The Wrong Race, Committing Crime, Doing Drugs, and Maladjusted for Motherhood: The Nation’s Fury over “Crack Babies”

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Introduction

DURING THE 1990S, WOMEN WHO USE ILLICIT DRUGS DURING PREGNANCY BECAME the subject of intense public attention and social stigmatization. They are regarded as incapable of responsible decision-making, morally deviant, and increasingly, unfit for motherhood. In recent years, the civil courts have terminated the parental rights of thousands of women whose infants tested positive for drug exposure at birth (Beckett, 1995). Women have also faced criminal prosecution for prenatal drug use, under statutes including criminal child abuse, neglect, manslaughter, and delivering substances to a minor. For the most part, the women targeted by the courts and the media have been black, poor, and addicted to crack cocaine (Roberts, 1991; Krauss, 1991; Beckett, 1995; Neuspiel et al., 1994; Greene, 1991).

I argue here that the phenomenon of the “crack-baby” is not produced simply by a tragic interaction between illicit substances and a growing fetus. The “crack-baby,” rather, has resulted from a broader conjunction of practices and ideologies associated with race, gender, and class oppression, including the war on drugs and the discourse of fetal rights. In the late 1980s and early 1990s, the image of trembling, helpless infants irrevocably damaged by their mothers’ irresponsible actions became a potent symbol of all that was wrong with the poor, the black, and the new mothers in the post-women’s movement, post-civil rights era. Crack-babies provided society with a powerful iconography of multiple social deviance.

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(nonmarital sexuality, criminality, drug addiction, aberrant maternal behavior), perpetrated upon the most innocent, by the least innocent: women who are in fact “shameless” and “scandalous” (Irwin, 1995).

Below I will discuss the issue of prenatal substance abuse, focusing on women addicted to crack and their children. As I will illustrate, the social, legal, and political trends that comprise the nation’s response to this problem have been largely inspired by racial, gendered, and socioeconomic imperatives, rather than by the blind hand of justice.

The Media and the Crack-Baby in the Popular Imagination

In the 1980s, a crack cocaine epidemic exploded in the U.S., sweeping through low-income black communities with a vengeance (Roberts, 1991). Perceiving a dramatic rise in the number of boarder babies and children born to women abusing drugs, the media began to present the public with reports on a drug like no other, crack, and on appearance of a “different” kind of child — the crack-baby. The narrative of the crack-baby interwove specific messages about crack, pregnant addicts, and crack-exposed children. Crack cocaine, journalists wrote, was a drug like no other previously on the streets. Crack was more potent, more addictive, and more likely to lead its users to acts of violence, crime, and desperation.

Among its most desperate and debased users were pregnant women. One of the most harmful effects of crack was said to be that it literally destroyed the maternal instinct in the women who used it (Irwin, 1995; Hopkins, 1990; Appel, 1992; Elshtain, 1990; Debettencourt, 1990). Utterly irresponsible and incompetent, addicted mothers were seen as “inhumane threats to the social order” who willingly tortured their helpless fetuses (Irwin, 1995: 635). One California doctor was quoted as saying, “with every hit the mother plays Russian roulette with the baby’s brain” (Hopkins, 1990: 108). Only concerned with feeding their addictions, mothers on crack were said to be incapable of taking care of their children or even caring about the irreparable harm that smoking crack would do to their unborn fetuses. A Rolling Stone article reported that the crack epidemic had left some social service workers “nostalgic” for the heroin mothers who “could buy groceries occasionally and give the kid a bath.” “Crack,” on the other hand, “leaves nothing to chance. It makes babies that only a mother could love, and wipes out that love as well” (Ibid.: 71).

The press often spoke of the frustration or anger that many health care workers felt toward pregnant addicts. The Economist, for example reported that:

Heartbreaking as it is for the doctors and nurses who care for the babies [to see them suffer]...they find it even more distressing to return the babies to mothers for whom drugs remain the dominant feature of life (Economist, April 1, 1989: 28).
In a 1990 *People* magazine interview, Katherine Jorgensen, head nurse in the neonatal intensive care unit at Boston City Hospital, explained that the hardest part of her job “is when new mothers come to look in on their children.” Seeing women come to visit their babies “with their pimps” or “while they are high,” she said, made her “want to slug them” (Plummer and Brown, 1990: 85).

In the eyes of the media, the inhumane actions of addicted mothers often produced children who were almost beyond the pale of humanity. Crack-exposed babies were “supposedly doomed to a life of suboptimal intelligence, uncontrollable behavior, and criminal tendencies” (Neuspiel et al., 1994: 47). According to *People*, some crack-babies “shake so badly they rub their limbs raw” (Plummer and Brown, 1990: 85). In *Rolling Stone* we read, “During a crying jag their rigid little arms flap about, which makes them even more frantic: They seem to believe their arms belong to someone else, a vicious someone who relentlessly flogs them” (Hopkins, 1990: 71). Pictures of children who tested positive for exposure to drugs at birth most often showed them crying, “shrieking like cats” or staring, bug eyed into space for hours. According to the logic of the crack-baby narrative, the variety of physical and emotional problems faced by these children could be attributed to a single cause: prenatal exposure to crack cocaine (Greider, 1995; Griffith, 1992).

Children exposed to crack in the womb, it was reported, were likely to suffer from any number of serious medical conditions. Among the most frequently cited were cerebral hemorrhaging and intercranial lesions, prematurity, birth defects, genitourinary and cardiac abnormalities, prenatal strokes, heart attacks or death, fine motor disorders, low birth weight, and neonatal growth retardation (Hopkins, 1990; Sexton, 1993; Hoffman, 1990; Plummer and Brown, 1990; Langone, 1988; Zitella, 1996). Fetal exposure to cocaine was also said to greatly increase the risk of postnatal neurological complications, such as extreme sensitivity to external stimuli, unpredictable mood swings, high-pitched “cat-like” crying, tremulousness, and difficulty interacting with others (Appel, 1992; Sexton, 1993; Hopkins, 1990; *Economist*, April 1, 1989). Even in the mildest cases, crack-exposed children would likely suffer grave emotional and cognitive abnormalities. Crack babies, we read, were generally unable to concentrate, prone toward violence and destructive behavior, and were averse to light, touch, and affection (Zitella, 1996; Hopkins, 1990).

From the inner cities, a new breed of child was being produced, one that was loveless, tortured, and demented. In the words of one pediatric researcher, “You can’t tell what makes these children happy or sad. *They are like automatons*” (Hopkins, 1990: 72; emphasis added). Even in the “best case scenario” crack-exposed children were somehow fundamentally “different” from the rest of us — somehow less human. As Doctor Judy Howard told *Newsweek*, “in crack-babies the part of the brains that makes us a human being, capable of discussion or reflection has been wiped out” (Greider, 1995: 54). Similarly, another piece asserted that crack cocaine “robbed [exposed] children of ‘the central core of what it is to be human’” (Irwin, 1995: 633).
Worst of all, the damage done to these children by their crack-smoking mothers was believed to be permanent and irreparable. In the chilling words of one journalist, “crack damages fetuses like no other drug...[and] the damage the drug causes...doesn’t go away” (Hopkins, 1990: 68). Though the press was generally sympathetic to the plight of crack-exposed children, it typically portrayed them as damaged goods, largely beyond hope or salvation, and damned by the actions of their irresponsible mothers. One article read “for [some] people this is truly a lost generation, and neither love nor money is ever going to change that.... Love can’t make a damaged brain whole” (Ibid.: 68–69).

State Response to Prenatal Cocaine Use: Prosecute and Terminate

The moral indignation, shock, and pity that such media imagery aroused in the American public were accompanied by an aggressive state response. Policy initiatives addressing the crack-baby phenomenon have been concentrated in the legal and social service arenas.

Legal Prosecution of Pregnant Addicts

In the later part of the 1980s, the country witnessed the emergence of a new and unprecedented legal strategy: the criminal prosecution of pregnant drug addicts. Due to the successful lobbying of the ACLU and medical, health, and women’s organizations, no state has passed laws that make prenatal substance abuse an independent crime (Beckett, 1995; Lieb and Sterk-Elifson, 1995; Neil, 1992). Therefore, prosecutors have used “innovative” applications of existing laws to bring cases against pregnant addicts. Women have been charged under statutes for child abuse, neglect, vehicular homicide, encouraging the delinquency of a minor, involuntary manslaughter, drug trafficking, failure to provide child support, and assault with a deadly weapon (Mariner, Glantz, and Annas, 1990; Beckett, 1995; Sexton, 1993; Paltrow, 1990; Roberts, 1991; Greene, 1991).

In July 1989, Jennifer Johnson, a poor, 23-year-old African-American woman, became the first person convicted in the U.S. for giving birth to a drug-exposed infant. She was charged and found guilty of delivery of a controlled substance to a minor. Florida prosecutor Jeff Deen argued that this had taken place in the 30 to 90 seconds after the birth of the infant and before the cutting of the umbilical chord (Dobson and Eby, 1992).

Johnson received a 15-year sentence, including 14 years of probation, strict supervision during the first year, mandatory drug treatment, random drug testing, and mandatory educational and vocational training (Sexton, 1993; Logli, 1990; Neil, 1992). Johnson was further prohibited from “consuming alcohol, socializing with anyone who possessed drugs, and going to a bar without first receiving consent from her probation officer” (Sexton, 1993: 413). The court also ruled that if Johnson ever intended to again become pregnant, she must inform her probation officer and enroll
in an intensive “judicially approved” prenatal care program (Logli, 1990; Sexton, 1993). Under Florida state law, she could have received a 30-year prison sentence (Curriden, 1990). Prosecutor Deen believed that prosecution “was the only way to stop her from using cocaine” and that Johnson “had used up all her chances” (Ibid.: 51). The case, Deen claimed, served to send the message “that this community cannot afford to have two or three cocaine babies from the same person.”

Another highly publicized case was that of Kimberly Ann Hardy, also a poor, single young black woman addicted to crack cocaine. Hardy’s case first came to the attention of the Department of Social Services in Muskegon Country, Michigan, when the local hospital reported that her newborn had tested positive for cocaine at birth. Hardy’s urine was tested for drugs because she had been identified as a “high-risk pregnancy” upon admission to the hospital: she had received no prenatal care and delivered six to eight weeks early (Hoffman, 1990).

Eleven days after she left the hospital, county prosecutor Tony Tague ordered Hardy arrested on the charge of delivering drugs in the amount of less than 50 grams — one generally used in prosecuting drug dealers (Ibid.). Though Hardy’s case did not result in a conviction, district attorney Tague felt that the prosecution served to fulfill several important goals: it got Hardy into treatment and gave other pregnant crack addicts a strong warning to get clean or face jail and the loss of their children. Muskegon County Sergeant Van Hemert stated that adopting the hard line in prosecuting mothers is “a form of caring.” Speaking with anger that many seem to hold toward pregnant addicts, he adds: “If the mother wants to smoke crack and kill herself I don’t care. Let her die, but don’t take that poor baby with her” (Ibid.: 34, emphasis added).

These two cases are fairly typical. The prosecutors are white males, the defendants are young black women, the drug is crack, and the rationale is safeguarding the health of babies. By 1992, 24 states had brought criminal charges against women for use of illicit drugs while pregnant. All of the defendants in these cases were poor and most were nonwhite (Beckett, 1995; Lieb and Sterk-Elifson, 1995). Nearly all of the convictions obtained in criminal prosecutions for perinatal substance abuse have been overturned (including Jennifer Johnson’s), on the grounds that the charges against the defendants were not congruent with legislative intent (Beckett, 1995; Logli, 1990). Despite this fact, district attorneys continue to bring pregnant women up on criminal charges for substance abuse. As Beckett (1995: 603) has stated, “the continuation of these efforts reflects their political utility in our cultural climate.”

Polls taken in the last few years have found that a large and growing proportion of the American public (71% in one survey) believes that women who use drugs while pregnant should be held criminally liable (Curriden, 1990; Sexton, 1993; Hoffman, 1990). The prosecutions of Johnson, Hardy, and others have boosted the careers of the attorneys who put them on trial, who some have heralded as “crusaders” in the war against drugs.
“Protective Incarceration”

Protective incarceration is another legal tactic that is becoming increasingly popular (Appel, 1992). In these cases, judges send pregnant women convicted of charges unrelated to their drug use to jail to “protect” their fetuses. At the 1988 sentencing of a pregnant addict convicted of writing bad checks, the judge stated:

I’m going to keep her locked up until that baby is born because she’s tested positive for cocaine.... She’s apparently an addictive personality, and I’ll be darned if I’m going to have a baby born that way (Roberts, 1991: 1431, fn. 55).

Other addicts have been sent to jail for violations of their probation, in lieu of a probationary sentence, or for longer periods than is standard (Lieb and Sterk-Elifson, 1995; Schroedel, Reith, and Peretz, 1995; Appel, 1992).

Hospital Policy

Currently, at least 13 states require that public hospitals test women “suspected” of drug abuse and that they report those who test positive to social services or the police (Sexton, 1993). As in the Hardy case, mandatory reporting is often what triggers prosecution. Yet, drug screening conducted at public hospitals regularly takes place without women’s consent or their being informed of possible legal ramifications.

In South Carolina, one hospital’s testing and reporting policy (which stipulated that the police be notified of positive prenatal drug toxicologies) landed it a three million dollar lawsuit on the grounds that it violated patients’ civil rights and discriminated on the basis of class and color. At the Medical University of South Carolina in Charleston, six lower-income women (five black and one white) who tested positive for drug use were “taken out of their hospital beds, handcuffed, and sent to jail without their babies” within days or hours after delivery (Furio, 1994: 93). At least one of the women “arrived at the jail still bleeding from the delivery; she was told to sit on a towel” (Paltrow, 1990: 41). The white woman was “detained for three weeks, put into a choke hold, and shackled by police during her eighth month of pregnancy...then placed against her will in a psychiatric hospital” (Furio, 1994: 93).

In September 1994, the case ended with a settlement and the requirement that the hospital abandon its practices. By that time, however, several hundred women had faced criminal prosecution under the reporting policy. Further, many other states continue to bring criminal or civil charges against women on the basis of drug tests performed without their consent.

Social Services — Unfit for Motherhood

The most frequent penalty for a mother’s prenatal drug use is permanent or temporary removal of the newborn and/or other children. Based upon the results
of drug screening, infants may be removed from their mothers right after birth, often without trial or hearing (Young, 1995). In today’s political climate “positive neonatal toxicologies raise strong presumption of parental unfitness” (Roberts, 1991: 1431). Increasingly, civil courts agree that prenatal use of drugs constitutes neglect and is sufficient evidence for termination of parental rights (Beckett, 1995). In the last decade, literally thousands of women have permanently lost custody of their children as a result of their addiction. Upon appeal, the lower and appellate family courts have generally upheld these decisions (Ibid.).

Representative Kerry Patrick of Kansas introduced legislation that would require female addicts to have Norplant capsules inserted in their arms or else go to jail. Patrick says of his plan: “I’ve gotten a lot of support from nurses who deal with crack-babies. Once you see one, you don’t care about the rights of the mother” (Willwerth, 1991: 62). Others echo his anger. One employee of the Los Angeles County Department of Health says: “Damn it, babies are dying out there!... You get someone with a terrible family history, stoned, no parenting skills — and we keep giving back her babies because we don’t want to look racist or sexist” (Ibid.: 62).

**Assumptions Behind the Crack-Baby Narrative and Punitive Treatment of Addicted Women**

The intensity of legal, civil, and journalistic activity centering on babies born addicted to crack cocaine has been undergirded by three main sets of assumptions: about the effects of crack cocaine on fetal and child development, about the pregnant addicts targeted by the courts and the press, and about the efficacy of prosecution and punishment. The following section explores each of these assumptions and shows that despite their power, they are not substantiated by empirical evidence. Their tenacity comes not from their basis in fact, but from their ideological resonance with popular beliefs about drugs, crime, race, and motherhood.

**The Medical Effects of Crack Cocaine on Fetal Health**

The first assumption fueling the crack-baby scare is that crack is far more dangerous to fetal health than any other drug. As new evidence has emerged in the last five to six years, it has become apparent that early reports as to the impact of crack cocaine on fetal development were grossly exaggerated, and that what was painted as the norm is most likely the worst-case scenario. Perhaps the primary shortcoming of the early research was that it failed to disentangle the effects of cocaine from the effects of other chemical and environmental factors (Appel, 1992; Greider, 1995; *Science News*, November 19, 1991; Gittler and McPherson, 1990; Neuspiel, Markowitz, and Drucker, 1994). This was a particularly serious flaw given the population of drug users under study. Women who use crack are more likely to smoke cigarettes, drink alcohol, use other drugs, and to be
malnourished; they are also less likely to obtain adequate prenatal care (Greider, 1995; Feldman et al., 1992; Griffith, 1992; Appel, 1992; Debettencourt, 1990; Neuspiel, Markowitz and Drucker, 1994). Each of these factors has been documented to seriously impair fetal development — in the absence of cocaine (Appel, 1992; Neuspiel, Markowitz, and Drucker, 1994; Science News, November 19, 1991; American Journal of Nursing, May 1995).

Moreover, the presence of post-natal risk factors has also confounded the results of many studies. Cocaine-exposed children, like many poor black American children, are exposed to a higher-than-average level of violence, neglect, and abuse in their daily environments. Some scientists claim that “the social context of crack cocaine use, or more commonly polydrug use, is more likely to be related to the poor medical and developmental outcomes than to the actual drug exposure of the fetus” (Lieb and Sterk-Elifson, 1995: 690; emphasis added).

Despite these and other shortcomings, it was fairly easy for researchers to get this type of research published; conversely, it has been difficult to publicize findings that crack’s effects on fetal development were minimal or nil (Greider, 1995; Pollitt, 1990; Beckett, 1995). Scientists whose work refuted the alarmist findings of the earliest published reports on crack cocaine and fetal development were often confronted with the disbelief, censure, and anger of their colleagues. In the words of one researcher, “I’d never experienced anything like this.... I’ve never had people accuse me of making up data or being an incompetent scientist or believing in drug abuse” (Greider, 1995: 54).

Dr. Ira Chasnoff has been a leading scientist in the field of prenatal cocaine exposure research since 1985. When Dr. Chasnoff recognized that his research was primarily being used to stigmatize and punish the women and children for whom he considered himself an advocate, however, he was appalled. In 1992, he stated that on average, crack-exposed children “are no different from other children growing up.” Indicating his disgust with the popular rhetoric on “crack-babies,” Dr. Chasnoff added, “they are not the retarded imbeciles people talk about.... As I study the problem more and more, I think the placenta does a better job protecting the child than we do as a society” (Sullum, 1992: 14).

Developmental psychologist Dan Griffith (formerly a member of Chasnoff’s research group) has also sought to rectify the misimpressions concerning “crack-babies” so prevalent in the public imagination. Griffith notes that the most common assumptions about crack-kids — “(1) that all cocaine-exposed children are severely affected, (2) that little can be done for them, and (3) that all the medical, behavioral, and learning problems exhibited by these children are caused directly by their exposure to cocaine” — are false. Dr. Griffith cautions that far too little research has been conducted to allow scientists “to make any firm statement about the long-term prognosis” for cocaine-exposed children (Griffith, 1992: 30). However, his own research indicates that with early intervention and the reduction of other risk factors, most coke-exposed children “seem completely normal with
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regard to intellectual, social, emotional, and behavioral development though age three" (Ibid.: 31).1

Recent studies, which attempt to "smoke out" crack's unique impact on fetal development, tend to agree that cocaine increases the risk of low birth weight and prematurity in infants (Greider, 1995; Feldman et al., 1992; Barone, 1994; Beckett, 1995). Scientists have also found that receiving adequate prenatal care and curtailing drug usage significantly improves developmental outcomes for cocaine-exposed infants (Appel, 1992; Griffith, 1992). The extent to which cocaine alone causes neurobehavioral and other abnormalities is still up for debate. However, the consensus is that the average harm posed to infants by cocaine is far less than previously feared. Prematurity and low birth weight are indeed dangerous conditions for an infant and each significantly contributes to the high rates of infant mortality and morbidity among African-Americans.2 Yet these two primary effects are a far cry from the cranial hemorrhages, severe retardation, and lack of "human" qualities said to be typical of children born exposed to crack cocaine.

Current evidence also suggests that the effects of crack are not so different from those of tobacco or some other common street drugs. Comparison of scientific data on the effects of several chemical factors on fetal development demonstrates that the selection of pregnant crack-addicts in particular for censure and prosecution "has a discriminatory impact that cannot be medically justified" (Roberts, 1991: 1435). It may make no more sense, then, to speak about "crack-babies" than it does to speak of "cigarette-babies," "pot-babies," or "speed-babies." Most crack-exposed children will not suffer permanent pharmacologically induced brain damage and are not, medically speaking, beyond "hope." Whatever developmental delays or antisocial behavior they appear to express in later life may have more to do with poisons in their postnatal environment than in the fetal one.

Pregnant Addicts Targeted by Courts

The crack-baby mythology is also powerfully buttressed by a set of assumptions and stereotypes concerning the pregnant addicts who have been targeted by the courts and the media. Despite popular mythology to the contrary, empirical evidence shows that rates of prenatal drug use are consistent across race and class lines (Neuspiel et al., 1994; Lieb and Sterk-Elifson, 1995; Beckett, 1995; Appel, 1992). Stated otherwise, white middle-class women are no less likely to abstain from the use of illicit substances during pregnancy than are poor minority women. Ira Chasnoff's 1989 study of patterns of prenatal drug use and reporting policies in Pinellas County, Florida, clearly documented this trend.

In a toxicological screen for evidence of alcohol, marijuana, cocaine, and/or opiate use, 14.8% of women in the study tested positive overall. Chasnoff found that "there was little difference in the percentage of drug detection between women
seen in public clinics (16.3) and those seen in private offices (13.1), or between blacks (14.1) and whites (15.4)” (Neuspiel, 1996: 48). There were, however, significant racial differences in the drug of choice. A higher percentage of pregnant black women (7.8) used cocaine than did pregnant white women (1.8); and pregnant white women (14.4) evidenced significantly higher usage of marijuana than their black counterparts (6.0). A more striking finding of the study concerned the discrepancy in the rates of reporting. In the state of Florida, health care providers are required by law to report both marijuana and cocaine use to authorities. Chasnoff discovered that “despite similar levels of use, black women were reported at 10 times the rate for white women” and that poorer women were reported more often than middle-class women were (Ibid.: 48, emphasis added).

If not substance abuse rates themselves, then what explains the overwhelming race/class discrepancy in reporting and prosecution of prenatal drug use? This discrepancy has its roots in the fact that “the process in which pregnant women are suspected of substance abuse, diagnosed, and prosecuted is suffused with enormous discretion” (Lieb and Sterk-Elifson, 1995: 691). As the data indicate, this discretion quite often translates into pernicious discrimination along lines of race and class.

The Health Care Profession: Should We Test? Should We Report?

There are many loci where discretion is exercised and discrimination occurs. It begins with the decision whether to test a woman for substance use. State guidelines for mandatory reporting and testing are often vague and underspecified, leaving the implementation of policies up to individual doctors, clinics, or hospitals. The criteria for determining likelihood of prenatal drug use vary tremendously, but most “risk factors” are associated with socioeconomic status (Beckett, 1995) and race. Physicians often decide whether to order a newborn urine screen based upon whether the mother received timely and adequate prenatal care. Since black women as a group “are twice as likely as white women to begin prenatal care late or not at all” (Krauss, 1991: 528), and poor women are often unable to afford adequate prenatal care, this testing criterion tends to discriminate by both race and by class.

Health care providers also may act upon the basis of straightforward prejudice. As Krauss (Ibid.: 527) writes,

suspicions of substance abuse may be informed by stereotyped assumptions about the identities of drug addicts…. [These stereotypes are] reinforced by studies in medical journals which list, with questionable accuracy, the characteristics of those presumed to be at risk.

Florida’s reporting policy “does not require documentation of maternal drug use, but only a ‘reasonable cause to suspect it’” (Ibid.: 527). Therefore, regardless
of actual drug history, all women who appear to "fit the profile" are at risk of being subjected to particular scrutiny by social services and the police.

The fact that most testing is conducted at public hospitals that service low-income communities also means that poor women of color are more likely to face drug screening than are women protected by race and class privilege. In private hospitals, pregnant women are usually not tested for drug use, even if drug use is suspected (Beckett, 1995). Furthermore, even if they present a positive drug toxicology or admit drug use to their physicians, most women seen in private facilities are not reported to the authorities. Prenatal drug use by women who are affluent and/or white may often be viewed by private and public physicians as an exception, a lapse in judgment, or as incidental. Prenatal drug use by poor black women, however, is often viewed as endemic, typical, and evidence of their unfitness for motherhood.

Prosecutorial Discretion

Once prenatal drug use is reported, the authorities must then decide what, if any, course of action to take. Dwight Green argues that the unchecked discretion of prosecutors, who are overwhelmingly white and male, means that prenatal drug cases are often based not upon "unbiased law enforcement," but on "pluralistic ignorance" and race, gender, and class discrimination (Greene, 1991). Prosecutors must first decide what statutes, if any, apply to the offense at hand. As mentioned, prosecutors brought prenatal drug abuse trials into existence by stretching the interpretations of existing laws.

Having found an appropriate statute under which to press charges, prosecutors then decide whether to take a given case to trial. There are many intervening factors that go into this decision, often colored by considerations of race and class. Women who drink alcohol or ingest marijuana are quite unlikely to face criminal sanctions for prenatal drug use, even when they are reported to the police (Hoffman, 1990). Greene (1991: 745, fn. 28) writes,

> If long-term harm to children was the triggering event, this would present the unlikely image of affluent pregnant white women being subject to arrest at their country clubs or in the suburban home of a friend for having a drink.

The relative influence of a potential defendant may also influence the decision whether to press charges. Suspects in "white collar" crimes, for example, are often able to:

- hire well-paid criminal defense lawyers with social, political, and professional access to the prosecutor's office to argue at case screening conferences against instituting criminal charges or to lessen the seriousness of the crimes to be charged (Ibid.: 755).
Even after initiating a criminal case, the prosecutor still has the option to discontinue prosecution. Although prosecuting a poor black crack-addict can boost a district attorney’s reelection chances, taking an expectant socialite to trial for popping a handful of barbiturates with a glass of wine may only bring him embarrassment or ridicule.

The Efficacy of Criminal Punishment

The oft-repeated rationales for taking punitive action against pregnant substance abusers are to force them to enter drug treatment and to safeguard the health of their fetuses. The reality is that taking such action does not ensure, and may often be counterproductive to, the realization of these goals.

Threatening women with jail time in no way ensures that treatment services appropriate for pregnant addicts will be available (Beckett, 1995). One of the great ironies of the criminalization of prenatal drug use is that as a “general rule,” substance abuse programs do not accept pregnant women (Sexton, 1993). A 1989 study of 78 treatment programs in New York City found that 54% refused all pregnant women, 67% refused pregnant women on Medicaid, and 87% would not accept pregnant women on Medicaid who were addicted to crack (Appel, 1992; Hoffman, 1990; Roberts, 1991). Few addiction programs provide prenatal or obstetrical care and therefore most turn women away rather than risk treatment without these services (Lieb and Sterk-Elifson, 1995; Roberts, 1991).

Drug treatment programs designed primarily to serve men can also be alienating and ineffective for women. Appel (1992: 141) writes, “most treatment approaches are based on the characteristics and dynamics among male populations and comparatively little has been done to define the unique nature of addiction to women.” Many female addicts, for example, “turned to drugs because they were sexually abused or raped as children, and they need help repairing the damage” (Willwerth, 1991: 63). According to one estimate, 80 to 90% of female alcoholics and drug addicts have been victims of rape or incest (Paltrow, 1990). A program that does not address the special issues facing pregnant addicts will doubtlessly have high rates of withdrawal and relapse. Yet the focus on punishment has generally not been accompanied by a correspondingly intense drive to increase the availability of services geared toward the needs of pregnant addicts.3

Instituting criminal sanctions for perinatal substance abuse is also counterproductive to the goal of helping women and children because it serves to deter pregnant addicts from seeking medical attention. Medical evidence (cited above) indicates that receiving adequate prenatal care and/or curtailing drug consumption can significantly improve developmental outcomes for cocaine-exposed infants. Yet many women will avoid seeking the information and treatment they need if they realize that a positive urine screen could result in their children being placed in foster care or land them in jail (Krauss, 1991).4
Putting women in jail for evidence of drug use upon delivery will not undo whatever harm was done to their newborns in utero. Sending women to prison while pregnant is unlikely to ensure the health of their fetuses either. While incarcerated, pregnant women “face conditions hazardous to fetal health, including overcrowding, poor nutrition, and exposure to contagious disease” (Ibid.: 537). Prison health facilities generally provide little or no prenatal care and are ill-equipped to handle the medical needs of pregnant women, especially those with drug histories. Like other inmates, pregnant addicts may also be able to obtain illegal drugs while imprisoned (Paltrow, 1990; Schroedel and Peretz, 1995). Moreover, if the supply of drugs is suddenly cut off, the physiological changes that immediate withdrawal brings about in the mother and the fetus can be dangerous to the health of both (Schroedel and Peretz, 1995; Appel, 1992).

Criminalizing prenatal substance abuse punishes women for failing to obtain treatment that is generally unavailable and may prevent them from seeking prenatal care. Because of the harm that it is likely to cause, prominent sectors of the medical community have taken a stand against this policy. In a paper published in 1988, the American Medical Association stated that:

the current policy of prosecuting women who use drugs during pregnancy is irrational because it does not further the state’s purpose of preventing harm to infants…. [D]rug addiction is an illness, which like any illness, is not due simply to a failure of individual willpower (Lieb and Sterk-Elifson, 1995: 693).

Similarly, in 1991, the American Nurses Association characterized the imposition of criminal sanctions against pregnant addicts as “extreme, inappropriate, and ineffective” (Sexton, 1993: 420–421).

**Race, Crime, Drugs, Motherhood**

If, as I have argued, the three primary sets of assumptions that have rationalized prosecuting crack-addicted mothers are false, then what is this really about? If not the neutral exercise of justice, what is the driving force behind the imposition of criminal sanctions for prenatal drug use? Why are prosecutors, judges, the press, and much of the American public now so eager to demonize and imprison drug-addicted mothers? Why is it that crack addicts and poor black women are targeted for reproach and condemnation? If it does not help mothers or protect their babies, what societal goal does punishing pregnant addicts serve?

The crack-baby phenomenon, it seems, has arisen from a particular confluence of contemporary ideas about race, crime, drugs, and motherhood. These ideas and practices have their most proximate roots in the Reagan/Bush era “war on drugs” and the discourse on “fetal rights.” In each of these discourses, the civil rights of “offenders” (pregnant women or drug users/dealers) are increasingly seen as an

War on Drugs: War on Communities of Color

The late 1980s witnessed the emergence of an aggressive anti-drug crusade, waged on several fronts. This crusade defined as criminal the use and sale of illicit substances. The federal government appropriated millions of dollars in public monies for the pursuit, arrest, and conviction of dealers and users (Beckett, 1995; Irwin, 1995). In response to federal initiatives, state legislatures wrote tougher drug laws and imposed stiffer penalties for their violation. The courts, in turn, sent more and more drug offenders to jail, for longer terms. Currently, one-third of the state prison population is composed of individuals convicted on drug-related charges (Beckett, 1995). The United States now has the highest incarceration rate in the world, with .4 percent of its population behind bars at any given time (Neuspiel et al., 1994).

Besides law enforcement, special interest groups, politicians, and news agencies turned their attention to the evils of illicit substances (Irwin, 1995). Through the popular press, these groups articulated “a language of intolerance and a rhetoric of contempt” for those who used drugs (Ibid.: 632). Pregnant addicts were subject to special scorn in the media and viewed as particularly deficient in morals (Ibid.; Lieb and Sterk-Elifson, 1995). According to the discursive arm of the war on drugs, increasing rates of drug usage were somehow responsible for much of the social disorder, moral decay, poverty, and decadence of the late 20th century.

Not all drugs received equal attention in the war on drugs: crack most firmly captured the nation’s imagination. With crack’s emergence in the mid-1980s, journalists “bombarded the public with frightening images of crack cocaine as a unique ‘demon drug’ different from any other...highly potent, instantly addictive, and conducive to systemic violence and moral decadence” (Lieb and Sterk-Elifson, 1995: 687). Crack cocaine was declared Time magazine’s “issue of the year” in 1986 (Time, September 22, 1986). According to Newsweek, the devastation wrought by crack was “as newsworthy as the Vietnam War, the fall of Nixon’s presidency, and the American civil rights movement” (Irwin, 1995: 633). With the issue of crack-babies, the war on drugs and the media’s sensationalistic stories reached new heights.

Despite the sudden burst of alarmist press and the appearance of the war on drugs, the overall prevalence of drug use in the U.S. did not increase in the 1980s (Beckett, 1995). What did occur during this period was that “the practice of smoking cocaine, formerly restricted to the middle and upper-classes, spread into the inner-city with the increased availability of [crack], a new, less expensive form of smokable cocaine” (Ibid.: 599). The war on drugs received its greatest intensity and its moral urgency from the fact that a new drug had found its way to the “lower colored classes.”
Periods of public alarm over the drug use of nonwhites have occurred repeatedly throughout the social history of the United States. During these drug scares, “‘moral entrepreneurs’ seek to blame a wide variety of social problems on chemical substances and those who imbibe them” (Ibid. : 597). In the 1870s, whites in California claimed that the state’s economic depression could be attributed to the presence of Chinese immigrants and, in particular, to their usage of opium. The image of opium-smoking Chinese in this period “became synonymous with immorality and depravity” (Ibid.: 598). Such racist scapegoating led to the passage of laws that made the use of opium illegal for Chinese-Americans, but not for those defined as white (Neuspiel et al., 1994).

In the 1930s, anti-Mexican sentiment was successfully exploited in the campaign to criminalize marijuana. Many whites in this period believed that “refer mad Mexican bandits” were largely to blame for the era’s skyrocketing rates of unemployment and general social upheaval (Ibid.; Beckett, 1995). Several decades earlier, Jews and Italians were believed to be threats to the moral character of the nation due to their predisposition toward drug addiction (Neuspiel et al., 1994). At the turn of the century, the fear of “the cocainized black” coincided with Southern attempts to strip African-Americans of the political and social gains of the Reconstruction era. The racially motivated anti-drug crusades of the previous 100-odd years share much in common with the war on drugs of the 1980s and 1990s. As in the past,

customary use of a certain drug [has come] to symbolize the difference between [a minority group] and the rest of society…. [It is thought that] eliminating the drug might alleviate social disharmony and preserve the old order (Musto, 1973, as quoted in Neuspiel et al., 1994: 52).

In many respects, the Reagan/Bush-era war on drugs has been a war on communities of color. Racism in current U.S. drug policy is reflected in several arenas. Most notable are the rates of arrest and conviction for drug trafficking and drug usage. Concordant with the Reagan administration’s mandate to combat “street crime,” law enforcement officials have placed greatest emphasis upon the arrest and conviction of “low-level street dealers,” who are disproportionately African American (Beckett, 1995; Neuspiel et al., 1994). Further, though 80% of drug users are white, the majority of those arrested and convicted for drug use are African American (Beckett, 1995). Increased police presence in inner-city neighborhoods, “ostensibly for the drug war — has resulted in a general increase of arrests and terror directed against people of color” (Neuspiel et al., 1994: 49). The rhetoric of “warfare” and portrayal of those who use and sell drugs as immoral social scum has legitimized the escalation of police brutality and harassment in inner-city communities, as well as the abrogation of the civil rights of suspected drug offenders.

Lastly, the tremendous discrepancy in federally mandated minimum sentences for the sale of powder cocaine and for crack (rock cocaine) is a clear manifestation
of the targeting of black drug offenders by the U.S. legal system. In 1986, Congress amended the Comprehensive Crime Control Act (CCCA) of 1984, such that gram for gram, mandatory sentences for possession or sale of crack are 100 times greater than those for offenses involving powder cocaine (Neuspiel et al., 1994; Lieb and Sterk-Elifson, 1995). A federal defendant currently faces five years in prison for the sale of 500 grams of powdered cocaine, 100 grams of marijuana, or only five grams of crack. As one scholar has noted, the CCCA constitutes “an excellent example of institutional racism” (Beckett, 1995: 599).

The war on drugs has helped to legitimize the dismantling of the welfare state and the government’s abandonment of the poor and the nonwhite. During the 1980s, the polarization of wealth in the United States reached an all time high; while the rich got richer, the poor only got poorer. With the restructuring of the economy and the disappearance of industrial wage labor, unemployment rates soared in urban communities. The income gap was further exacerbated by the Reagan administration’s attempt to stimulate the economy by giving tax breaks to businesses while slashing social service programs that might have provided a safety net for disadvantaged Americans (Irwin, 1995).

At this time, anti-drug rhetoric “provided the ideological explanation of why certain segments of the population experienced hardship [while] select privileged groups were amassing more and more wealth” (Ibid.: 632). The message that increasing drug use was responsible for the declining economic and social welfare of the black community diverted attention from the role of factors such as global economic transformations, domestic social policy, and institutional racism (Roberts, 1991; Irwin, 1995; Neuspiel et al., 1994). Politicians found that “criminalizing the poor” was more “politically expedient” than examining the deep social roots of urban problems, creating a national health care system, or investing in the public school system (Beckett, 1995; Neuspiel et al., 1994). Through increased police surveillance and violence, discrimination in drug arrests and sentencing, and locking up pregnant addicts, the U.S. government has waged a war on communities of color and has been able to exert a powerful mechanism of social control over those most likely to rebel against it (Neuspiel et al., 1994).

**Fetal Rights — Rescuing Fetuses from Pregnant Women**

The second political current that has deeply influenced the nation’s response to the problem of prenatal drug use is the fetal rights movement. Improvements in scientific knowledge and technology provided the medical foundation for the development of a discourse of fetal rights. In the mid-1800s, doctors began to position themselves as pregnancy experts, wrestling control of that domain away from female midwives and pregnant women themselves (Krauss, 1991; Beckett, 1995). As the status and power of the medical profession has increased, so has its tendency to distrust the ability of women to make childbirth and pregnancy decisions on their own (Krauss, 1991). Major advances in biomedical technology
in the last 40 years have made it possible to view fetuses in the womb and greatly improved our understanding of fetal developmental needs (Boling, 1995). Yet these developments have also legitimated a vision of the fetus as a “second patient” and reanimated the old patriarchal notion of the mother as “vessel,” who merely provides a host environment for the growing embryo (Beckett, 1995; Boling, 1995). Pro-life ideology has contributed considerably to fetal rights discourse as well. The argument that abortion is murder rests upon the notion that the unborn are human beings who should be accorded a moral and legal status equal to that of the mother (Beckett, 1995).

The language of fetal rights implies that pregnancy is an adversarial relationship involving a “conflict of rights between a woman and her fetus” (Ibid.: 593). Advocates of fetal rights assert that the state has an affirmative duty to protect the unborn from potential (or likely) harm at the hands of the mother, and that once a woman has made the decision to carry a pregnancy to term, she should be legally liable for actions that could result in harm (Krauss, 1991; Pollitt, 1990). The image of women as the loving protectors of their unborn has been supplanted by “the image of the negligent mother whose willingness to support her fetus must be enforced by medical and legal professionals” (Beckett, 1995: 597). Once models of self-sacrifice, pregnant women are now believed to be selfish, confused, potentially violent, and incapable of making responsible choices (Pollitt, 1990). In addition, while women are being sent to prison for their alleged crimes against the unborn, “doctors, judges, prosecutors, and politicians are lining up as fetal advocates and authorities” (Beckett, 1995: 588).

Scholars have observed that as the rights of fetuses have expanded, those of mothers have diminished (Pollitt, 1990; Sexton, 1993). Both in and out of the courtroom, fetal rights are seen to take precedence over those of pregnant women. In some cases, the needs or wants of the mother are treated as an impediment to the more legitimate needs of the fetus.

In addition to legitimizing the imprisonment of pregnant drug addicts, fetal rights arguments have been used to force or coerce women into medical treatment. In the name of their unborn children, women have been made to undergo cesarean sections and other obstetrical interventions. The great majority of pregnant women forced to undergo unwanted medical treatment have been poor, nonwhite, or foreign born. According to a national study of women subjected to court-ordered cesarean sections, intrauterine transfusions, or detained in hospitals against their will, 81% were of black, Asian-American, or Latin American descent, and 25% were non-native speakers of English (Krauss, 1991). Doctors and judges may decide whether to override a pregnant woman’s medical wishes based in part upon their assessments of her competency. This assessment of competency (like the assessment of likelihood of prenatal drug usage) may often be based upon racial, cultural, and class stereotypes. In one case, when a Bedouin woman, believing that she would die, objected to cesarean delivery, a team of physicians explained that
the woman’s refusal “resulted from the mother’s ignorance and prejudice, which prevented her from arriving at an intelligent decision” (Ibid.: 532).

The concept of fetal rights has been attacked from many angles. The most basic critique is that it violates women’s rights during pregnancy, and specifically the right to bodily integrity (in the case of court-ordered medical treatment) and the right to privacy, which includes the decision to bear a child (in the case of pregnant drug addicts) (Krauss, 1991; Garcia and Segalman, 1991; Neil, 1992). During pregnancy, it is argued, fetal rights reduce women to “second-class citizen[s] with constitutional rights inferior to those of men and non-pregnant women” (Krauss, 1991: 539).

Other critiques have been leveled at the very concept of granting rights to fetuses. The centerpiece of the theory of fetal rights is the notion that from the time a woman decides to carry her pregnancy to term, she has a special “duty of care” to her fetus. She must act in such a manner as to ensure the health of her unborn child, or risk legal punishment. The danger in this increasingly prevalent line of argumentation is that, potentially, a pregnant woman could be held legally responsible for any behavior that could harm her fetus. As Lynn Paltrow (1990: 42) of the ACLU points out, “prosecutions of pregnant women cannot be restricted to illegal behaviors because many legal behaviors cause damage to developing babies.” In 1980, the Michigan Supreme Court ruled that “a mother who has taken prescription medication for her own health could be held criminally liable for failing to provide ‘proper prenatal care’” (Beckett, 1995: 594). Other pregnant women have faced charges for consumption of alcohol, failing to follow doctor’s orders, and taking non-prescription valium (Paltrow, 1990; Pollitt, 1990). As long as the rights of fetuses are believed to be morally superior to, and in fundamental conflict with, those of their mothers, pregnant women who are obese, who take aspirin, travel by air, smoke cigarettes, change their cats’ litter boxes, eat junk food, have sex, or fail to stay off their feet “could all be characterized as fetal abusers” (Pollitt, 1990; Schroedel and Peretz, 1995; quote from Paltrow, 1990: 42). In calling for increased governmental regulation of prenatal behavior, the “duty of care” standard seriously threatens to undermine women’s reproductive autonomy.

There are many reasons to suspect that “fetal rights” is driven not by a concern for healthy children, but by a desire to control women (Pollitt, 1990). A universe of factors other than maternal behavior can jeopardize fetal health outcomes; but curiously, fetal rights activists have no interest in them. Outrage at pregnant women who use crack has not been accompanied by a corresponding level of outrage at the fact that many do not have health insurance, or that their children will be forced to live in roach-infested housing, or about the fact that many businesses have abandoned the inner cities. Fetal rights advocates have not campaigned for the building of day care centers in low-income communities, to increase the availability of prenatal care to poor mothers, or to expand eligibility for the WIC food vouchers program.
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Fetal rights theorists also ignore male behavior. Though a woman’s duty to her fetus may be “virtually limitless,” the men in their lives have no corresponding duty of care. This is true despite the fact that a partner or spouse’s drug abuse may itself contribute to neonatal mortality, low birth weight, learning disabilities, and abnormal newborn behavior (Krauss, 1991; Schroedel and Peretz, 1995). Male battering is also a common and serious threat to fetal health. Approximately one out of 12 women are beaten during pregnancy and pregnant women as a group are more likely than non-pregnant women to be beaten by their partners or spouses (Pollitt, 1990; Schroedel and Peretz, 1995).

Furthermore, men who beat pregnant women often aim their assault directly at the woman’s abdominal region, perhaps out of anger at, or jealousy of, the fetus. Battering can cause stillbirths, miscarriages, and other complications. In 1981, Lancet cited a case in which a baby was born “with bruises on its arms, neck, and shoulder, a swollen eye, and intraventricular hemorrhaging,” as a result of prenatal battering (Schroedel and Peretz, 1995: 94). The baby subsequently died from its injuries. In 1990, Dianne Pfannenstiel, a pregnant woman from Laramie, Wyoming, went to the police to file a claim against her husband after being beaten severely. The police brought no charges against her husband, yet Pfannenstiel herself was charged with child abuse upon admitting that she had been drinking (Pollitt, 1990; Paltrow, 1990). As Pollitt (1990: 416) writes, “the threat to newborns is interesting only when it can, accurately, or fancifully, be laid at the women’s doorstep.... If the mother isn’t to blame, no one’s to blame.” Male violence, malnutrition, lead paint, poverty, and racism, are immaterial to fetal rights advocates because they lie outside of the implicitly patriarchal and racist parameters of the fetal rights discourse.

Devaluation of Black Children and Degradation of Black Motherhood

In evaluating the motivations behind fetal rights actions, we must also consider the history of interactions between the government and their most preferred objects of salvation: poor black children. The record of “overwhelming state neglect” of African-American children casts doubt upon the sincerity of claims that the state is only looking out for their best interests in prosecuting their mothers (Roberts, 1991). Until the 1930s, black children were routinely excluded from eligibility for most child welfare services, including adoption and foster care (Hill, 1977). Currently, the slashing of social service programs, lack of concern about the notoriously high rate of black infant mortality (unless it can be attributed to black women’s prenatal drug consumption) and the underfunding of the public school system are indicators of the U.S. government’s continuing disregard for black children. Furthermore, the drive to incarcerate rather than to educate black youth and the iconography of fear of black males that dominates popular imagery reveal society’s disgust for the teenagers that these children will become.
Implied in the extreme demonization of crack-addicted mothers is the unlikely presumption that in-utero exposure to drugs is the greatest harm that drug-exposed children will face in their lives. Prenatal drug prosecutions allow the government to appear concerned about the welfare of black children “without having to spend any money, change any priorities, or challenge any vested interests” (Pollitt, 1990: 410–411). These prosecutions place the blame for the plight of black children and the black community at the feet of African-American women and absolve the white middle class of responsibility or guilt.

Fetal rights discourse champions the rights of the black unborn, but not those of black children, adolescents, or adults. It is particularly not a discourse of empowerment for black mothers. Fetal rights, in fact, “seeks to punish women who fail to act according to idealized concepts of motherhood” (Beckett, 1995: 589). Women who are poor and nonwhite (or homosexual) are the least able to conform to white middle-class standards of motherhood (Roberts, 1991).

The tendency to blame black women for the problems of the black community has a long history in American society. The most notable example in recent years is the infamous “Moynihan Report.” In this 1965 essay, sociologist Daniel Patrick Moynihan argued that domineering, matriarchal black mothers created emasculated black men who would fail in school, abandon their families, and be unable to succeed economically. Patricia Hill Collins writes that the black matriarchy thesis:

allows the dominant group to blame Black women for the success or failure of Black children...diverts attention from the political and economic inequality affecting Black mothers and children, and suggests that anyone can rise from poverty if he or she only received good values at home (Collins, 1990: 74).

The image of the black matriarch has lately been supplanted by that of the single black mother. With his 1984 book, Losing Ground, sociologist Charles Murray helped to validate stereotypical perceptions of the black “welfare mother” who “breeds” babies in order to increase the size of her government check and to avoid having to work. At the close of the 1990s, such images of black motherhood are as prevalent as ever. Patricia Williams argues that “the signifying power of the black single mother...as poor, drug addicted, and natally absent...is integral to the public articulation of fetal harm and abuse” (Bower, 1995: 144). On television talk shows such as Riki Lake, Jenny Jones, Richard Bey, and Jerry Springer, young women of color are routinely characterized as irrational, immature baby machines, who practice irresponsible sexuality and are scarcely fit for parenthood. Their multiple illegitimate children, it is frequently claimed, place a severe drain on the welfare system and thus heavily burden the nation’s economy. According to contemporary imagery, the fertility and sexuality of poor black women are “unnecessary and even dangerous” to the nation (Collins, 1990:
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76, and associated with disease, "pollution," and the downfall of Western civilization (Bower, 1995).

In this vein, scholars have argued that what many poor black women are being punished for is not any actual harm done to fetuses, but the crime of getting pregnant while addicted (Paltrow, 1990; Roberts, 1991; Krauss, 1991). It is the addict's decision to carry her pregnancy to term that results in criminal liability (Young, 1995). If she obtained an abortion, or had never been pregnant, there would be no case against her. Further, women who do not habitually engage in prenatal behaviors deemed actionable by the state do not face the prospect of jail upon conception. What appears as outrage that pregnant women use crack, then, is in fact outrage that crack addicts bear children.

According to Roberts (1991: 1472), "the value we place on individuals determines whether we see them as entitled to perpetuate themselves in their children." Like enforced sterilization, fetal endangerment prosecutions reflect society's judgment that poor, addicted African-American women do not deserve to become mothers (Ibid.). American society stigmatizes the pregnancies of all poor black women and it criminalizes those of poor black crack-addicts. In selecting crack-addicts for special punishment, the courts, health care providers, and the press are saying: "We don't particularly need any more of these people or their offspring. They are utterly unfit for motherhood and the damaged, subhuman children they produce will most likely become the nation's financial burden and later its criminal element."

It is curious to note that many of those who lament the tragedy of drug-exposed children apparently care nothing about the tragedy of their mothers. Yet,

pregnant women who are drinking excessively, abusing drugs, smoking, or eating inadequately are first and foremost hurting themselves.... In our rush to blame women for their failure to take care of others we are missing the point that they have never been encouraged to "selfishly" care for themselves (Paltrow, 1990: 45).

In deciding that the best way to deal with the problem of drug-addicted babies is not to empower, but to punish their mothers, society is blind to the fact that their fates are inextricably intertwined. Locking a woman behind bars and castigating her in the press does little to prevent her child from having to face the same conditions (poverty, racism, gender oppression, and sexual violence) that likely contributed to her addiction. Who is to say that the addict's daughter will not have the same fate and become a scorned and degraded pregnant addict herself? When and why does that black girl child change from being among the most innocent to among the most guilty?

The primary utility of stigmatizing and punishing poor drug-addicted black women lies not in the prevention of fetal harm, but in the defense of normative standards of gender and motherhood, the resuscitation of public innocence
concerning the plight of the black poor, and the legitimization of a status quo characterized by continuing oppression and inequality. With reflection upon the real imperatives driving the criminal prosecution of crack-addicted mothers, policymakers might begin to devise programs that empower pregnant addicts and allow them to be good mothers to their children. The policies pursued thus far have done little good for crack-exposed babies and have only helped undermine the fragile world into which they were born.

NOTES

1. All mothers in the study used cocaine and most also used other drugs during their pregnancies. Griffith’s recent research was conducted with a study population in which several prenatal risk factors had been eliminated: while pregnant, expectant mothers received prenatal care, nutritional counseling, and therapy for chemical dependency.

2. Infants born prematurely have increased risk of breathing difficulties, brain hemorrhage, and mental defects. Babies born underweight are 40 times more likely to die than are normal-weight babies and 10 times more likely to have cerebral palsy (Appel, 1992). The black infant mortality rate in 1987 was 17.9 deaths out of 1,000, compared to a white infant mortality rate of 8.6 per 1,000 (Roberts, 1991).

3. As of 1993, the states of Georgia and New York had instituted mandatory reporting requirements, yet had allocated no funding for treatment of perinatal addiction (Sexton, 1993).

4. In 1988, Minnesota became the first state to include perinatal drug use in its legal definition of child abuse. Since that time, observers have claimed that despite the fact that the revised law does not call for criminal sanctions against prenatal drug abusers, it has deterred pregnant addicts from seeking drug treatment and from disclosing their drug use to their doctors (Sexton, 1993; Paltrow, 1990).

5. This is primarily by adversely affecting the quality of the sperm and through the mother’s inhalation of second-hand smoke from cigarettes or illegal drugs.

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