

“I Am One of *Those* Women:”

Exploring Testimonial Performances of Stillbirth in/as Intervention,

Support and Advocacy

by

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ABSTRACT

The stillbirth of a wanted baby is a devastating and life altering experience that happens more than 26,000 times each year in the United States, but the impacts and implications of this loss on families is rarely discussed in public spaces. While another kind of pregnancy ending, abortion, dominates political discourse about reproduction, the absence of talk about stillbirth prevention or support in those same contexts is worthy of further investigation. This project explores stillbirth as a communication phenomenon and draws upon narrative, performance and rhetorical articulations of testimony to extend our understanding of how narratives of stillbirth circulate in current conditions of discourse. A model for viewing how dominant and counter narratives circulate is explained (Narrative Loop Model) and a new model for illuminating the unique functions of testimony is given (Testimonial Loop Model). This dissertation employs performance and rhetorical methods to explore testimonies of stillbirth, both naturally occurring and solicited through interviews, in order to create several performance texts that put pregnancy-ending narratives in conversation with each other on stage. Analysis of the performance text and choices, as well as reflection on the embodied performance experience and member checking, yielded several findings. The discovery of somatic sentience and its influence on performance ethnography is discussed. Themes of relationality and temporality were found in the performance of testimonies of stillbirth. The implications of these findings add to the communication discipline's understanding of how and why stillbirth testimony may circulate, its impact on conditions of discourse for pregnancy ending and its potential use as/in intervention, support, and advocacy. Ethical considerations and limitations are addressed.

Keywords: stillbirth, abortion, miscarriage, reproductive justice, testimony, ethnographic performance, critical rhetorical, health narratives, master narratives, counter narratives, public sphere theory, reproductive futurism, bodies on the line, somatic sentience, testimonial loop model

DEDICATION

To my son, Avery: You may have been small—but you were the biggest thing I had ever done. You changed my life in so many ways I will never regret.

To my son, Quinn: Thanks for believing in my capability and understanding why I spent so much time working on this project. Without your being positive when I wasn't, your patience when I lost mine, and your “cuds cuds” when I was feeling low, I wouldn't have been able to earn the three invaluable letters to put at the end of my name: M.O.M.

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CHAPTER 1

STILLBIRTH AS A COMMUNICATION PHENOMENON

Preface: My Testimony

As a Mom

Life changes when you see a pair of pink lines on a pregnancy test strip. If it's good news, your life becomes a 38-week countdown to holding your future, safely swaddled in your arms. You read books, you post sonogram pictures on the fridge, you make plans for a nursery, you put your name on child care center waiting lists. You don't plan for the doctor to tell you your future has no heartbeat. You don't plan to deliver a baby who will never open his eyes. You don't plan on coming home with an urn of ashes instead of a bag of diapers. (Pullen, 2006, p. 6)

You do not plan for the worst to happen, especially if you have no idea what the worst is. Before you see the positive test strip, what you know about pregnancy is what you pick up from friends or TV shows. The common story (or what we academics might call the dominant narrative) of wanted pregnancy usually involves the following: You keep it a secret for the first trimester because you could miscarry. If you miscarry, well, these things just happen, and you try again. You have morning sickness or cravings for ice cream and pickles. You gain weight. You get tested for genetic anomalies. You know that sometimes babies come early. Sometimes they come late. You can try for a natural childbirth or you might need a C-section. Sometimes they pop out quick and sometime the labor is really long. And there is usually lot of screaming.

The story does not end with the baby dying.

When I found out that I was unexpectedly pregnant at 35, I became a quick study on all things maternal. I read *What to Expect When You Are Expecting* and *Our Bodies, Ourselves*. I watched *She's Having a Baby*. I called friends with babies. I asked two of my closest friends, who were doulas, to help me through birthing class and be there for the delivery. I even switched health insurance plans so I could be with a highly praised OB/GYN practice and at a hospital where I knew a labor and delivery nurse. At no point in time did any book, magazine or movie warn me that my baby might die before birth. (Okay, *She's Having a Baby* had a harrowing moment that always made me cry, but everything turns out fine in the end.) The only cautionary tale I got from my OB was that miscarriage in the first trimester was common. Everything else I heard only reinforced what I thought I already knew about pregnancy. When I made it past the "safe zone" of 12 weeks, I thought I was home free.

"Are you doing ok?" My friend asks, putting down his glass of red wine. I hide the silence in my chilled orange juice. It is his 35th birthday and we are supposed to be celebrating. "You're kind of quiet," he tries again when I still say nothing.

It has been three days and I haven't felt the baby move. But I'm trying not to worry.

"Does my wife's office have an elevator?" It's a confusing question from the doctor examining me, who is the husband of the doctor I saw earlier this morning. I should hope her office would have elevator; it has eight floors. "Did you drive yourself? Does your car have a stick shift? Are you working today?" I'm not applying for a

delivery job, so I'm not sure how these questions are relevant. But I find myself answering them as if they are perfectly normal doctor/patient inquiries.

I have questions too, but I've read the signs posted around the exam room, and I know he can't tell me anything. So I hold my curiosity for his wife and leave the building when he's done. I lean on a low wall outside the lab, and for the first time, I begin to wonder what's really going on.

"Hey, Boo Boo. What's up in there? You're starting to make people worry."

I travel through heavy midday traffic back across town to my OB's practice. It is the first time in six months that I have gone to an appointment without a friend. I arrive at the building and use the elevator I had taken for granted before and head into the waiting room, only to be whisked into the doctor's office. Not the exam room. I have never met her before today, she's filling in for my regular OB, and already I get access to her inner sanctum. I feel special. Something must be wrong. I see a poster-sized portrait of her two young children on the wall. So she must know what this is like.

"I'm sorry, Suzanne, but I have some bad news. Your baby's heart stopped beating." I am not myself by the time she finishes her sentence. Reflex reaches for a pen to write down exactly what the doctor is saying. I must repeat it correctly when I am asked by others.

She sits in the chair beside me. Her hand on my knee. My chart in her lap. "What happens now?" I ask. She tells me what my options are. Her voice is gentle and kind.

The first person I call is not a close friend. She is a labor rep for the newspaper I work at. I do not know why I call her except that I know she and I share the same spiritual tradition and will understand and know what to do. It isn't until the phone is against my cheek, that I lose control of my body. I will repeat the same call half a dozen times in a row. Each time I have to say the words, glass shatters in my throat. I am crying so hard that I cannot understand my own voice. But I have to tell them so I will not be alone.

"Hi Erin. It's Suzanne. Can you come get me? Boo Boo died."

In the next few hours, I am very ... focused. I think it's my reporter training that takes over again. I want to make sure I get the things and people I need before I fall apart. Erin follows me in her car after I insist I can drive. I really just need time to cry by myself.

The first thing I do when Erin and I get to my house is to pack a bag of food and things for an altar at the hospital. Drissana is the first to get there and she has plaster strips to make a cast of my belly, something I had planned to do when I was 9 months pregnant. I am half naked, propped against the couch with a plaster cast covering the places that feel broken as one by one Joe, Nancy, Dress, Kala, Stas, Jason, Anna and Becky arrive.

I just have flashes of memory about what happens next. Sitting in the middle of a circle. They are singing and sniffing. Someone reads poetry. Someone is holding my hand. Someone, Joe, is playing a flute. Someone is crying. I have to get lower. I can't hold my body up any more. I slide to the floor. The hardwood vibrates with my

screaming. I am not in the real world anymore. I am between the worlds of life and death. I am in body and outside of it. And I hear his name. I whisper it into a stillness that I feel settling on my skin.

Avery. "Leader of the elves" is a fitting name since he is so small and elf-like in my belly. The elves are calling him back for important work on the Good Road and now I have to let his body join them. I am smiling. I am proud. I have been anticipating his arrival.

Even though it is too soon, I am his mother and I have to prepare for his special day.

We leave for the hospital sometime after 9:30 pm and my entourage and I are admitted. I immediately move the furniture around to use an instrument cabinet for an altar for Boo Boo where I can see it. Quan Yin for compassion, the pregnant fairy Stas had given me, items representing the four directions and a stuffed Eeyore, because if ever there was an appropriate time for a depressed donkey, it was now.

My doctor, Dr. F is on call and she comes in to administer the first dose of miso, which I am surprised to learn is not the soup, but the suppository to help start the contractions. Stas, Sam, Anna and Becky stay through the night. My mom and her partner Jen are driving from Arizona and should arrive around 4 a.m.

Jason, Heather and Erin visit several times and Tracy, who is also a labor coach, stops by. There are never less than four people in the room with me and most times there are eight. I have no idea how this is supposed to work. What proper protocol is for when your baby dies before it comes. But this isn't for the baby any more. This is for me. And I

can't imagine going through his death without the people who I had planned to be a part of his life.

When we packed up to come to the hospital, I had sent Anna and Becky for disposable cameras, chips and chocolate. I had collected markers and paper and put them in with the rest of the supplies. I ask my friends and visitors to draw pictures or write letters to Avery and hang them on the walls around the room. The nurses who walk into the room seem a bit surprised to see us laughing, eating, writing and making fun of ourselves. But that's what we always do when we get together, it's how we make sense of things. Why would this be any different?

Everyone is exhausted, but there isn't much room. There is a rollaway bed and a recliner, the kind present and non-functional in almost every hospital room? Every time Stas tries to lay back in one, she has to brace herself by splaying her arms and legs, and the minute she is relaxed, the damn thing tilts forward, snap close and causes her to slide to floor. It happens every time we need a laugh.

For the next 20 hours I get on the job training with Stas and Sam who help me labor. Breathing through contractions, walking, visualizing. The pelvic exams and the insertions of the miso every few hours become incredibly painful. I have made some progress, but my body is far from being ready for labor. My cervix has softened and thinned some, but I haven't dilated at all yet.

I finally decided to take a painkiller to sleep for a little while. After an hour-and-half nap, I wake up determined to go to the bathroom. I have had a fever of 102 since the beginning of my labor which is a side effect of the miso. Every time I go to the bathroom, I feel my limbs freeze up and start shaking uncontrollably. So I try rushing to get there as

fast I as I can, because I am afraid of feeling cold.

Only this time when I wake up I don't remember that I am attached to an IV on one side and a contraction monitor on the other side. Stas and Sam are finally dozing and so I get up on my own. The minute my toe hits the floor, it's like alarm bells have shocked them both awake and they are asking me what I am doing. I ignore them and head straight for the bathroom because I can't waste the warm air in my lungs.

*They both try to get me to slow down so I don't rip the IV out of my arm and pull the contraction monitor off the shelf. I can feel the shakes come on, so I ignore them and plow on. Sam says she's unplugging the monitor and Stas keeps trying to explain to me in a rational, yet urgent, voice that IV machine is plugged into the wall and it won't reach the bathroom. I, quite frankly don't give a shit, it is already too cold for me to care. I finally force my way to the bathroom, having no idea how the IV came with me, expose more of my flesh to the cold air pulling my mesh hospital underwear down and sit on an even colder toilet seat. They crowd in on either side of me, and then my mother is suddenly in front of me reaching out to touch my thigh asking me to calm down and relax which only makes me more cold and angry. I scream, **“DON'T TOUCH ME! LEAVE ME THE FUCK ALONE!”***

My howling rage brings Kala into the room. Everyone clears out. “Suzanne, this is the drugs talking. I think it's time for you to think about getting an epidural.” I do not resist, much to the relief of everyone. “Okay,” I say. I had wanted to give birth to Avery without drugs. I had wanted to feel as much of him traveling through me as I could. I wanted to feel him being born. But my body will not let go of him willingly. After an excruciating four tries for an ancient hellspawn anesthesiologist who repeatedly stabs my

spine inducing the worst pain I have ever known in my life, the world I have been tied to for the past 36 hours slides away.

“Suzanne? Can you hear me? Suzanne?” The voice is gentle and unfamiliar. My eyes flicker open and I see her face. It’s Dr. W, another OB in my doctor’s practice. “It’s time to push,” she says. I do not know what this means. I haven’t done the child birthing classes. I haven’t practiced breathing. I am not sure what I am supposed to do. I clumsily try bearing down. Four painless pushes later, he’s out. Dr. W hands me the scissors and I cut the umbilical cord. In the silence as Dr. W puts him on my chest she says, “It isn’t often we get to birth angels here.”

At 2:34 am Thursday, March 3, I meet my son. I cradle him on my breasts and tuck his small, but hairy head under my chin. He smells exactly the way I imagine all newborns do -powdery sweet. With his bright red lips, he would have been a heartbreaker. With his long fingers and big feet, he would have been a NBA all-star or a jazz pianist... being a child of mine, he probably would have been both.

He is perfect. To me.

“Do you want to hold him?” I ask my mom. She has watched him pass through everyone else’s arms, but she only reaches out a single finger to stroke his back while he was tucked under my chin. “I want you to hold him, Mom. Please?” Very slowly, she bends down to scoop Avery’s into her big hands and presses him to her neck. She holds him as delicately as a hollow Easter egg. She had always held back. She had always been afraid of her feelings. She never seemed comfortable in her own skin, as if she was living

her life in atonement for the mistakes she made. Like she didn't deserve to be happy.

I had never understood where the sorrow started, until that moment. My mother told me that her first child had been born with cystic fibrosis in the 1960s and she had never been able to do more than touch her through thick gloves in an incubator before she died. No one in the family acknowledged what had happened or that there had ever been a baby. But in holding my son—a baby accepted and embraced by close friends and family the minute they knew I was pregnant—my mother was telling me a long buried secret. She had lost a piece of her heart and no one had noticed. But in those moments that my mother held Avery, I saw the shadow of a baby girl being held by a deeply profound blessing.

“One pound, seven ounces. 13 inches long.” Kala has taken Avery’s measurements, helped me trim some tiny hairs from his head and take ink prints of his hands and feet. Erin, Heather and Jason come early before work to see him. Holding Avery made him real, for me and everyone else who held him in that room. But no, these hours later, he doesn’t quite look himself. He has gotten a bit sunken and developed a Mr. Magoo-like furrowed brow. Sometime around 9:30 am Thursday, just 48 hours after his heart stopped and after seven brief hours with him in my arms, I decide it is time to let Avery’s body go. One of the nurses takes him from my arms, wraps him in a blanket and takes him away. He may have been tiny, but he is the biggest thing I have ever done.¹

¹ Excerpted from *He Was Still Born*, the autoethnographic performance in my master’s thesis.

At six months pregnant, when my doctor said, “I’m so sorry, Suzanne, I have bad news. Your son’s heart stopped beating,” I was confused, dumbfounded, shocked, paralyzed. What did that mean? What was I supposed to do? I was a journalist, so I masked an overwhelming sense of disorientation and disbelief with procedural questions and requests for advice on what to do next. What happened to the baby? What do I do now? Do I have to have a C-Section? Once I got the information I needed to make some decisions, I started calling the people I needed to be there to help me through something none of us planned for. That is when I lost my fragile hold on the world I used to know and everything changed.

Eight months later, after biweekly support group meetings, an international conference on SIDS and stillbirth, and lots of research, I was furious. Why has there not been more research on prevention? How is it possible that the cause of half of all stillbirths is unknown? Why had I never been told that there are risks for some babies to die before they are born? Why had I never heard of this happening to anyone?

As a Journalist

After my son died, I wanted to wear a sign on the top of my head that declared to everyone I met, “I had a baby, but he died.” I wanted the world to stop. I wanted what happened to me to matter to people. I wanted everyone to know I was different. I wanted to tell my story, his story, to anyone who would listen. When I met other parents we introduced ourselves with the names of our babies, a brief description of our pregnancy, how we found out that our babies had died, the circumstances of their death, how we were treated in the hospital, how our family and friends reacted and how we have been

managing our grief since our babies died. Our own narratives ran counter to the story of pregnancy we were accustomed to.

As a journalist, as a bereaved parent, and as an avid researcher, I was uniquely positioned to challenge the dominant narrative and offer my story to world. So on the first anniversary of Avery's birth/death day, an article that braided my story and my research ran in the San Francisco Chronicle Magazine. The response I received was overwhelming. More than 300 hundred readers emailed with gratitude for the article, the vast majority of them were bereaved parents themselves. Almost every reader who responded that they were a bereaved parent did not stop there. They told me the story of their babies. Many wrote that they had no idea that stillbirth could happen to them—or even about never having heard the word “stillbirth” prior to the doctor giving them the news. If doctors do not talk about it, if books and movies do not focus on it, and friends who have experienced it do not share it, how else do potential parents become aware of—or prepare for—the experience that 26,000 families in the U.S. face every year?

The emailed responses to the article in 2006, and the follow-up article on subsequent pregnancy after loss in 2007, showed parents giving thick descriptions of the keepsakes of their babies as evidence that their babies were once a physical—material—presence in their lives. Parents wrote about how the future they imagined for themselves was torn apart when their babies died and others wrote how they try to imagine what that future might have held for them had their babies lived.

As an Advocate

In the six years between my first visit to Washington in 2007—which resulted in then-Senator Barack Obama drafting the first stillbirth related legislation aimed at

epidemiological research, risk reduction and bereavement support to be introduced to Congress—and my last trip in 2013 (ironically on the day that senator championing the bill died) more than 150,000 *wanted* babies died before birth.² The bill languished in committee despite repeated efforts by bereaved parents and dedicated advocacy groups. During that same period, more than 400 laws (Guttmacher Institute, 2011; Guttmacher Institute, 2014) were enacted to prevent the termination of seven million pregnancies³ despite sustained protests and litigation against such restrictions. How is it that the state and public interest seem overly invested in the reproduction of one kind of body (of a woman who does not want to continue a pregnancy), but utterly uninvested in the same reproduction in another kind of body (of a woman who wants to have a child)? These two types of reproductive bodies both experience the ending of a pregnancy, but advocacy for one group rarely involves allegiances with the other. The genesis of the division between these two kinds of reproductive bodies is in the “choice” one type of body gets to make (abortion) and the other type of body does not get to make (stillbirth); however, they are inextricably linked by the very political ramifications of the same “choice.”

My personal experience with stillbirth sensitizes me to the depth of grief and loss of identity experienced by bereaved parents as well as how private the process of recovering from the death of the baby can be. My sensitivity has also drawn my attention to other experiences of pregnancy-ending. In particular, I find myself noticing the ways that the abortion body and the stillbirth body have, despite both experiencing the ending of a pregnancy, very different levels of visibility in the public sphere.

² This number is calculated from the estimated 26,000 stillbirths per year times the six-year time span I reference.

³ This number is based on the 1.2 million estimated abortions per year.

This ground I have marked—between the abortion and stillbirth—is a contentiously polemic landscape riddled with political, religious and ideological landmines. To some, my daring to connect these two physiologically similar, yet often psychosocially opposite, experiences appears foolish, ignorant or incendiary. For others, linking these two types of bodies and their pregnancy-ending experiences is politically problematic—despite the fact that they are already linked if not overtly. This ground also seems not to be traversed by many rhetorical scholars interested in studying reproductive justice or abortion discourse. This dissertation will, in part, argue that miscarriage, termination of a wanted pregnancy and stillbirth should be, must be, included in the realm of reproductive justice. Narratives that bereaved parents tell are situated within complex sociopolitical and socioemotional contexts that either directly or indirectly influence the ways, if at all, the stories are told and circulated beyond message boards and support groups.

As an Academic and Activist

In seeking to uncover answers to the questions that underlie this inquiry, I choose not to limit the resources and sensitivities that both my personal investments, my professional experience and academic training have developed within me. My work as a stillbirth advocate has honed a unique awareness of the stillbirth landscape from the view of both the bereaved and a bereavement researcher. As a writer and former journalist, I have been trained to seek out narratives. Facts matter, but without an individual's personal experience to breathe the information into flesh, it is not a story. It is a news brief that will not sell papers. As a performance scholar, I understand the body as the site of the initial experience, the vehicle that communicates that experience and the vessel that receives sensory messages as a witness to another's experience. My investments in

critical ethnographic performance drive me to better understand the contexts in which the body performs, is read and is understood. My study of critical rhetoric compels me to care about power relations and institutional biases. I am driven to notice how bodies are treated differently and subjected to disparities in access and equity. It would be disingenuous for me to say that I could remove any of these tools from my box; instead, I am compelled to name them and claim them as the guiding frameworks for this dissertation to discover how the use of personal stillbirth narratives might improve the lives of the traumatically bereaved.

As a Critical Scholar

Aware of the concerns that Blair, Brown and Baxter (1994) have of the academic disciplining of the feminine, my own concern for the disciplining of reproductive bodies, and Palczewski's (2003) invitation for me to be present in my writing, I will not hide my body in the process of researching or writing this essay. My body is already straddling, balancing worlds: public and private spheres, individual and social constructions, personal and political ideologies. I imagine that the bodies I am seeking to understand perform these balancing acts as well. I also imagine those bodies also perform different balancing acts involving health disparities, access to resources, cultural practices and religious ideologies than I have. I must be careful to avoid the pitfall of seeming as if "one" story represents "all" stories. No matter how many stories of stillbirth or pregnancy-ending I have read, heard or share, I do not, cannot, must not appear as if I claim to know everyone's experience of loss.

But mine is an informed positionality. I cannot, nor do I wish to, hide the fact of my personal stillbirth experience. Nor can I leave behind my embodied experience and

research as a performer and performance studies scholar. A critical rhetorical focus demands that I attend to the political contexts in which these bodies find themselves situated in. It is in this intersection that I believe critical activist performance scholarship lives and where some knowledge can be uncovered that may improve the care of stigmatized reproductive bodies.

And yet...

I worry that the academic formulations of a dissertation will put the very work of these pages and this effort out of reach of the very people I wish to serve. I find myself writing to this committee, my colleagues, my institution, and my discipline. I have used words in the last nine pages that are only relevant to them so that I can prove that I have learned to speak a language commensurate with the degree I am seeking. A degree I sought so that I could speak with authority mutually understood by the medical institutions and policy-making organizations I am trying to influence.

And yet...

My authority to speak with/to/for parents whose babies have died is not my last seven years invested in getting two advanced degrees. It is the six months I spent growing a future I would never get to see come to fruition.

And yet...

My academic training allows me to understand the language and privilege of time that medical research demands. My own desire to have a subsequent healthy baby reminds me that time is a luxury that so many bereaved parents do not get. They need answers now. Not five years from now after funding is found, IRB approval is gotten, research is conducted and results verified. Not when 71 stillbirths happen every day.

And so...

While I write this dissertation in partial fulfillment of the requirements of a Doctor of Philosophy in Communication Studies, I really write this for the parents whose stories need to circulate beyond chat rooms and support groups—not so much for them, but for the next family whose baby dies before birth. I want this document to circulate beyond the Ivory Tower—for anyone who believes that stillbirth is not something that “just happens” and for those who have no idea what stillbirth even means.

Why are we not screaming from the rooftops? Twenty-six thousand deaths a year—half to unknown causes—is no longer acceptable. “These things just happen” is no longer acceptable for cancer, autism, and prematurity. We talk about saving the tatas at cafes and promote annual bend and cough exams at baseball games. Why do we not know about stillbirth until after it happens to us?

If you can name it, you can change it. Or so the saying goes.

What if there is no name for it?

Stillbirth as a Communication Phenomenon

Lose a male spouse and you're a widow.

Lose a female spouse and you're a widower.

Born out of wedlock and you're a bastard.

Raise kids without a partner and you're a single parent.

Lose your parents and you're an orphan.

Lose your child...and there is no name for what you are. What you become.

No words to measure what has been ripped from your heart.

Even the word “lose” implies you were the one who misplaced something.

It was your fault.

You were careless.

You didn't pay attention.

Now you'll pay with a dream that can no longer belong to you.

Etymology of Stillbirth

Any critical engagement of stillbirth as a communication phenomenon must begin with language. As reproductive justice advocate, Miriam Pérez explains, “language matters. It can invite people in, or discourage people from joining. It can allow people to feel seen” (2013, para 7). What to call the cells growing in a woman’s womb is a complex endeavor, informed by the relationship and positionality of the individual using the term. Silver, Branch, Goldenberg, Iams, and Klenbanoff (2011) explain that medical professionals use words like “fetal demise” and “spontaneous abortion,” depending on the gestational age of the developing cells, which do not provide enough information about the age or condition of the being. For example, he and fellow researchers find the current system of generic classification groups together all losses prior to the middle of the second trimester as spontaneous abortions. Silver et al. (2011) went on to say:

However, this nomenclature is arbitrary, outdated, and not clinically useful. Using this system, miscarriages due to genetic abnormalities, fetal deaths associated with abnormal placental growth and development, and spontaneous preterm births of liveborn fetuses at previable gestations are lumped together in a single category. In addition, the term abortion is fraught with emotional connotations for families suffering the loss of a pregnancy. (p. 1402)

Even in a well-meaning discussion of the need for new nomenclature for the death

of a baby in utero and shortly after pre-term birth, the problematic use of the term “fetus” and “fetal” does not take into account the mother’s relationship with the life with which she may have already formed an attachment. Similarly the use of the terms “life” or “products of conception” may depend on the political or religious ideology of the speaker. From a communication perspective, the language deployed by clinicians and parents may be differentially informed by their positionality and their perceived relationship to the fetus or baby. Writing this text, I struggle with the medical terms used to explain and differentiate diagnoses, my sensitivity to how those same words will be read by bereaved parents and stillbirth advocates, as well as my investments in reproductive justice.

As communication involves not only how words are stitched together to make meaning for the individuals using them, but also how that interaction is already and always influenced by broader public conditions of discourse, how this dissertation uses terms related to pregnancy-ending acknowledges these ongoing, and sometimes disconnected, conversations. I endeavor to choose language that is attentive to these investments and understandable to the constituents that I imagine are the audiences of a text like this one. For example, when this dissertation addresses the stillbirth experience, terms that recognize the relationship between the parent and the (once) developing being will be used (e.g., a baby, a life, a child). When speaking of abortion, this text will use terms that focus on the procedure or state of being of the woman (e.g., pregnancy, products of conception). In sections that address clinical pathologies or epidemiology, the language used will be recognizable by those institutions involved in diagnosis and treatment (e.g., fetal anomaly, fetal demise). In all cases, this text will strive to use the

language chosen by, or the vernacular common to, the individual or communities being discussed. This differential word choice foregrounds the type of relationship to the (once) growing being rather than declaring the ontological nature of that being for all parties.

Epidemiology of Stillbirth

While reports of stillbirth rates vary, on average, there are approximately 70 stillbirths a day in the United States. Nearly 25,00 stillbirths occur every year (MacDorman & Gregory, 2015) with a rate of 6 in 1,000 live births and fetal deaths. While infant death rates (a live-born baby who dies prior to their first birthday) historically have been higher than those for fetal deaths, by 2013 (the latest year for which the data is available), stillbirths outnumbered the number of infant deaths (MacDorman & Gregory, 2015). Half of all stillbirths occur between 20 and 27 weeks gestation (MacDorman, Munson, & Kirmeyer, 2007) and women 35 years or older who have never been pregnant are at higher risk for stillbirth (Waldenström, Chattingius, Norman, & Schytt, 2015).

The number of induced abortions is similar to that of total fetal losses (Ventura, Curtin, Abma, & Henshaw, 2012). In 2008, the latest date national birth statistics were available, there were an estimated 6.58 million pregnancies with 4.25 million live births, 1.21 million induced abortions, and 1.11 fetal losses (Ventura et al., 2012). According to the CDC, abortion rates have reached historic lows (Pazol, Creanga, Burley, & Jamieson, 2014). The abortion ratio was 219 abortions per 1,000 live births in 2011. 91.4% of abortions were performed at 13 weeks' gestation or less and just over 1% were performed after 20 weeks (Pazol et al., 2014).

The picture painted by these statistics is far from complete. A vast majority of these fetal losses occur early in pregnancy (commonly called miscarriage prior to 20 weeks gestation) before the reporting requirements for fetal deaths take effect; and fetal deaths of 20 weeks gestation or more (commonly called stillbirths) are underreported in vital statistics data (MacDorman, Munson, Kirmeyer, 2007). Reporting requirements can vary from hospital to hospital, county to county, state to state. Which pathology tests are conducted, what samples are collected, what questions are asked, and even if an autopsy is suggested to the parent(s) can differ from one physician to another even in the same hospital. Fretts (2009), who helped draft the American Congress of Obstetricians and Gynecologists' (ACOG) practice recommendations for the management of stillbirths, notes that the U.S. has the lowest stillbirth autopsy rate among developed countries. The practice bulletin highlights the lack of uniform protocols for evaluating and classifying stillbirths and the adverse impact on studying specific causes of death. The guidelines explain that:

In most cases, fetal death certificates are filled out before a full investigation has been completed, and amended death certificates are rarely filed when additional information from the stillbirth evaluation surfaces. In any specific case, it may be difficult to assign a definite cause to a stillbirth. A significant portion of stillbirths remain unexplained even after a thorough evaluation. (Fretts, 2009, p. 4).

Even the clinical specifications and definitions for the terms “stillbirth,” “perinatal loss,” “neonatal loss,” and “miscarriage” vary, and are still debated among researchers (Fretts, 2009; Silver, et al., 2011). How a hospital, or a clinical researcher for that matter, determines if a baby is stillborn can vary based on number of weeks gestation

and weight at birth. In the U.S., the Centers for Disease Control (CDC) defines stillbirth (also fetal demise or fetal death) as the death of a fetus at or greater than 20 weeks gestation (if gestational age is known) or weighing 350 grams or more (if gestational age is not known), and prior to birth. Miscarriage is considered the loss of a pregnancy prior to 20 weeks gestation. Perinatal loss (also perinatal mortality, perinatal death) includes fetal deaths of 20 weeks gestation or more and infant deaths of less than 28 days, although one systematic study (Gold, 2007) used 14 weeks gestation and longer. Neonatal loss (also neonatal death) is the death up to 28 days after delivery. Pregnancy loss is the involuntary loss of a pregnancy at any gestational age prior to birth. For the purposes of this dissertation, stillbirth is defined using the recommended definition of stillbirth in the United States—the delivery of a fetus at or greater than 20 weeks gestation with no signs of life present at birth (Fretts, 2009).

Even with adequate data collection at the time of death, some parents may never discover what happened; cause of death is only accurately determined or assessed in 50 percent of cases (Reddy, 2007). While the most common causes of death are generally ascribed to genetic anomalies, infections, maternal conditions, cord accidents, or placental complications, experts differ on recommendations for procedures to evaluate and classify stillbirths according to Silver et al. (2007). This high percentage of undiagnosed causes for stillbirth is not because it is unknowable, it is because not enough research has yet been done to discover why. Some insurance companies will not cover an autopsy, so unless a physician or coroner requests one, parents may not be able to afford to do enough testing to find out what caused the death of their baby. When additional efforts to determine cause of death are conducted, the most common causes are generally

ascribed to genetic anomalies, infections, maternal conditions and placental complications, in addition to cord accidents. Without adequate and consistent directives for data collection hospitals vary in how and what they report as a stillbirth. Benefits and post-natal care is dependent on how a doctor records the death. For example, in many states, if a doctor writes “stillbirth” on the report, the mother is entitled to certain family-leave provisions, tax breaks, and disability leave. These same provisions are not available to a mother experiencing a miscarriage.

Socioemotional Impacts of Stillbirth

Stillbirth is traumatic event that often occurs without warning and can have severe psychosocial and emotional consequences (Cacciatore & Bushfield, 2007; Gold, 2007). Mothers can experience profound psychological distress and may even experience posttraumatic stress disorder (PTSD) upon the baby’s death (Cacciatore & Bushfield, 2007; Trulsson & Radestad, 2004). Stillbirth bereavement has unique qualities that differentiate it from other types of grief (Condon, 1986). Following the stillbirth, a mother’s grief can be complicated by multiple factors, including the nature of the biological death occurring within her own body, the influence of culture on her perspectives on death, especially that of a child, and her own feelings of guilt, failure and anxiety (Cacciatore, 2010; Condon, 1986; Reddy, 2007). On the other hand, care providers receive a dearth of death education, generally feel unprepared to face stillbirth (Cacciatore & Bushfield, 2007; Chan, Chan, & Day, 2003; Säflund, Sjögren, & Wredling, 2002) and acknowledge that conversations with parents experiencing the death of a baby are more serious than conversations with patients about any other condition (Säflund, 2003).

Treatment of bereaved parents has been slowly evolving in the last 20 years and recognition of parents' needs is changing accepted practice. Prior to the 1990s, it was not common for parents to be consulted about their wishes following a loss: they were not asked if they wanted to hold their babies, asked if they wanted to take pictures or given the option to keep the blanket the baby was wrapped in. There was no research to guide hospital protocol about what to do should a "wished for" (Lauterback, 1993) baby die in-utero. Gradually, parents have increased the discussion of desired bereavement care through support groups, online message boards and in doctors' offices (Layne, 2006).

Some perinatal-loss mothers have reported that their biggest fear was that their babies would be forgotten, according to Capitolo (2004), and experienced heightened grief during holidays and anniversaries, including the birth/death and due dates of their children. Pictures, locks of hair, hand- and footprints and clothing were valuable keepsakes that helped parents create memories of their stillborn babies (Capitolo, 2005). Grief surrounding perinatal loss has been culturally dismissed since pregnancy loss is viewed as something that "just happens" until recent patient-based movements have demanded attention be paid to the needs of bereaved parents (Layne, 2006). Lack of validation of the loss by others can cause disenfranchised grief according to Capitolo (2005), who finds, conversely, the validation of grief, facilitation of ritual, creation of mementoes and sharing of stories can promote the healing process (Capitolo, 2005).

Stillbirth's Absence from Dominant Narratives of Pregnancy

Parents experiencing stillbirth do not know what to expect when their babies die (Pullen & Nalos, 2009) and while their doctors may have heard about the risk of having a

miscarriage, they were not similarly informed of the potential for their baby to die at a later gestation.

The dominant narrative about wanted pregnancy is that it ends in the birth of a baby. Yes, miscarriage is very common, so you might not want to tell anyone you are pregnant until after the third trimester. And yes, your baby might have a genetic anomaly so you might want to get an amniocentesis. Eat right. Take your vitamins and read “What to Expect When You Are Expecting.” Decide between home or hospital birth. Have a baby shower. When the baby comes you won’t sleep and breast is best.

Nowhere in this dominant narrative is that babies can die before birth after that first trimester. Nothing about how you can do everything right and your baby might still die. Nothing about what happens if your baby does have an anomaly (because, shhhhhh, that means you have to decide about an abortion and you don’t tell anyone about that). Nothing about what to do if your baby’s heart stops beating. Nothing about having to go to the hospital before you planned and go through pain of labor with the agony of loss and no crying baby at the end. Nothing about how to be a mom to a baby whose eyes will never open. Nothing about how those moments you touch his skin and hold his fingers and kiss his forehead will burn themselves gratefully into your memory; or how not being given a chance to do those things will burn in the pit of your stomach every time you wonder what she looked like. Nothing about what it means to be a parent of a baby who could never come home with you. The dominant narrative of wanted pregnancy offers you no solace.

You wonder why no one ever told you this could happen. You get angry. You feel betrayed. You want the world to stop and for everyone to know what have lost. But the absence of your baby is only visible to you. You seek out others who understand. A week after leave the hospital, you find a support group and return to the same hospital where your baby's body is still in the morgue. You tell your story for the first time. You sob your way through the fragments that fall in chronological order. "Everything was fine. I had a completely normal pregnancy..." You finish with "I showered for the first time today and came here because I needed to know I wasn't alone. I need to know this emptiness won't feel like it's the apocalypse every time I remember this isn't a nightmare." You attentively, and hungrily, devour everyone else's story, listening for details that match yours. Feeling a strange sense of comfort when you hear someone else whose baby died at the same gestational age as yours. Or who has his name. You spend hours on private message boards reading the stories of other bereaved parents. You tell and retell your story, some days some details pop up you forgot to include the last time or only remembered to include when you hear someone else say the same thing. And then at some point, you feel stronger. Your anger about what you didn't know or the questions you have that no one can answer become louder than the need to be with others who understand. You need more.

You ask questions of your doctor. You search the internet. You find small parent-led organizations that are asking the same questions you are. You realize this happens 26,000 times a year in the U.S. and half of the time no one knows why. There have been no major studies, like they do for birth defects, to find out why, what, who or how. There are no standardized protocols for reporting "fetal death" (you choke on the term because

your baby was more than a fetus to you) and there no best practice recommendations for how to help parents whose babies die, deliver and mourn their babies' deaths. You go to the first ever conference on stillbirth, held as part of the annual SIDS conference, in Washington, D.C. You meet other parents whose babies have died and who are asking researchers what they know and why they don't know more. You have your reporter's notebook and you interview every researcher doing work related to the potential "cause" of your baby's death or on best care practices for parents. You use the same pencil to record the stories of other bereaved parents. You decided you have to tell your story AND you have to raise the alarm bells that what we don't know could kill another parent's baby.

On the one-year anniversary of your son's stillbirth, your article comes out in a major metropolitan newspaper's Sunday magazine. Your testimony circulates on the paper's website and the audio/slideshow that accompanied the story gets more downloads than any one before it had. It gets the most hits on the page, other than the Oscar coverage. You get to work on Monday and there are more than 50 emails in your inbox. By the end of the week you will have received more than 200. It will receive more emails than the magazine had received before. And almost all of them will have story of the sender's own stillbirth. Your story circulates on the Internet and message boards where newly bereaved parents seek out stories like their own.

Since the magazine article about my son's stillbirth in 2006, and the follow-up article on subsequent pregnancy after loss in 2007, I have witnessed parents telling the story of their stillborn babies as a way to continue to parent their children. Their stories,

perhaps accompanied by photos or keepsakes, are their testimony (Park-Fuller, 2000) that their babies once existed and are still a part of their lives. Communication research of stillbirth support groups show three central narratives emerge among bereaved parents: the death story, coping/negotiating, and the connecting through communication with others (Umphrey and Cacciatore, 2011). Three forms of communication that support recovery from the fractured identity bereaved parents experience are acknowledgment, compassion and inclusion, explains Giannini (2011), who defines recovery as the “embodied communicative actions that support individuals to redefine and recreate their identities following traumatic loss” (p. 558).

Storytelling is a core behavior of stillbirth parents. They seek out each others’ stories and share their own. Stillbirth narratives beget other narratives of loss, grief and trauma related to pregnancy-ending. Bereaved parents share their stories with other parents in a wide variety of different forums found with a quick Web search. But stories of how your baby died are not easily overheard in line at Starbucks or summarized on a bumper sticker. In addition to standing in as evidence that a baby once lived or as a way to connect with other bereaved parents, narratives of stillbirth parents fulfill other recognizable purposes for parents, members of the bereavement community, and stakeholders in the medical community. Stillbirth stories serve the same five functions of health-related narratives identified by Sharf and Vanderford (2003). They help parents experiencing stillbirth to: *make sense* of their experience; *assert control* over their relationship to their baby and how they describe and understand their loss, *transform their identity* from parent-to-be into bereaved parent, *warrant decisions* about a range of

situations, including memorialization to future pregnancies, and *build community* with other parents of stillbirth online and face-to-face.

While research has been done on the content of the narratives of stillbirth families as well as the ways that enclaved spaces, including in-person support groups, online bereavement boards and websites dedicated to stillbirth, create opportunities to memorialize babies, grieve their deaths, reinforce parental identity and gather information, these domains are not the purview of this project. Instead this dissertation is interested in the *public* spaces in which the narratives of stillbirth circulate, as these spaces are where the dominant narratives of pregnancy circulate and are consumed by potential parents. Stillbirth narratives are not a part of the dominant discourses surrounding pregnancy or its outcomes. As a result, parents-to-be do not have the narrative resources to call upon in order to know what they could expect while there are expecting. Similarly, pregnancies ending due to miscarriage or stillbirth are not a part of the discourse of abortion or reproductive rights. However, this dissertation situates itself within the realm of reproductive justice efforts.

Stillbirth Advocacy as Reproductive Justice

I'm hanging a small cotton-puff angel on the black wooden frame of the street-side memorial on a busy weekday morning. We set up in front of a crowded San Francisco Starbucks across the street from the hospital where I gave birth to both my sons. A middle-aged woman walks by and slows, doing a double take at the sea-green paper messages blowing in the wind, purple flower vines and statue of a mother holding a baby.

“Is this about abortion?” she asks warily, seeing the hand-drawn signs representing the different types of pregnancy loss.

“It’s a memorial in honor of those babies who have died before birth,” I respond, carefully choosing my words. My graduate classmate and I created this public installation as a performance interruption. I had a stillbirth. She can’t ever get pregnant. We wanted to create an opportunity to allow people to recognize, remember or honor the ways that wombs (either their own or another’s) can lose something precious. We wanted to make public what is so often private, due to stigma, shame or fear: Abortion, infertility, stillbirth, genetic termination, miscarriage, and adoption.

“But is it about abortion?” she asks again, skeptically.

I know why she is stuck on this. She needs to find out what the ideology behind the memorial is. Will she, by interacting with it, be condoning abortion or supporting those who oppose it. She wants to know if it’s for or against her own position.

“It’s about whatever you need it to be about,” I answer.

The silence stretches as her eyes search for some piece of evidence that will tell her how she should respond.

My son once had a body. I saw his heart beating, his head turning and his hands reaching on an ultrasound image. I felt him move. I felt him stop moving. I gave birth to him. I named him. I have pictures of me and my family and friends holding him. I have a few ultrasound images of him. I have ink prints of his hands and feet. I cremated him. He was never given a birth certificate—only a death certificate. Was he ever alive?

According to the Bureau of Vital Statistics, he never lived. According pro-life

beliefs, he was a person at fertilization. According to pro-choice ideologies, he might be considered as a non-viable fetus. According to countless memorial websites, bereaved parent support groups and stillbirth advocates, his life mattered, if only to one person. Do 26,000 stillbirths each year matter to anyone but their parents? Pro-life groups organize, rally, fundraise, fight for legislation to limit abortion access, protest outside clinics across the country and even resort to threatening and murdering abortion providers to prevent what they consider the deaths of innocent, yet *unwanted*, babies to abortion. Why is there is not a correspondingly visible protest for legislation to improve research and support health interventions to prevent the deaths of *wanted* babies to miscarriage and stillbirth?

“Is this about abortion?” he asks.

The bright summer sun from the window frames the corner of the marble hallway we are standing in. The legislative aide did not commit seats in his congressman’s conference room, but rather gave us five minutes on his way to a DC coffee vendor.

“It’s about preventing wanted babies from dying,” I say. “This bill could provide funding for much needed research, advocacy for prevention and support for bereaved parents.”

“Yeah, but it gets really murky. Grief support means they are grieving a life, right? If we say it’s life, then we sound like we are siding with pro-lifers. Our pro-choice constituents won’t support that.” He’s already made up his mind that our legislation is a minefield and I doubt he’s going to take this bill to his boss.

“I’m ardently pro-choice. The stillbirth of my son didn’t change that. But this isn’t about abortion. It’s about preventing the ending of a wanted-pregnancy by starting to find out why it happens in the first place.”

“Yeah, but that’s not how it’s going to play.” He shakes his head and looks off in the distance, and I take his signal that the meeting is over.

According to the Guttmacher Institute (2015), 42 states prohibit abortions after a specified point in pregnancy, most often fetal viability and usually with the exception of the life or health of the woman; 32 states and the District of Columbia prohibit the use of state funds for abortion with limited exceptions; 46 states allow individual health care providers to refuse to participate in an abortion and 43 states allow institutions to refuse to perform abortions, 16 of which limit refusal to private or religious institutions; 17 states mandate that women be given counseling before an abortion that often includes contested or medically inaccurate information; 26 states require a woman seeking an abortion to wait, usually 24 hours, between when she receives counseling and the procedure is performed, and 10 of these states have laws that effectively require two separate trips for the procedure; and 38 states require some type of parental involvement in a minor’s decision to have an abortion. “Since the Supreme Court handed down its 1973 decisions in *Roe v. Wade* and *Doe v. Bolton*, states have constructed a lattice-work of abortion law, codifying, regulating and limiting whether, when and under what circumstances a woman may obtain an abortion,” (Guttmacher Institute, 2015, para 1).

How is it that the state and public interest seem overly invested in the reproduction of one kind of body (of a woman who does not want to have a baby), but

utterly uninvested in the same reproduction in another kind of body (of a woman who wants to have a child)? These two types of reproductive bodies both experience the ending of a pregnancy, but advocacy for one group rarely involves allegiances with the other. The genesis of the division between these two kinds of reproductive bodies is in the “choice” one type of body gets to make (abortion) and the other type of body does not get to make (stillbirth); however, they are inextricably linked by/in the very political ramifications of the same “choice.”⁴

“But the play isn’t about abortion, is it?” She asks, almost in a whisper. We are eating our deli sandwiches at a small card table in the anti-room of the church’s sanctuary. It’s the second day of the stillbirth conference in Minneapolis and she and her husband are heavy with information.

“It’s about the stories of stillbirth families. But it is also about the ways stillbirth is socially and politically entangled with abortion. Parents who have discovered their baby has a severe genetic anomaly and won’t survive might not have a choice about how to do the best they can for their baby if they live in a state that passes a 20-week ban. Or those states that are trying to pass legislation that would make miscarriage a felony.”

She’s looking down at the space just beyond her plate. She won’t make eye contact with me now. I feel her desire to change the subject, and I know this is tricky territory to traverse. Last month discussion boards were filled with hateful comments

⁴ My personal experience with stillbirth sensitizes me to the depth of grief and loss of identity experienced by bereaved parents. I’m also aware of how private a process recovering from the death of the baby is. But what has begun to draw my attention are the ways that the abortion body and the stillbirth body have, despite their both experiencing the ending of a pregnancy, very different levels of visibility in the public sphere.

from within our own community directed at a mom who blogged about having to end her wanted-pregnancy because her baby had no brain. Many of us long-time advocates were shocked at the vitriol and attacks on her and other parents who had to make a heart-breaking choice. Our community mantra has always been about being inclusive, about not judging each other's losses, comparing grief or dismissing another's experience.

But we never talk about the women who terminate because it's just too loaded. They usually hide their story in a cloak of miscarriage or deflect questions about the birth. The very first Walk to Remember memorial service I went to was started by six women who met in a support group for moms who interrupted their wanted pregnancies due to complications. But they never disclosed the means of their loss to participants, nor have they ever—in 10 years—included that kind of loss in the service. It wasn't until I interviewed them for a research project that I found out about their secret. Lena, the lead organizer told me, "We're afraid that it'll hurt those other moms who are still so raw in their grief. Or that they'll tell us that at least we had a choice, which it really isn't. We just don't want to deal with the judgment or the denial of us being parents."

Never once in all those services did those moms, who desperately loved their baby, feel safe enough in our community to share the shame or stigma they felt that made their baby's deaths doubly brutal. They didn't trust that anyone except someone who had to face making the same decision could understand. It's their stories of hidden pain that push me to look at the grieving mom across from me and continue on, even when it isn't socially or politically polite.

"It is about abortion. Because until we change how we can talk about abortion, we'll never be able to get action to end stillbirth. Until there is space to say "it's a life at

conception AND it's my choice on how or when to parent" people may never understand how losing a wanted baby is such a devastating life-altering experience. And because the laws that are passed to prevent abortion of unwanted pregnancies can have unintended impacts on wanted pregnancies too.

As someone concerned with issues of reproductive justice, I am sensitized to a set of conditions stigmatized pregnant bodies are subject to in social and political discourse (which I will take up in more detail in Chapter 3). This sensitivity shows me an overwhelming political, legislative, and social focus on one kind of pregnant body (*in preventing an unwanted pregnancy from ending by abortion*) but not on a corresponding focus on another kind of pregnant body (*in preventing a wanted pregnancy from ending by stillbirth*). A desire to focus on the impacts of this disparity informs several sensitizing queries that underlie my activist aims.

Framework of Reproductive Justice

“Reproductive rights + social justice = reproductive justice.” (SisterSong, *What is Reproductive Justice?* Para 7)

The move to shift from the use of “reproductive rights” to “reproductive justice” is more than just a shift in nomenclature. It calls into question the inclusivity of a social movement that has focused on the “choice” to have a baby or not. Most reproductive justice advocates believe that the movement should be intersectional and focus on efforts to insure people have the power and the resources to create the families they want. Ross (2007) explains, “reproductive justice is the complete physical, mental, spiritual, political, social, [environmental] and economic well-being of women and girls, based on

the full achievement and protection of women’s human rights,” (p. 4) Reproductive justice highlights the lived experience of reproductive oppression in communities of color. According to the reproductive justice organization, the SisterSong Women of Color Reproductive Health Collective, a human rights framework offers a more comprehensive approach to issues facing women of color, rather than a pro-choice movement grounded in a Constitutional right-to-privacy. They explain that:

It represents a shift for women advocating for control of their bodies, from a narrower focus on legal access and individual choice (the focus of mainstream organizations) to a broader analysis of racial, economic, cultural, and structural constraints on our power. (SisterSong, *What is Reproductive Justice?* Para 7)

According to Loretta Ross, member of SisterSong, the origins of the use of the term “Reproductive Justice” is credited to a group of African American women who, once they returned from the 1994 International Conference on Population and Development in Cairo, Egypt, met at the Illinois Pro-Choice Alliance Conference in Chicago (Ross, n.d.). Known as Women of African Descent for Reproductive Justice, they challenged the Clinton Administration’s health care reform campaign at the time because it did not include a guaranteed access to abortion. Ross explains that they did not want to use the language of 'choice' because of the relatively few choices that were available in the communities they represented. Instead they combined ideas of reproductive rights, social justice and human rights and coined the term “Reproductive Justice” and published it in an ad in *The Washington Post*. Then in 1997, SisterSong Women of Color Reproductive Health Collective was founded by 16 women of color organizations. The framework of the reproductive justice movement is informed by the

global and the transnational feminism movements (Chrisler, 2013) and broadly addresses “aspects of women's social status that promote or interfere with her power in relationships, bodily integrity, and ability to engage in family planning and reproductive decision-making” (p. 5). Chrisler (2013) explains that this reproductive decision-making is not always experienced as a “choice”:

For example, consider women who use contraception or abortion because of ill health, because they cannot afford to raise a child, or because of insecurity due to war, natural disaster, or a severe economic recession; women who want to be parents but cannot get pregnant, are prevented by law or custom from utilizing adoption or assistive reproductive technologies (ARTs), or lose their children to early death (infant mortality) or revocation of custody; and women who have been coerced or misled into sterilization, abortion, or contraceptive use (by partners, kin, courts, or medical authorities). (p. 3)

Those who frame their advocacy as reproductive justice seek to center the experiences of women of color whose reproductive health concerns go beyond choice. SisterSong explains that an intersectional framework that includes social justice and human rights issues affecting the lives of women of color is necessary in order to be inclusive and avoids pitting priorities against each other. It focuses on the right to have children or not, as well as the ability to parent children in safe and healthy environments and the duty government and society have to guarantee suitable conditions for acting on one’s decisions. As Ross (2015) explains, “This requires moral, political and legal systems in which individual and government actions are interdependent to achieve reproductive freedom and bodily autonomy” (p. 2).

Stillbirth is not usually named as a central issue in reproductive justice, but it clearly falls into this framework. The abjected experience of stillbirth and pregnancy loss is not just an interpersonal one, but rather is interwoven within a sociopolitical web of entanglements (Cacciatore & Bushfield, 2008; Martel, 2014). The silence within the conditions of pregnancy discourse for stillbirth, the lack of resources dedicated to stillbirth research and the health disparities experienced by pregnant women of color nominate stillbirth for a place under a reproductive justice umbrella. The stillbirth rate for non-Hispanic black women is 2.3 times that of non-Hispanic white women (11.3 versus 4.79 per 1,000 respectively) and rates for Asian Americans, American Indian or Alaska Natives and Hispanics were all at a rate of 6 or less per 1,000 (Hogue & Silver, 2011). Efforts to increase funding for prenatal health and stillbirth research, improve medical interventions and prevention strategies, and develop culturally competent patient care and support—especially for those disproportionately affected by perinatal death is in alignment with reproductive justice aims.

Additionally, the silence surrounding stillbirth and pregnancy loss may be served by an interrogation of the institutional marginalization of such a devastating experience. Martel (2014) explains that the political dimensions of silence demand an investigation of what “power relations might be transferred through the denial that death can be a part of birth” (p. 329). Sharing personal stories can challenge the silence and interrogate those power relations. According to Price (2010) storytelling is an invaluable resource for those working for, and needing, reproductive justice. “Stories can create space,” explains Price, “that is, storytelling can be a means by which those who are marginalized within society or in a specific community can create a reality that includes and addresses their

experiences, perspectives, and concerns” (p. 50). She goes on to say that these stories are also consciousness-raising tools for grassroots, political organizing. “Reproductive justice activists consciously use storytelling as a form of activism to document the experiences, history, thoughts, and emotions of women of color and other marginalized groups before these stories are lost or erased from official, public memory” (Price, 2010, p. 50). These claims lead me to ask, how then might I explore stillbirth narratives in service of reproductive justice aims?

Pregnancy Ending Testimony

How are the experiences of these two distinct, but compellingly linked, bodies understood, made in/visible, and marked within the current conditions of discourse? How do we even know these bodies as having once been pregnant when there is no living baby produced as evidence? Unless we have an intimate relationship with the person in question, an act of disclosure after the ending of a pregnancy is necessary to mark the body for it to be newly recognizable to us. This narrative disclosure of either having had an abortion, miscarriage or stillbirth, is an act of testimony. It is an act that marks the once-pregnant body as associated with the social stigma of abortion or the failure of stillbirth. But it is also testimony, as I will argue in the following chapters, because it has an orientation toward larger discourses. The current conditions for discourse for pregnancy do not include stillbirth. Stillbirth is not a schema that parents prepare for or are exposed to. And if such testimony is absent from the public sphere, are their bodies also invisible to us? Does this absence contribute to the conditions that stigmatize these bodies in the first place?

My dissertation seeks to engage testimonies of stillbirth, termination of a wanted pregnancy and abortion through performance to understand the political, emotional and social nuances of these lived experiences. While these experiences of pregnancy-ending have different causal triggers, they are similarly stigmatized, marginalized and politicized. They are highly personal and private experiences that are influenced by, and implicated, in public discourses and state interests. Due to the complex nature of these phenomena, I am employing narrative theory, performance methods and rhetorical criticism in my attempt to better understand, re/present and challenge the dominant narratives and discourses related to stillbirth as embedded in these other experiences of pregnancy-ending. In doing so, I will take up the extant scholarly explorations of testimony, and offer additional articulations of its distinction from personal narrative, its public orientation and its potential in activist performance.

A Critical Feminist Approach to Writing

As discussed in the preface, my resistance to the institutional disciplining of the feminine and the sociopolitical disciplining of reproductive bodies (Blair et al., 1999; Palczewski, 2003) means that I will not hide the fact of my personal stillbirth experience. My embodied experience and research as a performer and performance studies scholar imbue my critical aims. My performance self, which privileges the intimacy of my sensate body, my lived experience, and my body's knowledge, is unwilling to sublimate itself in my pursuit of understanding how rhetoric attends to the political and social body. My rhetorical scholar self cares about the larger conditions of discourse and believes that understanding the social and political contexts in which these bodies find themselves is essential to political action. It is in this intersection that I believe critical activist

performance scholarship lives. It is also where I believe critical rhetoric's attention to the body is most beneficial. Hence the ultimate work of this project will be to discover how the convergence of performance, narrative and rhetoric in testimony can help us to attend to stigmatized reproductive bodies in ways that matter. Palczewski reminds me to attend to both Wander's (1983) case for critical activity involving political action and Klumpp and Hollihan's (1989) claim that rhetorical criticism should be viewed as moral action: "The critic that emerges—the interpreter, the teacher, the social actor—is a moral participant, cognizant of the power and responsibility that accompanies full critical participation in his/her society" (p. 94).

Preview of Remaining Chapters

This chapter has outlined my own positionality and investments in relationship to stillbirth, introduced stillbirth as a communication phenomenon, provided a rationale for considering stillbirth as part of a reproductive justice framework, and introduced the value of personal narrative to understanding the experience of pregnancy-ending. Chapter Two expands upon the definition testimony, a specific type of personal narrative, and details its convergence in rhetoric, performance and narrative frameworks. The importance of the body as both the *cite* and *site* of knowledge will be explained calling upon rhetorical and performance frameworks. A rationale for using testimony as way to examine not only the experience of pregnancy-ending but the contextual discourses within which stillbirth testimonies are set. A mixed-methodological approach will be described using critical rhetorical and performance ethnography to explore both naturally occurring and solicited testimonies of pregnancy-ending narratives. The Narrative Loop

Model will be introduced, and will be applied, developed and modified over the course of the dissertation.

Chapter Three harnesses rhetorical sensitivities to analyze three types of publicly occurring pregnancy-ending testimonies that erupted in state forums and the public sphere in order to understand how testimonies of abortion and stillbirth might circulate in the current conditions of discourse. The analysis of these testimonies informs several performance choices explained in Chapter Four, which discusses the collection of a range of testimonial texts for use in the performance series. These include the private-cum-public letters about stillbirth bereavement of historic figures and the public letters employing private modes of address in support of abortion access. Interviews of eight women whose pregnancies had ended due to abortion, miscarriage, stillbirth or termination of a wanted pregnancy due to genetic anomaly, will be described. The crafting of three separate scripts, an ensemble ethnodrama based on the public letters, and two versions of the solo performance ethnography, are discussed and excerpts from the scripts will be given to introduce the different characters represented. The elements of the multimedia installation, based on the research of Chapters One and Three, will also be outlined. Chapter Five discusses the discoveries from these performances of testimony that were staged in October 2014, including somatic sentience in performance ethnography, and themes of relationality and temporality in the performance of pregnancy-ending testimonies.

Chapter Six focuses on the contributions this research has made to the understanding of testimony, the value of somatic sentience and the use of different performance styles for activist aims. The potential use for the performance of testimony

as support, intervention and advocacy - in particular for families experiencing stillbirth - will be outlined. Areas of future research and the limitations of this research project will be addressed.

CHAPTER 2
TESTIMONY'S RHETORICAL CONTEXT, NARRATIVE THEORY AND
PERFORMANCE PRAXIS

Whatever is unnamed, undepicted in images, whatever is omitted from biography, censored in collections of letters, whatever is misnamed as something else, made difficult-to-come-by, whatever is buried in the memory by the collapse of meaning under an inadequate or lying language—this will become, not merely unspoken, but unspeakable. -Adrienne Rich

When you grow up consuming public testimony about things previously kept in the dark, it's easy to believe in the transformational power of one person's story. My grandmother's generation grew up listening to fireside chats during World War II. My mother's generation grew up with Freedom Buses burning and peace protestors lighting up. My generation grew up with breaking the silence. Not just to family and friends, but to the American public in Congress, in magazines and on TV talk shows.

Their names were like family. Ryan White. Oliver North. Anita Hill. KD Lang. Their stories taught me about the world beyond my living room.

Sex can kill, but secrets can shame us to death.

I grew up in West Hollywood in the late 1970s and 1980s. I lived at the intersection of the gay main street and the heart of the Jewish quarter in Southern California. I regularly walked or biked two miles of Santa Monica Blvd. from my house on Fairfax Ave. to the public park on San Vicente Blvd. I made a hobby of memorizing

the names of the shops and gay bars I passed on the way: The French Quarter. Circus Books. Gold Coast. Hamburger Mary's. The Motherlode. I remember when I began seeing flyers on windows and alley doors. I saw posters about A.I.D.S and first thought they spelled it wrong because the diet pill was spelled A.Y.D.S. I noticed the men behind the counters of the pharmacy, the pet store and the pizza place disappear in hushed whispers. I heard parents talk in discrete tones about wanting to ban gay men from the public pool I spent more time in than my own bedroom. I saw bathhouses close and men hide their faces. By the time I was 14, I knew what AIDS was and knew that unprotected sex could kill me—before I even had my first kiss. But for me, it was an abstract distant knowing; it wasn't personal. It was about a disease, not about a person. Then the whispers turned to TV news reports of Rock Hudson dying in 1985 and then AIDS had a body. Then in 1986, Ryan White gave AIDS a body that looked like mine, that made me understand the pain of stigma and social shaming in the school hallways like mine. I listened to Ryan's testimony before Congress, read his book and watched his movie. I even used his words in high school Forensic competitions. I can't say that everyone approved.

Our government lies.

I watched almost every televised minute of the Iran-Contra hearings. I had just graduated from high school in 1987 and I was working a temp job for a Los Angeles Unified School District program that matched teens with potential summer employment. I took the bus 45 minutes each way to work eight hours a day in one of those air-conditionless portable units parked on top of sweltering black asphalt. And the hearings

were on every day. The lines on Oliver North's face on TV became as familiar to me as the strands of Andrew McCarthy's hair on my 16 Magazine's pull-out pin up poster. I learned about the secrets our government had kept and how someone can seem to answer a question, but hide the bigger lie. I learned that our government was based on secrecy and backroom deals that we will never know about.

Call out sexual harassment even though the system meant to protect the victim is filled with people who do not think they could ever be part of the problem.

I was in my final year of college in 1991 when Anita Hill became the face of courage for young girls and woman who had been leered at, felt up, cornered, pressed against, propositioned or subjected to dirty jokes and objectifying language. I was riveted to the broadcast of Anita Hill testifying before Congress. The faces of Orin Hatch and Arlen Specter reduced me to Exorcist-like Linda Blair head spinning and swearing in tongues vitriol. I wanted to do something with that pubic hair and Coke can that was illegal in most southern states. I remember thinking there is no way they are going to confirm Clarence Thomas. There is no way they can ignore her testimony. There is no way he can be trusted to protect the Constitutional rights of half of the citizens of this country. But I didn't realize that the Senate was 98% male. I didn't understand what it meant that Anita was a black woman being questioned by a panel of all white men. So I was shocked and dismayed when the news came out. Thomas was in.

But the dirty little secret of sexual harassment was out. Sexual harassment cases more than doubled after Anti's testimony and awards to victims quadrupled. I got a "I believe Anita" bumper sticker even though I didn't have a car. I voted for Barbara Boxer

and Dianne Feinstein the next year in the 1992 election dubbed the “Year of the Woman” when a record number of women ran for—and won—seats in Congress.

Being gay is okay.

Why my parents lived a closeted life in a gay neighborhood we watched draw boundaries around itself in order to become a city where being gay was okay is a mystery to me. My mother never told me she was gay because at the time she didn’t think she was, despite only having been with women since I was 5 years old. She didn’t recognize herself in the lesbians in the underground clubs in the 1970s, the leather dykes in the pride parades in the 1980s or even with KD Lang and Ellen in the 1990s. My mother was a professional woman, a single mom and pretty much celibate. But I never understood why she felt like she had to hide. I knew that she and her partner were “like that” when I saw them asleep in the same bed, even though my five-year-old self had no idea what being “like that” meant. Their abusive relationships, the alcoholism and their parenting choices put them inside multiple closets.

Closets that once buried sexual orientation, addiction, abuse, harassment, AIDS, political scandals and covert government operations behind cloaks of appearance and acceptability burst at the seams and coming out and outing the lie became must-watch TV and water cooler conversation during my generation. As I grew up, went off to college, got my own place, started a career (or two), I watched the testimonies of public figures, school children and caregivers challenge the silence my parents’ generation grew up with. I watched the lived experiences of people who publicly fought social stigma and

cultural shame become the focus of after-school specials, movies of the week, documentaries and Oprah.

If Oprah talks about it, you do not need to keep it secret anymore.

But what happens when it's something even Oprah won't touch...

In 2005, I became a member of a secret club. A statistic. A number. An abstract concept. One of the 26,000 each year in the U.S. One in every 110 pregnancies. One of the 71 a day.

Until my son's body was delivered, still, into my arms, I had no words to image what the experience was like. No one had ever told me their stillbirth story. I had never seen someone talk about it on TV. No one ever talked about the statistics of neonatal death in the books I read. Not even Oprah, who had a stillbirth at 14, talked publicly about it or featured it on her vast network empire. The talk show host who broke silences around molestation, alcoholism, mental illness, domestic violence, racism, homophobia and abandonment, wouldn't talk about this one thing that she kept as her deepest secret. With a single sentence she could have changed the public discourse long before I even knew the secret club existed.

If an experience is so unspeakable that it can't circulate where those not looking for it could ever discover it, how can we ever prepare ourselves for it happening to us? How can we find words to language it in a way someone else could understand it? Where do we find a user's manual to survive it?

I grew up understanding the world through testimony of others. It was after my son's death that I found myself seeking out testimony to understand myself.

This chapter will define testimony as it is taken up in this project, expanding how other scholars have defined it. This articulation draws upon scholarship within narrative, performance and rhetorical frameworks to provide a more comprehensive understanding of testimony component elements, in particular testimony's connection to the body of experience and its critical power. This chapter provides the rationale for using testimony as an organizing concept, asks several questions that direct the inquiry taken up in the dissertation, and explains the methodological approach to collecting and analyzing various texts for the purposes of creating the performances at the heart of this dissertation. Finally, a model describing the circulation of narratives and counter narratives will be offered, which, in future chapters, will serve as a compass to help track testimony's circulation and map its domain.

What Counts as Testimony?

The definition of testimony offered here expands on the previous disciplinary articulations and clarifies the uniqueness of its origination, orientation and trajectory. *Testimony is an abjected personal narrative delivered with a public orientation by the body of experience, in the absence of that experience, and is directed—either overtly or covertly, intentionally or suggestively—at dominant discourses either in confirmation, challenge, or denial.*

Testimony is more than self-disclosure, which usually happens in an interpersonal context. Testimony is not confession, which implies some sense of wrong-doing or regret. Testimony is contextually situated. Testimony is called forth, called on and called out. Testimony makes present what has been absent in the dominant narratives—that

which is usually abjected, stigmatized or taboo. Testimony is tied to the bodily experience. Testimony is tied to the body *of* experience. Testimony is rhetorical, informative, constitutive and public. Testimony has potential political valences that may or may not be intended by the author of the testimony. Testimony is political and personal. Testimony may be performed as an act of resistance, challenge or affirmation of the status quo. Testimony requires witnessing. Testimony is evidence. Contextualizing testimony in the larger dominant narratives may expose the lies or the taboo taken for granted as truth. If the act is taboo, then speech about the act is taboo. The performative speech act of telling calls the taboo into question. Testimony implicates the political and social frames within which those stories are situated.

Narrative and Testimony

Narratives are the textual basis of testimony. The narrative paradigm does not clearly define itself, but rather names itself in its constructions and functions. As such, I see several narrative theories informing my study of testimony. We employ a narrative logic (Fisher, 1985) to make decisions based on narratives that circulate in our environment and use the logic of good reason. Narrative (value/emotion) logic (fact/reason) unites the whole brain—logic and myth work together. Storytelling shapes reality (Shank, 1990). Our stories unfold as we tell them and are elastic (Holstein & Gubrium, 2000). Narrative is also at the heart of self-construction (Holstein & Gubrium, 2000) and interpersonal dialogue (Lederman, 1996).

In understanding testimony for/by stigmatized reproductive bodies, it is important to understand the five functions of illness related narratives (Sharf & Vanderford, 2003) as sense-making, transforming identity, warranting decisions, asserting control and

community building. There are also noted specific uses for narrative for the bereaved (Bosticco & Thompson, 2005; Giannini, 2011; Umphrey & Cacciatore, 2011). Health narratives are told through a “wounded body” (Frank, 1995). Health-related narratives are implicitly embodied rhetoric & implicitly relational (Beck, 2005) and our narratives are constructed in response to, and informed by, other people and with ourselves. Personal health narratives cannot be constituted independent of public narratives (Harter, Japp, & Beck, 2005). The value of public sharing of these health-related narratives (Beck, 2005) include: being a part of public dialogue about health, wellness, disease; helping others articulate their own story; legitimizing other’s experiences; and being constituted in dialogue with public and institutional narratives.

How then, might public sharing of stillbirth narratives be similarly valuable? In February 2014, I was invited to attend a webinar on the status of stillbirth with representatives from the National Institutes of Health (NIH), the Centers for Disease Control (CDC), the American Congress of Obstetricians & Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine. The two-hour session, which consisted of an hour of presentations by members of the aforementioned groups, and an hour long question-and-answer period, had been put together by a coalition of stillbirth organizations I work with called Action for Stillbirth Awareness and Prevention (A.S.A.P). Those of us who attended emailed our questions and silently waited for the responses. As the session was wrapping up, Lisa Kaeser, Director, Office of Legislation and Public Policy Eunice Kennedy Shriver National Institute of Child Health and Human Development/NIH, thanked the parent advocacy groups for pushing for the meeting and for sharing our experiences with them. Another researcher echoed the sentiment, "It has

been the parent groups asking 'Why did our babies die?' that has pushed us researchers to do our jobs. Your stories propelled action.”

There also can be value in the *act* of telling the story, especially if the focus is on traumatic events. From a psychotherapeutic perspective, the story is not told to purge the experience, but rather to integrate it. Herman (1997) explains, “In the process of reconstruction, the trauma story does undergo a transformation, but only in the sense of becoming more present and more real,” (p. 181). Park-Fuller (2003) describes performing her breast cancer narrative as an attempt “to break out of the prescribed, marginalized role of ‘patient-victim’ and exercise sociopolitical agency in the world” (p. 215) in order to influence society. As Langellier (1998) explains, “personal narrative responds to both the wreckage and the reflexivity of postmodern times when master narratives disintegrate,” (p. 207).

Rhetoric and Testimony

I call upon several strands of rhetorical theories in order to help me understand conditions of discourse, fields of context, orientation of speech acts and available means of argumentation persuasion that inform the use, circulation and valence of testimony. Broadly, my rhetorical approach to this project is influenced by critical scholars who have attended to discursive spaces and corporeal rhetoric. I am informed by Wander’s (2014) articulation of rhetorical studies “as an academic field of study that criticizes, invites, and produces talk about civic discourse” (p. 99). I call upon theories of public sphere(s), public(s), and counter publics (Asen & Brouwer, 2001; Felski, 1989; Fraser, 1992; Mansbridge, 1996; Squires, 2010; Sutton, 1992; Warner, 1992, 2002) in order to sharpen and clarify the valence and orientation of testimony. In particular, Warner (2002)

helps me understand that there are “damaged forms of publicness, just as gender and sexuality are, in this culture, damaged forms of privacy” (p. 63). Important in the study of stigmatized reproductive bodies is the understanding of spaces where marginalized/at-risk bodies might collaborate in enclaves or satellites (Squires, 2002) and the experience of publicness of (some) private bodies due to the intrusion of state interest (Bone, 2010; Gibson, 2008).

Palczewski’s (2002) articulation of the power in personal testimony is linked to the body. Personal testimony gains its power and legitimacy in its link to the body, the visual, and the presentational (Palczewski, 2002). Personal testimony is a unique form of argument that cannot be repeated by another without losing the site of the body and therefore its power and legitimacy (Felman & Laub, 1992). It is here, in personal testimony, that we may find the presencing of that which was absent: the incorporation of what has been invisible. When speaking for themselves, those who were absented, those who were victims, find authority and agency (Felman, 2001, in Palczewski, 2002).

It is important to note again, that in personal testimony "speakers are asking for others to assent not only to the claims, but also to their existence" (Palczewski, 2002, p. 16), and that not all audiences will accept or validate their claims or their right to existence (Brouwer, 2004). Critics of testimony, however, are suspicious of the ethics of its claims (Kauffman, 2009). While personal histories matter, Kauffman (2009) contends that “by insisting of the authority of my personal experience, I effectively muzzle dissent and muffle your investigation into my motives” (p. 329). This has also been a point of debate and further articulation in feminist and queer of color criticism as well as in performance and while worthy of discussion, I will not enjoin that debate here. The

performance of testimony, as well as the performance in testimony, offers the third and final leg on which my articulation rests.

Performance and Testimony

The ways performance studies scholars have taken up and unpacked personal narrative performance are as numerous as the names given to the variations in the types of personal narrative. Autobiographical and autoethnographic performance (Pineau, 2000; Spry, 2001, 2006, 2011), generative autobiography (Alexander, 2000), ethnographic performance and performance ethnography (Alexander, 2005; Conquergood, 1991, 1992, 1998, 2002, 2003; Jones, 1997; Madison, 2003, 2006; Turner, V. & Turner, E. 1982); performance of personal narrative (Langellier, 1999, 2009); and ethnodrama (Saldaña, 2005) are just a few of them. Saldaña (2005) discovered more than 80 different terms in performance and theatre studies for similar personal narrative forms. I wish to highlight just a couple of these forays that are relevant to the way I am articulating testimony here. Spry (2001, 2011) discussed the ways that performative autobiography allows for the re-appropriation of voice and reconstitution of self and the re-articulation of the lived experience. Madison (2003) highlighted the ways that it creates opportunities to focus on the experience of marginalized peoples. Langellier (1998) stated that “the voice needs a body which personal narrative furnishes. From social life, a complementary movement applies: the body needs a voice to resist the colonizing powers of discourse” (p. 207).

A key inspiration and foundational grounding for this paper is Park-Fuller’s (2000) articulation of testimony. Testimony is “a declaration of personal experience in the absence of that experience” (Park-Fuller, 2000, p. 22). In unmediated performances of

autobiography, like testimony, the audience and teller are face to face, they are both at risk in the telling and the witnessing, and this mutual act ruptures categories of public and private.

The work of performance specifically taken up in this dissertation involves performance ethnography (Conquergood, 1991, 2002, 2003), ethnodrama (Saldaña, 2005), the performance of possibility (Madison, 2003) and embodiment (Spry, 2011; Pineau, 2000). The work of these scholars informs how I employ critical performance ethnography to co-create a liminal moment with an audience when we can each stand with the other—inside issue, feeling, experience—willing to be transformed by the possibility of what an intersubjective understanding can do once we leave each other’s space. I first shared the story of my stillbirth in a public setting, outside of the support groups and friends, in the Sunday magazine of the newspaper where I worked. As a reporter, I told my story as a way to personalize the research about stillbirth I spent a year collecting. As a bereaved parent, I told my story because I wanted to put a face on a member of the “Secret Club” (what some stillbirth parents call ourselves). As Avery’s mom, I told my story because it was all I had to prove that my son had once been real. And now, as a scholar, I find myself telling my story to prove that the *story* matters. As a health communication educator, I tell my story because I believe making a connection between care provider and patient matters. As an advocate, I tell my story to Congressional representatives as testimony that stillbirth matters.

It is my belief that performance of testimony—especially by/for/about stigmatized reproductive bodies—facilitates, encourages and creates opportunities for a shift in the dominant narratives surrounding pregnancy. Testimony makes visible that which has

been unaccounted for. “Performed personal narratives give a human face to traumatic events, diseases, or oppression, and many people would prefer not to see it. It is emotionally painful to hear how others suffer, and many avoid that pain—even at cost to themselves and to the sufferer” (Park-Fuller, 2000, p. 36).

The Body as the Site/Cite of Testimony’s Convergence

Testimony is tied to the body of the experience. Someone else sharing my story, my personal experience, is not performing their testimony. How rhetoric and performance take up the body, in relation to the lived experience, is at the heart of their convergence in testimony. Centering the body at this stage of my inquiry allows me to explore two key intersections: How performance might enhance rhetoric’s materialization of testimony and how rhetoric might help amplify performance’s attendance to/focus on larger political/social discourses.

Body in/as Argument

In order to specifically view testimony from stigmatized reproductive bodies, I pause here to look at how rhetoric takes up the body. In particular, I wish to focus on testimony’s connection to the body (Palczewski, 2002); the body in/as argument (Campbell & Jamieson, 1978; Palczewski, 2002, 1997); the body as a social location ((Nakayama & Krizek, 1995); corporeal rhetoric, self-abstraction, and incorporation (Warner 1992; McKerrow, 1998), bodies on the line (DeLuca, 1999); and the constitutive potential in identifying and naming bodies of shared experience (Charland, 1987). *In situ* rhetorical field methods (Middleton, Senda-Cook, & Endres 2011), in which the critic is on site with their own bodies to observe what is happening as it is happening, requires that critics attend to the fact bodies in place, space, and time matter.

Rhetorical critics have approached the body in a variety of ways, some seemingly irrespective of each other, some elaborating on theoretical constructs in case studies. In some analyses, the ways that bodies were attended to was more visible than others. Campbell and Jamieson (1978) describe enactment as a reflexive form “in which the speaker incarnates the argument, *is* the proof of the truth of what is said” (Campbell & Jamieson, 1978, p. 9). The speaker enacts, by his/her very physical presence, the argument his/her text makes. Campbell and Jamieson (1978) argue that when Rep. Barbara Jordan became the first African American to give the keynote address at the Democratic National Convention in 1976, she herself embodied the argument she made that “my presence here is one additional piece of evidence that the American dream need not forever be deferred” (p. 9). Her body-as-argument continued long after she gave her speech and left the stage. I believe Jordan’s body in Congress continued to be an argument that held others in the body politic accountable to her. But it also denied her body the strategy of self-abstraction.

Traditional Western rhetoric allowed one (as long as you were the “right” one) the rhetorical strategy of self-abstraction: You were of rational mind, minus the pesky concerns of the body (Warner, 1992). This self-abstraction was also a source of domination and a differential resource and more available, if not explicitly available, to those who were “white, male, literate and propertied” (Warner, 1992, p. 382). Disincorporation marked as privileged the body that had the ability to be invisible. Such disincorporation was not available to Jordan.

When Rep. Barney Frank became the first openly gay Congressperson and Rep. Jackie Speier became the first Congressperson to admit to having had an abortion, their

bodies became newly marked. Until the moments in which their bodies became visibly associated with stigmatized identities, the gay body and the abortion body had been invisible in the political body that had the power to control how those bodies were liberated or constrained. Their bodies—newly visible as argument—exercise power and agency. This incorporation of their bodies was voluntary. The act of voluntary incorporation is not equally available to everyone. Jordan could not disincorporate from her gendered and raced body in the ways that Speier and Frank had the option to disincorporate from their not-readily visible stigmatized identities.

Not all bodies were equally able to be so disincorporated. Incorporated bodies were visible and marked by that which made them non-white, non-male, non-literate and non-propertied. “Self-abstraction from male bodies confirms masculinity. Self-abstraction from female bodies denies femininity,” (Warner, 1992, p. 382). And as Warner goes on to note, differences in gender, race, class and sexualities “already come coded as the difference between the unmarked and the marked, the universalized and the particular” (p. 382).

McKerrow (1998) looked at these divisions as a pair of pentads of the Western rhetorical tradition as men/mind/reason/culture/public sphere and women/body/emotion/nature/private sphere. While the bourgeois public sphere, as Habermas articulated it, discussed itself through texts in newspapers read and discussed in coffeehouses, it reified reason, *sans* the bodily experience, as the source of its legitimacy. Rhetoric tamed excesses like emotion, which was associated with women (Sutton, 1992). Western rhetorical criticism focused primarily on the speech acts of white educated males and was primarily conducted by white educated males and was primarily

an administrative rhetoric (McKerrow, 1998). Women and slaves were not featured as a part of the bourgeois public sphere as Habermas described as they were hopelessly subject to and marked by their flesh. Their bodies were incorporated in the private sphere as objects—not as participants. Western rhetorical critics who privileged the mind over the body, were not bodiless beings. They may not have attended to sensate influences in their criticism, but as McKerrow (1998) points out, they had them.

McKerrow (1998) called for a different kind of rhetoric to attend to those subjects and spaces that had been ignored by a Western rhetorical tradition that could not account for bodies, nor could be inclusive of women or people of color. He offered a corporeal rhetoric that encompassed both a diversity of voices sensitive to the diversity of embodied experiences as well as an administrative rhetoric. As Neo-Aristotelian critics failed to account for the ways that the body and the sensate are always/already a part of the construction of the written text, feminist critics foregrounded the body in rhetorical criticism. Zittlow, Rogness, and Foust (2011), among others, centered a woman's agency in her body, by highlighting *passion* as possible source of emancipation.

Even the act of writing is a bodily practice. Palczewski (1996) explains how the genre of letter writing is an embodied rhetoric in exploring Gloria Anzaldúa's open letter to Third World women (Moraga & Anzaldúa, 1981). Anzaldúa focuses not only of the sensual and bodily act of writing, but on the importance of "intimate, tied to life, embodied, and inviting of a response" content of writing as well (Palczewski, 1996, p. 7). A particular type of incorporation (and here I am borrowing McKerrow's term) that women experience in transformative writing is noted by Cixous (1976) who says, "Women must write their bodies, they must invent the impregnable language that will

wreck partitions, classes, and rhetorics, regulations and codes, they must submerge, cut through, get beyond the ultimate reverse-discourse, including the one that laughs at the very idea of pronouncing the word ‘silence’” (p. 886, in Palczewski, 1996, p. 13).

Not only is the body involved in writing the argument and a part of the argument, Palczewski (2002) contends, the body **is** an argument. “Ascriptive characteristics matter; who is saying what matters. Bodies are arguing, making present what has been absent...” (Palczewski, 2002, p. 5).⁵ It is Palczewski’s claim that the body is an argument that I will unpack later in this paper as I discuss the body’s link to testimony.

Bodies on the Line

When people are called to testify, in court or before Congress, their character matters, their experience matters, their physical presence matters. In public and state sanctioned forums incorporated bodies are called on to act as proof. When Congressional panels or hearings are called, people with expert knowledge are called to give testimony. Incorporated individuals are asked to share their lived experience, their bodies acting as proof of their claim. Brouwer (2004) demonstrates this incorporation by witnesses who are called upon to speak about the ban against gays in the military. Brouwer (2004) articulates the difference between the social body of the military and the physical body of the soldier and the ways in which strategies of disincorporation are not equally available to those arguing against the ban: “Anti-ban witnesses supplement their affirmation of the abstract category of ‘rights’ with *incorporating* scenes of violence or harassment against specific bodies that dramatize violations of rights” (Brouwer, 2004, p. 417). Testimony

⁵ Palczewski (1997) succinctly lists how other scholars have also articulated bodies as being understood which, while instructive and salient, exceed the constraints of this paper.

incorporates their bodies. This same incorporation, while making them vulnerable, also makes them able to argue.

It is in the very incorporation of the narratives of Frank and Speier in places that matter (i.e., the floor of Congress) that give them power. Because these newly marked bodies are associated with stigmatized identities, they remain marked long after their rhetorical act of outing themselves, or being outed by others. Until and unless the broader social and political ideologies shift and the stigma associated with their identity lessens or disappears, their bodies are on the line—not just during the disclosure but perpetually. Their bodies remain marked as evidence for/against/as an argument.

Bodies on the line are perhaps most visible as arguments in social movement criticism. DeLuca (1999) attributes the success of ACT UP and similar social movement protests to the foregrounding of the body: “The body is front and center in their arguments for it is the body that is at stake—its meanings, its possibilities, its care and its freedoms” (p. 17). He explains that ACT UP activists use their bodies in protests to show how the homosexual body is already constructed by mainstream and dominant discourses. Perhaps another way to articulate this is the ways that the homosexual body is already storied by the master narrative of homosexuality (Corey, 1998).

DeLuca goes on to say that, “often, image events revolve around images of bodies—vulnerable bodies, dangerous bodies, taboo bodies, ludicrous bodies, transfigured bodies. These political bodies constitute a nascent body rhetoric that deploys bodies as a pivotal resource for the crucial practice of public argumentation” (1999, p. 10). By focusing on performed acts of resistance in social movement criticism, the material implications of the body become more visible. Understanding the body in social

movements means we must understand it as symbolic and extra-symbolic (DeLuca, 1999). We must “craft a conceptual vocabulary that respects the body as both physis [nature] and nomos [convention], as material and symbolic” (Cox & Foust, 2009, p. 616).

Performance ethnography necessitates putting one’s body on the line, as Pollack (2006) explains, “whether that line is on the page or on the stage, in vigil or in protest, or connecting interlocutors in dialogue” (p. 325). While rhetoric *tells* where and how bodies are on the line; performance *shows* the bodies in action.

Performing Bodies in/as Arguing

Performance can help rhetoric’s understanding of testimony by foregrounding/watching/ witnessing the dialogic engagement of testimony. Performance can help rhetoric do this by attending to the liminality created by bodies on the line. Bodies being together in space matters: witnessing matters. Rhetorical criticism helps performance enhance its use of testimony by helping it attend to and focus on larger political/social discourses that constrain or contribute to the sharing of testimony. While performance focuses on the intimacy of a dialogical engagement that “encourages the performer to interrogate the political and ideological contexts and power relations between self and other, and self *as* other” (Spry 2001, p. 716), there is not always the same focus on the broader dialogues that are engaged at the public level. Rhetorical critics have extensive tools that can help focus on the broader contexts and conditions of discourse within which the testimony can be and will be witnessed within.

In order to shift the conditions of political discourse by the observing/receiving of testimony, it stands to reason that the audience must be willing to participate in that change. In performance we understand the interaction between the audience and

performer as a dialogic engagement (Alexander, 2005; Conquergood, 1991; Madison, 2006; Pelias, 1991; Spry, 2001). “The dialogic performative,” writes Madison (2006), “is charged by a desire for a generative and embodied reciprocity, sometimes with pleasure and sometimes with pain. It is a mutual creation of something different and something more from the meeting of bodies in their contexts” (p. 320). Performing testimony is both private and solitary, and public and communal (Feldman & Laub, 1992). By speaking for oneself, a public discursive self is created which influences the private internal self (Alcoff, 1991).

In rhetoric, we are much less attendant to audience response unless we are doing a specific analysis of the audience or are conducting rhetorical field methods. We have paid attention to the body as it delivers an argument. We have seen the body located in an argument and the body as the argument. We have also paid attention to the body of the critic. We have begun to focus on bodies interacting with bodies as argument. But what performance offers is a heightened sensitivity to the role of the body in relation to other bodies as the site of the co-presencing of the sensuous experience. We can see testimony as given by one body against/for/in support of/as rebuttal to an already ongoing argument/discourse. In a courtroom, testimony is given by a “witness” in the presence of the judge, lawyers on each side, gallery members, and a jury. The jury must make a decision, must judge the veracity of the truth claims made by the witness. We concern ourselves with the intended message and the intended audience of the text. And while we invest in the idea that rhetorical acts have effects, we do not necessarily have tools to assess the effect on the audience outside of traditional elocutionary impacts. We do not usually concern ourselves with measuring audience response as to whether a speech or

speech act was effective. Some rhetoricians have taken up this work by using rhetorical field methods and ethnographic field methods to interview/assess/analyze audience response. Some rhetoricians attend to audience responses by reading newspaper accounts and eyewitness reports that circulate in public discourse to understand how the artifact may be discussed or talked about.

But performance has a primary concern with the audience. It privileges the relationship between the audience and performer. Performance cares about and wants to understand the audience. Performers are taught to “read” the audience, much the way a rhetorical critic “reads” a text. When the audience sighs, shifts in their seats, coughs, laughs, applauds, boos, stands in ovation—all of these are messages the performer decodes, processes and interprets as audience response. Performance, especially activist theatre, hopes for dialogical engagement in which the audience may be moved to come to a different understanding and/or inspired into action. Performance often strives to attain or create a liminal moment that is felt by both the audience the performers in which an opportunity for change may occur. This liminal space allows, encourages, and creates an opportunity for the audience member to be pulled, drawn, or transported outside of their own embodied experience into the lived experience of another in this moment. It is this liminal space in which the performance imagines itself able to reach past prejudice and difference to create a unified moment, a unified experience. In this moment the audience members are carried into another life, another experience, another's emotions and they are able to feel them with their own bodies.

For rhetorical criticism, which has traditionally concerned itself with such things as logos and ethos, pathos can be dismissed as less venerable than reason and logic. But, as

informed by performance, we consider pathos as not as just an appeal to emotion, but *as* the domain of the body—the source and site of sensate experiential body—then pathos allows us to, has always directed us to, the value of the body. Palczewski (personal communication, November, 19, 2013) suggests that what performance offers to rhetoric’s conception and articulation of the body is constantly moving, living, breathing, evolving—not as a static text, a frozen moment in time, a captured image or a documented speech. For in performance, the body is always moving, speaking, and performing. And as audience we are watching, feeling, sensing, processing, experiencing. Performance moves. The body argues. The body, once identified/marked/seen as something it was not known as before, continues to perform that which it is/has now been made visible as to the audience. Because now the audience recognizes/sees/knows something about the body that is not obvious from “looking” at it, but becomes knowable while *watching/hearing/ experiencing* the testimony in a dialogical engagement that informs and shift our understanding and awareness. Again, it is the audience that undergoes a transformation of understanding that is not readily assessed either in rhetoric or performance, but, I would argue, is the goal of both. A performer shares her/his personal testimony with an audience in the hopes of convincing them that the experience is valid, important, and salient. In rhetoric, testimony also tries to persuade the audience of its validity, especially when given by an expert or eyewitness.

What rhetoric offers to performance is the ability to assess, tend to, care about the larger conditions of discourse the broader implications for interaction outside the performance space/performance interaction/venue/moment. Performance cares about immediacy, in the moment. Rhetoric concerns itself with the diachronic and synchronic

meanings of the text and the context in which it is given. Activist performance cares about context that situates the performance in larger social/political issues. It uses tools available to critical rhetoricians. Similarly, critical rhetoricians use tools available to performers. While rhetoric has begun to attend to the body in/as *argument*, performance attends to the body in/as *arguing*. The body continues arguing, always and ongoing, not always visible unless marked to a particular audience or witness. I believe that just as there are things made by words (Leff, 1992), performance shows me that there are *things made by bodies with/in words* worth understanding.

Testimony is linked to the body, as the source/site of the lived and embodied experience and/as the site of the evidence of that experience. The body is revealed in testimony. The body is both part of and key to the argument made in testimony that then continues arguing in the body's presence long after the testimony ends.

It is important to note here, especially when working with personal health narratives, the ways that the sharing and the witnessing of these stories is indivisible from the bodies marked by such experiences. As Charon (2009) explains,

Narrative medicine reminds us that illness unfolds in stories, that our bodies, being more than machines or vehicles, live through our lives with us, perform our lives, carry our scars, our bliss, and our memories, simultaneously both limiting and expanding our lives. Narrative medicine recognizes that the central events of health care are the giving and receiving of accounts of self. As human beings hear one another out, donating serious and generous attention, listening from the teller's side, they are able to perceive one another, bestowing and accepting recognition as a result." (p. 120)

Rationale for Testimony as Organizing Concept

Testimony's tethers in narrative, rhetoric and performance provide a multifaceted approach to studying stillbirth narratives. Wander (2014) makes the argument that rhetoric and performance are contiguous fields of study:

Consider the words 'critic,' 'performer,' and 'theorist.' I ask myself who I am and who I am not, and how I perform my text in relation to different audiences. When what lurks in the shadows of a text is made visible and/or audible, when we get a feel for what is being said, it adds new and sometimes surprising dimensions to who we are and what we ought to be doing. (p. 100)

Performance and rhetoric's mutual interests are also contiguous with narrative and these three are the component elements of testimony. Each of these communication approaches takes up *testimony* in similar ways, but emphasize different components as key investments. Rhetorical theories allow me to see the cultural, political and public contexts in which testimonies of stigmatized bodies circulate. A narrative paradigm provides the tools to understand the story and its component elements (construction and function) and its relationship to health and identity. A performance framework allows me to understand the process of co-presencing with participants and liminal possibilities in the production that can create opportunities to create social change.

Conquergood (1992) describes performance as the borderland between rhetoric and ethnography. He believed that performance allowed the two fields to make claims to poetics and persuasion, pleasure and power, solidarity and resistance, and in the interest of community and critique. As Fisher (1984) called humans, *homo narrans*, Conquergood (1992) claimed that we were also *homo rhetor* and *homo performans*. While he explains

that the connections are and can be contested, he also believed that critical rhetoric and performance both worked to destabilize “a worldview anchored in being, with a constructionalist worldview in the nature of becoming,” (p. 81). Instead of the understanding the world as ontologically given, it is “rhetorically constructed and performatively realized” (p. 81).

Testimony is the meeting ground of the context of rhetoric, the lived experience in narrative and the dialogic engagement of performance. Testimony is poetics and persuasion that can show solidarity or resistance and can be pleasurable and powerful while it creates community and critiques society. Testimony is personal narrative that is rhetorically composed in response to, directed toward, or in acknowledgement of already existing narratives as evidence of lived experience and as expertise.

Using Testimony to Study Stigmatized Reproductive Bodies

I would argue that while there are similarities and differences in the ways that rhetoric and performance treat testimony, it is only by converging these articulations that we can clearly understand how testimony functions. Separating or privileging one approach over the other returns us to Neo-Aristotelian bifurcations of the body and the mind. As Spry (2001) notes, “It is not that our bodies haven’t been in our work, rather, they have been shrouded in our research by dualistic separations of Mind and Body,” (p. 720). The study of testimony demands their unity. Spry explains:

The transdisciplinary desire addressed by alternate methodologies is, I would argue, partially motivated by our want to understand how we know what we know about pain, perhaps to quell it or console it, but at least to speak it and introduce its into the body of human knowledge (Spry, 2001, p. 720).

Performance tells me that testimony matters because of the reciprocal witnessing of the trauma. Rhetoric tells me by contextualizing testimony, we may expose taboos. If speech about the act is taboo, then the performative speech act of telling calls the taboo into question (Park-Fuller, 2000). When people testify, it is not just about their experience, but is also against the frames within which those stories are situated. Trinh T. Minh-ha (1991) argues that a responsible, reflexive autoethnographic text, which shares similar structures and grammar to personal narrative, “interrogates the realities it represents. It invokes the teller’s story in the history that is told” (p. 188, in Spry 2001 p. 721).

But I also want to be careful in my tending the body in rhetoric, the abortion body or the stillbirth body, that I am not absenting or abjecting the individual. I do not want to remove the humanity from the corporeal.. But it is through the narrative shaped by, communicated by, or ascribed to the body that the individual can become mis/understood to others. It is the bodily experience of the individual as communicated through testimony that allows me to understand, witness, or recognize stigmatized reproductive bodies. It is in my understanding of the larger conditions of discourse that I understand the potential risks and rewards of marking the body with testimony. By utilizing this disciplinary convergence of the testimony, or absence of testimony, of stigmatized reproductive bodies, I can focus on *things made by bodies with words* that show me what is worth understanding.

This articulation of testimony can provide a framework to analyze the ways that stigmatized reproductive bodies are made in/visible in the public and state forums for debate. It is with this framework, combined with my liberatory goals, that I hope to

discover opportunities to shift the conditions of discourse available to bereaved parents. Perhaps shifts in awareness will help motivate action to address the absence of 26,000 wanted babies who remain invisible—especially to those in power to make a difference in the lives of bereaved families.

Bereaved parents are not just a number or a faceless abstraction. Not only do their stories matter on their own, but they matter—and communicate—collectively. Perhaps testimony, on stage, in public and in state forums for debate conditions of discourse for stillbirth families can be broadened. Current discourse on reproduction currently silences the lived experience of women who have had an abortion just as it simultaneously absents their stigmatized bodies. The same polarized discourse absences, from both sides of the political aisle, the stillbirth body, the wanted babies who die, and the bereaved families in need of action.

The work of this dissertation will focus on the ways that various pregnancy-ending testimonies—put in conversation with each other—may represent multiple truths lived by women whose experience of pregnancy-ending is informed by various social, political and medical factors.

Methodological Approach

The methodological approach for this project finds itself at the intersections of narrative, performance and rhetoric frameworks in order to study pregnancy-ending testimonies. Previous research I have conducted has harnessed social science methods, both qualitative and quantitative research, to study the interaction of bereaved parents with health care providers and perceptions of stillbirth news delivery (Pullen & Nalos, 2009; Pullen, Golden, & Cacciatore, 2012). One study (Pullen, Golden & Cacciatore,

2012) focused on a thematic analysis of an open-ended question about what patients remember care providers said and/or did while telling them that their baby had died in-utero. The 624 stillbirth parents who completed a 118-item survey, which used mostly Likert scale responses, often answered the few open-ended responses with detailed narratives about their experience. While common themes emerged, the range of circumstances, the thickness of description, and the reported impacts of their experience proved to be hard to quantify or qualify in the length allowed for a conference paper or journal article.

While elements of their common and disparate experiences were highlighted, their unique bodies were missing. The whole of their experiences were broken down, by the necessity of traditional social science, into component elemental parts in order to be regrouped and rearranged for the purposes of supporting a claim or teasing out a theme. This type of research and parsable findings provide necessary evidence to institutional authorities as rationale and justification to change practice and policy.

However, in order to motivate systematic change, those in charge of administering, serving under or being served by those protocols have to *care* enough about their impact on others in order to buy into the professional and emotional labor required in sustainable perspective shifting. Increasing empathy by providing opportunities to understand a stigmatizing health or medical condition using an emotive, affective, embodied approach—not a just clinical one—is essential to my activist aims.

This dissertation does not take up the work of data analysis as might be readily recognized as quantitative or qualitative research, which might include audience analysis, thematic analysis or experimental design. This work, instead, combines the investments

of social science research—its theoretical frameworks, methodological rigor and member checking—with the investments of rhetorical and performance approaches—critical inquiry, self-reflexivity and contextual framing.

A critical rhetorical approach to researching stillbirth is a necessary component of my activist aims. Such an approach is concerned with power, institutional systems, issues of justice and equity, and health disparities. Critical performance ethnography is a key part of my process of conducting research, analyzing my findings, and facilitating advocacy. This critical approach has led to several questions about stillbirth testimony.

Research Questions

First, motivated by my critical investments of situating stillbirth within reproductive justice discourse, I want to explore the ways that performances of stillbirth testimonies might be framed by such discourses. How, and to what effect, might the larger conditions of discourse be re/presented in the performance, by performance space and to the audience?

Second, grounded in my experience in using performance as theory and method to explore my own stillbirth testimony, what might be discovered by putting the pregnancy-ending testimonies of others in conversation with each other?

A third line of inquiry guides my inclusion of narrative frameworks: What, if any, are the functions of the testimonies of pregnancy ending?

Finally, I want to explore the agentic limits of testimonial performance. Testimony is the meeting ground of the context of rhetoric, the lived experience in narrative and the dialogic engagement of performance. The study of testimony—and its tether to the body as the site and cite of experience, expertise, and agency—is located at the disciplinary

intersections of narrative, rhetoric and performance. But can it still be called testimony if someone else's body performs it? What happens when ones gives their private testimony to a third party with the knowledge that it will be used in/as argument to affirm, challenge or deny dominant narratives *by another* body? Is it still testimony?

Texts to Examine (For Con/text of Performance Scripts)

I intend to study two specific types of text to craft an ethnographic performance. I use a critical rhetorical approach to discover naturally and publicly occurring testimonies of pregnancy ending. I use autoethnography and performance ethnography to conduct in-depth interviews with women who have experienced pregnancy ending.

Eruptions in the conditions of discourse of pregnancy ending. I employ rhetorical sensitivities in observation and analysis of where I see pregnancy-ending testimony in state forums and public spaces. I focus on eruptions in the conditions of discourse for pregnancy ending through testimonies of abortion and stillbirth in various publics and state spheres to better understand the cultural climate and conditions for discourse regarding pregnancy ending. I concentrate on moments in which I observe bodies on the line. I chose a starting point after the midterm elections of 2010 that began what political and media pundits called “the war on women,” and end after the Emmy award campaign in 2014 surrounding the first motion picture to focus on stillbirth, *Return to Zero*. Texts I examine include the public testimonies of stillbirth and abortion, including female legislators who disclose their own stillbirths or abortions in the state's own forum for debate, online and print media publications that have published personal narratives about pregnancy ending, legislation related to the prevention of wanted, unwanted and/or unplanned pregnancies from ending. Since 2011, I have been scanning

public discourse (through social media, news reports and keyword searches) to track the ever-evolving debates, legislation and protests surrounding reproduction for contextual news, images, and events. I have kept links to videos, blogs and articles. I focused on the individual testimonies, their public uptake and their political use.

Interviews with women whose pregnancies ended prior to birth. I received IRB approval to conduct two separate research projects. Prior to beginning my work on this dissertation, a fellow doctoral student and I received a grant which, in part, was to gather, study and perform narratives of women who had experienced abortions, either the termination of a wanted pregnancy due to genetic anomaly or complication and those who have aborted an unplanned or unwanted pregnancy. We applied for and received IRB approval for this research and only the participants I interviewed are included in the performance project. Subsequently, I received IRB approval, with Dr. Linda Lederman as lead P.I., to conduct in-depth interviews (each interview lasting between 1 ½ - 2 hours) with women who have experienced the stillbirth or miscarriage of a wanted pregnancy.

Due to the sensitive nature of these subjects, I used snowball sampling to recruit participants. I posted PDFs of the recruitment flyer on my own Facebook and Twitter pages, several stillbirth organizations' social networking sites and ASU's listserv for graduate students. I brought flyers to ASU's health clinic and sent them to a local Planned Parenthood clinic. I designed similar interview guides that invited participants to share their pregnancy-ending stories; whether they had heard similar or related stories of pregnancy ending (either due to abortion, stillbirth or genetic termination) prior to their own pregnancy ending; and if they share their stories with others. Participants were told excerpts of their interviews would be interwoven into a play script and that only a portion

of their story would be able to be told. Interviews were audio and video recorded, with the consent of the participant, for the purposes of transcription and preparing the performance. Participants were offered a copy of the transcription of the interview. Member checks, with participants attending the performance, included review of script prior to the performance for any transcription errors or inaccuracies created in the editing process.

Ten women were interviewed, but only eight of the narratives were selected for analysis and performance. One interviewee was not comfortable sharing her own abortion experience and instead shared her mother's. This did not meet the criteria for the project. Poor audio quality from a stillbirth participant's interview made accurate transcription extremely challenging, so it was not used. In total, the eight interviews were distributed across pregnancy-ending experiences: three women had abortions, including one woman who had given her first baby up for adoption and had two subsequent miscarriages and two subsequent abortions; one woman terminated a wanted pregnancy due to genetic anomaly, a subsequent miscarriage and two subsequent live births; one woman had three miscarriages; and three women had stillbirths, one with a subsequent live birth. Four of the eight participants were women of color, two of whom spoke English as a second language. Their ages ranged from mid-20s to late 60s and the span of time from the pregnancy-ending experience and the time of the interview ranged from three months to 30 years.

My own testimony. I will offer my own testimony as bereaved parent (and the experiences of the death of my child), as supportive witness (my contact with other stillbirth families in support groups and memorial services), and as stillbirth advocate

(lobbying Congress, debating with researchers, arguing with doctors). I will use autoethnographic methods in crafting my own testimony. Sharing my testimony will mark the ways that I am insider (of the stillbirth community) and expert of a specific kind of experience (my own). I will also share the narratives of others, which marks me as researcher and observer. I will share context, which marks me as critic and historian.

Text to Be Created

As I have previously stated, I believe that the experiences of stillbirth and abortion are politically linked. But we rarely, if ever, hear how these stories—of the different ways that pregnancy ends prior to birth—speak to each other. How, if at all, might the grief of a stillbirth mother inform the way we understand the emotional experiences of a woman who has terminated an unwanted pregnancy? How, if at all, might restrictions imposed on abortion affect women who chose to interrupt a wanted pregnancy due to severe medical complications? How, if at all, might the “personal is political” context of abortion help shed light on the personal politics of stillbirth? While talk about abortion legislation often dominates public policy debates, stillbirth is rarely discussed beyond its often-private grief.

I engage these and other performances of possibility (Madison, 2003) by crafting a series of one-act performances that draw from texts I have collected. Each performance is devised from different types of testimonial source material and uses different ethnographic performance approaches/styles. For example, I am using actual video footage of state legislators testifying about their own experiences of pregnancy ending as part of a multimedia performance installation. I am exploring written text as testimony by interweaving the private letters of historical figures who have written about their stillbirth

experience juxtaposed to the public “open” letters directed at policy makers about abortion access. And finally, I am exploring the use of the ethnographic interviews given to me as testimony and then performed by me as testimony by a type of proxy.

As an advocate and activist, the choice to create and stage a performance was motivated by a desire for the text to circulate beyond an academic text, in part to increase the availability and visibility of the very stories I am focusing on. But it is also because I believe that bodies in space together matter—that through liminal moments change is possible. I believe in the power good performance has to create *communitas*, and bring disparate bodies and experiences together in a shared moment, and to expand the conditions of discourse for stigmatized reproductive bodies and to be a vehicle for social change.

Narrative Loop Model

In order to better visualize testimony’s development and circulation, a new model is offered to map the relationships between the dominant discourses, testimony and the functions of narrative. The Narrative Loop model (as shown in Figure 1) as designed by members of a graduate course in women’s health narratives to represent the co/process of narrative re/development. As I explain each of the phases of the narrative loop, I provide exemplars from the interviews with the ethnographic study participants who experienced the ending of a wanted pregnancy. Understanding how parents experienced stillbirth or miscarriage might shift from embracing the dominant narrative of wanted pregnancy to seeking a counter narrative in which they see themselves anew is key in understanding the value of stillbirth narratives. Later chapters will adapt and extend this model informed by the work of this dissertation.

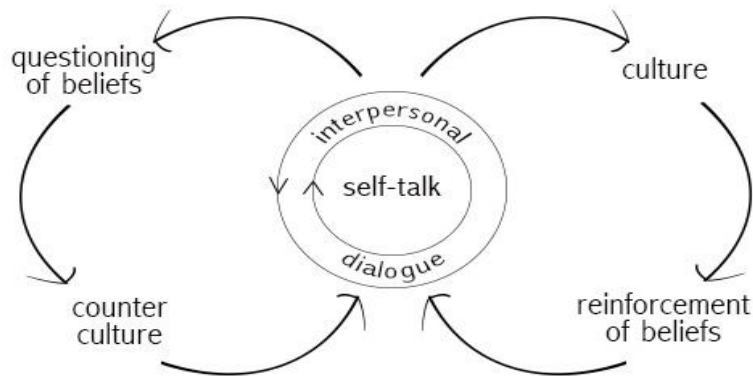


Figure 1. The Narrative Loop Model. This model is an unpublished class project created collaboratively by Dr. Linda Lederman and the students in her Women’s Health Narratives graduate seminar in the Hugh Downs School of Human Communication at Arizona State: Lori Bednarchik, Lou Clark, Brook Dorff, Megan Fisk, Trisha Hoffman, Yanqin Liu and Suzanne Pullen. Graphic designed by Brook Dorff.

Intrapersonal Communication

Determining which comes first, our internal self talk or the dominant narrative, can be like a chicken-or-egg conundrum. But as the self is the processing hub of our own experience, the self is a good place to take up the trajectory of narrative as narrative is at the heart of how we constitute our “self,” (Holstein & Gubrium, 2000). Stories shape our reality (Shank, 1990). They create order from chaotic fragments of events and information. The fragments get woven together with causal connections. The details that aren’t used are forgotten. The story becomes our reality.

According to Holstein and Gubrium (2000), narrating the self is part of the ongoing evolution of self-concept imbedded in an interpretive and social process. They explain that the self is crafted in relation to others, is disciplined by social forces, and is emergent from, and in response to, particular situations. Self-construction is discursive:

it happens in communication with others as well as in communication with our own self (Lederman, 1996). As Lederman (1996) explains, intrapersonal communication may be the most important discourse that affects our conception and development of self. We talk to ourselves to understand, to process, to challenge, and to engage our different selves and experiences. Hence, self-talk is at the core of our self-concept.

But as the self is socially situated, Goffman (1963) explains, it is vulnerable to stigmatization when perceived as non-normative or socially unacceptable. His concept of spoiled identity (1963) is helpful when conceptualizing the relationship between the self and health-related issues. When patients receive a diagnosis of a disease, condition or illness that fundamentally changes how they perceive themselves—like a pregnant woman who imagines herself as mother-to-be and then the baby dies prior to birth—their identity, or their self-conception, is radically altered. If the medical condition or diagnosis is stigmatized—like an unwed teenager who becomes pregnant and seeks to terminate the pregnancy in a culture that can cast both the condition and the choice with a shroud of shame and secrecy—maintaining a healthy self-concept may be hard to do. The creation of this self-concept, as well as our acceptance or resistance to normative identities, is at the core of our continuous self-talk.

This intrapersonal dialogue or internal muzak (Lederman, 1996) is where we make sense of the stories we are exposed to in our families, in popular culture and in our interactions with others. Often we internalize these stories as the way things are “supposed to be,” and we may proceed for a time under the guidance of dominant cultural narratives without recognizing that is what they are. Other times, we may more aware of the cultural narratives and their influence on us and we can ultimately choose which

narratives we reproduce or resist; and whether we embrace the dominant narratives or seek out counter narratives. This decision-making is often spurred on by a catalytic event, a disruption in our worldview, or an external interaction that interrupts the loop and causes us to recognize that there may be different possible narratives.

For example, Raven, a participant who had experienced her stillbirth in 2000, said the absence of dialogue about stillbirth makes it a shock when it happens.

If you don't know that that's something that happens, when it happens to you, it's like a thunderbolt out of the blue and it feels so alone. It's so isolating because you've never heard of this happening whereas if you've heard of it—and it's hard because it's like you don't want to talk to someone who's pregnant about it necessarily like, that baby could die.

When a parent experiences stillbirth, her intrapersonal dialogue can be filled with the chaos of uncertainty and confusion. For example, Tee, who was interviewed a little over a year after her stillbirth, said:

They put the monitors on me and I know at every doctor's visit that I never had a problem hearing her heartbeat...it was always very quick and strong and I remember telling the nurse "she's here." And she went to look for the heartbeat and there was nothing. And I... just told myself, "No, they're going to find it. They're going to find it." She continued to look and then she said, "Why didn't you come in earlier?" And I felt...I was in disbelief. I I obviously felt that she knew there was something wrong....because she asked me that question. And... I think I lost it for a second. I just kind of went into a really weird feeling.

Tee added that she was in a daze after getting the news:

I remember just sitting on the couch and just being so far in a daze and, and how the tears would just roll down my eyes. And they were hand feeding me because I wouldn't grab it. Telling me to drink water. And I just had no urge to do any of it. They were trying to get me upstairs to try and sleep and I couldn't sleep. I just kept crying hysterically and my husband was crying. Everybody in the house was crying. Nobody knew what to do anymore....

Many women experience regret and self-doubt about what they could have done and blame themselves, even if they “did everything right.” This can be especially true for women like Lena who are faced with learning that their baby has a genetic anomaly or that there is something very wrong in the pregnancy.

So I called my mom (audible inhale) and just said something wrong with the baby and just sobbed. And then went to sleep that night exhausted and talking to the baby. I'm like “I'm so sorry...” You know, really talking to the baby...and apologizing...and then going, “What did I do wrong, I must of done something wrong.” But I hadn't, you know?

For many women, sharing their story is part of a long healing process. While sharing one's story can be a part of the sense-making process or building community, some can do it specifically to organize their experience. Sanjana, a participant who had had three miscarriages, said:

You don't know how it feels unless you've gone through this. And for a person like me, who takes every word to the heart, I wouldn't really want people to say words they wouldn't have thought hurt me. Let the couple have their process on their own. Let them take their time. Cry hard. Because at the end of the day, it is

your baby, it's your expectations, your dreams that are being shattered. So I think I will need time to find myself to go through this process.

Sonya was pregnant multiple times in Iran as an unmarried women which is illegal. The first time she disclosed the told story of her three abortions was during the interview and she said sharing the story helped with her own processing of the effects of the abortions. She said, “The sharing the story also helps me to explore to myself and also help me to make sense of feelings and something...it’s been like buried thing inside me.”

Interpersonal Dialogue

The stories we tell are not pre-formed, (Holstein & Gubrium, 2000). They do not come already prepared prior to our interactions with others. Rather, these stories are elastic (Holstein & Gubrium, 2000) and they changed based on the situations we are in, the context in which they are told, who we are telling them to and why we are telling them. We may, once we are ready to move beyond our internal world, engage in conversations with others—informed by our intrapersonal dialogue. One reason we do this is to determine if others have had similar experiences. These interactions can be actual engagements with others or can involve media we take in and/or create including photographs, family histories, attitudes, art, the written word, television, social media and the Internet. It can be the externalization of our inner dialogue or inner musing for others to consume.

Many parents seek out and post their own stories online at memorial sites, blogs and message boards to guide them through the healing process. Participants also talked

about the importance of hearing the stories of others as a way of validating and supporting their own experience. Sanjana⁶ said:

I have read stories. Some of them really inspire me. I like reading those. But some are really hard for me. And there were some stories that were similar to mine and I wanted to know how they moved on in life and how they came through this process.

These interpersonal interactions are also a part of the community building process. Lena, who terminated a wanted pregnancy in 1995 and experienced a subsequent miscarriage, talked about the importance of finding other parents with a similar experience.

I went to one, just a general loss group and could not relate. I didn't like the person who was running it. I wanted to take it over. I just felt like I couldn't really be open about what really happened. Then I went to the one for people who had terminated a wanted pregnancy, and that's where I felt most comfortable. It was fantastic. Some of my best friends are from—I met through that group.

Dominant Narratives

Dominant narratives, also known as cultural or master narratives, are often assumed as a society's core beliefs. These narratives do not represent the only truth, just what appears to be generally and widely believed and reproduced. Some parents became aware of the dominant narrative of wanted pregnancy when they realized that it was no

⁶ Sanjana had asked that her real name be used, which I did in the performance. While it goes against my activist impulses to use a pseudonym here, it does not outweigh my concern for protecting her from potential harm by having real name published.

longer their own. Lena's story initially was in keeping with a common narrative of family creation.

My husband and I were newly married, and we married later in life to finish our graduate programs, he was doing residency in psychiatry and I got a double masters in counseling and psychology. And soooo, very excited, got pregnant pretty quickly. Just very very excited, very hopeful.

I was about 16 or 17 weeks pregnant and I'm on the table heh (*chuckle*) and the ultrasound the tech was very quiiiiet aaand the perinate comes in aaaand um he looks and I know something is wrong...And so I'm laying there um and while we're waiting for the radiologist to come this...how shall I say it...um...ASShole...excuse my French...um...starts chatting with my husband about where they did residencies. So I'm laying there...you know tears coming down my face... the tech is silent...and he's asking my husband where he did his residency and who they knew...and I'm like I feel like I'm in this surreal out of body mooovie experience watching from above...

Dominant narratives reinforce, and are reinforced by, institutional practices of medical institutions and health care providers. I hear from many parents whose babies had died generations earlier that the prevailing wisdom was to remove the baby from the delivery room immediately, without letting the family see or hold the baby, and encouraged the parents to not think about it and get pregnant again as soon as possible. Advocacy groups and current research recommend parents be given options and guidance about after death care choices. While some hospitals have bereavement programs and parent advocates, there are no national protocols or standardized care practices for

stillbirth. Until more research is done about the efficacy of interventions, like seeing and holding, many hospitals may be hesitant to make needed changes in bereavement care. Additionally, the parents they care for may have no frame of reference for the interventions they offer, especially if they have never heard of other bereaved parents doing things like holding their dead baby or taking pictures of them. Tee, whose baby was stillborn at 27 weeks, said:

One of the nurses had talked to us about an organization, *Now I Lay Me Down to Sleep*. And when she said there's photographers that will come out and take pictures of her and me and my husband, I think, we looked at her like, with daggers in our eyes. "How can you take a - how do you - why do want to take pictures of my daughter dead." The only thing I could think was how fuckin rude was that? And, she said "I know, I know." She goes "It's totally up to you, I'm just giving you the option." They were really amazing, the nurses and the doctors there. So me and my husband had to say yes, we wanted the photographer after thinking about it for a little while.

Lena experienced institutional hoops to the after-death care she wanted for her baby, in part because the hospital she was working said they had never received a request for the release of remains from a terminated pregnancy for burial, let alone for a Jewish one.

It should be when you found out there's bad news, you should receive a piece of paper of all the places with all these denominations that tell you where you can have a free service, a free burial, cremation, a free rain dance. I don't care what you want, but why didn't someone—I just was furious. I was so mad. There

should be a memorial service. There should be a way that we can all come together and we can do this, we can give honor.

Reinforcing Beliefs

When we engage with dominant cultural narratives, we also receive and reproduce messages that reinforces or strengthens society's core beliefs and stories. These reinforcements can appear as messages that validate conforming behaviors or correct transgressive behavior. These beliefs are not questioned but rather accepted and added to the dominant narrative. In order to maintain the dominant cultural narrative, those stories that do not conform to the norm are also silenced as part of the reinforcement of what is known and accepted. Miscarriage is common. Do not tell anyone you are pregnant until you are in the safe zone. If you miscarry it was not meant to be. You can always get pregnant again. Sanjana encountered these messages often and even though they were well meaning, they seemed to dismiss the pain of her experience.

And whenever I saw that book, *What to Expect When You Are Expecting* and things like that, I used to feel very bad because that reminds you. And the sympathy that I received that was really bad. People used to call me from home and they used to tell me, "Oh, that baby was not meant to be yours." That hurt me really bad. That's something I've heard a lot of times.

Questioning Beliefs

In cycling back through the center of the model, we come back to ourselves. When a triggering event happens, it can cause our internal dialogue to shift. We might begin to ask questions about what we have assumed to be true because our internal truth no longer matches the dominant narrative. For stillbirth parents, the death of our baby

plunges us into a well of questions that seem to arise from a complete absence of alternatives to the dominant cultural narratives. Engaging in interpersonal dialogue can also be challenging. How do we talk about the things we have not heard others talk about except maybe in a hushed whisper? Parents who experience stillbirth overwhelmingly report that when they learn that their baby has died, their world view changes and they are no longer the same person they were before (Pullen & Nalos, 2009). Lena said:

And so it was just surreal like we were hit by a truck. My husband was silent...he just didn't know how to comfort me...and I just cried and I cried and he was in his little world and I was in my complete "What the hell just happened?" place.

And then when we got home, that's where we kicked into research mode. We need to find out what this is, we need to call all your family members who are all doctors around the country and lets get on the phone...this is pre-Internet in 1995. I have a sister in law who is a OB/GYN and she was a resident at that point and um called her and then she called friends of hers and um ...you know just needed more information. We got home and we actually—we didn't go straight home. We went straight to the bookstore, and I walked up to the information booth, and I said to this young college student, "Do you have any books that describe how pregnancies are terminated around 18, 19 weeks?" I just said it. He said, "Let me get someone for you." I'm sure he's like, "Holy crap."

I suddenly just—I found my voice and he got probably some manager and said, "I don't know, let's look and see." We looked for information. I sat right there on the floor. It was cold, very cold, cement, I think, floor, and started looking through books and trying to find a description of how it happens. What is

the procedure? What are the choices like? What's it like for the mother and for the baby, and on and on? Then we went home and called family, and told them. They were all wanting to know.

Counter Narrative

A counter narrative can be a new way to tell the same or a story that represents a marginalized or invisible experience to the larger public. Counter culture is an awareness of new possibilities, shared and proclaimed as a resistance to the dominant culture. Sharing stillbirth narratives, both interpersonally and publicly, helps to shift the feelings of isolation and secrecy that families whose babies die experience in the absence of prior awareness. For example, Lena said,

I think I would like people to understand how complex the physical, the emotional, the spiritual, the community, the—and I—part of our discussion was about how would this impact our future children? To this day, my 17-year-old son says, “I’m really sad that those babies died, but I did the math, if they had lived, I would not exist.” He said that when he was pretty young. It was just fascinating. How I made a decision that my boys would know—I would talk about the story. I would bring them to the memorial service. They would know so that it would change the culture so that people would know that this happens and how complicated it is. It’s part of life. I hope that it has the impact that it gives them permission to talk about it.

Raven challenged the dominant narrative of grief, which focuses on its negative valence rather than its positive one.

One of the things that I've taken away from the whole thing is that grief is a universal thing. It feels very much like it doesn't always work this way but it has the potential to connect people because it's such a—because it's such a universal human experience. I think that something about the various systems that we live under now push people to turn grief into anger and rage and hatred, but I think that the more natural impulse is to connect over it.

Playwright and bereaved parent David Hansen wrote to me about the power of story after my article about stillbirth appeared in the Chronicle.

Every parent of a lost child wishes someone would ask to hear about their children, and so few do. Sometimes we need to step up and tell the story others simply do not want to hear. These are our children. We were expecting them. We wanted them. They were with us. (Hansen, personal correspondence, n.d.)

I wrote back to David, who had written and performed a play about the stillbirth of his son, Calvin, "I do agree, telling the story is important. Even if everyone isn't comfortable with hearing it, we need to tell it. And the more we break the silence, the more we create a model for how to talk about it." I had no idea how prophetic those words would be. How seven years later, I would come back to the core commitment in that very phrase: "Telling the story is important...the more we break the silence, the more we create a model for how to talk about it."

Exposure to counter narratives helps in the sense making process. It can help a parent put their finger on emotional experiences they have had difficulty articulating because they have not experienced them before, nor have they been exposed to the stories of others who have.

Participants also talked about the importance of hearing the stories of others as a way of validating and supporting their own experience. They internalize the counter narratives and engage in self-talk that helps them see and/or adopt the counter narrative as their own. Stillbirth stories, when shared socially, also contribute to the creation of a guiding narrative for stillbirth families that are representative of their experience. Tee said:

It is good and hard at the same time being able to talk about her. And she existed. And I know that all of our babies existed. And she's not just a faint memory or something people think I'm going to get over. It doesn't, you don't get over this. You just have to try to move forward without leaving them behind. And it's important, I hope that, you know sometimes telling my story helps the next person. And I think that's why I went to the support group for so long because I felt as though I was helping those other woman who had just had this happen. To know that you're going to move on somehow whenever you're ready....I think I just got up one day and figured that I had to pull myself out of the hole. And I remember telling my therapist...that I'm not in a hole, I'm just in a dark forest. And I'm finding my way out. I see light now. And for me, it's just, learning how to move forward without leaving her behind.

Once stillbirth parents encounter counter narratives, and embrace them as their own cultural narratives, they also engage in reinforcing behavior. They seek out communities of others who share or understand their story. They validate others and their experience and they continue to challenge the master narrative of live birth that is not representative of their own experience. For example, Raven, who had a full-term stillbirth

during a home birth in 2000, said that she felt her grief connected her with other people who had also experienced traumatic deaths.

I really had the experience where I felt like I was walking through the world in those weeks and months after [my daughter] died carrying this intense grief. It was probably invisible. That really cracked me open in a way of, like, just realizing any person I cross on the street could be carrying grief like that and I would never know it. Grief is a universal thing. It has the potential to connect people because it's such a universal human experience. I think that something about the various systems that we live under now push people to turn grief into anger and rage and hatred, but I think that the more natural impulse is to connect over it.

This foundation of the narrative loop model has laid the foundation for understanding how and where testimony can be created, located and circulated. Chapter Three will focus on the rhetorical aspects of testimony, as described earlier in this chapter, in order to better understand the conditions of discourse that exist for stillbirth testimony which provides the context for the performance choices outlined in Chapter Four.

CHAPTER 3

OBSERVATIONS OF PREGNANCY ENDING TESTIMONY IN STATE FORUMS & PUBLIC SPACES: COURTHOUSES, CAPITOL STEPS, AND THE COURTYARD OF PUBLIC DISCOURSE

Since I began lobbying for stillbirth legislation in Congress in 2007, I have had a heightened awareness about legislative actions regarding women's reproduction. As mentioned in Chapter One, more than 300 hundred laws have been passed in those seven years. Analyzing the range of legislation regarding abortion and women's reproductive health and the public response to it is far beyond the scope of this project. Similarly seeking out and discussing all instances of pregnancy-ending testimony in public spaces, whether live or online, is also too far-reaching of an effort for this dissertation. Instead, the focus of this chapter is to uncover naturally occurring pregnancy-ending testimony for the purposes of understanding the context within which a performance featuring stillbirth testimony might be set. As critical performance ethnography concerns itself with text as well as context, an activist performer should offer to an audience access to contextual politics, policies and social practices that inform the narrative they are presenting if the goal of the performance is to educate, advocate or motivate.

To further narrow the scope of analysis, this chapter focuses specifically on eruptions in public spaces rather than in enclaved or counterpublic(s) spaces that traffic in alternative narratives about stillbirth and abortion. Much of the discourse surrounding pregnancy ending involves public policy and the news media that disseminates and frames the policy for public consumption. Similarly, public events and popular culture inform issues taken up by the State. As such, each informs the other. This chapter marks

for analysis miscarriage or stillbirth testimonies given in affirmation, challenge or denial of the need for legislation related to reproductive health care that occur in state or public forms and are subsequently circulated by news outlets and social media. The goal of this analysis, in part, is to inform the contextual material used in the performance series at the heart of this dissertation. The chapter takes a closer look at three categories of eruptions that were observed during the period between 2011, the year of record breaking anti-abortion legislation, and 2014, prior to the creation of the performance series. The first is a series of testimonies by U.S. and state female legislators about their abortions while arguing against legislation that would restrict access to women's health care, including the first by a member of the U.S. House of Representatives, Jackie Speier (CA-12) in 2011. The second is the news, released in December 2011 and January 2012, of two public figures and pro-life advocates—former candidate for president, Rick Santorum, and star of *19 Kids and Counting*, Michelle Duggar, who also lobbied for the candidate—had both held, took photos and had a funeral for their extremely premature babies after death. The third is the discussion of stillbirth in daytime and late-night talk shows and news outlets during publicity for the international airing of the first motion picture to focus on the subject, *Return to Zero*, in 2014. For this final eruption, I offer my own observations of the events surrounding the film, rather than a thick rhetorical analysis, due to my own involvement with the film's social media campaign.

When Legislative Bodies Testify While Legislating Other Bodies

You know, I had really planned to talk about something else, but the gentleman from New Jersey has put my stomach in knots because I'm one of those women he just spoke about just now. I had a procedure at 17

weeks pregnant with a child...that procedure that you just talked about was a procedure that I endured.

–Rep. Jackie Speier (C-SPAN, 2011, Feb. 18b.)

On February 18, 2011, during a House debate on a federal spending bill, Rep. Jackie Speier (D-CA) became the first elected Congresswoman to disclose that she had had an abortion. Her three-minute impromptu speech was given in response to a graphic description of a dilation and evacuation abortion, a D&E, by Rep. Chris Smith (R-NJ) in which Smith said the doctor, "literally hacks that baby to death."

In the next 24 hours, accounts of Speier's near midnight (EST) revelation were spread over the wires, cable news channels, newspapers and network television. According to the San Jose Mercury News, the three-minute YouTube clip of her comments during the floor debate, covered by C-Span, went viral overnight (Newman, 2011).⁷ The media called her disclosure "emotionally gripping" (Doyle, 2011, para 2), "a remarkable and brave thing to do" (MSNBC, 2011) and "a rare and perhaps unprecedented moment" in Washington (ABC News, 2011).

In the 40 years since the landmark Supreme Court case *Roe. V. Wade* insured access to abortion as a constitutionally protected right, state and federal bills have been passed to narrow the grounds on which abortions may be obtained. A woman's right to an abortion was framed by the Court as a right to privacy and a doctor's right to conduct his business (Gibson, 2008). The Court also gave grounds for intruding into a woman's privacy when it could show a compelling state interest. The State's interest in protecting

⁷ As of 12/12/12, the most viewed clip of Speier's speech on YouTube had over 46,000 views and when these views occurred is not clear. A Google search (Jackie Speier abortion) produced over a 100 unique links to the video. A Lexis Nexis news search produced more than two dozen unique stories, from T.V. news shows, newspapers, wires, and web publications in the week after the speech.

the life of the child is subordinate to the mother's until, according to *Roe*, viability. The State then has grounds to intervene on behalf of its perceived interest in the life of the child. The State, however, is not obligated to do so as it can continue to prioritize the life of the mother, her privacy and/or her choice. The space between a woman's right to privacy and the state's interest in protecting is where the polemic nature of the abortion debate resides.

While the State's agents, both elected and appointed, are assessed based on their personal views and political actions in regard to abortion, their personal actions in regard to abortion are not usually a part of the discussion. So invisible is the abortion body in the State's own arena for decision making that Speier's disclosure momentarily disrupted the entrenched third-person discourse of abortion. The San Jose Mercury News noted "The customary Congressional debate pitting right-to-life versus freedom-to-choose took an abruptly personal turn this week, when Rep. Jackie Speier spoke on the House floor about once having had an abortion" (Doyle, 2011, para 1).

What is of particular interest is the way Speier's testimony momentarily shifted how the State conducts its own debate in its own forum for public deliberation about public and private concern. Often, the ways in which these deliberations take place are absent of the abjected bodies it attempts to legislate. In this instance, and several subsequent others, the testimony of a member of a legislative body widened the conditions of discourse surrounding the legislation of bodies seeking abortion.

As I take up this endeavor, I will first sketch abortion's dual relationality as a private matter that is a subject of public discourse and an activity heavily regulated by the state while the abortion body is absented from the very mechanisms that control and/or

protect its existence. Then I will explore Speier's disclosure of her own abortion on the House floor as eruption of testimony that resulted in the subsequent deployment of her abortion body as both a pro-choice argument and a pro-life rebuttal on multiple occasions. The effects of this abortion testimony appear to have expanded the conditions of abortion discourse as demonstrated by at least half a dozen other legislators testifying to their own abortions under similar situations. Five additional legislators offered their personal experience related to women's reproductive health (including rape, carrying a baby diagnosed with a genetic anomaly and miscarriage) as evidence of against abortion restriction bills since Speier's testimony.

Locating the Abortion Body

As articulated in the 1972 Supreme Court decision, *Roe v Wade*, the grounds for protecting abortion rights in the United States is contingent upon an individual's right to privacy. This means there must be some space, literal or theoretical, that is removed from the intrusion of others. While I recognize there are many limitations to Habermas's (1991) articulation of the bourgeois public sphere, I find this germinal conceptualization helpful in articulating how and where testimony of pregnancy ending functions and circulates. The private sphere, articulated by Habermas as the home and domestic matters, is also the source of legitimate access to the public sphere. Habermas acknowledges that in the early emergence of the public sphere of coffee houses and salons, women were not participants in public discourse. Other scholars have critiqued his lack of attendance to the implications of this formulation on women's agency (Felski 1989; Fraser, 1992; Mansbridge, 1996), so I will not duplicate those efforts here. But the limitation of women's participation in public discourse and their relegation to the private

sphere is a helpful demarcation for the purposes of an exploration of the contested grounds of women's reproductive rights.

Habermas' assertion that those in the public sphere are educated about the affairs of the day and have the freedom to speak their mind in critical, rational debate, has been challenged elsewhere. But I find the idea of a public site, physical and/or theoretical where political discourse and critique of the actions of the State happen, useful for the purposes of this essay. Also useful is Dewey's (1954) idea of the State, which intervenes when disagreements arise between private individuals that have consequences that reach beyond the direct individuals involved, is also a useful when analyzing the contentious spaces where rights to privacy and the good of the public are perceived to be at odds.

Arguments about what constitutes, and who is included in, the public and private spheres has been thoughtfully engaged by more worthy scholars. Discussions about the implications of the dissolving—if not already dissolved—boundaries between public and private spheres, if indeed these boundaries ever existed beyond the conceptualization of them in the Habermasian sense, are important (Brouwer & Asen, 2010; Sheller & Urry, 2003; Warner, 2002) but again not the work of this essay. Other scholars have outlined the ways in which the privacy of even our own bodies—in particular bodies of women, people of color and those with non-heteronormative gender identity or sexual orientation—has already, and always, been targeted or transgressed upon by state laws in the guise of a “public good” (Berlant & Warner, 1998; Fraser, 1992). The ongoing discussions about the public sphere, publics and counterpublics by these and other scholars has informed this chapter's conceptualization of how and where discourse pregnancy ending occurs. While articulating public, private and state realms as spheres

suggest a stability—which are often stabilized by things like laws, norms, habits of interactions, etc.—these spheres are often also contested and can be altered and can be practiced against.

As much I might be inclined to agree with the theoretical arguments that there are no clear boundaries between the public and private spheres, there is precedence for understanding and articulating the differences between the two. These terms and concepts have material and symbolic consequences (Asen & Brouwer, 2001). The parliamentary is deeply imbricated in how the state crafts public and private boundaries through how it legislates (Fraser, 1992). In the case of abortion, the public and the private mark particular territories that are both legally and socially embedded in how abortion is talked about in public and by the state. As much as public sphere theorists have done important work in challenging terms like “public” and “private,” we are left with the practical matter of how the laws of the state are constructed and applied.

Reproductive Bodies as/in Public and Private

Habermas’s articulation of the home being central to the location and source of the private sphere is in keeping with the “cult of domesticity” prevalent in the Victorian era that a women’s place was in the home (Welter, 1966 in Bone, 2010). The “cult of domesticity” created challenges for women to engage in discourse in the public sphere but even had these challenges not been present, access to information, venues for discussion and opportunities to voice concerns about contraception or abortion were not available. Pregnancy, and ending it, was a private matter. In the early 1900s there was no discussion of abortion, let alone contraception or reproductive health, in the public sphere (Bone, 2010). But by 1916, due to the growing popularity and circulation of pamphlets

containing educational materials and personal narratives about the need and use of birth control by Margaret Sanger and other advocates, women's reproductive health became a part of public discourse (Bone, 2010). By 1918, legislation allowed information on and products of birth control to be given to married couples and a court ruling in 1936 found that contraception for the purpose of saving a life or promoting a patient's well-being did not violate the Comstock Act. By 1937, 71% of Americans were in favor of birth control (McFarlane & Meier, 2001, in Bone, 2010).

But as the women's reproductive bodies were now a subject of public discourse, the regulation their bodies' reproduction became fair game for the state. Abortion had been and remained illegal with the exception of the life of the mother. In the 1950s, there were an estimated one million illegal abortions per year with over a thousand women dying each year. Women of color and the poor were at higher risk of dying from back alley abortions. For example, in 1969, 75% of those that died, mostly after having illegal abortions, were women of color. Ninety percent of all legal abortions that year were performed on private white patients (Boston Women's Health Book Collective, 1998) In 1970, New York became the first state to allow abortion on demand, up to 24 weeks gestation, if it was done in a hospital by a licensed physician. In 1973, the Supreme Court ruled, in *Roe v. Wade*, access to abortion was protected under the right to privacy—primarily by the doctor/patient relationship—guaranteed by the 14th Amendment. The Court also decided that since medical, philosophical and theological groups could not agree when life began, it would consider the matter from a medical lens. As such, it deemed that the state had a compelling interest to intercede at the point of viability of the fetus. This decision created a condition that allowed public interests to transgress into a

woman's private body. Critics argued that this propped the door to the doctor's office open and paved the way for a continued transgression upon a woman's body and the fundamental denial of her agency. Gibson (2008) argued that the Court's language perpetuates an authoritative "doctor knows best" rhetoric and positions "woman-as-patient." The Court focused on the doctor's knowledge, training and ability to practice medicine under an argument of the patient's right to privacy. Gibson (2008) also highlights that within the gendered context of the day, most doctors were male, so the ruling privileged a man's authority and took for granted a woman's need for protection and guidance by this male figure.

While *Roe* positions a woman's reproductive body in the private sphere, it also allowed the State to reach its hand into her womb when it deems it has an interest in protecting the life that grows there. Between 2011-2014, more than 231 laws have been passed aimed at restricting abortion (Guttmacher Institute, 2015). As Law (1984) points out, "The rhetoric of privacy, as opposed to equality, blunts our ability to focus on the fact that it is women who are oppressed when abortion is denied," (p. 1920). By foregrounding a woman's physiological conditions, the Court remained mute on, and thereby muted women's voices on, the social forces that often influence a woman's decision to have an abortion in the first place (Siegal, 1992 in Gibson 2008). These social forces affect the conditions of conception, voluntary or not; access to methods of prevention or termination, quality of care during pregnancy, ability to support herself during gestation, dependence on others, cares for the child when born, and the rewards or penalties for gestating and nurturing a human life (Siegal, 1992 in Gibson 2008). *Roe* denied women agency. It did done so by silencing women's voices and absenting their

bodies from the debate. Are women's bodies and voices any more present and visible in the current debates in the very chambers that constrain women's agency?

The narratives of women who have had an abortion that circulate widely in public sphere are rare. Jane Roe, the pseudonym used by Norma McCorvey, is synonymous with abortion rights. However, McCorvey never had an abortion and her narrative has only come out since her pro-life conversion in the 1990s. Bea Arthur's fictional character on *Maude* in 1972 was the first to have an abortion on TV, just months before the *Roe* decision was handed down. But nearly 30 years passed before abortion was discussed again in a network TV show, with a few programs alluding to the procedure. In 2001, on *Sex and The City*, Miranda considers having an abortion and decides not to, while Samantha and Carrie admit to having one. *Parenthood* in 2013 and *The Good Wife* in 2014 feature storylines in which teenage sons of main characters whose girlfriends get abortions and keep the information from their mothers until the news eventually comes out.

Even within the State's own forum for debate, the lived experience of women and their concerns for reproductive health access are rare and commonly silenced. Since the midterm elections in 2010, the hostile publicity issued from conservative state officials about Planned Parenthood, abortions and women's reproductive health issues, has circulated on news programs, social networks and late-night parody shows. The comments are often dismissive of women's actual experience, based on speculation, theology and, rarely, on actual biological or factual truth. An all-male bodied Congressional panel was convened to discuss birth control in the spring of 2012. Sandra Fluke, a woman who was to testify about the contraceptive needs of college women, was

denied a hearing because she was not deemed a relevant witness. State Rep. Lisa Brown (D-MI) was barred from speaking on the floor of the Michigan House of Representatives after she used the word “vagina” in debating a bill that would ban abortions after 20 weeks gestation. Her colleague, State Rep. Barb Byrum, was silenced after trying to introduce a vasectomy amendment to the proposed bill.

The silencing of women’s voices and the absenting of their bodies from debates about abortion, from places that matter when making decisions about reproductive issues, seems to continue a paternalism codified in the *Roe* decision and perpetuated in the absence of narratives and bodies as arguments that can hold representatives of the state accountable for their actions. Just as material findings in judicial rulings influence the conditions of public discourse, the law comes from public discourse. “It is therefore at least partially dependent upon the political action for the community in which it operates,” (Hasian, Condit, & Lucaites, 1996, p. 335). The relationship between women’s social roles and women’s ability to control their own childbearing process must be acknowledged in the provisions designed to protect women’s reproductive freedom in order to be effective, Gibson (2008) argues. But language to this effect is absent from *Roe*, and continues to be absent from subsequent legislation that attempts to further restrict abortion access.

Gibson urges reproductive rights advocates to shift their focus from clinging to the rights granted by *Roe*, to instead “insist on speaking about the lives, the liberty, and the equality of women” (Gibson, 2008, p. 328). It is this charge that argues for the importance of abortion narratives in the public discourse about reproductive rights. The testimonies of real life women who have had an abortion are so uncommon in public

discourse, that when they do occur, they are newsworthy events. From the framing polemics of the pro-life and pro-abortion debate that absents a woman's abortion body, to the fear of, and feelings of, stigma that create risky environments for personal disclosure, narratives of abortion may also be too risky to disclose in the public sphere and fail to circulate in the State's publicity.

To review, the abortion body, in the State's own forum for debate and decision making, is invisible and abstracted, has limited and highly contested agency and is spoken about/for rather than present and/or able to circulate its own narrative. It is in this absence of the abortion body that I take up Rep. Jackie Speier's disclosure of her own abortion on the House.

Speier's Newly Visible Abortion Body

Speier's personal life experiences were part of the public record long before 2011. In 1978, Speier was serving as a congressional aide for Rep. Leo Ryan (D-CA) when they were part of a delegation that traveled to Jonestown, Guyana, to investigate the welfare of members of Jim Jones' People's Temple cult. Ryan was among the 918 that died in Guyana in the ensuing massacre, but Speier survived after being shot five times. In 1994, after a failed adoption (in which the birth mother took the baby back), she was three months pregnant with her second child, when her husband, Dr. Steve Sierra, was killed in a car accident.

However, her abortion was a relatively private matter that few people knew about. The procedure was medically necessary during her second trimester when the baby slipped from the uterus into the cervix. As a member of the California State Legislature in 1996, she spoke about the procedure. "I was talking about it on the floor," she recalled,

"and a colleague on the Republican side was responding and in a closed-door caucus afterwards said, 'Jim Jones didn't finish the job'" (Newman, 2011 para. 24-25). Newman (2011) says that newspaper accounts of the time reported this disclosure, but a Lexis-Nexis search for such accounts were unproductive. It is not clear what the reaction to her disclosure was, but it was not widely circulated and does not appear to have come in her successful campaign for a seat in the House in 2008.

In February 2011, when she stood waiting for her turn to comment on a spending bill before the House, she represented a liberal district from a liberal state in a newly conservative legislature. In 2010, the midterm elections returned the House to Republican control (241 Republicans to 198 Democrats) with only 74 of the 439 members of the House being female. The anti-abortion sentiment became more visible in the states' own forums for debate in 2010, with over 600 anti-abortion bills being introduced by state lawmakers. The day after 112th Congress convened, the Daily Kos offered an article entitled "The Coming War on Women" (Grey, 2011) that predicted dramatic increase in anti-abortion legislation with a Republican-controlled House. Indeed, the Republicans first actions targeted abortion. H.R. 1 was a continuing appropriation bill that eliminated funding for Planned Parenthood and H.R. 3 was the *No Tax Payer Funding For Abortion Act* that also introduced proof of "forcible rape" as a requirement for Medicare coverage for abortion.

As Speier waited for her turn to debate the appropriation bill, Rep. Christopher Smith (R-NJ) spoke out against the ethics of Planned Parenthood. His 8-minute speech included a long reading of an excerpt from former Planned Parenthood clinic director, Abby Johnson's memoir, *Unplanned*:

The cannula was already being rotated by the doctor and now I could see the tiny body violently twisting with it. For the briefest moment it looked as if the baby was being wrung like a dishcloth, twirled and squeezed. And the little body crumpled and began disappearing into the cannula before my eyes. The last thing I saw was the tiny perfectly formed backbone sucked into the tube. And then everything was gone.

The image of that tiny dead baby mangled and sucked away kept replaying in my mind. What was in that woman's womb just a moment ago was alive. It wasn't tissue. It wasn't cells. It was a human baby fighting for life. A battle was lost in a blink of an eye... What I have told people for years what I believed, taught and defended is a lie. (C-SPAN, 2011a)

What Smith did was not unusual. Public officials often use the narratives of private citizens as part of an argument for or against an issue. The use of narrative to bolster or legitimize a position is often used as a way to appeal to the emotions of the voter or the undecided legislator or even just to look good for the cameras. Narratives humanize the statistics and are deployed as expert testimony about the impact of a particular law or spending cut. The story may be a part of the argument, but the originator of the story—the body of experience—is absent. Public officials may also retell these stories to attempt to enumerate the figurative constituents whose rights are at risk, whose needs should be privileged or whose bodies are on the line. This narrative appropriation simultaneously deploys their own agency, as an arm of the government, “on behalf” of the citizens whose liberties they are in control of. Smith then said:

There is nothing whatsoever benign or caring or generous or just or compassionate or nurturing about abortion. Abortion dismembers children piece by piece. Planned Parenthood's own fact sheet talks about D&E abortions done in the second trimester period. Have you ever seen what a D&E is? A doctor goes in with forceps and this device and literally hacks that baby to death. Planned Parenthood itself says it takes 10-20 minutes to literally dismember that child. So it isn't healthy for babies and we know for a fact it isn't healthy for women either. (C-SPAN, 2011a)

Smith is not speaking about his own embodied experience. He is not even speaking of a procedure he participated or witnessed firsthand. But he is borrowing the author's agency to make these statements. He has not described the experience of the woman having the abortion, but what he presumes to name as the experience of the fetus. The body of the fetus is drawn down into State's own forum for debate, in a type of holographic presencing, via the borrowed narrative of the clinic director, whose presence is also gestured at. But the woman having the abortion remains invisible—absented. As described previously, this presence-absence binary is a polemic of the abortion debate. Pro-life advocates appropriate the images of aborted fetuses but make invisible the body of the woman; pro-choice advocates put the woman's body center stage and hide the womb and its contents. But there is a polemic at work here in what gets presented and what is absented within public discussions of abortion. Palczweski (2002) argues that pro-life images focus on the fetus; the woman is absent. Her womb is located; she is not. Conversely, Palczweski points out in pro-choice images, the woman is foregrounded; the fetus and the womb are absent. The whole pregnant woman considering abortion, or

having had one, is not fully represented. Not just in the images, or the visual rhetoric Palczweski mentions, but in the public dialogue on abortion itself.

This absencing may be for protection. Women who have had an abortion can be vulnerable to being stigmatized by others and may choose to keep their procedures secret (Major & Gramzow, 1999; Thachuk, 2007). Women who have chosen to terminate a wanted pregnancy due to genetic or life-threatening conditions to themselves or their babies often feel a compounded sense of stigma and shame (Thachuk, 2007), and many chose to say they miscarried rather than say they had an abortion.

After a woman has had an abortion, there are no visible signs of her stigma on her body, and so choosing not to disclose her act may be one way to minimize the effects of the public response. But even if she feels no grief or regret in her choice, she still has a spoiled identity (Goffman, 1963): an identity that threatens to mark her as flawed, shamed and different from others and from what she once was if her secret is disclosed. And while not all women will see abortion as a negatively impacting their lives, people who conceal stigmas or inhibit discussion of a negative life event have increased risk for physical or psychological problems.

But Smith's closing remarks exemplify Naomi Wolf's (1995) concern about the narrowing grounds for argument by pro-choice advocates. When the pro-choice movement ceded the moral ground to the pro-life movement, by denying any legitimacy to life in the womb prior to birth, Wolf argues they had to dehumanize what was contained in the womb. The polemics of the argument meant there was not a clear way to consider the hypocrisy of calling unwanted pregnancies "products of conception" and at the same time marveling at the ultrasound image of a wanted pregnancy of the same

gestation. The freedom to choose also often meant that there was no freedom to mourn or grieve the ending of a life. Wolf (1995) argued for a more nuanced position that acknowledged life, but simultaneously argued for the right of a woman to also acknowledge and privilege her own life first. Without this agency over their own reproductive choice, women would be chattel—forced by the state to continue an unwanted pregnancy. She argued that a woman could—should—acknowledge the gravity of the decision to end the life inside her and still—must—be free to make the choice. She worried the polemics of the abortion debate in 1996 would become even more entrenched and polarized abortion. Personhood amendments, fetal pain bills, vaginal ultrasounds, proscribed scripts lacking medical veracity forced on care providers, unreasonable building code requirements for clinics, the elimination of exemptions for the health of the mother or in cases of rape or incest are just some of the examples of extreme anti-abortion legislation proposed since the 2010 elections that would seem to support Wolf's (1995) claim.

As Speier stepped to the microphone that night in 2011, however, she put her own body on the line in her argument for Planned Parenthood. She made an abortion body visible—one that had its own agency and its own story—in the State's own forum for debate. She offered, not only her narrative as argument, but her body as argument as well.

You know, I had really planned to speak about something else. But the gentleman from New Jersey just put my stomach in knots. Because I'm one of those women he spoke about just now. I had a procedure at 17 weeks... pregnant with a child who moved from the vagina into the cervix [sic]. And that procedure that you just talk about was a procedure that I endured. I lost a baby. But for you to stand on

this floor and suggest that somehow this is a procedure that is either welcomed or done cavalierly or done without any thought...is preposterous. (C-SPAN, 2011b)

By disclosing her abortion, Speier put her, now visible-as-stigmatized, body on the line. Just as Rep. Jeannette Rankin made the female body visible in Congress for the first time in 1917 during the height of the suffrage movement, Civil Rights leader Rep. Barbara Jordan made the black female body visible in Congress in 1972 and Rep. Barney Frank made the queer body visible in Congress in 1988 in the years preceding and during *Don't Ask, Don't Tell*, Speier put her body on the line. Their bodies were arguments, their narrative offered as capital in the debates about their own agency and the bodies of those whom they deliberated about.

Speier then leveraged her aborted body in support of the abortion services of Planned Parenthood:

There is a vendetta against Planned Parenthood. And it was played out in this room tonight. Planned Parenthood has a right to operate. Planned Parenthood has a right to provide services for family planning. Planned Parenthood has the right to offer abortions. Last time you checked abortions were legal in this country. (C-SPAN, 2011b)

It is in this act of leveraging her own abortion body in support of abortion—supporting the rights of both the provider to perform abortions and the rights of a woman like her to get one—that Speier presences narrative agency. But there is something else that happens in this moment. As she puts her body on the line and uses her body as argument, she opens herself—and her body—to be used as argument in future abortion debates.

Circulation of Speier's Testimony

Smith's reading of Johnson's narrative is in the Congressional record, but he is not asked to reread Johnson's story on news programs, talk shows or in newspaper interviews. Video clips of him describing a D&E do not circulate widely on the Internet nor is his own detail of the procedure reproduced at length in wire stories. Smith's reading of the graphic abortion procedure is mentioned only to provide context to Speier's remarks. Perhaps the quick dismissal of his reading is because the narrative he borrowed absences what Palczewski (2002) describes as the experienced body that created it and highlights what Goodnight (1982) said was the very problem of using personal narratives without connection to its agency.

The House amendment banning funds for Planned Parenthood passed. But in the 24 hours after Speier's disclosure, the C-SPAN clip of her speech was replayed on *ABC Nightly News*, Fox News and several news commentary shows on MSNBC. Wire stories recounted the events during the debate and local newspapers neighboring Speier's Northern California district ran stories about her disclosure and pro-choice advocacy. In the weeks and months after her remarks, she gave follow-up interviews on several TV networks, appeared on *The View* and spoke at NARAL's Power of Choice luncheon in front of an audience of 700 pro-choice advocates. However, her disclosure did not seem to circulate widely in conservative news outlets.⁸

During an NPR interview, she elaborated on why she disclosed her abortion and the response she received:

⁸ Based on a Lexis-Nexis news search using terms "Jackie Speier and abortion and House"

I was compelled to bring it up, because he was describing a procedure that I endured. He knew nothing about the procedure. He was talking in terms that didn't begin to explain the nature of the experience, and he certainly made it seem like somehow it was done without thought or without anguish. And I felt compelled to set the record straight... And I was expecting maybe an onslaught of anti-choice, you know, fervor. But what has been so remarkable about the experience is that I have received thousands and thousands and thousands of emails and Facebook and Twitter responses and people stopping me in the grocery store and at the bank saying, thank you so much for doing this. Young women, old women, men, members of the House came up to me afterwards, and men said to me, you made me cry. (Martin & Speier, 2011)

During an interview on MSNBC, she seemed to understand the implications of her now visible abortion body.

So it's not comfortable necessarily to have to describe a very personal and intimate set of circumstances, but under the circumstances, I felt compelled to do it because it's time that we stop demonizing women who have to endure this procedure. I'm one of them. If I'm the face of it moving forward, I'm proud to stand with other women across this country who make this decision with great care and with great sadness. (Mitchell & Speier, 2011)

Here Speier seems to also address the stigmatized abortion identity that has also played a part in the absencing of the abortion body. She seems willing to allow her abortion body to become a part of the State's publicity as well as the public's discourse. This mobilization of her abortion body becomes evident when she is subsequently called upon

to presence her narrative agency in similar debates, in the State's own forums and to the public at large, and lasting implications of her abortion body as argument begins to crystallize. By March of 2011, use of the phrase "The War on Women" had become more common and was often used to refer to the increasing restrictive legislation regarding women's health. In April, a shutdown of the Federal government loomed as the issue of funding to Planned Parenthood became the sticking point in the passage of the budget bill. Speier made the rounds on several liberal news commentary shows, all of which referred to her abortion disclosure two months earlier.

During an October 13, 2011, floor debate of the Republican-sponsored "Protect Life Act" Speier again used her own story, her own body as argument, in the State's own forum for debate. The proposed bill, which Democrats called the "Let Women Die Act," to amend the Affordable Care Act, which already prohibited federal funds from paying for abortion services, would prevent women from buying plans on the federal exchange that covered abortion services and would make it legal for hospital emergency rooms to deny abortions to women with life-threatening conditions. She said:

Basically, what this bill would do is say that any hospital could decline to provide services to one class of people in this country, and that one class of people are pregnant women. Now, let me tell you something. My story is pretty well known now. But I was pregnant. I was miscarrying. I was bleeding. If I had to go from one hospital to the next, trying to find one emergency room that would take me in, who knows if I would even be here today? (JackieSpeierCA12, 2011)

Again, clips of her speech on the House floor were circulated on TV news programs, she gave interviews and her comments appeared in newspapers. While her comments do not

appear to be circulated to the same degree, her abortion body and her story were mobilized as argument and as rebuttal.

And what my colleagues on the other side of the aisle are attempting to do is misogynist. It is absolutely misogynist. The time has come for us to stop taking up this issue over and over again this year and do something that the American people really care about. They want jobs. They want to be able to hold on to their homes. They want some mortgage relief. And what do we do? We stand here on the floor and create yet another opportunity for women to be cast in shackles.

(JackieSpeierCA12, 2011)

By the end of 2011, more than 1,110 bills had been introduced in legislatures across the country and 92 new abortion restrictions were passed (Guttmacher Institute, 2012).

Speier's Residual Circulation

In February 2012, Speier spoke on the House floor about her personal experience in response to the Susan G. Komen Foundation's decision to stop funding Planned Parenthood. The organization claims it made its decision because of its policy not to fund organizations under investigation by federal, state or local bodies. While a hearing to investigate Planned Parenthood's financial practices had been called by a member of the House the previous year, a hearing had not happened and no action had taken place.

Speier again used her own ethos as an argument. She does not speak of her abortion, but rather the ways she has lent her body to the work of Komen before:

A fine nonprofit that I have been associated with for years, I have run in the Susan G. Komen *Race for the Cure*, I have walked in the *Race for the Cure*, I have been the emcee at a number of events locally that they have held, so I have been a big

booster of the Susan G. Komen organization, but not anymore.

(JackieSpeierCA12, 2012, February)

None of the previous remarks commented upon on this essay explicitly named an audience other than her fellow representatives. But what is compelling in this next portion of her remarks, is her awareness of her publicity. The seeming awareness of the way her words in the State's own forum for debate can reach out to a public beyond the chamber walls.

All of you across this country that feel that Susan G. Komen should stick to what it knows and that is breast cancer research and breast cancer screening and support and promote those activities by organizations that do the research and do the screening, I ask you to call them at 1-877-465-6636 and tell them that you want them to stick to what they know. Let's not make this a race to the political bottom. (JackieSpeierCA12, 2012, February)

Here, Speier seems to be aware of the reach of her words and the power of the public to inform the debate within the State's own forum. She asks the public to act and perhaps to even put their own bodies on the line. She uses her testimony to challenge the dominant narratives of abortion within the deliberative chambers in which she works, and invites her constituents to do the same.

Just a month later, Speier again directs a portion of her remarks on the House floor outside its doors in condemnation of Rush Limbaugh. She chided Limbaugh for his comments about Sandra Fluke, the college student who was called to testify before a House subcommittee about the importance of access to hormonal contraception by those receiving health care from faith-based institutions. Fluke was ultimately denied access to

the chamber, and the hearings were conducted by an all-male panel in front of an all-male group of legislators. For three days, Limbaugh abused Fluke on air with sexist and incendiary remarks. Speier used her time on the House floor to address a member of the public:

Shame on you for being the hatemonger that you are. Shame on you for being misogynistic. Shame on you for calling the women of this country sluts and prostitutes, because that's what he did. And then Ninety-eight percent of the women in this country, at some time in their lives, use birth control. And yet he went on the air recently and called Sandra Fluke a slut and a prostitute because she was trying to access birth control pills as a third-year law student at Georgetown. (JackieSpeierCA12, 2012, March)

And then she targeted her comments specifically to an audience she now has become aware is listening outside the Capitol. She directs her publicity to the public and calls on them to act:

So I say to the women in this country, 'Do something about this.' I say to the women of this country, 'Ask Century 21, Quicken Loans, Legal Zoom, and Sleep Number to stop supporting the hatemongering of Rush Limbaugh.' And if they do not do that, then I ask them to boycott those companies. (JackieSpeierCA12, 2012, March)

One final deployment of Speier's body as argument, happened in the weeks before the 2012 election. Her abortion body was used as rebuttal to claims made by a fellow member of Congress seeking reelection. During a debate against challenger Tammy Duckworth, Rep. Joe Walsh (R-II) said that he did not believe in the life of a

woman as a justification for an exemption to a ban on abortion. In the press conference afterward, Walsh clarified his position saying women are no longer at risk of dying during pregnancy: “Let me briefly say that there is no exception, with modern technology and science you can’t find one instance. This is an issue that opponents of life throw out there to make us look unreasonable” (Chicago Tonight, 2012, October).

Speier was immediately called upon by several news sources to provide a rebuttal to Walsh’s claims and days later appeared at press conference beside Duckworth at the candidate’s election headquarters. In explaining the reason she decided to share her story the previous year she said that when a colleague on the House floor read from a book and “and said they sawed off the legs of fetuses” she felt the need to speak up since those speaking had never experienced it themselves (Lester, 2012). As she paraphrased Smith’s remarks by using the words “sawed off the legs of fetuses” while she standing next to Duckworth, a double amputee, it seemed to have the effect of marking Duckworth’s body in as argument as well. Speier added that she had had another abortion, a D&C, during another pregnancy when the 10 week-old fetus had no heartbeat. If D&Cs had not been legal, she said, she would have had to wait until it somehow was expelled by her body). Speier’s body is mobilized, outside the state’s own forum for debate, both literally and figuratively, as an argument. She again presences her narrative agency and offers her body as argument—as physical evidence and rebuttal witness. Speier then seems to gesture to the privacy intrusions from increasing anti-abortion legislation. "Congress has become a sandbox for extremists... We have every right to say, 'Yes, let's talk about the jobs and stop messing with our bodies and stop getting into our bedrooms,'" (Lester, 2012).

The State influences the discourse of the public and it decides the realm of the private. Sanger helped make abortion a public sphere concern that empowered women by giving them vital information about how to control their own conception. *Roe* then marked abortion as an issue of the private sphere, one the State had to show a compelling interest in order to violate. But since 1973, the arm of the state has increased its reach into the private sphere to drag the rights guaranteed by *Roe* out before the public to be shamed by bloody fetuses and contorted by moral repudiation. Until Speier's disclosure, the State was able to conduct its business talking about abortion bodies in the third person, at arm's length. Speier's presencing narrative agency may not keep them honest or keep them silent. But it holds them accountable to her body in the way that Rankin, Jordan and Frank's bodies held their peers accountable.

I have argued that her disclosure on the House floor presenced an abortion body within the State's own forum that had routinely absented those bodies. Instead of appropriating the narrative of a constituent, she instead deployed her own testimony and thereby constituted her body as an argument. She was both the agent and the user of her own agency in the context of abortion discourse, something few other politicians have done. At a time when factual inaccuracies, generalizations and faulty logic reign in abortion rhetoric, Speier's embodied narrative and abortion body is an undeniable counter argument.

"The language being used, the nature of the comments, it got so incendiary," Speier said in an interview the day after the 2011 Planned Parenthood funding debate (Newman, 2011, para 11). She said she felt a sense of disbelief at the vitriol and animus from fellow colleagues who she thought did not have clue what they were

talking about. "I was thinking to myself, 'Not one of you has endured this procedure...How dare you? How dare you talk about it in those terms?' That's why I changed what I was going to say" (Newman, 2011, para 9).

The abortion body made visible in legislative environments that have restricted/silenced/shamed/ marginalized their existence fits this description. As Warner (2002) instructs, it is not enough to "go public." The act of publicness must be available; they must count in a public way in order to be transformative. Speier had always been pro-choice. She had a reputation for being an outspoken member of the California State Legislature. But up until the time she disclosed her abortion on the floor of the house nearly two years later, she had a relatively low profile. Her experience and her public sharing of her abortion—by putting her body on the line—made her uniquely qualified to respond to arguments about abortion made her more visible in doing so.

In her initial disclosure, Speier marked her abortion body, an act that made other legislative bodies not just accountable to narratives by proxy, but made them newly accountable to her. This marking has both an immediate and persistent presencing effect. She has her own agency to shape how abortion discourse relates to and impacts her and serves to make present other abortion bodies. She is a representative of her constituent publics, by the nature of her job. But also by the nature of her private experience made public, she may be representative of a stigmatized public that cannot yet risk visibility, residing in what Squires (2002) calls an enclave. By presencing her own narrative and being a decision-making body that has agency, she is challenging the public's transgression on her private body, by making visible the consequences of the law that is

being considered. It is this visibility that widens the conditions of discourse for all abortion bodies, in private homes, at public protests or in the state's hallowed chambers.

When a Private Death Becomes Public Domain

In April 2005, the Washington Post ran a story on the cover of the Style section about a little known Pennsylvania Senator, Rick Santorum (Leibovich, 2005). The headline read: "Father First, Senator Second: For Rick Santorum, Politics Could Hardly Get More Personal." The story led with premature delivery at 20 weeks of his son, Gabriel Michael, who lived for just 2 hours after birth in 1996. The next paragraph detailed in empathetic tones the decision he and his wife made to bring his son home so that his other children could meet their brother, the family could take pictures and they could have a private mass. A month later the New York Times Magazine wrote an article about Santorum's faith-based politics that also featured the story of Gabriel (Sokolove, 2005, May 22).

Despite the fact that I was a primed audience member, I do not remember hearing anything in the news about Santorum when the article came out. I was a reporter at a major metropolitan newspaper and at that very moment, was scouring the Internet, bookshelves and magazines for anything I could find about infant death. Friends, acquaintances and co-workers were sending me links to organizations and research from all over the country. But Santorum's after-death care of his baby did not even register as a blip on my radar. If there was a reaction to the publishing of his decision to do so at the time, I was a candidate to have seen the discussion, not just because I was a newspaper reporter, but because my son had been stillborn a month earlier.

Nearly seven years later, during Santorum's failed Presidential bid, the family's choice to take their son home would once again appear in the news. This time, the private decision of the family would make headlines and be accompanied by derision and debate in blogs, on the 24-hour news channels and through various online news and social media websites. Just prior to the Iowa Caucuses in January of 2012, stories resurfaced of the Santorums' decision to take home his dead baby. During a Fox News interview, a liberal contributor attacked Santorum's extreme conservative positions, and made a reference to his taking his baby home "to play with his other children" (Bond, 2012). Less than a month earlier, in December of 2011, the news of the after-death care of another infant had also made headlines. The Duggars, a reality TV family of 19 children, were expecting their 20th baby when news broke in *People Magazine's* online edition that Michelle Duggar had miscarried in the second trimester (Dennis, 2011). Photos of the hands and feet of Jubilee Shalom Duggar from the funeral program were published online by *TMZ*, the celebrity paparazzi rag. Both the family's choice to have the photos taken, as well as *TMZ's* decision to post them, were discussed in a range of online and print publications from *TV Guide* to *Psychology Today*.

In both instances, the after-death care of babies was thrust onto center stage—if briefly—in a way that advocates working to bring the issue of helpful neonatal interventions for parents into hospital rooms and the floor of Congress have been unable to do. While public memorial websites, virtual support groups and YouTube videos made by families experiencing stillbirth have a visible presence online, they inhabit an enclaved space only discovered by active agents seeking material relating to perinatal death. But the news of the Duggar and Santorum photographs and after-death care

choices were displayed in news bullets before passive Yahoo users logging onto their email, TV Guide readers and 24-hour news channel viewers. These media events momentarily interrupted the silence normally blanketing perinatal death and erupted into visibility from shadows of normally hidden parental grief. These eruptions marked by national headlines are noteworthy, not just because of the subject matter and the political relationship between the two families, but because of the discussion, debate and derision that resulted from these disclosures. The gaze of those unfamiliar with the experience of the death of an infant in-utero or shortly after birth can range from compassionate to condemning. With no existing discourse about perinatal death, other than a rare case on a medical drama or the sensationalized murder trial of a pregnant woman, media consumers have little to contextualize the feelings and needs of bereaved parents whose baby has just died.

Framing the Duggar Pictures

In mid-December 2011, the Duggars, a conservative Christian couple whose reality show *19 and Counting* had been airing on the TLC network since 2008, learned that their baby had died in-utero during a 19-week ultrasound. They notified *People Magazine* while the miscarriage was still in the process of happening (Dennis, 2011). Dozens of other online media outlets and blogs picked up the story and ran various reports. Some included derisive statements suggesting the miscarriage was due to do the high number of children she'd had others included compassionate comments about the emotional impact of pregnancy loss.

But days later, when the photos of Jubilee Shalom's hands and feet surfaced on TMZ, the amount and intensity of the response escalated. TMZ ("Duggar Family Snaps

Pic,” 2011) initially ran the photos with the words EXCLUSIVE in a red banner across the top. The caption that accompanied it read: “The family from TLC’s ‘19 Kids & Counting’ chose a unique way to commemorate the life of their 20th child, who passed away this week in a miscarriage—they took an artsy picture of the fetal corpse...and distributed it at the memorial.” The images were subsequently removed, but they appeared on other online webzines and blogs as reprinted screen captures. Other stories about the memorial that chose not to run the pictures instead published links to the TMZ site. *Anorak*, a UK-based celebrity webzine, headlined the funeral story calling Jubilee death “the world’s first celebrity miscarriage” and asked if TMZ’s publishing the pictures the baby was “the nadir of entertainment” (“Duggar’s 20th child,” 2011, para 5).

Online publications that chose to run the photos often did so as links with warning labels with them. *Social Media SEO*, a social media commentary site, said “Warning, this picture is a little strange and graphic, please beware” (Reilly, 2011, para 1). *Snarkerati*, a pop culture website, said it thought it was odd for the Duggars to share pictures of the baby in public but then shared the pictures in public on its website (“Michelle Duggar shared miscarried baby photo,” 2011). Simply Showbiz ran the picture with “WTF” and “gross” written on a pair of pixelated images of Jubilee’s feet.

Perhaps the most widely circulated comment critiquing the Duggars after-death care choice was from Psychology Today contributor, Susan Newman, a social psychologist who has previously critiqued the Duggars for their large family size. She condemned the choice of the family to go public and questioned whether or not it was for more publicity. She then challenged their choice of taking pictures and sharing them with others. Newman said:

From what I know of parents who have lost children, it's horrific. It's not something you want pictures of. There are people who will argue with me and say it's a way of coming to terms with the death. But given the Duggars' history, their television show, and the way they exploit their children, I just find this a cog in the same wheel. I find it rather distasteful. (Fernandez, 2011, para 4)

Another Psychology Today contributor offered a counter argument. Deborah Davis, psychologist and bereaved parent, commented on the negative public response to the Duggars in her open letter to the family saying, "the skeptics are also products of our death-defying, death-denying culture" (Davis, 2011, para 6). Davis (2011) continued:

Dead bodies have become scary because for the past 140 years, we've increasingly dispatched them to funeral parlors. As a result, we've forgotten the after-death care practices that had been handed down through the ages. We've lost the time-worn traditions, such as washing, anointing, and wrapping or dressing the body. We've also abandoned the custom of making postmortem portraits. Creating an image of the dearly departed was considered essential, especially for a child, for whom it was likely no other portraits existed. Portraiture turned to photography in the 1800's, but nowadays, with cameras everywhere, we have plenty of photographs to hold onto in our grief-*except when the baby is a newborn.* (para 6)

The week before the new season of their reality show was to air in mid-February 2012, the couple went on *The Today Show* (where they had announced their 20th pregnancy the previous November) to talk about their late miscarriage, the devastating loss and their choice to take pictures of their baby (Dube, 2012 February, 14).

Interestingly, while the couple called it their 20th pregnancy—most likely to keep with the title of their previous season of the show, *19 and Counting* based on how many living children there were—the couple had also had a miscarriage in their second pregnancy, and do not seem to count either loss in their on-air tally.

Santorum at Home in the Public Eye

Even though the news of Santorum's decision to take his baby home had been published years earlier, it was not until he became a GOP presidential candidate that the news of this choice took center stage. Just before the Iowa primaries, liberal contributor Alan Colmes made an off-the-cuff comment on a Fox News program about Santorum's "bizarre behavior" that resulted in news of Santorum's after-death care of his baby blazed across the Internet. "Once (voters) get a load of some of the crazy things he's said and done, like taking his two-hour-old baby who died right after childbirth home and played with it for a couple of hours so his other children would know that the child was real..." (Bond, 2012, para 2), Colmes said before being interrupted by the anchor. He added later in the segment, "I'm not mocking the losing of the child, but what I'm saying is I think it shows a certain unusual attitude to take a two-hour baby home that died to play with his other children" (para 9).

Response in the media was swift. Later that day, while at a campaign event, someone in the crowd asked Santorum to talk about taking his son home. Both he and his wife were moved to tears during his response in which Santorum said, "We brought Gabriel home to bury him and we brought him home so our children could see him. [Karen] told all of us that it was important to recognize—for the family to recognize—the life of that child and for all the children to know that they had a brother," (Peterson, 2012,

para 4). *The Huffington Post* provided a link to the Colmes confrontation with the headline “Alan Colmes, Fox News Contributor, Criticizes Rick Santorum For ‘Crazy’ Behavior, Then Apologizes” (“Alan Colmes, Fox News,” 2012) and the *New York Times* ran a story titled, “After a Child’s Death, a Religious Politician Became a Culture Warrior,” (Stolbergian, 2012). *ABC News* online ran this story headline, “Experts: Rick Santorum Grief is Typical, But Taking Body Home, Unusual,” (Donaldson James, 2012). Headlines from *The Daily Beast* read, “Rick Santorum’s Dead-Baby-Ritual,” (Sessions, 2012) and *The Atlantic*’s read, “Was Santorum ‘Weird’ for Bringing Home His Stillborn Baby?” (Goldberg, 2012).

Colms’ derisive response was echoed the day after the Iowa primary. On MSNBC’s *The Rachel Maddow Show*, contributor Eugene Robinson said, “Not everyone is going to be down, for example, with the story of how he and his wife handled the stillborn child whose body they took home to kind of sleep with and introduce to the rest of the family. It’s a very weird story” (Christopher, 2012).

Robinson, and many of articles, blogs, and media posts about baby Gabriel misidentified him as having been stillborn. This error may, in part, be emblematic of the lack of familiar language we have in our culture to talk about different types of infant death and the associated implications for/in grieving. Rather than serving to broaden the discourse about infant death and after-death care practices, the public commentary was primarily framed through the incredulity of the practice and the insensitivity of Colmes (who immediately issued an apology) or Robinson. One public response that attempted to provide insight into after-death care choices came from the same source that had published a critique of it. In commenting on the response to the Duggar and Santorum

after-death care choices in an online column for *Psychology Today*, contributor Nancy Berns (2012) wrote:

When professionals take our deceased love ones away, almost immediately, most people do not have the opportunity to see, let alone care for, a dead body before it is embalmed and made to appear ‘more natural.’ So when others choose to keep a lifeless body with them longer than what has become the norm, people question the behavior. Some get squeamish and feel better when criticizing those grieving. (para 12)

It is important to give a closer look at this “squeamishness” within the public discourse. Both the Duggars and Santorums took photos of their infants after death. Santorum had his photo on display in his office and his showing of it to the reporter was mentioned in the opening paragraphs of the Washington Post article. As Davis (2011) had explained, displaying photos of the dead actually used to be quite common. In the early days of photography, it was expensive and only resources collected for funerals and weddings made it possible to afford such a luxury. Known as *Memento mori*, photos of the dead in various poses were once displayed on mantles and proudly shown to visitors, sometimes as evidence that the person died for those unable to make it to the funeral (Hilliker, 2006). Today, parents taking their infants home after death for private and community ceremonies and funerals is common practice in New Zealand, Australia, and parts of England, Ireland and Canada, but these choices are rarely talked about within the U.S. even amongst bereavement advocates. But Godel (2007) points out that photos of dead infants are often absent from print newspapers, books and TV accounts even when

there have been other smaller eruptions in the silence surrounding perinatal death discourse.

When I wrote about my own stillbirth experience in 2006 for a newspaper magazine, several top editors convened a meeting to discuss whether or not to use the photos of me holding my stillborn son in print. They were worried about how readers would respond and thought that the pictures might offend their sensibilities. Despite making my case that these photos were essential to the grieving process, for both myself and other bereaved parents I spoke with, the editors were resolved in both their own resistance to viewing the photos and to printing the photos and the print version of the story ran without them. However, editors of the online version of the article felt differently and allowed me to create an audio slideshow (photos with music and voiceover) that readers could click on to view. It received more hits than any other audio slideshow had before.

Pregnancy as a Sociopolitical Condition

In the context of stillbirth, Cacciatore and Bushfield (2008) articulate how both childbirth and motherhood are imbedded in gender politics. It is a lens through which society refuses to, or decides to, define and create policy and/or socially accept the life of a stillborn baby. Efforts by grassroots groups to pass legislation acknowledging the birth (not just the death) of a baby who has died in-utero were, and continue to be, hampered by pro-choice politicians concerned that it would create a slippery-slope erosion of *Roe v. Wade* insured freedoms (Cacciatore & Bushfield, 2008).

Public memorial sites and postmortem photographs, argues Godel (2007), are enmeshed within a socio-cultural context and reproductive politics. “There are many

players who join grieving parents on this particular social stage,” Godel (2007) said. “Together they reflect a rich, complex and difficult sociocultural landscape that includes pro- and anti-abortion lobbies, sacred and secular groups” (p. 267). This landscape, Godel (2007) goes on to explain, is where we find the parents’ constructed social identity that also gets located within a political discourse includes “pro- and anti-abortion lobbies, sacred and secular groups” (p. 267) so that a personal identity cannot be considered absent a sociopolitical landscape rife with ongoing private and public identity discourses.

For Santorum, Gabriel reinforced his faith and "fundamentally affirmed how I see the humanity of the child in a womb," (Leibovich, 2005, para 21). It deepened his resolve to champion the rights of the baby in-utero, denouncing abortion and pledging his support for personhood at conception. At around the time his son was diagnosed with a fatal birth defect and his wife’s health was in jeopardy from an infection from an in-uterine procedure to try and prolong the baby’s life, Santorum was arguing against “partial-birth” abortion as a freshman member of Congress. The couple refused an induction, because Santorum felt that would have been an abortion, but the infection led to a premature delivery of Gabriel anyway.

When Santorum spoke out against the “partial birth” abortion ban in 2005, he “appeared on the Senate floor with oversize illustrations of fetuses in various stages of delivery. He described the process by which a physician ‘brutally kills’ a child ‘by thrusting a pair of scissors into the back of its skull and suctioning its brains out’” (Leibovich, 2005, para 7). As a presidential candidate, Santorum had signed the Personhood USA pledge that argues life begins at conception and opposes abortion in cases of rape, incest and when the life of the mother is at risk.

The Duggars had been supporters for Santorum prior to their miscarriage, but it is possible that their shared experience of the death of an infant may have further deepened that alliance. In the days after the story of Santorum taking his baby home broke, just weeks Gabriel's death, the Duggars stood in for Santorum at campaign stops to stump for him. The media has framed the personal experiences of Santorum and Duggar as the galvanizing force behind their conservative political stances. This framing may also serve, intentionally or not, to deepen the political divisiveness of the personhood debate and entrenching pro-choice advocates in a defensive stance that continues to prevent them from acknowledging the needs and feelings of families who experience the death of a wanted child. But the visibility of their grieving and their after-death care practices, and not the political polemics surrounding a life at conception positionality, may provide a window through which the conditions of discourse about bereavement may open.

In the fall of 2011, I created a visual ethnography of 10 families that explained their perceptions of the value of postmortem photographs of their babies. Stillbirth advocates I worked with found the video powerful and were eager to share it with their hospitals. Bereaved parents asked for copies and wanted to share it with their support groups and online. However, classmates, who were in class I created the video for, responded to the screening with silence. One professor said, "I would never want to watch the video again. I mean it is powerful and important, but it was killing me. I had a hard time looking at it." Another I had asked to watch it declined after he found out that there were actual photos of dead babies in it. He apologized, but said that the images would be too hard for him. My living son's father (who was not the father of my stillborn son) said that looking at Avery's pictures was hard for him. It made him think about what

could have happened to our son. A week after showing the video in class, photos of the Duggars' baby appeared on the Internet. A classmate, who had not said anything during the viewing of my video, sent me a link to an article about the controversy stirred up by the photos and said she would not have understood why the family decided to take the pictures before, but now she could.

Perhaps, then, it is not just the public eruptions, like the Santorum and Duggar media events, that will potentially cause an evolution in perinatal death care discourses. Perhaps it is not just the individual accounts of memorial websites that inform us about the depth of the love parents have for their infants who have died. Perhaps, as parental identity is both individually and socially constructed, bereaved parent identity must also be individually and socially validated in order for the discourse in after death care to evolve. My classmate's response, I believe, was made possible by the exposure she had to the testimony of real parents related to her in an intimate way and because she saw similar images placed within a larger public discourse. The after-death care experience for these parents was important enough to make the news due to their celebrity, regardless of the framing, and she her prior exposure to a counter narrative allowed her to question the narrative framing of the Duggar photos.

In March 2012, TLC aired the episode in which the Duggars get their 19-week ultrasound. The cameras are rolling when the doctor discovers there is no heartbeat. We hear the words the doctor uses, we witness the devastating blow, see how Michelle reacts and watch as the couple hold each other as the news sinks in, up close on our television screen. We follow them as they gather their other 19 children to tell them the news.

That their personal tragedy has been packaged and promoted and was the source of increased ratings caused some critics to accuse the couple of capitalizing on their child's death and question whether the circulation of the pictures was an attempt to gain more public exposure. Michelle Duggar herself said she hoped that going public with the miscarriage news would help other grieving families. That viewing audiences, who may not have experienced the death of an infant, were exposed to such a traumatic event, in as intimate a way as reality TV can allow, interrupts the usual secrecy that shrouds the death notification of miscarriage or perinatal death. While the release of the Duggar photos and the disclosure of Santorum's taking his baby home were framed by commentary and critique that were louder than needs of the bereaved parents addressed by the after death care interventions, the depth of the loss the Duggars experienced in those televised moments spoke louder about the emotional impact of miscarriage than the concerns of media exploitation of the event.

Two bereaved parents wrote columns in the online versions of national publications that both highlight the resistance in public discourse to these after death care practices and point to the teachable moment the Duggar and Santorum eruptions might provide. In her open letter to the Duggars, bereaved parent Davis (2011) wrote:

You are undoubtedly educating many people about this often hidden bereavement. Because of you, some folks are realizing that parents shouldn't be denied the very rituals that would comfort them, such as photographs, spending time with their infant, providing after-death care of the body, and holding a memorial service. Perhaps in those resisting this lesson, you are planting seeds.

(para 8)

Bereaved father and writer for *The Washington Post*, Charles Lane, told his own story of his son's stillbirth and his hesitation at holding him. "I am glad that my love for the dead overcame my fear of him," said Lane (2012, para 5), who wondered if the Santorum story might provide "a teachable moment about neonatal death and stillbirth—and the special grief that these not-uncommon, but obviously insufficiently understood, tragedies inflict upon parents," (para 2). Lane (2012) went on to say:

I'm not defending Rick Santorum the presidential candidate. From what little I know about him, he seems to have his own issues with moralizing and judging. To the extent he has used his family's experience to make a point about abortion, I object.

But I am defending the right of the Santorums and all families to grieve an infant's death in accordance with their personal needs and beliefs. My plea is for a little more respect regarding the way people deal with loss, and a little more maturity about physical contact with the dead. If that puts me in sympathy, for a moment, with this right-wing politician, so be it. (para 9-10)

Perhaps the Duggar and Santorum events, and their accompanying testimony of their experience, might have provided the public with a moment to reflect. This space can allow for a shift in the discourse. Reflection can turn into reflexivity when the public considers experiences other than their own and when they consider the evidence of testimony and, in this case, photographs, of those who have lived through the death of baby they consider a life.

When Stillbirth Goes to the Movies

It was January 2013. My email box was filling up with announcements about a Kickstarter campaign. Friends were sharing the post on Facebook. Stillbirth organizations posted links to the fundraising effort. It was finally happening. Someone had made a movie about our lives. But the producers needed to raise \$50,000 help with post-production costs. A \$25 donation got you a DVD of the completed film; \$250 got your baby's name in the credits. Familiar stars—Minnie Driver, Paul Adelstein, Alfred Molina and Kathy Baker—were in it. It was based on the director and his wife's story about their son Norbert. They reached out people I work closely with as bereavement advocate to film promos and give background interviews. Finally, the silence would be broken.

At least that what I told myself. Make a movie about it and the public will finally understand how devastating stillbirth is and why it is so important to do something to prevent it. Some of the other stillbirth advocates and I had the same feeling during the final year of Oprah's talk show. Word went out that they were seeking guests for show on stillbirth. Dozens of people I knew signed via a link posted on the shows website. We were so excited that she was finally going to do a show on stillbirth. We knew she had had one when she was 14 years old, but she refused to talk publicly about it. The only reference she ever made was in an editor's note of O Magazine after she learned that a relative on staff had gone to the tabloids to tell the story of her teen pregnancy loss. So when the show began soliciting guests, we thought she was finally ready to break her silence. But no one I know was ever contacted, the topic was never featured on her show and as far as we know, one was never taped after the invitation went out.

Many activists felt as if we needed a celebrity to call attention to the cause. So in a month, when they collected more than \$70,000 from 451 backers, myself included, we allowed ourselves to believe that Return to Zero would be the thing that brought stillbirth into the conscious of those outside the Secret Club. Eventually, more 700 families contributed funds. The film was in the can and sent off to festivals. After a year of shopping the film, the producers hadn't been able to find a distributor. No one who was anyone in Hollywood seemed to think that people would want to see such a depressing movie. The director started a pledge drive to get as many people as possible to commit to seeing the movie on opening day weekend. Groups headed by volunteers who agreed to be "local leaders" from different cities or states organized teams and competed against each other to see who could collect the most pledges. A variety of prizes were offered. Facebook banner photos and Twitter avatars changed to the Return to Zero logo. My timelines were filled with reminders to get RTZ pledges.

Within a month, 2,534 local leaders in 45 countries got more than 113,000 people pledged to see the movie on the opening weekend. Distributors were impressed. But not convinced. Still, no one was willing to take the film. We waited. And waited. We hoped that a showing at a festival would change their minds. Then news came that Return to Zero was accepted to the respectable Cinequest Film Festival in San Jose, California. On March 8, 2013, a few days after the eighth anniversary of Avery's death and a few dozen miles from where he was born, the first feature film about stillbirth would have its world premiere.

We followed updates on the film's website. Some of us made plans to go to the festival. Then a Hollywood screening was announced for the weekend before the San Jose

festival. Photos of celebrities were taken outside the movie. Local leaders who had also pledged higher dollar amounts during the fundraising campaign dressed in their finest and flew to Los Angeles to see the movie. My Facebook page filled with images of people I had known and who had been working on stillbirth causes for years behind the scenes had their moment on the red carpet. Then the film's producer and director flew up to San Jose for the festival. I waited in line with dozens of others who wore Return to Zero T-shirts and two of the people who were with me when Avery was born. My body hummed with anticipation and my eyes were wide with excitement.

We filed into the theatre and chose our seats. A festival representative stood in front of the screen and introduced the director, Sean Hanish. He introduced the film by sharing the motivation behind the film. Then the lights went down and in bold white letters Return to Zero filled the darkness. The film opened with the scene of Minnie Driver laboring through a stillborn delivery. I clutched the hands of my friends. We are sniffing. Other audience members blow their noses. They are my kin. I recognize their familiar sounds. We have been in this Secret Club together for so long and finally, there are others to bear witness to our suffering on the big screen.

At the end of the movie, the credits roll and few people get up to leave. Some are waiting for the post film Q&A. The Secret Club in attendance are waiting for something much more personal. As the "In Honor Of" credits of more than 250 babies scrolls, camera flashes go off and there is more sniffing. Hundreds of names fill the screen in alphabetical order. I read them as they go, first and last names familiar to me from friends and activists I know who helped fund the film. And then I see my son's name.

Avery Pullen.

My friends clutch my hands as tears pour down my cheeks. His name briefly shines in a space where other people can see it. His death witnessed by people who finally understand what this bittersweet agony means.

After the last credits roll, Sean Hanish returns to the stage and tells more of his story and which ways the lives of the characters depart from his own. Everything about the pregnancy, birth, death, mourning and interactions with the doctors and their subsequent pregnancy was true to their experience. The rest, about the infidelity, family business and the other events were fictionalized, but not out of bounds for what we know to happen to couples experiencing stillbirth. He talks about the fundraising campaign and the hundreds of thousands of people who pledged to see the film. And then he makes an announcement. A deal with a distributor is close. It was a unique arrangement that was very exciting. He asked people to watch the website for news in the next week or two.

I went to the Return to Zero Facebook page and post my thoughts about the film. Sean took comments from viewers of the screening and encapsulated mine and a few others on his blog.

I saw my life on screen tonight...and by the laughter and sniffing, I could tell I was not alone. So deeply indebted to Kiley and Sean Hanish and everyone who made Return to Zero. It was a beautiful, honest, funny and emotional movie that got it right. (Minnie Driver was phenomenal!) I believe that this movie has the potential to change the landscape of awareness and care for stillbirth families. When it hits theaters...please, see it. If you haven't experienced the death of a baby...this film will help you understand all of us who have a little better.

(Hanish, 2014, para 13)

Sean added another post by me a few hours later:

Honored...grateful...proud... Still smiling from ear to ear 6 hours after watching a movie that sang to my heart “Look at our beautiful grief. We are not alone. The silence is breaking like a thousand morning birds calling out our babies names.” How I can be so happy after crying at a movie? Maybe because I was also in a room full of other parents who came together from around the country to do the same thing. (Hanish, 2014, para 13)

I crossed my fingers and waited. When the announcement finally came, I was, honestly, disappointed. The film wasn't going to be released in theatres, but rather it would have a global release on Lifetime network in May. On the one hand, that would mean potentially more people might passively be exposed to the film. It wouldn't take an active commitment to go out and buy tickets to see a movie about stillbirth. On the other hand, it wouldn't have the same publicity campaign. There wouldn't be trailers showing during primetime on various channels. It wouldn't get reviewed in major newspapers. These are the things I imagined were necessary for stillbirth to become the focus of national attention. Pledges to buy tickets on opening day turned into invitations to do viewing parties. I tried to organize one for weeks, but none of my stillbirth friends in the valley even had cable.

And then something surprising happened. My Facebook feed began filling with pictures of Minnie Driver with links to multiple interviews on daytime TV talk shows. Online magazines ran stories about the movie. Minnie Driver was on the Tonight Show talking about another project and the new host, Jimmie Fallon, told people to watch

Return to Zero. But it wasn't the acclaim for the film I was looking for. It was the importance of the story I searched for proof of. There was the write up in USA Today:

Minnie Driver and Paul Adelstein give first-rate performances in this lovely, moving film about a couple whose marriage falters when their baby is stillborn. There are a few moments where the drama gives way to educational aspirations, but it's a subject worthy of education and one that seldom gets dealt with on television. (Bianco, 2014, para 1)

And the industry magazine, Variety, said that the film "is a painful portrait of devastating loss, pivoting on a performance by Minnie Driver that acutely captures those raw feelings (Lowry, 2014, para 1). The review continued, "Hanish deftly zeroes in on how all the preparation and enthusiasm surrounding a new baby magnifies the enormity of the parents' pain here—as well as the different ways people cope, or don't, with such events," (para 6). And then there was TV Guide:

A delicately etched and intimately powerful portrait of grief and bitter loss, *Return To Zero* stars a fearless Minnie Driver and the ever-affable Paul Adelstein as a couple rocked to their emotional core by the loss of their unborn child, discovered to have died in the womb shortly before the delivery date. We follow them through the wrenching procedure and recovery process with a stark realism in which husband and wife are often seen at their worst, as their once-solid relationship frays when Maggie plummets into depression and neither seem able to say or do the right things to be able to heal and move on. Though sometimes hard to watch, *Zero* is a compelling and beautifully acted character study that will

make you care as it dramatizes a domestic tragedy with a minimum of melodrama, so rare for TV and TV-movies. (Roush, 2014, para, 4)

But the most encouraging of all the press, were the interviews Minnie Driver gave. She was on all the major networks during daytime talk shows, weekend news programs and late-night programs. She talked about the role being the hardest she had ever done, about the importance of the film and why people who had never been affected by stillbirth should watch it. It was her interview on CBS's daytime show, The Talk, that made the point the best.

It's the story of the director and his wife and it was extraordinarily hard. They lost their baby at 39 weeks (loud audience groans)...and we made it as an independent feature. And I would come out of the screenings with distributors and they would be shocked and saddened and none of them would take this movie because it was too hard and it's too hard a story and nobody wants to see that movie. But Lifetime took a different position and I'm so grateful and proud of them (audience applause and cheers). It's the story of...so many families go through this and no one's talking about it because, I know, who wants to talk about infant mortality and the horror and the sadness and the grief of that. But I feel like, if we are gonna tell hard stories, if we're going to have women sexually objectified in films, have heads blown off left, right and center, why not tell a story that is going to support a community of people who don't have anyone speaking for them. (Return to Zero, 2015).

The movie aired. People watched. Articles were written. More stories were shared. Minnie Driver was nominated for Emmy and Critics Choice award. Sean Hanish

received a Writers Guild of America nomination for Long Form Original Script. The film won the Satellite Award for Best Picture from the International Press Academy. The movie was released on DVD with extras that included educational materials, interviews and documentary shorts by other filmmakers. It spawned a book, based on stories people had posted on the movie's Facebook page, a healing retreat, and fundraisers for local organizations around the world.

For a brief time, the movie brought stillbirth to the lips of those who hadn't spoken it before, but its lasting impact seems to be the ways it has helped the Secret Club reach out to more members. It has become a resource for groups to tell stories and parents to be validated by seeing their own.

Conclusions

When Rep. Speier disclosed her medical procedure in response to a pro-life representative reading a graphic description of an abortion into the record, she said she had had the same procedure he was describing. She said she was disgusted and offended by his callous reading, and she identified herself as "...one of those women you are talking about." The next day, and in the succeeding months, the press circulated her abortion disclosure, she gave additional interviews, and she was called upon to respond to other anti-abortion arguments.

However, it should be noted, that the D&C she had was as a result of her wanted-pregnancy failing. The amniotic sac holding the baby slipped into her cervix. While she did not disclose whether or not the heart was still beating prior to the procedure, this complication often results in the death of the baby prior to delivery or shortly thereafter. Whether it was the political expedience of the moment, her choice of narrative framing,

or her decision to use her lived experience as a rebuttal to a specific argument, the result was the same. Rather than her body becoming visible for having a wanted pregnancy that failed—over which she had no choice—her body became visible for having had an abortion, which is associated with her having had a choice.

Absence of Stillbirth Bodies and Testimony

Another possibility, for Speier’s choice, is that in the absence of an already ongoing discourse about stillbirth in which to frame her experience, she saw herself as fitting into the only other discourse available to her—one of an abortion body. Without a living child, or physical evidence of a child who once lived, how does a stillbirth mother prove that she is a mother? How does a woman who gives birth to a stillborn baby prove that she once had a baby? The absence of living offspring may challenge the identity a woman may choose for herself as mother. But the absence of stillbirth testimony may also contribute to her not knowing that the identity as a mother is available to her.

Layne (2003) argues that there is a lack of visibility of the experience of stillbirth, “So focused has the women's health movement been in challenging biomedicine’s pathologization of pregnancy and birth, it has systematically minimized and marginalized negative reproductive outcomes.” Even natural childbirth guides like *The Bradley Method Student Workbook* minimize complications and infant death as “unpleasant possibilities” (Layne, 2003). *Our Bodies, Ourselves*, considered a foundational book on women’s reproductive health published by and for women, relegates information about childbearing loss to the back of the book. Layne points out that every chapter, including the one on abortion, has photographic illustrations except the one on pregnancy loss.

I found that I had a similar experience when advocating for the use of the photos of

my stillborn son in the magazine article I wrote for the San Francisco Chronicle. The editors refused my repeated request to include the photographs of him and his birth—despite the advocacy among bereavement groups to raise awareness about the value—and normalcy—of taking photographs of the stillborn. They instead commissioned abstract, depressing, charcoal sketches of a woman in vague poses of grief. My story was acceptable. My stillbirth body and the body of my dead son wrapped in a blanket and wearing a premie hat while in my arms was not.

But the circulation of fetal images may hint at other reproductive tensions. Palczweski (2002) notes how in pro-life images the fetus in utero is foregrounded, but the body of the pregnant woman is absent; similarly, in pro-choice images, the woman's body is foregrounded but the womb and its contents are absent. Layne seems to imply that absence of stillbirth images from *Our Bodies, Ourselves* is part of a political calculus. "One might deduce from this that elective abortions are events worthy of feminist support and that spontaneous abortions are not" (Layne, 2003, p. 242.). Layne (2003) also argues that in remaining silent on pregnancy loss, feminists have contributed to the shame and stigma associated with the experience. They have ceded the discourse of pregnancy loss to anti-choice activists:

One of the most important factors is, of course, the way the subject of pregnancy loss (particularly early losses) overlaps with issues central to the abortion debate. Because anti-abortion activist base their arguments on the presence of fetal, and even more important embryonic personhood, feminists has studiously avoided anything that might imply or concede such a presence. The fear, in the context of pregnancy loss, is that if one were to acknowledge there was something of value

lost, something worth grieving in a miscarriage, one would thereby automatically accede the inherent personhood of embryos and fetuses. (Layne, 2003, p. 240)

But Layne argues that if one accepts an anthropologically informed view of personhood, that personhood is culturally constructed and varies by culture and over time, then it is possible to understand how some embryos may be imbued with personhood and not others. “Feminists must frankly acknowledge the frequency and import of such events in women's lives and create a woman-centered discourse on pregnancy loss” (Layne, 2003, p. 239).

The lack of visible representations of bereaved families and the dearth of narratives about parents of stillbirth circulating in the public sphere may limit a bereaved parent's ability to conceive of such an identity, let alone know how to share that experience with others. If the master narrative of stillbirth is that it is a death that is too taboo to discuss, how does one construct a counter narrative that gives parents agency to voice their own story, makes their dead baby real to others and reconstructs their identity as parent?

It is my contention that the narratives that bereaved parents tell function not only as sense-making, constitutive acts for themselves. These narratives also function as self-defining to others: as testimony for their legitimacy as parents; as evidence that their babies, now absent, once existed; and as argument against the prevailing institutional narrative about stillbirth and pregnancy loss that “these things just happen.”

The elements of personal experience that a stillbirth mother shares—including how her pregnancy progressed, what her desires and dreams for her child were, how she was given the diagnosis of her baby's death, what happened during and after delivery, how she grieved and what her life after stillbirth is like—are the core elements of her personal

narrative. At the core of this process of her narrative construction, which may change over time as she mourns and adapts to her life after stillbirth, is a sense-making process in which she begins to construct a new identity. *When* she chooses to share her stillbirth narrative either with friends to help them understand her experience, with other bereaved parents as a source of support and understanding, she demonstrates her agency. When she shares it publicly as a way to raise awareness or advocate for change or when she shares it with an awareness of the ways that her abjected body and her abjected baby are missing from the discourse about reproduction in some way, she demonstrates her agency through testimony. By incorporating her experience and making visible that which is no longer present, her body is argument for her identity as mother. It is also an argument that her baby, and the 26,000 other babies stillborn that year, matter too—even long after their bodies are gone.

But as of this writing, there have been very few eruptions in the public discourse about stillbirth. While the Internet plays host to thousands of memorial websites and Facebook pages dedicated to stillborn children, these circulate in enclaved spaces sought out by those with a vested interest in bereavement. Stillbirth discourse circulates mostly within enclaves and counterpublics but has yet to come into the forefront of public discourse. Despite strong support from within the stillbirth community, a well-made movie with recognizable and popular stars could not make it to the big screen. Despite news circulating of the infant deaths of former Presidential hopeful Rick Santorum and *19 Kids and Counting* star Michelle Duggar at the height of their public fame, there was no quickening of interest among the public about wanted pregnancies failing.

All testimonies of pregnancy ending may not all same result, whether or not content

or form is similar. This difference may be in part due to target audiences, subject matter or the speaker themselves. The Santorum and Duggar testimony did not seem to have circulate much beyond the initial eruption period. This may be in part due to the viewer backlash to the way some in the media characterized or seemed to make fun of the way he held his dead baby. It is possible that due to the unfamiliar nature of the after death care practices of infants, people may have been hesitant to continue discussing the subject. Santorum's bid for president failed, so perhaps the interest in his life faded as a result. The Duggars did show the episode in which the ultrasound showed that the baby had died. TLC is a niche cable channel with a steady audience and mainstream viewers are unlikely to be exposed to the show unless they are already regular viewers of the program or the network.

There may be another reason why Santorum and Duggars' testimony may not have lingered in public view. In both cases, the stories of the after-death care practices were reported in the media and the testimony came in response to challenge or explain the reporting. In both instances, the testimonies were called forth as a result of their private practice being publicly "outed" by media. This may have affected both the goal and the orientation of the testimony which was directed toward, or in response, to the media's reporting rather than toward a policy in need of changing.

Staying Power of Speier's Story and a Dozen Testimonies

Unlike the seemingly limited staying power of the Santorum and Duggar eruptions, the waves of Speier's initial testimony in 2011 continued to ripple for as much as a year later as she was called on to share her story, or she stood up against other anti-abortion legislation. Her body, marked by her testimony, stood by other candidates in

support of women's health and continues to be marked with in the chamber she still serves.

Her testimony—with her story as evidence and her body as argument—however, also appears to have expanded the conditions for pro-choice discourse in the State's own forum for debate, beyond those in Washington, D.C. Since 2011 and as of this writing, at least five other female legislators that have come forward in state forums to share their own testimony of having had an abortion in response to anti-abortion legislation. The first of these was Wyoming State Representative Sue Wallis who spoke out with her colleague, Rep. Lisa Shepperson (both of whom were Republican), against the Abortion Available Information for Decision bill. She told the chamber that she had an abortion while she was going through a difficult divorce from an abusive husband. She already had three children and had a bout with cancer that had contributed to an earlier miscarriage:

And the thing I want to make sure you understand is that's just one story. There's a zillion variations out there. And we, as a state, should not be interfering with those very personal, very private, very—that our ability as free moral agents cannot justify these broad strokes...I just ask you as a human being, as a friend, and as a colleague, not to pass mass judgment on your fellow human beings.
(Rachel Maddow Show, 2011, para 133)

In 2013, while speaking out in support of a sex education bill, Nevada Assemblywoman Lucy Flores (D-Las Vegas) went off script and explained that the reason she was the only one of her siblings who had not had children in the teen years was because she had had an abortion. After her testimony, she was both praised and

vilified. The death threats she received caused her to temporarily shut down her social media sites. In 2013, Texas State Senator Wendy Davis (D-Fort Worth) testified that she had had an abortion herself during her now famous 13-hour filibuster of an extreme anti-abortion bill. During a panel discussion during the 2014 election, then-candidate for the Texas House, Molly White (R), said she had regretted her abortion and had experienced addiction issues and suicidal thoughts as a result. State Rep. Dawnna Dukes (D-Austin) shot back that she had also had an abortion and had no regrets or emotional distress. And in March 2015, Ohio State Rep. Teresa Fedor (D-Toledo) responded to the lack of a rape exemption in a bill that would have made it a felony for a doctor to perform an abortion once a heartbeat was detected. She explained that had been raped while serving in the military and had had an abortion (Provance, 2015). She called the debate purely political and said that she understood the stories of her fellow legislators, but that they did not understand hers. She later called out a male representative who laughed at her while she was speaking.

You don't respect my reason, my rape, my abortion and I guarantee you there are other women who should stand up with me and be courageous enough to speak that voice...What you are doing is so fundamentally inhuman, unconstitutional and I've sat here too long. I dare any one of you to judge me, because there's only one judge I'm going to face...I dare you to walk in my shoes...This debate is purely political. I understand your story, but you don't understand mine. I'm grateful for that freedom. It is a personal decision, and how dare government get into my business. (Provance, 2015, para 3-4)

While none of the legislators explicitly mentioned Speier's testimony, news outlets often referred to Speier's or other legislator's previous testimony when discussing the latest abortion revelations. Interestingly, all of the women noted that they had not planned to share or had never before shared their abortion stories, but did so because of either the comments of fellow legislators or the nature of the legislation itself. While some testimonies have been successful in stalling or amending proposed legislation, the circulation of these testimonies may have a broader reach than just the house chambers. The livestream of Davis' filibuster, for example, was watched by more than 180,000 people at its peak and #StandWithWendy was tweeted more than 570,000 times during the course of her speech (Know Your Meme, 2013). Much of her filibuster featured her reading dozens of abortion stories she had solicited from her constituents for the express purpose of reading them into the Senate record. She later shared more details about her decision to have an abortion prior to her unsuccessful campaign for Governor of Texas.

Also worth noting is that five other legislators have also shared other personal stories as reason why they oppose the anti-abortion bills being debated. In 2012, Georgia State Rep. Ron Stephens said he voted against a 20-week abortion ban with no exception provision because his daughter had recently discovered her baby had Trisomy 18. "At five months, they told her part of her baby's brain was outside the skull and the heart was inverted," Stephens said. "They said it would take only one or two breaths. She would have watched it die," (Bernstein, 2012, para 3). Stephens' daughter had considered abortion but the baby died during her fifth month of pregnancy. The article quoted Stephens as saying, "For something this cruel to happen to my daughter, or anyone's daughter," he said, "is just plain inhumane. I consider myself pro-life, but this provision

was a distortion of pro-life values,” (Bernstein, 2012, para 5). In speaking out against the Michigan’s proposed Rape Insurance bill, three state legislators shared their personal experiences in an effort to defeat the bill. State Sen. Gretchen Whitmer disclosed that she had been raped 20 years earlier; State Rep. Colleen Lamonte shared that she had a difficult miscarriage at 12 weeks; and State Rep. Vickie Barnett said she had to get advanced fetal testing for Tay-Sachs, a genetic disorder. “The highly personal stories, delivered with tears, rage and anger,” wrote reporter Kathleen Gray (2012), “accompanied the emotional debate Wednesday on a bill that will require women to buy additional insurance rider if they want abortion coverage in their health insurance plans,” (para 4). And in March of 2015, Arizona State Rep. Victoria Steele told the House that she had been molested as a child while speaking out against an abortion ban that had no rape clause (Ruelas, 2015). She, like Speier and several legislators who offered their testimony, said she had not planned on disclosing her rape, but felt she had to when she was asked by abortion should be considered a medical service.

The uptake of two of these stories may also demonstrate how little familiarity with miscarriage and stillbirth there is even within discussion of pregnancy ending. At least one news article circulating the story about Stephen’s testimony said his daughter had a miscarriage (Bernstein, 2012), but at five months gestation the baby would be considered to be stillborn. Speier had a procedure on a failing, but wanted pregnancy, which is commonly done for miscarrying women and is the same procedure used to abort an unwanted pregnancy. But rather than calling attention to the lack of research, awareness or support for miscarriage or stillbirth, her story is leveraged as an argument for abortion rights.

Also of note is how these eruptions in the conditions of discourse in the public spheres and state forums can expand our understanding of the way that testimony is oriented toward dominant narratives considering the Narrative Loop Model. Drawing on my earlier articulations of public sphere theory and testimony, we can imagine how and where the eruptions discussed above are visible in the loop model. As discussed in Chapter 2, a triggering incident causes an individual's acceptance of the dominant narratives to falter. It could be exposure to testimony or a traumatic event or personal experience that does not match the dominant narrative which circulates in the public sphere and serves to reinforce cultural and social belief systems. These publicly occurring and circulating narratives reinforce, and are reinforced by, state agencies and actors that re/inscribe beliefs in legal practice and legislative policies.

The internal dissonance triggered by a questioning of beliefs, when someone's experience does not match the dominant narrative, can find expression on an intrapersonal level or interpersonal level in the private sphere. An individual may wrestle with, feel liberated by, or be uncertain about this new awareness. This may cause the individual to seek out others with a similar experience in an enclave—a space that is protected from the dominant narratives and allows the individual to construct or reconstruct their narrative. These could be face-to-face support groups or online message boards or forums. This individual may continue to share their counter narrative within this enclave or in-private spaces with other close family and friends. Then the narrative continues the disclosure circle in the private and enclaved spaces. After this period of circulation, the individual may decide to share the story with others outside these enclaved and private spaces, or they may circulate their story within these same spaces

for the purpose of responding to the dominant narrative. Once this counter narrative is directed out of this enclaved space and toward the dominant narrative in the public sphere, in either affirmation, challenge or denial, this counter narrative becomes testimony. Both the triggering event and the public orientation of the story causes the narrative to jump the circular track and cross over into the other loop. The narrative loop provides a foundation for us to understand how narrative works, but does not help us account for the unique activist framework of testimony. The Testimonial Loop Model (as shown in Figure 2) incorporates the above in order to better visualize how testimony circulates.

TESTIMONIAL LOOP MODEL

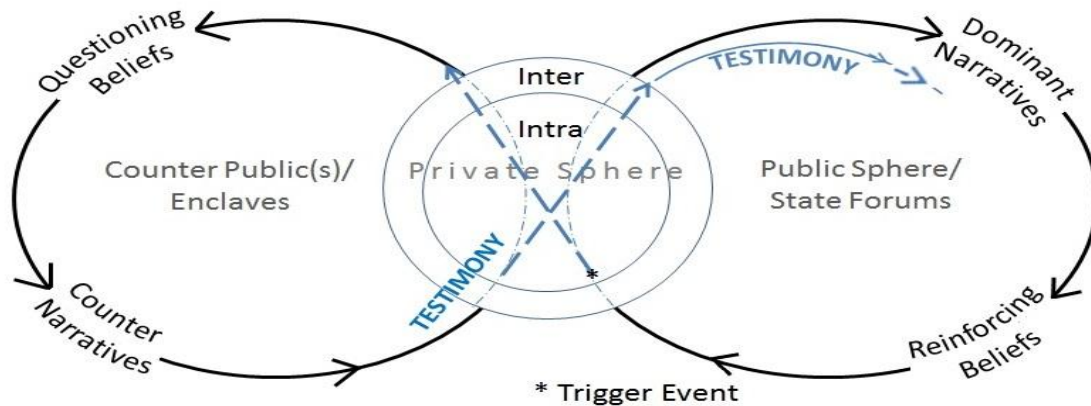


Figure 2: Testimonial Loop Model A. This model adapts the Narrative Loop Model, Figure 1, to incorporate public sphere theory and the trajectory of testimony.

CHAPTER 4

DESCRIPTION OF PERFORMANCE TEXTS AND CHOICES

This chapter is divided into two parts. The first section takes the reader on a front stage tour of the multi-media installation within which each live performance was situated. It highlights elements of the ensemble letters performance on Wednesday night and the full-length version of the solo-ensemble performed on Friday night.⁹ The second section discusses the backstage rationale for using three different performance styles and two different methodological approaches to developing the final performance texts.

To do a thorough description of all of the performance elements and explanation of the choices made in selecting, editing, crafting, rehearsing, staging, and performing a series that spanned four nights, had three different scripts, 15 cast and crew members, and variations in the preshow introduction and the post-show closing comments, could, itself, be a dissertation-length endeavor. Instead, this chapter attempts to offer reference material for the discoveries shared in the next chapter. This chapter hopes to provide enough salient details for the readers to create a sketch in their mind of the look, content, and execution of two of the play scripts and the multimedia installation, as well as a general sense of the audience and their engagement with the play, the space, and the performers. Ultimately, the chapter offers a rationale for exploring the use of three different forms of testimony—recordings of publicly occurring testimony, performance of epistolary testimony, and performance of elicited testimonies from ethnographic interviews—to discover how they might function in service of pregnancy-ending narratives.

⁹ Due to a medical emergency, an understudy performed in my place on Thursday night.

Part One: Front Stage

The Installation

On a Wednesday night in October, you attend a performance within a series titled, “*I Am One of Those Women*”: *Testimonies of Stillbirth, Abortion, and What Happens When Pregnancy Ends*. You cross the threshold of *The Empty Space* and discover that the intimate black box theatre has been transformed by vibrant pastel murals and text-rich wall art. The stage is in front of you, at an angle between two walls. The audience seating is diagonally across from the stage on moveable risers, also angled between two walls. You take a few steps into the room. Written on the wall left of the stage (and running perpendicular and to the right of the door you entered), you see five floor-to-ceiling columns of red and orange pastel chalk text written directly on the wall under the heading “Law passed to prevent abortion.”

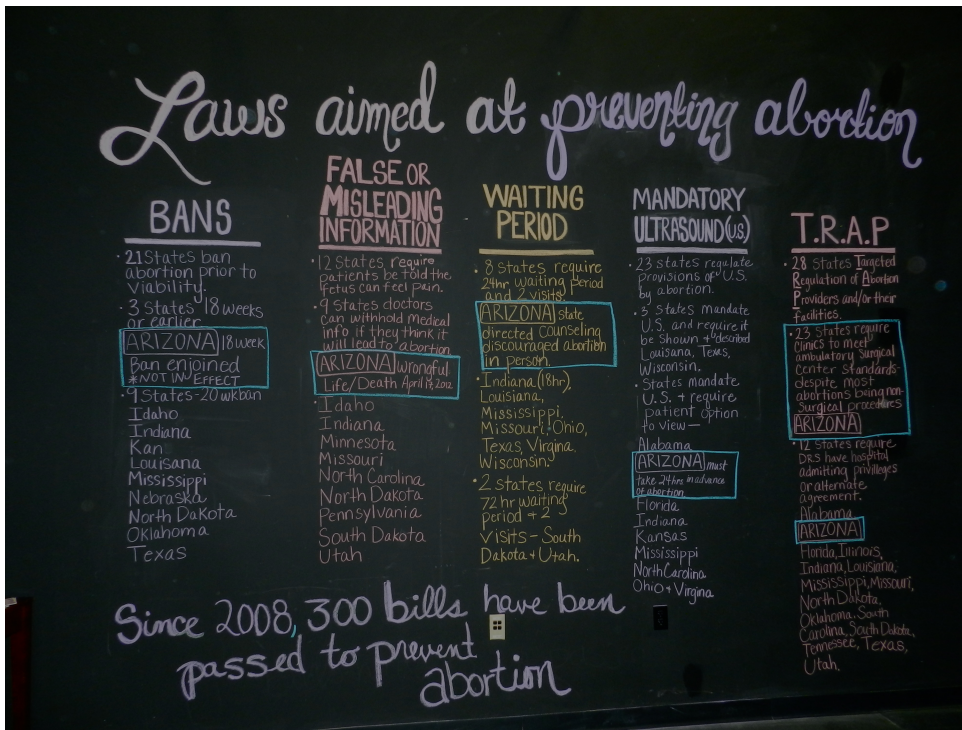


Figure 3. Installation Image: Abortion Laws.

The five columns are headed as “Bans,” “False or Misleading Information,” “Waiting Period,” “Mandatory Ultrasound,” and “T.R.A.P.” Across the bottom you read, “Since 2008, 300 bills have been passed to prevent abortion.” You notice that Arizona’s law under each category is surrounded by a box. You take a closer look to see what those laws say. In the middle, under “Mandatory Ultrasound (US),” you see several bullet points. “23 states regulate provisions of ultrasound of abortion,” “3 states mandate US and require it be shown and described” with Louisiana, Texas, and Wisconsin listed under it, and “States mandating US & require patient option to view” with nine states listed below it. You learn that Arizona requires an ultrasound 24 hours before an abortion. Under “Waiting Period” you see that Arizona is one of eight states that requires a 24-hour waiting period and a minimum of two medical visits, which include counseling that discourages abortion. Under “False or Misleading Information,” you learn that Arizona is one of nine states in which providers can withhold medical information if they think it will lead to abortion. Under the other columns, you discover that Arizona has a provision similar to 23 other states that requires abortions to occur in an ambulatory surgical center (otherwise known as T.R.A.P. or Targeted Regulation of Abortion Provider law). Also, Arizona’s law bans abortion earlier in gestation than almost every other state, at 18-weeks, but that the law is currently enjoined by the courts.

You step back and look at the wall to the right of the stage which has a similar header across the top, “Laws passed to prevent stillbirth.” The wall beneath it is empty. Along the bottom of the wall, it reads, “Since 2008, 0 bills have been passed to prevent stillbirth.” On a vertical beam to the right of the space is information on three stillbirth-related bills. One data point says, “In 2001, Arizona became the first state to issue a

certificate of birth resulting in a stillbirth. 33 states have since passed similar legislation.” The other says, “2 states have passed legislation to create standardized stillbirth data collection. Iowa, 2004; New Jersey, 2014.” Traveling further down the same wall, a video titled, *Picture of a Lifetime: A Visual Ethnography of Postmortem Photography for Families of Stillbirth*, is being projected onto a square of white paper acting as a screen. Underneath it is a table filled with books, pamphlets, and a photo display of items. You look closer at the table and see that the books and pamphlets are about how to cope with the experience of stillbirth. The photo display includes images of altars and memorial spaces on the left and right panels and in the center are several groupings of women holding a very small baby.

You turn the corner, behind the audience seating, and see that covering the entire wall, floor to rafters, is a mural of a butterfly. One wing is filled with white stars above blue water, and the other is filled with long-stem yellow and pink flowers growing from long green grass. The stars and flowers are outlines, and you can see they have been filled in with names and messages in some places. On a small table next to it are foam cut outs in the shape of stars, as well as pens and a cup of chalk, with the invitation to add names or messages to the mural. Within the barrel body of the butterfly is a poem and each ribboned antenna ends in a balloon, one pink and one blue. The poem, *The Mention of Their Name*, reads: “The mention of my child’s name may bring tears to my eyes/But it never fails to bring music to my ears./If you really are my friend/Let me hear the beautiful music of their name./It soothes my broken heart and sings to my soul. –Author Unknown.” You look closer and realize that the outline of the entire butterfly is made up of the cursive phrase “we will remember them,” repeated over and over.

You turn the last corner and see a square mural covering a third of the length of the wall, framed by another repeated phrase, “Free Speech Zone.” At the top, the mural asks “What are your thoughts...feelings...questions about...” and then beneath it in five words in quadrants like the dots you find on dice are “Choice,” “Life,” “Morality,” “Autonomy,” and “Reproductive Justice.” On a small table next to it are paper cut outs in the shape of thought bubbles, as well as pens and a cup of chalk, with the invitation to add comments to the mural.

Next to the free speech zone, drawn on the center of the long wall, are three larger-than-life, differently shaped female silhouettes in lavender and pink. A cursive ribbon of text weaving from one midsection to another repeats “One in three women,” and along the bottom a larger ribbon of text reads, “Will have an abortion in her lifetime.”¹⁰ Next to the “One-in-Three” mural is a table filled with bumper stickers, postcards, and fact sheets about abortion legislation. The centerpiece is a poster with an excerpt of a poem by Marge Piercy called “I Will Choose.” Above it, similar to the table with the stillbirth material, which is diagonally across from it on the other side of the room, a video is being projected onto a white paper screen. The video collage projected on this wall is titled, *Testimonies of Abortion at/in the Capitol*, which features footage of various state and U.S. representatives testifying about their abortions in legislative chambers, as well as women testifying on the steps of the U.S. Supreme Court.

As showtime nears, you find a seat and begin to read the program. After reading the title of the performance series on the cover, you skim the inside. You see the playwright has included her political and personal investments in this performance,

¹⁰ Inspired by the 1 in 3 Campaign, a non profit organization, that claims 1-3 women have had an abortion based on research by the Guttmacher Institute (2011).

including her own stillbirth in 2005 and her lobbying of Congress for stillbirth-related legislation. You learn that there are 26,000 stillbirths a year in the U.S., and the playwright has encountered conflicting messages about her advocacy.

Lawmakers ask me: “If we pass legislation for bereavement support for stillbirth families, aren’t we saying it’s a life? Our pro-choice constituents won’t go for that.” Some in the stillbirth community say, “They had a choice. It isn’t the same kind of loss.” There is little space for nuance in abortion politics. Nor does there seem to be in the stillbirth community. (Pullen, 2014, performance program)

The performance description in the program reads:

This performance series seeks to explore pregnancy-ending narratives as testimony and places the experiences of stillbirth and abortion—distinct, but compellingly linked—understood, made in/visible, and marked within the current conditions of discourse, in conversation with one another.

The murals and wall art (Wed.–Sat.) stand in for the political and social contexts the performance testimonies exist within. The two video projects represent varied documentations of testimonies about stillbirth and abortion.

The ensemble ethnodrama (Wed. & Thurs.), crafted from the private letters of historical figures made public and modern day public letters, helps us to understand the historical and modern experiences of pregnancy ending as both a private matter and a public concern. The solo performance (Wed. & Fri.) shares the testimonial narratives of nine women. I re/embody research interviews with these women about their experience with pregnancy ending, either due to miscarriage, stillbirth, termination of a wanted pregnancy, or abortion.

We don't talk about stillbirth. We do talk about the politics of abortion. But we don't often hear the lived experiences of women who have had either. What might we learn if we put these testimonies of pregnancy ending in conversation with each other? (Pullen, 2014, performance program)

The lights dim and the audio fades. An introduction about the performance series and dissertation project of Suzanne Pullen is given. This Wednesday night's performance features two plays, an ensemble performance with eight actors titled *To The In/Famous Members of The Secret Club: Letters on/when Pregnancy Ends* and a solo performance ethnography featuring Suzanne Pullen titled *No One Ever Told me*. In the performance space before you, there is a 10-foot long riser upstage center with a cushioned armchair and a small desk. Stage right is a high-backed Edwardian-style chair and a circular table. Stage left is a wooden chair and mahogany table. Center stage, five black stage blocks are set symmetrically around a thigh-high, four-foot-wide, multi-leveled bright display, draped with cobalt blue satin with a magenta and yellow shimmering runner.



Figure 4. Installation image: Memorial altar.

There are photos, poems, stuffed animals, figurines, blankets, keepsake boxes, flowers, flameless candles, and cards. Little signs on the display say “stillbirth,” “miscarriage,” “premature,” “adoption,” “abortion,” and “termination of a wanted pregnancy.” As the house lights go down, the white string lights glow brightly on what, you realize now, can be seen as either an altar or a memorial space. These lights remain on for the duration of both performances, and you notice each time a character adds something to it.

To the In/Famous Members of the Secret Club: Letters When Pregnancy Ends

This ethnodrama blends the historic private letters of John and Abigail Adams and Alfred, Lord Tennyson regarding the stillbirths they experienced with the public (open) letters of advocates of reproductive justice. The cast is made up of current and former Arizona State University undergraduate students, graduate students and lecturers.

Historic private letters. The first act's ensemble performance begins with ALFRED, LORD TENNYSON standing on an upstage riser and JOHN and ABIGAIL ADAMS downstage center. They speak their letters to each other in an offstage focus style reminiscent of a Reader's Theatre. The Adams' exchange begins with a series of letters written in advance of the Revolution in the spring of 1776. The exchange focuses on the politics of the time and demonstrates the intellectual content in many of the missives between them, one of which is perhaps the most famous of ABIGAIL's:

I long to hear that you have declared an independency. And in the new Code of Laws which I suppose it will be necessary for you to make, I desire you would Remember the Ladies, and be more generous and favourable to them than your ancestors. Do not put such unlimited power into the hands of the Husbands. Remember all Men would be tyrants if they could. (A. Adams, to J. Adams, March 31, 1776)

TENNYSON begins his narrative with excerpts from a series of letters about the birth of his son. They continue throughout the play and paint the picture of a father grieving the stillbirth of his son in 1851.

I have suffered more than ever I thought I could have done for a child still born: I fancy I should not have cared so much if he had been a seven months spindling, but he was the grandest looking child I had ever seen... I refused to see the little body at first, fearing to find some pallid abortion which would have haunted me all my life-but he looked (if it be not absurd to call a newborn babe so) even majestic in his mysterious silence after all the turmoil of the night before. (Tennyson to R. Monteith, c. April 24, 1851 in Ruderman, 2009).

One letter explains that TENNYSON did not want the story of his son's death in the papers, and instead, he says, he wrote more than 60 letters to family and friends detailing what had happened. TENNYSON describes his son as a proud father might, and each of the letters seems to describe a different element of his son's death and his own grief.

Dead as he was I felt proud of him. To-day when I write this down, the remembrance of it rather overcomes me; but I am glad that I have seen him, dear little nameless one that hast lived though thou hast never breathed, I, thy father, love thee and weep over thee, though thou hast no place in the Universe. Who knows? It may be that thou hast. (Tennyson to E. Lushington, c. April 24, 1851)

These letters, delivered in off-stage focus as if to the recipient, are interwoven with his poetry, directed to the audience. These poems focus on the grief surrounding the death of a loved one, which contain some of the most famous lines in literature.

I hold it true, whate'er befall;
I feel it when I sorrow most;
'Tis better to have loved and lost
Than never to have loved at all.¹¹

The poems, including the following about his son, and his letters are interwoven with the ADAMS letters.

Little bosom not yet cold,
Noble forehead made for thought,
Little hands of mighty mould

¹¹ Tennyson's "In Memoriam" 1849.

Clenched as in the fight which they had fought.
He had done battle to be born,
But some brute force of Nature had prevailed
And the little warrior failed.
Whate'er thou wert, whate'er thou art,
Whose life was ended ere thy breath begun,
Thou nine-months neighbour of my dear one's heart,
And howsoe'er thou liest blind and mute
Thou lookest bold and resolute,
God bless thee dearest son.¹²

The ADAMS' letters continue back and forth for several months late in ABIGAIL's pregnancy during 1777. The dates on the letters show at least a two-week lag time (due to the delays in overland travel and the inconsistencies of wartime mail delivery). The same day that the baby is stillborn, John is writing about his fears that he hopes are not premonitory for his wife and their baby.

Tis now 48 Hours since I can say I really enjoyed any Ease. The Dr. encourages me to Hope that my apprehensions are groundless respecting what I wrote you yesterday, tho I cannot say I have had any reason to allter my mind. I pray Heaven that it may be soon or it seems to me I shall be worn out. (A. Adams to J. Adams, July 10, 1777)

And:

¹² Previously unpublished poem fragment c.1849 (in Ruderman, 2009 p. 152)

Three Times have I felt the most distressing Sympathy with my Partner, without being able to afford her any Kind of Solace, or Assistance. When the Family was sick of the Dissentery, and so many of our Friends died of it. When you all had the small Pox. And now I think I feel as anxious as ever—. (J. Adams, to A. Adams, July, 10, 1777)

Within days of ABIGAIL's letter to John about their baby's death, John is still writing in anticipation of happier news.

My apprehensions with regard to it were well founded...I was as perfectly sensible of its discease as I ever before was of its existance...I was also aware of the danger which awaited me; and which tho my suffering[s] were great thanks be to Heaven I have been supported through, and would silently submit to its dispensations in the loss of a sweet daughter; it appeard to be a very fine Babe, and as it never opened its Eyes in this world it lookd as tho they were only closed for sleep... (A. Adams to J. Adams, July 16, 1777)

And:

Before this reaches you, I hope you will be happy in the Embraces of a little female Beauty. God bless her. Pray let me continue to hear from you, every Week. When you cant write, make some other Pen do the Duty. (J. Adams to A. Adams, July, 20 1777)

When he finally receives the letters, JOHN is devastated.

Never in my whole Life, was my Heart affected with such Emotions and Sensations, as were this Day occasioned by your Letters of the 9. 10. 11. and 16 of July. I feel a Grief and Mortification, that is heightened tho it is not wholly

occasioned, by my Sympathy with the Mother. Is it not unaccountable, that one should feel so strong an Affection for an Infant, that one has never seen, nor shall see? Yet I must confess to you, the Loss of this sweet little Girl, has most tenderly and sensibly affected me. (J.Adams to A. Adams, July 28, 1777)

Public modern letters. The performance of these letters begins in the audience as one by one each of the actors stands up as they begin to speak. The first character is the FATHER, who had to terminate the pregnancy of his very much-wanted baby, writing to Marianne Williamson about her desire to create speed bumps for abortion during her campaign for Congress in 2014.

You said that you thought there should be at least three mandated meetings with strangers who would try to talk the woman out of her decision before that woman was allowed to continue with the medical procedure. My first question is this - did you ever think about the real world implications of this way of trying to prevent women from having abortions? Or did you consider how what you were saying would hurt real people and you said it anyway? (Graham-Caso, 2014, para 4)

The next character is the CLINIC ESCORT writing to legislators in 2014 about the need to maintain buffer zones to protect patients seeking medical care from harassment from anti-abortion protestors.

I am a human shield. I stand alongside patients so they can access their doctor's office safely, without threats or shaming. I have seen and heard things that would offend you, even terrify you, on your city's sidewalks. I volunteer gladly because accessing basic health care is a right in this country that I am willing to stand for

until it is fully realized. I do this work knowing that it is not my job. It is your job.
(Klabusich. 2014, para 1-3)

The CLINIC ESCORT was followed by the DOCTOR who, writing in response to the anti-abortion legislation in Texas that was filibustered (and eventually passed) in 2013, argued that legislators needed to stay out of exam rooms and leave medical decisions to those with medical training.

There must be only two people in our exam rooms: the patient and the doctor. Legislative mandates to the practice of medicine do not allow for the infinite array of exceptions where the mandate may be unnecessary, inappropriate, or even harmful to an individual patient...Patient autonomy as well as individual needs, values, and preferences must be respected. (Conry & Hollier, 2013, para 6)

The fourth modern letter character was the ACTIVIST, who represented reproductive justice advocates protesting The Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act (PRENDA) of 2011 before the House of Representatives.

While [PRENDA] purports to support gender equity and civil rights, it does neither. Instead, it discriminates against women of color and calls into question our ability to make decisions about our own bodies. ("Letter from the reproductive justice community," 2011, para 2)

The fifth and final character was the MINISTER, representing a coalition of religious leaders, who addressed other religious leaders to consider abortion as moral choice.

The ability to choose an abortion should not be compromised by economic, educational, class or marital status, age, race, geographic location, or inadequate

information...Current measures that limit women's access to abortion services—by denying public funds for low-income women; coercing parental consent and notification; and banning medical procedures—are punitive and do nothing to promote moral decision-making. (“An open letter to religious leaders,” 2005, para 9)

ABIGAIL breaks the fourth wall of time that divides the historic and modern letters by addressing the five characters as they cross onto the stage, and at several other points throughout the play, with the line, “I desire you to Remember the Ladies.” During the rest of the play, the characters from the historic letters remain frozen while the modern letter performers address the audience and vice versa. The only other break in this pattern is when the CLINIC ESCORT collects the letters ABIGAIL has been writing to John about the death of their baby and delivers them to JOHN. The play ends with the modern letters cast returning to the audience and signing off, with JOHN and ABIGAIL, TENNYSON, and the FATHER placing keepsake objects on the memorial.

ABIGAIL

I desire you would remember

JOHN

This sweet little girl

A FATHER

Our family

TENNYSON

'Tis better to have loved and lost

*Than never to have loved at all.*¹³

ABIGAIL

I desire you would...

ALL MODERN/HISTORIC CAST:

...Remember

The lights come up and the audience has a brief 10-minute intermission during which they mingle through the space, get something to drink, and take a bathroom break. The cast and crew reset the stage by removing all the furniture and blocks. A rack of costumes, including a rainbow-colored tie-dyed shirt, a long black feather boa, a bright blue and white shirt, and nine pairs of different shoes are arranged on the stage platform. To the stage left side of the platform is a short stool and a table with a mirror, jewelry, and hair clips on top. A short black loveseat and ottoman are set down stage left, and a black-backed stool and high music stand are placed stage right. A small black chair is downstage center in front of the memorial, which remains lit. The program explains that the second act contains excerpts from the longer play *“No One Ever Told Me”*:

Testimonies of Stillbirth, Abortion and Ending a Wanted Pregnancy. It features stories of abortion from ANDI, DIANA, and SONYA; termination of a wanted pregnancy from LENA; and miscarriage and stillbirth from SANJANA, BRANDY, TEE, and RAVEN.

“No One Ever Told Me”: Testimonies of Stillbirth, Abortion and Ending a Wanted Pregnancy

Friday night’s program insert announces the full-length, one-woman performance of a solo ethnodrama based on interviews of women whose pregnancies had ended. The

¹³ Tennyson’s “In Memoriam” 1849

performance begins with SUZANNE directly addressing the audience about the moment when she discovered that she was pregnant as a single 35-year-old woman and faced the decision about whether or not to have an abortion. In marshaling her resources (including the more than half a dozen people who showed up in her kitchen after she found out), one of her friends told her that she had had an abortion.

The lights dim and SUZANNE crosses upstage and begins a costume change with soft piano music playing in the background. She puts on a blue fleece jacket, sits on a small stool at a waist-high table with a mirror on it, and slides on a headband. She leans over and pulls an ace bandage over her ankle and slips on athletic shoes. During this costume change, her physicality shifts, and her movements seem careful and measured. She stands and, as she crosses to the small chair downstage center, the lights shift. SUZANNE picks up a black binder on the chair and sits as ANDI. Her story comes soft-spoken and tentative, as if it is hard to recollect the specific details. It is 1985, and she is a teacher in Kansas. She drives to an abortion clinic with a friend after she finds out she has gotten pregnant by a man she loves, who is married.

And there was a former high school student of my mine, and she took class at my dance studio. She was there with her 2-year old daughter. And she was one of the protestors, and I went, "Ooh my gosh, I can't do this."

After the procedure, ANDI says that the staff and Dr. Tiller¹⁴ were kind and that the nurse said that her crying was a healthy response. ANDI is at peace with her decision because she did not ever want to be a mom. She says much of her lingering feelings were about the married man that she still loved but could never be with.

¹⁴ Dr. Tiller, the Kansas abortion provider, was shot and killed by an anti-abortion protestor while attending Sunday morning service at his Church.

So that next week in our, um, hometown newspaper, there was this big, full-page, pro-life, anti-abortion thing and all of these people signed it, and he and his wife had signed it. And that was like the next week.

They reconcile years later and she forgives him for the lack of support. She still rarely talks about the abortion and has never told her parents.

For me, abortion is a sacred decision, and it's not a flippant thing, you know. It was very conscious and thoughtful and emo-tion-al. When I hear really strong anti-abortion sentiment, I think, you know, that you don't know the whole story.

ANDI crosses to the memorial and places a small blue bundle near the abortion sign and then crosses to the upstage platform and begins to change clothes. (This pattern continues throughout the play, as the changing of a shirt, hairstyle, and jewelry for each character, while the physicality shifts into another persona.)

Now wearing a long black feather duster, a flower clip in her hair, and black sparkly flip flops, SUZANNE morphs into DIANA. Her body moves fluidly to the stage left loveseat, sits, and leans back while crossing her legs languidly. DIANA is garrulous, and her stories roll off her tongue with ease. She is blunt and at times brash, yet her voice is smooth and soft. She tells of how she gets pregnant at 17 in the 1960s, and her mother sends her to a home for "wayward girls." She tries to keep the baby.

It's a lot of work to have a baby. It's not easy. I was 17, you know. I wanted to go out with my friends, and I couldn't. They didn't have these little car seat thingies that—I used to hitch hike around with her, and this huge bloody fucking bassinet, you know?

After an incident in which she comes close to hurting her baby out of frustration, she decides to give the baby up for adoption.

I realized I have nothing to offer this child. Had a high school education. Didn't have a job. I'd have to live with my mom. I could see her just taking the child and raising it, even though I was there. Part of me has always known I would never make a good mother. Part of me was really sad because I wanted to keep the baby. But the biggest part of me knew giving her up was the right thing to do, you know.

When her mother finds out, she kicks DIANA out of the house. She becomes an exotic dancer and talks about the three miscarriages she had with her first husband. She describes the differences in attitude and care between the two abortions in different countries she has in her subsequent relationships. In looking back, she says the hardest to deal with was the adoption because of the long-term effects it had on her.

I think I kept that probably more of a secret, because it was mine (*coming to tears*). It wasn't so much a shameful secret, but it was...an accomplishment, and it was mine. Sometimes I would have fantasies, like what it would have been like if I had kept her. I would be like a single mom, and we'd be besties, that type of thing, ya know. I had one picture that I kept for a really long time.

DIANA says she's tried to forget, but the experience changed her. She brightens when she says she had heard the fetal cells linger inside the mother for years regardless of how the pregnancies end.

That's pretty cool. It means I have all my children with me. There's something about that that makes me really happy, in that sad kind of way. To know that there's part of them with me.

She crosses to the memorial and places a small photo next to the adoption sign and then crosses to the upstage platform. The flip-flops and floor-length duster come off and are replaced with a brown linen shirt, hair twisted up in a hair clip, silver earrings, silver bangles on both arms, and brown sling-back flats.

SONYA crosses gracefully, head high, to the high-backed stool downstage left, places the binder on the music stand, and sits, crossing her legs and arms in her lap. She speaks softly with a Farsi accent. She talks about getting pregnant with her boyfriend at the time and the harsh legal and religious consequences for women who get pregnant outside of marriage in Iran. But because her boyfriend was rich, he was able to get her into a hospital to see a doctor.

The doctor exam me, and then he proscribed some kind of fake kind disease in the fetus, and then we could go with that prescription to hospital to do cuttrage.

Because it was coordinated and managed by that doctor and they didn't ask anything....And em, I wasn't very sad about that maybe because I had this kind of support from my boyfriend and also because we were going to marry.

But they do not wind up marrying and break up. SONYA gets pregnant with another man and while the father was supportive, they do not have money. The clinic she goes to feels unsafe, and she worries about the police coming in and arresting her and the doctor. But the abortion gives her back a different kind of safety.

That abortion give me feeling of safety in terms of going back to society and back to family. I didn't love this boyfriend, and I didn't see any future for myself....But in other way, it kind of like why I should do that? Why nothing happen to him? Just to happen to me?

When SONYA gets pregnant a third time with another man, he calls her nasty names and abandons her. Despite the situation she is in, she struggles with wanting to keep a baby that she cannot have, because of the laws that govern her body, and has no means to leave and raise it somewhere else. After the third abortion, SONYA worries that she cannot have more children. "I never been to any kind of examination to see how my body is. I dink I may have lost dis chance, and I don't want to find out." She agonizes over being a feminist and supporting women's rights with her feelings against abortion, informed by her personal experiences.

Being a feminist you think you can do many things in your life, but it's not always that way. I was so strong resisting my family resisting my society. But you can't deal with all these barriers...I couldn't do anything in my personal or private life. Abortion is not private. It's very public, a very public issue.

After crossing to place a stone on the memorial, SONYA crosses upstage and takes down her hair, takes off the jewelry. SUZANNE changes into a bright blue and white shirt and brown sandals and becomes LENA, who begins talking energetically as soon as her shoes are on. She bounces quickly of the riser and crosses to the audience. She swears and laughs with ease. She and her husband are at a 17-week ultrasound and find out that their wanted baby has severe brain damage.

So I'm laying there...you know tears coming down my face... the tech is silent...and the perinate is asking my husband where he did his residency and who they knew... And I didn't know who I wanted to kill more, the perinatologist or my husband for chatting when we just received news that there is something's wrong with our baby's brain ... But I didn't have a voice. And I felt myself becoming more and more angry and I couldn't find words....

They do intensive research—which was difficult to do as it was hard to find any information on their situation before the age of the Internet—and more tests. They discover that their baby has a rare genetic disease and little chance to make it through the pregnancy, let alone survive birth. They decide to terminate the pregnancy. At 19 weeks, LENA meets with the only doctor in the area who can perform the procedure.

He was so sweet, he said, “I’m really sorry this has happened to you.” He pulled out this big box of photos of babies. He said, “These are all babies of people who have been in your chair, and they went on and had healthy babies.” He knew that this was a very wanted baby and how painful it is. It gave me hope. At the same time, to see pictures of babies and to realize I would never know what he was gonna look like. *[Pause]* I wanted to run away. I just wanted to move on and be able to come back and give him a picture of a baby. *[Chuckles]*

After the procedure, during which LENA cried profusely and experienced rage, deep sadness, and vulnerability, she says she wanted everyone at the hospital to know hers was a wanted baby.

I went to a support group for people who had terminated a wanted pregnancy. Some of my best friends I met through that group. It was so reassuring that it

wasn't some bizarre, rare thing. It gave me this safe place to really talk openly about all of the details of what had happened. I knew he was alive inside me, that I was giving him life, and that if he was out, he wouldn't survive. I don't struggle with that.

But I'm in this invisible group. We're not even talked about. I didn't choose to be carrying a baby, with... I wasn't notified until I was almost 18 weeks. Fetal development dictates when you learn about certain things. To make laws that are blanket, when all of these circumstances are so unique, makes no sense.

As LENA crosses upstage with a brochure for a public memorial event she does every year called the Walk to Remember year as part of the work she does counseling parents whose babies have died. As she places the brochure on the memorial altar, she talks about the power sharing stories has for bereaved parents.

Every time I talk with patients in the hospital that have losses, I say, "I want to thank you because now I will take into my heart your baby and your story and integrate it with mine." I hope sharing my story will allow other people to find words and the courage to share their story, whatever it is.

The first act ends. The second act begins with SUZANNE talking with the audience again and explaining how the father begged her to have an abortion. "You're a feminist. Your okay with ending it, right?" She decides to have the baby, but when she was six-months pregnant, the baby's heart stopped beating.

Again, I marshaled my resources, and in an hour, there were a dozen people in my living room to support me through what was going to happen next, including the

doula of a friend who had had a full-term stillbirth whose story I had never wanted to hear.

She crosses upstage, slides back her hair with a headband, pulls a flower-print shirt over her head, and slips black flats onto bare feet. SANJANA crosses with quick short steps to the downstage center chair and begins talking in an East Indian accent. She describes the three miscarriages she had back to back.

The doctor came back and she said that there's no heartbeat. You see that the baby has stopped growing in the sixth week and that you might have to go for a DNC and she also told me that this happens quite often in the first pregnancy. I felt bad. That was my first visit to a gynecologist in my life...I came out and I saw all the pregnant women outside...I was really shattered.

She says that the miscarriages will make her a better mother than if the pregnancies had come easy. The loss also strengthened their marriage.

My husband was there through the whole process. And it really strengthened my marriage. All the vows that my husband said, I think this was the time he proved it. I saw a friend, a brother, a father in my husband during this process.

SANJANA says that she kept most of the emotional pain of the losses from her family members because she did not want to burden them or to add to their own suffering by having them worry about her. She says that this is the first time she has ever told her story. "If this story helps someone, inspires someone, I'll feel that my baby has been honored. It has done its part. So I'll feel good about it."

She crosses to the memorial and places an ultrasound image next to the miscarriage sign and returns to the upstage riser. The headband comes off and the

flowered print shirt and flats are replaced by a black and white paisley empire-waisted shirt, large silver hoop earrings and black heels. BRANDY saunters over stage right and puts the binder on the music stand and sits sideways on the stool, with her arm propped up on its back. She talks in a thick New York accent about telling her friends immediately that she was pregnant. Later in the pregnancy, she visits the hospital multiple times because she senses the baby is not moving like it normally does.

My husband and I go to the labor and delivery unit. She immediately kicks the monitor. The nurse practitioner says— “Oh, these children’ll make liars outta you.” I felt very embarrassed because I knew what I felt. But as a first-time mom, I didn’t know the difference between a kick, a twirl, a tumble, a hiccup.

The third time she returns to the hospital, the baby is dead. She asks if they should have an emergency C-section. The provider says, “We can’t risk your life for a dead fetus.” BRANDY snaps back, “A dead fetus? (*angrily*) It’s my daughter. It’s not a dead fetus. She has a name—Jayden Sage.” She talks about how people may not understand the depth of this kind of loss unless it happens to them,

I went to church, and this woman told us, “Oh, she was good, but God’s gonna give you the best.” You know that it’s coming from a good place....I think that’s why sometimes people can’t really identify, because they feel like you didn’t have anything with your baby. Yes, I did. I saw our life together. I knew what we would wear. I knew where we would live. I could see our whole life and the love I would give.

At the end of her story, BRANDY takes a rhinestone-studded cat with “Jayden Sage” in glitter across the front and places it at the memorial near the stillbirth sign. She

returns to the riser and exchanges her shirt and shoes for a pink top and grey loafers. She pulls her hair back into a tight bun.

TEE walks stiffly down stage left, head down and arms crossed across her chest. She perches on the edge of the ottoman and looks down, rarely making eye contact with the audience. Her voice is tight and has a slight Northern California lilt and a barely perceptible Mexican accent. She recounts how she noticed that Thumper, her nickname for the baby who always kicked hard and regularly, was not moving very much around 27 weeks. She was very worried and tried to convince herself the baby was being lazy. She eventually goes to the doctor and finds out the baby has died.

She says that through the next few days, her family cries uncontrollably. She is in a daze, and tears are slipping down her face. After then the C-section she has to have because she has placenta previa, she feels so drugged that she cannot hold the baby the way she wants to and she cannot control her body.

The thing I wanted most was to lay her on my chest and to kiss her face and kiss her lips. And I couldn't do it...I remember trying to pull her blanket back and I couldn't. And my husband is asking me, "what are you trying to do?" and I said (*intense crying*) "I wanted to see her hands, I wanted to see her feet." They pulled out her hands and her feet for me. I just wanted her to hold my hand.

She says she kept coming in and out because of the morphine. She is crying with a desperation when she says, "I can't remember saying goodbye. I don't know when my baby left. I don't remember saying goodbye to her."

TEE "shows" us a tattoo she got of Thumper (the Disney character) on her arm and how seeing rabbits reminds her of her daughter, Belle. She stopped going to the

support group before the one-year anniversary of her birth because her husband decided he does not want any more than the three kids they already have. She places a stuffed bunny on the memorial near the stillbirth sign. “She's not just a faint memory I'm going to get over. You don't get over this. For me, it's learning how to move forward without leaving her behind.”

She becomes RAVEN as she crosses onto the riser, pulls down her hair, and takes off her pink shirt. She slips on a rainbow tie-dyed, long-sleeve shirt, blue ribbon bracelet, and Teva sandals. She begins talking matter-of-factly as she steps off the riser with her head tilted and chin lifted. RAVEN does not sit right away and leans on one leg when she stops to talk near the memorial. She explains that her baby was stillborn during a home birth, and it was a supportive experience. Her story focuses mostly on her life after her stillbirth.

In some ways, that's the hardest thing to do, to have to tell someone who'd seen me pregnant. It was like, I don't want to tell you this devastating news. You're gonna have a whole process, and I'm gonna have to fucking take care of you while you go through this process and feel awful about it *[laughter]* and I have to add how bad you feel about it on top of how bad I feel about it.

RAVEN says that at the time she was a hard-core environmental activist and that the support of her community was instrumental to her wellbeing.

But our friends were great. They organized to pay our rent for a month. People brought food every day. It was just like this community of people that had my back, had our back. It was incredible and really helpful for our long-term emotional health...We built an altar, and we had elements there, but also all the

stuff that people had given us. I still have his ashes. I mean, the ashes for a baby are not very big.

RAVEN feels a strong kinship to “kinship with women who have lost their children to miscarriage, stillbirth, disease, war, poverty.” She talks about how her grief cracked her open.

Just realizing any person I cross on the street could be carrying grief, and I would never know it. Even if they are assholes or I don't agree with them...there's just more of a tolerance of people. Grief is such a universal human experience, like anyone can suffer, anyone can go through a loss that seems unbearable. I think that something about the various systems that we live under now push people to turn grief into anger and rage and hatred, but I think that the more natural impulse is to connect over it.

She talks about how she feels she is a much more compassionate person these 15 years later and a better parent to her subsequent daughter because of Misha's death. “And feeling like if Misha hadn't died, I wouldn't have Natalie.” RAVEN ends her story by talking about the agreement someone makes if they decide to become pregnant.

It's like, if you get pregnant, by agreeing with yourself and the world to go forward and have the baby, you're also risking this loss. You can't just say women who get pregnant should just have the baby and give it up for adoption. It's not a light thing to get pregnant, your body changes, your entire life changes, whether you keep the baby, even whether the baby lives, like it's a huge fucking deal.

I actually want a world where everyone who wants to have a child can have a child. And that requires economic justice and racial justice. It's not justice if it's only that you can choose not to. You have to be able to choose to as well. And that means access to health care and food and adequate resources to raise a wanted child. I think every woman should be able to decide if she is going to have children, when she's going to have children, how many or to not have any at all. Those choices should be available to every woman.

RAVEN takes off the blue ribbon bracelet and puts it next to the stillbirth sign and crosses to the riser for the final time. She removes the tie-dyed shirt and tevas, and SUZANNE crosses downstage center to address the audience.

Over the last nine years since my son Avery died, I lobbied Congress three times to pass legislation to prevent stillbirth, and I have come up against the politics of reproduction and get asked, "Is this about abortion?" "Is this a pro-life thing?"

So I marshaled my resources (*gesturing to the spaces previously occupied by previous characters*) to try to imagine a future where I can believe that my baby was a life—that mattered to me—and still believe that I have the right to choose whether I end a pregnancy or continue it. Whether I grieve or am grateful. How I say goodbye and how I remember.

Part Two: Backstage Preparations

One of the explicit research goals of this dissertation was to put testimonies of diverse experiences of pregnancy ending in conversation with each other to discover what might be learned. But an explicit goal of the performance project was to discover what might be achieved by putting different styles and modes of performance of pregnancy-

ending testimony in conversation with each other. A rationale for the selection of the letters and ethnographic interviews for inclusion the play scripts is addressed in this section.

The Ensemble Letters Play

The impetus to interweave modern open letters in support of abortion access and reproductive justice that circulate in various spaces on the Internet was motivated by Abigail's famous line in the letter to her husband, John Adams, while he was drafting the constitution: "I desire you would Remember the Ladies." The majority of the letters selected were written between 2011-2014 during the largest increase in anti-abortion legislation since *Roe v Wade* and the resulting restrictions on women's bodily autonomy. That Abigail was concerned with the same legal constraints on women in her day foreshadows the importance of the equality she sought to enshrine in the guiding document of this country. As no such provision was included, its absence necessitated the (failed) push for the Equal Rights Amendment (ERA) in both 1923 and 1972.

That your Sex are Naturally Tyrannical is a Truth so thoroughly established as to admit of no dispute. Why then, not put it out of the power of the vicious and the Lawless to use us with cruelty and indignity. Men of Sense abhor those customs which treat us only as the vassals of your Sex.... I have sometimes been ready to think that the passion for Liberty cannot be Equally Strong in the Breasts of those who have been accustomed to deprive their fellow Creatures of theirs. I am certain that it is not founded upon that generous and christian principal of doing to others as we would that others should do unto us. (Abigail Adams, March 31, 1776)

Her unanswered call to “remember the ladies” becomes a recurring device throughout the ensemble play to connect the historic letters of Tennyson and John and Abigail Adams with the modern day ones in support of reproductive justice.

My first encounter with Abigail’s “remember the ladies” letter was during the crafting of an interactive Chautauqua performance on suffrage in honor of the 75th anniversary of the 19th Amendment granting women suffrage. The exchanges between them, preserved in digital archives and historical records, demonstrated John Adam’s value in his wife’s opinion. Rereading them for this play was a reminder that nowhere in the modern day document, which hangs in every classroom on ASU’s campus, is there evidence that Abigail’s pleas convinced him or his compatriots to redress the balance of women’s equality in our country’s founding document.

As part of the Chautauqua performance, I had researched more than 75 women and men involved in the suffrage movement. In the years before Google, scanning microfiche and library reserve room archives, pouring over primary source documents and historical timelines, and skimming childbirth announcements while searching for comments about working to achieve the vote was intensive training in searching for a needle in a haystack. Anything that did not have relevance to suffrage (the needle) was tossed aside as hay. But as I began to work on this stillbirth testimony project, dates and footnotes that had been pushed aside like flotsam began to resurface; tidbits from timelines and biographies bubbled into my mind that would footnote the death of a baby or a miscarriage. One such tidbit was a reference in a letter archive that Elizabeth Cady Stanton, one of leaders of the early suffrage movement in the 1800s, had had a late miscarriage not long after the first Women’s Rights Convention in Seneca Falls. Matilda

Joslyn Gage, another suffrage movement leader and a contemporary of Stanton's, had a baby die in infancy. And Lucy Stone, yet another suffragist leader, had a miscarried a boy. There were more, to be sure, but even with Google, references to these deaths are obscure and hard to find.

But it was an Internet search into these references and others that resulted in (my) discovery of the pregnancy losses and infant deaths of several of our country's founding mothers. Abigail Adams and her husband spent years separated before the revolution and during the Constitutional Conventions. History recorded their daughter's full-term stillbirth in 1777 in their own carefully crafted words. Martha Jefferson had a child die at less than two weeks old the same year, a death that had been preceded by another miscarriage in 1776. She, herself, was believed to have died from complications from giving birth. Two of the four children born to Martha Washington died before the age of five. The pregnancies, births, and deaths of the offspring of these founding couples are not commonly known facts on which the history of this country rests. But there is no doubt that bereaved parents gave birth to our nation. As childbearing and childrearing were considered both woman's chief occupation and the reason she was ascribed to the private spaces of the home, pregnancy and its failing seemed similarly constrained.

The Adams' letters were private, written between a husband and a wife and were intended to have an audience of one. The letters, on more than one occasion, reference fear that their content might fall into the hands of "unfeeling ruffians" and thereby contained implicit cautions against emotional responses and too much detail.

It seemed somehow important that their experience of love and loss over the death of their daughter be foregrounded in the performance being crafted for this dissertation.

Initially the focus was to be on the performance of stillbirth and abortion narratives and to discover how the interview, transcription, editing, staging process, and performance might be a part of the act of testimony and how contemporary testimonies might speak to each other. After reading the Adams' correspondence, the vision of the performance expanded into a project that sought to discover what might be discovered when historical letters, when considered as testimony, might speak to modern-day testimonies of issues that are still relevant to contemporary audiences.

Given the legislative climate surrounding pregnant, or potentially pregnant, women's bodies, "I desire you would Remember the Ladies..." seems to be as relevant a political charge today as it was when Abigail wrote it. Abigail referenced women's legal or political plight, as the law considered them property of their fathers or their husbands. She noticed the irony in men's fight against tyranny and desire for self-determination when men had a predisposition to "deprive their fellow creatures of theirs."

... If perticular care and attention is not paid to the Laidies we are determined to foment a Rebellion, and will not hold ourselves bound by any Laws in which we have no voice, or Representation. (Abigail Adams to John Adams, March 31, 1776).

In her letter, I read the plea for freedom and autonomy over her body. But the social mores of the day prevented her from speaking these demands in public spaces. Women were often told that they need not seek public spaces, as they were the real rulers of the private domain and, as such, exerted power over their husbands in that way. John Adams provides evidence of this age-old rebuttal to women's desire for a voice:

... We know better than to repeal our masculine systems. Although they are in full force, you know they are little more than theory. We dare not exert our power in its full latitude. We are obliged to go fair and softly, and, in practice, you know we are the subjects. We have only the name of masters, and rather than give up this, which would completely subject us to the despotism of the petticoat, I hope General Washington and all our brave heroes would fight. (John Adams to Abigail Adams, April 14, 1776)

Letters of public figures help give a particular insight into the private dynamics, desires, and dimensions of decision making. But the purpose of letter was not always meant as a solely private exchange. Letter writing, prior to technological modes of information transmission, was often the primary means of collaboration and communication between suffrage movement leaders like Stanton, Stone, Gage and Susan B. Anthony. Their letters document the strategy discussions and planning work over long distances and across state borders at a time when travel was costly and impractical for married women with small children.

Palczewski (1996) similarly describes the importance of the letter in building and maintaining community for Gloria Anzaldua and fellow Chicana activists. Palczewski (1996) notes that “the letter represents a means to maintain connections and ties, to maintain community over distance and time. In fact, the letter enacts community by recognizing, naming, and paying homage to her community members throughout the letter” (p. 4). Vonnegut (1991, as cited in Palczewski, 1996) explains that historically the letter has also been a way for women, specifically white women, to make public arguments while remaining in the private sphere. “Given that letter writing was deemed

acceptable and appropriate for women, it is understandable that the form was used as a rhetorical adaptation to the exclusion of women from the public podium,” (Palczewski, 1996, p. 3).

Letters from prominent abolitionists and suffragists appeared as regular features in movement newspapers as means of updating readers of the work done in the field, opinions on proposed legislation, comments from politicians, or as reports from the lyceum circuit. Letters were addressed to legislators, party platform organizers, and newspaper editors often in rebuttal to public arguments or as advocacy for suffrage policies. This open letter format continues to be used in modern social movements, including reproductive justice.

In searching for the letters for to be used in the performance, I wanted to find diverse voices that addressed institutions of power and that held sway in making decisions that affected women’s reproductive health. I found several letters addressing legislators and other political figures from religious leaders, parents, and advocates. The following letter is from a pair of leaders at the American College of Obstetricians and Gynecologists (ACOG) who address Texas state legislators about the same bill Texas state senator Wendy Davis had filibustered. Conry and Hollier (2013) wrote:

Women across this nation are completely capable of making their own medical decisions with their physicians, as they make many other important decisions every day for themselves, their families, and their businesses. Women do not need—or want—any government to make medical decisions for them. (para 9)

In the letter from the abortion clinic escort to legislators about the need for clinic buffer zones due to escalating harassment patients experience outside women’s health

care clinics:

The AHA picketers go beyond the typical "Don't kill your baby!" and "No, mommy, don't do it!" reported by volunteers around the country. Personal slurs are leveled against escorts from inches behind them by physically imposing men. Picketers demand that companions "Be a man, dad!" and go back inside to "Save your child!" I watched them relentlessly chase after a husband that had tearfully confessed to them the story of his wife's non-viable, but very much wanted pregnancy. (Klabusich, 2014, para 25)

In the letter from the bereaved father, in a situation similar to the father mentioned above, he questioned the reasoning of a legislative candidate who was advocating for “speed bumps” for abortion access:

You see, after the late discovery of my son's malignant brain tumor, and the tests we went through to be sure, and the retests we did to be absolutely sure, and the appointments and sleepless nights and unbelievable grief, we were nearing 24 weeks by the time my wife had the procedure. If we had to wait any longer, she would have been too far along to safely go through with the abortion that we decided was the most humane thing we could do for our son. Your delay would have worked and our government would have prevented us from making the decision we know in our hearts was right for our family. (Graham-Caso, 2014, para 5)

There was even a letter to religious leaders advocating abortion as a moral choice from a coalition of religious groups in support of reproductive justice:

We affirm women as moral agents who have the capacity, right, and responsibility to make the decision as to whether or not abortion is justified in their specific circumstances. That decision is best made when it includes a well- informed conscience, serious reflection, insights from her faith and values, and consultation with a caring partner, family members, and spiritual counselor. Men have a moral obligation to acknowledge and support women's decision-making. (“An open letter to religious leaders,” 2005, para 4)

The letter goes on to say,

Religious traditions have different beliefs on the value of fetal life, often according greater value as fetal development progresses. Science, medicine, law, and philosophy contribute to this understanding. However, we uphold the teaching of many religious traditions: the health and life of the woman must take precedence over the life of the fetus. (“An open letter to religious leaders,” 2005, para 6)

Echoes of these same demands continue to circulate through Facebook and Twitter calling for reproductive justice in other open letters. A woman’s physical autonomy, especially concerning reproduction, was not enshrined by the founding fathers. Her legal equality failed to be secured by the passage of the ERA, and the privacy of and access to reproductive choices has not been protected by *Roe v. Wade*. In the modern day letters for reproductive justice, Abigail’s call to arms is still in need of redress.

While the content of the private letters is intriguing, it is the testimonial implications in the different orientation of the letters’ address that is also of interest. When crafted as a private letter between two individuals, without the invocation of

another audience, the letter remains largely an interpersonal exchange. But once a private missive becomes a public, whether intended by its author or not, the letter acts as testimony to a broader audience about the experience of the writer. The letter becomes evidence of the writer's point of view, of their story, and of their interpretation of events. Alfred, Lord Tennyson had chosen such a form to announce the stillbirth of his son in 1862 to more than 60 friends and family, rather than have it appear in the papers in order to maintain his family's privacy.

The open letter style, like that of the letters mentioned previously, was also intriguing to me as a possible text to adapt to the stage. The open letter uses a private mode of address, is directed to a specific recipient, and yet broadcasts the message through public channels and imagines other audiences as reading its message as well. It intentionally subverts the constraints of privacy in order to draw witnesses to the exchange.

How might these two rhetorical forms, the private historical correspondence and the open letter, speak to each other on stage about the mode of address and about the concerns of reproductive justice? How might the weaving of these letters, some closely connected with the crafting of our Constitution, help us to understand the historical and modern experiences of pregnancy ending as both a private matter and a public concern?

The rationale included with the script given to the actors stated:

The stillbirth letters used in this script are between President John Quincy Adams and his wife Abigail Adams while he was away at the Continental Congress and the start of the Revolution, as well the letters and poems of Alfred, Lord Tennyson.

The open letters in support of abortion access are from a father, a clinic escort, the American College of Obstetricians and Gynecologists (ACOG), a reproductive justice activist, and the Religious Institute (a coalition of pro-choice religious institutions).

This ethnographic performance seeks to challenge the notions of public and private discourse surrounding the ending of a pregnancy by juxtaposing the private letters of public figures experiencing the stillbirth of a wanted baby with the public letters, using a private direct address, from pro-abortion stakeholders to state or religious institutions with the power to influence state and moral discourse surrounding the termination of an unwanted pregnancy.

The Solo Performance Ethnography

My performance background—the four years as an oral interpreter in Forensics as an undergrad, the time spent as an actor on small stages in San Francisco, the decades as a Chautauqua performer, and the countless workshops and classes in the improvisational somatic movement work of Body Tales—has shaped my current approach to performance ethnography. It has informed the choice to feature lived experience over fictional work, the presence of the script text as a physical part of the performance, the desire to connect with the audience motivating staging choices, and the selection of material that requires deep emotional engagement that foregrounds bodies on the line.

During my master's project (Pullen, 2010), *He Was Still Born*, a one-act autoethnography of my son's stillbirth, I re-engaged my profound grief and bittersweet joy as the parent of a stillborn child. I shared my rage and fury and frustration immediately and openly, without artifice. Re-engagement re-members the "then me" —

the feelings tangible, visceral, and accessible—but does not crush the “now me” under the power of those feelings. Re-engagement is like riding the barrel of a maverick wave using the skill of a surfer to navigate it without wiping out. I retold my own story by tapping into my own somatic and sensate memories of the feelings I experienced and allowing my body to re-engage those moments of pain or joy. Re-engagement allows the performer to become a vehicle through which the authentic emotion flows.

For my master’s performance project, I re-engaged my own stillbirth experience so that non-bereaved health professionals, community members, and potential parents could have access to what it felt like in order that they might feel an investment in improving them. I wanted “to open the space between analysis and action...and to pull the pin on the binary opposition between theory and practice” in order to focus on the intimacy of “knowing how” and “knowing who” rather than the distance of “knowing that” and “knowing about,” (Conquergood, 2002, p. 145–146). Re-engagement privileges subjugated knowledges (Foucault, 1980) and a view from the body (Haraway, 1991). In one scene in the play I re-engaged a moment of violent grieving:

I am kneeling on the floor digging furiously at an imaginary pit of beach sand. I am screaming my fury into a dark night where nothing seems important but my rage. I look up and see the metal chairs on deep grey carpet and the tear-filled eyes of a watching audience caught with me in my moment on the beach.

In this moment, I know this is scholarship. I believe it in a way that I have never allowed myself to trust in before, that performance is academic scholarship and can do what no paper, no study, and no essay could: navigate and engage emotional experience in a space of learning, feeling, and understanding. I am

embodying a prior experience for the purpose of inviting the audience to risk “feeling” that loss along with me. They are with me on the journey, feeling a moment they will hopefully never know for themselves. I can feel the mutuality of our grief as they are both witness and participant. (Pullen, 2010)

It is the performance moment that can help create the liminal space to explore the transformational possibilities of stillbirth storytelling in a way that no other act of scholarship can. Synder-Young (2013) maintains that, "kinesthetic knowledge, experienced in the gut, can provide the possibility of radical transformation—of real changes of perspective and real shifts in understanding" (as cited in Cavanagh, 2013, p. 287). When a performer puts her body on the line, she brings her attendant senses, experiences, and connective potential. Her presence invites, and may even compel (or repel), the audience’s bodies to join in the experience she is engaging on stage. “Whatever the reasons,” explains Gómez-Peña (2004), “the fact is that no actor, robot, or virtual avatar can replace the singular spectacle of the performance artist’s body-in-action” (p. 79).

Re-engagement allows the performer to return to the feeling time and again in order to pull back the curtain that separates what s/he “knows” and what the other has not yet experienced. This level of re-embodiment facilitates the liminality that allows transformation to occur. As the re-engaging performer listens to her body, re-experiences her body as site of knowledge, and uses her body as a channel for energy, connection, and awareness, she builds a bridge between her and her audience.

The purpose of both the text and the act of performing the text is to engross the audience fully, so that performer and listener meet in the liminal space between them

(Smith & Gallo, 2007). It is this potential for the audience to be affected by what it sees and hears that can motivate them to “act and think in ways that now beneficially affect (directly and indirectly) either the subjects themselves or what they advocate,” (Madison, 2005, p. 174). It is in this liminality that the hierarchy of knowledge shifts from the mental and the rational to the sensual and somatic (bodily) experiences.

It is the creation of this liminal space through re-engagement, where audience and performer can stand together in the same moment (Denzin, 2003) in affirmative aesthetic of unification (Alexander, 2000), when/where the audience resonates and engages with the performance and performer and the performer does the same with the audience. Alexander (2000) explains that:

In this relational dynamic, the audience members, as feeling, thinking, critical beings, enter the performative arena with a sense of self, a respect for other, and an appreciation for the aesthetic act. Autobiographical performance links the performer and the audience in a larger socio-political context of sharing and shaping meaning. (p. 103)

Miller and Taylor (2006) explain that testimonial performances invite audience members to draw connections to their own lived experiences and that the performance can function “as a frame within which audience members view their own experiences” (p. 177).

Ultimately, I chose to study the stillbirth experience of others using performance as a method because I believe that it has the most potential to explore and prioritize the emotive experience of the body. So much of what happens in the hospital and the weeks, months, and years after a parent must say goodbye to a child has been hidden from view. The extent of the grief is not commonly understood, and no real cultural references guide

parents through the experience. But the death of their child at once spoils their identity (Goffman, 1963) and creates a whole new one. Stillbirth parents experience much of their cultural identity as bereaved parents secretly and in silence. We often say we belong to a secret club for which we all paid a very high price to gain access. To outsiders in the larger world, the details of our loss do not seem to matter, and yet our experience marks us as different than those who have not had one.

The solo ethnographic performance applies this concept of re-embodiment to see how I might be able to use my ability to re-engage emotive experiences during the interviews with participants order to bring performance ethnography of others closer to a testimonial performance. Testimony is attached to the body of experience. Can I use the skills as a performer to re-engage my sensate and empathic experience of their testimony (during the interview) and re-embody the interviewee as I remember them? Is it possible that this form can bring the audience closer to the testimony of a person who is not present to tell it?

Of the 10 women who were interviewed for the performance ethnography, eight were featured in the creation of the performance text. They were of diverse ethnic, national, economic, religious, and educational backgrounds. Three characters had aborted either one or multiple unwanted pregnancies. Two of them had not wanted to be parents and had no regrets about ending the pregnancy. The other expressed a desire to keep the pregnancy, but due to political and religious circumstances was unable. One character terminated a wanted pregnancy due to an anomaly and also experienced a miscarriage. One character had three miscarriages, and three characters experienced stillbirth. In

addition, one of the characters who had had an abortion had also given her first baby up for adoption and had two miscarriages and two abortions.

The initial goal was to create a one-act performance under an hour giving each character 5–7 minutes. But the richness of the narrative and unique voices of the individual experiences made it difficult to capture the layers, range of emotions, and diversity of experience with less than 9–12 minutes. Two scripts were then created: a full-length, two-act play that would allow for a fuller narrative arc and emotional journey and a second, shorter, one-act play highlighting essential elements unique to each character, which was to be paired with the letters ensemble.

The transcriptions of the interviews (lasting between 1.5– 2 hours) were then edited in four stages. First, any material not relevant to the core pregnancy-ending narrative was removed. Second, repetitious or distracting material, as well as story elements that were not essential and could not be included due to time constraints, were cut. In the third stage, each of the character scripts were read aloud and in partnership with the director of the solo ethnography, Jennifer Linde, edits were made based on the concerns or issues that seemed to emerge as central to the participant. Since repeating the entire pregnancy and pregnancy-ending scenario across all eight stories would be repetitious, the scripts were then edited so that each character's story focused more on a particular stage of the process. For example, BRANDY was upset by repeatedly going in to check on her baby's lack of movement and was repeatedly reassured and turned away. While the stillbirth of her baby is described and what she did with her baby in the hospital is addressed, the focus was her anger and her frustration with a system she felt did not protect her baby. TEE also experienced decreased movement and spent a lot of

time talking about concern about the lack of movement in the weeks leading up to the stillbirth, but the birth process and what happened after her baby was born dead was a far more emotional and intensive part of the narrative. So the script edits focused more on this time. BRANDY and TEE's stories, as edited in the play, interweave similar elements of each character, but the script of each character draws the focus to, and highlights, a different aspect of the narrative. The fourth round of edits trimmed the full-length, 90-minute play into a 50-minute one-act.

After the final scripts were drafted and rehearsed, several excerpts of my own testimony served to frame and transition between the abortion and stillbirth narratives. These three one-minute monologues focused on my being single and unexpectedly pregnant and having to decide whether or not to have an abortion, the subsequent death of the baby I decided to keep, and my lobbying efforts for stillbirth-related legislation, including repeatedly being asked if it had to do with abortion.

The Wednesday night show featured the letters ensemble in the first act and the shortened solo ethnography in the second. The Thursday night show featured just the letters ensemble, and Friday night showcased the full-length solo ethnography. Saturday night's show focused more attention on the multimedia installation and featured the one-act solo ethnography.

CHAPTER 5

TESTIMONIAL DISCOVERIES

“Mommy! Mommy! Are you okay?”

His voice reaches me through the suffocating weight of pain. I can't find my tongue. My lips won't move. My eyelids shut out the world.

There is just pain and nothing more. Except my five-year-old is scared. And I need help.

“It's my belly pain. Go inside and tell Justin to call for an ambulance.” We are at the local batting cages. Everyone knows us. They'll help Quinn. They'll get help for me.

I am trying so hard to focus through the pain. Breathe. Focus on breathing. My labor coaches' voices come back to me telling me to focus low and relax into the pain. I haven't moved. But I need to pull up my pants and get out of the bathroom stall if they are going to help me. I need my mom to come get Quinn, but she'll freak out if she hears me like this. I pull out my phone and call her partner, Jennifer, instead.

“Come to batting cage. Help.” That's all I can manage.

Each word is an act of rebellion against this pain that owns my body. It's worse than before. This is the first time it has happened in a public place with my son. It is the first time someone else has witnessed what this pain does to me.

I hear the sirens. Thoughts creep in. Please turn them off, they'll scare Quinn more. They are going to ask questions. I'll have to make my mouth work. They won't be able to make the pain stop. It usually goes away within an hour. How long has it been? By the time I get to the hospital, the pain will have started to go away. Maybe I can just stay on the floor. Just make sure I don't die.

In the ER the doctor is shouting at me. Why is he shouting? My ears work. Talking is getting easier. The pain is releasing my throat now. He touches my belly and a scream throws itself at him. "Is there any chance you are pregnant?"

"No. None." The question jabs at my chest like his finger on my belly which is still emptying menstrual blood.

"We are going to send you for an ultrasound and a catscan to see what's going on, ok?" An ultrasound. In Arizona. The last thing I wanted.

In radiology, as the female technician prepares for the scan, she says, "Have you ever had a transvaginal ultrasound before?"

"Yes. When I was pregnant."

"Is there any chance you are pregnant now?"

"No. None." That question again. I know they did a urine sample to make sure I am not lying or wrong. They are required not to trust my answer.

"Ever since I had a stillbirth in 2005, I can get emotional during a pelvic exam or procedure, so I might cry." I have no memory of the tech saying anything to me.

A wave of pain shoots through my abdomen when she inserts the probe. It has never hurt like this before. The tears leak down my cheeks. This is supposed to help me. I know. But another part of me is screaming and yelling and wants her to take it out of me. I feel like I am giving into the enemy.

A transvaginal ultrasound. In Arizona. The last thing I wanted.

There are no beds in the ER, but I am in a small waiting room with my mother and she is holding my hand. The nurse comes in to give me some more morphine for the pain. He tells me what I have. What the problem is. At least what he is pretty sure it is. I

know as I hear the words that he is not supposed to diagnose; only doctors can do that. That's what my years as a stillbirth researcher and advocate have taught me.

"You'll need to get a hysterectomy." And he walks out of the room.

My mom's eyes get wide. I know better than to listen to him. He hasn't seen the scan results, just the urine test. He's an asshole and I report him. Because I know how the protocol works. I know how you are supposed to give bad news.

The doctor comes in hours later and tells me that he thinks I had an ovarian cyst rupture. There are still small cysts on my ovaries, one on the left is 3 cm. Nothing to worry about, but just keep an eye on. And follow up with an ob.

So that's what it is. I've had a few episodes a year during my period for the last 6 or 7 years. But they've gotten more frequent and lasted longer in the last year or so. This is the first time I saw a doctor about it and finally found out what it is.

Because I got a transvaginal ultrasound. In Arizona. The last thing I wanted.

In March 2012, Arizona passed an omnibus abortion bill that required a mandatory ultrasound prior to abortion to determine the age of the fetus, which when early in the pregnancy would necessitate a transvaginal ultrasound, and required that the woman be given the choice to see the ultrasound. It would ban abortion after 20 weeks from the last menstrual cycle, which translates to 18 weeks gestation—earlier than any other state at that point.

Just the year prior, Virginia legislature had passed a mandatory transvaginal ultrasound bill requiring a woman wanting an abortion to undergo an invasive—yet medically unnecessary—procedure. An abdominal ultrasound is taken on the surface of a

woman's belly. A transvaginal ultrasound requires a long wand, or probe, be inserted into the vagina and is better at picking up smaller images. The forced procedure was likened to state mandated rape and State? Governor Bob McDonald, earned the nickname "Governor Ultrasound." Due to the backlash, he removed the transvaginal requirement, but kept the mandatory ultrasound prior to signing the bill into law.

When I had that transvaginal ultrasound in April 2012, just after the law was passed, I was furious that I was having the procedure. For me and body it meant diagnosis and treatment but for another woman with an unwanted or unplanned fetus in her belly it meant state sanctioned invasive procedures used it challenge and constrain other women's medical decisions.

By October 2014, the cyst in my left ovary had grown to 8 cm and there was also a 4 cm one on the right ovary. I'd been to the ER five times and hospitalized twice. The specialist I was seeing at Mayo said I was too old to have kids and that I should remove my left ovary and possibly my uterus because my excessive bleeding was causing anemia and I didn't need it anymore. He was confident and calm in his tone, but he never asked me if I wanted to try to have more children. Nor did the OB/GYN I saw at my campus clinic who told me OVER THE PHONE that I was peri-menopausal and I couldn't have kids. Their cavalier and thoughtless pronouncements reassured me that my desire to train care-providers in improving empathy in patient-provider interactions was not misplaced.

I knew that I was going have to make a decision about surgery, removing my left ovary and possibly cauterizing my uterus. But I had a performance series I was mounting and a dissertation committee set to see my work. I put off doing anything until November.

But my body didn't agree to my plan.

“Suzanne? Are you okay?”

The voice of my director, Jen Linde, reaches me through the suffocating weight of pain. I can't find my tongue. My lips won't move. My eyelids shut out the world.

There is just pain and nothing more. Except a cast of actors waiting to start the show. A theatre filling with people. Members of my dissertation committee waiting to see what the last three and a half years have resulted in. My best friends, Stas, gets me water for a pain pill.

“I'm having a cyst rupture. Should get better in 45 minutes. Just wait.”

I am trying so hard to focus through the pain. Breathe. Focus on breathing. I know what this is now. But it has been getting worse. The last two times it happened I got a fever and wound up in the hospital. It didn't go away without antibiotics and lots of pain meds. They thought it was because of my appendix. They took that out. And now the pain is back worse than ever.

“Suzanne? We have to make a decision. Should we have someone sub in for you?” Just as I am about to tell her I can't do it. The grip of agony loosens, just enough for me to stand. Adrenaline races through the small space in the pain.

The show must go on.

Discoveries

The process of interviewing participants, creating the performance texts, rehearsing the scripts, creating the installation, performing for an audience and debriefing after the shows is a time of discovery. This fertile domain offers a wide range of complex

and interconnected material to explore and invites a rich and layered analysis suitable to rhetorical and performance methodologies. The primary data being analyzed comes from the ethnographic interviews and interview process, self-reflective observations during the performance development and rehearsal process, observations of self and audience during performance, and post-show member check-in with ethnographic interview participants who attended the performances.

Before discussing the findings discovered, it is important to address the specific method of observation used in the analysis. Prior to beginning the analysis, I had not realized the extent to which my observations of the participants and audience members was influenced by more than 15 years of training in somatic storytelling. Somatic sentience, a concept informed by this training and the growing field of sensory ethnography, will be addressed first in order to explain how this particular type of training, or at least this type of awareness, might help tend to the more ephemeral or intangible exchanges in ethnographic research.

In analyzing the data gathered from the sources mentioned above, two primary findings cut across all research questions: Relationality and Temporality. While these dimensions can be imagined as an X and Y axes and each additional finding could be plotted for primacy in each quadrant, for organizational purposes of this paper, the secondary findings are divided into either Relational or Temporal categories. While this division is necessary for organizational purposes, the secondary findings generally have tethers in both categories and, where relevant, dimensional intersections are addressed.

Somatic Sentience

While much of my methodological approach is recognizable as rhetorical and performative, the kind of performances I create are highly influenced by a particular somatic sensitivity that nearly 20 years of the Body Tales practice has developed in me. My training in this type of improvisational somatic storytelling has developed my sensate awareness as a witness. My witnessing body is present, vulnerable, open, empathic and grounded. Just as my critical rhetorical self is sensitized to ways that stigmatized reproductive bodies are at risk, my somatic self is sensitized to the energetic resonances of the body moving/storying before me. This sensitivity is possible in ethnographers who are present and open. But in order to re-engage—not just reenact or relive it—the emotional experience of the interview subject, it takes both somatic sentience and performance skills.

I am re-embodiment the testimony of the participants. I am re-embodiment what my body experienced in witnessing their story. (“This is what I heard” exercise; mirroring in Body Tales). When I say their lines, my body remembers the pause, the tension, the relief, the emotion. My body recognizes it.

Some acting strategies suggest calling upon a similar emotional experience in order to get to the place the character needs to be. The performer borrows an emotion to reenact an experience. But through the performing method discussed here, the performer is conjuring the embodied memory of resonance, the relation between performer and characters, how the personae expressed themselves and how the performer moves into a somatic memory of that moment in order to bring the memory of that moment—the embodied testimony—into and onto the stage. This requires somatic sentience.

Somatics is generally understood as the techniques that emphasize the mover's own proprioceptive sensations (rather than performance-based techniques). Sentience can be understood from a Western perspective as the ability to experience sensations. From an Eastern perspective, sentience can be understood as a metaphysical quality found in all things which is respected and requires care. This is not new epistemology. Pink (2009) notes that in 1907, sociologist George Simmel wrote about the “sociology of the senses” (Simmel, 1907/1997). He explained that our sensory perceptions of others play a fundamental role in human interaction. Sensory impressions can invoke emotional or physical responses in us and our sense impressions are a pathway to knowledge of the other (Simmel, 1907/1997). He explained:

Every sense delivers contributions characteristic of its individual nature to the construction of sociated existence; peculiarities of the social relationship correspond to the nuancing of its impressions; the prevalence of one or the other sense in the contact of individuals often provides this contact with a sociological nuance that could otherwise not be produced. (p. 110)

He believed that understanding the conditions that allow, invite, or resist social interaction among human beings required study of the “delicate, invisible threads that are spun from one person to another” (Simmel, 1907/1997, p. 120), These threads of relationality, perceptible by a somatic and sensory awareness, will be drawn into the analysis later in this chapter.

The articulation of a somatic sentience offered here draws from the definitions of performance ethnography provided in Chapter Two. It is additionally informed by Pink’s (2009) explanation of sensory ethnography as “a methodological focus on the role of

subjectivity and experience in ethnography” (p. 2). This methodological approach recognizes that ethnography is gendered and embodied, draws on theories of human perception, realizes that the researcher learns and knows through the whole body, and calls our attention to the corporeality and multi-sensoriality in all social interactions (Pink, 2009). It does not privilege one type of data or research method, but rather is open to multiple ways of knowing, exploring and reflecting on knowledge that are accessed by the senses. As ethnography is already necessarily sensory, Pink (2009) argues that somatic ethnography is an evolving field of practice that is already a part of traditional and systematic ethnographic research but not always clearly attended to or discussed (Pink, 2009). Performance ethnography’s epistemology is also embodied and sensory, but the *how* of the senses and *where* in the body are not often discussed in explaining *what* the body knows.

Somatics and sensory ethnography have been used in applied contexts for health-related research and practice. In somatic psychology, somatic resonance is the awareness of (and sometimes matching) what is taking place in the somatic field (bodily reactions, sensations, feelings) between the practitioner and the client. Edvardsson and Street (2007) consider the potential of the nurse as an embodied ethnographer due, not only to the sensory nature of social interactions in nursing, but also because care for “disrupted embodied beings are at the centre of concern,” (p. 30). They believe nurses can be taught to “attend to their senses and their embodied responses, in order to better understand the lived experiences of patients and their families,” (Edvardsson & Street, 2007, p.30). They explain that when a nurse is understood as an embodied ethnographer:

We found that subtle aspects of the lived experience of nursing practice became more visible and thus easier to explore and describe, as the researching body was not taken for granted. It was no longer a silenced or absent body, instead it became an object of inquiry that led to new questions and new levels of observations.” (p. 30)

Sensory ethnography has also been used in sociology to understand interactions in clinical contexts. Hindmarsh and Pilnick (2007) discussed *intercorporeal knowing* between anesthesia team members and Lammer (2007) explored the *sensual realities* of radiologists and patients in order to encourage empathy. These applied uses of somatic research are instructive as not only in realizing the potential of performance ethnography, but the potential of a stigmatized health narrative like stillbirth to be studied from a sensory approach.

These and other studies demonstrate what Howes (2005) calls a sensory revolution that hails an ideological shift that focuses on a full-bodied understanding of experience instead of privileging a linguistic one. Performance ethnography allows researcher/performer to share what s/he has learned and now knows through the same medium rather than just translating that knowledge to a written medium. Performance’s epistemology and methodology is both embodied and sensory. It is Pink’s engagement of Downey’s (2007 in Pink, 2009) question, “How does the body come to ‘know’?” (p. 25), that reminds me to address that which performance often assumes is understood.

How does my body come to “know” the interviewee’s testimony and how do I share what my body knows with an audience? My body knows the emotional affective experience in the interview first. An empathetic response requires being as fully present

as possible, being nonjudgmental and being vulnerable to respond emotionally and empathically. In my performance, I am re-engaging the emotions, the sensations and empathetic resonances I experienced during interviews with participants. In my performance I am weaving those invisible threads that spun between the interviewee in and myself in a well-intentioned yet potentially impossible effort to bring their experience to a wider public, so that the audience may pull a tensile strand of that performance tapestry out of the theatre, weaving it into their own narrative tapestry. “The task of the sensory ethnographer is in part to invite her or his reader or audience to imagine themselves into the places of both the ethnographer and the research participants represented,” Pink explains (2009, p. 42), “while simultaneously invoking theoretical and practical points of meaning and learning.” Performance knows this, invites this, and when done well, creates these trajectories. Critical performance ethnography understands this as a fundamental component for a call to action.

But performing the Other, especially someone from another cultural or linguistic background, is delicate business. Sanjana has a thick East Indian accent and speaks rapidly. Her speech patterns, accent and body gestures were the hardest for me to reproduce accurately. East Indians have often been mocked or ridiculed in pop culture (*The Simpsons*’ Kwik-E-Mart worker, Apu, comes to mind). Poor reproduction of her pronunciations might remind audiences of similar troubling ethnic representations and distance them from Sanjana’s story, rather than bring them closer. It had also been her first time telling her story. She told me that she was coming to the performance and her husband, who was not present for the interview, would be coming with her. I worried that

my performance of her would be a less than adequate representation due to our linguistic and cultural differences. I was afraid she might be disappointed.

Pink (2009) argues this potential disconnect may be insurmountable. “Sensory perception,” writes Pink, “is inextricable from the cultural categories that we use to give meaning to sensory experiences in social and material interactions” (p. 28-29). As much as I may strive to re-engage the interview experience as authentically as I can, I may not be able to perform a cultural experience different from my own with the same accuracy. Critically important here is the idea that as a performer, I may do my best, make ethical choices based on careful consideration, but fall short in satisfying the person I am representing. My director, who had viewed an excerpt of the interview, often said that I “got” her and I was solid on my performance of her early on. We are watching with our Western eyes, listening with our American ears, to me use my English-speaking tongue to reenact my experience of her during the interview. I cannot be her, any more than I can be any of the other women I interviewed or performed. I am trying for Madison’s (2006) *performance of possibilities* in order to better understand her and bring the audience closer to understanding her testimony.

I am trying to re-engage the moments together in the interview and what my empathic self sensed or read of their experience. I am not trying to reproduce the exact gesture made with each exact phrase, but rather use the language of their posture, gestures, body movement, intonation, tone, rate and pitch, and emotional expression as a vocabulary my body can use, as elements for witnessing them and resources for reengagement of my memory of them. In a sense, I am not doing a close reading of their

interview as much as I am doing a close reading of my sensory awareness of my memory of them.

Whether I get Sanjana's accent right or replicate the nuances in her emotions may be a technical shortcoming on my part, not a failing of the method. The audience, for the most part, has likely never met her, and only she, and those who know her (and know I am performing her), would be able to compare her to my performance of her testimony. I am invested in the ethics of performance, and some in the audience may be. Some may know enough about the issues to know whether or not I am being ethical in my performance and performance choices. But in looking at performance ethnography or ethnodrama as an event, if the performer is skilled and compelling, if the story had narrative coherence and fidelity, and if the performance was aesthetically pleasing, then the audience may be satisfied in the credibility of the performer as a performer. The audience member who is witnessing their story being told is an expert in how they have told their own story previously. A performance ethnography interviewee witnessing someone else perform their testimony, may dismiss it as hearsay, or, conversely, embrace the performer as a character witness to their experience and treat the performance as corroborating evidence of their lived experience.

What is essential here, is that re-engagement of another's testimony requires somatic sentience: a sensate ability to experience what is taking place in the somatic field between the performance ethnographer and the participant. This requires respect, care, vulnerability, presence and sacred witnessing. This somatic sentience, when applied to an analysis of the performance of testimony and already evidenced in several examples above, helps uncover two central findings: relationality and temporality.

Relationality

One of the primary findings that emerged from the analysis was the concept of relationality. Performance of testimony calls into being relationships between various individuals in ways unique to its constitutive and re/presentative nature. Two key relational categories, *intra-performance* and *inter-performance*, and two relational dimensions, *actual* and *imagined*, were evident.

Intra-Performance and Inter-Performance

Intra-performance relationality exists between those involved in the creation of the performance. This can be between the ethnographic interview participants and the interviewer/performer; the director, crew and performers; the interviewees and their testimony; performer and the testimonial text; and the performer and the space in which the performance happens. *Inter-performance* relationality can exist between those involved in creating the performance and those witnessing it. This can be between the performer and the audience; the audience and the characters in the performance; the audience and the space; the performer and the contextual discourses already/always informing the subject of the performance; the audience and the contextual discourses already/always informing the subject of the performance.

Actual and Imagined

But these relational categories are also influenced by two dimensional possibilities. They can be *actual*, as in there is a two-way interaction, however brief or sustained, between the actual individuals involved. This can be between audience and performer; performer and ethnographic interview participant; director, crew and performers; audience members and other audience members—who themselves may have

already existing personal relationships outside and irrespective of the performance. They can also be *imagined* between one individual without the actual participation of the other. This can be between the ethnographic interview participants and the audience; the performer and various conjured publics; and the audience and various conjured publics. These two categories and two dimensions of relationality also help discover answers to three of the research questions posed.

First, by putting pregnancy-ending testimonies in conversation with each other in performance, we find various intra- and inter-performance relationships. For example, that the intra-performance relationship an ethnographic performer has with the person whose story they are performing, also takes on an inter-performance dimension if they also become an audience member. If the interviewee reveals to a previously unknown-to-them audience member that theirs was one of the stories performed, there would also be a two-dimensional relationship between the audience and the interviewee.

For example, Sanjana, who shared the story of her three miscarriages, already has interpersonal relationships with her husband and their babies, as well as the doctors and family members she discusses in her testimony. Ethnographic performance calls into being an intra-performance relationship with myself, as the performer, but also invites a relationship with me as a fellow bereaved mother, and my own baby. Once I perform her testimony, the viewing audience has an actual relationship with me and Sanjana's testimony, as well as an imagined relationship with her and her baby. These relationships may also conjure relationality with other stillbirth parents and their babies now that the experience of this kind of loss as imagined them into being.

Internarrative Relationality

When multiple testimonies are performed, as was the case in this performance, there is an intertextual relationship between the various narratives. Individually, a testimony tells a stand-alone narrative; combined together, they speak to each other through the resonances and discords of their shared or unique experiences. “And as far as my experience is concerned, I never knew what a woman goes through when she has an unwanted pregnancy and what her feelings are like when she has to abort it until yesterday” (Sanjana, personal correspondence, October 24, 2014). Because of the performance, Sanjana’s testimony is put in a direct intertextual relationality with other performed stories of stillbirth and abortion. It provides context to, and is given context by, other pregnancy-ending narratives. But as an audience member, she also has an imagined relationship with the other testimonies she witnessed as they were speaking to/with hers. As part of the member check-in I did with her after the show, she wrote about her experience of the performance.

It was wonderful to see our story being enacted and I'm sure it would have helped someone in the group there. We feel good to know that our Aditi did her bit in this world. We really felt inspired hearing other stories as well....And as far as my experience is concerned, I never knew what a woman goes through when she has an unwanted pregnancy and what her feelings are like when she has to abort it until yesterday. In one of the stories, a mom said the fetal cells of all my babies are still inside me and it makes me feel that my babies will be within me forever. This was a new information to me and it means my two kids and Aditi are still somewhere within me. (Sanjana, personal correspondence, October 24, 2014)

Sanjana imagines an audience member having a relationship to her story just as she has an imagined a relationality with another interviewee's experience she saw performed that was unlike her own. But Sanjana's email also speaks to an additional complex relational interaction present in stillbirth testimonies: the multi-dimensional relationship between the interviewee and their stillborn baby.

Multi-Dimensional Parent/Child Relationship

Stillbirth testimonies demonstrate that parents perceive a real relationship with their dead baby, that was once living inside the mother's womb, that once kicked or moved in response to external stimuli that might have been from their parents' touch or voice. Hearing that there is a biological remnant of her beloved baby's lingering her body ("...it means my two kids and Aditi are still somewhere within me...") speaks to both a physical relationship on a cellular level that actually exists and to an imagined relation ("...and it makes me feel that my babies will be within me forever..."). Bereaved parents also maintain an imagined relationship to the child as they move through their life without their baby. They can continue parenting them by celebrating them at their birth/death day anniversaries, attending Walks to Remember in which they talk about their baby with other bereaved parents, and imagining what they might look like, act like and like to do as the years pass without them. But Sanjana also imagines, as do many stillbirth parents, her baby having relational relevance beyond that with her parents ("...We feel good to know that our Aditi did her bit in this world..."). Sanjana's testimony communicates the relationship between her and her baby, but is also, in part, constitutive of her relationship with her baby.

Some might say the continuing after-death relationship between a parent and a baby that never lived outside of the womb is imagined. For the women who testified to me about stillbirths, miscarriage, and terminations of a wanted pregnancy, they describe a real—to them—relationship with their baby. In describing my own relationship to my dead son, I called it an *attachment in absentia*—“attachment in ones’ absence.”

Attachment theory (Bowlby, 1982) explains that parents have different types of attachment styles that they form with their children, even prior to birth. This attachment develops both in the fantasy of expectant parenthood and the reality of the pregnancy. This in-utero bond may be enhanced by technological advances, including ultrasounds and other diagnostic procedures (Robinson, Baker, & Nackerud, 1999). Parents are able to watch the development of their child before the mother can feel those first early movements at about five months gestation. They are able to determine gender earlier, discover if there are any genetic anomalies and how healthy their baby appears to be. They are able to see their baby’s limbs form, hear their baby’s heartbeat and watch their baby grow. This constant window into the womb has the effect of assuring most women that their babies are healthy and that nothing bad will happen. Robinson et al. (1999) claim the degree of attachment is not only (if at all) determined by the length of gestation, but rather on the level of parent’s expectations and acceptance of the pregnancy. This attachment and can be intensified if the pregnancy comes later in life and families may need assisted reproductive technologies or when fewer babies are planned for, or able to be born.

The ultimate severing of the attachment is death (Bowlby, 1982), and rebuilding those attachments after death can be part of a healthy healing process, a health grieving

process. Several theorists (Stroebe, 2002; Robinson et al., 1999; Klass, 1993) suggest that bereaved parents may seek to reattach to their children after death. These post-death reattachments facilitate a continued relationship, even if that relationship is seen by others as imagined only in the hearts and minds of the parents, friends or family members of the dead baby.

For parents, however, these are not imagined relationships, and to say so would belie the depth of their love and the existence of the initial attachment. But these relationships are different from those with living children, if not only materially and physically, but practically and socially. They are *reattachments in absentia*. The grieving and healing process, for many, involves evolving their relationship in absentia. Saying their child's name at memorial services, honoring birthdays or death-day anniversaries, imagining what their child might be like, talking about their child, making quilt patches, creating web pages, writing letters to them when they would have turned 16, donating funds in their child's name, writing and directing a film about stillbirth, advocating for legislation to increase awareness and research, are just a few ways that parents continue to re/member their babies and keep them alive, if only in their own hearts and minds.

As a result of Sanjana's testifying to me, she created another set of relationships because she went out immediately and volunteered. She now helps other people in a support network. Those relationships stand alongside the potential or imagined relationships with the audience of her story, the imagined relationship the audience has with Sanjana and with her babies and the already existing relationships she had with own family.

Testimonial Performance Expands Agency

Sanjana called these relationships into being by performing the act of telling her story to someone; now she imagines how her story *acts* on other people. “It was wonderful to see our story being enacted and I'm sure it would have helped someone in the group there. We feel good to know that our Aditi did her bit in this world,” also speaks to the agentic possibilities of testimonial performance (RQ4). Because the interview participants knew that I would be performing a portion of their story for the stage, the *orientation* of the interviews was toward another audience beside me in mind—either consciously or unconsciously. The stories may have then been directed at or with an acknowledgement of being delivered to an audience and as evidence of their experience. The interviews I turned into performance texts then became testimonial performances.

If the personal narrative is given imagining an audience outside the interpersonal space between subject and interviewer, it is testimony. It is evidence of that experience that can be used or circulated for means other than personal disclosure. Once it has a public orientation whether it is directed at, in acknowledgment of, or in response to other already circulating narratives, it becomes testimony. Traditionally in social science research we see interview content being used as evidence, and I argue that the interview material itself is evidence of the individual experience and as such counts as testimony of such experience. Hence, when an interviewee tells a story to a researcher, they are testifying not just engaging in an act of personal disclosure. When interviewees tell me their story, they are testifying to me.

When I perform their interviews with me—re-embodying the ways they related the story recreating their gestures, postures, accents, tones and verbatim language use—I am re-engaging their act of testifying. As Madison’s performance of possibility suggests, I am trying to get my material self as close to their material self as possible, to get as close to being in their skin by embodying them and their experience as much as possible.

I have spent the last several years, as a performer, trying to reason how this kind of personal narrative performance—similar to oral history and verbatim performance style of Anna Deavere Smith and Sarah Jones—might be testimony. My goal in the performance is to slip into the skin of another and allow the audience as close to the other, through me, as possible, allowing them to witness the testimony as given to me. But testimony must be tied to the body of experience—and it was when it was given to me. But is it still testimony when I perform it? I am performing the testimony someone else gave me, but then am I performing testimonies? The question of agency keeps acting as a hiccup between these performances.

My performer/actor body tries to get close the experience. Madison argues this is part of where the power of performance as a bridge between bodies of different experiences is born. But what happens to the agency once the story is no longer mouthed by the same body that experience the elements of the narrative. I had to make a choice whether or not to have an abortion. I had a miscarriage and a stillbirth. I do not have the same agency to tell their story as I do my own. But they have given me permission to use their story for research, on stage, and in this dissertation. Are they lending me their agency? Am I testifying by proxy? Am I a vessel of their testimony? In wrestling with this question of agency, I approached Madison at NCA in 2015 and asked her if what I

was doing could still be considered testimony. “Yes, it is still testimony,” she said. “By re-embodiment their story you are expanding their agency. You are allowing their story to reach a wider audience than they could alone” (S. Madison, personal correspondence November 22, 2014).

In order for such a testimonial performance to succeed in such aims, the re/presentation of their narrative must do more than aesthetically re/produce a participant’s testimony. In order to get as close as possible to the body of experience, the performer must be physically present with the participant during the interview when they give their testimony. The performer must also re-engage the somatic and sensate experience of the interview encounter as well.

Relational Risks

Critical performance ethnography as activism cannot guarantee that the performance would not have negative impacts—no research project, indeed no performance project, can. But by inviting or creating an opportunity for participants to share any feelings they had, about the performance of their testimony, the performer takes responsibility for how their work operates, for audiences and for the participants. While performers may not intend to do their participants’ harm, the embodiment, the editing, and/or the effect of the performances felt hurtful, offensive or inaccurate to the people whose lives are subjects of the performance, they should have the opportunity to express such sentiments. If such unintentional wounds are created, critical performance ethnographers should consider ways to acknowledge, apologize and, if possible, redress the grievance. This may mean changing future performances (either in embodiment, the editing of the text or use of the material altogether). This may mean a minor change or a

complete overhaul of the performance. While the potential consequences can range from inconvenient to devastating, the issue of agency is crucial.

Testimonial performances expand the agency of the teller, circulating their stories wider than they could have done themselves. With this collaborative agency, then comes expanded responsibility. Ethical critical performance ethnography is not just about getting the text and performance accurate, it is about avoiding appropriation of their story by appropriately re/presenting their story in ways that do not just advance the performer or community's activist goals, but also advocates on their behalf as well as advocates for the understanding of their experience. If the representation of that experience is severely flawed, you may still broadcast the message of advocacy, the audience may feel closer to the character you portrayed, but the participant may not feel as if their story, their lived experience, was heard. These considerations and earlier theorizing about the relations called into being by the performer may also help unpack a final relationship performance of testimony conjures relationality to context.

Relationality to Context

The research question that led to this finding was primarily driven by the rhetorical investments in Chapter One's framing of stillbirth as a part of reproductive justice aims and Chapter Three's exploration of various eruptions in the conditions of discourse surrounding pregnancy ending. It asked: To what effect, might the larger conditions of discourse be re/presented in the performance or the performance space and to the audience? (RQ1)

Need for active versus passive provision of contextual information. The conditions of discourse are often the taken for granted or assumed as truth, similar to the

dominant narratives that are consumed as natural until challenged. Even when one is active in political discourse, one is not necessarily a critical consumer of the information and can easily be a passive audience member who receives wisdom rather than critically engaging it. Critical discourses of abortion and stillbirth are available to mass audiences, but often for those who are looking for it. Discourse about abortion that one might get exposed to on the evening news, on a popular television show or in a song on the radio are uncommon and often referenced as legislative battles or narrative subtext that the unwitting consumer may not even interpret. Discourse about stillbirth may bubble up as a medical drama's one-episode storyline representing an emotional tragedy for the pregnant woman, but stillbirth is rarely taken up as a political, medical or social issue in need of preventing. Rarely do these kinds of exposure conjure relationality with an actual person. This absence of actual relationality with an individual may have impacted how the contextual information provided in the performance installation was consumed.

One audience member who witnessed all three performances said that there was there was a factual context provided in the group ethnodrama that was missing in the solo performance ethnographies. Despite the passive context all around the space, on the walls, and on display tables, she said watching the testimonies in the ethnodrama alone did not have the same critical or political impact as they did when they were paired with the performance of the letters in support of abortion access.

The context written on the walls allowed the audience to passively bypass or glaze over the information. They could talk with each other, focus on one wall or image and not the other. In our original conception, the director and I had talked about roping off the stage and sitting area and compelling the audience to walk around the outer

perimeter of the space within feet of the walls for 15 minutes prior to the performance beginning. We would have ushers wearing bright reflective clinic escort vests allowing the audience in through the door at paced intervals. We discussed piping in audio from the corners and behind the curtains so that as the audience progressed around the space they would hear the chants of protesters outside abortion clinics or a doctor delivering news of a stillbirth. The idea behind this was to maximize the chances that audience members would engage with the installation. But the logistics of this pre-show arrangement proved incompatible with the way we ultimately configured the stage, the lighting and the audience. So we allowed the audience free access to wander around and watch videos, pick up informational material, or read the text on the walls as they liked for 30 minutes after the doors opened, including 15 minutes after the show was posted to begin.

But without being compelled or prompted to spend time reading or viewing the installation, information was only passively available to the audience. When the ethnographies were paired with the letter performances, the reproductive justice and abortion information was a *part* of the physical performance, shared by actual performer and hence delivered to the audience. Without such contextual relationality, the emotional depth of the personal testimonies were not as intellectually and ideologically provocative. Would the opposite have been true for the stand-alone performance of the letters play? Would the political context of the letters play be less personally impactful without the relationality to the emotionally provocative testimonies. The feedback from those who were present for the stand-alone letters of performance was that it was interesting, engaging and thought-provoking. But the feedback did not contain the comments about

the powerful emotions experienced by audience members, the way the comments did for the lived experiences of women performed on the other nights.

When the evidence provided by the personal narrative is situated within/against the context of the current legislative climate and health context, the audience has an actual relationship with the performer and an imagined relationship to those affected by the political and emotional landscape of pregnancy ending. They have access to both the personal and the political, are shown how the personal is political and can see how abstract political discourse impacts a real living person. As such, these relational dimensions conjured by the performance of stillbirth testimony have implications for intervention, support and advocacy for reproductive justice. These implications however are not limited to the performance moment, nor are they simply representations of a past experience. Testimony also has temporal attributes that affect both the performance of testimony, its circulation and its impacts on the conditions of discourse.

Temporality

A second primary finding that emerged from the analysis was the concept of temporality. Testimony works across different temporalities. It does not only reside in the moment of the participant testifying to me as the researcher/performer, but it also simultaneously projects itself into a possible future and future public of the audience that will receive it, some audiences that are known (October performances) and some that cannot always be known. Through my relations with the participants, they have given permission for their testimonies to do work in the future to do advocacy.

In Massey's (2005) notion of “the coexistence of different temporalities” contemporaneous temporalities—even in the temporal movement of a performance, the

past might be invoked and futures might be imagined and so all three senses of time are operating at the same time. But a performance might be moving in a time and space and it might call upon us to go to our past. It might call upon us to imagine our futures as we are witnessing a performance. We might also imagine a future in which we will act in some way as a response to the performance. As Muñoz (2009) explains while discussing Jean-Luc Nancy's concept to plurality, the singular plural "is always coterminously plural—which is to say that an entity registers as both particular in its difference but at the same time always relational to other singularities" (p. 10-11).

Testimony can be analyzed as synchronic—testimony that has been given at a specific time/space, about another time-space, that could potentially be used as a resource during another time/space—each iteration anchored to a specific time/space and a specific temporal context for each. But testimony can be analyzed diachronically—viewing testimony over time to see how has/might the testimony evolve/change given the different circumstances of devolving/evolving contexts and/or future or imagined audiences and/or the changing/shifting experiences of the teller or the multiplicity of tellers as the testimony circulates as resource.

When exploring what might be discovered by putting pregnancy-ending testimonies of others in conversation with each other (RQ 2), the theme of futurity was discovered in each one.

Futurity

For the woman who experiences an unplanned or unwanted pregnancy, the pregnancy can threaten the future she has imagined for herself. A woman whose unwanted pregnancy is the result of sexual behavior that is censured by family or friends

may worry about how those in her community will respond to her pregnancy and the choices she makes about it. When the law significantly constrains or penalizes sexual behavior, as in Sonya's case where both sex outside of marriage and abortion are illegal with few exceptions, fear about her own life and safety may be forefront in her mind. "I didn't see any future for myself but kind of that abortion give me feeling of feel safety in terms of living in society and [going] again back to society and back to family," Sonya said. "The doctor said to me that, 'ok now you are saved and you don't have any problem.'" But Sonya also had also begun to imagine how she might bring a possible future about if she kept the baby. One that she ultimately decides is impossible.

And I was thinking all the time before going to that clinic, I was planning to do something. If my family say something I would come up with something, you know. Even I was thinking I can escape and I can go out of the country and I was planning to do selling everything and returning back to my apartment and quitting my job and getting all the monies and leave the country. Because I like this baby and I liked to have this baby, but I couldn't. I was thinking that, okay, just leaving the country with that baby, crossing the border. And then what should I do?

For a woman who desires a child and gets pregnant, her life changes in that instant and she begins formulating her new future—in part based on the dominant narratives she has been exposed to about what pregnancy and having a child brings. Her future telos changes. But when she experiences a miscarriage or a stillbirth, the loss of the pregnancy eliminates the future she imagined and invested in. Her previous world view, one in which she imagined her future with a child, is incompatible with the reality

of her new world: one in which her child is dead and her imagined future abruptly shattered. Raven's stillbirth in 2000 made her even more acutely aware of the uncertainty of pregnancy.

Also I think probably for most people who have an abortion, there's the process of having to think about it and make the decision and so you're still giving up a potential future. If you get pregnant and you move forward with that pregnancy, not only is your entire life changed, you're also risking this loss. By being pregnant and agreeing with yourself and the world to go forward and carry this baby to term and have the baby, you're risking that it won't work out that way and that's kind of huge.

Pregnancy Ending as a Threat to Reproductive Futurism

"...we are no more able to conceive of a politics without a fantasy of the future than we are able to conceive of a future without the figure of the Child."

(Edelman, 2004, p.11)

Reproductive futurism argues that all political discourse is regulated and prescribed by a collective future and for which all the work of today is done to benefit the Child of tomorrow. This is not an already living or historical child, but rather a future imagined Child which "remains the perpetual horizon of every acknowledged politics, the fantasmatic beneficiary of every political intervention," (Edelman, 2004, p. 3). This future Child embodies "the telos of the social order and been enshrined as the figure for whom that order must be held in perpetual trust," (Edelman, 1998, p. 21). Edelman (1998?) proposed a queer oppositionality that challenged the universalized of the image of the Child as the hope of the future, that instead refused the insistence of hope itself as

affirmation, “which is always affirmation of an order whose refusal will register as unthinkable, irresponsible, inhumane”(p. 4).

While Edelman was not discussing the failure of pregnancy as an oppositional discourse, his framework is still helpful in seeing how stillbirth and abortion testimonies act as challenges to security and procurity of the future Child. While the politics of reproduction and issues of reproductive justice still con/figure the future Child within its possible schema, abortion is a willing act of rejecting both an actual potential child and figurative future Child. Anti-abortion rhetoric reinforces and privileges the personhood of the potential child over the woman whose body plays host to the fetus—which serves to reinforce the value of the future Child. In an exploration of somatic capitalism, Sheldon (2013) notes, “One possible explanation for the persistence of reproductive futurism is that the Child provides a justificatory rhetoric of future growth, a kind of reproductive economics that matches the vehement vitalism of anti-abortion activism” (Sheldon, 2013, para 4).

Stillbirth, itself a spoiled identity of motherhood, is stigmatized, perhaps in part, because of its failure to bring about the future Child. Such failure, then, casts its biological host as a threat to the future Child’s possible material reality. Abortion, also a spoiled identity of motherhood, is stigmatized, perhaps, in part, because it rejects the expectation to want to bring about the future Child. Such failure, then, casts its biological host as a threat to the social order. Perhaps then, the circulation of pregnancy-ending testimonies functions as a challenge to the telos of the future Child, but also the dominant narrative of how children come into being, or do not.

But pregnancy-ending testimonies function more than just as challenges to the dominant narratives. In exploring the functions of stillbirth testimonies (RQ 3), there were a series of findings with strong relational and temporal characteristics and, perhaps, the most practical implications for parents, care providers and the broader public(s): testimony of pregnancy ending as a resource.

Testimony of Pregnancy Ending as a Resource

Stillbirth testimonies are valuable for a variety of stakeholders and serve a variety of functions. Stillbirth testimonies are resources for bereaved parents and demonstrate the five functions of illness-related narratives Sharf and Vanderford (2003) outline: sense-making, transforming identity, decision making, asserting control, community building. Specifically, testimonies of pregnancy ending can function as resources for support and validation for those who have similar experiences. Stillbirth testimonies are resources for awareness for potential allies and public at large; resources for stillbirth activists as advocacy; and resources for Health Professionals as intervention.

As a resource for futurity. A study of stillbirth parents showed that they had little to no exposure to stillbirth prior to their diagnosis (Pullen & Nalos, 2009). While nearly half of participants had heard of the risk of having a miscarriage from a care provider, an overwhelming majority reported that no health professional had ever spoken to them about stillbirth before their baby died. Withholding information about potential risks during pregnancy may be done in an effort to decrease anxiety in patients; however, not having a discussion about the possibility that the pregnancy may result in a stillbirth may increase negative impacts on those who are blindsided with a diagnosis their care provider never even mentioned was possible. Just over ten percent agreed that they were

aware of the risk of having a stillbirth, while even fewer, just three percent, agreed that they knew what to expect if they had a stillbirth or neonatal death (Pullen & Nalos, 2009).

Adapting to a new reality requires substantial time and energy and can be complicated by the grieving process—especially if the grieving process is itself complicated, Parkes (1988) explains, and without established schema necessary to adapt to the new situation, individuals can feel helpless and in danger. For parents who have had a stillbirth, this is especially true. Parkes' (1988) Psychosocial Transition Theory [PST] suggests that when an event occurs that is permanent, life-altering and comes with little preparation, the individual is particularly vulnerable during the time in which they must create new and previously unimagined assumptions about their future. During this transition period, Parkes (1988) says bereaved individuals need “emotional support, protection through the period of helplessness, and assistance in discovering new models of the world appropriate to the emergent situation” (p. 59). This is also true of women who have terminated their wanted pregnancies—an experience even more shrouded in mystery and stigma. After Lena's procedure, she said care from a kind nurse during the recovery process was instrumental.

I felt like shit. I mean, I felt pain. I felt nauseous. I still felt pregnant. I'm like, “Is this a cruel joke? What happened?” She said, “No. It's over. It takes your body a while for the uterus to go back down.” She was just a gem. She was very grandmotherly-like, motherly in a way. I was crying and felt horrible physically and emotionally. I was in recovery for a very, very, very long time. I had a hard time. She said, “It's gonna be okay. It's gonna be okay.” She would say “dear,”

and she would touch me. She was just very caring...I didn't feel judged by her. She was very concerned about me. She knew, obviously, what had happened and would put cloths on my forehead and wipe my tears and just checked in a lot. The very nurse that helps Lena transition also becomes a part of the story that Lena constructs about her baby.

I will never forget her. I used to, later, see her once in a while around the hospital. I always just say, "Hi." I don't think she knows who—remembered who I was. Every time I saw her, I would just say, "Hi." She'd just always say, "Hi." I didn't care if she didn't know who I was, but she was part of my baby's story."

As evidenced by Lena's testimony, new models of thought necessary for transition into the future can be influenced by care providers. Without a narrative of what stillbirth is and what life after the death of a baby looks like, the intervening period a bereaved parent faces—between the world she knew that once held her future baby and a previously unimagined one that integrates her loss and begins to see a new way of life—the transition period can be confusing, traumatic and overwhelming to navigate. In Chapter Two, Tee talks about her the fog state she was in after she received the news of her baby's stillbirth. "I just kept crying hysterically and my husband was crying. Everybody in the house was crying. Nobody knew what to do anymore." She talked about the nurse that guided her and her husband to take pictures of her baby. It was also a nurse that had earlier helped her prepare for the delivery and may have validated Tee's relationship with her baby. Tee said:

[The nurse] was amazing. She was just trying to take care of me as much as possible. I could see the tears in her eyes. Just watching me cry...(crying). So she

was going through this pain as well...And, she was holding me, telling me exactly what to do for the spinal that they were going to give me and how it was going to make me feel. And one of the doctors came in...and she had told him, “we have Princess Belle coming out and she's the little princess.”

Each person’s story is unique, and so is his/her vision of what they expect or desire for the family. But common to each bereaved parent is the shattering of their imagined future and grappling with an uncertain, and possibly unimaginable, resumption of life without their baby. Stillbirth testimonies can act as resources for futurity during a parent’s psychosocial transition.

Additionally, these stories can serve as resources for parents attempting a subsequent pregnancy. These stories can help validate the normalcy in the range of feelings from devastating grief from the death of their baby, to anger and rage at other pregnant women, and to desperate desire to be pregnant again. But the stories can also be challenging for those whose desired future is no longer available to them. Tee stopped going to the support group after women who had losses around the same time she had were getting pregnant.

I could no longer handle the fact that me, my husband, has chosen not to have any more children. It's not a mutual decision. So while I'm hearing everybody's story of loss, there's also stories of new pregnancies and it just became too much for me.

Lena, who terminated her wanted-pregnancy due to a genetic anomaly, said that other women’s stories of subsequent pregnancies offered her hope, but at the same time reminded her of what she would never have.

[The doctor] was so sweet, an older gentleman, African American, and he just said, “I’m really sorry this has happened to you.” He turned around and he pulled out this big box of photos of all babies. I’m like, “What the hell’s wrong with this guy?” He said, “These are all babies of people who have been in your chair, and they went on and had healthy babies.” I’m like, “Okay. He gets it.” He knew that this was a very wanted baby, very wanted, and how painful it is to—and, again, I really felt like I wasn’t making the decision. I felt that medically the decision had been made. There were really risks for me to carry him to term as well.

I just felt like this is—it was in that moment that it gave me hope. At the same time, to see pictures of babies and to realize that I would never see him, I wouldn’t know what he was gonna look like. *[Pause]* I wanted to know what he looked like. It was hard and good at the same time.

Women with unexpected and unwanted pregnancies may undergo a psychosocial transition as well, but by having an abortion, they are able to return to some semblance of their previous worldview. Andi said her choice to terminate was informed both by the life her mother had lived and the visions Andi had for her own future.

My mom was really unhappy. She did a lot of self-sacrificing and she would kind of blow up. And in my twenties I was a lot like my mom. I was scared of my mom growing up and I knew that I would probably be the exact same way with a child, so when I was married I knew that I just I didn’t want children at that time.

My mom had wanted this life in the arts, and her parents said no, you can’t do that so she got married and her life was over. And I think I am living the life she wanted to live. And she’s just my biggest champion.

Andi explains that she had never imaged herself having children. While she has no regrets about the abortion she had in the 1980s, she does have feelings she has had to work through.

One can be very sad about the experience. One can go through the emotion with it and still know it was the right thing to do. So that sadness and emotion doesn't mean that I made a mistake. If that is the choice that one feels is important to make, we have to have a way to help that process.

As a resource for pregnant women. Testimonies of pregnancy ending can also be a resource for women whose pregnancies do not end prior to the birth of a live baby. Marilyn, a friend, had videotaped the first night of the performance while she was 32 weeks pregnant. She called me a few weeks after her baby, Emma, was born and eventually the conversation turned to the details of her birth story. Her plan for a natural birth had to change after 50 hours of labor (which started nearly two weeks before her expected due date). The decision was made to have a C-section. "Oh, you should have heard me," she said. "I gave it to them. I told them that no matter what, I wanted to feel her being born. I didn't want to miss a second. I wanted to be conscious and I wanted to be able to be with her right when she was born. I was like, 'You don't understand, I saw this performance and...'" (Marilyn, personal correspondence, February 11, 2015). Marilyn went on to explain how the performance informed her decision-making process and helped her advocate for her and her baby.

It was the performance that taught me- about advocacy, about the procedure, about what to ask/demand/plan for in case of an emergency, and I would say that your performance of Tee's narrative certainly gave me lots to think about, that

although meant "little" at the time (given my plan for a vaginal birth), sprung to mind the moment a decision was made to do a Cesarean. The C-section was unplanned, and at the time, I remember feeling like I failed- that my body failed, that perhaps I wasn't able/supposed to have children if I couldn't deliver vaginally, that I/my body had given up on Stella. Part of what helped me shake these feelings, was KNOWING that I had other important decisions to make, and KNOWING that I was educated enough to ask/demand for certain experiences. I denied anesthesia that would put me out, I denied the muscle relaxer that would calm me and the baby, I told EVERY NURSE and DOCTOR who entered the room that I was afraid I would be asleep and miss the moment Stella was born, I told them all that I must be awake and get to hold her, and that Shaun would not be leaving her side, that Stella would not be given formula but handed to me for breastfeeding. These things, in all my delirium, I was able to communicate... in large part because of the stories you shared. (Marilyn, personal correspondence, February 11, 2015)

The stories also serve as a resource for expectant parents with positive outcomes. In most cases, C-section is something that most parents and health professionals view as a last resort. But if parents do not have discussions with their doctors about what to do in the event things do not go as desired or planned, then decisions have to be made in the rush and anxiety of urgent medical interventions. When your doctor says, "We need to do a C-section," unless you know that the default practice is to put the mother under anesthesia so she is unconscious for the birth, then you will not know to ask for another

option. “Oh, yeah. Those stories can change the first moments parents have with their child,” Marilyn affirmed.

Marilyn’s cousin had a baby who was stillborn when Marilyn and I were halfway through our doctoral program. Marilyn had been familiar with my story and my advocacy for stillbirth families and had called me for advice the night she found out her cousin’s baby had died. I mentioned it to her as we talked about how information gets shared through story.

I called my cousin, before she went in the hospital, and shared your story and advice. I told her that she can ask to hold Rachel, to take photos with her, to keep her misc. baby trinkets from the hospital, these types of things. I remember her being surprised, somewhat, that she could "DO" these things. I think these made her experience more real, personal, filled with love- rather than just undergoing a "procedure." I know that she has the ashes of Rachel, that she held her in the hospital once she delivered her, that she has some photos and trinkets (though I don't think she can/will look at the photos quite yet), that she talks about Rachel as a living, breathing daughter. I can't even begin to imagine her experience, but I can imagine my cousin feeling empowered, smart, and prepared to ask questions and advocate for herself.

In these ways, stillbirth testimony becomes *resource for advocacy*. Awareness about options and potential choices available, increases agency and opportunity for access to preferred care. They are resources, not just for soon-to-be bereaved parents, but for their family members, health professionals and community members.

Stillbirth testimony also functions as a *resource for informed decision-making*. Knowing other parents hold their dead babies, take pictures, bathe and dress them, can challenge knee-jerk sentiments that people might think it is strange, morbid or unnatural to want to do these things. Without cultural rituals or customs to guide decision making related to infant death and dying, without stories of post-mortem care practices circulating in popular culture and without health professionals warning about potential negative outcomes or talking about what happens after a baby dies, newly bereaved parents have limited to no access to information what their options are—let alone time to figure out what options they want to choose.

As a resource for public awareness. Many audience members after the show commented on the ways that they had been unfamiliar with the experience of stillbirth or mentioned people they knew who had experienced pregnancy loss, including their own mothers or close relatives, but who had never talked about it. Several people mentioned they had never considered the impact of abortion laws on women who had wanted pregnancies.

Testimonies of pregnancy ending can also be a resource for medical professionals. Some hospitals and medical education institutions will have parent panels share their testimonies of stillbirth with health professionals about their experience. They are deeply personal and emotional sessions that are aimed at raising awareness and building empathy. Staged performances of stillbirth and pregnancy-ending testimony can do this as well. My own primary care doctor attended the full-length solo ethnography performance. He waited for me after the show to tell me that he had never realized how devastating stillbirth was for patients and had never known about the range of pregnancy

loss experiences. He added that he had been deeply moved by their stories and he would remember them should any of his own patients have a similar experiences.

As a resource for reproductive justice. Chapter One briefly touched upon the ways that some activists saw testimony as an essential resource for reproductive justice. Three participants explicitly mentioned the value of stories to help shift not only the conditions of discourse surrounding pregnancy ending, but legislative and medical policies surrounding it. Diana, who as a pregnant teen in the 1960s had given her baby up for adoption and had subsequent miscarriages and abortions, advocated sharing more stories of pregnancy ending to combat the associated stigma. She said:

I think it's really important because I think that's part of the reason all these laws are being enacted against us is because the stories aren't being told they aren't being shared. There is too much shame and guilt attached to it and so people think even miscarriage is somehow our fault—it's women's fault that we've lost the baby, you know? So I think if people share their stories and emotions that go with the stories with men they would possibly be more open minded to better laws. I do believe that.

Raven, explicitly referenced the relatedness she saw of stillbirth and abortion experiences, as well as their differences, within the realm of reproductive justice. She acknowledges, as has the work of this dissertation has, that choosing to have an abortion and having a wanted baby die are not the same socioemotional experience. However, she believes that:

It also feels intensely compassionate to me to include women who have had abortions in that framework because there is still—I guess there's a thing of—

well, first of all, no matter when you have an abortion, pregnancy from the moment it starts does all kinds of shit to your body, all kinds of hormonal changes and physical changes that are part of the process, so there's that.

I mean it's always been like one of my things about like reproductive justice stuff and feel like, well, women who get pregnant should just have the baby and give it up for adoption. It's like my body is completely different than it was before I ever got pregnant. It's not a light thing to get pregnant, whether you keep the baby, even whether the baby lives, like it's a huge fucking deal.

[Laughter] I'm serious. I weighed 120 pounds when I got pregnant and had tiny boobs.

She says that her stillbirth made her even more adamantly supportive of reproductive justice.

I have always been like prochoice is the short term of the short terminology—shorthand terminology. I definitely see it in the context of reproductive justice which is like that every woman should be able to decide if she is going to have children, when she's going to have children, how many or to not have, that those choices should be available to every woman.

Part of the thinking around that is that sometimes there can be a shortsightedness of like everyone deserves the right to abortion. Right, but I actually want a world where everyone who wants to have a child can have a child. And that requires economic justice and racial justice and probably total transformation of society to get there. It's not justice if it's only that you can choose not to. You have to be able to choose to as well.

Function of Stillbirth Testimonies for Bereaved Parents

Sharf & Vanderford's (2003) five functions of illness-related narratives are imbedded in performed stillbirth testimonies that then become resources for sense making, identity transformation, decision making, asserting control and community building for those who are pregnant, potentially pregnant and their caregivers. One of the participants, Sanjana, had a profound response to sharing the story of her three miscarriages and witnessing her story being told on stage.

Thank you for inviting us over to be part of your performance. It was wonderful to see our story being enacted and I'm sure it would have helped someone in the group there. We feel good to know that our Aditi did her bit in this world. We really felt inspired hearing other stories as well.

My husband feels your mission is a noble one. It will provide both confidence and awareness about abortion, miscarriage and stillbirth. And as far as my experience is concerned, I never knew what a woman goes through when she has an unwanted pregnancy and what her feelings are like when she has to abort it until yesterday. In one of the stories, a mom said the fetal cells of all my babies are still inside me and it makes me feel that my babies will be within me forever. This was a new information to me and it means my two kids and Aditi are still somewhere within me. We would have been at a loss if we missed your performance and it was an enlightening experience for both of us. (Sanjana, personal correspondence, October 24, 2014)

Even while witnessing her own story becoming a resource for others (“I’m sure it would have helped someone in the group there”), the stories of other women in the performance became a resource to her. One story seemed to help her *make sense* of the physical impacts of pregnancy loss as a potential for spiritual meaning and healing (“A mom said the fetal cells of all my babies are still inside me and it makes me feel that my babies will be within me forever. This was a new information to me and it means my two kids and Aditi are still somewhere within me.”) This shift in cognition might also contribute to *transforming her identity* and her conception of miscarriage as the absence of her babies to the continuing presence of some part of them still being with her. (“We would have been at a loss if we missed your performance and it was an enlightening experience for both of us.”)

For Sanjana, the act of testifying to me for the project seems to have been even more *transformational* to her.

I believe the email that I received from you requesting for women to share their experience on abortion, miscarriage and still birth via GradAd changed my mindset about my miscarriages. Till then I kept my stories (especially Aditi's) as a secret; something only my family knew. I wanted to keep my baby hidden from the world because I thought my story will scare women. Never did I think my baby had the power to inspire and give hope to other women. It was from your email that I knew my story can actually help someone. (Sanjana, personal correspondence, October 25, 2014).

Just knowing that someone was seeking out stories like hers was empowering to Sanjana. Instead of viewing her experience as something that “will scare women” she thought of it as a something with the potential to “inspire and give hope to other women.”

On the day of our meeting, I had no clue what you would ask or what I'd say. But at the end of our meeting I had poured out everything I wanted to tell the world. Those were the words that I wanted to say but never had the courage to. I kept my feelings and words suppressed. At the end, you asked me why I decided to share this story with you and I told you I want to inspire others. On the way back home I kept thinking what more can I do to help others with my story and I did my research online. The same day I applied for a volunteer position as a Women of Empowerment at Miscarriage Matters.com. I now help 11 women who have been through my path. Whenever they thank me I think of my babies. So as I said yesterday, it was after meeting you and knowing how you started doing something so good from your story that made me volunteer for this cause.

(Sanjana, personal correspondence, October 25, 2014).

Sanjana uses both my story and the act of sharing of her own story to *warrant the decision* to go from keeping “my feelings and words suppressed” to taking additional action to “inspire others.” She *asserts control* by signing up to volunteer the same day she told her story to anyone outside of her family for the first time. Instead of walking alone in her journey, she has now *built a community* of 11 other women within a larger online miscarriage community.

At the same time, there also may be a beneficial impact for some of the participants for whom the act of telling their story allows them to incorporate their

traumatic experiences into their new world view. Herman (1997) explains that the goal of sharing one's trauma story is not exorcism but integration. "The fundamental premise of psychotherapeutic work is a belief in the restorative power of truth telling. In the telling, the trauma story becomes a testimony," (p. 181).

Testimonial Loop Model's Relationality and Temporality

Testimony is inherently temporal. It acts as evidence of a past experience, that may be influenced by the shifts in perspectives and memory of the teller over time, and it calls for the events being related to the present into which it is told. It then may re/circulate digitally or face to face and it may be taken up as a resource to be used by others in the future.

Testimony is also inherently relational. The individual has a relationship with the events and experiences that the testimony represents. The listener or the witness of the testimony has a relationship, no matter how temporary or lasting, with the teller, and vice versa. The witness then has a relationship—through the testimony—with the characters and the events described within the narrative. These relationships may influence future decision-making, identity construction, sense-making, community building or assertion of control. Testimony conjures and names real and imagined relationships that are also temporally bound. While this chapter has focused mainly on evidence of relationality and temporality as dimensions in participant's individual testimony, the ways that relationality and temporality influence testimony's effect on dominant narrative will be address in the next chapter.

Conclusion

Every single relationship conjured by testimony is different and is constitutive of, and by the interaction. Performance of testimony can constitute new sets of relationalities which are distinct and be constitutive of relations that are both real and imagined. The relation between Sanjana and myself is real, if constrained and temporal. Constrained by the roles we are playing, interviewer and interviewee, researcher and participant. But we also have another contextual relationality as community members based on a similar experience of having a wanted pregnancy end. This relationality may be constrained by the differences in our pregnancy loss experience (her miscarriage, my stillbirth) or by cultural differences (she is an international student from East Indian, I am third-generation European-American) or by our experience of personal disclosure (I am the first person she has told her story to outside of her immediate family, while I have shared my story prolifically in different formats for the last 10 years).

This leads me to back to my earlier inquiry about the performance of testimony informed by Madison's performance of possibilities: Can I be an out-group member and still engage, understand and perform testimony the same way an in-group member would?

I was one of those unmarried women who got pregnant by accident and had to choose whether or not to have a child, and whether or not to have an abortion. I do not have access to the same sense memory of the experience of abortion and its biophysical and (potential) socioemotional consequences. Does that mean that despite my best intentions to represent their experiences as authentically as I can, I am unable to engage the same somatic experience? Perhaps those in the audience who have never had the

experience of abortion do not notice. Maybe my skills as a performer are good enough that those who have had an abortion will feel some resonance with the story. But what of the woman whose story I tell, but do not tell quite right? Or if her story is edited to fit a larger arc of the play itself and it does not tell the part she feels most important, or it is not performed in a way that resonates with her own sense memory of the interview or the originating experience itself.

Can I be an out-group member and still understand the way an in-group member would? No, but with cautious humility, I can work to get closer to the experience through embodied performance. As a performer, with specific training in a somatic storytelling and witnessing practice, I am sensitized to the exchange happening. Others can bring their awareness to the interviewing process as well, but it may require time and practice to become comfortable with the vulnerability and self-reflexivity associated with such a practice.

Is it still testimony? I am performing my testimony of their testifying to me. It is a performance of someone else's testimony. I am not claiming that it is my testimony, but rather that I am a vessel through which the testimony of another may travel. The videos I showed of Jackie Speier testifying that she had an abortion, which was actually the termination of a failing—wanted—pregnancy, traveled to the audience through a digital medium. I cannot provide that type of specific replication of the event that the video does. But I can bring enfleshment to the testimonies that bring a real-time experience closer to the audience in a somatic relationship with them. Live performances that, Conquergood (1992) explains, are limited in memetic capacity, but are richer in their

kinetic capacity as “discursive acts that insinuate, interrupt, interrogate and antagonize powerful master-discourses” (Conquergood, 1992, p. 84).

Bringing the performer and the audience together in a particular moment is both relational and temporal. Testimony is not claiming to capture the absolute Truth of an experience. But rather testimony re/presents a particular memory at a particular point in time as remembered, and has become truth for the individual whose body once experienced it. Testimony does not claim to speak as accurate historical record. Indeed, what historical record can or ever has re/presented the events in time accurate to all those who participated—even the most well-intentioned documentary based on a multiplicity of diverse sources? As time travel is not possible, we can only revisit or return to a past moment by a re/presentation of it. Video may document an event, but not the sensory taste or smell or embodied experience of the event. Performance of personal narrative testifies to the past, Park-Fuller (2000) explains, “but also against the frames and mythologies surrounding the crises and diseases they discuss” (p. 28).

Each performance is an epistemically incomplete telling of the landscape of pregnancy ending, as it does not/cannot represent all stories. Representing different types of stories and understanding that there is no *One* story. It is not realistic to think one performance can represent all stories of different influences of culture and sexual orientation and class and privilege and political oppression. Perhaps, for example, despite my best efforts, my dramaturgical choices may have seemed to reify the dominant narrative of abortion as something that should be treated as "a difficult choice" or something to be regretted.

Performance cannot speak to all experiences, nor can each story speak for the entirety of pregnancy-ending experiences or even of the entirety of the individual's experience. These are the inherent limitations of trying to capture another human being's experience or the human being capturing their own experience transparently communicating what we know, or we think we know, to be true. Testimony speaks only to its own experience. And as such, testimony claims its ethos in the body's memory and in its performance of re/membering.

Dear Suzanne. I, your son, was really scared when you were in the hospital. Please, if you can please, please, please, don't do that again. I know it can't stop it! I got a little dramatic. But that really scared the living daylights out of me! I know you didn't do it on purpose. But I really love you. (Quinn, personal correspondence, October 24, 2015).

After the show Wednesday night, once the pain meds and the adrenaline wore off, the fever and pain returned and I was taken to the E.R. They wanted to operate the next morning, but I convinced them to wait until I had finished the performance series. I missed the ensemble performance on Thursday night, but with antibiotics and pain meds I made it through Friday's full-length solo ethnography and Saturday night shorten solo show. But Sunday morning found me back in the hospital after the symptoms returned. They finally removed multiple ovarian cysts, including the large one that was first detected at 3 cm (shortly after I started the doctoral program) and was 8cm by the time of the performance. They discovered during surgery I had severe endometriosis that had gone undiagnosed and was the source of the extreme episodes of pain I had been

experiencing for the past three years. They were able to save my ovaries and removed as many endometrial adhesions as possible. In order to try and reduce the severe menstrual bleeding and removed the excessively thick lining from my uterus that was causing my anemia, they performed a D&C—the very procedure that five of the eight women whose testimony I had just performed had had.

A D&C. In Arizona. The last thing I wanted.

A procedure that, in Arizona, if I had had a fetus in my uterus, would have been highly regulated by the state; but because I didn't, it was considered a medically necessary procedure that the state doesn't interfere with much. My body experienced the differential treatment afforded me by the absence of a pregnancy that would have made me subject to the will of the state. But the procedure reinforced for me the importance of advocacy on behalf of women whose bodies are not afforded the same privilege I was.

CHAPTER 6

IMPLICATIONS OF TESTIMONY AS SUPPORT, INTERVENTION, AND ADVOCACY FOR FAMILIES OF STILLBIRTH

It has been the parent groups asking “Why did our babies die?” that has pushed us researchers to do our jobs. Your stories propelled action. (ASAP stillbirth webinar presenter, personal correspondence, March 24, 2014)

The work of this dissertation began in Chapter One by exploring stillbirth as a communication phenomenon and discussing its consideration in the field of reproductive justice. Chapter Two extended the definition of Testimony and detailed its convergence in rhetoric, performance and narrative frameworks, and a mixed-methodological approach laid out the use of critical rhetorical and performance ethnography in exploring both naturally occurring and solicited testimonies of pregnancy-ending narratives. Chapter Three observed three types of eruptions of publicly occurring pregnancy-ending testimonies in state forums and public spheres to understand how testimonies of abortion and stillbirth might circulate in the current conditions of discourse. It explored several moments of visibility offered by the testimony of grieving and after-death care practices that may provide a window through which the conditions of discourse about parental bereavement may open. Chapter Four discussed the collection of a range of testimonial texts. These included the private-to-public letters about stillbirth bereavement of historic figures and the public letters employing private modes of address in support of abortion access. Interviews of eight women whose pregnancies had ended due to abortion, miscarriage, stillbirth or termination of a wanted pregnancy due to genetic anomaly, were also described. The crafting of three separate scripts, an ensemble ethnodrama based on

historical and public letters, and two versions of the solo performance ethnography, was discussed, and excerpts from the scripts were given to introduce the different characters represented. The elements of the multimedia installation, based on the research of Chapters One and Three, were also described. Chapter Five discussed the discoveries from performances of testimonies that were staged, including somatic sentience in performance ethnography, and themes of relationality and temporality in the performance of pregnancy-ending testimonies.

This chapter focuses on the contributions this research has made to the understanding of testimony and will track one participant’s stillbirth interview through the Testimonial Loop Model. The concept of somatic sentience and its contribution to understanding the communication and relational interactions in performance ethnography will be clarified. The potential use for the performance of stillbirth testimony as support, intervention, and advocacy, are outlined, and areas of future research and the limitations of this research project will be addressed.

Contributions to the Understanding of Testimony

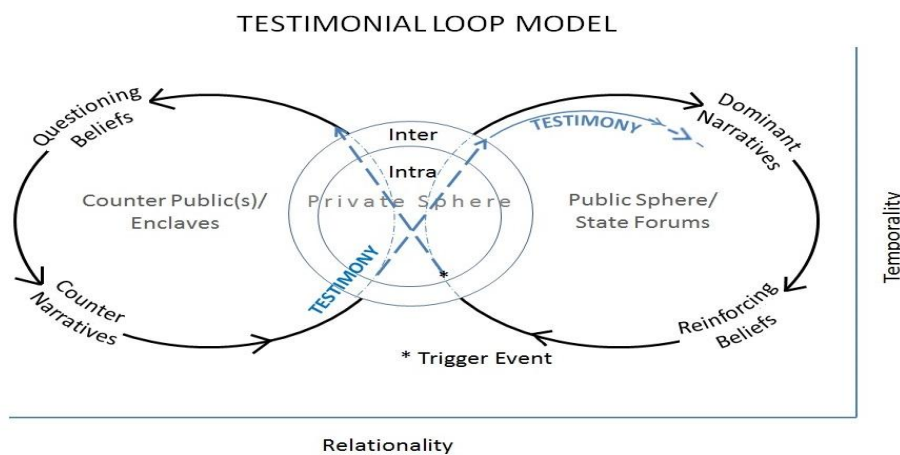


Figure 5. Testimonial loop Model B. This model incorporates temporal and relational dimensions to clarify testimony’s function and circulation.

Stillbirth and the Testimonial Loop Model

Chapter Two introduced the Narrative Loop Model. Chapter Three introduced a modification called the Testimonial Loop Model that incorporated public(s) and counter public(s) theory to show testimony's orientation and trajectory. In Chapter Five, the X and Y axis of relationality and temporality helped to deepen the explanation of testimony's function and circulation. In order to further illuminate how testimony travels through the entire loop, I will take one participant's interview and mark her narrative journey through the model. Brandy's interview nominates itself as the freshest narrative, as she met with me only three months after her daughter's full term stillbirth, and her story has many elements in common with other stillbirth narratives I have encountered. Additionally, African American women are at a higher risk for stillbirth in the United States but their bereavement and stillbirth experience is not often studied (Van, 2001; Van & Meleis, 2003). By selecting her narrative to analyze, I hope to amplify the experience of a member of an understudied population.

Dominant narrative and reinforcing beliefs. The interview with Brandy began with my asking her if, prior to her own stillbirth, she had ever heard anybody else's story of having one or if she had been familiar with what it was. Her reply is reminiscent of the discussions in Chapter One in which the language used to represent stillbirth hides the meaning of the experience. She said:

Before I got pregnant, I had never heard about stillbirth. I'd heard the word, but I didn't really know exactly what it was. I just knew the babies didn't make it. Which it is, but it's a lot deeper than that. I didn't know about it. I had a few people that I knew who lost their babies. Because you don't know about it and

because it's not talked about, you really don't think about what they go through or what happens.

While Brandy has had friends who had pregnancy losses and babies die close to their due dates, she said that they never used the word "stillbirth" and rarely gave any details about what had happened.

Just they lost the baby. That's the phrase I would always hear. "Oh, we lost the baby." [A] friend that I had, the same thing. She was pregnant. I think it was past six or seven months. It was like, "Oh, how's everything going?" "Oh, she lost the baby."

She remembers calling one day to see how a friend was doing.

All I know is that she was pregnant. Then, I called one day and, "Oh, how's the baby?" Her husband was on the phone. He was like, "Yeah, the baby's not here." I was like, "Oh." I didn't know what to say.

Sometime later, but several years before Brandy herself had her stillbirth, those same friends asked her and her husband to be godparents for their subsequent child. She says her friend never went into much detail about the previous baby's death. "I was there to support her, but not the way that I know I should've—*now* that I know I should've—because I didn't know that [then]." These excerpts show that part of the dominant or cultural narrative about stillbirth is that it is shrouded in secrecy and uncertainty. When the baby lives, as is expected, we publicly celebrate the new arrival; when the baby dies, which is unexpected, the grief is private and undiscussed. Brandy does not take the conversation farther with her friend whose baby died because, in part, she does not know

what she is supposed to say, but also because she has no existing reference or narrative resource to imagine what has happened and how her friends might feel.

When Brandy got pregnant, things seemed to be going well according to a five-year plan she and her husband had created and might be representative of a dominant narrative of wanted pregnancy.

My husband and I, we talked about children as soon as we got married....Everything was happening the way we wanted it to. We saved up money. We purchased our first home. We lost weight together. Sure enough, the first time that we actually tried—cuz I was using birth control before—I had an IUD. Two months after, when we were ready to actually try, I ended up pregnant. Things couldn't have been more perfect.

When she posted that she was eight weeks pregnant on Facebook, some people were upset because she was not out of the “safe zone” of the first trimester and she should not talk about it publicly before then. This demonstrates the cultural narrative of secrecy of pregnancy prior to the 12th week because miscarriage is common. But if more people talked about being pregnant from the first positive test strip to people outside of their inner circle, like co-workers, classmates or casual friends, then we would be talking more about pregnancy losses. That we do not reinforces the belief that we should not.

Stillbirth and the “doctor knows best” trope. In relationship to pregnancy, the “doctor knows best” trope reverberates to several effects. It was the core of the Roe vs. Wade decision (Gibson, 2008). It is still a common trope seen when pregnant women report being hesitant to call their doctor about a concern they have because they do not want to be seen as hysterical or a complainer. “I remember feeling a little nervous but not

something that would really throw me to go to the doctor's right away," Tee said, when she noticed her baby was not moving in a way that was usual for her. When the problem continued, she contemplated getting a Doppler from the local *Toys R Us* so she could listen for the heartbeat. "I was freaked out to that point but still...I didn't want to be so paranoid."

In the late stages of pregnancy, Brandy felt something was wrong. She felt as if her baby's movements were not what they should be, and she went to the hospital repeatedly with her concerns. But each time she felt as if she should not question the health professionals—who she believed were supposed to know better.

I'm not afraid to question what somebody tells me...I felt like I was doing my child a justice by shutting my big mouth up and letting the people who knew best do their job. Because I felt like I wanted to protect her. I felt like the doctors knew better than me. I've never been pregnant before.

She did not want the "stigma of being a first-time mom" who was worried about everything.

All pregnant women are paranoid. They make you feel like—they make you feel paranoid. They just make you feel paranoid. "Stop looking so much into that." Everything gets dismissed. "Oh, but I felt that." "Oh, no, that's just—oh, you're so cute."

Triggering event. After the two visits to the hospital over the course of several weeks, Brandy returns to the emergency room for the third time when she does not feel her baby moving. "I'm like, 'Let's go. Let's just go again.' I don't care. Whatever little thing I feel, I'm going. They gonna keep me." This time when she arrives, she

experiences three elements at the core of most stillbirth news delivery, a delay in news delivery (due to multiple exams by different care providers with different equipment), an expression of sympathy and death notification (Pullen et al., 2012).

This time, we went. Another person comes in, looking. Another person comes in, looking. “What’s going on?” “Sorry, we can’t find the baby’s heartbeat.” “Okay, well, what can we do to find it?” “No, the baby’s not with us anymore.” I’m like, “What? What are you talking about? We’re done. I’m past 40 weeks. What do you mean, the baby’s not here? How?”

Once she is told of her baby’s death, one type of triggering event, the trajectory of her birth story shifts. She has to process what the news means. This transitional time is filled with confusion, denial, or doubt about whether or not the baby is actually dead, especially if the death is implied (“We can’t find the baby’s heartbeat”), or phrased idiomatically (“No, the baby’s not with us anymore”), and without a direct statement of death (Pullen et al., 2012).

Intrapersonal and interpersonal dialogue. After Brandy is told by doctors that they cannot find a heartbeat, she is confused and in denial. Not only is she interacting with the care providers, but she is trying to reconcile, intrapersonally, the sudden collapse of what she has projected about her future, her identity as a mother and her expectation of giving birth to a living baby. She seeks guidance from her God and depends upon her faith for reassurance at the same time insisting that the doctors prove to her that her baby is dead.

My husband and I, we prayed. Then we asked them to look again. She’s like, “Oh, well, we had three people confirm it already.” I’m like, “You can’t look again?”

She looked again. Then she showed us where we should be seeing the heart flutter. She showed us where there should've been oxygen flowing, and showing how it would be color-coded.

Then Brandy asks what they are supposed to do next and is confused when she is told she can go home and let labor happen naturally. For the doctors, the emergency is over. The patient who requires careful monitoring during labor, the baby, is already dead. Since the mother shows no signs of an emergent medical issue, they send her on her way to let “nature take its course.” But for Brandy, the lack of a heartbeat means that the baby should be taken out to revive.

I'm like, “We can't have an emergency C-section?” “Oh, we can't risk your life for a dead fetus.” A dead fetus? It's my daughter. It's not a dead fetus. She has a name. It was just levels of insensitivity.

This comment, and the use of the medical term “fetus” rather than “baby,” infuriates Brandy, as it does many stillbirth parents—possibly because it does not represent the relationship felt by Brandy, but also because of how the word “fetus” is tethered to abortion discourses. She explicitly questions the doctor's medical advice and the construction of her daughter's identity and the seeds for an alternative narrative are planted. This discourse is still in the private spaces of interpersonal communication with close family and friends, but evidence of her questioning beliefs and building a counter narrative are faintly visible.

We asked to be induced. We called family members. We called our parents. We cried a little bit. I just couldn't believe that I was making this phone call. Family

members came. Our pastor, and assistant pastor, and my pastor's wife came. A few friends came.

We still was presenting it like she wasn't dead. We were like, "Oh, they're saying that the baby is dead. They're saying that there's no heartbeat." We were still praying.

Questioning beliefs. Brandy feels she knew something was wrong with her baby and she questions the ability of those entrusted with her care, and the care of her baby, to do their job—in part because they called into question her ability to sense changes in her baby's movements.

[When the nurse said,] "Oh, these children'll make liars outta you [*laughter*]."

Liars out of me. You're saying that it almost looked like I was lying. Not literally, but you know what I mean? That's how off [they thought] I was. Cuz she's kicking up a storm, so you don't even know what you're talking about, but I knew.

She questions their treatment of her and their dismissal of her mother's intuition—which actually may be a physiological awareness that her baby's movements have shifted from their pattern. According to O'Leary, Warland, and Parker (2011), prenatal motherhood is an embodied relationship to the unborn baby, and results "in the mother's special awareness of her unborn baby that no one else knows or can truly understand," (p.218) which, they explain, means that mothers can know when the baby is at risk. O'Leary et al., (2011) go on to say that, "Many times, bereaved mothers have told us that they intuitively knew their baby who died was in trouble, but they were unable to convince

others” (p. 218). Brandy says that part of the reason no one believed her is that when she was monitored in the hospital, her baby’s heartbeat presented as normal.

Which has to make you start thinking, okay, there are other indicators besides that. Or other things to look out for, besides just that. A baby’s heart rate can present well, and the baby could still be in distress. What are other signs of distress? What other things can we look at? Because how many babies are having normal heart rates, but they died?

This internal somatic sense may be invaluable to protecting babies’ lives, but the cultural narrative is that new mothers are paranoid and should not bother the doctor with every little thing because it will overload doctors with unnecessary visits. The dominant narrative may cause a paradox for mothers and could have the chilling effect of silencing their internal warning mechanism. How active dismissal by medical professionals or a dominant narrative that dismisses instinct as paranoia may contribute to the stillbirth rates is beyond the bounds of this project, but is worthy further study.

Counter narrative. Brandy’s stillbirth is a triggering event that causes her to realize that her experience of pregnancy is not represented in the dominant narrative. More specifically, she seems to pinpoint the comment from the nurse as the moment in which she begins question the belief in the “doctors know best” trope. “Cuz she’s kicking up a storm, so you don’t even know what you’re talking about, but I knew.” She knew her baby was in distress and she now knows that babies can die. Neither the dominant narrative of wanted pregnancy nor the trope that reinforces the superiority of doctors in the realm of pregnancy holds up for her anymore. In the vacuum created by a narrative she now rejects—and in the absence of another stillbirth narrative that might have acted

as a resource for her—she creates her own counter narrative in which doctors do not know everything, stillbirths happen, moms should listen to their instincts and they should demand that their doctors listen to them.

I feel like, with stories like mine, where you have gone to the doctor, I just feel like... You don't really know what to say, what to ask. It's not your area of expertise. Somebody can bully you with stuff that you don't know about. You feel a little inferior.

The biggest thing is speak up. What difference does it make if you are paranoid? What harm really happens by being paranoid? Even if nothing becomes of it, and they were right, what really happens outta that? Maybe your pride gets hurt... A little embarrassment for over-dramatizing, but that's about it. I'll take that than a dead daughter. That shoulda mattered more than me feeling embarrassed.

Counter narrative's transition into testimony. Brandy then calls forth a public beyond her interactions with family, friends and church members. She orients her counter narrative towards the broader publics she believes need to know what happened to her and that it can happen to them. In thinking of an audience beyond her family, and in imagining other potential other parents this could happen to, she directs her story toward the narrative that does not include her. Through this orientation, her narrative becomes testimony.

This has to be—it has to be known. I'm just upset that we never knew about this. I'm upset that I read my baby book, month by month. When my baby died, what are they talking about stillbirth? Cuz it wasn't in my book. I put that on my

website. Oh, nope, it was at the back, and I didn't make it to that chapter. That's why it means—to tell her story is addressing everything head on.

But not only does Brandy challenge the dominant narrative with her testimony, she denies that it is a representative one. “Because I represent the average person,” Brandy says. “We walk around, thinking that it can't happen to you. You know what I mean? But it can. We need to address it head on.” Brandy also takes an activist stance. So not only does she offer testimony as evidence, her testimony is a call to action that she herself has acted upon. She created a website dedicated to raising awareness about a particular cause of stillbirth (that she believed caused the death of her baby) and began volunteering with a stillbirth prevention organization.

This is my life now. I'm forever changed. I'll never be the woman I was before. I can't relate to the people I've related to before....[It's the] advocacy stuff, awareness stuff that I wanna do. It serves more of a purpose.

Once narrative transitions to testimony, several pathways are available to it. Testimony can continue to circle around in the left circular loop, and not leave the relative safety of the enclaved spaces of stillbirth organizations or support groups nor travel beyond the intra- and interpersonal realms of the private sphere. Testimony may keep one eye oriented toward the right circular loop or turn its back in rejection of the dominant narrative as a source of any validity. Either way, testimony has acknowledged a dominant narrative exists and has responded to it in some way. But when testimony speaks itself into spaces where anyone may stumble upon it or be exposed to it; when testimony shouts in defiance at the dominant narrative in public acts of protest; or when testimony quietly speaks its truth in places that matter, testimony goes public. Testimony

travels on a second pathway, transitioning into the public sphere or, possibly, into state forums.

Testimony's action on dominant narratives. Once on the pathway that takes it into the public sphere, testimony's action upon the dominant narrative, which is influenced by temporal and relational effects, can be observed taking two trajectories that have been addressed in this dissertation. The first trajectory is marked by an eruption. Like Speier's disclosure on the House floor, it ruptures the skin of the dominant narrative and forces a space for itself. The split flesh may grow wider as more people respond to or circulate the act of testimony. This may cause the surface landscape to change to incorporate a new topography. The dominant narrative then shifts to include the realities called forth by testimony and names those additional truths as its own. Or it is possible that the eruption may scab over and leave a scar that only those who were present for its making know what it means. The Santorum and Duggar eruptions seemed to have faded from view and left behind faint dermal abrasions discoverable on the Internet if you type in the correct search words.

But a second trajectory that testimony can travel upon in public spaces involves a marathon-like course. On this path, testimony speaks itself against the dominant narrative, not on its own or shouting through a media megaphone. Instead testimony finds itself spiraling along with other testimonies bumping up against strangers, acquaintances, co-workers, health professionals, other bodies like itself and other bodies that may not recognize it at first. Testimony speaks here in whispers that over time grow louder as more voices take it up or speak their own story. Like *Return to Zero*, it crowdsources its audience and gathers to itself more and more stories and the space it takes up expands,

spiraling out wider and wider. Once a critical mass is reached, these testimonies apply gradual pressure outward on the skin of the dominant narrative until they seep through its pores and slowly shift the dominant narrative's complexion. Hence, testimony's action on the dominant narrative is both relational and temporal.

Influence of relationality and temporality. Those who may have already questioned the dominant narrative may see testimony as an additional resource for their own testimonial construction. However, those who embrace the dominant narrative, who see themselves within it, may have a harder time accepting changes to it. They may resist testimony's validity or see it as a threat to their own truth. They can also appropriate testimony and use it as evidence of a countervailing claim in a way that becomes fuel for the dominant narrative. The types of testimony may also influence the distance between the loops. The public and state's proximity to abortion bodies means that the loops may even overlap. The invisibility of stillbirth bodies may mean that the loops are much farther apart and may make interventions in public discourse a longer trajectory.

The temporal duration and effect on the dominant narrative is different for each type of public circulation: the testimonial eruption most likely has a sudden uptake, the marathon spiral has a longer evolutionary cycle. An individual's path along the testimonial loops may be shorter and thinner or taller and wider. It may take less time for a counter narrative to become public testimony, if at all, as in Brandy's case when she created a website shortly after her stillbirth; or it may take decades, as in Andi's case in which it took her more than 25 years before she shared her story with me for the purposes of the performance

The temporal trajectory of testimony is also influenced by the relationality represented in the narrative. Brandy talks about the future she planned for when she was pregnant. But she also thinks the reason stillbirth grief may not be understood by those who have not experienced it is precisely because they do not understand how parents lose the future they imagined.

I saw our life together. I think that's why sometimes people can't really identify, because they feel like you didn't have anything with them. Yes, I did. Yes, I did. I knew what we would wear. I knew where we would live. I could see our whole life, and the love I would give.

She talks about a video she had been wanting to make for a song she wrote about her daughter.

I wanna show us, show our life, show us happy, show us getting married, show all these stages. Show us get pregnant. Show us have the baby. Show her as a toddler. Show her in her adolescent age. Let's show her taking off to the prom. Maybe even let's marry her off. Then, let me wake up. Then, show me in a bed, pregnant. Show me rushing to the hospital. Show them telling me that the baby's heartbeat is gone. Then, you experience the loss with me. Cuz, at this point, you went through the life of my daughter with me, so now you lost her, and now you understand.

Brandy shows both the *dominant narrative* (pregnant equals baby, toddler, adolescent, prom, marriage) and *counter narrative* (pregnant equals baby dying) in her video storyboard. She demonstrates the power she sees in directly placing her own testimonial experience in conversation with the absence of her experience in the dominant narrative.

But she demonstrates the use of futurity as an argument for the validity of the depth of her own relationship with her baby grief and as a resource to help other understand the impact of the grief and loss of stillbirth on families.

Performance Ethnography and Somatic Sentience

Performance ethnography's epistemology is embodied and sensory, but the *how* of the senses and *where* in the body are not often discussed in explaining *what* the body knows. By looking closer at the somatic field between the participant and the interviewer in performance ethnography, we can extend the tools we can use to understand the liminal exchange that happens during the interview process. The increased attention can help us better attend to these aspects of the lived experience similar to and different than our own. While sensitivity to these somatic fields may be in part instinctive for some, for others, it can be developed by practicing whole body awareness, reflexivity and deep witnessing. When performance is engaged from a place of somatic sentience, it can better weave those invisible threads between the participant's experience and a wider audience.

As a critical performance ethnographer, I know that my work is not to speak *for* someone else, but perform *with and alongside* them. Performance can amplify their voice and expand their agency. However, my performance of their story is not the same as their own body testifying to their experience. With cautious humility, I can work to get closer to their experience through embodied performance and put my body on the line in order to bring their testimony to an audience without putting their bodies at increased risk.

Implications for Applied use of Stillbirth Testimony

As Intervention in/for Care

The lives of parents are changed forever when they receive the news that their child has died before birth (Pullen & Nalos, 2009). Their world—once filled with planning for a baby, thinking about the child growing up, and visions of their future as a family—was shattered the moment their baby’s heart stopped beating. Constructing a new world as bereaved parents was completely unfamiliar to them. While our societal and cultural schemas about pregnancy and childbirth and “what to expect when you’re expecting” are abundant; having a stillbirth or infant die is rarely discussed, visible in popular culture or covered in pregnancy or parenting books. Developing new schemas for this new world of life after the death of a baby requires development of a new language and a new identity that medical professionals are often the first ones to introduce. The seeds for an individual’s long-term adaptation to the death of their baby is planted in the immediate moments, hours and days after the baby’s death.

Parkes (1988) explains that, “grief is essentially an emotion that draws us toward something or someone that is missing. It arises from awareness of a discrepancy between the world that is and the world that ‘should be’” (p. 54). He developed Psychosocial Transition Theory [PST] which suggests that when an event occurs that is permanent, life-altering and comes with little preparation, the individual is particularly vulnerable during the time in which they must create new and previously unimagined assumptions about their future (Parkes, 1988). Adapting to the new reality requires substantial time and energy and can be complicated by the grieving process—especially if the grieving process is itself complicated. Without established models of thought and behavior

necessary to adapt to the new situation, individuals can feel helpless and in danger. As their previous worldview is destroyed, Parkes (1988) states that emotional support, protection during helplessness and assistance in discovering new models of the world, post-loss, are three essential elements during the transition into a new reality by a bereaved individual.

The way that care providers frame the trauma and loss, by both acknowledging the impact of the experience and helping the parent to re-secure the sudden severed attachment to their baby, can ultimately help adapt to their new world without their child. If their identity as parent—albeit of a child who is not living—is validated it can ease their transition into a new, previously inconceivable future. Exposure to testimony, both by the care provider and the patient, can help with the formulation of new schemas. The testimony becomes a resource for futurity to help the parents imagine what their future world might look like.

But the exposure to stillbirth testimony can also serve as a resource for pregnant women to assert control in their care. Soon after Brandy shared her story on her website, she learned that her testimony had been helpful to another mother. “I already had a friend of mine tell me how she feels that [my baby’s] passing got her baby here safely,” Brandy said, adding that her friend used Brandy’s story to ask questions of her doctor. Not only does this comment call in the friend’s imagined relationship between her own baby and Brandy’s, it shows the perceived impact of testimony as a life-saving resource.

I think the biggest thing in my story is just being a voice, and speaking up for yourself. Each story is unique. So many stories that just sound preventable. Let’s tell the story wherever we can...if it could change a life, if it could save a life...

As evidenced by the findings in Chapter Five, testimonies of stillbirth also serve as resources for decision-making about medical care during pregnancy for parents of live children as well as after delivery with those that are stillborn. Those stories can also provide a range of options to parents and providers about how families have decided to meet or say goodbye to their babies. Holding them, bathing them, dressing them, singing to them, making ink prints of hands and feet, and having other family members meet them are becoming common practices, as well as recommended interventions. Nonprofit organizations like *Now I Lay Me Down To Sleep* send volunteer professional photographers to hospitals to take beautiful arranged photos of stillborn babies and their families. Hospitals provide memory boxes, often made by other bereaved parents. These after-death care practices are often a key elements of the parents' stories and they model post-mortem possibilities for families who may have no idea what to do.

Often in guiding parents in decision making, parent advocates will use phrases “many parents do this and find it helpful...” or “A mom I know did...” as a way to address resistance from newly bereaved parents about something they may resist as morbid at first, or worry what others will think of them, by showing that other bereaved parents have done it before. These stories can also help provide information about cultural differences that also help inform care providers that religious and cultural taboos prevent parents from doing some of the things that might be recommended as interventions. The more stories shared mean more avenues for care.

As Support in Bereavement

At the core of support group meetings, online networks and memorial websites is the story of the baby. Besides a few keepsakes and pictures, if they have any, the story is

the evidence a parent has that the baby once was a physical presence in their lives. The story becomes, in a way, their relationship to their baby. Parents seek out stories that have similar cause of death, gestational ages, challenges in care, and family configurations. They go to weekly meetings, or like Facebook pages. They participate in annual *Walk to Remember* activities wearing pictures of and telling stories about their baby.

Both sharing their stories and hearing the stories of others serves the five functions of health narratives that Sharf and Vanderford (2003) outlined. Hearing other parents' stillbirth stories validates their identity as parents and helps them make sense of their own experience. Their stories help mark their membership in the Secret Club and builds relationships with other grieving families and their stillborn children. Parents remember each other's children's names and the details of the other babies' deaths. They invoke images of being together watching their families and the babies yet to be born. They use the stories to help warrant decisions on how to honor and remember their own children, what to do in future pregnancies and how to create their future families. They are the agents of their stories and the narrative functions to assert control over how much, or how little, of their own very private experience they make public.

But when a stillbirth story leaves the enclaved or private spaces of bereavement and goes public in the pages of a local newspaper or in a movie, the impact of the narrative reaches farther and wider. The level of validation that parents feel when witnessing public testimony about their own experience is magnified. After watching *Return to Zero* at the Cinequest premiere in March 2014, one mom's comment posted on the director's blog that night said encapsulated how many parents that night felt:

On a broader scale, *Return to Zero* has the potential to change society's outlook on stillbirth. It increases awareness of the process and depth of the loss. It discusses the fact that this is a life-long loss—it's not something you get over. It's not something that will go away after having a healthy child. It's not something that is "meant to be." The death of a child is a life changing event. It's something that no parent should ever have to experience. It's a group that no one ever wants to belong to. However, we are gaining a voice. Through *Return to Zero*, the STILL Project, the MISS Foundation, and so many other organizations, companies, and resources... I feel blessed, proud, grateful, and inspired to be in the company of such dedicated, loving, and vocal individuals. Thank you, Sean, the cast, and crew, for changing the world with this film. (Hanish, 2014, para 40)

Return to Zero inspired Internet conversations, local media stories and viewing parties around the world. The movie project itself spawned a book featuring the personal stories people posted on the movie's website, a healing retreat and dozens of events featuring the film as a fundraiser for local groups and stillbirth organizations. The movie brought the testimony of the film's director, and hundreds of other parents, out of enclaved and private spaces and into pop culture and news outlets. The residue of the movie's initial eruption is evidence that people beyond the Secret Club were exposed to the lived experience of families devastated by stillbirth. A year after the film's worldwide release, it appears that the film may be the kind of testimony that spirals along with other counter narratives collective within the public sphere, applying pressure to the skin of the dominant narratives of pregnancy, rather than one that erupts into the public discourse and splits it apart. However, the impact of the exposure to such another narrative of

pregnancy that involves it ending on individuals who may experience stillbirth in the future is not yet evident. Nor is it clear how the film may impact stillbirth awareness or intervention in care. It is interesting to note, however, that a piece of stillbirth-related legislation that had been stalled in Congress for seven years, finally moved out of committee two months after *Return to Zero* aired in the U.S.

As Advocacy

So prevalent are abortion discourses, when stillbirth testimonies attempt to make themselves visible, they find little space to stand on their own. They are squished into or subsumed by other existing discourses. We can see this when we encounter legislative or medical policies that stage a collapse between these two very distinct socioemotional experiences. The absence of stillbirth testimony coincides with lack of nuance in the discourse around pregnancy-ending. Policy makers who craft legislation intended to constrain unwanted pregnancies from being aborted, may or may not be aware of—or even care—about the ways that the proposed laws encroach into realm of wanted pregnancies. The importance of stillbirth testimonies becomes even more salient when we consider the increasing amount of legislation of pregnant bodies brought about by ideological interests rather than epidemiological ones. In order to discuss future advocacy uses for stillbirth, two exemplars of the current conditions of discourse will be given. Between the performance series and the writing of this chapter, two eruptions regarding stillbirth occurred. The first, the passage of the first national bill involving stillbirth in December 2014, occurred with little fanfare. The second, just a few weeks later, was the trial of Purvi Patel in Indiana, which made international news headlines.

Stillbirth related legislation. So underreported was the passage of The Sudden Unexpected Death Data Enhancement and Awareness Act that even many of the advocates who had lobbied for the bill's passage were unaware it had finally been made into law. The law provides language related to the continuing "activities related to still birth [sic], sudden unexpected infant death and sudden unexplained death in childhood," (H.R. 669, 2014, para 4). While it provides no allocations, it directs the following:

The Secretary of Health and Human Services shall continue activities related to still birth [sic], sudden unexpected infant death, and sudden unexplained death in childhood, including, as appropriate (1) collecting information, such as socio-demographic, death scene investigation, clinical history, and autopsy information, on stillbirth, sudden unexpected infant death, and sudden unexplained death in childhood through the utilization of existing surveillance systems and collaborating with States to improve the quality, consistency, and collection of such data;

(2) disseminating information to educate the public, health care providers, and other stakeholders on stillbirth, sudden unexpected infant death and sudden unexplained death in childhood (H.R. 669, 2014, para 5-6)

Interestingly, this bill was co-sponsored in the House by 17 Democrats, including Jackie Speier (who became a co-sponsor after I met with her staff and asked for her support on the bill) and only three Republicans; and 17 Democrats in the Senate, including Barbara Boxer who I also lobbied) and five Republicans. It passed by voice vote in the House and passed the Senate by unanimous consent so no individual votes

were cast. While the bill provides a mandate of sorts related to data collection about stillbirth and infant death, there are no resources allocated to agencies to do it.

Criminalizing miscarriage. In reports of the Patel case, there is a convergence of abortion and stillbirth discourses, and her conviction stages a collapse of one type of pregnancy-ending into another. One of the key arguments used against her was that she inquired about an abortifacient early in her pregnancy, but there was no evidence that she had actually taken one. A second action used to seemingly prove she must not have wanted the baby is that after she said the baby was stillborn, she put the body in a bag and threw it in a dumpster. But this very act of throwing away the body is the common course of action in spontaneous miscarriages as well as those following induction procedures initiated by a doctor (either after a pregnancy has failed or was intentionally ended) to be completed at home. As Sanjana described her miscarriage, she reports the difficulty she had in following the doctor's instructions about what to do with the baby when it came out.

During the process of the medical induction, it took me 10 to 15 days for the process. So there was a stage when the baby came out. It was really shattering for me because it was my husband that helped me bring the baby out. We knew it was the embryo we were expecting so to just...trash that...in your uh...bathroom is very hard for me to do that.

So limited is the social understanding of the process of miscarriage and stillbirth, it is easy to characterize the putting the body into a bag—acceptable when directed by a doctor, but apparently not when not supervised by a medical professional—is not recognized as a customary act in certain cases.

Patel's conviction is not the only case in which a woman who reports having had a pregnancy loss, without any physical evidence that she attempted to purposely abort, has been charged with a crime. Between 1973 when the *Roe v Wade* decision was handed down and 2005, Paltrow and Flavin (2013) documented 413 cases in which a woman's pregnancy was a necessary factor leading to attempted and actual deprivations of a woman's physical liberty in the following instances: due to the occurrence of a miscarriage or stillbirth; in order to force medical intervention; to investigate potential harm or intended harm to the baby; to check for drug or alcohol use; and/or due to reports from health professionals. But as they noted, in a majority of 418 cases, the women being detained had no intention of aborting and wound up giving birth to a healthy babies.

Paltrow and Flavin (2013) also found:

In 295 cases women were charged with felonies, and 68 cases involved women who experienced miscarriage, stillbirth, or infant death. "In all but six cases, prosecutors attributed the loss entirely to actions or inactions that occurred during the woman's pregnancy. In 48 of those cases, women were charged under variations of the state's homicide laws, including such crimes as feticide, manslaughter, reckless homicide, homicide by child abuse, and first degree murder. (p. 321-322)

Some of the statues under which the women were charged did not require an intent to end the pregnancy, they explained, adding four cases resulted in murder or manslaughter charges where a woman's actions led to a self-induced abortion. Paltrow and Flavin (2013) also reported that African American women were more likely to be charged with felonies (85%) than white women (71%). In 240 cases, the race of the

woman and source who reported them to the police was known. Nearly half of African American women were reported to the police by health care providers, compared to less than one-third of white women. At least 47 cases involved disclosure of confidential health records.

Since 2005, they have identified an additional 380 cases, and note more arrests occurring every week. “This significant increase coincides with what the Guttmacher Institute describes as a “seismic shift” in the number of states with laws hostile to abortion rights. (Paltrow & Flavin, 2014, November 8, p. A21). Their opinion piece in the New York Times stated:

Many of the pregnant women subjected to this mistreatment are themselves profoundly opposed to abortion. Yet it was precisely the legal arguments for recriminalizing abortion that were used to strip them of their rights to dignity and liberty in the context of labor and delivery. These cases, individually and collectively, highlight what is so often missed when the focus is on attacking or defending abortion, namely that all pregnant women are at risk of losing a wide range of fundamental rights that are at the core of constitutional personhood in the United States. (Paltrow & Flavin, 2014, November 8, p. A21).

Anti-abortion laws effect on wanted pregnancies. Laws that are passed to prevent the abortion of unwanted pregnancies have the effect of impacting wanted pregnancies that parents chose to terminate due to genetic anomalies or life-threatening conditions. As most normally presenting pregnancies have their first ultrasound around the 19- to 20-week gestation mark— when many fetal anomalies present themselves—women who may decide to end a pregnancy based on what they discover during the ultrasound may find

that they cannot access those services. The state in effect then forces them to carry the baby to term, making them institutional chattel. Their parental agency is subsumed by the state that has not considered them in their legislative actions. And recently, their agency—and the autonomy over their own bodies—is directly targeted by legislators. In May, the Dallas Morning News (Martin, 2015) reported that Texas State legislator, Rep. Matt Schaefer (R-Tyler), introduced a bill to ban abortions for fetal abnormalities after 20 weeks, which is usually when the majority of abnormalities are discovered. The article included the story of Nicole Stewart and the discovery during the second trimester that in addition to other abnormalities, her baby’s brain never developed. “The child’s legs—like the thigh bones—had started to curve,” Stewart said. “The head had grown enormously in size. It was filled with fluid, and the baby was basically drowning in there,” (Martin, 2015, para 20). She said that the decision to terminate “Tutu” was not for her or her husband, but for him and for ending his suffering.

It was a story similar to Stewart’s that had sensitized me to complex ideological and political intertwining of abortion and stillbirth when I first began researching stillbirth narratives during my master’s program. I had met Lena while observing stillbirth and pregnancy loss memorials. During our interview she told me that she and the other organizers who hosted the annual memorial events never told anyone that they had all terminated their wanted pregnancies. She was afraid of the negative response she might get from stillbirth families because she had “chosen” to terminate the baby and afraid that pro-life groups would target the events in protest of their abortions. Lena talked about the double bind she and those like her are in.

But I'm in this invisible group. We're not even talked about. I didn't choose to be carrying a baby, with... I wasn't notified until I was almost 18 weeks. Fetal development dictates when you learn about certain things. To make laws that are blanket, when all of these circumstances are so unique makes no sense.

She explains that the decision to terminate her pregnancy was based on wanting to do the best thing for her very much wanted baby.

I actually felt like the choice was already made with the medical information he gave us. ...That it would be a more...um humane thing toooo...terminate the baby... *(pause)* I did not like the idea of waiting...for him to die. That felt too out of control aaand ...cruel to the baby. And cruel to me....There were also risks for me to carry him to term as well.

Circulation of stillbirth and termination of wanted pregnancy testimonies might serve to create more nuance in the discourse about what happens when pregnancy ends, as well as the impacts of legislation, or lack thereof, on families and their care.

Potential for Performance of Testimony as Activist Performance

Performance of testimony can help facilitate relationality between an individual who has experienced a stillbirth, but unless a contextual field for the narrative is provided, there may not be a perceived need to *act* by the audience. Similarly, a performance that focuses on the political and legislative landscape of abortion, and does not highlight the lived experience of women who terminate their pregnancies may not inspire an emotional response that moves the audience into action. A guiding principle underlying my advocacy, especially when speaking to health professionals, is that just talking to their heads invites debate and resistance. Engaging their hearts provides the

opportunity for them to feel the truth of the Other's experience. Combining the two approaches invites action. Someone can be *told* evidence as to why a change is necessary, but the sustained effort required to effect that change requires a sensory experience that *shows* the person why the change matters.

Understanding the rhetorical function of the narrative and how the audience perceives through multiple lens of personal experience, political ideology and popular culture is important too. When the evidence provided by the personal narrative is situated within/against the context of the current legislative climate and health context, the audience has an actual relationship with the performer and an imagined relationship to those affected by the political and emotional landscape of pregnancy-ending. They have access to both the personal and the political, are shown how the personal is political, and can see how abstract political discourse impacts a real living person. As such, these relational dimensions conjured by the performance of stillbirth testimony have implications for intervention, support and advocacy for reproductive justice.

Areas of Future Study

How can we provide an environment within which the stories told can be heard by the listeners so as to reconfigure their sense of who they are in relation to the speaker and the event—a reconfiguration that causes them to take up a stance of obligation in relation to this event as they recognize and meet it in the world?

(Salverson, 1996, p. 184)

For an activist performer, it is not enough to create a text designed with advocacy investments in mind. The performance should include opportunities for the audience to engage the subject beyond spectatorship. Providing an action station in which audience

members can fill out petitions, send postcards to legislators, or get on a mailing list for an advocacy organization are all possible avenues for advocacy. In an activist performance, conceiving the audience as an active witness, rather than a passive viewer, is especially important if the goal is to *cause*—not just *invite*—action. Determining the best ways to help audiences shift the way they may listen to, or talk about, controversial topics like abortion or taboo experiences like stillbirth, requires additional research.

Grant-seeking agencies and medical institutions may want evidence that performance of testimony has a beneficial impact on medical staff or patients before embracing it as a viable or valuable resource worthy of investment. Some potential types of future research might include: Conducting quantitative research to discover levels of familiarity with the subject matter before and after hearing testimonies; using qualitative methods to discover how people feel about the stigma associated with pregnancy-ending and how the performance impacted, if at all, their perceptions of the experience; and/or pairing the performance with a facilitated discussion format like Civil Dialogue¹⁵ and observe how, if at all, the audience discourse changes. The most effective way to combine context and testimony in order to move audiences to action warrants further study. More work can be done to discover the efficacy of different types of performance styles to meet different activist or community aims. Additionally, aesthetics matter (Saldaña, 2005) and the potential for aesthetic elements to enhance the somatic and sensory experiences of the audience and performers in addition to the research tools of performance ethnographer is worthy of further investigation.

¹⁵ Civil Dialogue is a discussion format created and practiced by John Genette, Jennifer Linde, Clarke Olsen, and the Institute for Civil Dialogue. Info at <http://instituteforcivildialogue.org/>

The call to conduct additional audience research invoked here is not to validate the efficacy of performance or rhetoric as theory and method. The performance *process* is scholarship just as much as the performance *product* is. But as performance and rhetorical scholars we talk about speech acts having effects. We imagine audience impact. We remind ourselves to “consider the audience.” Yet, we do not measure the audience to see if, indeed, the claims we make are supported—indeed we resist any form of measurement. As a stillbirth advocate and a mixed methods researcher, I understand that the systems I wish to impact, including legislative and medical institutions, value data that proves something makes a difference. The type of advocacy I am engaged in may require that I also show that the performance of advocacy has the impacts I say it does. As an activist performer, it is also important for me to know if my work actually aids in the goal social transformation rather than just hopes that it does.

Limitations of Re/Presentation

Because we care about political efficacy, we must also care about the artistic virtue of our performance and continuously study it, practice it, critique it, respect it, and improve upon it. (Madison, 2003, p. 481)

Performing the Other is delicate business. It is made even more complex when trying to re/present the testimony of someone of another cultural or linguistic background. Two of the three participants who attended the performance were women of color for whom English was not their first language. One of them reported that she was very happy with the performance, and felt that the text and interpretation of it represented her testimony of her miscarriage well. A second participant, who had had an abortion, raised concerns about the ways that linguistic, cultural, religious, political and legal

differences might impact how testimony is understood by the interviewer and how that might influence how testimony gets performed.

This section will discuss the limitations of this project's testimonial performance in terms of positionality and relationality by calling on feedback from member check-ins, returning to the ethics of representation and considering the influence of personal experience.

Positionality of/in Relationality

The deep presencing and liminal engagement that may occur in the interview setting between a fully present and empathetic interviewer and an emotionally open participant may not be possible to replicate in a performance setting. The *intra-performance* relationship during the interview, shifts to an *inter-performance* relationship when the participant becomes the audience witnessing her own story in the presence of others. The participant's relationality to the performer and the performer's relationality to the participant changes and, so too, does the relationality to the testimony. She may not be able to be fully present, especially if her experience is socially stigmatized. Hearing her story may trigger other thoughts, feelings and worries that take her out of the present moment of performance. The possibility that the participant is thinking about how the performer is representing her, while simultaneously wondering how others were reacting to her story, calls attention to the tensions in the two-dimensional intra-performance and inter-performance relationality of being both the subject and audience of the subject.

It is also possible that a voice of color coming from a white cisgendered Western body that has the privilege of self-abstraction may not be able to translate the layers of nuance, risk and incorporation of an Eastern body. For example, it is possible that the

relationality of my body (one that has not had an abortion, is white and Western, and has had a stillbirth) to the body of one of the participants who attended the performance (one that has an abortion, is a person of color, Eastern, and has not had a stillbirth) may have more of an influence on how I perform the story—and how the story is received through my body—than if my body’s experience was closer to the one I was re/presenting.

As much as may strive to re-engage the interview experience as authentically as I can, I may not be able to perform a cultural experience different from my own with the same accuracy. Critically important here is the idea that as a performer, I may do my best, make ethical choices based on careful consideration, but fall short in satisfying the person I am representing.

The positionality of the audience can also influence their relationality to me and to the testimonies being performed. An audience member who is anti-abortion may not like having to listen to characters speak about reproductive justice. A stillbirth parent might be upset that I have placed testimonies like theirs in relationship to abortion narratives. Salverson (1996) reminds us to consider how to the audience’s exposure to “primary narratives” and how they are “understood by our intended audience as their histories” which she explains are “collective, individual, intersecting” and how the performance may be “an attempt to insert counter narratives into those histories?” (p. 183). She continues by reminding us that we must consider the initial resistant responses on the part of the audience, as well as the performers. “How can we prepare to engage them in what will perhaps be a conflicted listening? How might the existence of trauma in the listeners relate to and affect the reception of traumatic narratives?”

Editing two-hour long interviews into 8-12 minute monologues requires choices that may privilege the goals of the performer, and an activist performance, and may leave contextual information out that may better reflect the whole experience of an individual. These editing choices are informed by the positionality of the performance ethnographer and, no matter how much care is taken in member checks, may not always satisfy the participants. Salverson (1996) also reminds artists to tend to the ethical concerns related to the participants by asking,

In what context are risky stories being told? Within what frameworks did they originate? And what is the cost to the speaker? Taking responsibility should extend beyond an ongoing inventory of who we are as individuals to an understanding that there are stakes for those with whom we work—stakes that exist, but are never more than partially knowable. Thoughtlessly soliciting autobiography may reproduce a form of cultural colonialism that is at the very least voyeuristic. (p. 181-182)

She continues by adding that the danger heightened when the voice of the artist goes unexamined or when choices made “for speech are privileged over choices made for silence, neglecting the highly complex negotiations that are involved in the politics of knowing and being known,” (Salverson, 1996, p. 182).

Even in carefully considering these questions, the critical performance ethnographer can make choices, based on political positionalities, activist aims, aesthetic influences and the limitations of the venue, the performers and time constraints. Naming the positionality of the performance ethnographer, implicating oneself in potential shortcomings and explaining the performance’s inability to represent every voice and

every experience are ways to help address the limitations of even the most diligently researched project.

Danger of the “One” Story and the Limitations of Testimony

Despite these disclaimers, it is still possible for critical performance ethnography to, in effect, silence some stories by not representing them and privilege other stories by performing them. This can have the danger of seeming to present the “one” story that is better or truer or more valid than others. Similarly, it is not possible for “one” performance project to be complex enough, sufficiently nuanced, that can provide points of entry for every viewer—even when a series of performances in different styles is offered. Park-Fuller (2000) in her initial work on testimony noted its potential to exclude the experiences of others, represent a singular version of the truth, be ethically ambiguous, value the victim and reinscribe privileged discourse.

Additionally, the potential risk to the bodies of those testifying cannot be underestimated. There women for whom disclosing they had an abortion or sharing their stillbirth experience publicly may be more harmful than liberatory. Culp-Ressler (2015, March 26) reminds us that while it is heartening to see women like Speier coming forward to talk about her pregnancy-ending experience on the floor of Congress, we must be cautious as well. Culp-Ressler (2015, March 26) says:

Is this too high of an emotional cost to demand from women in the public sphere?
Do we feel too entitled to women’s personal stories, when we should be able to understand the impact of proposed abortion restrictions without that invasion of privacy? (para 12)

While Rep. Steele says did not regret testifying about her sexual assault on the floor of the Arizona legislature, she resents “that women have to tell their deepest, darkest traumas in public, their most private moments in public, in order to get people to understand that these bills, these attempts to take away women’s rights, how devastating they are,” (Marty, 2015, para 8). Steele added that women “should not have to bare that part of our lives in such a public way to be able to access legal medical care” (Marty, 2015, para 18).

Testimony is not the historical record; as such, it does not need to withstand the scrutiny of fact checking, as the truth is the truth of the teller. Testimony can also change with each telling, and so can the relationality of the teller to each version of the story being told. However, in testimonial performance—where a critical performance ethnographer re-engages the testimony for an audience—the text of story stays the same. The quality of the re-engagement of testimony is dependent on the performer; just as the co-creation of liminal space to create opportunities for social change depends on an audience which is never the same.

Epilogue: My Testimony

As a Doctoral Candidate

I began this dissertation by saying that considering all of my investments—as a bereaved parent, journalist, stillbirth advocate, academic and activist, and critical scholar—I was writing this document for the parents whose stories needed to circulate beyond chat rooms and support groups. I said that I wanted this document to circulate beyond the Ivory Tower—to be read by anyone who believes that stillbirth is not

something that “just happens” as well as by those who have no idea what stillbirth even means.

As I finish this dissertation, it is my hope that it finds itself spiraling along with other testimonies bumping up against strangers, acquaintances, co-workers, health professionals, other bodies like itself and other bodies that may not recognize it at first.

May the articulations here help amplify the whispers of the testimonies within these pages and help to circulate other stories of pregnancy ending. May they together expand, spiraling out wider and wider, until one day a critical mass is reached. So that one day, the testimonies of the grieving, yet deeply loving, parents apply enough pressure outward on the skin of pregnancy’s story. For on that day, the voices bereaved parents will finally seep through the pores of “what to expect when you are expecting” and slowly shift the complexion of what we understand as the experience of giving birth—so that it includes both joyous life and bittersweet death.

REFERENCES

- ABC News (2011, February 18). *Jackie Speier; Planned Parenthood funding gets personal* [Video file]. Retrieved from <https://www.youtube.com/watch?v=0TjSVEaP76Q>
- Alan Colmes, Fox News contributor, criticizes Rick Santorum for ‘crazy’ behavior, then Apologizes. (2012, January 3). *The Huffington Post*. Retrieved from http://www.huffingtonpost.com/2012/01/03/alan-colmes-fox-news-rick-santorum_n_1180679.html
- Alexander, B.K. (2000). “Skin flint (or, the garbage man’s kid): A generative autobiographical performance based on Tami Spry’s Tattoo Stories.” *Text and Performance Quarterly*, 20(1), 97-114.
- Alexander, B. K. (2005). Performance ethnography: The reenacting and inciting culture. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research*, 3rd ed. (pp. 411–441). Thousand Oaks, CA: Sage.
- Alcoff, L. The problem of speaking for others. *Cultural Critique*, 20(Winter 1991–92), 5–32.
- An open letter to religious leaders on abortion as a moral decision. (2005). *Religious Institute on Sexual Morality, Justice, and Healing*. Retrieved from <http://www.religioustinstitute.org/open-letter-to-religious-leaders-on-abortion-as-a-moral-decision/>
- Asen, R., & Brouwer, D. C. (2001). Introduction: Reconfigurations of the public sphere. In R. Asen & D. Brouwer (Eds.), *Counterpublics and the state* (pp. 1–32). Albany: State University of New York Press.
- Beck, C. (2005). Becoming the story: Narratives as collaborative, social enactments of individual, relational, and public identities. In L. Harter, P. Japp, & C. Beck (Eds.), *Narratives, health, and healing: Communication theory, research, and practice* (pp.61-81). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Berlant, L., & Warner, M. (1998). Sex in public. *Critical inquiry*, 24(2), 547-566.
- Berns, N. (2012, January 3). Grieving when babies die: Why the controversy? *Psychology Today*. Retrieved from <https://www.psychologytoday.com/blog/freedom-grieve/201201/grieving-when-babies-die-why-the-controversy>

- Bernstein, Z. (2012, April, 2) Georgia state rep votes against radical anti-abortion measure, citing daughter's experiences. Think Progress. Retrieved from <http://thinkprogress.org/health/2012/04/02/456359/georgia-state-rep-votes-against-radical-anti-abortion-measure-citing-daughters-experiences/?mobile=nc>
- Bianco, R. (2014, May 16). Weekend TV: 'Return to zero,' 'Good wife.' *USA Today*. Retrieved from <http://www.usatoday.com/story/life/tv/2014/05/16/may-16-critics-corner/8822089/>
- Blair, C., Brown, J. R., & Baxter, L. A. (1994). Disciplining the feminine. *Quarterly Journal of Speech*, 84, 383–409.
- Bond, P. (2012, January 2). Fox news personality slammed for mocking Rick Santorum's "crazy" behavior after baby's death. *The Hollywood Reporter*. Retrieved from <http://www.hollywoodreporter.com/live-feed/rick-santorum-alan-colmes-iowa-caucus-277273>
- Bone, J. E. (2010). When publics collide: Margaret Sanger's argument for birth control and the rhetorical breakdown of barriers. *Women's Studies in Communication*, 33(1), 16–33.
- Bosticco, C. & Thompson, T.L. (2005). An examination of the role of narratives and storytelling in bereavement. In L. Harter, P. Japp, & C. Beck (Eds) *Narratives, health, and healing: Communication theory, research, and practice* (391-411). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.
- Boston Women's Health Book Collective. (1998). *Our bodies, ourselves for the new century*. New York, NY: Touchstone Books. Retrieved from <http://www.feminist.com/resources/ourbodies/abortion.html>
- Bowlby, J. (1982). *Attachment and Loss: Vol. I. Attachment*. London: Hogarth.
- Brouwer, D. C. (2004). Corps/corpse: The U.S. military and homosexuality. *Western Journal of Communication*, 68(4), 411–430
- Brouwer, D. C., & Asen, R. (2010). Public modalities, or the metaphors we theorize by. In D. Brouwer & R. Asen (Eds.), *Public modalities: Rhetoric, culture, media, and the shape of public life* (pp. 1–32). Tuscaloosa: University of Alabama Press.
- Cacciatore, J. (2010). Stillbirth: Clinical recommendations for care in the era of evidence-based medicine. *Clinical Obstetrics and Gynecology*, 53 (3), 691–699.
- Cacciatore, J., & Bushfield, S. (2007). Stillbirth: The mother's experience and implications for improving care. *Journal of Social Work in End-of-Life & Palliative Care*, 3(3), 59-79.

- Cacciatore, J., & Bushfield, S. (2008). Stillbirth: A sociopolitical issue. *Affilia: Journal of Women and Social Work*, 23(4), 378–387.
- Campbell, K. K., & Jamieson, K. H. (1978). Form and genre in rhetorical criticism: An introduction. In K. K. Campbell & K. H. Jamieson (Eds.), *Form, and genre: Shaping rhetorical action* (pp. 9–32). Falls Church, VA: The Speech Communication Association.
- Capitulo, K. (2004). Perinatal grief online. *The American Journal of Maternal/Child Nursing*, 29(5), 305–311.
- Capitulo, K. (2005). Evidence for healing interventions with perinatal bereavement. *The American Journal of Maternal/Child Nursing*, 30(6), 389–396.
- Cavanagh, S. L. (2013). Affect, performance, and ethnographic methods in queer bathroom monologues. *Text and Performance Quarterly*, 33(4), 286–307.
- Chan, M. F., Chan, S. H., & Day, M. C. (2003). Nurses' attitudes towards perinatal bereavement support in Hong Kong: A pilot study. *Journal of Clinical Nursing*, 12, 536–543.
- Charland, M. (1987). Constitutive rhetoric: The case of the people Québécois. *Quarterly Journal of Speech*, 73, 133–150.
- Charon, R. (2009). Narrative medicine as witness for the self-telling body. *Journal of Applied Communication Research*, 37(2), 118–131.
- Chicago Tonight. (2012, October, 18). Web extra: post-forum press conference, 8th District. *WTTW-11*. Retrieved from <http://chicagotonight.wttw.com/2012/10/18/web-extra-post-forum-press-conference>
- Chrisler, J. C. (2013). A global approach to reproductive justice-psychological and legal aspects and implications. *William & Mary Journal of Women and the Law*. 20(1), 1–25.
- Christopher, T. (2012, January 5). MSNBC contributor Eugene Robinson on Rick Santorum's "weird" reaction to death of newborn. *Mediaite*. Retrieved from <http://www.mediaite.com/tv/msnbc-contributor-eugene-robinson-on-rick-santorums-weird-reaction-to-death-of-newborn/>
- Condon, J. T. (1986). Management of established pathological grief reaction after stillbirth. *American Journal of Psychiatry*, 143, 987–992.

- Conry, J. A., & Hollier, L. M. (2013, July 9). Open letter to Texas legislators: Get out of our exam rooms. Retrieved from <http://www.acog.org/About-ACOG/News-Room/News-Releases/2013/Open-Letter-to-Texas-Legislators>
- Conquergood, D. (1991). Rethinking ethnography: Towards a critical cultural politics. *Communication Monographs*, 58(2), 179–194.
- Conquergood, D. (1992). Ethnography, rhetoric, and performance. *Quarterly Journal of Speech*, 78, 80-123.
- Conquergood, D. (1998). Beyond the text: Toward a performative cultural politics. In S. J. Dailey (Ed.), *The future of performance studies: Visions and revisions* (pp. 25–6). Annandale, VA: National Communication Association.
- Conquergood, D. (2002). Performance Studies: Interventions and Radical Research, *TDR: The Drama Review*, 46(2),145-156
- Conquergood, D. (2003). Performing as a moral act: Ethical dimensions of the ethnography of performance. In Y. S. Lincoln & N. K. Denzin (Eds.), *Turning points in qualitative research: Tying knots in a handkerchief* (pp. 397–413). Walnut Creek, CA: AltaMira Press.
- Corey, F. (1998) The personal: Against the master narrative. In S. Dailey (Ed.), *The Future of Performance Studies: Visions and Revisions* (pp. 249-253). Annandale, VA: National Communication Association.
- Cox, J. R., & Foust, C. R. (2009). Social movement rhetoric. In A. A. Lunsford, K. Wilson, & R. Eberly (Eds.), *The SAGE Handbook of Rhetorical Studies* (pp. 605–627). Thousand Oaks, CA: Sage Publications.
- C-SPAN. (2011, February 18a). *Rep. Christopher Smith (R-NJ) on abortion* [Video file]. Retrieved from <http://www.youtube.com/watch?v=xasJpDHiwb0>
- C-SPAN. (2011, February 18b). *Rep. Jackie Speier (D-CA) on abortion* [Video file]. Retrieved from <http://www.youtube.com/watch?v=Nz5DZJgclKQ>
- Culp-Ressler, T. (2015, March 26). Lawmaker says she’s ‘sat here too long,’ discloses that she was raped and had an abortion. *Think Progress*. Retrieved from <http://thinkprogress.org/health/2015/03/26/3639180/female-lawmakers-personal-health/>
- Davis, D. (2011, December 19). Precious photographs: An open letter to Michelle and Jim Bob Duggar. *Psychology Today*. Retrieved from <http://www.psychologytoday.com/blog/laugh-cry-live/201112/precious-photographs-open-letter-michelle-and-jim-bob-duggar>

- DeLuca, K. (1999). Unruly arguments: The body rhetoric of Earth First!, Act Up, and Queer Nation. *Argumentation & Advocacy*, 36(1), 9-21.
- Dennis, A. (2011, December 8). Michelle Duggar miscarries. *People*. Retrieved from <http://www.people.com/people/article/0,,20552173,00.html>
- Denzin, N. K. (2003). *Performance ethnography: Critical pedagogy and the politics of culture*. Thousand Oaks, CA: Sage.
- Dewey, J. (1954). *The Public and its Problems* (rev. ed.). Athens, OH: Swallow Press.
- Donaldson James, S. (2012, January 6). Experts: Rick Santorum grief is typical, but taking body home, unusual. *ABC News*. Retrieved from <http://abcnews.go.com/Health/rick-santorum-dead-baby-critics-lambasted-families-grieve/story?id=15306750#.T2vFeY6XuGV>
- Doyle, M. (February 18, 2011). Rep. Jackie Speier discusses her abortion in passionate debate. *Capitol Alert*. Retrieved from www.lexisnexis.com/hottopic/inacademic
- Dube, R. (2012, February 14). Duggars talk about their miscarriage, next pregnancy. *Today*. Retrieved from <http://www.today.com/parents/duggars-talk-about-their-miscarriage-next-pregnancy-174096>
- Duggar Family Snaps Pic of Miscarried Baby. (2011, December 15). *TMZ*. Retrieved from <http://www.tMZ.com/2011/12/14/duggar-family-dead-baby/#.T3X3tI6XuGU>
- Duggar's 20th child is world's first celebrity miscarriage. (2011, December 15). *Anorak*. Retrieved from <http://www.anorak.co.uk/305576/celebrities/20th-duggar-child-is-worlds-first-celebrity-miscarriage.html/>
- Edelman, L. (1998). The future is kid stuff: Queer theory, disidentification, and the death drive. *Narrative*, 6(1), 18–30.
- Edelman, L. (2004). *No future: Queer theory and the death drive*. Durham, NC: Duke University Press.
- Edvardsson, D., & Street, A. (2007). Sense or no-sense: The nurse as embodied ethnographer. *International Journal of Nursing Practice*, 13(1), 24–32.
- Felman, S., & Laub, D. (1992). *Testimony: Crises of witnessing in literature, psychoanalysis, and history*. New York: Routledge.
- Felski, R. (1989). *Beyond feminist aesthetics: Feminist literature and social change*. Cambridge, MA: Harvard University Press.

- Fernandez, M. E. (2011, December 16). The Duggars' photo of their stillborn baby ignites debate. *Daily Beast*. Retrieved from <http://www.thedailybeast.com/articles/2011/12/16/the-duggars-s-photo-of-their-stillborn-baby-ignites-debate.html>
- Fisher, W. R. (1984). Narration as a human communication paradigm: The case of public moral argument. *Communications Monographs*, 51(1), 1-22.
- Fisher, W. R. (1985). The narrative paradigm: In the beginning. *Journal of Communication*, 35, 74–89.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. New York: Pantheon.
- Frank, A.W. (1995) *The Wounded Storyteller*. Chicago: University of Chicago Press.
- Fraser, N. (1992). Rethinking the public sphere: A contribution to the critique of actually existing democracy. In C. Calhoun (Ed.), *Habermas and the public sphere* (pp. 109–142). Cambridge: The Massachusetts Institute of Technology Press.
- Frank, A.W. (1995) *The Wounded Storyteller*. Chicago: University of Chicago Press.
- Fretts, R. C. (2009). ACOG practice bulletin No. 102: Management of stillbirth. *Obstet Gynecol*, 113(3), 748–761.
- Giannini, G. A. (2011). Finding support in a field of devastation: Bereaved parents' narratives of communication and recovery. *Western Journal of Communication*, 75(5), 541–564.
- Gibson, K. (2008). The rhetoric of *Roe v. Wade*: When the (male) doctor knows best. *Southern Communication Journal*, 73(4), 312–331.
- Godel, M. (2007). Images of stillbirth: Memory, mourning and memorial. *Visual Studies*, 22(3), 253–269.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.
- Goldberg, J. (2012, January 5). Was Santorum 'weird' for bringing home his stillborn baby? *The Atlantic*. Retrieved from <http://www.theatlantic.com/politics/archive/2012/01/was-santorum-weird-for-bringing-home-his-stillborn-baby-updated/250957/>

- Gómez-Peña, G (2004). *Culturas-in-Extremis: Performing Against the Cultural Backdrop of the Mainstream Bizarre*. In H. Bial (Ed.), *Performance Studies Reader* (pp. 287-298). New York, N.Y.: Routledge.
- Goodnight, G. T. (1982). The personal, technical, and public spheres of argument: A speculative inquiry into the art of public deliberation. *Journal of the American Forensic Association*, 18, 214–227.
- Graham-Caso, D. (2014, May 21). *An Open Letter to Marianne Williamson About Abortion*. Retrieved from <https://www.facebook.com/notes/david-graham-caso/an-open-letter-to-marianne-williamson-about-abortion/10152981838962565>
- Gray, K. (2013, December 21). Lawmakers share personal stories in abortion debate. USA Today. Retrieved from <http://www.usatoday.com/story/news/politics/2013/12/12/michigan-lawmakers-abortion-debate/3996071/>
- Gregory, E. C., & MacDorman, M. F. (2015, July 23). Fetal and Perinatal Mortality: United States, 2013. *Natl Vital Stat Rep 2007*, 64(8), 1-24. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_08.pdf
- Grey, K. J. (2011). The coming war on women. *Daily Kos*. Retrieved from <http://www.dailykos.com/story/2011/01/02/932614/-The-coming-war-on-women>
- Guttmacher Institute. (2011, January 6). *State legislative trends in 2010—Abortion restrictions once again dominate*. Retrieved from <http://www.guttmacher.org/media/inthenews/2011/01/06/>
- Guttmacher Institute. (2012, January 5). *States Enact Record Number of Abortion Restrictions in 2011*. Retrieved from <http://www.guttmacher.org/media/inthenews/2012/01/05/endofyear.html>
- Guttmacher Institute. (2014, January 2). *More state abortion restrictions were enacted in 2011–2013 than in the entire previous decade*. Retrieved from <http://www.guttmacher.org/media/inthenews/2014/01/02/>
- Guttmacher Institute. (2015, April 1). *State policies in brief: An overview of abortion laws*. Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf
- Habermas, J. (1991). *Structural transformation of the public sphere: An inquiry into a category of bourgeois society*. Cambridge: The Massachusetts Institute of Technology Press.

- Hanish, S. (2014, March 10). Reviews & reflections on the world festival premiere. [Blog post]. Retrieved on April 28, 2015 from <http://returntozeromovie.com/blog/reviews-reflections-on-the-world-festival-premiere-march-8th-2014/>
- Haraway, D. (1991). *Simians, cyborgs, and women: The reinvention of nature*. New York: Routledge.
- Harter, L., Japp, P., & Beck, C. (2005) *Narratives, health, and healing: Communication theory, research, and practice*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc..
- Hasian, M., Condit, C., & Lucaites, J. (1996). The rhetorical boundaries of ‘the law’: A consideration of the rhetorical culture of legal practice and the case of the ‘separate but equal’ doctrine. *The Quarterly Journal of Speech*, 82, 323–342.
- Herman, J. (1997). *Trauma and Recovery: The aftermath of violence—from domestic abuse to political terror*. New York: Basic Books.
- Hilliker, L. (2006). Letting go while holding on: Postmortem photography as an aid in the grieving process. *Illness, Crisis, & Loss*, 14(3), 245–269.
- Hindmarsh, J., & Pilnick, A. (2007). Knowing bodies at work: Embodiment and ephemeral teamwork in anesthesia. *Organization Studies*, 28(9), 1395–1416.
- Hogue, C. J. R., & Silver, R. M. (2011). Racial and ethnic disparities in United States: Stillbirth rates: Trends, risk factors, and research needs. *Seminars in Perinatology*, 35(4), 221–233.
- Holstein, J., & Gubrium, J. F. (2000). *The self we live by: Narrative identity in a postmodern world*. New York: Oxford University Press.
- Howes, D. (2005). *Empire of the Senses*. New York: Berg Publishers.
- H.R. 699 (2014). *The sudden unexpected death data enhancement and awareness act*. Retrieved from <http://www.gpo.gov/fdsys/pkg/BILLS-113hr669enr/pdf/BILLS-113hr669enr.pdf>
- JackieSpeierCA12. (2011, October, 13). *Protect Life bill misogynistic*. [Video file]. Retrieved from <http://www.youtube.com/watch?v=00AZ4C0stoM>
- JackieSpeierCA12. (2012, February, 1). *Komen stops funding Planned Parenthood - Congresswoman Jackie Speier*. [Video file]. Retrieved from http://www.youtube.com/watch?v=eW91uy_Ealo

- JackieSpeierCA12. (2012, March, 1) *Speier calls out Limbaugh_advocates boycott_03-01-2012.mp4*. [Video file]. Retrieved from <http://www.youtube.com/watch?v=87Pjp-UwjdM>
- Jones, J. L. (1997). *sista docta: Performance as critique of the academy*. *TDR: The Drama Review*, 41, 51-67.
- Kauffman, L. S. (2009). The long goodbye: Against personal testimony, or an infant grafter grows up. In R. Warhol-Down, R., & D. P. Herndl, D. P. (Eds.), *Feminisms redux: An anthology of literary theory and criticism* (pp. 328-349). New Brunswick, NJ: Rutgers University Press.
- Klass, D. (1993). Solace and immortality: Bereaved parents' continuing bond with their children. *Death Studies*, 17, 343–368.
- Klabusich, K. (2014, April 1). Open letter to legislators from a clinic escort. *Truth Out*. Retrieved from <http://truth-out.org/opinion/item/22815-open-letter-to-legislators-from-a-clinic-escort>
- KnowYourMeme, (2013). Retrieved from <http://knowyourmeme.com/memes/events/senatorwendy-davis-filibuster#fn6>
- Lammer, C. (2007). Bodywork: Social somatic interventions in the operating theatres of invasive radiology. In S. Pink (Ed.), *Visual interventions: Applied visual anthropology* (pp. 91–116). Oxford: Berghahn Books.
- Lane, C. (2012, January 6). Rick Santorum's baby—and mine. *The Washington Post*. Retrieved from https://www.washingtonpost.com/blogs/post-partisan/post/rick-santorums-baby--and-mine/2011/03/04/gIQA0uH1eP_blog.html
- Langellier, K. (1998). Voiceless bodies, bodiless voices: The future of personal narrative performance. In S. J. Dailey (Ed.), *The future of performance studies: Visions and revisions* (pp. 207-213). Annandale, VA: National Communication Association.
- Langellier, K. (1999). Personal narrative, performance, performativity: Two or three things I know for sure. *Text and Performance Quarterly*, 19, 125-144.
- Langellier, K. (2009). Performing narrative medicine. *Journal of Applied Communication Research*. 37(2), 151–158.
- Law, S. (1984). Rethinking sex and the Constitution. *University of Pennsylvania Law Review*, 132(5), 955–1040.

- Lauterback, S. S. (1993) In another world: A phenomenological perspective and discovery of meaning in mothers' experience with death of a wished for baby: Doing phenomenology. In P. L. Munhall & C. O. Boyd (Eds.), *Nursing Research: A qualitative perspective* (pp. 133-179). New York: National League for Nursing Press.
- Layne, L. L. (2003). *Motherhood lost: A feminist account of pregnancy loss in America*. New York: Routledge.
- Layne, L. (2006). Pregnancy and infant loss support: A new, feminist, American, patient movement? *Social Science & Medicine*, 62(3), 602-613.
- Lederman, L. C. (1996). Internal muzak: An exploration of intrapersonal communication. *Information and Behavior*, 5, 197-214.
- Leff, M. (1992). Things made by words: Reflections on textual criticism. *Quarterly Journal of Speech*, 78, 223-231
- Leibovich, M. (2005, April 18). Father first, senator second: For Rick Santorum, politics could hardly get more personal. *The Washington Post*. Retrieved from <http://www.washingtonpost.com/wp-dyn/articles/A61804-2005Apr17.html>
- Letter from the reproductive justice community opposing PRENDA. (2011, December 6). *National Network of Abortion Funds*. Retrieved from <http://www.fundabortionnow.org/news/PRENDA>
- Lester, K. (2012, October 25). *Speier's remarks about her own abortion*. [Video file]. Retrieved from <http://www.youtube.com/watch?v=MlrMcnD6Y3s>
- Lowry, B. (2014, May 15). TV Review: 'Return to Zero.' *Variety*. Retrieved from <http://variety.com/2014/tv/reviews/tv-review-return-to-zero-1201175755/>
- MacDorman M. F., Munson, M. L., & Kirmeyer, S. (2007, October 11). Fetal and perinatal mortality, United States, 2004. *Natl Vital Stat Rep 2007*, 56(3), 1-19.
- MacDorman, M. F., & Kirmeyer, S. (2009). The challenge of fetal mortality. *NCHS data brief*, (16), 1-8.
- Madison, D. S. (2003). Performance, personal narratives, and the politics of possibility. In Y. S. Lincoln & N. K. Denzin (Eds.), *Turning points in qualitative research: Tying knots in a handkerchief* (pp. 469-486). Walnut Creek, CA: AltaMira Press.
- Madison, D. S. (2005). *Critical ethnography: Method, ethics, and performance*. Thousand Oaks, CA: Sage.

- Madison, D. S. (2006). The dialogic performative in critical ethnography. *Text and Performance Quarterly*, 26(4), 320–324.
- Major, B., & Gramzow, R. H. (1999). Abortion as stigma: Cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology*, 77(4), 735–745.
- Mansbridge, J. (1996). Using power/fighting power: The polity. In S. Benhabib (Ed.), *Democracy and difference: Contesting the boundaries of the political* (pp. 46–66). Princeton, NJ: Princeton University Press.
- Martel, S. L. (2014). Biopower and reproductive loss: Speaking risk, silencing death-in-birth. *Cultural Studies*, 28(2), 327–345.
- Martin, B. (2015, May 3). Legislature effort to ban late-term abortions for fetal problems hits home for Dallas couple. *The Dallas Morning News*. Retrieved from <http://www.dallasnews.com/news/politics/headlines/20150503-effort-to-ban-late-term-abortion-for-fetal-problems-hits-home-for-dallas-couple.ece>
- Martin, M. (Interviewer) & Speier, J. (Interviewee) (2011, March 3). Congresswoman reveals having an abortion. *Tell Me More: National Public Radio*. Retrieved from <http://www.npr.org/templates/story/story.php?storyId=134232655>
- Marty, R. (2015, March 13). Why this state representative revealed her sexual assault while testifying on an abortion bill. *Cosmopolitan*. Retrieved from <http://www.cosmopolitan.com/politics/interviews/a37718/victoria-steele-sexual-assault-arizona/>
- Massey, D. (2005). *For Space*. London: Sage Publications.
- McKerrow, R. E. (1989). Critical rhetoric: Theory and praxis. *Communication Monographs*, 56(2), 91–111.
- McKerrow, R. E. (1998). Corporeality and cultural rhetoric: A site for rhetoric's future. *Southern Communication Journal*, 63, 315–328.
- Michelle Duggar shared miscarried baby photo at funeral. (2011, December, 15). *Snarkerati*. Retrieved from <http://snarkerati.com/celebrity-gossip/michelle-duggar-shared-miscarried-baby-photo-at-funeral/>
- Middleton, M. K., Senda-Cook, S., & Endres, D. (2011). Articulating rhetorical field methods: Challenges and tensions. *Western Journal of Communication*, 75(4), 386–406.

- Miller, L. C., & Taylor, J. (2006). "The Constructed Self: Strategic and Aesthetic Choices in Autobiographical Performance." In D. S. Madison & J. Hamera (Eds.), *The SAGE Handbook of Performance Studies* (pp. 169-187). Thousand Oaks: Sage Publications.
- Mitchell, A. (Interviewer) & Speier (Interviewee). (2011, February 22). Rep. Jackie Speier Interview. *MSNBC-Special Report*. Retrieved from https://archive.org/details/MSNBC_20110222_180000_Andrea_Mitchell_Reports
- MSNBC. (2011, February, 18). *MSNBC Live [Video file]*. Retrieved from http://archive.org/details/MSNBC_20110218_230000_MSNBC_Live?q=jackie#st/art/2880/end/2940
- Muñoz, J. E. (2009). *Cruising utopia: The then and there of queer futurity*. NYU Press.
- Nakayama, T. K., & Krizek, R. L. (1995). Whiteness: A strategic rhetoric. *Quarterly Journal of Speech*, 81, 291-309.
- Newman, B. (2011, February 18). Bay Area Rep. Jackie Speier stuns House colleagues with story of her abortion. *San Jose Mercury News*. Retrieved from http://www.mercurynews.com/ci_17423970
- O'Leary, J., Warland, J., & Parker, L. (2011). Prenatal parenthood. *The Journal of Perinatal Education*, 20(4), 218-220. doi:10.1891/1058-1243.20.4.218
- Palczewski, C. H. (1996). Bodies, borders, and letters: Gloria Anzaldúa's "Speaking in tongues: A letter to third world women writers." *Southern Communication Journal*, 62(1), 1-16.
- Palczewski, C.H. (1997). Bodies that argue: Power, difference and argument. In J. F. Klumpp (Ed.), *Argument in a Time of Change: Definitions, Frameworks, and Critiques* (pp. 179-84). Annandale, VA: National Communication Association.
- Palczewski, C. H. (2002). Argument in an off key: Playing with the productive limits of argument. In G. T. Goodnight, K. Farrell, G. Klinger, L. Langsdorf, J. Long, G. Mitchell, R. Lee, & C. Willard (Eds.), *Arguing communication and culture* (pp. 1-23). Washington, DC: National Communication Association.
- Palczewski, C. H. (2003). What is "good criticism"? A conversation in progress. *Communication Studies*, 54(3), 385-391.
- Paltrow, L. M., & Flavin, J. (2013). Arrests of and forced interventions on pregnant women in the United States, 1973-2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy and Law*, 38(2) 299-343.

- Paltrow, L. M., & Flavin, J. (2014, November 8) Pregnant, and no civil rights. *New York Times*, pp. A21
- Park-Fuller, L. M. (2000). Performing absence: The staged personal narrative as testimony. *Text and Performance Quarterly*, 20(1), 20–42.
- Park-Fuller, L. (2003). A clean breast of it. In L. Miller, J. Taylor & M. Carver (Eds.), *Voices made flesh* (pp.215-236). Madison: University of Wisconsin Press.
- Parkes, C. M. (1988). Bereavement as a psychosocial transition: Processes of adaptation to change. *Journal of Social Issues*, 44(3), 53-65.
- Pelias, R. J. (1991). Empathy and the ethics of entitlement. *Theatre Research International*, 16, 142-152.
- Pérez, M. (2013, February 8). The meaning of reproductive justice: Simplifying a complex concept. *RH Reality Check*. Retrieved from: <http://rhrealitycheck.org/article/2013/02/08/communicating-complexity-reproductive-justice/>
- Peterson, H. (2012). Santorum blinks back tears in Iowa. *Washington Examiner*. Retrieved from <http://www.washingtonexaminer.com/santorum-blinks-back-tears-in-iowa/article/1037281/comments>
- Pineau, E. (2000). Nursing mother and articulating absence. *Text and Performance Quarterly*, 20(1), 1-19.
- Pink, S. (2009). *Doing sensory ethnography*. Sage Publications.
- Pollock, D. (2006). Marking new directions in performance ethnography. *Text and Performance Quarterly*, 26(4), 325–329.
- Price, K. (2010). What is reproductive justice?: How women of color activists are redefining the pro-choice paradigm. *Meridians: Feminism, Race, Transnationalism*, 10(2), 42–65.
- Provance, J. (2015, March 25). Ohio House votes across party lines for ‘heartbeat’ abortion bill: Fedor reveals she was a rape victim, had abortion. *The Blade*. Retrieved from <http://www.toledoblade.com/State/2015/03/25/Ohio-House-votes-across-party-lines-for-heartbeat-abortion-bill.html>
- Pullen, S. (2006, March 5). Calling all angels. *San Francisco Chronicle Magazine*, pp. 6–19.

- Pullen, S. (2010). *Giving birth to death: an ethnographic performance exploring stillbirth's memorable messages*. (Unpublished master's thesis). San Francisco State University, San Francisco, California.
- Pullen, S. (2010). The year of angels. In J.C. Atlas (Ed.), *They Were Still Born: Personal Stories about Stillbirth*. (pp.151-170). Landham, Maryland: Rowman & Littlefield Publishers.
- Pullen, S., Golden, M. A., & Cacciatore, J. (2012). "I'll never forget those cold words as long as I live": Parent perceptions of death notification for stillbirth. *Journal of Social Work in End-of-Life & Palliative Care*, 8(4), 339-355.
- Pullen, S., & Nalos, D. (2009, February). *Giving birth to death: A quantitative study of patients' perceptions of the news delivery of stillbirth diagnosis by health care providers*. Paper presented at the meeting of the Western States Communication Association, Mesa, AZ.
- Rachel Maddow Show. (2011, February 8). 'The Rachel Maddow Show' for Tuesday, February 8, 2011. [Transcript]. Retrieved from http://www.nbcnews.com/id/41499683/ns/msnbc-rachel_maddow_show/t/rachel-maddow-show-tuesday-february-th/#.UXN2-4JTskU
- Reddy, U. M. (2007). Prediction and prevention of recurrent stillbirth. *Obstetrics & Gynecology*, 110, 1151–1164.
- Reilly, B. (2011, December 14). Duggar family releases miscarriage picture. *Social Media SEO*. Retrieved from <http://socialmediaseo.net/2011/12/14/duggar-family-releases-miscarriage-picture/>
- Return to Zero. (2015, March 24). *Minnie Driver on The Talk*. [Video file]. Retrieved from <https://www.youtube.com/watch?v=TTz5bE8gJgo>
- Robinson, M., Baker, L., & Nackerud, L. (1999). The relationship of attachment theory and perinatal loss. *Death Studies*, 23(3), 257–270.
- Ross, L. (n.d.) What is reproductive justice? *Asian Communities for Reproductive Justice*. Retrieved from: <http://strongfamiliesmovement.org/what-is-reproductive-justice>
- Ross, L. (2015, May 1) Reproductive Justice Theory and Black Feminism: A Manifesto for Activism. Retrieved from <http://take-root.org/about/why-reproductive-justice/>

- Ross, L. (2007). What is reproductive justice? In Sistersong Women of Color Reproductive Health Collective and the Pro-Choice Public Education Project (Eds.), *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change* (p. 4–5). Retrieved from <http://www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf>
- Roush, M. (2014). Weekend TV review: Good Wife finale, Lifetime's Zero. *TV Guide*. Retrieved from <http://www.tvguide.com/news/weekend-tv-review-good-wife-finale-lifetime-zero-1081951/>
- Ruderman, D. B. (2009). The Breathing Space of Ballad: Tennyson's Stillborn Poetics. *Victorian Poetry*, 47(1), 151-171.
- Ruelas, R. (2015, March 12). In abortion debate, Arizona lawmaker reveals secret. *The Arizona Republic*. Retrieved from http://www.azcentral.com/story/news/arizona/politics/2015/03/12/arizona-abortion-debate-lawmaker-molested/70194810/?fb_ref=%5B%27Default%27%5D
- Säflund, K. (2003) *An analysis of parents' experiences and the caregivers' role following the birth of a stillborn child* (Unpublished doctoral dissertation). Karolinska Institutet Danderyds Sjukhus, Division of Obstetrics and Gynaecology, Stockholm, Sweden.
- Säflund, K., Sjögren, B., & Wredling, R. (2002). Physicians' attitudes and advice concerning pregnancy subsequent to the birth of a stillborn child. *Journal of Psychosomatic Obstetrics & Gynecology*, 23, 109–115.
- Saldaña, J. (2005). *Ethnodrama: An Anthology of Reality Theatre*. Walnut Creek, CA: AltaMira Press.
- Salverson, J. (1996). Performing emergency: Witnessing, popular theatre, and the lie of the literal. *Theatre Topics*, 6(2), 181-191.
- Sessions, D. (2012, January 3). Rick Santorum's dead-baby-ritual. *The Daily Beast*. Retrieved from <http://www.thedailybeast.com/articles/2012/01/03/rick-santorum-s-dead-baby-ritual0.html>
- Shank, R. C. (1990). *Tell me a story: A new look at real and artificial intelligence*. New York, NY: Scribner's Sons.

- Sharf, B. F., & Vanderford, M. L. (2003). Illness narratives and the social construction of health. In T. L. Thompson, A. Dorsey, & K. I. Miller. (Eds.), *The handbook of health communication* (pp. 9-33). Mahwah, New Jersey: Lawrence Erlbaum Associates
- Sheldon, R. (2013). Somatic capitalism: Reproduction, futurity, and feminist science fiction. *Ada: A Journal of Gender, New Media, and Technology*, 3. Retrieved from http://adanewmedia.org/2013/11/issue3-sheldon/?utm_source=rss&utm_medium=rss&utm_campaign=issue3-sheldon
- Sheller, M., & Urry, J. (2003). Mobile transformations of “public” and “private” life. *Theory, Culture & Society*, 20(3), 107-125.
- Silver, R. M., Branch, D. W., Goldenberg, R., Iams, J. D., & Klebanoff, M. A. (2011). Nomenclature for pregnancy outcomes: Time for a change. *Obstetrics & Gynecology*, 118(6), 1402–1408.
- Simmel, G. (1997). Sociology of the senses. In D. Frisby & M. Featherstone (Eds.), *Simmel on culture: Selected writings* (pp.109–119). London: Sage. (Original work published in 1907)
- SisterSong (n.d.). What is Reproductive Justice? Retrieved from: <http://sistersong.net/reproductive-justice/>
- Smith, C. A., & Gallo, A. M. (2007). Applications of performance ethnography in nursing. *Qualitative Health Research*, 17(4), 521–528.
- Sokolove, M. (2005, May 22). The believer. *The New York Times Magazine*. Retrieved from http://www.nytimes.com/2005/05/22/magazine/22SANTORUM.html?pagewanted=all&_r=0
- Spry, T. (2001). Performing autoethnography: An embodied methodological praxis. *Qualitative Inquiry*, 7, 706–732.
- Spry, T. (2006). A “Performative-I” copresence: Embodying the ethnographic turn in performance and the performative turn in ethnography. *Text and Performance Quarterly*, 26(4), 339–346.
- Spry, T. (2011). *Body, paper, stage: Writing and performing autoethnography*. Walnut Creek, CA: Left Coast Press.
- Squires, C. R. (2002). Rethinking the black public sphere: An alternative vocabulary for multiple public spheres. *Communication Theory*, 12(4), 446–468.

- Stolbergjan, S. G. (2012, January 4). After a child's death, a religious politician became a culture warrior. *The New York Times*. Retrieved from http://www.nytimes.com/2012/01/05/us/politics/after-childs-death-a-politician-became-a-cultural-warrior.html?_r=0
- Stroebe, M. (2002). Paving the way: From early attachment theory to contemporary bereavement research. *Mortality*, 7(2), 127–138.
- Sutton, J. (1992). The taming of *Polos/Polis*: Rhetoric as an achievement without woman. *Southern Communication Journal*, 57, 97–119.
- Thachuk, A. (2007). The space in between: Narratives of silence and genetic terminations. *Bioethics*, 21(9), 511–514.
- The Adams Papers Digital Edition (2008). Adams Family Correspondence, Volume 2, June 1776–March 1778. C. James Taylor (Ed.). Charlottesville: University of Virginia Press, Rotunda. Retrieved from <http://rotunda.upress.virginia.edu/founders/default.xqy?keys=ADMS-print-04-02-02&mode=TOC>
- Trulsson, O., & Radestad, I. (2004). The silent child—Mothers' experiences before, during, and after stillbirth. *Birth*, 31, 189–195.
- Turner, V. & Turner, E. (1982). Performing Ethnography. *TDR: The Drama Review*, 26(2), 33-50.
- Umphrey, L. R., & Cacciatore, J. (2011). Coping with the ultimate deprivation: Narrative themes in a parental bereavement support group. *Omega*, 63(2), 141–160.
- Wander, P. (1983). The ideological turn in modern criticism. *Central States Speech Journal*, 34, 1–18.
- Wander, P. (2014). Contiguous fields of study. *Text and Performance Quarterly*, 34(1), 99-101.
- Warner, M. (1992). The mass public and the mass subject. In C. Calhoun (Ed.), *Habermas and the public sphere* (pp. 377–401). Cambridge, MA: The MIT Press.
- Warner, M. (2002). *Publics and counterpublics*. New York: Zone Books.
- Wolf, N. (1995). Our bodies, our souls. *New Republic*, 213(16), 26–35.
- Van, P. (2001). Breaking the silence of African American women: healing after pregnancy loss. *Health care for women international*, 22(3), 229-243.

- Van, P., & Meleis, A. I. (2003). Coping with grief after involuntary pregnancy loss: Perspectives of African American women. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 32, 28–39.
- Ventura, S. J., Curtin, S. C., Abma, J. C., & Henshaw, S. K. (2012). Estimated pregnancy rates and rates of pregnancy outcomes for the United States, 1990-2008. *National vital statistics reports: from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*, 60(7), 1-21. Retrieved from www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf
- Waldenström, U., Cnattingius, S., Norman, M., & Schytt, E. (2015). Advanced Maternal Age and Stillbirth Risk in Nulliparous and Parous Women. *Obstetrics & Gynecology*, 126(2), 355-362.
- Zittlow Rogness, K., & Foust, C. R. (2011). Beyond rights and virtues as foundation for women's agency: Emma Goldman's rhetoric of free love. *Western Journal of Communication*, 75(2), 148–167.