(M)OTHERS IN ALTERED STATES: PRENATAL DRUG-USE, RISK, CHOICE, AND RESPONSIBLE SELF-GOVERNANCE

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ABSTRACT

The purpose of this article is four-fold. Firstly, it is meant to draw attention to Project Prevention, an American-based program funded largely by private donations used to offer people – mostly poor, racialized, drug-using women – up to $200 for limiting their reproductive abilities. Secondly, it highlights links between Project Prevention's mandate and prevailing discriminatory scientific-medical, legal, political, and media discourses which serve to constitute certain 'Truths' about the dangers of prenatal drug-use and parenthood, particularly for women. Thirdly, Project Prevention is framed and theorized within its neo-liberal context in order to underscore the ways that contemporary (pregnant) bodies often become governed through social initiatives which implode state/non-state agencies, public/private distinctions. Finally, to ensure readers are not left with overly simplistic readings of the issues at hand, the article concludes by considering the potential role of counterclaims in terms of who does and does not get constructed as a 'risky' reproductive agent.

KEY WORDS

drug-use; feminist legal theory; governmentality; neo-liberalism; parenting; pregnancy; resistance; self-governance

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INTRODUCTION

THE VILIFICATION of female drug-users can be traced to the height of the American-induced War on Drugs, with its emphasis on the iconic 'crack mom'. During the 1980s, various 'experts' disseminated gendered, racialized, classed, and ableist 'Truths' which continue to inform attempts to monitor and/or criminalize female drug-users in ways from which their male counterparts tend to be exempt. In this article, I support these assertions by reviewing Project Prevention, an American-based initiative which encourages drug-users to halt their reproductive abilities, at least temporarily. Juxtaposing Project Prevention's mandate with normative readings of prenatal drug-use provides contemporary confirmation that boundaries constructed between public and private realms are dangerous. More specifically, I argue that formal criminalization is not the only disciplinary response to drug-use(rs); as will be shown, condemning 'expert' readings regarding prenatal drug-use abound, converging in ways that challenge distinctions between individual, community, and official efforts to limit people's reproductive abilities.

This discussion is divided into four sections. First, an overview of Project Prevention, its stated aims, and academic evaluations of the program are offered. Second, connections are made between Project Prevention's guiding principles and dominant discourses concerning women's prenatal drug – particularly cocaine – use. Thirdly, academic deliberations of Project Prevention are extended by framing it in the context of neo-liberalist tendencies toward de-centering state power and increasing technologies of self-governance. The purpose of this section is to argue that Project Prevention is best understood, not as an innocuous community initiative, but as a state-supported effort which buttresses neo-liberal forms of governance. Finally, counter-readings of childlessness and medical sterilization are introduced to reveal the messy potentialities of resistance-claims vis-à-vis the construction of 'risky' reproductive agents.

PROJECT PREVENTION, OR 'C.R.A.C.K.'

> The figure of the pregnant drug addict serve[s] as a threatening portent of a cycle of contagion embodied by the compelling figure of the 'hard case,' the woman . . . beyond the redemptive reach of the therapeutic state. (Campbell, 2000: 174)

Project Prevention was founded in 1997 by Barbara Harris, the adoptive mother of 'four children out of eight born to one Los Angeles addict' (Project Prevention, 2008a). After adopting these children, Harris tried to get the state of California to enact legislation that would force women who birth babies with traces of narcotics in their systems to use a form of long-term birth control. When this attempt failed, Harris launched Children Requiring A Caring Kommunity (or C.R.A.C.K.), a program funded mostly by private donations used to offer people up to $200 for limiting their reproductive abilities. Now known as 'Project Prevention: Children Requiring A Caring

Community', the program has over 40 chapters across the United States and has received much media exposure, including interviews with Oprah Winfrey and Barbara Walters (Johnson, 2001).

According to Project Prevention's official website (2008b), 'clients' – as the program refers to them – receive a $200 lump sum for medical sterilization, including tubal ligation, or Norplant – a five-year contraceptive. Alternatively, $50 installments are offered every three months (up to a maximum of $200 a year, with no limit to how many years installments may be received) for shorter-term options such as Depo-Provera or intra-uterine devices. In addition, 'clients' receive $50 for each person referred to the program. In an effort to reach '2006 in 2006', Project Prevention offered 'a cash incentive of $500 to the first 100 clients to obtain long-term or permanent birth control' (Project Prevention, 2007). By March 5, 2007, they claim, '2054 women and 27 men . . . ha[d] made the responsible and logical choice' to limit their reproductive capacities and these numbers have since increased to 2517 and 29 respectively (Project Prevention, 2008c).

Academic evaluations of Project Prevention can be classified according to four trends. First, critical medical scholars have prefaced efforts to deconstruct normative medical claims about prenatal drug-use with descriptions of the program (Frank et al., 2001; Zuckerman et al., 2002). Second, scholars have critiqued Project Prevention for its underlying eugenic-like rationales (Boyd, 2004; Glenn, 2006; Monroe and Alexander, 2005; Ross et al., 2001; Shatila et al., 2005; Smith, 2005; Wilson, 2002). Third, the program has been described as an unattractive option compared with therapeutic, religious and/or spiritual alternatives (Moore et al., 2005a, 2005b; Yancey, 2005). Finally, scholars like Johnson (2001) and Mauldon (2003) have applied their legal and/or economic views to conclude that Project Prevention is an effective initiative.[1] Excluding this latter group, evaluations of the program have been overwhelmingly negative.

Many critiques launched against Harris' program have come from critical race scholars who, so outraged by the ways in which Project Prevention 'smacks strongly of racism and resembles a eugenic philosophy' (Monroe and Alexander, 2005: 20), devoted an entire issue of the *Journal of African American Studies* (2005: Volume 9, Issue 1) to deploring it. In this issue Project Prevention is located as one nodal point along a continuum of efforts to deter the reproduction of 'risky (m)others'. For example, Monroe and Alexander (2005) argue that contra claims that no one group of people is targeted by the program, participation rates reveal that women – particularly African American women – are over-represented when compared with national population statistics. Likewise Shatila et al. (2005: 37) maintain that contextualizing the original name of the program (C.R.A.C.K.) makes it hard not to read it as having racist-inflected origins; 'Harris did not choose to name the program M.E.T.H. or M.A.R.I.J.U.A.N.A., drugs that are typically associated with Caucasian drugs users', they state.

Other critiques that emerge from this journal are that the 'marketing strategies' used by Project Prevention target lower-class populations, especially racialized women. These condemned strategies include the distribution of

posters that read 'Don't Let a Pregnancy Ruin Your Drug Habit' in racialized communities and/or outside welfare offices (Shatila et al., 2005: 33; see also Monroe and Alexander, 2005). The culmination of such claims leads these scholars to conclude that 'some organizations, often operating under the guise of helping disenfranchised populations, seek to limit people's rights and the very programs touted as fixing social problems only serve to further marginalize these populations' (Shatila et al., 2005: 32).

Notwithstanding the importance of these insights, some journal contributors reproduce many stereotypes it seems they would want to dismantle. Consider, for example, Moore et al.'s (2005b: 11) claim that 'women who consent to sterilization procedures through the C.R.A.C.K. program may not be psychologically capable of fully understanding the process' (see also Shatila et al., 2005; Yancey, 2005). Such claims not only reproduce well-worn beliefs about women's tendencies toward irrationality, they also resonate with Project Prevention's *raison d'être*:

> to reduce the number of substance exposed births to zero [in order] to reduce the burden of this social problem on taxpayers, trim down social worker caseloads, and alleviate from our clients the burden of having children that will potentially be taken away. Unlike incarceration, Project Prevention is extremely cost effective and does not punish the participants. (Project Prevention, 2008d)

To appreciate this tendency for people so hostile toward Project Prevention to make claims which both dovetail with its stated goals and reproduce gendered, racialized, and classed stereotypes, it helps to contextualize these assertions within the context of circulating 'Truth' claims regarding prenatal drug-use.

CONSOLIDATING SCIENTIFIC-MEDICAL, LEGAL, POLITICAL, AND MEDIA 'TRUTHS'

> Those who are experts in the eyes of the state dominate official thinking on the problem and prevail symbolically and practically. (Campbell, 2000: 14)

Since at least the mid-1980s, prenatal drug-use has been constructed as detrimental to women, fetuses, and society as a whole. According to Boyd (1999: 3), since this time 'mass media and many members of the medical profession have demonized expectant mothers who use illicit drugs, viewing them as unfit parents who damage their unborn children through their continued drug use'. Indeed, these demonizing views are evident in the first American medical article published about the effects of prenatal cocaine use.

In this piece, Chasnoff et al. (1985: 669) conclude that 'cocaine [use] exerts an influence on the outcome of pregnancy as well as neonatal neurobehavior'. Given these findings, they urge their colleagues to 'evaluate the possibility of other problems associated with cocaine use during pregnancy' (p. 669). This request led to the publication of an entire journal published by the *Annals of The New York Academy of Sciences*. Skimming the table of contents, it is

clear that prenatal cocaine use was a central concern at the time of publication; of the papers that name a specific drug under consideration, the only rival to cocaine is alcohol. The journal is divided into eight sections, the longest of which is entitled, 'Cocaine, Amphetamine, Phencyclidine, and Caffeine'. Of the seven papers in this section, four concern in utero exposure to cocaine (Chasnoff and Griffith, 1989; Dow-Edwards, 1989; Spear et al., 1989; Woods et al., 1989). The main opinion expressed in these articles is that dramatic increases in cocaine use among 'women of childbearing age' pose significant threats insofar as women's cocaine use during pregnancy is said to cause behavioral and neurochemical harm to fetuses, spontaneous abortions, sudden infant death syndrome, and/or intrauterine growth retardation.

Significantly, the 'Truth' of these early conclusions has since been problematized on a number of counts. For instance, feminist scholars have argued that if women are to be held accountable for their actions during pregnancy, men's actions also must be acknowledged as impacting prenatal health and birth outcome (see Keren-Paz, 2005; Sheldon, 2006). In this vein, Roth (2000: 144) suggests that the relationship between men's drug-use on children's development often gets overlooked by researchers collecting data and within media coverage, despite 'epidemiological evidence suggesting a link between men's drinking and cocaine use and prematurity and low birth weights'. Thus, the contention here is not that drug-use never has any negative effects on children, whether in the form of physical and/or mental harm; rather the concern is with the confidence with which such claims, especially regarding women's drug-use, are made.

In relation to the reliability of early medical claims, scholars have also argued that 'external pressures placed on researchers during the 1980s to find negative effects of prenatal cocaine exposure' led to the proliferation of exaggerated knowledge claims (Toscano, 2005: 363). Again, it is important to note that this critique is not meant to deny that prenatal drug-use (by men and/or women) *may* have detrimental health effects; instead it is to suggest that 'the social problem of the "crack baby" . . . was partly created by medical researchers for reasons ranging from poor scientific methodology and faulty assumptions to concerns surrounding professional standing and pressure' (p. 364). Indeed, while research exists suggesting that the medical risks associated with prenatal drug-use can be mitigated by quality nutrition and/or healthcare, the claim here is that these findings have received much less attention than the bleaker verdict that (women's) drug – particularly cocaine – use + pregnancy = behavioral and neurochemical harm to fetus (see Boyd, 2004; Roth, 2000).

Such challenges notwithstanding, the power of the 'crack baby scare' and its salience as a disciplinary discourse aimed at shaping the conduct of (pregnant) drug-users should not be underestimated. Consider, for example, the following claims made by an employee of the National Institute on Drug Abuse:

> Maternal drug use effects are incremental and cumulative in the child's life; prenatally through risk of in utero drug exposure, postnatally through inadequate care or neglect imposed by maternal functioning decriments [*sic*] associated with drug use, and in developmental stages through the detrimental environment

> that is frequently part of the drug abusing woman's chaotic life. An important factor here is the impact of poor parenting skills on the child who may be in need of enhanced care and nurture to compensate for possible in utero exposure effects. (Vanderveen, 1989: 256)

As can be gleaned from this statement, underlying such normative medical claims are insensitive ontological assumptions about drug-use in general and female drug-users in particular. For example, not only does Vanderveen assume the incapacity of female drug-users to be adequate mothers, she further suggests that such women are either ignorant of or apathetic to the immense social costs of their actions. Ironically, despite research indicating that such stigmatization actually hinders pregnant drug-users in the US and elsewhere from seeking vital social services, the above (medicalized) claims blame this same population for overburdened health and welfare systems, thus glossing over access difficulties faced by many people wishing to treat their drug addictions in an era of increasing cut-backs to social services (see Boyd, 1999; Klee et al., 2002; Maurer, 2000).

Arguably, such individualizing readings of the 'crack baby problem' are given added impetus by the privileged status accorded to science. As Snider (2004: 277) suggests, because of its claims to objectivity and methodological rigor, science – even over law – tends to be accepted as 'the ultimate source of wisdom'. Claims presented in scientific-medical journals such as the *Annals of the New York Academy of Sciences* thus have the potential to become especially potent oppressive tools.

To substantiate this claim, consider that in a fairly recent case (*Whitner* v *State, 1997*), 'unlawful neglect' charges were upheld against an African American woman after her child was born with cocaine in his bloodstream. The woman was sentenced to eight years in prison. As Sagatun-Edwards (2000: 147) notes, under common law, this Supreme Court ruling is noteworthy because it defies the tendency for American judges to uphold statutes which deny fetuses personhood prior to birth, thereby setting the stage 'to render women criminally liable for a myriad of acts that the legislature had not passed into law, such as failure to obtain prenatal care or failure to quit smoking and/or drinking'.[2] In light of the foregoing discussion, this case is especially significant because South Carolina Supreme Court judges (who voted three to two against Whitner) relied on Chasnoff et al.'s (1985) study when forming their decision (Sagatun-Edwards, 2000). This reliance – particularly in light of concessions that these early findings were shaped by poor methodologies, including classed and racial biases (Chasnoff et al., 1990) – thus serves as an important reminder that medicine (read *science*) and law are discursive practices with the power to define 'Truth' and shape personal identities and public opinions (Smart,1989).

Analyzing (dis)connections between official statistics, political rhetoric, and media coverage of crack/cocaine during the 1980s leads Reinarman and Levine (1997) to a similar conclusion: media and political discourses merge in ways that lead citizens to believe that crack/cocaine use is on the rise, particularly among certain populations. Adding another layer to the argument that,

historically, it has been difficult to get counterclaims about prenatal drug-use heard, they insist that 'advocates of the crack scare and the War on Drugs [failed to report national statistics and] explicitly rejected public health approaches to drug problems that conflicted with their ideology' (p. 45). In other words, parallels exist between media coverage of crack/cocaine, political efforts to gain support, and punitive 'tough on drug' policies.

In relation to media depictions, Humphries' (2000) content analysis of ABC, CBS, and NBC coverage of the War on Drugs between 1983 and 1994 is telling. According to Humphries, clear classed and racialized patterns emerge within media accounts of drug-using women. Specifically, Humphries demonstrates that white, middle-class mothers tended to be portrayed as cocaine-using women in need of medical assistance whereas more 'punitive measures [were] targeted [at] poor [crack-using] women of color' (p. 125). The real-life implications of such coverage are made explicit by Toscano (2005: 362–3), who notes that 'crimes involving crack cocaine are . . . punished by the criminal justice system 100 times more harshly than crimes involving powdered cocaine'. Again, these insights corroborate the overarching assertion made in this article that normative drug-related discourses coalesce in ways that both constitute some people as more 'risky', 'irresponsible', and 'deserving' of punishment than others *and* blur distinctions between individual, community, and official efforts to manage (women's) drug-use.

RE-CONCEPTUALIZING PROJECT PREVENTION

> The cumulative effect of governing mentalities is a political imaginary of discourse on drugs. The disjuncture between knowledge of real-life behaviors and dreams, utopian schemes, and imaginary productions that find their way into the programs of governance is the distance between the imagined outcome of a policy and its actual consequences. (Campbell, 2000: 52)

Campbell (2000), Glenn (2006), and Zerai and Banks (2002) have all linked the War on Drugs – particularly the ways it has played out on pregnant bodies – to neo-liberal forms of state government. In these instances, increasingly punitive responses to prenatal drug-use, including rising incarceration rates of women and eugenic-like programs such as Project Prevention, are framed as the corollaries of a rolling back of drug (and other) treatment services in post-welfare states. More specifically, 'quick fix' responses to prenatal drug-use are understood as resonating with, and supporting, neo-liberal emphases on privatization, competition, minimal government intervention, managerialism, and freedom of choice; they are described as exemplars of the neo-liberalist injunction for individuals to take responsibility for their actions, thus minimizing state accountability. Surprisingly, however, these insights have not been used to link current medical, political, legal and 'community' responses to prenatal drug-use to a de-centering of state power. More specifically, missing are analyses linking Project Prevention with neo-liberalism as a form of de-centered state governance.[3]

An analysis of this type would necessitate the problematization of conceptions of Project Prevention as a non-government, non-state project (Boyd, 2004), arguing instead that it is more useful to represent this program – given its intimate links with various state-funded agencies – as an instance of 'governing at a distance'.[4] Such connections are made evident in the following description of the process of becoming a paid 'client' of Project Prevention:

> To be accepted into the program, individuals must be 18 years of age or older with a current or past history of substance use or abuse. Individuals must be self-referred or be referred by a social worker or other human service professional. Those meeting the program criteria are required to complete an application and arrange a meeting with a physician or family planning provider to discuss methods of birth control . . . Females who choose tubal ligation or permanent sterilization, are required by law to wait 30 days before having the surgical procedure . . . Once the birth control method has been decided, the participant provides written verification from his or her physician stating that the surgical procedure . . . has either been completed or the participant has consented to another form of birth control. A staff member at the C.R.A.C.K program confirms the written verification with the physician and then sends the participant a check in the amount of $200. (Moore et al., 2005b: 8–9)

If links between Project Prevention and state agencies are not made clear enough above, consider also that people receive tax breaks for charitable donations to the program.

Juxtaposing this process of becoming a Project Prevention 'client' with the above discussion of overlaps between normative readings of prenatal drug-use highlights the argument that formal criminalization is not the only punitive response to drug-use(rs). More to the point, this juxtaposition provides contemporary substantiation for claims that boundaries constructed between public and private realms are fallacious and dangerous; to separate personal from political, public from private, legal from medical, social from educational, state from non-state, etc., only serves to conceal the ways healthcare approaches to prenatal drug-use, for example, are intimately tied up with punitive, legal measures. According to this reading, while Project Prevention is not a matter of public policy per se, it exists alongside coercive state policies and discourses which rely on, reproduce, and leave unchallenged normative claims which constitute individual women as solely responsible for (healthy) social reproduction.

Reconceptualizing Project Prevention as, at least, a state-supported effort to govern drug-use(rs) from a distance is further facilitated by emphasizing links between its strategies and particular themes within governmentality studies. One such theme is the use of risk discourses, which Rose, O'Malley, and Valverde (2006: 95) describe as a way of framing and dealing with 'social problems' by employing 'a probabilistic technique, whereby large numbers of events are sorted into a distribution, and the distribution in turn is used as a means of making predictions to reduce harm'. As discussed, normative claims regarding prenatal drug-use resonate with Project Prevention's stated objectives and work to constitute pregnant drug-users as particularly 'risky'

to themselves, their fetuses, and to the larger (tax-paying) population. According to this logic, if future individual and social harms are to be mitigated, prenatal drug-use(rs) must be monitored.

It is within this context that increased surveillance by various 'state' and 'non-state' agents (such as Project Prevention) is encouraged in the US and elsewhere. Consider, for example, that,

> in practice and in collaboration between social service agencies and the medical establishment, women in this country [Canada], too, are labelled, placed under surveillance and threatened with losing their children. The charges are not necessarily specific to drug use: rather, the children are taken because they are perceived to be 'at risk' in their mother's care. (Boyd and Faith, 1999: 198)[5]

Again, the goal here is not to minimize the harmful effects that drug-(ab)use has for some children in and/or out of the womb; instead it is to problematize the *prima facie* association of prenatal drug-use with child abuse – an association which produces 'women who use illicit drugs . . . [as] the battlefield for increased surveillance, control, and punishment' (Boyd, 1999: 18). Significantly, such responses not only rely on the (medicalized) claim that women's drug-use in particular necessarily harms fetuses, they help to ensure that this will be the case; recall, for example, that stigmatizing and/or criminalizing pregnant drug-users has been shown to deter them from obtaining vital prenatal care said to offset the potentially harmful effects of drug-use during pregnancy. In this sense, it is not just prenatal drug-use (by men and women) that poses health risks; indeed, as will be discussed in more detail below, individualizing, punitive 'solutions' to prenatal drug-use (such as sending women to prison and/or offering cash incentives for halting one's reproductive abilities) also are rife with ethical and health-related concerns.

In addition to reinforcing the authority attributed to 'objective' risk calculations, normative 'solutions' to prenatal drug-use are contingent on the purported importance of the ideals of privatization, competition, minimal government intervention, managerialism, and freedom of choice. O'Malley explains these ideals as follows:

> the management of risks . . . involves shifts in many governmental relations, not least being that subjects are recast as rational, responsible, knowledgeable and calculative, in control of key aspects of their lives. The constitution of the liberal subject as active and self-directive is linked to change in the relations with authorities and professionals . . . the prudential subject . . . enters into 'partnerships' with public authorities . . . or becomes the 'customer' – literally and figuratively depending on the degree of marketization. (1996: 203)

In light of this explanation, recall that the use of 'partnership' language and a market logic are evident on Project Prevention's official website; Harris represents her program as a community effort to serve 'clients' who make the 'logical' choice to manage the risks they pose to society (in terms of the fiscal costs associated with their actions), to their un-conceived children (by ensuring they will not be born addicted and/or with disabilities), and to

themselves (insofar as becoming a 'client' reduces the risks of having their children removed from their care).[6]

Harris' use of the term 'clients' fits well with claims that the goal within neo-liberal states is for subjects to internalize dominant discourses which construct people 'as individualized and active subjects responsible for enhancing their own well being' (Larner, 2000: 13). Through this lens, Project Prevention's 'clients' might be read as employing self-technologies: 'ways in which human beings come to understand and act upon themselves within certain regimes of authority and knowledge, and by means of certain techniques directed at self-improvement' (Rose, et al., 2006: 90). In fact, it might be argued that while long-term birth control methods are not compulsory for substance-users 'of child bearing age', blame and risk discourse related to prenatal drug-use – including the fear of incarceration and/or of losing one's child(ren) – are so pervasive that they might as well be.

In relation to this claim, Shatila et al. (2005: 40) hold that while 'the [crack baby] myth has been discredited among qualified researchers all over the country, it has been engraved through society's awareness creating a social construction of reality'. In light of this reading, the monetary 'incentive' offered by Harris' program becomes a *reward* for coming to the *rational* and *logical* understanding of oneself as a (potentially pregnant) drug-*abuser* and accepting the money becomes a sign of responsible self-governance. Put differently, this language of choice and responsibility constitutes Project Prevention's 'clients' as (mostly) poor, African American women (see above discussion) who accept that they are *necessarily* incapable of being 'good' parents because they ingest drugs and/or that their actions disproportionately 'cost' society.

Questions regarding informed consent clearly become pivotal when discussing Project Prevention, especially given that 'clients' are (by definition) described as *choosing* to limit their reproductive abilities. According to Paltrow (2002: 166), however, this framing 'obscures the lack of choice that many people have and the larger economic and institutional barriers that deny people, particularly low-income women of color, the ability to make consumer-like choices'. Additionally, such astructural explanations neither make room for analyses of drug-users' choices as constrained by the very possibility that their (unborn) child(ren) may be taken away from them (by 'state' agencies) if they fail to choose this option (offered to them by a 'non-state' agency) nor do they engage interpretations of drug-use as a form of pleasure-seeking, not *prima facie* evidence of poor parenting, abuse, and/or irrationality.

In relation to this latter position, O'Malley and Valverde (2004: 27) suggest that pleasure is rarely cited by researchers as a determining – or even peripheral – factor of drug-use because in 'advanced liberal societies', pleasure is constructed and deployed as conflicting 'with other key requirements made of liberal subjects, notably "responsibility," "rationality," "reasonableness," [and] "independence"' (see also Mackenzie, 2008).[7] Thus, they argue, 'the silencing of discourses of pleasure with respect to . . . the inappropriate [*sic*]

consumption of drugs, appears as a strategy integral to liberal government's attempts to "govern at a distance"' – attempts whose strengths lie in their abilities to resonate with other, seemingly conflicting, governing mentalities (p. 28). This is an important insight not least because it provides further substantiation for claims that within advanced neo-liberal states, discussions about risk, choice, and responsible self-governance blend into one another, informing partnerships between allegedly antagonistic (i.e. individual, community, state) initiatives to manage 'risky (m)others'.

CLAIMS, COUNTERCLAIMS, COUNTER-COUNTERCLAIMS, AND CONCLUSIONS

> 'Maternal instinct' continues to be cast as fundamental to civilization and the very thing most eroded by drug use. If addiction portend[s] the breakdown of civilization, drug use by pregnant women symbolize[s] the destruction of the society's capacity for biosocial reproduction. (Campbell, 2000: 174)

As discussed, historically and cross-nationally, it has been rare for counter-narratives regarding prenatal drug-use to enter into popular discursive arenas. In particular, discourses which challenge prenatal drug-use as unequivocal evidence of poor parenting (particularly poor mothering) have not had the opportunity to shape public consciousness and individual subjectivities to the same extent as the more sensational, condemning, normative discourses discussed above. This is not to say that such efforts have not been made, however.

Indeed, Banwell and Bammer (2006) complicate arguments that the mothering capacities of drug-users necessarily differ from those of their non-using counterparts by comparing the experiences of mothers who inject heroin with those of low-income mothers who do not use illicit drugs, women whose partners are in the military and who often have to relocate with their children, and mothers with middle to higher incomes. Not surprisingly, they find that despite their best intentions women in all four groups have trouble being 'good mothers' all of the time, thereby drawing attention to the pervasive, discriminatory and constraining nature of conservative mothering discourses. Significantly, the major difference they find between these four groups, is that women with low incomes – and here they include heroin-using mothers – have more difficulties balancing domestic work, employment, child care, and 'quality' family time. This leads them to argue that 'poor' mothering practices do not result from drug-use per se and that not all women who use drugs are bad mothers.

Such an analysis does more than (re)draw attention to arguments that poverty may be a more important factor than drug-use in terms of 'poor birth outcome'; it also reinforces claims that normative knowledge claims often reproduce neo-liberal and conservative discourses used to judge women according to 'unrealistic standards' and to construct 'their difficulties [as] of their own making' (Banwell and Bammer, 2006: 512). More than this, Banwell

and Bammer (2006) find that such discourses are so pervasive that women's actions sometimes reinforce the very constructs that situate them in relatively less powerful positions than their non-female, non-pregnant, and/or non-drug-using counterparts. For example, they found that in some instances interviewees portrayed themselves as good mothers by describing other *drug-using* women as 'bad mothers'. Again, a common reading of this tendency is that dogmatic mothering discourses are so pervasive that all women, albeit to varying degrees, incorporate them into their senses of self and other, emulating them both consciously and unconsciously.

Notwithstanding the importance of this reading, Baker and Carson argue that some women can, and do, resist these confined conceptions. They state:

> although there is not much research to support the notion that an addict can, in some ways, be a good mother, addicted women who participated in this study described themselves as caring and committed mothers, thereby defying the dominant cultural stereotype of substance-abusing women as mothers who have little or no parenting skills, are out of control, and do not care for their children. (1999: 360)

What this study suggests, then, is that while substance-(ab)using women (may) have different mothering styles from their non-using counterparts, 'different' does not unequivocally translate into 'bad'. Moreover, in cases where 'different' may mean 'worse' (i.e. physically and emotionally abusive), contributing structural factors must be taken into account and addressed.

Brown (2006: 22) corroborates this argument, suggesting that 'the effects of poverty, racial disparities, and social isolation may increase the occurrence and intensify the magnitude of negative parenting styles, and compound parenting inadequacies perpetuated by substance abuse'. While Brown's analysis teeters on reproducing a number of discriminatory stereotypes, it, again, is in keeping with claims that 'the impact of prenatal drug use on fetal health is mediated by diet, prenatal care, and other factors associated with social class' (Sagatun-Edwards, 2000: 143).[8] Well-researched, counterclaims such as these are important insofar as they defy common, reductionist claims regarding links between drug-use, pregnancy, and/or motherhood.

Other challenges to normative readings of women's drug-use come from a juncture in the medical sterilization and voluntary childlessness literatures: womanhood and motherhood are not synonyms. In other words, mothering is not something for which all women strive, nor are women biologically wired with an intrinsic maternal instinct. Indeed, according to Campbell (1999), some women construct medical sterilization, such as that offered through Project Prevention, as a positive option – one which expands their reproductive rights. Likewise Gillespie (2000) suggests that some women value their voluntary childlessness as a logical lifestyle choice, especially in the context of women's augmenting responsibilities outside the home, and Schoen (2001) finds that constructing oneself as 'feeble-minded' is a conscious strategy some women use to have their applications for medical sterilization accepted. Again, the importance of these studies is that they bring women's

active agency into sharp focus, reminding us that women are not objects simply to be acted upon. Extending these insights in relation to Project Prevention, it is important to acknowledge that while some groups of women do find themselves particularly targeted by efforts to restrict their reproductive abilities, other women may actively embrace such initiatives because they do not want to have children and/or (drug-use notwithstanding) never wanted to be mothers.

Counterclaims have also emerged in reaction to efforts to criminalize pregnant women who use drugs. Such challenges include recognition that men's actions during pregnancy are rarely – if ever – subject to the same legal scrutiny as women's (Keren-Paz, 2005; Sheldon, 2006). In addition, scholars have noted the following: sending pregnant drug-users to jail overlooks findings that quitting any drug – whether illicit or not – cold-turkey can be harmful to both woman and fetus (Roth, 2000); licit and illicit drugs are available to female prisoners and, thus, imprisonment does not guarantee abstinence (Toscano, 2005); current prison conditions help ensure that miscarriages are more likely in prison than elsewhere, drug-use notwithstanding (Boyd and Faith, 1999); and much of the harm experienced by women and/or fetuses due to drug-use (illicit or otherwise, including alcohol) during pregnancy can be mitigated via social programs that address both the root causes of this use (e.g. poverty) as well as the ill-informed stereotypes associated with these conditions (e.g. that poor, racialized women who use drugs are not willing/able to modify their situations) (see also Boyd and Marcellus, 2007). Like efforts to impede drug-users from becoming pregnant (Project Prevention), these overtly punitive 'solutions' are critiqued for reinforcing uni-directional understandings of social problems as resulting from individual choices and for ignoring the well-being of women and fetuses.

One implication of the emergence of challenges to normative readings of women's prenatal drug-use from within medical, social welfare, legal, and social policy fields is that discriminatory representations of the emblematic poor, racialized 'crack mom' may not be as dominant and/or homogenizing as some would have it. A related implication is that power struggles involved in efforts (not) to have prenatal drug-use criminalized are not straightforward. In other words, it is erroneous to view power relations as dispersed only vertically, from top-down; instead, power must be understood as scattered, interlinked, and constituted vertically and horizontally within and across formal and informal social fields in ways that inform 'individual'/'community'/'state' initiatives *and* make room for the emergence of counter-readings and experiences to enter the discussion (recall Bourdieu, 1987; Foucault, 1977). According to this logic, drawing attention to fissures and inconsistencies within and between dominant knowledge-producing fields through the articulation of counterclaims may be an effective way to chisel out spaces from which to dismantle 'Truths' regarding prenatal drug-use.

In this context, Toscano (2005) optimistically suggests that interspersed counterclaims, such as those presented here, have prompted people to begin to deconstruct the 'crack baby syndrome' and have contributed to a reduction

in the numbers of criminal charges against pregnant drug-users in America. In this sense, it might be argued that people are beginning to take seriously claims that while 'no one argues that drinking or taking drugs during pregnancy is good for fetuses . . . there is no consensus on how widespread fetuses' exposure is or on how harmful it is, especially in the long run' (Roth, 2000: 142). Arguably, in the context of the foregoing discussion, this is an important step – one which moves us closer to common acceptance not only of the potential links between men's prenatal activities and fetal health, but also of the problematization of 'obvious' connections between men's *and* women's drug-use and 'poor birth outcome', between drug-use and addiction, and between drug-use and child abuse. At a more fundamental level, the emergence of counter-normative claims might be argued to indicate popular confrontation with the discriminatory 'logics' which bridge 'individual' (private), 'state' (legal), and 'non-state' (community) 'solutions' to prenatal drug-use.

Taking the above discussion seriously, however, also obliges recognition that the emergence of counterclaims is not a one-way, finite process. Indeed, we must acknowledge the productive powers of resistance-efforts (Foucault, 1977). We must recognize, this is to say, that where there are claims, there are counterclaims, and counter-counterclaims. Furthermore, following this logic, we must strive to be cognizant not only of the ways claims produce counterclaims, but also of how (counter- and counter-counter)claims get picked up and shaped in ways that resonate with dominant power assemblages. In the context of the present discussion, we must consider the multiple ways claims emerge and are used within advanced neo-liberal contexts, sometimes to challenge normative readings of prenatal drug-use, sometimes to constitute new groups of people as particularly 'risky' (reproductive) others.

Recall, for example, that in addition to their 2517 (plus) female 'clients', Project Prevention boasts at least 29 male customers. Given these statistics, throughout this article I have maintained that 'the racialized feminization of poverty under neoliberal[ism] . . . and the racialized "tough on crime" agenda of successive Conservative . . . governments . . . are key to understanding th[e] dramatic expansion of coercive state violence against [pregnant] women' (Sudbury, 2005: 168). In addition, I have explored the ways that 'coercive state power' has become dispersed, entering into public consciousness via normative representations of prenatal drug-use, blurring distinctions and informing partnerships between purportedly antagonistic efforts to manage women's (drugged) bodies. These claims have not been meant to deny the ways these same discourses can be – and are – used to frame and constrain men's prenatal activities, however.

Indeed, it must be acknowledged that one (unintended) outcome of increased exposure of counterclaims attempting to diminish women's (sole) accountability for 'poor birth outcomes' is that men have been brought into the fold. And while no legal charges have been upheld against a man for inflicting harm on a child prior to birth (Roth, 2000; Sheldon, 2006), as Project Prevention's claim not to target women attests, such efforts may not

be far off. In this sense, it must be recognized that as opposed to – or, perhaps, in addition to – being used to challenge the gendered, racialized, classed, and ableist assumptions which inform punitive readings of, and 'solutions' to, (women's) prenatal drug-use, counterclaims such as those presented here will likely contribute to:

> men, like women, find[ing] themselves called up to make 'responsible' reproductive choices, not just in avoiding unwanted pregnancy, but also in taking appropriate measures to safeguard their own reproductive health and to avoid conception of a child likely to suffer from illness or disability. (Sheldon, 2006: 195)

NOTES

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1. Please refer to Volume 5, Issue 1 of the *Journal of Law in Society* (2003) for more examples of academic discussions which fall into each of the above categories.
2. Please refer to Roth (2000) for an overview of the numerous criminal charges launched against women across the US for drug-use during pregnancy.
3. Following Larner (2000: 4), neo-liberalism is understood, not as a coherent policy project, but as 'a political discourse about the nature of rule and a set of practices that facilitate the governing of individuals from a distance'.
4. According to Rose, O'Malley, and Valverde (2006: 89), 'governing at a distance' denotes 'acting from a center of calculation such as a government office or the headquarters of a nongovernmental organization, on the desires and activities of those who were spatially and organizationally distinct'.
5. Please refer to Boyd (2008) for consideration of the ways drug-related discourses have informed surveillance practices in Canada, Britain, and the US.
6. Unfortunately, an engaged discussion regarding the ableist discourses pervading such logic is beyond the scope of this article. Please refer to Andrews and Hibbert (2000), however, for consideration about whether disability can be considered a legal wrong.
7. Rose (1996: 41) describes 'advanced liberal societies' as those which 'seek to govern through . . . the regulated choices of individual citizens, now construed as subjects of choices and aspirations to self-actualization and self-fulfillment'.
8. Brown (2006) uncritically suggests that urban drug-users are more likely than their rural counterparts to spend money on drugs instead of household needs and/or to abuse their children. She further suggests that women may be enacting 'a defense mechanism of denial' when they claim to be good mothers (p. 29) and supports claims that 'pre-natal care during pregnancy is an obvious place to target cocaine users, with its negative and often *lasting effects on the fetus and its role in precipitating premature labor*' (2006: 30, emphasis added).

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