Exploring and Working to Resist the Gendered, Colonial Discourses and Practices Within and Between the Child Welfare and Healthcare Systems

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Abstract

This paper critically examines the experiences of new mothers connected to both the child welfare and healthcare systems in a mid-sized city in Ontario, Canada. An anonymized practice exemplar illustrates the oppressive, traumatic nature of hospital perinatal care experiences for many new mothers. Drawing on Foucault's work, as well as risk theory, post-structural feminism and critical race theory, this scenario is analyzed in order to highlight the problematic gendered, neoliberal and colonial disciplinary discourses upheld within and between the child welfare and healthcare systems related to risk and "good" motherhood; the unquestioned power and paternalistic nature of the medical system; and how these power relations, practices and discourses play out in the lives and experiences of certain women in very harmful and oppressive ways. Ultimately, the paper argues that disciplinary discourses related to risk, and privileged Eurowestern ideals around "good" mothering upheld within and between the child welfare and healthcare systems impact on the lives, bodies and subjectivities of Indigenous mothers in particularly harmful ways. The paper concludes by discussing a feminist anti-carceral social work framework, as well as the concept of cultural humility. It argues that for white settler child welfare workers in particular, engaging in practice with these frameworks in mind is one way that child welfare workers can begin to combat the harmful practices and discourses that exist within and between their system of practice and other State institutions.

Keywords

Child welfare; social work practice; social justice; feminist practice

Introduction

This paper critically examines the experiences of new mothers connected to both the child welfare and healthcare systems in a mid-sized city in Ontario, Canada. The analysis presented is based on my own observations, as well as numerous discussions that I have had with colleagues and mothers I work with in the context of my role as a child welfare worker. This analysis formed the basis of my Master's thesis, however, it has been expanded on based on work I have engaged in since.

To begin, I present an anonymized practice exemplar that illustrates the oppressive, traumatic nature of hospital perinatal care experiences for many new mothers myself and my colleagues have worked with. Drawing on Foucault's work, as well as risk theory, post-structural feminism and critical race theory, I analyze this scenario in order to highlight the problematic disciplinary discourses upheld within and between the child welfare and healthcare systems related to risk and "good" motherhood; the unquestioned power and paternalistic nature of the medical system; and how these power relations, practices and discourses play out in the lives and experiences of certain women in very harmful and oppressive ways. Ultimately, I argue that disciplinary discourses related to risk, and privileged Eurowestern ideals around "good" mothering upheld within and between the child welfare and healthcare systems impact on the lives, bodies and subjectivities of Indigenous mothers in particular, in different and recurrently more severe ways (Cull, 2006; Greenwood & De Leeuw, 2006; McHoul & Grace, 1993). I conclude by discussing a feminist anti-carceral social work framework, as well as the concept of cultural humility. I argue that, for white settler social workers in particular (I am included in this category), engaging in child welfare practice with these frameworks in mind is one way that child welfare workers can begin to combat the harmful practices and discourses that exist within and between their system of practice and other State institutions.

Practice Scenario

The dynamics present in the scenario outlined below have played out in myriad ways in the hospital care experiences of women that myself and my colleagues have worked with. This specific exemplar, however, depicts a particularly oppressive and concerning occurrence. A new mother involved with my child welfare agency was deemed "aggressive" and "high risk" by hospital staff because she became upset with them after being given a medication during her labour that she had explicitly declined, and that was not necessary in the sense that this woman and her baby would have been fine had she not been given this. Because of the manner in which she was labelled, this woman was flagged by hospital security, and staff subsequently insisted that the door to her room remain open at all times. It is important to note that this mother was both young (18) and Indigenous. It is also significant to point out that this woman's worker had never had concerns about her behaviour in the context of their relationship with her as a child welfare worker. The remainder of this new mom's stay at the hospital was miserable and humiliating in terms of how she was treated and regulated by hospital staff.

Governmentality, Power and Discourse

Foucault developed the notion of governmentality to conceptualize the ordered practices - the mentalities, rationalities and control techniques - through which individuals are governed (McHoul & Grace, 1993; Rabinow & Rose, 1994). In his lecture entitled "Governmentality", Foucault (1994, as cited in Rabinow & Rose) defined this concept as:

> The ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security (p. 244).

Foucault's definition of governmentality encouraged a broader understanding of power that includes not only traditionally conceptualized government tactics of rule and authority, but mechanisms of social control inherent in and deployed by institutions such as hospitals, prisons and academia (McHoul & Grace, 1993; Rubinow & Rose, 1994).

Foucault also developed the notion that there exists a fundamental link between discourse and power (Foucault, 1997a; McHoul & Grace, 1993). He defined discourse as bodies of knowledge, inclusive of the social practices and power relations inherent to these knowledges, as well as the subjectivities they generate (McHoul & Grace, 1993; Rabinow & Rose, 1994). Foucault argued that certain bodies of knowledge are fundamentally tools of governmentality in terms of their application as mechanisms of control, power and discipline within State institutions, and he theorized that discourse and power relations "…work in the constitution of individual subjects to subjugate and govern them…" (Davies, Browne, Gannon, Hopkins, McCann & Wihlborg, 2006, p. 89).

Foucault's influence is evident throughout the literature on neoliberalism, and the adverse fallout of this on the welfare State, and human and social service provision (Gillies, 2005; Schram & Silverman, 2012; Webb, 2006). Neoliberalism can be understood as a governing ideology that prioritizes a competitive and unregulated free-market, capitalist expansion and economic globalization (Harvey, 2005; Pollack & Rossiter, 2010). Under neoliberalism, issues related to social justice and equity have become increasingly absent from government policy in lieu of austerity measures and political goals centred around market growth, competition and individual responsibility (Harvey, 2005). Neoliberal values rooted in individualism reinforce discourses that pathologize those living in poverty, and other marginalized groups, and valourize participation in the labour market (Gillies, 2005). Related to neoliberalism's pathologizing of marginalized groups is a preoccupation with risk thinking at a hyper-individual level. Risk thinking refers to the phenomenon wherein individuals who are viewed as being unable to effectively manage their own lives - typically those in socially vulnerable and marginalized groups - are regulated and monitored by "experts" based on the "burden" or "risk" they are assessed as posing to society (McHoul & Grace, 1993; Pollack, 2010; Rose, 1996; Rose, 2000). Mahon (2008) describes this particular

feature of neoliberalism as a "disciplinary apparatus [used] to contain the marginalized and dispossessed" (p. 344).

In her work on the treatment of women and girls within the Canadian criminal justice system, Jaremko Bromwich (2015) adds an important feminist analysis to conceptualizations of neoliberalism, governmentality and risk. She argues that there is a close relationship between social discipline, control and the body, particularly bodies perceived as being female (Jaremko Bromwich, 2015). She speaks to how, within the lives of girls and women, sites of governmentality are spaces where processes of power, politics and authority invade questions of identity, self and subjectivity via paternalistic and patriarchal State discourses related to virtue and gender hierarchies (Jaremko Bromwich, 2015).

This is very true of the child welfare and healthcare systems. These systems are microcosms of the governmentality and risk thinking processes described above; sites wherein an uncritical neoliberal bent, and a preoccupation with potential risk and liability abound (Rogowski, 2015; Webb, 2006; Wrennall, 2010). Consequently, within the child welfare and healthcare systems, certain discourses have been taken up as tools of governmentality and cast as control and surveillance strategies upon the lives, bodies and subjectivities of women in particular (Fiske & Browne, 2006; Krane & Davies, 2000; Wrennall, 2010). Specifically, institutionalized disciplinary discourses related to the patriarchal constructs of "good" motherhood and "good" womanhood, and notions regarding what it means to be an appropriate patient within the healthcare system. I discuss these further below.

Governmentality, Power, Discourse and Mothering within State Institutions

While theories related to motherhood have changed significantly over the years, and they remain contested across social and academic realms, O'Reilly (2004) argues that there are commonalities across conceptualizations:

> feminist historians agree that motherhood is primarily *not* a natural or biological function; rather, it is specifically and fundamentally a cultural practice that is continuously redesigned in response to changing economic and social factors. As a cultural construction, its meaning varies with time and place; there is no essential or universal experience of motherhood (p. 5).

In her groundbreaking work, Adrienne Rich also subscribed to the concept of motherhood as being a social construct. Rich (1986) differentiates between *acts* of mothering, which she defines as a woman's own empowering and subjective experiences of motherhood, and the *institution* of motherhood. According to Rich (1986), motherhood as an institution is grounded in the interests of male control, religion, capitalism, heteronormativity and racism (Kinser, 2010; O'Reilly, 2004; Rich, 1986). She emphasizes two main features of modern patriarchal motherhood that she argues are particularly harmful to women: the notion that mothering is natural to all women and that childrearing is the sole responsibility of biological mothers; and the fact that mothers are assigned

the sole responsibility of parenting, but are afforded little power to choose the conditions under which they mother (Rich, 1986).

These ideals and social constructs are harmful to all women as they perpetuate the social and self-surveillance of mothers, as well as render unacceptable any alternative mothering practices (Henderson, Harmon & Houser, 2010; O'Reilly, 2004). However, the profoundly oppressive nature of these discourses is intensified for marginalized women; and in the case of the practice exemplar outlined above, young and Indigenous mothers in particular (Browne, 2007; Gosselin, 2006; Greene, 2006; Greene 2008; McDonald-Harker, 2015; Savarese, 2015). Because of still prevalent discourses that denigrate young and/or Indigenous mothers (and Indigenous women in general), women who embody these mothering identities are socially constructed as inherently existing in opposition to the dominant Western social construct and confines of "good" motherhood described above.

On top of these already vilified identities, the woman in the exemplar was also a mother involved with the child welfare system. Thus, she was arguably constructed as unfit by medical staff from the outset of her attendance at the hospital, simply by virtue of her involvement with the child welfare system. The fact that this woman was also a young and Indigenous mother served only to compound, or in the eyes of medical staff, reinforce the identity that they arguably automatically constructed of her as being a "failed" CAS-involved mother.

Along with the unquestioned application of discourses and ideals related to "good" motherhood, I would argue that there are also disciplinary knowledges at play within this exemplar related to what it means to be a "good" patient, as far as the medical system is concerned.

There is ample literature related to how oppressive and exclusionary processes inherent to the Western medical system are often intensified for women (Fiske & Browne, 2006; Reid & Tom, 2006; Young, 1990). The healthcare system is an institution that has its origins in biomedical ideologies "entrenched in male dominated [notions] of health, functioning and child-rearing" (Jackson & Mannix, 2004, p. 154). This system remains a fundamentally paternalistic and patriarchal institution, wherein medical professionals are afforded often unquestioned and exclusive power over defining representations of what is real and appropriate in regards to the bodies, lives and functioning of individuals (Jackson & Mannix, 2004). Any kind of questioning of, or resistance to medical assessments and knowledge on the part of the patient is recurrently attributed to something bad or noncompliant within the patient, rather than something inherently oppressive or erroneous with the system (Pryce, 2000).

I would argue that it was a sort of convergence of denigrated identities (i.e. young, Indigenous, CAS-involved mother and "non-compliant" patient) that resulted in this client enduring such stigmatizing and oppressive treatment within the hospital. When women are seen as living, acting or presenting their bodies to the world in any manner outside of traditional societal ideals of appropriate womanhood and motherhood, they are habitually diminished in the public's opinion

and often cast, informally and/or formally, as a sort of permanent, deviant "other" (Minaker & Hogeveen, 2015). Women labelled in this manner frequently become the subject of multiple means of State-sponsored and State-justified control, surveillance and discipline (McDonald-Harker, 2015; Minaker & Hogeveen, 2015).

The woman in the exemplar outlined above was constructed, through the eyes, opinions and disciplinary knowledge of hospital staff, as embodying multiple inferior and "risky" identities. Subsequently, from the outset of her attendance at the hospital, she was viewed as deviant, or "a collection of risk factors to be managed" (Brown, 2006, p. 355). From here, it was conceivably fairly effortless for hospital staff, individuals operating within an already incredibly neoliberal risk and liability obsessed environment, to enact fairly extreme risk management and surveillance strategies against this woman, under the guise of concern for the safety of staff and other patients (Bolton, 2005; Mahon, 2008).

Although arguably justified, this woman's distress was read by medical staff as her inability to manage and regulate herself and her risk appropriately. This likely only compounded the perception hospital staff already had of her in this regard, given that she was a young, Indigenous mother and therefore, a "risky" body that had already morally and sexually "[gone] out of control" (Greene, 2008, p. 125).

Perceived risk and deviancy appear to have been the primary lens through which this woman was understood and subsequently treated while at the hospital. Her body and behaviour were assessed by hospital staff as being "consumed by risk" and the source of her warranted distress was ignored (Savarese, 2015, p. 103). This woman's identity outside of the ways in which staff members constructed her was disregarded and instead, she was judged and treated based solely on the ways in which she was deemed by medical professionals as falling outside of the dominant social constructions of how a "good" mother and a "good" patient should behave.

Embodied Paradox

Above I provided an analysis above of this woman's intersecting identities and the ways in which these appear to have been constructed, construed and regulated by hospital staff via various disciplinary discourses and practices. I feel that it is important to speak more specifically to her identity as an Indigenous woman.

Mzinegiizhigo-Kwe Bedard (2006) argues that "the perpetuation of stereotypic images of Indigenous women as promiscuous, and later as either Indian princesses or easy squaws" continue to inform the Canadian consciousness and dictate how Indigenous women are constructed and treated by the general public, as well as by staff within State institutions (p. 69). Such views and discourses, alongside government actions and policies steeped in assimilationist and colonial language and beliefs, have resulted in Indigenous mothering practices not merely been pushed to the margins, but being framed as utterly inferior and neglectful (Cull, 2006; Gosselin, 2006).

Razack (2000) highlights how the regular, "mundane" discourses and practices within State institutions - actions and policies often framed as care - are in fact the primary and most severe sites wherein the dehumanization of Indigenous individuals occurs. She refers to this as "…violence described as help" and argues that this occurs through the framing of Indigenous people by the State as being wholly dysfunctional, damaged bodies that are "…in essence, a lower level of humanity" (Razack, 2000, p. 85, 135).

Through these racist, colonial, patriarchal discourses and beliefs, Indigenous women are recurrently forced, within society and State institutions, into a sort of paradoxical space of high-risk "subhuman". By way of the convergence of various societal, government and institutional policies, discourses and actions, Indigenous women are framed and treated as being risky and irresponsible - and thus to blame for any harm they face - *and* as objects of apathy. In this way, Indigenous women embody a sort of paradox of heightened State and societal risk thinking, surveillance and control over their bodies and lives, while simultaneously, their existence is treated as something to be overlooked, or willfully erased.

Andrea Smith (2015) speaks to how such discourses and images regarding Indigenous women were essentially used as a means of population control. She argues that because of their revered ability to create and nurture life, and the traditionally collective and matriarchal structure of Indigenous communities, Indigenous women were viewed by settlers as being a threat to the European patriarchal mode of governance, and their continued conquest of land (Smith, 2015). Smith (2015) argues that it became necessary, as far as the settlers were concerned, to restrict and destroy Indigenous women's reproductive abilities, as a means of controlling and extinguishing the larger Indigenous population. This was accomplished and justified through the construction of Indigenous women as "polluting the body politic" (Smith, 2015, p. 79). Smith (2015) states that it is racist and colonial representations such as these of Indigenous women as both risky and "subhuman" that provided the necessary conditions for their forced sterilization to be carried out and rationalized by medical and child welfare professionals, and for other brutal colonial efforts such as the Sixties Scoop to occur. The abuses and human rights violations described by Smith (2015) echo the invasive, traumatic treatment illustrated within the practice exemplar.

Indigenous author, Lee Maracle (1988) speaks to how a consequence of colonization is the internalized belief, on the part of colonized individuals, to remain invisible. In regards to the practice exemplar, one has to wonder if this woman's verbalized anger towards hospital staff - her resistance to the neoliberal strategies of compliance and regulation within the medical system, and her refusal to have her reality, wishes and experiential knowledge further colonized and made invisible - increased the "technologies of power" that were deployed to maneuver her into appropriate ways of being and behaving, as defined by medical staff (Foucault, 1997a, 1997b; Rabinow & Rose, 1994). Within the exemplar, risk and control mechanisms were enacted to the extreme (i.e. staff notified hospital security, and insisted that the door to her room remain open at all times) because this woman embodied multiple "risky" identities.

In this way, the "technologies of power" present within the exemplar presented above - the risk thinking, disciplinary discourses, and mechanisms of control and surveillance - become in fact, *colonial* technologies of power. Through the convergence of certain discourses and practices within the medical system, this woman, by virtue of her behaviour and various socially constructed and subjugated identities, was paradoxically constructed as a body that was "risky" and deserving of increased force, regulation and control, *and* simultaneously, as a body that "existed outside the sphere of humanity" and thus, something that medical staff could invade and act upon, regardless of her wishes and consent (Razack, 2000, p. 90).

Conclusion: Cultural Humility and A Feminist Anti-Carceral Framework

The child welfare system plays a role in the harmful dynamics discussed above, both in terms of their cause and potential resolution. The Canadian child welfare system, like the healthcare system, is an institution founded upon and steeped in colonial, neoliberal and risk-obsessed thinking, and its impact in the lives of Indigenous mothers and families in particular remains extremely harmful and oppressive (Blackstock, Trocme & Bennett; 2004; Cull, 2006; Gosselin, 2006). The gendered, colonial, neoliberal discourses within the child welfare and healthcare systems become all the more powerful and oppressive when they intersect across institutional boundaries, as was the case in the practice exemplar.

Child welfare workers, myself included, must play a central role in troubling and resisting the harmful discourses and practices perpetuated within and between their realm of practice and other State systems. I propose a practice framework that centres feminist anti-carceral efforts and ideals, along with cultural humility, as one way of working towards this.

Carceral social work has been defined as "…a form of social work that relies on the logics of social control and white supremacy and that uses coercive and punitive practices to manage BIPOC and poor communities" (Jacobs, Kim, Whitfield, Gartner, Panichelli, Kattari, Downey, McQueen & Mountz, 2020, p. 3).

Feminist anti-carceral social work has been presented as an alternative to the neoliberal, carceral logic that comprises much social work practice nowadays (Jacobs et al., 2020; Richie & Martensen, 2020). While perhaps a bit of an oxymoron, I believe that it is possible for those working within child welfare to practice within this framework in terms of the ideals and goals that guide and inform our work. Feminist anti-carceral practice fundamentally rejects the political and societal discourse that regulating and punishing people keeps us safe (Jacobs et al., 2020; Richie & Martensen, 2020). Rather than making surveillance, control, risk, and partnerships with police and other carceral institutions the foci of social work practice, feminist anti-carceral practice centres the voices and needs of communities, - and in particular, the voices and experiences of racialized women - maintains an eye towards a systemic analysis of harm and violence, and engages strategies embedded in "…collaborative practices of care, compassion…community self-

determination…", harm reduction and transformative justice (Jacobs et al., 2020, p. 23; Richie & Martensen, 2020).

Cultural humility, developed by Tervalon and Murray-Garcia (1998), arose as an alternative to the notion of cultural competence, which has been critiqued for its depoliticized approach that foregrounds attempting to "know" and master another's culture, and "…its failure to account for structural forces" (Fischer-Borne, Cain & Martin, 2015, p. 165). Conversely, cultural humility is an emancipatory framework that acknowledges power imbalances and oppression, and that argues that problems are not the result of "…a lack of knowledge but rather the need for a change in practitioners' self-awareness and attitudes towards diverse clients (Tervalon & Murray-Garcia, 1998, p.118). The core components of cultural humility are personal and institutional accountability, ongoing learning and critical reflection, and challenging and mitigating systemic harm and inequities (Fischer-Borne et al., 2015; Tervalon & Murray-Garcia, 1998). The important differences between cultural competency and cultural humility are summed up by Fisher-Borne et al (2015) when they state: "mastery asks individuals to 'understand' others while accountability calls individuals and institutions to act" (p.175).

In adhering more closely to the feminist anti-carceral ideals described above, along with a stance of cultural humility, we can perhaps begin to move towards child welfare practice that is more genuinely grounded in anti-oppressive, socially just work. That is, by critically and reflexively foregrounding an intersectional and structural analysis of violence, risk and harm in our work (rather than maintaining a primarily individualized focus on so-called "risky" people), being mindful of and resisting the harmful, heteropatriarchal and colonial discourses inherent to child welfare practice and the other State systems it colludes with, genuinely centring the voices and needs of those we work with, and troubling child welfare's partnerships with police and other institutions whose practices and discourses remain embedded in neoliberal, carceral logics, the child welfare system can better align its practice with social work's fundamental commitment to social justice, instead of contributing to the opposite, as so often remains the case for many of those who are forced to interact with this and other State institutions.

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