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Intensive Mothering, Intensive Visiting

How Mothers View Prenatal Care Schedules

This work focuses on exploring intensive mothering as an ideological force in contemporary prenatal visit schedules and maternal views thereof. Scientific studies show no differences between intensive vs. reduced visit schedules for healthy women, but 30 of 40 expectant mothers expressed a general preference for intensive vs. reduced visits, primarily for reassurance on fetal health. The disproportionate focus on fetal as compared to maternal health reflected in both obstetric practice and expectant mothers' perceptions confirm the presence of intensive mothering ideology in medicine and in individual beliefs. The need to increase maternal services and address shifting prenatal services are discussed.

In the U.S. today, a culturally-defined "good mother" sacrifices whatever she must to unfailingly respond to her children's needs round-the-clock. Devotees of this "intensive mothering" ideology—which grew partly out of a research paradigm unintended for direct application by parents—endorse a general message of continuous parental, typically maternal, physical and emotional availability. In hearing my expectant mother friends talk about their obstetric care, I detected themes reminiscent of this same intensive mothering ideology but within the context of medical treatment. In this paper, I will present my formal research linking intensive mothering ideology to today's apparently outdated but routinely practiced intensive prenatal visit schedule and how that in turn relates to mothers' views on prenatal care. Because little public exchange has occurred surrounding specific maternal belief systems within the contemporary U.S. obstetric care context, this work's value lies in initiating a dialogue on the strengths and drawbacks of intensive mothering ideology in clinical practice and in its patients' perspectives. Ultimately, the work will contribute to further inquiry and

related action toward optimal treatment of the millions of women obtaining prenatal care each year.

Overview of methodology for obtaining and analyzing data on maternal perceptions

I constructed an interview containing questions on women's social backgrounds and their prenatal care following published professional guidelines (AAP and ACOG, 2002; ICSI, 2007). My institutional ethics board approved the research. From electronic bulletin boards (CraigsList, n = 40) and a community support agency for low-income mothers (n = 20), my research team and I recruited 60 pregnant women to interview on their medical experiences and adjustment in pregnancy and childbirth. Interviews were planned for the last trimester of pregnancy (Time 1), 2 months postpartum (Time 2), and 10-12 months postpartum (Time 3). Thirty-eight mothers completed the interview by phone; the 22 remaining mothers interviewed in person. To assess how many prenatal visits women attended before birth, it was necessary to include Time 1 and Time 2 participant data. Of the 46 mothers who could have completed both interviews by the time of this writing, 40 (86.96 percent) had. Retention among lower income (<25,000 vs. 50,000+) was slightly lower than among higher-income mothers (77 percent vs. 90 percent), though no other differences resulted on recruitment site, age, parity, or marital status.

In the final sample of 40 mothers, the average age was 28.31 years (range 19-42). Mothers had an average of 1.38 children (range 0-4), n = 32 (80 percent) were married, n = 10 (25 percent) were non-White, n = 20 (50 percent) had education ranging from < high school to one year of college; 50 percent had college degrees. Twenty five (62.5percent) worked full-time outside the home, and n = 9 (22.5 percent) reported annual family incomes < $25,000, n = 13 (32.5 percent) reported 25-50,000, and n = 18 (45 percent) reported 50,000+. Mothers were given a $20 gift card for each interview.

Content analysis (Weber, 1990) and grounded theory (Strauss & Corbin, 1990) were used as the analytic framework because they allow for systematic identification of emergent themes and subthemes. Using procedures outlined by Nancy La Pelle (2004), Microsoft Word® 2007 was used to reduce, code, sort, and count data. Recurring themes were first identified in a sample of interviews coded for subsequent analysis of remaining data.

Intensive mothering ideology in prenatal care

The science

Medical care of pregnant women as we know it in the U.S. today came into being about 100 years ago, when European data emerged showing that instituting sanitary practices in home-based childbirth dramatically reduced maternal streptococcal infection, then the most common cause of childbirth-

related death. To lower what was then the highest maternal mortality rate in the Western World (Loudon, 2000: 242S), U.S. health officials launched public programs in which specially trained nurses visited poor, urban- and rural-dwelling expectant mothers about 13-14 times during pregnancy to check blood pressure and to help institute hygienic practices (Posmontier, 2002: 758-60). In these programs, maternal mortality rates dropped to about five to ten percent, which was one tenth of the maternal death rates occurring in physician- or lay midwife-assisted childbirth in women's homes or in hospitals (Loudon, 2000).

Reducing maternal mortality was a primary goal of early nurse visitation programs, but reducing infant mortality also held priority and decreased alongside maternal mortality declines. As physicians became aware of these programs' dramatic effects, they began instituting similar prenatal practices in their own clinics and hospitals. Widespread improvements in hygienic control in pregnancy and birth as well as generally improved social conditions are considered key in helping steadily reduce U.S. maternal and infant mortality to their lowest reported rates by the 1970s (Luke, Williams, Minogue and Keith, 1993: 204). Once the rates hit such record lows, experts began revisiting the decades old tradition of 13-14 prenatal visits.

In 1985, a British medical team published a landmark study indicating that reducing the number of prenatal visits from the traditional 13 to around eight for first-time mothers, and fewer for women who had previously given birth, did not adversely affect mothers or infants (Marsh, 1985). This work triggered an accumulation of research in the U.S. and abroad supporting reduced-visit schedules as safe and effective (McDuffie et al., 1996; Patient Outcomes Research Team [PORT] 1998; Villar et al. 2001; Walker, McCully and Vest, 2001). Based on research and on cost concerns, the U.S. National Institutes of Health (NIH) in 1998 recommended 8-11 "focused" visits for first-time mothers (seven for women with children) rather than the traditional 13-14 (United States Department of Health and Human Services, NIH, 1989: 31-47). Global health organizations have echoed the recommendation as well; for example, the World Health Organization (WHO) recommended in 2006 four medical checks as a necessary minimum (C17).

Despite evidence supporting the safety of reduced visit schedules, the venerable American College of Obstetricians and Gynecologists (ACOG) has continued recommending an intensive 13-14 visit schedule in its most recently published guidelines (ACOG, 1990: 75; 1996: 309; AAP and ACOG, 2002: 419). In another well respected treatment guideline used within the health care industry, up to eleven but no fewer than eight prenatal visits were recommended (ICSI, 2008: 2-3). The question arises as to why major medical organizations would continue recommending "extra care" beyond that scientifically supported, particularly in our era of health care cost consciousness.

According to Thomas Strong, Jr. (2003), more maternal medical care simply means more clinic income. In directly measurable terms, low-risk U.S.

maternal medical patients collectively feed more than $15.1 billion per year into the obstetric system (Machlin and Rohde, 2007: 6). Many of those dollars go towards prenatal preventive services and screening tests with high profit margins because in most cases, pregnant women are not sick and require few if any high-cost follow-up tests or treatments. In addition, more visits mean more monitoring, giving the appearance of more responsible practice, which in theory should offer greater legal protection should litigation occur—though some research suggests inaccuracy in that assumption (Strong, 2003).

A more benign motive for providing women more prenatal care than they probably need is simply force of habit. After all, one could assume that more check-ups and monitoring would unlikely harm women, thus altering visit schedules hardly seems worth the trouble of making individual cognitive shifts and changing century-long institutional practice. But besides costing insurers and public agencies extra dollars for an unnecessarily intensive visit schedule, continuing with 13-14 visits has two important consequences for women. In the "days of old," nurses conducted medical appointments in women's own homes, with transportation time and costs borne by providers, not patients. Today, the equation has flipped; patients relinquish their personal time not just to their medical appointments, but to transporting themselves to clinics and hospitals, waiting for providers, and managing associated financial and other paperwork.

The other cost of unnecessary care borne by women is more subtle and ideological. Having 13-14 medical visits over seven or fewer months puts pregnant women's medical care utilization on par with patients who have serious chronic illnesses like diabetes or asthma. Further intensifying the experience is what has in the previous two decades become routine questioning of women's personal life circumstances, their health habits, and their sexual behavior, along with repeated physical invasions of the genital region. Expectant mothers also receive dozens of behavioral prescriptions—what to eat, how much weight to gain, activities to avoid. Having extended beyond the simple blood pressure checks and abdominal measurements nurse midwives practiced long ago, today's prenatal care can't help but reinforce an intensive mothering ideology of self-sacrifice: by medical definition, an expectant mother sacrifices whatever time, privacy, financial resources, and sometimes even routine behaviors deemed by others as necessary for ensuring her fetus's health.

Consistent with the hypothesis that habit underlies continued practice of intensive prenatal visit schedules as much as anything else, Philip Steer (1993) refers to prenatal care as a set of mostly unnecessary medical rituals. However, rather than citing economics or inertia as the primary motive for continuing prenatal traditions, Steer places responsibility on expectant mothers, stating that prenatal traditions "continue because women want them" (697). The accuracy of Steer's statement remains to be confirmed or disconfirmed by women themselves, so I began initial inquiry by talking with expectant mothers about their impressions of and experiences with prenatal care. Specifically, after briefly

describing research on reduced pvisits, I asked them what they thought, followed by discussing reasons for their preferences.

Maternal views on prenatal visit schedule

How many visits they had

At the Time 1 interview, all mothers had had at least five prenatal visits. When asked postpartum how many total visits they had had, no mothers, including those who had previously given birth, reported receiving fewer than nine, with a maximum of 15 reported visits from a mother of one whose pregnancy was considered "normal." The modal (most frequently occurring) number of reported visits was ten (n = 26, 65 percent); of those reporting ten visits, half had previously given birth. Two cases were "high risk," one due to maternal age and the other to multiple birth.

Knowledge and impressions of visit schedules

I asked mothers the question, "Were you aware of a recent government report showing most women get more prenatal visits than are actually necessary?" All 40 participants reported, "no." My follow-up question, "What do you think of such a thing," yielded mixed results, with 30 (75 percent) of mothers favoring the current schedule over any reduction in visits. In this "intensive visit schedule" group, one third (n = 10) had previously given birth and echoed this statement from Leticia, age 24, mother of one toddler:

> *What would they cut out?... I go every week now but at this point you kind of want to go … it was up to me because I already had a baby so they said if you want to you can but you don't have to … the number of appointments I think is fine … medically necessary….*

Like Leticia, other mothers with and without previous births presented their perspectives as matters of personal preference rather than linked to scientific data. Alma, age 42, mother of one adolescent, said: "I would not feel so comfortable about that [reducing visits] just because … it just felt like it was important … I kind of looked forward to going…."

In discussing their reasoning for their intensive visit preference, more than 80 percent (n =25) of these 30 mothers spoke to primarily to the theme I called needing support and reassurance. Only three mothers spoke of needing the support for themselves, as in the case of Evelyn, mother of one, who said, "I kind of needed to be babied along, as it were, to make sure everything was okay … " and here in greater detail from Melanie, 28 years old and expecting her first baby:

> *…you need to have a support system … can't always be your mom or your friend or whoever. It's nice to be able to go in, initially every four weeks*

> *and then every three weeks and then every two weeks and then every week and just be able to say, you know "hey, this is happening, is that okay or is that normal?"*

Vonda, 22-year-old mother to one toddler and 34 weeks pregnant, was less sure of exactly whom was best served by an intensive prenatal visit schedule, but mentioned maternal interests in her statement, "I'm kind of mixed. I don't know if necessarily it's better for the baby or for the mom's health, but for just the peace of mind, I think it's better in that way.… "

The remaining 22 mothers echoed those mothers' desire for reassurance, but instead of expressing any need for personal support, they referred to needing or finding comfort in reassurance on the status of the fetus. I begin here with Alicia, pregnant with her second child:

> *… it helps to monitor … baby's got a heartbeat … everything's running smoothly on the timetable … it gives you some comfort knowing your baby's okay.*

Along similar lines, Grace, a young mother pregnant with twins, spoke of finding ongoing monitoring most reassuring, saying, "…I've heard everything's fine, they're growing properly, they don't seem to have … like Down's syndrome." Reflecting on her belief that treating maternal conditions was necessary for protecting fetal health, 29-year-old Rachel said, "…they needed to check to make sure I didn't have any bacterias or anything to harm him." Repeated throughout the remaining narratives were references to need for ongoing fetal heart rate monitoring, for assessing fetal position for birth, and for assessing fetal development.

Like their intensive visit schedule counterparts, most expectant mothers who favored reduced visits cited personal rather than scientific or medical bases for their reasoning. In particular, four mothers (40 percent) spoke to feeling that more visits tended to increase focus on pathology rather than healthy or normal development. For example, Sasha, age 24 and mother of one toddler, said she had always suspected there were too many visits, going further to say that, " … they treat most pregnancies like there's something wrong." Similarly, Julia, who had suffered several miscarriages prior to her current pregnancy, preferred to keep visits to every six weeks because entering a clinic setting was enough to make her feel as if something were wrong. Two others shared their related views that more visits increased the likelihood of receiving negative reports on fetal development, and regardless of the accuracy of such reports, they would proceed with their pregnancies and wished to do so without the potential anxiety of receiving bad news early on. Stated more explicitly, 30-year-old Eleanor said:

> *…I think more care can actually be bad … . Every time … they find*

something … to just scare the crap out of me … Like this time, telling me this baby might be a dwarf.…

Of the remaining six mothers who preferred fewer visits, two cited inconvenience (travelling to distant clinics, finding child care for long appointments), whereas others believed prenatal care would do little to alter the course of fetal development.

The language mothers did and did not use in our interviews gave insight into how intensive mothering ideology is woven into their beliefs toward prenatal care. With the exception of three women, or less than ten percent of the sample, mothers made no direct mention of their psychological or physical health needs independent of those of their fetuses. Instead, they discussed how learning about their fetuses satisfied their desire for reassurance, lending the impression that they viewed obstetric care as existing solely for fetal benefit. Specifically, mothers referred to feeling reassured by the acts of monitoring fetal growth and development, checking whether the fetus was alive (listening to heartbeat), and assessing what health conditions they might have that could harm the fetus. Even mothers expressing preference for fewer rather than more prenatal visits based their views on fetal health: preferring to avoid bad news about fetal development or believing that prenatal care did little to affect fetal development or influence their feelings toward their fetuses.

Mothers' references to fetal well being mirror the grossly disproportionate emphasis on fetal as opposed to maternal health in obstetric care today. Stated previously, the aim of prenatal care a century ago was to reduce maternal and infant mortality, and both have decreased tremendously in the years since. In light of that progress, prenatal medicine has shifted its energy toward reducing morbidity, or negative health outcomes— but mostly for fetuses. For example, in an informal review of ICSI (2008: 2-3) prenatal care guidelines, about six percent of the total "screening maneuvers" and about 16 percent of the "counseling and education" interventions are directed toward mothers; often, even that small percentage of attention to women themselves is rationalized on the grounds of improving fetal or infant health. A more specific example lies in today's routine screening for fetal neural tube defects, problems in central nervous system development affecting anywhere from 1 to 10 per 1,000 fetuses, or 0.1-1 percent (Frey and Hauser, 2003). Maternal heart disease complicates pregnancy for one to three in 100 women—1-3 percent—and is the leading cause of childbirth-related death today (Swan et al., 2003: 27). Yet, clear protocols for assessing maternal cardiac problems do not appear in routine prenatal care guidelines.

Mothers' almost exclusive use of the term "baby" in reference to their fetuses can also be interpreted as reflecting their own intensive mothering ideology. Fetuses rely on their mothers to support their development, but mothers have to do little in the way of adjusting their own activity or behavior to tend to fetal needs: fetuses don't cry or need physical comforting other than what

the mother's womb already provides; they are fed more or less automatically, requiring no specific activity on their mothers' part; the fetus moves, sleeps, and walks right along with the mother. Babies, however, require that mothers adjust their behavior and psychological state to comfort, feed, move, and protect them. To paraphrase Daniel Stern (1998: 1251), the most psychologically demanding aspect of mothering is being charged with the awesome responsibility of keeping the infant—an organism distinctly separate in its needs and functioning from the mother—alive. Referring to fetuses as if they were fully formed babies from the early stages of gestation implicates mothers in all that happens from that point forward, giving not only a false sense of control, but false assignment of responsibility for developmental outcomes.

In no way would I intend for my data to be interpreted as some sort of advocacy for maternal needs over those of fetuses; the ideological or philosophical bases of institutionalized obstetric practice and personal beliefs are far too complex for the type of dualistic, either/or discourse characterizing contemporary policy debates. Instead, I view these data as speaking more to how obstetric medicine and obstetric patients appear to be seized by an ideology that places far too little importance on maternal well-being, reflecting how our culture overlooks the supports necessary to keep mothers healthy and whole as they go about the business of tending to children's needs. Stated another way, a starving mother deserves to be fed because she is hungry. Feeding her leads to the natural and desirable consequence of placing her in a better position to manage caregiving demands. Right now, our communities and institutions lack good models for how to best feed sometimes physically but more often emotionally starved mothers.

Putting that argument aside, I should reiterate that my findings at least partly confirmed Philip Steer's (1993) statement that "women want prenatal care," with my interview material showing they benefit mostly from reassurance surrounding fetal health and development. In today's corporate-run, profit-driven health care market, the sustainability of intensive prenatal visits is questionable, regardless of any value mothers might place on it. From a clinical perspective, identifying suitable substitutes for the reassurance women do gain from intensive visit schedules must be part of the process of shifting toward what I believe will inevitably become, and probably sooner than later, reduced visit schedules. In fact, some large health care corporations have already begun the shift, with a few adding in 24-hour phone lines staffed by nurses as another resource, or "mentoring groups," in which experienced mothers are available to support first-timers; some communities have replicated nurse home visitation for low-income mothers, shown to be beneficial on a range of maternal and infant health outcomes (Olds, 2006). Whatever form prenatal care eventually takes, the need to continue dialogue and action supportive of mothers from pregnancy forward must remain in the foreground.

This paper is dedicated to the memory of Lori M. Irving, friend and dedicated

mother. The author gratefully acknowledges the WSU Vancouver College of Liberal Arts and the Southwest Washington Medical Consortium for supporting the research on which this paper is based.

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