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# **PUNISHMENT, TREATMENT, EMPOWERMENT: THREE APPROACHES TO POLICY FOR PREGNANT ADDICTS**

IRIS MARION YOUNG

In this paper I bring some issues and concepts of feminist ethics, post-modernism, and critical theory to reflect on an important women's issue—policy approaches to pregnant women who are habitual drug users. Many people, including many law enforcement officials, child protection agents, and legislators, think that women who use drugs during pregnancy should be punished for the harm or risks of harm they bring to their babies. I analyze this punishment approach and argue that the situation of pregnant addicts does not satisfy the conditions usually articulated by philosophers to justify punishment. A punishment approach, moreover, may have sexist and racist implications and ultimately operates more to maintain a social distinction between insiders and deviants than to protect children.

Most of those who criticize a punishment approach to policy for pregnant addicts call for meaningful treatment programs as an alternative. I interpret this treatment approach as a version of a feminist ethic of care. For the most part, theorizing about the ethics of care has remained at the level of ontology and epistemology, with little discussion of how the ethics of care interprets concrete moral issues differently from more traditional approaches to ethics. By conceptualizing a treatment approach to pregnant addicts as justified by an ethics of care, I propose to understand this ethics of care as a moral framework for social policy.

Although I agree with a treatment approach to policy for pregnant addicts, from a feminist point of view there are reasons to be suspicious of many aspects of typical drug treatment. Relying on Michel Foucault's notions of disciplinary power and the operation of "confessional" discourse in therapy, I argue that treatment often operates to adjust women to dominant gender, race, and class structures and depoliticizes and indi-



Betty LaDuke, *Latin America: Timeless Time*, 1984. Acrylic. From *Multi-Cultural Celebrations: The Paintings of Betty LaDuke, 1972-1992* by Gloria Feman Orenstein (San Francisco: Pomegranate Artbooks, 1993).

visualizes their situations. Thus, I conclude by offering a distinction between two meanings of empowerment in service provision, one that remains individualizing, and one that develops social solidarity through consciousness raising and the possibility of collective action.

## **PUNISHMENT**

According to some estimates, as many as 375,000 babies born every year in the United States are affected by their mothers' drug use during pregnancy, although others think the numbers are lower.<sup>1</sup> Some of these babies suffer some disorders and problems at birth; however, it is difficult to isolate the mothers' drug use from other possible causes, such as poverty, poor prenatal care, or depression.<sup>2</sup> The degree of harm to babies is also quite variable. Some children are permanently retarded or physically impaired but others are normal and healthy, especially as they grow older.<sup>3</sup> For the purposes of this discussion, however, I will assume that a mother's frequent drug use during pregnancy usually brings some kind of harm, whether short term or long term, to the baby she bears.

Punitive responses to the problem of drug-exposed infants have significant support among policymakers, law enforcement officials, and the general public.<sup>4</sup> Many prosecutors, judges, and legislatures in the United States have acted on these sentiments. Some judges have sentenced pregnant addicts convicted of crimes like theft or shoplifting to much heavier sentences than they would have otherwise.<sup>5</sup>

Punitive legislation regarding pregnant addicts has been considered in more than thirty states and by the U.S. Congress.<sup>6</sup> Although the testimony of legal and medical experts appears to have succeeded in preventing the passage of congressional legislation, at least eight states now include drug exposure in utero in their definition of child abuse and neglect.<sup>7</sup> In several states without such laws, prosecutors have used existing drug-trafficking laws to file criminal charges against women who use cocaine or other controlled substances during pregnancy. By July 1992 at least 167 women in twenty-six states had been arrested and charged criminally because of their use of drugs during pregnancy or because of some other prenatal risk.<sup>8</sup> A number of these women have been found guilty and sentenced to as many as ten years in prison.<sup>9</sup> The majority of these cases have involved women of color, even though white women also use illegal drugs.<sup>10</sup> The controversy that has been boiling about this punishment approach to policy for pregnant addicts appears in some of the appeals of these convictions. As of November 1992, twenty-one cases had been

challenged or appealed, and all of these were dismissed or overturned.<sup>11</sup>

Even more common than criminal prosecution is court-ordered removal of the baby at birth, without trial or hearing, solely on the ground that the mother or infant has a positive drug test at the time of birth. Child removal on this ground appears to be increasing, even though there is a severe shortage of foster homes in many areas of the United States.<sup>12</sup> Despite the complaints of many lawyers and medical professionals that such procedures violate privacy rights and proper medical use of the tests, a number of states require healthcare professionals to report to the local welfare agency women who have or are believed to have used a controlled substance during pregnancy.<sup>13</sup>

As a result of increasing controversy over such punitive policies, some state and local governments have encouraged treatment as a complement or alternative to criminal punishment or child removal. Thus, California has enacted a law that requires drug treatment programs to give priority to pregnant women.<sup>14</sup> The state of Connecticut has mandated that outreach workers seek out addicted mothers and mothers-to-be to encourage them to get treatment.<sup>15</sup> In the fall of 1991, the city of New York instituted a program that allows addicted women to take their babies home after birth, provided that they enter treatment and agree to weekly visits from a social worker.<sup>16</sup> This program and many others that emphasize treatment over punishment nevertheless retain a punitive tendency to the degree that they are coercing women to have treatment.

The targeting of women drug users, especially poor women and women of color, for particular surveillance and policies in the "war on drugs" raises questions about sexism and racism implicit in such policies. Most of the municipalities and states that have prosecuted women who gave birth to drug-affected babies do not prosecute other women or men for drug use. There is a particular rage often being directed at *mothers* in this differential application of punishment, which I suggest reflects an identification with the infant.<sup>17</sup> Dorothy Dinnerstein argues that in a society characterized by mother-dominated infant care both adult women and men often carry an unconscious resentment of their mothers which is displaced on to women in general. The pre-ego infant is needy and desiring, and the mother can never be completely and fully there for the child. The lack of the mother, the permanent disappointment that the mother is not always there for me, is the permanent existential trauma of mortality. The social fact of the relative absence of men from infant care allows the unconscious to scapegoat women for this existential trauma that is an element in the human condition as such.<sup>18</sup>

The level of passion directed against pregnant addicts often seems higher than that felt for most ordinary criminals. It is not just anyone who has harmed her baby, as, for example, by shooting it up with cocaine. It's the child's *mother*. The mother is supposed to be the one who sacrifices herself, who will do anything for her child, who will preserve and nurture it. That's what mothering *means*. The rage directed at pregnant addicts unconsciously recalls the feeling we all had as children of rage toward our mothers who were not always there for us, did not always respond to our needs and desires, and sometimes pursued their own purposes and desires. The mother who harms her child is not merely a criminal; she is a monster.<sup>19</sup>

As Dorothy E. Roberts argues, moreover, the fact that Black women are particular targets for the punitive reach of the state against drug-using mothers suggests that we find racism here inextricably tied to sexism. Since the days of slavery, American society has systematically devalued Black motherhood. In the tradition of American racial attitudes, all Black women are by definition not "good" mothers, and it would be best if they did not bear children at all. The racism Black women suffer, combined with the fact that their economic status more often brings them into contact with state institutions, makes them more likely to be punished than white women. Their failure to fit society's image of the "good" mother makes their punishment more acceptable.<sup>20</sup>

Most prosecutors and policymakers who have pursued a punishment approach to pregnant addicts would deny that racist and sexist biases inform their practices. They claim instead that they are exercising their obligations as state agents to protect infants from harm and to hold accountable those responsible for such harms when they occur. Women who take cocaine or heroin while pregnant are wantonly and knowingly risking the lives or health of future persons and deserve to pay for such immoral harm. Punishing women who give birth to drug-affected babies serves notice to others that the state considers this a grave wrong and will thus deter such behavior. As with most punishments, the primary justifications for punitive policies toward pregnant addicts are deterrence and retribution. Neither justification, however, is well grounded.

A deterrence theory of punishment relies on an assumption that people engage in some kind of cost benefit calculation before taking the actions the policies are aimed at. In some contexts this makes sense. If a city wishes to discourage illegal parking, it raises the fines and threatens to tow, and these policies usually do work to reduce infractions. The idea that a pregnant addict weighs the benefits of taking drugs against the

costs of possible punishment, however, is implausible, because it assumes that it is within her power to refrain from taking drugs if she judges that the costs are too high.

Many health professionals argue that punitive policies toward pregnant addicts does deter them from seeking prenatal care.<sup>21</sup> Women are likely to avoid contact with healthcare providers if they believe that their drug use will be reported to state authorities who will punish them. Because drug-using pregnant women's fetuses and babies are often at particularly high risk, they need prenatal attention even more than most. Experts claim that the harmful effects of drug use on infants can be offset, at least in part, by good prenatal care, when health professionals are aware of a woman's drug use in a supportive nonpunitive atmosphere.<sup>22</sup>

I think that retribution is most often implicitly or explicitly the operative justification for punitive approaches to pregnant addicts. These women ought to be punished and threatened with punishment because their wrongful actions *deserve* sanction. Such a retributive justification for a punitive approach to pregnant addicts must assume that these women are responsible both for their drug use and for their pregnancies; if freedom is a condition for assigning responsibility, however, these are problematic assumptions.

Anyone who starts using drugs is responsible for that use. But the concept of addiction implies a limitation on the free agency, and thus responsibility, of the addicted person. There are paternalistic dangers in promoting a model of addiction that depicts the habitual drug user as completely irrational, unaware, out of control. But there are equal dangers in denying the reality of a substance dependence so ingrained in a person's habits, way of life, and desire that she is not responsible for her continuing use. Virtually no one uses drugs with the aim of becoming dependent. Indeed, affirming the norm of self-control, people deceive themselves into thinking that they can avoid addiction and too often refuse to admit to a dependence. Most experts agree that once a person has become dependent on a substance, stopping her usage is very difficult and cannot be accomplished by a mere act of will. Begun by a series of acts, her drug dependence has become a condition, which she is in rather than something she does. Criminal law should punish people for acts, not conditions. In recognition of this distinction, legal precedent has found that criminalizing drug addiction violates a prohibition against cruel and unusual punishment.<sup>23</sup>

Most states where punitive policies toward pregnant addicts have been pursued do not prosecute people for drug use alone. Especially where

this is so, women are essentially being punished for carrying a pregnancy to term.<sup>24</sup> Such punishment must presuppose that women are responsible for being pregnant, but there are several social conditions that limit women's choice to be or not be pregnant. Ours is still a society where women often are not really free in their sexual relations with men. Access to contraception, moreover, is not easy for many women, especially poor or young women. And, of course, even when they have it, the contraception sometimes does not work. With rapidly decreasing access to abortion for all women in the United States, but especially for young or poor women, finally, fewer and fewer women have a choice about whether to carry a pregnancy to term.<sup>25</sup>

Some prosecutors and policies claim to use a punishment approach primarily as means of encouraging or forcing women into drug treatment. In line with the above arguments, one might say that a pregnant addict is morally blameworthy for harming her child only if she does not seek help in dealing with her drug use. In recent years some small steps have been taken to increase the availability of drug treatment for pregnant women, and to design programs specifically for their needs; for the most part, however, access to more than perfunctory drug treatment is limited. Most programs either do not accept pregnant women or have waiting lists that extend long beyond their due dates. Most private health insurance programs offer only partial reimbursement for treatment, and in many states Medicaid will reimburse only a portion of the cost of drug treatment. Most treatment programs are designed with men's lives in mind, and very few have childcare options.<sup>26</sup> Mandatory reporting laws or other procedures that force women into treatment, moreover, create an adversary and policing relation between healthcare providers and the women they are supposed to serve, thereby precluding the trust relationship most providers believe is necessary for effective drug therapy.<sup>27</sup>

These arguments against application of a punishment approach to policy for pregnant addicts should not be understood to imply that pregnant addicts have no obligations regarding the fetuses they carry. There are many matters about which people think that there are obligations and responsibilities, for which people are not held criminally liable.<sup>28</sup> The above arguments show that women's freedom in respect to these responsibilities is often quite circumscribed, although not absent.

Philosophers typically describe the retributive theory of punishment as based on a social contract theory of the relation of the individual to the state. Laws express a compact among citizens, their commitment to limit their personal desires and interests to create a mutually respecting com-



munity of citizens. Social membership consists in and depends on such regulation and mutual respect. One who claims social membership and benefits from it implicitly promises to obey the rules. The lawbreaker violates this implied promise. She or he therefore has forfeited her or his membership in society and deserves to be punished as a way of paying a debt for a broken promise.

Jeffrey Murphy argues that this retributive theory of punishment implies a conception of society as a relationship among equals with shared values and ways of looking at the world. A retributive justification only works morally to legitimate punishment if those subject to punishment are indeed equal citizens who receive the social benefits which oblige them to obey the rules in return. Murphy points out, however, that most of those people capitalist societies define as criminals and punish are not in fact equal citizens. They are poor and working-class people, who do not participate in the power to set the rules or derive the benefits from social participation that the theory supposes.<sup>29</sup>

Murphy argues that where punishment is applied to those excluded from the full benefits of social membership, the actual function of punishment is to reinforce that exclusion. Either you obey the rules or you are marked as deviant and punished. The proper law-abiding citizen is not needy, works hard and is independent, has relations with others through contracts of mutual exchange, and exhibits temperance and self-control. Those who do not conform to this model—who are needy, irrational, dependent, unwilling or unable to work, who do not exercise self-control, or for whom there are no benefits in the legitimate market exchange game—are deviant and deserve punishment. As Foucault theorizes, the system of modern law itself creates the category of "delinquents," whose actions its punishments are designed to curtail, and re-creates them in subjecting them to the "carceral" system.<sup>30</sup> Because punishing the pregnant addict does next to nothing to prevent the birth of babies harmed by the chronic drug use of their mothers, punishment seems only to have the function of marking the women as deviant, publicly reaffirming their exclusion from the class of upstanding citizens.

## **ETHICS OF CARE AND TREATMENT**

Critics of a punishment approach to addicts in general, and pregnant addicts in particular, argue that addiction is a health problem rather than a problem of criminal justice. The problem of substance-using mothers should be the province of healthcare and social service agencies, not the

law and the courts. Like any other needy people, pregnant addicts should be cared for, nurtured, and helped to be made well and independent. The American Medical Association, along with any other organizations that represent service providers, has taken the position that punitive policies toward pregnant addicts, including coerced treatment, interfere with the professional-client relationship to inhibit the provision and acceptance of effective rehabilitative treatment services.<sup>31</sup>

Arguments for an approach to policy for pregnant addicts that emphasizes supportive treatment appeal to values much like those conceptualized by feminist moral theorists as an ethics of care.<sup>32</sup> The ethics of care emphasizes contextualized issues of harm and suffering rather than a morality of abstract principle. This ethic of care directly criticizes at least three aspects of the model of the relation of individual and society that I have argued underlies the punishment approach—its assumption of the moral self as independent, its assumption of social relations as exchanges among equals, and the correlative assumption that these relations are voluntary.

The usual arguments justifying punishment as retribution, I suggested above, presume a contractual model of society where individuals are autonomous and independent. The manual of social obligation in this conception consists of little more than traffic rules to ensure that each person pursuing her or his own distinct interests will not crash into the others. This picture of atomized selves ignores or devalues the facts of interdependence and multivariant relationships that structure human cultures and practices. As Annette Baier argues, reliance on the formalistic ethic of rights that this atomistic contractual picture generates does little "to ensure that the people who have and mutually respect such rights will have any other relationships to one another than the minimal relationship needed to keep such a 'civil society' going."<sup>33</sup>

Those developing an ethic of care argue that relationships of inequality and dependence call for different standards of moral responsibility than the equality presumed by the atomist contractual picture. Many social relations are between unequals, where one party is dependent on the other for some or all of her or his welfare. The relation of parent and child is paradigmatic here, but other hierarchical relations of dependency such as that between teacher and student, or physician and patient, have a similar structure, according to many theorists of an ethic of care. Unlike the relations assumed in the contract model of society, moreover, these unequal relations of dependence are also often not voluntarily entered; they are already constituted relations of kinship or community, which cannot be

severed by mutual agreement. The structure of moral obligation and responsibility in such relations operates more through empathy, and through the acknowledgment of pregiven interdependence and connectiveness, than through contracts and promises.

Theories of a care ethic have been influential among feminist psychologists and therapists, who have developed theories and practices of service provision and therapy that emphasize empathy and understanding the context of social relationships in which a client's self and problems are embedded.<sup>34</sup> Some of the few drug treatment programs that have been set up specifically to serve pregnant addicts claim to instantiate the values of an ethic of care, as distinct from more confrontational and achievement models they take to be typical of therapeutic techniques.<sup>35</sup> Although there are reasons to praise such efforts, in the next two sections I will also give some reasons to be suspicious of many therapeutic practices for pregnant addicts, including those that explicitly take themselves to be using an ethic of care.

For the most part, discussions of the ethics of care have located this model of obligation and responsibility in face-to-face personal relationships.<sup>36</sup> The values of an ethic of care, however, can and should be extended beyond face-to-face personal relations, to the interconnections of strangers in the public world of social policy and its implementation. A few feminist theorists have suggested that the ethic of care can serve as a general ethical theory to ground a normative conception of politics and policy.<sup>37</sup>

Despite these promising beginnings, feminist ethics in general, and the ethics of care in particular, has done little to apply its insights to the pressing social policy issues of justice and need that face all societies in the world. I think that at the very least such application means interpreting the reasons for welfare and publicly funded social services very differently from the dominant interpretation in the United States.

Public support and assistance for the needy is most often implicitly or explicitly understood as merely beneficent rather than obligatory, except where the person receiving benefits has earned them through her or his productive contribution. Thus, in the United States, unemployment compensation and social security are generally regarded as entitlements, and other forms of public assistance are regarded as handouts, mere charity that the public dispenses at its pleasure and convenience and not because it has a moral responsibility to do so. This distinction in kinds of benefits rests on an implicit contractual model of social relations. The society "owes" welfare to those who have paid for it through working but

owes nothing to any others who are needy.<sup>38</sup>

If one substitutes for this model of contractual equality a hierarchical model of social relations in which, by virtue of institutional structures and relations of power, some persons are vulnerable with respect to the actions of others, a different basis for obligation emerges. In relations of inequality, some persons are potentially subject to coercion, to being taken advantage of because they are needy. The privileged and the powerful have a duty to refrain from taking advantage and to protect the vulnerable from the consequences of their compromised situation.<sup>39</sup>

Applying an ethic of care to policy for pregnant addicts means, then, greatly expanded public and private funding for therapeutic drug treatment and social services specifically for pregnant women, mothers, and their children. Such services should include prenatal and obstetrical care, as well as other healthcare. Whether residential or outpatient, such services should include childcare, so that mothers are not inhibited from seeking or staying in treatment, because they have no one to care for their children or do not want to be separated from them. Treatment services for pregnant addicts must be designed with women's lives specifically in mind.<sup>40</sup> For example, programs should directly address the issues of incest, sexual abuse, or battery that are part of the life history of a high proportion of addicted women.<sup>41</sup>

In 1989 Lucia Meijer reported that there was nearly zero funding for such services anywhere in the United States.<sup>42</sup> Since then, both the federal government and a few states have helped develop and provided funding for drug treatment programs specifically designed for pregnant women and mothers. The extent of such services, however, remains pitifully meager. As of fall 1991, for example, Pennsylvania funded four treatment centers providing residential treatment for women and their children in the entire state. The city of Pittsburgh has one of these centers, which houses seventeen women and their children. The state funds a few more outpatient programs, which serve a larger number of women. The Maternal Addiction Program in Pittsburgh, for example, serves about sixty women; one and one-half counselors see these women three times a week in private and group sessions, and the center is unable to provide childcare. In Pittsburgh the ratio of women who need such services to space available may be as high as ten to one, and the problem is probably more dire in other cities.

The United States has been in a period of conservative retrenchment when all forms of publicly supported service provision have been curtailed. We have been moving away from a caring orientation toward

needy people. Social problems like poverty and drug abuse have been growing as a result, creating the punitive response toward people with such problems that we see exemplified in some policies toward pregnant addicts. Adopting a seriously caring approach for policy for pregnant addicts may be expensive, although one can argue that taking care of drug-affected babies is more expensive. But publicly supported treatment policies and programs for substance-dependent women, as well as for men, must be on the agenda for a restructured healthcare system in the United States.

### **FOUCAULDIAN SUSPICIONS OF TREATMENT**

Some feminist theorists doubt the usefulness of Foucault's analyses of power and society for understanding women's situations, but many more have found his work important as a tool of feminist analysis.<sup>43</sup> Relying on Foucault's notions of disciplinary power and the confessional discourse of therapies, I argue in this section that there are reasons to be suspicious of many typical aspects of drug treatment therapies from the point of view of feminist values. This disciplinary power can be conceived on a continuum from militarylike forms of rules and obedience paternalistically enforced, "for the patient's own good," to more caring, humanistic practices. Many punitive, paternalistic treatment practices and some more caring, humanistic practices are suspicious, I will argue, to the degree that they redefine a client's problem through the categories of expert knowledge; inhibit the client's freedom through surveillance; attempt to normalize her life and behavior, often in ways that reinforce privilege; and individualize the source of her problem and its solution.

As distinct from political and juridical power, according to Foucault, disciplinary power is enacted in the everyday microprocesses of many institutions of state and civil society—schools, factories and other workplaces, the enlightened rehabilitative prison, hospitals, mental institutions, and social service agencies. This power is largely constituted through application of the knowledge of humanistic and social science disciplines—medicine, psychology, social work, criminology, public administration, pedagogy, scientific management. The authority of disciplinary power comes not from commands of a sovereign, upheld and enforced through law, but from the rules that experts claim as natural, the normal structure of operation of human subjects. Disciplinary practices of medical treatment, exercise, therapy, school or workplace examinations, and so forth, aim to constitute subjects in conformity with those norms. Through sys-

terms of surveillance and self-examination, disciplinary power enlists the subject's agency in the formation and reformation of her self.<sup>44</sup>

The relation of addicts to the institutions and experts who administer treatment is certainly one of unequal power. Whether she has entered treatment voluntarily or under threat, the addict's situation is usually one of dependence, vulnerability, and need. The relation of power is often obscured by the neutral knowledge and skills providers have and by their real intentions to be helpful and caring. The combination of expertise and care often produce situations of paternalistic power and discipline.

This often means that women in drug treatment programs must obey a set of more or less onerous rules, and often they are subject to various forms of surveillance as well. There is a range of treatment models, some of which are more rigid than others. Programs usually enforce rules that clients must not have drugs on the premises, must remain drug free while in treatment, and must undergo random drug-screening tests. Residential programs frequently have rules about how people should spend their time and what kinds and number of possessions patients may have. Both residential and outpatient programs often discourage the formation of bonds of friendship and especially sexual bonds between clients. Thus programs sometimes have dress codes forbidding "sexually revealing" clothes and do not allow clients to walk alone in pairs. Surveillance by experts may be a normal part of the outpatient experience for pregnant addicts. In the New York City outreach program that allows addicted mothers to take their babies home, provided they go to treatment, for example, mothers must also agree to allow a social worker to visit their homes at least once a week to check on the progress of their babies and the conditions of their homes. Many of the women resent these visits and consider them onerous surveillance.<sup>45</sup> Rarely do drug treatment programs or other services impose rules or engage in surveillance practices arbitrarily; they usually articulate reasons that involve the good of the client. This fact does not usually change their being experienced as imposed disciplines.

Most drug treatment programs claim to enlist the participation of the client in determining the course of her therapy. Like most social service practices more generally, however, the introduction of the expert knowledge of social service disciplines often functions to reinscribe her needs and experience in a foreign language. The normalizing language of therapy defines her history and the particular attributes of her situation as a "case," that is, as a particular instance of generalized concepts of norm and deviance, health and disorder, self-fulfillment and self-destruction.

The organizations and providers often attach expert labels to these general conditions and behaviors, which then generate for them the service response.<sup>46</sup>

The object of treatment is to change behaviors, ultimately to transform the very self of the client. Drug treatment is nearly always medicalized insofar as this transformation is conceived as moving the client from a position of disorder to a position of greater health. When the subject of such healing is the "mind" or "spirit" rather than the body, however, these therapeutic norms easily become infiltrated with *social* norms that function to enforce and reproduce relations of privilege and oppression. A treatment approach toward pregnant addicts may often work to adjust her to dominant social norms of being a "good" woman and a "good" worker, in ways designed to adjust her to the prevailing structures of domination and exploitation.<sup>47</sup>

There are some parenting standards that pertain to the objective caring that children receive, and mothers can and should be faulted for neglecting the care of their children. Often, however, superficial and culturally biased evaluations add to or substitute for such legitimate evaluations. A woman's progress toward normality may be measured according to her development of a demure comportment, a pleasant voice, a cheerful presence. She may be encouraged to develop modestly feminine habits of personal attire. I spoke with the director of a residential drug treatment program for women, for example, who mentioned he and his staff try to teach the women not to dress and wear makeup in a manner he associated with prostitutes but, rather, to dress in a respectably feminine way. Mothers will often be encouraged to develop mothering and housekeeping styles that may in fact devalue their own cultural and neighborhood family styles and norms of housekeeping, to take another example. A woman may "earn" the right to live with her children by demonstrating a proper self-sacrificing attitude; orienting her concern away from her own needs and pleasures; adopting a work ethic where pleasure can and should be delayed, pursued in small amounts, and always kept under control. Much of her therapy will consist in developing her as a competent and compliant worker: developing habits of getting up and getting to work on time, following orders and meeting deadlines, learning proper self-presentation in interview settings, and so on. Drug treatment programs often include a certain amount of job training but usually only for "basic skills" in sorts of low wage work that may be quite sex-typed: a woman will be taught basic secretarial skills, for example.

Caring service providers usually do not consciously aim at adjusting

their clients to societal structures of domination and oppression. Institutional racism, sexism, and classism, however, are reproduced partly by the application of unconscious norms and stereotypes in many situations of interaction, especially between social unequals in disciplinary settings. My point here is that it is nearly inevitable for service providers to reproduce these structures as they may condition the lives of pregnant addicts, unless those providers are conscious of how social norms can enter their work and can actively undermine the processes of the reproduction of structures of privilege and oppression.

Drug treatment programs and similar services vary in the manner and degree to which they consciously or unconsciously impose disciplines and surveillances on women and vary in the manner and degree to which they normalize clients and adjust them to dominant structures of privilege and oppression. Many therapists and social workers are critical of the expertise, tendencies toward disrespect and the creation of a punitive atmosphere, and paternalism, which remain the norm in service provision, especially toward those defined as deviant, such as addicts or poor people. Another element that Foucault finds in modern educative and therapeutic practices is much more standard—the use of confessional discourse.

According to Foucault, the genealogy of modern therapeutic practices can be traced to Christian practice of caring and making the self by means of a confessional narrative that plumbs the depths of the soul, and seeks to root out illusion and self-deception.

Each person has the duty to know who he is, that is, to try to know what is happening inside him, to acknowledge faults, to recognize temptations, to locate desires, and everyone is obliged to disclose those things either to God or to others in the community and hence to bear public or private witness against oneself.<sup>48</sup>

In traditional and early modern Christianity, the goal of such confessional discourse is the renunciation of the self. Modern therapeutic practices transform and develop these confessional techniques to a new end, the fashioning of a new self. According to Nikolas Rose, twentieth-century therapeutic practices refine and multiply these confessional technologies with the goal of producing a transparently autonomous self, where the individual has internalized the skills and disciplines of self-inspection and self-direction that assure her independence and self-control.<sup>49</sup>

Most of the time clients spend in drug treatment, whether residential or outpatient, they spend in therapeutic talk. Typically a client participates both in individual counseling sessions and several group sessions per day or per week. Some of these individual and group meetings are edu-



cative, for example, focusing on the effects of drug use or on proper nutrition. Much of this individual and group talk, however, is confessional. Its aim is for the patient to discover and express the deep truth about herself. She constructs a narrative of her history that uncovers aspects of herself that account for her drug dependence. Often she finds relationships with others or fears about her capacities that she has been denying, repressing, hiding from herself, which she brings forward through talk and vows to overcome. Group counseling sessions in drug treatment programs are often explicitly modeled on the twelve-step techniques first developed in Alcoholics Anonymous. The confessional model in twelve-step programs is direct. Group members are exhorted to give over their selves to a higher power and plumb their souls' depths while the others bear witness to their discourse. The confessional narrative often includes an element of resolution, a forward-looking conversion toward new understandings and actions, and a construction of the means needed to achieve these goals.

The goal of therapeutic talk in most drug treatment programs is for the patient to bring herself under direction, to make herself an autonomous, independent agent. In this way typical drug treatment programs retain the atomistic and individualizing model of the relation of the person and society that I argued underlies the punishment approach to pregnant addicts, which I have also argued that a consistent ethic of care rejects.

The problem with the confessional talk typical of drug therapy, as well as most other therapies, is that it tends to be depoliticizing and individualizing. It enlists the patient's own complicity in her adjustment to existing institutions and relations of privilege and oppression, by encouraging her to construct herself, or at best her family, as the source of her pain and her problems. This self-reflective exercise diverts her from locating her life in the context of wider social institutions and problems and also discourages her from forming dialogic bonds with others in relations of solidarity and resistance. The solution to each addict's problems lies solely or primarily in herself, in her ability to develop coping skills, skills for managing her reaction and those around her to the dangers and disturbances that may surround her.<sup>50</sup> Some drug treatment theoreticians and practitioners recognize this depoliticized nature of the therapeutic tradition and have attempted to modify therapeutic practice to include more discussion of the oppressive social causes of personal distress. But an individualized model of self-discovery and conversion remains typical.

I have labeled a typical treatment approach to the problem of pregnant addicts "suspicious" on the grounds developed in this section. To "sus-

pect" them is not to condemn them outright. Support for treatment is still the only viable alternative for a policy approach to the problem of drug-exposed infants. Indeed, some of the causes of surveillance or paternalistic practices in drug treatment programs may lie in insufficient resources for the programs. The grounds for suspicion, moreover, apply to many kinds of therapy and service provision besides drug treatment. What we can learn from Nancy Fraser, Michel Foucault, Nikolas Rose, and some of the others I have referred to is how to view with suspicion precisely those liberal, humanist service-providing practices that seem to be an alternative to overtly dominative practices like criminal punishment. Contemporary structures of domination and oppression appear as often in the bureaucracy of the welfare state as in the prison, although not in the same form.

### **EMPOWERMENT AS AN ALTERNATIVE**

Empowerment is like democracy: everyone is for it, but rarely do people mean the same thing by it. For Jack Kemp, former secretary of Housing and Urban Development, "empowering" poor public housing tenants meant turning over to them the management and/or ownership of the old, deteriorating, and poorly maintained buildings in which they live and providing them with little in the way of resources to help renovate, run, and maintain them. The term "empowerment" appears frequently in literature on the philosophy of social service provision. Although usages vary, I identify two primary meanings. For some therapists and service providers, empowerment means the development of individual autonomy, self-control, and confidence; for others empowerment refers to the development of a sense of collective influence over the social conditions of one's life. I think that the second meaning is better, because it includes both personal empowerment and collective empowerment and suggests that the latter is a condition of the former.

In the previous section I pointed out, following Foucault, that therapeutic services are often sites of the exercise of power in modern societies, which normalize individuals and adjust them to the demands of the dominant oppressive institutions, often with their own complicity through confessional talk. Social service theorists who use the first meaning of empowerment challenge the more overtly dominative forms of power that sometimes appear in drug treatment programs. They challenge models of service provision that make the service provider an expert and authority and which rely on rules and surveillance.<sup>51</sup> They

advocate instead what Thomas Wartenberg calls a "transformative" use of power by the service provider in relation to the client. As Wartenberg describes it, in a transformative use of power, the superior exercises power over the subordinate in such a way that the subordinate agent learns certain skills that undercut the power differential between her and the dominant agent. The transformative use of power seeks to bring about its own obsolescence by means of the empowerment of the subordinate agent.<sup>52</sup>

This concept of empowerment fits with a certain parental model of an ethic of care. The parent, teacher, or service provider may exercise some disciplinary power in relation to the child, student, or client but only for the sake of the development of skills and resources that will lead the client to autonomy and equality. Thus, John L. Forth-Finegan notes that empowerment is "taught by giving choices, and images to hold onto, to help define a self."<sup>53</sup> Some theorists who use empowerment in this sense also derive their conception of the self that is so defined from the self-in-relation theory of the ethics of care. They argue that a woman's sense of autonomy must be structured not in an effort to separate from others as in many male-oriented concepts of autonomy, but that the autonomous self is established in a context of caring and supportive relationships. For this reason many therapists using this conception of empowerment encourage approaching a client in the context of her family system or other important relationships. Thus Janet L. Surrey defines empowerment as the mobilization of the energies, resources, strengths, or powers of each person through a mutual, relational process. Personal empowerment can be viewed only through the lens of power through connection, that is, through the establishment of mutually empathic and mutually empowering relationships.<sup>54</sup>

According to my analysis of the previous section, this sort of caring therapy may not be subject to the more obvious criticisms of disciplinary practices. It nevertheless remains suspect to the degree that it operates with a confessional model of therapeutic talk (as distinct from the dialogical model I will refer to below) where that confessional model encourages the client to look into herself and express her inhibitions and resolutions, while others bear witness. Despite its understanding of the self as constituted in the context of relationships, this meaning of empowerment tends to remain individualistic. It envisions the development of personal skills and resources through which a person can learn to "be on her own," "get on her feet," and be able to cope with the situations and responsibilities she encounters. This meaning of empowerment tends to stop short of a politicized understanding of the social structures that condition an individual's situation and the cultivation of effective action in

relation to those structures.

The second meaning of empowerment used by social service theorists, which I endorse, evolves from ideals of participatory democracy, critical self-reflection, and collective action. I define this meaning of empowerment as a process in which individual, relatively powerless persons engage in dialogue with each other and thereby come to understand the social sources of their powerlessness and see the possibility of acting collectively to change their social environment. In this process each participant is personally empowered, undergoes some personal transformation, but in the context of a reciprocal aiding of others in doing so, in order that together they might be empowered to engage in effective collective action.<sup>55</sup>

Empowering treatment involves a kind of talk very different from the therapeutic confessional talk I described in the previous section, which political movements have called "consciousness raising." Confessional therapeutic talk needs other people: the therapist and sometimes fellow confessors. Their function is to encourage the confession, bear witness, and absolve. Confessional talk, however, is monological: even though it requires the presence of others, it remains one individual reciting her individual story. Consciousness-raising talk, by contrast, is dialogical. Through the give-and-take of discussion, participants construct an understanding of their personal lives as socially conditioned, constrained in ways similar to that of others by institutional structures, power relations, cultural assumptions, or economic forces. The consciousness-raising group "theorizes" this social account together, moving back and forth between individual life stories and social analysis to confirm or disconfirm both. The members of the group propose interpretations of one another's life stories as well as propose accounts of the social structures and constraints conditioning those lives, and these proposals are tested through discussion. Participants in the discussion are equal in the sense that they all have an equal right to speak, an equal right to criticize the accounts of others, and to have their accounts criticized.<sup>56</sup>

Consciousness raising is empowering because it develops in people the ability to be reflective and critical about the situated social basis of individual action. Such reflection and criticism enables people to move from an acceptance of institutional forms as natural and given to seeing them as human constructs that are changeable, however difficult that may be. Especially when this reflection and criticism occurs in dialogue with others, group solidarities can form that portend the further empowerment that can come with collective action. The final aspect of empowerment, then, is organization: the establishment or joining of democratic

collectives that foster bonds of solidarity and bring the actions of many individuals together toward some end of social transformation.

Ruth J. Parsons describes a Head Start mothers' program she works in that embodies some of these ideas of empowerment. The mothers' program was started to address the fact that the women's children were identified by the Head Start workers as "discipline problems." Instead of defining this problem as one concerning the mothering practices of the women, however, and developing in them skills to better manage and care for their children, the program encouraged the mothers to come together in free-ranging dialogue about their children and their lives. The women discussed the problems in their neighborhood and their frustration in their interactions with schools, healthcare organizations, and so forth, which made parenting difficult for them. Through this group dialogue, the women began to see ways that they could work together to address some of these community and social problems that pressed on their lives as parents. Together they persuaded local community mental health centers to make home visits and to alter their services in ways the women would find more helpful.<sup>57</sup>

Presumably, drug treatment is a special case of service provision. Substance-dependent women sometimes have lost the ability to function in daily life at a basic level, and they are usually self-deceiving about their dependence and are often emotionally damaged from physical or psychological abuse. These special circumstances perhaps make it more difficult to provide empowering services for them than for women like those described by Parsons, but with sufficient care and resources it should be possible to do so. Many drug treatment professionals are aware of tendencies to normalize and individualize in therapeutic practice and aim in their own practice for more dialogical relationships with clients. But as Joel Handler points out, the good intentions of individual providers are not enough to make drug treatment programs or other social services empowering.<sup>58</sup> The structure, rules, and institutional relationships of programs in many cases must be redesigned to produce more institutional equality between providers and clients and to connect provider activities in treatment programs with wider community activity. I will close with some general proposals for how designers of drug treatment programs might think about the structure of those programs.

I have discussed why drug treatment programs for pregnant addicts should provide prenatal and obstetrical services, childcare, and gender-specific counseling that addresses issues of sexual abuse. But several other structured program elements are necessary to make services empowering.

Many of these are not specific to services for women or mothers but should apply to all service provisions that aim to empower. Although a few drug treatment programs contain some of these elements, my research leads me to believe that programs containing all of them are almost nonexistent.

First, programs should structure at least some therapeutic group sessions on the dialogic model of consciousness raising, whose goal is for the group collectively to identify social sources of individual pain and habit in structures of power and privilege. Such consciousness-raising dialogue can also seek to cultivate a positive culture of gender, racial, and/or class solidarity.<sup>59</sup>

Second, programs should include structured client participation and evaluation of the program, including the evaluation of individual providers. If programs have rules that clients must follow, then clients should participate in making the rules. Rather than merely asking clients for suggestions about services or encouraging them individually to voice complaints, programs can have regular periods of structured self-evaluation, in which client representatives formally and collectively participate. The power hierarchy between providers and clients can be reduced, finally, by formal evaluation of providers by clients, perhaps similar to the way that students now evaluate teachers in most colleges. My research leads me to believe that client participation in rule making and the formal evaluation of programs and providers is extremely rare.

Third, meaningful work is another element of empowering programs. Those addicts who have careers or satisfying jobs can be encouraged to continue them while in treatment. Others should be provided meaningful work, by which I mean work that issues in recognizable results, which develops the skills of workers, and from which workers derive significant benefits. Drug treatment programs, even those serving unemployed persons or persons working sporadically in unskilled jobs, do not usually include meaningful work. Such programs could try to link with community development programs in order to provide such work. For example, in many cities, nonprofit development agencies rehabilitate dilapidated housing using primarily the labor of future low-income residents, trained and supervised by skilled workers.

My fourth suggestion, linked to the last, is that empowering drug treatment programs need to be part of a wider network of participatory community organizations in which people work to politicize their needs and address community problems, much as in the situation Ruth Parsons describes. Dialogue about the social sources of individual problems and

the formation of bonds of group solidarity is merely abstract if those who discover such problems are not organized to take action to address them. The dominant tendency in drug treatment programs is still to isolate clients from community networks and for programs themselves to be self-contained. The goal of removing clients from the influence of those who would encourage them to continue their drug use is laudable. But this goal is better achieved by linking drug treatment with broader strategies of community control over networks and services through a set of interlocking institutions.

## NOTES

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1. See Jan Hoffman, "Pregnant, Addicted—and Guilty," *New York Times Magazine*, Sunday, 19 Aug. 1990, 24; some estimate that as many as 11 percent of women in labor test positive for illegal drugs; see Benjamin A. Niel, "Prenatal Drug Abuse: Is the Mother Criminally Liable?" *Trial Diplomacy Journal* 15 (May/June 1992): 129. Kary Moss, of the American Civil Liberties Union Reproductive Rights Project, in a personal communication, dated 8 Apr. 1991, tells me that these government statistics are badly sampled and do not adequately distinguish types of drug use.
2. See Michelle Harrison, "Drug Addiction in Pregnancy: The Interface of Science, Emotion, and Social Policy," *Journal of Substance Abuse Treatment* 8 (1991): 261-68. See also Wendy K. Mariner, Leonard H. Glantz, George J. Annas, "Pregnancy, Drugs, and the Perils of Prosecution," *Criminal Justice Ethics* 7 (winter/spring 1990): 30-41.
3. Emmalee S. Bandstra, "Medical Issues for Mothers and Infants Arising from Perinatal Use of Cocaine," in *Drug Exposed Infants and Their Families: Coordinating Responses of the Legal, Medical, and Child Protection System*, ed. Judith Larsen (Washington, D.C.: American Bar Association Center on Children and the Law, 1990). See also Joseph B. Treaster, "Plan Lets Addicted Mothers Take Their Newborns Home," *New York Times*, 19 Sept. 1991, A1, B4.
4. A survey of fifteen southern states by the *Atlanta Constitution* found that 71 percent of the 1,500 people polled favored criminal penalties for pregnant women whose illegal drug use injured their babies; see Mark Curriden, "Roe v. Wade Does Not Prevent Criminal Prosecution of Prenatal Child Abuse," *American Bar Association Journal* 16 (March 1990): 51-53. A *National Law Journal* Lexis news service poll found that the majority say a mother should be held criminally responsible when she abuses substances during pregnancy and as a result gives birth to an impaired child. See "Courts Disagree on Mother's Liability," *National Law Journal* 13 (13 May 1991): 30.
5. Curriden, 52; Ellen M. Barry, "Pregnant, Addicted, and Sentenced," *Criminal Justice* 5 (winter 1991): 22-27; Jean Davidson, "Drug Babies Push Issue of Fetal Rights," *Los Angeles Times*, 25 Apr. 1989, sec. 1, p. 1.
6. American Civil Liberties Union, Washington Office Memo, 3 Oct. 1989; Dorothy E. Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy," *Harvard Law Review* 104 (May 1991): 1419-82.
7. These states are Illinois, Indiana, Minnesota, Nevada, Florida, Oklahoma, Rhode Island, and

- Utah. See Dorothy Roberts, "Drug Addicted Women Who Have Babies," *Trial* (April 1990): 56-61.
8. Ruth Ann Strickland and Marcian Lynn Whicker, "Fetal Endangerment versus Fetal Welfare: Discretion of Prosecutors in Determining Criminal Liability and Intent" (Paper presented at meetings of the American Political Science Association, Chicago, August 1992).
  9. Alison B. Marshall, "Drug Addiction, Pregnancy, and Childbirth: Legal Issues for the Medical and Social Service Communities," in *Drug Exposed Infants and Their Families*, 31-50; Jan Hoffman and Matthew Burns, "Greenville Woman Sentenced to Prison," *Charleston News and Courier*, Friday, 19 Oct. 1990.
  10. Roberts, "Punishing Drug Addicts Who Have Babies"; Deborah S. Pinkey, "Racial Bias Found in Drug Abuse Reporting," *American Medical News* 32 (6 Oct. 1989): 4; Ira S. Chasoff, Harvey J. Landress, and Mark E. Barrett, "The Prevalence of Illicit Drug or Alcohol Use during Pregnancy in Pinellas Co., FL," *New England Journal of Medicine* 322 (26 Apr. 1990): 1202-7. Despite similar rates of substance abuse among Black and white women, Black women were ten times more likely to be reported than white women, and poor women are also more likely to be reported.
  11. Mark Hanse, "Courts Side with Moms in Drug Cases," *American Bar Association Journal* 18 (November 1992): 18.
  12. In June 1989 a survey of five major cities found that there were 304 "boarder" babies, most born to drug-using mothers; Josephine Gittler and Merles McPerson, "Prenatal Substance Abuse," *Children Today* 19 (July-August 1990): 3-7.
  13. See Wendy Chavkin, "Drug Addiction and Pregnancy: Policy Crossroads," *American Journal of Public Health* 8 (April 1990): 483-87. These states include Massachusetts, Minnesota, Oklahoma, and Utah; see Roberts, "Punishing Drug Addicts Who Have Babies," 1430; Bonnie I. Robin-Vergeer, "The Problem of the Drug Exposed Newborn: A Return to Principled Intervention," *Stanford Law Review* 42 (February 1990): 745-809.
  14. Judith Larson, "Creating Common Goals for Medical, Legal, and Child Protection Communities, in *Drug Exposed Infants and Their Families*, 3-18.
  15. Judy Mann, "Cure an Addict, Save a Child," *Washington Post*, 5 Apr. 1991, C3.
  16. Treaster, A1, B4.
  17. Cf. Harrison, 262.
  18. Dorothy Dinnerstein, *The Mermaid and the Minotaur: Sexual Arrangements and Human Malaise* (New York: Harper & Row, 1976).
  19. See Edwin M. Shur, *Labeling Women Deviant: Gender, Stigma, and Social Control* (Philadelphia: Temple University Press, 1983); allegations of "unfit" motherhood stand against the understanding that when a woman undertakes parenthood she subordinates her own needs, desires, or priorities to the welfare of the child.
  20. Roberts, "Punishing Drug Addicts Who Have Babies."
  21. Alan I. Trachtenberg, M.D., Testimony to House Select Committee on Children and Families, 19 Apr. 1990, Memo from ACLU; Barry claims that research shows that the threat of incarceration is no significant deterrent on the behavior of substance-dependent women and tends to deter women from getting prenatal care.
  22. Andrew Skolnick, "Drug Screening in Prenatal Care Demands Objective Medical Criteria, Support Services," *Journal of the American Medical Association* 264 (18 July 1990). Researchers conclude that care provided in the framework of support, rather than judgment, can improve the outcome for drug-abusing pregnant women.
  23. See *Robinson v. California*, 370 U.S. 660 (1962), cited by Roberts.
  24. See Lynn M. Paltrow, "When Becoming Pregnant Is a Crime," *Criminal Justice Ethics* (winter/spring 1990): 41-47; Mariner, Glantz, and Annas; Roberts ("Drug Exposed Infants. . .") argues that prosecutions of drug-addicted mothers infringe on the women's freedom to continue a pregnancy, which Roberts claims is essential to an individual's personhood and autonomy and impose an invidious government standard for the entitlement to procreate; see esp. 1445-56.



25. See Tamar Lewin, "Hurdles Increase for Many Women Seeking Abortions," *New York Times*, 15 Mar. 1992.
26. See "Substance Abuse Treatment for Women: Crisis in Access," *Health Advocate*, no. 160 (Spring 1989); see also Josette Mondonaro, *Chemically Dependent Women: Assessment and Treatment* (Lexington, Mass.: Lexington Books, 1989), esp. chaps. 1-3.
27. Wendy Chavkin, "Mandatory Treatment for Drug Use during Pregnancy," *Journal of the American Medical Association* 260 (18 Sept. 1991): 1556-61.
28. See Thomas H. Murray, "Prenatal Drug Exposure: Ethical Issues," in *The Future of Children* (Spring 1991): 105-12.
29. Jeffrey Murphy, "Marxism and Retribution," in *Retribution, Justice, and Therapy* (The Hague: D. Reidel, 1979), 93-115.
30. Michel Foucault, *Discipline and Punish* (New York: Pantheon, 1977). In Foucauldian usage "carceral" refers to discipline of the body.
31. Statement of the Board of Trustees of the American Medical Association, "Legal Interventions during Pregnancy: Court-Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *Journal of the American Medical Association* 264 (28 Nov. 1990), 2663-70; cf. Skolnick: Study showed that when pregnant addicts were in a supportive atmosphere and not threatened with punishment, 83 percent of patients who tested positive for drug use agreed to counseling and 61 percent of the women in counseling discontinued their drug use. See also Chavkin, "Drug Addiction and Pregnancy."
32. A literature in philosophy and political theory on the ethics of care has burgeoned that is too vast to enumerate. Carol Gilligan's *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982) is the starting point of this work. Other important works in addition to those I will cite below are Seyla Benhabib, "The Generalized and the Concrete Other," in *Feminism as Critique: On the Politics of Gender*, ed. Seyla Benhabib and Drucilla Cornell (Minneapolis: University of Minnesota Press, 1987); *Women and Moral Theory*, ed. Diana Meyers and Eva Kittay (Totowa, N.J.: Rowman & Littlefield, 1986); Marilyn Friedman, "Beyond Caring: The De-Moralization of Gender," in *Science, Morality, and Feminist Theory*, ed. Marsha Hanen and Kai Nielsen (Calgary: University of Calgary Press, 1987).
33. Annette Baier, "The Need for More Than Justice," in *Science, Morality, and Feminist Theory*, 47.
34. The Wellesley College Stone Center for the Study of the Psychology of Women has pioneered transferring the insights of Gilligan and other theorists of caring into a general theory of self-in-relation that can be applied in therapeutic situations. See Judith V. Jordan, et al., *Women's Growth in Connection: Writings from the Stone Center* (New York: Guilford Press, 1991); see also Emily K. Abel and Margaret K. Nelson, eds., *Circles of Care: Work and Identity in Women's Lives* (Albany: SUNY Press, 1990).
35. See Gillian Walker, et al., "A Descriptive Outline of a Program for Cocaine-Using Mothers and Their Babies," *Journal of Feminist Family Therapy* 3, no. 3 and 4 (1991): 7-17.
36. Nell Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1984); Lawrence Blum, *Friendship, Altruism, and Morality* (London: Routledge & Kegan Paul, 1980).
37. Virginia Held, "Non-Contractual Society: A Feminist View," in *Science, Morality, and Feminist Theory*, 111-38; Bernice Fisher and Joan Tronto, "Toward a Feminist Theory of Caring," in *Circles of Care*, 35-62; Selma Sevenhuijsen, "Justice, Moral Reasoning, and the Politics of Child Custody, in *Equality, Politics, and Gender*, ed. Elizabeth Meehan and Selma Sevenhuijsen (London: Routledge, 1991), 88-103.
38. See Theodore M. Benditt, "The Demands of Justice: The Difference That Social Life Makes," in *Economic Justice*, ed. Kenneth Kipnis and Diane T. Meyers (Totowa, N.J.: Rowman & Allenheld, 1985), 108-20. Nancy Fraser points out that the distinction between benefits that recipients have rights to and those that are merely gifts of charity is also gendered in the U.S. welfare system, as it is in many others. Such a gender division in social service, she suggests, perpetuates the second-class citizenship of women. See her "Women, Welfare, and the Politics of Need

Interpretation," in *Unruly Practices: Power, Discourse, and Gender in Contemporary Social Theory* (Minneapolis: University of Minnesota Press, 1988); see also Carole Pateman, "The Patriarchal Welfare State," in *The Disorder of Women: Democracy, Feminism and Political Theory* (Stanford: Stanford University Press, 1989).

39. See Robert Goodin, *Protecting the Vulnerable: A Re-Analysis of Our Social Responsibilities* (Chicago: University of Chicago Press, 1985); see also his *Reasons for Welfare: The Political Theory of the Welfare State* (Princeton: Princeton University Press, 1989), chaps. 5 and 6.

40. G.M. Beschner, B.G. Reed, and Josette Mondonaro, *Treatment Services for Drug Dependent Women* (Washington, D.C.: GPO National Institute on Drug Abuse, U.S. Department of Health and Human Services, 1981).

41. John L. Forth-Finegan, "Sugar and Spice and Everything Nice: Gender Socialization and Women's Addiction—A Literature Review," *Journal of Feminist Family Therapy* 3, no. 3 and 4 (1991): 25; a number of studies find a high correlation between women's substance abuse and a history of sexual abuse.

42. Lucia Meijer, Testimony before House Select Committee on Children, Youth and Families on Substance Abuse Treatment and Women, 27 Apr. 1989, mimeo from ACLU; see also "Substance Abuse Treatment for Women: Crisis in Access."

43. See Nancy Hartsock, "Foucault on Power: A Theory for Women," in *Feminism/Postmodernism*, ed. Linda Nicholson (New York: Routledge, 1990), 157-75; Nancy Fraser expresses skepticism about Foucault's conception of biopower in her chapter on "Foucault's Body Language: A Posthumanist Political Rhetoric," in *Unruly Practices*. Her papers on women and the welfare state from the same volume, which I will rely on later in this section, however, are informed by Foucauldian insights as well as insights from critical theory. For different views, see Jana Sawicki, *Disciplining Foucault: Feminism, Power, and the Body* (New York: Routledge, 1991); Shane Phelan, "Foucault and Feminism," *American Journal of Political Science* 34 (May 1990): 421-40; Chris Weedon, *Feminist Practice and Poststructuralist Theory* (London: Basil Blackwell, 1987), chap. 5; Sandra Bartky, "Foucault, Femininity, and the Feminization of Patriarchal Power," in Sandra Bartky, *Femininity and Domination* (New York: Routledge, 1990), 63-82; Susan Bordo, "The Body and the Reproduction of Femininity: A Feminist Appropriation of Foucault," in *Gender/Body/Knowledge: Feminist Reconstructions of Being and Knowing*, ed. Susan Bordo and Allison Jaggar (New Brunswick, N.J.: Rutgers University Press, 1986), 13-33.

44. See Foucault, *Discipline and Punish*; see also his *Power/Knowledge* (New York: Pantheon, 1980), 93-108. Mary Rawlinson provides a good summary and analysis of disciplinary power in "Foucault's Strategy: Knowledge, Power, and the Specificity of Truth," *Journal of Medicine and Philosophy* 12 (1987): 371-95.

45. Treaster.

46. Nancy Fraser, "Women, Welfare, and the Politics of Need Interpretation," and "Struggle over Needs: Outline of a Socialist Feminist Critical Theory of Late Capitalist Political Culture," both in *Unruly Practices*; Joel Handler, "Dependent People, the State, and the Modern/Postmodern Search for the Dialogic Community," *UCLA Law Review* 35 (August 1988): 999-1113; Ann Weick et al., "A Strengths Perspective for Social Work Practice," *Social Work* 34 (July 1989): 350-54.

47. See Fraser; Handler; see also Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (New York: Routledge, 1990), 224-37.

48. Michel Foucault, *Technologies of the Self*, ed., Luther H. Martin, Huck Gutman and Patrick Hutton (Amherst: University of Massachusetts Press, 1988), 40; cf. Foucault, *History of Sexuality* (New York: Random House, 1978), 1: 60-67.

49. Rose, esp. chaps. 16-20.

50. See Fraser, "Women, Welfare, and the Politics of Need Interpretation"; Ellen Luff, "Using First Amendment and Title VII to Obtain Woman-Centered Drug/Alcohol Treatment Programs," *Proceedings of the Second Conference of the Institute for Women's Policy Research* (Washington, D.C.: Institute for Women's Policy Research, June 1990), 1-7; Bette S. Tallen, "Twelve-Step Programs: A Lesbian Feminist Critique," *NWSA Journal* 2 (summer 1990): 390-407.

51. See Patricia Pasick and Christine White, "Challenging General Patton: A Feminist Stance in Substance Abuse Treatment and Training," *Journal of Feminist Family Therapy* 3, no. 3 and 4 (1991): 87-102; Judy Kopp, "Self-Observation: An Empowerment Strategy in Assessment," *Social Casework: The Journal of Contemporary Social Work* 70 (May 1989): 276-79.
52. Thomas Wartenberg, *Forms of Power: From Domination to Transformation* (Philadelphia: Temple University Press, 1990), chap. 9.
53. Forth-Finegan, 36.
54. Janet L. Surrey, "Relationship and Empowerment," in *Women's Growth in Connection*, 164.
55. For statements of this sort of meaning of empowerment, see Ruth J. Parsons, "Empowerment: Purpose and Practice Principle in Social Work," *Social Work in Groups* 14, no. 2 (1991): 7-21; Lorraine M. Gutierrez, "Working with Women of Color: An Empowerment Perspective," *Social Work* 35 (March 1990): 149-53.
56. Handler, 1083-1111; Fraser, "Women, Welfare, and the Politics of Need Interpretation," 156-58.
57. Parsons.
58. Handler.
59. A study by Laurence Gary et al., concludes that the nurturing of social and racial solidarity deters drug use in some African American communities. See their essay, "Some Determinants of Attitudes toward Substance Use in an Urban Ethnic Community," *Psychological Reports* 54 (1984), cited in James Jennings, "Blacks, Politics, and the Human Service Crisis," in *Blacks, Politics, and Economic Development*, ed. James Jennings (London: Verso, 1992).