg linked his request to efforts to fight intractable rates of obesity and diabetes. The USDA denied the request.

Texas legislators proposed three bills to limit food stamp purchases in 2011, one banning the purchase of cookies, candy, and soft drinks with SNAP benefits and another two calling on Congress to ban the purchase of junk food with SNAP benefits.²⁰ Texas Representative Richard Raymond described the bills as “one small yet vital step” toward tackling obesity in Texas.²¹ Speaking to a local television station, Raymond argued that “[w]e should not be on the one hand using money - tax dollars - to buy junk food, and then on the other hand using tax dollars to pay for the health related diseases that come about because of junk food.”²² At a hearing in favor of her own SNAP restrictions bill, Texas state representative Susan King told her fellow representatives, “[q]uite frankly, if I have the choice between a sack of carrots and two Milky Ways, and someone else is paying for it, of course, I will I pick the chocolate.”²³ In similar efforts, South Carolina attempted to ban cookies and cakes in 2013, citing high medical costs associated with obesity and the need to tighten-belts (literally and figuratively).²⁴ The same year, amidst Congressional proposals to significantly cut the program, the mayors of New York, Los Angeles, Chicago, and 15 other cities signed a joint public letter expressing their own desires and recommendations for the SNAP program. The letter asked that Congress maintain the program’s

²⁰ Chuck Lindell, "Lawmakers Seek to Crack Down on Junk Food as Obesity Epidemic Worsens," *American Statesman*, April 19 2011.

²¹ *Ibid.*

²² Caroline May, "Texas Legislators Consider Banning Use of Food Stamps to Purchase Junk Food, Energy Drinks," *Daily Caller*, February 9 2013.

²³ Lindell, "Lawmakers Seek to Crack Down on Junk Food as Obesity Epidemic Worsens."

²⁴ "South Carolina Health Agency Wants Food Stamp Restrictions," *WSPA News*, n.d., <http://wspa.com/story/22626108/sc-health-agency-wants-food-stamp-restrictions>.

funding and test requirements that would limit SNAP eligibility for products that “are contributing to obesity,” specifically citing sugar-sweetened beverages.²⁵ Congress did neither.

In September 2014, Republican Congressman Phil Roe introduced The Healthy Food Choices Act, which would apply the much more strict purchasing restrictions of the Women, Infants and Children (WIC) program to the SNAP program in order to “ensure the foods that SNAP recipients are purchasing are healthy and nutritious.”²⁶ Roe explained his motivation for the bill, saying that as a doctor, he realizes the importance of healthy eating.²⁷ Late in 2014 the Governor of Maine announced that he was considering proposing a ban on the use of SNAP benefits to purchase junk food in the state in an effort to improve the nutritional habits of low-income Maine residents.²⁸ Speaking to media outlets, Governor LaPage linked the possible ban to efforts to reduce health care costs, and argued that Maine cannot afford “a government that squanders their valuable tax dollars.”²⁹ At the time Republican state Senator Roger Katz had already introduced such a bill. Citing misuse of taxpayer’s money in support of a ban, he explained that “[i]f you just go to a grocery store and you ask 100 people if they think we ought to be using taxpayer funds for junk food I bet you 98 of them will say no.”³⁰ Similar arguments were made in favor of the most expansive proposed ban to date. In April of 2015, Missouri

²⁵ Notably the letter also encouraged the expansion of pilot programs that incentivized the purchase of healthy foods. Mayors of Baltimore, Boston, Chicago, Los Angeles, Louisville, Madison, Minneapolis, Newark, New York, Oakland, Philadelphia, Phoenix, Portland, Providence, Salt Lake City, San Francisco, Seattle, and St. Louis, "Open Letter to Congress," <http://perma.cc/HYJ8-6Q77>.

²⁶ Tiffany McGuffee, "Roe Introduces the Healthy Food Choices Act," news release, September 10, 2013, <http://roe.house.gov/news/documentsingle.aspx?DocumentID=348911>.

²⁷ *Ibid.*

²⁸ Mal Leary, "Lepage Proposal Would Ban Purchase of Junk Food on Food Stamps," *MBPN News*, December 1 2014, <http://news.mpbn.net/post/lepage-proposal-would-ban-purchase-junk-food-food-stamps>.

²⁹ Steve Robinson, "Democrats: Buying Junk Food with Food Stamps Is Awesome for Mainers," *Maine Wire*, May 10, 2013, <http://www.themainewire.com/2013/05/democrats-buying-junk-food-food-stamps-awesome-mainers/>.

³⁰ Leary, "Lepage Proposal Would Ban Purchase of Junk Food on Food Stamps."

Representative Rick Brattin sponsored a bill that would bar food stamp recipients from purchasing energy drinks, cookies, chips, soft drinks, seafood or steak. In explaining his motivation to reporters, he cited health, government spending, and the abuse of benefits by SNAP recipients.³¹

Despite all of this activity, no bans have been successfully implemented. The failure of these proposals is particularly interesting in light of public willingness to vilify recipients of need-based aid. In public discourse, the poor are increasingly framed as undeserving - a trend scholars have tied to a shift in the 1960s towards the perception that the poor are predominantly black.³² Since the War on Poverty, discourse surrounding aid to the poor has largely shifted towards a focus on the individual as opposed to the system, and towards a view that individuals are responsible for causing their own economic problems and should be responsible for solving them.³³ Legislators have been successful in increasing regulations for need-based cash assistance (also referred to as welfare or by its acronym TANF), including work requirements and a recent spate of drug-testing requirements.³⁴ Such food stamp regulations are popular among the public. A 2012 poll found that a majority (69 percent) of respondents supported SNAP exclusions for sugary drinks, as did a majority (54 percent) of SNAP recipients themselves.³⁵ Polling suggests that a slightly smaller majority (53 percent) of Americans favor

³¹ Roberto A. Ferdman, "Missouri Republicans are trying to ban food stamp recipients from buying steak and seafood."; Brian Johnson, "Missouri Lawmaker Proposes Restrictions on Food Stamp Purchases," *KMBC*, April 5, 2015, <http://perma.cc/C3Z5-BVUH>.

³² Martin Gilens, "How the Poor Became Black," *Race and the politics of welfare reform* (2003); Hancock, *The Politics of Disgust*; Michael B Katz, *The Undeserving Poor: From the War on Poverty to the War on Welfare* (Pantheon Books, 1990).

³³ Rose and Baumgartner, "Framing the Poor: Media Coverage and US Poverty Policy, 1960–2008."

³⁴ National Conference of State Legislatures, "Drug Testing for Welfare Recipients and Public Assistance," <http://www.ncsl.org/research/human-services/drug-testing-and-public-assistance.aspx>.

automatic drug testing for welfare recipients, a policy which has been implemented with more success than SNAP bans.³⁶

Why then have food stamps been spared greater regulation? The most significant differences between SNAP and welfare regulations are economic and bureaucratic. There are significant economic incentives for soft drink and snack industry leaders (and their lobbyists) to actively oppose SNAP bans. There are no industries similarly incentivized to fight against new regulations on TANF. In fact the drug-testing industry has actively lobbied for mandatory drug testing for TANF recipients.³⁷ Equally significant are the differences in how SNAP and TANF are administered. Though both programs are heavily subsidized by the federal government, only SNAP requires that states receive federal approval of any changes to the program.³⁸ By contrast, TANF's structure grants states broad discretion in determining who is eligible for benefits, an innovation central to 1996 welfare reform changes (while the USDA has consistently rejected SNAP exclusions, the only rejections of drug testing requirements have come amid lengthy,

³⁵ Michael W. Long et al., "Public Support for Policies to Improve the Nutritional Impact of the Supplemental Nutrition Assistance Program (SNAP)," *Public Health Nutrition* 17, no. 1 (2012).

³⁶ "53% Support Automatic Drug Testing for Welfare Applicants," *Rasmussen Report*, July 20, 2011, http://www.rasmussenreports.com/public_content/politics/general_politics/july_2011/53_support_automatic_drug_testing_for_welfare_applicants.

³⁷ Isabel Macdonald, "The GOP's Drug Test Dragnet How the GOP and the Drug-Testing Industry Are Targeting Americans Seeking Government Help," *NATION* 296, no. 16 (2013). The Drug & Alcohol Testing Industry Association (DATIA) employs lobbyists to expand drug testing. Lobbyists and industry leaders vocally advocate on behalf of testing of TANF and SNAP recipients. At a DATIA conference an industry leader whose company was preparing to test welfare applicants in Georgia told reporters that it was "a matter of time" before drug testing welfare recipients would be widespread. Another described welfare as "a huge potential market of drug testing." Yet another, who was currently marketing his company's "welfare drug-testing services" in several states, described it as the best way to "drive some of 'em outta the program."

³⁸ Notably the two presidents elected since welfare reform have been vocal advocates of the SNAP program. Throughout his presidency George W. Bush joined a bipartisan effort in Congress to reverse cuts to benefits and application hurdles established in the 1990s and reduce the stigma of food stamp receipt. In 2002 President Bush signed a Farm Bill expanding food stamp benefits and restoring benefits to legal immigrants. The same bill offered bonuses to states enrolling the highest portion of their eligible population. Elizabeth Becker, "House Passes the Farm Bill, Which Bush Says He'll Sign," *The New York Times* 2002.

difficult, and uncertain engagement with the courts).³⁹ The relative safety of SNAP programs from invasive regulations is thus largely a consequence of private industry exerting economic pressure and public agencies like the USDA exercising authority over the program, which was designed in such a way as to provide some protection from the tendency for public animus towards the poor.

While state and national-level politicians have promoted SNAP food restrictions, anti-poverty groups and bureaucrats at the state and local level have taken aim at broader set of barriers to access to healthy food among the poor. In fact, opponents of bans have recently proposed several programs as alternatives to policies restricting SNAP purchases.⁴⁰ In place of restrictions, these alternative efforts focus on creating incentives to purchase healthy foods and providing services that address the structural variables shaping the eating habits and health outcomes of SNAP recipients.

In 2005, as part of an effort to address the high cost of healthy foods, the New York City Department of Health and Hygiene began offering incentives for SNAP recipients to use their benefits at farmer's markets.⁴¹ Initially just a few thousand dollars were available for the program, which provided SNAP recipients who spent \$10 of their benefits at farmers markets with an additional \$4 in "HealthBucks" to be used to purchase more local produce.⁴² By 2008

³⁹ In 2013 the 11th Circuit U.S. Court of Appeals blocked Florida's mandatory drug testing policy for welfare recipients. *Lebron v. Secretary of the Florida Department of Children and Families*, 772 F.3d 1352 (11th CIR 2014).

⁴⁰ Leary, "Lepage Proposal Would Ban Purchase of Junk Food on Food Stamps." In 2014 Maine Senator Hastedt proposed creating a pilot incentive program in response to Governor LaPage's proposal to restrict purchase of junk food with SNAP.

⁴¹ Rachel Winch, "Nutrition Incentives at Farmers' Markets: Bringing Fresh, Healthy, Local Foods within Reach," (2008), http://www.farmlandinfo.org/sites/default/files/ebt_matching_programs_rachel_winch_1.pdf.

⁴² "How 'Double Bucks' for Food Stamps Conquered Capitol Hill." Narrated by Dan Charles. The Salt. *NPR*, November 10, 2014, <http://www.npr.org/sections/thesalt/2014/11/10/361803607/how-double-bucks-for-food-stamps-conquered-capitol-hill>.

almost a dozen similar pilot programs were underway.⁴³ In the largest such program, at the Crossroads Farmers Market just outside of Washington DC, recipients tell a volunteer how much of their SNAP benefits they want to spend, swipe their EBT card, and receive double that amount in farmers market tokens. The creators of the Crossroads Farmers Market program also founded an organization called Wholesome Wave, which has introduced similar programs in farmers markets from Connecticut to California.

In Michigan, the Fair Food Network has created its own incentive program called Double Up Food Bucks, now operating in over 150 locations in the state.⁴⁴ For every \$1 SNAP recipients spend on locally grown produce in farmer's markets and at mobile trucks, they receive an additional \$1 to be used on produce in the same locations. The program recently expanded to include select grocery stores. In an effort to encourage federal adoption of the program, creator Oran Hesterman invited United States Senator Debbie Stabenow, to visit one of their sites. At the time Stabenow chaired the Senate's Agricultural Committee, which oversees the Farm Bill and thus the SNAP program. In 2013 then-chair Stabenow proposed including a farmers market incentive program in the pending farm bill, and in the following year a new bill passed with a provision to provide \$100 million over the next five years to increase SNAP benefits spent on fresh fruits and vegetables.⁴⁵ Estimates suggest that the funding will increase current spending on produce incentive programs by tenfold.⁴⁶

In related efforts, many organizations fund and manage SNAP incentive programs that provide access to fresh fruits and vegetables through doctors. For example, Wholesome Wave

⁴³ Winch, "Nutrition Incentives at Farmers' Markets." Funding was provided largely by foundations, such as the Kellogg Foundation, and local governments, including the New York City Department of Health and Hygiene

⁴⁴ "About the Program," Double Up Food Bucks, <http://perma.cc/LMA9-CY54>.

⁴⁵ "How 'Double Bucks' for Food Stamps Conquered Capitol Hill." Narrated by Dan Charles.

⁴⁶ Ibid.

also operates a program called Fruit and Vegetable Prescription Program or FVRx. Through the program doctors at participating hospitals can offer overweight and obese children a “prescription” to eat fruits and vegetables in place of medication or reprimands to lose weight. Enrolled children set goals for healthy eating, receive nutritional education, and undergo regular weight and BMI reevaluations. They also receive Health Bucks in the amount of \$1 per day per family member, that can be redeemed at farmer’s markets for local fruits and vegetables. After four months in Wholesome Wave’s program, 40 percent of children had lowered their BMI.⁴⁷

Applying a Feminist Analysis

1. Fat Panic: How Ideas of Health are Shaped by Cultural and Political Context

While these proposals are ostensibly driven by a desire to promote health, they might also be described as the result of increasing anxiety about health, and in particular as the result of the often hyperbolic manifestations of concern about a national obesity “epidemic.”⁴⁸ Over the past two decades, media outlets and have grown increasingly interested in the topic of obesity. Scholars such as Abigail Saguy and Paul Campos now argue that obesity constitutes a “moral panic,” characterized by attention to an issue that is disproportionate to the seriousness of the problem because it is implicitly or explicitly understood to be a threat to social values and

⁴⁷ Jane E. Brody, "Attacking the Obesity Epidemic by First Figuring out Its Cause," *New York Times*, September 13 2011, <http://www.nytimes.com/2011/09/13/health/13brody.html>.

⁴⁸ As an example of the sometimes hyperbolic perspectives associated with concern about obesity, in a *Times* interview, obesity researcher, Dr. Thomas Robinson, explained “To gain 15 lbs in a year, you only have to have an imbalance of 150 calories per day, which is one soft drink...even a Lifesaver has 11 calories. An extra Lifesaver a day is an extra pound per year.” Kolata, Gina. "While Children Grow Fatter, Experts Search for Solutions." *New York Times*, October 19, 2000. Accessed September 12, 2015. <http://www.nytimes.com/2000/10/19/us/while-children-grow-fatter-experts-search-for-solutions.html?pagewanted=1>. See also: W. Wayt Gibbs, "Obesity: An Overblown Epidemic?," *Scientific American* 292, no. 6 (2005). Paul F Campos, *The Obesity Myth: Why America's Obsession with Weight Is Hazardous to Your Health* (Penguin, 2004). Michael Gard and Jan Wright, *The Obesity Epidemic: Science, Morality and Ideology* (Routledge, 2005).

interests.⁴⁹ Academic studies of discourse surrounding overweight people have found that the media consistently sensationalize the issue of obesity by emphasizing studies with dramatic findings, employing alarming metaphors, providing exhaustive lists of health risks associated with obesity (including those only tenuously linked to obesity), and ignoring scientific debates over the extent to which obesity represents a serious problem.⁵⁰ The discursive patterns that characterize the obesity epidemic include exaggerating the extent of the epidemic by, for example, including overweight individuals in discussions of health effects linked exclusively or predominantly to obesity.⁵¹ We see these traits at work in near-universal coverage of a recent study that suggested that obesity could decrease the average American life span by eight years, and in coverage of the most preliminary and tenuous links between obesity and conditions from infertility to hearing loss.⁵²

Scholars in cultural studies, sociology, women's studies, and fat studies have drawn on social constructionist theory to further challenge the discourse of the obesity epidemic by linking it to "powerful interests and cultural values about fatness that are historically rooted and socially constructed."⁵³ Critics link anxiety over obesity to moral concerns about sloth and gluttony,

⁴⁹ Abigail C Saguy and Rene Almeling, "Fat in the Fire? Science, the News Media, and the "Obesity Epidemic"" *Sociological Forum* 23, no. 1 (2008), 74; Paul Campos et al., "The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?" *International Journal of epidemiology* 35, no. 1 (2006).

⁵⁰ Natalie Boero, "All the News That's Fat to Print: The American "Obesity Epidemic" and the Media," *Qualitative sociology* 30, no. 1 (2007); Campos, *The Obesity Myth: Why America's Obsession with Weight Is Hazardous to Your Health*; Gard and Wright, *The Obesity Epidemic: Science, Morality and Ideology*; Gibbs, "Obesity: An Overblown Epidemic?."; Matt Patterson and Josée Johnston, "Theorizing the Obesity Epidemic: Health Crisis, Moral Panic and Emerging Hybrids," *Social Theory & Health* 10, no. 3 (2012); Saguy and Almeling, "Fat in the Fire? Science, the News Media, and the "Obesity Epidemic" 2."

⁵¹ Boero, "All the News That's Fat to Print."

⁵² "Obesity Linked with Hearing Loss," *HuffPost Healthy Living* (2013); Reuters, "Half of Us Women Are Overweight During Pregnancy, Study Finds," *Fox News*, July 1 2015.

⁵³ Patterson, Matt, and Josée Johnston. "Theorizing the obesity epidemic: Health crisis, moral panic and emerging hybrids," *Social Theory & Health* 10, no. 3 (2012): 266; Campos, *The Obesity Myth: Why America's Obsession with Weight Is Hazardous to Your Health*; Susie Orbach, "Commentary: There Is a Public Health Crisis—Its Not Fat on

aesthetic concerns about ideal bodies, and social and political concerns about personal responsibility and laziness. Among these critics, some reject outright the association between obesity and poor health outcomes.⁵⁴ Others suggest that scientific knowledge about weight gain is, if not entirely objectionable, at least imperfect and unbalanced, and that public perceptions and media coverage of obesity dramatically overstate the significance and soundness of medical work on obesity.⁵⁵

Regardless of the extent to which our understanding of obesity as an epidemic is shaped by social and cultural variables, scholars argue that how we think about obesity has significant consequences in the social world.⁵⁶ If, for example, we think of obesity as a biomedical problem, we might call for medical research on causes and treatment of obesity, place the blame for obesity largely on biology, and view obesity as a problem facing individuals and communities (as we do other epidemics). If instead we view obesity as soft drink companies suggest, as a result of individuals exercising their right to make choices in a free market, we would likely protect the right of individuals to make choices that we see as unhealthy (while still judging those whose choices result in obesity), and view obesity as a problem facing individuals.⁵⁷

Critics of the obesity epidemic have also highlighted the economic incentives of researchers and activists who receive funding from the pharmaceutical and weight loss

the Body but Fat in the Mind and the Fat of Profits," *International Journal of Epidemiology* 35, no. 1 (2006); Esther D Rothblum, Sondra Solovay, and Marilyn Wann, *The Fat Studies Reader* (New York University Press, 2009); Saguy and Almeling, "Fat in the Fire? Science, the News Media, and the "Obesity Epidemic""; Marilyn Wann, *Fat! So?: Because You Don't Have to Apologize for Your Size!* (Random House LLC, 1998).

⁵⁴ See note 54.

⁵⁵ Boero, "All the News That's Fat to Print: The American "Obesity Epidemic" and the Media," 46., p. 46

⁵⁶ Samantha Kwan, "Framing the Fat Body: Contested Meanings between Government, Activists, and Industry," *Sociological Inquiry* 79, no. 1 (2009); Abigail Saguy, C., *What's Wrong with Fat?* (New York: Oxford University Press, 2013).

⁵⁷ Kwan, "Framing the Fat Body: Contested Meanings between Government, Activists, and Industry."; Saguy, *What's Wrong with Fat?*

industries. Some obesity researchers manage weight loss clinics or offer weight loss counseling services, and have an economic interest in defining obesity as broadly as possible, sometimes exaggerating the dangers of weight gain in order to justify support (regulatory, legislative, and fiscal) of their products and services. For example, The Obesity Society, which has actively lobbied to have obesity formally recognized as a disease, is funded principally by pharmaceutical and weight-loss companies and defends collaboration between scientists and industry.⁵⁸ Critics of such relationships echo the concerns of radical second wave feminists who criticized the profit incentives of medical institutions and industries, as well as the tendency for such incentives to encourage medicalization. In identifying ways in which our understanding of obesity is shaped by subjectivity and unscientific motives, they also remind us that our concepts of health are produced through social and political processes.

Advocates of policies further restricting food stamp eligible foods engage in similar discourse. They regularly invoke the language of epidemics and draw direct and scientifically unsound connections between soft drinks and obesity. In their letter to Congressional leaders asking them to institute a “soda ban,” the coalition of mayors noted, “as a result of obesity, this generation of American children is the first to face the possibility of a shorter life expectancy than their parents.”⁵⁹ Their claim emerged in 2002 when Dr. William Kish of Texas Children’s Hospital told the *Houston Chronicle* that in his opinion the childhood obesity epidemic could result in children having a shorter life expectancy than their parents. In 2005 the *New England Journal of Medicine* published a highly publicized study by epidemiologist S. Jay Olshansky and

⁵⁸ Campos et al., "The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?"; Theodore Kyle, "Tos Applauds AHA for Recognizing Obesity as a Disease," news release, 2013; Mollie Turner, "The Obesity Society Encourages Science-Industry Collaborations to Support Obesity Science, Public Health," news release, March 24, 2014, 2014, <http://perma.cc/2XX7-GN67>.

⁵⁹ Mayors of Baltimore, "Open Letter to Congress".

several co-authors supporting Kish's intuition.⁶⁰ In light of criticism, including that of the CDC's lead author of the Center for Disease Control's National Vital Statistics Report, one of Olshansky co-authors, biostatistician David B. Allen admitted that the life expectancy forecasts were only "back-of-the-envelope plausible scenarios."⁶¹ Nevertheless the forecasts continue to be reported by news outlets.⁶²

Media coverage of restrictive food stamp policies, like that of obesity, is frequently sensationalizing. A CNN Money article was headlined, "Food stamp soda ban can save 141,000 children from obesity."⁶³ The highly publicized article found that a soda ban "would prevent at least 141,000 kids from getting fat and another 240,000 adults from developing Type 2 diabetes." CNN's coverage greatly overstated the certainty of findings that (as the authors themselves noted) only presented a prediction of possible outcomes of a soft drink ban.⁶⁴ The findings were more accurately represented in the title of the academic article, "Ending SNAP Subsidies For Sugar Sweetened Beverages Could Reduce Obesity and Type 2 Diabetes," which is significantly more subdued.⁶⁵

Critics of obesity discourse remind us that how we understand and respond to health problems – including what constitutes a health problem, what conditions we believe promote it,

⁶⁰ S. Jay Olshansky et al., "A Potential Decline in Life Expectancy in the United States in the 21st Century," *New England Journal of Medicine* 352, no. 11 (2005).

⁶¹ Harriet Brown, *Body of Truth: How Science, History, and Culture Drive Our Obsession with Weight--and What We Can Do About It* (Boston: Da Capo Press, 2015): 16.

⁶² Jennifer Warner, "Baby Boomers May Outlive Their Kids," (2010); Pam Belluck, "Children's Life Expectancy Being Cut Short by Obesity," *The New York Times*, March 17 2005; Sreedhar Potarazu, "5 Reasons Why We May Outlive Our Kids," *FoxNews*, September 5, 2013, <http://www.foxnews.com/health/2013/09/05/five-reasons-why-may-outlive-our-kids/>.

⁶³ Jennifer Liberto, "Food Stamp Ban Can Save 141,000 Children from Obesity," *CNN Money* (2014).

⁶⁴ Sanjay Basu et al., "Ending SNAP Subsidies for Sugar-Sweetened Beverages Could Reduce Obesity and Type 2 Diabetes," *Health Affairs* 33, no. 6 (2014): 1034.

⁶⁵ *Ibid.*

how severe it is, what should be done to address it, and who is to be blamed – is shaped by social and political context. Or as these critics might say, our understanding of health is socially constructed. As a result, particular constructions of health are imbued with moral valences and assumptions, and the seemingly objective good of “health” can be used to mask moral, aesthetic, or social motivations. At its most sympathetic, this view still suggests that even those who genuinely desire to improve the health of others may be motivated to address particular health problems, address health problems in particular (invasive or repressive) ways, or treat those suffering in particular (stigmatizing) ways, because of unscientific, implicit, social and cultural biases. Thus socially constructed views of health shape our social and political world, as they do in the case of policymakers’ efforts to alter the food stamp program to address concerns about obesity.

2. Obesity and Food Insecurity: Structural Causes and Stratified Biomedicalization

Proponents of SNAP bans tend to link obesity directly to the poor choices of SNAP recipients. However, scholarship in public health and nutrition suggest that there is a much more complex set of variables discouraging healthy eating, including higher costs of healthy foods, preparation time, knowledge, transportation,⁶⁶ and cultural practices. Food insecurity shapes not only the amount of food individuals can afford, but also the kinds of food they can afford. Today

⁶⁶ See Chung and Freedman on food price disparities in low-income neighborhoods, Coveny on transportation as a barrier to healthy foods, Gordon on black, low-income areas tending to have healthy foods available but far outnumbered by unhealthy options. Walker’s 2012 review of food deserts literature highlights the range of problems beyond geographic location, including the aforementioned barriers. Chanjin Chung and Samuel L Myers, "Do the Poor Pay More for Food? An Analysis of Grocery Store Availability and Food Price Disparities," *Journal of Consumer Affairs* 33, no. 2 (1999); John Coveny and Lisel A O’Dwyer, "Effects of Mobility and Location on Food Access," *Health & place* 15, no. 1 (2009); Cynthia Gordon et al., "Measuring Food Deserts in New York City's Low-Income Neighborhoods," *ibid.* 17, no. 2 (2011); Renee E Walker, Christopher R Keane, and Jessica G Burke, "Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature," *ibid.* 16, no. 5 (2010).

\$1 can purchase almost five times as many calories of cookies or potato chips as of carrots.⁶⁷ As a result, high-fat, energy-dense diets are less expensive than diets based on lean meats, fish, and fresh fruits and vegetables. Adults experiencing food insecurity often reduce the variety of foods in their diet to include a few low-cost, energy dense yet nutritionally poor foods in order to maintain their caloric intake.⁶⁸ Doctors Hilary Seligman and Dean Schillinger, writing in *The New England Journal of Medicine* have argued that these kinds of compensatory behaviors “have enormous implications for the prevention and management of chronic disease.”⁶⁹ Research has also found that food insecurity is associated with lower diet quality and a higher risk of being overweight.⁷⁰

The negative health outcomes associated with food insecurity are made worse by the insufficiency of SNAP benefits, especially for low-income individuals with diabetes. This insufficiency is particularly true near the end of the month, when many families have exhausted their monthly SNAP benefits. A recent California study found that hospital admissions for hypoglycemia – episodes of low-blood sugar accompanied by complications ranging from dizziness to stroke – spike in the last week of each month among low-income individuals.⁷¹ Similarly, risk for hospital admissions due to hypoglycemia increased by 27 percent in the last week of the month among the low-income population. The study found no variation in the high-income population, suggesting that exhaustion of food budgets can be a significant source of

⁶⁷ A. Drewnowski and S.E. Specter, "Poverty and Obesity: The Role of Energy Density and Energy Costs," *American Journal of Clinical Nutrition* 79, no. 1 (2004): 9.

⁶⁸ Ibid.

⁶⁹ Hilary K. Seligman and Dean Schillinger, "Hunger and Socioeconomic Disparities in Chronic Disease," *The New England Journal of Medicine* 363 (2010): 6.

⁷⁰ P Peter Basiotis and Mark Lino, "Food Insufficiency and Prevalence of Overweight among Adult Women," *Nutrition insights*; 26 (2002).

⁷¹ Hilary K. Seligman et al., "Exhaustion of Food Budgets at Month's End and Hospital Admissions for Hypoglycemia," *Health Affairs* 33, no. 1 (2014).

health inequities. Previous studies have found that adults with diabetes who experience food insecurity have five more physician visits per year than those with adequate food.⁷²

A biological view of obesity does not seem to be the source for the failure to recognize structural causes of poor health among those facing food insecurity. Though proponents of SNAP bans often cite health problems associated with obesity, they tend to focus on poor decision-making by SNAP recipients as causes, where a biological view might focus on a genetic predisposition to weight gain. Thus, as in the case of drug use, health is explicitly invoked, but not a narrowly biological view of health. Instead, individuals are held responsible for their own poor health with recognition of neither structural nor biological causes to relieve them of blame and disapproval. For the marginalized, the current tendency toward individualizing health and rendering it a personal responsibility can be particularly harsh.

In light of this finding, SNAP programs focused on making healthy foods more accessible to SNAP recipients seem particularly promising. Going beyond the assumption that SNAP recipients desire too much soda, the programs acknowledge that fresh produce can be more expensive, more difficult to find, or impossible to afford on a SNAP budget. Many of the incentive programs also do work to demedicalize weight by advocating better nutrition in place of medication or surgery. Of course these alternatives are not perfect. Critics of medicalization might worry about programs like FVRx, which involve medical professionals in the distribution of food assistance, and encourage them to “prescribe” fruits and vegetables.⁷³

⁷² K. Nelson et al., "Is Food Insecurity Associated with Health Status and Health Care Utilization among Adults with Diabetes?," *Journal of General Internal Medicine* 16 (2001): 408-409.

⁷³ As discussed above, as part of a 2010 incentive program, doctors at three health centers in Massachusetts began writing vegetable “prescriptions” to be filled at farmers markets and providing low-income families with farmer’s market coupons amounting to \$1 a day per family member.

Attempts to combat obesity among the poor also highlight significant disparities in experiences of biomedicalization. In SNAP bans and (to some extent) farmer's market programs, the structural problems of food insecurity and, more broadly, poverty are individualized with no reference to biological views of health, and with no effort to increase consumption of medical care. At the same time, government-funded researchers study the genetics of weight gain, and the weight-loss industry promotes expensive weight loss treatments, invasive gastric bypass surgery, and genetic testing for risk of weight gain.⁷⁴ Gonido, a for-profit company, offers "obesity management and nutrigenomics" services to help individuals overcome "genetic barriers" to weight and determine whether they might benefit from appetite suppressant medication.⁷⁵ The poor are both punished by SNAP bans and overlooked by biomedicine, confirming arguments about its stratification and exclusionary/disciplining tendencies.

3. Invoking Obesity and Entitlement: Health as Power

Exploring SNAP food and drink bans also reminds us that not some forms of attention to health might not improve the lives of those whose health and health care are generally marginalized. In the case of food stamp bans, we find invocations of health that are not only motivated by exaggerated worries or "moral panic," but also used in a host of strategic political efforts to stigmatize vulnerable populations, discourage participation in SNAP, and demonstrate disapproval of entitlements. A superficial consideration of these policies might suggest that they are reasonable insofar as they target obesity among low-income/food-insecure individuals,

⁷⁴ These efforts are perfect examples of the trends associated with biomedicalization. They remove the association of stigma and moral failure with obesity through an emphasis on biological variables while increasing medical surveillance and consumption of medical technology, and encouraging individuals to seek out medical goods (and manage risk) for themselves on the free market. See: Stuart Hogarth, Gail Javitt, and David Melzer, "The Current Landscape for Direct-to-Consumer Genetic Testing: Legal, Ethical, and Policy Issues," *Annu. Rev. Genomics Hum. Genet.* 9 (2008); Rothblum, Solovay, and Wann, *The Fat Studies Reader*; Saguy, *What's Wrong with Fat?*

⁷⁵ "Obesity Management & Nutrigenomics," Gonido, <http://perma.cc/X2NU-VEPN>.

whose food-security status is associated with higher rates of obesity. However, a closer look reveals that research has consistently identified a correlation between food insecurity and obesity only among adult females, though of course SNAP bans target all recipients.⁷⁶ And while food insecurity and SNAP receipt have been found to be associated with obesity among adult women, there is no research identifying a causal link. Further, obesity is a problem reaching far beyond the poor. Only 20 percent of obese individuals have incomes below 130 percent of the federal poverty level, and many SNAP recipients are not obese.⁷⁷

For these reasons, public health scholars have argued that soft drink bans are ethically unacceptable according to standards of public health ethics. The authors of an article published in *The American Journal of Public Health* argue that a SNAP ban on soft drinks does not pass its profession's ethical standards, because a SNAP ban on soft drinks that is not accompanied by soft drink restrictions across government programs disproportionately targets the poor in attempting to address the much more widespread problem of obesity.⁷⁸ According to these scholars, the most troubling aspect of such a policy is that it "sends a public policy message that poor people require government intervention to manage their food choices whereas higher-income persons do not."⁷⁹ Under this view efforts to reduce soft drink consumption that focus solely or disproportionately on the poor are ethically suspect.

⁷⁶ Adams, Grummer-Strawn, and Chavez, "Food Insecurity Is Associated with Increased Risk of Obesity in California Women."; Marilyn S Townsend et al., "Food Insecurity Is Positively Related to Overweight in Women," *ibid.* 131, no. 6 (2001).

⁷⁷ Katherine M Flegal et al., "Prevalence and Trends in Obesity among Us Adults, 1999-2000," *Journal of the American Medical Association* 288, no. 14 (2002); Cindy W Leung and Eduardo Villamor, "Is Participation in Food and Income Assistance Programmes Associated with Obesity in California Adults? Results from a State-Wide Survey," *Public health nutrition* 14, no. 04 (2011).

⁷⁸ As they argue, infringements on the liberty to purchase certain market goods are not equivalent to liberties that are essential to well being.

⁷⁹ Nancy Kass et al., "Ethics and Obesity Prevention: Ethical Considerations in 3 Approaches to Reducing Consumption of Sugar-Sweetened Beverages," *American Journal of Public Health* 104, no. 5 (2014): 791.

Evaluating produce incentive programs under this rubric is a bit more complex. Programs that provide additional benefits for fruits and vegetables are less repressive than bans, and they allow recipients to purchase the healthy foods that they themselves express a desire to purchase. In this sense they recognize the unique problem facing SNAP recipients, for whom healthy foods can be prohibitively expensive. But they also reinforce some of the same flawed assumptions at the heart of punitive SNAP bans. Granting additional funds only for fruits and vegetables seems to assume that the government needs to tell SNAP recipients what to eat, or how to eat well. Rather than increasing benefits and trusting that SNAP recipients will spend them in whatever way best suits their family's needs, farmer's market programs nudge SNAP recipients to purchase fruits and vegetables in ways that other citizens are not nudged. They target SNAP recipients for nutritional efforts in ways that other, equally unhealthy, citizens are not targeted.

Appeals to health can be used to support more tenuous or less universally accepted political claims. Though in discussions surrounding the bans, there is regular emphasis on healthy eating, nutrition, and battling obesity, arguments about entitlement, cutting government spending, abuse of benefits, and wasting taxpayer dollars are also common. In many cases, arguments about health are linked to these more political contentious arguments. The sponsor of Missouri's proposal to ban junk food and luxury items (seafood and steak) said that his program aimed to link the SNAP program more closely to nutrition, but also said that the abuse of SNAP to purchase luxury items was so troubling that it must be stopped even if it meant banning healthy non-luxury items such as canned tuna.⁸⁰

Arguments in favor of SNAP restrictions often invoke concerns common to welfare debates. Particularly, they invoke concerns about the trustworthiness and capabilities of recipients of social support, as well as about their deservingness. In the absence of more

⁸⁰ Johnson, "Missouri Lawmaker Proposes Restrictions on Food Stamp Purchases".

widespread efforts to improve nutrition, these targeted bans suggest that SNAP recipients in particular cannot be trusted to make their own shopping decisions. In rejecting Minnesota's proposal, the USDA argued as much, stating that SNAP restrictions of this kind are motivated by disproportionate mistrust of beneficiaries.⁸¹ Though proponents highlight their concerns about health, these proposals are in fact linked to arguments asserting the inferiority (in trustworthiness, in capability of managing their own lives) of SNAP recipients.

In addition, proponents invoke long-standing assumptions about the (over)entitlement and (lack of) deservingness of social support recipients. For example, introducing a SNAP restriction on "unhealthy foods" in 2012, Florida state Senator Ronda Storms explained that she had been surprised to see shoppers purchasing junk foods with SNAP benefits in light of the ongoing recession.⁸² Missouri Republican Rick Brattin defended his proposed ban on seafood saying, "I have seen people purchasing filet mignons and crab legs with their EBT cards... When I can't afford it on my own pay, I don't want people on the taxpayers' dime to afford those kinds of foods either."⁸³ These kinds of arguments echo President Ronald Reagan's infamous campaign story about taxpayers fuming while standing in the grocery line behind a "young buck" purchasing T-bone steaks with food stamps.⁸⁴ Arguments from legislatures around the country suggest that SNAP recipients are not only incapable of managing their finances responsibly, but

⁸¹ Ollice C. Holden, "USDA to Minnesota Department of Health and Human Services " (2004), https://www.heartland.org/sites/all/modules/custom/heartland_migration/files/pdfs/15364.pdf.

⁸² Richard Fausset, "Food Stamp Bills Seek to Restrict Junk Food," *Los Angeles Times*, January 29 2012, <http://articles.latimes.com/2012/jan/29/nation/la-na-food-stamps-20120130>.

⁸³ Roberto A. Ferdman, "Missouri Republicans are trying to ban food stamp recipients from buying steak and seafood," WonkBlog, *Washington Post*, July 1, 2015, <http://www.washingtonpost.com/blogs/wonkblog/wp/2015/04/03/missouri-republicans-are-trying-to-ban-food-stamp-recipients-from-buying-steak-and-seafood/>;

⁸⁴ Though they are far less explicitly racialized than Reagan's comments, arguments about entitlement made in discussions of food stamp bans invoke biases heavily influenced by assumptions about the race of the average welfare or social support recipient.

that they live luxuriously off other's money. Viewed through this lens, SNAP bans rely on and reinforce long-standing and deeply racialized assumptions that "welfare" beneficiaries misuse benefits, cannot be trusted to make wise choices, waste taxpayer money, and have a sense of entitlement that must be checked. In this sense they are linked to proposals advocating that we fingerprint or drug test welfare recipients. Like these proposals, SNAP restrictions grow out of and reinforce the historically racialized biases about recipients of certain kinds of social support.⁸⁵

As the USDA has noted in rejecting such policies, the stigma associated with SNAP bans and drug tests serve to discourage participation in the program.⁸⁶ Nevertheless, legislators continue to propose increasingly drastic SNAP restrictions and requirements while invoking health. In light of the unlikelihood of such restrictions ever being approved, it is not unreasonable to suspect that SNAP restrictions are proposed for purposes aside from, and even in conflict with, health promotion. Headline-grabbing SNAP restrictions serve the goal of stigmatizing recipients, discouraging program participation, and demonstrating to voters that proponents are tough on (perceived) overentitlement and opposed to certain kinds of government spending.

Proposed SNAP restrictions explicitly aim to limit the agency of recipients, particularly their ability to purchase snack foods, soft drinks, seafood and certain cuts of beef. Even the non-punitive farmer's market programs only grant additional benefits for the purchase of specific foods in specific places. Attending to these concerns about agency requires us to consider the

⁸⁵ Martin Gilens, *Why Americans Hate Welfare: Race, Media, and the Politics of Antipoverty Policy* (University of Chicago Press, 2009); Hancock, *The Politics of Disgust*; Jill Quadagno, *The Color of Welfare: How Racism Undermined the War on Poverty* (Oxford University Press, 1994).

⁸⁶ Susan Bartlett et al., *Food Stamp Program Access Study: Eligible Nonparticipants* (Economic Research Service, 2004). Eligible nonparticipants who cited stigma as their reason for declining benefits increased in the wake of welfare reform, which implemented a wave of new restrictions on recipients.

perspective of food stamp recipients themselves. If we look to the experiences of SNAP recipients and eligible nonrecipients, we find that most of these proposals do little address the food insecurity or its associated health problems. In addition, the discourse surrounding SNAP bans contradicts many of the experiences and desires of SNAP recipients.

A survey of over 9000 SNAP recipients supplemented by in-depth interviews with 90 families found that most could not afford to eat the healthy diet they would prefer, but use cooking strategies to make the foods they can afford as healthy as possible.⁸⁷ When asked about the makeup of a healthy diet, respondents emphasized the importance of fresh fruits and vegetables, and drinking a lot of water. Many said that juices were full of sugar and should be avoided, as should fried or greasy foods, candy, cookies, chips, and soft drinks. Many said they would choose healthier foods if they had more money to spend, but that healthy foods simply cost more.⁸⁸ Most respondents said that they would like to buy healthier foods, particularly lean meats, fish, fresh fruits and vegetables, but that they could not afford to do so. Interviews with shoppers at a food pantry in rural Ohio also found that all respondents expressed “a tension between healthy eating and affordable eating.”⁸⁹

One study of participants in the SNAP program’s Nutrition Education Program found that the vast majority of those interviewed were interested in teaching, learning about, or working cooperatively on a food based educational activity, but were not interested in engaging in these activities with a SNAP educator. Recipients much preferred a facilitator, who would link interested parties together to teach one another new skills, over an educator who would preside

⁸⁷ Kathryn Edin et al., "SNAP Food Security in-Depth Interview Study," (Mathematica Policy Research, 2013): 58.

⁸⁸ Ibid.

⁸⁹ Laura J Flamm, "Barriers to EBT Use at Farmers' Markets: Lessons in Empowerment Evaluation from Rural Ohio," *Journal of Hunger & Environmental Nutrition* 6, no. 1 (2011): 58.

over a class.⁹⁰ Far from being passive beneficiaries of government support, SNAP recipients preferred to actively participate in educating themselves and their community about nutrition.

Implications and Conclusions

As the case of SNAP health promotion efforts demonstrate, health is normatively and practically complex. Where the health of pregnant drug users is largely ignored in legislative efforts, the health of SNAP recipients is the subject of great public debate and frequent policy initiatives. However, many of those policy initiatives are punitive, and disproportionately target (and punish) SNAP recipients. An exploration of SNAP health programs demonstrates the extent to which health policy can be shaped by outsized and culturally-informed concerns about health (i.e. the result of “fat panic”), and motivated by political concerns outside of health (i.e. racially-informed views of social welfare). As is often the case with health problems facing marginalized women, punitive policies are favored over efforts to increase awareness, improve access to care, or address structural variables. For marginalized women, when health and medicine are at issue, they tend to serve particularly punitive functions, including stigmatizing SNAP recipients.

In place of stigmatizing policies, we might aim to include SNAP recipients in the growing movement for local, organic, nutritious foods. Low-income individuals have largely been excluded from the food revolution, and are unable to access farmer’s markets or organic foods, let alone afford “whole” foods, or adopt “clean eating” or gluten free nutritional regimens.⁹¹ As we now know, health and nutrition are closely linked, and low-income individuals can suffer poor health as a result of their difficulty accessing adequate amounts of

⁹⁰ Catherine Greenwell Arnold et al., "New Concepts for Nutrition Education in an Era of Welfare Reform," *Journal of Nutrition Education* 33, no. 6 (2001): 344-345.

⁹¹ Marian Burros, “Eating Well; A New Goal Beyond Organic: ‘Clean Food’ *The New York Times* February 7, 1996; Food Research and Action Center “Why Low-Income and Food Insecure People Are Vulnerable” <http://frac.org/initiatives/hunger-and-obesity/why-are-low-income-and-food-insecure-people-vulnerable-to-obesity/>

healthy foods. With this finding in mind, we might support efforts to link SNAP recipients to farmers markets and to doctors who could provide nutrition advice and “prescribe” fruits and vegetables.

The recent success of healthy food incentive programs may seem to offer hope. Anti-hunger advocates and proponents of SNAP appreciate that incentive programs increase benefits, are not punitive, and address the troubling barriers to accessing healthy foods. As such, an analysis focused primarily on exclusion and marginalization might applaud these efforts. However, healthy food incentive programs are successful where increases in benefits and SNAP bans fail at least in part because they offer something to everyone. Critics of SNAP who find recipients untrustworthy or over-entitled likely appreciate that incentive programs create limits on what can be purchased with at least some benefits (fruits and vegetables rather than candy bars and lobster) and encourage healthy eating (encouragement of which they assume SNAP recipients are uniquely in need). In this sense they reaffirm the same problematic beliefs justifying SNAP bans. Notably, the \$100 million in federal funding for healthy food incentive programs came alongside an \$8 billion cut to SNAP benefits over 10 years.⁹² Further, these programs do little to address the many structural variables associated with food insecurity, obesity, and other health problems disproportionately affecting the poor.

With these failings in mind, we might turn to a critical view of health. Within SNAP ban discourse and legislation, arguments about health are motivated by concerns beyond health, including concerns about appropriate levels of government spending, paternalistic acceptance of the micro-management of the lives of low-income individuals, and racist and classist beliefs about over-entitlement. Further, efforts to address nutritional health unnecessarily invoke

⁹² Douglas W. Elmendorf, "Letter from CBO to House Agriculture Committee on the Effects of Proposed Cuts," (Washington, DC: Congressional Budget Office, 2013).

medical authority, inviting doctors to “prescribe” fruits and vegetables to children. Thus an emphasis on critical analysis of the deployment of health might lead one to reject the association of SNAP with efforts to improve health. We might recommend that SNAP be framed in the vein of Temporary Assistance for Needy Families or Social Security, as a social support program with little direct relation to health. However we know that a number of health problems are linked to food insecurity, and that food insecurity is particularly common among women. Feminists require an explanation of SNAP that acknowledges its relationship to marginalized women’s health while remaining critical of certain uses of health or forms of health care provision.

Together, a critical view of health and attention to disparities and exclusions provides a much different understanding. Under this view, we recognize that obesity impacts individuals of all socioeconomic statuses, and oppose obesity efforts that disproportionately focus on the poor. We ensure that obesity efforts that do affect poor communities are not punitive or stigmatizing, and are on the lookout for policies drawing on race or class-based stereotypes or animus. In light of our recognition that health is not a discrete good, efforts to improve the health and nutrition of low-income individuals must address the many interrelated health-demoting conditions facing low-income individuals rather than focusing on one health-demoting behavior (snack food consumption) without attention to context. Such efforts must be quite broad, including expanding SNAP benefits to minimize cycles of food deprivation and overeating, improving access to farmers markets and fresh produce in local stores, improving neighborhood safety and access to safe, appealing physical activity resources, improving access to organized sports, and addressing poor working conditions (including low wages that make it difficult to purchase healthy foods, devote time to prepare healthy foods or exercise). Existing farmers market programs are only one

piece of this puzzle and unfortunately they currently operate in the context of a political discourse focused on stigmatizing the poor in the name of obesity prevention.

In addition to offering a better understanding of the relationship between SNAP and women's health, my analysis also confirms important insights about women's health more broadly. It reaffirms the value of critically examining how and to what ends health concerns are deployed in policymaking. In doing so it urges us to question arguments that frame health as objective or apolitical and draws attention to the use of health to uphold existing structural inequalities. In the case of SNAP, arguments about health are closely linked with raced arguments stigmatizing the poor, and asserting their over-entitlement. Exploring SNAP and health reaffirms the many ways in which health can be political, including in its substance (insofar as the response to obesity rates is influenced by cultural norms about appearance), in its deployment (insofar as obesity is disproportionately associated with poverty and insofar as health arguments for bans mask or work alongside raced arguments about the appropriate levels of social welfare spending), and in its outcomes (insofar as health outcomes are shaped by structural variables including poverty, access to safe spaces to exercise, leisure time, and discrimination). This analysis supports the increasingly popular understanding of health outcomes as the result of a complex web of biological and social variables. Thus it affirms the view that health is not a discrete good that can be more equitably distributed simply by improving access to care. At the same time, it does a better job of attending to the interests of those who have been excluded or suffered disparate health outcomes than would a less critical analysis of health. It calls us to question health and health care as we seek them out, to demand health while maintaining that not any health will do.

CHAPTER 4: DOMESTIC WORK & OCCUPATIONAL HEALTH

Occupational health and safety represent yet another relatively recent expansion of health issues into new spaces. Though occupational health and safety concerns have been prominent since the Progressive Era, the United States has been uniquely slow among industrialized nations to address them.¹ The Coal Mine Health and Safety Act was not passed until 1969, at which point four thousand miners per year were dying of black lung disease.² When the Occupational Safety and Health Administration was created in 1971, 14,000 workers per year were killed on the job – today that number is closer to 4,000.³ Thankfully most workers now benefit from safety regulations, worker’s compensation, and minimum wage and overtime requirements. Domestic workers, however, do not.

Where SNAP bans saw women targeted by new discourses of health, occupational health has seen women ignored and excluded. In this sense the occupational health of domestic workers has something in common with the challenges facing pregnant drug users, whose health problems are not recognized as issues of health despite expert recognition. Unlike drug use, occupational safety is widely recognized by experts and policymakers as a health issue, and subject to a wealth of legislation aimed at ensuring health. Still, the occupational health of domestic workers remains ignored and unprotected. In this chapter I apply a feminist analysis to explore why and how this occurs. Exploring domestic work through the lens of feminist health

¹ Herbert K Abrams, "A Short History of Occupational Health," *Journal of public health policy* (2001).

² Barbara Ellen Smith, "Black Lung: The Social Production of Disease," *International Journal of Health Services* 11, no. 3 (1981), 351.

³ "Timeline of OSHA's 40 Year History," United States Department of Labor, <https://www.osha.gov/osha40/timeline.html>.

directly challenges views of health as apolitical, objective, and individual. As I will demonstrate in this chapter, domestic work is devalued. It is more arduous and less stable than necessary, the workers are vulnerable and frequently mistreated, and their health is of little concern to employers and legislators in great part due to their gender and race.⁴

In the following chapter I highlight the health outcomes associated with domestic work, and draw attention to the extent to which these health issues have been ignored by legislators and scholars of occupational and public health. To explore how and why the health of domestic workers has been ignored, I draw on feminist insights about the subjectivity of our ideas of health, the contextual causes of health problems, the political nature of health, and the stratified nature of biomedicalization, as well as concerns about agency and the role women play in defining their own health. My analysis suggests that the ideologies and structures that form the context for domestic work play a significant role in obscuring hazardous working conditions and undermining efforts to address those conditions.

Domestic workers have made possible enormous gains for (other) women, yet they are among the most marginalized and vulnerable women in our society. Generally, domestic workers are poorer and older than the average worker, and far more likely to belong to a racial minority group and to be undocumented.⁵ Domestic workers rarely have power to negotiate the conditions of their work, which is characterized by low pay, long and unpredictable hours, few if any benefits, and minimal legal protections. In great part due to these conditions, domestic work is associated with a host of health risks, and with health demoting environments and experiences.

⁴ See for example Enobong Branch, *Opportunity Denied: Limiting Black Women to Devalued Work* (Rutgers University Press, 2011); Mignon Duffy, "Doing the Dirty Work Gender, Race, and Reproductive Labor in Historical Perspective," *Gender & Society* 21, no. 3 (2007); Evelyn Nakano Glenn, "From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor," *Signs* (1992); Dorothy E Roberts, "Spiritual and Menial Housework," *Yale JL & Feminism* 9 (1997).

⁵ Linda Martin and Kerry Segrave, *The Servant Problem: Domestic Workers in North America* (McFarland, 1985). Estimates suggest that vast majority, roughly ninety-five percent of domestic workers are female.

Yet domestic work has been excluded from both research on occupational health and from vital legal protections.

Most of the tasks involved in domestic work, paid and unpaid, are encompassed in the terms “social reproduction” and “reproductive labor.” Marxist feminists, including Margaret Benston, Michele Barrett, Connie Fox, and Natalie Sokoloff, adopted the terms from the work of Marx and Engels, who differentiated between work that produced goods in the economy and work that reproduced the labor power required to maintain the productive economy.⁶ Initially these scholars employed the concepts to argue that the activities of housewives, from cleaning and cooking to childcare, were central to the economy and society and should be acknowledged as such.⁷ Though women have long performed social and reproductive labor without pay, in this chapter I focus on paid domestic work. This includes childcare, in-home, non-medical care for the disabled and elderly, cooking, and cleaning.⁸ In reality the tasks performed by domestic workers often cover a range of job descriptions, as when childcare or eldercare providers are asked to prepare food or clean up after their clients. In addition to supervising children, childcare providers might bathe them, feed them, clean up after them, and wash their clothes. I emphasize

⁶ Michele Barrett, *Women's Oppression Today: The Marxist/Feminist Encounter* (Verso Books, 2014); Margaret Benston and New England Free Press, *The Political Economy of Women's Liberation* (Radical Education Project, 1969); Bonnie Fox, "Hidden in the Household: Women's Domestic Labour under Capitalism," (1982); Natalie J Sokoloff and Elise Boulding, *Between Money and Love: The Dialectics of Women's Home and Market Work* (Praeger New York, 1980).

⁷ See Jeanne Boydston, "Home and Work: Housework, Wages, and the Ideology of Labor in the Early Republic," *OUP Catalogue* (2009); Mariarosa Dalla Costa and Selma James, *The Power of Women and the Subversion of the Community* (Falling Wall Press Bristol, 1975); Heidi Hartmann, "Capitalism, Patriarchy, and Job Segregation by Sex," *Signs* 1, no. 3 (1976). More recent work has challenged this definition, specifically in relation to the paid domestic work of women of color

⁸ Some statistical work operationalizes domestic work as any paid work in a private household (see: the International Labor Office “Domestic Work” Policy Brief) which includes those who work as private guards, drivers, and gardeners. Yamila Simonovsky and Malte Luebker, "Global and Regional Estimates on Domestic Workers," in *Domestic Work Policy Brief* (International Labor Office, 2011).

cleaning because it is the form of work for which the most data about occupational hazards is available.

Once thought to be a dying profession, the number of domestic workers has actually grown over the past three decades.⁹ Between 2004 and 2010 the number of nannies, housecleaners, and caregivers working in private households and directly paid by those households rose from 666,435 to 726,437, a nearly ten percent increase.¹⁰ The actual number of domestic workers is likely higher, as the fluidity of domestic work and undocumented status of many workers makes it difficult to achieve an accurate count. The vast majority of these workers are women.¹¹ The growing market for paid domestic workers has coincided with (and domestic work has in turn made possible) the continued entry of women into the paid labor force, the growth of dual-earner households, and the move by white middle- and upper-income women into traditionally male professions structured around a male wage earner/female home maker model.

The Nature of Contemporary Domestic Work

Reproductive labor, paid and unpaid, has been of particular interest to feminists because of the gendered divisions in the burden of work.¹² More recent research has improved upon initial analyses, suggesting that reproductive labor in the United States has been constructed

⁹ Lewis Coser, a proponent of modernization theory, theorized that domestic service would become extinct with the modernization of household labor and the labor force. Lewis A Coser, "Servants: The Obsolescence of an Occupational Role," *Social Forces* 52, no. 1 (1973).

¹⁰ Linda Burnham and Nik Theodore, "Home Economics," (New York, NY: National Domestic Workers Alliance, 2012), 10.

¹¹ Linda Burnham (Head Researcher for the NDWA) in discussion with the author, February 2015. The Home Economics report estimates that 95% of domestic workers are female.

¹² Sarah Fenstermaker Berk, *The Gender Factory* (Springer Science & Business Media, 1985).

simultaneously around gender, class, and race.¹³ Historically reproductive labor work has largely been seen as undesirable work, and thus has been performed by women whose labor has been least valued in society, including first generation European immigrants in the North, black women in the South (and later in Northern cities), Mexican women in the Southwest, and Japanese women (and notably many Japanese men) in California and Hawaii.¹⁴ In recent decades there have been significant changes in the makeup of the domestic workforce, though it remains deeply segregated by race/ethnicity, nationality, and gender. Black women who might previously have performed domestic work have increasingly found work in the formal economy, particularly in low paying, gender segregated “pink collar” jobs.¹⁵

Today black women make up fewer than 9 percent of domestic workers, down from 60 percent in the 1940s.¹⁶ Sociologist and scholar of Latina domestic workers Mary Romero has argued that citizenship status has come to play as prominent a role as race in positioning women for domestic service. Together, the increasing demand for care work as more women in the United States work outside of the home, the movement of black women out of domestic service, and increasing global income inequalities make it far more lucrative for women from the global South to work in industrialized nations as domestics than to work in white collar professions in

¹³ See Enobong Hannah Branch and Melissa E Wooten, "Suited for Service Racialized Rationalizations for the Ideal Domestic Servant from the Nineteenth to the Early Twentieth Century," *Social Science History* 36, no. 2 (2012); Collins, *Black Feminist Thought*; Glenn, "From Servitude to Service Work."; Hilary Graham, "The Concept of Caring in Feminist Research: The Case of Domestic Service," *Sociology* 25, no. 1 (1991).

¹⁴ Glenn, "From Servitude to Service Work."

¹⁵ Notably these service sector jobs often provide services associated with reproductive labor in a market setting, including food preparation, childcare, elder care, and health care. Ibid. See also Collins, *Black Feminist Thought*.

¹⁶ Barbara Ehrenreich and Arlie Russell Hochschild, *Global Woman: Nannies, Maids, and Sex Workers in the New Economy* (Macmillan, 2003), 6.

their home countries.¹⁷ In fact some countries in the global south encourage women to migrate for work, believing that they are more likely than men to send back money for their families.¹⁸ As a result of all of this, contemporary demand for domestic work is predominantly filled by women migrating from low- and middle-income countries, including Mexico, and Caribbean, Central American, and South American countries, many of who are undocumented.¹⁹

Domestic work operates largely in the informal sector of the economy.²⁰ Often this means that employees are paid in cash or “off the record,” with employers opting not to comply with federal and state requirements regarding minimum wage or payroll taxes and declining to provide benefits.²¹ Nearly a quarter of domestic workers are paid below their state’s minimum wage, and fewer than 9 percent have employers who pay into social security.²² As of 2012, 65 percent of domestic workers had no form of health insurance.²³ A survey of over 1000 parents from a wealthy neighborhood in Brooklyn found that over half (61 percent) did not pay their nannies overtime, despite New York State’s Domestic Workers’ Bill of Rights mandating

¹⁷ *Global Women* A teacher in the Philippines makes fifteen times less than a Filipina domestic worker in Hong Kong. p. 8

¹⁸ *Global Women*. In 2003, developing countries received \$142 billion in remittances, up from \$7.8 billion in 1980. The U.S. is one of the top two sources of remittances, and Mexico and the Philippines, two countries associated with domestic workers, are among the top three recipients of remittances. In some Latin American and Caribbean countries, remittances make up as much as 1.6 per cent of GDP. Bimal Ghosh, *Migrants' Remittances and Development: Myths, Rhetoric and Realities* (International Organization for Migration (IOM), 2006). U.S. residents are the source of 98% of all remittance money sent to Mexico, which received \$24 billion in 2012, or roughly 2% of the country’s GDP. D’Vera Cohn, Ana Gonzalez-Barrera, and Danielle Cuddington, "Remittances to Latin America Recover - but Not to Mexico," *Pew Research Center* (2013), <http://perma.cc/DB93-DLE2>.

¹⁹ Burnham and Theodore, "Home Economics," ix.

²⁰ This trend does not appear to be changing, particularly in light of the growing number of domestic workers who are undocumented and thus must work informally

²¹ Internal Revenue Service, "IRC §3510."

²² The IRS code requires households employing domestic workers to request an employee identification number, pay employment taxes and file additional forms with their annual income taxes. IRC§3510.

²³ This may have changed somewhat with the passage of the Affordable Care Act, though the high proportion of undocumented women among domestic workers has likely limited the extent to which it has increased insurance coverage within the profession.

overtime pay.²⁴ Only one percent reported providing health insurance for their nannies, while three percent said that they helped pay for doctors' bills without providing full health care coverage.

Because of their location in the informal sector, domestic workers often work without contracts and lack recourse when employers change the conditions of their employment. This means that employers can arbitrarily change their requirements for workers, violating verbal and even physical contracts with relative impunity. Mary Romero refers to the "diffuse" borders of domestic work to describe the tendency for employers to expand job duties during a worker's tenure.²⁵ Lacking a contract, legal recourse, and negotiating power makes domestic workers uniquely vulnerable to exploitation. One quarter of live-in workers had responsibilities that made it impossible for them to get at least five hours of sleep per night in the week prior to their interview, while 35 percent of domestic workers reported working long hours without breaks in the previous year. In the most comprehensive survey of domestic workers to date, the overwhelming majority (91 percent) of workers who encountered problems with their working conditions in the previous year had not complained because they were afraid that they would lose their job.²⁶

²⁴ Park Slope Parents, "The Park Slope Parents' Nanny Compensation Survey: Results," (2013).

²⁵ Mary Romero, *Maid in the USA* (Psychology Press, 2002), 131.

²⁶ Burnham and Theodore, "Home Economics." Home Economics is the report that emerged out of the first national survey of domestic workers in the United States. The survey was a collaboration between a number of domestic workers associations, including the NDWA, as well as the University of Illinois at Chicago's Center for Urban Economic Development, and DataCenter, a national research organization. The groups surveyed over 2,000 domestic workers in 14 metropolitan areas, and conducted surveys in nine languages.

Health Outcomes and Domestic Work

Though it is rarely recognized as such, domestic work is a physically demanding and often dangerous occupation. Household labor has been associated with a range of health problems from back injuries to exhaustion.²⁷ Domestic workers are regularly exposed to toxic chemicals in household cleaners, and those who provide care can be exposed to contagious disease. Cleaning duties require women to stand, crouch, and kneel in uncomfortable positions for long periods of time, and those who provide care are often regularly required to lift the weight of another adult. Working alone in the homes of their employers also leaves domestic workers uniquely at risk of exploitation, harassment, and abuse. Unsurprisingly, domestic workers also experience high levels of on-the-job stress.²⁸

Emerging research on household labor suggests that domestic cleaners face regular health hazards in their work.²⁹ Exposure to harsh cleaning products is of particular concern. Researchers have found that exposure to cleaning products including bleach, degreasing sprays, and air fresheners is associated with higher rates of asthma and other respiratory diseases among

²⁷ Ahmed A Arif, Patrick C Hughes, and George L Delclos, "Occupational Exposures among Domestic and Industrial Professional Cleaners," *Occupational medicine* 58, no. 7 (2008); Deanne K Hilfinger Messias et al., "Defining and Redefining Work Implications for Women's Health," *Gender & Society* 11, no. 3 (1997); Karen Messing, "Women's Occupational Health: A Critical Review and Discussion of Current Issues," *Women & health* 25, no. 4 (1997); Phyllis Palmer, *Domesticity and Dirt: Housewives and Domestic Servants in the United States, 1920-1945* (Temple University Press, 2010); Daniel Tierney, Patrizia Romito, and Karen Messing, "She Ate Not the Bread of Idleness: Exhaustion Is Related to Domestic and Salaried Working Conditions among 539 Québec Hospital Workers," *Women & Health* 16, no. 1 (1990).

²⁸ Burnham and Theodore, "Home Economics."; Mujeres Unidas y Activas, Day Labor Program Women's Collective of La Raza Centro Legal, and DataCenter, "Behind Closed Doors: Working Conditions of California Household Workers," (2007).

²⁹ Though this section focuses on research on increased rates of respiratory illness, research has also documented that cleaning women express worries about exposure to physical, chemical and biological hazards as well as the health consequences of stress and work overload. Messias et al., "Defining and Redefining Work Implications for Women's Health."

domestic cleaners.³⁰ A study of cleaners in England and Wales documented an increased risk of death from lung cancer and respiratory disease.³¹ In addition to being exposed to harmful chemicals, domestic cleaners report insufficient information and training about safely using cleaning products. They are particularly ill-informed when compared to cleaning workers in the formal sector, and report more adverse respiratory symptoms as compared with those workers.³²

Cleaning is also physically strenuous. Household cleaning is highly repetitive, high-intensity work that is particularly hard on the shoulders, arms, and back.³³ According to the first nation-wide survey of domestic workers, the National Domestic Workers Alliance's "Home Economics" report, 38 percent of domestic workers suffered from work-related wrist, shoulder, elbow, or hip pain, and another 31 percent suffered from other soreness and pain. In the words of a Brazilian cleaning woman:

Ovens do my back in. I hate cleaning ovens because you have to bend down the whole time in the same position and you have to really make an effort with your arm, so you're pushing and pulling your arm and straining your back and bending over all at the same time.³⁴

³⁰ RA Jajosky et al., "Surveillance of Work-Related Asthma in Selected Us States Using Surveillance Guidelines for State Health Departments—California, Massachusetts, Michigan, and New Jersey, 1993–1995," *MMWR CDC Surveill Summ* 48, no. 3 (1999); M Medina-Ramon et al., "Asthma Symptoms in Women Employed in Domestic Cleaning: A Community Based Study," *Thorax* 58, no. 11 (2003); M Medina-Ramon et al., "Asthma, Chronic Bronchitis, and Exposure to Irritant Agents in Occupational Domestic Cleaning: A Nested Case-Control Study," *Occupational and environmental medicine* 62, no. 9 (2005); Mercedes Médina-Ramón et al., "Short-Term Respiratory Effects of Cleaning Exposures in Female Domestic Cleaners," *European Respiratory Journal* 27, no. 6 (2006); JP Zock et al., "Asthma Characteristics in Cleaning Workers, Workers in Other Risk Jobs and Office Workers," *ibid.* 20, no. 3 (2002).

³¹ Kath A Moser and Peter O Goldblatt, "Occupational Mortality of Women Aged 15-59 Years at Death in England and Wales," *Journal of epidemiology and community health* 45, no. 2 (1991).

³² Arif, Hughes, and Delclos, "Occupational Exposures among Domestic and Industrial Professional Cleaners."

³³ Asa Kilbom and Elisabet Broberg, "Health Hazards Related to Ergonomic Work Conditions," *Women & health* 13, no. 3-4 (1988); J. Winkel et al., "The Working Environment of Cleaners. Evaluation of Physical Strain in Mopping and Swabbing as a Basis for Job Redesign," in *Ergonomics of Workstation Design*, ed. T.O. Kvalseth (London: Butterworths, 1983).

³⁴ DeAnne K Hilfinger Messias, "Transnational Perspectives on Women's Domestic Work: Experiences of Brazilian Immigrants in the United States," *Women & Health* 33, no. 1-2 (2001): 7.

Many cleaning tasks involve uncomfortable postures that require static muscular effort – or the contraction of muscles for a long period of time – which interferes with circulation, causing musculoskeletal and circulatory problems.³⁵ Strain to the circulatory and musculoskeletal systems is made worse by the regular repetition of these motions and postures.³⁶ Studies of care workers around the world have found disproportionately high rates of musculoskeletal disorders among the group, and 29 percent of caregivers surveyed in “Home Economics” reported suffering a back injury in the previous year.³⁷ Numerous live-in workers reported being provided with inadequate sleeping conditions such as basement rooms with no windows, unheated rooms, or simply sleeping on the floor in the children’s room.³⁸

The general circumstances that characterize domestic work are also associated with health problems. Studies have shown that women working in “non-supportive, socially isolating, and highly demanding” environments where they have little control tend to have higher rates of cardiovascular disease than their peers.³⁹ Similarly, irregular or lengthy working hours and low

³⁵ Messing, "Women's Occupational Health."; V Woods and P Buckle, "Musculoskeletal Ill Health Amongst Cleaners and Recommendations for Work Organisational Change," *International Journal of Industrial Ergonomics* 36, no. 1 (2006).

³⁶ "Musculoskeletal Ill Health Amongst Cleaners and Recommendations for Work Organisational Change."

³⁷ Jan Å Johansson, "Psychosocial Work Factors, Physical Work Load and Associated Musculoskeletal Symptoms among Home Care Workers," *Scandinavian journal of psychology* 36, no. 2 (1995); Işik Urla Zeytinoğlu et al., "Self-Reported Musculoskeletal Disorders among Visiting and Office Home Care Workers," *Women & health* 31, no. 2-3 (2001).

³⁸ Jessika Auerbach, *And Nanny Makes Three: Mothers and Nannies Tell the Truth About Work, Love, Money, and Each Other* (Macmillan, 2007): 218; Linda Burnham (Head Researcher for the NDWA) in discussion with the author, February 2015; Burnham and Theodore, "Home Economics," 18-19. In her 2007 work on nannies, Jessika Auerbach encountered a live-in nanny who was paid just \$250 per week and forced to sleep in the family’s garage.

³⁹ Barbara S Collins et al., "Women, Work and Health: Issues and Implications for Worksite Health Promotion," *Women & health* 25, no. 4 (1997); Ellen M Hall, JEFFREY V Johnson, and TSUNG-SHAN Tsou, "Women, Occupation, and Risk of Cardiovascular Morbidity and Mortality," *Occupational medicine (Philadelphia, Pa.)* 8, no. 4 (1992); Suzanne G Haynes and Manning Feinleib, "Women, Work and Coronary Heart Disease: Prospective Findings from the Framingham Heart Study," *American Journal of Public Health* 70, no. 2 (1980); Jeffrey V Johnson and Ellen M Hall, "Social Support in the Work Environment and Cardiovascular Disease," in *Social Support and Cardiovascular Disease* (Springer, 1994).

influence over job-related decisions have been associated with higher hospitalization rates for heart attacks and higher rates of negative self-reported health status.⁴⁰ These conditions, as well as the general vulnerability of domestic workers to exploitation and abuse, contribute to heightened rates of stress among domestic workers. Stress is in turn associated with anxiety, depression, and physical health problems including hypertension and greater susceptibility to infection, as well as negative health behaviors including alcohol abuse and poor eating habits.⁴¹ When health problems do occur, domestic workers, who are poorly paid and usually lack health insurance and sick leave, are poorly positioned to address them.

Marginalizing Domestic Workers' Health

Early work in occupational epidemiology operated under the assumption that workers were men and that the hazards they encountered were those of a typical male worker in a typically male occupation.⁴² The field has consequently been slow to recognize women's occupational health issues. Women's complaints of health problems resulting from exposure to organic solvents in the electronics industry were incorrectly diagnosed as hysteria well into the

⁴⁰ Lars Alfredsson, Curt-Lennart Spetz, and Tores Theorell, "Type of Occupation and near-Future Hospitalization for Myocardial Infarction and Some Other Diagnoses," *International Journal of Epidemiology* 14, no. 3 (1985).

⁴¹ Susan T Charles et al., "The Wear and Tear of Daily Stressors on Mental Health," *Psychological Science* 24, no. 5 (2013); Sheldon Cohen, David AJ Tyrrell, and Andrew P Smith, "Psychological Stress and Susceptibility to the Common Cold," *New England journal of medicine* 325, no. 9 (1991); Deborah A Dawson, Bridget F Grant, and W June Ruan, "The Association between Stress and Drinking: Modifying Effects of Gender and Vulnerability," *Alcohol and alcoholism* 40, no. 5 (2005); Elissa Epel et al., "Stress May Add Bite to Appetite in Women: A Laboratory Study of Stress-Induced Cortisol and Eating Behavior," *Psychoneuroendocrinology* 26, no. 1 (2001); Jeffrey S Flier, Lisa H Underhill, and Bruce S McEwen, "Protective and Damaging Effects of Stress Mediators," *New England journal of medicine* 338, no. 3 (1998); Tara A Hartley et al., "Associations between Major Life Events, Traumatic Incidents, and Depression among Buffalo Police Officers," *International journal of emergency mental health* 9, no. 1 (2007); Emily Newman, Daryl B O'Connor, and Mark Conner, "Daily Hassles and Eating Behaviour: The Role of Cortisol Reactivity Status," *Psychoneuroendocrinology* 32, no. 2 (2007); Talma Rosenthal and Ariela Alter, "Occupational Stress and Hypertension," *Journal of the American Society of Hypertension* 6, no. 1 (2012).

⁴² Generally, this meant men engaging in wage-labor in the public realm, though models might more specifically be based on men working in industrial occupations.

late twentieth century.⁴³ It was not until the 1980s that studies focusing on the relationship between women's work and women's health began to emerge.⁴⁴ Work-related musculoskeletal disorders did not begin gaining attention in women's occupational health research until the 1990s.⁴⁵ Critics explain these gaps by arguing that the dominant male model of work obscures the work-related health hazards experienced by women.⁴⁶ Further, they suggest that workplaces dominated by women, including hospitals, schools, homes, and offices, are mistakenly assumed to be safe work environments with minimal hazards.⁴⁷

Michelle Murphy's work on sick building syndrome is particularly relevant here. The World Health Organization coined sick building syndrome in the late 1980s to describe situations in which occupants of a building experienced a range of minor health problems for which no specific cause could be found. Women made up the majority of complainants and the women office workers' movement played a pivotal role in identifying and raising awareness of

⁴³ Rosemarie M Bowler et al., "Stability of Psychological Impairment: Two Year Follow-up of Former Microelectronics Workers' Affective and Personality Disturbance," *Women & health* 18, no. 3 (1992).

⁴⁴ Jacquie Aston and John Lavery, "The Health of Women in Paid Employment: Effects of Quality of Work Role, Social Support and Cynicism on Psychological and Physical Well-Being," *ibid.* 20 (1993); Haynes and Feinleib, "Women, Work and Coronary Heart Disease: Prospective Findings from the Framingham Heart Study."; Glorian Sorensen and Lois M Verbrugge, "Women, Work, and Health," *Annual review of public health* 8, no. 1 (1987); Nancy F. Woods, "Women's Health," in *Annual Review of Nursing Research*, ed. Joyce J. Fitzpatrick, R.L. Taunton, and Jane Q. Benoliel (New York: Springer, 1988).

⁴⁵ Collins et al., "Women, Work and Health."; Karen Messing, "Women's Occupational Health: A Critical Review and Discussion of Current Issues," *ibid.*; S.S. Stock, "Women and Work-Related Musculoskeletal Disorders: What Are the Research Priorities?" (paper presented at the Proceedings of the research roundtable on gender and work place health, Ottawa, Canada, 1992); Isik Urla Zeytinoglu et al., "The Impact of Work on Women's Health: A Review of Recent Literature and Future Research Directions.," *Canadian Journal of Women's Health Care* 8, no. 2 (1997).

⁴⁶ Lucía Artazcoz et al., "Occupational Epidemiology and Work Related Inequalities in Health: A Gender Perspective for Two Complementary Approaches to Work and Health Research," *Journal of epidemiology and community health* 61, no. Suppl 2 (2007); Messias et al., "Defining and Redefining Work Implications for Women's Health."

⁴⁷ Michelle Murphy, *Sick Building Syndrome and the Problem of Uncertainty: Environmental Politics, Technoscience, and Women Workers* (Duke University Press, 2006); Jane S. Zones and Kate Karpilow, "Women's Occupational Health and Safety in California: Safe at Work?," (Sacramento: California Womens Health Project/California Elected Women's Association for Education and Research, 1993).

the problem. When occupational health investigators were called in to inspect office buildings their equipment, designed for use in factories and industrial environments, rarely registered the presence of chemicals. Investigators familiar with acute chemical spills found it difficult to see hazard in these seemingly safe, comfortable spaces. However, the particular social standing of office workers made them feel entitled to a safe work space and to making demands on government bureaucrats and scientists. Thus, Murphy argues that the emergence of sick building syndrome was fundamentally tied to the political context, since sick building syndrome “expressed an expectation of comfort and safety as conditions of daily life for the beneficiaries of the privileges of race and class.”⁴⁸

A review of research on the interactions between women’s work and health from 1966 to 1998 confirms that low-wage work performed by women is consistently excluded from research on occupational health. In her work, Lucía Artazcoz found that existing literature on work and health had largely failed to address gender and that it employed analytical frameworks based on traditionally male-dominated occupations.⁴⁹ Similarly, a 1995 study found that research on occupational back pain did not correspond to professions reporting the most back pain, since it excluded both cleaners and waitresses.⁵⁰ A 1997 publication on public health insights into promoting women’s health excluded domestic workers entirely, focusing instead on clerical workers, retail workers, women in traditionally male occupations, women in the health sector, and flight attendants.⁵¹ As we shall see, more recent research has begun to address health hazards

⁴⁸ Murphy, *Sick Building Syndrome and the Problem of Uncertainty: Environmental Politics, Technoscience, and Women Workers*, 27.

⁴⁹ Artazcoz et al., "Occupational Epidemiology and Work Related Inequalities in Health."

⁵⁰ How-Ran Guo et al., "Back Pain among Workers in the United States: National Estimates and Workers at High Risk," *American Journal of Industrial Medicine* 28, no. 5 (1995).

⁵¹ Collins et al., "Women, Work and Health," 16-17.

facing women in traditionally female occupations, though it remains somewhat limited in breadth and impact.

Domestic work has also been excluded from vital state and federal protections for workers. Household employees were explicitly excluded from Social Security benefits when the program was introduced in 1935. Scholars have argued that the exclusion of domestic workers and agricultural workers, the majority of whom were black, was the result of racial bias on the part of Southern Democrats in Congress.⁵² Domestic workers were not made eligible until 1951, and even then criteria for inclusion continued to bar many domestic workers. Further, the Social Security administration has acknowledged that there has been widespread noncompliance and underreporting among employers, and that many household employees have not received the benefits to which they were entitled.⁵³ In 1994 the IRS estimated that only 25 percent of those employing household workers were in compliance with requirements that they pay social security taxes for their workers.⁵⁴ The so-called “Nanny Tax,” passed in 1994, aimed to streamline the process of paying employment taxes for employers of household employees, and consequently qualify employees for benefits, including worker’s compensation and social security, but it has done little to increase employer compliance rates.⁵⁵

⁵² Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare*; Robert C Lieberman, "Race, Institutions, and the Administration of Social Policy," *social science history* (1995); Mary Poole, *The Segregated Origins of Social Security: African Americans and the Welfare State* (Univ of North Carolina Press, 2006). For arguments against this interpretation see Larry DeWitt, "The Decision to Exclude Agricultural and Domestic Workers from the 1935 Social Security Act," *Social security bulletin* 70, no. 4 (2010).

⁵³ Martin and Segrave, *The Servant Problem: Domestic Workers in North America*; Glenn, "From Servitude to Service Work."; Ruth Needleman and Anne Nelson, "Policy Implications: The Worth of Women's Work," in *The Worth of Women's Work: A Qualitative Synthesis* (State University of New York Press Albany (NY), 1988).

⁵⁴ Kathy Kristof, "Your Money: Employ Domestic? This Tax Change Hits Home," *Los Angeles Times*, October 30 1994.

⁵⁵ Kim M Bloomquist and Zhiyong An, "Geographic Variation in Schedule H Filing Rates: Why Should Location Influence the Decision to Report "Nanny" Taxes?" (paper presented at the Proceedings. Annual Conference on Taxation and Minutes of the Annual Meeting of the National Tax Association, 2005).

When the National Labor Relations Act passed Congress in 1935, guaranteeing the right of non-governmental employees to form unions, engage in collective bargaining, and strike, it explicitly excluded domestic workers. Scholars have argued that this too was the result of Southern Democrats demanding the exclusion of predominantly black domestic and agricultural workers.⁵⁶ As a result, domestic workers do not have the right to form unions or strike to address poor working conditions. Domestic workers were also excluded from the 1938 Fair Labor Standards Act, which established a 44-hour, seven-day work week and minimum wage and overtime requirements. Although were later included through amendments, companions of the sick and elderly remain without minimum wage or overtime protections. Similarly, most domestic workers and independent care workers are not covered by the Occupational Safety and Health Administration (OSHA) regulations because they fall in the category of “self employed.” While other areas of work dominated by women (including office work) and reproductive labor performed in institutions (including child care, janitorial work, and elder care) are covered, domestic workers are not protected. In addition, several statutory worker protections include de facto exclusion of domestic workers, particularly those that apply to workplaces only if they reach a certain threshold of employees. Among these are Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, and the Americans with Disabilities Act. In the majority of states, domestic workers are excluded from workers compensation, which provides wage replacement and medical benefits to employees injured on the job. Among the 24 states that require worker’s compensation coverage for domestic workers, almost all include exemptions for employers with a single employee, for employers who pay employees under a

⁵⁶ Southern household workers had begun organizing before the law was passed. In 1866 washwomen in Jackson, Missouri organized a strike. Laundresses and household workers in Galveston struck in 1877. In 1881 washerwomen in Atlanta organized a massive strike, demanding higher fees and more autonomy over their trade. Tera W Hunter, "Domination and Resistance: The Politics of Wage Household Labor in New South Atlanta," *Labor History* 34, no. 2-3 (1993).

certain amount per year, and/or for employers whose employees work fewer than 20 or 40 hours per week. This effectively excludes many, if not most, domestic workers.⁵⁷

Labor activists have been at the forefront of addressing these failures to recognize the health challenges facing domestic workers. Grassroots organizations like the domestic worker collective *Mujeres Unidas y Activas* have been pivotal in drawing attention to the lack of health care for household workers and the many risks to which workers are exposed.⁵⁸ Other organizations have partnered with state actors to improve the health of domestic workers. Staff from Massachusetts's Brazilian Immigration Center testified before the state legislature in support of their Domestic Workers Bill of Rights, and after passage partnered with the US Department of Labor's Occupational Safety and Health office to develop one of the nation's first two-hour Domestic Worker Safety and Health Training Courses.⁵⁹ The California Domestic Workers Coalition played a pivotal role in the passage of California's Domestic Worker Bill of Rights and in encouraging the San Francisco Department of Public Health to conduct a health impact assessment of the legislation.⁶⁰ The California Domestic Workers Coalition is an affiliate of the National Domestic Workers Alliance (NDWA), which in addition to organizing workers,

⁵⁷Martin and Segrave, *The Servant Problem: Domestic Workers in North America*.

⁵⁸ *Mujeres Unidas y Activas*, Day Labor Program Women's Collective of La Raza Centro Legal, and DataCenter, "Behind Closed Doors." This is just one of many examples of grassroots organizers working to address the health problems facing domestic workers. Damayan Migrant Workers Association has advocated on behalf of a Marichu De Sesto, a Filipina domestic worker who was fired by her employer of almost fifteen years after requesting time off for medical reasons as part of their efforts to "highlight the plight of all domestic workers." They also hold health fairs offering on-site mammograms, cholesterol readings, and doctor consultations to low-wage migrant workers. Leah Obias, "Filipina Domestic Worker Demands Wages from Former Millionaire Employer," news release, October 29, 2014.

⁵⁹ Natalicia Tracy, Tim Sieber, and Susan Moir, "Invisible No More: Domestic Workers Organizing in Massachusetts and Beyond" (2014). *Labor Studies Faculty Publication Series*. Paper 1.

⁶⁰ "Domestic Workers' Health & Workplace Safety," San Francisco Department of Public Health, <http://www.sfhealthequity.org/elements/work/22-elements/work/82-domestic-workers-health-a-workplace-safety>.

advocates for legal protections for domestic workers at the state and national level, including regulations targeting health hazards.⁶¹

More recently, thanks to the efforts of domestic workers and their allies, state and local governments have begun to establish legal protections for domestic workers. In 2008, following four years of campaigning, Montgomery County, Maryland passed a Domestic Workers Bill of Rights entitling domestic workers to a written contract, health insurance, paid sick leave, and paid vacations, among other provisions.⁶² New York State adopted the first state-wide Domestic Workers Bill of Rights in 2010, providing domestic workers with the right to overtime pay, one day of rest every seven days, three paid vacation days per year, and protection from sexual or racial harassment.⁶³ Hawaii passed its own domestic workers protections, establishing minimum wage, overtime pay, and a right to be free from discrimination in the workplace, in 2013. After vetoing one Domestic Workers Bill of Rights, Governor Jerry Brown of California signed what advocates described as a “gutted” version of the legislation that mandated only overtime pay (provisions most closely linked with the health of workers, including the right to meal and rest breaks and the right of live-in employees to eight hours of uninterrupted sleep and sanitary sleeping accommodations, were eliminated from the final version of the legislation).⁶⁴ In 2014, Massachusetts became the fourth state to pass protections for domestic workers, requiring written contracts, a notification of termination, and maternity leave. Connecticut has since

⁶¹ Unfortunately the provisions most closely linked to health tend to be politically contentious and when legislation does pass they are often removed in the legislative process. For example, the vetoed version of the California Domestic Workers Bill of Rights included provisions for rest and meal breaks, the right to eight hours of uninterrupted sleep, sanitary sleeping conditions, and paid vacation. The bill that eventually passed mandated only overtime pay. Burnham.

⁶² Guillermo Cantor, "Struggling for Immigrants' Rights at the Local Level: The Domestic Workers Bill of Rights Initiative in a Suburb of Washington, Dc," *Journal of Ethnic and Migration Studies* 36, no. 7 (2010).

⁶³ New York State Department of Labor, "Domestic Workers' Bill of Rights," <http://perma.cc/22NG-7WWY>.

⁶⁴ Linda Burnham (Head Researcher for the NDWA) in discussion with the author, February 2015.

established a Domestic Workers Taskforce in an effort to develop legislation protecting domestic workers. Most recently, in June of 2015, Oregon became the fifth state to pass a domestic worker bill of rights, which included provisions for overtime pay, uninterrupted rest periods, adequate sleeping conditions for live-in workers, paid personal time, and harassment protections.⁶⁵

There has been recent activity at the federal level as well, with equally mixed results. In 2007 the Supreme Court cited the companionship exemption of the Fair Labor Standards Act in ruling that Evelyn Coke, a domestic worker who worked three consecutive 24-hour shifts and regularly worked 70-hour weeks for \$7 an hour, was not entitled to overtime pay.⁶⁶ In 2007 then-Senator Obama accompanied Pauline Beck, a home care aide, on a day of work for an event called “Walk a Day in My Shoes.” While campaigning for president, Obama regularly invoked his experience with Beck to illustrate the need for better health care for American workers. In 2011, with Beck at his side, President Obama announced newly proposed rules to revise the Fair Labor Standards Act to apply minimum wage and overtime requirements to home care aides.⁶⁷ By 2014 the Department of Labor had revised the regulations and eliminated the companionship exemption. In response, for-profit homecare industry groups filed a lawsuit challenging the policy, and in January 2015 a District of Columbia Circuit Court ruling struck down the revisions.⁶⁸

⁶⁵ *An Act Relating to Employment of Domestic Workers; Creating New Provisions; and Amending ORS 659a.885, SB 552.*

⁶⁶ *Long Island Care at Home Ltd. V. Evelyn Coke*, 462 F. 3d 48 (2007).

⁶⁷ "Keeping a Promise to Home Care Aides," *The New York Times* 2012.

⁶⁸ *Home Care Association of America V. Weil*, 1:14-cv-00967 (2015).

Applying a Feminist Analysis

1. The Social Construction of Health: Gender, Race and the Definition of Work

Feminists, from early self-help activists Kay Weiss to bioethicist Susan Sherwin, and critical race scholars like Dorothy Roberts have argued that medical knowledge and ideas of health are shaped by context.⁶⁹ That is, they have argued that social norms, ideologies, and even stereotypes can influence how we understand health and the kinds of practices we engage in to improve it. In the case of domestic work, occupational health hazards have gone unrecognized and inadequately addressed as a result of gender ideologies that declare the private sphere a fundamentally safe place that is defined in opposition to work, and as a result of gendered and raced notions about the low value of domestic labor and the suitability of women of color for domestic work specifically and physical labor generally.

The gender ideology surrounding the private sphere further undermines appropriate recognition of domestic work and its hazards. Ideas about reproductive labor are the product of gendered ideologies dating back to industrialization. During this period, white women's productive roles were coming to an end as a result of the shift away from family farming, the movement of men from farm to workplace, and the increased ability of families to purchase goods outside of the home.⁷⁰ Private home life came to be seen as increasingly separate from the public world. Beginning in the late eighteenth century, the ideology of separate spheres, which defined gender in terms of these separate worlds, came to dominate ideas about gender. White women's place was in the private sphere (the home) and men's place was in the public (in

⁶⁹ Roberts, *Fatal Invention*; Susan Sherwin, "Feminism and Bioethics," in *Feminism and Bioethics: Beyond Reproduction*, ed. Susan M. Wolf (New York: Oxford University Press, 1996); Kay Weiss, "What Medical Students Learn About Women," *off our backs: a women's newsjournal* 5, no. 4 (1975): 24-25.

⁷⁰ Branch and Wooten, "Suited for Service Racialized Rationalizations for the Ideal Domestic Servant from the Nineteenth to the Early Twentieth Century."; Bart Landry, *Black Working Wives: Pioneers of the American Family Revolution* (Univ of California Press, 2000).

politics and the workplace). These gender ideals were impossible to attain for poor women, including many women of color, who could not afford to give up wage labor. In place of their productive labor, which was now the domain of men and the public sphere, white middle- and upper- class women were encouraged to embrace an expanding role as homemaker. This new role tasked women with making the home a safe haven where working men could escape the harsh public sphere and work world. The ideological division of the private sphere from the public sphere meant that women's domestic work occurred in a sphere defined in opposition to work, and (mis)characterized as a safe, restful haven.⁷¹

These deeply gendered ideologies about the public and private spheres present significant barriers to recognizing the connections between domestic work and health. The separate spheres ideology adopts the male-gendered, market-driven model of work, which devalues and obscures domestic work and its hazards. Accordingly, though domestic work was grueling, labor reformers saw it as the natural domain of women, and society largely perceived domestic work to be stress free. Progressive-era reformers and legislators encouraged working women to pursue domestic work for its clean and healthy working conditions, even though domestic workers often worked longer hours than workers in factories, mines, and shops, performing heavy labor and staying on their feet for hours.⁷² Despite this, in 1912 the Supreme Court of California refused to apply a law regulating working hours for hotel maids to women working in private homes,

⁷¹ Catharine A MacKinnon, *Toward a Feminist Theory of the State* (Harvard University Press, 1989), 191; Susan Moller Okin, "Gender, the Public and the Private," *Feminism and politics* (1998). Feminists have written extensively on this misleading characterization of the private, including Catherine MacKinnon's argument that privacy "is what men call the damage they want to be permitted to do as far as their arms extend to whomever they do not want permitted to fight back," and criticized the very notion that the public and private are separate or could be analyzed or theorized about as such.

⁷² Erica C Morgan, "Invisible Workers: The Exclusion of Domestic Workers from Protective Labor Legislation," (2008): 18. See also David M Katzman, *Seven Days a Week: Women and Domestic Service in Industrializing America* (University of Illinois Press, 1981); A Negro Nurse, "More Slavery at the South," *JENdA: A Journal of Culture and African Women Studies* (2011).

asserting (incorrectly) that hotel maids worked longer hours and that their working hours should be limited because they worked outside of the home.⁷³ These notions of public and private remain embedded in public-private distinctions in the law, which differentiate between labor performed in the public and private spheres in ways that continue to shield paid domestic work from government scrutiny and regulation.⁷⁴

Many employers seem to adopt the dominant model of work, finding it difficult to view domestic workers as traditional workers or the home as a workplace (let alone a place that might make someone ill). According to an organizer in Chicago:

[I]t's still very hard for domestic workers to get contracts... it's almost for some employers at the point that they're not going to hire anybody if there's a contract because they think, 'there's going to be a contract in your own *home*, for your *household*?'⁷⁵

This view of domestic work as something other than a profession or business relationship can justify a host of conditions that contribute to the health problems of domestic workers, including the failure to provide worker's compensation, health insurance, breaks, and paid sick leave. It can also mean that employers neglect to provide domestic workers with the tools necessary to perform their work safely and effectively. According to the same organizer in Chicago, some workers carry their own vacuums across the city because employers are unwilling to provide one. We see this mindset in a *Village Voice* column penned by the disgruntled employer of a domestic worker:

She [the domestic worker] made only one demand: You had to have the following cleaning ingredients on hand: Windex, 409, Spic and Span, sponge mop, Easy-Off, Drano, Comet, Vanish, rubber gloves, broom and dustpan, dust mop, several clean rags, plastic brillo, Joy, Cascade... Make sure all appliances are in perfect working order. This

⁷³ Matter of Miller 162 Cal. 687, 700 (1912)

⁷⁴ See Taunya Lovell Banks, "Toward a Global Critical Feminist Vision: Domestic Work and the Nanny Tax Debate," *J. Gender Race & Just.* 3 (1999).

⁷⁵ Anna Jakubek (NDWA Chicago Affiliate Domestic Worker Organizer) in conversation with the author, February 2015.

includes a vacuum cleaner, VCR, Juicer, and blender (she may want to mix herself a health drink).⁷⁶

If they do not view themselves as employers or their home as a workplace, it is not surprising that employers of domestic workers would find these requests unreasonable. However, if employers recognized domestic work as work and treated it as such, the refusal to purchase safer cleaning products or keep vacuums and dishwashers running would become absurd (it is difficult to imagine an office worker being required to bring in their own desk or write all of their work by hand when a printer is down). Further, if legislation recognized domestic work as it does other forms of work, safety and labor protections would render illegal the refusal to provide necessary safety equipment, including gloves, to provide the safest equipment available, including less-toxic cleaning agents (not to mention the refusal to provide sick leave and health insurance). In the case of domestic work, however, such regulations are rare.

Domestic work is also rendered invisible by another aspect of the ideology of “home”: the mindset that workers are “one of the family.” In the words of a domestic worker who migrated from the Caribbean and remained in an “extremely low-paying” position:

They give you lots of things. They say you’re one of the family and you start believing it. You hear it so much... That’s part of the way they keep you... They’re not losing by giving you “darling” and “sweetheart.” They’re not losing anything.⁷⁷

Scholars of domestic work, including Mary Romero, argue that thinking of workers as one of the family rather than as employees misrepresents working conditions and can be used to justify additional duties, a lack of benefits, and low wages.⁷⁸ According to Representative Sara Gelser,

⁷⁶ Viva, "Maid in New York: How to Get and Keep Help," *Village Voice*, September 35 1986, n.p. For more on the history of housewives complaining about the demands of domestic workers see Martin and Segrave, *The Servant Problem: Domestic Workers in North America*.

⁷⁷ Judith Rollins, *Between Women: Domesticity and Their Employers* (Temple University Press, 1987), 174.

⁷⁸ Alice Childress, *Like One of the Family: Conversations from a Domestic's Life* (Beacon Press, 2012); Romero, *Maid in the USA*.

the sponsor of Oregon's domestic worker bill of rights, her fellow legislators "raised concerns about whether they'd have to still pay their nanny if she comes to Disneyland to care for the children and she is given Mickey Mouse ears."⁷⁹ Thinking of domestic workers as one of the family can also mean attaching emotional meaning to their labor – viewing their reproductive labor as something done out of love rather than as part of paid work for an employer. This view masks the nature of domestic work as manual labor and misrepresents the relationship between domestic worker and employer as a personal rather than a business relationship, obscuring the problems of burdensome workloads, low pay, and no benefits.⁸⁰

Notions of gender and work in the United States have also been intertwined with ideologies of race. As Patricia Hill Collins has explained, since slavery black women have worked at the intersection of public and private, and the economic necessity that they work outside of the home for pay has rendered them deficient as women in terms of U.S. gender ideology. Thus black women, along with other working women of color, have generally been unable to fit the dominant (white) model of womanhood. As black feminists since Sojourner Truth have argued, while white women have been conceived of as mothers, wives, and homemakers, black women have been conceived of as workers.⁸¹ Where white womanhood was identified with fragility and purity, black womanhood was associated with strength and

⁷⁹ Sheila Bapat, "Oregon Domestic Workers' Bill Fails, Highlights Importance of Workers' Voices," *RH Reality Check* (2013).

⁸⁰ Notably many domestic workers do feel affection for their employers, and many employers feel affection for their domestic workers. However, the "one of the family" trope is unique to domestic work. When a CEO feels affection for her secretary she is not likely to think that she performs her duties out of love for her employer, nor does she think that this affection between them makes benefits any less necessary, or that their personal relationship negates the need for formal contracts and agreements about the role and its requirements.

⁸¹ Mimi Abramovitz, *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present* (South End Press, 1996); Evelyn Nakano Glenn, "Racial Ethnic Women's Labor: The Intersection of Race, Gender and Class Oppression," *Review of Radical Political Economics* 17, no. 3 (1985); Gwendolyn Mink, "The Lady and the Tramp: Gender, Race, and the Origins of the American Welfare State," *Women, the state, and welfare* 93 (1990); Virginia Sapiro, "The Gender Basis of American Social Policy," *Political Science Quarterly* (1986).

resilience, and often, sexual availability.⁸² Accordingly, black women have not been understood to be delicate, or in any way endangered by work outside of the home.

The turn of the century saw a fundamental shift in the nature and organization of domestic work, and in expectations placed on domestic workers. As documented in the work of Enobong Branch and Melissa Wooten, as white women left the domestic workforce for opportunities from which black women were explicitly excluded, emerging notions of domesticity led employers to expect greater deference and servility, to require longer hours, and to delegate work rather than working alongside employees.⁸³ Middle-class white women rationalized the emergence of a largely black domestic workforce with arguments about the suitability of black women for domestic work.⁸⁴ Dominant group ideology posited that the proper place of black women was in service, and the proper place of the dominant group was to be served.⁸⁵ Sociologists, including Branch and Wooten, argue that middle class white women believed that black women were uniquely suited to service work.⁸⁶ In her account of the pressures that limited black women to domestic work, Branch quotes white women in the 1930s explaining their preference for black servants, who they described as “natural born servants,”

⁸² See Tamara Beauboeuf-Lafontant, *Behind the Mask of the Strong Black Woman: Voice and the Embodiment of a Costly Performance* (Temple University Press, 2009).

⁸³ Branch and Wooten, "Suited for Service Racialized Rationalizations for the Ideal Domestic Servant from the Nineteenth to the Early Twentieth Century," 174.

⁸⁴ *Ibid.*, 185. See also Glenn, "From Servitude to Service Work."

⁸⁵ "From Servitude to Service Work."

⁸⁶ Branch, *Opportunity Denied: Limiting Black Women to Devalued Work*; Branch and Wooten, "Suited for Service Racialized Rationalizations for the Ideal Domestic Servant from the Nineteenth to the Early Twentieth Century," 185.

“obedient and respectful,” and “by reason of race, docile.”⁸⁷ Looking to the literature of this period, it becomes clear that these justifications were fundamentally informed by race, specifically in assuming that black women were more submissive as a result of the legacy of slavery.⁸⁸

These ideologies have since evolved to incorporate nationality as domestic workers increasingly migrate from other nations.⁸⁹ An exploration of contemporary work, including that of Jessica Auerbach, Susan Davis, Gina Hyams, Barabara Ehrenreich and Arlie Hochschild, on the experience of employing nannies from outside of the United States confirms as much.⁹⁰

Arguments about the suitability for care work of women from low- and middle-income countries include that they have a cultural or racial talent, that their nationality/ethnicity imbues a willingness to do degrading work, or that they lack better alternatives for work. The experience of a Dominican nanny, as told in *Just Like Family*, illustrates the latter frame: “when [an employer] discovered there were white, American-born nannies, she wondered aloud, ‘why would they do that? It’s so degrading.’”⁹¹ The most common frame, however, is that migrant

⁸⁷ Branch, *Opportunity Denied: Limiting Black Women to Devalued Work*, 65; Branch and Wooten, "Suited for Service Racialized Rationalizations for the Ideal Domestic Servant from the Nineteenth to the Early Twentieth Century."

⁸⁸ "Suited for Service Racialized Rationalizations for the Ideal Domestic Servant from the Nineteenth to the Early Twentieth Century."; Elizabeth L O’Leary, "From Morning to Night," (Charlottesville, VA: University of Virginia Press, 2003): 40.

⁸⁹ Banks, "Toward a Global Critical Feminist Vision."

⁹⁰ In response to the recent increase in the hiring of nannies from outside of the United States, there has been an influx of popular books about the experience of employing nannies. See: *And Nanny Makes Three* Jessica Auerbach, 2007). *Searching for Mary Poppins: Women write about the Relationship between Mothers and Nannies* (Davis & Hyams, 2006). *Other People’s Children*, (Wrigley, 1996). *The Perfect Stranger: The Truth about Mothers and Nannies* (NYTimes, May 27, 2007). There have also been popular works that focus on the experiences of the migrant care workers themselves, including Ehrenreich and Hochschild’s *Global Women* 2003), Chang’s *Disposable Domestic: Immigrant Women Workers in the Global Economy* (2000) and Blaine’s *Just Like Family* which follows three nannies in it’s attempt to “give caregivers a voice” (p. 5)

⁹¹ Tasha Blaine, *Just Like Family: Inside the Lives of Nannies, the Parents They Work for, and the Children They Love* (Houghton Mifflin Harcourt, 2009): 35.

women are racially or ethnically suited for care giving. References to traditional cultural childcare remedies and the giftedness of migrant nannies, particularly those from low- and middle-income nations, are ubiquitous in employer accounts of working with caregivers.⁹² In a 2003 anthology on care workers, Arlie Hochschild quotes a nursery director in California who says that “the teacher’s aides we hire from Mexico and Guatemala know how to love a child better than the middle-class white parents.”⁹³ Another author found that employers often express preferences for specific nationalities of workers, reflecting racial hierarchies that rank women by ethnicity and associate different races and ethnicities with different skills.⁹⁴

Due in part to the emphasis on the social distance between domestic workers and employers, domestic work remains characterized by relationships of benevolence and maternalism. Domestic workers are often given “gifts” from their employers in place of more formal benefits including bonuses, paid time off, or health insurance.⁹⁵ According to a domestic worker whose employer gave her clothes and furniture she no longer used, “she felt if she gave me things, she wouldn’t have to pay too much.”⁹⁶ Others see employing domestic workers as a kind of charity. As Mary Romero explains in her ethnography of Chicana domestic workers, “hiring a domestic was likely to be presented within the context of charity and good works; it was considered a matter of helping ‘these Mexican women’ rather than recognized as a work

⁹² See note 69

⁹³ Ehrenreich and Hochschild, *Global Woman*, 23.

⁹⁴ Bridget Anderson, *Doing the Dirty Work?: The Global Politics of Domestic Labour* (Palgrave Macmillan, 2000): 109.

⁹⁵ Often these gifts consist of used clothing and household items that would otherwise be donated to charity. Romero, *Maid in the USA*.

⁹⁶ Rollins, *Between Women: Domesticity and Their Employers*, 172.

issue.”⁹⁷ Through this lens employers can see their professional relationship as one of benevolence or generosity rather than a contractual work relationship. One employer explained the ways she helped her Filipina nanny saying, “there is just so *much* she is able to do for [her family] with the money we pay her. Literally, all these things we take for granted: food, an education, clothing, medication, just basics.”⁹⁸ This view, and its implications for employer/employee relations, do not go unnoticed by domestic workers. As one domestic worker noted while explaining her preference for working-class clients, “rich people think they’re doing you a favor by allowing you to scrub their toilets. Working people understand you are doing them a service by making their lives easier.”⁹⁹

As this section suggests, domestic workers face a host of ideologies, beliefs, and biases that make their work more difficult and less visible. The context in which domestic work occurs, in which reproductive labor is devalued, in which home is defined in opposition to work and as a safe space, in which women of color are thought to be naturally suited to reproductive labor, and in which the immense social divide between employer and domestic workers results in exploitation and paternalism, obscures the hazards of domestic work and make it difficult for many to recognize and treat domestic work as they do other kinds of work. As a result, domestic workers health is not conceptualized as an issue of occupational health and safety.

2. Workplace Wellness and Stratified Biomedicalization

In the era of biomedicalization, differently situated women experience health and medicine differently. Middle-and upper-income white women continue to experience

⁹⁷ Romero, *Maid in the USA*, 34.

⁹⁸ Auerbach, *And Nanny Makes Three: Mothers and Nannies Tell the Truth About Work, Love, Money, and Each Other*, 97.

⁹⁹ Michelle Crouch, "13 Things Your Housecleaner Won't Tell You," *Reader's digest*, February 2012.

biomedicalization as “co-optative,” or as the expansion of medical technology and authority into new areas of their lives. Increasingly privileged women’s experiences of biomedicine take the form of expectations to aggressively monitor and promote their own health, which often require consulting medical professionals and consuming medical products. Poor women and women of color are more likely to experience barriers to medicine or disciplining and punitive medicine, than they are to face encouragement to engage in more preventative care or consume more medical treatments. Thus biomedicalization scholars Adele Clarke and Virginia Olesen describe it as a stratified system in which privileged women face “co-optative” medicine while marginalized women experience medicine as exclusionary/disciplining.¹⁰⁰

It may seem counterintuitive to think of biomedicalization as an absence of medical intervention. Here it is important to remember that biomedicalization does not refer solely to expanding medical authority but to the current regime of health and medicine, which is characterized by new standards of health, new medical technology, new subjectivities, and unequal application of and access to services. As a result of the stratified or unequal nature of biomedicalization, marginalized women are denied access to care, and the care that they sometimes do receive is often punitive. The barriers to care and the punitive nature of the health efforts targeting marginalized women are central characters of the same system that continues to expand medical authority over the experiences of privileged women, raise their standard of health, and urge them to consume new medical technologies.

We find this kind of stratification in the case of occupational health. For example, the health of office workers has been studied in great depth, and is frequently the focus of wellness

¹⁰⁰ Clarke et al., "Biomedicalization" 170.

campaigns.¹⁰¹ Half of all organizations with 50 or more employees employ a wellness program, funding a \$6 billion industry aimed at improving workers' health.¹⁰² Wellness program offerings include free healthy snacks, courses for weight loss and healthy eating, ergonomics training, stress management sessions, and even corporate gymnasiums and computerized health-risk analysis programs.¹⁰³ Meanwhile the health of domestic workers has received negligible attention from researchers, legislators, and employers. In some cases, requests for safer working conditions are met with derision.¹⁰⁴ And in the rare cases in which legislation on domestic workers' rights is passed, it includes few of the proposed regulations targeting the health of domestic workers.¹⁰⁵ Critics of medicalization and healthism might argue that wellness trends are coercive and profit-driven, that they aim to place responsibility for health-maintenance on individuals, and that they encourage individuals (in this case workers) to internalize the desire to constantly monitor their health. However, in the context of marginalized women's health we find that wellness programs also represent the more privileged (if not necessarily more liberating) side of biomedicalization.

Attention to stratified medicalization also alerts us to the fact that the conditions faced by domestic workers are made worse by disparate access to health care and sick leave. Historically

¹⁰¹ Penny Singer, "A Company Offers Help in Managing Stress," *The New York Times*, March 9 1997.

¹⁰² Austin Frakt and Aaron E. Carroll, "Do Workplace Wellness Programs Work? Usually Not," *ibid.*, September 11 2014. See for example, Pepsi's workplace wellness program PepsiCo, "Talent Sustainability: Health & Safety," <http://perma.cc/HB5Z-GGAA>.

¹⁰³ Jim Hirsch, "What's New in 'Wellness' Programs," *The New York Times*, October 5 1986. Notably, in addition to offering free courses and workout facilities, wellness programs increasingly employ penalties (often in the form of higher premiums) to promote health. The EEOC recently sued a Wisconsin company for requiring an employee who declined a screening provided by the company to pay her full \$5000 annual insurance premium. This invokes feminist critiques of its own which I unfortunately do not have time to address here. Reuters, "Coming Soon to a Workplace near You: 'Wellness or Else'," *ibid.*, January 13 2015.

¹⁰⁴ Viva, "Maid in New York: How to Get and Keep Help."

¹⁰⁵ Linda Burnham (Head Researcher for the NDWA) in discussion with the author, February 2015.

the majority of domestic workers lacked health insurance, and, according to advocates with the National Domestic Workers Alliance, they have been particularly prone to slipping through the cracks of the Affordable Care Act.¹⁰⁶ In Hilfinger-Messias's ethnography of Brazilian domestic workers, she encountered a woman who was unable to pay her medical bills after being fired without notice.¹⁰⁷ The stress resulting from growing debt and the two jobs she took on to make up for lost income resulted in an ulcer. Her economic situation and fear of losing another job made it impossible for the woman to take the recommended time off to rest, further exacerbating her health problems. Similarly, a domestic workers' advocate in Atlanta recounted the story of a member who had four children and worked 77 hours per week (which translates to 11 hours per day 7 days per week or nearly 15 ½ hours per day 5 days per week). She had not been to the doctor in "something like six years."¹⁰⁸ Domestic workers' ability to maintain their health and address health problems resulting from their work are severely compromised by a lack of access to health insurance and sick leave, as well as the often prohibitive out-of-pocket cost health care.

3. Health Outcomes as Structural and Political

A feminist political theoretical analysis recognizes that while health problems can result purely from biological variables, they can also result from structural variables, including power inequalities, institutionalized biases, policies, and regulations. The health hazards of domestic work are consistently facilitated, made worse, or made less remediable as a result of structural

¹⁰⁶ Tamiaka Atkins (Chapter Director of the National Domestic Worker's Alliance of Atlanta) in discussion with the author, February 2015.

¹⁰⁷ Messias, "Transnational Perspectives on Women's Domestic Work: Experiences of Brazilian Immigrants in the United States," 9.

¹⁰⁸ Tamiaka Atkins (Chapter Director of the National Domestic Worker's Alliance of Atlanta) in discussion with the author, February 2015.

inequalities. As the groundbreaking “Home Economics” report explains, power inequalities are a driving force in shaping the conditions facing domestic workers:

There is a power dynamic at play. While the employer needs labor and the employee needs work, this is rarely an equal exchange...for domestic workers, this inequality is intensified for a range of reasons, some inscribed in law and regulations, some particular to the nature of the work itself, and some related to the demographics of its workforce.¹⁰⁹

Domestic work is made more hazardous by inequalities between employer and employee and by race- and class-based notions of what can be demanded of a domestic worker. Here we might think of the common requirement that domestic cleaners clean floors on their hands and knees rather than using a mop, or expectations that they perform tasks at a speed that makes the work particularly strenuous or harmful to them.¹¹⁰ This power imbalance, combined with the lack of contracts and legal protections, makes domestic workers particularly likely to tolerate poor and unsafe working conditions, and less likely to request time off to rest or seek medical care. One quarter of live-in workers surveyed in “Home Economics” were allowed less than five hours sleep per night, and many more suffered injuries and health problems as a result of their work.¹¹¹ The vast majority (91 percent) of those who had problems with their working conditions in the previous year did not complain because they were afraid they would lose their jobs, and 85 percent of undocumented immigrants did not complain for fear of having their immigration status used against them. Undocumented workers were also more likely than documented

¹⁰⁹ Burnham and Theodore, "Home Economics," 8.

¹¹⁰ Romero, *Maid in the USA*, 134. Merry Maids, the largest residential-cleaning service in the United States, boasts that they will “scrub your floors the old-fashioned way...on our hands and knees.” Barbara Ehrenreich, *Nickel and Dimed: On (Not) Getting by in America* (Macmillan, 2010), 83. Mary Romero reports that “one of the most common experiences reported by women of color in reference to different standards was the request to scrub floors on their hands and knees rather than simply mopping.”

¹¹¹ Burnham and Theodore, "Home Economics."

workers to be required to do heavy strenuous work, work with toxic cleaning products, be injured on the job, and work while sick or injured, or while experiencing pain.¹¹²

The fact that these hazards and hardships disproportionately affect immigrant women and women of color is no accident. Historically, women of color have been compelled and coerced into domestic service. Following emancipation, employers refused to hire black women in the roles that allowed white women to leave domestic service, including clerical work. During World War II, employers excluded black women from desirable wartime jobs despite an executive order banning racial discrimination in war production industries.¹¹³ Employment discrimination against black women has historically been motivated both by a refusal to allow black women entry into certain kinds of work, and a preference for black women in certain kinds of work, including domestic service. During the labor shortages of World War II, observers in the South noted that white wives pressured their husbands “not to hire black women and in the process ‘spoil’ good domestic servants.”¹¹⁴ Economists suggest that discrimination on the part of employers continued to play a significant role in limiting the employment prospects of women of color well into the 1980s.¹¹⁵

State agencies and policies have also encouraged women of color to pursue domestic work based on their race. During World War I southern city councils used “work or fight laws,” which had been designed to draft unemployed men, to arrest black women who were housewives

¹¹² Ibid., 20.

¹¹³ Laurie B Green, ““Where Would the Negro Women Apply for Work?”: Gender, Race, and Labor in Wartime Memphis,” *Labor* 3, no. 3 (2006).

¹¹⁴ At the time, rumors also circulated about “Eleanor Clubs,” named for the First Lady, through which groups of black women cooperated to withhold their labor from the job market while demanding “unprecedented wage concessions.” Jacqueline Jones, *Labor of Love, Labor of Sorrow: Black Women, Work, and the Family, from Slavery to the Present* (Basic Books, 2009): 201.

¹¹⁵ James S Cunningham and Nadja Zalokar, “The Economic Progress of Black Women, 1940–1980: Occupational Distribution and Relative Wages,” *Industrial & Labor Relations Review* 45, no. 3 (1992).

or self-employed outside of domestic service.¹¹⁶ During the Great Depression, black women reported that Works Progress Administration (WPA) officials refused to place them in WPA jobs and demanded that they accept private work in domestic service or be taken off relief. At the same time, WPA officials in the South trained young black women for employment as domestic workers, while training young white women in separate classes that prepared them to be housewives.¹¹⁷ Similarly, in Texas, the segregated El Paso school system designed the education of Mexican children to prepare them for domestic work and manual labor.¹¹⁸

In recent years the forces of globalization have left households in the global north in need of cleaning and childcare services as women move to work outside of the home, and household in the global South households struggling to replace disappearing means of subsistence. Increasingly women are migrating to wealthier countries for work, where they predominantly work in domestic service. For undocumented immigrant women who must work “off the books,” the informal nature of domestic work can make it one of very few possible means of employment.¹¹⁹ According to U.S. Census Bureau’s American Community Survey, which is known to undercount undocumented immigrants, at least 46 percent of domestic workers are foreign born.¹²⁰ The makeup of the domestic work workforce, historically and today, reflects the interplay of race, class, gender, and citizenship. In this sense, marginalized women experiences

¹¹⁶ Branch, *Opportunity Denied: Limiting Black Women to Devalued Work*.

¹¹⁷ Palmer, *Domesticity and Dirt: Housewives and Domestic Servants in the United States, 1920-1945*, 109. During the same period, black women reported that WPA officials refusing to place them in WPA jobs and demanding that they accept private work in domestic service or be taken off relief. Branch, *Opportunity Denied: Limiting Black Women to Devalued Work*, 60-64.

¹¹⁸ Cameron Lynne Macdonald. *Working in the service society*. (Philadelphia: Temple University Press, 1996): 124.

¹¹⁹ In this sense the lax regulation of employers of domestic workers can benefit undocumented workers seeking a job, but the same lack of regulation allows employers to go without contributing to social security or paying a minimum wage.

¹²⁰ Cited in Burnham and Theodore, "Home Economics."

health problems that their white, native-born peers are less likely to experience as a result of a host of purely non-biological variables, including state coercion, legal and illegal discrimination, and immigration policy, all of which are in turn influenced by racial, ethnic, and gender biases.

A feminist political theoretical view reminds us that many health problems cannot be adequately addressed by solutions that target individual biology. Addressing the health problems association with domestic work would require far more than access to medical care for workers. It would require a shift in the practices of employers, which would itself necessitate significant changes in public policy requiring provisions for fair, safe working conditions, and mechanisms for ensuring that those provisions are followed. It would require a cultural shift in the way domestic work is understood (as work, not pleasure, not family time, not something to be grateful for) and valued, and in the way employers see their home (as someone's place of work) and themselves (as an employer responsible for providing safe working conditions and reasonable accommodations and benefits to their employee).

4. Domestic Hazards: Power, Agency, and Knowledge Production

Concerns about authority, control, and voice are also vital to a feminist theory of women's health, particularly in light of the history of the medical profession's often-authoritarian relationship to female patients. Feminists, including the self-help feminist Boston Women's Health Book Collective, and reproductive justice activist Loretta Ross, have argued that having control over one's own body - the ability to make informed decisions about one's body and health - is a prerequisite for broader gender equality and a just society.¹²¹ Further, they have argued that meaningful agency requires not only that there be a range of choices available

¹²¹ See for example, Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990* (New Brunswick: Rutgers University Press, 2002); Ross, "Understanding Reproductive Justice"; Ruzek, *The Women's Health Movement*.

to women, but that they have the ability to carry out those choices. Yet many domestic workers lack the ability to demand safe working conditions, seek medical care, or take time off to address health problems.

The power employers have over domestic workers is substantial, the result of multiple sources. The absence of labor protections and refusal of many employers to use contracts leaves workers without recourse in cases of mistreatment or abuse. The economic vulnerability of employees means that they lack negotiating power and often will not risk confronting employers about problems with working conditions or requests for time off, let alone health insurance. Though some workers report leaving employers with whom they disagree over working conditions, many more cannot afford to leave or risk being fired by an employer. Among domestic workers who are fired, nearly a quarter report being fired for complaining about working conditions, and another 18 percent are fired for objecting to violations of their contract.¹²²

Undocumented women are particularly vulnerable to exploitation. Like day workers, the vast majority do not complain about problems with working conditions because they fear that their immigration status will be used against them.¹²³ Live-in workers are isolated from family and friends, often with little free time to leave the home of their employers. They might also face language barriers that make it difficult to seek help or engage with individuals outside of the home. They are dependent on employers for shelter, making the possibility of being fired a greater threat. In the most extreme cases, migrant domestic workers have been treated as indentured servants, under the complete control of their employers, with no knowledge of the

¹²² Burnham and Theodore, "Home Economics."

¹²³ According to the Home Economics Report's national survey of domestic workers, 85% of workers do not complain about working conditions because they of fears related to their immigration status. Ibid.

language, or outside support, or alternative housing, and working in unsafe and degrading conditions for little or no pay.¹²⁴ The “Home Economics” report found that 36 percent of live-in workers had been verbally abused in the last 12 months, though the disproportionately high non-response rate for questions about abuse suggests that rates may be higher.¹²⁵ In comparison, 7 percent of Americans report suffering abusive conduct at work within the last year.¹²⁶ Rates of abuse among domestic workers more closely mirror those of emergency room nurses, though the vast majority (92.3 percent) of these instances involved patients rather than employers, many of whom were under the influence of alcohol or prescription drugs, or were psychiatric patients.¹²⁷ The National Domestic Workers Alliance points to the story of Daniela, a Mexican immigrant, to exemplify the vulnerability of live-in domestic workers. Daniela worked 17 hours a day for \$3 per hour, with no breaks, overtime, or sick days. Her employer confiscated her cell phone and verbally abused her. Reliant on her employer for housing and desperate to send money home to her family, Daniela endured the abuse for ten months before leaving.¹²⁸

Given these circumstances and the absence of employment rights and protections, it should come as no surprise that many domestic workers do not have meaningful agency in shaping the conditions and safety of their work (let alone life) or in deciding how to address the resulting health problems. In most cases, domestic workers remain vulnerable to threats and without recourse in ways that other employees are not. In the absence of legal protections and

¹²⁴ American Civil Liberties Union Women's Rights Project, "Human Trafficking: Modern Enslavement of Immigrant Women in the United States," <https://www.aclu.org/human-trafficking-modern-enslavement-immigrant-women-united-states?redirect=womens-rights/human-trafficking-modern-enslavement-immigrant-women-united-states>.

¹²⁵ Burnham and Theodore, "Home Economics," 25.

¹²⁶ Gary Namie, Daniel Christensen, and David Phillips, "2014 Wbi U.S. Workplace Bullying Survey," (Workplace Bullying Institute, 2014).

¹²⁷ "Emergency Department Violence Surveillance Study," Emergency Nurses Association, (2011).

¹²⁸ National Domestic Workers Alliance, "Daniela's Story," <http://www.domesticworkers.org/daniela-s-story>.

regulation, the provision of benefits, safer working conditions, and living wages depend entirely on the benevolence of employers. The absence of basic rights as well as health and safety provisions means that when domestic work (almost inevitably) results in health problems, workers have limited ability to respond in ways that attend to their health by seeing a physician (since most lack health insurance), taking time off (since most lack worker's compensation coverage and sick leave), or temporarily refusing to perform certain tasks (since they can be fired without cause).

The current absence of protections for domestic workers is part of a larger problem with how we define and protect work generally. As such, it is not solely the fault of a restrictive notion of women's health, but also of restrictive notions of work and failures on the part of state and federal legislators. Encouragingly, grassroots women's organizations are working to improve the conditions facing domestic workers. Even more encouragingly, they are drawing on the experiences of domestic workers to do so. The National Domestic Worker's Alliance (NDWA) regularly surveys members to identify their needs and perspectives, including on issues of workplace safety and health. For example, the Atlanta affiliate of the NDWA began its efforts to address health problems by surveying local domestic workers, whom they refer to as "members." As affiliate director Tamiaka Atkins explained, when the group attempts to develop new programming, they always begin by "figuring out what our workers' most pressing needs are, when you're organizing that's where you need to start."¹²⁹

The NDWA's work also demonstrates the value of allowing women to be involved in defining their own health needs. While campaigning for Medicaid expansion in Georgia, the Atlanta NDWA surveyed their members to determine what health needs would be after the

¹²⁹ Tamiaka Atkins (Chapter Director of the National Domestic Worker's Alliance of Atlanta) in discussion with the author, February 2015.

implementation of the Affordable Care Act. Their survey found that many of their members would likely make too much money to receive Medicaid (barring its unlikely expansion) and too little for health insurance subsidies to be useful. As a result, most paid the minimum for catastrophic coverage in order to avoid penalties, but could not afford regular care. Many workers found that even clinics serving low-income populations were too expensive, since without traditional paystubs they lacked the documentation necessary to receive care on an income-based sliding fee scale. Others were deterred by the paperwork involved, or by personal questions about the number of dependents they had living in their home.¹³⁰

To address these barriers to care, the Atlanta NDWA partnered with the Center for Black Women's Wellness (CBWW), a group dedicated to providing affordable health care to women of African descent. The partnership allows the NDWA refer their members to the CBWW, where they can receive a physical exam and general screenings at a discounted rate. Before members visit the CBWW, they review all of the necessary paperwork with staff at the NDWA, who answer questions, explain what information and payment will be required at the wellness center, and even scan paperwork to be sent to the CBWW before their visit. To address the problem of lack of documentation of pay, the NDWA helps domestic workers estimate their income and "certifies" that income, creating a special form of documentation that the wellness center accepts to qualify workers for income-based care.¹³¹ The NDWA also follows up with members, particularly those who are unable to make their own appointments, in an effort to help address any remaining barriers to receiving care.

¹³⁰ Ibid.

¹³¹ According to National Domestic Workers Alliance affiliate director Tamioka Atkins, "We've had members pay \$45 for a three hours doctors visit...One member was able to get diabetes medication free for three months, one member's diabetes medication was free. Folks like it, they really like it." Tamioka Atkins (Chapter Director of the National Domestic Worker's Alliance of Atlanta) in discussion with the author, February 2015.

In addition to engaging domestic workers in defining their own health needs, the NDWA chose a partnering clinic (the CBWW) that explicitly links health to empowerment.¹³² According to their mission statement, the center “provides free and low-cost services to empower black women, and their families, toward physical, mental and economic wellness.” Their self-declared “broader sense” of health includes recognition of the relationship between poverty, stress, discrimination, and health.¹³³ Their annual report shares stories of patients praising medical professionals who treated them “with dignity and respect.”¹³⁴ In addition to offering preventative and maternal health services and mental health screenings, the CBWW runs a 17-week training to prepare women for self-employment. The center emerged out of the National Black Women’s Health Project, which similarly linked black women’s health to self-esteem and empowerment and their health problems to broader structural variables including poverty and discrimination.¹³⁵

The NDWA also recruits former domestic workers as organizers. In fact Anna Jakubek, a former domestic worker now employed by a Chicago affiliate, created their health and safety training program. The training includes a cleaning and chemicals session, during which participants make their own green cleaning supplies with common household ingredients. A session on ergonomics informs participants about problematic postures, teaches exercises to relieve muscle strain, and provides information about tools that minimize muscular and skeletal injury. In a final session devoted to dealing with stress, workers discuss when and why they experience stress. According to Jakubek, women generally find that their stress is the result of

¹³² "Who We Are," Center for Black Women's Wellness, <http://cbww.org/who-we-are/>.

¹³³ Center for Black Women's Wellness, *Annual Report 2013-2014*, (2013), 3.

¹³⁴ *Ibid.*, 5.

¹³⁵ Byllye Y. Avery, "Breathing Life into Ourselves: The Evolution of the National Black Women's Health Project," in *Perspectives in Medical Sociology*, ed. Phil Brown (Prospect Heights: Waveland Press, 1996).

conflict over “basic things that should be settled at the beginning [of employment].”¹³⁶ These include working hours, whether employees are expected to work on weekends, and which tasks employers expect them to perform.¹³⁷

To address stress, participants are not only taught coping mechanisms, but are also encouraged to take greater pride in their profession, to learn their rights as workers, and to demand that their employers use contracts to ensure better working conditions. Unsurprisingly, the NDWA’s Chicago affiliate has found that many domestic workers are hesitant to broach the topic of contracts with employers, who tend to dislike discussing such matters. With this in mind, the curriculum presumes that empowering domestic workers is key to addressing stress resulting from conflict and exploitation. As Jakubek explains,:

We concentrate on stress because this a very stressful occupation...generally it’s not treated as professional work even though it’s putting bread on the table...domestic workers are treated badly and that makes it stressful. So first of all...we’re trying to make them feel that they’re professionals. That might change your life, when they get that settled mind that they’re worth something more than just cleaning somebody’s house and stop looking at [domestic work] as a very demeaning occupation.

At the conclusion of the training, participants are encouraged to become members of the NDWA and participate in working towards better conditions for all domestic workers. Rather than simply addressing stress as an inevitable outcome of domestic work, or as an individual biological problem, the training aims to address the structural causes of stress and to empower participants with tools to address them.

¹³⁶ Anna Jakubek (NDWA Chicago Affiliate Domestic Worker Organizer) in discussion with the author, February 2015.

¹³⁷ Ibid.

Implications and Conclusions

More than any other case discussed here, the occupational health of domestic workers draws our attention to the exclusion of marginalized women from the increased attention to and scope of women's health. Addressing this exclusion would seem to require offering domestic workers the kinds of protections guaranteed to other workers, establishing formal rights, workplace safety requirements, and ensuring access to health care. And in fact, an emphasis on inclusion initially seems less troubling in the case of domestic workers. Domestic workers are not punished by attention to (fetal) health or in place of attention to their own health, as in the case of pregnant drug users, nor is health used to stigmatize and scapegoat, as in the case of SNAP recipients. Instead, domestic workers' occupational health is largely ignored.

Where domestic workers' occupational health is addressed, the attempts at inclusion are inadequate and impermanent. Federal efforts to enforce social security payment by employers failed, and workers have slipped through the cracks of Medicaid expansion. Efforts to pass comprehensive worker's rights legislation have ended with meager protections that largely go unenforced. Even the most expansive regulations place much of the burden for improving conditions in the hands of employees, who must be informed and empowered enough to make demands with no certainty that their employers will agree to them or that government officials will enforce them. And bureaucratic actions to expand protections have failed, undermined by employer lawsuits. In order to understand this exclusion and these failures of inclusion, we must turn to a critical view of health.

Here again, attention to exclusion alone is insufficient. Meaningfully addressing the exclusion of domestic workers from occupational health protections requires a critical analysis of how and why they have been excluded. In light of this chapter's analysis of the exclusion of

domestic workers from occupational protections, it is clear that improving occupational health will require substantial changes beyond formal rights and regulations, including significant institutional and cultural changes. Improving conditions for domestic workers will require changes to the nature of the relationship between domestic workers and employers, including a shift toward more professional relationships that accommodate contracts, negotiations, requests for breaks and basic benefits and protections. Such a shift would be aided by formal protections (and enforcement of said protections), but would also be aided by much more difficult to achieve (and impossible to legislate) shifts in how we conceive of and value domestic work. Empowering and organizing domestic workers could help in this respect, as well as in increasing demand for and awareness of rights, and helping to change norms for employer/employee relationships. Addressing the occupational health of domestic workers will require formal legislation and protections but, as evidenced by past failures, it will also require new, more effective means of enforcing these protections in private homes. Unprecedented regulation of workers in the home would certainly be aided by popular support for worker protections, which brings us back to the need for recognition of domestic work as work and the home as a potentially hazardous workplace. All of this affirms the insight that health, and perhaps marginalized women's health in particular, is not a good that can be easily distributed through improved access to health care or recognition by medical professionals.

A feminist view of health allows us to recognize that the hazards of domestic work are made worse by the power dynamics at play in the profession, such as when employers require workers to perform tasks in ways that are unnecessarily hazardous, or when employees are unable to persuade employers to provide them with breaks, benefits, or healthy living conditions. The inability of domestic workers to draw attention to their collective health issues or address

their individual health problems with employers is similarly tied to their relatively marginalized position in society and their limited power in relation to employers. The obfuscation of domestic workers' occupational health is also the result of gendered and raced ideologies about reproductive labor and what constitutes work. Efforts to address these occupational hazards are made more difficult by ideas at the very foundations of our political system (including notions of privacy and the appropriate scope government that discourage regulation of work in the home) and our limited institutional means of regulating private employers of domestic workers.

Attending to domestic workers' occupational health reveals that marginalized women's health issues are not simply overlooked, they are often unintelligible under existing conceptions of health, risk, responsibility, and in this case, work. Moreover, they might be unresolvable through existing practices or institutions. As evidenced by the cases of drug use during pregnancy, food insecurity, and domestic workers' health, addressing marginalized women's health is not just a matter of including those women, because often the problem is simply not that these women do not merit public attention (though that is an element of it), but that their experiences do not fit our models of health, motherhood, workers, or deserving recipients of state support. In such cases, we cannot fathom marginalized women's needs as needs of health, let alone adequately address them.

CHAPTER 5: MOTHERHOOD AND MEDICALIZATION

Given my emphasis on marginalized women in the current discourses and practices of health, it may seem odd to turn in this last chapter to an issue through which I explore the experiences of privileged women. I have two aims in doing so. First, an exploration of postpartum depression throws into relief the differences between the experiences of privileged and marginalized women in the context of health. Second, it demonstrates the value of the approach I have taken in analyzing health as it operates in multiple sites, revealing that health is normatively complex for both marginalized and privileged women.

Where marginalized women have had their health ignored, or addressed without any attention to their own perspective, white women have often played a central role in drawing attention to their health problems. But that does not mean that discourses and practices of health are unproblematic for white women. As critics of healthism and biomedicalization have argued, in the era of biomedicalization, increased attention to health can have negative consequences, including notably expanding medical authority and obscuring social and political solutions to health problems. The following exploration of the medicalization of postpartum depression offers a view of the privileged side of biomedicalization, and the ways that the conceptualizations and practices of even the most attended-to health issues fail both privileged and marginalized women.

Here again my analysis is driven by the concerns central to feminist understandings of women's health. These include the recognition that our conceptualizations of health and illness are shaped not only by social and cultural context, but also by active negotiations over their

meaning. In the case of postpartum depression, activists lobbied medical professionals to formally recognize the condition, and lobbied legislators to provide funding for research, screening, and awareness raising. The recognition of postpartum depression as a medical condition was also profoundly shaped by cultural expectations about how mothers should feel and behave following the birth of a child. A feminist analysis is also attentive to the role of biomedicalization in shaping women's health, and to the stratified nature of health and medical care. These disparities predominantly occur between the privileged and marginalized groups, including between economically and racially privileged women and poor women and women of color. Studying postpartum depression allows for a particularly fruitful exploration of the role structural variables play in shaping health outcomes. Finally, a feminist analysis of women's health is attentive to the ways in which arguments about health can be used for strategic political purposes, and how women's health discourse can intentionally or unintentionally result in limitations on the agency of women.

The Medicalization of Postpartum Depression

Though severe postpartum reactions have been documented for centuries, the symptoms were not recognized as a disease by the medical profession until the early nineteenth century. Around this time, doctors began noting that some women became despondent after childbirth, suffering from depression or fits of rage. Some yelled at and beat their husbands while others refused to leave the bed and lost all concern for their appearance.¹ These behaviors were particularly notable for their deviance from strict gender norms of the time, which makes it an illustrative example of the close ties between social norms and notions of health and illness.

¹ Nancy Theirot, "Diagnosing Unnatural Motherhood: Nineteenth-Century Physicians and 'Puerperal Insanity'," *American Studies* 26 (1990).

Eventually this set of symptoms came to be known as puerperal insanity.² The identification of this disorder, and its clear location within medical and psychiatric disciplines served a strategic function, strengthening doctors' recently won authority over childbirth. However, by the late nineteenth century the diagnosis had fallen out of favor, after doctors came to agree that its causes and symptoms were not sufficiently uniform or narrow to constitute a unique disease.³

While doctors were once eager to accept puerperal insanity as a means of expanding medical authority over the childbirth process, following the nineteenth century they were resistant to women's efforts to identify their postpartum distress as a disease. Despite years of pressure from postpartum depression activists and researchers, the American Psychiatric Association did not officially acknowledge postpartum depression until 1994, when it was added to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* not as a distinct condition, but as a subcategory of another condition, major depression.⁴ Previously, the "postpartum onset" specifier was applied to cases of major depression if the symptoms began within four weeks of childbirth. With the publication of the *DSM-V* in 2013, a postpartum onset of major depression can now be diagnosed if it begins within four weeks of birth or during the pregnancy itself.⁵ This was a significant victory for postpartum depression activists and health care professionals, who have sought to expand the range of onset timing and open up the possibility of screening and

² Ibid

³ Ibid

⁴ The *DSM* is published by the American Psychiatric Association and provides the standard criteria for the classification of mental disorders. It is used by clinicians as well as researchers, health insurance companies, drug regulation agencies, the legal system and policy makers.

⁵ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (Washington, D.C: American Psychiatric Association, 2013).

treatment during the period of prenatal care.⁶

Postpartum mood disorders cover a spectrum of symptoms, from the common “baby blues,” feelings of melancholy or anxiety that resolve themselves relatively quickly after birth, to the much rarer and more extreme postpartum psychosis.⁷ Though the baby blues are not recognized under the *DSM*, in the lay-discourse surrounding postpartum depression they are frequently referred to as part of the spectrum of postpartum depression. The most common of the *DSM* recognized mood disorders is postpartum depression, which is characterized by unstable moods, irritability, insomnia, anxiety, tearfulness, and interpersonal hypersensitivity. According to the most recent *DSM-V*, postpartum depression occurs in between 3 and 6 percent of new mothers.⁸ Postpartum psychosis, the more acute condition, is characterized by severely depressed mood, disorganized thinking, hallucinations and psychotic thoughts, and occurs in only about 1 percent of the general population.⁹

It was not until the 1960s that researchers began investigating depression occurring in the postpartum period. At the same time, women involved in the women’s health movement began organizing postpartum depression self-help groups.¹⁰ By the late 1970s, both postpartum depression research and grassroots organizations had experienced rapid growth, with researchers

⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*.

⁷ About half of women experience symptoms associated with the postpartum blues. Laura J. Miller, "Postpartum Depression," *Journal of the American Medical Association* 287, no. 6 (2002).

⁸ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. The recorded prevalence of postpartum depression varies somewhat significantly, with other studies placing it between 10 and 20% of new mothers. Miller, “Postpartum Depression.”

⁹ Susan Hatters Friedman, "Postpartum Mood Disorders: Genetic Progress and Treatment Paradigms," *American Journal of Psychiatry* 166, no. 11 (2009): 1201.

¹⁰ The case of PPD shares much with other issues in women’s health and women’s movements generally. Its activist organizations emerged out of the women’s health movement of the 1960s and ‘70s and since then have become increasingly professionalized, and shifted from efforts to provide women care and support outside of traditional institutions to also working closely and successfully with state and federal legislators to better incorporate women’s needs into existing institutions.

developing concepts and hypotheses still in use today and organizers creating a national network of activists that began to raise public awareness of postpartum depression.¹¹ By the 1980s the grassroots organizations had finally transformed into a full-fledged movement, thanks in part to media exposure.¹² Grassroots efforts to raise awareness about postpartum mental distress were made easier by the media's longstanding preoccupation with motherhood and crime, as evidenced by the media frenzies surrounding cases of women accused of killing their children, including Andrea Yates, Susan Smith, and Casey Anthony.¹³ At the same time, postpartum depression became better known and more widely accepted as a legitimate medical condition. By the 2000s, celebrities including Gwyneth Paltrow, Courteney Cox, and Brooke Shields were coming forward to publicly discuss their struggles with postpartum depression.

In the wake of the postpartum activism of the 1990s, funding and legislation on postpartum depression have grown significantly. In 1999, in the midst of growing public attention to the issue, Congress passed a resolution urging hospitals and clinics to improve education and treatment of postpartum depression.¹⁴ Over the past decade twelve states, including Illinois, New Jersey, Washington, and Texas have initiated mandatory screening for postpartum depression, and others, including New York, have considered similar legislation.¹⁵ Between 2000 and 2013 the number of studies of postpartum depression funded by the National

¹¹ Taylor, *Rock-a-by-Baby: Feminism, Self-Help and Postpartum Depression*.

¹² Angela Thompson, who had committed postpartum-psychosis induced infanticide, came forward to tell her story on the nationally televised Phil Donahue show in February of 1988

¹³ Cheryl L. Meyer and Michelle Oberman, *Mothers Who Kill Their Children: Understanding the Acts of Moms from Susan Smith to the "Prom Mom"* (New York: New York University Press, 2001). Yates' case inspired at least two feature films and the television show *Desperate Housewives*, in addition to countless episodes of true-crime television series.

¹⁴ *Expressing the Sense of the House of Representatives with Respect to Postpartum Depression*, 106th Cong., H. Res. 163.

¹⁵ David Bornstein, "Treating Depression before It Becomes Postpartum," *The New York Times* 2014.

Institute of Health more than quadrupled, and funding increased from around \$2 million per fiscal year to over \$15 million in 2013.¹⁶ Following the highly publicized suicide of Melanie Blocker-Stokes, who suffered from postpartum psychosis, Congressman Bobby Rush introduced the Melanie Blocker-Stokes Postpartum Depression, Research and Care Act of 2001.¹⁷ The act provided funding for research into the causes of postpartum depression, and efforts to educate the public about the condition, as well as resources for new mothers. The bill never made it out of committee, but Congressman Rush continued to reintroduce the legislation in subsequent sessions. The legislation did manage to advance to the Senate in 2007, where it again died. It finally passed as part of the Affordable Care Act of 2010.

The *DSM-V*, published in 2013, represents a notable evolution in the relationship between medical professionals and postpartum depression activists. At a 2010 panel on DSM-5 revisions, the working committee revealed that the postpartum onset specifier would not be extended and that they had not found persuasive evidence to recognize postpartum depression as a disorder distinct from existing depressive disorders. During the question and answer period, postpartum depression activists from Postpartum Support International, Postpartum Progress, and Postpartum Support Virginia, challenged the committee to reconsider these decisions. During the public input and testimony phase of the *DSM5* revisions, the American Psychiatric Association invited a representative of Postpartum Support International, a network of PPD activists, researchers and health care professionals, to a briefing meeting. There PSI called for the extension of the onset period from four weeks to six months, and for the recognition of

¹⁶ Information available via the National Institute of Health “RePORTER” Research Portfolio Online Reporting Tools Expenditures and Results.

¹⁷ *Melanie Stokes Postpartum Depression Research and Care Act*, 107th Cong., H.R. 2380.

postpartum and peripartum anxiety disorder and obsessive compulsive disorder.¹⁸ The DSM's postpartum depression working group did eventually considered expanding the window for the postpartum onset specifier, noting in a committee report that "studies conducted subsequent to DSM-IV have shown that the period of elevated risk following delivery extends to 6 months in unipolar depression."¹⁹ In the end, they expanded the diagnosis to include depression during pregnancy, but did not extend the onset timing beyond four weeks after birth, to the satisfaction and frustration of activists.²⁰ Though, as a review of the DSM In practice however, many researchers and clinicians acknowledge that postpartum depression can begin well after the first four weeks of motherhood, and employ a working definition of the postpartum period lasting up to 6 months to a year after delivery.²¹

Applying a Feminist Analysis

1. "Healthy" Mothers and Gendered Parenting

Postpartum depression discourse emphasizes women's roles as wives and mothers. Specifically, it laments the fact that postpartum depression undermines women's ability to properly or fully experience new motherhood. In the 2004 hearing U.S. Representative Capps described postpartum depression as a condition that strains families "just at the time when they

¹⁸ "Postpartum Support International and The DSM5," *Postpartum Support International* (blog). <http://www.postpartum.net/professionals/postpartum-support-international-the-dsm5/>

¹⁹ Michael W. O'Hara, and Jennifer E. McCabe. "Postpartum depression: current status and future directions." *Annual review of clinical psychology* 9 (2013): 379-407.

²⁰ Postpartum Progress, "What The New DSM-V Says About Postpartum Depression & Psychosis," available at: <http://www.postpartumprogress.com/what-the-new-dsm-v-says-about-postpartum-depression-psychosis>; Postpartum Support International, "Postpartum Support International and the DSM 5," available at: <http://www.postpartum.net/professionals/postpartum-support-international-the-dsm5>

²¹ Timothy Rogge, "Postpartum Depression," National Institute of Health, *Medline Plus*, September 2, 2014, <http://www.nlm.nih.gov/medlineplus/ency/article/007215.htm>. Michael W. O'Hara, and Jennifer E. McCabe. "Postpartum depression: current status and future directions." *Annual review of clinical psychology* 9 (2013): 379-407.

expect to be able to revel in the joy of the birth of a child.”²² In 2007 Representative Marsha Blackburn suggested that it was “so hard and so difficult for many of the medical community to realize what it [postpartum depression] was when it happened because having a baby should be such a joyous time.”²³ NIH Women’s Program Director Nada Stotland suggested that childbirth “should be a joyous experience.”²⁴ In her prepared statements, Representative Anna G. Eshoo got to the heart of the problem, saying that women do not tell anyone about their symptoms because they are ashamed about feeling depressed “when they’re supposed to be happy. They worry that they will be viewed as an unfit parent.”²⁵

Rather than suggesting that our ideas of motherhood are idealistic, or unattainable in the current social and political context, postpartum depression discourse identifies women who do not conform to those ideals as unhealthy. This medicalization is particularly troubling in light of the conceptual slippage between all forms of postpartum mental distress, regardless of their severity. The frequent reference to baby blues as postpartum depression means that women who might be responding quite reasonably to the challenges presented to mothers in our society, and doing so in a way that does not threaten her health or that of her child, can be labeled as ill. These same women can be encouraged to blame their dissatisfaction or stress on biology (and address it with medicine), rather than on social and political variables (which would better be addressed by consciousness-raising, empowerment, and political action).

The social construction of postpartum depression is, like most issues of women’s health,

²² Subcommittee on Health of the Committee on Energy and Commerce, *Improving Women's Health: Understanding Depression after Pregnancy*, 108th, September 29 2004.

²³ Subcommittee on Health of the Committee on Energy and Commerce, *The Melanie Blocker-Stokes Postpartum Depression Research and Health Care Act*, 110th, May 1, 2007 2007.

²⁴ Ibid.

²⁵ Ibid.

complex. Gendered notions about what healthy motherhood should look and feel like determine what counts as an abnormal experience of motherhood, and thus who might be unhealthy. At the same time, those cultural norms exert pressure on individual women, many of whom feel anxiety, stress, or guilt when they find that they cannot live up to them. Thus cultural models of motherhood both influence how maternal mental illness is defined and create situations in which women are more likely to exhibit behaviors (now symptoms) associated with maternal mental illness.

2. Postpartum Depression and Biomedicalization

One of the key contributions of feminist critics of biomedicalization has been challenging the tendency to focus almost exclusively on biological (and increasingly, genetic) causes of health problems. Under this tendency the causes of illness are either internal (genes, hormones, mutated cells) or external physical forces that directly affect bodies (smoking, falling off of a ladder). Health outcomes, under this view, are biological, and the ways that structural variables, such as gender norms, state and federal policies, and exposure to poverty, can shape health outcomes go unaddressed.

Though researchers and medical experts often note social causes for postpartum depression, the main focus of postpartum depression discourse tends to be on biological causes. For example, a 2000 House Resolution on postpartum depression describes it as “the result of a chemical imbalance triggered by a sudden dramatic drop in hormonal production after the birth of a baby.”²⁶ In a 2004 hearing on the Melanie Blocker Stokes Act, Dr. Catherine Roca, Chief of Women’s Programs at the NIH, highlighted research identifying hormonal causes of postpartum

²⁶ *Expressing the Sense of the House of Representatives with Respect to Postpartum Depression*, 2.

depression.²⁷ Again in 2007, Dr. Roca explained that current funding explored the role of “stress, hormones, genetics, psychosocial and cultural variables” contributing to postpartum depression, but went on to describe only hormonal studies.²⁸ As recently as 2010, an update on National Institute of Mental Health research on postpartum depression focused solely on biological research, describing a study aimed at determining whether changes in estrogen levels act as the primary hormonal trigger for postpartum depression and a study on the brain and neurochemical vulnerability to postpartum depression.²⁹

Peer reviewed medical journals offer both biological and psychosocial explanations for postpartum depression, but tend to focus on the former. Work on biological causes from the 1990s up to the early 2000s credited hormonal changes. More recent work has looked to identify genetic causes or risk variables for postpartum depression.³⁰ In a 2009 editorial in the *American Journal of Psychiatry*, Dr. Susan Hatters Friedman suggested that the distant future would see “a genetic screen test for risk of postpartum depression and postpartum psychosis at prenatal appointments along with other screening tests.”³¹ Though most medical research focuses on biological causes, other scholars including Cheryl Beck and Elizabeth Howell have drawn attention to psychosocial predictors of postpartum depression. These include poverty, low levels of education, racial minority status, prenatal anxiety, a lack of social support, child care stress,

²⁷ *Improving Women's Health: Understanding Depression after Pregnancy*.

²⁸ *The Melanie Blocker-Stokes Postpartum Depression Research and Health Care Act*, 110th Cong. 29 (2007) (statement of Catherine Roca, M.D., chief, Women’s Program, National Institute of Mental Health, Bethesda, MD).

²⁹ A. Perheentupa, A. Ruukonen, and J.S. Tapaniainen, "Transdermal Estradiol Treatment Suppresses Serum Gonadotropins During Lactation without Transfer into Breast Milk," *Fertility and Sterility* 82, no. 4 (2004); Jamie Maguire and Istvan Mody, "Gabaar Plasticity During Pregnancy: Relevance to Postpartum Depression," *Neuron* 59, no. 2 (2008).

³⁰ I Jones et al., "Bipolar Affective Puerperal Psychosis: Genome-Wide Significant Evidence for Linkage to Chromosome 16," *American Journal of Psychiatry* 164, no. 7 (2007).

³¹ Susan Hatters Friedman, " Postpartum Mood Disorders: Genetic Progress and Treatment Paradigms," *American Journal of Psychiatry* 166, no. 11 (2009).

and fatigue following delivery.³² Though these authors referenced not go so far as to adopt a social causation approach, the predictors demonstrate the influence of larger social problems on postpartum depression and the need for less exclusively biological approaches to the issue.

Of course postpartum depression advocates, such as Postpartum Progress and Postpartum Support International, would not advocate for medical recognition if it did not come with benefits. One of the positive outcomes of medicalization is that it often removes stigma associated with a condition and grants it medical and social legitimacy.³³ In the case of postpartum depression, advocates understood that both public awareness and government action would increase if medical authorities formally recognized the condition. In the 1980s, PPD researchers and activists argued that recognition in the *DSM* would grant the condition “administrative validity” within the healthcare system, giving PPD researchers greater standing in competition for funding, and making it easier for those suffering to receive and be reimbursed for treatment.³⁴ Jane Honikman, founder of PSI, argued in a 2007 interview the absence of a distinct category for PPD in the *DSM* meant that fewer resources were be made available to those who suffered from PPD.³⁵

Advocates also call for medical recognition in the hopes that recognition, and efforts to raise public awareness of the newly recognized condition, will reduce stigma. Concerns about

³² Cheryl Tatano Beck, "Predictors of Postpartum Depression: An Update," *Nursing Research* 50, no. 5 (2001); Ingrid Bozoky and Elizabeth J. Corwin, "Fatigue as a Predictor of Postpartum Depression," *Journal of Obstetric-Gynecological and Neonatal Nursing* 31 (2002); Elizabeth A. Howell, Pablo Mora, and Howard Leventhal, "Correlates of Early Postpartum Depressive Symptoms," *Maternal and Child Health Journal* 10 (2006).

³³ Dubriwny, *The Vulnerable Empowered Woman: Feminism, Postfeminism, and Women's Health*. "Having a diagnosis removes the stigma from the deviant emotions mothers experience after birth. Instead of living with stigma, women are asked to live with – and treat – a medically identifiable disease." P. 75

³⁴ Rebecca Godderis, "Iterative Generation of Diagnostic Categories through Production and Practice: The Case of Postpartum Depression," *Culture, Medicine and Psychiatry* 35, no. 4 (2011).

³⁵ "A Tricky Object to Classify: Evidence, Postpartum Depression and the DSM-IV," *Journal of the History of Behavioral Sciences* 49, no. 2 (2013).

stigma were at the forefront of the first Congressional statements on PPD, a House Resolution adopted in October of 2000:

postpartum depression dramatically distorts the image of perfect new motherhood and is often dismissed by those suffering and those around her. It is thought to be a weakness on the part of the sufferer—self-induced and self-controllable.³⁶

The Resolution goes on to assert that this social stigma prevents early detection, diagnosis, and treatment. Similarly, in later hearings about postpartum depression, Representative Capps expressed regret at the stigma surrounding postpartum depression, explaining that “so many women still feel ashamed of the feelings that they are experiencing. This mainly comes because so many people don’t understand the condition.”³⁷ As these accounts note, much of the shame associated with postpartum depression stems from its divergence from social expectations about how new mothers should feel.

Efforts to address stigma focus on increasing public awareness of the condition. In addition to limiting stigma, efforts to educate the public about postpartum depression aim to teach women and their families to be on the lookout for signs of postpartum depression among new mothers. As Representative Capps explains,

This is information that should be widely disseminated across the country to mitigate some of the stigmas that are attached and to allow women and their families, who will sometimes be the first to observe symptoms, the opportunity for early intervention.³⁸

Similarly, Representative Gene Green of Texas suggested that stigma leads some women to resist treatment and worried that women “aren’t getting the information they need to detect the warning signs of postpartum depression.”³⁹ Here normalization is explicitly paired with other

³⁶ *Expressing the Sense of the House of Representatives with Respect to Postpartum Depression*, 4.

³⁷ *The Melanie Blocker-Stokes Postpartum Depression Research and Health Care Act*.

³⁸ *Ibid.*

³⁹ *Ibid.*

effects of medicalization, specifically increased medical surveillance of and intervention in women's lives. In this case education both decreases stigma and increases surveillance of women for signs of what is now understood to be a legitimate and serious medical condition.

Considering the dangers of biomedicalization, we might also worry about the tendency to overemphasize and even exaggerate health risks. As discussed, under biomedicalization nearly everyone becomes a potential patient who must monitor themselves for risk factors and, in the case of postpartum depression, accept monitoring and intervention by friends, family, and medical professionals. Though there is not a single agreed-upon prevalence rate of PPD, meta-analyses suggest that the prevalence rate of non-psychotic postpartum depression is around 13 percent.⁴⁰ However, as we will see, discourse surrounding PPD tends to cite much higher rates. More subtle, but equally troubling, is the tendency toward conceptual slippage, through which multiple forms of postpartum distress are included under the umbrella of postpartum depression. In her scholarship on postpartum depression discourse, sociologist Rebecca Godderis describes this as the collapse of the "postpartum triad."⁴¹ Godderis argues that though the term postpartum distress includes three very different conditions (the baby blues, postpartum depression, and postpartum psychosis), the three are often combined in discussions of postpartum mental health and even in discussions purportedly focused specifically on "postpartum depression." This collapse often happens when speakers want to emphasize the statistical frequency of postpartum distress. However, in the medical nomenclature the baby blues are not considered a form of postpartum depression. In fact, medical professionals often emphasize the need to differentiate

⁴⁰ Heather A Bennett et al., "Prevalence of Depression During Pregnancy: Systematic Review," *Obstetrics & Gynecology* 103, no. 4 (2004); Michael W O'hara and Annette M Swain, "Rates and Risk of Postpartum Depression—a Meta-Analysis," *International Review of Psychiatry* 8, no. 1 (1996).

⁴¹ Rebecca Godderis, "Precarious Beginnings: Gendered Risk Discourses in Psychiatric Research Literature About Postpartum Depression," *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 14, no. 5 (2010): 457-462.

the baby blues from depression, which formally and in popular understanding denotes a serious medical condition that requires treatment.⁴²

Emphasizing and exaggerating the prevalence of postpartum depression and collapsing the postpartum triad are common among legislators. For example, the 2006 Moms Opportunity to Access Help, Education, Research and Support for Postpartum Depression (MOTHERS) Act uses the term postpartum depression to refer to the entire triad and redubs postpartum depression “postpartum mood and anxiety disorders.”⁴³ The Act also notes that the baby blues affect 80 percent of mothers, and that postpartum depression occurs in 10 to 20 percent of new mothers. Similarly, Representative Frank Pallone began a 2007 hearing on postpartum depression by saying that “postpartum depression is a devastating mood disorder, ranging from the baby blues to full-blown postpartum psychosis.”⁴⁴ Representative Anna Eshoo of California similarly folds the postpartum triad into postpartum depression, explaining that “postpartum depression is a serious mental health condition which in various forms affects up to 80 percent of new mothers.”⁴⁵ An October 2000 House Resolution on postpartum depression refers to postpartum psychosis as a “rare form of” postpartum depression.⁴⁶ Other Representatives initially differentiate between the baby blues and postpartum depression but clearly align the baby blues with other medical conditions, collapsing the distinction between women who are ill and those who are reacting “normally” to childbirth. Similarly, two 2013 NIH studies focus on “maternal”

⁴² Michael W. O'Hara, "Postpartum Depression: What We Know," *Journal of Clinical Psychology* 65, no. 12 (2009).

⁴³ *Mom's Opportunity to Access Health, Education, Research, and Support for Postpartum Depression Act*, 109th Cong., S. 3529.

⁴⁴ *The Melanie Blocker-Stokes Postpartum Depression Research and Health Care Act*.

⁴⁵ *Ibid.*

⁴⁶ *Expressing the Sense of the House of Representatives with Respect to Postpartum Depression*.

depression, which includes depression during pregnancy as well as in the postpartum period.⁴⁷

According to these accounts, between 80 and 100 percent of new mothers will suffer from postpartum depression. As a result of this collapse in terminology, it appears not only that all women should feel that they are at relatively high risk (and thus should actively be monitored) but also that the vast majority of new mothers will actually experience a form of postpartum mental illness that requires medical intervention. Of course, as we know, the most common form of postpartum distress is not classified as a mental health condition, nor does it require medical treatment. In this sense, the case of postpartum depression exhibits some of the qualities for which biomedicalization has been most criticized, particularly the emphasis on and exaggeration of risk. Exploring postpartum depression also demonstrates that normalization can be linked with creeping medical authority. This effect of normalization is somewhat counterintuitive since it would seem that asserting that a condition is “perfectly normal” would mean that it might not require medical attention. In fact, feminist self-help activists have made similar arguments in their efforts to take back control over experiences including menstruation and childbirth.⁴⁸ In the context of biomedicalization however, the commonality of a condition can actually work to increase the scope of medical authority, creating justification for more expansive surveillance and prevention, and expanding the pool of patients requiring treatment.

⁴⁷ Cynthia D. Connelly, "Collaborative Model Addressing Mental Health in the Perinatal Period," *National Institute of Health Research Portfolio Online Reporting Tools*, Project Number: 5R01MH075788-05.

⁴⁸ Boston Women's Health Book Collective, *Women and Their Bodies: A Course* (Self-published, 1970), <http://www.ourbodiesourselves.org/uploads/pdf/OBOS1970.pdf>(1970); Ian Jones et al., "Bipolar Affective Puerperal Psychosis: Genome-Wide Significant Evidence for Linkage to Chromosome 16," *American Journal of Psychiatry* 164, no. 7 (2007); Ruzek, *The Women's Health Movement*; Boston Women's Health Book Collective, *Our Bodies, Ourselves: A Book by and for Women* (New York: Simon and Schuster, 1971)

3. Stratified Biomedicalization

In the case of postpartum depression, race is particularly salient because notions of motherhood in the U.S. are deeply raced. As documented repeatedly by black feminist thinkers, white middle- and upper- income women have historically been considered inherently good mothers who are deserving of having more children, while poor women and minority women have been characterized as unfit mothers, unworthy of or too irresponsible to have more children.⁴⁹ This assumption has often manifested itself in state policies that encourage motherhood among well-situated white women and discourage it among poor women and women of color. For example, in 1970 black women in the United States were sterilized at twice the rate of white women, and Latina women, Native American women, and recipients of public assistance were sterilized at higher rates than white women and non-recipients.⁵⁰ Often sterilization was coerced, and women and young girls reported being pressured to undergo sterilization by medical professionals at federally funded clinics, and by welfare administrators.⁵¹

More recently, the work Gwendolyn Mink has argued that the race-valuation of motherhood is evident in the difference in policy design between Social Security survivor's benefits and welfare programs like Assistance to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF). Specifically, she notes that predominantly white Social Security survivor's benefits are more generous and less stigmatized than TANF, and they support mothers who choose to stay at home to care for their children. TANF benefits are

⁴⁹ Collins, *Black Feminist Thought*; Richie, "The Social Construction of the "Immoral" Black Mother."; Roberts, "Unshackling Black Motherhood."; Roberts, "Racism and Patriarchy in the Meaning of Motherhood."

⁵⁰ Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: New York University Press, 2003): 66-67.

⁵¹ *NWRO V. Weinberger*, 377 F.Supp 861 (1974); Angela Davis, "Racism, Birth Control and Reproductive Rights," in *The Reproductive Rights Reader: Law, Medicine and the Construction of Motherhood*, ed. Nancy Ehrenreich (New York: New York University Press, 2008); Helen Rodriguez-Trías, "Sterilization Abuse," *Women & Health* 3, no. 3 (1978).

not only less generous, but also require that mothers work outside of the home. Mink suggests that these policies send a clear message to poor, single, and often black mothers that their care is not valued.⁵² Thus race not only influences how the public views mothers, it can also determine the shape of policies targeted towards particular groups of mothers, as we saw in previous chapters.

Postpartum depression is generally presented as affecting white middle- and upper-income married women, despite the fact that it is most common among black and Latina teenagers and unmarried mothers.⁵³ Attempts to raise awareness of and normalize postpartum depression in public discourse often include the stories of women who have experienced postpartum depression. These women are almost exclusively white and middle- or upper- income mothers.⁵⁴ Some of the most prominent celebrities who have spoken out publicly about experiences with postpartum depression have been white; including Princess Diana, Gwyneth Paltrow, and Brooke Shields. Those women of color who are presented favorably in postpartum depression discourse, like Melanie Blocker-Stokes, are clearly identified as middle- and upper-income mothers, and their academic and social achievements are regularly referenced.⁵⁵

The identification of postpartum depression with white mothers has meant that postpartum depression is viewed sympathetically, and that those suffering have been supported rather than devalued as mothers. Coverage of white mothers who suffered from postpartum

⁵² Gwendolyn Mink, *Welfare's End* (Ithaca, NY: Cornell University Press, 1998). As Mink explains, once women of color came to dominate welfare rolls the programs became more restrictive, punitive, incorporated more surveillance, and no longer supported women who stayed home with children rather than working.

⁵³ Uriel Halbreich, "Prevalence of Mood Symptoms and Depressions During Pregnancy: Implications for Clinical Practice and Research," *CNS Spectrums* 9, no. 3 (2004).

⁵⁴ Tasha N. Dubriwny, "Television News Coverage of Postpartum Disorders and the Politics of Medicalization," *Feminist Media Studies* 10, no. 3 (2010): 294-295.

⁵⁵ See e.g., *Improving Women's Health: Understanding Depression after Pregnancy*.

depression tends to depict them, once cured, as naturally good mothers. In television news coverage, these women are shown expressing their love for and playing with their children, cooking for their families, and even declaring that they value motherhood above all else.⁵⁶ The narratives suggest that these women are “good” mothers who were diverted by biological illness, but who with medical treatment (in their “healthy” state) are model mothers. The stigma surrounding postpartum depression is undermined through this association with idealized, white mothers, and through the implicit argument that feelings of postpartum depression are not the woman’s true or natural feelings, but are the fault of biological rather than personal failings.

The cultural capital and professional connections of well educated white women have also played a role in the political successes of the postpartum depression movement. Leaders mentioned in Verta Taylor’s account of the postpartum depression movement include the founder of Postpartum Support International (PSI), Jane Honiken, a white woman who graduated with a sociology degree from Whittier College and belonged to the American Association of University Women.⁵⁷ Honiken initially funded PSI using her own personal funds.⁵⁸ The founder of Depression After Delivery (DAD), Nancy Berchtold created the organization while working as a teacher and eventually passed the presidential torch to a woman working as a women’s counselor in a private practice.⁵⁹ Ohio’s Postpartum Depression Task Force, the nation’s most professionalized PPD organization, was initiated by Karen Mumford, who holds a bachelor’s degree in childhood education and was employed as a teacher, and the then first lady of Ohio, Dagmar Celeste, who attended Oxford University and used her position to promote women’s

⁵⁶ "Television News Coverage of Postpartum Disorders and the Politics of Medicalization."

⁵⁷ Taylor, *Rock-a-by-Baby: Feminism, Self-Help and Postpartum Depression*, 69.

⁵⁸ Ibid.

⁵⁹ Ibid, 73-74.

issues. In her work as a teacher at a psychiatric center, Mumford had developed professional relationships with psychiatrists, psychologists, social workers, and educators.⁶⁰ Considering the credentials and social capital of these women, it should be no surprise that they were able to cultivate relationships with a wide range of professionals and policy makers.

Postpartum depression activists have been instrumental in gaining medical recognition for postpartum depression and in passing legislation at the state and federal level. Race and class have played a key role in their success. First, the public image of postpartum depression is largely white, which allows activists to be seen as good, well-meaning, valued mothers, and thus to be listened to and sympathized with by the public, the media, and eventually state actors. It also makes it possible for them to successfully argue that they were not bad mothers for having the feelings of postpartum depression, and that they were in fact blameless victims of biology. Second, the fact that activists are well-educated, middle- or upper- income, and well connected facilitated professional organizing and lobbying. The race and class privileges of white mothers enabled postpartum activists to successfully petition for medical recognition for their condition, which in turn codified the sympathetic view of postpartum depression and of suffering mothers as blameless victims.

4. The Structural Causes of Postpartum Depression

Because biological and medical explanations hold so much power in contemporary society, it is not surprising that they can overwhelm an issue, obscuring alternate explanations or approaches.⁶¹ An overemphasis on biology can obscure the roles social status (race, gender, and

⁶⁰ Ibid, 80-82.

⁶¹ Though not the focus of this chapter, the emphasis on biology - in particular female biology and hormonal causes of postpartum depression - also obscure the extent to which fathers experience depression following the birth of a child. A 2014 study in *Pediatrics* found that depressive symptoms among fathers increased on average by 68%

class), cultural norms, and institutions and policies play in shaping experiences of motherhood and depression. I do not argue that the biological elements of postpartum depression should be ignored, but that they should exist alongside social approaches to postpartum depression.

For example, gender roles and workplace policies significantly shape women's experience as mothers, including the proportion of household labor they perform, the amount of leisure time they have available, and the amount of stress they experience as a result of insufficient time and conflict between work and family demands. Research has consistently shown that women, particularly married women with children, spend more time performing household labor than men, even if both are employed.⁶² Marriage, employment, and children, none of which have a substantial effect on the leisure time available to men, result in consistent decreases in women's leisure time.⁶³ For women, the transition to parenthood marks a critical moment in the shift towards an unequal division of household labor, suggesting that women take on the majority of the new work created by children.⁶⁴ Unsurprisingly, women tend to report greater difficulty in adjusting to parenthood than men.⁶⁵ Many women experience a decline in marital satisfaction following the birth of a child, as a result of this increase in housework and

during the first five years after a child's birth. Craig F. Garfield et al., "A Longitudinal Study of Paternal Mental Health During Transition to Fatherhood as Young Adults," *Pediatrics* 133, no. 5 (2014).

⁶² Liana C. Sayer, "Gender, Time and Inequality: Trends in Women's and Men's Paid Work, Unpaid Work and Free Time," *Social Forces* 84, no. 1 (2005). Suzanne Bianchi, M. et al., "Is Anyone Doing the Housework? Trends in the Gender Division of Household Labor," *Social Forces* 79, no. 1 (2000).

⁶³ Marybeth J. Mattingly and Liana C. Sayer, "Under Pressure: Gender Differences in the Relationship between Time and Feeling Rushed," *Journal of Marriage and Family* 68, no. 1 (2006). Janeen Baxter, Belinda Hewitt, and Michele Haynes, "Life Course Transitions and Housework: Marriage: Parenthood, and Time on Housework," *Journal of Marriage and Family* 70, no. 2 (2008). Scholarship suggests that there is "extraordinary stability" in the amount of housework men perform across transitions in cohabitation, marriage and parenthood.

⁶⁴ "Life Course Transitions and Housework: Marriage: Parenthood, and Time on Housework."

⁶⁵ Daniel F Hobbs Jr. and Jane Maynard Wimbish, "Transition to Parenthood by Black Couples," *Journal of Marriage and Family* 39, no. 4 (1977).

the perception of an unfair division of labor.⁶⁶ As parenthood continues, women are more likely than men to interrupt their own sleep to attend to family matters, and on the whole get fewer hours and lower quality sleep than men.⁶⁷ An unequal division of domestic labor in dual earner households also means that women experience work-family conflict more frequently than their male partners. In addition to harming performance at work, persistent work-family conflict has been linked to mental health problems including depression, anxiety disorder, and problem drinking.⁶⁸

The inequalities in the gendered division of labor offer a good example of the way social and political variables can shape mental health. Sleep abnormalities are present in 90 percent of individuals with major depression, and have long been considered a key symptom of psychiatric disorders including schizophrenia, mood disorders and anxiety disorders.⁶⁹ In the late 1980's, researchers began to suggest that insufficient sleep might actually be a causal factor in mental illness, finding that consistent sleep deprivation increased an individual's risk of experiencing mental illness.⁷⁰ More recent clinical research on sleep deprivation has shown that it causes increased reactivity in the emotional center of the brain, resulting in emotional instability,

⁶⁶ Jeffrey Dew and W. Bradford Wilcox, "If Momma Ain't Happy: Explaining Declines in Marital Satisfaction among New Mothers," *Journal of Marriage and Family* 73, no.1 (2011).

⁶⁷ Sarah A. Burgard, Jennifer A. Ailshire, and N. Michelle Hughes, "The Night Shift: Sex Stratification of Sleep among American Adults," *PSC Research Report* 09, no. 693 (2009).

⁶⁸ Michael R Frone, "Work-Family Conflict and Employee Psychiatric Disorders: The National Comorbidity Survey," *Journal of Applied Psychology* 85, no. 6 (2000); Joseph G. Grzywacz and Brenda L. Bass, "Work, Family and Mental Health: Testing Different Models of Work-Family Fit," *Journal of Marriage and Family* 65, no. 1 (2003).

⁶⁹ M. Billiard et al., "Sleep and Psychiatric Disorders," *Journal of Psychosomatic Research* 38, no. 1 (1994).

⁷⁰ D.E. Ford and D.B. Kamerow, "Epidemiological Study of Sleep Disturbances and Psychiatric Disorders: An Opportunity for Prevention?," *Journal of the American Medical Association* 262 (1989).

specifically in increased sensitivity to negative stimuli.⁷¹ We can look to this research for an example of how clinical medical research could work *with* rather than *against* a more comprehensive view of women's health. In the case of insufficient sleep, medical research demonstrates the negative consequences on the brain, on one's mood, and on the ability to cope with stress. Attention to social and political variables helps to explain why insufficient sleep occurs in the first place, and why it might be particularly prevalent among female parents, while also directing us to areas where social and political change might be beneficial. Hence, as a result of this research, we might aim to change attitudes towards the division of household labor, encourage paternity leave, or support public childcare, whereas without attention to the context of insufficient sleep we might prescribe exercise or pharmaceutical sleep aids.

Thus, in addition to offering individual medical care, we might tackle postpartum depression by attending to the inequalities and expectations that put undue pressure on new mothers. Addressing gendered parenting expectations and the lack of support for new parents would mean pushing for broad institutional changes in state support for child-care and guaranteed family leave, as well as working to change cultural expectations for new mothers and their partners. Comparative studies of division of household labor have found that in countries with greater access to public child care and paternity leave, women spend less time on the kinds of housework that are most likely to limit paid work and leisure opportunities.⁷² Predictably, research has also shown that flexible workplace policies can reduce work-family conflict.⁷³

⁷¹ Seung-Schik Yoo et al., "The Human Emotional Brain without Sleep - a Prefrontal Amygdala Disconnect," *Current Biology* 17, no. 20 (2007). Specifically, in the amygdala and medial-prefrontal cortex.

⁷² Jennifer L. Hook, "Gender Inequality in the Welfare State: Sex Segregation in Housework, 1965-2003," *American Journal of Sociology* 115, no. 5 (2010): 1481.

⁷³ S.R. Madsen, "The Effects of Home-Based Teleworking on Work-Family Conflict," *Human Resources Development Quarterly* 14 (2003). P. Voydanoff, "The Effects of Work Demands and Resources on Work-to-Family Conflict and Facilitation," *Journal of Marriage and Family* 66, no. 2 (2004).

Childcare subsidies have been shown to have a significant effect on the amount of work-family conflict women experience as well, particularly for low-income women.⁷⁴ Due to their broad impact, these efforts would benefit all mothers, as well as benefitting their partners and children. Cultural changes are far more difficult to achieve (let alone legislate) but are equally important. Lowering expectations of new mothers could reduce the guilt and stigma associated with the baby blues and postpartum depression. Encouraging partners of new mothers to take on a more active role in parenting could also reduce much of the pressure and stress associated with a new baby.

5. Motherhood and Health as Social and Political Power

Recent efforts to address postpartum depression have emphasized the need to monitor the behavior of new mothers for signs of depression. In ten states, doctors are required to perform screenings for postpartum depression. Though efforts to recognize postpartum depression early are laudable, little attention is paid to the fact that they encourage family, friends, and doctors to closely monitor the behavior and emotions of new mothers. Monitoring for PPD seems to put even greater pressure on women who are already made enormously self-conscious by the impossible standards of motherhood (made more impossible by a context in which mothers lack social support, child care, and an equitable division of household labor). Many mothers note that their depression was associated with and even resulted from feelings of inadequacy, guilt, and shame when their experience of motherhood did not live up to their expectations. As if women were not under enough pressure to be good mothers, they are now under surveillance to ensure that they are behaving “healthily” and responding “appropriately” to motherhood. Further, the collapse of the postpartum triad into postpartum depression mistakenly suggests that responses

⁷⁴ Julie E. Pree, Jay Fagan, and Lynda Laughlin, "Taking Pressure Off Families: Child-Care Subsidies Lessen Mothers' Work-Hour Problems," *ibid.* 68, no. 1 (2006).

that are in fact normal (if not fitting with expectations for model mothers) represent mental illness and warrant the intervention of medical professionals.

The discourse surrounding postpartum depression also draws attention to the effects it has on the fetus and the child.⁷⁵ For example, in a 2007 Congressional hearing, Representative Nathan Deal of Georgia described postpartum depression as “a very serious matter” that “has consequences not only for the woman but for the child and the family as a whole.”⁷⁶ In the same hearing, Representative Jan Schakowsky of Illinois described postpartum depression as “a women’s health issue and a children’s health issue,” and noted its “immediate and long-term consequences on the mother/child bond and the subsequent emotional and cognitive development of the child.”⁷⁷ Unsurprisingly, arguments that expand the scope of the impact of postpartum depression often aim to justify demands that greater public attention or state funding be devoted to the condition.

Almost all NIH studies on postpartum depression from 2013, even those with no relation to childhood wellbeing, refer to the harms PPD causes to children. In fact, researchers in the 1970s and 80s often emphasized harms to children over those to women and families when explaining the importance of their research.⁷⁸ Several postpartum depression studies focused explicitly on children or the mother/child relationship. A 2013 study of how postpartum depression can increase risk for insecure mother-child attachment, described postpartum depression as a condition that “impacts the health of more than 400,000 mother-infant dyads

⁷⁵ See for example, S.L. Sohr-Preston and L.V. Scaramella, "Implications of Timing of Maternal Depressive Symptoms for Early Cognitive and Language Development," *Clinical Child and Family Psychology Review* 9, no. 1 (2006).

⁷⁶ *The Melanie Blocker-Stokes Postpartum Depression Research and Health Care Act*.

⁷⁷ *Ibid.*

⁷⁸ Rebecca Godderis, "Precarious Beginnings: Gendered Risk Discourses in Psychiatric Research Literature About Postpartum Depression," 452.

every year.”⁷⁹ Another investigation, aiming to fill a gap in research, explained that existing studies have examined the effectiveness of postpartum depression treatments in improving the mother’s symptoms, “but not necessarily her parenting or her child’s development.”⁸⁰

A 2000 House Resolution on postpartum depression warns of numerous harms to children, including socioemotional difficulties later in life, insufficient levels of stimulation, and insecure attachment to caregivers, which can result in challenges coping with difficult times in adulthood, lower levels of curiosity, difficulty getting along with other children, and performing less well in school than children who are securely attached.⁸¹ The resolution closes by recommending that all obstetricians inquire about any psychiatric problems mothers may have experienced, including substance abuse, and to repeatedly screen new mothers for postpartum depression. As we saw in the case of maternal drug use, such inquiries can and have led to the limitation of women’s autonomy in the name of child welfare. However, in the case of postpartum depression, such limitations are more likely to take the form of limited patient autonomy and increased surveillance by family rather than detainment and surveillance by the criminal justice system.

The emphasis on children may seem unavoidable and even quite reasonable in the case of depression affecting mothers. But it should raise questions in light of the history of state interventions into women’s lives on behalf of children. Concerns for child welfare have justified significant violations of women’s civil rights and bodily autonomy. Such violations have been particularly common in the case of pregnant women, and the reach of concern for child welfare

⁷⁹ Alison M Stuebe, "Mood, Mother and Infant: The Psychobiology of Impaired Dyadic Development," *National Institute of Health Research Portfolio Online Reporting Tools* (2013), n.p.

⁸⁰ Nastassia Josephine Hajal, "Neurophysiological and Behavioral Dynamics of Emotion in Mothers with Infants," *National Institute of Health Research Portfolio Online Reporting Tools* (2013).

⁸¹ *Expressing the Sense of the House of Representatives with Respect to Postpartum Depression*.

is only expanding. As discussed in Chapter 2, the minimal standards for recognizing a subject as a subject, and bearer of legal rights have changed dramatically in recent years.⁸² Previously, the “threshold of the living subject” was reached at birth. With the creation of the concept of “perinatal,” the fetus and the newborn are increasingly seen as equivalent in both public health and legal discourse. Today the threshold for bearing rights is often understood to reach back into pregnancy, justifying increased governance of female bodies during pregnancy and labor in the name of protecting the interests of a now rights-bearing fetus. To the extent that the discourse of postpartum depression reinforces this view, and more so because it emphasizes the unintentional, long-lasting harm pregnant women can cause children, it represents a threat to the bodily agency and autonomy of pregnant women.

Implications and Conclusions

Framing postpartum depression as a women’s health issue has had undeniable benefits. It has helped to remove much of the stigma associated with the condition, raised awareness, and discouraged mothers from blaming themselves for postpartum distress. It has also aided in activists’ efforts to persuade state actors to take action on postpartum depression. With formal medical recognition, PPD became a much more compelling cause to legislators. Now understood as a women’s health issue, it is responded to with immense sympathy, and with legislation that encourages increased education, research, screening, and funding to provide services to affected women.

Although we would hope that the successes of the largely white postpartum depression movement would also benefit women of color, this is not necessarily always the case. Even in instances of an issue’s inclusion in women’s health, exclusion of marginalized women remains a

⁸² Lorna Weir, *Pregnancy, Risk and Biopolitics: On the Threshold of the Living Subject* (London: Routledge, 2006).

concern. Postpartum depression has been carved out as a women's health issue, but in part because it does not challenge (raced and classed) notions of motherhood, it does not seem equally welcoming to all women. Efforts to address postpartum depression do not tackle structural variables such as stress and lack of support, which are likely tied to higher rates of PPD among young mothers, those with lower educational attainment, and poor women.⁸³ Mandatory screening does not improve access to health care, or mental health care, for poor women after they are diagnosed, nor does research for (likely expensive) new medications and therapies improve their access to those treatments. At a conceptual level, the cultural devaluation of mothers of color complicates efforts to apply a postpartum discourse produced by and for white women to women of color. As we have seen, portrayals of women that aim to destigmatize postpartum depression largely focus on otherwise culturally ideal white mothers.

Biological views of postpartum depression also tend to individualize, further discouraging structural views of the condition. Researchers search for and identify causes of postpartum depression that are individual and internal (a woman's hormones or brain chemistry) and treatments target the individual (therapy or antidepressants). To the extent that women collectively organize or petition the government, they do so to get more or better medical attention in the form of research or medical treatment options, which will in turn be directed at women individually. Though many acknowledge the political elements of postpartum depression, by and large activists are not petitioning for structural changes as a means of addressing postpartum depression. Not surprisingly, neither are medical professionals nor legislators. Even in the case of legislation to provide home visit services to help new mothers

⁸³ Segre, Lisa S., Michael W. O'Hara, Stephan Arndt, and Scott Stuart. "The prevalence of postpartum depression." *Social Psychiatry and Psychiatric Epidemiology* 42, no. 4 (2007): 316-321. K. Brett "Prevalence of Self-Reported Postpartum Depressive Symptoms." *Center for Disease Control Morbidity and Mortality Weekly Report* 57(14): 361-366.

with postpartum depression, the focus remains on the individual and her immediate surrounding, and does not incorporate broader structural or institutional critiques.⁸⁴ This focus on the individual also functions to depoliticize postpartum depression, ignoring the role that power inequalities, gender norms, and family-leave policies play in shaping the conditions (and stresses) facing new mothers.

Of course a critical view of health offers many more insights about postpartum depression. Though privileged women have been successful in advocating for medical recognition of postpartum depression, their success has come with negative consequences. The medicalization of PPD encourages those around new mothers to monitor them for signs of abnormal behavior, behavior that is very loosely organized around an often-collapsed postpartum-triad. Thus behavior prompting recommendations of medication and medical intervention can include even emotions that medical professionals themselves deem perfectly normal. Further, the emphasis on a biomedical view of PPD has meant that the many structural variables making the lives of new mothers difficult, and the absence of basic policies supporting new mothers, go ignored. Though privileged PPD advocates may seem to have done well for themselves in comparison to marginalized women, a critical feminist analysis suggests that PPD politics, like contemporary ideas and practices of health more generally, fail privileged women as well.

Postpartum depression presents a particularly interesting case study in light of what we have learned about the health of marginalized women. Here (predominantly white, middle- and upper-income) women demand and receive medical recognition, as well as attention from policymakers, who aimed to raise awareness of the condition, and destigmatize it. Women who had suffered from PPD speak for themselves in the media, and in Congressional hearings. In

⁸⁴ *Mom's Opportunity to Access Health, Education, Research, and Support for Postpartum Depression Act.*

some ways it seems impossible for an issue to be more different from the health issues of marginalized women. In this sense, analyzing PPD highlights the vast differences in how the health issues of privileged and marginalized women are understood and addressed. Notably, it also demonstrates that when women's health issues are recognized, sympathized with, and destigmatized, those issues can be (and perhaps tend to be) defined and addressed in ways that exclude marginalized women. Here again we find that fully understanding and addressing exclusion requires a careful, critical consideration of the uses of health in the issue at hand. The models of health, illness, and womanhood that lend themselves to medical recognition, popular attention and sympathy, and active legislation, seem to mirror ideals to which marginalized women find it difficult if not impossible to conform.

CONCLUSION

In light of the popularity of the idea of “women’s health,” and the unprecedented value of “health,” in contemporary discourse, it should be a matter of concern that the label of health is denied to some women’s problems. For those who believe ideas and practices of health are objective, neutral, and apolitical, it should be worrying that legislators have been more active in creating anti-obesity legislation targeting a limited portion of the population than they have in addressing the occupational health of domestic workers or access to anti-addiction treatment for pregnant drug users. Though it can seem that concern about health is everywhere, it is noticeably absent in some corners. As I have argued here, which health issues receive attention, research, funding, and legislation, and even how we conceptualize issues whose relationship to health is ignored, is determined by political expediency, culture, and power.

What does it mean to attend to bringing marginalized women to the center of health when discourses and practices of health have been so profoundly bound up with power, punishment, and stigmatization? In attempting to answer, this work has explored several pressing but ignored or misrecognized issues of marginalized women's health, along with one well-recognized issue associated with privileged white women. In analyzing the ideas and practices of health at work in (and missing from) these issues, I have been motivated as much by considering the possibilities for an empowering and inclusive understanding of women's health, as by the need to understand the exclusions and failures of current models of it.

I have argued that contemporary discourses and practices of women’s health are characterized by a significant increase in attention alongside persistent disparities in health

outcomes, and the exclusion of certain women and their issues from the growing attention to women's health. This work began with an interest in those issues that are left out despite the unprecedented attention devoted to women's health, and I quickly found that embracing such contradictions was vital to understanding contemporary women's health. Methodologically, understanding contemporary women's health as both exclusionary and substantively flawed, has involved identifying the failures of discourses and practices of health where they are present and where they are absent. It has also revealed that a critical feminist view of health -- as a set of discourses and practices that are contextual and political -- is vital to understanding the how and why of exclusion, which is in turn vital for efforts to address exclusion without replicating the failures of contemporary health discourse and practice. Women's health practices and expectations have become a model for health more broadly, and as a result it is a useful entry point into larger discussions of contemporary health politics, biopolitics, and biopower.

The analyses of marginalized (and privileged) women's health issues in this work were accompanied by concepts and critiques essential for rethinking contemporary women's health. In addition to attending to exclusion, I have argued that women's health (and health more generally) must be understood as far more than a simple good, in two senses. First health is not solely a good, but a powerful concept. Ideas of health have historically reinforced problematic norms or power inequalities, and arguments framed as health can be used to justify punishment and stigmatization, depoliticize social problems and personalize responsibility for problems from poverty to violence. Once health for women meant refraining from physical activity. Once mental disease for slaves meant attempting to escape slavery. In this sense, health is not only a good to be pursued, or distributed more broadly, but also a concept that requires critical investigation.

Second, health outcomes cannot be improved, nor can exclusions be addressed, in any simple or limited manner. Health is thus not an isolable good that can be easily distributed or more evenly distributed solely through measures such as expanding access to health care. Whether one is healthy (and even which specific conditions one suffers from) is shaped by structural variables: by poverty, by exposure to violence, by malnutrition, by exposure to pollutants in substandard public housing. None of these variables are randomly distributed among the population of the United States.

Methodologically, I hope that a significant contribution of this work is its effort to contend with the contradictions inherent in contemporary women's health. Attention to exclusion and the failures of health reveals that marginalized women are not just ignored; rather, arguments about health are often used to punish or stigmatize them. It reveals that efforts to include marginalized women require a fundamental rethinking of our practices and ideas of health, because it is often those very practices and ideas that render marginalized women's issues incomprehensible.

This kind of critical consideration of marginalized women's health can and should continue with other neglected health issues. Future work might focus on the health of incarcerated women, to whom basic health care and even hygiene products are regularly denied. The health of transgender women, including the care required to transition, and exposure to violence, also deserves far more attention than it receives. Similarly lesbians have long struggled to receive adequate care, suffering under caregivers' assumptions of heteronormativity and experiencing discrimination when they make their sexuality known.

To study women's health, particularly marginalized women's health, is to recognize the rewards and the risks of engaging with a concept and set of practices that have long been shaped by biases and power inequalities. Consequently, drawing attention to marginalized women is

both necessary and dangerous, as evidenced by the cases cited here. This work seeks to identify and analyze the risks of inclusion and offer an analysis sufficiently sophisticated to allow us to move toward a more rewarding inclusion. The reminder that not any health will do takes on the form of a mantra. The right kind of inclusion of marginalized women has the potential to benefit them enormously. And, because including marginalized women requires us to challenge some of the most problematic tendencies and characteristics of contemporary health, this project also benefits privileged women, and anyone affected by ideas and practices of health (i.e. everyone). At stake in the issues addressed in this dissertation is not just who is included in the growing realm of women's health but what “health” is and does.

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