NOTHING SHORT OF REALLY HEALTHY CHILDREN: MOTHERS, THE CHILDREN'S BUREAU, AND DISABILITY, 1914 – 1933

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In 1931 the United States Children's Bureau asserted that "nothing short of really healthy children should satisfy parents." This thesis examines how literature published by the Children's Bureau from 1913 to 1933 shaped perceptions of motherhood and of maternal control over the body. As the bureau taught mothers how to care for their children, it also taught them that by following bureau advice, mothers could shape the bodies of their children to adhere to normative body standards. The research considers the relationship between mothers, the state, and the physical body. This thesis is divided into chapters about prenatal care and maternal marking; infant care and maternal policing; and child care and maternal control.

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CHAPTER 1

INTRODUCTION

In 1931 the United States Children's Bureau asserted that "nothing short of really healthy children should satisfy parents."[1] With this charge, thousands of mothers wrote to the bureau asking how they could support the healthful growth and development of their children. To the bureau, no issue was too small. Advice covered topics ranging from infant feeding to clothing materials to whether or not it was alright to take infants to birthday parties. However, the aspiration of "really healthy" was not an objective, ahistorical standard, but rather a reflection of what the bureau believed to be normal. Throughout this quest for child welfare, the bureau attempted to define health and teach mothers how to raise their children to that standard.

This study examines advice literature published by the Children's Bureau from 1913 to 1933 to explore how this literature shaped motherhood and the understanding of maternal control over the body. As the bureau taught mothers how to care for their children, it also taught them that by following bureau advice, mothers could shape the bodies of their children to adhere to normative body standards. This implication of control meant that mothers bore the responsibility of the health of their children and that failure to meet health standards was a consequence of poor mothering. As a federal agency, the work of the Children's Bureau carried influence that went beyond the home and influenced how Americans in the early twentieth century thought about and experienced their bodies. By creating and disseminating seemingly objective metrics on health and instructions on how to achieve them, the bureau contributed to a larger process of defining the boundaries of disability and creating standards for what it means to be healthy. This

[1] US Children's Bureau. *The Child from One to Six: His Care and Training* (Washington: Government Printing Office, 1931), 10.

means that by interrogating the content of these guides we are better able to understand state interests in the body and the role of mothers in federal public health policy.

Though the Children's Bureau was not the only institution working toward child welfare and creating child rearing advice literature, studying its publications offers several historical benefits. First, the authority of the federal government imbued this body of literature with reach and influence. A core arm of bureau activities centered on the production and distribution of *Prenatal Care*, *Infant Care* and *Child Care* which made this literature widely accessible to the public and minimized cost barriers. Though offering similar content to popular publications such as Dr. Luther Emmett Holt's *The Care and Feeding of Children*, bureau literature's greater accessibility made them influential to an audience that went beyond the middle-class.[2] Second, as governmental publications not intended to make a profit, bureau literature was less influenced by consumerism than other bodies of advice literature. Popular works, such as *Good Housekeeping* or *Parents Magazine*, paired content on child welfare with advertising and product recommendations.[3] While these economic motivations pose interesting historical questions, they also obscured the influence of maternal labor.[4] Rather than depending solely on the work of mothers, these advertisements offered products as an answer to maternal concerns. Studying bureau literature allows us to interrogate the influence of maternal labor without these commercial interests.

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[2] Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare and the State, 1890-1930* (Urbana: University of Illinois Press, 1994), 82.

[3] Rima D. Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick: Rutgers University Press, 2006) 71-75.

[4] For more information on consumerism and motherhood see: Barbara Katz Rothman, "Motherhood Under Capitalism," in *Consuming Motherhood,* ed. Janelle S. Taylor, Linda L. Layne, and Danielle F. Wozniak (New Brunswick: Rutgers University Press, 2004).

While the Children's Bureau was created to serve the interests of all children, bureau literature reinforced racial and economic power dynamics and promoted cultural standards of whiteness as part of its health policy.[5] The boundaries of who was included as white was and continues to be a complicated intersection of power dynamics. Rather than a static definition, whiteness as a category grew and changed along the lines of a black/white dichotomy.[6] Many bureau field studies and events focused on recent European immigrants in urban neighborhoods and largely ignored the high infant and maternal mortality rates for black families. Though the bureau acknowledged that poverty and race greatly influenced mortality rates, their programing focused on educating and Americanizing immigrant mothers instead of widespread economic reform. Additionally, the bureau focused most actively on European immigrants rather than Asian or Hispanic immigrant communities.[7] This racial focus reflected the broader social and political context of the bureau and means that this history is not necessarily reflective of the lived experiences of the women and families who were often excluded by the bureau. Though the bureau was not a eugenic organization, the doctrine of eugenics nonetheless influenced the scope and programing of the bureau. White supremacy underpinned bureau literature and reinforced long standing power inequalities and the hegemonic placement of whiteness in the bureau's definition of a normal body. This means that as this research considers boundaries of disability, whiteness rests at the core of the bureau's vision of normalcy.

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[5] Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991), 117.

[6] Nell Irvin Painter, *The History of White People* (New York: W.W. Norton & Company, 2010), 201; Matthew Frye Jacobson, *Whiteness of a Different Color: European Immigrants and the Alchemy of Race* (Cambridge: Harvard University Press, 1998), 6-7.

[7] Kristie Lindenmeyer, *"A Right to Childhood:" The U.S. Children's Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997), 64.

Previous scholarship on child welfare policy has highlighted the Children's Bureau's role in acknowledging and campaigning against high infant and maternal mortality rates in the early twentieth century. Both Kristie Lindenmeyer and Richard Meckel's research into child welfare policy offer insight into the work of state and local organizations to support the welfare of mothers and children.[8] These works catalog the institutional history of the bureau and its larger role in Progressive reform. The bureau has also been an important site of study for historians of women as child welfare reform offered women increased opportunities in the public sphere. Robyn Muncy's work *Creating a Female Dominion in American Reform* charts the emergence of child welfare as a women's issue in the early twentieth century and the power of women in that field.[9] Additionally, Molly Ladd-Taylor's *Mother-Work* demonstrates the politization of maternal labor in the establishment of welfare policy. Together, these works highlight the influence of women in the public sphere, the importance of child welfare to Progressive reform, and the broader context of the Children's Bureau.

Also important to this research is the historical literature on scientific motherhood. Scientific motherhood, or the belief that motherhood was not instinctual, but rather a skilled profession requiring training and expert knowledge colored the work of the Children's Bureau. As maternalists, the bureau embraced the understanding that women were uniquely suited to child welfare work, had a duty to raise the nation's citizenry, and that the male breadwinner family structure was best suited for child welfare. However, as Progressives, the bureau was also dedicated to the right of women to work and serve in the public sphere, maternal responsibility

[8] Lindenmeyer; Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Rochester: University of Rochester Press, 2015).

[9] Muncy.

for democracy and justice, and the supremacy of science in childrearing. This combined ideology of Progressive maternalism, as coined by Ladd-Taylor, characterized the bureau's reform work and childrearing content with appeals to both feminine and scientific authority.[10] Research from Rima Apple demonstrates that scientific motherhood was not unique to the Children's Bureau and rather was a broad movement that redefined motherhood and the relationship between experts, mothers, and their children. Focusing on the relationship between mothers and experts, Apple's research highlights the transition of authority over childrearing from mothers to medical professionals. Though scientific motherhood required a deference to medical authority, Apple shows that mothers maintained an active role in the care and wellbeing of their children.[11]

Where previous scholars have focused on the relationship between women, experts, and the state, I instead am focused on the relationship between mothers, the state, and the physical body. Existing scholarship shows how Children's Bureau literature contributed to the larger process of state building, changing roles of women, and Progressive reform, but it does not speak to how the content of this literature reflects and constructs how Americans think about the body and the role of mothers in shaping the body. Rachel Moran's *Governing Bodies* demonstrates that the bureau was just one part of advisory state policy throughout the twentieth century. Advisory state policy, as defined by Moran, was not explicit legislation, but rather an indirect nudging of citizens to behave in ways that served the state. Policies ranging from the Civilian Conservation Corps to food aid programs of the 1970s were sites of intervention from the government in the bodies of Americans.[12] Understanding the advice literature from the

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[10] Ladd-Taylor, *Mother-Work*, 74-75.

[11] Apple, 2-3.

[12] Rachel Louise Moran, *Governing Bodies: American Politics and the Shaping of the Modern Physique*, (Philadelphia, University of Pennsylvania Press, 2018), 2.

Children's Bureau as part of this larger process allows us to take seriously the content of this advice literature as a method of state intervention into the body. Additionally, the incorporation of disability theory, which is discussed in more detail in chapter 3, allows us to denaturalize body hierarchies and question the intent and implications of this advisory policy. Recognizing the Western fear of disability as a key motivation for the content of this advice literature we are able to see how this reflects broader systems of power in how the state values bodies.[13] Therefore, my research contributes to the larger historical scholarship by considering how bureau literature defines boundaries of disability, the role of mothers in enforcing these health standards, and the context of the state in advocating for these standards in the early twentieth century.

This research is organized topically by the Children's Bureau's major childrearing guides – *Prenatal Care, Infant Care,* and *Child Care*. Within each chapter, I place the editions of these guides in conversation with each other to show how they changed over time and formalized increasingly stringent standards of health. Between 1913 and 1932, each of these primary guides were revised and republished with important changes and continuities between editions that reflect the formalization of what it means to have a normal or abnormal body and the role of mothers in enforcing that scheme. I've limited this analysis to the early 1930s because it encapsulates the first era of the Children's Bureau and the peak of their Progressive maternalist ideology. Though the bureau continued to revise their literature throughout the rest of the century, the first twenty years of the bureau were a unique period of influence. The fall of women's professional claim to child welfare, the failure of the Sheppard-Towner Act and child labor reform amendment, and the decline of Progressivism meant that by the 1930s the bureau

[13] Catherine J. Kudlick, "Disability History: Why We Need Another "Other," *The American Historical Review* 108, no.3 (June 2003), 765.

was "increasingly administrative and apolitical."[14] Limiting the scope of this study allows us to see these changes reflected in the literature without entering an entirely new political ideology.

Chapter 2 centers on the Children's Bureau's guides on prenatal care and their content on maternal marking. Maternal marking, also called maternal impressions, is the belief that a pregnant women can injure or deform their child in utero through their state of mind. Though the bureau makes efforts to debunk this belief, bureau literature reveals that marking isn't dismissed as much as it is rebranded into a scientific form. Rather, the bureau still found pregnant women capable of changing their children in utero, it was just cloaked in the language of nutrition and mental hygiene. Chapter 3 focuses on *Infant Care* and the bureau's use of maternal policing which instructed mothers to quantify, compare, and report on the health of their infants. Though maternal policing required near constant attention, the bureau also warned mothers against over-mothering. By telling mothers to both give their infants constant attention and to not over-mother them, the bureau created a narrow window for appropriate maternal labor which was ultimately directed toward achieving emerging health standards and rearing normal infants. The fourth chapter of this study investigates the expansion of maternal policing in the bureau's literature for preschool age children. Building upon the care work established in infancy, the bureau instructed mothers to also police the use of their child's body in order to prevent deformity and rear physically optimized children.

Together, these chapters tell a story of prescribed maternal control over the body. While child rearing best practices continue to evolve, what remains is the understanding that mothers can – and should – try to influence the development of their children. The work of the Children's

[14] Ladd-Taylor, *Mother-Work,* 97.

Bureau was the federal government's first venture in directing this maternal influence. The child rearing content that resulted from this venture, though cloaked in the promises of scientific motherhood, reflects how the state defined acceptable and unacceptable bodies.

CHAPTER 2

PRENATAL CARE AND MATERNAL MARKING

Maternal marking, also called maternal impressions, is the belief that a pregnant woman's state of mind can injure, harm, or otherwise "mark" her unborn child.[15] The classic story of marking is that a pregnant woman goes out in public and sees a physically disfigured or disabled person in the street. The pregnant woman is then so shocked or repulsed by the sight of this disfigured person that her unborn child is physically altered to have a disfigurement or disability akin to what the mother had just seen. While a very early trope, the mythology of marking continued to be popular enough that when the United States Children's Bureau began publishing prenatal care guides in 1913, they included paragraphs to debunk the belief in their publications through to the 1960s.[16] Rather than making having external forces, such as the sight of a disabled person, The Children's Bureau was part of a broader movement that redefined marking to be dependent on internal forces, such as the diet and mental state of the mother.[17] An interrogation of early Children's Bureau prenatal care guides demonstrates that the bureau did not necessarily try to bust the myth of marking as much as it attempted to rebrand it into a new form.

This essay argues that, through their publications on prenatal care, the Children's Bureau

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[15] The language I use throughout this research matches the language used by the Children's Bureau. Rather than using the term "fetus" the bureau used "child" or "baby."

[16] During the 1960s, new technologies in fetal imagining and testing revolutionized how prenatal care and health was discussed and measured. There was an increased ability to detect deformities and fetal complications in womb, leaving mothers with the choice of whether to terminate their pregnancies. For more information on this technology and its influences, see Ilana Lowy, *Imperfect Pregnancies: A History of Birth Defects and Prenatal Diagnosis* (Baltimore: Johns Hopkins University Press, 2017).

[17] Though this research focuses exclusively on the Children's Bureau's role in this process, other advice literature throughout this period offered a similar perspective on maternal marking and impressions. Despite asserting that mothers could not mark their child, these external guides and literature also embraced the importance of nutrition and mental hygiene in securing the physical wellness of newborns. For examples of this trend in literature outside of the bureau see: William Lee Howard, "The Child That is to Be: What Mental Attitudes Can Do to the Unborn Child," *The Ladies Home Journal* 29, no. 10 (October 1912): 32; Woods Hutchinson, "Before the Stork Comes," *Good Housekeeping* 58, no. 6 (June 1914): 813-817.

sought to transform the belief of maternal marking from a myth dependent on external forces to a standard of care dependent on the choices and actions of mothers. The Children's Bureau emphasized the role of nutrition and mental hygiene in its discussion of how women could directly affect their unborn children, and I engage these two topics to examine how the bureau attempted to appropriate the trope of marking to place responsibility principally on the mother for their infant's health. Bureau guides discussed nutrition as an overt way that women could alter the development of their children, while mental hygiene was more covert. Though the language and technicalities of marking may have been different from the mythology, the bureau maintained mothers' power to shape the bodies of their babies in utero.

This control given to women over the bodies of their unborn babies carried with it several larger implications that continue to matter in how we think about health and the body. The first of these is that women were established as primary actors in the health and bodies of their children by a federal agency. This does not necessarily mean that women were given the authority to decide what was best for the health of their infants, but rather that women were doing the work to practice these given standards of care through their role as mothers. Prenatal care guides were the instruction books given out by the federal government on how to accomplish this work, but mothers, with the aid of medical professionals, were the ones responsible for making it happen. The second of these implications is the purpose of this advice literature, which was to teach women how to have healthy pregnancies to produce normal, healthy children. Through the creation of this body of literature, the Children's Bureau established that the measure of a successful mother was in her ability to birth a normal child. While this may seem like an obvious goal of childrearing, the definition of normal was narrow. It reinforced the stigma for being disabled or otherwise outside of the realm of normalcy, be that in

terms of weight, height, or any other factor of difference in the physical body. Prenatal guides established how mothers had the ability, and the responsibility, to shape their children's bodies through their actions during pregnancy, and then supposedly gave women all the information and tools they needed to give birth to a normal child, which meant that any failure to have a normal or healthy child was the fault of the mother. These guides expressed a preference for able-bodied babies and demonstrated a continuing ableism that valued healthy bodies over unhealthy. Together, the analysis of these guides, with consideration of these larger implications, demonstrate that the perceived agency over health that the bureau gave to mothers was coupled with blame or stigma for failing to do pregnancy in the "correct" way.

Previous historical scholarship on the Children's Bureau's content on maternal marking has focused on the bureau's call to abandon folk beliefs and superstitions. In her study of *Prenatal Care* through the twentieth century, Agnes Howard places marking as a signifier of the bureau's adherence to science and the need for full deference to medical authority and instruction. Howard asserts that abandoning folk beliefs about pregnancy was a foundational part of the bureau's idea of a healthy pregnancy and the twentieth century culture of pregnancy.[18] Additional work into the rise of scientific motherhood similarly focuses on the source and authority of prenatal advice, but not on the particularities of the advice itself. Building upon this existing scholarship, this chapter instead considers how the bureau's framing of marking and maternal control over pregnancy reflects early twentieth century understanding of the body and disability.

[18] Agnes R. Howard, "Changing Expectations: *Prenatal Care* and the Creation of Healthy Pregnancy," *Journal of the History of Medicine and the Allied Sciences* 75, no. 3 (July 2020), 324-343.

Social Construction of the Body and Stigma

Stigma surrounding the body is socially constructed, meaning that how society interprets health, disability, and the body is contingent on a combination of social, political, and economic factors, rather than a natural, unchanging perspective.[19] This is why, for example, different periods posited different female body shapes as the physical ideal. Different preferred types, such as the Gibson Girl of the late nineteenth and early twentieth century, the flapper of the 1920s, Marilyn Monroe in the 1950s, or the heroin-chic models of the 1990s, were not the result of inherent differences in women's bodies, but rather the result of different ways of thinking about and interpreting these bodies. The same is true in terms of health and disability where disability is not a homogenous, static status, but rather is subject to change based on both the physical body and the social, political and economic context that the body is operating in. Because disabilities can be found in countless forms, the disabled as a group are only defined through their shared abnormality and inability to fit into the period's physical norm. This means that a body is not disabled until it is barred from participating in society through isolation, inaccessibility, or social stigma.[20] By recognizing disability as a social construction that is dependent on the larger context of the body, we are able to denaturalize normalcy and understand disabilities or abnormalities as simple difference instead of as a lack. This understanding of the body removes the moral connotations of health and demonstrates that it is not morally or inherently better to be healthy or normal but is just a different lived experience in a different body.[21]

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[19] Rosemarie Garland Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (New York: Colombia University Press, 1997), 41.

[20] Ibid., 24.

[21] Ibid., 23.

Social construction of health and disability are important in this research both because it is a core assumption of my historical analysis, and because it shows how stigmatization of the body works. Since moral implications of the body are not intrinsic, they must come from somewhere, and one of those places is power holding people and institutions, such as the Children's Bureau. Stigma at its core is an exercise of power that asserts that the holders of power, typically a majority group, have the correct or normal bodies or culture, and everything outside of their scheme is incorrect, abnormal, or even deviant. Through the creation of a normate, an epitome of the characteristics of the dominant group, these institutions wield power to universalize their experience and shame, restrict, or otherwise oppress groups that stray too far from the norm.[22] Though in practice the normate is often an extremely narrow definition that few people, even in hegemonic groups, fit in, the real question is how far people's bodies deviate from this normal.[23]

In the early twentieth century, the normate, like many other factors of this period, was in flux and was influenced by a variety of changes and innovations that occurred at the turn of the century. One of these factors was the popularization of eugenics, which argued that white, Anglo Saxons were genetically superior to people of other races. Eugenics codified a "scientific" hierarchy that ranked different racial groups and articulated that these differences were biological and immutable, and rearticulated whiteness as the default, normal race, and all others as

[22] Thomson, 40.

[23] Ibid., 32. This is where intersectionality really comes into play and we see race, class, and ethnicity as large factors in systems of oppression and in whether a certain individual is stigmatized. For example, a white person with a disability will have a different lived experience than a black person with a disability, just like an immigrant who speaks English will have a different lived experience than an immigrant who does not. This is not to say that one life in inherently worse than another, but rather to complicate how these dynamics work together and to illustrate that stigma is unevenly applied to different individuals.

inferior.[24] In addition to codifying a racial hierarchy, eugenicists asserted that social characteristics, such as criminality and pauperism, and physical and mental disabilities were equally as inheritable, and advocated for a systematic erasure of these traits.[25] In addition to eugenic rhetoric, industrialization altered labor and the economy and placed an increased emphasis on an individual's ability to be financially independent. As labor reform movements advocated for increased worker rights and benefits, it also helped codify what an ideal laborer's body looked like. So, while an amputation may have been previously seen as a sign of a skilled worker, new regulations reframed these physical abnormalities as sign of carelessness and as a reason to bar these workers from employment, despite their ability to perform the job.[26] This is by no means an exhaustive list of the changing ideas of the Progressive Era, eugenics and industrialization were just two of the factors involved in the process of creating the normate. Overall, the normate in this period was cisgender, heterosexual, married, economically independent, protestant, able bodied, white, with a proportionate height and weight.[27] When the Children's Bureau wrote about birthing normal children, this was the baseline they were referring to.[28]

Together, the social construction of the body and the stigma resulting from the use of the normal allow us to interrogate the implications of public health initiatives on how we think about

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[24] Stephen Jay Gould, *The Mismeasure of Man*, rev. ed. (New York: W.W. Norton Company, 1996), 56-57.

[25] Edwin Black, *War Against the Weak: Eugenics and America's Campaign to Create a Master Race* (New York: Four Walls Eight Windows, 2003), xvi.

[26] Sarah F. Rose, *No Right to Be Idle: The Invention of Disability, 1840s-1930s* (Chapel Hill: The University of North Carolina Press, 2017), 7.

[27] Thomson, 8. This normate is representative of the hegemonic characteristics that continue to persist today. This continuity is demonstrative of continuing systems of oppression.

[28] It is important to note that though eugenics was a significant influence during the Progressive Era, the Children's Bureau was not a eugenic organization and did not advocate for biological determinism.

and value the body. The Children's Bureau, as one of the first federal public health institutions, was one of the early voices of the federal government's response to infant and maternal mortality and large-scale programs to educate women on how to be mothers, so its work was representative of both the goals of the federal government and the scientific understandings of the period. With the previously discussed concepts in mind, the next section briefly outlines the bureau as an institution and articulate the larger context of these prenatal care guides within the institution's work. I then discuss the coverage of marking in four prenatal care guides published between 1913 and 1930 and how the bureau attempted to rebrand marking to be within the control of the mother, rather than by consequence of external forces. This discussion of marking is divided topically to first cover how these guides address nutrition as a way for mothers to shape the bodies of their children and then to cover how these guides address mental hygiene as a way for mothers to shape the bodies of their children.

The Children's Bureau as an Institution

At the start of the twentieth century, childhood was acknowledged as a separate phase of life, especially vulnerable to industrialization, disease, and poverty. As infant and maternal mortality rates were on the rise, maternalist reformers identified the need for intervention in the lives of children. Coupled with an increasing interest in scientific motherhood, reformers believed that the federal government had an interest in the preservation of childhood through maternal education, child labor regulations, and general welfare initiatives.[29] The Children's Bureau was established from the work and advocacy of these reformers to improve the lives of all children.

[29] Lindenmeyer, 11-14.

The proposal for the Children's Bureau was signed into law on April 9, 1912, by President William Howard Taft and formally created the institution as a bureau under the Department of Labor.[30] First led by Chief Julia Lathrop, the bureau was tasked with investigating and reporting on all matters related to the welfare of children. These matters included infant mortality and birth rates, child labor, orphanages, diseases, and a variety of other factors that impacted the lives of children. [31] One of the primary tasks of the bureau at its founding was to gather statistical data to diagnose and figure out how to reduce the high maternal and infant mortality rate. In the infancy of the Children's Bureau, Lathrop focused on maternal and infant mortality as a primary issue because it was measurable, uncontroversial, and did not encroach on the work of other federal agencies. Therefore, maternal and infant mortality was both a critical issue that needed attention and one that helped cement the legitimacy of the new bureau.[32] The Children's Bureau attempted to reduce the maternal and child mortality rate through two main initiatives, the registration of births and the creation of educational programs.

Birth registration first became an issue in relation to new child labor laws that limited employment by age. However, with no governmental documentation of birthdays, enforcement of these laws depended on affidavits from parents to confirm the age of their children which rendered this information inconsistent or untrustworthy in the eyes of the law. In conjunction with the US Census Bureau and other local organizations, the Children's Bureau worked to make vital statistics, birth and death registrations, a formal governmental record which gave this

[30] For more information on the establishment of the Children's Bureau, see Lindenmeyer; Muncy; Ladd-Taylor; James L. Nolan, *The Therapeutic State: Justifying Government at Century's End* (New York: New York University Press, 1998).

[31] Children's Bureau Act, 62 P.L. 116; 37 Stat. 79, Chap 73; 62 Enacted S. 252 (1912).

[32] Lindenmeyer, 37.

information credibility.[33] However, unlike the Census Bureau, the Children's Bureau valued vital statistics not only for their statistical value in understanding the demographics of the country, but also for their use as practical documents for full participation in society and governmental programs.[34] To the public, Lathrop called the lack of knowledge of the number of children a shameful ignorance and asserted that the U.S. could not advocate for the welfare of children without at least knowing how many were born and died each year.[35] The bureau believed that if they were to register all births, they would both be able to assess why babies were dying and create a record of children that could be tracked by local health organizations to promote infant health and wellness. In practice this effort was conducted largely through advocating for mandatory birth registrations in each state, promoting it to individuals, and stressing the value of birth registration as an important cornerstone in a newborn's citizenship.[36] However, Lathrop made clear that birth registration "was in the hands of women to control."[37] By gendering the responsibility of registering births, Lathrop not only reaffirmed that child welfare was a woman's issue, but she also created a responsible party for blame for unregistered births. When coupled with the bureau's understanding that the registration of births was the first step in advancing the welfare of children, mothers were branded as both a problem in child welfare and a possible solution.

The other portion of the Children's Bureau's effort to reduce the maternal and infant

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[33] Susan J. Pearson, "'Age Ought to Be a Fact': The Campaign Against Child Labor and the Rise of the Birth Certificate," *The Journal of American History* 101, no. 4 (March 2015): 1145.

[34] Ibid., 1159.

[35] Julia C Lathrop, "Is Your Child's Birth Recorded?" *Ladies Home Journal*, January 1913, 51.

[36] Lindenmeyer, 43.

[37] Lathrop, 51.

mortality rate was through education programs for mothers. This included cooperation with local women's clubs, support of child health clinics, and the creation of childrearing advice guides. Lathrop made the creation and dissemination of education materials one of the first priorities of the bureau because she believed that teaching mothers about health practices and standards of care would significantly reduce infant mortality. Written to be accessible and friendly, these guides were structured to promote middle class standards of childrearing and health literature to the public.[38] Booklets covered a myriad of topics with some of the most popular being *Prenatal Care* and *Infant Care*. Many women were eager to receive this information and wrote letters to the bureau requesting specific publications or advice for specific childcare problems.[39] These guides were in accordance with the larger social belief in science and demonstrated that health was not a result of strictly genetics, but rather through proper training and care.[40] This trend, called scientific motherhood, emphasized that mothering was a technical skill rather than the result of maternal instinct and deferred authority in childrearing to the expertise of medical professionals. In articulating a rigid system of motherhood dependent on scientific accuracy, scientific motherhood illustrated that mothers could be a danger to their own children if they relied on only their instincts and traditional advice for mothering practices.[41] In coordination of the other educational programs led by the bureau, this body of advice literature placed the health of children in their mother's control and implied that with enough training and effort, mothers would be able to secure health and normalcy for their children.

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[38] Ladd-Taylor, *Mother-Work,* 82.

[39] Molly Ladd-Taylor, *Raising a Baby the Government Way: Mother's Letters to the Children's Bureau, 1915-1932* (New Brunswick: Rutgers University Press, 1986), 5.

[40] Ibid., 34.

[41] For more information on scientific motherhood, Apple.

Together, these two arms of the Children's Bureau reached individuals and communities to become a national children's health agency. Backed by science and mother's alike, Lathrop and the bureau were able to earn the trust of women and families to intervene and make childrearing not only a private concern but a public one. While these programs had demonstrably positive effects in maternal and infant mortality and helped to fill a need in communities, they also offered a specific form of motherhood.[42] For example, the specificity in the type of motherhood can be seen in the interactions with immigrant communities. Though the bureau and other reformers largely acknowledged or respected the ethnic differences in immigrant communities, their programs still attempted to assimilate immigrants into the American ideal of scientific motherhood and housekeeping with confidence that American methods were inherently better than foreign ones. This attempt to Americanize immigrant mothering and health practices was a conflation of larger socioeconomic conditions of poor, immigrant communities with the bias that new immigrants were less intelligent, civilized, or competent in the care of their children and homes.[43] While there was an attempt to help, it was based on the belief that the scientific motherhood taught by the bureau was the only way to be a successful mother. In practice, many women did not fully reject traditions and superstitions surrounding motherhood, and instead blended new scientific standards with cultural practices.[44]

Prenatal Care and Marking

Despite the continuance of cultural traditions, the body of literature that the Children's

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[42] Ladd-Taylor, *Mother-Work*, 89.

[43] Meckel, 130-131.

[44] Molly Ladd-Taylor, "'My Work Came Out of Agony and Grief': Mothers and the Making of the Sheppard-Towner Act," in *Mothers of a New World: Maternalist Politics and the Origins of the Welfare States*, ed. Seth Koven and Sonya Michel (New York: Routledge, 1993), 331-333.

Bureau produced to educate mothers reflected the highest standards of care available to the lay person at their time of publishing. As part of their education campaign, the bureau disseminated these guides to communities throughout the country in an effort to educate mothers and reduce maternal and infant mortality. Between 1913 and 1930 the Children's Bureau published four advice pamphlets intended to teach pregnant women the best practices for achieving a healthy pregnancy. Though the medicalization of pregnancy and childhood began in the nineteenth century, the start of the bureau was when the government first got involved and this intervention not only embodied growing state power, but also reflected the perceived utility of mothers in creating a healthy nation. A healthy citizenry was valuable to the state for variable reasons including economic productivity and military power, however this was not something that could be legislated, so the state utilized an advisory approach to shaping the bodies of Americans.[45] The bureau's work on health and pregnancy was an arm of this advisory state and their body of advice literature was a fundamental way that they sought to alter the practices, and by consequence the bodies, of mothers and children.[46] After the first edition of *Prenatal Care* was published in 1913, the bureau continued its initiatives to reduce infant and maternal mortality through research and education programs, established support from local women's clubs, and dedicated itself to the principles of scientific motherhood, until it published a revised edition of *Prenatal Care* in 1930. The transformation between these two editions, and the mediating pamphlets published between, reflects how the idea of a healthy pregnancy and the ability of a mother to shape the body of her child shifted.

Maternal marking appears in all four of the Children's Bureau's prenatal guides

[45] Moran, 2-3.

[46] Ibid., 36-37.

published during this period. The inclusion of marking in even the small brochures reflects that marking was a large, widespread cultural belief that the bureau felt was necessary to address. For example, marking was represented in literature as a cause for monstrous births that were often dramatic deformities or human-animal hybrids. Though either fiction or folklore, these works highlighted the role of the mother's imagination in the form of her fetus. [47] Also, starting in the mid-19th century, state and local legislators cited marking as a concern in the creation of anti-begging legislation. These ordinances outlawed public displays of disability and demonstrated that legal action was necessary to protect pregnant women from the negative effects of seeing a disfigured person.[48] Though many physicians would agree that marking was a myth by 1913, the cultural impression of marking continued to carry weight and warranted coverage by the bureau.

Each piece of the advice literature from the Children's Bureau made three major points about marking. I discuss the specifics of each guide below and highlight their changes overtime, however in essence, the bureau always first asserted that the myth of marking was false, and that mothers could not alter the bodies of their unborn children through their mental state during pregnancy. Then they would clarify that pregnant women could influence their child's body through their diet and nutrition, as this was the only way the mother's body communicated with that of the fetus. Lastly, the bureau asserted that it was still important for women to maintain good mental hygiene for the health of herself and her baby. This approach redirected the burden of marking from the unsightly disabled person in public and placed it upon the mother instead. This shift in responsibility of marking not only centered women as shapers of their children's

[47] Dennis Todd, *Imagining Monsters: Miscreations of the Self in Eighteenth Century England* (Chicago: University of Chicago Press, 1995), 46-52.

[48] Susan M. Schweik, *The Ugly Laws: Disability in Public* (New York: New York University Press, 2009), 153-156.

bodies, but also articulated two axes of control women were thought to have over the development of their child - nutrition and mental hygiene.

Diet and Nutrition

Progressive reformers spoke considerably about diet and nutrition as an essential part of health and wellness. Emerging information about nutritional science, and the understanding that women were essential to the planning of the family unit's diet, centered feeding and nutrition in the Children's Bureau's baby saving campaigns.[49] This included issues such as pure food and drug regulations, access to clean milk, and the debates over breast feeding or bottle feeding of infants.[50] Bureau research showed that gastrointestinal issues were a major cause of death for infants under a year old which was, in theory, preventable with proper training and information on food safety and nutrition. However, despite the acknowledgement that these factors were important barriers to the prevention of gastrointestinal diseases, this method failed to fully account for socioeconomic conditions that limited families' access to food and sanitary living conditions.[51] In terms of prenatal care, the bureau directed this focus on nutrition to pregnant women to assert that, if they maintained a balanced and nutritious diet, their babies would be strong and healthy at birth.

The first edition of *Prenatal Care,* published in 1913, was written by Mrs. Max West as an accessible guide to prenatal care and home birth. As a mother, West's writing was personable and echoed the familiarity of speaking with a friend, but still carried with it a badge of scientific

[49] Moran, 11.

[50] For more information on infant feeding, see Janet Golden, *A Social History of Wet Nursing in America: From Breast to Bottle* (Cambridge: University of Cambridge Press, 1996); Rima D. Apple, *Mothers and Medicine: A Social History of Infant Feeding, 1890-1950,* (Madison: The University of Wisconsin Press, 1987).

[51] Meckel, 157-158.

authority. West herself had university training and experience in governmental research as a staff member of the bureau, but the guide was also reviewed by a myriad of physicians, nurses, and mothers to confirm its scientific value and use to mothers.[52] In comparison to future prenatal care guides, West offered the least specific information on diet. West broadly stated that, assuming the woman's diet had been "chosen with due regard to its suitability," she could generally continue whatever diet she was following before and only needed to cut out foods that caused digestive distress or discomfort. The most in-depth information West gave was to highlight the importance of excretory functions during pregnancy, as the woman was removing waste for both herself and her baby, and a buildup of waste was dangerous for both of them. To keep these functions in check, West suggested that "an ideal diet include[d] a relatively large portion of liquids, a small portion of meats, and a correspondingly generous portion of fruits and vegetables." [53] West also demonstrated that women did not need to "eat for two" but rather, until the final weeks of pregnancy should eat their usual amount. In the last 8 weeks of pregnancy, when the baby gains most of its weight, West directed women to add a few glasses of milk, or another light food, to their usual diet to support the growth of their child.[54] This advice gave pregnant women flexibility in choosing their diets and demonstrated that if they were hydrated, ate a nutritious diet, and didn't have digestive or excretory problems, they were sufficiently providing for the health of themselves and their baby. The ambiguity surrounding what a nutritious diet looked like allowed for women to make their own choices and assumed a general level of competence in nutrition. Though West highlighted the importance of nutrition and

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[52] Julia C. Lathrop, "Letter of Transmittal," in *Prenatal Care* (Washington: Government Printing Office, 1913), 5.

[53] US Children's Bureau, *Prenatal Care,* by Maxine West (Washington: Government Printing Office, 1913), 8. Hereafter called: *Prenatal Care* 1913.

[54] *Prenatal Care* 1913, 9.

asserted nutrition was the only way a mother's body communicated with her unborn child, the definition of a successful prenatal diet was broad.[55]

In 1921, the Children's Bureau benefitted from the passage of the Shepard-Towner Act, which matched funds to states for education programs and clinics and facilitated their work training women to be mothers. Though the act was allowed to lapse in 1929, funding from the Sheppard-Towner Act was used to produce and revise more advice literature and videos on pregnancy and childrearing.[56] One of these pamphlets, published in 1924, was called "Minimum Standards of Prenatal Care," and included "the least a mother should do before her baby [was] born."[57] This small, seven page brochure was largely a streamlined version of West's *Prenatal Care* and articulated similar advice for prenatal care, sometimes even with the same language. There was a continued deference to medical authority, suggesting that pregnant women see a physician monthly, and the brochure broadly advocated for "simple, regular, normal living."[58] The major difference in dietary advice between the 1924 brochure and the 1913 edition of *Prenatal Care*, was more specificity in the types of food recommended. While the 1913 publication only offered a structure for relative dietary balance, the 1924 brochure included more specific examples of what types of food were most important to creating a balanced diet. Meals were expected to "include one quart of milk, a leafy vegetable, a root vegetable such as potato, fresh fruit, cereals and bread, and an egg, meat, or fish." While this listing still allowed for some flexibility, these guidelines were much more specific than the previous rendition and provided

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[55] *Prenatal Care* 1913, 19.

[56] Lindenmeyer, 98-99.

[57] US Children's Bureau. *Minimum Standards of Prenatal Care: The Least a Mother Should Do Before Her Baby Is Born* (Washington: U.S. G.P.O., 1924), 1. Here after called: *Minimum Standards of Prenatal Care*.

[58] *Minimum Standards of Prenatal Care*, 2; 7.

more structure for a successful prenatal diet. If this was the minimum standard for prenatal care, as the title of the brochure suggested, then a pregnant woman whose diet did not conform to these standards, even if still nutritionally sufficient, would be failing to provide the minimum care. This left less wiggle room for women and narrowed the diet of a successful mother to reflect American food culture.

This guide also provided definitions and examples for "growth foods," milk, vegetables, and fruits, and "fuel foods," starch, sugar, or fats.[59] Categorization of food in this way reflected the growing field of nutritional science, but also helped convey how these foods were understood to work inside the body. By encouraging the consumption of growth foods and warning against the overconsumption of fuel foods, the bureau reproduced the Progressive understanding that nutrition could be quantified and then uniformly distributed to mass populations which would fix socioeconomic, public health problems such as poverty, sanitation, and accessibility.[60] The bureau doubled down on its efforts to standardize a prenatal diet in their 1925 brochure, "What Builds Babies?: The Mother's Diet in the Pregnant and Nursing Periods." In this publication, the bureau delineated example meal plans for the day for pregnant women. There were three versions of this meal plan, one for the average pregnant woman, one for the hardworking or under-nourished pregnant woman, and one for the overweight pregnant woman.[61]The key difference between each of these meal plans was the caloric values prescribed for each weight class. All pregnant women were first expected to consume 1000 calories as the daily essential for growth through the consumption of "one quart of milk, one raw-vegetable salad, one egg, one

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[59] *Minimum Standards of Prenatal Care*, 3.

[60] Moran, 15.

[61] This brochure does not provide guidelines for what constitutes each of these weight categories but rather asserts that diet should be at a doctor's discretion.

citrous fruit or tomato, one cooked green leafy vegetable, and one serving of *whole-grain* cereal or bread."[62] After these first 1000 calories, the average pregnant woman was expected to consume 2000 more calories, the hardworking or under-nourished pregnant woman was expected to consume 3000 more calories, and the over-weight pregnant woman was expected to consume 1000 more calories.[63] This dietary information was much more specific and left no room for error. Definitions of each food group and examples were included so that even a woman who did not know which foods were fruits, vegetables, or whole grains would be able to follow this advice with relative ease.

By standardizing prenatal diets, the Children's Bureau not only supported larger understandings about nutritional equivalency and the ability to standardize food values, but also told pregnant women exactly what they should eat each day. The bureau still deferred authority to physicians and urged readers to follow their advice, and women could still simply ignore their recommendations, but in terms of advisory methods, this was as explicit as the state could get. These exacting standards removed the variability allowed by previous publications and instead gave a specific list of what pregnant women should eat, with a list of substitutions so that these meal plans were practical for the duration of their pregnancy. However, this was not presented as simply a suggested diet with sufficient nutritional values, but rather as imperative for the unborn child. Additionally, bureau promotion of specific foods in the proper prenatal diet was evidence of the bureau's middle-class affiliation. Selected foods in the sample menus were often inaccessible to communities outside of the middle-class or required an abandonment of ethnic

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[62] Emphasis in original. US Children's Bureau, *What Builds Babies?: The Mother's Diet in the Pregnant and Nursing Periods*, (Washington: U.S. G.P.O., 1925), 3. Here after called: *What Builds Babies?*

[63] *What Builds Babies?* 4, 6, 8.

food traditions. Bureau distaste for ethnic and spicy foods revealed that this guidance was about cultural assimilation as much as it was about nutritional standards.[64]

This framing, which continued with much of the same language in the revised edition of *Prenatal Care* published in 1930, asserted that the bureau's diet was the correct way to eat as a pregnant woman and that failure to abide by these standards was not only wrong, but also hazardous to the development the unborn child. These later guides directly argued that "constructive feeding" gave the baby a "better chance of being born a fine, healthy child, vigorous, and resistant to disease."[65] In this sense the bureau casted diet as a way women could facilitate the healthy development of their unborn children, and in a sense directly influence their bodies. Eating enough essential growth foods was articulated as an important part of a pregnant woman's work in "safeguard[ing] the bones and teeth, brain and muscles of the baby."[66] Prenatal diets were not simply about feeding the mother enough to have excess energy to also feed the baby, but about the motherly duty to craft her child's health. Bureau literature placed mothers, not external forces or factors, as the barrier between the unborn child and "nutritional disaster" and "[ab]normal growth."[67]

From 1913 to 1930, the Children's Bureau's advice on prenatal diets became increasingly specific. With this increased specificity, came increased stakes and increased stigma for failure. By outlining an ideal daily meal plan for pregnant women with a list of equitable alternatives, the bureau made following nutritional advice simple. All pregnant women had to do was eat what they were told, and their health and the health of their unborn child was expected to be vastly

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[64] Ladd-Taylor, *Mother-Work,* 88.

[65] *What Builds Babies?* 2.

[66] Ibid., 3.

[67] Ibid., 8.

improved. If achieving a healthy pregnancy was truly this simple, then there was no acceptable reason for a woman to live outside of these guidelines and therefore the choice to ignore these suggestions was a sign of a bad or ignorant mother. While the bureau acknowledged that poverty, poor sanitation, and inadequate healthcare were major barriers to public health, diet and nutrition was within the direct control of individual mothers and therefore was an overt way that women could have agency in the bodies of their children and in a sense counteract external conditions.[68] The implied ease of achieving health through a proper diet implied that if a mother birthed a child who was sickly or physically underdeveloped or abnormal, it was due to some negligence or failure on her part during pregnancy. The stigma associated with failing to meet these standards reinforced body hierarchies and increased the social value of producing strong, vigorous babies.

Mental Hygiene

Despite the assertion that pregnant women were only vessels for nutrient delivery and waste removal for their unborn children and were otherwise unable to affect their growth, the Children's Bureau's advice literature demonstrated that mental hygiene was also an important part of having a healthy pregnancy. Mental hygiene was concerned with practices that encouraged positive mental health, including but not limited to activities like spending time outdoors, positive thinking, and eliminating anxiety. Many of psychiatry's new diagnoses in the late nineteenth and early twentieth century, such as neurasthenia, shellshock, or anorexia, linked emotional and behavioral symptoms to a biological cause. While these biological causes were often hypothetical at this point, the ability to use psychiatric diagnosis to medicalize and treat

[68] Lindenmeyer, 64.

undesirable behavior served as an avenue of social commentary. [69] This means that bureau concerns over mental hygiene were inherently tied to the period's broader power dynamics of race, class, and gender. However, unlike psychiatry, mental hygiene focused on a noninstitutional setting and held that widespread disease could be controlled by environmental reforms and individual behavior.[70] While still scientific, this less medical perspective fit well with broader bureau reform and did not overstep the boundaries of private medical practice. As a white and middle-class organization, bureau content on mental hygiene projected the social and political perspective of white, middle-class women to all mothers, despite the variations caused by racial and economic inequality. This ideology commonly described these white women as nervous, anxious, and fretful, and when coupled with the added stressor of pregnancy, maternal anxiety was interpreted as a serious risk to both the mother and her child.[71]

The bureau used the same gendered language in the way it discussed mental hygiene for pregnant women, however, the bureau also connected the need for good mental hygiene with the idea of maternal marking. Despite their insistence that marking was not possible, the continued coupling of marking with the need for good mental hygiene illustrated that the risk of harm to the baby through the mother's mental state was not fully dismissed. Rather, the risk was coming from strictly the mothers and not from the influences of external sights. The qualifications that follow the disavowal of marking in these prenatal guides demonstrate that the bureau was not attempting to fully dismiss the ability of a mother to influence or harm her unborn baby through

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[69] Charles E. Rosenberg, "Contested Boundaries: Psychiatry, Disease, and Diagnosis," *Perspectives in Biology and Medicine* 49, no. 3 (Summer 2006): 414-415.

[70] Gerald N. Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 144-145.

[71] David G. Schuster, *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1896-1920* (New Brunswick: Rutgers University Press, 2011) 95.

her mental state but rather to clarify that these risks were from the mother's response and therefore within her control.

The first edition of *Prenatal Care* published in 1913 covered the idea of marking in the most depth. This is possibly because all the discussed publications after this edition were written by a committee of primarily male physicians, so these latter guides had a more clinical, less motherly tone. However, West's coverage of marking was scripted to comfort pregnant women and reduce their fears or anxieties about hurting their child and was an expressed attempt to correct what she considered to be one of the most misinformed topics of pregnancy. West first defined a maternal impression as "an injurious physical modification of the child through the influence of some harmful state of mind in the mother," and then offered the example of seeing a disabled person, having the idea impressed upon the pregnant mother, and then having a "corresponding defect" in the child. West then asserted that "doctors and other scientists [were] practically agreed" that this belief had "no basis in fact".[72] This reassurance of medical authority reflected scientific motherhood's ideals. Mothers were expected to abandon older, traditional mythologies of pregnancy and child rearing in favor of scientific instruction from physicians to achieve a healthy pregnancy.[73] Deference to medical authority called for an abandonment of superstitions and was applied especially to immigrant communities in an effort to Americanize their childrearing practices.[74]

West then gave three reasons to disprove the validity of marking. The first of these reasons was seen in the discussion of diet, West asserted that the only communication between

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[72] *Prenatal Care* 1913, 19.

[73] Howard, 325.

[74] Meckel, 130.

the mother and the child was in the exchange of materials. This exchange of food and waste was done through the placenta meaning that no other liquids or materials from the mother, including blood, entered the body of the baby. This also meant that the nervous system, where maternal anxiety, fear, and other emotive responses were understood to originate, was barred from interacting with the unborn child. West asserted that this barrier between the mother and the child acted as natural protection of the child from the mother.[75] The focus on the mechanical limitations of marking once again encapsulated the authority of science over superstition. Rather than challenging the power of women's emotional responses, this advice literature offered a logical explanation for the process of pregnancy.

Next, West continued this logical deconstruction of marking by asserting that if marking were possible, most children would be marked since most mothers experienced something disturbing during their pregnancy. Since the number of upsetting things was so high and the number of abnormal babies in comparison was so low, then the experience of "strange and unhappy things" must have been unable to affect the shape of the baby. West's final point to disprove marking was that the form of the child was developed by the beginning of the third month of pregnancy, which was before many women knew they were pregnant, and that anything that happened to the mother and child afterward could have no effect on the child's physical form. This meant that women, not knowing they were pregnant, were living their lives normally and were unworried about their unborn child or the possible damage external experiences could have upon them. When paired with the relatively low number of disabled or deformed children, West asserted that marking is simply not mechanically possible, and that the

[75] *Prenatal Care* 1913, 19.

mental state and emotional experiences of women was not able to alter the bodies of their unborn children.

However, the qualification that followed the list of reasons to debunk maternal impressions revealed that women were still active participants in shaping their child's bodies. West clarified that "the harm which a mother may do to her child in the uterus [was] not in the fortuitus, accidental manner" suggested by the idea of making, "but rather by her failure to order her own life and happiness in the way that [would] result in the highest degree of health and happiness for herself, and therefore, for the child."[76] The important distinction made here was that effects to the body of the baby were not accidental but rather caused by a failure of the mother to be pregnant in the correct way. While it is easy to accept that insufficient nutrition during pregnancy would be of detriment to a fetus because a certain amount of energy is required to produce a human, the Children's Bureau was not simply saying that a pregnant woman needed to consume enough food to overtly influence the development of her baby. Rather the bureau continuously highlighted the need for a woman to be happy during her pregnancy to best serve the health needs of her growing child. West clearly articulated this in her description of a mother who lamented her pregnancy and then birthed a small and frail child. While this hypothetical baby was only described as small and weak, with no physical deformities, the inclusion of the mother's bad attitude toward her pregnancy reinforced the connection between mental state and the prosperity of the pregnancy. While the bureau was continuously asserting that mental state had no bearing on the vitality of the pregnancy, they also continuously asserted that mental state was an important part of birthing a child with "a sound and normal body and brain."[77]

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[76] *Prenatal Care* 1913, 20.

[77] Ibid.

This contradiction over the importance of mental hygiene continued in future publications. In the 1924 brochure, the paragraph on mental hygiene and marking urged mothers to "try to be serene, happy, and cheerful" and asserted, following a disavowal of marking, that "excitement and special cases for anxiety should be avoided because they disturb general health" which was believed to be of detriment to the baby.[78] However, excitement and acute anxiety were the core of the idea of marking. It was the stress and the shock of seeing the disfigured person that was thought to alter the baby. The change that the bureau made was that these emotional experiences were within the mother's control and if a pregnant woman could maintain a cheerful disposition and avoid any intense or negative emotions, then the outside stimulus was unable to affect her child. It was no longer the fault of a disabled person in the streets, but rather the fault of the mother because she allowed herself to be upset by it.

By the revised edition of *Prenatal Care* in 1930, the conveyed importance of mental health in producing a healthy and normal child combined with heteronormative expectations and middle-class luxuries. This edition expected women to not work outside of the home and emphasized the husband's role in supporting a pregnant woman's mental ease and security.[79] Despite the fact that this middle-class, heteronormative ideal was inaccessible to a large portion of the population that the bureau most tried to educate, the emphasis on women as homemakers and men as breadwinners conflated with the importance of mental hygiene and implied that working outside of the home and being unmarried would negatively affect a woman's mental health which therefore would hamper her ability to have a successful pregnancy. This edition

[78] *Minimum Standards of Prenatal Care*, 6.

[79] US Children's Bureau, *Prenatal Care* (Washington: U.S. G.P.O., 1930), 20-21. Hereafter called: *Prenatal Care* 1930.

reaffirmed the pervious assertions that a woman's poor mental health could negatively affect her unborn child, but the addition of the larger home support system was new. Pregnant women were expected to be happy housewives during pregnancy and help create a "happy and harmonious home." If she had anxieties about her pregnancy, she was expected to consult her physician who would be able to put her at ease, and then to simply stop worrying.[80] This inclusion not only reaffirmed the gendered expectation for women to submit to male authority, but also made a normative home dynamic part of the definition of happy and healthy. In this sense, the American domestic ideal was scripted into pregnancy advice as a way to measure happiness and health. If a pregnant woman's life did not look like this, it was implied that she was not living up to her potential for health and happiness, and therefore was opening the door to risk for her unborn child.

Together prenatal care guides produced by the Children's Bureau demonstrated that, though unpleasant sights were unable to affect the body of an unborn child, the mental state of the mother could. In an essence this was a rebranding of marking took the responsibility for birth defects from an external stimulus to the internal conditions of the body that were affected by mental hygiene. This was coded as a covert axis of power because it seemed unscientific and didn't fit into the larger scheme of scientific motherhood. Therefore, the bureau centered proper nutrition in the foreground of pregnancy advice as the most important thing a mother must do, but continually brought up mood and mental hygiene in the background of this advice to birth a normal or healthy child. This was just marking in a different form. The importance of this difference was that in the mythology of marking it was outside of the mother's control and she

[80] *Prenatal Care* 1930, 20.

was relatively blameless for any deformities in her child, this was an act from an external force. However, in this new version of marking, responsibility and blame for the health and body of the child was placed firmly onto the mother.

The Children's Bureau's discussion of prenatal care and marking demonstrates that women were directly responsible for the health of their child through their diet and mental state during pregnancy. As a tool of the advisory state, these prenatal care guides casted women as agents in public health policy and information, even if they were not the ones directly creating it. Advice literature acted as the guide and tool to achieve normalcy in the bodies of their children, but mothers were responsible for taking this information and applying to their daily lives to produce the correct results. Women's voluntary involvement and support of the bureau's reform movements, and the letters asking the bureau for advice literature, illustrated that many women joined this education effort willingly because they wanted this information for themselves and for their communities. Increased access to and information about prenatal care from this cooperation with mothers produced tangible results, including a significant decrease in maternal and infant mortality rates. From 1915 to 1919 the estimated infant mortality rate among all races was 95.5 deaths per every 1000 live births and the maternal mortality rate for all races was 727.9 deaths per 100,000 live births. By 1930 to 1934 the infant mortality rate was down to 60.4 deaths for every 1000 live births and the maternal mortality rate 636.0 deaths per 100,000 live births.[81] Though these statistics are complicated and cannot fully measure the whole of the population, the decrease in these mortality rates reflected the utility of baby saving reform programs.

These maternal education movements helped many mothers and saved many lives, but

[81] Meckel, 238-241.

with this intervention from the state on health also came state intervention in the types of bodies women were producing. These guides used normalcy as the benchmark of a successful pregnancy, meaning that if a woman birthed a normal child, she was believed to have done a good job at being pregnant. The existence of a successful pregnancy implies the existence of an unsuccessful pregnancy. For mothers, this was not an exercise of bodily autonomy, but rather the enrollment of women in state sanctioned child rearing practices to serve the needs of the state. From the Children's Bureau's literature an unsuccessful pregnancy was not simply one in which the mother or child died, but also included ones where the baby was small, disabled, or otherwise abnormal. Combined with the perceived control prenatal advice gave women over their pregnancies, this use of normalcy as a signifier of success increased the stigma for physical difference and casted the mothers of abnormal children as bad or ineffective. While this trend of control continued after birth, the subject of this advice changed to focus on the body of the child. Where pregnant women were once only monitoring themselves, the bureau instructed mothers to police both their own bodies and that of their infant.

CHAPTER 3

INFANT CARE AND MATERNAL POLICING

Much like with their literature on prenatal care, the Children's Bureau produced and later revised a booklet on the care of infants. Published originally in 1914, *Infant Care*, written by Max West, covered topics of infancy ranging from how to set up the nursery to how to toilet train to markers of common childhood diseases. In creating this instructional guide to motherhood, the bureau also created developmental and health standards that established a standard for the health of infants. Communicated through charts, developmental narratives, and physical descriptions of the body, these health metrics were a self-assessment tool for mothers to determine if their child was normal. Normalcy equated to good motherhood. In this system of maternal policing, health, which was defined by its conformation to normalcy, was both the goal and the responsibility of motherhood.

This chapter demonstrates that in its 1914 to 1929 publications on infant care, the Children's Bureau adopted a system of maternal policing that implored mothers to quantify and measure the health and development of their infants to determine both if the child was normal in comparison to their peers and if the mother was doing a good job mothering. As much of the labor involved in maternal policing depended on a sense of urgency and anxiety over the health of their children, the bureau was careful to emphasize a "productive" anxiety that improved child health rather than an unproductive anxiety of maternal panic. In creating this distinction between good and bad maternal attention, the bureau created a fine line for good mothering and suggested that mothers were simultaneously an asset and a threat to the health of their children.

I use the term maternal policing in this chapter to refer to a mother's surveillance and enforcement of rules or regulations upon the body of her child. Though the Children's Bureau

did not use this specific terminology, bureau literature actively encouraged mothers to compare their children to established physical standards and then adjust their mothering as necessary to minimize disability and help their child conform to the boundaries of normalcy. Much of the labor involved in maternal policing, which included variations of monitoring, measuring, and reporting, reflected the broader, Progressive attempt to quantify and standardize qualitative problems like health or poverty.[82] A major part of encouraging this policing was communicating to mothers what it looked like to have a healthy child and that the cost of having an unhealthy child was far greater than the cost involved to keep a child healthy. By embracing a system of maternal policing in which mothers were instructed to quantify and assess the health of their children the bureau communicated that health was within the mother's control. If mothers followed bureau instructions, their infant would be normal. It also implied that the inability to meet these physical standards was a symptom of maternal incompetence. Despite the importance the bureau placed on mothers, the bureau maintained that it was also possible for a mother to do too much mothering and risk being overbearing or smothering. When a mother went beyond the required labor for maternal policing she was not interpreted as an extra good mother, but rather as a fretful, obsessive, threat to her children.

To demonstrate how the Children's Bureau used maternal policing to direct maternal labor to minimize disability, I first discuss the context and nature of the bureau's middle-class influence and how an assumption of maternal anxiety stemmed from the larger context of gender and class. I then discuss maternal policing as the bureau's productive outlet for this sense of anxiety. Despite exceptionally high stakes and substantial labor, maternal policing occupied and

[82] Moran, 12.

directed the energy of mothers to bureau sanctioned, scientific avenues. Lastly, I examine bureau warnings against maternal panic and how those warnings cast mothers as potential threats to their children. Together the bureau's use of maternal policing and warning against maternal panic clarified that the goal of motherhood was to rear physically normal children through a strict adherence to bureau childrearing advice.

Prescription of Anxiety

A core feature of the Children's Bureau reform was its belief in white, middle-class standards and ways of living. This commitment was embodied by the bureau's early leaders Julia Lathrop and Grace Abbott who were products of the Chicago Hull House settlement which sought to spread the benefits of education and social reform to the surrounding community of recent, European immigrants. Hull House residents, including Lathrop and Abbott, offered classes and provided services intended to ease the burdens of the working class. Programing and community reforms, which focused heavily on the needs of women and children, included a day nursery, space for female labor unions to meet, and a fellowship system that sponsored professionals to fill needs in the community.[83] This community centered reform embodied the belief that though women were responsible for the care of their own families, true health and prosperity could not be achieved without a collective effort.[84] Many Hull House residents, and reformers in similar communities, were motivated not only by a genuine concern for the welfare of the needy and disadvantaged, but also by broader social expectations for middle-class women

[83] Muncy, 13-17.

[84] Lorraine Krall McCrary, "From Hull-House to *Herland*: Engaged and Extended Care in Jane Addams and Charlotte Perkins Gilman" *Politics & Gender* 15, no. 1 (March 2019), 69.

and their professional potential.[85] Despite their maternalist insistence that motherhood was a worthy and skilled profession that was essential to the success of the nation, Lathrop and many others employed by the Children's bureau never married or had children. Rather, these women built for themselves careers outside of the home by instructing other women to stay within it.[86]

Lathrop replicated Hull-House's style of women-led reform in the Children's Bureau by not only hiring women from similar reform backgrounds who were white, middle-class, well-educated, and unmarried, but also by embracing the warm, community-centered ethic of the settlement house.[87] Despite their compassion for their constituents, bureau advice focused on teaching mothers the necessary information to make good decisions for their children based on Progressive standards of science. This focus on professionalism in mothering from the bureau was reflective of their respect for maternal labor and a recognition of the grueling conditions that many families were living under. In treating motherhood as job that required training and expertise, the bureau portrayed mothers as capable, hardworking, and well-intentioned.[88] The boundaries of what constituted good decisions for children, however, was greatly influenced by American culture and a belief that middle-class, American values were essential for child health and welfare.[89] General anxieties about the dangers of immigrant ignorance strengthened a cultural interest in nostalgia in child rearing that heralded simple, agrarian living as the American ideal.[90] Bureau emphasis on things like moderation and time outdoors was a way to translate the

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[85] Muncy, 30-31.

[86] Ladd-Taylor, *Mother-Work*, 80.

[87] Muncy, 51-53.

[88] Ladd-Taylor, *Mother-Work*, 83-84.

[89] Meckel,130-131.

[90] Laura L. Lovett, *Conceiving the Future: Pronatalism, Reproduction, and the Family in the United States, 1890-1938* (Chapel Hill: University of North Carolina Press, 2007), 7.

benefits of rural living to the urban poor and encourage all mothers to adopt this vision of American life.[91] When combined with the maternalist attitude of the bureau, educational materials reflect an understanding that, despite their respect for mothers, the bureau knew what was best for child welfare and that a failure to follow this advice was a sign of ignorance and poor motherhood.

In addition to the importance of class and education in shaping the ideology and programing of the Children's Bureau, gender was a key influence in how the bureau interacted with mothers. Simply being women made Lathrop and other bureau employees seem uniquely interested in and suited for child welfare work. This branding of children as a women's issue allowed the bureau to be a feminine space and gave women an opportunity to build a career in politics. The femininity of the bureau also allowed for a more personal relationship between government officials and the public. Many women wrote to the bureau with their deepest secrets, woes, and worries and received back personal responses of support and advice. Though this level of intimacy went beyond the official duty of the bureau, it reflected the high level of trust between women and the bureau.[92]

While this gendering of child welfare reform offered women professional and interpersonal opportunities, contemporary gender norms also complicated the expectations and interpretations of mothers. Since antiquity, medicine and science has interpreted women as more unstable, irrational, and neurotic than their male counterparts, attributing this to an essence of womanhood and complications of the female reproductive system. Though scientific study has

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[91] Gail Bederman, *Manliness & Civilization: A Cultural History of Gender and Race in the United States, 1880-1917* (Chicago: University of Chicago Press, 1995). In this period there was also a notable anxiety over the threats of over civilization to both the health and character of Americans. Without a rigorous outdoor life, many people believed that the new generation would be weak in character and body

[92] Muncy, 52-53.

done little to clarify firm boundaries of sex difference in this regard, the social belief that women are uniquely prone to hysteria, anxiety, or any other form of nervous disorder continues to be influential.[93] In the early twentieth century, this understanding of women as sensitive to nervous disorders was tied to both motherhood and the burden of domesticity in the middle class. Historical scholarship has shown that, though both men and women could be hysteric, the notion of hysteria was most actively applied to white, middle-class women as both a reflection of their perceived fragility to the changing role of women in modernity and as a threat for breaking traditional gender scripts.[94] Broad diagnoses of hysteria, neurasthenia, or tired nerves, were characterized by symptoms such as exhaustion, pain, insomnia, and indigestion and considered to be psychosomatic manifestations of over civilization unique to middle-class women who ventured outside of the home.

Though an agency run by middle-class women who have left the domestic sphere, the threat of hysteria, anxiety, or overexertion in women underpinned Children's Bureau literature. This was previously seen in the discussion of mental hygiene during pregnancy and continued to be a concern after birth. During infancy this concern over the mental status of mothers was less focused on the biological connection between mother and child during pregnancy and more focused on the potential emotional impact of the mother's anxiety on her infant. This meant that though the bodies of mother and child were now separated, the attitude, disposition, and mental hygiene of the mother still actively affected the health and development of the child. Instead of using the language of marking, the bureau depended on a broader notion and expectation of

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[93] For more information on the rhetorical shifts that shape how scientists, physicians, and laypeople discuss the broad notion of "female problems" see: Amy Koerber. *From Hysteria to Hormones: A Rhetorical History* (Philadelphia: Pennsylvania State University Press, 2018).

[94] Laura Briggs, "The Race of Hysteria: "Overcivilization" and the "Savage" Woman in Late Nineteenth-Century Obstetrics and Gynecology," *American Quarterly* 52, no. 2 (June 2000), 247.

feminine anxiety to articulate and warn against that threat. This was seen in *Infant Care* in repeated warnings to avoid anxiety, worry, or stress which I discuss in more depth below.

Though the content of these guides reflects this cultural expectation for mothers to be anxious about their children, this is a prescriptive body of literature and does not necessarily mean that all women who read Children's Bureau guides were neurotic. Letters written to the bureau reflected both women who were anxious about their children and those who were not. For example, Mrs. L.R. of Montana wrote to the bureau in 1923 for clarification on her infant's vegetable consumption. The mother wrote, "the baby [was] in excellent health; and his diet seem[ed] to agree with him splendidly… however, [she] had him examined by a baby specialist [nearby] to ensure [her]self that nothing was wrong with him."[95] Though this mother had no reason to believe that her child was in ill health, she nonetheless carried a sense of anxiety about the health of her child. To contrast, another mother living in Colorado wrote in 1920 to state that she believed there was "too much foolishness attached to the feeding of children" and that "in many instances the child [was] ruined from too much attention to dieting and medicine."[96] In practice, the experience of motherhood varied by the individual and the source base consulted in this research cannot speak to these variations. Rather, this research demonstrates that the bureau believed mothers had a predisposition to anxiety that could be directed to serve the health and development of infants.

Maternal Policing

Maternal policing depended on metrics of normalcy to quantify and standardize health in

[95] Ladd-Taylor, *Raising a Baby the Government Way*, 76.

[96] Ibid., 75.

infants. These metrics, which included weight charts, developmental milestones, and physical descriptions of the body were born from the scientific focus of the Children's Bureau and broader Progressive reform. With their seeming objectivity, these measurements of normalcy offered a simple way for mothers to assess health and identify if their child needed medical care.[97] Additionally, these metrics articulated what the state believed to be the correct kind of body and offered firm boundaries to what was and was not acceptable. By branding these charts and developmental narratives as scientific, objective, and relatively absolute signifiers of health, the bureau could attempt to direct maternal behavior to meet these standards. Maternal policing was the bureau's system for mothers to exert control over the body of their child to prevent disability and abnormality.

One of the most notable health metrics offered in *Infant Care* was weight. The Children's Bureau privileged this metric both because it was able to speak to the quality of nutrition and digestion, a major medical concern of the period, and because it seemed relatively easy to control and adjust for. Emerging nutritional science and the rise of the calorie demonstrated to the bureau that nutrition could, if only for the purpose of educating mothers, be simplified to numbers. If a child received enough calories from the different food groups, they would grow – it did not matter if the food was stale or low quality.[98] However, in the care of infants, nutrition and feeding was more complicated. Debates on breast feeding versus bottle feeding were raging throughout the early twentieth century and, though they believed breast was often best, the bureau included detailed instructions on both feeding methods. Insufficient or otherwise poor feeding was one of the leading causes of infant death and both feeding methods carried potential

[97] Moran, 36.

[98] Ibid., 13-14.

dangers.[99] Bottle feeding was complicated by inconsistent access to clean, safe milk, sanitation, and incorrect milk ratios; breast feeding was complicated by the mother's milk quality, quantity, and the ability to breast feed at all. These dangers meant that, no matter how they chose to feed their children, the bureau believed mothers needed to track and monitor their infant's nutrition through their weight.

When *Infant Care* was originally published in 1914, the Children's Bureau was itself in its infancy. This meant that though the bureau was charged with gathering and reporting on information related to child welfare, the institution did not yet have large bodies of data collected and organized. Instead, the bureau adopted guidelines from existing, well-respected child rearing experts, including Dr. L. Emmett Holt, for its first content on normative infant weight. *Infant Care* author Maxine West wrote that "in order to determine how the baby [was] thriving, it [was] necessary to weigh him at stated intervals and compare the results."[100] Though a healthy newborn could weigh anywhere from five to twelve pounds, West asserted that what was important was that the infant was steadily gaining weight. The definition for what was an appropriate rate of weight gain was about three-fourths of an ounce a day for the first month, half an ounce a day at seven months, and a fourth of an ounce a day at the end of the first year. If an infant was losing weight or gaining weight at a significantly different rate, this meant that the mother should consult a doctor to help her adjust her feeding practices.[101] The 1921 edition of *Infant Care* offered similar information to mothers with a focus on relative growth but also

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[99] Apple, *Mothers and* Medicine, 4.

[100] US Children's Bureau, *Infant Care*, by Maxine West (Washington: Government Printing Office, 1914), 37. Hereafter called: *Infant Care* 1914.

[101] *Infant Care* 1914, 38.

offered the average weight for infants for each month.[102] With guidelines that were based on relative growth, West's advice offered mothers flexibility in the policing of weight. We see that weight was an important metric of overall health, but it was based on long term, individual trends.

This relative flexibility in weight guidelines changed once the Children's Bureau built a large enough data set to create height and weight charts. Infant weighing was a significant part of early bureau work through local better baby contests and the 1916 and 1917 Baby Week events, with the measurement of preschool age children first prioritized by the bureau as part of their 1918 Children's Year campaign.[103] The bureau utilized networks of women's clubs to weigh and measure masses of children throughout the country to both demonstrate to mothers the importance of this information and to create a bureau-backed dataset for the average sizes of children. The process for weighing and measuring children was not as simple as placing a child on scale, rather the bureau created detailed instructions on how to weigh and measure children and even how to record the data. The volunteer women who did the bulk of this labor had to be trained and were often supervised by a physician or nurse to further ensure the information's scientific accuracy. The charts that resulted from this Children's Year campaign became the golden standard of height and weight information and became a primary tool for a baseline health assessment. Mothers were encouraged to measure their children, track their growth, and to seek medical advice if their child deviated from the normal established by these charts.[104]

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[102] US Children's Bureau, *Infant Care* (Washington: Government Printing Office, 1921), 74-76. Hereafter called: *Infant Care* 1921.

[103] Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1995), 494; Lindenmeyer, 71.

[104] Moran, 29-35.

The incorporation of this data, coupled with a shift in authorship to a committee of physicians, raised the stakes and labor surrounding the policing of weight in the revised 1929 edition of *Infant Care*. Instead of offering a normative rate of daily weight gain, the revised guide used weight-height-age tables to communicate the average weight of male and female infants at a specific age and height. The bureau instructed mothers to bring their child to a physician for weekly weighing and measuring in order to gauge her child against this established normal and to determine whether or not they were healthy. If a mother was unable to go to a doctor or clinic, she was still expected to record the weekly measurements and report them to her local physician.[105] The use of height and weight charts as a metric of health reaffirmed the Children's Bureau's commitment to normalcy as the goal of the body. Though these charts had critics at their conception, the use of the charts allowed the bureau to quantify an otherwise abstract definition of the normal.[106] Quantifying what was a proportionate height to weight translated what was a largely aesthetic value to something that could be easily compared, tracked, and assessed.

While the use of height and weight charts to measure health was problematic, it was also a succinct example of the bureau's expectation of maternal policing. The bureau told mothers to meticulously record and measure their child's growth, compare that number to a statistical average, and then to report this information to a physician for further guidance. The bureau heralded weight as the "only one reliable indication of whether or not a baby ha[d] sufficient

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[105] US Children's Bureau, *Infant Care* (Washington: Government Printing Office, 1929), 12-16. Hereafter called: *Infant Care* 1929. Within *Infant Care* the Children's Bureau offered little advice as to where to get a scale. The bureau directed mothers to their doctor's office, local clinics, or local well-baby events for child weighing and emphasized the need for scientific accuracy.

[106] Moran, 22.

food and only one sure way to tell how much he [was] taking at a meal." [107] If weight was a direct result of the mother's feeding, then an average weight would mean that the mother had taken proper care of her child. In this way, maternal policing was both monitoring the health of the child and the quality of the mother. If good mothers had average weighing children, that that means deviation from the average was the reflection of a bad mother. Additionally, the focus on normalcy clarified that the goal of maternal policing was to minimize physical difference and abnormality.

Notably, the Children's Bureau depended on self-reporting for the vast majority of its programing and research. This meant that since they could not force mothers to take their children to the doctor or attend bureau events, they made significant efforts in the literature to convince mothers participation was in their best interest. The bureau framed this participation as not only useful to mothers but also as essential to the survival of their children. With the threat that "nine-tenths of all infant illnesses" were caused by improper feeding, the need for "intelligence of the mother" was framed as an issue of life or death, not as an issue of compliance with state programing.[108] While many issues of infant welfare were truly life or death, the bureau escalated the stakes of this conversation and asserted that everything about childrearing was essential to the future wellbeing of the child. Statements like, "even when he sleeps the baby is not cut off from experience, for the weight and texture of the bedclothes and the resistance of the mattress are having their effect upon his body," communicated that every

[107] *Infant Care* 1921, 54.

[108] *Infant Care* 1914, 64.

detail was of utmost importance and mothers could not afford to rear their children without bureau and medical guidance.[109]

The stakes of this childrearing advice were the Children's Bureau's vehicle for its prescription of anxiety to mothers. If everything was crucial to child welfare – from the method of feeding to the weight of the bedclothes – then everything was worth worrying about. Considering the gendered conception of anxiety common to the early twentieth century, this worry was a potential threat to mothers and their families if left unchecked. However, the bureau also demonstrated that by following its guidelines, mothers would have nothing to worry about because they would be following best practices, monitoring their children, and seeking medical intervention at the earliest sign of abnormality. Therefore, the use of maternal policing allowed for the bureau to maintain a balance between the high stakes of motherhood and the potential danger of unchecked anxiety. Maternal policing offered mothers a way to check and compare their children to established norms and offered comfort in knowing if they were being good or bad mothers. Though the definition of what made a good mother was artificial, it offered a way to decide if her "baby [was] properly thriving or not."[110] This gave mothers a sense of control over their infant's health that hinged on their compliance with bureau guidelines.

Letters to the bureau confirmed that motherhood and managing the household was often an overwhelming amount of work. Women requested help managing their schedules and minimizing the amount of work they needed to do in order to maintain intensive feeding schedules and support other needs of the household.[111] For the vast majority of women, hired

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[109] *Infant Care* 1929, 1.

[110] *Infant Care* 1914, 51.

[111] Ladd-Taylor, *Raising a Baby the Government Way*, 129-131.

help was financially inaccessible, leaving mothers to do this domestic labor. Even in homes that could afford to hire a nanny, the bureau suggested great caution in the hiring and supervising of the nanny, providing horror stories of children traumatized by lies or left locked in a highchair for hours on end.[112] The bureau also cautioned mothers against relying too heavily on their other children, most actively young girls, to help rear infants, citing that children needed their own free time to play and that their small bodies may not be physically strong enough to handle the infant securely.[113] The seldomly mentioned father of the home, though a safe caregiver option, was identified as the breadwinner and therefore unavailable to help with the majority of the child rearing. Rather, fathers were largely excluded from these childcare guides and only mentioned in the broadest terms.[114] This left mothers as the primary labor source in the home and with relatively few options for assistance. For working mothers and multi-generational families, this amount of labor was even less accessible.

In addition, maternal policing offered structure to the type of care labor mothers should do. The measuring, comparing, and reporting inherent to maternal policing was exceptionally labor intensive. The Children's Bureau claimed that in order to be an intelligent mother, they had to be experts in the bodies and lives of their children. This expertise was not from simple familiarity, but rather from consistent, scientific attention. In 1914, West framed the need for maternal attention around prevention and the ability to identify symptoms of illness or abnormality. As guardians of their children, mothers were responsible for noticing illness and

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[112] *Infant Care* 1914, 26.

[113] *Infant Care* 1921, 38-39.

[114] *Infant Care* 1914, 60. Fathers were only mentioned a few times throughout each of these guides. When there was content on fathers it was to state fathers were unavailable or that they should simply help reduce the mother's workload and stress. There was no actionable statements or real direction given for how fathers could help with parenting. So, though fathers existed, the bureau did not treat them as part of the domestic labor force.

getting appropriate medical treatment.[115] By 1929, the scope of this maternal expertise expanded to include all aspects of the baby. The bureau stated:

> When the baby is well the mother should observe the normal position of his body, his normal activity and wakefulness, the expressions of his face, the color of his skin, also the color of his tongue and the condition and temperature of his skin, so that signs of discomfort, pain, unusual drowsiness, or irritability can be noticed quickly. The character and number of bowel movements and the amount and color of the urine should be watched.[116]

Though ultimately serving the same purpose, identifying illness in the child as soon as possible, this broader, more encompassing scope of maternal observation required near constant attention on the part of the mother. However, the bureau did not brand this attention as obsessive, rather this was a guided, scientifically focused observation necessary to being a good, intelligent mother. In this way, requiring such large amounts of labor in order to be a good mother was a way for the bureau to direct the prescribed anxiety of motherhood to a useful, if not excessive, end. Rather than fretting over the state of their children, the bureau instructed mothers to carefully and meticulously observe them in a way that follows their guidelines.

For the Children's Bureau, maternal policing offered two major benefits to its advice literature. First, it reinforced the bureau's adherence to normative body standards as markers of health. These metrics themselves reflected what the state considered to be an ideal body and created firm boundaries around what is normal and what is abnormal. Secondly, maternal policing instructed mothers how to control the bodies of their children. The expectation of maternal policing was that labor from mothers could ensure that their children would be physically and developmentally normal. While the practical scope of this influence was limited

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[115] *Infant Care* 1914, 64.

[116] *Infant Care* 1929, 108.

and imperfect, the bureau's literature gave mothers tools to physically mold their children through the labor of measuring, comparing, and reporting. While a useful structure for mothering, maternal policing offered mothers a way to feel as if they were able to impact and control their child's health. Together, these two factors placed health as both the objective and measurement of sufficient maternal care.

Complications of Maternal Panic

Despite the vast amount of labor required for the Children's Bureau's scheme of mothering, the bureau made sure to clarify that it was possible for mothers to do too much for their children. Rather, being a good mother was about conforming to a fine line of maternal labor and attention as defined by the bureau – too little was ignorance and neglect, too much was overindulgent and smothering. While the bureau strongly advocated against neglectful parenting and encouraged mothers to engage in the labor of maternal policing, the bureau's warnings against over-mothering revealed that even with their best intentions and effort mothers were still a threat to the health and wellness of their children if they strayed from the recommendations of science. The bureau identified this threat in two primary ways. Panic first served as a threat to the physical body of the mother and child and secondly as a threat to the emotional and nervous development of the child. Through the interrogation of both of these facets, we see that the bureau continued trends from the prenatal period and emphasized the potentiality of damage from the mother.

For clarity, since the bureau used a variety of terms and contexts for the threat of too much maternal attention, I've adopted the term "maternal panic" to broadly refer to this threat from mothers. The bureau addressed smothering largely from the perspective of maternal anxiety, worry, or obsession, and while these terms all have nuanced connotations, they came

from the gendered expectations of mental health. By using maternal panic, rather than smothering, over-mothering, or obsession, I intend to highlight the prescribed sense of anxiety coming from the bureau at the root of this threat and how that affects the interpretation of women throughout these guides.

Physical Body

Like the prenatal period, the mental state of the mother continued to be important to the wellbeing of infants. The Children's Bureau did not frame this threat in terms of post-partum depression or infanticide, but rather in the functionality of the mother's body. Maternal panic was psychosomatic so if a mother was fretting over her child, she might develop physical symptoms such as exhaustion, weakness, or indigestion. When coupled with the labor intensity of good, intelligent mothering, physical illness of the mother was a direct threat to the health of the child. However, the Children's Bureau also discussed maternal panic as a choice. This meant that even though maternal panic caused real physical symptoms, a change in maternal attitude could reverse these physical affects. This sense of control was offered most actively in relation to a mother's ability to breastfeed.

Breast feeding was an essential task for the Children's Bureau's description of an intelligent mother, despite the inclusion of information on bottle feeding. In 1914, West asserted that human milk was different from that of any other animal and was designed by nature to fit the needs of an infant which should be reason enough to "induce a thoughtful mother to nurse her baby."[117] Furthermore, West asserted the "comparative failure of artificial feeding" meant that bottle fed infants were more likely to die or suffer from a variety of illnesses which could create

[117] *Infant Care* 1914, 31.

long term "defects and deficiencies" that could have been avoided if the child "had passed the period of infancy in perfect health." [118] This demonstrated that though bottle feeding was an option that many mothers used, the bureau strongly advocated for breast feeding as the ideal method for ensuring the health of the child. This bureau held breast feeding as the most scientifically sound and best suited to supporting strong, normally developed infants. Additionally, West expected most women and their infants to, with "suitable care and advice," to have the potential to successfully nurse, rather:

> So intimate [was] the connection of the mammary nerves with the mind that the mental states of the mother [were] readily reflected in their function. Fear, anger, or worry may serve to check the secretion of the milk, or to change its quality so much that, for the time being, it [was] unfit for use, while, on the other hand, a calm mind, joy, laughter, and delight in life, coupled with the desire and intention to nurse the baby [would] make it possible to do so. Failing this spirit, all other measures may prove futile.[119]

Though West included that diet, rest, and exercise were important to milk production, this focus on mental hygiene was the primary facet in successful breastfeeding.[120] By emphasizing the role of mental state in successful breastfeeding, West both warned against the dangers of maternal panic and asserted that mothers were in direct control of their ability to nurse. If all women had the potential to breastfeed with the correct attitude, the failure to do so was simply the mother sabotaging the process at the expense of her child, not a result of some other physical barrier. Since the bureau placed breastfeeding as one of the essential components to rearing a healthy child, the danger of maternal panic to milk production was a tangible threat to infant welfare.

Though the 1914 edition of *Infant Care* discussed complications of breastfeeding almost

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[118] *Infant Care* 1914, 32.

[119] Ibid., 32-33.

[120] Ibid., 33-34.

exclusively in terms of maternal panic, the bureau later broadened its list of potential barriers. In 1921, the Children's Bureau published a supplementary guide dedicated to breast feeding which included an extended list of things that affect the ability to breastfeed. These factors included the strength and development of the infant, the technique of breastfeeding, and any physical abnormalities of the child.[121] Though this list expanded the potential barriers to breastfeeding, the bureau maintained that "freedom from worry and emotional excitement" was still important to the success of a nursing mother.[122] In the 1929 edition of *Infant Care*, this trend continued where the bureau acknowledged other barriers to breastfeeding, but still continued to emphasize the mother's "determination to nurse her baby" as an essential part of breastfeeding.[123] The bureau continuously asserted that "contentment of spirit" was an important part of producing breastmilk and that living an "even, regular life without emotional upsets" would facilitate breastfeeding.[124] Such a conception of breastfeeding echoed the bureau's stance on prenatal marking where there was an expectation that the mind of the mother can directly influence the body.

Throughout these guides the Children's Bureau maintained that the failure to breastfeed was directly related to maternal panic, despite additional, identified barriers to successful nursing. This perspective was an important reflection of the bureau's gendered expectations of mothers because it revealed that the bureau, despite their respect of the labor of mothers and the profession of motherhood, anticipated women to be unstable, emotional, and a danger to

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[121] US Children's Bureau, *Breast Feeding* (Washington: Government Printing Office, 1921), 7-8. Hereafter called: *Breast Feeding.*

[122] Ibid., 10.

[123] *Infant Care* 1929, 62.

[124] Ibid., 65.

themselves and their children. However, this danger came not from apathy, but rather from too much attention and concern. Though the bureau wanted mothers to do an immense amount of labor, they did not want an emotional response to the stakes of that labor. Mothers had to both track and observe their child, but also could not worry; they needed to know everything about their child but could not stay home and watch them child all the time.

Nervous Development

Maternal panic was also a threat to the infant's emotional or nervous development. According to the Children's Bureau and other leading childcare experts, infants were sensitive to all kinds of excitement and stimulation and the exposure to stress or excitement could permanently change their brain to mimic those experiences.[125] This understanding meant that by exposing young children to their anxiety, mothers were actively altering their mental processes and potentially making their child weak or nervous – traits that the bureau stigmatized as defects. Additionally, the bureau's commitment to "middle-class values of moderation, simplicity and control," extended to the emotional bond between mother and child.[126] Though the bureau expected mothers to love their children, they branded appropriate maternal dedication as professional and emotionally objective – not overzealous or exuberant. While this supported the bureau's perspective of motherhood as a skilled profession, it also meant that the bureau's advice literature spoke not just to the skill of motherhood but also to its ethos.

According to the Children's Bureau, a key threat maternal panic posed to the nervous development of infants was through overstimulation. In 1914, West warned heavily against

[125] *Infant Care* 1914, 63.

[126] Ladd-Taylor, *Mother-Work*, 88.

playing with or too frequently moving the baby because it was likely to disrupt the child's nerves and routine and to make the child "dependent upon these attentions".[127] Rather, West advised that it was better to hold the child quietly in a variety of positions during their waking hours and to train older infants to sit on the floor or in their playpen. Despite this plea to leave the child alone, West attempted to communicate a perfect line between enough mothering and over-mothering but offered little guidance as to what that line looked like – it was simply giving the child the correct amount of attention. Instead, she warned against the consumption of "nervous energy" from minding the baby and recommended mothers train their infants to not need that much attention from the start. West noted that this type of overstimulation could make a child weak, anxious, or needy.[128] Here the danger to the infant was not from neglect or carelessness, but rather from too much maternal attention and labor.

The call for emotional distance from the infant continued in the 1929 edition of *Infant Care*. The Children's Bureau continued to advise mothers to minimally handle their children in order to preserve their nerves and sense of routine. Here, the bureau expanded this warning against maternal panic to support the discipline of the infant. Framing infants as manipulative, the bureau instructed mothers to abide by strict scheduling for the feeding, sleeping, and care of infants without deviation. This meant that if the infant was crying, but was generally well cared for, not ill, and not in danger, the mother should simply leave the child alone to let them cry it out. The bureau stated that to accommodate the child's every cry would give the child satisfaction and allow them to control the parents and household, a habit that could last for the

[127] *Infant Care* 1914, 60.

[128] Ibid., 59-60.

rest of their life.[129] While the appropriate response to crying continues to be debated in parenting circles, the bureau's coverage of this issue branded a maternal response to crying as a foolish, overindulgence motivated by maternal panic.

Similarly, the bureau advised against fussing over the child to coax them into specific behaviors. For example, mothers were instructed to "show no anxiety nor excitement throughout" feeding their children because it could encourage the child to resist foods for attention. The bureau warned that the mother's desire to have their child gain weight could make them overanxious and desperate for the child to consume food. While the bureau certainly wanted children to eat, they interpreted the mother's emotional response as the potential problem in actually getting the child to eat.[130] Despite the extensive content the bureau provided on the importance of diet and nutrition for infants, mothers were not to express any anxiety about meeting the nutritional needs of their children because that emotional response was in itself dangerous to the child. The solution to this problem was therefore to remove that emotional investment in the child's diet and to appear apathetic.

Together, the threat of maternal panic to the mind and body reflected the Children's Bureau's belief that mothers could be emotionally dangerous to their children. Though much of the bureau's educational efforts centered on getting mothers to correctly care for their children and to be aware of all the potential threats to their health, displaying an emotional response to these high stakes was not allowed. Rather, the bureau instructed mothers to do all of the labor involved with maternal policing without appearing like they were doing a lot of work. Mothers were to be concerned with their child's health but also not worried or anxious about it. Finding

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[129] *Infant Care* 1929, 54-55.

[130] Ibid., 56.

the perfect balance between "on guard" but not "unduly alarmed" depended on conforming to the bureau's prescription of appropriate anxiety dedicated to completing labor, not emotional expression.[131]

The Children's Bureau's used the system of maternal policing to show mothers how they could control the bodies of their infants. While gendered notions of anxiety colored the boundaries of maternal labor's usefulness to assuring the normal health and development of infants, maternal policing structured mothering and created measurable benchmarks for the bodies of infants. The understanding was that by following bureau guidelines, mothers could practically assure the health and wellness of their infant. While the bureau communicated high enough stakes to encourage mothers to comply, they also gave mothers the answer to infant health. This system reflected both broader concerns about infant mortality and the belief that good mothers raised healthy, normal children. By placing infant health as a marker of maternal success, the bureau reinforced the stigma of disability and physical abnormality. As these infants became toddlers, the implications of this need for normalcy became more explicit and the scope of maternal policing expanded.

[131] *Infant Care* 1914, 52.

CHAPTER 4

CHILD CARE AND MATERNAL CONTROL

U.S. entry into the First World War in 1917 spurred a new phase of American body panic as a third of new military recruits were deemed unfit for military service.[132] The Children's Bureau believed many of the ailments found in adults were the result of insufficient care and hygiene in childhood and therefore, with proper education of mothers, could be prevented.[133] The concern of national, physical strength in the face of international conflict was a motivator for both the declaration of Children's Year in 1918 and the distribution of child rearing advice for mothers of preschool age children. Though previously underserved in bureau literature, poor health reports from the draft and exposure of diseased, malnourished refugee children to reformers working with the Red Cross directed focus to this age group of children [134] This body panic and the resulting cultural and political interest in physical perfection was written into the 1918 edition of *Child Care* and continued to be present in subsequent publications as the bureau, and by extension the federal government, made an effort to refine the bodies of children so they could grow to be fully optimized adults.

The scope of maternal policing as discussed in the previous chapter expanded with this new age group. As toddlers grew and used their bodies in new ways, the Children's Bureau instructed mothers to police not just the material of the body, but also the way the body was used. In addition to measuring qualities like height and weight, the bureau expected mothers to monitor use of the body and correct abnormalities in characteristics such as posture or gait

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[132] Lindenmeyer, 72.

[133] Julia C. Lathrop, "Letter of Transmittal," in *Child Care: Part 1. The Preschool Age* (Washington: Government Printing Office, 1918), 5.

[134] Meckel, 200-201.

through the training of health habits. This did not mean that habit training could take the place of a physician and medical care, the Children's Bureau made this distinction and repeatedly directed mothers to physicians for acute, severe conditions. Rather, this meant that there was a class of physical defects that the bureau demonstrated were within the mother's realm of influence and control that could be fixed in the home. The key difference here was that this class of defects required a different kind of care that was less invasive and focused on redirecting behavior in order to better support bodily functions. By teaching their children how to correctly use and care for their bodies, the bureau believed that mothers could refine the bodies of their children in order to attain the standard of "really healthy."[135]

This chapter investigates how the Children's Bureau expanded the scope of maternal policing and used the promise of health habits to teach mothers how to perfect the bodies of their children. Adopting the language of behaviorism, the instillation of health habits was where the bureau demonstrated mothers were able to intervene in their children's physical development and prevent a variety of defects or imperfections. Bureau literature reflected intentions to optimize the health of children and to minimize physical difference or abnormality. To demonstrate this point, I first discuss the broader context of this advice and the impacts of behaviorism on the bureau's framework for this advice literature. I then explain the expansion of maternal policing for the preschool age and the bureau's increased focus on visibility and use of the body and provide examples of this process from the literature. Together, this research shows the bureau's literature on preschool age children was not only about keeping children alive and healthy, but also about making children as perfect as possible.

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[135] US Children's Bureau. *The Child from One to Six: His Care and Training* (Washington: Government Printing Office, 1931), 10. Hereafter called: *The Child from One to Six*.

It is important to note that the physical characteristics I discuss in this chapter are better described as defects than disabilities. As previously stated, disabilities are extremely heterogenous, mutable, and are only defined by their inability to conform to what is considered normal. Since a society's normate is narrowly defined, many people don't fully conform to normalcy, but are still considered able bodied. The question then of who is considered disabled comes down to the degree nonconformity which is affected by a culmination of social factors such as race, class, and gender and characteristics of the disability itself such as cause and visibility. The category of disabled is a reflection of power and is characterized by a degree of inaccessibility and social stigma.[136] The Children's Bureau child care guides did note threats of disabilities such as blindness, deafness, or mobility issues, most often from childhood diseases, but this was not where the bureau concentrated the agency of mothers. Rather, the bureau focused maternal control on physical characteristics that fell between the boundaries of normal and disabled. These qualities, such as crooked teeth, flat foot, and poor posture were deviations from the socially constructed normate, but they were not qualities that would incur stigma or bar people from fully participating in society. Since these traits were not paired with social, political, or economic exclusion, they are not necessarily disabilities, but rather physical characteristics, no different than height or eye color.[137] However, the bureau did not make this distinction, and used the same language for any kind of physical nonconformity calling everything a defect, no matter the degree of commonality, impairment, or accompanying social stigma. The resulting implication from this broad use of the word "defect" was to pathologize any physical

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[136] Thomson, 24.

[137] It is important to note that social considerations of aesthetics and beauty were relevant to how these physical traits were interpreted. Since the Children's Bureau directed mothers to get medical care to fix problems in their children, I have decided to focus on the social construction of disability rather than beauty, though they are certainly intersecting systems of power.

abnormality into the medical model of disability in which the body was interpreted as a problem to be fixed through medical intervention.

Behaviorism and Control

The establishment of the Children's Bureau in 1912 reflected the growing value of children to the American culture, economy, and state. Changes such as growing urbanization, increased opportunities for women outside of the home, and increased divorce rates implied a state of crisis for the American family. Much of this sense of crisis centered on the eugenic notion that "fit" couples were not having enough children while "unfit" couples were having too many, threatening the strength and survival of the American way of life.[138] Despite this logic's inherent dependency on racism, a significant portion of Progressive reform was committed to supporting child welfare through direct intervention, such as the work of the Children's Bureau, or though indirect methods that would increase broader standards of living such as labor reform and environmental conservation. Progressive reformers often heralded children as the most valuable investment for the future of economic production and political strength, but this value largely derived from their physical health and potential for economic productivity.[139] Throughout this same period, industrialization, labor reform, and the creation of worker's compensation changed the relationship between the body and labor and pushed people with disabilities out of the labor market, even if they were still able to work in a reduced or modified capacity.[140] When coupled with the wave of body panic that arose from poor results of the draft, the bureau's focus

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[138] Lovett, 7.

[139] Melanie A. Kiechel, "Health is Wealth: Valuing Health in the Nineteenth-Century United States," *Journal of Social History* 54, no. 3 (Spring 2021),781; Janet Golden, *Babies Made Us Modern: How Infants Brought America into the Twentieth Century* (Cambridge: Cambridge University Press, 2018), 31.

[140] Rose, 11-13.

on preschool age children as an essential site of prevention gave mothers and reformers a sense of control and agency to combat and prevent these issues for the future of the nation.

The question of how to rear children to be their best and most physically capable selves was essential to how the Children's Bureau approached its child rearing advice. As a collection of "the best accepted opinions," the bureau pulled from popular and innovative understandings of child development and psychology to offer relevant, up to date advice.[141] The major understanding of child development that influenced many of these early bureau publications was the psychological school of behaviorism. Popularized by James B. Watson in 1913, behaviorism rejected psychology's focus on introspection in favor of the study of observable behavior. Branded as a much more objective science, behaviorism centered on the observation, prediction, and control of behavior.[142] Watson asserted that observable behavior was a reaction to a specific stimulus and if a subject was exposed to the stimulus again, the same reaction would occur. Animal studies demonstrated that in addition to their predictability, responses to stimuli could be trained through repetitive conditioning. The most famous example of this was Ivan Pavlov's 1897 study of digestion in dogs where Pavlov noticed that the dogs salivated when they saw the technician who regularly fed them even though they had not yet seen any food. Though Pavlov was a physiologist and not psychologist, his study introduced the idea of classical conditioning that behaviorists would later adopt and expand.[143] Watson brought this understanding of stimulus

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[141] Julia C. Lathrop, "Letter of Transmittal," in *Child Care: Part 1. The Preschool Age* (Washington: Government Printing Office, 1918), 5.

[142] David Hothersall, *History of Psychology* (New York: McGraw Hill Publishing Company, 1990), 375-376. Though previous psychologists had proposed similar behaviorist visions for the field of psychology before Watson, such as William McDougal in 1905 and Walter B. Pillsbury in 1911, Watson's brash personality carried a sense of radicalism that elicited a response from both psychologists and the public. Watson quickly and often faced criticism from his peers, but he still revolutionized the field.

[143] Hothersall, 392.

response and conditioning to the domestic sphere in 1916 when he studied infants and children.

In his study of infants, Watson found that children also had predictable responses to stimuli, however they did not give fear responses as a reaction to situations that many older children were afraid of such as the dark, snakes, or fire. Since newborns did not have these innate fears, Watson asserted that these fears were learned. In his most infamous and ethically questionable experiment, Watson tested this theory by conditioning a fear response into an 11-month-old child referred to as "Little Albert." Watson presented Albert with a white rat along with a loud noise. After repeating this association of the rat with a loud sound several times, Albert gave a fear response to the rat without the loud noise, even though he had previously shown no fear of the animal. On future occasions, Watson again presented Albert with various objects and Albert maintained his fear of the rat and even of items that resembled it.[144] Though the credibility and repeatability of the Little Albert experiment was suspicious at best, Watson used this to show that parents had agency in the development of their children. Since behavior was learned, a mother could train their child to have specific responses to specific stimuli and intentionally build in their character and psychological development.[145]

Watson applied this behaviorist perspective specifically to emotional responses as he considered himself unqualified to speak directly on physical health, and even on many facets of behavior as the field was still relatively new.[146] However, the understanding of children as a psychologically blank slate waiting for the environment to impress upon them with observable and predictable habits was easily applied to the physical body as well. Many of the core

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[144] Hothersall, 379-380.

[145] John B Watson, *Psychological Care of the Infant and Child* (New York: W.W. Norton & Company Inc., 1928), 38.

[146] Ibid., 4.

characteristics of Progressive ideology about the body and poor social conditions (control, quantification, and efficiency) were supported by the belief in behavior modification, conditioning, or training. This was seen in the mission of the Children's Bureau's educational campaign as a whole: if mothers can be trained in the best way to rear their children, they will act according to that knowledge. This was an attempt at large-scale behavior modification. Even though psychologists focused on emotional and mental development, their specialization did not stop the spread and use of this ideology to broader, social conditions.[147] At some capacity, behaviorism was a scientific packaging of ideas that already existed in American social science and reform in the early twentieth century.[148]

The importance of behaviorism to this chapter centers on the implication of control that it offered to mothers and the Children's Bureau's adoption of its language to communicate this control. If children were truly blank slates that mothers could mold through intentional training, then this was an immense amount of power. The bureau leaned into the rhetoric and promises of behaviorism to communicate the framework of maternal intervention in the body, even though in reality the relationship between nature and nurture on child development was complicated and undefined. Much like Watson, the bureau told mothers to focus on observable phenomena in the assessment of their children – this was maternal policing. Then, the bureau used the notion of habits and training to teach mothers that they can prevent misusing their body and causing some sort of defect. This ability to change contrasted the core tenets of eugenics that focused on biological determinism and heredity as the most important factors in in physical and mental development. Though the bureau still supported eugenic standards of the ideal body, the bureau

[147] John A. Mills, *Control: A History of Behavioral Psychology* (New York: New York University Press, 2015), 154.
[148] Ibid., 70.

also supported an individual's ability to change. This did not mean for example that the bureau believed a person of color could simply become white, but rather that they could change things about themselves, such as Americanizing, to more closely resemble the normate. Though this was a relatively narrow window of control, the bureau's embrace of control over the physical body to prevent imperfection reflected an understanding that health could be earned. Each of the following examples fits within this process. The mother identifies a behavior or trait as something that is bad and needs to be fixed, and then she changes the child's behavior or habits to correct the problem and prevent physical imperfections. It is the sense of control and ability to change and fix the body that stigmatized these individual traits as consequences of poor mothering or lack of care.

Expansion of Maternal Policing for Preschool Age Children

In the 1918 edition of *Child Care*, West asserted, "it should be the aim of every mother to prevent every possible hour of illness among her children."[149] This statement not only formalized rearing healthy children as the goal of motherhood, but also affirmed that maternal labor could prevent disease and disability. To do this, the Children's Bureau taught mothers how healthy children looked and acted and provided metrics with which mothers could assess their children. Many of these health metrics were continuations of those established in infancy, such as height and weight charts and nutrition standards, but the preschool age and its inherent growing autonomy broadened the scope of wellness to include not only material of the body, but also the use of the body. So, in addition to policing nutrition, height, and weight, the bureau told mothers to remain vigilant for the quality of actions such as gait, posture, and sight. With each of these

[149] US Children's Bureau, *Child Care: Part 1. The Preschool Age*, by Maxine West (Washington: Government Printing Office, 1918), 65. Hereafter called: *Child Care* 1918.

additional metrics came an additional threat of defect or disability that mothers were responsible for preventing.

One of the primary threats of long term "weakness and defects" was childhood illnesses such as diphtheria, scarlet fever, and measles. To prevent spread of disease, West and later Children's Bureau writers urged mothers to be familiar with the early signs of each illness, quarantine the sick, and to bring an ill child to the doctor immediately.[150] This system of disease containment was and continues to be an essential and expected part of preventative care and was reflective of the period's lack of vaccines and penicillin which are now used to treat many of these illnesses. However, West expanded upon this prevention of acute illnesses to include chronic issues that she coined weakness or defects. These problems were not from a communicable disease nor from a nutritional deficiency, such as rickets, but rather were from incorrect use of the body. Disease prevention and nutrition continued to be vital to the bureau's advice literature for the health of mothers and children, but this new site of maternal policing refined health to be greater than simple functionality. It was no longer enough to have a working body, now the bureau was helping mothers create optimized bodies. This is where maternal policing escalated to the construction of disability.

West gave mothers a list of things to watch for in their children through her content on caring for individual aspects of the body.[151] This included a variety of issues such as posture, teeth formation, and breathing, but West notably focused her attention on things mothers could watch. Content on the care of the eyes and the hears exemplified the necessity of visibility in maternal policing. For care of the eyes, West stated that "no trouble is too great to secure [sight],

[150] *Child Care* 1918, 65.

[151] Ibid., 52-63.

nor is carelessness anywhere more inexcusable than where the sight is involved."[152] This once again placed sight within the mother's realm of control and implied that poor vision was a result of improper care. West then listed activities that were indicative of poor eyesight and required medical intervention or that were potentially damaging to the eyes. This included things such as holding a book closer than 14 inches from the face, reading in light that was too dim, reading in light that was too bright, or even seeing reflective snow or ice too often. This content demonstrated that there was a correct way for a child to use their eyes and that incorrect uses required swift intervention.[153] In contrast, the section on of care of the ears was limited to getting medical treatment for ear infections, keeping the external ears clean, and not putting any objects inside the ear canal. Rather than listing a series of precautions, West showed it was better to simply leave the ears alone.[154]

This inequitable coverage of the ears and the eyes reflected where the Children's Bureau thought mothers had agency. Though there was significant social stigma for both the blind and the deaf in this period and the ears and the eyes were equitably important for economic productivity, much more attention was paid to caring for and preventing damage to the eyes than it was to the ears. A key difference between these two organ systems was that mothers could watch how children used their eyes, but they could not see how children used their ears. A mother could see their child squinting, holding a book too close to their face, or becoming cross-eyed, but she could not see if a child had diminished hearing in one or both of their ears. This relative inability to police hearing meant that, assuming that their child was not entirely deaf and

[152] *Child Care* 1918, 55.

[153] Ibid., 55-56.

[154] *Child Care* 1918, 60.

did not have an ear infection or obstruction, there was nothing a mother could do to ensure the functionality of their ears. Such a discrepancy in coverage was demonstrative of the limits of maternal policing and, by extension, maternal agency. Things that mothers could not witness or measure were cast outside of her realm of control and were not a priority for maternal labor. This did not mean that a mother would not take her child to the doctor if they had an ear infection, but instead meant that visibility was an essential part of maternal control over the body. It was through this visibility that mothers and the bureau identified abnormality and assigned stigma to those traits.[155] The bureau expected mothers to remain vigilant over the bodies of their children in order to prevent disease and disability, but they were limited by the things they could see – symptoms of disease and incorrect use of the body.

The importance of visibility to maternal policing continued through subsequent Children's Bureau publications on preschool age childrearing. However, with these new publications, metrics of health formalized, and the scope of maternal policing grew. This development first came in the bureau's 1929 brochure "Out of Babyhood into Childhood" which was an abbreviated guide on the best practices for the care of children ages one to six.[156] This brochure mirrored West's *Child Care* with sections on nutrition, bathing, and outdoor play but with a more rigid illustration of child health and maternal competence. This updated brochure stated,

> A healthy child has pink cheeks, red lips, and bright eyes with no circles under them. His body is straight and strong; he has smooth skin, clean teeth, and firm muscles. He grows tall and gains in weight. He is active – runs, shouts, jumps, and climbs – is always interested in something, and is often noisy. He is hungry at mealtimes, and he sleeps

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[155] Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (London, Verso, 1995), 12.

[156] The bureau did publish two guides for mothers of this age group between the 1918 *Child Care* and the 1929 *Out of Babyhood into Childhood*. First, the bureau republished *Child* Care in 1922 with no changes to its content, and second, the bureau published a booklet in 1925 called *Child Management* which centered on behavioral problems.

> soundly and long. His bowels move daily. He has no abnormal discharge from eyes, ears, or nose. He breathes with his mouth closed. He does not have pains or aches. To keep him healthy he needs plenty of good food, plenty of sleep, and plenty of vigorous outdoor play.[157]

With this information, the bureau told women exactly how preschool age children were supposed to look and behave and if they found a discrepancy, mothers were expected to take action to fix it. This type of health metric was reproduced using largely the same language in the completely revised edition of *Child Care* that the bureau published in 1931. This new edition, renamed *The Child from One to Six: His Care and Training*, continued to expand these health metrics with the addition of more developmental milestones, specific instructions for getting medical care, and continual reassurance of maternal agency in prevention.

One of the key differences that influenced the transition from West's advice to the content from 1929 and 1931 was a change in authorship. While West's literature was an embodiment of Progressive maternalism's approach to mothers and highlighted their faith that mothers were doing the best that they could with the information they had, this movement had fizzled out by the end of the 1920s. Earlier bureau literature combined scientific authority with women's reform movements and a gendered interest in child welfare reform which allowed West, who was educated but not a physician, to be the voice of federally-sanctioned mothering advice. However, increasing professionalization of the AMA, the rise of pediatrics, and conservative backlash to women-led reform made it imperative that the bureau's literature be authored by a group of credentialled physicians.[158] This affirmation of medical authority and shift to physician authorship meant that this literature was firmer and lost much of the "good

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[157] US Children's Bureau. *Out of Babyhood into Childhood: 1 to 6 Years* (Washington: Government Printing Office, 1929), 12. Hereafter called: *Out of Babyhood into Childhood.*

[158] Apple, *Perfect Motherhood*, 51-52.

faith" expectation of mothers to do "right" by their children. Rather this literature promoted absolute deference to medical authority and highlighted the ability of mothers to harm their children by missing signs of disease or disability and failing to get medical intervention.

The importance of maternal policing in securing medical care was demonstrated in length throughout *The Child from One to Six*. The bulletin's content on "preserving health and preventing disease" wrote of the importance of going to the doctor, the procedures of a regular medical exam, and the role of the mother in aiding the doctor to provide the best care. The much more specific description of health meant that there was a greater number of things that a mother could find wrong with her child, and all these factors were branded as equally important to child welfare. The bureau asserted that a "child who [was] 'not really sick' [was] usually the same child as the one who [was] 'not really well," and equated imperfection with ill health. The bureau believed "too many people [were] satisfied with a child that is "not sick," and made excuses that ill health was unavoidable. This stance on the health of children carried two larger implications. First, it reaffirmed a dichotomy between healthy versus unhealthy. A child either "measure[d] up to the best standards of health," or they were sick, there was no room in between. According to this section, a child could not be both a mouth breather and healthy; a child could not slouch and be healthy.[159] This sense of a dichotomy eliminated the grey area for mothers in determining health and branded any deviation from the provided health metrics as something that required fixing. Second, it implied that the real problem was not the child's health condition itself, but rather the mother's failure to notice or report it to a physician. The lamentation of parental satisfaction with children who were less than physically perfect demonstrated that this was

[159] *The Child from One to Six*, 10.

unacceptable behavior for caring mothers. Rather, the bureau demonstrated that caring, "intelligent" mothers were ones who brought their children to the doctor regularly, were honest about their child's habits, and followed the doctor's instructions.[160] Together, these two implications demonstrated that it was the mother's responsibility to monitor and report upon her child's body so that she could enable them to meet the highest standard of health.

However, it is important to again note that the bureau's description of a healthy child was specific to the white, middle-class, American ideal that served as the period's normate. Dark skinned children were unlikely to have "rosy cheeks and red lips," height and weight charts only included white children, and even the instructions for hair care assumed whiteness.[161] This meant that mothers of color were less likely to meet the Children's Bureau's standard required to be a "good" mother and to have healthy children, simply because of their race. Though this lack of racial awareness was a common feature to be expected of the early twentieth century, it was nonetheless a major shortcoming of the bureau's advice literature.[162]

Despite the shortcomings of this literature, the health metrics described were intended to pathologize physical non-conformity and encourage mothers to correct the bodies of their children as soon as possible. Through their watching, measuring, and reporting, mothers were an essential part in preventing physical defects, as defined by the bureau. Since the Children's Bureau repeatedly defined child health by the care they received, maternal policing not only evaluated the child's body, but also the quality of mothering itself. Though the core of maternal

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[160] *The Child from One to Six*, 11; 14-15.

[161] Ibid., 10; 17; 40; 124-127.

[162] For an example of how racial prejudice influenced public health movements see: Tanya Hart, *Health in the City: Race, Poverty, and the Negotiation of Women's Health in New York City, 1915-1930* (New York: New York University Press, 2015).

policing was a significant feature of the bureau's *Infant Care* advice, the broadening of this process to include scrutiny of the visible use of the body, rather than just the material of the body, demonstrated the bureau's interest in physical optimization by the preschool age. Armed with the assumption that children were born blank slates, bureau literature held that with proper attention and dedication, mothers could actively train their children to have perfect – or as close to perfect as possible – bodies. A key feature to this perspective was the belief that many of the ailments that riddled adults were caused by a disfiguring misuse or mismanagement of the body in childhood. Bureau content on the care of teeth and body mechanics exemplified this belief and their expectation of mothers to prevent the potential disfigurement of their children. Below, I explore the presence and context of these two concerns in the literature and demonstrate how they reflect larger conceptions of maternal control and influence over the body.

Care of the Teeth

The Children's Bureau's coverage of the teeth and mouth focused largely on hygiene and cleanliness. In 1918, West demonstrated that though the teeth that children have before the age of six are temporary, their care was still vitally important to digestion and nutrition, avoiding infections, and even in staying on track for the start of school. Despite reports that the vast majority of school children had some level of dental defects, including things such as cavities, crowding, and general uncleanliness, West assured preschool age mothers that they could train their children to properly care for their own teeth to avoid such a fate.[163] West then described to mothers the proper teeth brushing technique: after every meal, children should brush their teeth

[163] *Child Care* 1918, 56-57.

up and down, rather than side to side, followed by a rinse with water.[164] West urged mothers to teach their child to use a toothbrush very early, but to continue to supervise their brushing throughout childhood since they could not be trusted to do a good job.[165] The emphasis here for mothers was in training this habit early on so that even when the child became an adult, they would maintain these habits and avoid tooth damage and decay. In this way, hygiene habits were essential to the maintenance of children's presumptively healthy teeth and the prevention of dental problems in the future.

West's advice, however, was limited to the cleanliness of teeth. Even though she mentioned that malformed teeth were a defect, she did not offer any remedies other than keeping teeth clean and intact in order to prevent their premature loss. Similar advice was offered in the 1931 edition of this guide with a focus on cleanliness and teaching children to brush their teeth young, however the new edition written by physicians expanded upon this advice. The 1931 edition of this guide stated that good permanent teeth were "straight, strong, regular, with the upper and lower sets meeting to form a good chewing machine," and to attain this, children must first have good temporary teeth.[166] This statement communicated a benchmark for dental success that depended on both cleanliness and form. Much of the prescribed care centered on forming habits of hygiene, as West's did, but the bureau also instructed mothers on how to build straight, regularly spaced teeth which required a different type of training and prevention.

The Children's Bureau identified the habit of sucking, often thumb sucking, as a primary threat to the malformation of the mouth and teeth. This was notably not an inherent fault in the

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[164] *Child Care* 1918, 59.

[165] West did not define what counts as "very early," I assume this means as soon as a child can hold a tooth brush up to their mouth. West, 58.

[166] *The Child from One to Six*, 41.

body, but rather damage that occurred through prolonged, incorrect use. The bureau traced this habit in toddlers to how they were cared for as infants, stating it was often a result of allowing an infant to fall asleep during feeding or giving them a pacifier. By demonstrating that this was a learned behavior, the bureau both blamed mothers for this bad habit and told them it was within their control. However, it is important to note that the thing that made sucking a bad habit was the potential for disfigurement. Though the social undesirability was likely implied, the bureau did not explain that sucking was in poor social form or unhygienic, the problem was that it could cause a defect. The bureau offered a variety of methods to stop this habit depending on the age of the child and the severity. For infants, the bureau recommended redirecting behavior to prevent the habit from formalizing. For young children with a more established habit, the bureau suggested placing their arm in a stiff cuff that would keep the child from bending their arm to their mouth. For children ages two to three, the bureau told mothers to remove all items they sleep with. For the oldest children, the bureau stated that mothers had to make the child *want* to stop by offering small rewards for going time without sucking. [167]

Through this series of interventions, we see an application of behaviorist language to give mothers control over their child's teeth. If a mother can train her child early to clean their teeth correctly, they won't face problems with decay later. The later insistence that mothers could also train their children to have straight, regularly spaced teeth was an escalation of this sense of control. This escalation implied that at birth, all children were born with perfect teeth, and it was therefore the mother's role to prevent any damage coming to the body through misuses like thumb sucking. If children were born as physically blank slates that could be molded by external

[167] *The Child from One to Six*, 71.

intervention, then the failure to attain this physical perfection was a result of inadequate care or poor mothering. Such a prioritization of form and function demonstrated that it was not enough to be able to eat without pain, children also needed to have straight teeth to attain standards of health.[168] From 1918 to 1931, the bureau's definition of healthy teeth narrowed and centered on perfection in both form and function.

Body Mechanics

The term body mechanics refers the movement and use of the body, especially regarding the muscular and skeletal systems.[169] For the Children's Bureau, this meant an increased focus on posture and gait as a reflection of health and strength. As preschool age children first began learning to walk, the bureau instructed mothers to police their children to ensure they were evenly walking and standing. Though the bureau described the mechanics of an even gait and balanced muscle use, their primary sites of concern in this period was in the prevention of flat foot and poor posture. These interdependent conditions offered a unique site of maternal control that was specifically tied to correct use of the body. Where in my pervious example of vision and hearing the functionality of the body was a mitigating factor, for flat foot and posture functionality of the body was assumed.[170] This not only excluded children with mobility

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[168] Patrick K. Turley, "Evolution of esthetic considerations in orthodontics," *American Journal of Orthodontics and Dentofacial Orthopedics* 148, no. 3 (September 2015), 374. Notably, the Children's Bureau did not recommend mothers seek out care from orthodontists. This was likely because the age group had temporary teeth, so they were too young for orthodontics and because orthodontics was likely largely inaccessible. However, it is worth noting that a core tenet of orthodontics was achieving facial beauty so as orthodontics professionalized from 1901 to 1930, this idea spread.

[169] For more information on the rise of body mechanics and evolving aesthetics see: Carma R. Gorman, "Educating the Eye: Body Mechanics and Streamlining in the United States, 1925-1950," *American Quarterly* 58, no. 3 (September 2006): 839-868.

[170] *Child Care* 1918, 62; *The Child from One to Six*, 30-32. I say that this was assumed because the bureau made no comment on any form of disability that could limit a child's ability to walk. It is especially telling that they excluded any connection to rickets which was both common and related to skeletal development.

limitations or skeletal irregularities from the start, but also communicated that the problem in question was not the material of the body but rather the quality of its actions.

Characterized by an over pronation of the foot which caused muscle strain in the foot and ankle, flat foot was branded as a social ill after it was identified as one of the most common debilities to cause draft rejections from the First World War. Rather than being classified as an individual medical problem, flat foot became a broader threat to national strength caused by a lack of education and proper exercise. Orthopedists working with the US Army asserted that flat foot was both preventable and treatable with non-invasive strength and conditioning exercises.[171] With military 'Flat Foot Camps' established as soon as January of 1918, this condition was important and threatening enough to merit the use of military resources to train recruits to properly use their bodies with a focus on their feet and backs.[172]

The military context of flat foot underpinned the Children's Bureau's coverage of this issue. Orthopedic surgeons identified young children as one of the populations most likely to have perfect feet largely because they had not had the time to develop a chronic condition.[173] During the early twentieth century, many people believed that over civilization was a primary threat to the health and strength of American bodies and character. Industrialization, urbanization, and the closing of the frontier led Americans to believe that many children were missing out on the strenuous, out-of-doors childhood that characterized the American spirit. This concern was addressed in a diverse range of programs including the creation of national parks, fashion reforms, and organizations such as the Boy Scouts of America, but what these things had

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[171] Beth Linker, "Feet for Fighting: Locating Disability and Social Medicine in First World War America," *Social History of Medicine* 20, no. 1 (April 2007), 92.

[172] Ibid., 102.

[173] Ibid., 99.

in common was a focus on nature and its utility for individual development. For the prevention of flat foot, one key intervention provided by the bureau was instruction on correct footwear which would support the natural shape and mobility of the foot. Bureau advice illustrated that leather shoes with firm, but moderately flexible soles were the best type of shoes for children, but they actively emphasized that shoes needed to be correctly fitted. The bureau suggested that mothers have their children's shoes professionally fitted but, if that was not possible, taught mothers how to measure their children's feet and chose the correct size. First, mothers should trace their child's foot and then use that image to select or order shoes that were one fourth of an inch wider on all sides and three fourths to an inch longer.[174] This relatively simple metric for determining the correct fit of shoes meant that correct footwear was a baseline requirement for the prevention of flat foot. As footwear was something that had to be purchased, the bureau placed it firmly within maternal control. The bureau even suggested mothers lobby local stores to sell the preferred style of shoes to combat regional inaccessibility and supply issues.[175] Through this emphasis on shoes, the bureau largely disregarded the economic limitations that kept many families from buying new shoes and rather phrased this issue as a simple question of maternal intelligence in child welfare, even though the poor was one of the major demographics the bureau set out to serve. Such material limitations to health reaffirmed the narrow construction of normalcy and the economic, social, and cultural barriers to achieving it.

The Children's Bureau also instructed mothers the correct way for their children to stand and walk to build upon the foundation of proper footwear. Much of this instruction focused on balanced gait and straight posture, with the understanding that these two qualities support each

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[174] *Child Care* 1918, 35; *The Child from One to Six*, 78.

[175] *Child Care* 1918, 35.

other for correct body mechanics. Posture was tied to the physical embodiment and projection of wealth and decorum in American culture since the eighteenth century. Late nineteenth century developments in furniture, fashion, and general consumerism allowed for a relaxing of the body for respectable middle-class culture as Americans became increasingly casual.[176] However, with these changes also came a distinctive counterculture that sought to maintain Victorian ideas about posture and fought back against the relaxation of the body. While earlier interpretations of posture focused on manners and social status, this twentieth century counterculture embraced posture as a signifier of health and a potential threat to the functionality of organs.[177] Photos of child laborers with rickets or other postural abnormalities brought the concern of posture into the mainstream and made children a key target for this reform. The connection of poor posture with rickets gave credence to the idea that poor posture was a disability in the same way that rickets was, even though poor posture was not a disease. As such a visible aspect of the body, posture was further associated with morality, character, and overall physical fitness. This association branded poor posture as a physical problem that required fixing, not just a symbol of poor manners.[178]

Pediatricians believed over half of children had spinal curvatures or deformities that parents either failed to notice or did not take seriously enough.[179] Early twentieth century physical education professionals used posture as a key issue in their school curriculum to both combat this assumed parental ignorance or negligence and to bolster the professionalization of

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[176] David Yosifon and Peter N. Stearns, "The Rise and Fall of American Posture," *The American Historical Review* 103, no.4 (October 1998): 1067.

[177] Ibid., 1070.

[178] Sander L. Colman, *Stand Up Straight: A History of Posture* (London: Reakiton Books, 2018), 116.

[179] Yosifon and Stearns, 1070

their field. Grade schools and universities alike adopted posture-centric physical education curriculums that were intended to strengthen the backs of children and to combat against the perceived physical toils of education. This school led posture crusade included expert examinations of children to detect posture defects and educational programs to teach children how to stand up straight. Dependent on charts and visual aids to define good posture, these programs established and enforced a strict, military style of posture that was expected to reflect the broader physical and emotional wellness of a child. This meant that children who slouched were expected to be in poor physical, emotional, or mental health and that by addressing the posture problem, these broader metrics of wellbeing would also improve. For example, posture experts held that low confidence would lead to slouching and better posture would lead to better confidence. This understanding meant that posture was both a visible symptom of the problem and the solution to the problem – so by fixing posture, experts could also fix the underlying issues that were believed to cause the poor posture.[180] This reasoning fit well with broader, Progressive notions of self-control and discipline of the body and embraced the belief in an individual's ability and responsibility to manage and improve their bodies.

The Children's Bureau conducted studies and produced literature to support these grade school posture programs. However, the professionals at the bureau used their child care advice literature to highlight the importance of proper posture development for preschool age children and attempted to expand portions of these school programs into the home. In 1931, the bureau first included information on identifying and correcting bad gait and posture in their literature for mothers. Bureau metrics for correct walking and standing depended heavily on balanced muscle

[180] Yosifon and Stearns, 1075.

use. Children were supposed to walk and "stand with their feet forward and knees springy" and to use muscles in their abdomen to hold themselves erect. The bureau also provided illustrations of good and poor posture to help mothers identify how well their child was standing. If, based on the metrics provided, children developed any "peculiarity in gait," they should be seen by a physician.[181] The incorporation of posture into bureau literature in 1931 again reflected increasingly stringent definitions of health and the professionalization of bureau advice literature.

Beyond this maternal policing, the Children's Bureau established that it was the parent's responsibility to "encourage the children to use all their muscles and to provide apparatus and toys that will give them the opportunity to do so." This prescribed role resembled the physical education posture campaigns happening in schools and even the non-invasive, physical therapy techniques that were used to combat flat foot during the First World War. We see a similar focus on perfecting the body and use of strength and conditioning methods, instead of braces or surgical intervention, to teach people the correct way to use their bodies and to form long lasting habits. The major difference was that for the preschool age children, loosely trained mothers did this labor in the home. All these programs had similar goals, with similar stakes, they were just each done in a different setting with different kinds of people.

Though *The Child from One to Six* included a sampling of interventions for mothers to take in their child's body mechanics, the Children's Bureau published a separate booklet dedicated to training good body mechanics in 1933 called *Good Posture in the Little Child*. This publication first echoed the general care instructions published in the full child care guide including emphasis on nutrition, rest, and regular doctor visits. The bureau then offered mothers

[181] *The Child from One to Six*, 30-32.

more extensive descriptions and images of what good posture looked like, identified the parts of the body that had to work together to achieve good posture, and provided a list of games intended to teach, train, or strengthen the muscles needed for ideal body mechanics. These games, which were really more like physical therapy exercises cloaked in imagination, were the key tools the bureau gave mothers to shape and train the bodies of their children. The bureau was careful to assert that proper body mechanics was a learned skill that required training and practice to master.[182] This meant that if a mother wanted her child to have good posture, she could use these games to teach them how to use their body to support it. However, this also meant that if a child had poor posture, it was because their mother had failed to properly care for them or to train them. Though this collection of posture games gave mothers a sense of control over the bodies of their children, it was coupled with a moral obligation to meet the established standards.

In addition to offering a sense of control, these posture games reflected the goal of the Children's Bureau in creating this literature. There was an obvious intent to improve the posture of preschool age children, however these games were targeted to improve normal, able-bodied children, not to fix children with scoliosis or other structural abnormalities. Images of poor posture did not depict children with severely curved spines or even dramatically hunched shoulders, rather they showed children with moderate, perhaps lackadaisical at worst, posture next to a child with a rigid, military style posture. Similarly, there was no expectation that having a child walk as tall as possible pretending to be a giant or tuck their knees into their chest to pretend to be a roly-poly would help straighten the back of a child with a spinal issue. Rather,

[182] US Children's Bureau. *Good Posture in the Little Child* (Washington: Government Printing Office, 1933), 4.

these interventions were intended to perfect the bodies of already normal, relatively healthy children to meet optimized body standards.

Through their guides on the rearing of preschool age children, the Children's Bureau contributed to the broader construction of health and disability. Rigid benchmarks for health and the quest to raise "really healthy children" reflected the state's interest in minimizing physical difference.[183] However, the bureau instruction to police observable behavior and train it to best support physical perfection was not simply health advice, but rather an attempt to use science to eliminate physical difference. Borrowing from the growing school of behaviorism to create seemingly objective and scientific metrics of health and solutions to problems, the bureau leaned on the Progressive trust in science to support interests of the state. As the state discovered the bodies of its citizenry were not fit for the First World War, they made active efforts to change this for the next generation. Preschool age children became the front lines for public health reform and the future security of the state.

Though the bureau made efforts to educate mothers to avoid truly disabling experiences for their children such as rickets or blindness, the bureau equally campaigned against small imperfections where they deemed mothers had agency. Defects like crooked teeth and poor posture were emblematic of the maternal sphere of control and these heightened standards of health. Continuing their role as informal agents of the state in public health policy, mothers held the primary responsibility for attaining, or more importantly failing to attain, these physical standards. Despite the ability for children to grow into content and productive adults with these

[183] *The Child from One to Six*, 10.

physical defects, bureau literature effectively stigmatized common traits as symbols of neglectful or unintelligent mothering.

CHAPTER 5

CONCLUSION

Children's Bureau literature asserted that what made a good mother was her ability to birth and raise a normal child. Temporarily disregarding the complications of normal as a concept, the dependance on health and the body to assess the quality of mothering implied that health could be worked for and earned. This belief in a transactional relationship between effort and health continues to be present in and often dominates conversations on topics like fitness and intentional weight loss. Though the reality of control over the body is difficult to define, what further complicated this discussion was the belief that mothers could shape a body that was not theirs. Through their labor of mothering, the bureau held that mothers were responsible for, and by extension believed to be in control of, the health of their children. Despite the practical inability to prevent or control contagious diseases, accidents, or congenital conditions, mothers bore the blame for a failure to reach bureau standards of health. The bureau offered no appeals to divine intervention or plain bad luck, poor health was a symptom of unintelligent mothering.

By prescribing this level of control to mothers, the Children's Bureau made mothers the primary agents of their public health policy. Though information and direction came from experts in the bureau or the medical field, mothers were the ones doing this work. Mothers were the ones taking their children to doctor appointments, tracking their infant's weight, fitting their child's shoes, playing posture games, and keeping an upbeat attitude throughout – lest they negatively impress an attitude upon their child. This control is important historically for several reasons. First, it validated and recognized the immense and essential labor of mothering. Though unpaid, domestic labor continues to be undervalued, this recognition of mothers as vital for the strength of the nation was one of the biggest benefits of maternalism. Second, because mothers

were equally invested in receiving expert information from the bureau, this prescribed control was further evidence of cooperation between mothers and the state. As an advisory state project, the bureau was not directly legislating or demanding that women cooperate with its programing, but many women still did. There was an interest from both mothers and the state to define and enforce these normative body standards. This is important because it shows that the body standards that came as a result of this advice literature was not a tyrannical dictation from the government, but rather an agreed upon value system with the American public. The bureau did not invent ablism in child health, they just codified it.

The last reason that this belief in maternal control over the bodies of children is historically important is that it was the guiding principle of scientific motherhood. The reason that Progressives embraced science as the answer to infant, child, and maternal mortality was because it offered them a way to predict and control outcomes. Just as Watson advocated for a more scientific psychology based in observable phenomena, advocates for scientific motherhood sought a school of motherhood that could predict and control the health of children. I do not wish to dismiss the benefits of scientific motherhood, as charted decreases in mortality rates prove that it was a useful system that saved countless lives. However, reframing scientific motherhood as an attempt to control the body allows us to see the systems of power that benefitted from this quest. The goal of scientific motherhood was to rear children that would conform as closely as possible to the hegemonic normate – cisgender, heterosexual, married, economically independent, protestant, able bodied, white, with a proportionate height and weight. In supporting these characteristics as the ideal outcome of motherhood, scientific motherhood reinforced the systems of oppression that privileged those qualities.

It was in this reinforcement of systems of oppression that Children's Bureau literature codified boundaries of disability. Through these child rearing instructions, warnings of characteristics to report to a physician, and tools to train out bad qualities, the bureau articulated what made their vision of the ideal body and deemed that as normal. The bureau's continual use of the word "normal" demonstrated that this was more complicated than minimizing contagious disease and nutritional deficiencies. Instead, this was a large-scale attempt to use scientific mothering to minimize physical abnormality. During pregnancy, this was done through the mother's body where she was instructed to eat and behave in a way that would enable her to birth a vigorous child. A successful pregnancy was not one through which the mother and child both survived, rather it was one that reached the benchmark of normalcy. Through infancy, this trend continued, the bureau advised mothers to police their infants and themselves to meet developmental milestones and average weights. Bureau advice focused on the mother's support of the material of their infant's body and established nutrition standards and appropriate growth rates. In early childhood, the bureau expanded the scope to include how children used their bodies. Mothers monitored their child's vision, gait, posture, and teeth to ensure that they conformed to the normal and were not disfiguring themselves by incorrectly using their body.

It was in this latest phase of the literature that the bureau did the most explicit work in constructing disability. Here, child health metrics strayed from statistical averages and were instead rooted in qualitative assessments. Though the bureau acknowledged that most children had less than clean and straight primary teeth, the bureau established that normal, correct teeth were clean and straight. Though the bureau acknowledged that most children had subpar posture, the bureau established that normal, correct posture was rigidly erect. The effect of branding these qualities as the normal and rewarding mothers for achieving that standard was to formally

stigmatize any deviations. This means that though poor posture was not disabling, there was stigma for it anyway. Additional stigma to the body reinforced the broader, existing stigma for disability in general. Since disability is itself defined by abnormality, refining the definition of normal to an even higher standard pushed disabled people even further from social and political inclusion.

Though the trends of childrearing have changed since the work of the Children's Bureau in the Progressive era, what remains is the role of mothers in recreating and enforcing normative body standards upon their children. Tasks like achieving developmental milestones, maintaining average weights, and conforming to physical normalcy continue to be the markers of good motherhood, even if we now understand that many factors of health and disability are outside of our control. However, the continuing quest for "really healthy" children demonstrates a continuing effort to avoid disability and physical difference at every parenting choice.

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