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**Flying with the Storks:
Communication, Culture, and Dialoguing Knowledge(s) in Prenatal Care**

A Dissertation Presented

by

LILIANA L. HERAKOVA

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2014

Communication Studies

**Flying with the Storks:
Communication, Culture, and Dialoguing Knowledge(s) in Prenatal Care**

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LILIANA L. HERAKOVA

Approved as to style and content by:

Leda Cooks, Co-Chair

Claudio Moreira, Co-Chair

Aline Gubrium, Member

Erica Scharrer, Department Head
Department of Communication

DEDICATION

To my family.

To children.

To listening.

ACKNOWLEDGEMENTS

This text would be empty without the voices in it, as perhaps any text would. The voices in here weaved themselves in, each in a different way, each by a different path. It would be tempting to say that the voices are only those of the men and women who graciously shared their time and stories with me throughout the years - in random meetings, as well as in structured interviews. My first deep thank you goes to you.

Other voices are in here, too - maybe not in a concrete story, but in every line and between the lines. Leda (Cooks) and Claudio (Moreira), thank you for years of friendship, mentorship, and intellectual vigor. Thank you for being different, for listening, and for talking. Thank you for opening an academic space from wherein I can look at what we do with new theoretical and methodological lenses. And thank you for inviting me in that space, for letting me crash on your intellectual couches, and supporting me in every way possible as a scholar and as a mother. Aline (Gubrium), this text won't be what it is without you. I will always appreciate your perspective as a public health scholar and a scholar of culture. You will also always be my inspiration for mothers in academia. And without you I am not sure I would have believed this text has any real implications outside of communication. Thank you for giving me that confidence and for asking the critical questions of application. Colleagues and friends at the UMass Department of Communication - Erica, Dijana, Ellen, among others who are too many to mention - it hasn't always been easy, but our conversations have sustained me, challenged me, build me up. There are not enough words of appreciation for that.

Finally, my own voice will not be heard were it not for the voices of those whose love has pushed me, driven me, and held me safe and powerful since I was a child. There

are two people who will never hear my thank you, but whose voices, in some way, continue on through me - to my departed grandparents, *баба Милена и дядо Петър*, thank you for the immense gift of loving language and seeking poetry in everyday life. To my living grandparents, *баба Лили и дядо Стоян*, thank you for the lessons in perseverance, humbleness, simplicity, and honesty. *Мамо, татко, батко - без думи, но толкова дълбоко* - it is because of you that I learned what it means that "a person cannot dream of a better family." I can only dream to be that family. To my nephews - *Мику и Илия* - thank you for the hope, for the smiles, for asking about me.

Lest you think you're forgotten, my loves - Remi and Sammie - there is no world, no words, no meaningful silences without you. Thank you for being patient in the long months of writing. Thank you for always expecting me when I emerged out of them. Thank you for keeping me grounded and dreaming at the same time. For believing in me, of course, more than I believe in myself. Most importantly, thank you for us. You are literally in every word in and behind this text.

ABSTRACT

FLYING WITH THE STORKS: COMMUNICATION, CULTURE, AND
DIALOGUING KNOWLEDGE(S) IN PRENATAL CARE

MAY 2014

LILIANA L. HERAKOVA, B.A., CONCORDIA COLLEGE, MOORHEAD

M.A., NORTH DAKOTA STATE UNIVERSITY, FARGO

Ph. D., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor Leda Cooks and Professor Claudio Moreira

Approximately 6 million women in the U.S. become pregnant every year. Over 4 million give birth. Over 1 million babies annually are born with low birth weights or prematurely - phenomena, statistically linked to both lack of "adequate" prenatal care and to worsened health outcomes (www.americanpregnancy.org). Additionally, maternity "care" in the U.S. has been called a "human rights failure" (Bingham, Strauss, Coeytaux, 2011, p. 189), referring to the trend of increasing maternal mortality, despite the fact that child-birth related expenses in the U.S. are the highest healthcare expense in the country and are also much higher compared to other "industrialized" countries.

In this context, the dissertation presented here looks at the construction and negotiation of pregnancy and prenatal care knowledge. Fusing performative, narrative, autoethnographic, and dialogic methodologies, the text looks at and performs interpersonal interactions occurring in varying contexts of pregnancy. The dissertation puts different voices and cultural knowledges in dialogue with one another in order to explore the communicative construction of dominant/authoritative knowledge (Jordan,

1997) and the subjugation of other knowledge streams. I look at health and health care as everyday phenomena, not limited to clinical contexts. Finally, based on this consideration, I propose a relational model of health communication.

The dissertation begins with an overview of the conceptualizations and applications of culture in health communication. It, then, summarizes critical ethnographic and performance methodologies, considering their potential contributions to health communication research. In the first substantive chapter, I first explore the dialectical tensions (Baxter, 2011) that nuance narratives of pregnancy and prenatal care, exploring what dominant and marginalized discourses of pregnancy they voice. Next, I look at affect as relational and as shaping pregnancy knowledge and practices. Finally, I consider the interplay of structures and agency as pregnant women, their families, and prenatal care providers engage in everyday practices of care.

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CODA UPFRONT

(OR WHAT DO YOU CALL THAT?)

These reflections are coming up for me at what would hopefully be the "final" stages of writing/drafting this dissertation text. But they *should* be read first, so I'm turning the thing upside down to recognize that what comes at the "end" is a beginning. I am grateful for that.

In the process of thinking and writing this dissertation, I was often frustrated - I knew what I should do to get it done quickly, but I couldn't bring myself to doing that. I knew and know how to write a (fairly) clear thematic analysis of interview/narrative data. I knew and know that based on such an analysis, I could and should list implications for practitioners of prenatal care, including pregnant women, their families, partners, friends, and formal prenatal care providers. I knew and know how to recognize, guard against, and address the limitations of the sample, of the geographic location, of my own "biases." And throughout those typed data, implications, and recognitions, I would talk about how important this actually is - yes, even in the U.S. context, where after all:

(...) United Nations data show that between 1990 and 2008, while the vast majority of countries reduced their maternal mortality ratios for a global decrease of 34%, maternal mortality nearly doubled in the United States.¹ For a country that spends more than any other country on health care and more on childbirth-related care than any other area of hospitalization — US\$86 billion a year — this is a shockingly poor return on investment.^{3,4}

*Given that at least half of maternal deaths in the United States are preventable,⁵ **this is not just a matter of public health, but a human rights failure.**⁶ (Bingham, Strauss, Coeytaux, 2011, p. 189; emphasis added)*

I am doubled-over under a burden of suspicion that the above may actually be true.

Under the pressure for interventions against interventions, under the pressure for solutions, measurements, and outcomes that validate interventions, under the pressure to

produce a text with clear answers that clearly promise positive differences, I doubled over and inside, longing for the human in rights.

Thinking and writing this dissertation has been and continues to be profoundly transformative (for me), as I continue to push myself to rehearse and then delicately abandon theories and methods I (thought I) have learned in seven years of graduate education in communication. It has been an exercise in exhilaration, confidence, insecurity, and humility - constantly moving between the poles of Remi's equally helpful reminders:

"no one could have told Neo [from The Matrix] that's he's the one, he had to find out for himself"

and

"you're a privileged woman for being able to turn down the text you know you can write quickly for the one you want and believe in."

Educationally, this dissertation has asked me, moved me to put down on paper and then carefully distance myself from aspects of theories (e.g., critical and feminist) and methods (e.g., ethnography and narrative analysis), while coming closer to other aspects of these same theories and methods. It has asked me to reconsider what I have learned, how I think, and where could I go from here. It has moved me. Can a student ask more of a text? Perhaps... to move others, to make a difference for/in the lives of others... I am also a text.

I started this project thinking that it would "explore" *what are the knowledges of pregnancy and prenatal care and how knowledge moves among people*. How does communication (as used by individuals) construct and navigate those knowledge streams

to build identities and realities, what is made possible, what is invisible, and what sort of meanings of pregnancy, parenthood, family, care are made real, available? Parts of those questions, and parts of their answers are still frayed in the dissertation. But now, the thread that holds it all together, is, I think, about *how knowledge moves us* in relation to one another and our senses of humanity. Communication - practices of talk, movement, listening, and silences - is still constitutive, perhaps more fundamentally so in/with this focus.

This is communication. And getting here, as well as out of here, is a process. A process that has asked me continuously to face how I relate to others and what worlds does that create. Looking at one's child, at my child - however little he may have grown up (it still seems like a lot) - a parent is perhaps faced with that question always. I think I am, though sometimes I don't want to be, and I know that our Sammie has his own creative prowess. But I want him to ask - how do I relate to others and what are the worlds that we make?

I believe this text is fundamentally about relating. Some may say that stating this is a discovery of self - that this is my own deep existential question and now I, narcissistically, impose it on this text and its readers. Relationality *is* my orientation. And, I guess, even a political goal of sorts. But this text is hardly, I hope, a finality, as discoveries are often made to be. Finality refuses relationality. This text is a process. And though I often struggled with the methodological implications of this, though I struggled with the paradigm that expects a clear statement of discovery, though I struggled with the desire and impulse to fulfill this paradigm, evaluating the process itself as non-research worthy of reporting, this text is a process you are invited in. Relationality.

PROLOGUE

Random First Page of an Unfinished Journal...

Attempting to perform how prenatal knowledges and pregnancy experiences are relational, continuous, disturbing linearity of time and space & how, when and if the time comes they shape pregnancy practices and identity construction during pregnancy

February 14, 2009. Visiting my husband's family in Worcester, MA. It was his aunt and uncle's wedding anniversary and family had come from all over the East coast. Their family had immigrated to the U.S. from Poland in the early years after the "end" of communism and, from what I understood, celebrations in Worcester were kind of family reunions. That day we were also celebrating the 80th birthday of one of the grandmas. Sitting at the head of the table, she received a greeting card from a blond Polish granddaughter and her husband – a white U.S.-born physician. The card sang happy birthday joyfully, but the bigger "present" was inside it – an ultrasound picture of a great-grandchild to be. I was sipping wine that lost its sweetness.

"trying" for almost three years.

Trying and preparing

Doing the right things

stop smoking

start prenatal vitamins

make time when there's no time

try not to think about it...

... too much

At the “prime” of our reproductive age

Reading and dreaming

preparing my body with patience

being a good mom before it’s even began

Ritualizing prenatal vitamins and calendars

trying “not to try”

just having fun in bed –

love, I know it hurts you, too – the waiting

knowing, as it were, that there’s more to me than

being

a mother

and more to us than being

parents

But it doesn’t feel, it doesn’t hurt, it doesn’t smile

that way

Though we were pregnant then

We didn’t quite yet know it

February 14, 2009

We were pregnant long before my body was

And *that* we knew

between the two of us

Introduction and Rationale

In my own understanding of good fortune, I am lucky enough to have birthed a child and to continue becoming a mother every day. Becoming a mother began long before the much-awaited plus sign on a generic pregnancy test. But my sensitivity to this process-of-becoming grew with my belly – larger and increasingly more public. And now that my belly has subsided to its previous dimensions, it grows with my child. Much has been written – in scholarly and lay outlets, on the blogosphere, internet forums, and advice columns – about the unsolicited professional and strangers’ advice to and interest in the pregnant female. And although perhaps much more hushed, there is just as much social interest in the non-pregnant and never-pregnant female, especially after a certain age. Pregnancy is an expectation in more than one sense. One can argue that the experience of pregnancy is ubiquitous even in the face of phenomena such as age-related infertility (ARI) and purposeful childlessness that have recently received more attention by feminist scholars of reproduction than ever before (Bute, Harter, Kirby, & Thompson, 2010; Foster, 2010; Hayden, 2010) – ubiquitous because during our life time it will inevitably happen to people around us, people who may be close to us, if not ourselves; ubiquitous because the cultural narratives of pregnancy are part of our social landscapes whether we ourselves get pregnant or not; ubiquitous because pregnant or not, we participate in the writing and re-writing of these narratives.

Ubiquity, however, hardly means simplicity or lack of complexity; it hardly means obviousness or one single thing. To the contrary, critical considerations of ubiquitous social processes, such as pregnancy, can bring about the dialogic complexity of cultural scripts that are otherwise veiled behind assumptions of naturalness (Mazzoni,

2002) – i.e., allows us to problematize the idea that the “natural birth” movement is culture- and ideology-free because of its (rhetorical) association with nature. Such considerations allow us to focus on the intersections of (cultural) norms and (subjective) affect as they shape diverse experiences of the “same” ubiquitous process. How is power coded and transformed in cultural scripts of prenatal care and pregnancy? How are social knowledges constructed, sustained, and changed in and by such scripts? How do such scripts shape social relations?

Because I experienced pregnancy and prenatal care in a cultural environment markedly different from the one I grew up in, I was perhaps extra sensitive to these questions. In between here and there, then and now (Diversi & Moreira, 2010), I could not ignore to invisibility the norms of neither here nor there, neither then, nor now. The dialogues between scripts I grew up with and scripts I was now encountering in a “foreign” land were loud, as I was trying to fit in and make sure I was being perceived as good and knowledgeable (future) mother both here and at home. Of course, I wanted to, still want to, be a good parent for my child (not just to appear as one) – the point is that during pregnancy to a large degree the confirmation of my goodness came from the positive evaluations of those who cared for me and had more expansive prior experience with pregnancy. These included occupational “professionals,” such as OBGYNs, midwives, and nurses, and experiential “professionals,” such as my mother, grandmother, friends, and other women, some of whom were also occupational “professionals,” who have carried and birthed before.

In this project, I critically question the construction of individual and communal prenatal knowledge(s) and, in the process, of the pregnant subjectivity. Starting with and

reflexive of my own experience, I explore how discourses that circulate in interpersonal relationships (Baxter, 2011) – as sites where multiple knowledges dialogue with each other – shape the necessary complexities of pregnancy and prenatal care. For example, how do the narratives told by pregnant women and their partners discursively negotiate the dynamics between culture-specific knowledges and scripts they/we have grown up with, on one hand, and biomedical knowledge in the U.S., on the other? Furthermore, how are such culture-specific knowledges discursively negotiated in the narratives of prenatal care (medical) professionals? More importantly, how do those narratives of knowledge negotiation construct social realities? Who do they position as belonging within pregnancy and prenatal care and how? What are some of the meanings, structures, identities, and relationships produced in such negotiations? Throughout, I use "knowledge" in a broad sense to include both specific and localized prenatal care practices, as well as the positioning of these practices vis-a-vis larger cultural structures, assuming "knowledge" of such structures.

Informed by transnational feminist thought and critical health communication research, I am interested in processes of shifting and establishing knowledge boundaries around, through, and within affinity networks¹ and the cultural discourses circulating in and among such networks. Thinking of the mundane experiences of pregnancy and prenatal care alongside and in dialogue with more ritualized clinical interactions during

¹ I am not guided in my use of this term by the fairly rigid, predictability-oriented method of social network reality. I use the term to highlight the notion of relationality, as it enters the very "design" of this project – what familial, friendship, and authority relations (bleeding into one another) shape (trans-)formation of prenatal knowledge(s) and identities during pregnancy. How is pregnancy relationally experienced and what knowledges and identities are produced in the process? How is culture (trans-)formed therein? Affinity networks in this project, thus, simply refer to the (groups of) people who matter to a pregnant woman during her pregnancy and who may be, thus, co-experiencing the pregnancy and forming their own sets of prenatal knowledges.

pregnancy means to take health, health care, and health communication as existing and variously practiced both outside and within “clinical” contexts. In this sense, I am concerned with tracing communicative processes of prenatal/pregnancy knowledge construction as they are linked to experiences and affect of belonging (Carrillo-Rowe, 2005) to/with affinity networks and as they perform and create (dominant) cultural discourses in narratives of pregnancy and prenatal care. Thus, I am less concerned with "objectively" following the travels of knowledge among members of affinity networks, and more concerned with the processes - communicative practices as dialoguing performances of culture - that construct such travels and their significance in the narratives of pregnant women, their partners, family members, friends, and prenatal care providers.

My primary interest - through performative narratives - is to heuristically explore interpersonal experiences of cultural scripts and performances – of gender, parenthood, friendship, care, health – as they are storied (and, in the process constructed) in relation to (prenatal) knowledge(s), relationships, and identities in the context of pregnancy. At the same time, considering the claims and approaches of critical health communication, these contextualized interactions transform and shape cultural scripts, building and re-building communities of practice. I am also looking at these constructive processes. Thinking of culture as “local contexts within which health meanings are constituted and negotiated” (Dutta, 2008, p. 7) allows the linking of micro-level practices and interactional moments to macro-level processes of discourse formation and power negotiation. At the same time, this definition of culture recognizes the multiplicity of voices as necessary to/in meaning-making, not as counter-productive to it. Transnational and critical feminist authors have

long recognized the dialoguing co-existence of multiple knowledge systems as a wealth of critical engagement with the world, despite often being cast by the dominant discourse as incoherent and deficient in that their “hybridity” is not a singular articulation of self (e.g., Anzaldúa, 1987/2007; Collins, 2000; Hill, 1995; hooks, 1984; 2000). In this sense, critical health communication and transnational feminist work – as the two theoretical strands intertwined in loose guidance of this project – share a dialogically-driven (Baxter, 2011) commitment to understanding identity and culture as a continuous processes of becoming (rather than fixed entities), an understanding of interpersonal interactions as sites and contexts of such self-reflexive becoming, and a politics of inclusion and social justice.

What I think is missing from both perspectives, however, and what I hope this project builds toward is a relational understanding of inclusion and power in knowledge-production processes. It may be “easier” to argue that certain groups of people (and, hence, a wealth of knowledge) are excluded from formal processes of knowledge production based on their lack of representation and/or on their structural inability to prescribe actions. However, perspectives and knowledges are excluded even when individuals seem to be included and imbued with decision making-power. Some knowledges are deemed relevant, while others are rendered irrelevant, contributing to a discursive dominance that may or may not coincide with social group dominance and power. Discussing the implications of Bakhtin's dialogism in interpersonal communication scholarship, Baxter (2011) writes of dialogic contraction - "a discursive playing field so unequal that all but one monologic, authoritative discourse are silenced" (p. 9). Rather than examining the possible motivations of individuals or groups, the

analytic focus is on discursive processes of silencing, of markings, highlights, connections, and erasures and on the (cultural) meanings made available through such processes.

Perhaps the above is a little convoluted... Let me give an example with a socio-political issue that at the time of writing of this draft receives much attention in the U.S. – insurance coverage of contraception. Although the controversy began gaining publicity when some religiously-affiliated employers refused to offer insurance plans that cover contraception for female employees, it has now grown to include conversations around excluding women from relevant policy-making. Political parodies and feminist activists have been working hard to discredit white wealthy middle-aged congressmen as competent decision makers on the issue, given their, the congressmen's, (natural) inability to be pregnant. In a classic Foucaultian fashion, the large-scale question behind this controversy is, in my mind, who has access to the domain of reproductive knowledge and, hence, who should have the authority to make relevant decisions. While I respect and align with the efforts to include women's experiences in policy-making, I can't help but muse at the underlining framing of reproduction, reproductive rights, and reproductive decisions as individual choice (for criticisms of this paradigm, including its link to white middle-class feminism, see Bone & Meyers-Bass, 2010; Palczewski, 2010). Claiming males' incompetence on the issue due to their male-ness and their bodies' inability to be subjected to a host of pregnancy-related procedures (including prevention, termination, and birth) excludes the possibility of viewing reproduction in relational terms, experienced affectively, as well as physically. It contributes to a dominant social discourse that links reproductive responsibility with female-ness and masculine alliance

with feminisms with stepping back – an essentializing link that, in my opinion, does very little to forward feminist visions of equality. How do such arguments contribute to sexual health knowledge among young men and the range of meanings available to them? How do they contribute to scripts of parenthood and more, specifically, fatherhood? How is masculinity (and femininity) constructed here in relation to reproductive rights and legislation?

While, in this project, I do not want to argue that a relational model is necessarily better, I hope to suggest it is a possibility that opens up multiple potentialities, and, hence, its repression has social and policy implications. I believe pregnancy and prenatal care provide the perfect context to do so since pregnancy (in fact most reproductive matters) is rarely (if ever) experienced in complete social isolation. The assumption of (hidden) relationality in prenatal knowledge production is also suggested in the methodological approaches I take in this project. Striving for social and discursive inclusion, I follow critical and performative ethnographic methods. As I review in much more detail in the chapter on methodology, in this project, this means a commitment to dialogue, respect for story-telling, and focus on the constructive, connective, and transformative power of storied experience. As I include and reflect on my own (family's) experience of pregnancy throughout – in “data collection,” in writing, and in writing as data collection – I hope this project works as a process in itself, moving toward collaborative meaning-making and understanding of the structures that shape our experiences.

With this in mind, in the next sections I summarize the relevance of critical health communication and transnational feminist work to this project, and consider existing

research on authoritative knowledge, pregnancy and prenatal care, and reproductive discourses as it has informed the design of this study. These sections will form the theoretical foundations of a critical-relational approach to understanding the dynamics of knowledge and identity production in the context of pregnancy as a cultural event. The theoretical implications of such an approach mean not that I will be looking for specific patterns and “testing” their performances in a particular context. Rather, a critical-relational approach foregrounds explorations of the multiple unpredictable ways in which power is negotiated as we construct our worlds, our relationships, and our identities in communication. In this, as I explain in more detail below, such an approach also allows us to think of spaces of resistance and to imagine and perform different social worlds.

CHAPTER 1

(DIS)PLACING CULTURE, KNOWLEDGE, AND PREGNANCY

Theoretically and politically, this project is guided by critical, culture-centered approaches to health communication and by transnational theories. As I will describe in more detail below, I borrow from (feminist) transnational theories the notion that knowledge is necessarily fragmented by/in-between the borders it crosses and inscribes. In this sense, transnational does not mean international (Shome, 2006) and the cultural experiences of a person or a group that appears to be firmly and longitudinally planted within one nation-state can still be transnational, breaking through the linearity of time and space, incorporating knowledge that may be perceived to be of other-culture(s) and developing and transforming this knowledge in/through interactions. As Raka Shome wrote, transnational feminist thinking “forces us to confront how histories, geographies, nations, cultures, and economies remain simultaneously *connected* and *disconnected* in complex and unpredictable ways in the continual making and unmaking of gender across diverse (and often incommensurable) times and spaces, modernities and histories” (2006, p. 255).

Similarly, critical health communication theorizing has been instrumental in moving health communication scholars to consider 1) the systemic construction of health and illness experiences, and the identities associated with such experiences, at the intersections of multiple contexts (Lupton, 1994) and 2) the ways in which such experiences are part of and construct transnational macro- and micro-networks of power (Dutta, 2008; Zoller & Dutta, 2008). Although health, sex, and gender remain intricately linked to the body, and thus very personal, they are also social and cultural experiences

and constructions, and they are linked to a multitude of (global) economic, national, and representational processes.

Below I discuss in more detail transnational feminist thought and critical health communication theorizing of culture, the links between the two, and their relevance to this project. The concepts of cultural scripts and cultural knowledges (in dialogue) are engaged in both sets of literature and thus are central to this project. Therefore, I begin by considering the ways in which culture has been traditionally engaged in health communication research and the ways in which I understand culture in this particular project. Next, I discuss how transnational (feminist) theories continue to (re-)shape understandings of culture and power. Finally, in this section, I turn to the links between power, cultural discourses and the social construction of prenatal knowledge and pregnancy.

Culture in Health Communication

Much research in health communication is concerned with culture. From a traditional perspective, cultural differences are perceived as possible obstacles to providing quality and effective health care. Thus, for example, studies commonly cite language differences as “barriers” to prenatal care, linking them to fear and cultural misunderstanding (e.g., Flores, 2006; Timmins, 2002; Wheatley, Kelley, Peacock, & Delgado, 2008). From this perspective, health care providers are often charged with the need to increase their cultural competency, while additional services in the health care context, e.g., medical translators, attempt to decrease patients’ deficiencies in receiving quality health care. Critical health communication authors (e.g., Dutta, 2008) and cultural-difference centered health ethnographies (e.g., Fadiman’s much acclaimed *The*

Spirit Catches You and You Fall Down (1998)) have criticized this approach, recognizing that there is more to intercultural encounters in the healthcare context than addressing providers' and patients' deficiencies. Nevertheless, the view of cultural differences as always counter-productive to quality healthcare persists in health communication research. Less often considered are the ways in which cultural differences, and the dialogic encounters among different cultural scripts, are productive of particular types and ways of knowing. Interactional difficulties notwithstanding, Hsieh (2011) shows, for example, how the unique meanings of health and health care are collaboratively produced in bilingual health communication interactions, including patients, health care providers, and medical interpreters.

Although, in this project I pursue a more critical and relational line of understanding culture in health contexts, I cannot ignore the practical implications of understanding culture primarily as a pre-determined set of differences that divide or unite health care providers and patients. I cannot ignore the possibility that this is how both providers and patients may think of culture. In light of dialogic understandings of discourse (Baxter, 2011), such conceptualizations of culture would be part of the distal-already-spoken (or broader ideologies) that play a role in shaping the range of meanings available in particular contexts. For this reason, in what follows, I summarize - as discursive constructions that have guided scholarly research and story-telling - three approaches to culture and health communication – the dominant (culture-sensitivity) approach, the cultural approach, and the critical culture-centered approach.

This is a slightly different typology from the dichotomous classification offered by Mohan Dutta (2007; 2008), in which he, recognizing a debt to the cultural approach,

subsumes it in the culture-centered approach. Distinguishing between the two, I believe, allows us to look at conceptualizations of culture in health communication on a continuum rather than as two opposing camps. This is important since, at present, health communication research and practice has not accepted one singular definition of and approach to culture, but rather may offer opportunities for putting the different perspectives in conversation. In this context, I also have no guarantees for how/what “culture” will mean and will be made to mean in the experiences of others that will contribute to this project, making a continuum a much more suitable way of thinking about conceptualizations of culture than a dichotomous categorizing would be.

The Dominant or Cultural-sensitivity Approach

The most common and long-existing understanding of culture in health communication research defines culture as a shared and closed system of values, beliefs, and customs that is learnt and transmitted through time (e.g., Street, 2003). The definition highlights the collective “nature” of culture as well as the assumption of differences between collectives. As Cooks (2001) summarizes (and, later in the essay, criticizes), such a definition relates to dominant theories in intercultural communication, such as uncertainty reduction, in that uncertainties and intercultural encounters can be controlled and eased by learning and appropriately acting upon cultural behaviors and differences.

Very similarly, uncertainty reduction has been perceived to be a major facet of the medical/clinical experience (in the Western paradigm), as health-related encounters are charged with fears and uncertainties. And similarly, when culture is conceptualized from the dominant perspective in health communication, it is seen as a set “box of characteristics” (Dutta, 2007) that can be learnt and appropriately manipulated. Thus, in

health communication research coming from this perspective, culture and cultural sensitivity (or the ability to appropriately respond to cultural differences) is seen as a set of independent variables that have effect on various health outcomes (e.g., understanding of a prescribed treatment plan). Thus, research focuses on identifying differences in culture that are relevant to health communication and on testing different ways to appropriately respond to such differences.

This cultural-sensitivity approach to culture in health communication research is also suggested in models that presume to be more democratic and holistic, such as ecological and transtheoretical models of health and health behavior. For example, Street (2003) discusses his view of an ecological model in the *Handbook of Health Communication*, where the cultural context is one of the specific contexts (others include interpersonal, politico-legal, health care system) that shape a medical/clinical encounter. But even in his recognition that each individual present at the particular interaction is uniquely shaped by the intersections of multiple contexts, he does not consider the possibility of particular health and cultural meanings emerging in the interaction. Rather, he encourages participants in the health interaction to consider and try to understand (be sensitive to) the different contexts. In this proposal, the cultural context is reduced to racial and ethnic characteristics, while differences are “resolved by a suggestion that issues of language use should be attended to in order to increase understanding among the different parties in the interaction. ”

The cultural sensitivity perspective to culture in health communication is present in research on pregnancy and prenatal care. For example, Lazarus (1997) finds that women of different socio-economic classes have different “wants” for prenatal care.

Much of Brigitte Jordan's work focuses on how birth knowledge differs among different cultures and goes at great lengths to describe those different patterns of birthing.

Although, as I will talk in the upcoming sections, her work does much to explore the interactional negotiation of authoritative knowledge and power during the birthing process, it nevertheless seems to attempt binding observations into neatly labeled categories of cultural difference. Such approach has implications for the interactions between prenatal care providers and pregnant women, as well as between pregnant women and members of their support system. Rather than seeing each interaction as its own process in which knowledge is negotiated and produced (Baxter, 2011), a cultural sensitivity approach shapes a view of the interaction as diagnostic of cultural difference that needs to be acted upon. Furthermore, in much "training" literature, the responsibility of diagnosing a patient's cultural box is placed (unsurprisingly) upon the medical professionals, arguing that "cultural sensitivity" is something they need to develop in order to provide better care. This has a twofold effect – first, it clearly works to inscribe agency to act upon cultural matters onto the medical professional, and second, it erases the possibility that the medical professional him/herself might be negotiating multiple sets of cultural knowledge, that experiencing culture – for both patient and medical professional – could be fragmented, fluid, multi-dimensional.

From these examples it would be easy to see why a critical theoretical approach to health and culture – with its emphasis on power relations, structures, contexts, and identity construction (Lupton, 1994) – will be displeased with cultural-sensitivity approaches. In his book *Communicating about Health: A Culture-centered Approach*, Dutta (2008) addresses these criticisms specifically. I summarize them briefly below and

add a couple. First, Dutta charges, a cultural-sensitivity approach to culture in health communication sees culture as static, while, and as Cooks (2001) also points out *Pedagogy in the Borderlands*, a critical approach would look at culture as constantly becoming in interaction and discourse (Conquergood, 1989). Second, such a view maintains power hierarchies – it assumes that there are experts on culture and health and supports their power to construct the best health messages and strategies. Consequently, a cultural-sensitivity approach locates expertise outside of (non-dominant) communities. In its attempts to capture, describe, and respond to all characteristics in the cultural box, this approach others and exoticizes culture and co-opts marginalized voices, committing what Conquergood (1985) might call the researcher's sin of *curator's exhibitionism*.

Related to these criticisms and indebted to research ethics in health communication and ethnography explicated by Conquergood (1988; 1989), I'd like to add that a cultural-sensitivity approach highlights difference as a barrier to be overcome. In *Pedagogy in the Borderlands* (2001), Cooks criticizes dominant intercultural perspectives on culture for the same and argues, as does Conquergood, for a dialogic knowledge that allows the holding of opposites and multiple belongings in a productive tension. Finally, this line of conceptualizing culture in health communication seems to have led to a reductive operationalization of culture as national/ethnic differences to the exclusion of groups based on sexuality and ability, for example, from dominant health communication research on culture. This movement toward a narrow conceptualization of culture is also criticized by Dreama Moon (1996) in intercultural communication and may be seen as a convenient system of categorization that result from the train of thought that sees culture as a set of characteristics. In response to this, critical and cultural

scholars in health communication have attempted to develop alternatives for theorizing culture in relation to health.

The Cultural Perspective

In the 1990s critical perspectives made their way into published health communication research and theorizing about culture and health. Responding to criticisms that the dominant perspective over-values individual action and choice in health promotion models, such as the Health Belief Model and the Theory of Reasoned Action, the critical perspective began to draw attention to underlining structures and ideologies. In her seminal article on the critical perspective to health communication Lupton (1994) emphasizes the need for an ideological investigation of/in health communication research – one that questions its taken-for-granted assumptions and pays more attention to power structures and a Foucaultian sense of governmentality to which health care and health promotion/education contribute both in terms of ideological discourse and in terms of everyday practices. In *The Spirit Catches You and You Fall*, Fadiman (1998) narrates how taken-for-granted assumptions shape and are constituted in health-related behaviors. As an approach to research for social justice, this perspective is vastly different from the dominant perspective, as it attempts to address not as much individual behavior per se as it does the structures that constitute social inequalities; individual behaviors, documents, and interactions become the discursive texts in which structural inequality can be read.

Airhihenbuwa (1995), (re-)defined culture as “a collective sense of consciousness that is vocal enough to reveal its sense of history and language, and quiet enough to render its structures, values, and beliefs natural and common” (p. 17). This definition

suggests a move toward a broader sense of culture than a “box of characteristics” and emphasizes that there are structural influences that should be minded even more so because they are “quiet” and assumed “natural.” The definition is dialectical (Baxter, 2011), suggestive of the importance of silences in the vocalized sense of history. It asks about what is assumed, and therefore, quiet, in post-positivistic assumptions about the linear progression of time and modernity in Western medicine and health promotion (Lupton, 1994). By drawing attention to the quiet taken-for-granted structures that are nevertheless constructed, this definition also speaks to a possibility of transformation, linked, as it were, to the voicing of the un-voice-able naturalized structures that organize health practice.

To some degree this approach also incorporates dialectic of commonality and uniqueness and de-couples an understanding of culture from the exotic other understood as someone ethnically or nationally different. For example, Hughner and Kleine (2004) find that lay (non-medical professionals) people in the U.S. hold a wide range of views and definitions of health that cannot necessarily be categorized by people’s ethnicity. Yet those beliefs, although shaping health communication, are part of the structures that are “quiet” enough to seem natural and common. Drawing attention to these quiet beliefs and thinking about how they may be constituted and how they play a role in health-related interactions (even, and perhaps especially when they are quiet) works as a resistance to assuming the omnipresence and unchallenged power of medicalized knowledge. At the same time it begins the work of re-framing deficiency discourses of patients’ non-compliance with medical professionals’ advice and of seeing both patients and medical professionals as engaging in process of knowledge production in relation to one another.

To assume that health beliefs do not enter the doctor's office, even when unspoken, would be naïve and would mean a retreat to a culture-sensitivity approach in which patients and medical professionals constitute different cultures whose characteristics can be boxed up and controlled.

Because of its attention and critique of ideology and dominant structures, Dutta (2008) sees the cultural perspective as part of what he outlines as the culture-centered approach, citing Airhihenbuwa's definition of culture. However, I distinguish between the two approaches. The cultural perspective, although mindful of structures, still appears to me to hold a deterministic view of culture as static; the critical culture-centered approach, as I outline in more detail below, attempts to put structure and agency in dialogue. In its more deterministic approach, the cultural perspective does not appear to be particularly mindful of context and inter-subjectivity², while context and the emergence of meanings within context is central to the critical culture-centered approach. In other words, a cultural approach to health communication and culture is primarily concerned with critiquing the ideologies that 1) privilege certain health knowledges while undermining others and 2) work to constitute identities (patients, providers) that are in relations of domination with each other. On the other hand, a critical culture-centered approach attempts to put this critique in dialogue with resistive and supportive actions

² Although inter-subjectivity has various uses and definitions, the most benign of which emphasizes shared meanings between/among subjectivities, here I use it in a way inspired by feminist traditions – to emphasize processes of collaborative meaning-making in which subjectivities encounter one another in the space between. This use clearly has ethical and moral implications, connecting to the axiological assumptions of critical theories and research methodologies. At the same time, however, Baxter (2011) criticizes the emphasis on inter-subjectivity as non-dialogic in the sense that the emphasis is still on the individual (subjectivity) as a texts-producing agent, rather than on/in the texts themselves. Such an emphasis, she argues, leads to a research tendency to "discover" and "understand" the underlying back-stories and/or motivations of the individuals, rather than focus on active processes of meaning construction within discourse.

that are part of everyday, mundane lived realities – articulating both a “problem” and an active re-working of the “problem.”

Critical Culture-Centered Approach

In this approach which has only been articulated in the last few years, culture is defined as “local contexts within which health meanings are constituted and negotiated” (Dutta, 2008, p. 7). This definition highlights dynamism of both culture and health. The attention to contexts is also an attention to the structures that are 1) present in this context and 2) constituted by every-new interactions within particular contexts. The constitution and negotiation of meanings suggest that culture, indeed meanings themselves, are in a process of becoming, not set – but they also cannot be excerpted out of histories and ideologies. In terms of Bakhtin’s dialogism³, the constitution of meaning is always in dialogue with what has been (distal and proximal already-spoken) and what will be (distal and proximal not-yet-spoken). In terms of health communication research and social justice, such a perspective opens up both sites of exploration and of resistance.

In short, a critical culture-centered approach to culture in health communication is concerned with the production of meanings of health within contexts – neither culture, nor health is a fixed concept, but rather they are both constantly negotiated. This negotiation is in the nexus between structure and agency, recognizing their dialectic relationship – thus, for example Basu and Dutta’s (2008) research with commercial sex workers (CSWs) in India shows that economic structures confine their safe sex practices,

³ The term was first used in Bakhtin’s (1981) literary theory in *The Dialogic Imagination* to suggest that literary works are in continuous dialogue with one another and, hence, their meanings are never set, but are always transformed by each new work. This view has been extended to larger processes of meaning making beyond the literary field. Most relevantly, Baxter (2011) theorizes the time/space connectedness of dialogism to be foundational in interpersonal meaning-making, suggesting that any communicative behavior is connected to, transformative of, and acquires meaning only in relation to past and future communicative behaviors.

but they also show that CSWs have a voice and enact an agency from within. In highlighting agency, the culture-centered approach locates expertise from within and puts different knowledges in dialogue toward the production of a new contextual knowledge (Conquergood, 1989). Dialogue here is not a mode or an ideal of interaction between/among people, but is a discursive, multivocal process of meaning making (Bakhtin, 1986; Baxter, 2011) in which different times, spaces, experiences, relationships, and interactions are brought together in an utterance/moment/text that is part of a larger "chain of speech communion" (Bakhtin, 1986).

In addition to linking discursive dialogue to agency, the critical culture-centered approach attends to structures, linking global and local contexts as they intersect in the production of health conditions, experiences, and meanings. In this aspect – the intersection of structure and agency – the culture-centered approach is not often found in works concerned with interpersonal health communication. According to Baxter (2011), who cites her own content analysis work with Dawn Braithwaite, in interpersonal communication research as a whole, "only a scant 2.9% of research articles in communication journals from 1990 to 2005 were critical in orientation" (p. 14). The lack of critical perspectives in health communication research has also been criticized (Dutta, 2007; Lupton, 1994). Specifically, in *interpersonal health communication*, much of the work produced is concerned with patient-provider interactions in post-positivistic prescriptive terms, as if health-related communication does not happen outside of and in interaction with the clinical context. Such a myopic focus narrows the contextual scope of considering structures and their interplay in shaping health processes and experiences. Furthermore, even when interpersonal interactions are the focus of health communication

research, the questions asked typically follow the traditional approach to culture, asking what patients and providers can do to improve understanding in the clinical encounter – e.g., patients are advised to ask questions and health care providers are advised to develop cultural sensitivity and learn to listen.

In one study that attempts to consider pregnancy in its larger social context and in relation to the various interpersonal interactions pregnant women have, Root and Browner (2001) discussed how pregnant women's beliefs and familial relationships are linked to the degree to which they integrate medical advice in their prenatal care. Their study speaks to the experience of pregnant women for whom the health care system is far from being the only social structure that organizes prenatal care and pregnancy – instead women in their study talked about navigating and synchronizing knowledge they receive from their mothers, fathers, friends, from books, television, and medical professionals. This navigation – agency – happens at the intersections of all these structural contexts (family, media, health care) and works to additionally intersect them in the process of meaning-making and identity construction.

However, one thing that Root and Browner's (2001) study does not attend to is how this navigation and negotiation happens in interactions. Building on women's narratives, they convincingly find that the agency of pregnant women is embodied in their drawing from multiple streams of prenatal knowledge toward the construction of an ethical pregnant subjectivity. Yet, the process seems to be metaphorically described as more or less linear – i.e., pregnant women get advice and information from multiple sources, sift through it, and come up with a prenatal practice. This approach is consistent with an activist attempt to recover pregnant women's agency as producers of prenatal

knowledge. Working within the juxtaposition of doctors have power/patients do not, studies such as this one do much to show that patients are not dupes, but are choice-making agents. In highlighting agency, the focus is thus on the individual more than it is on dialogic processes. I hope, in this project, to be able to focus more on such processes by centering narratives around relational moments (e.g., narrated interactions), rather than only on the content of advice. In addition, by creating opportunities for relational partners to tell their stories together, with and to one another, as well as with and to me (as the "researcher"), I hope this project will begin addressing what Baxter (2011) identifies as a major "gap" in interpersonal communication research - attention to "meaning making that unfolds in the moment between relationship parties" (p. 61).

Narrating interactions, story-ing experiences in a conversation with another, rather than summarizing advice, allows for the narrative, discursive bringing together of multiple knowledges performed in both interactions and in the act of story-telling. The narrative bringing together of such knowledges is interpreted in feminist approaches to research as agency – an active construction and negotiation of identity. In *The Voices of Don Gabriel* (1995), Hill suggests that realities are actively produced, ideologies are actively contested, and knowledge actively negotiated in the very telling of a story. In the area of reproductive discourses research, Peterson (2010; 2011) finds that discursive disjunctions in narratives mark clashes between cultural scripts and between ideology and experience, allowing feminist critiques of dominant discourses of motherhood, work life, and depression. Foster (2005) performs how pregnancy and motherhood discourses in interplay with larger cultural discourses of privacy and empowerment can turn onto

themselves, simultaneously legitimizing silencing secrecy and voiced disclosure. Baxter (2011) calls such rupturing of discourse "semantic fragmentation" (p. 80).

The contradictory multivocalities in those examples, the tensions that they perform are not seen, in those cases, as cognitive and moral shortcomings in attempting to construct a unified subject. They are not seen as a (psychological) deficiency, as they might be from a post-positivistic perspective. Rather, they are creative, dialogic processes of making sense and of bringing into becoming complex identities and struggles with social structures. I see this as one of the most important and, in this project, inspirational influences of transnational feminist research – the recognition of multi-subjectivity that is constituted and negotiated in communication. This is recognition of agency in relation to structure in the very places where it might have been previously discarded as sub-quality data, recognition of sense-making contributions in the very places where neurosis might have been previously diagnosed. And it is this dynamic multiplicity of selves and knowledges that interests me here.

Despite such contributions, one of the drawbacks, it seems to me, of feminist theories, such as standpoint theory⁴, extended to transnational (health) contexts, is the methodological move to a-priori ascribe privilege, as an explanatory mechanism, to bodies, occupations, positions. Thus, doctors must be assumed to necessarily represent and perform a biomedical (dominant) model of care without negotiating different streams

⁴ Standpoint theory/theories, although variations in uses and controversies around them abound (Harding, 2004), hold in their most basic premises that one's (view of) reality is shaped by the social positions s/he occupies. Dominant versions of reality are constructed by socially powerful groups, while marginalized groups are excluded from (mainstream) knowledge production. At the same time, however, because they have access to both dominant versions of reality/experience (circulating more widely socially) and to their own marginalized experiences, members of marginalized groups are able to see the world from a larger number of vantage points (though still partial) than are members of dominant groups, contributing to what Harding (1987; 2004) calls "strong objectivity."

of knowledge in their interactions and narratives, and without experiencing the (productive) tensions of such negotiations. To do so would mean to undermine the possibility of agency and to advance a narrow-sighted view of culture as a vertical power structure. Instead, in this project, I hope to explore, as the culture-centered approach to health communication would suppose, dialogues between agency and structure, and an understanding of culture as both vertical and horizontal, multi-directional, constantly negotiated. In the next section, I consider how these concepts – agency, structure, culture – and their implications have been considered in transnational feminist theorizing of identity, knowledge, and power.

Transnational Theorizing and Feminism

“Transnational” and “transnationalism” are not unequivocally used in existing literature. Vertovec’s (1999) review of literature outlines the interdisciplinary academic uses of “transnational,” listing six distinct “takes” on the subject, recognizing that they are “not exclusive; indeed some rely on others” (p. 448). Vertovec reviews conceptualizing of transnationalism as: 1) *social morphology* (e.g., diaspora) or communities formed beyond national borders, but often held together by a shared sense of (original) nationality; 2) *type of consciousness* that accommodates a sense of belonging to a number of different national, ethnic, etc. communities; 3) *mode of cultural reproduction* in which the hybrid consciousness materializes itself in fashion, film, etc; 4) *avenue to capital*, such that scattering one’s “assets” (including family members) geographically around the world leads to increase in economic, symbolic, educational, and cultural capital (see Ong, 1999); 5) *site of political engagement*, or a global public

sphere materialized in transnationally-acting organizations; and 6) *(re)construction of locality* in which people's relations to space are re-configured.

These six uses seem to be unified by dialectic (Nakayama & Martin, 1999) of location/scattered-ness, and the negotiation of that dialectic at the borders as in-between spaces (Diversi & Moreira, 2010; Mignolo & Tlostanova, 2006). I use borders in a broad sense to include both borders structured by cultural norms and borders that mark the territories of nation states and the crossing of which is regulated by nation states. In fact, one of the ways in which critical use of “transnational” separates itself from conceptualizations of globalization and multiculturalism, for example, is that thinking transnationally includes a consideration of the continuing role of nation-states and nationalism(s) in shaping global relations of power.

Crediting the “entrance” of transnationalism in communication studies to influences of feminist and postcolonial work, Shome and Hedge (2002) oppose transnationalism to globalization and multiculturalism, which they see as an “ahistorical, benign articulation of culture and difference” (p. 261). Instead of uncritical celebration of surface-diversity and open borders, the authors argue for a heuristic use of “transnationalism” that draws attention to situated and historical explorations of the power-relations that produce and are produced by formulations, representations, and consumption of culture. In this conceptualization, the transnational is relational and dynamic, not so much a condition (Vertovec, 1999) as it is a process. Specifically, Hedge (1998) uses the term “transnational” to “give primacy to the processual nature of cultural flow and expression. It is also used to conceptualize locations in a more mobile manner and take into account the dialectical tension between center and periphery” (p. 285).

Coming from such considerations, in the proposed study I use “transnational” in a broad critical and process-focused sense to mean, after Croucher (2004), the “*crossing of borders, the breaking of boundaries, and the transgression of established forms of belonging*” (p. 92).

This is a dialogic definition (Baxter, 2011) - in crossing, breaking, and transgressing multiplicity of voices is not only "invited," it is normalized as constructive and transformational weaving among ideologies (Sandoval, 2000). In a discursive dialogic framework (that focuses on the utterance as a dialogic site), monologue only exists when a particular discourse is so powerful that it silences all others (Bakhtin, 1984).

In monologue, there is no movement;
dialogue is
moving along, among, and with
discursive streams,
weaving them,
untangling them,
all at once.

The above definition of transnational is dialogic, as it foregrounds movement
in the verbs
in the -ings
in the struggled permeability

Just as Bakhtin's dialogism listens for the multivocality in utterances, this conceptualization means that “transnational” thinking is available even to those who

seem to be fairly stably placed within one particular nation state – while emphasizing how cultural structures (borders) within the particular locality matter in critical ways. Borders are recognized, felt, stumbled over, as they are encountered - this is not a borderless world (as some globalization advocates might claim), it's a world of border-crossings and, sometime, stoppings. The definition also highlights that one's crossing is consequential in potentially disturbing and re-establishing forms of belonging and community.

This conceptualization also connects to what Shohat (2001) discusses as “relational form of multicultural feminism” which involves “the translation of ideas from one context to another” by being attentive to “the operative terms and axes of stratifications typical of specific contexts along with the ways these terms and stratifications are translated and reanimated as they travel from one context to another” (p. 1271). Such relational and dialogic meaning-making also suggests cultural dynamism, envisioning and understanding of culture that is closer to the one fore-grounded in critical culture-centered approaches to health communication – as “local contexts within which health meanings are constituted and negotiated” (Dutta, 2008, 7).

In this sense, Shome (2006) recognizes that transnational feminisms have lead communication scholars to think about “how contemporary conditions of mobilities and immobilities, cultural flows and stasis, produce new hybrid spaces (and practices) of consumption that productively throw into crisis any notion of the audience as being a culturally stable and predictable object” (p. 264). Moving away from predictability in understanding prenatal care, this project centers interactional processes of knowledge production – and the *transnational not as something an individual carries, but as a*

dialogic epistemological experience and accomplishment. In the above quote, Shome echoes notions of the transnational as a mode of cultural reproduction and as (re)constructing of locality (Vertovec, 1999), such that audiences' potential for agency and resistance is recognized. The transnational is at once a painful and a hopeful embodied lived reality – performed beautifully in feminist scholarship such as Anzaldúa's *La Frontera* (1987/2007) and Lorde's *Zami: A New Spelling of My Name* (1982).

Anzaldúa and Lorde are conscious and reflexive of their multiple “transgressions of established forms of belonging” (Croucher, 2004, p. 92) – transgressions are both painful in the social sanctions that meet them (in that pain they perform structures and borders), and they are potentialities for new forms of belonging, producing unique and ever transforming knowledges of social realities. Writes Anzaldúa,

As a *mestiza*, I have no country, my homeland cast me out; yet all countries are mine because I am every woman's sister or potential lover. (As a lesbian, I have no race, my own people disclaim me; but I am all races because there is the queer of me in all races.) I am cultureless because, as a feminist, I challenge the collective cultural/religious male-derived of Indo-Hispanics and Anglos; yet I am cultured because I am participating in the creation of yet another culture, a new story to explain the world and our participation in it, a new value system with images and symbols that connect us to each other and to the planet. (p. 102-103)

Chakravartty and Zhao (2008) talk about “transculturation” or “the new cultural forms which emerge from unequal global encounters” (p. 13). Their use of “transculturation” as opposed to the more common “glocalization” (which suggests local adaptations of globally-traveling cultural forms) is significant in highlighting the transnational as a relational process. A transcultural approach does not ignore macro-processes, but looks for their “representations” and enactments in everyday practices. The authors draw connections between macro-level and micro-level processes, reflecting on

the ways in which their “encounters” are full of frictions out of which transculturation emerges. One such transcultural form – critically at the intersections of macro- and micro and of locality and transgressions – is what Marciniak (2008) refers to as “transnational mothering” in which mothers, participating in a transnational labor market, often as “illegal” and low-paid workers, raise their children from a distance. With their bodies crossed and framed, at the same time, by global processes and multiple borders, their knowledge of these processes is deeply felt and relational (Gibson-Graham, 2006), complexly painful and hopeful, subjugated and resistive all at once.

Thinking of the transnational as dialectical/dialogic processes opens up a space for critically engaging our stock “critical” responses (e.g., of “transnational mothers” as capital-exploited gender slaves) and for considering potentialities for resistance and agency in everyday “oppressions” which are in themselves communicative practices and critical discourses. It allows for alternatives to the dominant historic, economic, cultural, etc. narrative and, I think, can be a useful methodology for transnational research, as it explores exactly the ways in which realities are not isolated, but do, in fact, intersect and contribute to community and knowledge building within, between, and beyond borders.

Furthermore, Duara’s (2002) observations on the role of national pedagogies and the taming of heterogeneous time-space for the purposes of building the nation suggest that alternative discourses (other ways of knowing) can be folded in even into dominant discourses. He posits that transnational events were commonly re-told as national histories, leaving some narratives of the event outside of official history, while blending other multiple ones in it. Thus, he proposes that one may re-read national histories

locating specifically the moments when and places where identity borders were built by homogenizing time-space into a singular linear narrative.

This proposition can be similarly applied to dominant discourses other than history and, in fact, in the context of reproductive discourses, Mazzoni (2002) finds that many “old wives’ tales” are folded into biomedical prenatal care advice, pointing that the knowledge in this advice is not singular in itself, but rather is fragmented, multiply transcultural in a way that problematizes origins. The push for and social value of singular and unified representations is in itself a cultural construction, dating back, as Mazzoni demonstrates, to European Renaissance ontological beliefs embraced in science – that the being-within-being configuration of “mother and fetus was emblematic of the unity of the world and of the magic relations that governed the universe. This, in turn, confirmed the connection between human beings and the cosmos, between microcosm and macrocosm, between body and soul” (p. 16). In addition to critically centering processes of knowledge formation, such explorations that disturb the linearity of time and space also bring to focus questions of power as contextual and unstable “regimes of truth” that are constantly in flux (Foucault, 1978).

Thus, the use of loaded, but ambiguous, categories such as “disempowered” and “marginalized” would be misleading in transnational/transcultural research. The assumption and application of such labels to identify groups who need help can also work to blind, deafen, and petrify critical scholars to marginal power – the myriads of ways in which the “disempowered” resist, fight, exercise, and transform power in everyday ways. Similarly, Lazarus (1997) criticized the demonizing of the concept of nationalism. Quoting Guha (1982), he writes: “What... historical writing of this kind cannot do is to

explain... nationalism for us. For it fails to acknowledge, far less interpret, the contribution made by the people on their own, that is, independently of the elite to the making and development of... nationalism” (p. 37). In other words, it fails to acknowledge an experience of or a sense of being actively resistant and creative. It perpetuates a dichotomy of powerful-disempowered.

Starting transnational analyses from the presumption of such a dichotomy carries with it the risks of only seeing lack of power, even when a unique transnational and/or local performances and transformations of power are happening. These considerations, inspired by transnational theory, are especially relevant then to processes of establishing and negotiating authoritative knowledge – a monologic (Bakhtin, 1984) state of relations that makes itself seem “natural” and “common sense,” veiling both regimes of governmentality - state, family, media, capital – and the intersections, re-workings, and interactional accomplishment of such regimes. In the next section, I turn to the concept of authoritative knowledge as it is evoked and re-worked in scholarly literature on pregnancy, prenatal care experiences, and birth.

Power/Knowledge and Reproductive Discourses

Because of its link between the individual body and the literal extension of that body into time, space, and society through the process of reproduction, pregnancy and prenatal care are at once very personal, embodied processes and very public, cultural processes. Pregnancy discourses, thus, promise the dialectic interplay of individualism and community (Baxter, 2011). As many authors on topics of reproductive discourses contend, it is little surprise that various institutions, as well as individuals, are implicated in the governing and shaping of pregnancies and prenatal care as cultural experiences

(good summaries and examples are included in the anthologies *Contemplating Maternity in an Era of Choice* (Hayden & O'Brien Hallstein, 2010) and *Childbirth and Authoritative Knowledge* (Davis-Floyd & Sargent, 1997)). As Ivry's (2009) ethnography of pregnancies in Japan and Israel shows, the culture(s) within which families expect and prepare for the arrival of their children has as much (if not more) influence on the experience of pregnancy and prenatal care as do pregnant women's physiological experiences. In addition, interpersonal ideologies (Tracy, 2002) about gender, expectations and beliefs about pregnant women shaped how medical professionals in Ivry's study conducted and communicated during prenatal visits.

Similarly emphasizing the importance of cultural context, Hall (2011) discussed how mediated representations (or lack of such representations) of complicated pregnancies, as part of the normative cultural discourse, shape in a negative direction the prenatal experience of women whose pregnancies were considered to be "complicated." Not seeing their stories included in popular TV shows, such as *Baby Story*, and not having many personal reference points, women with "complicated" pregnancies felt ostracized, unprepared, and had a long-lasting sense of being cheated out of a "magical" birth experience. To translate this through a dialogical lens, as Baxter (2011) advises, would mean to recognize that there are multiple cultural discourses and radians of meaning dialoguing in these stories - the seemingly assumed unpredictability of pregnancy as transformation is recast as the "magical" predictability of something wonderful that bumps against the unconventionality of painful complications. Furthermore, as in Foster's (2005) autoethnography about motherhood, discourses of individualism and community dialogue with one another as the narratives perform

simultaneous struggles for individual experiences to be included/heard and community-linked responsibility for those experiences to not "spoil it" for others.

Examples such as these ones suggest that various cultural discourses shape a pregnant woman's prenatal care experience, her own experience and construction of identity during pregnancy, and her birth expectations. The argument for representation then is that it broadens the cultural discursive landscape, it legitimizes multiple discourses (still recognizing that some are centripetal and some are centrifugal), so as to open pregnancy as dialogic. In Hall's research, (partial) inclusion of one's experience in mediated discourses also felt empowering in conversations with health care providers in the sense that it legitimated bringing up for discussion certain topics and examples, making prenatal knowledge more open to negotiation. This also points at a socially-constructed facet of pregnancy and prenatal knowledge(s) – that what gets included in the knowledge system(s) to begin with is highly contingent and contextual.

Thus, to speak of "authoritative knowledge"⁵ in the singular is at the least deceptive, and, at its worst, highly discriminative. Or, as Root and Browner (2001) write, "To categorically label one practice authoritative and the other subjugated is not only disingenuous, it diverts attention from the more important point, that practices are functions of diverse relations, with oneself and others, as well as texts" (p. 206). This relational framework of constructing prenatal knowledge(s) becomes even more complex when applied not only to pregnant women, but also to prenatal care providers, whose

⁵ As forecasted briefly at the end of the previous section, authoritative knowledge (AK), a concept first introduced and used by Brigitte Jordan (1974/1992) in her study of *Birth in Four Cultures*, refers not only to a set of principles of birthing that trumps all other such sets, it is also the dominant organizing system of power relations that maintains its dominance by making itself seem natural and the world unthinkable in any other way. In this sense, the concept holds close connection to Foucault's (1998) power/knowledge.

work and experiences are often one-dimensionally classified as THE authoritative knowledge in research focused on critical considerations of contemporary reproductive discourses. Confronting such representations, Ivry (2009) finds prenatal care to be a collaborative accomplishment in which health care providers, as well as pregnant women and their families, negotiate “‘medical,’ ‘folk,’ or ‘private’ theories of gestation” (p. 17), making those theories “work together and facilitate the interactions surrounding pregnancy” (p. 17).

I believe the exclusion of a consideration of the ways in which multiple knowledge systems are communicatively navigated towards the embodied performance of care – be it a future mother’s care of her body, a medical professional’s advice giving, or a family member’s support – contributes to a view of authoritative knowledge (AK) as fixed and necessarily oppressive and obliterates the social processes and relations through which it is negotiated, affirmed, and/or resisted. A handful of research on authoritative knowledge in prenatal care (e.g., Browner & Press, 1997; Root & Browner, 2001) suggests that (authoritative) knowledge is contextual, situated, and changing, and indeed emphasizes agency, although, as I mentioned above, this is still done at the expense of the interactional moment as a space of negotiation and construction. Daviss (1997) finds that there are several different “systems of logic interacting with each other in each act of birth” (p. 443), including scientific logic, clinical logic, personal logic, cultural logic, intuitive logic, political logic, legal logic, and economic logic. In fact, Jordan’s early use of the concept of AK speaks to its relational dimensions – in the sense that she finds, for example, that “in some situations, some kinds of knowledge count and others don’t” (1997, p. 59) and that what counts is accomplished interactionally by all participants.

However, much of later critical feminist literature on reproductive discourses has taken up the concept in a different way – substituting a consideration of its interactional and dynamic negotiation and accomplishment with a critique of its (assumed) oppressive dimensions and an attempt to “expose” those for what they are in order to raise awareness of how an arguably technocratic medicalized model of prenatal care and birth subjugates feminine ways of knowing and, in turn, contributes to patriarchal oppression. To use a critical health communication framework, such uses of the concept focus exclusively on structure in hopes of promoting agency, but in the process may overlook the mundane ways in which resistance and agency are already present. Following Foucaultian theorizing of the structuring power of discourse, such work privileges an analysis of structure to critically point at directions and places where change needs to happen. Understandably and necessarily the question is what needs to be changed in the structure toward a more just and equal society. Yet, such focus, as needed as it is, may obliterate the ways in which change, as a process, might be happening already, ignoring, as I explain later below, Foucault’s notion of power as dynamic. Continuous criticisms and revisions of the concept of authoritative knowledge, such as the ones described above, suggest that it continues to be influential in the development of reproductive discourses research and, thus, its inclusion in a study such as this one is imperative.

Authoritative Knowledge, Pregnancy, Morality

The concept of *authoritative knowledge* (AK) was introduced by Brigitte Jordan in the specific context of exploring birth models in different cultures and of thinking about the social processes through which certain norms, beliefs and practices become common sense. I use “common sense” here to draw a deliberate parallel to Gramsci’s

work in order to emphasize two things: first, the process of continuously constructing and legitimating knowledge, in which we are all implicated; and second, the notion that “authoritative knowledge is persuasive because it seems natural, reasonably, and consensually constructed” (Jordan, 1997, p. 57). Said in other words, “authoritative knowledge (...) is a way of organizing power relations in a room which makes them literally unthinkable in any other way” (Rapp, quoted in Jordan). Engaging this definition in relation to reproduction, pregnancy and birth, in the U.S., the feminist health movement has argued that medical professionals and technocratic health practices have been given (have taken?) legitimacy to the detriment of women’s empowerment and toward subjugation of women's ways of knowing (Saukko & Reed, 2010), constructing a discursive monologue in which "all but a single totalizing discourse is erased" (Baxter, 2011, p. 14).

I imagine it is this impetus of equating OBGYN-assisted prenatal care and birth with “misrecognized” (Bourdieu & Passeron, 1977) authority that prompts many people with whom I’ve talked about this project to ask, “But have you considered talking with women who go to midwives? What about talking with midwives themselves?” Bourdieu and Passeron refer to “misrecognition” as the process by which authority that may be coercive and beneficial to one particular segment of society comes to be “mis-recognized” as natural and benefiting all segments of society, as authority for the common good. Such a process of misrecognition is documented in Paul Starr’s (1984) account of how health care in the U.S. has been transformed from a pluralistic health care system into an allopathic-centered medical care.

In this sense, and thinking back to the definition of AK as “a way of organizing power relations” so that they appear natural, advising me to attend to midwives’ practices may be an invitation to consider a (assumed) different organization of power relations, but it also reifies cultural discourses - most importantly perhaps, in that it moves away from discursive dialogism and toward a focus on the individual (or the occupation/relationships) as a container of a certain type of knowledge and discourse. Such an advice also performs a midwife/OBGYN opposition (also, described as the natural/medicalized opposition), in which somehow the so called “natural” approaches also presuppose a more equal and horizontal distribution of power between prenatal care professional and patients. It implies that authoritative knowledge and its practices change with the authority figure, while at the same time affirming a vertical distribution of power in which having an authority figure matters in how power relations are con-figured. Lastly, it obliterates an important dimension of the dynamics of power and knowledge negotiation whereby people and identities are seen as complex and always in the process of negotiation/becoming, and not as the containers of singular and unified knowledge systems which then “battle” as the people/containers interact (Baxter, 2011).

My own experience provides a brief clarifying example. Early in the morning on the day our son was born we had called the doctor, telling him that I’ve had contractions that are one minute apart and one minute in duration for at least the past two hours. We were following a recommendation we, first-time parents, learned during a brief birthing class a few weeks back. At the point of our phone call, I have been in labor for 14 hours, but we

“knew” it’s better to labor at home for the most part and so we weren’t in a hurry. When we eventually arrived at the hospital birth center – a cozy little place – a few hours later,

we sat in the overstuffed chairs,

we were quiet,

barely exchanging a few words here and there.

We were excited and impatient beyond words.

The nurse looked at us skeptically and scoffed a little bit. The doctor came in and asked us to report on the contractions and any other signs of impending birth, checking several times if I was sure these were indeed contractions. “Well,” he said finally, “we’ll hook you up to the monitor and see.” I left the comfort of the overstuffed chair and trotted to the bathroom, robe and rubber-sole socks in hand. Got naked. Peed. Got semi-dressed in the robe and rubber-sole socks. My husband helped me up to the bed. Elastic belt and a few cables, two monitors. Baby was there. Sure enough contractions were, too, as reported. The doctor confirmed, pointing at the lines on one of the monitors, showing me spikes. Spikes = contractions. As if I didn’t know. “But,” he says, “you totally don’t look in labor. This can last another week.” I ask my question. “Yes, this strong and this often, this can last a week,” he says, “because you really don’t look like you’re in labor. When you can’t maintain a conversation, when you can’t say more than a word at a time, then you’d know you’re in labor. It happens to first-timers.” So, I get dressed and lay the robe and rubber-sole socks on the bed. A week... In the afternoon, we were back in the hospital and two hours after our return, our son was born.

What’s the point of this story? A story to which I return many times with different feelings... but more about that affect later. I mean, sure, as “first-timers” and despite all

my embodied certainty that the nurse and the doctor were wrong to scoff at us, we followed medical instructions and advice. In this, we participated in the construction of authoritative knowledge, much in the ways in which Jordan (1974/1992) discusses happens in the U.S. birthing room. And sure, this is more of a birth story than a “prenatal” care story. But it provides a good counterpoint to the above-stated critique that, in its attempt to bring about structural change, reproductive discourses research has created the following equation U.S. medical system = authoritative knowledge about birth = oppression of feminine ways of knowing = evil. Although the doctor in our experience did engage a host of medical technologies and his medical knowledge in obtaining the “history” and “state” of the allegedly laboring woman, his decision to send us home contradicted the technologically-obtained information. It was a sensual decision – based on what he saw and heard in comparison to what he culturally knows labor looks and sounds like. It was an experiential decision – based on his prior encounters with “first-timers” and with “real” labor.

In our story, experiential knowledge (both mine and the doctors) dialogues with medical one dialogues with discourses of responsibility and authority dialogues with technology/sensuality. Following a dialogic perspective (Baxter, 2011), I cannot psychologize the processes of negotiation/dialogue/tension that might have gone on for the doctor, for me, for my husband, for the nurse, for my mom waiting at home, who, when she was pregnant, was admitted to the hospital eleven days after her due date with no signs of labor, for my dad waiting at home, who was there for the entirety of my mom's pregnancies, but was not allowed to hold his children until a week after they were born... The point of looking at this situation dialogically is not to glean a sense of some

inner desires, motivations, or goals that juxtapose the doctor vs. the pregnant woman, it is not to predict how to control those inner states and traits next time. The point of a dialogic perspective is heuristic - what does looking at this phenomenon in this way allow us to see? Our encounter that morning changed what I knew about (authentically) performing birth in the U.S. I'd like to imagine it also spilled into the discursive/knowledge streams the doctor and the others raft in. I'd like to think those streams are now mixing a-new, as we listen to some of the voices - both centripetal and centrifugal - in our story.

In Jordan's conceptualization, AK highlights an analytical interest in the processes whereby certain knowledge systems become common sense, while others are devalued and those who espouse them come to be seen as "backward, ignorant, and naïve" (1997, p. 56). However AK is not a necessarily fixed and unchangeable system of practices through which a-priori domination is enacted; rather, "the constitution of authoritative knowledge is an ongoing social process that both builds and reflects power relationships within a community of practice" (Jordan, 1997, p. 56). Thus, for example, she observed a horizontal distribution of power in Yucatan births, where knowledge and support were multi-faceted – "physical, emotional, ritual, spiritual" (p. 60) – and "the store of knowledge required for conducting birth is created and re-created by all participants jointly as they do the work of birthing" (p. 60).

Later, in discussing "the achievement of authoritative knowledge in American hospital birth" (p. 61), she also shows that AK is jointly accomplished, in the process also accomplishing the expert power position of the OBGYN attending the birth. Jordan discusses how the birthing woman's own version of knowledge – what she knows with

her body, the urge to push – is suppressed by the use of machines that tell else-wise. She discusses how patients, medical students, and nurses all participate in “staging the physician’s performance” (p. 69) of his “unquestioned status and authority” by simple practices, such as waiting for him to ok the pushing, by holding up his white coat, by claiming certain spaces in relation to the spaces occupied by the pregnant woman, etc. Jordan concludes that authoritative knowledge is ultimately constructed by means of “access to the various participation structures” (p. 70) in the delivery room, and that, hence, limiting a birthing woman’s access to only directed dyadic interactions with her partner or with the nurse accomplishes subjugation of her own knowledge.

The interactional detail of the analysis notwithstanding, what is striking to me is that, as is perhaps often the case with conversational analysis, the moment seems extracted out of its complex social context. If we consider intersectionality (Collins, 2000), how would our social contexts and circumstances – interacting with each other – structure the joint accomplishment of authoritative knowledge? And once again, is the only context that matters for the OBGYN, for example, that he is a physician? What other knowledge systems should the OBGYN negotiate to contribute to the accomplishment of his “status” in the delivery room? How do the researcher’s own epistemological beliefs and political commitments (e.g., to one version of feminism), her own set of knowledge systems and experiences, enter the interpretative scene here, interacting with observable performances to produce knowledge about birth in the U.S.?

Following Jordan’s early research in the 1970s, much feminist work on authoritative knowledge in the U.S. has focused on the moment of birth and on the birth narrative as a site of identifying how power is produced and, literally, reproduced (e.g.,

Jordan, 1974; Pollock, 1999). For this reason, much of the literature reviewed here also focuses on birth, even though the intended focus of this project is that which precedes birth – prenatal care and pregnancy. The few studies that actually link pregnancy and birth in a continuum of dialoguing knowledge systems, clearly suggest that authoritative knowledge cannot be de-contextualized. Thus, the affective experiences of the above birthing moments may also be different, leading sometimes to a perception of oppression and sometimes to a perception of a collaborative birth even when medical knowledge might seem prioritized. At the same time, the medical professionals’ affective experiences of such moments may also vary, contributing to an *affective knowledge system* that may influence future interactions.

Affect as a way of knowing seems to be largely missing from conceptualizations of authoritative knowledge. While, Daviss (1997) defines *personal logic* as the logic used when decisions are made about what one stands to “lose or gain on a personal level” (p. 443) by making a particular birth decision, and *intuitive logic* as the catch-all logic used when an individual makes a birthing decision without “necessarily depending on the other forms of logic” (p. 443), neither one of these seems to fully consider the possibility of linking knowledge to a complex web of emotions. Yet, critical and feminist pedagogy continuously emphasizes the importance of (engaging) affective experiences in the formation of knowledge (Freire, 1970; Probyn, 2004; Sedgwick, 2003).

One of the narratives in Pollock’s *Telling Bodies Performing Birth* (1999) also illustrates how affective knowledge and “illogical” rationalizations work to co-construct an experience of (heavily) medically-assisted conception, pregnancy, and birth as positive and filled with gratitude – an experience that resists traditional U.S. feminist readings

vilifying reproductive technologies. In this story, birth is, in fact, not a moment, but a process that has begun at the moment of conception after a couple's continuing attempts to become pregnant. Their collective knowledge of the pregnancy as a healthy one is marked by "signs." Their narratives, they resist the vilification of reproductive science and technologies by weaving them into a web of "this is how things were supposed to be for us." Their affective and symbolic experience of these technologies in relation to the pregnancy and the birth shapes their knowledge of what pregnancy and prenatal care are, as well as their evaluation of reproductive science itself.

Hall (2011) demonstrates that social experiences and interactions during pregnancy shape a woman's experience of and satisfaction with the birth of her child/ren. Root and Browner (2001) suggest that through the practices of self care, prenatal care is a process of "pregnancy ethical subjectivity in the making" (p. 196) by, to varying degrees, complying to and/or resisting formalized prenatal norms, as they are performed in pregnancy advice books and by medical professionals. Considering this, it is also difficult to imagine this process of "pregnancy ethical subjectivity in the making" as isolated, not dialogic. From an interactional perspective, it seems deceptive to think of a woman's identity as an identity-in-flux and "under construction" during pregnancy, while holding everyone else's identities fixed and one-dimensional, with the only important dimension of others' identity being the interactional dimension (Tracy, 2002) defined in relation to the pregnant woman – OBGYN, nurse, mother, spouse, midwife, friend, etc. These individuals, as well as the communities they shape, must also be navigating knowledge systems, continuously negotiating and revising knowledge claims toward a complex prenatal knowledge system, integrated in a web of cultural meanings of gender,

motherhood, family, health. Not negating that certain knowledge claims are institutionally sanctioned, and thus, especially in the contexts of institutional encounters, carry more social power, these continuously dynamic knowledge systems can be seen as “transcultural,” borrowing from Chakravartty and Zhao (2008), or as “new cultural forms which emerge from unequal” relations (p. 13).

Returning to this relational aspect, Jordan notes:

The central observation is that for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. In many situations, equally legitimate parallel knowledge systems exist and people move easily between them using them sequentially or in parallel fashion for particular purposes. (p. 56)

Linking this statement to processes of producing “scientific” knowledge, one may observe a similarity between Jordan’s movement among knowledge systems and practices of other-world traveling, which Madison (2004; borrowing from Lugones) advocates as the ethical approach to critical ethnography. Reading Madison and Jordan in dialogue makes a strong argument for the benefits of the continuous dialogic production of knowledge, in which knowledge is not only about knowing something, but it is about the process of learning about others, about one’s self, and about “meanings of power and positionality” (Madison, p. 105). Furthermore, Jordan’s development of the notion of AK as a process also highlights that knowledge (and identity) production is rarely as benign and benevolent as it may appear, but rather it is interwoven in political, economic, and cultural projects.

Specifically, feminist and critical scholars, building on Foucault’s notions of governmentality and biopower (Bone & Meyers-Bass, 2010; Rose, 2008), have argued

that the pregnant body (yes, the body as a container) has become state responsibility for the sake of producing healthy and productive laboring bodies. In these critiques, prenatal technologies (such as ultrasound and genetic testing) and the knowledge associated with their use become surveillance, pregnancy becomes pathologized, and pregnant women who rejoice in the technologically-mediated possibility to see their future offspring on a screen, for example, become “victims” of scientific discourse. This line of critique – although fruitfully relating pregnancy and prenatal care to political-economic and nation-focused projects – has also led to (perhaps inadvertently) vilifying medical professionals who become the enforcers of technocratic governmentality and “rob” women of the empowering and powerful experience of birthing “naturally” (whatever that means).

Yet, this perspective, despite being the one that is perhaps most often expressed by reproductive and women’s rights activist in the U.S. (and pop-culturalized in documentaries such as *The Business of Being Born*), is full of “feminist paradoxes” (Schwartz Cowan, 2001, p. 195) and is in its own right criticized for being too essentialist and de-contextualized (Mazzoni, 2002). In this sense, it (re-)creates oppositions where alliances and relationality might be possible and even experienced. It also negates the webs of social networks and meaning-making within which pregnancy is experienced – by pregnant women, yes, but also by their families, friends, and prenatal care providers (both formal and informal). In the next section, I first review some of the literature on the development of the contemporary pregnancy and birth models in the U.S. (and the debates around understanding this models), and then I discuss some ways of knowing that remain inaccessible in the context of an essentialized and dichotomized reproductive debate.

Pregnancy and Feminist Paradoxes

That a technology-monitored pregnancy is only one possible model of prenatal care should probably go without question. In fact, the very critique of this model by women's rights activists suggests that there are other (unrealized, subjugated?) possibilities, as well. What critiques of this model target, then, is not an all-encompassing, dictatorship-like pervasiveness, but rather the ideological positioning of pregnant women vis-a-vis state governance and subject formation in the process of a pregnancy. Yet, as I will discuss in more detail below, the very "choice" of reproduction as the battlefield where female power is portrayed as both most pronounced and most contested, essentializes reproduction as *the* feminine domain, re-inscribing gendered divisions that in patriarchal societies have been seen as the very foundation of subjugation of the feminine and of women (Mazzoni, 2002). Recognizing such paradoxes is to be self-reflexive - to hear the multiple voices (Baxter, 2011) - of the ideological positions on which (supposedly) empowering critiques themselves stand, and, as Ruth Schwartz Cowan (2001) warns, such on-going critical self-reflexivity is necessary because "not all hypotheses generated from a feminist standpoint will turn out to be true" (p. 192).

At present, the main hypothesis pitched from critical feminist perspectives against arguably "medicalized" prenatal and birthing practices is that they are often unnecessary and their performance pathologizes a natural process and, thus, disempowers women as the agents of this process. This hypothesis is based on both critical theory and some very telling statistics, according to which unnecessary medical interventions during birth are both expensive and linked to worsening birth outcomes (e.g., Bingham, Strauss, &

Coeytaux, 2011). The scary persuasiveness of statistics notwithstanding, what is discursively and dialogically important about the set-up of this hypothesis is that dichotomizes a much fluid process and models of prenatal care and birth, despite examples that possibilities other than an antagonizing struggle (Baxter, 2011) are possible.

To engage only one such example, drawing on Kristeva, Peterson(1987) writes there are two main discourses organizing stories of pregnancy – the medicalized or crisis model, and the natural/theological or prepared model. Yet, he goes on to develop at least two more possibilities for pregnancy discourse – one, he calls the “relational” but goes on to explain that in this model pregnant women are conceptualized as industrialized (re-)producers of group identity as a commodity. It is not quite clear, however, why according to this discourse men/fathers are excluded from the (re-)production process. Furthermore, in more recent developments of feminist critiques of medicalized prenatal care and birth, this discourse has been integrated with the crisis model to make a stronger case against the exploitation of women based on a neoliberal ideology (e.g., Rose, 2008). Finally, Peterson, again based on Kristeva, discusses the possibility of what he calls “continuity of conscious experience” (p. 45) discourse in which birth is not seen as an isolated event, the woman is not seen as an isolated entity, and the family – not as an isolated unit, but all are connected in an ever renewing process of identity, knowledge, and culture formation.

Considering such possibilities, the question becomes, I contend together with Ivry (2009), not which one is present at any given moment, in any given interaction or story, but rather how the multiple possibilities intersect and collaborate in the production of

prenatal knowledge; and no one involved in experience or narratives of pregnancy – the pregnant woman, her family and friends, possible partner, caring professionals – is automatically excluded, due to their social role, from the possibility of such intersections. In fact, a switch to a dialogic perspective (Baxter, 2011) would mean switching focus away from the individual and toward discourses hear-able in narratives. The question of power moves away from *who* holds AK to *what* discourse(s) or system(s) of meaning are made present or absent, central or marginalized in the telling of stories.

To take this a step further, if we see research itself a genre of story-telling, Baxter (2011), among others, would argue that the dominant system of meaning is one that juxtaposes opposites in an either/or fashion, rather than bringing them together in a productive, tense interplay. Thus, as discussed above, it is the divisive dichotomy of natural vs. medical, rather than a dialectical interplay of natural with medical with other systems of meaning, that frames much of contemporary reproductive texts. The militant juxtaposition is linked to the development of the women's health movement in the U.S., and is stated by the much-cited Ehrenreich and English (1979): "the expert's authority rested on the denial or destruction of women's autonomous sources of knowledge: the old networks of skill-sharing, the accumulated lore of generations of mothers" (p. 4). Not denying the possibility of experiential and experienced truth in this statement, it still begs the question from whose perspective is this conclusion reached. And why are "authority" and "power" envisioned as a win-lose-type give and take? The hypothesis excludes the possibility for the "professional" ("expert") to learn and to have learned through and in such networks, for example. It embodies a too-many-guarantees approach (as opposed to Hall's "no guarantees") in which the social role (e.g., medical professional or pregnant

woman) seems to be an (en)closed promise for communication and knowledge production/flow.

In contrast to this approach, it is interesting to see Rapp and Ginsburg's (2001) open treatment of kinship in the case of raising children with disabilities. They argue for flexible kinship, based on performances of support and shared experiences, destabilizing presumed social roles – a kinship of community rather than one of blood, as the conventional meaning of the word suggests. Aimee Carillo Rowe (2005) similarly argues for such networks of belonging. Both essays highlight the transformative potential in such networks. Rather than arguing that this type of “kinship” is possible in one model of prenatal care and not in the other, I believe its possibility and affective experience should be explored regardless of the model. To this end, and as I explain later in the methodological section, I approach this project with a wide-open definition of “affinity networks” and relationships, leaving it up to collaborators to define the kinship that mattered/matters in their own experience of prenatal care and pregnancy. In this way, I believe, the narratives can speak to relationality on their own terms, making it possible in its different incarnations and in various contexts. Relationality, as narrated by both Carillo Rowe and Rapp and Ginsburg, is configured differently, but is affectively experienced as closeness, dialogic creativity, and support (granted the meanings of those remain local and locally-negotiated).

Overlooking the possibility of relationality, an extension of the hypothesis that medicalized models of prenatal care and birth disempower women also concerns a view of prenatal care as fetus-centered rather than mother-/woman-centered, and thus negligent

of women's rights and full subjectivity. Both of these criticisms, as well as their political implications, are well-summarized by Laura R. Woliver (2002, p. 18):

Women's birth power, for instance can be challenging to males. The history of obstetrics, when seen from the women's point of view, seeks to problematize, pathologize, and then control and rescue reproductive power. (...) Obstetrics reduces women to their bodies alone, as Robbie Pfeufer Kahn points out: "Not only is her body denied consciousness, but her elemental physical powers are also suppressed. Consciousness and physical prowess reside in the doctor who works upon the body of the mother, as if he or she were mining ore from the earth" (1995: 94).

Clear in this statement, especially in the quote it includes, is the juxtaposition between nature and technology, earth and industry, the pregnant woman and the medical professional. In the "critical" feminist discourse itself, these opposites are not dialectic – they are not co-existing and held in a productive tension (Baxter, 2011; Martin & Nakayama, 1999). They are other-negating, impossible to view as "continuity in difference" (Mazzoni, 2002), and, moreover, they struggle over power.

This understanding of power, although purportedly evoking Foucault's (1978) notion of biopower, is quite negligent of his own view of power as circulating in society. As Saukko and Reed (2010) quite succinctly summarize, there are three dimensions of Foucault's notion of governance: 1) it refers to the art of governing nations and populations, and thus, national discourses are recreated in health practices, 2) "governmentality (...) is never simply a force of dominance" (Saukko & Reed, p. 3) in the sense that one is simultaneously an object of governance and a subject of governing, and 3) power is understood as multi-scaped and horizontal (as opposed to vertical, base-superstructure models). That the complex web that these dimensions weave is reduced to a negatively valorized use of "biopower" as state-sanctioned control, is evident in the tendency to qualify and target as mis-recognition (Bourdieu & Passeron, 1977) women's

stories of finding the use of prenatal imaging and testing technologies to be/feel empowering (Georges, 1997). Similarly ideological and context-specific is to present the use of such technologies as a power/knowledge struggle between pregnant women and their doctors – ultrasound images, for example, can (and do) have both “diagnostic” and affective value, and experiencing the ultrasound ritual together with a partner or a family member can be a strong bonding experience, an occasion for producing knowledge together rather than an event in which a woman is made to give away her power by revealing an embodied secret.

On the other hand, Ivry (2009) offers an interesting account of the complexity of governmentality in the case of Israeli prenatal care. Putting her ethnography in a historical context, she points out that from the very beginning of the Israeli state, pregnancy and delivering healthy children has been clearly declared as a responsibility to the nation. Primarily for this reason, the Israeli prenatal system is highly technology-based with a wide range of tests administered routinely. Furthermore, larger cultural scripts clearly underline the experience. For example, Israeli participants in her study – patients, family, OBGYNs, etc. – uphold a sense of ambiguity and fear that is related to pregnancy. While for pregnant women this might be performed by adhering to routine testing, it is also an expectation that affects OBGYNs’ interactions with pregnant women, so that when they discuss the results of a test, for example, “ob-gyns [sic] often understand ‘hysteria’ as an underlying state of mind that might easily take over a pregnant woman or ‘erupt’ at any moment” (Ivry, p. 48).

This type of comment may be exactly what fuels feminist anger in a move toward reclaiming some essentialized female power that is not reduced to a mental dysfunction.

Yet, it is worth reading Ivry's account because we find out later that the same sense of ambiguity underlines pregnant women's critical reflection on and questioning of medical diagnosis on the basis of knowledge generated other-wise (e.g., in personal stories). Drawing on a "whole 'genre' of salvation stories that some women offer to resist medical authority" (p. 208), one of the women in her study questions the suggested amniocentesis test. In fact, Ivry concludes that "For Israeli women, contesting the accuracy of the information and challenging the medical indications based on it were inseparable parts of consuming the information" (p. 205). Thus, while "natural"-birth advocates may be skeptical of technology as robbing women from the power of the unique knowledge they naturally carry, participants in Ivry's study show that "naturality" is as much of a cultural construction as any, and that, furthermore, the (possible) use of technology does not automatically produce a subordinated object of governance and does not subjugate "feminine" ways of knowing.

Her study also shows that, following Foucault's first dimension of governmentality, prenatal care is quite directly (as well as indirectly) related to the project of the nation (in all its classed, raced, gendered, etc. dimensions), as well as to projects of transnational influence. As many scholars have noted, there's much more at stake in reproduction than the continuation of a family through the birth of an offspring. In even the most benign ways, practices of prenatal care and of birthing, similarly to other performances of knowledge and/in care (Conquergood, 1989; Covarrubias & Windcheif, 2009), (re-)produce culture and perform recognizable belonging – beliefs that pregnancy and birth are associated with fear, or that women tend to be emotional in the face of uncertainty are both performed and perpetuated by the Israeli prenatal care

practices described by Ivry (2009). In this sense, when scholars talk about pregnancy as a moral responsibility and practice (e.g., Root & Browner, 2001), two things seem to be implied: 1) the morality is in regards to the birth of a (healthy) child, to the maintenance of a healthy mother, and to properly (re-)producing culture and society, and 2) pregnancy as a moral practice has both private and public dimensions; as intimate as the experience might be, as “secretive” as it might remain in the womb, it is (obviously) never outside of culture and relationships. Both of these implications highlight a view according to which knowledge(s) is multi-dimensional, complex, and navigated among and according to various relational systems.

Studying the knowledge “navigation” and negotiation of pregnant women, Root and Browner (2001) write:

In this paper we contend that contemporary prenatal care, given its plethora of technological and social monitoring mechanisms, can be viewed as a set of moral acts derived from implicit and explicit moral codes. (...) How pregnant women assess their own behaviors, we argue, takes us beyond the politics of dichotomized doctor-patient relations into the heart of Foucault’s so called ‘self relations’ (...) We suggest that pregnancy is, above all, characterized by a split subjectivity in which women straddle the authoritative and the subjugated [knowledge] in telling and often strategic ways. (p. 196)

I come back to the topic of “other” ways of knowing during pregnancy and what constituted subjugated knowledge in Root and Browner’s study in the section following this one. Here, I’d like to summarize that, similarly to Ivry (2009), Root and Browner find pregnant women to be active agents in the construction of prenatal care and the knowledge(s) associated with pregnancy – in responding to medical advice on an ever dynamic continuum of compliance-resistance, women in their study constructed “ethical subjectivities” as “good mothers.” In constructing these subjectivities future mothers had to negotiate discourses not only as “baby-containers,” but as women, spouses, daughters,

patients, friends, and media consumers. The strands of cultural meanings that weave into the construction of a woman's pregnancy experience and prenatal care go well beyond the pregnancy context to include gender, race, class, filial relations, political views, etc.

Yet, despite showing the unique and active negotiation and production of knowledge on the part of pregnant women (and despite not considering that a similar dynamic process is part of the family- and provider-experiences), I feel that Root and Browner leave much to be desired in considering the influence of relational and communicative contexts in negotiating those varied strands of meaning. The group of women talked about in their study seems to be homogenous enough – with pregnancy being the lowest and sufficient common denominator. What are the women's backgrounds and types of family climates and how is that relevant to the negotiation of prenatal knowledges coming from various sources? Who is included in women's meaning-making systems during pregnancy and why? What are the specific communication practices that enact compliance/resistance, or how does the synergetic knowledge of pregnant women function interpersonally? What if the same set of questions were extended to health care providers, whose identity can also be seen as “ethical subjectivity in the making” (Root & Browner, 2001, p. 195)? Far from following the traditional approach to culture in health communication (seeking to highlight and control differences in boxed-up characteristics), such questions imagine reflexivity, so that those participating in the process of constructing prenatal knowledge(s) can critically engage (with) their own experiences, with contexts that matter to them, with choices and constraints on such choices as they are uniquely and affectively experienced. Responding to this, in this project, I hope to and methodologically plan to extend the understanding of

“ethical subjectivity in the making” along those additional dimensions, mindful of the critiques of “choice discourses” (Hayden & O’Brien Hallstein, 2010).

It is exactly “choice” (and its systemic constraints) that become the crux of “feminist paradox[es]” (Schwartz Cowan, 2001, p. 195) when it comes to reproductive discourses. In a capitalist context, the notion of choice itself evokes morality and responsibility – “free” choice is at once valued and imbued with an expectation of accepting the consequences. The morality of choices, especially in the reproductive realm, is also socially-judged (Hayden, 2010) and frequently legislated. For such reasons, many of critical scholars have criticized the illusion of choice, let alone “free” choice, created by neoliberalism and by transnational capitalistic process. According to Kroløkke, Foss, and Sandoval (2010), legislating “the female body in relation to reproduction creates additional constraints on women’s choice particularly in regard to the rights afforded a fetus. (...) The pregnant body is inseparable from the fetus as well as distinct from and responsible for it” (p. 96-97).

Tracing the rhetoric of choice back to second-wave of feminism in the U.S. (O’Brien Hallstein, 2010; 2011), feminist critics have drawn attention to ways in which co-opting the rhetoric may work both to create a sense of empowerment and to actually undermine women’s rights. Fixmer-Oraiz (2010) writes:

For Solinger (2001), choice is, at best, a *derivative* of rights – a kind of “rights lite”: “by the end of the 1970s fathers were recognized as having rights, fetuses were granted rights, and ‘children’s rights’ were newly and broadly acknowledged. Women on the other hand were accorded only ‘choice’” (p. 193). Thus, in the realm of reproduction, women’s claims to autonomy, freedom, and/or protection under the law are rhetorically and materially relegated to a kind of peripheral status, subsumed within a discourse that assigns rights to every imaginable party within the process of conception and childbearing except the woman herself. (...) Second, within the context of contemporary biopolitics and neoliberalism, the language of choice has been effectively co-opted and used

against women. (...) Mainstream feminisms of the 1960s and 1970s claims to a “woman’s right to choose” is, and has been, easily absorbed and appropriated by a broader discourse of consumption and responsibility that troubles inclusion and solidarity within feminist communities. (p. 43)

Similarly, O’Brien Hallstein (2011) discusses a “post-second wave crisis in femininity” that is linked to the rhetorical construction of motherhood in light of co-opted second-wave values of having a choice to do what one (woman) wants reproductively, professionally, and in self-care. She sees this crisis as a backlash to feminism in which new gender normativity and forms of oppression and exploitation are forged under the banner of “doing it all.”

What O’Brien Hallstein (2011) sees as a feminist backlash and/through co-opted rhetoric, constructs experiential paradoxes for other scholars. For example, Schwartz Cowan (2001) talks about the development and use of prenatal testing technology, responding to criticisms that the use of such technology allows for unethical sex selection of the baby, where there exists a preference for male children (note, again, the rights of the fetus are evoked here). In the brief history she recounts, not only does she show that prenatal testing technology was developed to identify *male* fetuses at risk for hemophilia and that access to such a technology in the U.S. used to be, and still is, a class- and race-marked privilege, she also notes that as the technology became more widely available and in many cases routine during hospital prenatal care, it was perceived to enable, rather than disempower, women’s choices. She also shows how the women’s health movement (from its particular social position) advocated for the development of prenatal and contraceptive technologies as part of (perceived) women’s empowerment. This, she writes, put some physicians who were asked to perform abortions for sex selection in a “feminist paradox”: “Physicians who refused to terminate pregnancies for sex selection

were compromising the autonomy of their female patients (...) *and* placing restriction on the right to abortion that had been granted in *Roe v. Wade*. Which feminist principle ought to take precedence?” (p. 195).

King (2010) finds a similar paradox in considering how in the case of the “fight against breast cancer” movement what is seen and performed as empowering (the rhetoric of survival and fighting), following the women’s health movement in the U.S., has actually contributed to the formation of uncritical consumer subjectivities. These subjectivities are realized, for example, in the affective bond symbolized by pink ribbon merchandise and economy. Participating in the pink ribbon economy as a mode of fighting and celebration of “survival” empowered by social support minimizes the importance of research that links cancer prevention and treatment to environmental factors and to access to health care. It furthermore, obliterates the experiences (and deaths) of all those who can’t participate, who may be most affected by environmental factors, and who are least likely to get regimented treatment due to their social and cultural positions. Furthermore – with its white middle-class supporters and flare – the “pink ribbon” is a convenient cause of corporate philanthropy, reinforcing structural forces supporting systemic inequality in U.S. society in general and in health disparities in particular. Rather than highlighting structural inequality, then, contends King, pink ribbon campaigns participate in building of a profitable discourse of individual perseverance, highlighting the survivor as a rhetorical trope. Thus, the paradox is that while “pink ribbon” campaigns empower cancer patients and their support networks to feel “in control” and to be public in their struggles with a disease that was once also marked by a social stigma – empowerment associated with the women’s health

movement – they are also supportive of larger discourses of inequality, quite to the contrary of professed feminist principles.

Notably, as King (2010) also discusses in her essay, the second-wave rhetoric of choice and second-wave women’s health movement as a whole have important race and class dimensions and have been mostly associated with white middle-class feminism (Hayden & O’Brien Hallstein, 2010; Saukko & Reed, 2010) and linked to a pronounced division in (possible) feminist alliances. Such divisions may be especially strong when discussing one’s “choices” of prenatal care. While wide-spread criticism in the U.S. and now reaching to other countries around the world, such as my native Bulgaria, notices the effects of medicalizing births as constraining choice, those constraints themselves are implicated in larger social systems of inequality and access. To the extent to which reproductive and prenatal technologies are (still) seen as a marker of modernity and their use by families may be related to economic well-being (e.g., consider the cost of IVF), their use – and one’s ability to make use of them, or refuse to use them as part of an “informed choice” (as in birthing at home, for example) – is also part of constructing and embodying symbolic capital. To de-historicize and de-contextualize discussions of “medicalized” and “natural” model of prenatal care would, thus, also mean to obliterate not only specific affective and cultural positions from within which those models are experienced, but also the structural inequalities that frame such experiences.

In this sense, and also linking to the implications of the U.S. “second wave” and women’s health movement, scholars have theorized the ideological return to “natural” prenatal care and birthing as white middle-class, educated (e.g., Mazzoni, 2002; Peterson, 1987; Rich, 1976/1995). I emphasize here that this is an *ideological* (re-)turn to draw a

line between actual practices of prenatal care and the moral valorization of such practices as “good/better mothering”. Commenting on both the classed and raced character of appropriating (misleadingly, as he points out) the “natural” label, Peterson (1987) writes

As Rich (1976) points out, prepared [“natural”] childbirth is a middle class phenomenon that depends on a secure economic and emotional context to reduce the fears of survival, acceptance, and motherhood. And the connotation of naturalness is also inappropriate since most “prepared women” end up in a hospital for childbirth. In fact, the childbirth educator usually provides a role model for appropriate hospital behavior by demonstrating how to speak to nurses and doctors and by describing what to expect at the hospital. (p. 44)

Although arguably things have changed since 1987 and women of certain social positions in the U.S. today have more options for giving positively-valorized “prepared” natural births (e.g., at home in the attendance of a certified midwife who can respond to an emergency), it is again the ideological dimension of “natural” that, paradoxically, professes empowerment but sets its own constraints on the experience of pregnancy and birth. Mazzoni (2002) contends that the ideological invocation of a “natural” discourse is problematic because it undermines other ways of experiencing pregnancy, prenatal care, and birth as less-than ideal. Supportive of this view is the experience of women who antagonize for years over not having a pregnancy and “birth experience” as perfect as the ones shown on programs like *A Baby Story* (Hall, 2011).

Further commenting on the feminist paradox of uncritically ideologizing “natural” pregnancy and birth, Mazzoni (2002) writes, “That feminists should be skeptical of the concept of nature comes as no surprise. It is in the name of nature, and particularly the nature of reproduction, that women have traditionally been subjected” (p. 160). The surprise, as she later contends, is the constrictive ways in which such skepticism is lacking – the unconditional, all-guarantees essentialism that incapacitates visions of

transformative possibilities. Mazzoni herself, as well as other writers I have mentioned earlier (e.g., Carillo Rowe, 2005; Rapp & Ginsburg, 2001), imagine such possibilities of collaborative and respectful construction of knowledge(s). I turn to this other ways of knowing in relation to pregnancy in the next section, because I believe it is important to be tuned-in to the possibilities so as to be attentive to them, while, at the same time, keeping categories fairly open and unstable, always fluid, contingent and reflexive of the context. Building the link between context and open and relational knowledge production, I close this section with a rather long quote from Mazzoni that critiques feminist essentialism and brings us back to the importance of self-reflexive positionality:

Even many of today's feminist critics who discuss the disempowerment of pregnant women in contemporary society often fail to place their considerations in any historical framework, falling into generalizations that maybe rhetorically powerful yet historically unfounded. (...) [citing Kaplan] "Culture now imposes constrains on this body, dictating what the mother will, or will not use her body for... No longer is the womb the safe, idyllic sanctuary it has long been mythically celebrated for" (132).

The constraints on the pregnant body are not new. I would argue on the contrary that this 'mythical celebration,' to use Kaplan's expression, is itself a mythical construction without historical bases. (...) an unabashedly ideological construction, one aimed at buttressing the unwittingly essentialist argument that, in matters of pregnancy and abortion, 'mother knows best.' (...) For as the theory of maternal impressions attests, the womb has not been perceived as a 'safe, idyllic sanctuary' for a very long time. (p. 15)

Knowledge(s)

The theory of "maternal impressions" that Mazzoni (2002) explores at the intersections of female-authored literature, psychoanalysis, scientific discourse, and feminist criticism is a theory of relationality. Rejecting an un-impression-able sanctuary view of the womb, it focuses on the mutual impression-ing among pregnant woman, future children, and society. It is a theory of knowledge production – what ontological, epistemological, and axiological social beliefs guide the "treatment" and experience of

pregnancy as a process that always leaves a mark (impresses) the child, the mother, and society; how do unborn children impress their (future) mothers with embodied and affective knowledge otherwise unattainable; how is this knowledge made meaningful and/or tamed; how does it enter the (cognitive) knowledge systems of those knowledge-makers who will never be pregnant. In exploring the contemporary implications of the theory, refracted through her own experiences of carrying and birthing three children, Mazzoni attempts to revive and legitimize knowledges and representations of pregnancy that “easily risk being obfuscated in a worldview that has relegated all senses other than seeing or hearing to a secondary status and defined all knowledge that is not disembodied and abstract as useless” (p. 106).

Although this re-covering of voice, narrative, and knowledge has long been a focal feminist and critical process, what I find interesting in Mazzoni’s development of the theory of maternal impressions is her claim, reminiscent of co-cultural theory of communication (Orbe, 1996, 1998; 2004), that these representations and knowledges are not lost, but might be “obfuscated” by being folded into dominant discourses of prenatal and birthing knowledge. That means, that these strands of knowledge – cultural, embodied, affective – must be woven, and the patterns negotiated, in the knowledge production and interactional processes of even those are most likely to be charged by critics as hailing dominant discourses. For example, one familiar incarnation of the theory of maternal impressions is that what the pregnant woman eats under certain circumstances (e.g., if she’s craving it or have stolen it) during her pregnancy, will (re-) appear as a birth mark on the future baby. Mazzoni writes,

Although maternal impressions, which recur time and again in the works of late-nineteenth- and early-twentieth-century scientists and women writers, are quickly

dismissed as superstitions on the rare occasions in which they are mentioned in today's pregnancy advice manuals, they have very real counterparts, poignant translations into the language of contemporary popular and medical culture. (...) as Helena Michie and Naomi Cahn note, 'the mother's every move, whether it be taking a bite of dessert or choosing underpants, is carefully inspected, calibrated, and quantified with respect to the baby inside her' (25). (p. 13)

In experiences of pregnancies and births, then, the translation is not only from old wives' tales to medical literature, it is also from un-see-able and un-heard-able knowledge to observe-able data with which others can also interact (and inspect). Yet, translation is also negotiation, it is evoking cultural scripts, it is ever-reworking them (Weber, 2008). And why should we assume that, in the context of pregnancy, it is only the pregnant woman that does this labor of translation, subjecting herself (and the potential baby) to others' surveillance? It is perhaps easy to isolate the possibilities of other ways of knowing in the case of pregnant women, because of the physical presence of another within the body (Kristeva, 1981).

Reflecting on her own experience, Mazzoni writes: "at the center of my discovery was a sense of shared knowledge as it is developed through the bodily, psychological, and spiritual connections between pregnant woman and fetus. Far from repressing it, this knowledge openly embraces its corporeal genealogy" (p. 53). And it is perhaps easy to imagine ethics of relationality in that case; of joint, collaborative, in-translatable knowledge production. But, it seems to me, it is naïve, and re-inscribing an individualist ideology, to imagine that relationality and knowing through connection to an-other across time and space is attainable only to a pregnant woman. It is hard to imagine, for example, that the affective and embodied knowledge of what grief *feels* like, is absent in the digitally-told story of a nurse (Erickson, 2008) whose interactions and educational philosophy are forever impressed by the pain of experiencing the death of a baby she

took care of early in her career. Taken together, the above two stories may teach us is that, as a form of knowledge, the embodied and affective are present – the question becomes how are they transformed in entering interaction with an-other?

Furthermore, in the case of medical professionals who assist and may even guide prenatal care, the question becomes of how to interactively integrate these strands of knowledge in a relational way. Evoking the subjugation of female/feminine knowing on matters of pregnancy sometimes suggests that women have been made to forget what should be “natural” knowledge; yet, considering the memory of the body and of affect, a much more convincing argument is the one according to which the subjugation is not through forgetfulness, but rather through not qualifying these ways of knowing as knowledge. Similarly to Mazzoni’s claim to obfuscation, Root and Browner (2001) found that among the women they interviewed, “emotions, fatigue and hunger” were the “primary means by which they acquire and access knowledge of their bodies,” while, they continue, “these phenomena also constitute those aspects of pregnancy which biomedicine trivializes (...) Relegated to the margins of pregnancy ‘management,’ they accrue their subjugated status” (p. 201) What counts as knowledge is an old and central question to critical theorists and scholars. Yet, in affirming these (discounted) knowledges, it seems important to take this question a step further: how does the process of discounting – as an *interaction* – happen, and how can it be interactionally transformed?

Highlighting that discursive, negotiating dialogue of knowledges happens in interactions, as well as narratively, Root and Browner (2001) found that women navigate dialectics between affirming their own (subjugated) knowledges and being good mothers

by complying to biomedical (authoritative) knowledge. The authors saw this in women's narrative fluctuation between the use of "I" (embodied experience with focus on their own body) and "you" (general claims more typical for othering the self) and between everyday language of pregnancy (telling stories on their own terms) and using biomedical terminology to describe their experiences. Similarly, Peterson (2010) talks about such negotiations performed in a discursive disjunction – places in narratives where two different, often opposing, social discourses and experiences intersect in a meaning-making process. On the plot level such negotiation in Root and Browner's study was performed by the narratives "travelling" back and forth between women telling the health professionals about their experiences (e.g., feeling overly tired) as an affirmation of their own knowledges about their pregnant bodies and looking for medical affirmation of this knowledge (e.g., the nurse saying that it's perfectly normal given the household work and care for other children).

Such studies have yielded fairly consistent results in identifying ways of knowing other than the science of biomedicine. There is the embodied knowledge – (stories of) fatigue, hunger, enlarged breasts, (lack of) quickening, responses to different foods and drinks, etc. There is the affective knowledge – changes in mood, anxiety, expectation, the (myth of) nesting – the contribution of recognizing emotion as a unique way of knowing being distinctly linked to feminism. As Probyn (1993) writes, "an emotional foregrounding of the self [is] a way of critically acknowledging the ontological and epistemological bases of knowledge formation" (p. 83). Mazzoni (2002) also acknowledges that prenatal knowledge is about more than the "health" of the body/bodies

it sustains. In her experience, affective prenatal/pregnancy knowledge becomes about identity:

At the same time, as I give birth I experience a crisis little recognized and acknowledged by society and the medical profession. (...) My self-identity is challenged and often destroyed and re-created in vital ways, different for each woman, in the course of pregnancy (...) a maze through which you have to find your own way because no one can adequately prepare you for it. But no one even tried, it seemed to me, certainly not any of the six doctors in the practice that assisted me in the birth of my first two children. Their job was to take care of my body, to read it for signs of pathology, for symptoms of dangerous motherhood, and not to soften the impact of its wild storms of passions, hurricanes of love, pleasure, desire. (p. 157)

Two points are relevant to make in relation to this quote. First, Mazzoni's criticism of biomedicine here is foundationally epistemological – that the meaning of knowing about health in this context is constituted by knowing about the machinery of the body.

Similarly, experiences of pregnancy-related and post-partum depression, for example, may be known to women affectively (Peterson, 2011), but are explained by biomedicine as a function of changes in hormone levels. Root & Browner (2001) mark this disconnect in knowledge formation and ways of knowing when they summarize the finding of their study, “above all, the reports of the women in this study demonstrate how the biomedical representation of pregnancy is inadequate for grasping women's experiences of their bodies and prenatal norms during pregnancy” (p. 219). However, a question remains, the answer of which seems to be often assumed, of whether “biomedical representation of pregnancy” is adequate for “grasping” even medical professionals experiences, and even if it is, how is this adequacy communicatively accomplished? Differently from Root and Browner and other studies on prenatal knowledge formation among pregnant women, Mazzoni's critique, recognizing the contextual dimensions of interactions, as well as the personal affect associated with these interactions, seems to me to be more open to

dialogue than an essentialist medicine vs. nature dichotomy. It recognizes to at least some degree the (cultural) structures that shape our experiences of embodied reality toward a particular knowledge of that reality.

The second point in relation to Mazzoni's (2002) quote above is her consideration, or lack thereof, of the role of culture in shaping emotions and affective experiences, as well as of emotion culture's propensity to shaping how we experience reality, included the embodied reality of pregnancy and birth. Hochschild (2003) pioneered the idea of emotion management/work in the field of the social science, to suggest that in experiencing and expressing our emotions we dialogue with context-specific cultural norms (feeling and expressive rules) of affect. Furthermore, building on the political dimensions of shaping normative rules and of emotion work, she developed the thesis that feelings are commodified in service professions, becoming part of paid labor. Foundational to this thesis is the idea that deep acting – i.e., the “truthful” experience of the particular emotion – rather than its mere expressive appearance, is profitable, sought after, and rewarded. In her discussion of emotion culture Kotchemidova (2010) takes this idea further to consider how the continuous performance of emotion work and its communicative dimensions (i.e., expression) shape an overall outlook on and experience of reality. Her study explores the perspectives of West-European immigrants to the U.S. who suggest that their interpersonal interactions with U.S.-nationals (of unreported class, race, sexuality, religion, education, etc.) and the “culture of cheerfulness” these nationals embody has changed the ways in which participants in the study experienced emotions and reality in a more positively-valenced, more exuberant, and less critical direction.

This question of emotional framing is important to the present project, as it links knowledge, experiences of reality, and affect. Pregnancy and childbirth are very emotionally-complex contexts. At the same time, pregnancy, childbirth, and child-rearing are seen as socially productive, despite mostly unpaid, labor. With this in mind, it is important to consider how emotion cultures and emotion work frame the formation of (affective) prenatal knowledge. In the reproductive context, although in a different vein, Hayden (2010), for example, remarks in a footnote that reproductive realities and decisions are shaped by larger cultural discourses about the emotional and political implications of motherhood. She writes,

Feminist scholars have argued decisively that women of different races experience mothering in unique way. In particular, white feminists have critiqued the institution of motherhood as oppressive, and as I argue later in the chapter, some of my interviewees refer to the idea of oppressive motherhood when discussing their decision to remain childless. African-American feminists, on the other hand, have argued that motherhood has not traditionally been an obstacle to African-American women's freedom (hooks, 1984). (p. 290)

Considering cultural framing of experience does not necessarily require a view of culture as static (as is suggested in Kotchemidova's (2010) article or in the above quote, for example). As the self-reflexive and identity-focused writings of Audrie Lorde, Gloria Anzaluda, Dorothy Allison, and Carolyn K. Steedman, among others, narrate, culture, as both an organizing and continuously negotiated structure, can be seen as historically-specific, public, and observable, as well as uniquely private at the same time. Thus, one of the focal points of this study becomes an exploration of the larger cultural discourse(s) into which pregnancy is experienced by the pregnant woman and (co-)experienced by those who are an integral part of the pregnancy. Furthermore, such focus requires us to also explore how these cultural discourses are privately experienced and interactionally

responded to in (co-)experiences of pregnancy. How are these discourses experienced in dialogue and how do they shape the formation of knowledge(s) during pregnancy?

Review and Purpose of the Study

So, mindful of my own framing of the proposed study, I close this section with a reminder of the theoretical and practical lessons that inform it. From the critical development of the concept of culture in health communication, I take away two major points: 1) a critical consideration of culture in health contexts requires us to see it as both structure and agency – “locally negotiated contexts,” and 2) despite such critical considerations, a traditional view of culture in health context, highlighting characteristic difference presumed mostly based on national or ethnic origins, is influential on the field and guides interactions about health. From transnational (feminist) theory, I borrow an understanding of consciousness and affect of identity and knowledge as in flux, multi-dimensional, at the borders, unruly and restless. Considering such unruliness, one can understand privilege/dominance, in the context of “modernity,” as the experience of unified, uncomplicated identity and knowledge. Studies of authoritative knowledge (AK) in prenatal care and birthing are supportive of the link between social privilege, power, and the “possession” of fixed and legitimated ways of knowing (e.g., Mazzoni, 2002; Root & Browner, 2001). But such studies also trouble dominant discourses, by focusing on processes of collaboratively establishing (and hence, potentially transformative of) authoritative knowledge. Studies of the processes by which authoritative knowledge is accomplished are also helpful in highlighting the communicative practices that build knowledge/power interactionally.

However, these studies can also stand to learn from narrative approaches to communication that explore knowledge negotiation and construction in the telling of personal narratives (e.g., Peterson, 2010; 2011), for, as Bakhtin's dialogism underlines, every communication encounter links past, present, and future, and as such has internal and external dimensions that interact in the negotiation of identities. Narrative approaches to the study of knowledge dialogues in the context of prenatal care have also highlighted ways of knowing pregnancy and prenatal care other than the physically-measurable and cognitively-analyzable. By examining pregnant women's stories, scholars (Ivry, 2009; Ketler, 2000; Mazzoni, 2002; Root & Browner, 2001) have shown that pregnant women negotiate streams of knowledge – cultural beliefs, mediated and personal narratives, biomedical advice, embodied and affective experience – in shaping their prenatal care practices. The same might be (and likely is) true for other people linked to the experience of the particular pregnancy – family, friends, care takers – whose experiences of relational and dialogic knowledge and identity negotiation are largely excluded from existing research. Such exclusion may lead to one-dimensional criticisms that are rhetorically powerful but have paradoxical effects for gender and health care rights.

Responding to the above considerations, I began this project with a narrative exploration of processes of prenatal knowledge(s) negotiation and formation in the experiences of interactions surrounding pregnancy. Furthermore, the project was concerned with how identities and belonging are relationally negotiated and constructed in the context of a pregnancy and how the affective experiences of such processes of negotiation shape one's experience of pregnancy. Again, I would like to emphasize that

by “experience of pregnancy” I do not mean only the experience of the pregnant woman, but also of those people who, in one way or another, are co-experiencing the pregnancy. Broadly, I started this project by wondering, "What counts as knowledge in pregnancy and prenatal care? What (if any) knowledges count more/speak louder? What identities are accomplished, deconstructed, and/or questioned in processes of knowledge negotiation and formation around pregnancy?"

CHAPTER 2

STORY - TELLING AS METHODOLOGY AND PREGNANCY: CREATIVE, TRANSFORMATIVE, RELATIONAL

Personal experiences - revised and in other ways redrawn - become a lens with which to reread and rewrite the cultural stories into which we are born.
(Gloria Anzaldua, 2002, *Now Let Us Shift...*)

"An author is not the bearer of inner lived experience, and his reaction is neither a passive feeling nor a receptive perception. An author is the uniquely active form-giving energy that is manifested not in a psychologically conceived consciousness, but in a durably valid cultural product."
(Bakhtin, 1990, p. 8)

Supporting my theoretical and political commitments explicated above, this project is broadly based on critical methodologies. According to Ronald Jackson II and his colleagues (2007), whereas methods (e.g., participant observation, interviews) refer to how data are collected, methodology refers to why data are collected in certain ways – why do we ask the question we do about a social phenomena and why do we approach the phenomena in such particular ways. Thus, while below I describe the particular methods I engaged, I want to begin by emphasizing the project’s overall critical orientation. This means that – in content, as well as methodology – in this project I am concerned with issues of voice, examining relationships between structure and agency, the negotiation and meaning of power, dialogue, self-reflexivity, and non-exploitation (Gunzenhauser, 2004; Madison, 2005).

Methodologically, I strived for what Lather (2008) calls *scientificity* – research that puts empiricism, philosophy and ethics in conversation. This methodology of scientificity is based on her reading and development of three feminist approaches – Sedgwick’s “reparative reading,” Spivak’s “dislocating negotiation,” and Elizabeth

Wilson's "analytics of breaching." From Sedgwick, Lather borrows ethics of love (rather than suspicion) and epistemology of potentiality that builds on "rich phenomenological accounts of embodied experiences, feelings, and intimacy" (p. 56). Such readings allow for "doubled analysis" – one that both brings critical feminist readings to cultural objects and practices (e.g., pregnancy or cheerleading in the U.S.) AND recognizes the pleasures and joys that are experienced in relation to these practices as sources of multitude of meanings rather than as markers of oppression. With Spivak, Lather's scientificity "rescues" the empirical, arguing not for negating it, but for wrestling with it, dialoging with it. Together with Wilson's "analytics of breaching," this means to put critical and traditional methodologies in debt to one another because "breach is both the refusal of static borders and the space this refusal opens up" (p. 59). Scientificity is, thus, not the same as empiricism – it is similarly "rigid" in the sense that it asks us to engage our "necessary categories of analysis" (e.g., gender, authoritative knowledge, culture), but is differently political and affective, asking us to put these categories "in crisis" – to both use them and trouble them, to "see how such categories work across time and what they exclude" (p. 60). With the implementation of this methodology in the project, I've moved toward scientificity of critical feminist research of reproductive discourses and practices. In this section, I first discuss the methodological considerations that guide my use of specific methods and then, provide a structured overview of the "procedures" I followed in implementing this methodology.

Dialogic Qualitative Inquiry

The primary methodology in this project is one of dialogic qualitative inquiry – this refers both to processes of "data collection" and of "data analysis." I put the previous

two phrases in quotation marks not because I want to question their truthfulness and embodied performance, but because I want to point attention to what Denzin (2010) discusses as qualitative researchers' post-positivistic adoption of quantitative terminology. Such adoption is not inconsequential, it is not just words, because the research and knowledge we produce and the ways in which we perform this knowledge and engage it with its contexts shape our being in the world and the world itself. For Denzin, continuing logo-centric production and performance of knowledge solidifies categories of dominance and oppression, continuously undermining other ways of knowing – a paradigmatic criticism that is especially fitting the focus of the proposed project. However, to be truly resistive and transformative, a project should not simply declare a negation of dominant knowledge production discourses and processes, but needs to instead critically engage them, continuously asking what meanings would be made and from what positions. Thus, the very methodology of a project is imbued with agency and ethical responsibility, at the same time as mundane experiences and our performances therein are all transformative “projects” when assuming a critical methodology to our own lives in relation to others.

These considerations – overwhelming in their implications of *what am I doing* and *with (to?) whom* – seem to me especially important in the beginning of this section, as I try to negotiate the legitimate belonging of this project to an academic space, to social and personal ethics, and to relationships that I have created or am about to create. In attempting to belong to one version of academic space, I feel compelled to talk about “data collection” and “analysis” – yet, in presuming my position as *the collector and analyzer*, this particular academic space becomes hostile to my desire for dialogue. At the

same time, to imagine that just because I desire a relationship of dialogic equality with others such relationship will happen seems shallow and presumptuous, especially in the context of a project that argues that identities and knowledges are interactively and contextually negotiated and produced. In this sense, although I *will* be collecting data and analyzing it, I resist the linearity presupposed in this schema of collection-analysis (i.e., collection comes before analysis and the one excludes the other), I resist its interpretative singularity and phase-by-phase implication of replicability. Instead, I expect that this project will generate stories – some of those told multiple times before and since, and yet, non-replicable. The theory-building capacity of these stories will not be judged by the falsifiability criterion, but rather by their ability to offer and invite "seeing things in ways different from what otherwise would be the case" (Baxter, 2011, p. 7).

Thus, when I said at the beginning of this section that this project is methodologically one of dialogic qualitative inquiry, I meant that it consists of discursive interactions, of multiple voices (including my own – as a student, mother, researcher, foreigner, etc.) meeting with and being made in relation to other multiple voices. We, those involved in the project, were and will be telling stories (some of which guided by my questions) together, and the telling of these stories is as much a process of collection as it is a process of analysis and self-reflection. I use reflexivity and positionality not as social categories we occupy universally, but as the social categories that we occupy and that matter in relation to one another within the particular contexts (Turner, 2010). My eventual (re-)telling of these stories, their arrangement in a different narrative toward the completion of this project, is analytical and performative of my positionality (Turner) and does not claim to *objectively* represent others' fixed truths and cultural belongings. I

don't think I will be ever able to take those outside of the interpretative contexts in which tellings and re-tellings will happen. At best, I can hope for a dialogic telling – where dialogue isn't a matter of just turn-taking in conversation, but is a critical process of reflection.

This approach and hope – though they might be criticized by some as non-science – don't lack in methodology and scientificity (Lather, 2008). They follow an interpretative and critical tradition in the social sciences. According to Mosco (1996) “realism” in the epistemology of the political economy of communication refers to the co-creation of meaning in the processes of observation and interpretation. Denzin and Lincoln (2005) put it another way when they say that ethnographic practice locates the observer in the world *and* transforms the world. Traditional ethnographic approaches saw the good researcher as an impartial observer who captures culture as it is (e.g., Angrosino, 2005). However, in critical approaches (concerned with issues of social justice and power, as is this study), the movement has been from the value of unobtrusive observation to engagement in dialogue (e.g., Madison, 2005; Conquergood, 1989). Angrosino, for example, even argues that observation should be seen no longer as an ethnographic method, but rather as an ethnographic context – that an interaction between human beings happens in that context and therefore, should be considered as structured by it. This also emphasizes that all knowledge is contextual and thus – partial, rather than universally generalizable.

In critical ethnography perhaps the strongest advocate for dialogue – in both theory and applied research – is Dwight Conquergood who sees his method of dialogic performance as both an ethical and scholarly commitment. In the conclusion of *I Am a*

Shaman (1989), for example, he argues more directly what his monograph performs – not an amusing account of an-other’s cultural practice, but rather that knowledge of the self and the other is constructed in the encounter of the two, following Bakhtin – in the space between. Further, Conquergood asserts that dialogic respect for others’ views and values needs no special praise, as it is the humane thing to do, but what dialogue as an ethnographic pursuit really contributes is a critical examination of one’s taken-for-granted cultural assumptions. In other words, learning about the self and the structures that guide the construction and expression of self is just as valuable as learning about “the exotic other.”

Such a move highlights that self-reflexivity is part of the epistemology of (post-)critical ethnography. Self-reflexivity means the engagement of the researcher’s subjectivity and positionality. According to Cahill (2007), subjectivity refers to the conscious and unconscious ways in which one sees one’s self in the world. Madison (2005) highlights that in comparison to subjectivity’s focus on the self, but related to it, positionality refers to being-with-others in the world. Considering Angrosino’s (2005) notion that ethnographic observation is part of the research context, the epistemological assumption of partial/standpoint knowledge and self-reflexivity suggests that the cultural knowledge produced by ethnographic means is necessarily refracted through the lenses (empirical, emotional, experienced, embodied) of the researcher. Part of the ethical obligation then is not taking these lenses for granted. Problematizing the researcher’s own experience and interpretation becomes a part of the multi-focal process of ethnographic inquiry. In this sense, “empirical” in the context of critical methodology does not necessarily engage an assumption of an outsider’s objectivity, but rather

connects one's paradigmatic views and personal histories with the knowledge-production process and reflects on those connections.

The epistemological assumption of dialogue and collaborative knowledge-production informs self-reflexivity, but it also informs the major ontological assumption of ethnography. According to De La Garza (2000) traditional ethnographic ontology assumes a linear process of existence in which the researcher has the power to follow and convey this process. In *The Four Seasons of Ethnography*, she suggests a different ontology, based on holistic and naturalistic cycles, this is also a dialogic ontology – one of cyclic co-existence rather than linear existence. In this ontology, the power of the researcher as the interpreter of the world is no longer aggrandized, although the researcher is still in position of power in relation to the researched because of the (academic) structures that validate this power. Thus, in the cyclic ontology of ethnography, the researcher is responsible for careful preparation and mindful and devoted engagement and story-telling. De La Garza does not negate the traditional ethnographic “procedures” – researching the context, getting appropriate ethics board approvals, fieldwork, etc. – rather she highlights their roles as a way of being with others and not a self-centered pursuit of universal knowledge.

Story-telling as Dialogic Inquiry

Such ontological rethinking of qualitative ethnographic inquiry also moves toward a dialogic approach to story-telling – not only is not the researcher the ultimate interpretative authority, but stories themselves are no longer perceived as independent nuggets of realities out of which generalizations can be excerpted through objective procedural analysis. Instead, as Bute and colleagues (2010) note,

Stories evolve across time as constituencies take up and play out others' stories. A dialogic perspective permits movement from a message production standpoint (i.e., storyteller as a sole owner of the story) toward one that recognizes how narratives are fluid, coconstructed, meaning-centered productions of experience achieved in particular contexts and subject to varying frames of intelligibility. (p. 54)

This interaction-centered view of story-telling is suitable to the present study, as it aims exactly to consider how different meaning-making frames are negotiated toward the production of situated prenatal knowledges and how these negotiations and frames shape processes of identity and knowledge production. With the goal of continuously situating stories and identities in systemic contexts, this view of story-telling has been promoted by conversational techniques such as circular questioning (e.g., Cronen & Lang, 1994). As a way of framing stories, circular questioning prompts story-tellers to consider their experiences in relation to other people, to particular times, and spaces – in other words, to place it in a system (grammar) of meaning-making, rather than view it as isolated and culturally unbound. In this sense, story-telling becomes an identity-articulating experience (I mean articulating here in its double sense – as reflection and as connection⁶). Narrative critical scholars (Bute et al., 2010; Peterson, 2010; Ellis, 1991) argue for the importance of narratives in critical inquiry, as the sites where subjectivities are fought for, where tensions are explored, where cultural meanings intersect with affective experience in a rhetorical attempt to forge identities. In addition to that, stories and the ways in which they are told have social consequences:

Poststructural feminists agree that *narratives* remain primary rhetorical resources through which subject positions are legitimized and privileged (e.g., to be a woman is to be a mother) while others are disqualified or denied expressions (e.g., to be infertile is the result of bad choices). Feminists rely on storytelling to raise consciousness about the lived inequities and emphasize that the personal is political, meaning, among other things, that personal experience is inescapably

⁶ Following Stuart Hall's (1996) conceptualization

social, and social experience in inescapably political (Fixmer & Wood, 2005).
(Bute et al. 2010, p. 53)

It is this feminist commitment to and belief in the power of story-telling as transformative agency that guides the much acclaimed work of writers such as Anna Deavere Smith and Eve Ensler. Furthermore, their work is also an example of a story-telling methodology that reaches far, that engages different audiences in thinking and talking about how the world is structured, constructed, experienced. As activist literature, then, their texts are not end-alls of academic research and analysis, but support and encourage practices of critical dialogic inquiry, as they enact citizenship. Thus, story-telling is at once a method for data collection, data analysis, and social change. Non-humbly enough and inspired by the work of Deavere Smith and Ensler (as it also relates to health-related experiences), my hope for story-telling in this project follows in this vein.

In story-telling as a methodology, however, dialogic practices are extended beyond a conversation between/among people. Following Bakhtin's (1981) theory of intertextuality, stories themselves are dialoguing – dialogues happen among contexts, identities, selves, cultures. Stories are multi-vocal even when told by a single individual (Baxter, 2011; Hill, 1995). They are dialogic in connecting and bringing together times and spaces in a nonlinear fashion, complexly building a world that is not fixed (a representation of reality), but is always in a process of becoming. When verbally recalling a story and positioning it in a particular (historic) context, the narrator does not represent a fixed context of how things used to be, but rather builds a dialogue of how things then matter now, in the particular interactive moment.

In proposing an analytical framework for life stories, Zilber, Tuval-Maschiach, and Lieblich (2008) suggest that narratives are embedded in multiple contexts –

intersubjective (micro), social field (meso), and meta narratives (macro). The intersubjective context refers to the particular moment of story-telling, “the immediate relations and interactions within which the story is produced” (p. 1052). The social field context refers to “sociohistorical structure within which life was, or is lived and referred to” (p. 1052) and may include narrator’s situating of the story in relation to a particular organization, historical events, political figures, etc. Finally, the meta narrative context includes the “cultural conventions that imbued a life story with form and meaning” (p. 1052) – these may often be implicit, the “hidden transcripts” (Kelley, 1995) in regards to big social identity categories, such as gender, sexuality, familiarity, class, etc. In exemplifying the application of this framework to actual stories, the authors assume an objective outsider interpretative position, saying in the conclusion even that interpreters should “defend” their readings.

Despite such a post-positivistic stance, the authors’ idea of “embedded narratives” is suggestive of the multiple contexts that dialogue in a single story. In intersecting this perspective with dialogue as a research methodology and ethics, a more engaged approach may emerge that does not see the story as data to be interpretatively managed by the researcher. Rather, the story becomes simultaneous processes of creations and reflections. This approach can become part of the research process and interactions themselves, the dialogues among texts and contexts engaged in dialogues among people, and, in the writing of the research project, the scholarly work written as a story, as analysis-able, rather than as a definitive analysis. Going back to De La Garza’s (2000) cyclic ontology, the written text, then, will not be the end-product of the research process, but part of knowledge (re-)generating development.

This means, for example, that in writing my own stories and the stories of others for this project, I can reflect on and elaborate the (context and contextual) dialogues that I see present and shaping my experiences with others (see Turner, 2002). The form of this reflection (e.g., as its own story, rather than an authoritative thematic summary) is also consequential. Ellis (1991) argued for narrated introspection as an analytical technique that stimulates dialogue:

Introspection permits us to prompt and collect our own and other people's stories about the lived details of socially constructed experience. To stay as close as possible to the details reported, introspection is best presented as narrative text. Such accounts will provide a stimulus for discussing issues of the relationship between presented text and feeling/thought and comparing experiences across groups and culture. (p. 45)

Although introspection, in this sense, has entered much feminist qualitative work, Ellis' assertion can also serve as an ethical guideline for the process of research as interaction. Thus, there is a place for narrated introspection in our conversations with others (research collaborators). And while, guided by more traditional expectations and habits, I did prepare an interview guide for this project, I strived for conversations that leave plenty of room for narrated introspection – my own, others', shared ones. In fact, often time, those I met with commented on how our conversation has gone astray, in unexpected direction - comments that were met with my verbalized reassurance that each conversation is its own (never-ending) journey. From the many conversations I have had with friends throughout the years about pregnancy and childcare advice, I know this – telling stories about “what happened to us” and thinking out loud about those stories – to be a lively “technique,” as it has more than once taken prominence over direct assertions of “this is what you should do” (something that Tannen (1990) and other two-culture scholars of gender would probably see as unsurprisingly feminine).

As a “guideline” (and perhaps an ideal) for interaction, this approach seemed especially salient to me in this project that explores the negotiation and construction of prenatal knowledge and of identities during pregnancy. In its bringing together of multiple dialogues, the story is a process of such becomings – as a form, the story destabilizes knowledge and identity to highlight that even as we explore how prenatal knowledge has been shaped in the past, we are in the process of constructing such knowledge. As Della Pollock (1999) writes,

The *one who tells* is ‘always reworked in ... enunciation.’ The mother-I tells what/as she becomes. Subject to the contingencies of reiteration, she slips from the privileged place of identity or *being* into the rougher ways of identification or relational *becoming*. (p. 70)

She continues, in a fashion similar to the one proposed by Zilber and colleagues (2008) to explore how multiple contexts intersect in the telling of the birth story of her second daughter, performing that such consideration of dialogic contexts does not have to be objectified and separated from affective and embodied experiences. In naming and reflecting on these contexts, she performs that story-telling itself is (a methodology of) introspection, that it is a rigorous, and yet inevitably partial and contextual, way of knowing. This way of knowing is different from the rigor upheld in Western scientific models in that it is not judged by standards of predictability and generalization. Yet it is not excerpted out of the multiple structures (contexts) that might lend a sense of predictability *and* introspective intelligibility.

Because this performative model of writing – as a cyclical research methodology – is so important to this project, I allow myself the inclusion of a longer quote in which Pollock reflects on the way she tells her daughter (Isabel) about the day when she (Isabel) was born:

My stories are concentrated in images that are keyed to larger narratives: Isabel felt *like a giant golden ball* (a *golden globe*, I sometimes say now). The contractions hit like *bullets in my back*. The nurse was condescending, *reprimanding*. *dumpty old hospital room*. *born blue*. *the Creation! got lost!* These were first words. But they were also old words. Imports. Clichés. Citations. (...) These words, hard and fixed as they may seem, tied as hard and fast as they are to expectations for class privilege, to the easy deployment of high culture references (*the Creation!* [reference to a theater play in this case]) and narrative competencies (*like a golden globe, born blue*), to heteronormative complacencies (*Daddy and I both held you and we were so happy*), to a patriarchal family history lined with embarrassment and shame (condescending, *reprimanding*), and to popular comedies of getting lost, getting through, and finally getting a baby, nonetheless also signify the *disturbance* of narrative at its root, in exchange. In even the most rudimentary acts of telling, these stories, these words are always already partial, contingent, loaded, cut through with other words, stories, and histories. (p. 70-71)

In this truncated reflection of/on a narrative, we can see the intersubjective context in considering how telling the birth story between a parent and this parent's offspring is (re-) producing birth and familial relations, as in how is knowledge about origins produced and who takes part in producing it. On the level of sociohistoric context, this story is institutionally located in relation to the hospital and comedic media representations as institutions. And on the meta-narrative contextual level, Pollock clearly reflects on class positions (through "high culture references"), sexual normativity, norms of family structure, and birth models. These contexts are articulated in relation to one another, and, furthermore, they are known through the, first, embodied and, then, narrated experience of giving birth. The story is a way of knowing of all these different contexts and it brings them together, as they are experienced; the story is, thus, a situated knowledge of birthing as a complex cultural practice. Knowing (about) pregnancy and birth is knowing not only what to eat and when to push – practices that are often the object of interest for critical scholars of reproductive discourses – it also knowing about how one's experiences fit interpersonal and cultural contexts; it is reflecting on those experiences.

As Pollock shows, story-ing pregnancy and birth allows us to rethink knowledge in such a way. And this re-thinking through narrative can take us outside of re-inscribing the biomedicine vs. nature debates, since such debates often harden biomedical categories of care as the places where power is located and negotiated. The possible rethinking of what constitutes prenatal knowledge on different contextual levels raises important questions for the proposed project – are such different ways of knowing already a part of a summative of prenatal knowledge, what happens to them in interactions, what happens to the interactions and relationships, what would a model of care attentive to these ways of knowing look like? Thus the dialogic methodology of story-telling in contexts – both as collecting and analyzing data – is appropriate to this project in that it does not simply reflect people’s unique knowledges and experiences, it weaves them into continuous knowledge production in interaction.

Story-ing Selves and Autoethnography

In thinking about the cultural contexts that participate in this knowledge production and how these contexts may be negotiated in interactions, I draw on/from autoethnographic story-telling. I view autoethnographic story-telling as both a continuation and integrated part of the collaborative story-telling with others, described in the previous sections. Autoethnographic practices are important to me as enacting ethical commitments and critical epistemology, especially in relation to the topic of this project. Mazzoni (2002) writes, “autobiography stages the happy fact that pregnancy cannot possibly claim to be among those fetishized ‘universal human experiences’ so dear to humanism, and so it is also a subject that tends to resist formal academic knowledge” (p. 5). Autoethnographic (and) performance texts have been explicitly linked to critical

pedagogy and the decolonizing of knowledge, to centering ways of knowing other than the normative/dominant ones (Alexander, 2005; Denzin, 2005; Holman Jones, 2005) – a commitment and possibility that directly speaks to the hope and purpose of this project. In the face of post-positivistic criticisms of being narcissistic pseudo-research, autoethnographic scholarship contributes uniquely to reflexively experiencing the many social and cultural intersections that are part of our lives and relationships. Ellis, Adams, and Bochner (2011) summarize the methodology by writing “Autoethnography is an approach to research and writing that seeks to describe and systematically analyze (*graphy*) personal experience (*auto*) in order to understand cultural experience (*ethno*)” (n.p.). While the methodology includes the telling of personal stories in different aesthetic and creative formats, intended to elicit emotive and cognitive relational experiences in readers and audiences, it also includes the reflexive analysis of such narratives. This analysis may be explicitly stated in links to existing literature, for example, but it is also performed in the acts of selecting and arranging personal experiences with regards to the cultural contexts that frame it:

The personal narrative always stands in relation to the master narrative, which is the reflection of culture and our relation to/in culture. Hence, the personal narrative is always a reflection on and excavation of the cultural contexts that give rise to experience. In this sense, personal narratives move from what some might presume to be an insular engagement of personal reflection, to a complex process that implicates the performative nature of cultural identity. (Alexander, 2005, p. 424)

As a research process and a method of writing, autoethnography is also analytical in that it often performs the gaps in normative discourses of knowledge and science, and thus serves as a cultural critique. For example, autoethnography can center emotions and affective experiences as reality, rather than relegate them to the margins of objective observations. Speaking to the possibility of (feminist) autobiography to create theory,

Elsbeth Probyn (1993) writes, “While experience is not necessarily emotions, and emotions cannot take the place of theory, what I want to argue is that emotions can point us in certain critical directions” where the possibility exist for “an emotional foregrounding of the self as a way of critically acknowledging the ontological and epistemological bases of knowledge formation” (p. 72).

Probyn’s (1993) “argument” is important to me in this project on several levels, highlighting the place for an autoethnographic methodology at every step of the research process. The very choice of a topic foregrounds an emotional (as well as embodied) experience at the same time as the project aims to both narrate and produce knowledge(s). The project itself arose from my own reflection on what and how did I learn about pregnancy and birth and how did I (and others) produce my identity as a pregnant woman, a future parent, a partner, a patient, etc. in my interactions with others. The project arose from my own difficulty to fully translate and encompass the transformations of self and relationships that occurred in the years before we were able to conceive (which I consider part of the prenatal period) and during pregnancy. It arises from my conviction that knowledge(s) were negotiated and produced in this time, knowledge(s) that I find myself would be insufficiently and incompletely summed up and (re-)presented in the categories of traditional scholarly writing, and would be inadequately organized in/by a linear timeline, suggestive of predictability.

While I am able to describe some parts of these learning experiences on a prescriptive cognitive level (e.g., the ban on eating sushi during pregnancy), other experiences overflow the words that try to describe them. These are simple and yet complex moments. I remember, for example, my mom telling me about the amusement

with which she had watched the unborn me shift positions in the womb, the movement physically visible on the outside of the belly, as well as felt inside. This small nugget of a recollection is insufficient to contain the multi-dimensional longing I felt while holding the phone, listening to her talk – longing to feel and see the same as a reassurance, but also longing for the experience as a new mother-mother/daughter bond. A knowledge of what might be a sign of a healthy pregnancy and of what to expect originated (ontologically) for me through my mom’s story. Knowledge also originated in her body, as well as in observation. My mom’s nugget of a story locates an embodied epistemology that has been (“naturally”) linked to pregnancy and to illness/health experiences.

But my experience of her story also speaks to relational, affective, and collaborative epistemologies that surpass standards of objectivity and the ability to categorize. In this, my experience of the story – in the context in which I listened to it and in the context in which I now re-write it – also challenges normative discourse of knowledge production. Whereas in post-positivistic approaches to scholarship, my struggle to verbalize the knowledge within existing categories may lead to conclusions of deficiency and to negating the validity of this knowledge, a performative autoethnographic perspective draws attention to this difficulty as an epistemological tension – how do I enter what I know into knowledge discourses that don’t have categories and “tools” for what I know? Suitably, I experienced some of this epistemological tension during my own pregnancy and later, when asked for advice by pregnant friends.

Stacy Holman Jones (2005) writes that “This is a hallmark of autoethnography and autoethnographic performance – speaking in and through experiences that are

unspeakable, as well as inhabiting and animating the struggle for words and often our failure to find them” (p. 772). Part of the methodology of this project is reflexivity about my (and others’?) “struggle for words.” When? How? With Whom? How does it feel? What does the struggle say about the limits of and possibilities for knowledge production? This is an autoethnographic and ethnographic reflexivity. I expect to weave in autoethnography in processes of others’ story-telling at the intersections of what Ellis and colleagues (2011) term “layered accounts” and “interactive interviews”⁷ (n.p.). Thus, I expect that my own experiences of pregnancy and prenatal care will enter both the interviews and the write-up of this project. At the same time, I expect that autoethnographic narrative of the interviews themselves (e.g., personal “epiphanies” (Denzin, 2005) that happened during the interview process) will be as much a part of the emerging written text, as would be moments from my own experiences of pregnancy.

As many other pregnancy and birth stories perform (e.g., Mazzoni, 2002; Pollock, 1999), pregnancy and birth as primarily affectively experienced by pregnant women and their close supporters are created a-new every time the story is told – the emotions are not just narrated, they are often either performatively experienced or consciously controlled and, in the process, transformed into new knowledge(s) and identities. In this sense, narrative performances of pregnancy stories seem to me similar to what Conquergood (1989) noted about the work of Hmong shamans:

⁷ *Layered accounts* refers to a style of autoethnographic research in which writer’s experiences are considered alongside “data, abstract analysis, and relevant literature” (Ellis et al., 2011, n.p.) to draw attention to the simultaneity of data collection and analysis, to invite the readers to enter the doing of research, and to highlight a view of identity as becoming, and not fixed. *Interactive interviews* is also a style of autoethnographic research in which knowledge is collaboratively produced, as collaborators (interviewer and interviewees) “probe together about issues that transpire, in conversation, about particular topics” (Ellis et al., n.p.)

What is really being refurbished and recreated every time a Hmong shaman performs is the system of meanings and web of symbols that grant coherence and comprehension. Whether the sickness abates or lingers, the shaman's real accomplishment in every performance is that she or he *establishes the world*. (p. 50)

Autoethnographic reflexivity allows me to strategically think about the processes of establishing the world, and how my own communicative actions are implicated in such processes, rather than simply focus on a view of culture (the world) as fixed normativity. Autoethnographic reflexivity allows me to continue thinking about the ways in which the narratives performed in this project establish the world, at the same time as it allows me to continue thinking about the cultural structures that shape my performances in this world. Autoethnographic reflexivity allows me to move between structure and agency, as advocated by critical approaches to health communication (Dutta, 2008), in the best and most complete way I know – that which engages my (and hopefully others') full personhood: body, heart, mind, the spaces between me and others, and the spaces in and out of which I move.

Methodological Summary and “Procedures”

Project Collaborators

As explained earlier in the review of literature, with this project I hoped to begin a more holistic, communication-centered, exploration of the construction of prenatal knowledge(s), experiences of pregnancy, and identities in the context of a pregnancy. This means that I deliberately sought and included the perspectives and experiences of pregnant women, as is traditionally done in feminist research on reproduction. In addition, however, it was important for me to also include the experience of people whose prenatal knowledge(s) may also be (trans-)formed and negotiated in processes of an-other's pregnancy – (involved) partners of the pregnant woman, family members,

friends, and, of course, medical professionals (including midwives, nurses, OBGYNs, dietitians, etc.). With this in mind, I set out to conduct a variation of purposive snowball sampling. I proposed to start with five pregnant women and extend conversations to members of their formal and informal networks of support during pregnancy.

I imagined this would be easier than it turned out to be. A number of women, some of whom post-pregnancy, contacted me with interest to talk about their experiences. Despite what I perceived to be a wide reach of publicizing this "story-telling" project, it is telling that all the women who contacted me were associated, either directly or through a relative, with one particular midwifery practice, located in an admittedly liberally-minded area and admittedly serving primarily middle-class, well-educated families. In terms of affinity networks, I suppose at the very least, this ensured that I was meeting with families and the medical professionals who served, for at least part of the pregnancy, as their prenatal care providers. A few husbands wanted to be a part of the conversations. Others, even when present in the house during our conversations, did not want to share their experiences. All the people with whom I met for these formal conversations were in heterosexual marriages and the majority were white and well-educated. In addition, all members of affinity networks with whom I met were related to the pregnant women by blood, marriage, or professionally as their formal prenatal care provider -- that is to say, I met no friends, acquaintances, etc.

But besides the formal conversations, I had many informal ones - and these speak in those pages through me, my thoughts and experiences, just as much as the formal conversations do. I went to community events, play groups, or simply had unexpected random conversations at various public locations or family gatherings. Sometimes, I

asked those I met to contact me to be a formal (i.e., consent-signed) collaborator in the project. That never happened. There was something about the place and occasions in/on which our conversations were happening that was not transferrable to the "research" context. Perhaps...

In chapter 3, I acquaint the reader in more detail with the people I met - named and anonymous - and the situations in which we met and talked.

(Yet here, I feel compelled to re-produce the post-positivistic summary by which the methodological value, scope and limitations of this project will be measured: I met with 15 individuals. Of these: 4 heterosexual couples (plus, in one case, the mother of the pregnant woman), 2 pregnant women sans their (male) partners, 4 healthcare providers (2 midwives, 1 OBGYN, 1 nurse) - all of whom in heterosexual partnerships, all of whom female, all of whom mothers. One of the couples I met was significantly post-pregnancy, but they were involved in providing community education partner-support during pregnancy and after childbirth. One of the midwives was also the mother of the husband in that pair. All of the women I met were either pregnant or had birthed a child. Our conversations lasted between an hour and a half and 3 hours and yielded over 250 pages of single-spaced transcribed text...

Up there (^) where is the space for our cousin who became pregnant in Canada (she is Bulgarian and married to a Bulgarian man), who "changed her life completely," who followed the prenatal care calendar to the T and excitedly went to her first prenatal care appointment - at 12 weeks! - to find the heart of the fetus had stopped in utero? Up there (^) where is the space for another cousin who grew up in the U.S. in a Polish immigrant family, who moved back to Poland as an adult and became pregnant, who was

"simply pissed" upon finding out she was expecting twins and visualizing double strollers, dual breastfeeding, double the diapers? Where is the space for her profound sense of missing her mother? Where is the space for the Latina mother who was worried about the emotional health of her 16-year old pregnant daughter, going back to school in a month with her belly "popped?" And for that mother's own story of having no support, "besides [my] sister who knew nothing" during her own teenage pregnancy? Where is the space for the daughter's happy smile and her cheerfully moving around in an emerald green dress? Where is the space for the father-to-be who wraps his arms around that emerald green-clad belly and looks forward to three weeks from then when he will begin college on a full athletic scholarships? Where is the space for the mother, about to become a grandmother, who raised her daughter alone, who is happily married now, holds a Master's degree, works, and is also raising a 6-year old?

Stories weave beyond the numbers. More than (just) anecdotal evidence.)

“Data Collection and Analysis”

Following critical ethnographic and auto-ethnographic methodologies, stories of lived experiences were collaboratively created by/in co-presence and dialogue. In more traditional ethnographic approaches, these methods are sometimes referred to as observations and interviewing. However, I believe the use of terminology – e.g., collaborative story-telling instead of interviewing – is important, as it indicates differences in ethical commitments and views of knowledge production, as explained in the previous sections on methodology. Our conversations happened in settings of varying degrees of formality – homes, coffee houses, in passing, in hallways, while taking care of children, or cooking, or eating, in waiting rooms, clinics, birthing centers, doctors’

offices, hands on bellies, hands off bellies. We, whether we are pregnant ourselves or simply happen to be consciously aware of our presence around pregnant women, rarely experience pregnancy and prenatal advice in carefully orchestrated interview environments, except perhaps during scheduled prenatal visits.

By drawing attention to this variety of environments and contexts that are relevant to this project I am not claiming “naturalistic” observation, assuming that my presence (as a heterosexual researcher, mother, accented foreigner, married, fairly highly educated, working, etc.) had little to no effect on the “validity” of the data collected. I am drawing attention to these contexts and their varying degrees of formality and mundane-ness to alert and orient myself toward a reflexivity that does not end once an “interview” is completed. This also means, as Ellis and colleagues (2011) discuss, that the boundaries between “collection” and “analysis” are blurred in the story-ing of (personal) experiences vis-à-vis normative discourses.

As I describe in the section on story-telling above, in this project, story-telling is a methodology of both data collection and analysis. In the section of this project that is more traditionally delineated as analytical, I (re-)tell stories, perform narratives following performative interviewing models (Deavere Smith, 2011; Denzin, 2003), so that they can be reflexively experienced by readers and audience in conversation with my own reflections on the "data." I didn't use any of the standard ethnographic procedures of coding and analysis according to a singular and fixed theoretical framework. Yet, I could not escape hearing what would traditionally be termed "themes." In writing/performing the analysis, the question became, "How do I present data, so as to invite others' different

hearings? So as to invite readers' voices and experiences into the text and into the theory?"

My analysis did/does not “test” theory. Instead, analysis was performed in the process of organizing and presenting stories toward the goal of kinesis (Conquergood, 1998) or reflective movement, experienced in the shared space of the text, yet uniquely engaging readers’ positionalities. I strive for analytical co-experience of tensions and negotiations of knowledges and identities during pregnancy. My own positionalities are also made present by what may be read as "analytical" or explanatory notes to pieces of data. Similarly to Pollock (1999), I linked the telling of the stories with existing empirical and theoretical literature in the areas of reproductive discourses, critical health communication, and transnational feminisms (as summarized in the literature review). In this again, I hoped to answer Lather’s (2008) call for scientificity – not rejecting existing analytical categories off hand, but engaging (with) them toward an overarching consideration of how we produce knowledge and what are the limits on processes of knowledge production.

As I hope to have articulated on several occasions earlier in this manuscript, this project has implications for prenatal care practitioners, for pregnant women, and their support networks. But these implications are not of the prescriptive kind, guaranteeing outcomes of better compliance to doctor’s orders or a physician’s better understanding of a patient’s cultural values, for example. Instead, I believe the greatest implication to be in the exploration of a different model of interpersonal interactions as constitutive of realities – a model that is based on possibilities for relating rather than on ones for juxtaposing, a model that aims at recognizing modalities of knowing and personhood that

allow us to experience ourselves as connected to others, and not (only) as entities whose (individual) “empowerment” depends on discrediting another’s. How would a collaborative production of health (knowledge and care) look like in such a model?

CHAPTER 3

CAST, CREW, AND VIEWS: NARRATORS, CHARACTERS, SETS

I am a character; my changing bodies (body with changes) and selves live here.

I am one of the narrators.

I am also the one (re-)writing stories I heard.

I am an author (Diversi & Moreira, 2010), but so were/are others - in some way.

And now you, reading the stories, are an author, too, and perhaps, in your own way - a narrator. Can I introduce you here? I can only imagine...

In my conversation with people around this project, there is a very numerous group of "anonymous" - people I met and talked with, people who talked with me during my own pregnancy, during their pregnancies, during the pregnancies of their daughters and friends.

Conversations that stayed with me and

wove into our story,

the mythos of our pregnancy.

Conversations without signatures on informed consent forms.

Uninvited conversations

Welcome conversations

I am to introduce the people with whom I've met and conversed, who shared stories. I am to tell you of the places where we met and the places that we talked (back) into the present moments of meetings. But I am starting, knowing that some stories are to remain moments, that some (probably all) backgrounds are far from complete. I am starting with those whose stories can only be told here, under IRB-ed ethics, because I am

telling them as "my" stories, stories of conversations that happened to/with me. I am starting with the anonymous - and in some cases, truly, I did not know a name - who were many and whose stories come into the next chapters.

Although I cannot "chart" your demographics, you are not "extras" on a set. We've met randomly on the streets, one time in a bathroom on a rest-stop between here and Boston. (Do you remember? It must have been one of the standard large bathrooms, but as we talked by the sink, where the smells of soap and cleaner mix with those of the many people who have passed through the stalls, it felt to me we were in a small foyer that was completely filled by my pregnant body, your pregnant body, and the non-pregnant one of your mother.)

Sometimes we only talked for a few minutes. Like, when we were washing our hands in that bathroom and found out we were both 7 months pregnant, but looked quite different. And your mom said, she is certain you will be going in pre-term labor "any day now," because that's what happened with her and your pregnancy has been so much like the ones she's had.

We've met at community events, and the grocery store, and at play groups, and playgrounds. We've asked questions of one another and have spoken in the first person, and somehow always with smiles

have told stories that hurt

*Like the Latina mother of the cheerfully pregnant 16-year old high school student who said she **was** her daughter once, but back then*

"I didn't have anyone

just my sister who was here

but she knew nothing of babies"

And although that mother, was her daughter once, she did not want her daughter to be her. So, she said,

"I'll do what I can to support her

I don't want her to be alone

but she'll finish school and go to college

and learn that too"

The room then was washed with sun and we, a bunch of women, some of whom pregnant, sat at an empty run-of-the-mill rectangular table in the August sun.

There was you,

and you, whose 2 year old was sleeping in the stroller

and you, who were expecting in December and worried about returning to work,

and you, who never birthed, but adopted 4 or 5 girls and they all had been pregnant,

and you, who were one of those children, expecting your first child in less than a month,

and you spoke about learning from your sisters who were pregnant before you,

and you spoke about your mother coming with you to appointments,

and you were smiling - radiant bright smile set off by the darkness of your skin,

darker yet when seen against the pale white of your mother's hand on your cheek -

and you were smiling, not saying a word, but hinting at the missing partner,

of single parenthood and your sisters' knowledge

and learning from others

and learning from our own

how to be with others

what we wished we learn

Anonymity is different in those meetings. Now, when I go places with my child who is quite verbal in his own way, others often resolve to the old ice-breaker, "What is your name?" Sometimes I ask that of other kids, too. But when I was pregnant and with others, I don't remember many times when I had to introduce myself. Well, except for the time during the prenatal/birthing class we attended. In that class, pregnant women sat together with their partners. Prompted by the instructor, pregnant women spoke (for): "Hi, I am Lily. And this is Remi [turning to my husband]. Our son will be born in October." Others referred to the creature growing in the womb other-wise, "We're expecting a... surprise" or "Our surprise will be born at the end of September." Yet others already had names for their not-yet-born children. We were prompted to name ourselves and name others. And so we did...

... about naming/anonymity and motherhood. Others have asked it - would being a mother take so much over who I am that my name will no longer mean, that I'll turn "Lily" into "Sammie's mom?" Names have been brought up and insisted upon in rhetorical and critical feminist research in relation to, for example, women keeping their "maiden" names after marriage (Boxer & Gritsenko, 2005; Foss & Edson, 1989). Names are about identities, but does anonymity negate identity? Naming may be about recognition, but not mentioning a name does not have to mean non-recognition.

Anonymity feels different in those meetings. Naming is linked to authorship and power, to a self and experience that's (one's) own (thank you, Audre Lorde, for teaching me this!). But no one asked about names in our chance encounters in the bathrooms, in the store, on the playgrounds. When visiting some of the community events - as a

researcher - I introduced myself, but to no reciprocation. And I remember that when I was pregnant and talked with "strangers," I never mentioned my name, never felt I had to.

I remember that then we spoke of and from our bodies (Ellingson, 2008) - what we were feeling, how we were looking (often reflected through the eyes of others), what we were craving, how much we were sleeping. One time in a random place, I proudly bared my leg to all who cared to see its hairless glory - I gushed about my thankfulness to pregnancy-related hormonal change that brought about a new body for me, one that among other things slowed down in growing hair. I was also remembering a time when I was about 14. The swim coach of the team I was a part of was pregnant with her second. And she told us that after first becoming pregnant, she never had to shave her legs again (this is very important to a swimmer, believe me!) thanks to how her hormones changed. And I felt her, *Galia Ilieva*, there - though she will never know, nor will the others who were with me.

There is presence and materiality in naming, but also (danger of) fixity (Ellingson, 2008) that eludes the (knowing/changing) body. In anonymous chance encounters during pregnancy, I was thankful that our pregnancies somehow opened conversations about topics that may otherwise be taboo and/or too intimate - changes and pleasures in sex practices or fears about physical appearance, for example. And from/within those places - where my body mattered (differently) because it was in the process of creating another, where I together with others realized that we're in processes of experiencing and relating to selves and/as others differently - anonymity felt like a promise; not dismissing the self, but recognizing selves beyond-the-self. I experienced *this* anonymity as connection - in contrast to our interactions with formal prenatal care providers who knew our names

(Remi's and mine), but rarely, if ever used them. In her work with low-income women in Ontario, Sword (2003) also noted the importance of the "social aspect" of prenatal care. Though they never commented on particular practices of (not-)naming, women interviewed by Sword marked connecting with others - in group prenatal care, informally, or sometimes as a longing for what they wished happened - as knowledge in their experiences of prenatal care.

In thinking about how to introduce the people I met in the course of this project to the readers who may come in contact with their/our re-told and re-created stories, I am thinking about connections. Relationality. And those (people) that are assumed.

Traditionally in dissertations and other such scholarly texts,

family members

are mentioned (if at all) in

acknowledgments and dedications

or anecdotally

personal experiences and

the people they involve

are in introductions

(almost apologetically - they somehow screw up the theory)

As I began writing this chapter, I thought about how to introduce the "backgrounds" of the 15 people (besides my family) who signed interview consent forms and whom I interviewed. How to talk about our meetings, the sets that staged our conversations. I looked to Della Pollock's *Telling Bodies* (1999) over and over again in hopes for a model I can emulate. And there is one, one in which this chapter won't be

really necessary, as the back stories make their way into preludes to reported conversations; as in screenwriting, characters were introduced before the scenes they enter. We learn about Ruth - the black single mother who is also a student that impressed Pollock - before we hear her critique of the social and medical system she cleverly tried to navigate. We learn about Ruth and entertain/face our own judgments as her story develops in talk, but is also framed by Pollock's own mentions of and commentaries on health and welfare policies she is familiar with.

(No, I don't want disembodied voices in the pages to come. I don't want to write others' voices and stories as if they float detached from materiality and/or culture - how could I?! I don't want my voice to be there disembodied and de-contextualized. But who knew that context would be so ethically tough to write? I type and erase, and try the typing again. How do you make context less definitive?)

As I began writing this chapter, I thought about how to introduce the "backgrounds" of the 15 people (besides my family) who signed interview consent forms and whom I interviewed. Much, much later, I asked myself - what about those who have been an integral part of this project since it began with my pregnancy (and maybe long before that). Where do I draw the line in deciding who is included? I thought I'd write the part about the anonymous others and then write the part about those 15 I met and whose real names are hereby turned into pseudonyms. But as I tried to make the transition between anonymous and non-anonymous/pseudonym-bearing research collaborators, I fell into a gap. The gap is filled with contexts of which I know much more (I think) than the contexts of the 15 or the contexts of the countless anonymous. There, in that dialectical space, are my personal histories with family members and friends, with

healthcare providers, with sexual violence, with (feared) infertility, with nuances of race and social class as I've changed "habitats," with culture as a living phenomenon...

And as I linger in that space,
in the gap I know:
it must be there for others
and
I could not trans-write it fully on the page

So, I think again about the 15 people that I met and should introduce, about the unnamed in unnamed/unmarked spaces, about naming myself and my family members. I think about the gaps, the empty spaces, and still wonder how/where do I write myself in. If presented with an organizational chart of research collaborators, as the one below, how would you do it? Where would you fit me? Yourself?

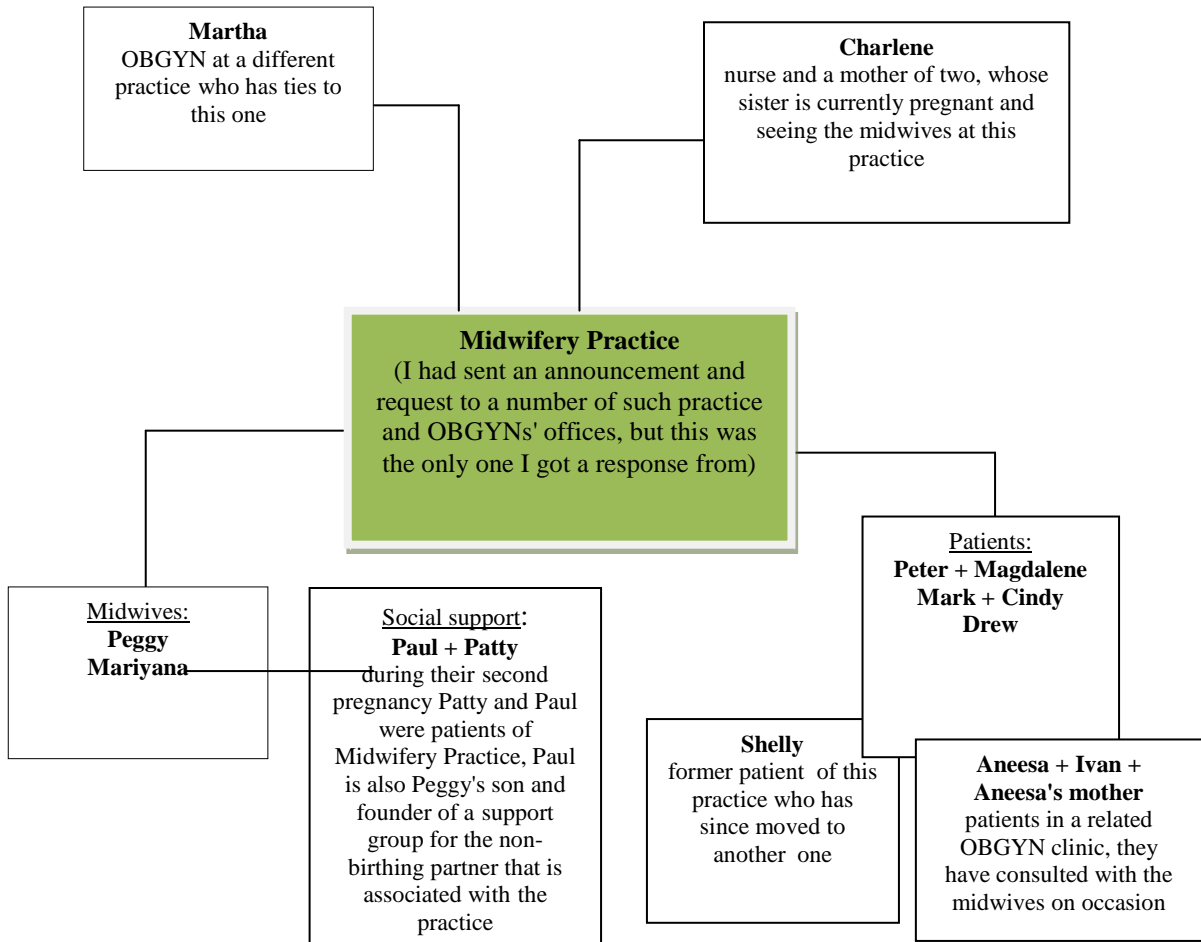


Figure 1: Relational Chart of Co-Researchers

I was born and grew up in Bulgaria, in a "normal" two-parent heterosexual family of the ethnic majority. I have one older brother and a happy childhood, formatively marked by Bulgaria's long (and unsuccessful) "transition to democracy" after 1989. When I was 14, I heard from a friend that two boys from school (friends with one another) were talking about who will get a first chance of asking me out. In response, I declared to my friend that I intended on becoming a nun. One year later, on a hiking trip, I began talking to whomever had ears to listen about my longing to have a child. That was 17 years ago. Our son was born 3 years ago.

There was a child born of my imagination much sooner than the one born of my body. Perhaps it is little wonder then that I am often caught in surprise by little things like English - my child's mother tongue is English, but that's not his *mother's* tongue. Scenes of our lives that I've imagined for years, now come with subtitles. But, I always tell friends, we're lucky our Sammie is here and is healthy. In the years in which I dreamt him up, health/sex education came in unnamed nuggets - my mom giving me a little pocket calendar to track my periods (something I was never really good at); my mom sitting next to 16-year old Lily, asking "Do you have any reason to worry?" when my period was 3 weeks late; birth control injections for my "apparent" hormonal imbalance; no one ever naming "pregnancy" or "child," and me not knowing how to ask. Living in the then.

Samuel Leon Paluszak (Sammie) was born October 17, 2009. When Remi (Sammie's father) and I started dating, we talked children early, feels like almost right away. We both wanted them for a really long time and that, among other things, brought

us together. Sammie was born with a "full head of hair" that was black and soft. Next to mine, his skin was so much lighter; and yet, there was/is this line running from his belly button down, marking a darker and a lighter half - where the darker Indo-European whiteness meets the fairer Slavic one. In those first weeks after his birth, whenever we had to drive, the voice of Nina Simone filled the car:

Black is the color of my true love's hair
His face so soft and wondrous fair
The purest eyes
and the strongest hands
I love the ground on where he stands...

Remi loved that song long before. Remi, who was born in Poland, moved to Germany at 8, and to the U.S. at 16, brought with him and deepened a 4 generation-long family history of migration, of trying to fit in, of toughness and emotions often concealed by humor or silence. But there was something about this song and about Nina Simone's voice that unlocked unspoken depths. And when we listened to it in the car, quiet tears rolling into our even quieter smiles, into our hands holding each other's, with our black-haired Sammie asleep in his car-seat, it made sense.

I met Martha⁸ in October 2012. We met at a restaurant in a town neither one of us lived in. I didn't use a recorder, it would have been futile to do so in the jumble of sounds that filled this college-town restaurant. Martha, an OBGYN with a "midwife commitment," was captivating. She had travelled the world and made an effort to show it - from the way she ordered her "fusion" cuisine to the stories she told. She was a little heavier-set, in the comforting way in which I remember my diseased grandma. White

⁸ Besides my own name and the names of my family members who have agreed to being named, all names used in this manuscript are pseudonyms.

skin. Peppered thick hair. Assertive, yet calm voice. She asked me about my project and my interests, she mentored, showing me that she knew research, and yes, perhaps she knew what she was getting into. Martha's stories wove in her motherhood with her medical practice, her love and partnership with her husband (also a well-travelled OBGYN) with her political and ideological commitments. And when we parted in the warm October night, the hug I wanted to give her was genuine and filled with the promise of an even longer conversation.

Mid-way through our conversation though, I wished I had turned on the recorder - not because I was missing something or because I wanted to transfix the memories we were (re-) creating together, but because

Black is the color of my true love's hair
His face so soft and wondrous fair
The purest eyes
and the strongest hands
I love the ground on where he stands...

Nina Simone's voice - that song in her rendition - was the background, for its few short minutes, of all conversations in that restaurant. And I couldn't help but be embraced in the (secret) symbolism that scripted our encounter, as Martha continued her tales.

She understood that story-telling can be a methodology for research and even an evidence-based medical practice, though we don't use that term. Martha's own practice, her professional paradigm began with a birth story - her own. And "stories are valued in midwifery," she said, directing me to see the new documentary about Ina May Gaskin and the Farm Midwives, *Birth Story*. In telling her stories, telling me of her children now, telling the stories of women, families, nurses, and other OBGYNs with whom she's worked through the years, Martha affirmed the value of a story, though we both know

we've made a special place and time for it - Nina Simone in the background, fusion cuisine, chatty college students, and all.

It would be a few months before I realize the value of personal narrative - of telling stories as a speech act - in the ideology of midwifery. Not that place and time for the personal story are made at *every* prenatal appointment with a midwife, but that (the idea of) the act of "telling" has a special meaning of resistance in the midwife philosophy of care. Having drunk the cool-aide myself, having embraced the value and importance of autoethnography as a transformative methodology of social science research, I think I was somewhat blind to the careful use of personal narratives to construct midwife identity that stood in opposition to a perceived dominant models of care (more about this in later chapters).

The dominant critique of the biomedical approach to healthcare highlights in a negative light a perceived tendency to turn people into objects (Dutta, 2008). Though this criticism typically positions patients as objectified by the actions of dogmatically-acting physicians, a similar argument may be made for the absence of the healthcare providers' stories from medical interactions. If the objectification critique is thus expanded, a broader metaphor of de-personalization and de-humanization may emerge: if the patient is perceived as the "machine" that's being "fixed," the provider then becomes the "tool" that "fixes." It seemed to me that the prenatal care providers with whom I've met actively resisted this metaphor with the stories they told in our conversations.

Of course, the project was framed as a storytelling one and I had several times emphasized the value of personal narrative to this project. I have also unabashedly included my stories in the conversations. Perhaps that set the tone...

Both midwives met with me in the house where their prenatal care practice was located. That is to say, we had other opportunities to meet, but they did insist on meeting me there on a day when they were "on call" and, thus, would perhaps have some time. The hominess of the house (in implied opposition to the institutional setting of a hospital or a biomedical practice), was emphasized as soon as I was greeted, "We have a lovely space here, don't we?" And yes, the contrast with the practice I visited during my pregnancy is quite stark, but I keep thinking that this only becomes important if it is symbolic, if the warm loveliness stands in for care that is different from the one that happens in the cold sparseness of a traditional medical practice. And yet, we were in a professional medical space, as reminded by nurses and assistants in scrubs, by boxes of gloves and syringes, and the Purell available in abundance.

There, in that house, I was particularly mindful that the space where storytelling was about the happen must itself be an important part of the story. Besides Martha who was getting ready to move to Vermont and whom I met in that restaurant, and besides the two midwives whom I met in their workplace, I met with all other storytellers in homes - mostly theirs, but Drew and her daughter Brooke came over to our house for a play date and a conversation. So, besides the three exceptions - all of which with formal prenatal care providers - stories about pregnancy and prenatal care were told in the privacy of homes, at least when it came to "interview data collection." I go back to wondering, where do different participants in pregnancy *practice/do* prenatal care.

Thinking about the space, made the midwives' telling of their pregnancy and birth stories as entry points into midwifery that much more important. Their presence in this space, in this context, in this profession was legitimated - no, almost spiritually

commissioned - by their own experiences of pregnancy and birth when they either saw or wished for something else.

Mariyana was the younger of the two midwives I met. White, petite with striking blue eyes, made even more noticeable by her aquamarine earrings and oversized necklace in the same color. We sat at a conference room table that was too big for two - Mariyana at the head of the table, closest to the door, and me in the adjacent corner chair, closest to her. For the most part, she spoke slowly and softly, taking us through her mental and physical journeys. Her voice changed sharply when she talked about lack of resources and social (in)justice in prenatal care. Mariyana has traveled much of South America, she runs a prenatal and birth-focused non-profit in the Dominican Republic, she is a professor at a large and well-respected university in the U.S., she had worked with some of the poorest and most marginalized groups of people in the area where we live, she self-described her approach to nursing and midwifery as public-health oriented and "mindful of the social determinants of health." Her stories and her efforts, the way she told (on) them, were deeply embedded in local contexts. This included her own decision to work for the prenatal care and birthing center that supplies her family's primary income and, by her own words, serves primarily privileged family - not ideal, but "what's best for my family right now." Mariyana is also a mom and I asked her if her kids travel with her; affirmatively, she told me of the importance of experiencing different cultures.

On the other hand, Peggy's (the other midwife I met) entry into midwifery was deeply rooted in her own experience of giving birth in the U.S., right around the high-times of *Our Bodies, Our Selves*, when a rhetoric of (informed) choice and agency framed (white, middle class) feminist emphasis on women's health (Hayden & O'Brien

Hallstein, 2010; King, 2010; Saukko & Reed, 2010). Peggy was in her early 20s when she had her first child. She would never forget how it felt to not hear him cry right away and to, upon finally seeing him, lay eyes on his bluish body. Peggy's first-born is ok and a parent of his own today, but she said that memory still drives her emotional understanding of women's and parents' fears. In her case, she said, what happened during her birth and with her newborn was due to a medication she was given that shouldn't have been given to her and that she knew nothing about. So, as a young nurse and a mother in the late 1970s and early 1980s, she "picketed" and "knocked on doors," and "protested," and finally went to midwifery school. When I met her, Peggy looked tough and weathered in all the good ways, speaking with conviction and confidence and holding on to the youthfulness of passion and commitments.

Peggy is Paul's mother. I would meet Paul and Patty about a month after I met Peggy. Welcoming me to their home in a dark rainy evening, as Paul is putting their two kids to bed, Patty seemed relaxed in her wide-leg belted jeans and a sweater. She spoke slowly, almost too slowly and offered me tea, as we transitioned from the kitchen to the warm living room. As we were waiting for Paul, our conversation trailed around typical topics of "tell me about this project" and "what do you do?" Patty had mentioned her own work interviewing and I asked her about her occupation(s). Though she listed many in the past tense, I wonder if my question somehow stepped on the toes of a potentially stay-at-home mother. I want to apologize, but am not sure how or if to go back to that topic. Patty curled up on the couch, hot tea in hand, and we moved on. Paul joined us in a few minutes and sat next to his wife.

By their own admission, Paul and Patty are in their 40s, have two kids, a fairly big and nice house, a routine - for many, perhaps, a white middle-class dream. Although I imagine they, too, must have their struggles, that evening they appeared perfectly comfortable, calmly content, healthy, and lovingly close to one another. We met primarily because of a support group for the non-birthing parent that Paul had started, yet our conversation began with memories of their own experiences with pregnancy and moved into "mother issues" and knowledge topics. Paul was quick to talk about how he found himself amazed by the process of pregnancy despite (or because of) his casually mentioned education and work as a Physician's Assistant. However, there was little room, he felt, for his amazement and his fears and his questions in the way their pregnancies were "managed" and "treated" by society. So, to make that room for all the "I don't know," as he said, he began the group. Of course, though never mentioned, it did perhaps help logistically that the "other parent" group was associated with the midwifery practice and birthing center where Peggy, Paul's mother, has worked since the practice was found.

But it was actually Mark, whom I met the week before meeting Patty and Paul, that had mentioned the non-birthing parent group. He said, "I actually heard about you at this group" and that opened a new conversational direction (there will be more inclusion of that in the coming chapters). When I met Mark and Cindy, there was so much that was still fresh and raw for them - perhaps for Cindy in particular. I remember trying to move the conversation more toward Mark at times and feeling like I didn't succeed at any of those times. I remember feeling unwilling to deter from the emotions that built Cindy's accounts, and unprepared to find ways to include Mark's. Perhaps that is why I remember

him mentioning the non-birthing parent group and the trace of disappointment that this group did not provide the same sense of community as the group prenatal care in which Mark and Cindy were involved together before the birth of their child.

When I met Cindy and Mark, their newborn son was just two weeks old. We have been trying to set up a meeting during the pregnancy, but, as I was soon to find out, the last two months of the pregnancy were quite trying for this couple. The week before our meeting, I had e-mailed Cindy again and cautiously suggested, "Perhaps you already had your baby..." And the answer was a "yes," followed by a welcoming invitation to join them at their home.

On a warm afternoon, I arrived in front of a big house with a small driveway, shaded by venerable trees, whose relentless roots curled up and cracked the asphalt under the car's tires. Cradling her newborn in her arms, blond, smiling, plump in her jeans and black t-shirt, Cindy ushered me in through the dusky hallway and into an inviting sitting room the walls of which were lined with windows overlooking the grand trees outside, the street, and the neighbor's house. One of the non-windowed walls was bookshelved, the other one was marked by a piano - closed now - that was adorned with countless congratulatory cards. I sat on an older sofa and put my bag on the floor. The middle of the room was wide opened, bordered by the sofa, the bookshelves, and the reading benches underneath the windows. Cindy, holding and nursing her son sat on that impromptu stage and seemed eager to begin. "Where do we start," she asked. "Well, tell me about your pregnancy this time around? How was it different or similar to before?" I asked in turn. I knew that Cindy had another child, but I did not know at that point that her eldest was 9 years-old and that Mark was not her father.

Coming in - perhaps 10 minutes into our conversation - Mark walked in barefoot, clad in wide khakis and an orange t-shirt. Taller, thinner, and balder than I expected, he offered me tea while his boney, but warm, white hand shook mine. I refused the tea, but he stepped into the kitchen to warm up some water for himself. Mark seemed reserved, deferring or checking much of his experience of pregnancy to/against that of Cindy. Among the love and care that filled that quiet old house, as we three carefully arranged our words around/about birth, I also felt a lingering fear, a scar that was too fresh to pick on... That the baby was born two weeks before our meeting was both moving our conversation and stifling it - on the one hand, pregnancy with all its expectations, preparations, and complications was fresh in the parents' experiences; on the other, the event of the birth, heightened by its drama that had, up to this moment, only been shared between the two parents and their birthing team, was thoroughly engulfing most experiences that had come prior to it.

I am reminded again of Della Pollock's (1999) inclusion of emotionality as a factor in creating stories of birth and ourselves within them - the emotion work (Hochschild, 2003) that is performed in telling a birth or a pregnancy story, Cindy's articulated need to tell those who were pregnant with her and her agonizing self-censorship, keeping the story to herself, because who wants to hear the scary side of birth?! I will talk more and in more detail about emotion work in chapter 6, but I note it here because, given that Cindy had given birth at the time we met and that she had complications in pregnancy, I cannot help but notice how different the emotionality of our encounter is compared to my conversation with Charlene that also happened (significantly) after the last time she gave birth following a "high-risk" pregnancy.

Charlene is a nurse and a military spouse who, at the time of our conversation, had just completed yet another move of her family - this time to Tennessee. She is a mother of two, with the younger child a little over a year old . We "met" for a nearly 2-hour long conversation over Skype. She had contacted me after her sister, who was pregnant and visiting with the midwife clinic I had contacted, had forwarded her my information. Charlene's excitement and openness to talk and her overall bubbly chattiness surprised me. I had made the mistake to unwittingly, but admittedly, group her within a composite stereotype that I was familiar with through my playgroup interaction - that of the white, working middle-class mother, who is also the primary caretaker for the children and the house. I expected guardedness, for, I had come to believe, in those circles ideological judgments run fast and deep. Charlene herself talked about such judgments - critically. She had frustrations - those judgments being some of them - and complications, yet her stories were all framed by the decided and decisive emotion with which she started our conversation and which carried on throughout - " I am actually one of very few whom I know who actually enjoyed pregnancy (...) I just loved being pregnant."

Shelly echoed some of that sentiment, too. Expecting her third child - a girl after two boys - Shelly had her gripes with prenatal care providers, but pregnancy altogether was resolutely joyful affair, punctuated by Shelly's frequent laughter and almost constant smile during our conversation. A freelance graphic designer and an active (former) member the major mother-support group in the area, Shelly welcomed me to her home on an early Saturday morning. She was eight months pregnant when we met. Walking through the living room and into the kitchen/dining room, I heard kids' footsteps and

laughter. Soon, the garage door opener and Shelly's husband and two sons came in carrying boxes. "We had a late-night trip to Ikea," Shelly explained, "and they're putting together desks." I offered to help, especially since some heavy lifting was required. "Yeah, maybe," was the answer. I sat on a high barstool facing the kitchen where Shelly was heating up water for a French press coffee and grinding the beans from a local roaster. She laughingly excused her husband's obsession with coffee and I understood, thinking back to the morning that was probably unfolding in my own home. As we waited for the water, we talked about parenthood and work, about the frustrating need to drive everywhere and about how much more difficult and time-consuming driving to a store becomes when one needs to pack three children in the car. We talked about the differences between men and women when working from home. Both Shelly and her husband work from home for at least part of their income; she shared with me that she found it incredibly difficult to detach from her home and family members and devote to work from home; a difficulty that she didn't think her husband, whom she described as "much better at compartmentalizing," didn't seem to have.

I was at ease in their airy house. A wall railing with kids' paintings hung decorated the entire length of the wall dividing the living room and the kitchen. There was no TV in sight. And this reminded me that I actually saw no TVs in any of the homes I visited. Ceilings seemed high, perhaps even more so because of the light-colored walls and minimal furniture; there was no clutter - just a lot of open space and a composting box under the sink. Though Shelly talked about some financial difficulties in the past, especially during her second pregnancy when both her and her husband were unemployed, their life now, on that idyllic Saturday morning, seemed to me - a stranger -

to have been marked by some measure of stability that comes with the privilege of fitting in, having found a place that's felt as one's own, and/or feeling content with and confident in one's life (choices) in the present.

This security and confidence marked Shelly's story of switching prenatal care providers late in her pregnancy because the midwives' panic around finding (out) her anemia did not match her own approach to it. I remembered Shelly's story again as I was talking with Drew about her search for and switch in prenatal care. The two women's reasons were quite different and, it seemed to me, so were their life situations. Drew arrived at our house mid-day on a weekend. She brought her daughter Brooke, just about Sammie's age, for a play date, supervised by Remi, while the two of us talk. We did not know Drew before that, she had heard about the project through the midwives and contacted me. She is the only person I've met through this who preferred to come over to our house, though it was quite a drive from the hill-town where she lived. Soon after they came in, Drew talked (it sounded to me apologetically) about the very small house in which they lived, how they did not have space for the baby or for themselves, how, since her mother's house was devastated by an unexpected tornado, they have been housing her, too.

But she was excited about having another child and she talked of motherhood lovingly and happily, despite mentioning that, due to her husband's work-related traveling, she was often alone. With the sounds of our kids footsteps echoing in us, as the kids chased each other, we decided to go downstairs to a quieter space. It was here, in this darker space, that I noticed Drew scarf was actually hiding a scar on her neck, she fidgeted with the scarf right around that place, but I didn't know if or how I should ask

about it. There was so much kindness in the soft and patient way Drew spoke, but I also hear hints of pain and wishing for something different. Perhaps that was the motivation for Drew's switch of prenatal care providers, although she told me that because it was clear she was so different from the "population" served in the first practice she went to. She described driving the long distance to a largely working class town nearby to find herself in the waiting room with a lot of "young, teenage mothers" and she wondered if the midwives had experience with this group of people could they also serve her needs sufficiently well. Put that way, perhaps her reasons to switch providers were not that different from Shelly's - perceived ideological and experiential differences. Yet the focus, she placed on the "population" of the first clinic made me think about questions of belonging and seeking that place while expecting a child.

I have to admit, hearing Drew talk early on about switching providers because of "the people in the waiting room" made me feel uncomfortable, uneasy. It made me think of (and feel?) Sara Ahmed's (2010) "killjoys" and "affect aliens" (this thread will be developed further in chapter 5). Though I did wonder, had it been me in that waiting room, what my presence there would have signaled and though I did have the stereotype-alert knee-jerk reaction academia has trained me for, I was glad Drew and I kept talking. In the following nearly three hours, with our kids' joyful interruptions and baits of our attention, I developed a deeper appreciation of the complexity and longing that nuanced both that early statement and our interaction. Remi joined us in talking about parenthood, learning, and growth and when it came time for a good-buy, the kids hugged and there was, I thought, a real sense of warmth between all of us. We insisted on continuing our

conversation and getting the kids back together. And though we made multiple attempts, our schedules "failed" our good intentions.

Yet, this was one of those times, as with Charlene, for example, or the unexpected conversations on playgrounds and in rest-stops, where it seemed to me that "research" as the context of storytelling and connecting was pushed to the background. That is not to say that we didn't do research, but rather that my role as "the" researcher became irrelevant rather quickly. I had, of course, strived for that in all the interactions I had - formally and informally - in the course of this project. But is one's striving enough? Many of the people I met more formally (i.e., those whose participation was accompanied by a consent form) engaged in meta-conversation about research, most notably methodology. Despite my repeated use of "storytelling," "dialogue," and "conversation" to frame our interactions, despite my own telling of personal stories and unresolved wonderings, my conversational partners used different terms to make sense of me and of themselves in that situation that we now shared. "Interviews." "Thematic analysis." "Qualitative research." "What other questions are in your guide?"

Many whom I met for consent-formalized conversations commented in one way or another on their own experience with doing research, establishing perhaps both an education "status" and an implied common-ground understanding according to which they're familiar with my need for "participants" and the challenges that a research process might entail. I was/am grateful for that and also realize, perhaps more clearly than before, that others' knowledge of and past performances of research defined me as a particular type of participant in that interaction. And I remember thinking many times, "They must think I'm a terrible researcher/interviewer for sharing personal stories, for talking too

much, for opening myself..." And I remember asking myself "How would this interaction feel if it were the research I imagined?" And then I remember wondering if maybe, starting with our own hopes and expectations for research, we still made it meaningful and new.

Just as I was leaving their home, Magdalene said "I can't believe it's been 2 and a half hours! Time really flew by." And we all smiled and went on with our day.⁹

Magdalene was a social worker who had just finished her degree less than half a year ago and Peter, her husband, was in graduate school. Early on in our conversation, it felt, in my overly self-conscious appraisal, as if that educational common ground - the sense of, "oh, I know what you're doing here and I'm gonna help a fellow student" - framed our interaction. But we had had very different experiences with pregnancy, though we shared some views on parenting - and we dove in those differences and similarities for two and a half seamless hours.

Magdalene's due date was just four days away when we met. Between bouncing on the large medicine ball, sitting on the couch, trips to the bathroom, and short pacing walks in the room, movement, expectation, and the body's demands and discomforts were all around us. For me, they were perhaps the most kinetic reminder of the last days of my own pregnancy. I almost felt like I was going to get up and accompany Magdalene in her comfort-seeking dance. But instead Peter and I remained seated on the couch for almost the entire time of our conversation, considering our words and her body and the body within hers. Seated on the edge of that couch, pushed to the wall behind a small coffee table, the room and all of Magdalene's movement in it and out of it, and in it again, was

⁹ A day that would come to be remembered not for our conversation but for something the three of us - Peter, Magdalene, and I - were blissfully unaware of as we parted. December 14, 2012.

so real and surreal - the desk with the computer to the right side, the windows right in front and to the left, the Christmas tree by the windows, the small icon on the wall behind it, the loveseat, and mostly Magdalene navigating that space.

Rented space. Peter and Magdalene lived in an apartment in a near-by town highly valued for its neo-hippie politics, venues, and cultural life. If you peaked out of their living room window to the left, you could see the college and, I joked as I came in, "you could practically walk to the birthing center." A large house had been divided in apartments and they lived on the fourth floor, up a narrow staircase. Though the old charm of the house and the apartment, tucked in among grand trees, was undeniable, as I was climbing up those worn-carpet stairs, all I could think of was the impossibility of bringing a stroller up there and the exercise that would be involved in carrying a baby up and down. But I shared none of that with the expectant parents. In some ways, Peter and Magdalene were, to me, quintessential for the area - young, white, soft-spoken, well-educated, concerned with matters of social justice, global volunteers, nature-loving world travelers who had committed their lives to community work and fostering relationships.

Having wanted to do these things and be/become that sort of person during my college years, I also knew, from where I stood, that those positions of documented and continuous social contributions, while desirable to many and certainly shaping a moral ethos, were not available to all. Instead, I stuck to my necessary occupation - low-wage (still higher than a library job), limited hour dining services job through the school year and the summer. There is much in the service learning and community engagement scholarship that criticizes a particular "brand" of white, middle-class U.S. volunteerism (e.g., Guthman, 2008). While this is not directly relevant here and while I still think that

such criticisms do not take away from the importance of community work, I do mention it here because it illustrates how the values of social responsibility, simplicity, and natural-ness - in this particular version - perform a certain racial and social positionality, from within which they are at once taken for granted and morally valued and valued. As the next chapters will engage in more detailed complexity, these values - social responsibility, simplicity, and natural-ness - also shape particular versions of prenatal care, pregnancy, and birth that are similarly valued in particular affective and political transnational contexts. Such valuations and their interpersonal performances contribute to experiences of (not) belonging.

Although the topic of moral judgments - and hence, the construction of ethical subjectivity (Root & Browner, 2001) - during pregnancy, prenatal care, and early parenthood was often brought up in conversations, it was rarely tied to (perceived) social positionalities. Except when...

Ivan: And I grew up in this culture being different, even being American also, cause I was raised... my mother uh... has different spiritual practices other than the mainstream and she, we always had a, you know, whole grain bread and then the person eating next to me in the lunch room had white bread sandwiches and it looked really good to me, but my mother, my parents were always like very health conscious and, you know, they didn't have a fancy car and weren't interested in any kind of such stuff, so uhm... even I felt alienated in this culture being you know **from** this culture, having different parenting, raising, experiencing different parenting techniques.

[3 sec]

Aneesa: It is and... I think a part of that has made it easier for us to fit in because his parents were counter-culture within the American culture, they basically fall into the more New-Age-y crowd of people who are interested in - like the hippie new age-y sort of tradition of being more interested in, you know... but, but having said that, one thing that I find, that I wanted to tell you is that [to Ivan] - even though you grew up feeling different because your parents made different choices from the, say, the mainstream in the U.S., still your parents were white and they **fit in** a counter culture, and **established** counter culture, meaning they

have... For example, when I work in the holistic clinic, I was telling him, it's very difficult working in the new age field being a non-white person, because automatically... first of all, they think automatically I'm from India, and because I'm from India, hence I'm Hindu, even though I'm from a Muslim family, and everybody Namastes me and all that stuff, and, you know, so hence... What I'm trying to say is that since his parents are white and they fit into an established counter-culture of hippie, New Age, etc., they still have a place here. They don't know what to do with people like me, they don't in this country, in the New Age field. There is very little room for people who are not white in counter-cultures in the U.S. and...

I met Aneesa, Ivan, and Aneesa's mother in the fifth month of Aneesa's pregnancy. Race and not being born in the U.S., but conceiving a child, birthing it, and raising it in the U.S. was a major concern for Aneesa who, after nearly 10 years of living here, continued to feel not-belonging. Aneesa and Ivan lived in the same liberal, tolerant, accepting neo-hippie town where Peter and Magdalene lived. And by many outside markers, they were just as quintessential - graduate students, renting an apartment in a big house tucked among big trees, interested in growing, preparing, and sharing their food, community-oriented, rich in values not material possessions, etc., etc. Even the de-cluttered, minimal furnishing style and the bright windowed walls I notice in Aneesa and Ivan's living room resemble those of Peter and Magdalene's. But while Peter and Magdalene feared that their planned disavowal of attachment parenting for their child might be the cause of some judgment in the area, Aneesa feared that it would be her brown body or the body of her white husband next to their biracial child that might cause judgment. While Peter and Magdalene were preparing to "defend" and "maintain" their

individual choice of parenting and family, Aneesa (and, not to such a degree, Ivan) was preparing to answer questions of the "Is this how it's done where you're from?" variety.

In similar houses and similar towns,

In bodies similar with pregnancy,

Culture is (also) experience of culture.

Culture is (also) experience of others.

Culture is (also) experience with selves as/and others.

CHAPTER 4

WITH THE SELF AND OTHERS: DIALECTICS OF/IN PREGNANCY STORIES

"Relational thinking requires us to step beyond simplistic (yet powerful) dichotomies to recognize a dialectic relationship, a 'third space' wherein many possibilities exist for combinations of both/and. Each woman's life represents a different story with a different combination of desires regarding her private/public lives, and this story evolves over time as different events and opportunities arise."

(Foster, 2005, p. 78)

"A person has no internal sovereign territory, he [sic] is wholly and always on the boundary; looking inside himself, he looks into the eyes of another or with the eyes of another."

(Bakhtin, 1984, p. 287)

"To be human entails the obligation to answer - to act toward - the other, thereby participating in the joint action of creation."

(Baxter, 2011, p. 25)

The idea of dialogue and dialogism was from the very beginning central to me in listening to and rendering these story-tellings, as evidenced even in the title of this project (*Flying with the Storks: Communication, Culture, and **Dialoguing** Knowledge(s) in Prenatal Care*). But I have to admit, I did not expect that the concept of "relational dialectics" (e.g., Baxter, 2011) would become so important to my listening and later re-readings of the stories AND silences I heard told and heard myself telling. I expected that I will hear some "competing discourses" and identify some "dialectics," but I did not expect that dialogue and dialogism would so deeply frame my story-telling of and about story-telling; would so deeply frame my whole process of hearing, remembering, writing, re-experiencing. I may never see the women and families I met again, but the pieces of story they shared will forever be with me and between us, as they are now parts of my story. They are (in) me and not (in) me... and that troubles ethics.

By dialogue here I don't mean an idealized mode of interacting with others where we listen, have space to tell, etc. - rather, I am talking about the dialogues in the silences and stories we tell and hear, as our (unsaid) words perform and attempt to narratively bring together and against one another the tension-filled discursive domains in which we live. The focus isn't (an attempted) resolution, but the creative/authoring processes of engaging multiple voices.

There is no comfort in that -
no comfort reading multiplicity in others' words,
no comfort hearing it in mine.
No prescription.
No best practices.
No evidence-based care.
But there is
care,
creation,
community
-- not absolute, not categorical --
relational, response-able,
(I believe)
There's much to gain in hearing that.
So, let the (unborn)
let the (not-yet-born)
be the dialogic:
the metaphor,
the trope AND the physicality,
the symbolic AND the semiotic¹⁰
of our careful communal creation -
none of these as an ideal,
and all of them as tensions.

Although the concepts of dialectics and dialogism are explicitly central to this chapter, they will carry on to the next chapters and even when I don't return to them in explicit "analytic" words and voices, I hope that readers will hear their tones and think about them in their own - authoring, but not authoritative - ways. The goal of my project from the very beginning was

¹⁰ See Stacy Holman Jones (2005), Julia Kristeva (1981), and Della Pollock (1999) among others

not to discover and prescribe,

but to engage and invite -

to provide text and context for those who come in contact with it to engage in and reflect on the authoring and knowledge-production processes we participate in during pregnancy. I begin this chapter by returning to this goal - as a reminder, as a frame, and as a rationale. After an overview of dialogism, dialectics, and the place of narrative in healthcare, I turn to *stories that narrate pregnancy as a creative and relational process in multiple directions*. Beginning with these stories in the context of dialectics is to perform tensions as productive and connecting (rather than dividing). In concluding this chapter, I explore the possibilities of multiples - the relational (rather than dichotomized and dividing) possibilities that a dialogic view of pregnancy offers to practices of prenatal care, as they already exist and/or are imagined in the narratives I heard.

Dialogue and Dialectics

Baxter (2011) asserts that a dialogic approach to communication research resists a focus on the individual, resists the notion of intersubjectivity (between-subjects/individuals), and resists, to some degree the notion of individual agency and power located in individuals. Instead the focus is on the interplay of discourses/voices in language-in-use. She goes on to say, "In the context of the study of discourses, participation focuses on which discourses can be voiced in a given social moment, and by implication, which discourses are marginalized or silenced. (...) Power, in other words, is conceived as a relation between discourses" (2011, p. 13).

(Dr. Baxter, I am just not sure quite yet how to include silence in such discursive relations... what to assume or make of silence?)

Yet, approaching the same discourses as stories - from a narrative perspective (e.g., Riesmann, 2002) and especially in the context of healthcare - we see the story-teller cast as someone with agency, as someone rhetorically constructing identities in the stories told. Conquergood (1989) sees the same productive energy in the healing actions of a shaman, as the world is (re-)created in every ceremony. The social world might be created and reformed in the dialoguing voices within a story (Hill, 1995), but

stories are still told by certain someones

to certain someones

and not by/to/between others.

Agency, thus, is not only in the content of the narrated interaction or situation - it is in the performative act of (not) telling, chanting, dancing, etc. This is why acts of telling are seen as discursively rich and socially transformative - a paradigm of telling that is highlighted in narrative medicine. Writes Riessman, "Approaching illness narrative performatively opens up analytic possibilities that are missed with static conceptions of identity, and by essentializing theories that assume the unity of an inner self. Because narrators control the terms of storytelling, they occupy 'privileged positions in story worlds of their own creation' (Patterson 2002: 3); the performative approach emphasizes narrative as action, an intentional project (Skultans 2000:9)" (p. 27). More specifically commenting on the particular types of knowledge produced by patients' own stories of health and illness, she notes the practical importance of such story-telling in constructing diagnosis and treatments, but she also sees it as a discourse in itself, doing important ideological work: "narratives of illness can provide a corrective to

biomedicine's objectification of the body and, instead, embody a human subject with agency and voice" (p. 3).

This emphasis on agency (in relation to and influencing structures) seemed even more important to me in this project because so much of the academic social science literature relating to women's health and reproductive experiences and rights comes from a critical feminist perspective. As summarized in Chapter 1 (the theory chapter), much of that literature traces its inspiration to second-wave feminism in the U.S. and is concerned with issues of voice and choice - giving, getting, claiming voice and opening up choice. Both actions - voicing/talking and choosing - are seen as performances of social agency. But as some critiques (e.g., Dutta, 2006) poignantly point out from a transnational perspective, discourses of voice and choice are also embedded in larger neoliberal ideologies that emphasize (in false dichotomies) individual over community, freedom over accountability.

The theory I wanted to embrace - for the ease of writing this, containing it or allowing it to spill out of stories in which the tellers construct - that theory ruptured.

In August of 2012, I went to a Community Baby Shower - an educational celebration, organized by a local Women, Infants, and Children (WIC) chapter. Sammie, 2 years old at the time, was with me, asleep in his stroller. Besides the reality of not having day care and having to bring him with me, I saw his presence there as an asset. Ever since Sammie has been visible as a being or a becoming, I feel more comfortable in social situations when he is with me, more fitting, more belonging. The physical presence of his body next to mine legitimates my being in public spaces (in a "foreign" land) and,

in cases of awkwardness, gives me and the others to whom I am a stranger something to talk about. Just as my pregnant belly did.

But on that day in August, there was something else. I was going there as a "researcher" and desperately felt that it's beyond important for me to seem relatable, to make sense in that space where I am about to ask others to consider sharing their stories of/to/with mothers, children, bodies. Carolyn Kay Steedman (1987) wrote about the child as a "bargaining" chip in family relations and histories and, for me, there has always been something crude in this materialization. In my discomfort with the phrase, there are multiple truths - there is the recognition that I have, in fact, interpersonally invoked our child in this way; there is also the recognition that such an exploitive de-humanizing is morally un-motherly; there is also the recognition, which I see in Sammie's smile, when I ask for *his* help, that he matters to me more than others do. Even when I can't bargain discomfort away, I bargain many ways.

I go to that WIC community baby shower in August - scared, embarrassed, guilty, excited, prepared with my child who legitimates my being there (at least in my eyes), prepared with my intro, and with a flier (see below). I have prepared, I think, to fit in a little, to not intrude, but invite an-other's agency of telling. Besides the organizers, I am the first one there. I bring a box of soaps I made with lavender from our garden to donate to the raffle. I don't want their invitation for me to attend the baby shower to be left unrewarded. It's a small sunny room - seating space for about 20 and few display tables along the walls. I leave my fliers in the middle of the seating tables and walk by the display tables - dental practice, birth education service, WIC table with information on healthy nutrition for children.



Story-telling Project: Flying with the Storks - Communication, Culture, and Dialoguing Knowledge(s) in Prenatal Care

~ Share your stories of flying with the storks! ~

If you are pregnant, a family member or a friend of a pregnant woman, or if you are a prenatal care practitioner or educator, I would love to hear from you! I am collecting stories about pregnancy and prenatal care beliefs and practices and how they are tested, negotiated, and/or affirmed in interactions with others during pregnancy.

My hope for this story-telling project is that, as a provocative "in-your-own-words" collection, it will foster a culture-centered and dialogic model of prenatal care that will be more inclusive of all the different people involved and the different knowledges we bring to and negotiate during pregnancy.

What would you do:

- *Meet me in a setting of your choosing*
- *Tell your stories, prompted by questions if needed*
- *If you're interested, meet in a story-telling circle with others*

What would you gain:

- *Chance to tell your stories and influence a holistic model of prenatal care*
- *Thank you gift (for each story-teller): handmade herbal soaps*
- *Thank you raffle: enter to win an Amazon gift card for \$50*

Contact: Lily Herakova, lherakov@comm.umass.edu, 413-230-4840

Figure 2: Recruitment Flier

The first guests come in and others slowly trickle in. *Funny, I think, the only person who's here alone is the white, blond, heterosexually married, and employed woman in her 30s who is due in December.* The other pregnant women who come in - bodies, bellies changing space in different ways - are younger, a couple still in high school, and darker-skinned. I try to resist easy categorizations of any of the women in there, but I know I am also looking with the eyes of others - and shouldn't I, are we not part of others' recognitions (Bakhtin, 1984)? Struggling in between resistance and cultural embrace, I almost forget to look at the other bodies in the room. I am surprised I did not see earlier that now non-pregnant people (like me) outnumber the pregnant ones in the room. Pregnant women (except the one, and I wonder how she feels now?) did not come alone - there were mothers of mothers-to-be, there were sisters, friends, and also fathers-to-be. I felt confident - pregnancy is (in/about) community. I felt excited: so much telling agency to invite.

I talked with people, asking about their experiences and telling them mine, also telling them about this "story-telling" project (never once called it research). No consent forms were signed, no stories recorded, but I think I learned a lot and a few people have assured me they want to talk, they'll be in touch to talk with me more. I leave excited and hopeful, I feel like *something* happened, a dialogic peak moment of some sorts (Goodall & Kellet, 2004), a "felt wholeness" (Baxter, 2011, p. 141).

So where/when does theory rupture?

In the months to come, not one person that I met at this community baby shower, would contact me.

*"Understood in this way, silence is not there to be broken
(as the strange alliance of some feminist and TV/consumerist discourses might suggest)"
(Pollock, 1999, p. 188).*

Is an agency of telling abdicated and suppressed?
Is an agency of not-telling powerfully claimed?
Is voice refused? Are choices made?
And maybe simply - who cares
to be a "subject"
"co-researcher"
"story-teller"
to/with the listener who brought
her child
her accent
her stories
and her fears
to bargain (for) others' stories
to hope that maybe theirs will be more like hers
like mine -
my stories
left me feeling
not belonging
- not here -
and longing
for a there
I hope to find
in stories
I will never hear

The silence is familiar and close,
yet I long for words erasing it -
my research ego humbled,
desires raw-fully exposed.

A secret exists in performative relation to its other, its mirror double: exposure, explicitness. Secrecy marks a border; it is a border space, a play space (...) Secrecy constructs the borders it guards. It is the place where knowing and not knowing divide - but it is also the place where disguise and surveillance meet.
(Pollock, 1999, p. 185-186; emphasis added).

Suppose, I could have written something like this...

According to Baxter (2011), "the term dialectics emphasizes the struggle of competing discourses" (p. 45), where discourses are defined as cultural systems of meanings that render language intelligible. In formulating Relational Dialectic Theory (RDT), these discourses are often framed through oppositional discursive pairs, such as individualism-community, predictability-novelty, and disclosure-secrecy. To evoke the notion of dialectics means to explore how those competing, often oppositional, discourses are in creative interplay with one another, not negating the other, but engaging it - we are concerned with both processes of interplay and with meanings produced in those processes. And indeed, as turning points (Baxter, 2011) in one's relational and relationship life, pregnancy and pregnancy stories are fertile (pun intended) sites for competing discourses to meet and dialogue as voices, as the narrators negotiate personal and relational identities in the process of telling.

Stories are important because they are "templates for action and identity. They are sites of reflection, critique, self-making, self-theorizing, and collectivization" (Pollock, 1999, p. 187). Rather than reading/hearing stories as a way to discover a core, hidden self of the narrator, we engage with the stories reflexively, as in the process of reading we dialogically create ourselves and the narrators. In story-telling and story-listening we

enter not a process of discovery, but a process of collaborative (re-)creation of reality. Our own competing discourses meet with those in the story, as we try to con-figure how we fit relationally - as a mother and child perhaps, or an interviewer and interviewee, as two different mothers, as a woman and a man, or not at all.

Suppose I could have written something like this...

In dialogic theory, every utterance/performance/act is part of larger "chain of speech communion" (Bakhtin, 1984), meaning it becomes intelligible as part of larger on-going processes in which distal-already-spoken (cultural discourses and echoes) and proximal-already-spoken (relationship-specific histories and discourses) intersect in processes of making meaning of what is presently uttered or done with the future also in mind. Future-oriented, utterances (any speech or performative act) are also always addressed. Thus, their meaning-making processes are shaped by sense of addressivity, including proximal-not-yet-spoken (consideration of who the immediate addressees of an utterance are and how relationships are constructed) and distal-not-yet-spoken (consideration of super-addressees - unknown others and society). By bringing all this in a single utterance, the utterance itself becomes polysemic, multi-vocal.

Stories of pregnancy and prenatal care are dialogic, animated by multiple voices, even when told by a single individual. In them, a discourse of individual choice meets that of a socially-constructed responsible mother whose health is that of her baby and of her community. In them, a discourse of "special beings" meets that of another "part of a chain," as a pregnant woman narrates herself and is narrated by her partner both into the miracle and social ordinariness of growing (another) life. In them, a father's desire for predictability and preparedness meets the longing for enjoying the unanticipated

moments, not capturing them. The stories shared below talk to and with each other. In them, relational and cultural pasts and futures also talk to and with each other.

Suppose I could have written something like this...
But then again,
I did(n't), dialectics.

Integration: Identities with/out Belonging

In reviewing relational dialectics research, Baxter (2011) identifies one of the main discursive struggles of culture (on the level of distal-already-spoken) as that of integration, defined as the dialogic meeting of ideologies of individualism and community in "mainstream" U.S. society. When performed on the level of inter-relationship dynamics, between partners, she names that struggle *autonomy-connection*; when on the level of interactions between a dyadic couple and other social systems (e.g., between a married couple and their extended families), she names it *seclusion-inclusion*.

Overtone of this struggle of/for integration can be heard throughout the stories I listened to and told myself. When we visited my husband's Polish-immigrant family in Worcester again this year, their daughter, Paulina, who had returned to marry and live in Poland, was visiting with her new husband and with not-yet-showing promise of grandchildren (expecting twins). In everyone's excitement about the "start" of a new family, in the precious joy of being together now and for a little, un-spokenly expressed in the ordinariness of doing daily tasks, like cooking, together and for one another, in the unsolicited hugs, in the hushed expectation of separation, in the pain and fear of mother, father, and a daughter who might not be together when the new generation "arrives" - in all of this and more, there was longing and belonging (inclusion), as well as a tacit, lived

understanding that this "new" family will (and perhaps, needs to) have a life of/on their own (seclusion).

Relationships - past, present, and future - are (re-)defined in the presence of the promise of new bodies entering those relationships. Performing the seclusion-inclusion dialectic, as version of the integration struggle, invokes (normative) discourses of family and parenthood. The struggle, the tension, the multiple voices within a single story resist a view of simple cultural reproduction (and narrators as dupes) within narratives. In pregnancy stories and interactions during pregnancy, discourses of the internal family system may bump against what is lived to be socially dominant discourses of pregnancy - such that, for example, while the extended and deep involvement of (future) grandparents performs a (pleasurable) discourse of connection within the (extended) family, it also (painfully) marks that family as different from a dominant cultural version of a nuclear family - centering, in the process, micro- and macro-dimensions of belonging. Hyper-awareness of (not) belonging.

That the inclusion-seclusion dialectic - voices of belonging - was so prominently present in pregnancy narratives and interactions (differently for different narrators) highlights how deeply social the phenomenon of pregnancy is - a social phenomenon, but not a social fact (Denzin, 2003). In the dialectical in-between (Diversi & Moreira, 2010), ways of (not) relating during pregnancy have deeply personal and political implications - who and how belongs (or passes) in this particular system? How are selves, others, and relationships constructed as (not) belonging when narrating pregnancy? Answers and experiences within these questions are deeply affective, and the affect of pregnancy was often discursively employed to signify (not) belonging - a political discourse, which was

otherwise silenced, not explicit. I will talk about affect in more detail in the next chapter, but I want to alert the listener/reader to it here, as it discursively constructs relationships and identities.

Voices of Integration, Episode 1: Ordinarily Special

Dear you,

I am surprised that yours is the an-other's story with which I begin. Without you knowing, I had a simultaneous respect and disdain for your profession - respect for what it could be and disdain for what I thought it had come to be in the place we live. It wasn't your fault and I wanted to hear your story, of course, I just never could quite forget that it was (the suggested choice of) your occupational relation to me that took the place of what I thought should have been a special moment. There is no way you could have known and, having heard what you've said, I don't think that you would have asked like that... So, I apologize. In this text, I give you my mother's name - Mariyana.

When we first found out I was pregnant, we didn't want to tell anyone... you know, we've been told to keep it quiet for the first 3-4 months, because who knows. For days (before I actually did the home pregnancy test) I imagined telling people. I took the bus to school. Before that, I walked up the hill to the Mt. Holyoke College bus stop - 2 miles every day in February. I wore Remi's sweater that my mom had sent him, and my jeans, and the green winter jacket. I walked with my hands in my pockets, on my belly, and smiling, occasionally whispering. I was trying on different words, imagining saying them to different people

I am pregnant.
We're gonna have a baby.
It finally happened.
Ще имаме дете.

Бременна съм.
Ще имате внуче.

I was walking alone, knowing, though I haven't yet tested and I haven't yet even shared my suspicion with Remi. After so many moments of "maybe" before, he had asked me to stop buying the pregnancy tests and crying over them, and that's what I did. But I couldn't help imagining. And all these people that I wanted to tell, came with me on that walk to the bus stop.

Then, of course, one Friday on the way back from school, I walked by the BigY, sharing our secret with some imaginary confidant again and I thought, enough is enough. And that early afternoon, alone in our pink bathroom, our dreams were marked - "positive."

Remi came back from work and I did the second test, we just stared at it. We knew we shouldn't tell, but we wanted to scream. Remi ran across the street to a neighbor we've known for half a year. He came over for dinner, he was the loving father of two kids who didn't live with him, he could not stop the hot stream of memories of their births, holding them. We were all smiling. It was so warm in that little kitchen. It felt good to tell - and to tell someone whose heart won't break with ours if something were to happen.

On Monday, I went to school and ran into someone who knew of our unsuccessful, un-succeeding prior attempts at pregnancy. I was so excited still, my heart - every bit the colorful rainbow as the sweater I was wearing that day. By the door, in front of a classroom, I imagined one of the conversations I've had walking up to the bus stop - coming true, real, outside of my head. I spoke.

You won't believe it - I say - I am pregnant.

Will you see the midwives? - responds the someone.

That's **not** the conversation I imagined. But how could that someone know? And how could you know, Mariyana the midwife, that it would be a mention of your profession that would shatter my imaginary magical moment.

Little moments, why do you stay with me so?

So, I am surprised that yours is the other's story with which I begin - in that way at least.

Other-wise, I am not... I may have wished your story as I walked up the hill.

Mariyana: That's why I decided to be a midwife.
Because I was living in a nomadic ahh... community of hunters and gatherers in the Amazon Jungle
and uh... ah... they were not open to me at all,
but when **I became pregnant**,
the community
came out
and **embraced** me,
so when I went from one village to the next
to ah... to do health teaching in the school or help with the chicken project,
the community would send their children to accompany me,
I wasn't allowed to go anywhere **alone**
and they would come every day with foods
that they thought that I should eat during my pregnancy,
so it was this whole...
community
came out to support
this new life,
it was like something that they recognized,
and it was because of that, that I realized that
it's through women
through pregnancy,
it allows this door into healthcare that often isn't open
You know? Otherwise, it doesn't really,
it's just not open in the same way (...)
and that's when I knew I wanted to be a midwife.

I am so moved that this is the story that comes at the end of our conversation that time - a story of beginning coming at an "end." It's also a summary, a metaphor, an image, cultural spiritual scripts of walking with others and discovering self.

Bookends?

Our conversation started here:

Mariyana: How did I end up here?!
Like how, how...
How much do you wanna know?
That could take a long time...
Well, I was born in Philadelphia.
And I was a ... music major at Bart College in New York,
and dropped out,
and hitch-hiked to Mexico,
and, while I was hitch-hiking, I realized I had no skills,
and so, came back and decided to be a nurse,
so I went to nursing school,
and then wanted to work internationally,
so I went to Peace Corp
and that's where I did, you know,
two years in Ecuador and in the Dominican Republic,
and while I was there, that's when I realized that
women's health
is very, very important to
the community
because women are the ones who
teach their children
about nutrition
they teach their children
about hygiene
they are the ones who
access the healthcare system,
so to really improve the health of the community
you need to educate and work with women,
so then I knew I needed to be a midwife.

Leslie Baxter (2011): Because members of mainstream U.S. society swim in a discourse of individualism, the discourse of rationality is taken for granted as the natural way to understand human action. Stated simply, this discourse presumes that if a person

wants or desires something, believes that a given action is a means to attaining that something and is capable of engaging in that action, then the person will undertake the action (Rosenberg, 1988) (...) From inside the discourse of rationality, it seems only natural to speak of the importance of having goals, making plans to accomplish those goals, making wise choices, and understanding that actions have consequences. (p. 58)

Bill Moyers (talking with Joseph Campbell in *The Power of the Myth*, 1991):

we are not on our journey to save the world, but to save ourselves. (p. 183)

Joseph Campbell (1991): But in doing that you save the world. (p. 183)

Joseph Campbell (1949/2008): Furthermore, we have not even to risk the adventure alone; for the heroes of all time have gone before us, the labyrinth is thoroughly known; we have only to follow the thread of the hero-path. And where we had thought to find an abomination, we shall find a god; where we had thought to slay another, we shall slay ourselves; where we had thought to travel outward, we shall come to the center of our own existence; where we had thought to be alone, we shall be with all the world. (p. 18)

Charlene: [Sigh] I just loved being pregnant
I loved being able to feel my babies inside me
I loved ... just little things

Shelly: Yeah, I mean, I think I deal pretty well with pregnancy, just like in a physical sense.

Yeah, I don't feel like
burdened

like, oh my gosh, this is this
huge different state of being
and at the same time,

it's not like

oh, I feel amazing

I'm glowing

It's just kind of like

yeah, you know,
some things are different,
you know, I've got
yeah
not necessary ...
cause I don't have a lot of ...
but you just feel things differently, like,
your body moves in a different way or something
gravity is different
But for the most part it seems like a normal
normal state to me

Lily: Do you think that maybe you've grown more comfortable with each one, just, you know, knowing yourself?

Shelly: Knowing... yeah,

[kids come rushing in, interrupting, laughing]

Shelly: Yeah, I don't know if this is necessary...
I mean this pregnancy,
I am doing a lot of acupuncture
and so I think that, that it, that's, I don't know, just help balance things in a way ahh (3
sec)
I don't know
I enjoy being pregnant
I don't know, it's funny cause this is -
in all likelihood, 99% sure that this is my last pregnancy [laughs].
Not making any guarantees, but you know, probably uhm... and I think,
I'll **miss** it
in some way.
I think like,
especially like when the baby is first born, it feels weird to not be pregnant any more
I mean it's almost like you have sense of what do you have -
hiccups
for a few hours, like a really long time, and then all of a sudden, they're gone and it's like
"oooooh ... that's different"
you know, like,
I think feeling
feeling the baby move
feeling another **person** inside you
is really strange and completely alien
and still kind of like baffles me
and at the same time is like a really
nice feeling
that you get used to

I get used to it and
it's really strange not to have that anymore -
you have like a physical baby in your arms
instead of "ohh..."
I miss that like kicking and turning
Yeah, I think, I think
I'll **miss** that
I still, I still like,
well not actually now when I'm actually pregnant
but I feel like between the boys,
I got like phantom kicks,
I don't know if you ever [laughs]...
I've definitely, I've talked to a few women who have gotten that afterwards - it almost
feels like...=

Lily: = I sometimes feel =

Shelly: = like a kick or something =

Lily: = I sometimes think that I'm feeling this still.
But it's also like, you know,
wishful thinking
cause we wanna have more children and sometimes
I just wanna imagine =

Shelly: = yeah, I don't know, I think there is some
body memory though
it's like =

Lily: = but even with like =

Shelly: = it's not just gas [laughs]

Paul (Patty's husband): I, I just...
I just loved her pregnancy [laughs].
It was just uhm...
it's just, it's so miraculous to...
watch you changing
and all the beauty in that
and then, like, then the movement
and the, you know, feeling, like
becoming
more and more
real
You know, I uhm... there is some aphorism that
women... it's a big change when they're pregnant,

but men when the baby is born
cause I'm not feeling it move or feeling changes in my body,
so I was like, there were still moments when I was like,
"ok, I guess there is going to be a baby at some point" [laughs]
cause it was more, it was kind of abstract in some ways
it wasn't like, "yeah, this means there's going to be a baby"
my brain knew it
but
I didn't really
get it
So that was really amazing to...
to be **witness** to
and I, I, I am a physician's assistant,
I do medicine,
and study,
I know,
I kind of know aaaall the things that are going on
- I mean like, how, development -
but it's like "Man!"
It was just amazing the... the...
a miracle even more so to me cause I kind of knew
how the parts will all happen,
we hoped,
and they did [laughs] -
amazing that it goes as well as it does. And ah... yeah...

Charlene: [Sigh] I just loved being pregnant
I loved being able to feel my babies inside me
I loved ... just little things
anywhere I walked, people would look at me with just like
it almost seemed to **bring out the best** in people
when they look at a pregnant, when they look at pregnant people,
they automatically like
smile,
it was... I don't know, I just
I just wonder if I would have liked it as much if I did get sick
I mean the worse complication I had was heartburn, but you know,
I just loved
To me it was so amazing what my body can do, you know
like just, you know, such a
surreal feeling getting,
you know,
doing the little home pregnancy test the first time around
the first pregnancy and
seeing the positive result on it
I was just like

actually shaking
I just couldn't believe it
it was just like so surreal at times
and just seeing how my body was able to change so much
and accommodate another life inside of me
it's just, it's just
amazing
just the thought of it more than anything
and like I said, just, you know
how everyone is around you and just nice
you don't have to worry about going to the store and dealing with rude people
everybody seemed very pleasant
and my co-workers were fantastic
you know, if they saw me rushing around
and they didn't like seeing me rushing around, you know, being pregnant
they would tell me to stop and, you know, help me.

Shelly: It's, it's been really ... I don't know
interesting to me to see with all of my pregnancies -
and again, I don't, I don't feel it a ton in this area,
but as soon as you're pregnant
as soon as you're visibly pregnant
people feel like they have the right to tell you what to do, you know,
and have some kind of like (2 sec)
say
about the baby.

The baby
you know
the baby
which is
the baby -
when, you know, the baby is 10, 10 weeks, you know,
10 weeks into the pregnancy,
it's like it's NOT **the fetus** or anything
it's the baby
Uhm...

Leslie Baxter (2011): In some dialectically informed research, the discursive struggle of individualism and community is evident in a radiant of meaning surrounding priority to one party's self-interests as opposed to giving priority to the partner's interests. (...) The discourse of individualism underscored self-interest, allowing a pregnant woman a discourse of justification of her choice to drink during the pregnancy because of the benefits it provided to her (e.g., a release from stress). Competing with the discourse of individualism was a discourse of responsible motherhood (...) a mother is socially accountable for her actions, and others are given social license to hold a mother accountable for her actions. (p. 68-69)

Paul: People feel... with pregnancy unlike anything, people just feel like they can just come, like people come and touch the pregnant belly or will tell you, "Oh, I see you're pregnant, my friend had a miscarriage." It's like, **why would you do that?!** It's just that... but people do that all the time and there is all these ammunitions both ways about things - "oh, you know, you're gonna have a c-section, right?" or "you're never gonna have..." it's like, people throw those things out there.

Patty: Yeah.

Paul: I, I think we both felt fairly balanced about that, but there were things about it that would irritate me.

Patty: That's coming back now, too.

Paul: But I was able to kind of do what your husband did, "Ok, thanks. Bye," you know, "Is this gonna be a bad story, cause if it's a bad story about pregnancy, then thank you, no!"

Lily: Yeah, no

Paul: But, yeah, just...

Lily: Well, I heard from people actually who have had a fairly... straightforward, uncomplicated pregnancy that it feels nice to, tooo, to... you know, gather attention to yourself in that way, or that people can be nice, or that it creates a connection with just random strangers where it hasn't existed, so it has a positive dimension.

Paul: That's true.

Patty: Hm... I can hear, I can understand that.

Paul: Yeah, people... there is a softening, I think, and ... with other people seeing a pregnant woman. But I think that softening is also... what then becomes an in-road for "**my** perspective on what you should be doing, too" - so I think they're a part of a similar feeling-closer because of that, that woman being pregnant.
[Paul clears his throat.]

Cindy: And ahh, you know, it's been, it's been interesting ah... (2 sec) just to see uhm... having a baby as a community builder because we moved here about a year ago and, you know, we have been trying, kind of looking around, making new friends and finding our way into the community slowly, but, you know, there's this, it's really interesting, you know being pregnant like immediately spawns

people's
desire
to connect with other people

Mariyana: so it was this whole...
community
came out to support
this new life,
it was like something that they recognized...

Lily: You know, it's interesting cause I've heard quite a few women comment on how much fun it's been to be pregnant, here in the U.S., too, because you get this attention from people, you know, people are nice to you in the stores =

Mariyana: = Uh-hum =

Lily: = or they smile
or they ask about your baby
and it really isn't perceived as intrusive =

Mariyana = Uh-hum =

Lily: = but it really "brings out the best in people" =

Mariyana: = Uh-hum =

Lily: = and I ... [sigh] you know, for better or worse, mostly I've talked with women who are from around here and are very... middle class =

Mariyana: = Uh-hum =

Lily: = white women.
And I keep thinking ah...
if this might be experienced any different if they were ... =

Mariyana: I think it would, yeah, if she was 14 or =

Lily: = and I think you can see that, in the judgment,
"What are you doing?" you know, "Having a baby?!" =

Mariyana: = You can see it in the hospital!
If, if... if you were pregnant
or if the woman who's had two children taken by DSS and she's a heroin addict,

they're gonna be treated different
in the hospital
by professionals.

Lily/Tour Guide: As an expression of community, I can see how what Baxter and colleagues (2004) call the discourse of "responsible motherhood" would be operative in situations like the one constructed above. Perhaps in situations of addiction, many would want to see a different treatment, would see it as necessary. Earlier in our conversation, Mariyana had told me that they, as midwives and healthcare professionals, are legally obligated to inform a pregnant woman in the above situation that DSS would be called. We work and live within constraints, parameters, and structures (more on how structures play a role in prenatal knowledge and care will be developed in chapter 6).

But there is also something else... something I find not fully accounted for in Baxter's development of discursive dialogism, even as she asserts, "... *power is conceptualized as the discursive capacity to define social reality*" (2011, p. 125)

After finishing the above statement, Mariyana pauses for 5 seconds, she knuckles the table with an audible, but quiet "bam, bam." Then she says fast, beginning her phrase with a "but" that signals a counter-discourse to the unsaid one:

Mariyana: But, in Ecuador was a traditional culture that supported family, you know. But, as we were talking about, when you start getting into ah... you know, more difficult social situations, there's a lot more judgment.

Lily (reflecting): Baxter's dialogism does not address what critical theorists may refer to as "normativity" and intersectionality (e.g., Collins, 2000) in relation to the grand social identity categories - race, sex, social class, gender, sexuality, etc. Developing Bakhtin's notion of centrifugal-centripetal struggles, a relational dialectics perspective

recognizes some discourses as dominant and others as marginal/marginalized. But in its commitment to discourse (and not the individuals producing the talk), this perspective also de-couples bodies and their social meanings from the discourses that make us/them meaningful. Or perhaps there is something to be said about RDT's admitted focus on mainstream U.S. society.

Back to the CODA Upfront: I am also a text.

More difficult social situations

Ambiguous?

Lily/Tour Guide: According to Baxter (2011), ambiguity allows "semantic wiggle room," so that relational parties "don't have to confront the different systems of meaning which they attribute to a communicative utterance" (p. 134-135). Furthermore, "When a competing discourse is addressed directly, it suggests a legitimization of it that is denied when dismissively polemic speech is employed indirectly" (Baxter, p. 135). The legitimization here does not refer to validating the competing discourse as the correct one, rather it refers to recognizing directly its operative existence, it refers to legitimating the voice of that discourse as part of the playing field.

A discourse of prejudice and discrimination is cautiously hinted at, but un-named. That's a tough one in mainstream U.S. society. The ambiguity performs that difficulty. It's not simply that it gives wiggle room, it performs the political need for such room, the uncertainty in how to talk about "those" issues (at least from within certain social spaces and contexts).

And the matters of strangers' involvement in pregnancy? They are powerful in constructing the body as a public/private terrain where individualism and community can

"interplay," producing varying affects and connections to another. But they are also silent on matters of their normativity and the bodies associated with such normativity. They are silent on the material effects of discursive power, on matters of constructing belonging as a focal point of living and telling pregnancy and prenatal care as (not) relational or (not communal). I return to an in-depth exploration of the affective voices and silences of belonging in the next chapter, *(M)other Lands, (M)other Ways, and Constructing Belonging*. But beyond its more broadly social dimensions, beyond its links to societal in/exclusion, questions of belonging are also meaningful within the (con-)structure of a family, as it is performed in/by pregnancy narratives - who is included in these stories, in what ways, and how do struggles of individualism and community animate such inclusions?

Voices of Integration, Episode 2: Mothers! and/with Others

Shelly: Yeah, do you think it like changed your connection with your mother - being pregnant?

Lily: Definitely. Yours?

Shelly: Yeah, I mean, it was... We really had an adult relationship before, you know, for years, but yeah I think it changes something just like we both, we both got through this and we both done this, yeah...

Charlene: Nothing brings a mother and a daughter closer than something like a pregnancy

Peter: Yeah, because not everyone has... I don't know... agreeable relationships with their parents or parents-in-law. Magdalene's mom has been **soooo** excited.

Magdalene: [nods and laughs quietly]

Peter: You guys would talk every day or every other day.

Magdalene: She. She's calling every day.

Peter: Now she does.

Magdalene: But I [laughs]

Peter: Now, it's like, several times a day.

Lily: Cause you have two brothers other than you?

Magdalene: Right, I'm the only

Lily: There is something there
(...) And my mom had also said, you know,
(...) "I'm talking to him" [our son, before he was born] -
and my mom is not a very esoteric person,
I mean, she's just such a realist on so many levels,
I was like, "What are you talking about? You're going crazy!" =

Peter & Magdalene: = [laugh] =

Lily: = She's like,
"I'm talking to him every day when I go to work" -
we knew we were gonna have a boy -
"But I'm talking to him and I'm saying
'Please wait, please wait for me to come,
please wait for me to come,
don't come early!"
And she goes,
"I cannot imagine not seeing you pregnant,
this is gonna break my heart!"

Charlene: Like I felt
my relationships with my mother wasn't as good before I got pregnant, as it is now, you
know.
Like I said, I talk with her **aaalll the time**, you know.
Like anything goes wrong with the kids,
I don't care how much education I have as a nurse or how much I know as a nurse
anything goes wrong with my kids,
I tend to turn to her,
lean on her,
to make sure I'm thinking about things in the right way
I just think it's so interesting
cause I've seen the same kind of changes in my sister -
my sister's pregnant right now -
aaand ahhh, I've seen that kind of change in her relationship with my mother:
just a little bit closer, talking to her a lot more often
I've seen it in friends of mine, I've seen

a girl I knew years ago, you know,
had a very, very rocky relationship with her mother
and as soon as she got pregnant like she got so much closer with her mother -
it really is amazing how it can
bond people to their loved ones like that
(...) I don't know, I just think it's amazing overall how much pregnancy affects everyone

Patty: That's a... that's a loaded story.

My mom and I had issues that we have been trying to work out over the years,
and they really exploded around the birth of the first child.
And we had to sit,
set very clear, strict, firm boundaries and
actually had to un-invite her to the birth at one point uhm...
because she needed it to go her way rather than being able to honor what we wanted.

Shelly: Thankfully, I haven't gotten much of that, yeah,
from my mother or my mother-in-law.

My mother is very, I don't know, she's really respectful about pregnancy and about child-rearing and, you know, it's kind of ... She has a really strong recognition that, you know, she had her turn, you know, that was her time and she got to decide what decisions she made and, you know, she's big on saying "Well, alright, this is your time, this is you guys, you're doing what you wanna do."

At the same time, I think that we've made a lot of the same decisions, soo [laughs]
if we were making drastically different ones,
I don't know that she would be as kind of supportive and hands off,
but yeah, she's kind of hands off;
my mother-in-law is also kind of hands off.

Patty: Uhm... ahh.. and so... that crisis with **my mom** may,
probably played into the crisis around birth, which,
I hear,

happens around mother
mother issues
Uhm... but we were trying to heal those issues
with my mom being present
at the second child's birth,
so that felt very healing, to have her there...
in her own way... albeit [laughs]

Karina Quinn (2012; in *The Body That Read the Laugh*): The mother-body writes herself, and is made new. (n.p.)

Peggy [Patty's mother-in-law and a midwife]: We get really into mothers when we're having babies; when we become mothers ourselves, that's when all our mother stuff emerges.

Karina Quinn (2012): The mother-body writes her own mother, and knows she was always-already here. (n.p.)

Julia Kristeva (1981): As for time, female subjectivity would seem to provide a specific measure that essentially retains *repetition* and *eternity* from among the multiple modalities of time known through the history of civilizations. On the one hand, there are cycles, gestation, the eternal recurrence of a biological rhythm which conforms to that of nature and imposes a temporality whose stereotyping may shock, but whose regularity and unison with what is experienced as extrasubjective time, cosmic time, occasion vertiginous visions and un-nameable *jouissance*. On the other hand, and perhaps as a consequence, there is the massive presence of a monumental temporality, without cleavage or escape, which has so little to do with linear time (which passes) that the very word "temporality" hardly fits...(p. 16)

Lily/Tour Guide: The motherhood or maternity connection has been explored at length by feminists, psychologists, and, as read-able in the excerpts above, perhaps many of us in our everyday ways. What can be "added" or disentangled or entertained that hasn't been yet? And perhaps that's not what's important to begin with... Perhaps the key performance to begin with is that of the continuous and repeated entangling in telling (on) pregnancy - both in words and in bodies, in the symbolic and the semiotic. The motherhood-connection told over and over - not in the essentializing way of which Judith Butler (1990/2006) criticizes Julia Kristeva, not to put bodies or femininities outside of culture, but to link them in a jointly constructive performance. Telling over and over - the repetition performing culture and connection, the novelty of the telling constructing its own "monumental temporality." (Kristeva, 1981, p. 16).

Kristeva's "Women's Time" is a dialectical time - not of oppositions, nor of synthesis in simple Hegelian terms, but of connectedness that is tense and productive. I agree with Söderbäck (2010) that a (re-)turn to the maternal, as the one in Kristeva's oeuvre, is one of possibility, of connection to past and future in non-linear terms, of community. It is not one of hurtfully naturalizing and reducing woman-hood to

reproduction. It is one of thinking with and through reproductions - as structures, as "choices," as politics, as/in dialogue.

But, as my choice in story-telling, I want to distance this text from Kristeva's psychologism. Following a dialogic approach (Baxter, 2011), I deliberately try to stay away from attempting to discern individual motivations, fears, etc. Perhaps here I come closer to Butler - in a focus on (re-)production of culture and meanings. I am complicit in that, more than complicit, inciting it in a way - by asking "What do you know of your mother's pregnancy? Is yours similar?" I assume that by asking "What have you learned in/from your family about pregnancy and birth?" I would open up different knowledge-relationship and knowledge-sex couplings. But answers, stories are inhabited exclusively by mothers and grandmothers. I explicitly ask if anything has been learned from fathers and other such figures - to an articulation of absence ("My father was not allowed in the delivery room") both of bodies and of processes (what about the pregnancy preceding the birth?). In the predominantly white, middle-class, heterosexually married, U.S. citizenship context in which my story-telling encounters during this project happened, mother-knowledge of reproduction was privileged. Women told (on) it, but men did also - often, in relation to the mothers of their pregnant/birthing wives (as in Peter's words above), but also in relation to their own mothers.

Paul: Uhm... I mean, my mom has been studying birth, she was studying to be a midwife when I was 7 or so, so... the idea that was something natural that happened was always in my consciousness. I was actually 8 or 9 when she was at her dorm thing and she was teaching me, she had the tool - teaching me to sew an epidu... ahh, an episiotomy on a foam mannequin [laughs].

Ivan: My mother was also, didn't also... did a natural birth for all of us. Uh... three, there is four boys, and three of us were born home So, we also have that kind of tradition...

Lily (reflecting): Perhaps a meta-discourse of knowledge as a template, as a model can be heard in the above excerpts. But there is also a discourse of relationality, of learning about pregnancy and birth in and from a relationship with one's mother, or more simply - of learning relationship. More of this can be heard in Paul's repeated positively-valenced mentions of his mother's instincts and intuition about birth, linking it to his own practice of medicine, parenthood, and partnership.

Paul: I am [2 sec] fairly intuitive, when I am at my best, but this was a big deal! This, you know, **big things** are happening, the excitement of WOW and there comes a baby - in a day, in a day of labor, the [???] was there, and my own fears, so i-i-i, I don't know how available I was to the whole process. And my mom was a, I felt really lucky to have her have that role and to be present, to be able to be there for both, both of them. Uhm... yeah, I mean, I mean, I'm a health care provider and I have trouble treating friends and family cause there is a part that... I either wanna over-diagnose, where I want, I don't wanna, I wanna make sure that all those bad things that could be aren't happening, or to just trust and then I'll go "I'm sure it's fine." So, I'm not as objective and I do not, did not see that with her [his mom] at all, she was just...

Patty: No, that wasn't, that wasn't entirely the case.

Paul: Uh-huh?

Patty: Yeah, I remember with G., I had some lighter shade of gestational diabetes, so in one of my check-ups, she was actually, your mom was actually on duty uhm... and tending to me directly and ah... I think I had eaten a bowl of cereal out of desperation that morning, so my blood sugar was way up and when she checked it, she was like [elevated, louder, dramatic voice] "OOoK! What's going on here?!" and it was right after that point - cause she got **reeeaally** anxious [laughs] and I was kind of like, it uh, uh... "It will be fine, don't worry" [laughs]"about it." She was like "I think I need someone else to be doing these check-ups on you." Because I was so high-stakes for her... like you were saying.

Peggy [Paul's mom; in a separate conversation]: We see this all the time, **we know** that the chances of this being a baby with Down Syndrome are veery small [quietly and slowly]

uhm, so you know, we tend to say "oh, yeah, yeah, we see this all the time"
But that happened to my son
[she has this way of saying some things definitively, as if putting a period at the end of them, to punctuate]
when they were pregnant with their second one
and I **was terrified**
I - who have seen this hundreds of times
and try to reassure women that
"it's ok, it's gonna be fine"
[again voice changes here, it's as if she embodies these different personas, but also mocks them]
uhm (3 sec)
Then I realized that they don't care how many,
they don't care how many times I've seen this
they're dealing with the possibility that your baby [speeds up quite a bit, re-creating the urgency]
and these things that they see -
what is the brain
and the other thing is a little thing in the heart [slows down again] -
now what are the two most important things that we have -
our brain and our heart -
and the
terror
that that strikes is very real
and I learned from that
and this was 3-4 years ago.

Lily/Tour Guide: Mother-knowledge here is narrated (created) as always moving **relational knowledge**. Relational knowledge does not follow conventions of linear time, it skips, and narrates memories that sometimes are not even one's own. Over and over, women and men with whom I've met in the course of this project told (on) their mothers' experiences - in the 1960s, in the 1940s, in the 1970s - experiences narrated with one eye looking at the (medical) system and the other one at the relational systems, as they were narrated then, as they are lived and narrated now, as they are narrated (imagined) in the future, in relation to future pregnancies and births that would be both repetitious and monumental (Kristeva, 1981). Times and pregnancies and births are thus connecting/connected, but in non-reductive ways - as a memory that is less set than

constructive, as a memory in the future that is somewhat carnivalesque (Bakhtin, 1984; Baxter, 2011).

Lily: Were any of you mom's pregnancies like that?

Magdalene: No, no, uh-uh, nope.
And that is the other thing I remember,
my mom always telling me that
she was the **happiest** and **healthiest** she's felt in her life when she was pregnant -
and I - there're three of us - and I was like, "Alright! I'm gonna feel really happy and
healthy!" =

Peter: = I don't know if that's really true...

Magdalene: [???) [indistinguishable... through laughter]

Lily: Maybe she just wants to remember it that way.

Peter: Yeah.

Magdalene: Yeah...

Peter: She wants you to have it that way.

Magdalene: I'll have to remember that when our kids have kids.

Lily: [laughs]

Peter: Wooowww!

[collective laughter]

Lily/Tour Guide: The "third space" is "where it's at" in feminism, but what Kristeva long ago drew on and what I in some ways heard and told in the stories about pregnancy is a third time. A different kind of temporality. Pollock (1999) had already written about this to some degree, noting that the birth stories in *Telling Bodies*, *Performing Birth* are jumpy, non-linear, drawing together in unlikely connections events of the past, the not-yet-known future, and the immediacy of (what once was) the present. But there is more to claiming that something IS a different time than claiming it rejects a

particular (masculine) version of time. The third temporality, "Women's Time" in Kristeva, is not only connecting, it is also dialogically differentiating and creating, like dialogic language (Baxter, 2011) - drawing on and together sometimes unexpected already-spoken and not-yet-spoken.

Julia Kristeva (1981): Or is it, on the contrary and as avant-garde feminists hope, that having started with the idea of difference, feminism will be able to break free of its belief in Woman, Her power, Her writing, so as to channel this demand for difference into each and every element of the female whole, and, finally, to bring out the singularity of each woman, and beyond this, her multiplicities, her plural languages, beyond the horizon, beyond sight, beyond faith itself? (p. 33)

Lily: There are ethics of interpersonal communication (t)here.

Julia Kristeva (1981): (...) to emphasize the *responsibility* which all will immediately face of putting this fluidity into play against the threats of death which are unavoidable whenever an inside and an outside, a self and an other, one group and another, are constituted. (p. 35; emphasis in the original)

Lily (reflecting): Dear Judith Butler and Gayatri Spivak, I respect your work so much, but I can't hear the criticism of determinism, of positivistic, naturalising politics that you read in Kristeva. I tried, it was part of my repertoire. When I first heard and when I then listened again and again to the stories - my own as well as others' - I really thought I am going to critically write about the narrative erasures of others and the reproduction of motherhood as essential femininity, as female pre-destination. I could have said that the maternal role is (oppressively) emphasized over and over by men telling (on) their wives' pregnancies, of men telling (on) their own mothers as essentially maternal, as well as by the women themselves who in many different ways concluded similarly to Mariyana:

Mariyana: because it's just so integral to who I am, it would be like saying what have you learned from like... being a mother - it's shaped who you are,

it shapes who you are, doesn't it

But, in the end, dear Judith Butler and Gayatri Spivak, I couldn't write that. Frankly, I never felt a mystic connection to my mother through pregnancy and birth, although I now do feel connected to her in a way I have never felt before - not mystically actually, but realistically and in her admission that she is also learning (grand)mothering from me, as I have and learn from her. I never saw myself, as did Martha, the OB-GYN I talked with, who literally narrated a vision during one of her children's births, where she saw herself in a "long, long line and circle of women who have birthed and are all connected." I can't say that I ever felt more of a woman (or a person for that matter) because I was pregnant and because I had birthed. I was all set to echo your criticisms of Kristeva and others - for the sake and political belief of preserving the right to choose (which I still believe must be preserved) and the valid multiplicity of choices. I was all set, and how much simpler it now feels that would have been. But, with the cursor blinking in the unsaid spaces of what is now all memories perhaps, I couldn't.

Because there was an-other in me
Because we grew together
and then we split apart,
and are bound by what is in between,
and both of us connected with all the others,
and now, I have no other explanations, no other words,
but those that tell me that - once we've been a part of it -
no other telling can tell it quite as well
Please don't take this as an obligation,
it doesn't mean we (who?) all must do it,
it simply opens up to an admission:
my language, me - are marked and changed -
that's not outside of culture,
not how everything should be,
but inside culture, that language is through me¹¹

¹¹ Of course, I am not the first to attempt articulating this. In probably an insufficient list of examples and ancestors, I could list all feminists, including Kristeva (e.g., *Stabat Mater*), who

In the stories I heard and told the connectivity to culture, as well as knowledge, the connectivity to others - physical family or esoteric ancestors - was narratively accomplished though (the figure of) the mother. Fathers-to-be and fathers of young children did not narrate their fathers - at least not, uninvited and definitely not as elaborately. While fathers-to-be attended the WIC Community Baby Shower together with their pregnant partners and while mothers of pregnant women were also there with their daughters, there were no fathers of pregnant women. In the face of and together with recent examples (e.g., Alexander, Moreira, & kumar, 2012) that perform fatherhoods relationally - in all different tensions - I wanted to criticize the cultural primacy of motherhood as parenthood and of the woman-mother connection, (re-)created again and again in the stories I heard, incited, and told.

Recently, the photo below circulated the social networks, together with what was called an "emotional essay" by actor Dax Shepard about his dad's last days dying of cancer in a Michigan hospital.

Narrating the photo...

Dax Shepard (2012): At one point, and unbeknownst to both of us, my wife walked into the room. She had flown in from LA without any warning. It was a surprise. It was an amazing, incredible, perfectly timed surprise. She lifted her shirt up and he put his hand on her swollen stomach. He left it there for the better part of an hour. He was smiling from ear to ear, sitting contently, unable to put together a sentence, but still capable of connecting to the new family member we were creating. He wasn't going to make it to the birth, but that didn't get in the way of him meeting the new baby. It was an emotional and triumphant moment. One I will never forget.
(n.p., http://daxtumblr.tumblr.com/post/45876994574/my-fathers-horniness#_=_)

have written about their personal experiences of becoming a mother. But has any one of us been successful in "putting it into words" - intelligible words for others to read (me)? Here again I find it useful to think dialectically of the "singularity of each woman, and beyond this, her multiplicity, her plural languages" (Kristeva, 1981, p. 33).



Figure 3: Dax Shepard, Family Moments

Lily (reflecting): A "tabloid culture" (Pollock, 1999) of celebrity pregnancies, as well as celebrating our own pregnancies publically, "doesn't dispense with distinctions between what's public and what's private as much as it fetishizes privacy in the public realm" (Pollock, 187). In such a culture, the above was hailed over the internet as a true and genuine moment, it was blogged and re-blogged, and trended, and touched a lot of people.

But in the silent
"better part of an hour"
with the hand just so
and the promise
and the memory
of a mother
(both - physically not quite there),
in the gaze of a father and a son,
as she look and smiles
to him,
there - I read the potentiality
not the essentialism of
mother-knowledge

As relational knowledge, it is, in different ways, accessible to all of us.

"Of Woman Born" (Rich, 1976)

And so, with the cursor still blinking into memory, I chose to write of the narrative construction of the mother and the mother-bond not as reductive and essentializing, but as dialogic with potentiality of meanings and culture.

To say this is not to idealize relational or mother-knowledge, it's not to mystify it as the tree of life we all must find. The connection and connectivity I tell (on) are not ideals of relationships, but they are relationships. A third temporality in which repetition and eternity crack (with novelty) into making. So that a discourse of seclusion-inclusion, a struggle of integration (Baxter, 2011) animates Patty's "loaded story" of/with her mother or Shelly's thankfulness for her mother's and mother-in-law's "hands off" involvement in pregnancy as a recognition that "this is your time, this is you guys."

Relationships and relationality are foreground in mother-knowledge - whatever tense narratives of interactions it may produce - because the struggle of/for/with integration (Baxter, 2011) is not storied on the level of mother-child relationships, it's not between partners within a (romantic) relationship, rather it is on the level of relationship definition ("this is you guys" or "she needed it to go her way rather than being able to honor what we wanted") or, in other words, a seclusion-inclusion dialectic as a narrative construction of family¹². To center mothers as knowledge(-able) in that way is to invite the relational dialogue of temporalities, identities (child, parent, medical professional), and cultural norms.

Aneesa: a third-person interaction,

¹² This, in some way, relates to Peterson's (1987) "continuity of conscious experience" (p. 45) pregnancy discourse in which birth, women, and families (both semiotically and symbolically) are inter-woven in ever renewing processes of identity, knowledge, and culture formation.

but
both people are yours
because
one gave birth to you
one you gave birth to

Lily/Tour Guide: The place where I think culture is more reductively and categorically (rather than dialogically) created is where the accessibility of relational knowledge is somehow linked to woman-hood, where the potentiality of mother as knowledge(-able) is divisively broken. As a cultural discourse, this echoed in the stories and storied gripes of men I talked with. There, the integration struggle was more within the husband-wife relationships, as men felt a relational separation from a (uniquely) knowing mother-to-be and created (sometimes quite literally) spaces and times for their own (unique) knowledge and tellings (Alexander, Moreira, kumar, 2012). Yet, perhaps even more remarkably, in the context of pregnancy and prenatal care, the narrative return was to relationality as ways of being and becoming - as a relational pair¹³ in the context of other relationships and culture(s) at large.

Paul [who founded the Partners' group]: Uh, hmm, but there, it was a great circle [their group prenatal care], it was nice to be with these people, but, you know, its focus was on the birth, and the pregnancy, and things, so... the partners - I was glad to be there and support her, but not really able to talk to other hmm... yeah, it wasn't really a place for me to talk about what was happening for me and... the group was actually originally called "What about me?" [laughs]. So, that idea like... Hey... So, yeah, I think it serves a pretty good purpose, there's a... especially with once the baby is born, with the first one... like, "There you gooo, you know, you're nursing and I'm... you have this bond with him that I **didn't have**" and I, you know, as lousy as - especially as that first birth was -you know, there were many times that I wished I could've been the birthing parent and gotten the bond that goes with that and everything. And I'm not... you know, woozy-eyed about it... I, I, I know what I'm saying, I haven't lived your experience, but uhm... there's an aspect of

¹³ In the context of this study, as described earlier, all narrators were involved in heterosexual, married relationship. The relational pair was, thus, both contextually and narratively imagined as romantic heterosexual couples, partnered parents-to-be. I would like to think that the relationality can be unhinged from that dominant (not majority) cultural discourse of family and romance, but who knows...

feeling
left out
as the partner
And that
wanting
to help
"This is entirely new, I don't know what it means"
That was my experience and that's why I found the group to be helpful.

Mark: There're not many times in life when you have something so obvious in common with people [as pregnancy]. Uhm... and that's... actually, I found out about you from a dad's group that I go to - and the community in the dad's group is not as strong as it is when I'm there with Susan, so I think mothers have an easier in to that vibe than fathers do

Cindy : Hmm...

Mark: But couples have an easier vibe maybe even if you went to a mom's group than just a mom would. And... that might be function of just having both of us there.

Cindy: Yeah... I mean, I went to one of the beyond birth support group at Hospital A and that was just moms, I went last week, and it didn't feel like immediate community, although the women there who have been going to the group together seemed to know and care about each other and, you know, be at least, you know, friendly and... But it wasn't the same as like going into the group as a couple. I think there is something about being present in the world as a family and being there as a couple and saying like "Here we are and we're here to create this experience" and all these other couples were there to, like, try to figure out what they, what experience they wanna do and...

Voices of Integration, Episode 3: Gestation of a Family

Della Pollock (1999): I wonder to what extent I have in fact complied with a heterosexual norm by telling birth stories. To what extent do I and other birth storytellers, in telling our stories and subjecting ourselves to others', contribute to the rising cult of the bio-baby - at the same time as new technologies make mom-and-pop baby making as obsolete as the corner grocery? Does taking pleasure in our respective lines of

(re)production exclude alternative family formations - gay/lesbian families, adoptive families, families without children, single-parent families, families born in difference?

Lily: Are there chances that we're missing? Potential connecting points, touch, openings?

Yesterday, I told a story about a Bulgarian ritual. I learned about that ritual not so long ago myself. Although I grew up in Bulgaria, this particular ritual was not part of my cultural repertoire. I asked my parents and grandparents and they didn't know of it either.

I wished I had known about it during the 3 long years of trying to conceive.

Semen den i shtipana pitka

(Seed day and pinched round bread)

On February 3 (seed day), a woman who wants to "beget an offspring," makes *shtipana pitka* and gives it away at a crossroads. *Shtipana pitka* is a round bread that needs to be made entirely by the hands of the longing woman. Before baking it, she must form in the middle of the bread, by pinching the dough, a cross/cross roads. At the each end of the cross, she must put a little round ball and pierce it with a wool-spinner. When the bread is baked, the woman brings it to a crossroads and gives a piece to anyone who passes by. Receiving the bread, one must respond, "This year pinched bread in your hands, next year - dear child in your heart."

Lily: Who and how many plant the seed?

Meredith Small (2003): Anthropologist Stephen Beckerman was well into his forties before he finally understood how babies are made. He had thought, as most people do, that a sperm from one man and an egg from one woman joined to make a child. But one summer day, as he and his colleague Roberto Lizarralde lounged around in hammocks, chatting with Rachel, an elderly woman of the Barí tribe of Venezuela, she pointed out his error. Babies, she explained, can easily have more than one biological father. "My first husband was the father of my first child, my second child, and my third child," Rachel said, recalling her life. "But the fourth child, actually, he has two fathers." It was clear that Rachel didn't mean there was a stepfather hanging around or a friendly uncle who took the kid fishing every weekend. She was simply explaining the Barí version of conception to these ignorant anthropologists: A fetus is built up over time with repeated washes of sperm— which means, of course, that more than one man can contribute to the endeavor. (...)In total, the researchers recorded claims of 916 pregnancies, an average of eight pregnancies for each woman. But child mortality was high—about one-third of the children did not survive to age 15. Naming secondary fathers was a critical factor in predicting which babies made it to adulthood. (...)The researchers also found that this decrease in mortality occurred not during the child's life but during fetal development: Women were less likely to have a miscarriage or stillbirth if they had a husband and an additional male contributing food. This result was a surprise because researchers had expected that help during childhood would be more important. (...)Indeed, such flexibility

suggests there's no reason to assume that the nuclear family is the natural, ideal, or even most evolutionarily successful system of human grouping. As Beckerman says, "One of the things this research shows is that human beings are just as clever and creative in assembling their kin relations as they are putting together space shuttles or symphonies." (n.p.)

Magdalene: I think friendships for us are really important, as well as our family relationships, cause our friends are really like family for us, too

Peter: Yeah

Magdalene: I think

Peter: Magdalene does an amazing job, I don't know how she does it, but

Magdalene: [laughs]

Peter: Seriously! Like she gave this ahh, she decided to do this project to have all of our friends and family sew a quilt square. For the baby.

Magdalene: Where is that?

Peter: It's in the bag somewhere.

Magdalene: [chuckles] it's in the bag [gets up to get it]

Peter: We brought it to show the midwives this morning. But stuff like that, you know, bringing people together to participate in...

Lily (re-member-ing): Peter unfolded the quilt and, though I had my skepticism for white, middle-class, heterosexual, globe-traveled ultra-hippy-ness, I was warmed up by seeing it, cheerful and promising in all its colors and seeming randomness... And some place, deeper inside me, I was reminded of the chills I used to get when reading about the significance of embroidering (now folklore) clothes and blankets, aprons, of the significance of putting art on bread - of the literal and metaphorical travels and transformations of these symbolic acts as ways to tell stories, to connect people, and sustain community when there was no, to such degree, permanence of location (space),

duration (time), or symbolism (script). So, without even covering myself with this quilt-in-process, I was warmed by (imagined) memories. And, like a weave, the quilt story was not finished with showing me the actual quilt, it went through our conversation, coming back as a process and a metaphor for family, being sewn together during pregnancy.

Peter: I think it's cool, I mean, and exciting for me, too, to see that my friends are that excited about me having a baby cause I never thought that they would be that excited uh... but they are excited, they made quilt squares and

[we laugh]

Magdalene: And they do not have, you know, sewing backgrounds

Peter: Or so they would have us believe! They made some pretty killer quilt squares!

Lily: Hidden talents and you're giving them a chance to express...

Peter: Exactly, yeah.

Lily: What were your instructions? Like, did you just tell them, "Make a quilt square?"

Magdalene: Yup. Like originally like I was thinking something that they wanna share with the baby or something of themselves, you know, but really I just stopped giving anything, it was just like "Whatever you wanna do!"

Peter: Well, Magdalene invited people to participate if they wanted to =

Magdalene: = Uh-hum =

Peter: = and that was after we had gone up to the Material Store in a town and picked out all different kinds of - what do they call it? Sq =

Magdalene: Sack squares =

Peter: = sack squares.

Magdalene: It was something new for us, we were very excited about sack squares. =

Peter: = sack squares. So, there're just squares of material, you know, so we picked out all this material and then Theresa sent out invitations to people, and then, asked them if they wanted to do it and that she would send it to them. So people responded and then, she **sent** them all materials.

So she sent them,

so it was like really intentional, you know what I mean?

You sent, cut up different types of material and

sent it to them and thread,

and then, you know, they would do it and send it back,

and some people would make like 3 or 4,

others - kids would do one,

or they'd use material from, that was like recycled material from their kids' clothing,

or, you know, there's all these different =

Magdalene: = It's actually really nice =

Peter: = different stories behind these cloth pieces =

Magdalene: = storytelling-like... cause they all have like meanings -

the guitar from Sarah and Marco was

cause they met in Spain

and Peter ah... Sarah bought Peter a Spanish guitar

and he, we, he played at their wedding,

it's nice - so, she made a Spanish guitar,

so they all have different =

Peter: Yeah, it's that guitar over there.

That guitar got stolen in Spain

and then she was going back to visit her boyfriend,

and they just got married 10 years later or something

Magdalene: Yeah

Peter: And so, I gave her money and asked her to
and so, she got me this guitar,

yeah so, you know,

all these long threads, too

that go with the uh...

the quilt.

Lily: Yeah, and your connections to the people.

Magdalene & Peter: Uh-hum

Peter: Yeah.

Magdalene: And then we get to tell the baby all about it.

(returning to the beginning of our conversation to tie the thread)

Peter: = Well we're excited about
the baby being part of community, too =

Magdalene: Yeah =

Peter: = and not being isolated =

Magdalene: = Just=

Peter: = and so I think, that's one of the things too that we think about maybe in terms of
having a, having too much focus on the baby and, you know, overly-protective or not
having a lot of exposure to other people where as
we really like the idea of having
a lot of people around us,
and holding the baby,
and being there =

Magdalene: = Yeah =

Peter: = in the first days and weeks afterwards
and ah... it's different, it's almost a different culture in some ways,
I mean because [slowly] we also get a lot of comments in the
birth classes and from different groups about
you know, you wanna be on your oown,
and tell people to go away, =

Magdalene: = Yeah =

Peter: = this is your special time, and...
you know what I mean?
And these are all different ideas ...

Ivan: I feel like the way children are raised here [in the U.S.] is more isolating uhm...
We grew up in kind of, a normal kind of neighborhood,
but neighbors don't even talk to each other...
It's our way to live
there's no community
it doesn't, it's not good for the kid to grow up that way
I think it's really important to have ah...
different influences in your life
besides just your parents or immediate siblings

Debora Spar (2012; In *Why Women Should Stop Trying to Be Perfect*): Meanwhile, American women may also want to consider returning to the kinds of social structures that prevailed in earlier decades, to things like coffee klatches and neighborhood clubs that we have somehow banished from our more atomistic and hard-driving schedules. Recently, I found myself listening enviously as a high-profile businesswoman from Mumbai described her backup network. When one mom had an early-morning meeting, she dropped her toddler off with a neighbor; when another had to travel abroad, a friend handled lunches and carpools for her kids. These Indian women also spoke of their extensive family networks, of the parents and in-laws and cousins who lived nearby and regularly pitched in with the myriad tasks of daily life. Few people in the United States live this way anymore. Instead, we move away from our parents, away from our childhood friends, away from the communities that might help us achieve saner and more balanced lives. In most parts of the country, we don't even let our kids roam around the neighborhood, chauffeuring them instead in solitary splendor and ripping them from what might otherwise be—used to be—a neighborhood.

Aneesa: I need a few people in my life,
but as long as they're there,
I'm happy.
I don't need like this extended bandwagon of people surrounding me, I need some...
true love in my life
through my parents, through my husband, through **my child**,
and I really miss my grandmother, my dad's mother,
I lived with her, growing up.
She died a year and a half ago, ah...
she was 92
she was very spirited woman
and ah... so, that's the only person I consider to be family, **real family**,
apart from , of course, my husband, and my mom and dad, and my baby.

Lily/Tour Guide: Aneesa returns to defining "real family" multiple times in our conversation. When her narrative dialogues with that of her husband (Ivan) or that of Peter and Magdalene, whose stories are inhabited by (longing for) a larger community - perhaps for a community as it is imagined in white middle-class educated heterosexual U.S. - the different voices coming from very different bodies and experiences really stand out. The ideology of a nuclear family is present/implicit as a (counter-)point in all narratives and in that, they all come together around this (dominant) discourse, but the voices multiply and divide as narrators perform their own (not) belonging in cultures,

communities, family structures that, during pregnancy, crystallize as planning for parenthood and family, while at the same time speak (to) relational/relationship histories.

Aneesa: We announced to them that we were gonna ...try having a baby... right before we were, we started preparing, meaning, we started intentionally not using condoms and...
I always, I am very close to my mom and dad,
I'm the only child and I come from **an exceptionally** close-knit family, ah...
the 3 of us - my mom, dad, and I - we're really, we're really - touch wood - we're friends.
Like... my mom, dad, and I, we are, we went through a lot together,
so like, if you're interested in the background story, you can ask me.
There are reasons why we are very close together and ahh...
so basically, yes, my parents know every move I make [laughs]
and I know every move they make in, in every sense of the word and ah...
the good side is we're gonna have support from grandparents, which, I think is **massive** in this...
because in... I, I absolutely have issues with ah... ideas of parenthood in this country, where it's mother and father only, or, you know, one of the persons from the nuclear family you take,
I think grandparents should be an integral part of growing up of children, because I think it's **healthy**,
because I think spirits get transferred from one generation to the next and grandparents often have more to teach than parents, cause parents are young and stupid, the grandparents have done this twice

Lily: The thing is, this is what starts with - you know, I have to give my parents the credit for this - you know, we're both working on maintaining these relationships.
Now, when I look at them as grandparents, I think, you know, if... god willing, one day I am to become a grandparent, I need to st..., I need to, if this is the kind of thing that I want, that I like, and I think it's good for our kid, I gotta start working on it now, you know what i mean?

Aneesa: Exactly, exactly. And I feel the same way, exactly the same way, that I hopefully will be able to return the favor to my children when they have their children =

Lily: = Yeah, you know, that's so... when, when my mom was first here, right before and after Sammie was born (...)
and I kept telling my mom when they were here, just...
and not that that's something that I haven't done before on other occasions, but I was just extremely grateful (...)
... and she says,
"You know, my biggest motivation for doing this is that I hope that you can do the same for your child one day" =

Aneesa: = Right =

Lily: = And I, I don't know, it's just like you said earlier - it's nice to like really physically experience that connection that generational

Aneesa: Generational.

Which I think is so important and I believe in a lot of spiritual stuff and I'm really scared of this stuff cause I've seen it happen too many times where unresolved issues get passed on from generation to generation (...)

Aneesa: One thing that I wanted to tell you and that has left a huge impact on me about childrearing is that in Ayurveda especially there's a, there's a **pattern** that you follow as a woman which is ahh... what diseases your grandmother carried unless your grandmother purges herself, or tries to, is passed down to your mother, your mother passes it, in turn, down to you, and you, in turn, pass it down to your daughter So there are four generations of toxins that go according to Ayurveda so, that's why it's that much more important that you take responsibility of your health before you conceive, because once you conceive and once you =

Lily: = has long generational impacts =

Aneesa: = you're basically passing along for three generations before them worth of crap So, it's kind of... if you look at it that way, you become a more responsible parent right from the start you're like "I don't want to pass on more crap than the kid will have any way" [laughs] you know...

And Then... or Bringing Dialectics into Prenatal Care

When Baxter (2011) wrote of dialogism, and more specifically of Relational Dialectics Theory (RDT) as a "descriptive/sensitizing" (p. 7) theory, she emphasized that its strength is not in offering replicability and predictability, that it is not evaluated by the criterion of falsifiability, but by its heurism, by opening different ways to see a phenomenon. What, then, is the utility of looking at pregnancy, pregnancy interactions, and narratives through a dialogic lens? If I, through this study, am not able to offer prenatal care practitioners¹⁴ clear strategies and guidelines for improving their practice, then how does this project "contribute" to socially useful knowledge?

Pause.

When Patty described that the first time she got pregnant it was a huge surprise, because she still had a contraceptive IUD at the time, she said,

Patty: And I had bit of a prenatal care involved around that because I went to an emergency room in a women's hospital.

When I asked Aneesa and Ivan about their prenatal care, they also remembered with much angst and pain a time when they had to wait in the emergency room for a long time while Aneesa suffered Hyperemesis gravidarium (yes, the same thing as the much publicized case of Kate Middleton), was severely dehydrated, and vomiting blood.

When I asked others about their prenatal care, they told me of providers, switching practices, midwives, and OBs, nurses, and family members with degrees (RNs, CNMs). A few told me about Centering or group prenatal care (to avoid copyright issues)

¹⁴ Again, "practitioners" here refers to anyone who somehow is part of the practices of prenatal care; it is therefore, not limited to and does not place all responsibility and definitive say on medically-licensed professionals.

that was conducted in their midwives' practice. People told me of hospitals, practices, offices, birthing centers.

Homes, walks, foods, quilts, moms, dads, and husbands, sisters, older children, work-spaces, restaurants... these and others were told (on) when I asked about "taking care of yourself" or about "the pregnancy in general."

That a division between formal and informal systems of prenatal care was thus narratively constructed seems fairly obvious and probably not that surprising. That same division is implied in the titles and contents of (summaries of) important research pieces, such as "*Comprehensive Prenatal Care Can Decrease Rates of Low Birth Weights*" (2012, <http://www.news-medical.net/news/20120925/Comprehensive-prenatal-care-can-decrease-rates-of-low-birth-weights.aspx>).

But what exactly is included in "comprehensive" prenatal care? Who and how defines it? Administers it? How do such definitions speak to/with "the Latina Paradox" (Gálvez, 2010; McGlade, Saha, & Dahlstrom, 2004)¹⁵ and the associated recognition of importance for social support and knowledge networks?

A dialogic perspective into pregnancy and prenatal care opens up the possibility to seeing these experiences as cultural and relational. The integration dialectic (Baxter, 2011) and associated tensions and opposing discourses, as performed in the above episodes, suggests that interactions around pregnancy are (also) about belonging (which will be developed in the next chapter), as well as about recognition of one's singularity, uniqueness, special-ness within various contexts of belonging. Through and in intimate

¹⁵ The Latina Paradox refers to the (unexpectedly) favorable birth outcomes among immigrant Latinas, which is linked to "informal systems of health care;" the more "acculturated" an immigrant woman became and more separated from her social support network, the lower the likelihood of a favorable and uncomplicated birth outcomes.

and professional relationships, through the stories and interactions that materialize them somehow, narrators also learn how they (don't) belong in others' worlds and this impacts experiences of pregnancy and prenatal care practices (and more on that will be said in relation to agency in the coming chapters). In Peggy's story about responding to the possibility of her own grandchild having Down Syndrome and what she learned there, we hear the voices of a mother, a grandmother, and a midwife - all of these dialogue in complex ways in a single narrative. Similarly, in Charlene's story about becoming closer with her mother through pregnancy and about turning to her mother whenever "anything goes wrong with my kids," we can hear the RN ("I don't care how much education I have as a nurse"), the mother ("my kids"), the daughter ("I tend to turn to her/lean on her [her mother]")... The security and insecurity of knowledge intersect and they shape and are shaped by the relationships that allow such complexity, rather than restrain it. So, Peggy's job as midwife becomes not to pacify and reassure the scared future parents, but to open and guide them through the emotions.

Indeed, one of the metaphors that consistently narrated pregnancy was that of a travel and transformation. However, this metaphor is also dialogic, engaging and embodying the dialectic of novelty-predictability (Baxter, 2011), as past and familiar histories and ideas of who one is (also, discourse of individuality) were put in conversation with (visions of) becoming that are also ones of community (e.g., what would our family be like and how would it belong). Within the grander narrative of pregnancy as a journey, the prenatal care provider was often seen as a guide - someone who can mark milestones, but leaves enough room for all to walk the journey differently. I also want to clarify that - through the stories of the integration dialectic - I came to think

of prenatal care providers in broader terms than conceptualized initially - pregnant women provide prenatal care, as do their family members, and certified professionals involved in their pregnancy.

In the continuity of care and pregnancy, what the narratives both perform and teach is that knowledge is plural, dynamic, and multi-directional, while learning is, in different ways, expected from (all) those involved in pregnancy both as a way to build community and as a way to respect and validate one's individuality (e.g., think back to Paul's story about the need to start a "What about me?" group for partners). Narratives created the dialogically expansive (Baxter, 2011) spaces and temporalities where prenatal care was (positively) experienced in such terms. Narratives also created and, often discarded or narrated physically abandoning the dialogically contractive spatialities and temporalities, especially since the narrators operated from within social positions where such abandonment not only seemed possible, but was discursively positioned as a choice.

Root and Browner (2001) had already suggested that women's informal support system and social networks play a big role in the prenatal care decisions they make about following "professional" prenatal care advice. At the same time, Jordan's concept of authoritative knowledge (AK) has gone a long way in supporting an argument about the biomedical dominance in birth practices in the U.S., and how multiple parties (including pregnant women) are complicity involved in endowing medical doctors and their perspectives on pregnancy with dominant authority. However, through a dialogic focus on pregnancy - and on pregnancy as larger social processes of family and community construction - the moment of birth becomes one utterance in the utterance chain (Bakhtin, 1984; Baxter, 2011). Considering the relational histories and social discourses brought

into that utterance (even by a single person), it becomes very difficult to imagine it as monologic, as AK would suggest. In one definition, “authoritative knowledge (...) is a way of organizing power relations in a room which makes them literally unthinkable in any other way” (Rapp, quoted in Jordan, 1997, p. 57).

But the stories shared here imagine power, relations, and power relations in many different ways in the course of a pregnancy and pregnancy-related interaction, while issues/discourses of belonging mix spatialities and temporalities beyond those of the "room." This is not to say that discursive and interpersonal struggles for dominance do not happen in this context, it is rather to see them as struggles in process... for even the idea of un-thinkability begs the question of "For whom are power relations 'literally unthinkable in any other way'?"

In other words, a dialogic perspective on pregnancy narratives opens up the concepts of "knowledge" and "power" when it comes to pregnancy and prenatal care. In a process of becoming, knowledge is not only about "do-s" and "don't-s," about tests and their results, not even only about bodies and emotions, as if these can ever be sufficiently comprehended - rather all of these become performative (in Butler's sense) in constructing (knowledge of) selves and relationships. The personal and the multiplicities of personals become more than self-indulgency or, from an-other point of view, voyeurism. As is perhaps often with story-telling, the personal becomes a tense discursive battle-ground - through and in the personal as an ever-moving journey, relationships are negotiated, prenatal care is evaluated, and decisions are slated.

Lily [paraphrasing a question asked differently in different conversations]: So, what matters to you in pregnancy care? What would you like others to know?

Charlene: Like I said, I'm definitely more comfortable in smaller situations,

in smaller groups of people,
I want to get to know who - I mean especially such a
personal part of your life,
and a personal area of your body and stuff like that,
I want to know that person
and I want them to know **me**,
you know what I'm saying, I just, I don't know, I guess I... that was just important to me
(...)

In both offices I went to - the one in NC and the one in FL -
I was like, they knew me -
because I was seeing them so frequently, you know,
we were on a first-name basis, me and the nurses and stuff -
they knew my face, they knew my history, they knew what I was there for and stuff.
Even I, I, it's funny because I went for my GYN exam a year after -
you know how they do one like 6 weeks after you deliver,
and then you go in a year for your routine GYN pap smear -
and I went a year later for my pap smear and they actually
remembered my face
remembered my name
they held on to the baby
while the doctor was doing -
cause she was with me that day, I don't think I had a baby sitter -
they were just phenomenal,
it was just amazing to me that they remembered who I was...

Shelly: ... the best prenatal care probably
- for me or in my opinion -
centers around
how normal it is to be pregnant [laughs]
and that, you know, kind of
working
with women's bodies
to encourage positive,
normal state of being.

Mark: The prenatal care providers (...)
I loved it when they told us what the deal was,
give us options,
and then let us make the choice.
Often there is no right or wrong way to do it,
there is a range and
you have to find what works best for you.
So, for the prenatal care, that's my main thing.
And for pregnant couples,
find a birthplace that you really like and you really feel good at
and switch if you don't have that.

Paul: I guess there is the point
with health care providers
trying to bare in mind that this is a...
this is not an everyday occurrence ... for most ...
you know, pregnant people and their partners
and I think that
having some place
where the real issues can get talked about
is important.

Lily: ... so when I talk about pregnancy and conception and all that,
for me, it all started,
it feels like it started long before I was actually pregnant.

Aneesha: Yeah, exactly. I feel exactly the same way, because
I was consciously working on my body for the last 2 years,
it was a lot of hard work,
I was doing spiritual cleanses,
I was doing physical cleanses,
I was making my husband do cleanses, because it's his body... parts that is
going to contribute to it, and it's his ah.. sperm, really to be, so his body...
cause a lot of people forget
that it's
two people making it work
two people making it happen,
so both their bodies need to be in a good place

Mariyana: ... it will be important to start prior to pregnancy
if you really wanted a really healthy pregnancy,
then you would start working with the family
prior to pregnancy
so that... and at that point,
prior to pregnancy,
there will be the development of
a relationship
between healthcare providers and the family
and that would be a relationship that is characterized by
honesty, mutual respect, care, you know,
all of the **intimacy** in that relationship would be developed,
and **through** that relationship,
you would start to
identify
together
with the family
what their healthcare concerns are
(...)

so, pre-conceptionally to work with the family
that they could identify
how they would like to improve their health,
and then, how they would like to do that,
and then, my job would be to support them in that,
that would be the first step
And then, once they are pregnant, it would be
walking with them through that process
of, of, you know, the information that they need to have
(...) quality care is
that every family who comes to us has the opportunity to really be heard and be listened
to,
and be an active participant in their care.
So, that's like a big piece of it.
Another piece is that all the resources are available for whatever situation arises -
like we have running water, and medication, and clean sheets and all that kind of st... like
stuff.
And the other thing, which is really important is you have skilled providers
like you can have the nicest provider in the world, but if they don't h... if they're not
skilled,
what good is that gonna do you, you know?
So you have to have all of those things to really be able to provide like good quality care
and it's not very many places that have those, all those components, so...

CHAPTER 5

(M)OTHER LANDS, (M)OTHER WAYS, AND CONSTRUCTING BELONGING

Belonging is about where you long to belong, whom you want to nestle beside at the end of the day, who you call when you are in pain, or who accompanies you in ritual—in signifying practices that give life meaning, if by no other means than to call mindful attention to the awesome beauty of now.

(...)

This yearning to belong is grounded in politics. Belonging, in and of itself, is neither resistive nor oppressive. One can belong to or with a skateboarding group, a white man, a community of color, or the Ku Klux Klan and feel the desire for connectivity being produced and conveyed. A sense of national belonging often evokes military patriotism, corporate belonging evokes competition, and belonging to whiteness evokes a sense of entitlement that the world is our oyster. Thus it becomes vital to interrogate the conditions and effects of inclusion within various sites of belonging.

(Carrillo Rowe, 2005, p. 27-28)

*To start in the middle is precisely not to perform a phenomenological reduction. It is to accept the challenge to regenerate your terms, and their cohesion to each other, at each repeated step in your thinking through the nexus. Rather than a definition, what you have is a proposition, less in the logical sense than in the sense of an invitation. **Starting from affect in this way is an invitation for an indefinitely constructive thinking of embodied, relational becoming.** The emphasis on embodiment, variation, and relation gives it an immediately political aspect...*

(Massumi, 2009, p. 3)

Amma, Aneesa's mom, is sitting on the edge of the couch, hands clasped tight and in her lap. Her whole body seems tense and that worries me, makes me feel tense, mostly because I can see my mom in Amma. She'd want to speak, questions she had never been asked before, but she'd doubt her credibility, the value of her knowledge, shared thousands of miles away from home with an inquiring stranger. I think she's told me so, or maybe I imagine it... Looking at Amma, I imagine, long for my mom and giving her a hug, there is an inexpressible love and devotion that was never put in words between my mother and I, but was always there. And, knowing of our fights and struggles, I am suddenly tender and raw and a little but in awe of the possibilities of motherhood. Perhaps longing to hear my own mom answer this, I say...

Lily: So, do you know some things about being pregnant, that you remember or are bringing to Aneesa that you think are ... some things that you tell her, that she should know?

Amma: Yeah...

I pass some memories
because I was so far from my own homeland and
I was carrying her,
so, you know, some of it... But ah... my...
that time, I was very lonely at that time
so what I feel that
I would tell her
not to keep herself, stay from anything she wants or she feels
Maybe I was too young to recollect -
I, I don't think I, I mistook the age I was carrying a child
(...)
My most, probably 8 months I was just alone
my husband was there, but he had to work like from 7 to 7-8
But I waaass... I was doing fine, you know,
the people were around,
the African people they were nice, you know,
I had some helping people from home,
and I went out
I didn't feel anything that I was so left alone,
I'd rather felt sad,
not bad, but it's just a different atmosphere, environment, everything:
the people
the food
the smell you have
the whatever you see in the morning
it's just something you've never seen, you know, country

Aneesa: Next year is going to be my 10th year of living in the U.S.
and I am 28
I came here when I was 19,
so... I don't feel any less, I don't know,
American
than an average person,
but I also feel like there are
many definitions
of what American is
cause... I actually **will** become American in January,
I'm getting naturalized in January, and...
so, but... I don't think we have to let go,
there are many ways of being American

and not one way
and I think it's all connected,
because I really feel
I really wanted to mention this and this is really important to me -
of **how weird**
I have felt
from a lot of so-called white Americans in this country
throughout my pregnancy
of being made
to feel
subconscious
about my family structure
and about the kind of parenting I am interested in
It's as if, they don't...
(...)
it's so isolating sometimes here
because it's almost like
my ideas about parenting
my ideas about pregnancy
my ideas about **food** for pregnancy
what kids should have vs. what I should have
what my husband should have
to prepare our bodies
to give birth to babies that don't cry all the time -
everything is a struggle here
because to me it's like
anti-the-culture
everything that I believe in is
against the mainstream,
it's almost
exhausting
sometimes
(...)
I'm very lucky to have a partner who is actually receptive enough to ideas that I have that
are not in the mainstream in any way. And to actually absorb them and take interest in
them, he has read enough on them. It's just that...
I don't know,
I don't feel alone in this as much,
some days I just feel annoyed, that's all.
Like I'll come back some days and like vent on,
I vent on him [her husband], like,
"I've just had it! I've met another person who's like given me **sniide** comments about
[make up voice] "Oh, your mother's gonna help you, is your mother gonna be here the
whole time?"
Yeah, what is that, why is that your problem?
[fast, gesturing, animated]

Wha-wha-what is it to you?
Am I taking your money to bring my mom in?
Or how, is she living in your house, is she...
Am I borrowing food from you?
Am I making... Wha-Why can't you be happy? or
Why can't you, at least, why can't you **let it** beeee?
You know, why is that...
[switches to matter-of-fact]
The first thing people ask when they see my mother and us walking together:
"Ahh, where is she staying? Is she staying with you?"
(...)
people are always talking about
commuunityyy
but when it actually comes to
living in one,
they, they're like...
[whispers]
"Why is your mom living with you?"
Ahhhh...

Analytical voice/Guest from Chapter 4: Pregnancy and related arrangements and prenatal care activities provide the context in which the interplay of the discourses of inclusion and seclusion, individualism and community, frames a struggle of/for belonging. The discourse ruptures - a discursive disjuncture (Baxter, 2011; Peterson, 2010), where "discourse can easily turn on itself and do counterpoint work in legitimizing opposing actions" (Baxter, p. 87). The discourse of individualism in "Why is that your problem? What is it to you?" is employed to actually protect a version of community that is not part of the mainstream, it's both a bid for "letting be" in its own realm and, by this, performing inclusivity, acceptance **and** separation.

The excerpt above is dialogically expansive (Baxter, 2011) in that multiple voices are invited in it. In directly reporting her own and others' speech, Aneesa legitimates both competing discourses as present in her/their cultural contexts. Moreover, the discourses

are constructed as antagonistic. Their struggle is constructing belonging, transnationally conscious of borders and of border transgressions (Croucher, 2004).

Lily (reflecting): Questions.

Otherwise seen as dialogically expansive, inviting different perspectives, questions Aneesa told and told on in her story are constructed as dialogically contractive, as marking and performing difference that builds exclusion. Questions can be ambiguous, allowing for "semantic wiggle room" (Baxter, 2011) - which is also how/why they become problematic, sites of discursive and material struggles. The acts of particular people asking other people particular questions in particular contexts (kumar, 2010) perform locations and movements toward/with an-other and, in this, are variably constructive of identities and identifications. Sometimes (painful) difference is encountered in the questions we get (or those we ask), in that we don't make the same assumptions as the people (of whom we're) asking the questions, in that some questions won't even be asked if we made the same assumptions... "Where is she staying?" is a question that will never occur to me to ask about someone's visiting mother.

Affect and/as Pregnancy

Aimee Carrillo Rowe (2005): From the perspective of identity, one is merely white or female or heterosexual, or all three, and this identity conditions one's standpoint in various ways that must be interrogated (see Frankenberg 1993). But in thinking belonging, these identities are placed into motion and the **terms and the effects of inclusion/exclusion come into sharper focus**. And with these come **the possibility for the formation of critical and collective modes of agency**, as well as new demands for accountability (p. 28; emphasis added).

Lily (reflecting): How, where, with whom do I (want to) make myself fit? How, where, with whom am I made to fit by/with others? Whose bodies is my body (allowed/imagined to be) next to? Whose bodies are suspect(s) next to mine?

Catherine Chaput (2011): (...) Brian Massumi (2002b) believes affect creates an ecological “coming-together or belonging-together of processually unique and divergent forms of life” (p. 255). Moving across thresholds and propelling individuals into and out of different situations, affect offers a way to explore how we have come to belong together as well as the imminent possibilities for belonging differently (p. 1).

Lily (reflecting): But similarly to the use of *dialogue* in the previous chapter, I have to wonder if *belonging* here is unhinged from the idealism of conflict-free togetherness and understanding. In togetherness, neither dialogue, nor belonging are friction-less. And friction is a creative struggle of cultural production (Tsing, 2005). So, maybe I should re-ask my questions above - not in terms of "fit," but in terms of being present *заедно/at once*¹⁶.

Aimee Carillo Rowe (2005): The meaning of self is never individual, but a shifting set of relations that we move in and out of, often without reflection. My work aims to render transparent the political conditions and effects of our belonging. It gestures toward **deep reflection about the selves we are creating as a function of where we place our bodies, and with whom we build our affective ties**. I call this placing a “politics of relation” (p. 16, emphasis added).

Lily/Tour Guide: Some of us may have - or know of - more choices we have during pregnancy and prenatal care. Some choices may be limited by structural

¹⁶ I use the Bulgarian word for "together" here because its structure and (social) meaning conjure questions and possibilities - in a short word, there are the implications of "for one," "at once," and "becoming one."

constraints, such as insurance coverage. To "place our bodies" in certain places and in certain times may seem (im-)possible and (un-) desirable. It may be, in fact, placing ourselves (and in the case of pregnancy, possibly our not-yet-born) outside, in the center, or on the margins of desirable, profitable, normative locations. Gálvez (2010) convincingly situates Mexican immigrant women's use of hospital- and biomedical-based prenatal care services in New York City within a larger cultural discourse of *superación* that frames immigrant experience and aspirations. Physically placing their bodies in the crowded waiting rooms of public hospitals and prenatal care clinics is also physically placing their bodies in the realms of "modern" medicine, it is inscribing one's self within the borders of what is public in the U.S.. Despite marked experiences of discrimination and despite separating immigrant women from their "home" practices that are working to support better maternal and infant outcomes (the Latina paradox), "consumption of health care becomes a measure of social capital that marks the distance traveled from hometowns in which most migrants describe not having access to affordable, modern, biomedical care" (Gálvez, p. 38). Performances of pregnancy management and care become mechanisms for inscribing separations and belongings.

In narrating and performing her experience as a struggle, in verbally bringing together and against one another the competing discourses, Aneesa's story also constructs versions of normative and alternative discourses on pregnancy, prenatal care, family structures, and citizenship/community. And her story - told to me who has also shared with her a strong feeling of not-belonging "here," while longing for "there" during my pregnancy - also negotiates her belonging, her future child's belonging in the story. When normative belonging is fairly secure (e.g., a white, employed, heterosexually married,

home-owning, insured, U.S. citizen, mother in the U.S.), one can talk about and practice "alternative" prenatal care as a "personal (informed) choice" with the danger of hinging that choice to cultural difference and identity politics minimized. Women in Gálvez' (2010) ethnography inscribed their bodies, their names, their children's names into a dominant institutional discourse (that comes with its own prejudice) in a bid for legitimate belonging. When such belonging precedes the pregnancy, inscribing one's self in the margins through prenatal care and birthing practices is framed as empowerment, resistance to dominant ideology, an informed choice-making that comes with certain change in social status (just watch Ricki Lake's still popular *The Business of Being Born*). Both of these extremes, and anything in between, are political and emotional, consequential to both material and affective economies (Ahmed, 2004) and the politics of relation (Carrillo Rowe, 2005) these economies shape.

The stories write the stories, write the selves in relation to others.

In doing so, stories also perform knowledge of a social system or multiple social systems, it performs life on the borders and between borders. Belonging - and in it, "the meaning of self" (Carrillo Rowe, 2005, p. 16) is at stake in the dialogic interplay of competing discourses. Stories "tell and tell on" (Holman Jones, 2005) that - on the complex negotiation of self in relation to others even when "identity" may, at first blush, seem permanently lodged into demographic categories of privilege and normativity.

Encompassing the physical, the body, inseparable from it, pregnancy and prenatal care (perhaps even health and healthcare altogether) and the interactions that they incite and/or silence become about possibilities and political choices of (longing for) belonging. Part of the knowledge involved and produced is knowledge of dominant and

marginalized discourses, norms, feeling rules (Hochschild, 2003), relationships, practices, and selves, and communities, and bodies, and cultures.

Magdalene: Uh-hum. I think it's funny, funny that I think a part of me has forgotten about the first four months, how hard it was, cause I think during that part, I was more sensitive to people, what people were saying and, you know, even when people were really positive, I was **sooo** sick, and I **was not** feeling beautiful and happy, and all the things people told you [that] you should feel when you're pregnant, so I think that part was hard cause then I'd be like "I really wanna be happy and I **am**, but I'm really miserable and sick, so that, that was hard, not that I wanted people to be like... =

Peter: = Sorry =

Lily: = Sorry for you =

Magdalene: = Right, but it was a little bit weird for people, to keep hearing, you know, "But it's **such a** wonderful time and it's beautiful!" and I'm like "Urgh..." it wasn't really wonderful

Cindy: (...) the thing that's felt really different for me in terms of like telling my story or talking about things or advice on what people say to you is that because we had some scary complications at 33 weeks, I found myself being really [2 sec. pause] tz... it's not that anyone besides myself made me feel this way, but I felt really silenced...

Sara Ahmed (2010): Affect aliens are those who experience alien affects. You are unseated by the table of happiness. (n.p.)

Lily/Student: How does the unseating happen? Who unseats an-other? Do we become/feel like affect aliens when we don't feel the way we know we ought to, when we, thus, don't conform to the feeling rules (Hochschild, 2003)? But in the quest for belonging the alien could be covered up. Is another's recognition necessary?

Kate Boyer (2012): Ahmed suggests that concepts of the kill-joy and the affect alien can serve as ways to highlight the exclusions and violences on which certain forms of happiness and types of comfort depend. (p. 552)

Cindy: ... like I shouldn't talk about my complications to other women who are pregnant cause how... that's unfair, that's really scary for them. Whereas in my other community, which I didn't have a complication in that pregnancy, but I felt like I could tell these people anything cause like... they were there a year ago, they had already moved on, nobody was pregnant. You know... and i felt like to be surrounded by all these people, a lot of them are pregnant for the first time, you don't want to be... =

Lily: = scare them =

Cindy: = scaring them, you know. And so, talking about all the things... like [speaks quietly, hushed] "here are the things that could go wrong, how scary birth and delivery was" and so... whereas...

Lily: Who did you talk with? Anyone?

Cindy: Ah... [sigh, continues very quietly] Mark [her husband]. Mark and I talked about it a lot. I talked about it some... with friends of mine uhm... who are kind of like, who are already part of my already-there community, friends I've had over the last 10-20 years who, their kids are much older, a little bit with them. But uhm... and a little bit with the midwives, like we had conversations with them... But mostly with Mark.

blue milk (2012)¹⁷: A big part of the modern birth experience for women is fear, it is the way we portray birth in film and on TV, it is the way we pitch public health messages to women about pregnancy, and it was certainly a big part of my experience of birth (both times) in spite of efforts on my part to overcome that by going to a birth centre instead of a mainstream hospital. Your philosophy, in many ways, is trying to redress that isn't it? To overcome 'fear' as the dominant message for women about birth?

Ina May Gaskin (2012): You're right. The women I selected to work as midwives with me and I were able to establish a birth culture in our small community that minimized fear and was, for at least a decade, isolated from the fear that could have been imported via television, films, and the worries coming from anxious relatives. We were successful enough in the beginning years of our practice that the evidence then spoke for itself.

This is why I like to send women to watch other mammals give birth—to see what it's like when a female moves freely and feels what is happening, without being afraid.

Lily (reflecting): Of course, Ina May Gaskin is talking about "normally-progressing" birth, no complications. Elsewhere, including in the documentary *Birth Story*, she does talk about pregnancy and birth-related situations that have been frightful for her, too, but a big part of the care philosophy that she brings forth is based on the idea that fear closes us - for the birthing woman, quite literally, closing her body and making birth more difficult - and that, therefore, it should be minimized and transformed for prenatal care and birth to be as uncomplicated and connecting as possible¹⁸.

Sans fear -

or with little anyway -

we can move closer to an other

more closely connected to the other

who is pushed, and wiggling, and sliding from within

¹⁷ This excerpt is from an interview with Ina May Gaskin - a foundational figure of modern midwifery in the U.S. - on the Australian blog *blue milk: thinking + motherhood = feminist*.

¹⁸ The movement against fear-full discourses of birth and pregnancy is also indicted by the existence of numerous online support groups and sites, such as *Birth Without Fear* (<http://birthwithoutfearblog.com/>)

Although, as is the trend these days, much attention is focused on the event of the birth and the contexts and circumstances of that event and although the process and visualizations of birthing are also dominant in popular representations of Ina May Gaskin and the Farmwives, her own writings often emphasize the midwives', family's, and pregnant woman's work of minimizing fear *during pregnancy, as part of prenatal care.* Emotion work.

Arlie Russell Hochschild (2003): By "emotion work" I refer to the act of trying to change in degree or quality an emotion or feeling. To "work on" an emotion or feeling is, for our purposes, the same as "to manage" an emotion or to do "deep acting." Note that "emotion work" refers to the effort - the act of trying - and not to the outcome, which may or may not be successful. Failed acts of management still *indicate what ideal formulations guide the effort*, and on that account are no less interesting than emotion management that works (p. 94-95; emphasis added).

Lily/Tour Guide: Like Massumi (in the quote opening this chapter), Hochschild goes on to highlight that emotions and emotion work are political. But emphasizing the processes of "thinking feeling," of consciously doing and shaping, and working on emotions and their social frames and consequences, she moves away from Massumi's affect-instance of "rebeginning of the world" (Massumi, 2009, p. 5).

Brian Massumi (2009): You can sometimes feel the in-bracing itself, most noticeably in startles or frights. Before you can even consciously recognize what you're afraid of, or even feel that it is yourself that is the subject of the feeling, you are catapulted into a feeling of the frightfulness of the situation. It only dawns on you in the next instant that you'd better figure out what might have done the catapulting, and what

you should do about. It is only then that you own the feeling as your own, and recognize it as a content of your life, an episode in your personal history. But in the instant of the affective hit, there is no content yet. All there is is the affective quality, coinciding with the feeling of the interruption, with the kind of felt transition I talked about before. (...) In that moment of interruptive commotion, there's a productive indecision. There's a constructive suspense. Potentials resonate and interfere, and this modulates what actually eventuates (p. 4-5).

Lily/Tour Guide: For Massumi and other affect philosophers, affective moments are political because people can be attuned to the same "affective environment" and because even in a seemingly uniform reaction to an affective event, there will be minor lines of difference that will be "left as a reservoir of political potential" (Massumi, 2009, p. 6). For Hochschild (2003), emotions and emotion work are political because they regulate and are regulated by (unequal) social relations, such that, for example, negative emotions, such as anger, travel with more acceptance down the social hierarchy (e.g., boss to employee). At the same time, emotion work is political because redefining or conforming to feeling rules (how one ought to feel in a particular situation) affects the social and relational status quo. In yet a third perspective, Sara Ahmed (e.g., 2004) takes up emotions as doing the work of building communities and separations, of creating "the very effect of the surfaces or boundaries of bodies and worlds" (p. 117). Though Ahmed mentions both Massumi and Hochschild in her various texts, the three are rarely considered together.

Through a focus on a belonging/"politics of relation" (Carrillo Rowe, 2005), this chapter considers these different perspectives on affect and emotions as they play out in

the context of pregnancy and prenatal care. From Massumi, I borrow the attention to the body and movement in relation to affect; from Hochschild - the notion of emotion work and the social normativity of feeling; from Ahmed - the transnational feminist focus on borders and transgressions, and affects' roles in accomplishing these. Again, as in chapter 4, rather than giving "prescriptions" of what one should do during pregnancy or what works as prenatal care, this chapter functions as an invitation - to struggle with the complexities of pregnancy and prenatal care as a communication phenomenon, as shaped by and shaping conversations, interactions, relationships, and norms/forms of belonging. The stories dialoguing here perform variably dominant and marginalized discourses of citizenship, gender, and pregnancy, among others. They are here imaginatively - flushed into the streams of knowledge, of knowing our worlds - as a possibility, not as a causality or predictability.

Mohan Dutta (2008): The dialogical approach provides a space for presenting alternative viewpoints and for contesting the dominant framings of health (p. 107).

Lily/Tour Guide: Doing health care and health communication research in particular ways is in itself consequential. Emphasizing (controlling and enticing) individual choices of patients, interventions, and statistical predictability performs (monologically?) a dominant model. That is not to say that this approach cannot and does not produce physically healthier bodies with increased longevity. It is to say, however, that it is culturally reductive.

Mohan Dutta (2008): The dialogical stance in the culture-centered approach creates communicative spaces for conversation (...) the dialogical stance foregrounds the mutually interdependent flow of communication among the different approaches to

health, illness, healing, and curing, thus creating spaces for the exchange of meanings.

Rather than attempting to change the participants into a receiving culture (...) the

dialogical approach places emphasis on meanings and new possibilities (p. 130-131).

Lily: An interruption.

Affect, Episode 1: Affect, Bodies, Cultures, and (not) Belonging

Lily: May, 2009. The last day of class. A wonderful, warm, intelligent group of students. On the last day of class, we party, talk future, goof around. Then Danny, from the left corner of the room, way back and next to the window, says this to me.

Danny: So, when are you going to start having babies?

[I move closer to him, from the center of the room in front of the teacher's desk to the left side and in between the students' desks; moving closer, it is also time. Then I say this.]

Lily: In October.

Danny: No, seriously.

Lily: In October.

Jami: Wait, are you pregnant? Like, right now?

[I remember my response as a beaming nod and somehow the room got louder, students standing up from their desks, moving closer to me, I remember them beaming, too, and myself surrounded by warmth.]

Someone: Do you know if it's a boy or a girl?

Lily: A boy.

Danny: Do you have a name? You should totally name him Danny!

Lily: Daniel is actually a name we're considering...

Jami: Wait, but are you really? I mean, you must be like 5 months and you're not showing at all! So, you've been pregnant this whole semester?!

Someone: She's pulling an Angelina Jolie on us. Now, I see those wide pants and the wide shirts, I just thought it was your style.

Laughter and hugs and more baby questions in this college classroom. My secret - out, in this place, with this people - good and celebrated and shared.

Brian Massumi (2009): The ultimate vocation of micropolitics is this: enacting the unimaginable. The symmetry-breaking point, the point at which the unimaginable eventuates, is but a cut, “smaller” than the smallest historically perceivable interval.

Lily: So small that a single word is too big to narrate it, so I need many instead that perhaps will create it (for someone). So significant that I can't forget it.

Brian Massumi (2009): That is to say, qualitatively different. A moment of a different color, one you never see coming, that comes when it's least expected. Inevitably, a next micro/macro complementarity will quickly settle in. But it will take a form that could not have been predicted, but is now suddenly doable and thinkable. Micropolitics is what makes the unimaginable practicable. It's the potential that makes possible (p. 20).

Lily (reflecting): Suddenly, I am reminded of the definition Jordan (1997) offers of a concept she first introduced: authoritative knowledge (AK) - "a way of organizing power relations in a room which makes them literally unthinkable in any other way" (Rapp, quoted in Jordan, p. 57). I have been too constrained by the application of the concept to a circle of participants that involves prenatal care/birthing professionals (doctors, nurses, midwives, doulas), pregnant/birthing women, and sometimes their families. In articulating "authoritative knowledge," Brigitte Jordan's questions have been who has (more) power in that circle, how is that accomplished jointly by all participants, and how does that affect other forms of knowledges and practices of pregnancy and birthing. Of course, my experience in the classroom pointed out the obvious - authoritative knowledge - if at all suitable to be phrased in the singular - has many dimensions, quite a few of them negotiated in rooms outside of and other than **the** room

housing the particular birthing "experience" or prenatal care interaction, in the continuous relational projects of one's (dis)placement in the larger social fabric.

Particularly in my own immigrant experience, I am sensitive to issues of othering and acceptance. I am sensitive to the processes of my identity becomings of being constructed and of constructing myself. During my pregnancy and later - as a parent - I think I became even more sensitive to that, incapable of not asking myself questions about our (unborn) child's belonging. I don't remember others ever asking me about it. Yet, they were questions I could not escape asking of myself. I understood Remi's honest concern that in fearing "othering" and in feeling "different" I create a self-fulfilling prophecy by failing to perform belonging. But what would have the performance of belonging looked like? How would it have shaped the different streams of knowledge? Perhaps belonging is being non-apologetic or secretive about the knowledge I bring? Not forsaking my own agency entirely, nor my own position

in that classroom

on the last day of class,

I think I knew belonging

(which is also transitive, not cemented)

that day, that room, the people -

an aura of warmth - unexpected - suspended in a remembered positivity.

My pregnant foreign body with its accented tongue not only had a place in this U.S. academic classroom, not only did my students open a context for me to talk my pregnancy into academic discourse, they opened their arms, and they hugged me. Unexpected. Though still strange - it seemed it was my impending motherhood, in the

context of an academic performance, that opened their arms. More importantly to this chapter, it was what I remember as their overwhelming positivity that created the same in me, what I remember as our movement towards each other that created belonging - both physical (of our bodies together in this place) and discursive (of pregnancy into an academically-framed interaction, of me and the future baby into a shared transnationality). And I'd like to think that this was a micropolitical moment. Who is to say how it may play a role in some room, at some time, with some people who are negotiating knowledge and belonging?

Moments of (not) **announcing** or (not) **revealing** pregnancy became unexpectedly focal in the conversations I had with others, as well. I never asked a question about these moments, they just came up - and came up as formative and important. When told, re-membered, (re-)experienced, these moments were emotionally tainted, the affect as informative and factual as the events. Rippling across bodies, signifiers, and times, as Ahmed (2004) would have it, these living affective moments were/are about relationships.

Sara Ahmed (2004): ... emotions work by sticking figures together (adherence), a sticking that creates the very effect of a collective (coherence) (p. 119).

Shelly: (...) my mother-in-law's reaction has, has been an issue in this pregnancy...

her immediate reaction was **not**
"Hey, congratulations, this is great!
kids,
We're so happy for you!"
siiit"

but kind of like
"Ohhh, well, I don't know if I can care for 3
I don't know if I'm gonna be able to baby-

[laughs a little, but also sarcastic, imitating unpleasant surprise]

you know, "how is this gonna impact your health and your finances,"
you know, kind of like, I was "ohh, thanks" =

Lily: = not pretty supportive? =

Shelly: = yeah, not supportive at all and I think that ...
she kind of recovered quickly, once it
"oh, wow, that was not appropriate,
oops, I was kind of voicing my inner thoughts that
might have not needed to be voiced."
But it's kind of caused tension for me.

Peter: Yeah, when we announced it,
we announced it at a work party at the end of last semester,
a work party for me -
and there was a roar!
People just "Wooohhh!"
Jammed
We were surprised at how loud they were,
but they were really excited, so
they've been pretty awesome.

Mark [addressing Cindy]: You had that period of time
when your work didn't know
and Mave didn't know
and there was some
concern about not showing...

Cindy: Yeah... yeah, or just people
not figuring it out
'cause I was constantly tired and sick

Mark: Right... And I forget the exact circumstances now, but you would often come and
say
" I think Liz knows"
" I think whoever knows"
that you'll be very
hyper-aware
of everybody else's sense that you might be pregnant

Cindy: Yeaah, like, if people made the comments
But then, toward the end of my pregnancy, it was interesting, like,
I work with a lot of older people and
I had like 3 or 4 different people who, once I did really start showing, they'd be like
"Oh, stand up, let me see how fat you're getting!" [sounds almost cheerful]
and then i'd get fully mad [we laugh]
"It's not **that**,
I'm pregnant,

I am bigger,
I am supposed to be getting bigger
because [quietly] there is a baby ... growing."
And that ... really, and that really...
annoyed me, you know.

Lily/Tour Guide: Family, friends, work, strangers, society at large... Not surprisingly, there's much more at stake in sharing pregnancy with the world than a simple exchange of health-related or family-planning information. For example, a key theme in Peter and Magdalene's pregnancy story was the integration of the pregnancy and the (future) child into their existing networks, commitments, and social realities - this was beautifully metaphorically sewn into the quilt they asked family and friends to make together. Just as with the quilt, their "big reveal" story performs this integration and others' acceptance. It performs the past - in the re-telling of the announcement - as well as the future - in the hope and belief that the reaction was symptomatic and symbolic. The affect of that moment is re-membered into the present (telling of the) story, into the past, and into the future as a "roar", a "Woohhh!" No affect aliens or killjoys (Ahmed, 2010a) re-membered there. The pleasure brought on and back by this binding remembering, as well the pleasure of its promise, moves Peter's animated face and is carried by his arms going up and out of his own body. Moved.

Pregnancy announcements or the attempts to prevent moments of reveal are remembered. I remember when I've said it and I remember when I've thought about saying it, tasting and trying the words, spitting them out or deciding not to. I remember, because these moments meant and still mean hopes and/or fears of (not) belonging.

Sara Ahmed (2010): If you lose your seat what happens? Activism is often a matter of seats. (n.p.)

Lily (notes): Can I be pregnant at school? Should I always wear my wedding band when I start showing? How much do I elaborate when I say anything about my planned "support network?" Like Cindy above and like me, Drew was worried about people at work finding out about her second pregnancy. Pregnant in her fifth month and away on vacation since before she started showing, Aneesa worriedly asked me about my experience of pregnancy at work. At the community baby shower, the mother of the pregnant teenager quietly spoke about how afraid she was her daughter would be ridiculed in the Fall when she returned to school clearly showing. Even in their highly positive story of the "big reveal," Peter and Magdalene hinted at an earlier fear that this might not have been the case. The tiptoeing dance of announcing pregnancy - especially in the workplace or in a professional context - speaks to the *knowing of pregnancy's precarious place in the social imagination*. For women, this was often heightened by nervous hyper-awareness of the body - it could not hide and at the same time was open to others' interpretations and their placements of belonging.

Sara Ahmed (2010): ... the mere proximity of some bodies involves an affective conversion. We learn how histories are condensed in the very intangibility of an atmosphere, or in the tangibility of the bodies that seem to get in the way (n.p.).

Lily/Tour Guide: Linked to the body and oftentimes on the body, affect was always narrated into moments of (not) announcing or (not) revealing pregnancy. The remembered and re-experienced feelings qualified the pregnancies themselves - as good, happy, hard, etc. - despite the physical "facts" of the experience (e.g., being put on bed rest or medication). Others' reactions to the telling were (re-)told, (re-)remembered, and (re-)experienced, too. In the process of pregnancy, the responses of others were part of the

social construction of the pregnancy experience itself. Thus, Charlene, for example, remembered her pregnancies very positively, with the smile and the joy of it, (re-)animating her face even as we spoke. In chapter 4, her stories performed joyfully how pregnancy "brings out the best in people" and "brings people together" like nothing else. She re-membered her pregnancy happily despite what some might see as complications, including the preemptive classification of her second pregnancy as high-risk, based on her first pregnancy.

-- telling -

how it's linked to the affect of pregnancy -

as the others' reactions reflect and create the space we have in that network,

our accepted or contested belonging, our imaginations for the child's belonging -

-- the ways in which other lands (can) become M-other lands

Lily (reflecting): Much feminist writing has focused on criticizing mechanisms of dismissal and exclusion. Who is in/excluded here and why does that matter to prenatal practices and health communication? I hear the voices of skeptical reviewers... how does this all matter to the question posed at the beginning about the different streams of knowledge that enter and shape prenatal care practices? Is social knowledge part of that and how should a health care practitioner (yes, this includes "patients" too, for they also practice health care) respond in his/her practice? In relation to breastfeeding, Boyer (2012) argued that the "emotional and corporeal management" (p. 559) affected the practice itself. The design of public spaces and/as others' responses to women breastfeeding in public created these women, by the mere proximity of their breastfeeding bodies, as killjoys and affective aliens and contributed to discontinuing the

practice. In other words, (negative) affect and/as the social knowledge of (not) belonging shaped a health care practice.

Of course, I am in no place to, nor will, make causal claims here. But I go back to knowing, as I discussed earlier, that stories of (non) acceptance - of one's pregnancy, prenatal care, or plans for support systems - were narrated in both uninvited and central ways. I know they matter, though certainly dialogically - in unpredictable ways.

I can't help, but note then, an overall sense of mostly shared joy about pregnancy that was present in both my conversations and my experiences. Despite occasional resistance or what some re-membered as snide comments, most reactions to pregnancy in the stories I heard and told were positive ones, stories of shared excitement and interest - coming even from strangers in public places. Within the fabric of this collective text, then, our shared experiences of pregnancy are affectively made "normal" and normative - we all, who met to share our stories in signed-consent conversations - of appropriate age, marital status, employment status or prospects, educational background, and, with two exceptions, white U.S. citizens, telling our stories in white, educated, tax-paying, choice-valuing area of the United States. That kind of shared belonging established, distinction and dimensions of (not) belonging were told and told on differently, not categorically and rarely as a matter of social identity (Tatum, 1992), but as a matter of (informed) choice and taking on (the sharing of) affective responses toward particular prenatal care practices or physical and emotional experiences of pregnancy.

One of those shared affective responses was that of (varying degrees of) caution towards what was variously named "the Western," "biomedical," "traditional," or "dominant" approach to pregnancy, prenatal care, and birth. In communicatively placing

themselves in relation to dominant cultural models (without even naming them), people with whom I met told stories of (imagined) other lands and other ways. Other lands were both (knowledge-producing) experiences and metaphors of distance and differentiating from perceived dominant cultural models in the U.S., popping up in our conversations to walk the dialectic of uniqueness-tradition (Baxter, 2011).

In light-filled, warm rooms
tea-kettles whistling,
feet folded underneath bodies,
cushion-like on cushioned couches,
time set aside from chores and work and dailies,
other lands
m-other lands
are told,
owned,
lusted,
romanticized
criticized,
imagined,
brought here.

I just now realize that in these rooms
when I talk of my motherland,
it becomes an other land...
Viscerally.

I cannot not feel that the telling of these stories of other places visited or imagined, the telling of these stories by white, employed, married people, the telling of these stories in these homes, is a creative mix between Conquergood's (1985) ethnographer's infatuation and curator's exhibitionism. Colonial. But I cannot also overlook the affective work of these tellings - a work of aligning and locating. Positively-affected talk of far-away lands as the basis of (learned) practices for here and now, is quite literally performing the distancing from an unspoken norm for here and now. Ambiguously-affected talk about far-away (and sometimes, pre-modern, to add the

dimension of time) lands also performs dialectical alignment with here/there and now/then.

Having lived there/then and living here/now and having lived here/then, Peter and Magdalene, for example longed for and "quilted" a pregnant community that they imagined would also be there for their child ("And that's the way they're gonna be with the baby, too"). When Aneesa and I were telling our stories of insistence that our parents, especially mothers, were here for parts of our pregnancies and for the birth, and for the days after, we were also in the there/then of having imagined being pregnant and we were in the here/now of pregnancy and longing.

Affected.

Narrated mythologies of communities "over there"
perform and invite

anxieties

fantasies

reflections on longing

statements of affective ties

in the mythology of our communion "right here"

Belonging is about where you long to belong... (Carrillo Rowe, 2005, p. 27)

Paul: I suspect there are

women who have

willing and able partners,

who really would rather be

off

in a tent

with the other women

in their culture or in their village,

who would really rather

not have their partner there,

I mean, there is something more elemental, I would imagine, about partners' roles =

Patty: Mmmm, hmmm [quietly] =

Paul: = And just like i was saying,

we only have

40 years

in which the partners **are allowed** to have anything to do with it [birth and pregnancy],

it's hard to get at speed =

Patty: = [laughs] =

Paul: = and that maybe that isn't something that... that on some level, maybe you would just rather - you or anyone - just be out in a tent with other women.

Patty: That sounds lovely, too, but ... given that roles have shifted so much over time, you are one of, you are the person I am closest to now, so I was so thankful to have you there That first pregnancy, that first birth especially, I think I probably would have been bereft without you.

Magdalene: I think both of, I mean, I guess, my experience living... especially abroad, like I think about South Africa - living there, uhm... I mean, it was different cause I was in an orphanage, but I also was around a lot of people with their own children in the community and this sense of like shared responsibility for the children - and that's something that I always felt was important - to have like a community around family, but I feel like just seeing it work in that way was really, I don't know, it was kind of inspiring I mean and to, like, women would just pick up anyone's child and act as if it was their own, you know, and it was really nice to see the children so connected to so many different people, not just to their mom or to their, you know, to their dad, or to their whoever it might be, and like, children, too, taking responsibility for other children, and uhm, and like breastfeeding, and things like that, you know, just things seemed a lot ... I don't know ... it was more ... I don't know ... it just seemed a little bit more straightforward =

Peter:= It's just common, right, it's everywhere?

Magdalene: Yeah, yeah.

Lily: So, here people talk a lot about natural, but it's produced natural,

it's not hmm... I don't know if organic is the word =

Magdalene: = Yeah, yeah=
It's really interesting **here**,
like we have all these classes to teach us how to do things =

Peter: = Right =

Magdalene: = in a way that, that, just hap - I mean,
it's so common sense, I feel like so much of it,
but uhm, but it is interesting.

Peter: And it is also, I mean,
it's filling a void
where that knowledge
would've traditionally
just been available,
I mean cause everyone around you is having kids,
and you just go and talk to the neighbor, you know,
talk to your mom, you know what I mean,
so that kind of information is just in a different format

Magdalene: Uh-hum

Mariyana: When I did that research in the Dominican Republic I was telling you about,
we interviewed **faaathers**,
and it it was
sooo tragic
how **helpless** they felt
because in the DR fathers are not allowed into the delivery rooms,
they're not allowed in the maternity,
so here's a culture of men
who feel very protective of their pregnant wives,
they feel very responsible for them,
and they had to
turn them over
to these other professionals who they didn't know and they didn't trust,
and there was nothing that that partner could do to be a part of her care,
and it was **sssuch un-empowerment and helplessness**,
and it's like ok, so then when she comes out with this baby,
that then he **knows nothing** about her experience,
what happened
- simple things like, did you have a hemorrhage, how do I care for this baby -
like, like, it's like a **time-warp** or something that
all of a sudden, then she's back again and
he is supposed to pick up as being involved in their lives in some way,

so like, it, it, it just doesn't make any sense,
and we all do it.
Like, what you experienced is a smaller version of that, it's not so dramatic =

Lily: = Right =

Mariyana: = But when we exclude the family,
we're, we're, you know, we're doing exactly that,
we're separating the woman from this huge network and resource that she's got in her life

Peter: And both of us have worked
in different countries
and Magdalene worked in an orphanage for almost a year in South Africa
with newborns and infants,
and I worked and lived in Guatemala for several years
and we've seen the different conditions
and the different families
and different ways that babies are brought up into the world, too,
I mean, being here in this liberal college town, it's like - Come on! =

Magdalene: = It's like... =

Peter: = I mean, we have
birth classes
and =

Magdalene: = There's so many resources =

Peter: = lactation classes
and
beyond birth classes
and
group course-work
and
you know, I mean, it's really awesome =

Magdalene: = Yeah =

(...)

Magdalene: Well, it's kind of like the, the same idea of that...
we're trying to, you know, we're trying to provide
what is sometimes there as a part of a community, you know what I mean, like,
but because of whatever reasons,
because of the way we're **set-up** in this community,
we have to have a special =

Lily: = reconstruct it =

Magdalene: = yeah, reconstructed =

Lily: = specifically for the purpose =

Magdalene: Riight, which is kind of funny, but...

Peter: *Inducing*

[... feeling? community? knowledge? be-longing? ...]

Affect, Episode 2: Silenced Exclusions and Other Spaces

Lily/Tour Guide: In her work on affective economies, Sarah Ahmed posits that emotions do not have a positive residence in an individual body. Rather, they circulate among bodies and signifiers, allowing the alignment of physical bodies with social communities. It is not necessarily the type of emotion that is binding, but the shared-ness of a particular emotion. Thus, there is nothing particular that makes love, for example, more binding than hate. Ahmed demonstrates that the shared emotion of hate directed to the same set of signifiers is just as constitutive of community as would be the case with love or any other positively-valanced emotion. Thus, exclusion and not-belonging is constituted and responded to when two or more people who are supposed to share the same "care" in relation to pregnancy diverge in their affect, as it is directed to particular signifiers in particular contexts. That is to say, it is not only difference in opinion that constitutes rifts among different participants in prenatal care, it could also be difference in affect and/or the absence of certain affective possibilities from a given context.

Knowing (of)
be-longing (together)
in (shared) affect,
constructs prenatal care (interactions).

In such cases, overt or covert claims to "appropriate" affect - in quality, degree or both - negotiate power and knowledge. Affect (and its shared-ness) can also be a marker of (differing) epistemologies. For example, in her blog interview, cited earlier, Ina May Gaskin bonds fearful approach to pregnancy and childbirth with a "dominant" and "medicalized" epistemology that is predicated on discovering and minimizing risks. As a marker of epistemology in the power/knowledge nexus, **affective dissonance**¹⁹ has direct consequences for healthcare decisions, especially with regards to managing the relationships between pregnant women and professional prenatal care providers.

Shelly, for example, switched providers late in her pregnancy (after 30 weeks) after becoming disappointed at how the midwifery practice she was using at the time responded to - both medically and emotionally - to discovering she was anemic. The affective "match" was key in her experience with different prenatal care providers she met in this context. Affective responses were also tied to knowledge and knowledge validation - the prenatal care providers' panics she describes below not only don't match Shelly's own level of (no) concern, they also serve to invalidate her knowledge of her body, her life at present, and her approaches to taking care of herself during pregnancy.

Lily:... So, what happened at "Practice 1"... if you don't mind me asking

¹⁹ Here **affective dissonance** refers to instances when key players in a given situation have mismatched emotional responses to that situation. I believe the term isn't widely used and especially not with such definition. To some degree, borrowing from theories of cognitive dissonance, Hochschild's "emotion work" refers to attempts to change an emotion when it does not match the socially-expected and accepted norms (feeling rules). In this sense, affective dissonance can also be used to describe the mismatch between an emotion felt and social expectations for feelings in the particular context. **But I do use the term with interactional/relational meaning here**, as perceived differences in affect influence relationships and identity negotiations. As I will discuss in the next section of this chapter and as the end of Shelly's story here performs, communicative expressions of affective dissonance can sometimes be deliberate, doing purposeful emotion work.

Shelly: They uhm... They were not very good with my anemia in the sense that - I forget when the... I forget when the tests are, I think the first blood draw is like 16 weeks, and I was mildly anemic and...

Lily: And that hasn't happened with your previous pregnancies?

Shelly: It diid. I actually, I tend toward anemia anyway, like even not being pregnant, and so ... I don't know if it was with both pregnancies that I was anemic, certainly with one of them. And I took Yellow Doc, which is like a herbal tincture, and it was fine, it was kind of like, just not a big deal uhm... I guess it brought my levels back up, I don't even remember specifics just because it was kind of like a non-issue And so, this time around, when I tested as, you know, slightly anemic with the first blood test, they were like "You wanna do ... supplements?" I said, "No, you know, I'm doing the acupuncture, I'll talk with, you know, my Chinese doctor and, you know, eat more beef or whatever" And, at that point, they didn't, I feel like they didn't do... That was kind of it, they were just like "Oh yeah, you're a little bit anemic, we can give you supplements or not" You know, they didn't really talk about diet they didn't really talk about any integrated plan And I didn't pay attention to it, to be honest I wasn't so severely anemic uhm... you know, I was kind of borderline and I do eat red meat and I cook out of cast iron and I just kind of, didn't give it that much thought and I also - yeah, I have two kids and a job and, like, I'm doing a lot of other things, so I didn't really do much of anything with it and was getting, you know, progressively more tired but I have two kids and a job I was just kind of like, yeah, you know I'm pregnant it's pretty normal for me to be exhausted and when they retested - and I did ask them actually at one point, you know it was like 20 weeks or 22 weeks or something, I was like "Do you wanna retest?"

And they said, "Oh, we're not gonna retest until later,"
which was, I think, you know, 28 weeks -
and when they retested at 28 weeks
uhm... I was, you know,
quite a bit more anemic
and they kind of
panicked
a little bit
and it was just kind of like...
they started getting heavy, heavy on like
interventions
"So, we want you to go and have this other blood test"
First of all, the midwife who called - I think
she called like 4 or 5 times
and I was like, I don't know, working or driving or something... like, she wasn't leaving
messages,
but I could see that she was calling and was like "wow."
She also called [her husband] 2 or 3 times and by the time we finally,
I don't know, she left a message and then I left her a message, it was kind of like
"You're really anemic, we need to talk right away."
And, you know, my levels weren't such that I was super concerned.
I was more concerned with her response
and she was like, alright "So, we want you to go and get follow-up blood work"
I said, "Alright, fine, I'll do the full panel or whatever"
And ahh.. the next day was Saturday, so I couldn't go the hospital on a Saturday
with my kids
in the rain
to get the next, the next, you know, levels taken
So, she called me on Monday to be like
"Have you done it yet?"
while I was, you know, at the doctor's having my blood taken
and ah... it was just kind of a lot of
panic
and fear
around it
She was like, you know, "You need to go see a hemathologist"
and I was like "Ahhh... I don't really think I do"
and she suggested that I start on this iron supplements
that I know
from my research
to be the worst tolerated iron supplements that, you know, don't work that quickly or
effectively and
make women constipated and
just like nauseous
I just felt like, yeah,
there was a lot of concern

And, you know, we went,
we met with one of the other midwives
we talked how this other midwife had been really kind of ...

Lily: Overbearing?

Shelly: Yeah, yeah, really overbearing
and she was really, you know,

calm

and reassuring

and we set up together kind of a plan

like, "well, we'll recheck one level in two weeks and recheck the other in four weeks, and
can take this supplement" -

you know this supplement that

I had researched and

I had talked about with, you know, my regular care practitioner

and so, you know,

midwife number 2

and I

had set up this plan that I felt really good about

and then ahhh (2 sec)

you know, it was like,

...

I'm trying to remember what happened

(3 sec)

next, it was like a week or so later that

I got a call from

midwife number 3

and it was like

"So, our back-up care provider want you to go in and do this other, other iron level test
that you need to get done"

and I was like

"What IS this TEST?"

You know, she told me a little bit, but

it was just not good communication about

who was ordering these tests

why were they ordering these tests

what they **were hoping** to find

It just felt like they were searching for something, you know, like

they

really

wanted me

to have some like rare blood disorder -

that's why you're anemic

it's not just that you don't have enough iron or that, you know,

or your diet or, you know, just the fact that that's your natural like tendency

it's like
we found it!

(...)

Lily: So, how did you, did you... How did it go when you told them that you wanna switch?

Shelly: Ahhh... I didn't. My... [husband's name] did =

Lily: = OK =

Shelly: = He was the one who did, I was just like
soooo fed up
sooo, yeah, just **upset** [intonation goes up] and
I thought like... I have enough stress in my life,
like there should be one area that is really like easy and
a really nice relationship and it's easy, you know.
Yeah, I just felt like "you guys are creating more stress for me," more than...
this isn't even medically a situation that I, I am concerned
I mean, I would say I'm concerned in the sense that I wanna pay attention to this and
like,
let's see what we can do to get my iron levels back up,
but I didn't feel panicked about it and
so, the fact that they were panicking, you know, stressed me out and it just... yeah, it
just...

Lily: I do wonder, however, about the positioning of affective responsibility here: in the patient - medical provider interaction, who is expected and allowed (not) to feel certain things and whose responsibility it is to validate the other's feelings... I remember what Peggy, a midwife with decades of experience, told me about a time when tests indicated a miniscule chance that her future grandchild might have Down Syndrome²⁰. I remember her saying,

Peggy: I was terrified
I, who have seen this hundreds of times
and try to reassure women that
"it's ok, it's gonna be fine"
(...)
I learned from that that I can't just say that to women.
I have to say, "these things are scary, they are"
instead of saying "oh, yeah, it's probably fine," whatever
(...) it's our job to acknowledge that that's kind of scary

²⁰ The larger excerpt from that conversation is in chapter 4

Lily: And I remember that I longed for an acknowledgement even, if not more so, of the highly positive affect, of the excitement I felt through pregnancy. Somehow I felt that if our provider shared at least a little of the wonder with which we welcomed any new development during our (first) pregnancy, I was also better cared for.

Paul: Yeah, I think... and I see both sides cause I work in health care, so ... an aspect of what I do day-to-day that is just my job and then, there is... you know big things that happen, you know there are big fears or concerns that people have come to my office - I don't have as much of the joy things that happen with pregnancy - but and yet, for me, so it's a challenge for me to remain ugh... not objective, but to keep their perspective, the other person's perspective who this **isn't** their job, this is their one visit to come and see a health care provider **this year**, in mind, as I'm doing my job all day, right... So, I guess what I'm extrap... to bring it to your question, yeah, I get the sense of just doing the visits, but yet, the ones I would go to, I'd be like "Yeah, but there is magic happening here" = **Patty:** [laughs] =

Paul: = "Do you know that?"
Like it's just, that's never gonna.
I mean, I've delivered babies as part of my training and theen, I was like [louder, theatrical]
"There's another person in the room. There's somebody. This is amazing!" =

Patty: [keeps laughing]

Paul: And that was so not part of the perspective of the healthcare providers when I was in training and,
[voice gets calmer, less animated, quieter, matter-of-fact]
then, same with the visits - like kind of,
this is just what we doooo
and pee in a cup,
and we measure your belly,
and listen to the heartbeat,
cause these are the things I just have to do to get you off my schedule today -
that's a little cold, a little more sterile than it really was, but, on some level, that's their perspective, where [animated again]
"This is the first time, this has ever happened to meee! This is like, this is amazing!"

Patty: [laughs again]

Paul: So, I kind of felt a **mismatch** of my energy and their energy, going me - like WOOOOWWWW
and they're like "Please check this box for me"

I'm like "alright, uh, ok"

Lily (reflecting): And so... it seems that (some) spaces and others' affective responses in these spaces structure our own affective performances and discipline bodies and behaviors . Boyer (2012) suggests that this process is fully consequential to health care and practices, as it is this process of affective exclusion from public spaces that women in her study linked to their decisions to stop breastfeeding. Similarly, and I will come back to this in Chapter 6, prenatal care visits were often narrated here as "going through the motions" and "doing the necessary" - the active disengagement from the prenatal visit as care linked in those stories to perceived affective dissonance/mismatch that excluded from certain, more institutionalized spaces of/for care²¹. Through affect, spaces (both physical and metaphorical) were constructed as inclusive of some knowledge and bodies and exclusive of others.

Paul: I, you know, as lousy as - especially as that first birth was -you know, there were many times that I wished I could've been the birthing parent and gotten the bond that goes with that and everything.
And I'm not... you know, woozy-eyed about it... I, I, I know what I'm saying, I haven't lived your experience, but uhm...
there's an aspect of
feeling
left out
as the partner
And that
wanting
to help
"This is entirely new, I don't know what it means"
That was my experience and that's why I found the group [partners' group] to be helpful

²¹ It is worth noting here how often the patients and midwives all commented on the "nice house" where Midwifery Practice 1 was located - as if the very building broke down assumptions about institutions and suggested the possibility of a different, more private and shared affect. Yet in Gálvez' (2010) book immigrant pregnant women narrated the structured, cold, uniform routine of the hospital as part of what signaled a more normative belonging. Women in Gálvez' ethnography had other spaces for sharing and matching affect; doctors' cold routines were narrated as "professional" care and imagined as a symbol of social status, of the distance away from underdeveloped and not-so-hopeful "homes" outside the U.S.

Magdalene: I think it's hard for the partners a lot of times. You know, there is, like I get - I'm obviously pregnant - and I get, everyone can be compassionate to me and, like, understand like, she's going through this, you know, but I feel like it is... like Peter goes through a lot, too - just like trying to figure it all out, and prepare, and imagine what it's gonna be like, and support me, which isn't always easy - I mean, if I'm like - there are certain things that he just can't fix, like when I was really sick, there's nothing he can do to make it better, and that's really hard to just like sit by, and be like, "Ok, well, she's just gonna throw up all day."

Paul: It would have been good to actually just hear kind of like, like... like, "Tell us the real dirt..." kind of, kind of, so it kind of brings towards the partners' group, too, cause that's what we're trying to do, just like
create a space
where you can just say what's going on and
"I'm scared about this"
and "I don't know," you know...
some people come to our group and want the **actual** answers
- what do we do, i'm scared -
and I don't think there's answers to some of those things, but just
having a place
to kind of voice them,
I feel like that's really welcome
is...
would have been helpful,
like I don't think that at first we even knew what to be scared about, not that... not that I would say, "Oh, you should know all the bad things that can happen,"
but it's more the abstractness of
"I don't know what to do, I don't know what my role is, I'm not sure" [looking for words],
it's more like the abstract ideas of what, what is it like -
to be able **to share this**,
to share all the "I don't know's"
would be, would be valuable
to, to have heard from other people
without answers

Lily/Tour Guide: Knowledge is in (the acts of) sharing uncertainty itself. Does this emphasis on shared "I don't know's" not challenge norms of authority, masculinity,

knowledge production. We know that we don't know together, the not knowing - and the range of emotions that come with it - normalized as a shared affective experience of pregnancy. The space for that - with others who know about not knowing. Research on group prenatal care (Novick, Sadler, Kennedy, Cohen, Groce, & Knafl, 2011) supports that one of the most important learning aspects of group prenatal care are processes of normalization beyond exchange of know-how and questions²².

Novick and colleagues (2011): Beyond acquiring information and understanding about these changes, being with other women in groups also helped women to feel less unique in their concerns and to feel that they were “not crazy.” They also learned that other women experienced difficult personal circumstances surrounding their pregnancies. This normalized their own social and economic situations, and helped women to feel less isolated and less fearful. (p. 108-109).

Lily (reflecting): Finding a place at the table...

Affect, Episode 3: Emotion Work in/as Prenatal Care

Lily (reflecting): ... feeling un-seated, sometimes... finding a different table altogether. Having *that* choice and the "right" and confidence to act on it.

Shelly's midwives' responses to finding out she was anemic were stressing her out, creating affect; she knew that. That wasn't the response and emotion she considered "prenatal care." Shelly and her family switched providers at 30 weeks or so. Mark told the story of a future parent at the partners' group. They had switched providers at 32 weeks...

Mark: ... cause they just didn't like it, and I thought it was pretty

²² I return, in more detail, to collaborative learning and knowledge production in group prenatal care in Chapter 6.

bold and great of them,
just to say,
we don't **feel** good where we are.

Lily/Tour Guide: According to Arlie Hochschild (2003), feeling is a conscious process, we are aware of our feelings, we think about our feelings and about how we should feel, what are the expectations and ranges of appropriate feelings in a particular situation. If my feeling in the particular context falls outside the range of expectations, I know that and (may) work to change the feeling and/or the situation, since I might feel more appropriately in a different situation. Emotion work - or that working to change feeling - may be done onto one's self (e.g., I think happy thoughts) or by others onto the self (e.g., my friends is making jokes to cheer me up).

In Shelly's story, one explanatory version may go something like this: The midwives were doing emotion work - stressing Shelly out, in her words - in a direction she didn't feel was appropriate/expected during pregnancy and as part of prenatal care. She tried her own version of emotion work in response - going about her daily activities, not prioritizing tests, and not responding to the "frantic" calls by the midwives. A performance of a non-worried routine may do emotion work in two directions - both to ease Shelly's mind into "normalcy" and to ease the midwives' worries and "panics." The outcome, however, seemed to have been an intensifying of the initial affective response - stress, prompting Shelly and her family to seek a better "match."

Then, of course, there's the other part about emotion work/labor - materially and/or symbolically rewarding those who successfully make themselves and others feel according to the expectations. Hochschild (2003) and others afterwards have documented the toll emotion labor may take on an individual and a relationship, as well

I can continue worry about **the now** in the same way."

I mean, I do to some degree, but I'm not like day-to-day white-knuckling it.

Like I kind of was at the beginning hearing about the IUD.

But I remember having a
conscious moment of going

"Ok, I can either worry about, I can either start worrying now for the rest of our life, or...
not"

Patty: Hmm

Paul: And then, easier... it feels,

the memory, the memory of it is that it was easier to do than I would think it would be at
this point.

So that was a really great...

ahh, I'm amazed that I was able to do it.

Ah... and then I,

I just... I just loved her pregnancy [laughs].

Martha²³: When there is a crisis or something really scary or dangerous, I become this...
calm

quiet

use the quietest, slow voice I can,

alarms are beeping,

nurses are shouting,

they shout at me, "Speak louder,"

but I'm like

calm and quiet

if you want to hear me,

you calm down, too

and then I tell this pregnant woman,

"Hey, you get to ride the helicopter today"

when things are so bad, she's about to be airlifted

But it works to get things under control,

not panic,

quiet voice

Lily: How do you think your own emotions and your own experiences come into play
when interacting with women and their families here, do you try to keep them separate?

Peggy: Ya,

well, yes and no.

There are certain things I can relate to because of my life experience,

there're certain things I will never be able to relate to completely uhm... (4 sec)

²³ Martha's words are not a direct quote, but recreation of our dialogue, based on my notes and memory of talking with her. I wasn't able to record during the interview with Martha, so I took detailed notes and then down the story of our conversation soon after we talked.

That's hard, that's a hard question (4 sec),
I guess I try to (5 sec)
to remember (4 sec)...
That's a really, that's a tough question.
I see, I think, when I see a woman who's fearful,
I think back as though it was yesterday to
seeing my first-born blue
and having this problem
and nobody else seemed to be all that upset,
but I was
because I was the mother
and I didn't know squat
about what was going on, so, you know,
things that are routine to us
are not routine to the woman
In other words, if I hear the baby's heart rate is down a little bit,
I'm ok with that,
she's terrified.
And it's just like, ok, put yourself in her place and say, ok,
how would I feel if it was happening to me
and I didn't know any of this stuff.
You know it's all stuff we take for granted as routine,
that woman does not.
She doesn't know that
She doesn't know that
She doesn't know that an occasional dip to the baby's heart rate is ok
She doesn't know that uhm she's measuring small, but the baby is probably really healthy
You know,
I may know that,
but she doesn't
and that's what I have to remind myself
and that's when I flash back to that little baby in the, in the warmer, being worked on,
the ice in my heart when that happened
So, that's probably one of my most profound memories that shaped the way I personally
try to deal with women when things aren't going right or when in their perception it's not
going right

Lily: I think that even when things are great, I don't know... Like for me, I do think that
there is certain knowledge that we derive from our bodies and we can know - and there
sometimes there might be signs, there might be spotting or something, or you feel your
ligaments stretching - that kind of stuff,
but at the same time, I feel like
every little thing that somehow
materializes that being
and that connection more.
I mean it's you know, it's one thing... hmm, i don't know how to explain it.

I just mean to say that even in the joyful moments,
those things that might seem routine, they matter =

Peggy: = For you

Lily: For me, like every time we got a count on the heart beat I will "report" it to my family and friends, because to me that's =

Peggy: = Right, right, that's what I mean when I say, "this isn't boring" - you know, there's a lot of routine stuff, but it's not routine to you. This is your kid, this is your baby, it might be my thousand birth, but it's yours and we have to honor that and remember that and remember how special it is uhm and... I think that once birth stops, once the whole process of pregnancy and birth starts being routine and stops being an adventure for us, then it's time to quit.

Lily (reflecting/notes): I've noticed that I leave our (most all) meetings/conversations smiling, feeling at peace, and at the same time somehow elated. Oh, I love talking about babies and beliefs and hopes and expectations and the worries around them, questions and wonderings... And most of our conversations have been painted with smiles and laughter, even when moments in the conversations themselves have been critical. There has been, it feels, "pregnancy glow" between and among us. Pregnancy glow not as a special, romanticized beauty of the pregnant woman, but as a connecting mood around pregnancy in these largely normative contexts that provide the canvas to the stories shared here.

Kotchemidova (2010) writes about a (rather uncritically homogenous) culture of cheerfulness in the U.S.: expectations for positivity, met and reinforced by excessively exclamatory communication that frames reality in a relatively optimistic way. Under that assumption, affect aliens (Ahmed, 2004) would be those who are critical, angry, disappointed, sad, and perceived as complainers. And while there might be some situational contexts when the lack of overall "cheerfulness" may be excused and other

emotional norms expected as more appropriate, is pregnancy a time when "cheerful" joy is particularly the norm? When experiencing and exuding that expectant joy is the norm of **healthy** pregnancy, promising **healthy** parenthood - physically and emotionally? When lack of expressed and shared joy makes a person at least a "suspect" if not an "alien," creating something that needs to be addressed? And especially if the lack of cheerfulness comes from the expectant parents? In an effort to fit in, what knowledge, what care, what suspicions may be dismissed, subdued, overlooked? Or in the process of "working on feeling" - as the prenatal care of getting to that peaceful (if not joyful) state - during pregnancy, what knowledge is produced, what bonds negotiated, what culture(s) brought in and/or created?

Lily: So, I know you spoke quite a bit about this already, but... what role do you think emotions play in pregnancy and prenatal care or what have you seen?

Peggy: Absolutely an incredible role uhm... they (3 sec) which is (2 sec) you know, whether it's fear, whether it's family issues, whether it's sexuality - all of these emotions, all of these **own** feelings contribute to how a woman approaches becoming a parent. Whether it's... sometimes it influences conception, sometimes it... and it can continue to influence the pregnancy and it can also continue to influence birth which is why I see one of our major jobs, one of our major roles in this as talking, talking about that

Mariyana: ... helping people to have what they need to have to be able to take ownership of their own healthcare, because at the end, no matter what the outcome, that woman should feel that she was a part of a team and feel like really at peace with all the decisions that she and her team made for her for the healthcare of that pregnancy and that birth. Even if it was a really difficult horrible thing,

there should be, at the end of it all, there should really be
a feeling of peace
that all the things were considered that need to be considered and
correct decisions were made as best as they could be made.

Peggy: ... obviously some women don't feel like talking and that's ok but
it's gonna come out some way -
either during the course of her labor or something,
something, something is going to happen
if the issues, deep-seated issues don't get addressed.
Uhm... which is why, we don't want to push somebody "tell your mother, tell your
mother,"
but it will come out
Uhm, like I said, women who have been abused tend to stop labor, they get to a certain
point where
uh-uh, uh-uh [indicating no],
or people have certain issues where the baby's father [quietly]
or people who have issues with maybe they don't want to be a parent [quietly], you know.
Women can stop their labors
They don't realize it's happening,
which is why it's important to, you know, as much as possible
bring these things to light,
so that they can be dealt with uhm (2 sec.) you know
and so they can be dealt with before she becomes a mother uhm...
(...) And I [laughs] one of my favorite
sayings
which I don't try saying until after the baby is born
no matter how hard your labor is,
it's the easiest part of parenthood
because it ends [cuts it sharply here]
no matter how - even if it's long and miserable and hard -
labor ends
parenthood is forever.

Lily/Tour Guide: In the documentary *Birth Stories* (2012), the mother of modern
U.S. midwifery, Ina May Gaskin also draws attention to the emotion-aspect of prenatal
care. Taking the viewers up a tiny path to a special green spot that's part of *The Farm*, she
tells about meditation and about that spot and the walk to it as the place and process of
emotional cleansing - necessary for an easier birth and necessary to re-shape a culture of
fear around birth. This is a place and a process of connecting with demons and joys, of

learning and of knowing, of confronting and becoming self, physically and emotionally performing the process of transition and transformation that is birth itself in this philosophy/mythology.

Emotion work during pregnancy is a process of learning about self and culture; it is knowledge production and creation - that is narrated as health-ful prenatal care.

Emotion work is also a process of relating to others. It can be a process of trying to match affect, to achieve some degree of shared affect, to create a space of belonging by activating the body and its affective memory:

Peggy's body and "the ice" in her heart that remembers the quiet blue-ness of her first-born

the bodies Peggy narrated -

bodies that stop processes as they affectively remember abuse

bodies that go to the process and transform affects and identities

bodies and their people who go from "a scared little mouse to a roaring momma she-bear"

bodies and their people that felt alone and then walked together, embraced by community

bodies and their people that keep the distance and sometimes make it larger

working on indifference or riot

looking for the peace

learning and knowing and be-longing.

Afterword and the Words After

Lily (reflecting): A summary... conclusion, something to close the chapter, move us to the next one... but I was hoping more for - getting you, the reader, to think on your own terms, connect with experiences you might have had, engage, wonder, etc. ...

inconclusive on all levels. I understand why this might be undesirable for a dissertation... But it is desirable for **this** dissertation. If this text claims to be relationality-centered and performative, then it is important for the text itself to also perform the lack of analytic conclusions. I think/hope in that way, it engages questions of the applicability of a relational perspective in actual health care interactions - what are its challenges (lack of certainty being the biggest perhaps), as well as what possibilities are offered in the process...

CHAPTER 6

KNOWLEDGE AND DECISIONS

Perplexity is the beginning of knowledge.
Khalil Gibran

The previous two chapters centered around the complex relational dimensions of knowledge as it was performed in the stories I heard and told. In the constructed dialogues, I strived to perform pregnancy and prenatal care as interactional moments of heightened reflexivity with real implications for conceptualizations of health and health care. I also strived for these performances to be open, invitational, rather than interpretatively closed and prescriptive. I hoped, in this way, to expand and extend the movements of reflexivity.

... that pregnancy knowledge and knowing is not only about facts and applications.

... that pregnancy knowledge is about dis/connecting
and the social implications of such processes.

Chapter 4 focused on the multiple voices, spaces, and temporalities that are activated in pregnancy and prenatal care stories. In this, I read and re-told narratives as dialogically expansive (Baxter, 2011), seeking to highlight a relational and cultural elements of pregnancy knowledge and the multiple identities that are in interplay during prenatal care interactions. I read performances of "care" as the co-constructed possibility to bring together multiple, often opposing voices and discourses about experiences of cultures and relationships, as well as physiological ones. Knowledge was less stable, more in-process.

With focus on affect as orienting framework, chapter 5 developed further the theme of prenatal care and knowledge as complex on-going processes of in/exclusion. More than a matter of "fitting in," I read affective experiences and emotion work as performing prenatal care in terms of situating one's self in relation to other distant and close participants in pregnancies. Such positioning, as previous research suggests (e.g., Boyer, 2012; Root & Browner, 2001) and this chapter continues to perform, is consequential in making health decisions.

Knowing Pregnant

Looking at prenatal care as the cultural and relational negotiation of belonging/affiliation is relevant in light of health communication literature that supports the link between health-relevant decisions/practices and interpersonal and cultural experiences of in/exclusion (e.g., Boyer, 2012). In addition, historical overviews of reproductive practices and rights in the U.S. (e.g., Solinger, 2007) suggest systemic changes, such as *Roe v. Wade*, have structured and changed experiences of acceptance. Particularly, Solinger argues that *Roe v. Wade* had repercussions for women's choice(s) far beyond abortion and contraception decisions. There were also relational repercussions, as men (assuming heterosexual partnerships) felt increasingly excluded from reproductive matters, even as their supportive physical presence in birthing rooms and abortion clinics increased. According to Solinger, "A culture that has constructed maleness and femaleness as perfectly complimentary opposites must pay a high price for improving the status of women. Any gain of autonomy - or power - for women as a group necessarily appears to undermine the power available for men" (p. 217).

As reviewed in much more detail in Chapter 2, the developments Solinger describes and links chronologically to *Roe v. Wade* are part of a cultural shift in the U.S. and the U.S. white middle-class feminist movement in particular. Identified as the beginning of an "era of choice" (Hayden & O'Brien Hallstein, 2010), this was a time when women's healthcare empowerment was linked to awareness models and calls for reclaiming decision-making, especially in relation to one's own body. Exemplifying both of those tenets, the Boston Women's Health Book Collective published *Our Bodies Ourselves*, updated editions of which are still in circulation and have expanded their reach through the use of a web site (<http://www.ourbodiesourselves.org/>) and specialized foci on various groups of women both locally and globally. For many of the women and families who told their stories in this project, this was the book they received at their first prenatal care appointment at the midwifery clinic.

In the context of women's empowerment through awareness and choice, two narrative constructs²⁴ form a dialectical pair of their own:

nature/technology

Women can take "control" and be "empowered," we can resist patriarchy, by knowing our bodies and heralding that knowledge as decision-making agents (and again, this a very particularly white, middle-class, normatively feminist situated discourse).

When a return to the natural (but oft-subjugated) power/knowledge of the woman's body is advocated, technology (or more broadly, science) can become the patriarchal enemy,

²⁴ They are both, of course, quite material. I use the term "narrative constructs" here not to undermine "nature" and "technology" as fantasies, but rather to highlight their structuring functions - they are more than un-valORIZED facts of life. In the context of pregnancy, prenatal care, and birth in the U.S., the pair nature/technology is has become decisive in morally evaluating pregnancy, birth, and women. This fits in a larger cultural landscape, referred to as the "mommy wars" (Akass, 2012) and critiqued for its divisive relational consequences.

colonizing the woman's body in its quest for knowledge in controlled circumstances. Yet, “that feminists should be skeptical of the concept of nature comes as no surprise. It is in the name of nature, and particularly the nature of reproduction, that women have traditionally been subjected” (Mazzoni, 2002, p. 160). Much of the literature on purposeful childlessness as a unique feminist struggle (Hayden, 2010) engages the skepticism Mazzoni wrote about. We reclaim nature and also modify it - both acts are of empowerment and agency. In the discourse of "choice" v. "destiny," technology can be a compatriot to women's liberation - from the pill to IVF, surrogacy, and voluntary sterilization, technology makes choices possible, especially for the "empowered" middle-class woman in the U.S. (Solinger, 2007).

Lily (remembering): Will I forget it? Her? April 2012 - the first and last (so far) reproductive rights conference I went to at Hampshire College. I went to this session at which a graduate student presented "shocking" historical evidence of how women in the U.S. have been stripped from their reproductive decision-making powers, especially when it came to childbirth. I can tell that it was "shocking" by the reactions of the others in attendance. We had to identify/introduce ourselves, so I found out that in an audience of roughly 30, there were 3 mothers - me, the African American mother of 5 and doula-in-training who sat next to me and was my partner for the rest of the session, and the white, silver-haired mother-grandmother-doula who sat next to her. There was one OB medical student in training. All the other attendees were in their late teens and early 20s, white, college students, self-identified never-before-pregnant feminists. Terrified by what the presentation told us the medical establishment does to women, many of them

admitted at the end of the session that they're even more afraid of childbirth now.

(Un)Intended consequences of empowerment? I'll never know... I started this story with something else in mind...

I was sure the presentation was well-researched and it rehearsed well and with appropriate support the argument that contemporary Western biomedicine undermines women's choices. But as someone who's had mostly positive personal experience with pregnancy and birth in a moderately-medical environment, I felt the need to present a more nuanced perspective, to give examples from my own pregnant life of refusing tests and interventions, of respectful, though distant, (male) doctors who guided me through, even encouraged me to switch positions during Sammie's birth. I was, still am, against a priori vilifying people because of their profession. In the face of "look at all this horrible things **they**'ve done and do to us!" I wanted to recover agency and accountability, I wanted to recover the interactional, and I didn't think that the fear purportedly created in/by medical discourses of birth should be countered by fear of the medical profession. So... I told my stories and asserted that there could be a positive version of the medical experience of pregnancy and birth.

My partner/Doula-in-training: Wait, where did you have your baby?

Lily: At XY hospital and birthing center.

My partner/Doula-in-training: I did too, the first two anyway. I had the other 3 at home with a midwife. That's why I want to become a doula actually. My experience was sooooo nooooot whaaaat you described? From the moment I got there, I was shoved in the corner, shouted at to do what I'm told; "another black single mother," I think I heard someone say. I was suggested sterilization, but not even directly, just hinted.

Hooked to IVs , no questions asked. No one ever asked about my birth plan or anything. Just horrible. But maybe things have changed since, I just would never wanna give it a try again. That's why I wanna be a doula, cause I know it can be different. All my kids are healthy now, it doesn't matter, but it matters to me, it still matters to me after all these years.

Lily/Tour Guide: Pregnancy and prenatal knowledge are processes. I'd like to think that in that conference room, such knowledge was alive in its always temporary, in progress becoming. Together, we were reflecting and making pregnancy knowledge - a very particular version that, as suggested by the theme of the actual workshop, negotiated divisions and continuums between women's/nature/"alternative" birth and men's/technology/medical birth. In this chapter, I take up such version of pregnancy knowledge as on-going and ubiquitous, though incredibly varied. The narratives dialoguing below perform sources of prenatal care knowledge and engagement with such sources and knowledge. They perform affirmations and resistance. In some ways knowledge here is less relational than in the previous two chapters. Knowledge here is about do's and don'ts, and interactions that are deliberately about raising awareness and informing choices. It is also about the structures that shape awareness and about knowing how to navigate such structures toward particular decisions. It's about decision-making as morality.

Hayden & O'Brien Hallstein (2010): ... in *Of Woman Born*, Adrienne Rich (1976) proposed that understanding maternity required exploring both institutionalized motherhood - institutionalized ideologies of good mothering - and the potential for

mothering to be a site of agency for women - women's lived experiences of mothering. (...) In short, Rich understood that maternity is a complex site of agency and constraint, a negotiation between larger shaping forces and women's abilities to resist, reshape, and rework maternity. (p. xxviii)

Lily/Tour Guide: The concepts of "structures" and "agency" are focal in the critical culture-centered approach to health communication (Dutta, 2008). The power with which structures may legitimate certain knowledges and link them to particular positions is also important in building a culture of professionalism that develops around legitimated knowledge (Bledstein, 1976). So the narratives here open a conversation about the ways in which knowledge of structures is linked to professionalism, agency, and decision-making within the context of pregnancy and prenatal care. Lastly, because the nature/technology dialectical pair emerged as an organizing schema both in existing literature and in the stories I heard, it is also here in this text - as a question, in progress - throughout the dialoguing narratives below.

Learning and Knowing, Episode 1: Sources or the Knowledge Wells

Amma: But one thing that I say...
I didn't know so much
like her [her daughter, Aneesa]
that time I was carrying a baby
so, it's a very good advantage for her
she knows so many things
what we don't used to know earlier
Yeah

Lily: What is something, is there something that you wished you knew?

Amma: Yeah, maybe...
I don't know if I did anything wrong for my body,
so it's better to know about something, that's what I think.

Lily: Sometimes, I wonder if it can also be too much...

Aneesa: Yeah, you're right, it can be a jumble.
Plus it sets you up for a disappointment because you want to do everything right
when realistically you can only do so much
But I would rather know than not know
that's just who I am

Lily/Tour Guide: Research has documented that pregnant women get pregnancy-related information and knowledge from multiple sources, including their own bodies and sensations, close friends, relatives, medical professionals and tests, books, the Internet, etc. (e.g., Deave, Johnson, & Ingram, 2008; Gálvez, 2011; Ivry, 2010; Jordan, 1974/1992; Root & Browner, 2001). Specifically, the cultural ethnography work of Ivry (2010) and Gálvez (2011) suggests that public performances of such knowledge, embodied in the prenatal care practices pregnant women follow, are constructive of identities. Thus, for the immigrant women in Gálvez' study, for example, attending formal prenatal care appointments at New York City's public clinics was an act of writing themselves and their future children into the system of U.S. citizenship. In Ivry's study, pregnancy management was also contributing to nation state projects and moral ideologies of motherhood. Root and Browner argued that by making their own prenatal care decisions, based on sifting through various advice coming from multiple sources, women construct "pregnancy ethical subjectivity" (p. 196).

However, a focus on the pregnant woman as the one who is the "subject," albeit an active subject, of prenatal care obfuscates the multi-directional knowledge production and navigation happening during pregnancy. We expect that the pregnant woman would (want to) learn from her mother, prenatal care provider, friends, books, whatever... In my own quest for "I want to know," I used to get frustrated when my mom would say, "I don't remember" or "Things were so different back then and in Bulgaria than you have it

in the U.S. now, I just don't know." I used to be so frustrated... but my mom was learning, too. Like Amma above, she was learning not only about me and my pregnancy and care, but she was also learning about and from her own experience 30 years ago. Time and knowledge-directionality were far from linear.

All of the prenatal care providers I talked with also simultaneously affirmed and troubled narratives positioning them only as sources of knowledge. They emphasized how much they learn from/with each patient and her family, how every pregnancy and birth is a learning experience - the pregnant woman and her family becoming the sources of knowledge here. Yet, having assisted multiple pregnancies and births, they were also depository sources of prenatal care knowledge - knowledge that went far beyond physiology to include affective mantras of "letting go" and communication strategies for having various knowledge-transferring and challenging conversations with patients and family members. As a communication process, the pregnancy knowledge is more than checklists and advice columns. It is mixing and developing, it is

processes in context,
performing and creating
echoes of
personal and others' experience
beliefs
bodies
instincts
intuitions
"professionals"
tests
technologies
making the invisible observable
resistances
mixing and developing
spilling

Mariyana: Yeah, yeah, my life as a midwife is **full** of stuff like that
You know, it's full of things like that

and it's also full of fear -
women who might die
or their child might die,
it's pretty sick -
you know, it's full of all of that, too.
So, there's lots of unexpected,
I don't know if I can like boil them into a sentence,
because it's just so integral to who I am,
it would be like saying what have you learned from like...
being a mother -
it's shaped who you are,
it shapes who you are, doesn't it -
well, that's kind of like what my work is,
it shapes who I am,
makes it very
fluid,
like, you know,
it's not just like,
my person is
not like **fixed** entity,
it's always like moving and changing
because of all this, of this opportunity to be in
such an intimate relationship with all of these people.

Lily: Has it changed anything in how you think of your own childbirth experience and your own pregnancies? =

Mariyana: = [chuckles] =

Lily: = If you're thinking in retrospect or...

Mariyana: Yeah, yeah.
Well, I wasn't a nurse when I had my oldest son.
I lived in Ecuador at the time,
I wasn't a nurse
Uhm...
So, being a midwife,
looking back on that experience,
I was really, really lucky
because I had my son in
the Amazon Jungle
of Ecuador
[laughs rollingly]
and everything went just fine
[laughs again]

So, I feel like, that was, that was good -
I was sick,
I had parasites,
I wasn't well nourished,
my son was only 6 pounds,
but none of this I knew
as being dangerous
in any way
until I went to midwifery school
four years later, four-five years later.
Uhm... and then, with the twins,
I was taken care of by Peggy, whom you interviewed,
and I delivered here at XY,
and ah... so I was already a midwife,
I think it made me very suspicious of the healthcare system
being a midwife
and knowing I'm having a high-risk pregnancy =

Magdalene: I feel like it would be tough also if you have like one source of information
one person that you're close to and you get everything from them,
I feel like that's one thing that I've learned is that
everybody is, everything is, everybody is **so** different
and their experiences are so different and
so, some things that work - I mean even in pregnancy - some things that work for some
people don't work out for others.
Uhm, cause I remember thinking, going through that when I was really sick,
people would just go, "Oh, just try this" and I'll get it, and it didn't work, and I'll go
"Oh..."
So, so, yeah... I feel like as long as you remember that everybody is different,
then that's helpful to go into it.

Mariyana: Yeah, so you might find this all the time here
things that we
when we come from our own belief system, you assume is true,
but when you come up
against
somebody who has a very different belief system
when they tell you something,
all of a sudden, you have to be like, you know, kind of like
"Wow, maybe what they're s...
maybe what I'm thinking isn't right!"
So, I have experience over experience with that in the Dominican Republic
with things that I thought were a 100% true
and they think are a 100% wrong
and I have to realize
they're raiiiight! I'm wrooong![laughs]

Lily: At least in that context...

Mariyana: At least in that context. Exactly, exactly.

Lily (reflecting): The ideas of "multiple sources" and "context" are integral of the ideology of informed choice-making. In the broader social context, we teach "critical thinking," part of which is accessing, evaluating, and responding to information coming from different sources and with different goals. And even then I have to wonder, what sources are seen as non-sources, what knowledge - as non-knowledge for the sake of managing or segmenting complexity... Magdalene's comment above is prescriptively non-prescriptive, i.e., the ethical approach is to respect individuality and respond to difference. Mariyana's mention of "belief system" and contextual variability are classical cultural relativism. Yet both position possible "clashes" somehow outside one's self or between selves, arguing perhaps for what Dutta (2008) might call a sensitivity approach.

At the crux of the uniquely individual embodied experience of pregnancy and its social positioning in/through prenatal care practices and rituals, thinking about knowledge and decision-making during pregnancy is perhaps the ultimate exercise in standpoint (Harding, 1987; Lupton, 1994). Despite its much needed attention to power, however, standpoint theories seem themselves to be based on a cultural-difference model, allowing, albeit fluid, apprehension of social categories. But in pregnancy, I found that as much as knowledges (are allowed to) dialogue in conversations among individuals, they also dialogue, perhaps even more so, in individual narratives and experiences that make an-other present. I find myself dismayed at the clarity with which Shelly wove a complex knowledge net in making sense of her anemia during her last pregnancy - not a matter of a singular "belief system," her story makes present and in dialogue:

acupuncture, Western notions of diet management, her own body knowledge of tiredness, experiences of prior pregnancies and care, conversations with midwives, medical testing, and everyday family patterns of work and nutrition.

Shelly: ... this time around, when I tested as, you know, slightly anemic with the first blood test,
they [midwives] were like
"You wanna do ... supplements?"
I said,
"No, you know, I'm doing the acupuncture,
I'll talk with, you know, my Chinese doctor and, you know,
eat more beef or whatever"
And, at that point, they didn't, I feel like they didn't do...
That was kind of it,
they were just like
"Oh yeah, you're a little bit anemic, we can give you supplements or not"
You know,
they didn't really talk about diet
they didn't really talk about any integrated plan
And I didn't pay attention to it, to be honest
I wasn't so severely anemic uhm... you know, I was kind of borderline
and I do eat red meat
and I cook out of cast iron
and I just kind of, didn't give it that much thought
and I also - yeah, I have two kids and a job and, like, I'm doing a lot of other things, so
I didn't really do much of anything with it
and was getting, you know, progressively
more tired
but
I have two kids and a job
I was just kind of like, yeah, you know
I'm pregnant
it's pretty normal for me to be exhausted
and when they retested -
and I did ask them actually at one point, you know it was like 20 weeks or 22 weeks or
something,
I was like
"Do you wanna retest?"
And they said, "Oh, we're not gonna retest until later,"
which was, I think, you know, 28 weeks -
and when they retested at 28 weeks
uhm... I was, you know,
quite a bit more anemic
and they kind of

panicked
a little bit
and it was just kind of like...
they started getting heavy, heavy on like
interventions

Lily (reflecting): If I were to psychologize, I may pay attention to the use of pronouns (I vs. they), as is common in some feminist research to discern ideological and community affiliation or one's relationship to her own body and self (e.g., Root & Browner, 2001). I may say that Shelly is defining her unified belief system (what *I* do) against that of the midwives (what *they* do). Thus, adjusting the diet, talking with the Chinese doctor, understanding the contribution of everyday life to bodily signals, such as tiredness, will stand against testing and interventions. Though it was Shelly's blood that was tested, though she provided that blood voluntarily, it was "they" who re-tested and suggested supplements, and panicked. In making those choices, I may say, echoing Root and Browner (2001), Shelly is making herself as a particular ethical subjectivity, as a particular type of a mother and a patient. She is. We are.

But, from a dialogic perspective (Baxter, 2011), I am more interested in who/what is brought into the fabric of prenatal care and in what ways. How are fragments pieced together into knowledge mosaics, or how are streams making a river, where it's not just a matter of subconscious/linguistic denouncement or acceptance, but of on-going fragmented creativity. Letting others in.

Learning and Knowing, Episode 2: Knowledge Integration, Knowledge Evaluation or Mixing Waters from the Knowledge Wells

Lily: Uhm... what are the some of the things that you did, then, as prenatal care? What are some of the places you felt included or you didn't?

Mark: Cindy signed us up for a looooot of classes. So, we took two birth classes - one at XY and one at AB. Uhm... and the AB one was the one that we got more out of uh... for sure.

And we did:
breastfeeding class,
sleep class =

Cindy: = newborn care class =

Mark: = newborn care class.=

Cindy: = I think that's =

Mark: Was that it?

Cindy: Oh, and the partner massage class

Mark: Right

Cindy: [whispers] that's the one I liked

Mark: So, there was the class part of it, and then there was the sort of soft part of it - the car seats, the crib and all of that, and so, that was an on-going thing kind of itself I don't know if you count that in your opinion or not.

And then there's this sort of psychological, just getting ourselves around the fact that we're going to have this baby and what we need to do uhm... before that time comes.

Cindy: Yeah... I think ah... I think the class at, it was first the class at AB where we really felt like it was a community, and we were included, and we connected with people, and uhm... you know, I think I definitely felt like ... You know, at work people were **happy** for me and, I mean, even my boss was, I think, pretty ecstatic, I think she's hoping for some grand kids soon, but there was also a piece of me that felt like I couldn't really ... fully embrace the pregnancy there, because like it had a double meaning for them - like they're happy for me, but it also meant like, I was gonna be working from home, I was gonna be on leave, I was gonna be cutting back, and people, you know, felt really nervous about that and so, it wasn't like I could be just totally like "Oh, this is so great and so wonderful" and uhm... yeah, there was like a little bit, like a double entendre there or something.

And... what else, I guess, like my, well our families, well Will's family was especially excited. My brother had just had a baby, so there was a really nice kind of bond around that. Aaaand... I think my parents were just strange aaand uhm... initially not as excited or happy because they were surprriiised and because we're not maaaarried and all of this stuff around that.

So... kind of... what other, what other ways did we prepare?

I mean, we did a lot of reading together, like we had like that we would choose together and do the reading, and the classes were really a way of =

Mark: = After the complication, too, we had to go in for check-ups twice a week, so I felt like we were driving to XY every day all the time. We made the trip there constantly for either a class or for care, so in the last 6 weeks, it was pretty constant stuff.

Cindy: Yeaah. Like it kind of felt like they weren't people that we were talking to, you know

like necessarily at length like you would with a friend,
that there was this like community that made the 6 weeks =

Mark: = The ultrasound =

Cindy: = Like the ultrasound receptionist, "Oh, hi, you're here again" =

Mark: =Yeah [laughs]

Cindy: "You haven't moved since last time"

Mark/Cindy: "Still living on Same St?" [simultaneously]

Cindy: Yeah, and ah... and the ultrasound techs =

Mark: = Molly =

Cindy: and all the folks at the midwife center, I think we, they got to know us a lot more than, you know, other people. We might know them just because we were there so often and ah... yeah, there was just this whole little (1 sec) circle that kind of made our prenatal care system that last 6 weeks.

Lily/Tour Guide: Others and being with others was perhaps the major source of pregnancy information for the story-tellers in this project. Interactions with others also provided contexts for negotiating and shaping pregnancy knowledge. Echoing recent research (e.g., Novick et al., 2011) on group prenatal care (trade-marked as *Centering*) and a larger cultural ideology of support groups as health-beneficial communities (e.g., Rapp & Ginsburg, 2001), expectant families narrated the physical, emotional, and social health benefits they felt "group" offered.

Cindy: ... our midwives do this particular kind of care that's called... uhm... I think some places call it Centering, but it's group care, it's group prenatal care. And so we had appointments with like 5 other families who were all due around the same time that we were and... so, that was really interesting because ... So, the idea was... we would go to these appointments and they were really different from **your normal** doctor's appointment, they were like in a community roooooom and you get there, and you're there for 2 hours, and you take your own stats, and your own weight, and, you know, you get to chat with the midwife for a few minutes about any personal concerns and it's just in this big group with all these other people who are expecting at the same time as you, to just kind of chat what you're going through and it really takes away the feeling of it being medicalized and it feels much more of a community-oriented **happening**.

Lily [to Mark]: So, was that your experience as well?

Mark: The community-oriented happening?

Lily: Or with other partners who were there? How was it?

Mark: I would say, almost word for word it's **our** experience.

Patty: Ok, uhm... I remember being very hesitant about that [group], because this was the second pregnancy and I didn't want to be investing that much time in it. You know, this - what was it, like once a month or something - having to go in. But for us, it ended up being like a date.

Paul: Yeah. That was the night we got out of the house and left our 2-year old at home or almost 2-year old, so, yeah.

Patty: That was as close to a date as we can get.

Paul: So, that was... I don't know, I enjoyed, there was a social aspect to it, I think, that was nice.

Patty: I really liked the community aspect of it. Yeah, the sitting around, talking and sharing,

and just the beginning of an appointment that was just gathering the facts on us.
And there was food there [we all laugh] - that's always big for a pregnant person. Uhm...

Paul: I don't remember the logistical things that were... new... you know, I mean, we talked about epidural, and things that would happen, and the stages of pregnancy, but it was really good to have other experience.
I think anybody else, the other 3 maybe had one kid already that was roughly around a year or two old - the same situation as us -
and being able to just get some
affirmation
of people going
"What's gonna happen here?!"
like... which was what I was doing, so it was nice to get,
to have that
community
in order to just bounce it off and feel like that "I'm not alone" business with it.

Magdalene: And I've **liked** it
cause I often feel like, like...
I really like going to the midwives, to the, to the regular appointments,
but there's only so many things that you can remember that you have questions about
or, or that you feel comfortable asking, I don't know... and so,
so this Centering is uhm... is nice because you have the same,
like you go, and you have,
you hear the baby's heartbeat,
and you check all your vitals and stuff,
and then it's just like an hour of talking with the group,
and then everyone asks questions and everyone has different input or feedback -
and that I think is really nice,
cause there's a midwife there, there's a, a facilitator, and then
also, like two couples in our group have already had children,
and so, they have different perspectives, too,
so if someone asks, "Oh, I'm having trouble sleeping,"
then everybody can kind of, "Oh, I've tried this and this, and..."
You know what I mean? So, I feel like that's been nice -
to have like a group,
everyone thinking about the same questions
and wondering the same things,
and being able to talk about it.

Lily: What are the kinds of things that come up there?

Magdalene: Ahh... I think, the stuff about labor - what it's like, what is helpful, what's not,
stuff about pediatricians, and stuff about -
I feel like there's just so many questions that come up during pregnancy -

or like what's normal and what's not,
you know, like, "Is it normal that I can't feel my hands anymore?"
You know what I mean? And someone is like, "Oh, yeah, my hands get numb, too"
and those things are really nice
because if you're **just** with your midwife and she's like,
"Ok, yeah, it feels different" =

Lily: = "It can happen; it happens with some people, but might not with others."
And then you - actually can hear it then.

Magdalene: Yeah. I feel it's kind of **normalizing** and it's nice
It just - I like that part of it
just talking about our own experiences
and brainstorming different ways of getting through tough parts.

Lily: We didn't have group care when I was pregnant, but some things... I'd look for
"what's normal" in others' experience, as well. For me, a lot of this came...
sort of came back,
things that I remember hearing during my childhood or growing up,
some of like stories from my grandma or friends that I haven't really paid a lot of
attention to then,
they came back later.
So, one of the things that I always...
and I, you know, I was surprised by it, but
I think was sort of a guiding... uhm...
a guiding standard for me during my pregnancy
was something that my mom had told me growing up all the time -
and it's a very small, tidbit of a thing, you know -
she said, when she was first pregnant with my brother, he's 3 years older than me, they
lived in this like small seaside town, she would go there in the garden there by the seaside
and how she was always so hurt because there were kids who would make fun of her,
how fat she was, and she always wanted to tell them "But I'm pregnant, I'm not fat." (...)
So, then, when I was pregnant, I kept th...
I wasn't really conscious that I was thinking that,
but I would pick up my husband's pants, for example, or whatever,
and this would come back,
and I would think... when they did the weigh in and stuff like that,
I would think, "can I pass for fat?"

Cindy: Yeah, I think that the stuff that my mom had said, like,
there definitely were things where I said,
"Oh, my pregnancies were like my mother's"
in the sense that, like, my pregnancy with M. uhm...
like my mom always said she didn't show,
she didn't look like she was pregnant until she was 6 months or more
and that was very true with me.

And then, she said something like
"But with your brother, I started showing right away, like, I think, the day we found out I was pregnant," she would joke about showing right away.
And like, being with him [the baby], I kind of expected to start showing right away like, I was like, "Oh, it's not going to be like it was last time."
... "Oh, people are gonna be able to tell right away."
Like, I had that expectation and
I went out and got lots of maternity clothes right away
before we really needed them and I kind of
gave myself more permission
to look different.

Aneesa: [I have a] Very similar pregnancy [to my mother].
Almost identical, minus the blood.
She didn't have the blood, she didn't have it that bad.
But same.
Ah... she had to go to the hospital due to...
she had severe vomit and nausea, like me and ah...
very similar pregnancies.

Lily: Did you know any of that before you became pregnant?

Aneesa: I did, but not **to this level**.
Because, you know, you never really had to know all the details
until it started happening to me,
then I started asking her questions and
I realized we're almost having identical pregnancies.
And ah... turns out I was a daughter, and this is a daughter, and so...

Cindy: It's really interesting because after our birth, Mark said to the midwives,
"So, that seemed like it was really intense and hard. Is that how all births are?!"
And I think
it's like a really interesting point
cause **you can't know anybody else's experience**
I mean, even if I am there during the birth,
it's like, I'm not in your body
I don't know what the pain felt like
so, you have
no sense of knowing
where you were on any kind of spectrum
ever
Even for a midwife, I mean, they could try to look at where people are,
but it's an analysis
of people's expressions of pain =

Lily: = [quietly] not the embodied experience =

Cindy: = Right. Some people have different levels of pain control, pain management, or different pain tolerance than others, and so...

Mark: Well, it's not even just the pain vs. no pain.
I wasn't in pain because ... I wasn't giving birth
and yet, it was still
really horrid
for me...

Lily/Toug Guide: While others' experience is
sought after as knowledge in matters of pregnancy and birth,
while it is often narrated as one of the most powerful sources,
while it creates and deconstructs social scripts (Pollock, 1999),
normalizes
diversifies
connects,
others' knowledge is also
bordered
exclusive
Like the belly itself, it's right there
(on) the borderline.

The stories I heard and told performed social comparison during pregnancy as one form of prenatal care and knowledge. Contact with others - be it in a group prenatal care setting, in appointments, or with mothers in the past - provided contexts for both learning about and evaluating one's own pregnancy. But, as Cindy's comment shows, there was also the profound understanding of the knowledge gap between self and other.

Narrating pregnancy materializes the personal/public dialectic dance. We know some knowledge is bordered in our bodies, but we try to tell (on) it. Private and personal experience and values are one of the most important sources of prenatal care knowledge, and in narrating that "fact," it becomes no longer private. AND in narrating it, sharing it with others, it becomes yet again private and intimate in new ways, an-other's ways... we learn...

Peggy: You do this long enough and you think

"oh, gosh, this one is going to have a long hard labor" or
"this one, this one's 21 - her baby's gonna fall out."
So you know... you sort of...

Lily: How do you, how do you get this sense?

Peggy: What I find is that the women who are the most in control in their lives are the ones who have to give up control in labor because you can't control labor. You have to, you have to...

Labor is the biggest act of

surrender

the woman ever does

and those of us who are: we've established our profession, we're in a stable relationship, we've got eevrythign under control, we think we can control labor

we can't

we can't

So part of the challenge of what we have to do is teach these women to let it happen, to give up that, that "I have to do it this way" you know "I can't have medication!" or "I have to have medication!"

To just, you know, let things unfold

Because I really believe that each pregnancy and each birth has something to teach us (...)

It's funny, it's funny because

my experiences

with labor and birth were pretty easy when I stopped to think about it ahh.

Until I really started working in the field, I didn't know it could be long and painful and hard,

so I was like

[very quietly] "Oh my gosh, I'd better revise what I tell people"

Cause it's not always as easy as what I had, so

Lily: So how was it when you were first assisting, for you, how was it when you were first assisting births and ... do you remember?

Peggy: Of course, of course

I remember my first delivery

in 1976

and it was pretty cool

but of course

I had to remember

all the *maneuvers*

and put your hand here

and put your hand there

Lily: So more technical than what you do now?

Peggy: Right, so I was ... Heh-heh-heh [short laugh] It was like I had, had to learn by the book and I think all of us learn a whole lot more after we get out of school I mean you learn, you learn the science in school You learn **the art** afterwards And it is, it is It's a science and an art and what we do in midwifery is blend the two and I think it works beautifully.

Shelly: I think that's something that... you know, I've seen a different way of dealing with that with my acupuncturist who, you know... will kind of will ask (...)
she has a really **relaxeed, but attentive** ... kind of attitude about pregnancy
Yeah, she's just kind of like, so reasonable and **scientific** about things - like more scientific to some degree than Western medical doctors, but also more intuitive and kind of like "listen to your body" to get a bigger, a bigger sense of the overall picture
Yeah, I mean, she'll ask about, you know, ask about life, which is clearly like so important and big part of pregnancy and everything physical - "Hey, how are your boys doing?" or, you know, "How's, you know, how's your husband's schedule been?" (...)
cause she's interested to know about my moods and stuff - "God, I'm really irritable this week"
"Are you irritable in good proportion or relation to what is going on in your life or not?"
You know, maybe I'm really irritable because, you know, R. been working all nights and I haven't had a childcare break, in which case it's kind of like well, it's normal to be irritable it's not a good state for me to be in, but it's kind of like to be expected or is it like - oh, you know, R. just had two days off and I don't have any freelance projects and the kids have been delightful and I still feel irritable and then, it's kind of like well, that's clearly something out of balance there

or something hormonal
or something, you know, going on
and I think that that's something that
I like that Chinese medicine distinguishes and
that there's kind of a range...

Lily/Tour Guide: The integration of "art and science" is doubly-articulated here as the professional standard for prenatal care. In this articulation, the professional standard is narrated as shared between prenatal care providers and patients, at least from the patients' perspective. Definitions and experiences of the professional integration of "art and science," however, differ. Pregnant women and their partners were explicitly reflexive of their experiences with different sources and streams of prenatal care knowledge. Thus, they performed identities of critical decision-makers (I return to the implications of this at the end of the chapter). Through deliberately accessing anecdotal, bodily, and scientific information, through social comparison, evaluation of information and sources, and reflection on one's own belief system, patients' *stories perform the patients themselves as prenatal care professionals who integrate "art and science" in the complex environments of their own lives, identifications, and values.*

Research in the past (e.g., Root & Browner, 2001) has relegated such processes of knowledge-production to the domains of "lay views." Though not invalidating such perspectives, this distinction, as part of a culture of professionalization (Bledstein, 1978), has contributed to a hierarchy of knowledge in which "professionals'" formally-educated perspectives rank higher than those of patients or "lay" assistants (Jordan, 1997) at least when it comes to decision making. However, Jordan's extensive research has concentrated on experiences of birth and on patients compliance in constructing medical knowledge as authoritative *during* birth. Extending the scope of consideration to

pregnancy and prenatal care paints a less linear and role-definitive picture, even as one reflects on the construction of authoritative knowledge within her or his own knowledge system.

Aneesa: So, (...) in Ayurveda, you're supposed to - a pregnant woman is supposed to have a lot and lot of ghee, so you're supposed to up your intake of oil. The idea is that not only it acts as a strengthening tonic to your body and your baby but it helps with getting the baby out... at the end. It's like the baby comes faster. So, you know, following diet principles and then, my mom always say, you know, "Try to maintain cool head." She knows I don't have one and then ah... she's like, think positive thoughts, you know, because... And, you know, these are things that I read all the time in the books, and I understand these things, but just having it come from someone who is - like your own mother - is good.

Shelly: Yeah, I think, I think if you're a person who does reading and research yourself orr... have, you know, resources friends or parents or relatives like, the childbirth classes are not all that useful. I know we thought well, maybe we'll meet other couples =

Lily: = Yeah =

Shelly: = that would be nice to like meet other people who were having babies because I felt like I've read books and birth has been just kind of like a thing in my life (...) I felt pretty well-informed already so taking a child-birth class was kind of like uhhh... not that useful I think the most useful - and maybe the only useful - thing really was they had some pictures of different kinds of poop [laughs] that a baby could have [laughs] I was like, "oh, ok, I would have not known that!"

Cindy: I guess from my old friends it was kind of... I was, I was always looking to them as like, what was your experience, you know, it's kind of their, it's more anecdotal, "Oh, what did you experience?!" And it's interesting, but I would never like say, oh, because they did this, I'm automatically gonna do this too, but with the midwives, I think, one of our big questions was always like

"What are the options? What are the alternatives?"
You know, "What should we, what should we expect?" and
we were always asking like "What's the range?"

Mark: Yeah, 3 of those things are pretty separate from each other
- the friends, the midwives, and the books -
I don't think there's ever much of a ... which one of the three do we go to.
They all serve very different purpose and
the books will just give you what the book gave you, you can't ask it a question.
Uhm... we did, we had some baby apps that would always send tips and articles and
things,
and so maybe that was more of that...
(...)

So, I see us going through all of those, a mix of those things, but there isn't...
can't think of a time when there was a big clash
when one said one thing, one said the other, and left us confused.

Cindy: Yeah. Well, I just kind of think that
we knew
where they all fell in the range, you know.
We knew
there were like certain books that we were reading... like the...
"Our Bodies, Our Selves" version of birth and labor, that was going to be more crunchy,
and then the baby app out of Baby Center was going to be more traditional,
and the midwives were
our kind of like, I guess...
testing ground
Like what they... we would be like
"Oh, so we've read this and we've seen this, you know, what would you guys do? What
would you do about the [indistinguishable]? What's your perspective?"
And I think we put the most thought in what they said,
mostly because - or not mostly, but I think one of the factors was that
they never told us what to do, they just would give us like lots of information.

Peter: Yeah, and it's different, too if it is
if it comes from someone with mediical background,
you know, so people would have a
different type of knowledge
that you respect or that you feel like you should listen to.
(...)
Cause I feel like people
get a lot of different messages, too,
from you know their doctor or whoever is their, their point person,
or it might be a doula or someone in their town who's pregnant,
so I feel like there's also different levels of kind of
social uh... responsibility

to talk to someone who has different knowledge about having a baby.
We also, I guess, I also feel that we've kind of been -
the, the midwives, **from the very beginning**, have said that
it's not black or white
it's not either or
it's not abstinence, or, you know, over-indulgence, or =

Magdalene: = I mean they weren't telling us to go have like 5 beers on the way back,
but I feel like part of it, part of it,
I feel like part of it is - and I think that's important
learning to trust yourself - as a mom, you know...

*(Lily (reflecting): What are we all making together here? We're smiling and thinking in that sunny room, forgetting it's December outside, and it feels we're all wrapped in this blanket, their quilt, of knowing different things differently. I read Magdalene's words and her warmth toward Peter here as directly performing the construction of authoritative knowledge, it's in process right now. She says "as a **mom**" and motherhood becomes. Pregnancy as a whole becomes a learning period, parenting practice. Prenatal care and knowledge become about developing these competencies of learning to listen and trust...)*

Magdalene: ... like I feel like
I know -
cause sometimes I have a really hard time sleeping -
if I have, like, a little bit of red wine, like it really helps me sleep,
but I know,
like I had a little bit, Peter poured me a little bit last night,
and I was like "Oh, it's good,"
but I just feel like
I know what my body can, =

Lily: = can take =

Magdalene: = Right, and what is or what feels like it's too much, or even, you know,
having a cup of coffee,
you know, like, I can feel,
I feel like I know
what feels ok and what doesn't.
Do you know what I mean?
And maybe I'm being a little bit naive about this,
but I think that's a good thing to start paying attention to, you know.

Peggy: Mothers know things [said hush, quietly]
about their babies before they're born
there's an **instinct**

(Lily (reflecting/afraid): And if I don't know "things," have no "instinct" or don't recognize it?)

Peggy: We don't, we don't
pu-pu (poo-poo?)
mother's fears along those lines
we take that very seriously
and we'll - if she tells me something, something doesn't feel right
we'll look into it with her uhm
and, you know, again
(5 sec)
over the...
a practitioner will develop **an instinct**

(Lily (reflecting): Who are the practitioners?)

Peggy: a practitioner will develop an instinct
I don't know how else to explain it
you know,
sometimes you'll see
on a monitor
the baby's heart rate
is a little bit,
a little bit not perfect
and sometimes
you know
that this baby is going to be fine or
you know
"I'd better get a pediatrician here"
and I, I,
I don't know
where that comes from but
I think
(4 sec)
[quietly] this is part of mystery and things that can't be explained

Lily (reflecting): And yet, "mystery" explains much. Made present above are different technologies of/for knowing - the monitor, the guidelines for evaluating heart rate in-utero, the experiences - as both a mother and a midwife, the intuition. They swirl and mix. And though they speak into existence an underlying assumption that binds (proper) motherhood with "naturalness" (through the instinct association), this

assumption does not exclude technological developments in "modern" medicine. Both Peggy and Magdalene narrate embodied knowledge, the special unique knowledge a pregnant woman (practitioner) brings to prenatal care. Embodied knowledge is narrated as an interpretative framework in the context of using multiple sources to make health decisions and regulate health-related interactions in the course of pregnancy.

Browner & Press (1996): In other words, patients are active interpreters of medical information. They pick and choose, using and discarding advice according to internal and external constraints and considerations. In the case of our pregnant informants, embodied knowledge and everyday life exigencies proved to be pivotal in their selective designation of certain biomedical knowledge as authoritative. (p. 152)

Aneesa: But uhm... I look at, I have a very ahh... detached relationship from OB-GYN people, meaning in terms of uh... I have a very nice nurse working with me, she's German American, she works in the acupuncture clinic at XY and she's a fantastic woman, but I limit my interactions with them, the OB-GYN visits and stuff, ultrasounds or whatever that we have to do. Basically, I have a very detached relationship with Western medicine and I will, I only do what...

Lily: = the minimum =

Aneesa: = the minimum that is required and I don't have any implication for following a diet and what they say or what they do. I don't follow anything they say because I don't, they don't, they don't know what they're talking about from my perspective and it can work for them, it doesn't work for me and it never will and ah... it's just, you know, I take what is good from them they know what they're doing when they're checking my weight, I trust them to give birth to my baby, you know, those kinds of things, but when it comes to, you know what I should be doing to preparing my body or preparing the health,

I don't pay attention to anything they say,
because none of it fits into what I think is right and ah...
my guidance has been
my mother
myyy ... books
my knowledge
and what feels good in my body
and the various things that I've done
And ah... do we feel included?
Yes, we feel included,
but I find it a little intrusive -
the number of ... stuff that they do,
like the number of times they take blood,
I think people are a little paranoid here about different diseases too much
before having a baby -
the traditional way, the traditional hospital way, I mean,
I think too many tests are done...

Lily (reflecting): The use of biomedical technologies, such as testing and surgery, in pregnancy and particularly during birth has become one of the most often addressed and contentious topics in feminist and critically-oriented research of pregnancy (e.g., Browner & Press, 1996; Hayden & O'Brien Hallstein, 2010). Sometimes, the use of technology during pregnancy is positioned as "medical surveillance" (Browner & Press), highlighting unequal power distribution between medical professionals and pregnant women. Pregnant women's ambivalence toward prenatal testing and the use of technology during pregnancy has also been documented by research (e.g., Sapp, et al., 2010). So, I expected that technology-related experiences of biomedicine during pregnancy will also be narrated here in fluid morally-valuated ways; meanings of technology and its use will be produced and revised locally, yet will reflect larger cultural tensions and ideologies in the realm of women's health (Dutta, 2008).

As Aneesa was telling the story of their first ultrasound, I remembered ours. I cried. And I smiled. Laying on the table, baring my tummy, sweater held up by shaking

hands, jeans unbuttoned. And that room - with me and Remi, the ultrasound technician, and a little blinking light on the monitor - was weirdly one of the most intimate environments I have ever experienced. It is a story, we still tell Sammie and it is recorded in the book we made for him, along with the photo - and in it, the little light that was his heart.

Ultrasounds, when done in moderation (we had 2 in the course of the pregnancy), are perhaps the only technology excused, to some degree, by feminist criticism of U.S. prenatal and maternity care. In cultures where "seeing is believing," there is also a desire for materiality that, especially in the early months of pregnancy can be satisfied by a blinking light on a screen, smooth "wand" gliding on lubricated non-showing belly of promise²⁵. Of course, this does not negate the embodied knowledge - the enlarged breasts, excessive tiredness, back aches, and nausea - the early symptoms of pregnancy, all caused by the very material and very invisible hormonal changes. Perhaps for someone like us - who have longed for that moment for years and who dared to stop hoping - there is pleasure in confirming what we already know. That screen with the blinking light and that machine that looks like an old radio, miraculously reproducing a heart-beat otherwise inaudible, are also bridges and I am glad, happy that they were there for Remi and I to walk together. As Aneesa, guarded against and suspicious of Western prenatal care, was telling their ultrasound stories, I looked at Ivan. He was smiling.

Lily [to Ivan]: What was that [seeing the baby on the ultrasound] like?

Ivan: Yeah, very exciting [smiling]

²⁵ Research (e.g., Georges, 1996) suggest that pregnant women are appreciative of the ultrasound as making the pregnancy "more real." Yet, the use of "prenatal imaging technology" (Hayden & O'Brien Hallstein, 2010) has also raised ethical questions linked to selective abortions based on "seeing" the sex of the fetus and/or signs of genetic malformations.

Aneesa: [laughs] Very!
(...)

Aneesa: My parents have gone to couple [visits] and my dad was here, they went to both.

Lily: Did they listen to the heart and...

Aneesa: Yeah, yeah.

They saw the...

when we saw the...

[to Ivan] - was it the second ultrasound or the first that all four of you were there?

Ivan: Ssecond.

Aneesa: So, the second ultrasound.

Yeah, so they were.

Everybody was there -

my mom, dad, and ah...

so, **we** saw the baby

and ah... so, it was, it was...

it was the first time my dad had seen an ultrasound at all,

because when my mom had seen my ultrasound,

when I was in her belly in Vienna,

he was in Freetown then,

so he didn't actually,

they were not together,

so this was the very **first** ultrasound

that my dad ever saw,

so it was very exciting for him.

Lily (reflecting): Of course, to some degree ultrasounds and tests provide
information about the fetus -

is the heart beating

are there anatomical irregularities

is everything ok

But ultrasounds are also about making "baby" real through the act of relating by
witnessing together, which may explain the ultrasound photo in that birthday card for
grandma's 80th birthday or the posting of such photos on Face Book walls.

And there is more, I think...

Because medical technology allows shared witnessing that is perceived to be "accurate and incontrovertible"²⁶ (Browner & Press, 1996, p. 152) - an image on a screen, a score on a test - its use and interpretation also offer a glimpse into a system that is otherwise mystified. In conversations about and co-experiences of the use of technology in "managing" pregnancy, one encounters systemic ideologies and develops a more intimate knowledge of the technology-using or technology-rejecting structures. The use of technology during pregnancy, then, produces different types of knowledge and relationships, of which the fetuses' health and development are just a fraction. In performing "ambivalence" (Sapp, et al., 2010) toward the use and interpretation of technology and testing during pregnancy, there is also a situating engagement of one's own assumptions. There is also an articulation of the knowing self - cognitively, affectively, and bodily knowing self - and of the relationally situated knowledge production process.

Magdalene: = I feel really happy that we were both, we felt very similarly about a lot of the testing we just felt like really... we didn't really feel like it was necessary in, in that... I mean, I feel like a lot of it would just tell you, "Well maybe, you'll have this much percentage chance that something could be..." And I feel like, what would we do with that information? I feel like it would just add anxiety to the pregnancy, and I feel like, we just didn't need it.

Peter: Yeah, we didn't think it was necessary for us, because we didn't think that it would change our mind by anything and we decided not to find out if it was a boy or a girl either, because we just thought - how cool to find out until... And I can see, too, why people would wanna know, but we're excited to find out and then, it's also been nice to not get all pink or all blue =

Lily: I don't know... like I don't even remember why

²⁶ This assumption of accuracy is powerfully questioned and refuted in the stories below.

I don't even remember if we had particular reasoning one way or another, but testing was one of those topics where we were - and we actually got a lot of pressure cause we didn't do the Down Syndrome test - cause we had two ultrasounds, so the second one - I don't know if this is similar to you, but this was part of the routine here when they did it, so the second one is when they can check for some =

Magdalene: = Oh, yeah. =

Peter: = Yeah.=

Lily: = When they would actually tell you the sex of the baby if you wanna know it then, and they would check on something, like they'd measure the length of the arms and the legs, and =

Magdalene: = Hmm, they did do that =

Peter: = Yeah, that was actually strange. I remember feeling like it was really weird because they were doing all these measurements =

Lily: = Right, with the little "x" =

Peter: Yeah. With the little "x" everywhere and then, they would say "Oh, and here's a bleed" and you're like, "What?! What's a bleed?"

Magdalene: = that was a little scary =

Peter: = and then, they'd say, "Oh, that could go, it's typical, but it could go away and it happens because of this build-up" =

Magdalene: = The way they =

Peter: = and I was like "Wow, what..." =

Magdalene: = tell us =

Lily: = Was that the technician? =

Peter & Magdalene: = Uh-hum =

Magdalene: = She was like, "Let me," she just said something and then she was "Let me get the midwife on the phone."

Like - a little bit scary,
so then we went to the other room and talked with the midwives,
and they were like "You have a bleed, and..."
it was just like - something like that,
well, the midwives were really good at explaining it,
because they basically said,
"You know, we never used to have ultrasounds all the time,
and so, now that we have these testing things,
you see
different things that look alarming throughout the pregnancy,
but they... 99% of the time, they resolve,
you know, they just it's part of it."

Charlne: I never felt anything,
I mean like, even during the first pregnancy
when he told me there was the issue that arose in the 20th week,
I didn't feel any different, I mean
(...)
Uhm, the progesterone was definitely just preventive, just preventive based on the fact
that
they couldn't get my,
that one test that they kept doing
they couldn't get that to come out negative
For some reason
my body just kept coming back positive **on them**
and like I said, the positive didn't tell them no, but it didn't tell them yes either, soo...

Root & Browner (2001): (...) the biomedical deployment of technology has produced a complementary and simultaneous **culture of haptic resistance** (emphasis added). This is especially important if one considers Haraway's observation that vision is "a much maligned sensory system in feminist discourse" (1991: 188). If vision is in some measure embodied in order to be made meaningful, then what we may be hearing in women's words are the haptic means by which they empower the biomedical knowledge lent them by optical means: their bodies make such knowledge relevant, rendering the optical dependent upon the haptic for its embodied import. (p. 219)

Charlene: I don't even know why they even use that test, because it was kind of
the more you...
it was very confusing basically
(...)
... overwhelming, yeah...
Even me with, like I remember sitting there, you know,
going through and listening to all these tests that
they're doing to me,
with my first pregnancy they were drawing my blood
every time I went in for the first like couple of months

taking blood for this, that, and the other thing
and I remember sitting there, thinking
"I am a medical professional and I hardly understand this stuff,
I can't imagine what it's like for the lay person
or not even the lay person, how about an 18 year old
who doesn't really know very much at all about life, you know,
trying to make sense of all that."
I just don't know how women do it now-a-days,
I just wish it wasn't so medicine-driven;
maybe that there was more of a balance of
natural
versus
medical
driven practice.

Mariyana: I think it made me very suspicious of the healthcare system
being a midwife
and knowing I'm having a high-risk pregnancy =
(...)
I was very, very aware
of the encroachment of technology
into what is supposed to be a normal, healthy process,
and by having twins
and needing a Cesarean
and when you have twins,
they wanna do all these tests on you,
so I always said,
"No, I don't want this test" [taps table with hand]
"No, I don't like this test" [taps again]
"No, I don't have this test"
"It's not medically necessary, they're fine, they're fine"
You know, like, you just feel the
feel the pressure of technology
and fear
and fear of liability,
you feel all that encroaching on you,
so, you know,
I had to
kind of
stand up
to some of that.

Lily: You also, you also knew that you could.

Mariyana: Right, right. I also had the knowledge and the...
Yeah, I didn't have much fear. It's a lot of people, a lot of fear.

Uh-hum.

Lily (reflecting): Charlene's resisting body that "keeps coming back [positive] **on them**" tells on the nature-technology tension. Her story declares a desire for balance, but performs a struggle even in the use of a simple connector - "versus" (instead of, say, "and") tells on a juxtaposition experienced through/in the body. Because pregnancy is so profoundly and fluidly embodied experience, the use of technology to produce knowledge of the bodies - the pregnant woman's and the not-yet-born children's - is also experienced as more than a simple desire for information and prevention.

"You feel all that encroaching **on you**," says Mariyana.

Medical technology and testing that is perceived to be unnecessary and/or confusing is experienced on the physical, affective, and cognitive levels. As such it also produces a more intimate knowledge of the structures that regulate and explain pregnancy in formal prenatal care. It also produces and engages knowledge of agency and of positions within the structures

a couple whose "seeing" of a future child is veiled with fear, seeking explanations

a midwife challenging that too much information may not always benefit care

a pregnant body that keeps resisting clear-cut ways of knowing

...

knowing, feeling, standing up

Learning and Knowing, Episode 3: Structures and Agency

Lily/Tour Guide: Knowledge of the structures within which care is provided seems essential to (a perception of) informed decision-making, which is the ideological basis for contemporary prenatal care models in the U.S.

Browner & Press (1996): In the United States today prenatal care is fundamentally about getting and giving information³. Providers collect data on the state of pregnant women's bodies and on the condition of their developing fetuses. At the same time they want their clients to understand how and why their bodies are changing, in part because they expect this will make them more likely to follow providers' recommendations. In reality, much of prenatal care can be seen as a process of medical socialization, in which providers attempt to teach pregnant women their own interpretations of the signs and symptoms the women will experience as the pregnancy proceeds and the significance that should be attached to them. (p. 144)

Lily (wondering): Hmm... what should I do with that knowledge? Could there be something good about "medical socialization?" Does the provider also get socialized? Where does that leave experiences I have outside of interacting with medical providers? Where does it leave their experiences outside of interacting with me? I mean, birth stories are embodied interpretations and no less real for that (Pollock, 1999)... Does knowledge and interpretation travel other-ways? Are there openings?

Now, look, my husband is a nurse. He knows things I don't. And he knows things I do. He knows things about my high threshold for pain and that I don't exhibit pain in a "traditional" way. He knows I sometimes invent symptoms, but most of the time when I say I'm concerned about something, there is a good reason for that, even though I may not look like it. He knows no medical professional here will pay much attention to me if I present as I do.

When I haven't felt the baby move for a few hours and that included the time I was laying down.

When Remi and I know this is unusual for the pregnancy.

When I think it's important to report exact medical condition and history.

We go to the hospital
and say, exaggerate
"We haven't felt the baby move in 24 hours"
We are seen right away.
When I am freaking out because a technician from Dr. L's office called
reciting terms
I don't understand
saying over and over one word I do understand -
cyst, cyst, cyst...
and listing
test after test
I can't remember
but I know it has to do with Down Syndrome
and I know we - Remi and I - decided we don't care
and I know we - Remi and I - are expecting the baby with every fiber of us
It is Remi who tells me what to say
how to say it
to get them off our backs.
They are his colleagues in a way
and may be parents, too
and yes, indeed, as a medical provider,
my Remi socializes me
He knows things I don't
that help.

Lily/ Tour Guide: Things that help... are sometimes not of the body, but of the body within systems (Rich, 1976). Peggy re-members her journey into midwifery - the birth of her first child.

Peggy: So, I was a nurse, not a midwife,
the only deliveries I had seen were in training
and those were awful,
but I wanted to do it
naatural
And I said to my doctor,
I said, "I want, I want to do it natural,
Can you tell me where to get some birth classes"
And he said, "oh, no, you don't need birth classes, they'll just confuse you."
So being young and not real savvy, I said
"ook, sir" [sounds like she mocks a submissive tone of voice]
and I, I went into labor and I had made arrangements - the only way my husband can be
with me during the **labor** was if I had a private room and paid for it, so I did.
And my labor, my labor was induced, it was very fast aand, there was a point -
oh, the other caveat was that if i had any medication, my husband had to leave -
so, so... [laughs]
so, I got to a point when I had to...

I just said, "Can I have a little something to take the edge off and have him stay"
-- "Aaalright" [quietly, imitating doctor or nurse, what would seem like an "annoyed"
response]
Now! [switches back to strong, authoritative voice]
Nobody checked me,
they gave me some Demerol IV, which is great stuff [said mockingly]
but my son was born...
Again nobody checked me!
My son was born with Demerol on board
and it's one of the most frightening things I ever remember.
And again, now, now-a-days
if I see a baby who's not crying right away, I don't panic,
but I remember seeing him - he was blue and he wasn't crying and they,
they [doctors] got excited about it
and it was because of the Demerol.
And if someone had checked me and said "ok, you're almost ready to deliver"
I wouldn't have taken it, so...
So, the other thing
The other thing that happened is that since I was such a
good patient
my husband was allowed to watch in, by a little window
when I went into this very sterile delivery room
Afterwards, I was in a recovery room and I'm starving and I want my baby.
[quietly] my baby was waaaaaay into the nursery
And I look around and there is all these women snoring -
it turned out I was the first one in that hospital to have a delivery without general
anesthesia and
people came in and said "you're the one with" [almost whispered]
I'm thinking "what are you talking about,
this is the way it needs *to beeee*"
(...) The doctors thought I was stupid to do it, uhm, aaand,
it was just a really, it was sort of eye-opening and I though huh, it's gotta be better than
this,
so I started teaching birth class and became an activist,
I'm banging on doors and picketing hospitals to let fathers in and to treat women more
humanly.
By the time my second kid was born, in 1972,
my husband was in the room with me, camera on each hip, snapping those pictures.
So, it got better.
And I became a crusader for family-centered care
Aaand, ahhh
Then I decided that the best way to deal with this is to become a provider and
I went to midwifery school.
So, so that stayed... and, and, you know,
certain things stay with you...

Lily (wondering): So, it's far from a straightforward process... even for providers? But we build knowledge of the health care structures through our varied experiences with(in) them. We also build that knowledge together and in conversation. As a "researcher" and a parent, I actively participated in this knowledge production process even in my conversations with the story-tellers presented here. In short phrases, following each other quickly, we navigate our experiences together toward interpretations that affect our decision-making. Conversations are creative...

Aneesa: Yeah, the tech, the side people are more friendly than the actual doctors, you're right.

Ivan: Yeah, well the doctors are so pressured to see so many people.

Aneesa: Mass production, produced.

Lily: But it's weird... because I would think like, at XY's local clinic that really doesn't.. I don't know, whenever you, whenever we've gone there, there was nobody else =

Aneesa: [laughs loud] yeah

Lily: = Like after us or something =

Aneesa: = you're right =

Lily: = Plus, it's like, you know, one thing... I'm not excusing it at all, but one thing is the so-called emergency room and another thing is like a routine prenatal care visit. You know? So that this sort of mentality "I don't have time for you" has seeped into something like this seems so strange to me.

Aneesa: It does and =

Ivan: = Its own self-fulfilling prophecy almost like =

Lily: = yeah, maybe =

Ivan: = like they've been **trained** to think that they don't have any time, so they act like they don't

Aneesa: Yeah, that's right =

Novick (2009): Twenty-two, or nearly two thirds of the articles [reviewed] reported on time spent obtaining PNC. Results from one focus group study²⁵ and three surveys (combined N=2,116)^{30, 41, 42} collectively suggest that women preferred waits under 30 minutes, and when this occurred, women were more satisfied with care. (...)Women also desired unhurried visits.⁵ When clinicians spent time with women, it fostered trust³⁵ and increased overall care ratings.⁴¹ Yet, many women reported rushed visits,^{26, 35,40, 44, 45} which were associated with decreased satisfaction with PNC in two studies.^{43, 46} In a third study, however, women who spent over 15 minutes with practitioners were not more satisfied than those who spent under 15 minutes.⁴² (p. 230).

Shelly: R. [her partner] hasn't been to any of the appointments there yet because to find a time that works for **both** of our schedules is really challenging
and ah...., I mean it's further away, we wait,
so it ends up being like 2 hours, which is really kind of like a big a deal when it's like -
alright, I need to find this 2 hours in my week
and then do, I need to bring both of the boys
if I bring both of the boys,
the environment up there is just not as fun for them,
so it's kind of like not as nice to bring them to appointments,
which means I have to find childcare, which is another piece uhm...
So, yeah, I mean, I'm kind of toughing it out through the prenatal stuff (...)

Lily: Would you like to maybe be able to skip some of the visits?

Shelly: I would, would love [rising intonation] to! I mean I feel like...

Lily: If everything is going fine and...

Shelly: Right, yeah, and that's the thing -
it ends up being
alright we did in the waiting room for 20 minutes,
I waited in the exaaaam room for 20 minutes,
now I finally see you and I get to meet and I'm trying to -
that's the other thing, I'm trying to schedule it,
so I'm trying to meet all the new midwives whom I haven't met -
so, it's like, I can't just say every Thursday at 4 is a good time for me because, you know,
what if Laura doesn't work Thursdays and I wanna meet Laura.
But it's like aohhh.... [sigh] everything is ok, you know,
so I see the midwives and they're like
"How's everything going?"
and I say "Oh, it's going fine" or "I'm having some pelvic pain"

and they're like "Yeah, it's your third baby, it's totally normal. Do you have any questions?"
and I, I hate that, because I feel like
what questions am I supposed to have -
this is my third time around [laughs] =
(...) It's kind of like, you know,
if I have a complaint or a symptom,
then they're happy to listen or suggest something or tell me they can't suggest anything,
but like, **I don't** really, so it's kind of like...
I would love to, like, let's just sit and chat for half an hour,
so I can get a sense of who **you** are and you can get a sense of who **I** am,
but they have other patients to see,
so I'm not gonna like take up their time, just being
"How did you get into midwifery? And how many... You know, what's your favorite
thing about birth..." Trying to like engage them in a conversation that is more meaningful
to me...
instead it's like "Oh, I have this weird rash, can you look at it?"
which is, I think, that's, that's what they are looking for, is anything going wrong -
if not, then great, we'll see you next time.
It's kind of like, oh, do I really have to take 2 hours out of every week to do that?
It's kind of ah... yeah, it's a pain. [laughs]

Lily (reflecting): Talking with Novick's (2009) review of research on women's experiences with prenatal care, Shelly's story and my conversation with Aneesa and Ivan perform a different reflexivity - that the experience of and satisfaction with health care structures, as measured by surveys, is only one part of the knowledge production process. Our contextualized interpretations, our positioning of experience within larger cultural structures, and our positioning of ourselves in relation to these structures, are yet another part. Culture and particularly (perceptions of) cultural norms are structures relevant to practices of prenatal care - but not simply in the one-directional way of cultural sensitivity (Dutta, 2008) models. Culture does shape practice, but practice also shapes culture and our knowledge of cultural norms.

Shelly's story performs time efficiency in prenatal care as a cultural norm that is mutually-understood, even valued, in the personal context of her life and the professional

one of health care. Yet that norm and its minute-by-minute measure become meaningful in a particular way only in light of the actual interaction that takes place during the prenatal care appointment. When the conversation is not "meaningful" to me, the time invested becomes time wasted, and efficiency, as a cultural category we are familiar with, becomes relevant.

Mariyana: Uhm... No, I didn't wanna go to Med School because doctors the whole profession isn't woman-friendly, you know... it's not a... there is no opportunities for conversations with people, there is no opportunity to get to know them well, to really be with them during these processes, it's fear-based, it's medically-based, it's not based on education and prevention, it's based on liability, technology, and so... that wasn't something I was ever really interested in

Lily (reflecting): As Mariyana performs knowledge of professional structures - in her assertion of how things happen - she also performs her own professionalism in contrast to and rejection of these structures. Over and over, as seen variously in the previous chapters, pregnant women and members of their support systems performed connection as a desired element of care - both in formal and in informal interactions. As discussed in the previous chapter, connection is about belonging and, as affect, belonging is about security. But that is not to say that connecting is performed the same way communicatively. Especially when considered in the "professional" context of health care, it is the provider's responsibility to inquire into the patient and the patient's responsibility to share, to bare what the provider has selected as important in order for good care to be provided.

But what about Shelly's discontent with the rhythm of baring it at prenatal appointments? What may seem trivial and unprofessional to a medical provider - her or his own self-disclosure with a patient - could make an interaction meaningful, connecting, and invite explicitly the different streams of knowledge, as in Peggy's story above, that shape the interaction. Our shared knowledge of cultural structures in the health care context is performed by following, in a coordinated manner, norms for self-disclosure and information exchange during interactions.

Rituals.

Contexts.

That culture structures and wherein culture is structured.

Roles.

Models.

Knowledge.

Learning.

Maryana: You know, the culture of the acculturated immigrant is very, very different than the culture of an individual within their own country, within their own system. So, the kinds of issues that a Puerto Rican or a Dominican woman, or El Salvadorian, or whatever might face here are very, very different than what they would face in their own country. So, in U.S. Town Here it was a lot of teenage pregnancy a lot of drug abuse homelessness poverty uh... stuff like that In Puerto Rico, there was definitely poverty, but you didn't have that much drug abuse, you didn't have as much domestic violence Yeah...

Lily: Were these things that you address during, you know, in your interactions with women?

Mariyana: Oh, of course.

Lily: And how did that, how do those things go? Like...

Mariyana: Well, we address it all the time, no matter who we're working with because...

Just because a woman is a professor
or married to ... a doctor

doesn't mean that they're not abused
So, we always screen for all of that,
you know, we always screen for that,
and what we do is...

some things we formally screen for,
but most things
come out

on the basis of our relationship

because one of the important things about being a midwife is
creating relationships with your patients

and so it usually
comes out naturally

and if that...

does begin to come out

or if there is a suspicion, we try and

first, offer this as a safe place -

you know, as a place where people can talk openly and safely
without feeling judged

and then, we try and get them into the referrals, to the larger network of, of
support systems

which they don't have in other countries,

but we do have here.

(...)

It's more about finding ways to work with people where they're at,

but **that's** where I think it helps that I've had a lot of experience uhm... in different
cultures

cause if you look at every individual as their own culture

it's our responsibility

to get to know that person

as their own individual culture...

Shelly: "How did you get into midwifery?

And how many...

You know, what's your favorite thing about birth..."

Trying to like

engage them in a conversation

that is more meaningful to me...

Mariyana: ... and then you can help them work through whatever their particular issues
are.

Dutta, Anaele, & Jones (2013): The CCA [culture-centered approach] foregrounds the role of structures in perpetuating health disparities, noting that differentials in health outcomes ultimately reside in inequalities in organization of societies, institutions, and organizations. (p. 161)

Mariyana: [In U.S. Town] there were a lot of authorities
in people's lives
because they were poor, you know like...

Lily: That makes things more complicated =

Mariyana: = It doees... =

Lily: = because you talk about choice for example, you know, making that =

Mariyana: = Yeah =

Lily: = informed decisions, but at the same time so much of your life is regulated by =

Mariyana: = Exactly, so if you have a poor woman...
Like, here you have a woman,
she's got her car,
and she's got her paid maternity leave,
you know, she's got a partner,
maybe a mother who would come to help her.
But you start working with people who are poor:
she's alone,
and she doesn't have a car,
she has to go to all of her appointments to get welfare checks,
and she has to go to all of these different places to pick up food stamps,
and maybe she has to check with DSS a certain amount of times each week,
maybe she's been in jail, and now she's out, and she has a parole officer that she has to
check in with,
So her whole -
and all, she has to do all of it on a bus with like a 2-year old in tow and pregnant,
you know
So, when you start realizing what people's **lives** are like, what they have to juggle, it's, it's
a lot, yeah...
But not so much up here, just once in a while up here, yeah, just once in a while
We recently had a woman who was fleeing from another state because of domestic
violence
and so... it was the saddest case because as she came here,
she had been here a very short period of time,
she was in **complete** hiding, absolute complete hiding
she didn't want her, the father of her child to know where she was,

so her family didn't know, nobody knew,
but she has a 6-year old son,
so who's gonna care for her son while she's in labor,
who's gonna take care of her child while she delivers, you know, she delivers her child,
you know, what's gonna happen to this little boy?
Well, we could have called the Department of Social Services
that they put the child in foster home
until she is healthy enough to pick him up again... uh...

Lily: And that just starts another =

Mariyana: = Doesn't it break your **heart**...
Like, we didn't do that, but that was one of the things that's on the table, so... [sighs]
it can be very heart-breaking
how inadequate the system is...

Lily/Tour Guide: Another key conceptual contribution of the culture-centered approach (CCA) to health communication is the mutual constitution link between structures and agency. On one hand, we are all active agents in constructing social realities, but we're also "bound" agents moving within structures - social and perceptual. The problem of excluding disenfranchised voices from policy-making and social programs is central to the CCA - one, because it cements marginalization, and two, because it strips away any dominant perceptions of marginalized populations as active agents, contributing to further devaluation and discrimination (Dutta, 2008; Dutta, Anaele, & Jones, 2013). Thus, the "recovering" of marginalized voices is conceived as recovering of agency into the dominant imagination. It is also bound with explicit consideration of the structures and systems that limit and regulate participation. Through this, the CCA aims at changing the structures. In this sense, recognizing structural inequality in health care - the knowledge of structures - becomes central to transformative agency and social change.

Lily (questioning naively): So there is more learning in a prenatal care interaction than the list of guidelines and the rituals of weight, blood pressure, tests, conversations? What does agency have to do with it all? What is agency in prenatal care?

Root & Browner (2001): (...) we contend that contemporary prenatal care, given its plethora of technological and social monitoring mechanisms, can be viewed as a set of moral acts derived from implicit and explicit moral codes. (...) . By listening to and reflecting on a group of U.S. pregnant women's "self-relations" on a range of issues relating to pregnancy and prenatal care, we avail ourselves of an opportunity to witness a pregnancy ethical subjectivity in the making. (p. 196)

Lily/Tour Guide: Root and Browner emphasize repeatedly that ethical subjectivities, even "self-relations" are intricately webbed with interpersonal relationships. In speaking of a continuum of resistance-compliance with biomedical prenatal care advice, they suggest that decision-making is never stripped away from a pregnant woman. Thus, agency is present even at the complete compliance end of the spectrum. It is processes of decision-making in relation to normativity that allows the understanding of prenatal care as moral acts. Acts need agents. In acts, in-acting, we're our own makers. Are "pregnancy ethical" subjectivities "in the making" only of/for the pregnant women?

Peggy [to other hypothetical providers]: a pregnant, birthing -
a conceiving, pregnant, birthing woman -
is a whole being, not just a uterus with a baby,
listen to the woman, respect her, honor her choices, honor her history,
uhm, and realize that she's not,
she's more than just a body with a baby,
there's a lot more to her than just that person who gets
weighed, and measured, and heart beat listened to, and tested...
and again, respect who she is, where she comes from, and where she's going

Lily: Have there been times when that's been difficult to do - to honor that or even...

Peggy: Right, yeah. Sometimes that's challenging uhm

(5 sec)

But I guess what I would say is,

there are times when I have to step in and say,

"You know I honor that, your wishes,

but I really think that this needs to happen and this is why I think it should happen."

And if I give the explanation, and why, and the consequences of not doing it, what could happen -

if after that, the woman chooses not to follow my advice [sigh and a pause],

I, I have to honor that

even though it would have not been my choice,

but my job is to give her the information to make an informed decision

and if she chooses not to, then I have to, sometimes

I have to get her to sign a waiver. For example, =

Lily: = Sure, because you have your own legal =

Peggy: = Exactly, exactly, part of my job is I don't like, but yes, we have to do it -

is to tell someone what all the horrible things are that could happen if you don't do this

Lily: You work in a system and...

Peggy: Absolutely,

you don't want to do this test

that I think is really important for your well-being or your baby's well-being,

this is what could happen and you need to know that

and sometimes you need to sign and say,

"I understand that this is what could happen."

It doesn't happen very often because most of the times what we find is that by,

by listening to this woman, by honoring her,

we build up a relationship of trust, so that if I say to her,

"I don't really like what I'm feeling, I think we should do this" or

"I don't like the way you're measuring,"

a lot of times we've built that relationship of trust and she'll say ok.

Mariyana: I had a woman in our practice who's a wine-taster and she's pregnant,

she drinks **a lot** of wine,

you know, not only drinks it, I mean she tastes it and spits it out, but also drinks a lot of wine

and here she is pregnant

and I know that alcohol can affect her baby

I don't know how much or whatever, but

we know that alcohol will cross the placenta and go to the baby,

but she doesn't believe that it will, she's like

"No, I don't believe that it will,
I think I'm really fine,
I can continue drinking at the level that I am drinking"
And so, if the door is just closed like that, you know,
and I, I kind of explain my point of view,
and she's like [rubs hands, as if wiping something off] "No,"
then there's nothing I can do,
I can talk myself **blue in the face**,
and she's gonna do whatever it is that she chooses to do,
but if somebody then, let's say,
what ended up happening in her pregnancy is
later in the pregnancy, she began to think about what was said,
and she did some of her own research,
and she came back again,
and she talked again what would be a safe -
what **would I** consider to be a safe amount to drink.
And so, then, you allow a discussion,
and then with the discussion you might be able to actually
start on working to change behaviors.

(...)

Now, obviously there come points where sometimes the law gets involved
if somebody's using cocaine or heroin, then we have to warn them -
I mean, tell them very clearly -
what the effects can be on the baby
and that they'll be drug-tested
and that they can lose their child
and then the law, the law steps in,
you know, the Department of Social Services can actually take away their child,
so people have to know that, as well.

Lily/Tour Guide: Much on the literature on the midwifery distinguishes this
model of care from more traditional OB-GYN approaches on the basis of a commitment
to empowering women as informed decision-makers (Sassi Matthias & Babrow, 2007).
To say, however, that one serves as a resource to build another's agency is not to absolve
one's self from agency. The above assertions of standards of practice, be it, as they are,
framed within legal structures, are also a moral stance that is relationally made in
interactions with others. As such, they are also not set. Nor are they tied firmly to
particular social or professional/occupational roles.

Thus, Martha - an OB-GYN and a mother with long years of pregnancy care practice - tells story after story of her travels and work with "other cultures" both "at home" and "abroad." She tells me she's the one that brought "birthing chairs and balls" into the very "technology-driven" medical environment of a large hospital. Not that "birthing chairs and balls" aren't technology... "It's just about the options," Martha says and affirms she's always been in a very good and close professional relationship with the midwives at the hospital, which, she says, isn't the case the OBs who are there now. Reversing a question that is often asked of nurses and midwives, I ask Martha if, with all of this experience and her ethical orientation, she's ever considered becoming a midwife. She tells me her practice really started developing after completing medical school and that to become a certified midwife, she would need a nursing degree first. This would be an unnecessary investment, she says, when she can bring midwifery principles in her OB work.

Root & Browner (2001): Different streams of authoritative/subjugated knowledges, rules, and experiences yield a variety of pregnant practices that converge in the course of women's daily routines, rendering an "unconfounded" analysis of each stream impossible. To categorically label one practice authoritative and the other subjugated is not only disingenuous, it diverts attention from the more important point, that practices are functions of diverse relations, with oneself and others, as well as texts.

(p. 206)

Lily (reflecting): Practices also inscribe us **into** diverse relations,
inscribe relations,
agency-filled
reflections on relations
creations,
no?

Mariyana: the... the system opens the door - in the way we're set up - to the woman, but she is part of a family, so it's my job to open the door wide enough to invite whoever her family is into the system as well - it might be a husband, it might be a wife, it might be children, it might be a grandmother, might be a pastor, whoever it is that to that person is a part of their life and then to enlist all of them in her care, at her support You're gonna, you, you get better outcomes, it's just completely, you might actually change and have an impact and the woman is more apt to have a positive experience and have a good outcome, and it's also more sustainable.
(...)
it's through women through pregnancy, it allows this door into healthcare that often isn't open You know? Otherwise, it doesn't really, it's just not open in the same way of really being able to change health behavior happens during pregnancy and that's when I knew I wanted to be a midwife

Lily/Tour Guide: Mariyana tells me that her work as a midwife is really community health work, that communities and their members learn about health and health practices from women, from mothers. And because pregnancy is a period of heightened awareness of sustaining (another) life, it is also the perfect opportunity for health education with long-lasting impacts for the health of a community. Isn't that "pregnancy ethical subjectivity in the making" (Root & Browner, 2001, p. 196)?

Lily (reflecting): So much of research in pregnancy and prenatal care has focused on [pregnant] "women's experiences"

quantifying them
describing them
explaining them
contextualizing them
symptoms of a (sick?) system
within a system of care
in need of care
"pregnancy ethical subjectivity in the making"

Shelly: ... pregnancy it's not
it doesn't happen in a vacuum

Lily (reflecting): I know. I agree. "Pregnancy ethical subjectivity in the making" -
as performed in our actions and reactions, compliance, modifications, and resistance in
relations to others - is not just of the pregnant woman. And yet...

Cindy: Yeah, I think it feels more personal because like...
it was more about **me** being
my body
being able to do it
or not do it
or my choice
ultimately,
I was the one who said...

Charlene: Like I said, I wouldn't do it [take progesterone] again probably
Not because I felt ill from it or anything like that,
it's just that I'm settling mentally
mentally
and in a way like
my conscious...
I just felt like
I knew that if
if
my daughter was born and there was something wrong with her
I would always wonder if it was
because I
was taking the progesterone...

Lily: Did you talk with anyone about your concerns?

Charlene: I did [quietly, sounding slightly as resound, as if saying, "but to no avail"]...
I talked with my doctor and I believe I talked with the midwife at the office, too.
And they were very big supporters of like, the progesterone, like, as far as uhm...

the way it's presented to me,
they were supportive of the research and stuff, they were uhm..
I don't know, I don't know how to say
They weren't pushy about it,
they definitely were on board if I had said no
and treated me just the same no matter what,
but uhm... they also believed in it too
I felt like it wasn't going to do much, you know
the benefits outweighed the risks, basically, so

Lily: What about with family members or friends, did they have anything...

Charlene: Iiiii, you know, anything that happens with my kids or with me or anything,
I always call my mother
I mean that's just like
She's a big support system because
number one, she's a nurse as well
and number two, she's kind of the person that I call to bounce things off of
and you know she has the same concerns I do basically and so
she and I both researched it together,
like she would do her research
She lives in MA, I lived in NC at the time,
she was doing her research when she could from her home
and I was doing my research at my home
and we kind of came back together again and went over what we each found
yeah, and she was supportive of whatever I did

**But in the end,
everybody kind of left it that
it was my decision**

I am the one who has to live with the decision I make and stuff like that, so...

Peter: Remember when the car broke down and the guy was like
"Are you drinking coffee? Cause you know you're not supposed to?"

Magdalene: I was like, "Yes, I am, I am drinking coffee"

Peter: "It's cool, we checked with the midwife"

Lily: You said earlier that you think you've taken good care of yourselves throughout the pregnancy. What do you mean by that? =

Magdalene: = I feel like... =

Lily: What are the kinds of things you did?

Magdalene: ... we're really fortunate in that like...

we have a farm share, so we have access to really good healthy food
So, I think like, we've eaten really well =

Peter: = Yeah [quietly]. =

Magdalene: = I think that nearing the end, I'm getting more like
eating a lot of cooookies
and wanting spicy food -
like not that spicy is bad -
but I'm having more like
just eating a little bit of everything,
but uh... but yeah, I feel like our diet has been really good,
we, you know, get ... a lot of exercise typically,
but now I feel like I lay down a lot more,
I feel like everything is "Up until a couple of weeks..."
But just in terms of
keeping busy,
and also getting enough time to sleep,
all that kinds of stuff
is taking good care of ourselves.

Peter: Yeah. And I feel like we haven't taken on too much,
but we also made time to spend with, like to go,
like still go drive, or see people, or go to (...)

Magdalene: Yeah, I feel like all that stuff has
felt really healthy, too -
spending time with friends and family and...

Shelly: ... the best prenatal care probably
- for me or in my opinion -
centers around how normal it is to be pregnant [laughs] and that, you know, kind of
working
with
women's bodies
to encourage positive, normal state of being
(...)
I guess just finding out where you are
and working
with
where you are
and encourage, you know, encourage
either for you to continue at the state where you're at
or to, you know, slightly nudge in a better direction

Mariyana: ... it shapes who I am,

makes it very
fluid,
like, you know,
it's not just like,
my person is
not like **fixed** entity,
it's always like moving and changing

Lily: writing this text is "pregnancy ethical subjectivity in the making"
reading it could be, too

CHAPTER 7

INSTEAD OF A CONCLUSION: TAKING FLIGHTS

At this project's conception, I imagined it would be about identifying different pregnancy practices and beliefs and linking them to relationships we have with others (and with communities) in our lives. I imagined that practices of prenatal and pregnancy care will be complex, mixing knowledges from the different groups with which one identifies. I imagined this would be a similarly complex process for prenatal care providers, pregnant women, and members of pregnant women's support networks. And I imagined that in some cases, particularly for formal prenatal care providers, under social and occupational pressures, this complexity might be contained and reduced to a particular type of "authoritative knowledge" (Jordan, 1997).

To engage this complexity, I left the definitions of "prenatal care" and "pregnancy knowledge" deliberately open. However, as my conversations with others progressed, I realized that I did have, for myself, underlying definitions and expectations. I had assumed that prenatal and pregnancy care refer to encouraging and maintaining physiological well-being of the pregnant woman. From my own upbringing, I had also learned that emotional well-being is important as well, but only in the sense that it does not cause or contribute to physiological stress that would have adverse effects for the pregnant woman, and consequently, for the fetus she grows. In the course of my encounters with others, these definitions were continuously challenged.

I learned that through the physiological, prenatal care, pregnancy practices and decisions are about belonging - both in the more interpersonal relational contexts and in broader cultural contexts. There is more at stake in interactions during pregnancy than the

physical and emotional well-being of the pregnant woman. Through topics and conversations that center around the body and physiological changes and experiences (e.g., "is it normal that I can't sleep?"), as well as how we learn about and monitor such experiences (e.g., by prenatal imaging technology, by "listening" to one's body) pregnancy-related interactions are process of reflectively engaging social structures. Facing one's in/exclusion in these structures. Responding to structures. Positioning one's self in them in particular ways. Pregnancy is about *becoming* in relation to others. And that does not refer only to the pregnant woman or the not-yet-born child, it variously encompasses partners, families, and medical professionals, with some of these roles intertwined.

I said at the beginning of this text and at several places throughout it that it is non-prescriptive, it is heuristic in the sense that it provides lenses to look at a social phenomenon, yet the views through those lenses would be tainted by the viewer. Coming towards a temporary end, however, I believe this text can and does offer an intervention, advocating, as part of prenatal care, for multiple spaces where multiple becomings are possible. Some newer group-based models of prenatal care, such as Centering, emerged as a way to offer such spaces to pregnant women and to some degree to their partners (Novick, Sadler, Kennedy, Cohen, Groce, & Knafel, 2001). However, reflecting a woman-centered ideology of care, these spaces can also be exclusionary of certain knowledges. The relational perspective, which this text offers, suggests instead that pregnancy-related interactions should be opened to and attentive to the multiplicity of knowledge and experience of each participant. As I would discuss later in the section on implications, this might suggest that prenatal care interactions, including with professional care

providers, may benefit from happening in contexts outside of formal institutional structures.

Perhaps one can say that I was "leading" the text in this direction from the very beginning, my "biases" underlining every phase of the project and necessarily reinforced by my choice of methodology. But I have to say, this methodology has led me to look at something I know very intimately - my/our own pregnancy with Sammie - from a different angle, see it new, ask different questions, and learn different knowledges. Isn't that what we should ask of research? Because the performative dialogic methodology has been so central to this project, as well as its greatest challenge, I begin this chapter of temporary conclusions with methodological reflections. After that, I summarize the "implications" of this project - as the directions in which it moved me. I leave the text off with a brief discussion of the project's limitations and hopes.

Flying, Episode 1: Methodological Reflections

When I first humbly dipped my toes in the area of social science research (circa 2004), I was told (or perhaps I thought) that scholarly writing is dialogue-oriented. Research is supposed to invite, produce, etc. conversation, so that scholars may continue to advance science (or should I say, scientific discovery) for the purpose of the greater good. I totally drank that cool-aid! I mean, how cool was that - I've been philosophizing with my friends since I was a teenager, and now - not only would I get to learn/use some tools, but, if I work hard enough, I could enter a forum of nerdy nuts like us, who love that stuff?! Alright, is that too rosy?

In "traditional" (post-positivistic) modes of research, there might be some kinds of conversations... In a literature review, a scholarly writer may talk with the existing -

published and accessible - literature (or do we rehearse it?); in methods, a scholarly writer explicates tools and their applications (so that others may replicate, i.e., buy their ticket to the conversation); and then, there's conclusions, discussion, implications, limitations - Hey! There's some conversation topics for you, welcome to the club. In Baxter's (2011) terminology, research has proclaimed (perhaps attempted) to be dialogically expansive - to invite and include multiple voices, discourses, and thrive from their interplay. But in many cases, research has been dialogically contractive - in that in its own discourse, language, techniques it had set the parameters, cutting through and out centrifugal voices.

This criticism is nothing new, really. Different versions of science and scholarly labor have attempted to mark the injustice of exclusion - with very material consequences. Different versions of science and scholarly labor have created alternative enclaves, so our choices of clubs to join are more than they used to be. So now, when I talk about what matters in my work or my life, my overall orientation to science and the like, I have more categories to choose from, but I still choose categories and being in one makes it difficult to be in some other ones, even when it seems that there might be something completely different there, in meeting.

Great things don't happen in tiny little increments. They happen when someone thinks completely differently. And all you geniuses, you're just modifying algorithms.
(Lip Gallagher, *Shameless*, March 17, 2013).

*Yeah, when we... it's an interesting dilemma because when you...
structure provides a way to move forward,
you know, by having structure and a technique or whatever,
and whether it's in medicine, or whether it's in a conversation or problem-solving,
like on these committees that I'm on,
it's structure that allows the conversation to move forward,
but the very presence of that structure also limits the kinds of things that get talked about.
So, it's a, it's a challenge to have the structure*

*and to use it as a way to move the conversation forward,
but also to allow it to be open enough
without getting
stuck (!)*

(Mariyana, Interview, October 2013)

My greatest challenge (although I had my gripes with them all, unable to fully shed a post-positivistic upbringing into research) in thinking and writing this dissertation has been

not the "sample"

not the analytical categories

not the conclusions

etc. etc. etc.

My greatest challenge has been

writing

a dialogically expansive text.

And still not knowing if it is... could it be known?

I never imagined really how much more difficult it would be to include voices the way they are here as compared to, for example, presenting themes I "discovered" in my readings of interviews and then supported with snippets of data. No, you'd think it's just a matter of copying some text, somebody's words, attributing them to that person, and then doing the same with a bunch of other words from other people. No, you'd think, what is the scholarly labor there? Where is the scientist? But what I found out, at least for myself, is that when research, when science is done this way - as clumsy as this text probably still is in its current form - the questions are different, too. And I was confronted like never before with a question and a responsibility of ethics, of morality! Qualitatively extracting

themes, as I have done in the past and will probably do again sometime in the future, removes me from the person-hood I encountered in the face of an-other. It turned out, surprisingly to me, that more traditional versions of thematic analysis are easier when it comes to felt accountability of the researcher.

In this, I think, there is a shared line between the research process and prenatal care, or health care in general: how does a certain conversational and communicative practice - as a researcher, or a medical professional, or a patient - position us in relation to others, in terms of our accountability to their humanity²⁷? I'd dare say that it was through this performative methodology that I, as a researcher, a mother, a spouse, a patient, etc., was in frequent deep state of awareness and reflection that as I'm writing my story, I am also writing someone else's. I couldn't look from above any more... What would that story be like?

I'd dare to say that even dialogic communication scholarship has not always produced very dialogic texts. Under the assumption that others' texts (interviews, narratives), which we have included in our texts, are dialogically expansive, there is the promise that the text as a whole is expansive and invitational. And to some degree it is - after all, it does include multiple voices. But perhaps wonderfully performing a dialectic, such texts are also dialogically contractive, as they follow a structure that fails to perform, invite, include certain other voices (Moreira, 2007). And, of course, we all make choices - in writing a text, there is no un-refined "reality," but we (strive to) produce reality of some sorts. So, I go back to my *CODA Upfront*: how do I relate to others and what are the worlds that we make?

²⁷ Of course, the inconclusive openness of this text - as format - will not always, if ever, be desirable in medical care when preserving the physiological being takes precedence over everything else.

*Those who perform culture critically are learning to
use language in a way that brings people together.*

(Denzin, 2003, p. 79)

I struggled - and hope others, too, will take the challenge of such struggle seriously - to write a text that invites (not only declares that it does), a text that makes you want to argue, to question, to say, recognizing your own existential crisis of representation (Denzin & Lincoln, 2005), "yes, this is (only) a version of reality, but one that I can't help but engage with!" Of course, I don't know that I have been successful - and likely, this is not a wondering with a clear resolution. Why include others' stories? And why in this ways? Why not "analyze" traditionally? Why not tell others' stories, as they are weaved in through mine alone? Why interview? Why snip pieces of interviews and transplant them with others?

*Interviews are part of the dialogic conversation that
connects all us to the larger moral community.*

Interviews arise out of performance events.

They transform information into shared moral experience.

(Denzin, 2003, p. 79)

Well, yes, I drank Denzin's utopian cool-aid, too. And here I go, explaining why this method is morally just, accountable, more dialogic than others. But has it been? Or only within the walls of that club, but not the other?

These questions are haunting and not simply post-factum. Not seeking the "nothing you can do about it now" consolation at the end. Moving forward... and backward... and sideways. These questions are significant because I would like this text

to be read by others, to be mulled over, to be the question mark, the **indentation**. I want doctors to read it, and nurses, and midwives, receptionists, community educators, pregnant women, women who think they might want to be pregnant, men who think they might want to be fathers, fathers, grandfathers, and grandmothers, and siblings, and friends... you get the idea. But here I am at the temporary end of it and I wonder what are the limits of conversationalism? When does brining in (too) many voices become "a jumble," as Aneesa put it, and when is it discredited as a non-conclusion pseudo-research? For, as dialogic as I may proclaim this text to be, its contributions will be minimal if doctors, for example, put it down as lay people's non-research mumbo-jumbo.

I stand this text, humbled and self-critical, next to and against studies, such as Root and Browner's (2001) that included over 150 interviews with pregnant women or geographer's Ranjana Chakrabarti's (2009) mixed-methods dissertation on pregnancy and prenatal care experiences among Bangladeshi and Indian women in NYC. With an urgency that is beyond the impending "need to defend," I ask myself how do we, whose voices are here, add to that conversation? What do we offer here that enriches considerations of an already complex social, personal, and physiological process? Since I rely on Baxter's (2011) notion and use of dialogism as a heuristic approach to make possible new ways to look at a phenomenon, what are these "new" ways? What knowledges have we produced?

Flying, Episode 2: Implications, Variations

This project contributes to and expands existing (feminist) literature on reproductive discourses and health in at least two ways. First, unique to this research is its explicit focus on the role of affinity networks and various interpersonal interactions in the

production and experience of pregnancy and prenatal care knowledge. Much of the scant communication research on reproductive issues seems to re-inscribe an epistemology of Western (feminist) individualism by exploring reproductive histories as personal choices and isolated female experiences that, although lived and considered in a cultural context, are rarely seen as *relationally constrained, constructed, and relationally constructive* (e.g., see chapters in Hayden & O'Brien Hallstein (2010)). In conversation with such work, this project articulates different, relational epistemological possibilities for prenatal care.

Second, this project problematizes one-dimensional dichotomies, such as the medicalized-natural birth juxtaposition, that are often associated with reproductive (rights) discourses in the U.S. (Saukko & Reed, 2010) and are linked to identity politics that uncritically link relational and interactional identities (Tracy, 2002) to certain bodies and professional occupations. Thus, in work that pronounces itself “critical,” medical workers are often implicitly assumed to only represent and act according to a biomedical discourse. This discourse is (again) presumed to be hurtful to female empowerment, which is accomplished more properly through a midwife care and “natural” birth, leading to a dogmatically-perceived notion of “true self” (Saukko & Reed). Such a-priori stances may be helpful in reifying the many mundane ways in which women (of what race, class, sexuality, age?) are “oppressed” in the U.S., but they do little to help us consider how intersectionality and lived experiences continuously shape our relationships and our agency. This strategic essentialism may be useful in critiquing structures, and that is an aspect that I've retained here. However, I also sought to dialogically engage the naiveté of *presuming* the vulnerability of a pregnant woman and the omnipotent power of a

medical provider. Rather than (re-)inscribing juxtapositions, I hope this project engages the ways in which, in coming in contact with one another, multiple knowledge(s) and identities are vulnerable to revisions and re-workings. This is not to deny that certain social positions are structurally awarded more legitimate authority than others, but it is to see this authority and the knowledge(s) and identities associated with it as moving, in process, fluid (Foucault, 1978).

At the intersection of relationality and problematic dichotomous oppositions, this text performs both needs for and models of inclusive pregnancy and prenatal care. The call for inclusive and dialogic (often called patient-centered) health care is nothing new. But what does inclusivity and dialogue look like? This project's contribution is in its implication that experiences of care during pregnancy are deeply about belonging - to a family, a community, points of view, knowledge and power structures. It is perhaps easy to see how this would be fairly obvious in relation to pregnant women. However, the stories of prenatal care providers, pregnant women's partners and family members - the other stories included in this project - perform that for them, too, experiences and performances of care are about belonging and reflectively (even if not explicitly) engaging perceived and desired positions in society.

Providers' knowledge, thus, is not only about performing and reading tests or physical exams. As we saw in chapter 6, they are also highly knowledgeable about health care structures and limitations - and have experienced those both professionally and personally. Their knowledge is also moving and developing with every new interaction. Though it might not always seem "professional" in the medical encounter (based on standards of distant objectivity), bringing in those experiences in the context of care

interactions may be positively perceived by patients. Additionally, it would allow providers to engage their own changing and complex experiences with health care structures in non-conclusive, critical, and fluid way - that, as we see in the stories of Peggy, Mariyana, Martha, and Charlene their medical knowledge does not (have to) exclude their mother knowledge, woman knowledge, partner knowledge. Belonging to these multiple knowledge communities does not have to be mutually exclusive or linear.

Some of the stories in this project suggest that it might be the structure of the interactions and/or expectations of/for the providers that exclude certain knowledges as irrelevant or inappropriate for the situation. If pregnant women and their partners turn to friends for "anecdotal" knowledge of pregnancy and care (e.g., Cindy & Mark), why seek it from a provider? Does keeping sources separate, looking for different things from each one, also preclude the creative mingling of knowledge streams coming from a single "source?" As part of her study of pregnancy and prenatal care experiences among immigrant women in NYC, Gálvez (2011) describes her attendance at a community event at which women (pregnant or not, of various ages) were constructing some sort of photo family trees, identifying and linking health knowledge and beliefs to their journeys. This was not a specifically health care context, in fact, it seems to have been deliberately taken out of the health care context. A space for the different, often dialectical, contradicting knowledges and impulses was made.

To some degree, group prenatal care serves to create a similar dialogic experience in the formal context of health care and, as such, was narrated as highly positive in this project, as well as in prior research (e.g., Novick, 2009; Novick, Sadler, Kennedy, Kohen, Groce, Knafel, 2011). However, by positioning this interaction within the formal structure

of prenatal care, the providers are still presumably included strictly in their role as providers. In one story here, they were called "facilitators." In Gálvez' (2010) study, providers were not mentioned as participating in the community event. So, where are the spaces for engaging their knowledge multiplicity in creative ways? The intertwined stories of Peggy, Patty, and Paul in this project suggest an appreciation and a stronger bond, a sense of belonging in various ways, when prenatal care interactions allow for an intimate inclusion of various knowledges - medical, personal, affective, relational. But... Peggy, Patty, and Paul are a family. Is belonging the a priori there? Do known relational and personal histories make the varied kinds of knowledge more obvious there?

The stories told here perform multiple knowledges *are* "operative" and intersecting in interactions during pregnancy, which is what makes such interactions formative and constructive of belonging as the affective experience of care. However, what is done with such multiplicity? Where does it go in phrases, such as "evidence-based," that purport to guide practice:

Peggy: ... it should be evidence based, you know, evidence tell us...
you wanna do things that are evidence-based -
they throw that term around all the time
evidence-based, evidence-based
but there is a place for intuition
in the, in the, in the equation somewhere

If this project were to suggest an "intervention," it would be to allow the spaces for intuition and other types of knowledges - providers', patients', partners', etc. - to be engaged freely in non-definitive ways. A place or an event outside of the liability-marked context of the medical encounter where the multiplicity of knowledge is not necessarily toward making conclusive health plans, but toward connectivity. A place/space for

ambiguity and uncertainty as dialogically constructive. As Paul had put it, a place for the "I don't know" as knowledge.

If such places are already carved and created in interpersonal interactions around pregnancy, as some of the stories included here perform, what is the utility of inscribing the "care" and organizing them in more structured ways? Here is where culture-centered approaches (CCAs) to health communication (Dutta, 2008) provide an insight - inscribing something (new) into the structures changes the structures and opens up recognition and performance of agency where it might have seem invisible or impossible before.

Recently, the Oregon Foundation for Reproductive Health launched an initiative that they describe as "groundbreaking, yet simple, solution to making Oregon women and families healthier and ensure that more pregnancies are *wanted, planned, and as healthy as possible*" (<http://www.onekeyquestion.org/>). The simple solution is for general practitioners to ask women "one key question" during annual check-ups - "Do you plan to become pregnant in the next year?"²⁸ This, it is posited, will contribute to dialogic, rather than prescriptive, conversations about pre-conception care (if the woman plans to conceive) or contraception (if the woman does not plan to conceive). Supposedly, the "one key question" changes structures, allowing women to speak from within their experiences and concerns, as well as performing the importance of thinking and caring about reproductive health as routine preventative health care.

I read the article in *Bitch Magazine* on the "one key question" initiative shortly after I had my annual OB-GYN exam (which, as the doctor, nurse and I acknowledge

²⁸ For more on the initiative see, Bitch Media magazine (<http://bitchmagazine.org/post/one-key-question-birth-control-healthcare-oregon#comment-74311>) and the OFRH's powerpoint (http://www.oregonpublichealth.org/assets/2010_Conference/bellanca_onekeyquestion.pdf)

with laughter, had not happened for the past 3 years). At the typical visits to which I go as a female patient who has given birth, I am always asked

"What method of contraception do you use."

I say, "We don't."

Follow up, "Are you trying to get pregnant?"

I say, "We are not NOT trying."

That particular time the nurse, with whom I had cheerfully chatted about our kids and daycare and work, says, "Oh, ok, so expect to get pregnant in December, cause there's no way you'd get pregnant before you defend your dissertation, it's too much stress."

But it is during this highly pleasant interaction, where I feel welcome and comfortable, and connecting, that I think to myself... I wonder if Remi is ever asked about his/our reproductive health and decisions in such a systematic manner. I ask him. He is not. But, he says "it's not so immediately relevant to my, to men's physical health." No?!

I remember all the stories told and told on in this text by men and their pregnant partners, stories of felt exclusion and desired inclusion - in different ways, but still stories of belonging. Stories of longing and fear of "inadequacy" of "not knowing" (though that's also knowing). Stories of wanting to carve spaces where there is room for that different knowledge and uncertainty. These stories have thought me a lot, they're not inconsequential, they're not data for my professional advancement... I think these stories, told in-between, alongside, interrupting other stories are interventions.

Then, I read the article in *Bitch Magazine* endorsing the "one key questions" initiative as transformative and woman-centered. I post this as a reply to the article:

Yes, and... but...

Posted by lily (not verified) on October 2, 2013 - 4:25pm

It's a good idea to attempt an open conversation instead of only presumptuously "prescribe." But 1) the ideas of family planning and informed choice (let alone discussing it) come from a very particular version of feminism - white, middle class, going back to the 1970s and 2) if we were in any way to transform the culture into one of shared care and responsibility, men should also regularly be asked about their reproductive health and plans during annual check-ups - pre-conception health is relevant to men, as well as women, as are matters of contraception. Perhaps if those questions were routinely asked of men as well as women, we can transform a culture that generally places the moral responsibility of reproductive health onto women (it's part of WOMEN'S health, after all), while legislation of reproductive health is largely outside of women's hands - both of these are equally unjust and close off amazing opportunities for connection!

(<http://bitchmagazine.org/post/one-key-question-birth-control-healthcare-oregon#comment-74311>)

In all of my learning and co-experience during this project, it differs from and contributes to existing literature in two major ways – first, it engages pregnancy and prenatal knowledge from an interactional perspective, incorporating the experiences of variety of people who are identified by pregnant women as important during the pregnancy; second, it destabilizes dichotomies of natural vs. (bio)medical and feminine vs. masculine ways of knowing – dichotomies that are re-inscribed in much of the existing literature. Taken together, these two contributions of the present project, have a broader practical implication toward the possibility of a dialogic approach to culture and interaction in the praxis of healthcare in a diverse society, where more cultural “sensitivity”²⁹ is consistently called for from health care providers and positioned as the work of health communication practitioners (Ford & Yep, 2003). I believe this text and

²⁹ I use this term here, but very cautiously to only mark attention to and engagement of culture as both structure for and structured in health care interactions. See culture-centered criticism of the "cultural sensitivity" (Dutta, 2008)

the multiple intersecting stories in it contribute to a different way of thinking about prenatal care and health care in general, changing the interactional dynamics not simply toward a better understanding, but toward a more ethical co-presence. I believe this to be a political and transformative contribution toward a process of knowledge production by standing on “both shores at once, and, at once, see[ing] through serpent’s and eagle’s eyes,” in the words of Anzaldua (1987/2007, p. 100).

Flying, Episode 3: Limitations and Futures

To include traditional consideration of "limitations" in a purportedly performative text would be somewhat disingenuous. The greatest limitation of such a text would be if it fully fails in reaching and moving the reader in at least some small way. I discuss "limitations" here in terms of hopes... hopes that are left or arose out of this project are hopes that were not satisfied by/in it. As such, they are directions and they are also what would traditionally be called "limitations" of the present project. Some of these missed/future hopes were fantasies I had at the beginning of the project, they were hopes and remain such...

Perhaps this - a research stance of hoping - would be what some would see as the biggest limitation of the project – a subjective position guiding my interpretations, my listening, my conversations, my writing. Without a doubt, this is so. I am present in this text through and through. As in the *CODA Upfront*, I am also a text. I have sought to (at least partially) dialogue with this dynamic by choosing performative story-telling as a methodology for this project – not to (objectively) present some “truth” as spoken by somebody and to abdicate analytical responsibility, but to open to readings – readings of me and my experiences (including those of narrating others’ stories) as a cultural text.

With this project, I did not strive for suggesting specific guidelines and interventions – I hope(d) for possibilities, for this project to be an intervention in itself. To perform, to try out a different way of thinking about prenatal care. While I can see that a clear intention to “look for” patterns of destabilizing dichotomies and dominant discourses may be an interpretative limitation, I believe the deliberateness of this orientation was necessary in light of seeing such possibilities.

On a more “practical” level, a limitation of this project was related to my intention to talk with a variety of people whose presence is seen as important in a woman’s experience of her pregnancy. Reaching and talking with multiple people in a woman’s affinity network was difficult and was not encouraged by the pregnant women themselves. On occasions, even when the partners were present in the house during our conversations, they did not join, despite being explicitly invited. In itself, this dynamic may be performative of a dominant social norm that associates pregnancy and child care - at least in their public appearances - with women's work. This position is also reflected in calls for *woman-centered* maternity care. While, when prompted and sometimes spontaneously, pregnant women and prenatal care providers discussed the role of family members and friends during pregnancy, it seemed still that it was the women who took on the narrative authority over such involvement.

Thinking back to my own family dynamics and stories of pregnancy, two things come to mind. Firstly, majority of collaborators in this project (considering those who signed consent forms) had white, middle-class, educated, heterosexually married families of U.S.-born individuals. As discussed in chapter 5, a dominant discourse of family performed in collaborators' stories was that of the nuclear family. Yet my own

experiences and ideals of family and friend care during pregnancy had led me to expect a much busier prenatal care social environment.

Secondly, however, I think "participation" was guided by an underlying hierarchy of knowledge and more so of knowledgeable people. While I was hoping this project would disturb such hierarchy (and maybe it still does in some ways), I saw it performed in the dynamics of arranging project participation. Though multiply-targeted "recruitment" strategies were used, including direct correspondence with the partners' group at XY, with one exception, it was only pregnant women, midwives, or an OB-GYN who contacted me. No family members of pregnant women, no nurses, no prenatal care clinic receptionists or ultrasound technicians. This suggests an assumption of the key-involvement figures in pregnancy: the pregnant woman and the highest-positioned medical provider responsible for prenatal care. This was also part of the dynamic in conversations where pregnant women and their partners were present together - for the most part, there was a tendency for pregnant women to answer questions first and for their stories and voices to dominate the conversations.

The inclusion of pregnant women and their partners in the same conversational situation was important in light of Baxter's (2011) call for considering relationship dynamics and histories when exploring dialectics. On a personal level, I think such inclusion is also transformative because it troubles hierarchies of knowledge - performing that "yes, you also have experience and knowledge and they matter a great deal, especially in relation to another's, to your partner's." At the same time, future research might consider both creating dialogic spaces for partners to tell their stories with each other, as well as separately.

While it might seem like together-telling has been part of the methodological repertoire of interpersonal communication for a while, it has not perhaps been a part of that repertoire in relational ways. Baxter (2011) writes,

... underrepresented in research to date are utterance chains that are implicated in the conversational exchanges between relationship parties. Reliance on self-reports *overemphasizes meaning-making to third parties (researchers)* and provides us with limited insights into the meaning making that unfolds in the moment between relationship parties. (p. 61, emphasis added)

Thus, methodologically, it is not simply about arranging for families and/or friends to be "interviewed" together, but it is more about critically engaging the interaction of which we are all a part together in the course of the "interview." This would mean a recognition that stories and story-telling are not so much "self-reports" as they are creative processes in moments of becoming. As a "research" model, such an approach could be especially beneficial in health communication, when considering provider-patients interactions, as it could shift the form of the interaction - from one where a person submits him/herself to an examination or a diagnosis to one where health and its meanings are reflectively engaged as collaborative creations.

Akin to such processes, one of the commitments of a culture-centered approach (CCA) to health communication is inclusion of "marginalized voices" (Dutta, 2008) and creating contexts respectful of and engaging marginalized groups' agency. Some of the models emerging from CCAs are town halls, performances, and community organizations, built from the ground up and involving multiple stakeholders (e.g., Dutta, Anaele, & Jones, 2013). Much of critical feminist research on pregnancy and birth has

positioned (generalized) women's voices in the U.S. as marginalized in relation to presumably dominant biomedical views and institutions. And similarly to more recent CCA practices, birth and women's health collectives have been organized as a way to seek and establish inclusion. *Our Bodies Ourselves* (<http://www.ourbodiesourselves.org/>) is perhaps one of the longest-running and most prominent among such collectives. This may make the application of a CCA to this project obvious.

Yet, I contend that beginning with a CCA here raises a number of important questions and potential limitations around inclusion in this project. CCAs to health communication are concerned with *group* participation and the ex/inclusion of particular social groups in policy-making and daily practices that impact them directly. In this sense, I have to say that I was/am painfully aware that this project included a very narrow, and in many ways dominant, segment of the population. Women in this project narrated repeatedly that differences in beliefs between them and their providers caused tensions, while a sense of agreement and openness, even when there was no agreement, was perceived as "good" care. Both prenatal care providers and expecting family constructed the image of an ideal provider as an informed, but flexible guide through the journey of birth and pregnancy. Families and providers alike emphasized the importance of choice and feeling empowered to choose. As discussed in the previous chapters (particularly chapter 2), this emphasis on choice is a very particular socio-historical orientation (Hayden & O'Brien Hallstein, 2010). Yet, I imagine that as such - as a dominant discourse - it would have surfaced as important in the narratives of members of various other racial, national, socio-economic, sexual, etc. communities.

It was performed by my doula-in-training partner at the Hampshire Conference who felt doctors at XY shoved her in a corner and told her what to do. A painful, scarring experience that makes obvious an experience of discrimination, linked to the illusion of choice, as well as to its importance. While the bigger theme - the importance of choice as humanizing - may be relevant to various groups and their members, it would likely be so in different ways. The families and individuals I talked with (under signed consent) had socio-demographic profiles that were similar to one another and would hardly fit ordinary definitions of "marginal." Besides being a non-U.S. citizen, I largely fit that profile, too. And you know what? We have a seat at the table (Ahmed, 2010). It might be a corner seat, unstable, but it is a seat nonetheless. A seat from where-in we can muse and fume over impositions of technology over the natural miracles our bodies are capable of.

But, if anything, this project emphasizes how important is a sense of social belonging to an experience of a "healthy and happy" pregnancy and to motivations of taking care of one's self. So, how would the questions of choice and power look like among members of socially-marginal groups? From where I stand and fear exploitation of the "subaltern," I still can't help but see this as my greatest disappointment and most significant limitation of this project - the relative socially-powerful homogeneity of the people whose stories are included here. Perhaps tied to my post-positivistic upbringing in research, I had hoped for more nuance and socio-demographic diversity. There were various issues with "access" and recruitment that contributed to that and I turn to them in the next section.

But first, I want to outline briefly one way in which this project revises and contributes to CCAs and their practices. As others have discussed before (e.g., Lipsitz

(2006) in relation to whiteness), social hierarchies are supported by the performative enactment of certain positions. The CCA contends that hierarchies can also be troubled by making room for agency where it is suppressed and/or discounted. However, from a dialogic perspective that focuses on "utterances" more than the (groups of) people who perform them (Baxter, 2011) this project draws attention to the question of what prenatal care and pregnancy experiences become marginal discourses by not being admitted in pregnancy interactions. Thus, marginal voices (what is sometimes referred to as subjugated knowledge (Jordan, 1997)) and the marginalization of voices are part of the experience of (presumably) socially-dominant groups, as well. There is room, in other words, for CCAs to health communication to explore the marginalization of pregnancy care discourses in the practices and stories of health care providers or white, middle-class, educated, employed, heterosexually-married women. Looking at discursively marginalizing practices of (presumably) dominant social groups makes sense for CCAs from a systems point of view, since, as Baxter (2011) has demonstrated such a study can become a study of "openings" for inclusion.

Having "learned" the above, however, does not lessen my hopes for having included more varied voices in the conversations told and constructed here. Everyone who signed a consent form for participation was, in one way or another, linked to single local prenatal care and birthing clinic/practice, be it through its midwifery or its OB-GYN branch. Though repeated recruitment contact was established with several midwifery and OB-GYN practices in this geographic area, only representatives of this one particular practice - XY - contacted me back and sent out several recruitment announcements to their patients/clients and support groups. As discussed in chapter 3, from other

interpersonal contacts I established at community events, there was not a single person who contacted me back for a more formal participation in the project. Other interpersonal efforts to "recruit" collaborators were also in vain. Most reflectively striking for me was the response of an OB-GYN doctor from a local big, Trauma 1 teaching hospital to whom (and others) I have reached out via a scholar engaged in another on-going study of experiences of low-income pregnant women and mothers at that hospital. The physician had responded that the present study - of pregnancy knowledges - "sounds interesting, but apparently lacks clear research design."

This response focused my thinking on limitations of "access" on several levels. Firstly, my "access" to certain groups of people was limited and guarded against by "health care gate-keepers," who may or may not see the value in what I was proposing to do. It is little wonder that the one practice that was responsive to my requests is also the practice that is most immediately, openly, and politically involved in transforming practices and standards of maternity care. This "attitude" was shared by their patients - mostly educated, well-to-do locals - who *chose* the practice precisely because of its values. And even in that situation, when I had asked about the possibility to attend some of the group prenatal care meetings they organize, or the partners' group, or a class... even when I had asserted that patients' consent will be obtained, I was denied access "in order to protect patient confidentiality" and "keep the safe-space climate" to which the practice proclaimed a commitment.

Secondly, bearing in mind that my ability to connect with people was regulated by various "health care gate-keepers" who were evaluating this research in terms of seriousness, implications, impact, etc. before forwarding the information to others,

"recruitment" was possibly negatively affected by seeing this as a "student" project. The University at which I am completing my PhD has established research partnerships with a few local hospitals with research using a combination of qualitative and quantitative post-positivistic methodologies. There is an established pattern of doing "valuable" research with recognized faculty partners. This project did not conform to such a pattern, reducing its credibility to possible collaborators.

In fact, engaging OB-GYN physicians in this project was one of the hardest recruitment tasks, despite personal calls and outreach. Only one OB-GYN agreed to participate and again, Martha had a self-proclaimed midwifery mindset, strong appreciation for story-telling and a link to the XY practice. For me, this raises questions of "access" in a new way - is performative dialogic research, which purports a democratic method, difficultly accessible to those who are trained to value a more rigid, prescriptive scholarship? Stories have no/are not research design... The messiness, the dialogue - rejected as deficit (lacking) and uncertainty (design)... What are the accessibility limits of performative conversationalism? I fear this project will fall short in reaching readers, similarly to the way it fell short in reaching collaborators... At the same time, I know this is not the end and it can be just a beginning of collaborative story-telling. I hope this project demonstrates the heuristic, scholarly value of the method, particularly in the complex, inherently messy, context of health care. For even "limitations" and rejections are stories - meaningful, reflective, constructive. Relationality.

Post-Script

At this point - transition, rather than an end - I move with fears, expectations, hopes.

anticipating
possibilities
the uncertainty
(of) pregnant knowledge

APPENDIX A

INTERVIEW GUIDES

Interview Protocol for Pregnant Women

- 1) Tell me about being pregnant this time around. What are the joys and challenges?
- 2) What comprises good prenatal care? Examples? What do you do as prenatal care?
- 3) Tell me about a memorable (may be positive or negative) interaction about prenatal care that you have had in relation to your own or somebody else's pregnancy?
- 4) Tell me about receiving advice about what to do and not to do during the pregnancy. What kind of advice have you received? Who gives you advice? What kind of advice do you implement and why?
- 5) How do you respond to advice? What things might you say or do if you like the advice? If you don't like it?
- 6) When do you seek advice from a prenatal care medical professional? What about from family and friends? Books and media?
- 7) How does receiving advice affect your experience of pregnancy and prenatal care?
- 8) What did you know about pregnancy and taking care of your pregnant body before you became pregnant? Do you remember hearing things growing up?
- 9) Do you experience your own pregnancy differently from what you have heard other people talk about? How so?

10) Tell me about interactions you have about being pregnant and about prenatal care.

How do your medical visits go? How do conversations with family member go?

With friends?

11) What, if anything, would you like medical professionals to learn from your experiences of pregnancy and prenatal care? What would you like your family and friends to learn?

12) How, if at all, do you maintain privacy boundaries in interactions during prenatal care?

Interview Protocol for Prenatal Care Providers

- 1) Tell me about the women that you serve and about their families. Joys and challenges?
- 2) What kind of knowledge about being pregnant and taking care of the pregnant body do they bring to the interactions? Is there a memorable moment when you thought that you really learned something unexpected from a pregnant woman and/or her family?
- 3) What do you remember knowing about being pregnant and prenatal care before entering education toward your current profession of a prenatal care provider?
Do you remember hearing things growing up?
- 4) Is there anything you know and believe about pregnancy and prenatal care that is different from the formal medical perspective? How do you deal with such differences in interactions with pregnant women and their families?
- 5) How, if at all, do you maintain privacy boundaries in interactions during prenatal care?

- 6) What role(s) do emotions play in prenatal care and pregnancy?
- 7) How, if at all, do your own emotions affect interactions with pregnant women and their families? Do you think it shows?
- 8) Tell me about a memorable (may be positive or negative) interaction about prenatal care that you have had in relation to your own or somebody else's pregnancy?
- 9) What, if anything, would you like prenatal care professionals to learn from your experiences of pregnancy and prenatal care? What would you like pregnant women, family, and friends to learn?

Interview Protocol for Members of a Pregnant Woman's Support System

(e.g., family, friends, partners, co-workers)

- 1) Tell me about your experience with pregnancy and prenatal care.
- 2) What is your role in [pregnant woman's name] current pregnancy? In what ways do you feel included or excluded?
- 3) How is [pregnant woman's name] current pregnancy affecting your daily life and interactions? Your thoughts? Feelings?
- 4) What do you remember knowing about being pregnant and prenatal care before experiencing pregnancy – either your own or a significant other's? Do you remember hearing things growing up?
- 5) Is there anything you know and believe about pregnancy and prenatal care that is different from the typical advice? How do you deal with such differences in interactions with pregnant women and their families? What about with prenatal care providers?

- 6) What role(s) do emotions play in prenatal care and pregnancy?
- 7) How, if at all, do your own emotions affect interactions with pregnant women and their families? Do you think it shows?
- 8) Tell me about a memorable (may be positive or negative) interaction about prenatal care that you have had in relation to your own or somebody else's pregnancy?
- 9) What, if anything, would you like prenatal care professionals to learn from your experiences of pregnancy and prenatal care? What would you like your family and friends to learn?

APPENDIX B

INFORMED CONSENT FORM

Consent Form for Participation in a Research Study

University of Massachusetts Amherst

Researcher(s): Liliana Herakova, PhD Candidate, Department of Communication
Advisors: Dr. Leda Cooks; Dr. Claudio Moreira, Dept. of Communication
Study Title: Flying with the Storks: Communication, Culture, and Dialoguing
Knowledge(s) in Prenatal Care

1. WHAT IS THIS FORM?

This form is called a Consent Form. It will give you information about the study so you can make an informed decision whether you would like to participate. Your signature at the end of this form will serve to confirm your desire to participate in the study described below.

2. WHO IS ELIGIBLE TO PARTICIPATE?

The only restrictions for participating in this study are that you are at least 18 years of age and are presently pregnant and/or involved with somebody else's pregnancy. This last category may include involved spouses, partners, parents, family members, and friends of pregnant women. It may also include medical and prenatal care professionals (midwives, doulas, obgyns, nurses, technicians) who are presently involved in the prenatal management of pregnancy.

3. WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to collect and tell diverse stories of pregnancy and prenatal care. Many of our stories are not told, and even if they are, they are often not-listened-to because they're seen as unimportant, irrelevant, or unscientific. For example, a male partner's experience of pregnancy may be seen as unimportant because men serve "merely" a support function during pregnancy. Or the lessons a pregnant woman has learned from her grandma and friends and which she incorporates in her prenatal care may be discarded as old wives' tales. Similarly, much of the knowledge of medical professionals may be seen one-sidedly as biomedical, discarding the different cultural influences on how a medical professional interprets biomedical information toward prenatal care.

By focusing on the stories and multi-faceted experiences of pregnant women, their partners and/or other people who are close to them, and the stories of prenatal care professionals, this study will think about how culture and interpersonal interactions matter in experiences of pregnancy.

4. WHERE WILL THE STUDY TAKE PLACE? HOW LONG WILL IT LAST?

Should you agree to participate, your total time commitment will probably be anywhere between 5 and 8 hours in the span of 2-3 months. We will meet to talk about pregnancy, prenatal care, culture, and relationships at a location and time that is comfortable to you (the co-researcher/ participant). Dates and meeting locations will be scheduled ahead of time. Conversations will likely last between 1 and 2 hours and we will probably meet more than once.

5. WHAT WILL I BE ASKED TO DO?

In this study, you are asked to participate in a series of conversations/interviews. As our conversations progress, you are free to refuse answering any question or talk about any topic that you are uncomfortable with. Questions/topics included in or conversations may include ones about growing up, cultural and religious practices and beliefs, your use of media, prenatal and pregnancy practices and beliefs that you engage in. Our conversations will be recorded in audio and written form, and confidentiality protected as described below.

This study will consist mostly of conversations between you and the "researcher" on the topics of pregnancy, prenatal care, culture, and interpersonal interactions. In addition, if you feel comfortable with that, the "researcher" may accompany you during prenatal care visits and informal interactions with pregnant women, family, friends, and prenatal care providers about pregnancy and prenatal care. Finally, if time and scheduling permits, we may organize a 1-2 group meetings in which pregnant women, their informal support systems, and prenatal care providers dialogue on the topics outlined above.

6. WHAT ARE MY BENEFITS OR RISKS OF BEING IN THIS STUDY?

There will be no immediate materials benefit or risk to you if you participate in this study. The major benefit of this study is that it will increase our understanding of what are legitimate practices of prenatal care. In this way, tangentially, this study may contribute to a more positive and holistic experience of prenatal care.

Minimal to no risks may be expected in the process of this study. Some inconveniences may be produced due to the study's time demands. There might also be some discomfort from being recorded during both formal and informal social settings. This discomfort, however, will be minimal since your participation is voluntary and only interactions you agree will be recorded.

7. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?

The following procedures will be used to protect the confidentiality of your study records and, if applicable, of audio recordings. The researcher will keep all audio and written records (including any codes to your data) in a secure location (locking file cabinet as an example). Research records will be labeled with a code. A master key that links names and codes will be maintained in a separate and secure location. The master key and records will be destroyed six (6) years after the close of the grant or three (3) years if unfunded. All electronic files (e.g., database, spreadsheet, etc.) containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. At the conclusion of this study, the researcher may publish their findings. Information will be presented in summary format and you will not be

identified in any publications or presentations. If study data are to be released, you can refuse to have your name distributed or mentioned in any way.

8. QUESTIONS AND FURTHER INFORMATION?

Take as long as you like before you make a decision. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, (Lily Herakova, 413-230-4840). If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at humansubjects@ora.umass.edu.

9. STATEMENT OF CONSENT

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

I have read and/or informed about the contents of this form and decided that I will participate in the project described above. The general purposes and particulars of the study as well as possible hazards and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time.

Participant Signature:

Print Name:

Date:

By signing below I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Signature of Person
Obtaining Consent

Print Name:

Date:

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