

Discursive Practices in Working with Pregnant Women “At Risk”: Implications for Social Work Ethics

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Abstract

Perinatal social workers often find themselves participating in practice situations which involve pregnant women who are deemed “at risk” by health and social care networks. Through the theoretical lens of Michel Foucault, this paper will discuss the process and implications of designating some pregnant women as “at risk,” identify challenges in ethical social work decision-making practices, and consider competing discourses and discursive practices that surround knowledge, power, and discipline.

Key Words: Foucault, Perinatal, Hospital Social Work, Ethical Decision-Making, Ethics

1. Introduction

Social work is among a number of different professions that pride themselves on values and ethics. However, the lens through which social workers view ethics constantly evolves over time (Reamer, 1999). Social workers are encouraged to view issues through multiple lenses and these lenses shift in response to cultural and societal developments (Reamer, 1999). Hospital social work is diverse and responds to psychosocial issues pertaining to vulnerable “at risk” populations including the perinatal and neonatal population. The emergence of complex psychosocial issues involving competing values suggests the importance of critically examining the implications of ethical

dilemmas that surround the process of designating certain pregnant women as ‘at risk’. Social work recognizes ethical dilemmas as situations with competing values, principles, and obligations (Reamer, 1999). Principles that are often embedded in policies or legislation are not necessarily in “harmony with one another” and they often conflict with professional codes and/or personal ethics (Beckett & Maynard, 2005, p. 12). Ethical dilemmas involved in deeming pregnant women ‘at risk’ have tremendous impact on the way that women are viewed by healthcare practitioners as well as on how they view themselves. In this paper I argue that Foucauldian analysis is well suited to help social workers understand the interdisciplinary discursive processes

involved in designating someone psychically and socially as 'at risk' and the ethical and personal implications of those processes. Informed by Michel Foucault's (Foucault, 1977; 1989) works on knowledge and power, I will explore the discursive practices that underpin how pregnant women 'at risk' are positioned within health and social care systems in ways that condition society's beliefs that affect the women's power and agency. I will explore the effects of power relations on pregnant women 'at risk,' because it is through the exploration of power that it becomes possible to uncover the invisible mechanisms that underpin ethical decision-making (or unethical decision-making) in perinatal social work practice.

2. Considering Foucault: Discourses, Discursive Practices and Discipline

Foucault's concepts, some would argue, form part of the postmodern turn in the social sciences. The main idea from Foucault that I want to explore is "that knowledge is inextricably bound to power" (Cheek, 2000, p. 22). Foucault focused on knowledge, power, and discipline and their inter-relations, which operate through the mechanisms of discourse or discursive practices. Discourses are merely ways of thinking, perceiving, and communicating reality - they give organization to a subject (Cheek, 2000). For example, in the hospital, discourses revolve around medical knowledge about the body. In order to understand bodily functions, therefore, certain truths about anatomy are realized and accepted by others and a hierarchy of medical professionals (doctors, nurses, etc.) are afforded a title as an 'expert' in their field of practice. This knowledge is embedded with authority, powers, responsibilities, and privileges that

are delegated to the professionals accordingly. However, healthcare has many other discourses such as political, legal, social, or religious knowledge that permeate understanding and drive thoughts and actions. When discourses converge they form discursive frameworks mediating the production of some truth-like statements and the exclusion of others (Cheek, 2000; Foucault, 1989; Pease & Fook, 1999). Cheek (2000) points out that "at any point in time there are a number of possible discursive frames...and not all discourses are afforded equal presence" (p. 23). Furthermore, whichever discursive frame is given precedence is a direct result of relations of power that do not always need to be repressive (Cheek, 2000; Henderson, 1994). Power can be repressive and potentially liberating at the same time, especially "[i]n situations where people are at risk due to their own lack of power, professionals with a duty of care may need to exercise control over others in order to protect them. This applies to children being abused, where social workers may apply for court orders to intervene in and overrule families in order to protect children" (Beckett & Maynard, 2005 p.120). Thus, Foucauldian analysis is helpful in exposing discursive practices around pregnant women 'at risk' by bringing awareness of those discourses that dominate understanding and those that become marginalized in the healthcare setting. Discursive practices are repressive when they desensitize those with authority to the seriousness of their use; when they are used without negotiation or consideration of the long term consequences; when they erode trust that is required to be able to work in supportive and non-threatening ways; when they are used to meet our own needs, to allay personal fears of losing control, or to punish a service user (Beckett & Maynard,

2005).

'Gaze' is a concept that Foucault introduces into his writings as a means of referring to the way people and populations are constituted and objectified. The 'observational gaze' explains the practice of scrutinizing individuals and groups based on particular dominant disciplinary discourses. Foucault's use of 'gaze' sheds light on the relationship between disciplinary practices and power (Cheek, 2000). The 'observational gaze' is derived from the example of the panopticon, a circular prison in which the guards were constantly observing the inmates from a concealed position (Cheek, 2000; Foucault, 1989; Henderson, 1994). Through the mechanism of the 'observational gaze,' a person or population becomes visible, objectified by the disciplinary gaze and as objects to themselves (Cheek, 2000). Foucault (1977, 1989) revealed that these observations are not mere passing looks but normalizing practices that assess their object according to some evaluative standard. Some of the characteristics of the object are then defined as deviant or are devalued in comparison to the implicit norms embedded in the disciplinary discourse. That is, the dominant discourse ultimately adjudicates what is normal and what is not. These Foucauldian concepts have implications for healthcare social work practice because vulnerable people, like pregnant women 'at risk,' innately believe themselves to be vulnerable, and therefore live up to and live out the expectations of those who hold the balance of disciplinary power.

In healthcare discourses, the body is an object of scrutiny and subjected to knowledge of science and anatomy as 'experts' examine evidence regarding

disease and treatment (Cheek, 2000; Foucault, 1977, 1987; Lukes, 2005). However, the body is also subject to political and social scrutiny with corresponding regimes of truth allocated to them from other disciplinary discourses.

Even before hospital admission, pregnant women are subjected to different expectations than others in such matters as getting adequate prenatal care, abstaining from harmful substances, and displaying acceptable moral qualities (Lind & Bachman, 1997). As soon as a pregnant woman becomes known to an 'expert,' such as a social worker or healthcare practitioner, a web of disciplinary practices unfold "under the scrutiny of even more senior experts, such as funding bodies, health bureaucrats, and politicians" (Fitzgerald, 1996, p. 3). Discipline and surveillance of pregnant women 'at risk' does not rest entirely on an individual or individuals but rather relies on a web of relations that navigate the effects of power and which draw from one another (Foucault, 1989, p. 155). After the birth of the baby, the mother's behaviors are further scrutinized by means of sifting through existing discourses about what it is to be a 'good mother' versus a 'bad mother' (Swift, 1995). However, discourses can also reflect mythical assumptions that all parents are judged on "level playing fields" and that "all [parents] are subject to the same rules and scrutiny, and all who fail will be caught and punished by the same systems" (Swift, 1995, p. 10). Furthermore, a discourse is dominant not because it is logical or rational but because of the "power that both underpins and maintains the discourse" (Cheek, 2002, p. 30). Foucauldian analysis is invaluable in underscoring how pregnant women 'at risk' are positioned within dominant

discourses, thereby revealing the dynamics that potentially perpetuate oppressive practices.

3. Pregnant Women ‘At Risk’

In order to understand what the concept of ‘at risk’ means, it is important to explain the surrounding social issues that prevail within this population. However, it is also a paradoxical task, because instituting a label, which is embedded in a disciplinary discourse, also reveals the power of Foucauldian thought. However, an explanation of ‘at risk’ is necessary in order to set the stage for understanding the concepts.

‘Risk’ in regard to the fetus or developing child is set out in statutes and powers that have developed over time based on cultural, moral, and societal beliefs in order to protect those individuals who can not protect themselves. Political bodies establish policies on child welfare that delegate powers, establish rules, and deliver consequences for contravention of those rules for parents and guardians of vulnerable children. This is evident in provincial child welfare acts that are administered by child welfare designated workers. The delegation of the term ‘at risk’ is interpreted differently based on which discourse is given dominance and which ‘expert’ is believed to hold the balance of power (which may fluctuate). Therefore, there is a struggle around the interpretation of the meaning of ‘at risk’ by those who define ‘at risk’ according to the various discourses (i.e., medical, political, moral, social) of those who want to protect the fetus or newborn infant. The following determinants of health suggest social issues that have potential to put a child ‘at risk’ when identified on a scale of minimum to extreme risk regarding what is

acceptable in a given society. Issues that suggest risk are persistent social (e.g., poverty and homelessness); emotional (e.g., coping and capacity); physical (e.g., HIV and drug use); and/or cognitive (e.g., mental illness or developmental) issues (Friedman & Alicea, 2001; Lind & Bachman, 1997).

4. On Becoming ‘Docile Bodies’

Foucault (1977) points out,

“...power cannot be understood except in relation to the establishing of a power exercised on the body itself... There is a network or circuit of bio-power, or somato-power, which acts as the formative matrix of sexuality itself as the historical and cultural phenomenon within which we seem at once to recognize and lose ourselves” (p. 186).

Foucault argues that as power is internalized, it becomes ingrained in thoughts and behaviors that become a part of the context in which we live, breathe and know ourselves. Thus, marginalized women learn what is acceptable and what is not through interactions with agents who impose disciplinary discursive practices. Disciplinary discursive practices can be used to oppress, and they can support the cycle of victimization that can permeate the thoughts and actions of marginalized women. On the other hand these discursive practices also assist the mother to be conscious of potential harms to herself and the baby and may also be beneficial. Discursive practices have a potentially dual character.

Friedman and Alicea (2001) discuss the consequences of women revealing personal

information that is painful or potentially self-incriminating because this knowledge can be undermined. For example, if drug-using women seek out help because they become pregnant they are aware that this information will put them at risk of losing custody of their child. Given this reality, they may not be motivated to seek help for their addiction. Additionally, addiction continues to be viewed as a moral failing rather than as a disease in need of treatment. The discourses that surround pregnant women 'at risk' place them at a morally disadvantaged position as compared with 'norms' of other more advantaged women. Thus, pregnant women 'at risk' are often deemed failures by the medical and social care professions. Their choices or rights to make decisions that affect their children or their own bodies are often not taken into consideration. Subsequently, by sharing their stories, women are rendered "voiceless" (Friedman & Alicea, 2001, p. 116). In this way, pregnant women 'at risk' become 'docile bodies'. Health and social care professionals become agents of disciplinary discursive practices rendering "control over women's bodies, recreating power hierarchies that place nonconformist women at the bottom of the social ladder while simultaneously perpetuating the dominant status of scientific knowledge" (Friedman & Alicea, 2001 p. 116). Scientific knowledge is not wrong in itself; it is the way in which power is attached to that knowledge that drives unethical discursive practices that are often employed by social workers. On the other hand this presents us with the opportunity to consider the influences on ethical decision-making practices. It is important to understand that by not acknowledging relations of power we encourage women to continue to look to the experts for guidance, which in turn reproduces

patriarchal oppression and reminds them of their failures as women and as mothers (Friedman & Alicea, 2001).

5. Practice Example

Jane was labeled a pregnant woman 'at risk' because she was suspected of using drugs during her pregnancy. The local child welfare agency had informed the hospital prior to delivery without Jane's consent or knowledge and a 'child-welfare alert' was flagged on the hospital computer system. There is a procedure between the child welfare agency and the hospital that when an 'at risk' pregnancy is admitted to the hospital, medical staff is expected to request drug screens for mother and baby. However, when the time came, Jane refused to consent to the drug screen for the baby based on a matter of principle. The child welfare social worker stated that if she had nothing to hide she would agree to the drug screen. However, Jane refused the drug screen because she did not want her baby to begin life with what she called a "black mark," or paying for her past mistakes. She stated that she no longer used drugs and she was being implicated in a vicious lie by her ex-boyfriend who wanted to discredit her. However, the comments from many nurses declared that if she had principles she would not have used drugs in the first place. The child welfare social worker had determined that if Jane had nothing to hide she would submit the infant to the drug tests. As a result, the child welfare social worker denied her right to breastfeed until she agreed to the drug screens.

The nurses were confronted with the task of not only caring for Jane's and the newborn's physical healthcare needs but also policing her motives and the relationship between her and her newborn.

Her bond and relationship with her infant was dependent on her following rules dictated by the child welfare social worker who had the power and authority to investigate under legislated acts. The child welfare social worker was, in turn, influenced by the decisions of her superiors who were assigned the task of interpreting the legislation and giving direction to the child welfare social worker. In the end, Jane chose to relinquish her position and agreed to the drug screen in order to reinstate her bond with her newborn. The perinatal social worker was afforded the task of negotiating and mediating the competing discourses and ensconced power relations in order to meet the needs and expectations of all the parties involved.

6. Theory Meets Practice

The fundamental need for the ‘subject’ to return to ‘normal’ is based on the initial finding of personal defects and establishing a diagnosis. The scenario focuses our attention on the nursing staff, who were observed to be overprotective of newborns under their care and used stigmatizing language and behaviors towards Jane. This is because the dominant medical discourse that drives nursing knowledge, communication, and understanding undervalues other ways of looking at the interaction between clinical and social (Foucault, 1987; Lind & Bachman, 1997). Disciplinary discourses are often taken for granted, but have a huge influence on both individuals with material means and those who are marginalized. However, it is those who are marginalized that usually become the “scapegoat” for social disciplinary action (Swift, 1995). The reality is that professionals fail to realize that stigmatizing comments and behaviors may

in fact negatively influence women from receiving perinatal or antenatal care, thereby placing both the woman and the unborn or newborn child at considerable risk (Carter, 2002; Lind & Bachman, 1997). This not only defeats the mandate of caregivers to care for both the woman and the fetus or infant but also encourages an “adversarial relationship between the mother and the fetus [and] works to no one’s advantage” (Lind & Bachman, 1997, p. 77).

For example, in the scenario described above, knowledge of protection policies, child safety, and ‘personal’ interpretation of Jane’s morality drove the child welfare social worker’s use of her authority to restrict Jane from breastfeeding. The child welfare social worker was motivated by a mandate of ‘child safety,’ but her methods of uncovering the truth were based on competing personal norms, legislation, regulations, policies, and other organizational demands. It is easy to assume that the request for drug screens might not have been done on the basis of medical concern for the child but rather to reinforce power relations that permeate protective child services. The ethical conflict stems from the child welfare worker’s authority to bypass medical knowledge. In fact none of the medical staff questioned the legitimacy of her authority to restrict breastfeeding. Yet she did not have the medical knowledge to determine that her decision was ‘safe’ for the child. This disciplinary action not only affected the newborn, which requires breastfeeding for optimum health, but also disrupted the bonding process for the mother (Lind & Bachman, 1997). Comments made by medical staff and the child welfare worker reflected a presumption of guilt in the mother. The driving force behind this presumption

seems to be previous knowledge of similar situations that informs and influences new situations, rather than medical or scientific knowledge (Cheek, 2000). Typically physicians have the legally mandated authority and knowledge as healthcare experts to question or deny the request for drug screens, but they often acquiesce to the power of child welfare. Lind and Bachman (1997) point out that this might be due to several reasons, such as lack of knowledge regarding child welfare legislation, or unwillingness on the part of the physician to become personally involved in the outcomes.

For example, consider the issue of disciplining pregnant women 'at risk' by means of litigation. This situation is not uncommon in some U.S. states which can prosecute women who use chemical substances while pregnant (Lind & Bachman, 1997). Though prosecution of drug-using pregnant women is not a practice in Canada, the information provided during interactions between healthcare professionals and child protection agencies is used as evidence gathering, pursuing knowledge to act as a means toward disciplinary action. This demonstrates how "authorities of various sorts have sought to shape, normalize and instrumentalize the conduct, thought, decisions and aspirations of others in order to achieve the objectives they consider desirable" (Cheek, 2000, p. 28).

Typically, the profession of social work has two roles in clinical practice. One role is individual change and the other is individual control (Lukes, 2005; Dolgoff, Loewenberg, & Harrington 2005). This is important to consider because it is easy for social workers to be caught in a maze of being used strictly as a means of individual control, by means of social controls (or

socially sanctioned means), i.e., policy, regulations, and 'best' practices. Such is the case in the scenario described above. The child welfare social worker was focused on correcting Jane's resistant behaviors and then imposed constraints for failure to meet expectations (Lukes, 2005). The peril of social workers acting predominantly as means of individual control is that the resulting coercion becomes the normal practice.

The 'observational gaze' presupposes someone is watching (evaluating, defining, and categorizing) without the conscious awareness of the one who is the subject and object of the gaze. An example of this is the alert system used to direct medical staff to a potential 'at risk' birth. Jane was unaware of this 'alert' throughout the pregnancy; yet the child welfare agency, physician, hospital social worker, and nursing staff were aware of her 'at risk' status in order to enact a disciplinary process. For example, when Jane entered the hospital and delivered her baby certain protocols were invoked that drove knowledge, power, and disciplinary practices. Was this ethical? Could she have been told about the 'alert' by child welfare beforehand in order to confront and deal with the accusations prior to the birth? Child welfare legislation would be an influencing factor inhibiting the child welfare social worker from direct contact with Jane prior to the baby's birth. In part this is due to the fact that in Canada the fetus does not have any rights as a child in need of protection until after birth. The Child, Family and Community Service Act (1996) defines a child as less than 19 years of age, but is silent on issues of the unborn. This mandate may conflict with child welfare social workers' protection priorities or ability to initiate preventive work with pregnant women 'at risk'. This

is important to consider because it may drive social workers to extraordinary measures in attempts to impose control on mothers, even violating ethical principles in order to obtain information to further a personal or legislative agenda. The more social workers impose control, the more marginalized women internalize oppression and continue the cycle of 'docile bodies'.

7. Implications for Ethical Social Work Practice

The concept that drives understanding of pregnant women 'at risk' being known to others and themselves as a 'docile body' is important because it reaches to the very core of ethical tension in perinatal social work practice. For pregnant women 'at risk,' experts are required to consider 'potential' risk for an unborn child, thereby attributing secondary concern for 'risk' to the woman. This duality can compromise equality of care for both mother and infant. In considering 'risk,' protective services may implement measures that restrict or inhibit appropriate bonding for the newborn due to lack of available staff to adequately assess the woman's situation in a timely manner. Additionally, the woman's mental health during this stressful time (including the psychological consequences and ethical implications of the imposition of disciplinary control) is seldom considered important based on the adversarial approach that is common practice (i.e., guilty until proven innocent). Furthermore, current competing discourses about 'risk' have an impact that often influences social workers' need to 'do good,' when in fact they may be responding to the mandated 'risk management' agenda without adequately considering the long term effects on the bond between the mother and child.

Lukes (2005) points out that because of

“... a desire to reduce appeals to the judiciary and reliance on the penal system, social work would depend on a psychiatric, sociological and psychoanalytic knowledge for support, hoping to forestall the drama of police action by replacing the secular arm of the law with the extended hand of the educator” (p. 101).

What Lukes (2005) may have meant in this disparaging quote is that professions like social work may exchange one means of disciplinary power for another; in another sense it is *how* social workers implement that knowledge and power, and to what ends, that make the difference. Power relations work in concert with hegemonic discourses to produce and shape particular truths (Foucault, 1987). Ethical social work practice must understand the nature of competing discourses in order to influence change “at different sites of the capillary relations of power that pervade any context...” because this would offer workers the opportunity to analyze options for “resistance at the very edges of power networks - in the hospital ward or in the home” (Cheek, 2000, p.32).

Secondly, legal and political discourses determine the parameters surrounding acceptable 'risk' to newborn safety. This gives recognition to 'safety' as the highest priority within the professional ethical hierarchy. 'Safety' usually bypasses all other principles such as self-determination and confidentiality (Dolgoft et al., 2005). Therefore, when ethical principles converge with discourses that suggest that a woman 'at risk' is somehow not normal, the collision can result in justification of unethical actions. It is very important to

consider that 'safety' or any other ethical principle is viewed differently according to who possesses the knowledge that enacts disciplinary power in order to gain a desired outcome (Guttman, 2006; Reamer, 1999). One recent study (Boland, 2006) indicated that formal frameworks for considering ethical dilemmas are rarely used by social workers when determining ethical decision-making practices. Instead, the rationale used in ethical decision-making is "based more on skills and rules than on a systemic ethical process" (p. 18). Studies such as Canda and Furman (1999), Haynes (1999), and Dolgoff and Skolnik (1996) (all cited in Doyle, Miller & Mirza, 2009) point out that personal values and practice experience are more likely to influence the resolution of ethical decisions. It is imperative that perinatal social workers should instead constantly reflect on competing disciplinary discourses, the power inherent in these discourses, and relations of professional power, in order to guard against the pitfalls of unethical decision-making practices.

Finally, it is important for perinatal social workers not to cover up the problem or to be seen as 'doing something' or acting mainly as an agent of control, but rather to actively pursue the best interests of pregnant women 'at risk' in relation to changing the conditions that inform the cycle of marginalization that seems to overtake them. Social workers are often perceived as having considerable influence arising from their position in working with vulnerable people like pregnant women 'at risk' because they often control access to services and resources (Lind & Bachman, 1997; Beckett & Maynard, 2005). Social workers and healthcare professionals are perceived as having expert knowledge and skills. However, knowledge and skills often camouflage the reality of whether

they are indeed 'free agents' able and willing to apply them appropriately. Lukes (2005) postulates that there are degrees of freedom based on rival views of what freedom is, as well as degrees of what constitutes invasion or infringement upon that freedom. For example, in the scenario, was Jane 'free' to choose for or against her conscience in not wanting to test her baby for drugs? Are social workers 'free' to withhold 'confidential' information? As described in the scenario, the child welfare social worker was given direction from her superiors who interpreted the legislation; but it was the child welfare social worker who responded by what could be interpreted as coercion. However, did the child welfare social worker feel justified or strongly compelled to use coercion to meet this agenda? Or were lack of resources influencing her choices? Similarly, it is important to be aware that professional codes of ethics are guidelines, and are open to interpretation by individual social workers and according to organizational and political mandates. Furthermore, codes are by definition methods of professional ethical control subject to review by the professional associations' mandated ethical bodies (Dolgoff et al., 2005).

8. Conclusion

The strength of Foucauldian analysis lies in providing a powerful analytic framework for determining a reflective and informed response to ethical dilemmas that perpetuate disciplinary discourses and related discursive practices that influence how pregnant women 'at risk' are positioned within dominant systems of care. Perinatal social work is uniquely placed within the healthcare system to negotiate within the networks of power to bring awareness of ethical actions that

counter the current situation, in which hospital social workers are sanctioned to function merely as agents of control. Furthermore, by linking theory with practical experience, I have underscored the challenges that pregnant women 'at risk' face in situations that produce and reproduce feelings and behaviors of helplessness. As a value-based profession, social work has an ethical responsibility to continually look at professional practice and the effects on client outcomes. In keeping with client-centered social work philosophy, further research is needed to reflect personal narratives of pregnant women 'at risk' becoming known as and knowing themselves as 'docile bodies'.

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