

Making valuable mothers in Finland: Assessing parenthood in publicly provided maternity healthcare

Riikka Homanen School of Social Sciences and Humanities, University of Tampere, Finland

Abstract

This article discusses the e/valuation of motherhood in the assessment practices of maternity healthcare provided by the welfare state. It argues that while middle-class women can position themselves more easily than working-class women as neoliberal, reflexive and self-responsible client-consumers, and can have their family values reflected back to them by maternity nurses, there is also room for values and subjects of value beyond the dominant symbolic of parenthood. The study draws on ethnographic material from four clinics in Finland. Assessment encounters are considered as sites where mothers-to-be are e/valuated on the basis of classificatory struggle. The analysis shows that in concert with the emphasis of Nordic policy on social equality, a recently introduced standardised numerical risk assessment enables moral judgements on the basis of seemingly class-neutral, scientific, statistics-based knowledge. The nurses integrate this risk assessment into more intuitive, practice-oriented and experience-based assessments of problems. Maternal subjects emerge during these practices that might not always fit into the scales of normality in risk assessment, and that fail to perform respectability and responsibility. However, they are not simply blamed for their own shortcomings, but rather practical solutions are sought in teams, and a variety of values may be recognised or at least tolerated.

Keywords: Assessment practice, e/valuation, maternity healthcare, respectability, social class, transition to motherhood

There has recently been a shift towards more client/patient self-responsibility and autonomy in social and healthcare, even in large redistributive welfare states of the Nordic type (Lawler, 2000; Rose, 1990; Sulkunen, 2009). Scholars have observed transformations in social and healthcare systems, including marketisation, decentralisation and deregulation in the name of cost-cutting and efficiency (Clarke, Shim, Mamo, Fosket, & Fishman, 2003; McGregor, 2001). These changes have been associated with an increased orientation towards individual responsibility (Petersen & Lupton, 1996). Gone are the days of Parsons' theory of the sick role in which the responsibilities of the ill were merely to desire wellness and seek appropriate help. Nowadays, individuals must demonstrate responsibility for their own health and well-being in order to be regarded as competent moral citizens (Ayo, 2012; McCabe, 2016). The state no longer guarantees or defines the 'good life' for citizens, instead merely guiding them as 'equal' partners (Sulkunen, 2009). This extends to the provision of parental support and counselling: my research, for example, has found that service providers nowadays refuse to take a strong stand on what constitutes 'good' parenthood (Homanen, 2013; Homanen, 2016).

Expectations of self-responsibility and autonomy imply that health and social misfortunes can more easily be treated as self-inflicted. Individualising misfortune in this way can be described as individualising social inequality (Gillies, 2005; Mäkinen, 2014; Skeggs, 2011; Tyler, 2015). A new generation of sociologists call this detachment of structural conditions from the person, 'class de/recomposition' (Paton, 2014; Skeggs, 2011; Tyler, 2015). People recognise the impact of social classes less readily, and do not identify as belonging to any one in particular. However, hierarchies of personal value are simultaneously re-enacted in many sites of classification (Skeggs, 2011, 2015;

Tyler, 2015). One such site is maternity healthcare, where people are e/valuated on the basis of classification systems in decisions about services and interventions.

However, it would be an exaggeration to reduce the (ideal) subject of the Nordic welfare state to a neoliberal individual or consumer citizen, as might be done in some AngloAmerican or European contexts. The Nordic model is still seen as a guarantee of social support and equality, although also as a mechanism of authoritarian control (Homanen, 2016; Oinas, forthcoming; Sulkunen, 2009). Drawing on my ethnographic research in Finland, I discuss in this article how everyday practices of parental support in maternity healthcare straddle the binary of neoliberal individualisation and collectivist assumptions about 'good' parenthood. By analysing how healthcare personnel in maternity healthcare clinics assess problems in the transition to parenthood, I show how this welfare service avoids an either/or response. Nurses participate in various ways in the value struggles of those positioned symbolically as doing things wrong, making defective transitions or lacking value.

Studies of the value struggles of those with little or no access to the resources usually necessary to constitute oneself as a subject of value – such as paid work or cultural capital – have shown that care, especially in relation to motherhood, offers them an alternative source of value (Gillies, 2007; Lawler, 2000; Skeggs, 1997, 2004, 2011, 2014; Skeggs & Loveday, 2012; Skeggs & Wood, 2012, pp. 198–199). Care and motherhood offer women a route to moral authority outside the pressures of paid work (Skeggs & Wood, 2012) and the culture of self-interest (Skeggs & Loveday, 2012, p. 484).

At the same time, care and motherhood themselves are sites of moral struggle (Nätkin, 2006; Skeggs, 1997, 2011, 2014). Many women resent the respectability forged through caring by the middle-class state representatives – nurses, social workers, teachers – who judge them (Berg & Peltola, 2015; Edwards & Gillies, 2011; Gillies, 2009; Lawler, 2000; Skeggs, 1997, 2004; Skeggs & Wood, 2012). The family values expressed and practised by mothers(-to-be) do not always coincide with those of state representatives.

In this article I show how in contemporary maternity healthcare, e/valuation is done through classificatory struggle. As Tyler (2015, p. 497) recommends, I go on to discuss the (potential) consequences of this classification for pregnant women. I also suggest that it is possible to perceive other ways of being and doing institutional e/valuations and assessments – an alternative ontology – practised by state representatives/caregivers. This logic of care is situational and unstable, but allows room for values and subjects of value beyond the dominant symbolic.

Maternity healthcare in Finland

In Finland, maternity healthcare services are provided by public health nurses in maternity healthcare clinics. Pregnant women and sometimes their partners meet their appointed nurse approximately 10–13 times. This state-funded preventative primary care is provided free of charge by municipalities. It involves the provision of support in the form of advice on matters such as healthy lifestyles, and the monitoring of somatic changes experienced by the pregnant woman and foetus, including ultrasound screenings. Increasingly, attention is also paid to the psychological and home environment by encouraging future parents to reflect on and discuss issues such as parenting. In addition to individual appointments, the nurses' work includes family counselling classes for groups of parents-to-be, and teamwork with other professionals including social work, family care,

child psychology and obstetrics specialists. These teams meet regularly to assess and address individual families' problems.

The care provided in Finland is quite different from that in many other Western countries, which offer more technologically oriented medical care provided by doctors (Benoit et al., 2005, pp. 727–729; Williams, 2005). While researchers in other countries have highlighted the historical medicalisation of maternity healthcare (e.g. Martin, 1987; Oakley, 1984), this pattern is not fully applicable to Finland (Kuosmanen, 2007; Kuronen, 1999).¹

Historically, maternity healthcare has directed a middle-class gaze on the lower classes. The formation of maternity healthcare was greatly influenced by bourgeois women's movements, and early care emerged as a way to resolve social problems. These included population anxieties over infant mortality, and moral concerns pertaining especially to working-class women's lives (Benoit et al., 2005; Kuronen, 1999). Maternity healthcare has been one of the institutions through which women are incorporated into the nation in order to fulfil their responsibilities as (mother) citizens in the name of pronatalist politics. All pregnant women have borne responsibility for attending healthcare institutions since the end of the 1940s, when maternity benefit was made conditional upon such attendance. Until roughly the 1960s, the ideal of transforming women into mothers according to the moral standards of middle-class homemakers went uncriticised. The need for intervention in problematic cases was regarded as an attribute of the lower classes (Nätkin, 2006; Wrede, 2001). Under the current ethos of preventative healthcare, everyone who walks through the door is treated 'the same' in principle and may become 'a problem family', regardless of life circumstances (Homanen, 2013).

After the first decades of the 20th century, Finnish maternity healthcare became increasingly specialised, medically and psychologically, as part of a more general trend towards professionalisation and institutionalisation. Consequently, the emphasis on social problems started to disappear (e.g. Wrede, Benoit, & Sandall, 2001, pp. 36–40). Around the 1970s welfare and reproductive politics started to lose their pronatalist characteristics and gain a more gender-neutral and individual emphasis with regard to parenthood. In the new model of the family, both mother and father participate 'equally' in care and paid work, and they procreate by choice, not out of obligation to the state or nation (Benoit et al., 2005, p. 728; Nätkin, 2006, p. 30).

In recent decades there have been several interventions in maternity healthcare arising from the policy that support during pregnancy should focus more on psychological well-being and family relationships (e.g. National Research and Development Centre for Welfare and Health, 2007; Viitala, Kekkonen, & Paavola, 2008). It seems that a psychological discourse as the model for individualism in healthcare is taking over. This new emphasis on individualism in public services may be seen as a response to the market demand that welfare services should offer and require more autonomy and choice to and of citizens (Foucault, 2008; Homanen, 2016; Sulkunen, 2009). The state has constructed itself in market terms and developed policies that figure citizens as rational, self-reliant (economic) actors in every realm of life (Foucault, 2008). State services responsabilise individuals using techniques not of strong discipline but subtle persuasion (Homanen, 2016; McCabe, 2016) or 'guidance from a distance' (Crawshaw, 2012; Sulkunen, 2009).

The welfare state has arguably been in crisis since at least the 1990s, and some even claim that Finland has departed from the Nordic welfare model (e.g. Yliaska, 2014). This claim is based on the state's adoption of a neoliberal rationale which portrays citizens and advocates of the welfare state as self-servingly hungry for ever more public services. Yliaska (2014) has studied the cuts to

Finland's public sector and the attempts to make it more 'efficient'. He argues that social policy deemed the values of the welfare state morally dubious, out-of-date and vague because they could not be properly 'measured'. This paved the way for the adoption of neoliberal management doctrines that seemed value-free.

Nevertheless, the ways in which Nordic state services encourage mothers-to-be to relate to the social cannot be reduced to a simple nudge to orient themselves towards others – an orientation for which they themselves remain responsible. Women are encouraged to relate to (ideal) maternal subjectivities, state institutions and personal support networks, and are e/valuated on that basis. However, the goal is neither a collectivist *Gemeinschaft* nor commitment to a Soviet-style larger unit. If women fail or refuse to adopt the ideals presented to them, they are not simply devalued or excluded.

Ethnography of e/valuation in maternity healthcare institutions

My study was particularly interested in how motherhood was assessed and enacted in everyday practices of maternity healthcare through classificatory struggle and collaboration among all involved. To account for the whole process of care, and to be able to look directly at the care activities involved, I used ethnography (Harbers, Mol, & Stollmeyer, 2002).

Empirical fieldwork was conducted at four different maternity healthcare clinics over a three-month period during 2006–2008, in short periods of approximately one week per month. This was done so that the fieldwork would not be exhausting for the participants. A large amount of data-intensive material was collected in those three months through the use of video-recordings, and it seemed that I had covered all the settings, activities and temporal cycles of maternity healthcare in that time.

The material includes videotapes and observations from individual appointments with pregnant women and (sometimes) their partners (69), multi-professional team meetings (11) and family counselling classes (8). I also interviewed public health nurses (7), to examine their particular experiences of being a care worker. Documentary material was gathered, such as guides and handouts distributed to families, local and nationwide guidelines for care work, and forms used to collect information from families. The nurses identified this material as documents they used in their work.

Before fieldwork began, I obtained formal permission from the municipal Committee of Research Permissions for the Welfare and Health Institute, and consent from the healthcare staff. Consent to participate was sought separately from all the pregnant women and their intimates who came to the appointments and classes.

The field clinics are situated in a large city in Finland with a population of approximately 200,000. Three of the clinics are walking distance from the city centre, and the fourth is in a suburb. There are over 20 clinics in the city, scattered across local neighbourhoods. The field clinics operate in their own facilities, which is typical of inner-city clinics. As is common across Finland, the clinics are assigned a local client population, with each nurse responsible for approximately 40 pregnancies and 200 preschoolers. Four clinics were chosen to capture a diversity of practices that would not be explained away by specific clinics' or nurses' styles.

The video material was partially transcribed unless more detailed transcription was considered relevant, because full transcriptions of all of them would have been too onerous. Separate field

notes were written for the video-recordings. The recorded interviews were fully transcribed. As is common in ethnography, analysis of the material involved ongoing reframing through knowledge produced collaboratively with participants in the field (Hammersley & Atkinson, 1995; Holmes & Marcus, 2008).

In my analysis I apply Skeggs's concepts of e/valuation and respectability (Skeggs, 1997, 2004, 2011, 2014; Skeggs & Loveday, 2012). Respectability is required of people repeatedly positioned as pathological in different practices of e/valuation. In institutional contexts the terms and conditions of performing respectability and the subjectivities it entails are often forced on people evaluated as being in moral crisis because they do not fit the mould of neoliberal self-reliance. There are, however, other subjectivities of respect and value that are brought to places and spaces of e/valuation but do not coincide with (middle-class) experience and values linked to individualism and personal achievement (Skeggs, 1997, 2004, 2011, 2014; Skeggs & Loveday, 2012; Skeggs & Wood, 2012). I am especially interested in how maternity healthcare assessment practices both devalue and make room for values and subjectivities beyond the dominant symbolic.

Maternal responsibility and/in becoming a parent

According to my observations, partners – still implicitly men – appear to need special invitations and support to start the transition to (shared) parenthood, and often the task of invitation and support is handed to pregnant women (see also e.g. Almeling & Waggoner, 2013). Nurses encourage women to get their partners to attend screenings and family counselling classes, for example. Hence maternity healthcare in practice is arguably more about the subjectification of women into mothers (responsible for the fathers) than subjectification into fatherhood (Homanen, 2016).

In line with maternity healthcare's more recent emphasis on psychological aspects, a mental transition to parenthood is sought. Women seem to be accorded such mental processes 'naturally' by virtue of their female bodies.

A family counselling class at a clinic: A nurse is showing transparencies about parenthood on the overhead projector. There are different transparencies for 'fatherhood' and 'motherhood'. The fatherhood transparency describes fathers in terms of 'safety', 'love for the family', 'friends for mothers' and 'carers for babies'. The nurse acknowledges that work limits participation. Then she notes that the father's role is different from the mother's, and that women have a nine-month head start on motherhood: women, according to her, 'have pregnancy and baby issues on their minds all the time during pregnancy'. (Fieldnotes, 14 May 2007, Clinic P)

As implied in this ethnographic snapshot, fathers/men are assigned a supportive role and do not 'naturally' 'have baby issues on their minds'. Their role is characterised in terms of providing 'love', 'safety', being a 'friend' and sharing care. Women are assigned the task of nurturing, which they acquire (mostly) during their 'nine-month head start'.

It is rarely explained in classes or appointments how to perform the vague, abstract family values of providing 'love' and 'safety' or, in women's case, developing a 'maternal instinct' (defined as 'special sensitivity and love'). Nurses often talk about 'sufficient parenthood', a kind of 'good-enough' parenthood that, for example, the nurse cited above described later in the same class as:

... attachment to the child, workable everyday life, warm atmosphere and clear ground rules. (Fieldnotes, 14 May 2007, Clinic P)

Nurses' avoidance of a strong stand on the particularities of parenthood can be seen as an attempt to support women (and men) to become self-reliant in family life. It is subtle guidance that is often backed up with scientific facts – for example, about developmental psychology or foetal damage. This guidance is expected to give parents-to-be the means to reflect upon their journey into parenthood. The emphasis on self-reliance and empowerment, and the adoption of psychological discourse, suggests an approach that figures parents as rational, self-sufficient (neoliberal) individuals responsible for their own 'good' parenthood as parents of value.

This ideal accords with (new) middle-class values in the sense that parenthood appears somewhat as a personal achievement (Gillies, 2005; McCabe, 2016). Avoiding a strong stand on what constitutes 'sufficient parenthood' potentially also allows room for creativity in the establishment of family life and parental identities.

Risk assessment as classificatory struggle

When mothers-to-be neglect their parental responsibilities, no matter how vaguely those responsibilities are presented to them, they are given at least a moral lesson. Self-sufficiency and privacy are highly valued as rights (and responsibilities) of the individual family, but only if they stay within the parameters of 'normality'.

According to more recent guidelines, nurses are supposed to make numerical assessments based on multi-item form interviews designed to report on 'mental well-being' and 'early interactions' in the family. This is in line with the emphasis on psychological aspects of family life: self-reflection is sought about one's journey into parenthood and immediate family relations. For many items on the form, the lowest score is given not for having negative mental images about one's future with a baby, but for having no images at all. Furthermore, a family is likely to be designated a 'risk family' if it appears unable not just to reflect on troubles in immediate family relations but also to converse about them – e.g. if it 'resolves disputes with violence' instead of 'conciliatory methods'. Another risk group is those who are 'too' dependent on institutional support, such as those requiring a lot of baby care, financial help or mental health services (according to Instructions for the numerical assessments distributed among the healthcare personnel, which I received in 2007 during fieldwork).

Couples are asked to give answers on different numerical scales according to how well a given statement corresponds to their own situation. Hence the forms are very fixed and compartmentalising. Those who gain poor scores are referred for further care. The more 'traditional' appointment and home visit practice of long-term affective 'probing' (as the nurses call it) for potential problems achieves the same goals, but does so in a less standardised, visible and measurable way. The nurses understand 'probing' as the intuitive, practice-oriented clinical decision-making often assigned to nursing (see also Bowker & Star, 1999, pp. 229–254). Unlike long-term 'probing', the form has the tendency to draw on statistical knowledge of the probabilities of multiple risk factors at a single moment in time, and consequently to produce 'problem/risk families' in need of intervention.

The form thus has the potential to reinforce the power of risk variables and averages produced at the level of population statistics, and to override local nurses' recognition of problems not included in an assessment form designed around this 'average family' (see also e.g. Bowker & Star, 1999, pp. 240–250; Gubrium & Holstein, 1990). The 'normality' represented by this average family is determined by normal distributions on risk scales. This entails breaking down the characteristics of family life and individuals into measurable units, and then fitting them into a framework of multiple social and health risks in order to generate population-based statistical knowledge. The average family can thus be 'scientifically' designated the 'non-problem family'.

Within the form's classificatory system, the average family is the family of value. The form also values a person who can do the work of appraising and quantifying herself when it comes to emotional, psychological and financial family issues. Thus it assumes a person with a fixed and rational sense of herself, her pregnancy and social relations. However, the nurses often diverge from the structure of the form. All the topics on the form are covered during the interview appointments, but never in a structured way. At the appointments the nurses did not always look at the parents' completed forms. They simply kept an empty form in front of them so as to keep track of the overall structure.

The rigidity of the form is transformed when nurses summarise a whole topic in one relevant question, approach a topic from a different angle, encourage women/couples to talk in their own words, return to earlier discussions at other appointments, and offer advice, encouragement and confirmation. They also give information about the forms in general, the 'meanings' of particular questions, and questions quite unrelated to the forms, such as medical procedures. Since the interview situations are not totally predetermined by the forms, a wider variety of issues may be dealt with. Furthermore, while the forms impose a certain segmentation on the enquiry, in practice the continuity of care prevails.

Critical risk scores are triggered by, for example, discussions of lone motherhood, mental problems, substance abuse, family violence or other problematic issues (also predictable at the population level). Nowadays, lone motherhood by itself rarely appears to raise major concern during appointments. If coupled with youth or a refusal to accept advice, however, it may set off alarm bells. Through the form interviews and more informal chats, clients are channelled into team meetings and other services for further assessment. The following ethnographic snapshot is from a multi-professional team meeting:

A 15-year-old girl who is 34 weeks pregnant and her mother are coming to the meeting. The meeting starts with the public health nurse describing the situation to the other team members. Before the pregnant girl and the mother enter, the team agrees an initial plan of referring the girl to different welfare services. The girl's story goes as follows: at the age of 14 she met an 18-year-old man online. They met and had sex a few times, the girl became pregnant, and now the man refuses any contact with her. She was hiding the pregnancy until just a few weeks ago. Finally somebody at school informed the school nurse. The girl saw the maternity nurse once, and soon after that a consultation team meeting was suggested to the girl and her mother. The nurse describes the girl as very confused and silent, scared about giving birth and not knowing how to take care of the baby. The nurse has brought up the question of pressing criminal charges against the father of the baby-to-be, but the pregnant girl's family does not want to do that. The girl has said fairly little about the father of the

baby-to-be and 'seems to be hoping for some kind of relationship with him'. At this point the nurse expresses her regret that the social worker from child welfare services could not attend the meeting, because she would have known about the procedures involved in pressing criminal charges without the family's consent. The psychologist then expresses concern over the emotional relations between the child(-to-be) and its father. Finally the team decides to deal with any child welfare issues later, and only in relation to the social rights of the baby. The protocol for the meeting is agreed: to go through the practical worries the girl and her mother have now, such as planning a Caesarean section and arranging help from family care workers. (Videotape TTeam4, 1 April 2008, Clinic T)

The decision to perform a Caesarean had been arrived at before the meeting, and after the girl had made only one visit to the clinic. In Finland, a Caesarean is regarded as a last resort in cases of fear of childbirth. Usually healthy women expressing fear at the prospect of birth are referred to a psychologist and/or special hospital outpatient clinic. Here, the particularities of the (psycho)social context of teenage pregnancy are taken in themselves as signalling the need for treatment, even though this is not indicated by the girl's overall health.

Obviously the age factor has altered the care here, combined with the stated fear of childbirth. The wider context is also problematic, namely the circumstances under which the girl became pregnant and with which she had to cope alone before someone intervened. She is treated at the team meeting as the victim of a crime,² and is evaluated as a mentally confused child who does not possess the maternal competence to care for a newborn, and as a person in need of several professional social and healthcare actors – the police, child welfare services, family care workers and medical doctors (and implicitly psychologists) – in order to sustain everyday life with a baby. In sum, she does not fit the ideal of a self-sufficient mother-client.

In this case, problematic life conditions have accumulated to the point that the risk of the girl not coping on her own is too high for the professionals involved. The option is even considered of pressing criminal charges without consent from the girl or her parents: they appear incompetent to be (legal) subjects.

Nurses insisted in my interviews that age, education, wealth or lone motherhood did not determine problems in families per se, as these extracts illustrate:

There are those who read a lot and are well educated, think about things, sometimes perhaps too much, things like interactions [with the child] or separation anxiety. They even use [professional] terminology that obviously comes from something they have read or heard. And then we have this 18-year-old young mum and she does everything just as well as this 40-year-old educated mum, but it comes naturally. The premises are just different. (Nurse 1)³

There are these very young pregnant people, because I have rented accommodation [in her area] with tenants who started their studies and then got pregnant. They place totally different requirements on my work than people who have studied for a long time. With them we even start with things like cooking, and things that I like and think I know very well. (Nurse 4)

Nurses made a distinction between well-educated, more mature mothers-to-be and young women without education or wealth; but they also seemed to think that regardless of age, cultural capital or

living circumstances, some care tasks remained the same. Overall, they held onto the policy discourse that labels such as ‘problem family’ could be attached to anybody who fell outside the scale of ‘normality’. Perhaps nurses’ refusal to admit they label clients as ‘problem families’ on the basis of social background is simply blindness to class impact: after all, young (and single) motherhood is often associated with the working class (e.g. Walkerdine, Lucey, & Melody, 2001). On the other hand, portraying motherhood as ‘naturally’ occurring grants mothers-to-be an innate orientation towards motherhood, while at the same time also recognising the role of the nurse’s expertise and knowledge in empowering their autonomy.

It is through (numerical) risk assessment that seemingly neutral and apolitical scientific (statistical) knowledge and classifications are used to make moral judgements about people’s lives, identifying them as abnormal. As it turns out, statistically produced bundles of risks to ‘good’ family life coincide with characteristics that used to be associated with the working class, while the ‘normal’ are associated with the middle class (see also Skeggs, 2004; Yesilova, 2009). This is the way class is re/decomposed in maternity healthcare in Finland today.

There is more to the classification struggle, however. In the meeting cited above, the child welfare action is eventually moved to the postnatal future, and its object is transformed into the newborn. The here-and-now concern that the team finally arrive at is the practicalities of teenage pregnancy – more specifically, sustaining everyday life. The professionals’ joint negotiation of different concerns is not just about managing tensions but also intertwined with sharing tasks in an ever-changing way. Pregnancy is a process in which the here-and-now project may be to arrange a ‘proper’ home environment with the help of family care workers. A little further along, the matter of concern is the Caesarean with doctors.

The more-or-less balanced judgement made does not precede team practice, nor can argumentative ethics be disentangled from it. It is impossible to be sure what is good to do and what the consequences of each decision might be, but in a team one does not have to think it through alone. It seems that technicalities are kept open when different professionals call on each other to make suggestions for action. Furthermore, regular meetings ensure that this work of assessment and decision-making is a process: if something went wrong earlier, what was it that went wrong with the activities? How can we make better assessments/evaluations? What do the family members think?

Self-reflection and respectability

According to my observations, how a pregnant woman and her family are judged by the nurses and whether she is referred for further care are also linked to her ability to accept the support offered. In the snapshot above, for example, the pregnant girl has not accepted advice about criminal charges, has not been responsive during the nurse’s appointment, and has behaved in a manner that has led to her being characterised as ‘confused’.

In the assessment, parents(-to-be) are expected to open up about their thoughts, experiences and feelings. The aim is to tutor them into reflecting on their pregnancies as mental and emotional paths towards parental(-to-be) selves that show love, attachment and attention to their child(-to-be) in their own autonomous way. This is the therapy-like code of the assessment encounter. In light of these reflections, nurses then reflect on their previous assessments and give support and advice

accordingly, which in turn may result in further elaborations from family members, and so the process goes on.

Regardless of the abstract nature of the advice, parental values such as 'love' and 'attachment' have to meet some commonly shared, yet not too specific, standards. If the pregnant woman's views diverge significantly from what is conceived as normal, the reflections are geared to steer social relations towards the norm:

The nurse and the woman are discussing the woman's ability to sleep. The woman states that usually she is able to sleep fine but 'now that he [the baby's father] is coming tomorrow to visit' she did not sleep well last night. The nurse says, 'so you have been thinking how things will go'. The woman concurs. The nurse comments to the baby on the woman's lap that 'you have a chance to get to know your dad a little', and goes on to ask the woman if the father is 'doing any better now'. The woman says that she does not know because she cannot trust him. The nurse asks if he has kept in contact. The woman says that this time he did contact her. The nurse seems content, commenting 'so he is interested and motivated to keep in contact'. The woman downplays his willingness to maintain contact by saying that it is usually his parents that encourage him [to call]. The nurse asks if he has been making his child support payments. The woman says that apparently he has been fired from his job, and it will take time before he gets unemployment benefit and can pay. He has said that it will take couple of weeks, but the woman does not seem sure that this will be the case. Later during the appointment it surfaces that the ex-couple fight all the time. The woman's parents have tried to talk to her about reconciliation 'as if I could just forgive him for everything that he has done and forget'. The nurse replies that trust is a process, and asks if the woman and man have thought at any point about 'going somewhere to talk about these issues'. The woman firmly replies 'no'. The nurse then asks if it feels like a too-distant thought that they might get back together. The woman laughs and says 'we will not get back together'. The nurse explains about the family counselling centre in the municipality, where there is mediation and therapy for couples. The woman replies that she does not think that will help in their case and she does not think that anything will change. The nurse tries once more, saying that nothing will change in one day and that from the father's perspective it would be good to attend the services: he might get his act together. (Videotape T12N, 10 May 2007, first child, five months old)

This clip was discussed with the nurse in question after the recording. I asked why she did not seem to take into account the woman's obvious concern that the father was not reliable. This interpretation was based on the nurse's insistence that the situation with the father had improved, although the woman kept insisting otherwise. The nurse said that she had discussed the father's drug abuse and mental health problems, and their influence on family life, several times from the woman's perspective. Here she wanted to discuss the possibilities of an emotional bond from the baby's point of view, the preference being that such a bond is good for the child, whatever the circumstances.

Both my original interpretation of neglect of the woman's concerns, and the nurse's gloss on her own behaviour as ensuring paternal contact, hint at a preference for holding the family together,

even if not under the same roof. Keeping parents together for the sake of the child is valued greatly at the clinics, and parents are encouraged to repair their relationships (see also Yesilova, 2009).

The woman in this snapshot is apparently not attuned to the nurse's line of discussion. She keeps escalating the problems, and the nurse keeps insisting, so the conversation does not flow very smoothly and the woman is not emotionally supported in her reflections on family relationships. The woman refuses to follow the code of interaction, and by implication refuses her baby paternal relations by not trying every possible way of reconciling with the father.

Refusing or not knowing how to attune oneself to the social conduct of the therapeutic code may lead not just to erratic flows of interaction and self-narration, or to care interventions, but also to a psychopathologisation of the process of transformation into motherhood, and to character descriptions such as 'confused', 'confrontational' and 'aggressive', as I found in my data. In other words, e/valuations of women and their social circumstances use the terminology of emotional and personal problems, rather than, say, economic or social problems.

Not fulfilling the cultural ideals of parenthood in pregnancy does not result per se in the fracture of the therapeutic code, however. Skeggs (1997, pp. 56–72; Skeggs, 2004, pp. 120–134) has argued that confessional methods of self-reflection and self-narration are a way to display cultural ability not just for the affluent but also for the 'unprivileged': the 'non-average family'. Proving oneself capable involves attuning oneself to the competences of mothering, even if those seem an unattainable goal. For example, even if the nuclear family is not an option, one should at least express the desire to have one and try one's best to get one. Reflection on one's parental journey, pregnancy and baby-to-be is sufficient to confer some parental competence. It is the way to be heard as able subjects – the strategies of respectability in institutional orders.

Respectability is usually a concern of those who are not seen to have it, and taking up familial responsibilities offers status and respectability to working-class women (Skeggs, 1997, pp. 52–54). The position of the respectable appears as something that should be enjoyed, because it is a property of those that are valued and legitimated. 'To not have respectability is to have little social value and legitimacy' (Skeggs, 1997, p. 3). No wonder that refusals to accept advice were quite rare in my material.

Self-examination may also become a form of self-surveillance for those trying to escape culturally negative classifications. This is because these methods of the self – the therapeutic form of talk and the subjectivities it entails – are historically and characteristically a middle-class experience and have been used as a condition for lower class people to receive state benefits, for example (Skeggs, 2004, pp. 5, 120–124). Some people are given the moral terms in which to tell their stories in order to become respectable and 'self-reliant/responsible'. If they refuse, they are characterised as 'abnormal' and refused a position as moral maternal subjects.

Discussion

Prior studies of parental support and guidance show that middle-class parents are often able to impose their definitions of 'good' parenthood, which mostly coincide with the professional definition. In contrast, working-class parents struggle to assert their views or have control over interventions. This often results in feelings of inadequacy, but also resistance (e.g. Berg & Peltola, 2015; Edwards & Gillies, 2011; Gillies, 2009; Skeggs, 1997, 2004; Yesilova, 2009). The working

class are also able to just get on with their lives – aware, resentful, angered by devaluation, but nonetheless ‘generating person value through investment and connections to others rather than investments in distinction and self’ (Skeggs & Loveday, 2012, p. 487).

My ethnographic enquiry into the practices of maternity healthcare reveals how state representatives, in this case public health nurses in maternity healthcare, in practice e/valuate mothers-to-be in everyday assessment encounters, both formal and standardised and informal and intuitive. My study confirms previous findings (Berg & Peltola, 2015) that middle-class Finnish women position themselves more easily than working-class women as client-consumers who choose professional advice and have their family values reflected back to them by nurses. The idealised maternal figure realised in these practices is the rational, self-reliant, self-reflexive, empowered mother who is not/should not be disciplined to conform, but is merely ‘supported’ to ‘freely choose’ somewhat conservative and gendered family values in the name of the scientifically ‘neutral’ goal of psychological well-being.

The emphasis on empowerment, self-reflection/reliance and the psychological discourse as a model of individualism in motherhood treats social problems as subjective and emotional ones. It opens a space for moralising on women who, because of their social position, have less control over their life circumstances, are less able to make ‘free choices’, or lack the ability or will to engage in self-reflection. As McCabe (2016, p. 183) puts it: ‘constructions of empowerment reflect neoliberal values such as autonomy, selfresponsibility, and informed/rational consumer choice that mute racial, cultural and class difference’. Treating social and financial problems as subjective problems of (emotional and moral) maternal competence responsabilises women for their misfortunes, and under the guise of individuality it restricts women’s reproductive choices and freedoms to the norms of middle-class decency.

It is *women* who are invited to ‘freely choose’ familial lives and values, at the clinics and in society at large. Brown (2015) argues that women disproportionately and invisibly remain responsible for the care of children, adults, the disabled and the elderly as responsabilisation and the appreciation of human capital increasingly become the governing truth of all spheres of life. Ontologically the generic neoliberal individual is socially male in the late-capitalist gendered order of things.

The ability to align oneself with this ideal figure is dependent on one’s position in the market. Prior studies have shown that while both middle- and working-class men highly value equality, it is usually working-class men who participate in the mundane caring activities associated with motherhood (Brennan & Nielsen, 2006; Gillies, 2007). Despite the Nordic policy emphasis on gender equality and neutrality, it seems that Finnish maternity healthcare practices – with their implicit emphasis on fathers’ secondary role in everyday care – allow such class-derived differences.

The recent introduction of numerical standardised risk assessment into care practices, and hence the creation of a numerical scale of normality for parenthood, is a change in the focus of control over mothers: it is population-based control not of people per se, but of the people-specific risk of failing to become the self-reliant parent defined in psychological discourse. In concert with the historically strong Nordic discourse of social equality, this works in favour of neoliberal class decomposition by detaching social conditions from people with the claim that anyone might be a problem family under this uniform and scientifically ‘neutral’ assessment practice. In fact, such assessment is about the e/valuation and composition of class relations and inequality in the form of seemingly objective

classifications based on population-statistical data: the poor, the dependent, the uneducated and lone mothers seem to remain more responsible for their own misfortunes.

Currently this risk assessment coexists in different ways with more historical, local and intuitive nursing practices. Women are not merely disciplined to conform to middleclass values, and no knowledge is completely negated by professional knowledge at the clinics. Even when mothers-to-be do not fit into the scale of normality in risk assessments, even when there is judgement and intervention, when performances of respectability and self-reliance fail, they are not left alone to ponder their parenthood, competences or feelings of not fitting in. Rather, practical everyday working solutions are sought in a team. Long-term support, trusting professional relationships and listening to women's experiences have been the guiding principles of maternity healthcare since its establishment in the early 20th century (Wrede, 2001). Different parenting values may also be recognised, or at least tolerated. Care always escapes from and collides with the logics and interests of capital(ism) (Mol, 2008; Skeggs, 2014): care is an open-ended process with no clear boundaries. Clients of care are never merely consumers in the market sense. They cannot choose care acts as if they were products, and the result of care often requires interactions between carers and cared-for that make the latter into fellow team members rather than targets of care (e.g. Mol, 2008, pp. 17–21).

Advising about 'good' parenthood in abstract terms of love, shared care and attendance – which exceed interest, self-enhancement and rational choice – can also be interpreted as respect for the fact that pregnancy and transition to motherhood is a process in which maternal identity is acquired experientially. Furthermore, refusing to give a precise content to abstract parental values also takes parenthood beyond middle-class (neoliberal) values. The result is a mother who is neither a mere product of control nor a neoliberal individual solely responsible for her own parental defects. She is a subject of value, not just in the private homes of certain families but also in the institutional context of public care of the Nordic kind.

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Notes

1. Sweden and Denmark have similar systems: in Sweden nurse-midwives provide antenatal care, while in Denmark it is nurses. In Norway GPs have responsibility for care. Nursemidwifery

centredness is not exclusively a Nordic characteristic in maternity healthcare. For example, in the UK care is provided by midwives and involves elements of demedicalisation, such as social support. It is not only in Nordic societies that nurses in maternity care offer a counterbalance to the medical profession, whether as, for example, performers of emotional labour or intuitive and practice-oriented decision makers.

2. In Finland the legal age of consent is 16.

3. Further fieldwork details withheld for purposes of anonymity.

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