

Guilt, Healthcare and Profit

**Guilt, Healthcare, and Profit:
Cultural and Media Influence over Parents' Choices**

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It is obvious to even the most casual observer that today's young adults, born in the 1970s and '80s, have grown up in media-dominated culture, laden with all kinds of advertisements and imagery. Whether the advertisements are for breakfast cereal, the latest toy, "cool-brand" clothes, cars, or beer, many of them include the implied but obvious message that buying the advertised product will make one "cool" or popular; and perhaps even more importantly, protect one from a feared label like "geek" or "nerd." That these young adults and we, their baby-boomer parents are profoundly influenced by, and respond predictably to such advertising and imagery is proven by the fact that American industry is projected to spend over \$280 billion next year in an effort to influence our buying decisions ("Spending on Advertising," 12/07/04). It comes as no surprise then, that governmental, quasi-governmental and private health agencies would employ similar methods to influence healthcare choices, as demonstrated in the familiar ad campaigns that remind us to "just say no," or that "friends don't let friends drive drunk." Now these young adults are becoming parents themselves. For most parents, the desire and willingness to spend money to be "cool" is far subordinate to the desire to have a healthy child. But healthcare and parenting choices are far more complex than the jeans they wear or the car they drive. Many of the "routine" choices parents must make also have risks that are rarely *mentioned* in the pediatrician's office, let alone fully disclosed and discussed. Most importantly, there is a *child* who is affected by the

parent's decisions. This paper explores and examines how fear and guilt are used, and full disclosure of risks and benefits withheld, to manipulate parents' healthcare choices.

The use of fear and guilt are standard mechanisms in the world of advertising. The two can be identified as utilized with similar frequency in magazine advertisements (Huhmann & Brotherton, 1997). As we begin discussion on how these tactics are applied to young parents' healthcare decisions, it is instructive to briefly highlight the distinctions between the two. According to Huhmann and Brotherton (1997),

...guilt is the primary motivational factor in a mature conscience (Izard 1977)...Guilt differs from fear in that guilt is an internal emotional response following the violation of a standard or the contemplation of violating a standard, whereas fear is an a priori anticipation of an external punishment or threat (Ghingold 1981; Rawlings 1970). Guilt and fear also differ in terms of the individual's level of control. Guilt is likely when one has some control over a situation, whereas fear occurs when one has little, if any, control over a situation (Burnett and Lunsford 1994). In addition, guilt and fear have different outcomes. Guilt compels one to make retribution for a transgression, whereas fear compels one to avoid an unwanted outcome (Gingold 1981).

Because varying locus of control is integral to the experience of parenting, new parents can be expected to be especially vulnerable to the

emotions of fear and guilt as they make healthcare choices for their newborns.

In their extensive research of the literature, Huhmann and Brotherton (1997) find three types of guilt identified: reactive guilt, which is a response to one's behavior that violates one's own standards; anticipatory guilt, which is experienced as one contemplates a potential violation of internalized standards; and existential guilt, which is experienced as a result of the awareness of a discrepancy between one's well-being and the well-being of others.

An example of reactive guilt in health advertising would be a pregnant woman smoking. The guilt appeal is reactive, targeting the pregnant woman who smokes and knows that she shouldn't, reminding her of the harm she is inflicting on her unborn baby (assuming, of course, that her standard is a healthy baby).

Examples of anticipatory guilt appeals are most common in vaccine advertisements, which aim to convince parents that failure to vaccinate their child will potentially result in their child contracting the disease(s) against which the vaccine(s) will purportedly protect. Parents who want to do the best for their child will be affected by anticipatory guilt.

Existential guilt appeals are most commonly found in ads promoting charitable activities or donations for victims of poverty or disasters rather than ads attempting to influence health behavior or choices, and are therefore not relevant to this discussion.

Huhmann and Brotherton (1997) find that of the three kinds of guilt appeals, anticipatory guilt appeals appeared most often in magazine ads for consumer goods, and that the most commonly used guilt statement was a statement of fact. They also found ads combining a verbal guilt-message (a negative but preventable circumstance) with a visual image of the potential victim of that circumstance, designed to elicit a sympathetic or nurturing response (such as a baby or a puppy.) I found that to be true with health behavior ad campaigns, as well. Examples will be discussed and referenced here.

In the United States, the Ad Council is the primary producer of public service announcements (PSAs). Much of their work is done in co-operation with the Department of Health and Human Services and non-profit organizations. Their stated mission is “to identify a select number of significant public issues and stimulate action on those issues...to create awareness, foster understanding and motivate action” (Ad Council, 2003, “Frequently Asked Questions”). In an article discussing their own research, they state, “The results conclusively show that public service announcements are an effective means of communication and education, as they increase awareness, re-inforce (sic) positive beliefs, intensify concern and move people to action” (Ad Council, 2003, “Impact of Public Service Advertising Campaigns”). While many of their ads are educational or inspirational, one can find quite a collection of guilt appeal ads on their Web site, many of them aimed at parents. At the click of a mouse, one can

view ads to see the tragic consequences of drunk driving, including pictures of children and young adults killed; the consequences of inadequate prenatal and early childhood nutrition: a little girl who can't remember the words of a common childhood song; famous figures asking the viewer questions about themselves that are common knowledge to regular TV audiences, then asking if they know the same things about their children (Ad Council, 2003, "Campaigns").

As we see from the ads described above, public service announcements seem to be distributed over a continuum of education-persuasion/inspiration-fear-guilt. PSAs unrelated to health issues are generally educational and persuasive or inspirational. If related to health or disease prevention, they often move along the continuum into fear and/or guilt. In most cases, it's very difficult to make a distinction between them: what frightens one person may not frighten another, and what evokes feelings of guilt in one may not do the same in another. There can be little question as to the guilt appeal of an ad saying, "Each night millions of kids go to sleep starving. For attention from their dads" (Ad Council, 2003, Campaigns, "Father Involvement"). The problem is, as one of my colleagues wryly observed, that the dads who *should* feel guilt reading that ad, probably won't. Conversely, reading the known risks of formula feeding may evoke feelings of guilt in a mother who didn't breastfeed, perhaps in part because she had only been presented with breastfeeding's benefits, and not the risks of formula. This was an issue between the Ad

Council and the American Academy of Pediatrics in the recent “Babies were Born to be Breastfed” campaign. Upon learning that the campaign would portray formula feeding as a risky practice, the AAP responded with concern for non-breastfeeding mothers’ potential guilt feelings (O’Mara, 2004). There was no similar concern expressed by the AAP in the nutrition ads promoting WIC (Women, Infants and Children) services or in warnings against smoking or alcohol consumption during pregnancy, or booster seat education.

This brings us to a closer examination of the messages and the facts behind them. Some of the issues are obvious, with compelling conclusions drawn from existing research, as in the cases of smoking and alcohol consumption during pregnancy, and breastfeeding vs. formula feeding. Other issues are debatable, with different researchers coming to different conclusions or whose research leads them to ask new and different questions, as is the case with co-sleeping and vaccines.

First among the obvious issues is smoking during pregnancy. In all of my searching of the literature, I could find no debate on the risks, and of course, no benefit to the practice. The Department of Health and Human Services Office of Women’s Health sponsors a Web site titled “The National Women’s Health Information Center,” where simply typing in a search for “smoking and pregnancy” produces publications from the Center for the Evaluation of Risks to Human Reproduction, the American College of Obstetricians and Gynecologists, the Center for Disease Control, and the

March of Dimes, all warning of the risks to both mother and child of smoking during and after pregnancy. The descriptions are detailed and explicit. Such information is educational, but could also evoke feelings of fear in women whose environment makes it difficult or impossible to avoid second hand smoke – or feelings of guilt in women who still smoke. The comprehensive descriptions, devoid of hyperbole, present the facts, which speak for themselves and lead one to a compelling conclusion. A guilt response from a pregnant woman who smokes would be a healthy sign of a mature conscience.

The same is true of alcohol consumption during pregnancy. The same organizations listed above, plus the National Institute on Alcohol Abuse and Alcoholism, offer gut-wrenching descriptions of Fetal Alcohol Syndrome, a tragic consequence. As with smoking, there is no “up-side” to alcohol consumption during pregnancy. Clear messages are appropriate.

With regard to breastfeeding, this same Web site (DHHS, “The National Women’s Health Information Center”) lists references stating that breastfed babies have less diarrhea, ear infections, respiratory illness and obesity (“Science Behind the Campaign” 2004). Another article on this Web site states further, “Breastfeeding lowers the risk of breast and ovarian cancers,” and lists health and emotional benefits to mother and baby, societal and environmental benefits, and refers the reader to many breastfeeding publications, several of which describe in further detail the

risks of formula: more respiratory illnesses, higher incidence of juvenile-onset diabetes, lower IQ, and increased incidence of obesity (“Benefits of Breastfeeding” 2004). These are just a few of the risks which exist when the formula is uncontaminated, correctly mixed with pure water, and bottles sufficiently cleaned. The human factors of contaminated formula or water and bottles or nipples not sufficiently cleaned present additional risks to the health of the formula-fed baby.

Repeating much of the evidence suggesting that the case against formula is as clear as the case against smoking and drinking, this Web site also gives a detailed presentation of the differences in the cardiovascular health of formula-fed teens compared to their breastfed peers (“Breast-Feeding May Protect Against Heart Disease” 2004). The evidence is stark and compelling. But the article ends with the following: “But if a mother can’t *or doesn’t want to* breastfeed, that doesn’t mean she’s a bad mother” (emphasis mine). Of course, no one would fault the mother who really *couldn’t* breastfeed due to extenuating circumstances, physical anomaly, previous mastectomy, disease requiring contraindicating drugs or in the case of adoption. But the break in logic is clear: there is no similar statement about smoking or drinking during pregnancy, such as, “But if a mother can’t or doesn’t want to quit smoking (or drinking), that doesn’t mean she’s a bad mother.” Why the different treatment of breastfeeding? Breastfeeding’s challenges are generally much milder and of shorter duration than those of quitting an addiction such as tobacco or alcohol.

If the logic regarding the guilt issue begins to soften in the obvious cases, it only gets worse in the debatable cases as in co-sleeping and vaccines.

Regarding co-sleeping: the Web site of The American Academy of Pediatrics, there is a news brief on studies published in the October 2003 issue of *Pediatrics*, “The peer-reviewed, scientific journal of the American Academy of Pediatrics,” stating, “The suffocation risk for infants is 40 times higher in an adult bed than in a crib, according to the study.” Their Web site also offers a link identified as “SIDS Fact Sheet” which leads to a document titled “Reducing the Risk of SIDS in Child Care,” where a list of instructions is given, instructing parents and daycare providers on sleep position, what to put in a crib, what to keep out, and at what age a child no longer must be supervised during sleep (who does that, anyway?). Parenthetically, the very last item on its list is “Support parents who want to feed their children human milk (breastfeeding).” That statement, while offered in the context of sleep position, reveals an incredibly strong bias against breastfeeding in two ways: first, the message implies that parents who want to feed their children “human milk” are somehow not the norm; why else would daycare workers be explicitly asked to support them? Secondly, the act of feeding a child human milk is subsequently defined as breastfeeding. Are they, and do they assume their readers are so unfamiliar with breastfeeding that it must first be described as “feed(ing) their children human milk,” and *then* given a word?

There are links between the AAP and many other child-health websites, including “KidsHealth for Parents,” sponsored by the Nemours Foundation, where in an article titled “Cosleeping,” the following statement can be found:

An AAP policy statement says that although cosleeping *may have* benefits (such as promoting breast-feeding), there are no scientific studies suggesting that it reduces SIDS. In fact, the opposite *may be* true. The AAP says that *some studies suggest that under certain circumstances, co-Sleeping may increase the risk of SIDS.* (emphasis mine)

No politician’s top speech-writer could have done a more masterful job of saying nothing. The initial reading implants the thought that co-sleeping *may increase* the risk of SIDS – and what parent wants to take that chance? So the “may” part is forgotten. A closer examination of the message would reveal that it offers *no* real information, but only a lot of qualified suggestions.

“Solitary infant sleeping is a principally western practice which is quite young in terms of human history” (Breaseale, 2001). In her internet-published master’s thesis, Tami Breaseale examines the issue from an anthropological perspective, where she also finds that co-sleeping is the cultural norm for approximately 90% of the world’s population. She goes on to discuss and address the concerns voiced in the widely published warning against co-sleeping issued by the Consumer Product Safety Commission in 1999, and informs her readers of what was left out:

“Neither media announcement mentioned the 2700 infants that died in the final year of that study of Sudden Infant Death Syndrome (SIDS), formerly called ‘crib death’; the vast majority of those infants died alone in their cribs (Seabrook, 1999).” Of course, no mention is made of the guilt felt by the parents of *those* babies.

The logical question that follows then is, “Why did the CPSC leave such important data out of their report?” Possible answers to this question will be presented later.

Arguably, one can find no area where the guilt card is more aggressively played than in the area of childhood vaccinations. As one who elected against vaccinations for my youngest son after examining the evidence and politics behind the issue, I have first-hand knowledge of the scare tactics, intimidation and attempts at coercion to which parents making this decision are subjected. The debate on the advisability of vaccines is beyond the scope of this discussion. I would refer the interested reader to begin his or her own investigation at “Think Twice,” the Web site of the Global Vaccine Institute, where thorough research and discussion is posted.

Vaccine advocacy can be found in government, non-profit and private organizations. *Every Child by Two* is a non-profit organization founded by former first lady Rosalynn Carter and former Arkansas first lady Betty Bumpers. According to their Web site, they are focusing their efforts on promoting immunization registries. It goes on to say, “To

forward our agenda, ECBT has enlisted the co-operation of gubernatorial and congressional spouses, elected officials, concerned community leaders, grass-roots organizations, coalitions and representatives of many national organizations” (“The Birth of Every Child By Two,” 2005). Rare indeed is the parent who can stand against all that “co-operative power.”

The World Health Organization (2003) also advocates for vaccines, and states their agenda as follows:

Advocacy is best described as those activities designed to influence policy and decision makers, to *fight for social change, to transform public perceptions and attitudes, to modify behavior, or to mobilize human and financial resources. Such activities are vital if immunization is to be maintained...There is irrefutable evidence that vaccines save lives...* (“Immunizations, Vaccines and Biologicals, 2003).

The logical questions in response to the above are: Since vaccines have been an accepted part of American culture and health care since the first half of the last century, why the need to “fight for social change, to transform public perceptions and attitudes, to modify behavior, or to mobilize...resources?” And why are such activities “vital” to maintain vaccinations? Perhaps because of opposing data and research at “Think Twice” as well as the Website for the National Vaccine Information Center, the statement “There is irrefutable evidence that vaccines save lives...” can be exposed for what it in fact is: editorial.

The fact is, the government's own Center for Disease Control Web site informs the public that each year there are 10,000-12,000 reports made to the Vaccine Adverse Event Reporting System (VAERS), and that 20% of them are classified as serious, causing disability, hospitalization, life threatening illness or death (*Overview of Vaccine Safety, 2004*). Its own statement, "At present, the VSD [Vaccine Safety Datalink] project is examining potential associations between vaccines and a number of serious conditions" is followed by a description of the Vaccine Injury Compensation Program, which covers "all routinely covered childhood vaccines." It also discloses the fact that settlements are based on the Vaccine Injury Table developed by a panel of experts who reviewed the literature and "identified the serious adverse events that are reasonably certain to be caused by vaccines...injuries include anaphylaxis, paralytic polio and encephalopathy..." (ibid 2004).

Again, the purpose here is not to debate the safety or advisability of vaccines. Rather, to juxtapose the above listed risks to which the CDC admits; governmental, non-profit and private advocacy of the vaccines, including verbiage designed to intensify a parent's fear of the disease against which vaccines are offered (remember when chicken pox was a disease mothers *wanted* their children to get?); the guilt messages targeting parents' healthcare choices that have been described and referenced here; the evidence of the benefits of breastfeeding and the risks

of formula, and the sudden concern for the possibility of guilt feelings in the parent who received full information about those risks.

What evidence does the AAP have to suggest that encouraging parents to review evidence on both sides of an issue will cause them to feel guilty? Or that keeping information from parents will protect them from guilt? Is guilt really the issue after all?

ABC's news magazine, *20/20*, explored the profit motive that drove the political pressure to modify and stall the "Babies were Born to be Breastfed" campaign, explaining how the ads were "watered down" prior to their release last June (Ross & Rackmill, 2004). Katie Allison Granju (2003) presents an exhaustive examination of the issue in her article "The Milky Way of Doing Business." These are just two places in published literature where political power, profit, fear and guilt all come together and the question becomes, "Who pays and who profits from fear and guilt-inspired health choices?" Provocative answers are proposed.

As a childbirth educator, I occasionally discuss with my colleagues our charge to promote "freedom of choice based on knowledge of alternatives" (ICEA, 1995). Why should we expect any less from our healthcare providers? Without knowledge of alternatives, including the risks and benefits of "routine" practices, "choice" becomes a meaningless word. Fear and guilt appeals subvert parental empowerment by manipulating parents' healthcare choices for their infants. Such manipulation is so common and accepted that it is scarcely even

recognized for what it is. It is time that our healthcare authorities and providers accept a similar charge to at least provide parents with information resources that examine all the options, and let *them* decide.

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