

NEGOTIATED CONCEPTS: BODY, MIND, EMOTIONS AND SELF
IN WOMEN'S CHILDBEARING NARRATIVES

By

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by

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Abstract of Dissertation Presented to the Graduate School
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This research project uses a social constructionist perspective to analyze women's uses of the concepts of body, mind, emotions and self in their pregnancy and childbirth narratives. Data are derived from eighteen in-depth interviews with women who had given birth within two years prior to the interviews.

The women in this study construct pregnancy and childbirth as experiences that encompass their bodies, minds, emotions and selves. However, the meanings and relationships between these concepts are negotiated throughout their narratives. At times, the women's narratives focus on a single component and construct it as isolated from the others. The content and meaning of each concept vary depending on the context of the narrative. Other times women create a variety of relationships between body, mind, emotions and self, whereby one of these components acts upon another. Each relationship that is established (e.g., self influences body) is followed by constructions of an opposing relationship (e.g., body influences self). Finally, some of the narratives

weave the concepts of body, mind, emotions and self together without distinguishing between them.

This project concludes that body, mind, emotions and self are negotiated concepts. Their content and meaning are dependent upon the context in which they are used. Based on follow-up conversations that presented the analysis to the participants, it is concluded that the concepts of body, mind, emotions and self are narrative resources that enable individuals to articulate their experiences. Everyday experience, particularly during pregnancy and childbirth, is not as neatly compartmentalized as these often taken-for-granted concepts suggest.

Nevertheless, the existence and persistence of concepts that compartmentalize the human being into separate parts legitimizes biomedicine's purported focus on the body in isolation from the rest of the individual. This compartmentalization also legitimizes the claims made by social scientists that biomedicine focuses solely on the body. The multiple meanings, definitions and relationships between the body, mind, emotions and self that were created by the women in this study challenges the validity of the concepts themselves and raises questions about how healthcare professionals, social scientists and other members of society construct, maintain and negotiate these concepts.

CHAPTER 1 PROBLEM AND PREVIOUS RESEARCH

One of the few social experiences that every living human being shares is that we all come into this world through birth. However, childbirth has not attracted much attention from sociologists. Most sociological research on childbirth focuses on the relationship between childbearing and socio-demographic characteristics such as age (Barber 2001; Lee 2001; Wu and MacNeill 2002), race/ethnicity (DuPleisses et al. 1997; Franklin 1988; Musick 2002), social class (Franklin 1988; Hanna 2001), education (Musick 2002; Upchurch et al. 2002; Wu and MacNeill 2002), and marital status (Musick 2002; Upchurch et al. 2002), and the impact of childbearing on other social phenomena such as education (Beutel 2000) and employment (Drobic 2000; Jacobs 1997; Werbel 1998). Childbirth itself is rarely deemed significant in its own right by sociologists.

When childbirth is considered by sociologists, research tends to focus on the social and emotional aspects of giving birth. This research often explores women's perceptions of social support and levels of satisfaction with their childbirth experiences (Campero et al. 1998; Fowles 1998). Whereas sociological research generally emphasizes the social and emotional aspects of childbirth, biomedical research emphasizes the physical aspects (Davis-Floyd 2001; Hahn 1987). Overall, these two bodies of research suggest that the socio-emotional and physical realms of childbirth are completely separate.

Research on body, mind and emotions suggests that the physical, mental and emotional components of human beings are more interrelated than biomedical and sociological research on childbirth imply (Garro 1992; Lupton 1998; Williams and

Bendelow 1996). The self is part and parcel to these various components of human experience, as it is commonly accepted that the self has and experiences a body, mind and emotions (Holstein and Gubrium 2003; Schutz 1971; Williams 2003). Bodies, minds, emotions and selves are also largely influenced by the social context within which one operates. For example, research on pain has found that social meanings, responses to and experiences of pain vary by culture and social group membership (Freidson 1970; Helman 1990; Scarry 1985; Zborowski 1952; Zola 1966). Thus, the body in pain elicits different types of physical, mental and emotional reactions depending on the social context. Research on the sociology of emotions indicates that emotions encompass mind and body and are related to the broader social context in which they are experienced (Hochschild 1979, 1983; Williams and Bendelow 1996, 1998).

In terms of childbirth, nursing and midwifery research indicates that mental and emotional responses to birth, such as fear of pain or childbirth, can slow and even stop the physical progress of labor (Arms 1994; Goer 1995, 1999; Lowe 1992; Peterson 1981; Sears and Sears 1994; Simkin 1986). Taken together, this research suggests that the human body, mind, emotions and self are more integrated than is implied by biomedical and sociological research on childbirth and that they are influenced by the larger social context.

The current research project explores women's constructions of body, mind, emotions and self in their pregnancy and childbirth narratives. In particular, this research focuses on the ways in which common distinctions and relationships between these various concepts are constructed and negotiated in women's childbearing narratives. The central research questions are: (1) how are body, mind, emotions and self constructed in

women's pregnancy and childbirth narratives? (2) how do women construct and negotiate relationships and distinctions between body, mind, emotions and self in their pregnancy and childbirth narratives? and (3) what narrative and discursive resources do women rely on to construct and negotiate relationships and distinctions between these concepts?

There are three reasons this is an important project that warrants attention from a sociological perspective. First, an understanding of women's constructions of the relationships between body, mind, emotion and self in their pregnancy and childbirth narratives can have implications for the care and treatment of pregnant, birthing, and postpartum women by healthcare professionals and preparation guides. The current biomedical model of childbirth focuses primarily on treating the physical aspects of pregnancy and childbirth (Arms 1994; Davis-Floyd 1992, 2001; Hahn 1987).

Understanding the ways that women construct body, mind, emotions and self in their pregnancy and childbirth narratives can aid in the assessment of the extent to which the current biomedical model is meeting women's needs. Second, an analysis of women's negotiations of these concepts in their childbearing narratives can advance our theoretical understandings of body, mind, emotions and self. Third, a focus on narrative and discursive resources is important because it can demonstrate the ways that our understandings of concepts such as body, mind, emotions and self are shaped and constrained by language.

Biomedical, Social Science and Feminist Perspectives of Childbearing

Childbearing has been researched and theorized from a variety of disciplines. This section summarizes current childbearing research and theories from the three disciplines of biomedicine, social science, and feminist studies. Particular attention is paid to the

perceptions of the childbearing body, mind, emotions and self that are embedded in each perspective.

The Biomedical Model

Much research demonstrates that the biomedical model of childbirth dominates contemporary birthing practices in the United States (Arms 1994; Davis-Floyd 1992, 2001; Goer 1995; Mitford 1992; Oakley 1986; Rooks 1997; Rothman 1991; Wertz and Wertz 1977). The biomedical view of childbirth is based on the Cartesian model of mind/body dualism in which the human mind and body are conceptualized as completely separate, distinct entities. Pregnancy and childbirth are considered physical events that take place within the female body while possible mental and emotional aspects of childbearing are minimized or ignored (Arms 1994; Davis-Floyd 1992, 2001; Mitford 1992; Wolf 2001). The subjectivity, individuality and personhood of birthing women are typically also excluded from the biomedical perspective (Cosans 2001; Hahn 1987; Martin 1992; Rothman 1991).

Social scientific analyses conclude that the biomedical model of childbirth utilizes the metaphor of body as machine. While the body as machine metaphor is widely documented in other realms of biomedicine (Bendelow and Williams 1995; Thompson 1993; Williams 2003), the female birthing body is different in that it is viewed as an inherently defective machine (Davis-Floyd 1992, 2001; Martin 1992). In her analysis of texts and handouts used to train medical students in obstetrics, Emily Martin (1992) argues that biomedical discourse constructs childbirth in terms of a mechanical production metaphor. She argues that the birthing woman is either viewed as a laborer or ignored altogether, while the uterus (machine) works to produce the baby (product). The doctor is construed as the supervisor or foreperson who oversees the production process.

Martin writes, “A nearly universal expression of the doctor’s role is that he ‘manages’ labor . . . it is of course the doctors who decide when the ‘pace’ of work is insufficient and warrants speeding up by drugs or mechanical devices” (1992:63). Thus the female body as machine cannot be trusted to function properly on its own; it requires supervision and assistance by healthcare providers and technology. Robbie Davis-Floyd (1987) found similar metaphors in biomedical discourse in her interviews with twelve obstetricians. Many of the obstetricians Davis-Floyd interviewed agreed that modern obstetrics could be viewed as an assembly line in which the desired product, produced by the mother “machine,” is a “perfect baby.” This view of the female body as a defective machine is conveyed to pregnant and birthing women through information booklets, handouts and self-help books that construct the pregnant and birthing body as pathological (Marshall and Wollett 2000; Rudolfsdottir 2000).

Within the biomedical model of childbirth, the pregnant and birthing woman is generally denied subjectivity. Through his analysis of the first seventeen editions of *Williams Obstetrics* (1903-1985), the most popular reference book for obstetricians, Robert A. Hahn (1987) identifies four main themes in the conceptualization of women and childbearing portrayed in the texts: (1) woman as “maternal organism” and “generative tract” without subjectivity or personhood; (2) childbirth as pathological and requiring medical control; (3) woman as passive, doctor as active; and (4) women as agents only in obstructing their own births. Martin (1992) notes similar portrayals in her analysis of obstetric texts in which laboring women are viewed as subjects only in their potential interference with the productivity of the body-machine. Women’s lack of subjectivity within the biomedical model has also been found in self-help texts that

generally address women in a patronizing manner that affords them little agency and construct the body-machine as detached from any subject (Marshall and Wollett 2000; Rudolfsdottir 2000). Overall, the pregnant and birthing self is afforded scant subjectivity within the biomedical model of birth; the self has agency only in potentially disrupting the birth.

Mind and emotions are also granted little attention within the biomedical model of pregnancy and childbirth. Hahn's (1987) analysis of *William's Obstetrics* notes that while token efforts are made to include the social and psychological aspects of pregnancy and childbirth in later editions, they are present only in a single separate chapter and are not incorporated into the remainder of the text. In his response to Hahn's analysis, Michael Newton, Professor of Obstetrics and Gynecology, former Director of the American College of Obstetricians and Gynecologists, and co-author of *Scientific Foundations of Obstetrics and Gynecology*, writes,

The purpose of the book was to give information, based on currently available data, to physicians and physicians-in-training about the physical care of pregnant, laboring, and puerperal women. If the book had digressed to any extent into psychological and social theory, it is unlikely that it would have gone through 17 editions. (1987:283)

Thus, in his rebuttal of Hahn's analysis, Newton upholds the exclusion of the mental and emotional realms of pregnancy and childbirth in obstetric texts. Mental and emotional aspects of childbearing are also largely absent in mainstream self-help pregnancy and childbirth guides, except in their depictions of pregnant women as emotionally unstable and irrational (Marshall and Wollett 2000; Rudolfsdottir 2000).

Social Science Research on Childbearing

Where the biomedical model of childbirth emphasizes the body and virtually excludes mind, emotions and self, social science research emphasizes emotions and self

and minimizes body and mind. Sociological and psychological research that focuses specifically on childbirth typically examines women's levels of satisfaction with their births and the care they receive during labor and delivery. Most of these studies suggest that the social aspects of childbirth have a much greater impact on women's levels of satisfaction with their childbirth experiences than the physical aspects of labor and delivery (Campero et al. 1998; Fowles 1998; Norr et al. 1977; Rudolfsdottir 2000). When the physical aspects of childbirth are cited as sources of dissatisfaction, women tend to focus on the physical pain that results from medical interventions rather than the pain of childbirth as their sources of discontent (Fowles 1998).

According to this research, women's dissatisfaction with their childbirth experiences results from condescending treatment by healthcare providers, the invasion of privacy by unnecessary spectators, a lack of control over decisions regarding medical interventions and hospital procedures, and a lack of information about what is going on with their bodies (Fowles 1998; Rudolfsdottir 2000). Dissatisfaction with the physical aspects of childbirth typically results from frustration with the physical pain caused by medical interventions such as episiotomies, epidurals, and cesareans (Fowles 1998). Conversely, women who report positive childbearing experiences emphasize support and encouragement from birth attendants (healthcare providers and/or family members) and perceptions of control over medical interventions (Fowles 1998). Research also indicates that the presence of a doula (a woman who provides emotional support during labor and delivery) improves women's responses to childbirth by offering social and emotional support and providing information regarding medical interventions and the physical

processes of labor and birth (Campero et al. 1998; Chalmers and Wolman 1993; Langer et al. 1998; Zhang et al. 1996).

Taken together, social science research on childbirth suggests that social factors such as perceived control over medical interventions and social support from birth attendants have a much greater impact on women's levels of satisfaction with their childbirth experiences than their actual physical experiences. There seems to be a disjuncture between the aspects of childbirth that birthing women attend to and the aspects that healthcare professionals focus on. Whereas postpartum women focus on the social and emotional aspects of their childbirth experiences, obstetricians and preparatory guides focus almost exclusively on the physical aspects. This disjuncture is shown to be related to many women's dissatisfaction with their childbirth experiences.

Social science research has also examined the implications of women's perceptions of their childbearing experiences. Research indicates that women's levels of satisfaction with their childbirth experiences have long-term effects on the psychological and physical well-being of mothers and their children. Dissatisfaction with the birthing experience and perceived lack of control and social support are consistently found to be strong predictors of postpartum depression (Johnstone et al. 2001; Marshall 1995; Oweis 2001) and post-traumatic stress symptoms (Czamocka and Slade 2000; Radosti 1999; Soet 2002). Women who perceive their childbirth experiences as traumatic as a result of their lack of control over medical interventions and procedures often use the same language and metaphors to describe their experiences as sexual abuse survivors (Kitzinger 1992). These responses are shown to have long-term effects on women's emotional well-being and self-esteem (Simkin 1991) and impact women's psychosocial

adjustment to future pregnancies and the physical progress of subsequent births (Cohen and Estner 1983; Panuthos 1984).

Women's responses to their childbirth experiences also impact the ways that women relate to and interact with their children (Kitzinger 1990). Women with postpartum depression and post-traumatic stress are less likely to breastfeed (Field et al. 2002; Galler et al. 1999) and are more likely to perceive their infants negatively (Cohn et al. 1990; Whiffen and Gotlib 1989) than their non-depressed counterparts. Breastfeeding is shown to reduce infant morbidity and mortality (Giugliani 1994; Hanson et al. 2003). In addition, research demonstrates that children of mothers who suffer from postpartum depression have lower levels of intellectual development and lower standardized test scores than children from non-depressed mothers, even when other social factors such as breastfeeding, social class and parental intelligence is controlled (Brennan et al. 2000; Sharp et al. 1995).

Feminist Theories of Reproduction

Feminist theories of reproduction, like the biomedical model, tend to focus on the physical aspects of pregnancy and childbirth. Feminist theorists typically cite the physical nature of women's childbearing experiences and lack of physicality of men's experiences as the root of women's oppression. Early feminist theorists who focused on reproduction, such as Simone de Beauvoir (1952/1989), Shulamith Firestone (1971), and Sherry Ortner (1974), argue that women's reproductive functions inextricably tie women to both their bodies and to nature. In a society that dichotomizes concepts such as body/mind, emotion/rationality, nature/culture, nature/technology and woman/man and values the mental, rational, cultural and technological realms over the physical, emotional

and natural realms, women's association with their bodies and nature is considered detrimental to women's status in society.

These theorists argue that women's association with the physical and natural realms of existence through their childbearing capacities is the root of women's overall oppression. The solution proposed by these theorists is to find a way to connect women more with culture, rationality and the mental realms of existence, and essentially make women more like men (de Beauvoir 1952/1989; Ortner 1974). Liberation in this sense means removing childbirth from women's bodies (Firestone 1971). These theories are critiqued for both their inability to transcend dualistic conceptual thinking (Butler 1999; Haraway 1991; MacCormack 1977) and for failing to provide reasonable solutions. In response to de Beauvoir's analysis, Mary O'Brien writes, "there is no way [for women] to escape, except by an undignified catch-up scramble along the paths which men have beaten" (1981:71).

Mary O'Brien (1981) agrees with earlier feminists that biological differences in reproduction are at the root of women's oppression, but she associates physical differences in reproduction with consciousness. O'Brien argues that men's discontinuous childbearing experience results in a dialectical structure of reproductive consciousness (Hegel 1948/1802), in which conflict exists between the negation of self in the sex act and the human tendency to resist negation of self. Since this dialectical structure of reproductive consciousness cannot be mediated within the reproductive process, O'Brien argues that men must create artificial means through which they can mediate these contradictions and verify their own integration in the human species. Patriarchy enables men to mediate these contradictions through the legal appropriation of children,

appropriation of women through marriage, and physical separation of women from other men through the public/private split.

Through the legal appropriation of children, men claim ownership over women's reproductive labor, thereby creating a dialectical structure of reproductive consciousness in women. Other feminist theorists argue that men have claimed ownership over women's reproductive labor through technological interventions such as reproductive technologies (Corea 1985) and the "technocratic" model of birth (Davis-Floyd 1992). What these theories share in common is that they rely on the assumption that pregnancy and childbirth are physical events that take place within women's bodies and that the physicality of women's experiences lies at the root of women's oppression. While reproductive consciousness is a component of the theories posited by O'Brien, Corea, and Davis-Floyd, it is assumed that this consciousness results from the physical experience of giving birth.

Other feminist theorists have focused on the ways in which pregnancy and childbirth disrupt binary concepts, particularly self/other, subject/object and subjectivity/alienation. Julia Kristeva (1982) and Iris Young (1990) both conceptualize pregnancy as a time when a woman's bodily boundaries are disrupted. Kristeva conceptualizes the pregnant female body in terms of an "abject body," a body that has blurred boundaries between itself and the developing child within. According to Kristeva, this abject body threatens the pregnant woman's self-identity, as the boundary between self and other, subject and object is disrupted.

Similarly, Young writes about the "doubling of the pregnant self," a self characterized by both subjectivity and alienation. In part, this doubling of self results

from the experience of having another living being within one's body, a being that is both separate, having its own subjectivity, yet fully a part of the pregnant woman's body.

Additionally, as the pregnant body is constantly growing and taking up more physical space, it is difficult for the pregnant woman to conceptualize where her body begins and ends. Young writes, "in pregnancy I literally do not have a firm sense of where my body ends and the world begins" (1990:163).

While Kristeva and Young's theories contribute to our theoretical understanding of pregnancy and childbirth as a time when bodily and self boundaries are disrupted, there are no data to support these theories aside from the theorists' anecdotal reports of their own experiences. The social scientist is left to wonder whether laywomen also perceive bodily and self boundaries disrupted during pregnancy and childbirth or if this phenomenon is found only among feminist academics who have borne children. In addition, these theories focus solely on the body and self, ignoring possible mental and emotional components of childbearing.

Sociological Perspectives of Body, Mind, Emotions and Self

Contemporary sociological theories and research have focused much attention on the ways in which human experience both transcends dualisms and is shaped by society and culture. What follows is a brief summary of current sociological scholarship that highlights the various interrelationships between body, mind, emotions and self as they are conceptualized within three sociological domains: sociology of the body, sociology of emotions and phenomenology.

Sociology of the Body

It is widely recognized among sociologists of the body that an intricate relationship exists between the human body and self. In many facets of social life, the body is viewed

as a signifier of one's self. That is, the body "outside" symbolizes and represents the individual "inside" (Holstein and Gubrium 2003; Turner 1984). Given that the body is a representation of the self, the self must put forth a considerable amount of effort to portray a socially appropriate and desirable self through the body. Michel Foucault (1977) associates this self/body relationship with social power through his analysis of contemporary modes of self-regulation. Foucault argues that whereas the body used to be a locus of social control through physical torture, power is now enforced through control over the mind. Through control over ideas, individuals become subjects that regulate their selves through regulation of their bodies. The result is what Foucault calls "docile bodies" or bodies that conform and submit to societal control.

Similarly, Chris Shilling (1993) identifies the "body as project," something that substantial work is invested in and is accomplished as part of one's self-identity. Mike Featherstone (1991) argues that as part of one's identity, the self is responsible for "body maintenance" or ensuring that the body is clean and healthy. Embedded in these ideas is the expectation that the self maintains control over the body, which, in turn, represents the self. A self that loses control over the body loses its social acceptability (Featherstone and Hepworth 1991). In these conceptualizations of the body/self relationship, the self maintains power and subjectivity over the body as object.

Sociologists of the body have also discovered ways in which the body is perceived as a subject that maintains control over the self. In her research on individuals suffering chronic pain and/or dysfunction related to the temporomandibular joint, Linda C. Garro (1992) notes that the body may refuse to comply with an individual's attempts to exert control over the body. The body's refusal to comply with the individual's demands

inhibits the individual's ability to complete whatever task s/he was trying to accomplish. Garro argues that when the body refuses to comply with the self's demands, the body maintains the "upper hand;" the body's influence over the self is greater than the self's influence over the body.

Sociologists have also documented experiences in which the body is both subject and object in relation to the self. Byron J. Good (1992) conceptualizes the body in pain as an "aversive agent." Pain originates within the body, thereby granting the body subjectivity to interfere with the self's activities, yet pain acts upon the body as an object. Similarly, illness creates a forced recognition of the body as separate from the self. The ill body is both an object in need of repair and a subject that constrains the activities of the self (Gadow 1980; Garro 1992).

Sociological scholarship on the body has also explored the relationships between the human body and mind. Most research on the mind works within George Herbert Mead's (1934) conceptualization that the mind is not a tangible entity, physically located within the parameters of the human body, but is a social construction that emerges through language (Gubrium 1986; Sanders 1993). Consequently, much sociological research on the mind/body relationship has focused on the ways that mind and body are constructed in individuals' narratives of their bodies. Similar to research on the body and the self, research on the mind and the body concludes that both entities can be constructed as subjects and objects.

In their research on individuals' stroke narratives, Christopher Faircloth and colleagues (2004) identify the body as both a passive, foreign object and an active, familiar subject. Within the construction of the body as a passive, foreign object, the

mind tells the body what to do, but the body does not comply with the mind's directives. Thus, the mind acts within the common assumption that the body is a compliant object, similar to the body as object in the self/body relationship; however the body does not respond. Additionally, the participants in their study construct the body as an active subject that "speaks" to the mind. The body in this context tells the mind what to do. The authors relate these body/mind constructions to individuals' conceptualizations of self. In following the body's directives, the participants often find themselves "testing the limits" of what their bodies can do. In testing their bodies, they are also testing their selves. Hence, the body and mind in their reciprocal subject/object relationships are inextricably linked to the self.

Linda Garro's (1992) analysis of pain also provides insights into the interrelationships between mind, body and self. She argues that the mind, through meditation and art, can be used as a tool for disembodiment, or the removal of the self from the body, so that pain is no longer felt. The mind in this context is a subject that has the ability to change the pre-existing self/body relationship.

Sociology of Emotions

Sociologists of emotion have also focused on the interrelationships between body, mind, emotions and self. Within this realm of sociology, emotions are often viewed as lying at an intersection between body, mind, self and/or society. Simon Williams and Gillian Bendelow (1996) argue that emotions are the "missing link" between body and mind as they provide an escape from mind/body dualisms. They conceptualize the emotional body as a "mindful body" or a "mediatrix between the individual, social and political body" (1996:28).

Deborah Lupton (1998) also conceptualizes emotions as interrelated with the body, mind and self. In her analysis of 41 women and men's narratives of their experiences of emotions, Lupton notes that emotions are frequently articulated as having physical effects on individuals. Where the individual may have been previously working within what Drew Leder (1990) calls the "absent body," or the taken-for-granted body that is not reflected upon, emotions bring the body into one's consciousness through their physical manifestations. In addition, the individual loses a certain amount of control over the body and self, as emotions cannot be fully controlled by the mind.

Arlie Hochschild (1979, 1983) also examines the interrelationship between the body, mind and emotions but she incorporates the broader society in her analysis. Whereas emotions are commonly thought to be deeply personal experiences, Hochschild argues that emotions are social. Most social contexts provide a framework for socially appropriate emotions. Oftentimes, individuals find themselves in situations where the emotion that is called for by the occasion is not automatically experienced. Through her research, Hochschild found that on these occasions, individuals will often use what she calls "deep acting" to mentally induce and then physically manifest and exhibit the socially appropriate emotion. Hence, the mind is used to create an emotional response within the body that is appropriate for the social occasion.

Phenomenology

Phenomenologists conceptualize body, mind, emotions and self as inseparable parts of a human being. The focus of phenomenology is "lived experience." As such, phenomenologists point out that in the "lived experience" of everyday life, individuals do not necessarily compartmentalize their experiences into discrete factions of body, mind, emotions and self. Rather, human experience takes place within what Alfred Schutz

(1971) calls the “undivided total self.” Where the body is discussed, it is conceptualized in terms of the “lived body” or “embodiment;” self and consciousness are embedded and integrated within a living body (Bendelow and Williams 1995; Leder 1990; Turner 1992). Leder’s (1990) concept of the “absent body,” or the taken-for-granted body that is not always present in everyday actions, is part of this concept of embodiment. Leder points out that in everyday life, individuals are not always directly attending to their bodies. Nevertheless, it is from within that body that the individual negotiates the world around them.

The Importance of Language

George Herbert Mead (1934) argues that individuals only have indirect access to their “selves.” That is, humans can only think about their selves, or determine what they are thinking, feeling and acting through an “internal conversation” that is mediated by language. It follows that individuals have only indirect access to their bodies, minds and emotions since these too are ascertained through internal conversations one has with their self or spoken conversations with others. It is through these internal or verbal conversations that individuals actively and artfully create their own constructions of reality (Garfinkel 1967). Because this reality construction takes place through the medium of language, language limits the amount of freedom one has in constructing their reality, or in this case, their bodies, minds, emotions and selves. In Foucault’s (1977) terms, language and discourse set “conditions of possibility” for what can be constructed by an individual within any given setting.

What one constructs as their reality, or in the case of this project their body, mind, emotions and/or self, is not merely a play on words or something one might do in their spare time. Drawing on Thomas and Thomas’s (1928) famous “definition of the

situation,” what we believe is real *is* real in its consequences. Similarly, what one believes is their body, mind, emotion and self is, for all practical purposes, whatever they believe it to be. Due to the importance of each individuals’ perceptions and constructions of reality, this dissertation will use what Gubrium and Holstein (1997) call “interpretive practice” as its primary theoretical and methodological foundation.

Interpretive Practice

The main theoretical perspective used in this study is the social constructionist approach which posits that reality is actively constructed by individuals in the context of their everyday lives (Gubrium and Holstein 1997). James Holstein and Jaber Gubrium (2000) draw on ethnomethodology (Garfinkel 1967) and Michel Foucault’s (1977; 1980) work on discourse to present reality as something that is both actively produced yet institutionally constrained. Ethnomethodology is useful for Holstein and Gubrium in that it leads them to examine how reality is actively constructed by agents in the social world. Through what the authors call “discursive practice,” ethnomethodology lends insights into the tools and resources individuals use to construct their everyday lives. However, they argue that ethnomethodology is limited in that it examines only how realities are actively constructed, discarding what is constructed and why.

Holstein and Gubrium (2000) also draw on Foucault’s (1977; 1980) work on the relationships between discourse, knowledge and power. They point out that Foucault analyzes discourse more in terms of what it creates than how it is created. In his historical analysis of the subject in a variety of institutional contexts, Foucault points to the ways that shifting discourses result in different perceptions and treatments of the human subject. Thus, power and discourse are intricately intertwined. Holstein and

Gubrium use Foucault's work to illuminate the institutional constraints that limit the realities each individual is able to construct. They refer to this as "discourse-in-practice."

Holstein and Gubrium view "interpretive practice" as the site of convergence for discursive practice and discourse-in-practice. The authors contend:

We view the respective analytics of discursive practice and discourses-in-practice as converging on the local construction of social structures. As far as subjectivity is concerned, an analytics of discursive practice highlights the interactional articulation of meaning with experience, centering on the artful procedures through which selves are constituted. The analytics of discourses-in-practice accentuates the discursive possibilities for, and resources of, self construction at particular times and places. Taken together, they elucidate what we call 'interpretive practice'—the constellation of procedures, conditions, and resources through which reality . . . is apprehended, understood, organized, and represented in the course of everyday life. (2000:94)

Holstein and Gubrium view the individual as an active agent who constructs reality within the constraints of institutionalized language and discourse. They challenge qualitative social science researchers to attend not only to what experiences are portrayed in narratives and accounts of lived experience and everyday life but how they are produced.

This constructionist approach has been used to disclose the ways that institutional discourses shape individuals' narratives of their selves and their experiences.

Institutional Selves: Troubled Identities in a Postmodern World (Gubrium and Holstein 2001) is a collection of nine "institutional ethnographies" (Smith 1987) that highlight the ways in which a variety of specific organizations shape individuals' constructions of their identities. Gubrium and Holstein explain in their introduction that the compilation of institutional ethnographies "document the way the social and discursive environments of particular going concerns provide for the construction of troubled selves" (2001:16). The essays in this collection demonstrate the ways in which specific organizations, such as

Alcoholics Anonymous (Pollner and Stein 2001) and battered women's shelters (Loseke 2001) actively create the "selves" they need to do their work. These institutions shape individuals' constructions of experiences and selves by providing discursive resources and formula stories, and actively negotiating individuals' stories into their own institutional discourses.

The social constructionist perspective is useful in research on pregnancy and childbirth in that it focuses on both what story is produced in the social encounter (in this case interviews) and how it is produced (Gubrium and Holstein 1997). A constructionist perspective takes as its starting point the symbolic interactionist idea that human experience is not intrinsically meaningful. Rather, we attribute meanings to our experiences based on our interpretations of those experiences (Blumer 1969). Drawing on a social constructionist perspective, my analysis focuses on participants' narratives of their childbirth experiences rather than the women or the experiences themselves. I attend to both what women construct as their bodies, minds, emotions and selves and how these bodies, minds, emotions and selves are constructed. A focus on language and discourse rather than particular subjects lends insight into the ways in which women's interpretations of their childbirth experiences are shaped by the words and concepts available to them through the English language and the broad institutions of biomedicine and science.

Outline of the Study

This chapter has summarized biomedical, social science and feminist perspectives on pregnancy and childbirth as well as sociological scholarship on the body, mind, emotions and self. This chapter concluded with an explanation of the importance of language and a description of the main theoretical approach used in this project. Chapter

two will include an outline of the research method used in this study and a description of the study's participants.

Chapters three through six will describe the results of this study and the analyses of the data. These chapters are divided into the categories of body, mind, emotions and self, but these categories are often intersecting and overlapping. Because the women in this study construct a variety of relationships between body, mind, emotions and self, these concepts cannot be discussed solely in isolation. Nevertheless, the division of chapters in this way enables some analytic distinction between the concepts and enables me to address each component both individually and in relation to the others.

Each chapter builds on the concepts addressed in previous chapters, but the primary focus is on the constructed relationships between the body on the one hand and the mind, emotions and self on the other. Therefore, chapter three focuses on the body, analyzing the various ways that the body is constructed throughout women's childbearing narratives. Chapter four focuses on the mind, emphasizing both the ways that the mind is constructed as its own entity and its relationship to the body. Chapter five focuses on emotions, first highlighting the emotional aspects of pregnancy and childbirth and then focusing primarily on the relationships between body and emotions, incorporating the mind when necessary. Chapter six focuses on the self, beginning with women's constructions of their pregnant and birthing selves. Chapter six then moves into a discussion of the various relationships women construct between their selves and their bodies and concludes with a brief analysis of the interrelationships between body, mind, emotions and self. This study is concluded with chapter seven, which highlights the main

points of this research project and emphasizes its practical and theoretical contributions both to the treatment and care of pregnant and birthing women and to sociology.

CHAPTER 2 RESEARCH METHOD AND PARTICIPANTS

This chapter explains the research method and participants used in this study. This chapter begins with an explanation of how the specific research questions for this study were formulated. It then moves into descriptions of participant sampling and the participants who were involved in this research project. This chapter then outlines the methods of data gathering and concludes with a description of data analysis.

Formulating a Research Question

My research interest in pregnancy and childbirth has been both inspired and informed by my own experiences. I became pregnant during my second year of graduate school and gave birth to my son at a birth center shortly after I graduated with my Master of Arts degree. While I was pregnant, I was required to take a contemporary social theory class for partial fulfillment of my degree requirements. The assignments for this course consisted of reading and writing a five-page paper on each of twelve assigned theory books. Each paper was expected to be either a critical analysis of a particular component of each theory or an example of how the theory could be used to analyze data. Being pregnant, I found myself much more interested in reading self-help pregnancy books than focusing on my schoolwork. I was able to compromise these two aspects of my life by applying the perspectives presented in my theory texts to my self-help pregnancy books. This marked the beginning of my scholarly interest in pregnancy and childbirth.

Having never had a child before or any interest in the childbearing process, I was completely unfamiliar with the self-help literature on pregnancy and childbirth. I mostly read the two books that were given to me by others, which happen to be two of the most popular books on the market: *What to Expect When You're Expecting* (Eisenberg et al. 1996) and *The Girlfriends' Guide to Pregnancy* (Iovine 1995). While reading these books and analyzing them from various theoretical perspectives, I was disheartened by the fact that the bulk of the books focused solely on the physical changes that occur within the pregnant woman's body and the developing fetus. Emotional components of pregnancy were briefly discussed in each book, but the emotions emphasized were fear, irrationality and moodiness. I felt that my experience encompassed so much more than just bodily changes, fears and mood swings, but I was not exactly sure how to articulate the changes I was experiencing. I did know, however, that my entire world and everything in it, including my self, was changing.

I decided to begin doing research on pregnancy and childbirth in part because I wanted to know if the changes I was experiencing were "normal" and also because I was hoping that I would find other women who were able to articulate what I could not find words to describe. Because I was interested in how women articulate their experiences, in-depth interviews seemed like the most appropriate form of data collection. In many ways, I did find that the women I interviewed were better able to articulate some of the issues that arose for me during pregnancy than I could. Some of these experiences were similar to mine and others were quite different, but the same issues were being addressed nonetheless and were often brought up by the participants themselves. What was also common, however, was that women would find themselves at a loss for words in

describing their pregnancy and childbirth experiences. For example, consider Teresa's response when asked to describe her pregnancy experience.

I don't know if I could describe it. It was cool to have something grow inside of you. But I can't look back now and describe how it was, which is kind of weird. I don't know if I could put it into words. I'd do it again, I mean I liked it, I enjoyed it. We've already talked about having more kids. But I don't know if I could describe it.

While still providing me with rich data to analyze, Teresa, along with several other women I interviewed, expressed difficulty in articulating their pregnancy and childbirth experiences.

In order to formulate specific research questions to guide this study, I conducted six preliminary interviews that asked vague, open-ended questions such as "tell me about your pregnancy." The themes that I found particularly interesting throughout these interviews were the various ways that women used and negotiated the concepts of body, mind, emotions and self in the context of telling their pregnancy and childbirth narratives. Although these interviews provided a starting point for reformulating interview topics and questions and beginning a coding scheme, data coding and analysis have been ongoing processes throughout this research project. The final research questions, as outlined in chapter one, are: (1) how are body, mind, emotions and self constructed in women's pregnancy and childbirth narratives? (2) how do women construct and negotiate relationships and distinctions between body, mind, emotions and self in their pregnancy and childbirth narratives? and (3) what narrative and discursive resources do women rely on to construct and negotiate relationships and distinctions between these concepts?

Participant Sampling

Participants for this study were recruited through personal and professional contacts as well as through parent-child play groups. Four of the initial six participants

that took part in preliminary interviews were recruited through a parent-child potluck playgroup sponsored by a local birth center and a child-care cooperative that grew out of the playgroup. Participants in both the playgroup and the coop (which were often the same people) consisted primarily of women who had given birth either at the birth center or at home with one of the two midwives who worked at the birth center. As I began to recognize the homogeneity of this group in terms of their healthcare choices, I recruited two additional participants through professional contacts. These two participants had both given birth in hospitals with obstetricians as their healthcare providers.

Recruitment of additional participants was based on what grounded theorists call “theoretical sampling,” or sampling that is based on the development of a theory rather than the representation of a specific population (Charmaz 2000, 2002; Glaser and Strauss 1967). After conducting, coding and analyzing preliminary interviews, I gained a better sense of who I wanted as my participants, yet consistent with theoretical sampling, this changed over time. I initially recognized a few differences between the narratives produced by the women who chose to give birth in hospitals and women who chose out-of-hospital settings, particularly in their use of the concepts I became interested in studying. Because I was interested in the variety of ways that these concepts were employed, I decided that it was important to recruit respondents who had chosen to give birth in diverse settings. As data collection and analysis progressed, some of these differences disappeared. Although the ways that concepts were negotiated were not entirely consistent among women who chose to give birth in a particular location, similarities emerged in both the content of the concepts and the context in which the concepts were negotiated. Therefore, the selection and recruitment of respondents who

gave birth in diverse settings and through diverse methods was integral to the richness of the data.

For a variety of reasons, my biggest challenge in obtaining participants who had given birth in diverse settings was recruiting respondents who had given birth in hospital settings with an obstetrician as their healthcare provider. One reason for this challenge is that I was very much immersed in settings where most of the women who had children had given birth either at home or at a birth center. The parent-child playgroup and child-care cooperative that I mentioned earlier were two of those settings. I had also accepted a part-time position as Academic Director of a midwifery school, which further immersed me in a community of midwives and midwifery consumers. While it seemed that birth was literally taking place all around me, it was difficult to find participants who would add to this form of diversity in my research. The second reason that recruiting participants who had given birth in a hospital with an obstetrician was challenging was that I had purposely selected a few participants based on an erroneous assumption that they had chosen an obstetrician as their healthcare provider only to discover during the interview that they had chosen to receive care from a midwife. Despite these challenges, I did manage to recruit participants who had given birth in all settings and through diverse childbirth methods.

After my preliminary interviews, I also decided that I wanted to interview women who had given birth only once. Although I did eventually change my mind throughout the course of collecting data, there were two main reasons why I made this initial decision. The first reason was based on one of my preliminary interviews with a woman who had given birth for the second time a few months prior to the interview. I found that

while I wanted her to focus her narrative on her most recent birth, there were many times when she could not talk about her second birth without talking about her first. This made the data much more difficult to analyze, but I also initially viewed the data on her second birth as somehow “contaminated” with data on her first birth. It took me a while to overcome this perception, but I eventually came to view the narratives of her first birth as enriching the data, as it provided her with narrative linkages (Gubrium and Holstein 1997) and contrast structures (Smith 1978) that she used throughout the interview. Thus, I came to view narratives of previous births as assets to the current data. However, this realization occurred late in the data collection process, so most of the participants in this study had given birth only once when the interviews were conducted.

The second reason that I initially wanted to limit my sample to women who had given birth only once was that I thought that the birth of a first child would be a greater “life transition” than the birth of subsequent children. Because the birth of a first child can be conceptualized as transforming a woman from non-mother into mother, I thought that a woman’s first pregnancy and birth would encompass more of a profound change in her sense of self than subsequent births. A friend helped me reveal to myself this assumption that I was making and convinced me to include women in my sample who had given birth more than once. I am grateful that I made this decision, as not only did these interviews add to the richness of the data, but my initial assumption was also proven to be untrue for one of my participants. In my interview with Seva, who had given birth three times, I discovered that she considered her third birth a major life transition, even more profound than her first or second births. While the following excerpt is lengthy, it captures Seva’s conceptualization of her third pregnancy as a major

life-changing event, thereby refuting my previous idea that a first childbirth automatically marks a woman's transition to motherhood.

I was really looking forward to this birth and feeling like, I had that feeling that something new is coming. And not just my baby. I knew that he was going to really change the whole dynamics of everything. That this one was really going to change, that everything was really going to change with him, more so than with [my second child], even more so than with [my first child]. Because [my second child] was four, and we had established ourselves as a little four-person family, so I was really anticipating and looking forward to how things were going to be different. . . . The one thing that struck me when I was pregnant with him was that I needed to reflect on my relationships with [my husband] and with the kids and outside relationships too with people that I am close to. And realizing that, and I don't know if it's because of my experience as a mother, or just a realization that the weight of responsibility of bringing somebody into the world where I'm not realizing the change that I'm bringing in my relationships with other people because you feel that it changes you foremost. And that's the biggest change that pregnancy has. And maybe that accounts for some of the weight of the emotional swings because you're changing who you are to other people, in relation to other people. You're becoming somebody else to your husband or your partner or whatever, to your parents, to your siblings, you know. You're becoming somebody else. And that's something that struck me more during this pregnancy more than with the other two. . . . I think with my first I was still, I was insecure, I sort of felt like I really need the outside, I needed other people to tell me what to do. And I didn't really trust my own judgment. I didn't really think that I was, that I knew the right things to do or how to go about things. I thought I needed to be helped. I was just not confident with me and you know, at the beginning, you're taking advice from everybody. And I was not used to that. You know, everybody is really willing to give you advice and tell you what to do. And as William got older and then Brian came along and then I had a little bit more experience. But because my sister had more experience than I did and my mother had more experience and other people, and with my parents around me, everyone had more experience and by the time this pregnancy came around, I thought, "you know what, I'm a mother too. Just because so and so has five and I only have two or someone has twins, that doesn't necessarily mean they know more about it." And by that time William was old enough that I had gone through lots of things with him and I just trusted myself more and it changed my relationships a lot. I didn't feel like I was still dependent on anyone, I didn't really think about so much what other people thought, I was outspoken more. And I think it was that I had to speak for more than just me now. And I was around that when I was pregnant with him, emotionally. [Interesting. It sound like it was a big transition. It's interesting because you think of that with the first child, but it sounds like this was just as big a transition.] Yeah it really was.

Seva describes her third pregnancy as a major life and self-changing experience. This counters both common-sense understandings and my assumption that first births would be a bigger transition than subsequent births.

The final decision I made after I conducted preliminary interviews regarding which participants I would recruit for this study was the appropriate length of time between the woman's birth and the interview. I had initially decided that conducting interviews as soon after the births as possible would be ideal because women would be most likely to remember the details of their pregnancy and childbirth experiences soon after the events. Again, I was challenged by a friend who had found a potential participant for this study, but the participant did not meet my criteria. This potential participant would have been a fascinating interview because she gave birth vaginally to breach twins. However, this event took place more than 30 years ago. In deciding whether or not to conduct this interview, I reconsidered my rationale for trying to recruit subjects who had given birth within the year prior to the interview. Because the unit of analysis for this study is the narratives that women produce rather than the women or their experiences, it really did not matter to what extent women recalled the "actual" events that took place during their pregnancies and births (see Garfinkel and Sacks 1970). In addition, previous researchers have found that women's recollections of their childbearing experiences are typically quite accurate and vivid, even twenty years after they give birth (Simkin 1991). However, I did want to have the ability to analyze contemporary issues in childbearing in this study and extending my sample to include anyone who has ever given birth would have limited that ability. For that reason, I decided to limit my sample to women who had given birth within the previous five years, or between January 1, 1999 and December

31, 2003. As it turned out, all of the interviews took place within two years after the woman gave birth to her most recent child, and all of the births took place between January 1, 2000 and October 1, 2003.

After I made the initial decision of the “type” of respondents I wanted to recruit, I began networking through personal and professional contacts in order to gain access to the desired respondents. I also used “snowball sampling” by asking participants if they knew anyone else who fit the criteria for the study who might be willing to participate in my research project (Warren 2002). As data collection and analysis progressed, I tried to access more specific populations. For example, at one point I was looking specifically for women who had given birth by cesarean. At other points, I sought specific people who I knew or had heard about from one of my “recruiters” because I thought their situation would add richness to the data. For example, although I thought that I did not really need additional participants who had given birth with midwives to participate in the study, two women were recruited because of their relationships to the birthing professions. One participant is Annie, who was working as a medical resident during her pregnancy and had chosen to give birth with a midwife. I thought that her narrative would add depth to the data based on her simultaneous medical training and choice to give birth within the midwifery model rather than the biomedical model of care. The other participant is Jasmine, who was a midwifery student and had also chosen to give birth with a midwife. Another participant, Aimee, was specifically selected because she had previously adopted a child. Having already become a “mother” through adoption, I thought that Aimee’s narrative would be interesting because she could compare and

contrast her two experiences. Susan was also specifically selected as she had not only had two cesareans, but became pregnant through in-vitro fertilization both times.

Participants

Participants in this research project consist of eighteen women who had given birth within two years prior to the interview. This section describes the demographic and childbearing characteristics of the sample as a whole.

Because theoretical sampling was used to recruit participants based on the location of their births, healthcare providers, and methods of childbirth delivery, this sample is diverse in terms of these characteristics. Eight participants received healthcare from either a licensed or a nurse midwife. Among women who selected midwives as their healthcare providers, three gave birth at home, two gave birth in birth centers, one began labor at a birth center and transferred to a hospital, and two gave birth in hospitals. All of the women who received care from midwives delivered their babies vaginally, and six of the eight women received no medical interventions or pain relief medication. One participant who gave birth with a Certified Nurse Midwife (CNM) in a hospital received epidural anesthesia. The respondent who transferred from a birth center to a hospital received epidural anesthesia and gave birth vaginally with vacuum extraction.

The remaining ten participants received care from an obstetrician/gynecologist. Among women who received care from an obstetrician, all gave birth in hospitals and all received some form of pain relief medication (nine received epidural anesthesia and one received morphine). Six out of these ten women delivered their babies vaginally without additional birthing interventions, two gave birth vaginally with vacuum extraction, and two gave birth by cesarean section. In addition, one participant became pregnant through

in-vitro fertilization. See Appendix A for a description of each participant's healthcare provider, location of birth, method of childbirth delivery and medical interventions.

The geographic state in which the births took place determined the healthcare options available to the participants in this study. Ten of the eighteen participants gave birth in Florida, six gave birth in Michigan, one gave birth in New Mexico, and one gave birth in Pennsylvania. The women in Florida and New Mexico had the greatest flexibility in their healthcare choices due to both the legal status of midwifery in these states and the availability of midwives in the specific regions in which the women resided within these states. In both Florida and New Mexico, direct-entry midwifery is legal and Medicaid will cover the cost of healthcare received by a licensed midwife (Midwives Alliance of North America 2003). Since direct-entry midwives work primarily in out-of-hospital settings (Maternity Center Association 2001), women in these states could choose to give birth in a hospital, birth center, or at home. In Michigan and Pennsylvania, direct-entry midwifery is "alegal" or legal by interpretation of a statute, but not specifically legal and not regulated (Midwives Alliance of North America 2003), and nurse-midwifery is legal (Maternity Center Association 2001). While some nurse-midwives do choose to work in out-of-hospital settings, the overwhelming majority work in hospitals (American College of Nurse Midwives 2003). Some of the nurse midwives in the two regions within Michigan that respondents resided in offer the option of home birth, but there were no birth centers in these regions at the time that the women in this study gave birth. While most of the women who gave birth in Michigan did not consider this an issue in their decision of where to give birth, Annie indicated that she would have given birth at a birth center if there had been one in her geographic area.

The women who participated in this study were relatively diverse on most socio-demographic characteristics. Ten of the eighteen women were married to their partners at the time of conception. Seven women were cohabiting with their partners at the time of conception; four of these couples became married during the pregnancy and three remained cohabiting couples. One participant had no contact with the father of her child. Participants in this study ranged in age from 24 – 49 at the time they gave birth. Ten of the participants were between the ages of 24 and 29, seven were between the ages of 30 and 39, and one was 49.

Participants in this study were also diverse on various indicators of social class. Most of the respondents self-reported that they were somewhere in the range of middle class, which has been found by other researchers to be a common theme in most self-reports of social class (Kerbo 1991). Nevertheless, five participants self-identified as either lower-middle, working, or upper-lower class, ten participants self-identified as middle class, and three participants identified themselves as upper-middle class. In terms of education, three participants had either a high school diploma or some college but no degree, three had Associate's degrees, seven had Bachelor's degrees, two had Master's degrees, and three had either a PhD or a professional degree. Additionally, four participants relied at least partially on Medicaid to pay for their healthcare costs during pregnancy and childbirth, which could also be considered an indication of social class since there is a maximum income requirement in order to qualify for Medicaid. Two of the participants actually paid out of pocket for their healthcare needs during pregnancy, birth, and the postpartum period; one had no health insurance and the other had a health insurance policy that did not cover any of her pregnancy-related healthcare expenses.

The remaining twelve participants had some form of private insurance policy that covered most or all of their healthcare costs.

There were two socio-demographic characteristics that were more homogenous than I had hoped. The first socio-demographic characteristic that I had hoped would be more diverse among my sample was race and ethnicity. Fourteen of the participants in this study are white, two are Hispanic and white, one is Hispanic, and one is African American and white. Because I was recruiting participants primarily based on their method of childbirth delivery and because this recruitment process took place through personal and professional contacts that I had made prior to collecting data, I did not have access to more diverse racial and ethnic groups. The second characteristic is sexual orientation. I was hoping to find at least one woman who had given birth within the context of a same-sex relationship, since most of the women talked at length about their partners' experiences. Unfortunately, I was not able to locate any women who fit both this description and the criteria for the study.

Data Collection

Data were collected through in-depth semi-structured interviews. An initial interview guide was created for the six preliminary interviews (see Appendix B). Based on preliminary interviews, I developed a more extensive set of interview questions to guide subsequent interviews (see Appendix C). Although I was interested in women's perceptions of their bodies, minds, emotions and selves during pregnancy and childbirth, I did not ask these questions directly. Because the "active interviewer" (Holstein and Gubrium 1995) is viewed as co-collaborator in the production of narratives, I did not want to create pregnancy and childbirth as a physical, mental and/or emotional experience through the questions I asked. Instead, I asked the same questions in a variety

of different ways in order to stimulate different types of narratives. For example, after women told me about their pregnancies, I would ask “what was it like being pregnant?” and “how did you feel while you were pregnant?” These questions elicited additional narratives and various women interpreted the word “feel” differently; some described physical sensations while others described their emotions.

Following the “grounded theory” tradition, in which data collection and analysis take place simultaneously and new questions are developed as patterns are found in the data (Charmaz 2002; Glaser and Strauss 1967), I continually added and revised questions throughout the data collection process. Because data collection and analysis took place simultaneously, some participants were asked to discuss topics that others were not asked to discuss. Therefore, some participants are quoted several times throughout a single chapter, while other participants are not quoted at all.

I employed a variety of interviewing techniques throughout the course of the interviews. Among these techniques, “active interviewing” (Holstein and Gubrium 1995) was the most prominent. In active interviewing, the researcher typically asks the respondents questions and might begin with a rough interview schedule, but the goal of the interaction is to “activate narrative production.” The active interviewer remains flexible during the interview process, allowing the respondent to take the conversation in different directions, without losing sight of the goals of the research. In active interviewing, both the interviewer and the respondent participate in the production of the story or narrative. The interviewer’s role is to stimulate narrative production through broad open-ended questions. The respondent is viewed not as a passive vessel of feelings, attitudes and experiences, but as an active creator of such narratives. In the

active interview, the interviewer and the respondent are viewed as co-collaborators in the construction of the narrative produced.

Active interviewing was utilized in this data collection process by asking broad, open-ended questions, allowing participants to take their narratives in various directions, and by actively collaborating in the production of narratives. Each interview began with the broad statement, “tell me about your pregnancy.” Often times, participants launched into lengthy discussions of the context in which they became pregnant, their entire pregnancy experience (often told in chronological order and divided into trimesters), and finally their birth or some other related component that I had planned to ask later. Throughout these narratives, I would probe participants to continue their narrative in whatever direction they chose to take their stories. When participants covered topics that I had planned to ask in the interviews, I usually still asked the questions I had planned to ask anyway. I would acknowledge that they had already addressed the topic, and ask if they could expand on it. Because I was interested in the variety of ways that the women used particular concepts, I wanted to see if bringing up the same topic in a different context would produce a different construction of that same topic, which did occur throughout the interviews.

There were also times when I would ask the participant to theorize whatever topic I was working on during their interview. For example I asked Jasmine specifically what she thought about the “mind-body relationship” during pregnancy and childbirth. Elizabeth was asked to theorize the “boundary” between herself and her child during pregnancy. In this way, both the researcher and the participants collaborated in analyzing and theorizing the data.

I also often engaged in “feminist interviewing.” While feminist interviewing techniques are diverse, I mainly employed those described by Ann Oakley (1981) and Shulamit Reinharz (1992). Similar to “creative interviewing” (Douglas 1985; Ellis and Berger 2002), in feminist interviewing both parties share their experiences, feelings, and interpretations with each other, engaging in mutual self-disclosure (Reinharz and Chase 2002). In addition to sharing tales of experience, some feminist researchers also offer assistance, advice and information to their respondents (Oakley 1981; Reinharz 1992). Often during the interviews, I would interject my own pregnancy and childbirth experiences into the conversations. Many times I did this simply because it felt like the appropriate thing to do, but other times participants would ask me if my experience was similar to theirs. These questions would stimulate a conversation where both parties shared their experiences with each other.

Other times, I would provide information about pregnancy or birth to the participants. Some participants would describe an experience and then either ask if their experience was “normal” or explain why they thought their experience was “abnormal.” Most often, whatever they described was either something that had come up in other interviews or that I had read about somewhere. While women’s constructions of their experiences as “abnormal” provided interesting data, it also seemed to create discomfort among the participants. When a participant showed distress over an experience she thought was abnormal, I would assure her that many women share her sentiment. A few participants described things to me that I knew about and thought that they would benefit from the information I could share with them. For example, in discussing what she would do differently if she were to have another child, Tracy explained that she would

want a trained assistant to help her through her contractions, but was unsure whether or not that was possible. I knew that she was describing a doula and that doulas are widely available, so I shared information with her about doulas because I thought it could enhance any future births.

All of the interviews took place face-to-face, except one that was completed over the phone. Most of the face-to-face interviews took place in either my home or the respondents' homes, and one interview took place in a restaurant over dinner. Many of the interviews that took place in either my or the respondents' homes were attended by both my son and the participants' children. I decided to have children present at the interviews for a variety of reasons. First and most importantly, I did not believe it was appropriate to ask my participants to find a childcare provider so that they could participate in the interviews. Many of the participants had very young babies (as young as nine days old) and even among those with older babies, many had never been apart from their babies. It is probable that these women would not have separated from their babies for the first time just to participate in an interview. The second reason I wanted children present during the interviews was because the children contributed to the overall relaxed nature of the interview setting. A mother and her son coming over to play and talk about birth feels much different than a scheduled interview that might take place in somewhere like an office setting, for example. The third reason I wanted to have children present at the interviews was that it was easier for me to schedule an interview if I could bring my son with me. Like my respondents, I did not always have easily accessible childcare, especially when my son was very young. While the children did ease the difficulty of scheduling and contribute to the relaxed interview environment,

they often interrupted the interviews or became a source of distraction. Nevertheless, I believe that the children's presence contributed more than it detracted from the interviews.

The one interview that took place over the phone was both challenging and time-consuming. I wanted to interview Annie because of her unique perspective of having completed medical school yet chosen to give birth with a midwife. The problem was that I lived in Florida, she lived in Michigan, and neither of us had any plans to travel at that point in time. We decided to do the interview over the phone, both with the understanding that it would take longer than any of the other interviews. We agreed that the best way to proceed, given our lack of assistive technology, was for me to simultaneously participate in and transcribe the interview. This was much more challenging than I expected, and I continually needed to ask Annie to repeat herself and slow down. The interview took us a total of six hours over the course of two separate nights, but we finally did complete it. Although I was not always able to record every word that Annie said, and sometimes she would say something differently when she repeated it the second time, the bulk of her transcribed interview is her original words. After my interview with Annie, I decided only to conduct subsequent interviews face-to-face.

All of the face-to-face interviews were tape-recorded and transcribed by me. While the transcription was time-consuming, it was an integral component to how I read the transcriptions. Having conducted and then transcribed the interviews myself, I had heard each participant say several times the words that appeared on their transcribed interviews. This enabled me to hear in my head the tones and inflections women used when they told

their narratives. In other words, as I read and re-read each transcription for data coding and analysis, I was able to read them in the voice of the actual participant. This was helpful because sometimes it is the tone in which something is said that gives it meaning rather than the mere words on a piece of paper.

Data Analysis

Data were analyzed using a variation of “grounded theory” (Glaser and Strauss 1967). Grounded theory includes the merging of the data collection and data analysis processes, whereby interview questions are added or revised as categorical themes are created from the data. In grounded theory analysis, the researcher must ask, “what is going on in these data?” rather than “which of my preconceived categories does this statement fit into?” Thus, the analysis is driven by the data. However, it is important to recognize that any researcher enters a project with some previous understanding or notion of the topic of interest, which may or may not evolve throughout the data collection/analysis process. Therefore, the researcher actively constructs the emergent categories rather than objectively discovering them (Charmaz 2002).

As stated earlier, this research project began with preliminary interviews with six women who were within one year postpartum. The theme that stood out in these interviews was the multiple ways that women discussed their bodies and emotions throughout the course of their narratives. For example, when asked to tell me about their pregnancies, women commonly distinguished between their physical and emotional experiences and discussed them separately. Various relationships between the physical and emotional realms would emerge and then change throughout their discussions of pregnancy and childbirth. At times the women would explain the physical aspects influencing the emotional, other times the emotional influencing the physical, and other

times the two were completely intertwined and inseparable. As data collection and analysis progressed, I noticed that mind and self were also prevalent throughout the narratives and were being constructed in much the same way as body and emotions. Based on the results of preliminary interviews and ongoing analysis of the final data set, the research questions stated earlier in this chapter guided data analysis.

I encountered a “postmodern dilemma” in coding and analyzing these data. The goal of my research project is to demonstrate the multiple ways that the concepts of body, mind, emotions and self are constructed and negotiated in women’s childbearing narratives. The purpose of this research is to show the relativity of these concepts as they take on multiple meanings and subjectivities throughout the analysis. This presents a dilemma: how can I code and analyze concepts that I am arguing have no concrete reality? How do I as the researcher determine where one concept ends and another begins?

I addressed these issues by employing “working definitions” of the concepts of analysis. This required “bracketing” (Schutz 1970) my own definitions of these concepts as permeable and negotiable and treating them as concrete in order to analyze the data. My working definition of the body included any specific mention of the body, body parts (such as leg, cervix, blood), and the physical (indicated by the words physical or physically). I also included activities that are commonly associated with the body, such as labor contractions, cervical dilation and membrane ruptures in my working definition of the body and physical aspects of childbearing. To some extent, I also categorized pain as a physical experience, though I was careful to consider the context of the narrative when associating pain with the body.

My working definition of the mind consisted of talk of the mind, brain, thoughts, thinking, and mental components. I considered emotion to encompass any talk of emotion in general or specific conditions that are commonly thought of and considered by other sociologists as emotions, such as fear, love, overwhelm, excitement and anxiety (Cuthbertson-Johnson et al. 1994). The self encompassed talk about the self, person, I and me. These working definitions provided a starting point from which I could code and analyze data.

I chose to use a hand-coding scheme rather than a software package because I wanted to maintain the ability to quickly access the context of each narrative excerpt. I maintained this ability by coding the printed interviews with different colored sticky notes. I read, coded and analyzed each interview several times to ensure that themes were accurately portrayed and that relevant themes were not overlooked. Initial analysis consisted of coding excerpts into the broad categories of body, mind, emotions and self. Since many of the narratives construct relationships between these concepts, excerpts were often noted with more than one category. This initial coding process was repeated at least once for each interview.

The second stage of data analysis consisted of re-reading the noted excerpts and searching for sub-themes within each category. I employed “analytic bracketing” (Gubrium and Holstein 1997) by alternately searching for themes in what bodies, minds, emotions and selves were constructed in the narratives and how they were constructed. I then made a list of sub-themes that emerged within each category. These lists were generally lengthy, consisting of approximately twenty sub-themes per category. I then searched for similarities among sub-themes and collapsed sub-themes into approximately

five themes per category. At that point, I cut and pasted all of the excerpts into documents that were based on the four broad categories of body, mind, emotions and self and organized by sub-theme. Each sub-theme was further analyzed and coded and excerpts were selected that best articulate or demonstrate particular themes.

CHAPTER 3 THE CHILDBEARING BODY

The biomedical perspective of childbearing locates pregnancy and childbirth primarily within the realm of the physical body (Davis-Floyd 2001; Hahn 1987; Martin 1992). Within this perspective, the pregnant and birthing body progresses through a series of physiological changes as it works to create and ultimately release a child. This primary focus on the physical body as the site of pregnancy and childbirth is replicated in self-help pregnancy guides (Marshall and Wollett 2000).

Social science research on childbearing and the body has primarily focused on the body as the site of biomedical authority and control (Davis-Floyd 1992; Rothman 1991) and body image during pregnancy (Charles and Kerr 1986; Earle 2003; Wiles 1994). Whether or not women perceive pregnancy and childbirth as a physical, bodily experience and the ways that women perceive their bodies during pregnancy and childbirth (beyond body image) have not been explored from a sociological perspective.

This chapter explores women's constructions of pregnancy and childbirth as physical and non-physical experiences and focuses on the various ways that women construct their bodies, specifically in narratives that focus primarily on the body or physical aspects of pregnancy and childbirth. Discussions of the body in the context of other aspects, such as mind, emotions and self, will be explored in subsequent chapters.

This chapter begins by establishing that throughout the narratives in this study, pregnancy and childbirth are constructed at least partially as physical experiences. This chapter then moves into an explanation of the different "bodies" women construct in their

narratives that focus on the body. This discussion is broken down into three sections: body as object, body as active subject and activating the body.

Childbearing as Physical Experience

A bulk of the narratives in this study focus on pregnancy and childbirth as physical experiences. These narratives emphasize various physical components of pregnancy, childbirth and the immediate postpartum period. While talk of the physical aspects of childbearing varies widely in content, all of the narratives to some degree or another construct pregnancy and childbirth as physical experiences.

Many women's pregnancy narratives highlight the physical aspects of pregnancy. Often, women use the term "physically" to emphasize that they are describing the physical rather than other components of pregnancy. For example, Aimee describes her pregnancy:

Physically, I felt great. I had a lot of energy. The first trimester was a little nauseating, but physically, I mean, I worked. I didn't get any sick days except for my regular doctor visits. I worked up until, Jefferson's due date was on November 22, which was Thanksgiving, and we were out of school the day before Thanksgiving and I worked right up until that day. . . . So, physically I felt wonderful. I didn't ever, I mean, you get the regular aches and pains and stuff but I didn't have any problems that would cause me to stop working. I felt pretty energized.

Aimee's narrative emphasizes the physical aspects of pregnancy, thereby constructing pregnancy as at least partly a physical experience. Aimee uses the term "physically" to indicate that she is talking about her body and the physical aspects of pregnancy in her narrative. She associates energy, nausea, aches, pains and her ability to work with her physical body.

Many women's childbirth narratives also emphasize physical aspects. Sarah describes part of her labor in what might be considered physical terms though she does not specifically indicate that she is talking about her body until the end of the excerpt.

My contractions never really went into a regular pattern and [the baby] never dropped until towards the end. And then around noon I started getting sick. I started vomiting and, yeah, not a good scene. And the contractions were really painful and before we went [to the hospital] we talked about whether I would get an epidural or not and my attitude was sort of, I'm going to see how far I can go and if it works out I won't and if I feel like I need it I will. So around twelve in the afternoon I got an epidural and I felt immediately better. Cause I was already getting exhausted and then the physical pain.

In this portion of her narrative, Sarah describes her labor mainly in physical terms. The focus of her narrative is the body, as it contracts, vomits, and feels pain. Sarah associates pain with her physical body at the end of this excerpt. These excerpts provide brief examples of the construction of childbearing as a physical experience. Childbearing as a physical experience is prevalent in many of the narratives in this study and will be further demonstrated throughout this project.

However, in some portions of the narratives, women de-emphasize the physical aspects of pregnancy and childbirth. These women acknowledge that childbearing includes a physical component, but construct the physicality of childbearing as either insignificant or less significant than other components.

For example, Cindy virtually excludes her physical body from her pregnancy narrative. Instead, she focuses primarily on the emotional aspects of pregnancy and the social context in which her pregnancy took place. When asked specifically about the changes going on in her body, Cindy responds:

Mostly I thought it was pretty neat. . . . You know, I don't think the changes were a big deal to me. . . . I knew what to expect and I felt like the changes that were going on were just part of the process.

Cindy acknowledges that physical changes are one aspect of pregnancy, but for Cindy this component is insignificant. The bulk of Cindy's attention in her pregnancy narrative is on her relationship with her partner rather than physical changes that took place within her body. For Cindy, the physical component of pregnancy is "just part of the process."

Victoria also minimizes the physical aspects of pregnancy in her narrative. Until further probing, Victoria's only mention of the body in her pregnancy narrative is in the following excerpt:

I thought pregnancy was not what people said it was going to be about. I didn't get into like, liking how my body changed or any of that. Do you know what I mean? Really I think I was more nervous than anything. I think it was kind of a nervous time.

While both Cindy and Victoria acknowledge physical components of pregnancy, both women construct them as insignificant. For these women, pregnancy is not so much a physical experience as it is an emotional or mental experience that is embedded in a particular social context.

Taken together, the excerpts in this section demonstrate that childbearing can be constructed as either a physical or a non-physical experience. The extent to which women construct their experiences as physical or non-physical depends on their individual interpretations and the social context in which childbearing takes place.

This chapter now turns to a discussion of the variety of ways that the body is constructed throughout women's narratives that focus specifically on the body. Particular attention is paid to the construction of the body as both object and subject and its multiple subjectivities.

Body as Object

Many of the narratives in this study construct the childbearing body as an object. Webster's Collegiate Dictionary defines an object as "something mental or physical toward which thought, feeling, or action is directed." Hence, a body becomes an object when one thinks, feels or acts upon the body. The narratives in this research that construct the body as an object are organized into two categories: (1) bodies in relation to the "gaze" and (2) bodies as temporary objects.

Body and the Gaze

Much feminist research and theory has focused on women's adherence to cultural standards of the slender female body (Bordo 1993; Bartky 1990; Wolf 1990). Within this scholarship, the body is viewed as an object; it is something to be looked at, judged and molded through diet, exercise, eating disorders, cosmetic surgery, and an array of other "normative feminine practices" (Bordo 1993). The "gaze" (Foucault 1977), or judgmental observation of the body by oneself and/or others, is considered an apparatus through which cultural expectations of the thin female body are enforced (Bartky 1990; Bordo 1993).

While it is widely acknowledged that most women, to some degree, discipline their bodies within the "tyranny of slenderness" (Chernin 1981), very little is known about pregnant, birthing and postpartum women's bodily perceptions and disciplinary techniques. The scant research that has been conducted has yielded contradictory results. Some researchers argue that pregnancy is a time when women are liberated from the confines of dominant body ideals (Charles and Kerr 1986; Wiles 1994) while others argue that pregnant women are equally subjected to bodily ideals as non-pregnant women (Earle 2003). The data in the current study support both conclusions. What is interesting

and perhaps telling about the current data is that I did not ask women directly how they perceived their pregnant, birthing and postpartum bodies; the following accounts were offered by the women themselves.

Many of the women in this study expressed that their growing bodies were not a source of discomfort or discontent. These statements are consistent with other researchers' conclusions that dominant body ideals do not apply to pregnant women (Charles and Kerr 1986; Wiles 1994). In fact, some women describe their attempts to make their bodies look bigger than they actually were. For example, Annie explains:

I loved my pregnant body. I had nice big breasts which I'd never had before and don't have now and it was summer and I had a tan on my big belly. And even before I was really showing I would wear something that was tight across my stomach so that my stomach would stick out more than it did. I would wear like stretchy pants and a tight shirt so it looked like I was more pregnant than I was even when I was only twelve weeks. So I loved my pregnant body; it was big and brown and round. And it was funny because Andrew would call it whatever it was. If I was wearing an orange shirt, I was an orange. If I wore a blue shirt I was a blueberry and when I just had my bare belly I was a walnut because I was so tan.

Like Annie, Aimee also expresses taking pleasure in her larger pregnant body. In addition, Aimee describes pregnancy as a period when women are free from societal expectations of thinness.

Women in general I think are unhappy with their bodies and I just felt, I felt more at peace with my body because I figured okay, it's supposed to be big. I just felt like I didn't have to worry about it as much. I figured people looked at me and went, "oh, she's pregnant." And I didn't have to think, oh, these jeans make my butt look big because everything was focused on my belly. So I felt very, very comfortable being pregnant. . . . I know some women feel like, "oh I felt so fat when I was pregnant" and I didn't. I felt great. I loved wearing little tight tank tops with my belly poking out. We went to the beach and I wore just a sarong and my top and had my belly. I thought it was wonderful. So I thought pregnancy was great. I feel badly for women who are so concerned with the stretch marks and I think that's so sad. They're missing out on all the great parts. And it's one time in your life when you can be fat and nobody cares so I loved it.

Aimee constructs pregnancy as a time when women are able to deviate from cultural standards of thinness without social ramifications. Pregnancy is constructed here as a time when women are liberated from the “gaze” (Bordo 1993; Foucault 1977) that encourages and perpetuates the ideal (and mostly unattainable) thin female body.

It could be argued that a different body ideal exists for pregnant women. In these excerpts, the body that women are happy with is the noticeably pregnant body with its protruding round belly. The participants in Sarah Earle’s (2003) research expressed similar satisfaction with their bellies, or what she calls “bumps.” More research would be needed to draw any conclusions as to whether or not an “ideal pregnant body” is perceived among pregnant women, what that body looks like and how it is attained. Nevertheless, many of the women in the current study do not express discontent with their inability to conform to dominant body ideals of thinness during pregnancy.

Some women did express concern over the way that their bodies would look after pregnancy. While the body during pregnancy was constructed as liberated from cultural ideals of female slenderness, the postpartum body is not liberated from such ideals. Concern over the size and shape of the postpartum body was said to take place both during and after pregnancy. For example, in describing her pregnancy, Sarah states:

I guess that was one of the hardest things particularly early on but maybe even more so towards the middle when your body really, when you make that jump kind of. It was about at four months, five months. . . . I felt good and I had always exercised beforehand so I was able to continue to do that which helped a lot, but of course despite that you’re still gaining weight and all. So that middle part I remember feeling depressed a little bit and anxious, you know, what am I going to look like when this is over and all of that. But then once I passed a certain point it mattered less somehow and I guess I was more caught up in the whole amazing part of the whole thing and then she started moving and I could feel that, so it mattered less as I went along. But I remember at first I was worried about it, and then when things actually started happening I could see my body changing and I was like, what’s gonna happen to me?

Sarah describes herself feeling anxious and a little bit depressed over her noticeable weight gain during pregnancy. However, the focus of her concern is not how her body looked during pregnancy but how it would look after the pregnancy was over. Sarah states that this concern became less salient the further the pregnancy progressed. Again, the dominant body ideals of thinness seem to apply to the post-childbearing body rather than the pregnant body. This finding is consistent with Sarah Earle's (2003) research that demonstrates women's acceptance of a larger pregnant body and non-acceptance of the larger postpartum body.

Whereas some women describe pregnancy as a time when women's bodies are liberated from the slenderness "gaze," other women describe events in which their bodies were the objects of others' gaze. Interestingly, these accounts do not specifically attribute the gaze to the size and shape of one's body. For example, Isabel describes her body as the object of others' disapproving gaze during pregnancy, but the reason for their disapproval is as much about her clothing as it is about her pregnant body.

I didn't want to wear any clothes. So I'd wear little bikini tops and my belly was sticking out everywhere and I got lots of looks. Sometimes we'd go sit and people watch at the mall because it was cool there and people at the mall really looked down on my belly. Places like the health food store, they loved it. But other places, you know, they were just.

The gaze of which Isabel's pregnant body was the object varied depending on the social space in which the encounters took place. At the mall, Isabel received disapproving looks whereas at the health food store the looks were approving. Isabel's experience coincides with Robyn Longhurst's (1998) finding that the pregnant body becomes increasingly welcomed into environments that are associated with domesticity and unwelcomed into environments associated with popular culture, entertainment and sexuality. Isabel attributes these varied responses not so much to the size and contour of

her pregnant body itself, but her lack of clothing to cover her pregnant body. Regardless of the type or reason for the gaze, the body becomes an object when it is subjected to the gaze of others.

Tracy describes a situation that is unique in this data whereby her vagina is the object of a disapproving gaze by her healthcare practitioner. Tracy's perineum had torn during the delivery of her child and needed to be repaired.

Both times I needed to have repairs done and the first time, the midwife does the repairs and it was just a very unpleasant experience. And I don't know whether it's like that, whether it's just the fact that it's after the birth, but we really had an unpleasant time with it. Partly because I had gotten a local anesthetic, but either it wasn't enough or it wasn't done in the right place and it was really painful, acutely painful, not like labor, it was bad. And it took some persuasion to get him to up the local, to put more in. So part of that was communication, part of it was that he just wanted to finish the job, to be done with it. And also he was saying particularly inappropriate things. So it was immediately after the birth, dealing with this painful process of repairing, and he wasn't particularly reassuring about it. He said stuff like, "How did this happen? I don't think I've ever seen it like this before."

Through his choice of words that construct Tracy's perineal tearing as abnormal, Tracy's healthcare provider makes her aware that her vagina is the object of his gaze. In this example, the gaze is largely disapproving.

Overall, these narratives construct the childbearing body as an object to be looked at, evaluated and often commented on. Previous research often conceptualizes the body-as-object as a body that is subjected to others' gaze. This gaze becomes a mechanism of control, as the individual internalizes the gaze and turns it in on herself (Bartky 1990). By and large, the women in this study construct pregnancy as a time when women are liberated from the dominant cultural gaze that mandates female slenderness. However, the pregnant and birthing body is constructed by some women as the object of a different gaze—a gaze that expects the pregnant body to remain covered in public spaces and/or a gaze that defines and perpetuates "normative" female anatomy. In addition, the

postpartum body is not considered to be afforded liberation from dominant slenderness ideals.

Body as Temporary Object

Many of the narratives in this study construct pregnant and postpartum bodies as temporary objects. The temporary nature of childbearing bodies is emphasized by distinguishing between the different bodies one has at different points in time. For example, Annie describes her body after the birth of her child.

It's kind of weird though because you rub your stomach and its just this big pile of mush. I can't say I was too fond of the postpartum body for a little while. I loved my pregnant body and I like my body now, but the postpartum body, I just wanted to wear a girdle. It was fine when I was at home. But I went back to work when she was seven weeks.

Annie distinguishes between three different bodies that she had throughout the course of childbearing: a pregnant body, a postpartum body and a current body (18 months postpartum). Conceptualizing each of these forms of Annie's body as separate bodies suggests that the body is a temporary object. Within this construction of the body as a temporary object, women move from one temporary body to another throughout the course of childbearing.

These different bodies and their parts are also referred to using different words. Many women in this sample refer to their "pregnant belly" but the same region of the body is never referred to as a belly in regards to the pre-pregnant, postpartum or current body. Like Annie, in most of the women's narratives in this study, in the context of the non-pregnant body, the pregnant belly becomes a stomach or a gut. This word choice seems to be influenced by the presence or absence of a child within that region of a woman's body. Like the word "tummy," "belly" is often used with and by children. Hence, a woman can have a belly when that belly encompasses a child within it. In the

absence of a child within the same region of a woman's body, "belly" is replaced with the more adult terms of "stomach" and "gut."

Susan also describes the childbearing body as a series of temporary bodies, but for Susan, the pre-pregnant body is her "real" body—a body that will return when the childbearing period is complete.

With Jeffrey, I didn't take the weight off as quickly. Initially, or for about a week, I still looked pregnant. With Alexa, within about 3 days I looked heavy but not pregnant. With Jeffrey I still looked pregnant. So that was a downer. And it was like, real gushy. . . . So I didn't feel as attractive after Jeffrey as I did after Alexa because my body didn't get back as quickly. It's still not back.

According to Susan, the body she had before she became pregnant is *her* body. In saying that her body is "still not back," Susan suggests that the pre-pregnant body returns after the completion of childbearing and the postpartum period. The pregnant and postpartum bodies are temporary bodies but the pre-pregnancy body—the body that will eventually return—is her "real" body.

Some women emphasized the temporariness of the childbearing body by expressing concern that some of the characteristics of the childbearing body would be permanent. For example, Cindy explains her reaction to her pregnant body:

I guess there were some things that were a little scary, you know wondering if I was normal or if this was going to be permanent. [Like what?] Well, one thing was when my belly button disappeared. I was like, oh my gosh, is it ever going to look normal again? And I was really concerned about gaining too much weight because I was overweight to start with so that was a big concern for me.

Cindy's concern over the permanence of the characteristics of her pregnant body demonstrates her expectation that the pregnant body is a temporary body.

Teresa expresses similar concern over her postpartum body:

I started getting worried, like is my skin ever going to go back to where it belongs, you know? Are these stretch marks ever going to get any lighter or am I stuck like this forever? It was a little traumatizing.

Like other women in this study, Teresa's concern over the permanence of her postpartum body emphasizes the expected transitory nature of the postpartum body. In these narratives, the individual moves in and out of an array of temporary bodies throughout the course of childbearing. These bodies are objects in that they are observed, evaluated and compared with each other.

Body as Active Subject

Discussions of bodily activities, or activities that take place within one's body that the individual has no specific control over, are abundant in the women's childbearing narratives in this study. In describing bodily activities, the body becomes an active subject. Unlike the body as object, in which the body is something to be looked at, evaluated and acted upon from the outside, the active body has its own agency and is relatively unaffected by the outside. Constructions of the body as an active subject are divided into two subcategories: active bodies and active body parts.

The Active Body

Some women describe their bodies as active subjects during pregnancy. The pregnant active body shifts its organs to make space for the developing child within and works to create a child. The woman has no specific control over this process, as the body is its own active subject. For example, Elizabeth explains why she thought pregnancy was enjoyable:

Just the way your body changes. Just the way women's bodies change automatically to care for this human being. Especially during our class we took and seeing how your hips realign and things shift and all your organs shift up and everything. It's just, your body automatically does that just to make room for this baby and how the baby can be turning and flipping and moving, but then when it's ready, it goes head down, most of them, it goes head down and is ready to go.

Elizabeth constructs the pregnant body as an active subject by describing the body's "automatic" processes. By automatically doing something on its own, the body becomes an active subject.

While other women also discussed the pregnant body as an active subject, it was even more common to hear the laboring and birthing body described as an active subject. Women often constructed the laboring body as an active agent that the women themselves had no control over. This was particularly evident in discussions of women's membranes rupturing, or what is commonly referred to as one's "water breaking."

Meka describes the onset of her labor, which began with the rupturing of membranes:

Well, my water broke at 2:00 in the morning. And that was how I expected. It was exactly what I expected. I woke up in a puddle of water. . . . See, I thought, you know, it kept going and going and going. And I got up, and it's just running, just pouring out of me as I go to the bathroom, just all over the place and I sit down on the toilet and it goes and goes and goes and then it stops. And I thought that was it. That wasn't it. It just keeps going. And I'm just standing here and I'd already changed my clothes and dried myself all off and I'm just standing here in the kitchen. I go to the bathroom and it's all over the place. It just kept doing it and doing it. I must have changed my clothes like six or seven times.

Meka's description of her membrane rupture demonstrates her lack of control over her body's activities. Despite her expectation that her body would eventually stop releasing fluid, the fluid continued to be released from her body. Thus, the body is an active agent in this description. Other women described their bodies similarly in their discussions of membrane ruptures. Elizabeth explains, "I had this wonderful gushing and I couldn't stop it. That's why I knew my water had broke."

Other constructions of the body as an active subject appear in women's descriptions of their labor contractions. Annie distinguishes between pain created from

within her body and pain created specifically by her self. Annie's distinction between the different types of pain she felt emphasizes the body as active subject during labor.

The labor was really intense. It was very painful and it came in waves. And the birth too was very intense but it was more like a strong intense. The labor, by the end the waves were such intense pain that it felt like they were knocking me off my feet. I felt like I was just floating in a sea of pain. I felt weak with pain. I couldn't feel anything else. I couldn't feel touch, the floor, anything. It was just this intense pain. But the birth part, where I was pushing the baby out was concrete. That was like a strong pain. It still hurt, I still felt a sensation of pain, but it felt like I was pushing through the pain. I was creating the pain. I was using my muscles and my strength and pushing through the pain. I felt strong through that whereas during the contractions I felt really weak, like I was going to faint because of the pain.

In distinguishing between pain created by herself and pain created from within her body, Annie highlights the body as an active subject that creates labor pain. Here labor contractions are created by and within the body. The individual does not have control over the sensations created by the body.

The Active Body Part

Some women also construct specific body parts as active subjects. Like the active body, the active body part has its own agency. For example, Cindy describes her cervix as an active agent during her birth:

[The midwife] said that I was fully dilated and she could see the baby's head, but part of the cervix kept slipping down over the baby's head so he wasn't able to come out. So she had to stick her hand up there and hold the cervix back and wait for a contraction for me to push his head through.

The cervix is not only an active subject because it is performing its own activities, but it is interfering with the activities of the individual. Cindy is trying to give birth to her baby, but her cervix is serving as an active agent in disrupting her attempts. Hence, the cervix itself becomes an active body part in Cindy's narrative.

In Rebecca's narrative, the placenta becomes an active body part with its own agency. When describing the moments immediately following her birth, Rebecca states:

It was so bloody that they were kind of concerned. Apparently when I had her, when she came out the placenta detached right then and they worried that only part of it came out and that it retained, the placenta. . . . They tried to get cord blood but because it detached right away there wasn't enough.

Rebecca's placenta is constructed as an active body part by detaching right when her baby is born. The placenta in this context is its own agentic subject. Like the active body, the active body part has its own agency; it acts on its own free will despite the wishes of the individual.

Activating the Body

The women in this sample described various techniques that were used to activate the body, or transform the body from its current state into an active subject. Bodies that needed to be activated fell into two categories: inactive bodies and semi-active bodies. Inactive bodies are bodies that are not performing their expected activities at all. Semi-active bodies are bodies that are performing their expected activities, but the activity is not taking place at a pace that is sufficient to either the woman or her healthcare provider.

Bodies that require activation are constructed as both object and subject. These bodies are objects in that the activation technique is something that is done to them. The activation technique is performed at the will of the woman or her healthcare provider regardless of whether or not the body wishes to be activated. Bodies that require activation are also subjects because despite the individuals' wishes for the body to be active, the body remains either inactive or semi-active. Thus, it is the body rather than the individual that initially determines whether the body will be active, semi-active or inactive. It is also the body that decides whether or not to respond to the activation technique.

Inactive Bodies

As previously stated, inactive bodies are bodies that are not performing their expected activities. In the current study, inactive bodies are typically bodies that are not in labor despite the woman's wishes for labor to begin. The women in this study describe a variety of activation techniques that were employed by either themselves or their healthcare providers. Inactive bodies were activated through bodily activities, non-technological interventions and medical technology.

Many women in this sample describe bodily activities that were used as techniques to activate the inactive body. Kristy describes her use of sex as an activation technique:

I really didn't do anything to prepare [for the birth]. The day before, I wanted to, you know, I was *so* ready. I had a pizza with everything on it, and sex, and it wasn't even that I wanted to have sex so bad, but the nurse told me that if you do and the semen stays it can help thin your cervix, you know? It was like it was a procedure almost at that point. I was just so ready.

Despite Kristy's desire to begin labor, her body remained inactive. Kristy describes her use of sex as an activation technique to attempt to stimulate labor. In this example, sex is essentially a bodily technique that is used to activate the body. While the effectiveness of this bodily technique for Kristy is unknown, her body did begin labor early the next morning.

Isabel also describes a variety of bodily techniques that she used to try to activate her body.

I'd take walks, really vigorous walks. I tried *everything*. I tried all the stimulations they tell you to try. I can't even think of them now, like nipple stimulation, sex, everything under the sun I tried except for that herbal thing. I can't remember what it's called. I didn't try that because they said it was more of an intervention. . . . I was just a walking maniac. I was like, "I'm gonna walk myself into labor." And I didn't. Anyways, I was five days late. I wasn't late as far as [the midwives] consider, but I expected to have her on my due date, you know. Like a fool.

Like Kristy, Isabel describes an array of bodily techniques that she used in an attempt to activate her inactive body. However, Isabel emphasizes that her activation techniques were ineffective. Despite her attempts to activate her body, Isabel's body refused to be activated through bodily activation techniques.

Some women also describe non-technological techniques that their healthcare providers used to activate the inactive body. Non-technological activation techniques were commonly described by women whose healthcare providers were midwives. Isabel describes the activation technique that her midwife used after Isabel's own techniques were ineffective.

Also you know after seven days if you don't have [the baby] you can't give birth at the birth center and they would send you to the hospital to have them induce more, do more induction things. Anyways, [the midwife] tried one last thing, which was stripping my membranes she called it. Basically she just got rough with me a little bit and it just got it going. It just stimulated the labor a little bit. I went in in the morning and then by noon I was having harder contractions.

While only a few women in the sample describe non-technological techniques used to activate the inactive body, many women describe technological activation techniques. Technological activation techniques were more commonly used with semi-active bodies, but a few women's inactive bodies were activated with medical technology. One technological activation technique is the use of pitocin, a synthetic form of oxytocin that stimulates or speeds up the progress of labor.

Maria describes her experience of bodily activation through pitocin.

So I pre-registered and they brought me to my room which was really nice and I got into my gown and everything and they hooked me up to, you know just to check my blood pressure every so often. And I met the nurse that was on duty then and I was just in my gown and I was, you know, I wasn't in labor. And by the time that was all said and done it was a little after 4:00. They hooked me up to the pitocin and it didn't take right away. They kept having to turn it up because I wasn't having any contractions yet. And so, I think an hour later it started to kick

in and I started to feel contractions. And they were really mild and, you know, no big deal.

While the pitocin did eventually activate Maria's body by stimulating labor, Maria explains that the hospital staff had to keep increasing her dosage. Maria's body initially remained inactive despite the introduction of synthetic labor-stimulating hormones. Eventually her body was activated by the medical technology.

One participant's body was initially inactive and essentially remained inactive throughout her birth. This participant had two planned cesarean births because her first baby was breach and her doctor recommended that her second baby also be delivered by cesarean. What distinguishes her narrative from many of the others is her use of pronouns during her childbirth narrative. Whereas many of the women use "I" to describe the activities that led to the birth of their child, Susan uses "they." Thus, it is "they" who ultimately deliver Susan's baby while Susan and her body are relatively inactive participants.

I never went through labor. I never had a chance to do that. . . . Once they started touching my feet or whatever and saying, "Can you feel this?" and I said "No" then they brought Noah in. And then it was really fast. It was like five minutes after he came in that they were done. So they got the baby out and then they took the baby over to get tested right away and then Noah got to hold him and then he brought him over to me. [So you didn't feel anything?] Nothing.

Later in the interview Susan describes what she wishes she could have done differently:

I wish I could have given birth to them. Especially Alexa, not so much Jeffrey. But she was the first. . . . You know, people say it's like giving birth. And I guess I did give birth, but it almost doesn't feel like it, because you hear stories about labor. And not that I really miss it but I'm curious about it I guess. Because I've never seen anyone go through it and now I've never been through it and I came with labor but it was different. . . . So I'm sort of curious about what labor was.

Susan's narrative is similar to the others in this section in that a technique was used to begin or speed up the process of getting to the same end result: the birth of a baby.

However, Susan's descriptions of the processes involved do not construct her body as ultimately being active or activated. In Susan's narrative, the inactive body does not become an active subject.

Semi-Active Bodies

The semi-active body is a body that is performing its expected actions but this performance is not occurring at the pace expected by either the woman or her healthcare provider. In the narratives in this study, the semi-active body is typically a body that is in labor, but the progress of labor is deemed insufficient. The women in this study describe a variety of activation techniques used to further activate the semi-active body. On occasion, these techniques were used at the laboring woman's request. However, it was more common for the healthcare providers, particularly obstetricians, to determine when the semi-active body required further activation.

One participant who determined that her body needed further activation was Annie. Throughout her childbirth narrative, Annie stated that she had been disappointed each time her midwife checked her dilation. Annie emphasized that the only report she would be happy with was that she was ten centimeters dilated.

So [the midwife] checked me again and I was lying on my side and I was about nine [centimeters dilated], which isn't what I wanted to hear. So at that point, I was like, "Francis, make this end." And she was like, "I can break your water and that would probably put you past nine." And I was like, "okay." I was just desperate. Something's got to get this thing moving along. So she just did it. She put that little thing in, it looks like a knitting needle. It just snags the amniotic sac and the water comes out. And that pushed me to about nine and a half. She said there was just a little lip of cervix that I could probably push past. They call that a little cervical lip, medical lingo. They won't let you push at eight or nine. But with just a little cervical lip, they were like "why don't you just see if you can push past it?" So I was very happy to be told that I could start pushing.

Annie's assessment that her semi-active body was not active enough prompted her to seek activation techniques from her healthcare provider. Following Annie's request, her midwife ruptured her membranes, which further activated Annie's body.

What was much more common in these narratives was women's healthcare providers, particularly doctors, nurses and obstetricians, deciding that women's semi-active bodies required further activation. Activation techniques in this context are technological techniques, either in the form of the synthetic hormone pitocin, vacuum extraction or cesarean.

Three women in this study report beginning labor with their membranes rupturing but having either no contractions or sporadic contractions. In all three of these cases, the women were required by their healthcare providers to have pitocin to stimulate contractions and cervical dilation, thereby further activating their semi-active bodies.

Elizabeth explains her experience:

I was having little contractions but they were very far apart and they weren't strong at all. So they let me walk around for about twenty minutes but I still wasn't dilated. It was maybe a pinky, or like maybe one, not even one centimeter. So they put on the pitocin and the doctor said, "nope, you're on pitocin." So then I was bedridden. I couldn't get out of bed, which really bothered me because I really wanted to try the birthing ball and walk a lot and go in the Jacuzzi and stuff like that. But I really wanted to have a water birth. So, but because I wasn't dilated they didn't allow that. [Is that the main reason that you didn't want the pitocin?] Yeah, I was bedridden. And I felt very confined, well, I was. And I got over it when the contractions started. I was kind of excited for the contractions to start. The contractions were not bothering me at all. They were coming on a little strong and they say that with pitocin they come on stronger.

Elizabeth's body is semi-active in this narrative because although it was contracting, the contractions were not very hard and her cervix was not dilating. Her doctor determined that her body's level of activity was insufficient and needed additional activation. The

method of activation used is pitocin, which was chosen by Elizabeth's healthcare provider.

Meka reports a similar experience:

Well, we got to the hospital, and you're supposed to you know, wait here instead of just go in. So they were going to give me until like a certain time, I don't know if it was ten hours, I don't really remember, to see if my contractions would get going. But they were so, like, first there would be like an eight-minute space, then there would be a three-minute space, then there would be like a twelve-minute space. They were really erratic. So, I needed to be induced. . . . You know, they had the pitocin and then they had this other stuff called micopron or something and it was like a pill and they were still testing it out but they're doing a random thing where they have a survey of people who try, someone decides, I don't know who, whether you get the micopron or the pitocin. So I just got the pitocin anyway. . . . So after the pitocin, the contractions were rough. I mean, they were very painful and it was very shortly after they gave it to me. It was really rough. And it got worse and worse and worse and worse and I was exhausted since I had been up since two in the morning.

Like Elizabeth, Meka reports that her healthcare providers decided when and how her body would be activated. These narratives echo previous research on the biomedical model of childbearing, in which time is an essential feature (Simonds 2002), and doctors rather than birthing women determine when the body is making insufficient progress on its own and warrants medical technology to speed up the labor and birth (Davis-Floyd 2001; Goer 1995; Martin 1992).

Summary

This chapter has outlined the variety of ways that the women's narratives in this study construct the childbearing body. This chapter began by establishing that many women in this study construct childbearing as at least partially a physical experience, while other women minimize the physical components of childbearing. This chapter then moved into discussions of a variety of bodies women construct in their narratives, focusing primarily on the body as object, body as active subject, and body in need of

activation. The body as object was discussed in relation to the “gaze,” in which the pregnant body is constructed as both liberated from the traditional gaze that expects the female body to be thin and subject to a different gaze that expects the pregnant body to remain covered with clothing and reinforces “normative” female anatomy. The childbearing body is re-subjected to cultural expectations of thinness immediately following pregnancy. The childbearing body is also constructed in these narratives as a “temporary object,” whereby each woman has a series of bodies that she moves in and out of throughout the childbearing process.

This chapter also explained women’s construction of the childbearing body as an active subject, whereby the body performs its own activities that the woman has no direct control over. In addition, women also construct active body parts, in which a single part of the body acts as its own agent. This chapter concluded with a description of the two bodies that were constructed in relation to the need to activate the body: inactive bodies and semi-active bodies.

While the current chapter has focused primarily on the body as its own topic of research, other constructions of the body will be explored in subsequent chapters. In each of these chapters, the body will be examined as it is constructed in relation to other facets of pregnancy and childbirth that women talk about in their narratives, specifically mind, emotions and self. Chapter four begins by establishing pregnancy and childbirth as mental experiences, identifying the different types of mental experiences women describe in their narratives. This chapter then explores the various relationships that women construct between their minds and bodies, focusing specifically on how both mind and body are constructed in these relationships.

CHAPTER 4 THE CHILDBEARING MIND

The mind is largely excluded from biomedical, sociological and feminist scholarship on pregnancy and childbirth. These bodies of research and theory tend to focus on childbearing as primarily physical and/or emotional experiences, overlooking the possibility that pregnancy and childbirth might also be considered mental experiences. One exception is the psychoprophylactic method of childbirth developed by Fernand Lamaze. Based on Ivan Pavlov's (1927) theories of classical and operant conditioning, Lamaze (1970/1984) argued that women could have pain-free childbirth without anesthesia by conditioning the mind to associate labor contractions with a modified rhythm of breathing, or "contraction-respiration reflex," instead of pain. Although initially resisted by doctors (Wertz and Wertz 1977), Lamaze eventually gained popularity in the United States and is used by many women today (Lamaze International 2001). Aside from Lamaze's theory of childbirth, the mind is largely absent from scholarship on pregnancy and childbirth.

Sociological perspectives of the mind argue that the mind and its presumed activities are social rather than personal or individual. As many sociologists have pointed out, the mind is not a tangible entity, located within the human body and detectable through dissection, but mind is a social construction that emerges through language and social interaction (Gubrium 1986; Mead 1934; Sanders 1993). Human thought and knowledge are also considered social in that they generally take place through the medium of language (Berger and Luckmann 1966; Cicourel 1974; Mead 1934; Whorf

1956; Zerubavel 1997) and individuals' thoughts are based on and related to other groups or individuals' previous thoughts (Mannheim 1936). In addition, an individual's social position within a society influences their access to certain knowledges and perceptions of the world around them (Collins 2000; Marx and Engels 1947; Zerubavel 1997). In this sense, mind, thoughts and knowledge are not viewed as personal entities, but are social accomplishments that are shaped and constrained by language, culture, and the individuals' social location in society.

This chapter explores the ways that women's childbearing narratives in this study construct the mind. The first section of this chapter establishes that the women's narratives in this study construct pregnancy and childbirth as both mental and non-mental experiences. The second section explores in more depth women's constructions of childbearing as a mental experience, focusing specifically on the "mental work" that women engage in throughout pregnancy and childbirth. The third section of this chapter examines the various relationships women construct in their narratives between the mind and the body and the constructions of mind and body within the context of these constructed relationships.

Childbearing as Mental Experience

Many women in this study describe mental components of pregnancy and childbirth. One of the mental components of childbearing that is emphasized is thinking about the physical processes that take place within one's body during pregnancy and childbirth and the impact a child will have on one's life. In describing this mental component of childbearing, the women in this study construct childbearing as at least partially a mental experience. A few women in this study also explained that they did not think about pregnancy or childbirth at certain times throughout their childbearing

experience. In these excerpts, childbearing is constructed as a non-mental experience. This section highlights women's narrative constructions of pregnancy and childbirth as both mental and non-mental experiences.

Childbearing as Mental Experience

Many women describe themselves thinking about and conceptualizing human reproduction throughout their childbearing experiences. For many women in this study, this conceptualization process required a considerable amount of "mental work," an issue that is addressed further in the following section. The current section establishes that, for many women in this study, childbearing is constructed as at least partially a mental experience.

For example, America describes her pregnancy:

There were some physical things that bothered you like acid reflux and the big belly and trying to find comfortable ways, you know. But it was all just like, the most awesome experience thinking about what's going on in your body and watching your body grow.

According to America's narrative, thinking about and watching the body is part of the pregnancy experience. In this sense, pregnancy is constructed as partially a mental experience.

Kristy constructs childbirth in mental terms in her description of pitocin-induced contractions:

It was awful. I think that if you start having contractions on your own that you get kind of, you gradually go into it, but then they gave me that stuff and it felt like it just started from nothing to instant pain. And I had all these thoughts. I didn't want an epidural, I didn't want any of that.

Kristy describes her thoughts as part of her experience immediately after receiving pitocin during her labor. By describing thinking as part of the childbirth experience, Kristy constructs childbirth in partially mental terms. These narratives emphasize that

pregnancy and childbirth are not merely automatic biological and physiological processes, but they also contain a significant mental component. This point will be supported and addressed further throughout this chapter.

Childbearing as Non-Mental Experience

A few women also describe themselves not thinking during certain parts of pregnancy or childbirth. In these narrative excerpts, pregnancy and childbirth are constructed as non-mental experiences, experiences that do not involve the mind.

For example, when asked to describe how she felt during pregnancy, Teresa explains:

I just didn't feel that much different. Like, emotionally I was excited, but it all seemed really far away until those last two weeks, you know? Because it was like, oh, it's still not until October, so I didn't really think about it too much. Until those last few weeks and then, you know, I got a little anxious. . . . Really the rest of the time was just kind of a blur. I was so busy with school and work that I never really stopped to think about, you know, feeling different. I just kind of did my thing and went on my way. It didn't really change much. I still traveled and did all that kind of stuff up until those last few weeks.

Teresa describes parts of her pregnancy as an experience that requires no mental reflection. Unlike many of the other women in this study, Teresa states that she did not think much about her pregnancy. Thus, Teresa constructs childbearing as an experience that requires no mental reflection and therefore does not really encompass a mental component.

Similarly, Victoria describes her birth as a non-mental experience. In describing why her childbirth preparation techniques were not useful during her birth, Victoria explains:

I have watched every episode of Birth Story and Maternity Ward. . . . So I knew—I could deliver a baby. I'm telling you, I could deliver a baby. But it's still different. It's still, when you're laying there doing it, you're not thinking about "oh, well, on the Birth Story this happened and blah, blah, blah."

Victoria's narrative focuses on the thoughts she was not having during her birth. Victoria explains that childbirth preparation was not useful for her because she did not think about what she had learned during her birth. In this way, childbirth is constructed as a non-mental experience.

This section has focused on the ways that women construct pregnancy and childbirth as both mental and non-mental experiences. While most of the women in this study describe themselves thinking about and conceptualizing human reproduction throughout pregnancy and childbirth, a few women construct themselves not thinking about childbearing, specifically at certain points throughout their experiences. The conclusion is that childbearing can be constructed as a partially mental or non-mental experience depending on who is doing the constructing and to which portion of their childbearing experience they are referring. The following section focuses in more depth on women's constructions of childbearing as a mental experience.

Childbearing and Mental Work

A common mental process described by women in this study is mentally conceptualizing pregnancy and childbirth. Referred to in this dissertation as "mental work," conceptualizing pregnancy and childbirth entails mentally working to understand one's bodily processes and perceived upcoming changes in one's life as a result of childbearing. In the mental work of conceptualizing childbearing, the mind is an active subject; it thinks about and reflects on multiple components of childbearing. The objects of the mind's mental reflection is typically either the body or the self.

Many women's narratives describe mental work that focuses on the body and its physical processes. Within the process of conceptualizing childbearing, the mind is an active subject and the body is an object of reflection. However, the content of mental

reflection is often the body's subjective activities over which the individual does not have specific control. Therefore, while the body is the object of one's mental reflection, it is the body as active subject that is typically reflected upon. The body in this context is both an object and an active subject.

In an example cited in the previous section, America explains in her pregnancy narrative, "it was all just like, the most awesome experience thinking about what's going on in your body and watching your body grow." In America's description, her body is the focus of her mental work during pregnancy. America's body is both the object of her mental reflection and an active subject that is performing its own activities.

Similarly, Victoria describes mental work that occurred immediately after the birth of her child.

It was just like a, just this, in the moment, just rush. I don't know how else to describe it. I think it's just so cool when they come out of you and you look at this person, you know? I grew that in my body. There's something so crazy about that to me. You know what I mean? It's just crazy. So it just kind of blows your mind.

Victoria's narrative emphasizes the body and baby as the objects of mental reflection.

The content of Victoria's mental reflection is the body's ability to create a child. In this context, the body is both an object and a subject.

Victoria's narrative also highlights the difficulty many women expressed in their attempts to conceptualize pregnancy and childbirth. Like Victoria, other women in this study commonly describe childbearing as "mind-blowing" or "mind-boggling" experiences. Some of the narratives that emphasize the difficulty of conceptualizing pregnancy and childbirth draw on scientific and/or spiritual discourses as ways of understanding human reproduction.

Jasmine describes the birth of her child as a “mind-blowing” experience. She draws on scientific explanations of reproduction in her narrative, yet concludes that these explanations fall short of fully enabling her to conceptualize childbearing. It may be significant to note that Jasmine was a midwifery student when she became pregnant, and has therefore studied intensely scientific explanations of the physical processes of childbearing. When asked to describe what it was like immediately after giving birth, Jasmine explains:

My friend told me once, my friend Eric who had a baby a few years ago, said, “you know, everyone tells you it’s like the happiest day of your life and you know, it’s just like the best feeling.” And he was like, “I don’t know about all that, but I can tell you one thing, it was the weirdest day of my life.” And that’s exactly how I felt. When he was born, 95% of me felt relief that the pain was over. I was just, like ahh, I feel so good, you know, it’s like *done*. And the other 5% was totally weirded out. . . . It felt just like the strangest dream, you know, the strangest dream where you wake up and you’re like, that was so weird. Like it was just trippy, just trippy experience. [What felt trippy about it?] Just that finally he was this slimy warm thing and I was just like, just looking at him, it was so, I mean, I don’t think anybody can wrap their mind around that. That first moment, there’s no way, it’s just too huge. I’m still wrapping my mind around it. I probably will be forever. [What do you mean wrapping you mind around it?] Just getting that he’s my baby and that he is what was there that night that I found out that I was pregnant. You know, teeny-tiny, that that was him. And that he is a mixture of Aaron and he’s a part of all his relatives in Germany. You know, it’s just huge, it’s just really weird. . . . I don’t ever say that it’s a miracle, because it’s not. It’s like, I mean, it sounds crass, but it’s kind of like saying that an airplane is a miracle. No, there’s things that make sense to where an airplane can fly. It’s like, okay, there’s things that make sense that this baby’s conceived and we all know about the cells dividing and la, la, la, but it’s just mind-blowing. That’s what it is. It’s just like, really cool. And you know, I hear women saying on the Baby Story saying like, women can’t describe to you what it felt and that makes it sound like it was just utter joy. Like I can’t describe this joy to you. And for me it wasn’t joy, it was like, I can’t possibly describe how weird this was to you. I cannot even begin to describe it. It was just totally weird. I remember talking to my friend Eric about it and it was totally true. It’s just the weirdest thing that’s ever happened to you. It’s super strange. But yeah, the whole conception and to connect that is just really too much. I think that, I don’t know, I’ll never fully get it. It’s just really, really weird.

Jasmine draws on scientific explanations of ancestry and the division of cells that explain human reproduction in her narrative. Despite her understanding of these scientific

explanations of reproduction, Jasmine still constructs childbearing as “trippy,” “weird” and “mind-blowing.” In Jasmine’s narrative, scientific explanations alone are inadequate for conceptualizing her experience of childbearing. Jasmine does not offer an alternative explanation, as she concludes that the whole thing is “just too much” and she will “never fully get it.”

America also draws on scientific explanations of childbearing in her narrative.

America explains:

I thought it was a really neat experience to have another person growing inside of me. You create another person. I thought it was amazing. It was mind-boggling to me. I never understood what people said when they talked about the miracle of birth, the miracle of life. I was just like, “everything reproduces, what’s the miracle about it? It’s just the way that things are. It’s just a fact of life.” Then when I had a baby growing in me, especially when he was born I was like, “wow, this is a miracle. This is amazing.” It made you think about like on a cellular level what’s happening. And it’s just amazing to think that cells join, and create this (points to her son). And all of your DNA knows exactly how to line up and how to talk to each other and how to make the perfect little baby, you know? It’s weird. So I thought that was really neat.

America explains that her own childbearing experience changed her perception of human reproduction. Whereas before she became pregnant she did not view reproduction as a “miracle,” her own experience influenced her to change her mind. America draws on scientific discourse to explain why childbearing is a miracle. She explains the “miracle of birth” as the division, fusion and reproduction of cells to create a child.

Aimee’s narrative constructs much more of an overlap between science and spirituality. Aimee draws on both discourses in her description of the mental work of conceptualizing childbearing.

There’s definitely a bond you form during the whole pregnancy process where you feel this life growing inside you and there’s just nothing that can match that, you know? Your body is forming this whole other entity, which I still just find completely flabbergasting. So, I mean, I just think it’s amazing that me, my cells, could form that amazing kid that’s obsessed with cars and trucks and all that good

stuff. But just to feel all that going on and to look at the books every week and say okay, this is what he looks like now, and this is when his fingers are forming. I just, I don't understand how people can have children and still not believe in God, because I think that's very spiritual to have that whole little universe happening inside you. And I mean, you can paint a picture and make something and you can create music and make something but to make a whole human being. That's incredible. So I think that's more fulfilling than anything you could do in life.

Aimee creates a bridge between science and spirituality in her narrative, whereby her cells are forming the child, but the process of having one's cells form a child is constructed as spiritual. Although Aimee draws on both science and spirituality to conceptualize reproduction, she still concludes that childbearing is “flabbergasting” and “amazing.”

Many women in this study construct the mental work of childbearing as an ongoing experience. Some women state that they began conceptualizing childbearing before they became pregnant while others state that they are still working to conceptualize childbearing long after the birth of their child. Thus, the mental work of childbearing is constructed as ongoing rather than beginning during pregnancy and ending immediately after the birth of a child.

Sarah constructs the mental work of conceptualizing childbearing as beginning long before she became pregnant in her description of her mental activities during labor.

I was hoping that everything was going to be okay. That she was going to be okay. And fear, you know. In some ways I guess I was like, oh my God I want this to be over with so she's here, and in other ways I felt, your entire life you, I've always thought about this moment, the birth of your first child. So, I thought about what she was going to be like and what she was going to feel like and what it would be like to hold her for the first time.

Sarah's narrative constructs the mental work of conceptualizing childbirth as something that began long before she became pregnant. She states that she had thought about this moment her entire life.

Other women construct the mental work of conceptualizing childbearing as continuing long after the birth of their child. Jasmine provides an example in her explanation of what it felt like to be pregnant:

I had to keep reminding myself like what was really, and I still feel like today even though he's four months old, I still feel like it hasn't hit me yet that I have been pregnant and had a baby. I think I talked to Terra and she said that it took her until [her baby] was two and all the sudden she looked at him and was like "wow. I was pregnant and I gave birth." And it's so much to conceptualize that it's taken me a really long time to get it.

Jasmine continues her description of mental work as ongoing later in the interview.

I'm still, you know, thinking about it. Like I said, I'm still digesting it. Which is why, it's good that you asked questions about it because it's so hard to, it's like a really large task, you don't even know where to start. I'm still kind of starting to think about where I should start to think about this whole thing. I remember Terra saying, you know, "I didn't really get it until he was two. And I'm like, oh yeah right. I've had, I had that baby in me." And then she started to get it. I'm still, still thinking about it.

Jasmine's description of her struggle to conceptualize childbearing emphasizes her ongoing mental work. Even though Jasmine's baby is four months old at the time of the interview, Jasmine explains that she is still working to understand that she was pregnant and gave birth to a child. Thus, Jasmine constructs the mental work of conceptualizing human reproduction as an ongoing task.

This section has demonstrated that the women in this study construct childbearing as encompassing a mental component that entails working to conceptualize human reproduction. Some of these narratives focus specifically on the body while others focus on scientific or spiritual explanations of reproduction. These narratives demonstrate that childbearing is not simply a physiological experience, but is described as requiring a considerable amount of mental effort. In the process of describing their work to conceptualize reproduction, women draw on culturally embedded definitions and

explanations. In this way, the thoughts women have and the ways that they think about childbearing are shaped by the larger social context.

Mind and Body

Many of the narratives in this study that focus on the mind also focus on the body. The “mind-body problem” (Krakow 2002) has generated much research, theory and debate among scholars in a variety of disciplines in recent years (Bendelow and Williams 1995; Freund 1990; Lynch 1977; Merleau-Ponty 1962; Shilling 2003; Turner 1984, 1992; Williams 2003; Williams and Bendelow 1996). Much of this scholarship centers on Rene Descartes’ (1901) mind/body dualism, with the goal of transcending this dichotomy. While escape from the mind/body dualism is well documented in the areas of sociology of emotions (Hochschild 1979, 1983; Williams and Bendelow 1996), sociology of pain (Bendelow and Williams 1995), and phenomenology (Merleau-Ponty 1962; Schutz 1971), sociology scholarship on body and mind, particularly that which uses a social constructionist perspective, is critiqued for focusing primarily on either the body or the mind, thereby reproducing the Cartesian mind/body separation (Shilling 2003; Turner 1984).

This section explores the variety of mind/body relationships that women construct in their childbearing narratives. Following Cartesian philosophy, some of the narratives in this study compartmentalize mind and body, or construct them as two distinct components of childbearing. However, other narratives construct a variety of mind/body relationships. These relationships are organized into two categories in this section: mind influences body and body influences mind. This section concludes with an example of a narrative that constructs the mind and body as interconnected and inseparable.

Compartmentalization

Some of the narratives in this study compartmentalize mind and body by distinguishing between mental and physical components of childbearing.

Compartmentalization is describing different components of an experience (in this case mental and physical) as completely separate realms that have no connection to each other. The terms “mental” and “physical” are used as narrative resources that aid in the construction of mind and body as separate, distinct components of the human being.

Jasmine compartmentalizes her pregnancy into mental and physical realms. When asked to describe her pregnancy in just one word or a couple of words, Jasmine replies:

I think heavy. Just heavy in the mental, like heavy, heavy experience and literally heavy. Towards the end, I felt like I was physically, like when I used to wait tables for twelve hours a day, that's how I felt in an hour in the last month. It was just like, my feet hurt. And it was a heavy, it was a huge thing to grasp, like mentally it was heavy. . . . I take a long time to process stuff and I'm still now, things will hit me that happened like five years ago and I'll be like, whoa, that's really intense. So that's what I mean by heavy, just real, real big and hard to fully get all at once.

Jasmine compartmentalizes her pregnancy into two distinct realms of mind and body. By distinguishing between mental and physical aspects of pregnancy, mind and body become two separate components of the same experience that are not connected to each other.

This compartmentalization is consistent with Descartes' (1901) philosophy of mind/body dualism. It is significant to note that this is the only narrative excerpt in this study that employs this dualism by compartmentalizing mind and body. Compartmentalization is more commonly used by women in this study when distinguishing between emotional and physical components of pregnancy and childbirth, which will be explored in the following chapter. In terms of mind and body, the women in this study were much more likely to construct relationships between mind and body than to fully separate them.

Mind Influences Body

In one of the mind/body relationships constructed in this study, the mind is a subject that influences the body. The construction of mind influencing the body most commonly appears in women's descriptions of labor, particularly when laboring without anesthesia. The body in these narratives is a body in pain, and the mind is used to help the body get through the physical pain of labor. Mind and body in these narratives are both active subjects; the mind acts as a subject that helps the active laboring body tolerate pain.

In response to a question that asked whether or not she ever wanted to go to the hospital to get an epidural during her labor, Rebecca explains:

No. I remember one point when I crawled out to [one of the midwives] and I was like, "Jenny help me." Like wanting some help but it wasn't that. I just wanted someone to help me mentally to get through the physical. [What do you mean by that?] I was to a point where I was wondering how I was going to do it. I knew I was gonna do it, I had to do it myself, it was all up to me. But it was to a point where I needed somebody outside of me to help me. Even just to hold my hand or just to look at me and tell me to chill out, that you can do it, you know?

Rebecca explains that she needed someone to help her "mentally to get through the physical." As her physical body is experiencing pain, Rebecca's mind becomes a tool that can assist the body in enduring that pain. The mind is used to influence the body, or help the body get through pain. Both the mind and the body are active subjects in this relationship as the mind's activities are used to help the body endure its activities.

Rebecca seeks help from an outside person to help her employ her mind as a subject that can assist her body.

Tracy describes a similar scenario, but in Tracy's narrative the outside person uses medical technology to report the trajectory of Tracy's contractions. This knowledge helps Tracy deal with the physical pain of her contractions.

[One nurse] did a much better job of coaching. She actually worked with the monitor in a way that was helpful. She would watch the monitor as I was in a contraction and coach me through while she was paying attention to that. . . . The one nurse who was really helpful was able to say, “okay, you’re at the early part so breathe, take it easy, okay, you’re about to peak, you’re peaking, it’s bad, but breathe, okay, that’s it, and now it’s going to get better.” And so knowing that, knowing the trajectory helped.

For Tracy, knowledge of the trajectory of her contractions helps her deal with the physical pain that she is experiencing. By watching the monitor, Tracy’s nurse is able to report that trajectory to Tracy.

Other women also describe knowledge as a tool that helps them deal with the physical pain of contractions. In many of these narratives, the knowledge that the labor will eventually end helps women deal with their bodies’ physical pain. For example, Jasmine explains that she continually focused on what she planned to be doing at the end of the day, which helped her get through contractions.

I kept telling myself, by the end of this day, I’ll be watching American Idol. Because it was on Tuesday and I got ridiculously into that show. . . . I was thinking about American Idol. Because it made me feel like this is going to end and then at this time, I will be doing this. I will not be doing this at 8:00. I won’t. [Did that help?] It helped a lot. To know that this, because I really was progressing like Freedman’s Curve. You know, like one centimeter an hour, and it took him 13 hours. So every time she checked me it was like, all right, we’re doing this. And I thought to myself, you know, we really are doing this. We’re doing this, we’re going, it’s going to be over. It’s noon now, so I’ll be watching American Idol by 8:00. I actually said that to my mom.

Jasmine’s knowledge that her labor would eventually end and that she would be engaging in a different activity at the end of the day helped her deal with the physical pain of contractions. Other women made similar statements, explaining that they were able to tolerate the pain of contractions because they knew that the pain would eventually end and they would be holding their babies by the end of the day. In these narratives, the mind is used to help the body tolerate the physical pain of labor contractions.

This construction of the mind as a tool that helps the body tolerate pain differs from previous research and theory in the sociology of pain. Previous sociologists argue that pain bridges mind and body not because the mind is used to assist the body in pain, but because pain encompasses an emotional element, which comprises both mind and body (Bendelow and Williams 1995; Scheper-Hughes and Lock 1987). Within this perspective, mind and body are related in pain only in that both are mediated through emotion. The narratives in the current section suggest a more direct relationship between mind and body during pain, where the mind works with the body to assist in the tolerance and management of pain. The perception of time is also an important feature of this relationship as the expectation that the pain will eventually come to an end is one of the tools that the mind is able to draw upon to assist the body.

Body Influences Mind

The narratives in this study also construct the body influencing the mind. The subject/object positions in these narratives are less consistent than in the narratives of mind influencing body. In some narratives the body is constructed as an active subject that influences the mind as object. In other narratives the body is constructed as an active subject that influences the mind, which is also an active subject. Still other narratives construct the body as object that influences the mind as subject.

Aimee's narrative is an example of the construction of body as subject influencing the mind as object.

I didn't feel [the tearing], so it was no problem. But the stitching up part I felt, which was unpleasant. And the healing, that was by far the worst part. . . . I was actually at my sister's house and sneezed and popped a stitch. I thought I was going to lose my mind. I was like, "wheeew." So I was like, "oh my gosh, I just popped a stitch." My voice was ten octaves higher than usual. So, stitches are the worst, by far. Everything else was fine.

Aimee constructs her body as an active subject in this narrative. When she sneezes, one of her stitches “pops.” This bodily activity causes Aimee to “lose her mind.” In this sense, the mind as an object that resides within the individual and ultimately can be lost (Gubrium 1986), is acted upon by the body. Hence, in this construction of the mind/body relationship, the body is a subject that influences the mind as an object.

Like Aimee, many women in this study describe themselves “losing their minds” as a result of the body’s activities. Isabel provides another example:

So [the midwife] burst my water and then [the contractions] start coming, like they were two minutes apart. It’s about four in the afternoon, two minutes apart, really, really strong, lasting about two minutes and I couldn’t do anything. I was actually like peeing all over the place and like, I was just going out of my mind.

Isabel’s contractions, along with her lack of control over her body’s release of fluids, cause her to “go out of” her mind. In this construction of the body/mind relationship, the body is an active subject that acts upon the mind as object.

Other narratives in this study that focus on the body influencing the mind construct a subject/subject relationship between body and mind. In these narratives, both body and mind are constructed as active subjects, yet the mind’s activities are influenced by the body’s activities.

Cindy describes the beginning of her labor:

Sunday morning I woke up about 4:00 in the morning and I thought I had wet the bed. It was a flood. And I went to the bathroom and sat there on the toilet for a while thinking that the water was going to stop eventually, which it didn’t. And then so anyhow, I went back to bed with a towel and I just laid there with my mind racing, like what am I going to do? It’s 4:00 in the morning, the rest of the world is asleep and my water has obviously broken three weeks early.

Cindy constructs both body and mind as active subjects in this narrative. The body is active in its membrane rupture and subsequent release of fluids, both activities over which the individual does not have direct control. These bodily activities cause the mind

to become active as it “races” to try to figure out what to do. In this construction of the body influencing the mind, both body and mind are active subjects.

Cindy reinforces this construction as she describes her activities later in the day:

I tried to sleep, but every time I'd start to fall asleep another contraction would happen. I was in so much pain that I didn't, I was like, this is why women used to die in childbirth. So I was laying there in bed and trying to figure out a way that was comfortable and I could lay on my side and start to fall asleep and then another contraction would happen. I could tell they were getting closer together but I had no way of timing them. I was just, I couldn't, I was becoming like I couldn't get my thoughts together. I was totally disoriented. . . . So, I wasn't even, well I was wearing a night shirt and the day wore on and I was like dying and the only way I felt remotely comfortable was hanging over the toilet. So I was doing these little circles around the house and Greg came back and he was like “it's 4:00 are you ready to go?” And I'm like, “no.” And then I was so disoriented I couldn't figure out how to get myself dressed. It took me awhile just to get a few things together, I mean, I couldn't think. And I knew I was supposed to bring some food with me and I didn't know what to bring. Finally at 4:30 [the midwife] called and was like, “are you guys coming?” I was like, “we're trying to.”

Cindy's narrative begins with a description of her body's laboring activities. As her contractions become closer and closer together, Cindy describes herself becoming disoriented and unable to get her thoughts together. In this narrative, Cindy's body influences her mind because her body's activities cause her mind to become disoriented and unable to think clearly. Both the body and the mind are active subjects as they engage in their own activities over which the individual has little control.

Meka's narrative constructs a body/mind relationship in which the body as object rather than subject influences the mind.

I was so out of it, and all the sudden they come in there, “okay, you ready to push now?” And I'm like, “what? No.” I was like, “I want more morphine.” They were just totally laughing. They were like, “no, no, no, you can't have any more now.” They were like “push.” And I was just freaked out, like oh my God, I've gotta push now, what's going on? All this stuff is going through my head, like I was going insane for a minute, you know? And then I just pushed. And that part took about ten minutes.

In Meka's narrative, it is her knowledge of what her body is ready to do that causes her to "go insane." The body is not specifically acting upon her mind or sending her any messages, but it is the knowledge she gains about her body from people outside of her that stimulate mental activities. As Meka reflects on her body as object, she temporarily "goes insane." By going insane and having "thoughts go through" her mind, Meka's mind becomes an active subject.

This section demonstrates women's constructions of their bodies influencing their minds during childbearing. Throughout these narratives, the subjectivity and objectivity assigned to body and mind is negotiated. To some extent, these narratives transcend the mind/body dualism by constructing mind and body as interrelated. At the same time, mind/body dualism is to a certain degree upheld in these narratives because the concepts themselves are still utilized. Body and mind are constructed in these narratives as separate yet interrelated components of the human being. The following section examines one excerpt in which the participant resists this separation.

Mind and Body Inseparable

One of the narratives in this study constructs the mind and body as inseparable. In the following excerpt from Rebecca's interview, Rebecca explains that she began pushing when her cervix was eight centimeters dilated and her membranes had not yet ruptured. I asked Rebecca why she started pushing because I knew that most research and literature on childbirth recommends that women begin pushing when the cervix is ten centimeters dilated and the membranes have ruptured. Rebecca's response makes no real distinction between body and mind. I then begin to try to determine whether Rebecca was pushing as a result of a physical urge or a mental decision. Rebecca and I go back and forth, with

me trying to put her experience into one category or the other and Rebecca resisting this categorization.

At some point I was like, I cannot deal with this anymore, I was so uncomfortable, I'm just gonna start pushing. They had checked me again. [The midwife] could tell that I was pushing, she could tell by the way I was moaning and she was in [the family room] and I was in the bathroom. So she wanted to check me again. She's like, "I think she's pushing." So she checked me and I was like eight centimeters dilated I guess, maybe it was more than that. Because after she checked me I went in there and I was like, oh, I'll just push a little bit. I didn't say it to anybody, that I was pushing, but I was doing it. Then they could really hear it, so they wanted to break my water. So they did that. [Why were you pushing?] I don't know I just felt like it. And I guess it was the point where I needed to push. I don't know I just felt like pushing. [Did your body give you the urge to push or you just wanted to push?] I just wanted to. And maybe it was a physical urge too, maybe there were like, I just wanted to. I just thought, well maybe it will move things along a little bit if I push. So maybe it was a physical urge, but it wasn't like everybody says you will feel the urge to push, it wasn't like that. I was like, why don't I try pushing and maybe I'll be more comfortable. [Okay.] That was what it was. [So it was a decision more than a response?] I guess, yeah, I guess so. Cause I was like, this is really uncomfortable, maybe it will feel better if I push. So it could have been like it was physical, do you know what I mean?

Rebecca and I go back and forth in this excerpt, with me trying to categorize Rebecca's reason for pushing as either physical or mental and Rebecca resisting this classification.

In Rebecca's part of the narrative, her experience is constructed as something that cannot adequately be divided up into mental and physical components. Rebecca seems to entertain my idea of classifying her experience as either mental or physical, but she conveys that her decision to push is based on both mental and physical components that cannot entirely be disentangled. In Rebecca's narrative, mind and body are constructed as inseparable components of her childbirth experience.

Summary

This chapter began by establishing that many women construct childbearing as partially a mental experience. The primary mental component of childbearing emphasized by the women's narratives in this study is the mental work of

conceptualizing pregnancy and childbirth. Many women struggled to conceptualize human reproduction as they were experiencing it, and many women's mental work has been ongoing, either beginning before they became pregnant or continuing after the birth of their child. In working to conceptualize childbearing, many women draw on both scientific and spiritual explanations of human reproduction. Despite these explanations of childbearing, women describe reproduction as "amazing," "mind-boggling" and "flabbergasting." While most women construct childbearing as at least partially a mental experience in their narratives, a few women construct childbearing as a non-mental experience by explaining that they did not think about or conceptualize human reproduction during a specific stage of pregnancy or childbirth.

This chapter then explored a variety of relationships women construct between the mind and body throughout their childbearing narratives. One narrative is reported that compartmentalizes mind and body, constructing the two as completely separate, unrelated entities. Some of the narratives construct the mind influencing the body, while other narratives construct the body influencing the mind. Mind and body take on a variety of subject/object relationships depending on the specific narrative. This chapter concluded with an analysis of one narrative that constructs mind and body as inseparable components that cannot be disentangled.

While this chapter has focused primarily on the mind as its own topic of research and the mind in relation to the body, the mind is also incorporated in the remaining chapters. The following chapter explores women's constructions of emotions in their pregnancy and childbirth narratives. Emotions are first considered on their own, and then explored in relation to the body. While the mind is not a prominent feature in narratives

of emotion and the body, mind is sometimes constructed as a mediator between emotion and the body.

CHAPTER 5 CHILDBEARING EMOTIONS

Sociological research and theory on emotions have flourished in recent years (Williams and Bendelow 1998), with emotions often conceptualized as lying at the intersections of mind and body (Hochschild 1979, 1983; Williams and Bendelow 1996), biology and society (Wentworth and Ryan 1994; Wentworth and Yardley 1994), agency and structure (Bourdieu 1990; Giddens 1984), and the personal and political (Mills 1959). This newly emerging subfield of sociology has attended to emotions in multiple and diverse substantive areas such as work and employment (Hochschild 1979, 1983), love and intimate relationships (Beck and Beck-Gernsheim 1995; Giddens 1992; Simon et al. 1992), and healthcare (James and Gabe 1996; Lawler 1991; Smith 1992).

Despite sociology's growing interest in emotions, only a handful of researchers have explored emotions in relation to reproduction, and these investigations have not focused on the emotions related to pregnancy and childbirth in the context of the intent to subsequently raise a child. In addition, much of this research has not focused specifically on childbearing women. For example, Sally Ruane (1996) conducted research on the techniques used by social workers and healthcare providers to facilitate appropriate emotional displays by birthing women who give up their newborn infants for adoption. Jessica P. Maguire (2002) investigated the midwifery movement's attempts to legitimize new vocabularies of emotion that replace the biomedical model's emphasis on fear, pain and emotional neutrality with trust, pleasure and love. Both of these studies focus on professionals who work with pregnant and birthing women rather than the childbearing

women themselves. The only sociological study to date that focuses specifically on women's constructions of their emotional experiences of pregnancy explores the ways in which women manage their emotions throughout abortion (Keys 2003). Hence, researchers who bridge the sociology of emotions and the sociology of reproduction have virtually excluded women who become pregnant and give birth.

When emotion is considered in the context of women's childbearing experiences, it is often viewed as a variable that influences something else, such as satisfaction with labor, birth and treatment by healthcare providers and perceptions of control in medical encounters (Campero et al. 1998; Fowles 1998; Simkin 1991). Sociologists have not looked specifically at whether or not childbearing women construct pregnancy and childbirth as emotional experiences or which emotions women consider part of their experiences. Biomedical literature on childbirth also excludes or marginalizes women's emotions during pregnancy and childbirth (Davis-Floyd 2001; Hahn 1987).

Whereas scholarly research tends to marginalize emotions in childbearing, self-help literature focuses a great deal of attention on emotions. *What to Expect When You're Expecting* (Eisenberg et al. 1996) provides a month-by-month trajectory of the emotions women can expect to feel throughout pregnancy. The emotions emphasized are instability, irrationality, fear, frustration, anxiety, and to a lesser degree, excitement. Each section on emotions is followed by an extensive section titled "what you may be concerned about." *The Girlfriends' Guide to Pregnancy* (Iovine 1995) addresses emotions in a chapter titled "Pregnancy Insanity." The introduction to this chapter warns in capital letters "crazy people are often the last to know they are crazy" (1995: 48). Similarly, *Your Pregnancy Month By Month* explains:

Women are not likely to escape episodes of emotional storms during pregnancy. Most of these storms consist of depressive interludes that come and go, usually in the early months and usually without any apparent cause. So when you have the blues and dissolve into tears and can't understand why, don't worry, and don't try to figure it out. It soon passes. (Gillespie 1992:35)

These books provide women with a normative structure of emotion during pregnancy and childbirth that emphasizes emotional instability, anxiety and fear. These emotions are linked to the hormonal changes that occur within women's bodies during pregnancy and childbirth and echo the "raging hormone syndrome" that is commonly associated with menstruation and menopause (Page 1993; Tavris 1992).

This chapter explores women's constructions of emotions in their childbearing narratives. The first section of this chapter examines women's constructions of pregnancy and childbirth as both emotional and non-emotional experiences. The second section explores in more depth the specific emotions women associate with childbearing and their explanations of the reasons for these emotions. The third section examines the various relationships women construct between emotions and the body in their pregnancy and childbirth narratives.

Childbearing as Emotional Experience

Many of the narratives in this study construct childbearing as an emotional experience. This first part of this section establishes that many women construct both pregnancy and childbirth as inherently emotional experiences. The second part of this section demonstrates that some women construct pregnancy and childbirth as non-emotional experiences. Overall, this section demonstrates that women construct pregnancy and childbirth as both emotional and non-emotional experiences.

Childbearing as Emotional Experience

Many women's narratives in this study construct pregnancy and childbirth as emotional experiences. In these childbearing narratives, emotion is constructed as an integral component of pregnancy and childbirth. For example, when asked to describe her pregnancy, Isabel replies:

The pregnancy was very good as far as health-wise. I was really healthy the whole time, she was really healthy the whole time. I think more, the hardest part was actually emotional, like not having anyone to talk to about it. I could talk to the midwives about certain fears that they would dispel and I would read books, but a lot of them are used for hospital concerns and issues. A lot of the stuff they were concerned about was, I don't know, they just made it sound so horrible. Like, I'm getting fat and all this is depressing and for me it was like, one of the most alive times and I felt so awesome to be pregnant, but I didn't find that in any book at all. And I didn't know anybody who was pregnant and all the people that had already had babies were so much older than me that they, I don't know. [What kinds of things did you see in books that you didn't find useful?] Like I said, just the whole dieting issues and people being concerned about their weight, which I didn't care about. And people being concerned about like, what do we buy? How many shirts? Stuff that just wasn't really the focus. I wanted to talk about how I was changing, like how my identity was changing, how our relationship was changing, how I was going through it all, what that meant emotionally, psychologically, sort of, and things about babies.

In Isabel's narrative, emotion is an integral component of pregnancy, yet she did not find discussions of the emotions she was feeling in self-help pregnancy books. Isabel mentions fear as one of the emotions she felt while she was pregnant but she states that her midwives were able to dispel whatever fears she was having. For Isabel, the changes she was experiencing in her self, her identity and her relationships had emotional significance. These emotionally significant components of pregnancy were not addressed in the books she read about pregnancy and birth.

Maria provides an account that is similar to Isabel's, but Maria constructs childbirth rather than pregnancy as an emotional experience. Maria explains that she did not find much discussion of the emotional components of childbearing in self-help pregnancy

books. When asked if there was anything the books did not explain that she wished they would have covered, Maria responds:

I think, they were pretty thorough as far as medical, you know scientific kinds of things, but I think the one thing might just be the emotional part. They talked a little bit about it, you know, but it doesn't, I mean, and that too I don't think you can really know what to expect until you go through it, but I wish some of them would have went into more of that, you know, not necessarily how it felt physically to give birth, but emotionally.

Maria's narrative constructs childbirth as an emotional experience. Like Isabel, Maria states that she wishes self-help pregnancy books had discussed the emotional components of childbirth in more depth. By focusing on emotions as a topic that should be covered in self-help books, Isabel and Maria both construct emotions as an intrinsic part of pregnancy and childbirth. They do not construct anything special or unique about their own pregnancies or births that made them more emotional than other people's experiences, but rather emotions are constructed as an integral component of pregnancy and childbirth.

Childbearing as Non-Emotional Experience

Some women's narratives construct pregnancy and childbirth as non-emotional experiences. These narratives focus on women not feeling emotional during specific parts of childbearing or construct childbearing itself as non-emotional. For example, Tracy describes the onset of her labor:

So the next day the contractions got more serious, and we were just running errands in the morning and by about 12:30 the labor was serious enough that we were like, it's time. And we weren't really nervous about it, we were just like, okay, you know, it's time. And I think because the contractions had been going on for so long, we were just like, okay, this is it, no problem.

Tracy's narrative focuses on the emotions that she and her partner did not feel during the beginning of her labor. Tracy reports that she and her partner did not feel nervous when

they determined that it was time to go to the hospital. In this part of Tracy's narrative, labor is a non-emotional experience. Victoria also describes her birth as non-emotional. She states "It seemed pretty quick. But you know what's funny, I don't even really remember that. I didn't feel real emotional. Not like I cried or anything."

These narratives construct pregnancy and childbirth as non-emotional experiences. Conversely, the narratives in the beginning of this section construct pregnancy and childbirth as intrinsically emotional. The overall conclusion is that some women construct pregnancy and childbirth as emotional experiences while other women do not. In addition, some of the women in this study construct pregnancy and childbirth as emotional in some parts of their narratives and non-emotional in others. Therefore, pregnancy and childbirth can be constructed as either emotional or non-emotional depending on who is doing the constructing and in what context they are speaking.

Rationality and Childbearing Emotions

While the narratives in the previous section construct childbearing as either intrinsically emotional or not, this section explores the specific emotions women associate with pregnancy and childbearing and the women's explanations for their emotions. Common Western dualistic thinking polarizes emotion and rationality, constructing the two as mutually exclusive, oppositional concepts (Ani 1994; Coulter 1996; Jaggar 1989). Women (as opposed to men) are commonly associated with emotion, both of which are viewed as inferior to men and rationality. Pregnant, birthing and postpartum women are particularly vulnerable to this association with emotionality and irrationality due to the biomedical and psychological association of estrogen and progesterone with emotion. As demonstrated in the introduction to this chapter and supported by other research (Marshall and Wollett 2000), the cultural construction of

pregnant and birthing women as irrational and emotionally unstable is communicated directly to pregnant women through self-help pregnancy guides.

Despite the common perception of pregnant and birthing women as emotionally unstable, irrational beings, most of the women in this study describe their emotions in very rational terms. The construction of emotions as rational is accomplished by describing a specific aspect of pregnancy and childbirth or something unique to the woman's own experience that elicited an emotional reaction. These descriptions are often followed by an explanation of the reason for one's specific emotional response. Through contextualization of the emotional experience, emotions are constructed as rational.

This section demonstrates women's constructions of their emotions as rational by exploring the aspects of pregnancy and childbirth that women describe as emotional and the specific emotions women report experiencing. The first part of this section focuses on emotions in the context of anticipated changes that result from bringing a child into the world through birth. The second part examines women's constructions of their emotions as responses to specific events during pregnancy, labor or birth. The third part of this section focuses specifically on fear because fear is a prominent feature in both the normative discourse of childbearing emotions and some of the narratives in this study.

Anticipated Changes

For many women in this study, the emotional components of childbearing are based on the anticipation of upcoming changes. Some women focused on the upcoming changes that would occur in their own lives while other women focused on the changes that would occur in other people's lives as a result of the birth of their child.

Elizabeth describes feeling emotional during her pregnancy about the expected changes that would occur in her life after the birth of her child. When asked how she would describe pregnancy to someone who had never been pregnant, Elizabeth explains:

As far as emotions, I will say I was real emotional. Even though we planned it, I had a lot of high emotions about having this person that's going to totally be reliable on me. And that I had such a big responsibility coming to me.

Elizabeth constructs herself as emotional during pregnancy as a result of the expected future changes in her life and the added responsibility of having a child that will be dependent on her. In this narrative, Elizabeth constructs her emotions as rational and reasonable responses to the anticipated changes that would occur after the birth of her child.

Other women describe feeling emotional during pregnancy and childbirth about the expected changes that would occur in other people's lives as a result of their child's birth. Susan describes her emotions regarding the changes that would occur in her daughter's life as a result of the birth of her son. Susan became pregnant twice using in-vitro fertilization and was forty-seven years old when she gave birth to her first child. She became pregnant for a second time when her daughter was only one year old because she believed that she would not be able to become pregnant if she waited longer. Susan's narrative that describes her emotions during the birth of her son focuses largely on how she expected the birth to change her daughter's life.

It's pretty emotional. The first time I saw him I cried and Noah was crying. That was all pretty emotional. [Which emotions were you feeling?] Well, happy, scared, not sad, but happy and excited. And I had a lot of feelings about changing her life. It's better now, but there's a lot of emotion about what you do to her by bringing another life and then taking all the attention away from her, or you know, splitting it, because she never gets it all now, except when we are alone together. Just that change was pretty emotional. But, I was really glad that we did it. If I could have waited a couple of more years I probably would have, but we didn't have time.

Susan attributes her emotions during childbirth to her perception of the changes that the birth of her son will cause in her daughter's life. Like Elizabeth, Susan's emotions are constructed here as a rational response to the anticipated changes that result from giving birth.

Specific Events

Some women describe their emotions as responses to specific events that occurred during pregnancy and childbirth. For many women in this study, indications that their babies may not be healthy, the use of unwanted medical interventions, and disruptive and uncaring healthcare personnel are constructed as factors that elicited emotional reactions. Emotions in this context are a response to a specific event.

Rebecca describes herself during pregnancy as non-emotional until a specific event elicited an emotional reaction.

I wasn't really, it wasn't really emotionally crazy. I was really calm about it. Everything was cool until towards the very end I didn't gain weight and so [the midwife] wanted me to have a screening and that was scary. That was the only thing that was scary, to see if the baby was growing properly and there was enough fluid and stuff like that. That was the only thing that was stressful.

Rebecca describes herself as not "emotionally crazy" during most of her pregnancy.

Rebecca seems to be responding here to the popular definition of women as emotionally unstable during pregnancy as a result of "raging hormones" (Tavris 1992). In addition, while Rebecca constructs herself as non-emotional throughout most of her pregnancy, she describes herself becoming emotional in response to a specific event during her pregnancy that indicated that her baby might be unhealthy. Rebecca constructs her emotions as a response to an event rather than an integral component of childbearing.

Elizabeth describes her emotions as a reaction to the use of pitocin during her birth.

We got to the hospital about 5:20 in the morning and they confirmed that it was my water and everything. And then I had to go on pitocin, which I was really, really upset about because I really did not want to go on pitocin. . . . So then I was bedridden. I couldn't get out of bed which really bothered me because I really wanted to try the birthing ball and walk a lot and go in the Jacuzzi and stuff like that. But I really wanted to have a waterbirth. So, but because I wasn't dilated they didn't allow that.

Elizabeth constructs her emotions as a calculated response to the use of unwanted medical interventions during her labor. Elizabeth wanted to avoid the use of pitocin during labor in order to maintain the ability to move about freely and give birth in water. The use of pitocin meant that Elizabeth was confined to a bed and unable to give birth in the manner that she wanted. Her emotions are constructed as a rational response to these consequences of the use of pitocin during her labor.

Teresa constructs her emotions as a response to the knowledge that she will have to give birth by cesarean section.

When she told me [that I would have to have a cesarean section] I got scared because I had never had anything done, I never had surgery, I'd never been cut open. So I was like blubbering and crying. So yeah, I was freaked out a little bit.

Teresa describes her emotions as a rational response to the knowledge that she was going to give birth by cesarean section. Although Teresa portrays an image of herself that does not seem rational on the surface through her description of herself as "blubbering and crying," she justifies her emotional response with a very rational explanation. For Teresa, having a cesarean was scary because she had never had any type of surgery before and had never been "cut open." The cesarean surgery was scary to her because it was a new experience that was unlike anything she had experienced before. In this context, Teresa's emotions become a rational response to a specific event that occurred during her birth.

A few women describe their emotions during labor as responses to events that were unrelated to medical interventions. Tracy describes her emotions during labor as a response to the comments made by two unwanted spectators.

It was fairly medical in its approach because the monitor was there and I don't know if they were residents or medical students, probably med students because they didn't have a clue. It was two of them and they were just sort of sitting there in the room while I was in labor, not contributing, not doing anything useful, but somehow learning about the process and occasionally saying totally inappropriate things. [Like what?] Like looking at what was, the paper that was being spit out and looking at the screen and commenting on the magnitude of the contractions as they were going on. And I guess the monitor tells you, there's one monitor that monitors the baby and so you get the heart rate and they monitor the contractions as well. So they would sit there and say, "oh my gosh, that was a big one." And for me being in labor, I'm trying to stay focused first of all, so it was an awful distraction, but I was also getting angry with them because I didn't need that. I didn't need to have somebody totally uninvolved and uncaring sitting there going "ooh, wow." So that bugged me and of course I was in pain so I didn't need a spectator.

In Tracy's narrative, her emotions during labor are constructed as a rational response to the social events that took place. She explains that she was bothered by the two students because they were disrupting her ability to stay focused during contractions, they were uncaring and not contributing to her labor, and she was in pain. For these reasons, Tracy's emotions are a rational and justified reaction to the social context of her labor.

Contrary to popular representations of pregnant and birthing women as emotionally unstable and irrational, the women in this study construct their emotions as calculated, rational and justified responses to specific events that took place during their labors and births. This is particularly emphasized in Rebecca's narrative, where she states that she was not emotional until a particular event occurred that caused her to become emotional.

In addition, the women in the above excerpts describe a range of emotions that they experienced throughout pregnancy, labor and birth. Some of these emotions include happiness, excitement, concern, anger and upset. According to self-help pregnancy

guides, the primary emotion that women should expect to experience during pregnancy and childbirth is fear (Eisenberg et al. 1996; Gillespie 1992; Iovine 1995). While some of the excerpts provided so far in this section include fear as one of many emotions experienced, fear has not been constructed as the primary emotion that made up women's experiences. I now turn to narratives that emphasize fear and examine the ways that fear is constructed in the context of pregnancy and childbirth.

Fear

Some women's narratives emphasize fear as a significant emotion during pregnancy and childbirth. The two most common fears were that the woman's body would not function properly to create a healthy child and that unwanted medical interventions would be used despite the woman's wishes to avoid them.

For many women in this study, fear that the body would not function properly was a great concern that brought with it anxiety and nervousness. For example, Victoria describes her pregnancy:

Really I think I was more nervous than anything. I think it was kind of a nervous time. [What were you nervous about?] Well because I was pregnant before and had a miscarriage early on. So it was, I was constantly making sure I wasn't bleeding. And the feeling, is this a normal feeling? So I didn't, it was a little scary. I think that's the word that sums it up. I thought it was a really scary time.

Victoria describes her pregnancy as a scary time filled with fear. Much like the biomedical definition of the pregnant female body as a dysfunctional machine (Davis-Floyd 2001; Martin 1992), Victoria's fear focuses on the possibility that her body may not function properly to create a healthy child. Victoria rationalizes her fear by contextualizing it within her previous pregnancy experience that resulted in miscarriage. Since her body had terminated an earlier pregnancy, Victoria feared that this experience would be replicated in her current pregnancy. In the context of her previous miscarriage,

Victoria's fear is constructed as both justified and unique to her own experience rather than generalized to all pregnant women.

Sarah also describes herself being fearful that her body will create an unhealthy child. Sarah draws on the biomedical definition of her pregnancy as "high-risk" based on her age to validate her concern.

I remember just physically what was going on and feeling happy, feeling scared too that everything was going to work out okay, that she was going to be okay. I guess particularly, not that I'm that much older, but I turned thirty-five while I was pregnant with her so they considered it a high-risk pregnancy. Even though, I mean anything over the age of thirty-five they do. Of course you know the risks go up the farther away from it you get so it wasn't a big deal but still I, you know, that was maybe more of a concern. I don't know, maybe it was more of a concern than it would have been because everybody probably worries about it to a certain extent.

While Sarah describes a variety of emotions that made up her experience, this portion of her narrative emphasizes fear as a prominent emotion. Sarah reports that her fear is based on the medical definition of her pregnancy as high risk due to her age. She also constructs fear as a normative emotion during pregnancy by stating that "everybody probably worries about it to a certain extent." However, Sarah constructs herself as more fearful than the norm as a result of the medical definition of her pregnancy as high risk.

This section demonstrates that women describe themselves experiencing a range of emotions during pregnancy and childbirth. It is significant to note that none of the women in this study associate their emotions during pregnancy and childbirth with hormonal changes. Rather, women construct their emotions as reasonable and rational responses to a specific event or the social context within which pregnancy and childbirth took place. This chapter now turns to a discussion of the relationships between emotions and the body.

Emotions and the Body

Much work within the sociology of emotions conceptualizes emotions as “embodied” modes of being (Hochschild 1979, 1983; James and Lange 1922; Williams and Bendelow 1996, 1998). Within this context, emotions are conceptualized as physical experiences that take place within the body. At the same time, it is argued that emotion is not simply a physical experience as there is typically some form of mental or cognitive component that defines the physical state not solely as physical, but as emotional. In this way, emotion is conceptualized as lying at the interface of mind and body and has been named by Simon J. Williams and Gillian Bendelow (1996) as the “missing link” between mind and body.

This section examines the different relationships women construct between their emotions and their bodies in the context of telling their childbearing narratives. The first part of this section describes the use of compartmentalization, or the construction of emotions as completely separate from the body. The second part of this section focuses on the ways that the body is constructed as influencing emotions. The third part of this section examines women’s constructions of emotions influencing the body, particularly through physical manifestations of emotions in the body.

Compartmentalization

Many women compartmentalize the emotional and physical components of pregnancy and childbirth in their narratives. Through compartmentalization, women construct emotions and the body as two completely separate, distinct components of childbearing that are not related to each other. Many women use the terms “emotional” and “physical” as narrative resources to distinguish between these two components of childbearing.

Cindy compartmentalizes her pregnancy into physical and emotional components when asked to describe her pregnancy.

The physical part of the pregnancy went pretty good. It was pretty straightforward for me. I didn't have any problems with that. For me the emotional part of it was much harder to deal with, particularly because of the tension that was between my husband and I through the whole thing.

Cindy constructs physical and emotional aspects of pregnancy as two separate, unrelated parts. For Cindy, the emotional components of pregnancy were much more significant than the physical components. Cindy constructs her own pregnancy as particularly emotional due to her relationship with her partner during pregnancy. In this narrative, emotion is not so much an integral component of pregnancy as it is a consequence of the social context in which pregnancy takes place. This emotional component is completely separate from any physical experiences during pregnancy.

Teresa also compartmentalizes her pregnancy into emotional and physical components.

Emotionally I was excited, but it all seemed really far away until those last 2 weeks, you know? Because it was like, oh, it's still not until October, so I didn't really think about it too much. Until those last few weeks and then, you know, I got a little anxious. And physically I felt fine up until those last few weeks and then I really started aching and I started feeling a lot of pressure and it started feeling a little bit more real.

Like Cindy, Teresa compartmentalizes her pregnancy into emotional and physical components. Both women use the terms "physically" and "emotionally" to distinguish between these components and construct them as separate parts of pregnancy.

Contrary to current sociological theories of emotions that conceptualize emotions as "embodied" experiences, these women construct more of a dualistic relationship between body and emotions. Much like the mind/body dualism associated with Enlightenment thinking, emotions and the physical body in these narratives are

constructed as two distinct, unrelated and almost opposing aspects of pregnancy.

Emotions in this context are disembodied—they are separate and distinct from bodily experience.

Body Influences Emotions

While some women’s narratives construct body and emotions as separate, other narratives construct relationships between body and emotions. Many women in this study describe scenarios in which their bodies influence their emotions during pregnancy and childbirth. These scenarios are most often described during women’s narratives of labor. The body in these narratives is an active subject in that it produces a stimulus that elicits an emotional response while emotions are reactions to the body.

The women in this study report a variety of emotional reactions in response to the body’s level of activity. Most often, women report feeling sad, angry, frustrated or disappointed because their bodies are less active than they want or expect them to be. Many women describe these emotions in response to the inactive body described in chapter three.

Annie describes the days surrounding her due date:

I really wanted my baby to come at the start of my maternity leave but my biggest fear was a c-section so I didn’t want to be induced for any reason because I know there’s a bigger risk of c-section than babies that come on their own. . . . So here I am, my due date comes and goes and my phone rings every day with people asking me if I’ve had the baby and it was two days past my due date. On the day of my due date it was like I woke up, Andrew’s mom called, asked if I was pregnant and I wanted to kill her. I was like, “yes, I’m still pregnant.” And it was hot but I had nothing to do. I was just like, I can’t take it. I was really down in the dumps.

Annie describes herself feeling “down in the dumps” as a result of her body’s inactivity.

Although the body is inactive in Annie’s narrative, it is still the agent that elicits an

emotional response. Annie's emotions are a response to her body not beginning labor when she wanted it to.

Tracy reports a similar scenario:

Then it got serious enough that Friday my husband took off from work. In the morning I could feel the contractions and I had heard stories about second babies coming faster so we were just like, let's take the day off. So we spent the day doing things like finally buying the car seat and stuff like that and we bought a camera because we thought we should have one. So that was the day before and it was a little frustrating because we were sure that it was going to happen and it didn't.

Like Annie, Tracy describes her feelings of frustration as a reaction to her body's lack of activity. Although it is the inactive body that is the focus of these narratives, the body is active in that it provides a stimulus that elicits an emotional response. Emotions in these narratives are dependent on the body's subjective activities. The body can also be the object toward which emotions are directed.

Many women in this study report similar emotions in response to the semi-active body. These emotions are commonly described as arising after a healthcare provider reports the number of centimeters the woman's cervix has dilated. These reports commonly result in feelings of disappointment and anger. For example, Rebecca describes her labor:

I was really uncomfortable. I was like, oh my God, I don't know if I can do this. This is *so hard*. And I was crying. I mean I wasn't like I can't do this, but it was just really hard. It was really, really hard. So I guess at like 4:00 or 4:30 Jenny checked me again and she said I was only like three or four centimeters, not very much more. And you know, it was just only after 4:00. I know lots of people are in labor forever. After she did that I was kind of disappointed. I was really disappointed.

In Rebecca's narrative, her feeling of disappointment is a response to her body's level of activity. The body in this narrative provides a stimulus that elicits an emotional response. However, Rebecca's body is not alone in creating this stimulus. Rebecca does not know

how many centimeters her cervix has dilated until her healthcare provider tells her. In this scenario, it is not just the body but knowledge of what the body is doing and how quickly it is progressing through a given task that elicits emotional reaction. The mind is a mediating factor here because it is not just the body that elicits an emotional response, but knowledge of the body.

Annie describes a similar scenario in her labor narrative. Annie previously explained that she had been laboring at home and felt that it was time to go to the hospital because her contractions were becoming intolerable. Based on the intensity of her contractions, Annie thought that she would give birth to her baby shortly after she arrived at the hospital.

So that's when she checked me and I was like three centimeters. And I was pissed. I was like, what? That's when I felt guilty. When I was a medical student I always wanted to check people. And I cursed myself for doing that because when you're in labor you don't want to hear that. I would be like "oh you're eight now." Eight's not enough. You don't want to know until it's ten. So at that point, we were just like ready to go. Like, okay, more of the same. Then I stayed in the tub until the tub didn't work anymore and then I needed to get out right then. I was like "tub's not working, time to get out." And I got out right then. So at that point I got out and they checked me and I was six centimeters. And they were very excited that I was six centimeters but I was not very excited. So I was disappointed. At that point I was kind of frustrated because I was out of tactics. I had used the tub and used the shower and those were my tactics and they weren't working anymore and I still had a long time to go.

Like Rebecca, Annie describes herself feeling disappointed and angry at her body's level of activity.

These narratives suggest a more complex relationship between emotions and the body than other literature in the sociology of emotions suggests. In these narratives, the body is an active subject in that it is conducting its own activities and its activities provide a stimulus that elicits emotional response. The body and mind work together here as it is the mental knowledge of one's body rather than the body alone that produces

the stimulus. Emotions are also active subjects in that they are not forced by the body or the self. At the same time, the body is the object of one's emotions. The body is crafted into these narratives not so much as the site of emotionality, but as the subject and object of one's emotions.

Emotions Influence Body

While some of the narratives in this study construct the body influencing emotions, other narratives construct emotions influencing the body. Much more in line with the conceptualization of embodied emotionality, these narratives commonly describe physical manifestations of emotions in the body whereby a particular emotion elicits a physical response from the body. Both emotions and the body are active subjects in these narratives in that the emotions stimulate bodily activity. The part of the body that is often emphasized in relation to emotion is the heart.

Annie describes a situation during her pregnancy that she considers particularly emotional. In this narrative, Annie explains the physical sensations within her body as manifestations of her emotion.

I had a lot of stress from work. I was doing a surgery rotation and any time you weren't completely eager to learn it was considered that you weren't doing a good job. Especially the head doctor in the unit. So I would get in trouble for not walking fast enough. I mean it was just a nasty, nasty situation. So work was not a pleasant place to be. I would try to take naps because I would get really tired. And no one cared. I was doing surgery and I would have to stand forever and my legs would get tired and no one cared. And it was only for two months but I failed that rotation and then I started another rotation where I worked a hundred hours a week. So work was stressful and it was an unsupportive environment. It wasn't about being pregnant. They didn't care. Nobody cared. And it was work/school so when I found out I failed that unit it was like to hell and back because they were telling me I'd have to do it again with a brand new baby. And I was just like, really it just killed me. I spent a lot of hours crying and a lot of energy being angry and yelling and you know when you're angry you're just, you know, your heart's beating fast. I knew it wasn't good for me or the baby but I just couldn't control it. I was just devastated, you know, it was like I was trapped. I'm trapped in my field because I have so much debt.

Annie describes herself feeling anger and devastation as a result of her work environment during part of her pregnancy. Like Cindy who described her emotions earlier in this chapter, Annie attributes her emotions more to the social context of her pregnancy rather than the pregnancy itself. Annie constructs the emotion of anger as physically manifesting in her heart by making her heart beat fast. Emotion is an active subject in Annie's narrative because it stimulates bodily activity. The body, specifically the heart, is also an active subject because it is performing its own activities. Annie explains that she did not have specific control over either her emotions or her body's heart rate.

Kristy also describes her emotions during labor physically manifesting in her body.

They went ahead and they set up, they gave me pitocin I guess to start the contractions and that was awful. It was awful. I think that if you start having contractions on your own that you get kind of, you gradually go into it, but then they gave me that stuff and it felt like it just started from nothing to instant pain. And I had all these thoughts; I didn't want an epidural, I didn't want any of that. And my blood pressure got so high because I was just kind of freaked out about the pain. They were like "you need to calm down" and I couldn't calm down. Then I ended up getting the epidural and I didn't want it.

Kristy explains her heightened blood pressure as a response to her emotion of feeling "freaked out." Kristy's emotion is an active subject in this narrative because it causes her blood pressure to rise. Her body is also active because it pumps blood more quickly as a result of Kristy's emotion.

Annie describes another scenario that constructs emotions physically manifesting in her body. In this narrative, Annie locates emotion generally within the heart and then describes her heart's activities as a response to her emotions.

Once the birth happened and once the baby came out the feeling was just like exhilaration. It was like joy and exhilaration. It was just very emotional. The feelings went from being in my uterus and down my birth canal to being in my heart and in my head, like the upper part of my body. [What do you mean by that?] It was like that's where the feeling and the focus was. Before it was like I had this intense pain in my uterus, like pushing against my body and then the feeling was

pressure on the birth canal and I was pushing against it. Then when she was born the feeling was more like up in my heart and in my mind and I had joy and exhilaration. It was like an intense exhilaration, like my heart was beating really fast and I was crying. It was just uplifting.

Annie locates her feelings of joy and exhilaration in her heart. In Annie's narrative, the heart is the site of emotional sensation. She supports her statement that her emotions took place in her heart by describing the heart's physical activities, such as beating fast. Both emotion and the body are active subjects in this narrative; emotions correspond with bodily activities and the body acts in such a way that cannot specifically be controlled by the individual.

This conceptualization of the body/emotion relationship is much more consistent with current theories of emotion as embodied experience than the narratives reported in previous parts of this section. In the narratives of embodied emotion in this study, women tend to first describe the emotion that they were experiencing and then describe its physical manifestation. The implication here is that the emotion itself elicits a bodily response.

Summary

This chapter begins by establishing that pregnancy and childbirth are constructed by the narratives in this study as both emotional and non-emotional experiences. Some of the women in this study construct pregnancy and childbirth as intrinsically emotional but do not specify which emotions are experienced. Other women contextualize their emotions as responses to anticipated changes that result from giving birth and specific events that occurred during pregnancy, labor or birth. Emotions are rationalized in these narratives through contextualization and justification. Some women also emphasize specific emotions, such as happiness, excitement, nervousness and fear. Finally, some

women construct pregnancy and childbirth as non-emotional experiences. Overall, these narratives demonstrate that pregnancy and childbirth are constructed as intrinsically emotional, contextually emotional and non-emotional.

This chapter then explores the relationships women construct in their narratives between emotions and the body. Some of the narratives compartmentalize emotions and the body, constructing emotions and the body as distinct and unrelated components of pregnancy and childbirth. Other narratives construct the body and emotions as interrelated, whereby the body influences emotions or emotions influence the body. These relationships are sometimes constructed as being mediated by the mind.

CHAPTER 6 THE CHILDBEARING SELF

This chapter focuses on women's constructions of the self in their pregnancy and childbirth narratives. This chapter begins by exploring the perceptions that childbearing both influences and does not influence the self. The second part of this chapter focuses on the self and the body, highlighting the various relationships women construct between the self and body in the context of their childbearing narratives. The final section of this chapter focuses on holistic narratives of the self, whereby body, mind, emotion, and self are integrated.

Childbearing and the Self

This section explores women's constructions of the impact of childbearing on the self. The first part of this section explores women's constructions of childbearing as changing their sense of self and highlights the various changes in self that women describe. This subsection is organized into the four categories of motherhood, adulthood, magnitude of self and empowerment/disempowerment. The second part of this section highlights women's constructions of childbearing as having no impact on the self.

Childbearing Changes the Self

Many of the narratives in this study construct pregnancy and childbirth as experiences that change one's sense of self. This part of the current section focuses on the different selves women construct as emerging from their pregnancy and childbirth experiences. Some of the women in this study spoke specifically about taking on new selves such as mother and adult as a result of childbearing. Some women also construct

childbearing as changing the magnitude of their selves, resulting in either a loss or enhancement of self. Some of the women in this study also focus on empowerment, where many women construct themselves as empowered selves after the birth of their children and a few women construct themselves as disempowered.

Many women in this study construct pregnancy and childbirth as resulting in a new self, particularly that of mother. This theme was most commonly prevalent among women who had given birth only once at the time the interviews took place. Some women define themselves as becoming mothers during pregnancy while others construct themselves as becoming mothers immediately after birth.

Annie constructs herself becoming a mother during pregnancy. Annie's narrative contrasts her own and her partner's experiences during her pregnancy:

We had one episode you know where he revealed that he wasn't quite ready to be a parent yet and that was just really disappointing to me because being pregnant, I didn't know exactly how much more like a parent I was going to feel like. But I definitely felt more responsible and had a different mindset like I was in a different realm of my life. And it was very disappointing to me that he seemed like he wasn't quite ready, but we worked through it.

Annie constructs herself as becoming a parent during her pregnancy. In Annie's narrative, becoming a parent means feeling more responsible and having a different mindset than before she became pregnant.

Elizabeth also constructs herself becoming a mother during pregnancy, but Elizabeth contrasts herself as mother during pregnancy with herself as mother after her son is born. When asked how she felt when she was pushing, Elizabeth replies:

I was so excited. I was so excited to see my baby. That was my main thing, I was just so excited to see the baby. . . . I was like, "okay. I know he can't stay inside of me anymore, so let's just get him out so I can meet him." And I was real excited about nursing and I wanted to, I was just ready to be that mom. Even though I was the mom while he was inside of me I was ready to be the mom with him now outside of me too. So it was a lot of excitement. Lots of excitement.

Elizabeth constructs herself as a mother both during pregnancy and after her child is born. She implies that these two forms of “mother” are somehow different by contrasting them in her narrative.

Other women construct themselves becoming mothers at the moment that their children are born. Maria explains her feelings during the moment that her son was born:

Everything changed in that moment. Like for me, all the sudden we had a son. I had a baby and I was a mother, and it was just, it was amazing, it just meant pure love. Like, I have this little person now that depends on me and that loves me and you know, I love him unconditionally. I don't know, it's just, it was very cool. I just changed instantly, I just felt different.

Maria constructs herself becoming a mother in the moment that her child is born. In Maria's narrative, becoming a mother is an instant change that caused her to feel different. The new self that Maria becomes in the instant that her son is born is a self that now has a baby who is completely dependent upon her.

Meka also constructs herself becoming a mother the moment her child is born. In describing how she felt when her daughter was born, Meka states, “it meant a whole new life for me. I had a beautiful little daughter and I was a mother.” In Meka's narrative, becoming a mother occurs at the moment one gives birth and means having a whole new life.

Victoria also constructs herself becoming a mother in the moment that her daughter is born. However, Victoria states that she is less sure about how to be a mother.

Then I just remember feeling like I didn't know what I was going to do. Because all the sudden I had this kid and I'm like, oh my God. And it really made me nervous. You know, because then I'm laying in the room and I'm like, okay, my kid is, she went to the nursery. Because everyone had always said, “take advantage of it, take advantage it.” But I didn't even like that, yet I didn't know if I wanted her in my room either. Not that I was feeling like I didn't want her or, you know how some, you hear that some people don't feel a connection? It wasn't like that. It was just kind of a weird feeling. I don't know how to describe it. [Like I don't know if I'm ready for this?] Like, oh my God, now here we are. This is it. Now

I'm a mom. And what's really weird is you know, they're like, oh the wristbands, check the IV. But then when it's time to go home they clip it off and you just walk right out of the hospital. And it's like, oh, you're just taking this baby. It's very weird. I mean, you know. It was really weird. Doing it next time I will not have the nurses take her or whoever. Now that I know that I can do it. But it was like I didn't know about eating, it was just like I didn't know what to do, so if I gave her to the nurses they would know what to do with her. So that was why I did that.

Like Maria and Meka, Victoria constructs herself as suddenly becoming a mother when her child is born. Victoria describes herself feeling nervous about becoming a mother because she lacked information on how to feed and care for a child.

Some of the women in this study construct themselves as becoming adults during pregnancy and childbirth. These women contrast their new adult selves with their former child selves. Kristy describes how she felt the moment her child was born.

I was like, it's still hard to understand, you know, this baby. You know, I've never really been around children a whole lot and the whole time you're pregnant you know you've got a baby in there, but you just like, it's hard to believe until it happens. And then you've got this little kicking, screaming, covered in white wet slimy thing on you. You know, it's overwhelming, it's like this is my baby. It's the most wonderful thing in the world. . . . You're excited, you're scared, you're nervous. Am I going to do this right? I was scared that I wasn't going to be a good mother. You know, my lifestyle, up until the point that we got pregnant, it was all about clothes and partying and going out and having a good time and living the life of a kid. And then all the sudden it's like wait, I'm an adult. That's what pretty much seals it. You know, it's like, life as you've known it is over. And you know, I don't miss it at all. It's the best thing in the world.

Kristy contrasts her pre-pregnancy self with her self after her child is born. She describes her pre-pregnancy self as "living the life of a kid" by focusing on clothes, partying and going out. Kristy constructs herself as becoming an adult the moment her child is born. She states that the birth of her child "seals" her status as an adult. For Kristy, becoming an adult means leaving behind the behaviors she associates with her pre-pregnancy childlike lifestyle.

America also constructs herself becoming an adult during her pregnancy and childbirth.

Being pregnant made me settle down. Everything needed to settle down, but I couldn't find any reason I guess or anything to connect to that would settle me down. It kind of quieted this raging spirit I had. Being pregnant and becoming a mother did which has been a really good thing for me, a very healthy, positive change in my life. So, I have to thank Richard for that. [What kinds of things were you doing before hand? Like what kind of actual things did you stop doing?] I just didn't want to grow up. I didn't want to be responsible for myself or anyone else or anything. I just wanted to have a lot of fun and indulge in anything I wanted to without any consequences or any ties or responsibilities. Which is unrealistic. I mean, that's realistic when you're a teenager for a very short period of your life, but it's not realistic when you're twenty-eight. So I just sort of hung on to childhood *forever*. And now that I've actually taken responsibility for things and grown up it's nice. It feels really good. It's like a gradual progression in life.

For America, pregnancy and motherhood are experiences that caused her to settle down and become healthier. She contrasts this with her former self, which she describes as a self that was "hanging on" to childhood. America constructs this child self as being irresponsible, having fun and indulging without consequence. Both Kristy and America consider their transitions to adulthood positive changes in their lives.

Some of the women in this study describe pregnancy and childbirth as changing the magnitude of their selves. For some of the women in this study, pregnancy and childbirth result in a loss of self. To these women the addition of a child to their lives means that they can no longer just focus on themselves. Elizabeth explains,

I have a friend who is pregnant and she's just having a miserable time with it and is so unhappy about it and she's always in pain and everything else. I didn't have any pain. My back ached, the pressure in my legs bothered me, but I don't know, I think the way that people look at it, the way that women look at it, you just do something about it. Elevate your legs. If your legs are hurting, listen to what they're going to tell you is going to help. Elevate your legs. Don't go out shopping that day, or whatever. You've gotta, if you're a selfish person, you no longer can be selfish, or like I said, you've got this humongous responsibility on your shoulders now because there's someone else who is solely dependent on you from day one. And I think if women in general, because we're the ones responsible, thought more like that and stopped thinking so much, well me, me, me, me. I think

that was the biggest challenge, not challenge, but the biggest thing for me. Instantly there was no more me. Instantly. As soon as I found out. There was no more just me. It was everything I do now affects myself and my child. No matter what it was. So I had that outlook on it and, you know, I was okay with that. I think some women aren't okay with that. And that, "well I want to do this and I want to do that." Yeah, go ahead, but there's consequences if you're going to think like that.

Elizabeth contrasts her own outlook on childbearing with her friend's outlook. In her comparison, Elizabeth constructs pregnancy and childbirth as resulting in a loss of self.

She states that as soon as she found out she was pregnant, "there was no more me."

Elizabeth explains this statement by stating that everything she does now influences her child. For Elizabeth, being pregnant and giving birth means relinquishing the ability to focus solely on one's self.

Kristy constructs childbearing similarly in her narrative.

I remember being a kid and thinking, not even a kid, like a teenager, a young adult, twenty or twenty-one years old I guess. And friends of mine were having babies and I was like, God, I just don't think I could do that. You know, especially when you're younger. Because it does happen. Where I'm from, there's a lot of underage kids, they get pregnant and it's just a different era of people. And they just do things different. I think a lot of kids get pregnant when they're still in high school. And then a lot of my friends, all they could talk about was getting married. And I was like, not me, I want to see the world, I want to do this. And my friends, I don't know, I just never thought that I could do it. You know, give up my life to someone else. And then after you do it's like you have this feeling, it's like you're giving the world something. It's like you're responsible for this child, but it's not, you know, you're responsible for how the world's going to be someday by the way you make this child to be.

Like Elizabeth, Kristy constructs childbearing as resulting in a loss of self. According to Kristy, having a child entails giving up one's life to someone else.

A few women construct childbearing as amplifying their self. In these narratives, pregnancy and childbirth are constructed as making the individual more of a person than they were before they had children. Annie describes her pregnancy:

What I also liked about [pregnancy] was that it was an opportunity, it gave me an opportunity to be more of a person. It was like there was more to me than just being a medical student. The patients could relate to me better. They were like “oh, when are you due?” It gave us more to talk about and it made me more of a person. It gave us more of a connection. I felt like I had more depth to myself too than just a medical student or a doctor and I think the patients felt that too. They could just talk to me about regular stuff and that made everything more relaxed. They would be like “oh you’re pregnant. I have a two year old at home.” And of course I told everybody I was having a midwife and I got a lot of slack from other people in the hospital. But the patients would ask me about that and it was like all the sudden there was more to life than just medicine. There was just something to talk about.

Annie describes childbearing as increasing the magnitude of her self. She describes being pregnant as making her “more of a person.” Annie explains that pregnancy and parenthood afforded her the ability to relate to others in a way that she had not been able to before. Rather than being viewed as solely a medical student or a doctor, other people recognized and acknowledged Annie’s pregnancy, which provided both a topic of conversation and a way for Annie to connect to other people.

Many women’s narratives of the self during pregnancy and childbirth focus on empowerment. Most of the women in this study construct themselves as feeling empowered as a result of giving birth. Women often felt that they could accomplish anything after they gave birth. This sense of empowerment was particularly prevalent among women who gave birth without any anesthesia or analgesia, but it was also present in many of the women’s narratives who used anesthesia/analgesia. For example, Jasmine describes how she felt after her child was born.

When I was done I was like “man, I’m the king of the world, dude.” That’s how I felt. I was like, “I can do anything.” Seriously. What did I say yesterday? I said something like, “I’ve given birth and something else, and that means I can do anything.” I said that yesterday. I forgot what I was talking about.

Jasmine constructs herself as empowered as a result of giving birth to her son. Childbirth in this context is constructed as an accomplishment of the self. Jasmine believes that because she has given birth, she can do anything.

Annie constructs herself similarly:

I felt great about myself. I felt like there wasn't anything I couldn't do. I thought if you could give birth, you could endure just about anything. I felt like I was up to any task. I didn't think I could endure anything, there are things in the world that people go through that are painful but they are bad, like cancer or something like that. I was feeling pain, but there was a baby at the end. And it was for that reason that I felt like the pain of labor was different. It was like the pain of running a marathon. I've never run a marathon but I've run ten miles before and it hurt, but when you're done you feel good. I also felt like, I did it. I felt a big feeling of accomplishment. I did what I set out to do the way I wanted it to be done and I felt proud of myself and accomplished in that sense.

Like Jasmine, Annie constructs herself as empowered and accomplished as a result of her birth. Annie explains that her sense of empowerment resulted not only from giving birth, but from giving birth the way that she had wanted to give birth, which was without the use of any type of pain relief medication.

Elizabeth constructs herself as both proud and disappointed in herself after her birth. Elizabeth states:

I felt strong. I was proud of myself. To be honest, I was a little disappointed at the same time because I'd always told myself I didn't want the epidural, I didn't want the epidural, I didn't want the epidural. Why did I do that? I didn't focus on it, but I was like, "God, I can't believe I got the epidural." I don't know if it was just because I always wanted to do it natural or what that was. I can't explain necessarily what that was, but I was proud of myself. I was like, "oh, look what you did, you're so wonderful." And my husband played a big part in that because he was like, "oh, our boy's so beautiful. You did so good." And he was real encouraging on how good I did and so I felt real happy and I wasn't sad.

Elizabeth's narrative oscillates between the construction of herself as proud and accomplished on the one hand and disappointed on the other. Elizabeth is proud of herself for creating and giving birth to her child. She also draws on her husband's

construction of her self in her narrative. The construction of Elizabeth as proud and accomplished is a collaborative effort between Elizabeth and her husband. At the same time, Elizabeth is disappointed in herself for giving birth with epidural anesthesia, which she had planned to avoid.

One woman in this study reports questioning herself after the birth of her child. Teresa's labor was medically induced before her due date. She labored for two and a half days before finally giving birth by cesarean. In describing how she felt after she gave birth, Teresa states:

Even now I sort of ask myself, "was it supposed to be that hard? Could I really have done better? Could I really have pushed her out if I tried?" Even though my doctor totally reassures me she just wasn't coming out. I mean even before we went in for the induction she asked me how I felt about a cesarean just because [the baby] was so big and she saw how my cervix was reacting. But I still ask myself "could I have pushed harder? You know, like gone longer or if I tried harder?" But, it just wasn't anything like I expected. I thought I was going to go in there, and you know, you see everybody else do it. So, it was a little, I mean, it was way more than I had bargained for. Especially being in there, you know, two and half days of just contracting and nothing really happening. It was way more than I bargained for.

Teresa's narrative is much different than the women's narratives that focus on feeling proud, accomplished and empowered as a result of giving birth. Teresa states that she continually asks herself if she could have given birth vaginally if she did better, pushed longer or tried harder. Teresa's narrative focuses on self-doubt and disempowerment as a result of her childbirth experience.

Contrary to the narratives in this study, the self is largely absent in the biomedical model of childbirth. Biomedical discourse constructs childbirth as a collaborative process between the woman's body-machine and her healthcare provider. Pregnant and birthing women are largely absent from biomedical discourse and when they are present, they are generally subjects only in obstructing their own births (Davis-Floyd 2001; Hahn

1987; Martin 1992). Conversely, the women in this study construct their selves as responsible for the type and outcome of their birth. Feeling pride or disappointment in one's self as a result of childbirth suggests that it is the woman rather than her body or her healthcare provider who gives birth to a child.

No Change in Self

A few women in this study construct pregnancy and childbirth as not changing their self. In these narratives, childbearing is constructed as having no impact whatsoever on one's sense of self. For example, Tracy describes her pregnancy:

Let's see, pregnancy started in August and at that point I was in my post-doc, so it didn't really affect me one way or another. My schedule was flexible at that point, so I was tired more than before but it really didn't matter.

Tracy constructs pregnancy as having no real effect on her at all. She states that she was more tired during pregnancy but that this change was insignificant.

Jasmine also constructs pregnancy as having no effect on her self. When asked what she did to prepare for her birth, Jasmine replies:

I did nothing. I felt like I kind of, obviously I know what's happening and I had all this stuff already. I already had all the stuff, like the towels and receiving blankets and all that stuff. I had all the supplies. I didn't really do anything. I didn't read anything to keep me going. Like I said, I thought pregnancy was going to be super spiritual, like really big. And I kind of felt like, I felt like it was all happening to me. I wasn't really experiencing it. I don't know, I thought I would keep a diary and meditate. I didn't do any of that, I don't know why. But I just, I went with that. I went with just being me, just bigger. I didn't do anything.

Jasmine contrasts her pre-pregnancy image of herself as a pregnant woman with the actuality of herself during pregnancy. While Jasmine imagined herself taking up spirituality, journaling and meditation during pregnancy, she states that she actually did not do any of that. Instead, she "went with just being me, just bigger." Thus, Jasmine constructs pregnancy as having no impact on who she is as a person. Jasmine's self did

not change during her pregnancy. In contrast to the narratives in the previous section where women construct childbearing as changing the self, the narratives in this section construct pregnancy and childbirth as having no impact on one's sense of self. Thus, pregnancy and childbirth are constructed as experiences that both change and do not change the self.

Self and Body

As outlined in chapter one, the phenomenological perspective conceptualizes the human self and body as inseparable. The individual in this context is an “embodied” subject (Bendelow and Williams 1995; Leder 1990; Schutz 1971; Turner 1992) that gains a sense of self through ongoing relationships and interactions between the body and the external world (Cosans 2001; Merleau-Ponty 1963). This phenomenological view of the self and body stands in contrast to the mind/body dualism embedded in Enlightenment thinking that associates the (predominantly white male) self with the mind and not the body (Ani 1994; Bordo 1993). Susan Bordo (1993) observes that throughout the writings of Plato, Augustine and Descartes, the body is constructed as an alien object, the site of confinement and limitation, and the enemy of the self.

Recent theoretical and empirical work on the self and body reflects multiple viewpoints of self and body and results in a diverse array of self/body conceptualizations. One common perception is that the self maintains control over the body and the body, in turn, represents the self (Featherstone 1991; Featherstone and Hepworth 1991; Shilling 1993). This perspective echoes the Foucauldian (1977) analysis of self-regulation as a mechanism for societal control over the body. Much less common is the conceptualization of the body exerting control over the self, which is mostly documented in circumstances of chronic pain and illness (Gadow 1980; Garro 1992; Good 1992)

rather than in the everyday lives of healthy individuals. Even less common is the conceptualization of the self as completely separate from the body, or “disembodied,” which is documented primarily in such extreme circumstances as anorexia/bulimia nervosa (Bordo 1993), agonizing pain (Morse and Mitcham 1998) and sexual abuse (Friedrich et al. 1997).

The self/body relationship has not attracted much attention from scholars who study reproduction, but where it has warranted investigation, research results have tended to fall in line with the conceptualization of the self maintaining control over the body. Robyn Longhurst (1999) notes that pregnant women are frequent recipients of advice from healthcare professionals, friends, family members, male colleagues and strangers. The underlying message that pregnant women receive through this exchange of advice is that it is the woman herself that is responsible for the outcome of her child. Her self is perceived as maintaining control over her bodily functions and it is the self rather than the body that will be at fault if the baby is less than perfect. The ideology embedded in the biomedical model of childbirth is also consistent with this perspective, whereby the woman is afforded agency only in potentially disrupting the birth of a healthy child (Davis-Floyd 2001; Hahn 1987; Martin 1992).

This section explores women’s constructions of relationships between the self and the body in their pregnancy and childbirth narratives and the ways that the self and body are constructed in these narratives. Following the organization of previous chapters, the first part of this section focuses on the construction of self and body as separate. The second and third parts focus on the constructions of self influencing body and body influencing self respectively.

Self and Body Separate

Some of the women in this study construct their selves as separate from their bodies. The self is most commonly constructed as separate from the body in narratives that describe the use of epidural anesthesia. The women in this study often report feeling “disembodied” as a result of having part of their bodies numb.

Aimee describes the pushing stage of her labor:

When you have an epidural you don't feel yourself pushing. So I knew that I was telling my muscles to push and I knew that I was going uhhhh, but you totally don't feel it at all. So I continually asked throughout the whole six hours “am I pushing?” And the doctor's going “yeah, you're doing great, you're doing great.” And I knew I was getting tired and I knew that my brain was telling myself to push, but you just don't feel it at all. So that was a little disturbing. After a while I almost wished I hadn't gotten the epidural because it was totally throwing me off that I could not feel myself pushing at all. But yeah, mostly my brain just kept telling myself “okay, you're doing it. He's telling you that you're doing it. So just keep doing what you're doing and eventually this kid's going to come out.” But it was very uncomfortable. I totally can feel for people, not totally, I have no idea what it feels like to be paralyzed, but for your brain to be telling your body to do something and your body not feel itself doing it, it's a very odd sensation. It's like, I went to the dentist once and they numbed me and they said, “don't eat anything for an hour.” And I was so hungry. I was like, “whatever.” So I went and had something to eat and about two hours later I noticed the inside of my mouth was all bloody and I had chewed the hell out of my cheek and didn't realize it because it was so numb. And that's, I mean it's very odd for your brain not to recognize what your body is doing. It's a very disembodied thing. So, while I was glad that I wasn't in so much pain that I was screaming and scaring Brittany, I also was a little disappointed because you feel kind of disembodied. I mean I knew I was there in the moment and I was getting tired, but it's very odd not to feel anything from the waist down. It is a weird feeling. If I got pregnant again I would totally do it natural. I wouldn't get an epidural.

Aimee constructs herself as feeling disembodied during the pushing stage of her labor.

She states that while she knew that she was telling her body to push, she could not feel herself pushing and was unsure whether or not she actually was pushing. Aimee's self is constructed as separate from her body in this narrative because the self, as well as the brain, is not sure what the body is doing.

Aimee's narrative also constructs a need for the self and/or the brain to work with the body in order to push a baby out of the body. While Aimee and her brain were telling her body to push, she was unable to feel whether or not her body was pushing. This separation of the self and body complicates Aimee's ability to push her baby out of her body. In the midst of an activity that requires collaboration between the self and the body, Aimee's self and body are disconnected.

Susan also describes herself feeling disembodied as a result of epidural anesthesia. Susan had previously described her cesarean birth. When asked if she felt anything during the birth, Susan replies:

Nothing. In fact, you know, your legs are up in the stirrups and at one point they pulled my knee up and I could see my knee above the thing and I went, "that's my leg." But it, I mean it was like as if it was your leg. I recognized it as mine but it felt like it was yours because it felt like nothing, so that was pretty strange. [What was that like?] It was very, it was like out of body. It's like, "that's my leg." I mean it could have been off. I mean it was, so yeah, that's a pretty strange feeling.

Like Aimee, Susan constructs herself as disembodied as a result of her use of epidural anesthesia, whereby her self is separate from her body. Susan states that she felt like her self was outside of her body. She constructs her body as both a familiar and a foreign object (Faircloth et al. 2004). In looking at her leg, Susan recognizes it as her own, yet at the same time she states that her leg could have been off or it could have been mine because she did not feel any sensation. In this way, Susan constructs her self as separate from her body as a result of the numbing effect of epidural anesthesia.

Like other women in this study, both Aimee and Susan construct disembodiment as an "abnormal" experience. Terms such as "strange," "weird," and "odd" are commonly used by women when describing their selves as separate from their bodies. This finding is consistent with other research on self and body whereby disembodiment is associated

with extreme situations (Bordo 1993; Morse and Mitcham 1998) rather than “ordinary” everyday life. The construction of disembodiment as abnormal suggests that embodiment is more commonly experienced, as is posited by phenomenologists.

Self Influences Body

Many of the narratives in this study also construct the self influencing the body. These narratives fall into three main themes. The first theme is based on the assumption that the self influences the body, whereby the self is responsible for the body’s activities. In the second theme, the self has only a limited ability to influence the body. The third theme is like the first in that it is based on the assumption that the self influences the body, but in this theme the self is unable to influence the body.

Some of the narratives that focus on the self influencing the body construct the self as responsible for the body’s activities. This theme is particularly prevalent in narratives that suggest that the body may function improperly. In these narratives, the woman often blames herself for her body’s misfunctions or questions whether or not she is at fault for her body’s activities.

In the following narrative, Tracy questions whether or not she could have prevented the perineal tearing that took place during her birth. Tracy questions her self as a result of comments made by her healthcare provider.

He was saying particularly inappropriate things, so it was like immediately after the birth, dealing with this painful process of repairing and he wasn’t particularly reassuring about it. He said stuff like, “how did this happen? I don’t think I’ve ever seen it like this before.” And it’s this kind of thing, you don’t want to be hearing that, but it was also a little alarming, like is there something wrong with me? Did I do something wrong to cause the tearing? And, you know, there are apparently ways that you can do things to avoid it, but there’s a limit to how much you can prevent it.

Tracy interprets her healthcare provider's comments to mean that she may have done something wrong to cause the tearing of her perineum. The self in this context is an active subject that is responsible for the body's activities. In this example, the self is responsible for the body's potentially improper functions. This construction of the self/body relationship parallels women's subjectivity in both the biomedical model of childbirth (Davis-Floyd 2001; Hahn 1987; Martin 1992) and the sharing of advice (Longhurst 1999), whereby the woman is a subject only in potentially obstructing her own birth.

Victoria also constructs her self as responsible for her body's activities as a result of comments made by her healthcare provider. Like Tracy, Victoria's construction of the self/body relationship is similar to the perception of female subjectivity in the biomedical model.

You know when you start going [to the doctor] every few weeks, like at the end kind of? Well my blood pressure was going up. So one time I went in and it was way up and I was freaked. I was in the doctor's office, I was by myself. And they were like, "you really have to watch this now." And me being worried the way I was, I went in my car after I left and I was just sobbing. And then they made me go get blood work done, like right then. So I was really afraid. And so they said "you can't work. You can't do anything." So I go to work right after my appointment, pack all my crap up, and then go lay in bed. And I had to *lay in bed*. I could get up to pee, I think they said I could be up for one hour total for the day.

Victoria's healthcare providers convey the image that Victoria is responsible for her high blood pressure by telling her that she needs to watch her blood pressure. The implication is that Victoria will be at fault if her blood pressure gets higher or if something goes wrong with her baby as a result of her blood pressure. In this construction of the self/body relationship, the self is fully responsible for the body's activities. The self is assumed to be an active subject that can exert full control over the body. While the body is also an active subject, the body is constructed as more of an innocent entity that

willingly complies with the demands of the individual. Should the body function improperly, it is the self and not the body that will be at fault.

In some of the narratives, the self has only limited agency over the body. In these narratives, the self attempts to exert control over the body, but the body decides whether or not to respond. When asked what she did during contractions, Annie replies:

Lots of different things. It depended on which stage I was at. At the early ones I could talk through them or walk through them. We were just chit chatting, having conversations, walking around the house. Then once they got too intense for that I started to try to do stuff to just make them go away. I wasn't trying so much to work through them, I was just trying to make them go away. And each thing I tried was successful for a short while.

Annie is able to exert only limited control over her body in her quest to relieve contractions. She later describes an array of techniques that she used to try to make her contractions stop, including a bath, shower, and hot washcloths. Annie's self is an active subject that is working to alleviate the physical sensations in her body. The self's attempts are only partially successful, as the active body responds only temporarily to the self. The self in this context is afforded only minimal agency over the body.

Like Annie, Jasmine constructs her self as having only limited agency over her body. Jasmine describes herself making a request of her body, but it is her body that ultimately decides whether or not to comply with her request.

I remember later I was in the pool, one of the tub experiences that was not a good idea, and I was saying, "I need a break, I need a break, I need a break, I need a break." It was in that transition where [the contractions] just come one on top of another one. And my body gave me a break. It just stopped for long enough to just catch my breath and get a little re-fueled.

Jasmine requests that her body give her self a break from contractions and her body complies with her request. The self has only limited control over the body in this situation because Jasmine cannot make her contractions end completely. In addition, in

the statement “my body gave me a break,” it is the body and not the self that is afforded agency; the body in this narrative is constructed as giving something to the self. Thus, while the self exerts limited control over the body by requesting a break, the body is even more active than the self because the body decides whether or not to comply with the self’s request.

Some of the narratives in this study construct the self as unable to influence the body. The inability of the self to influence one’s body is often cited as a source of stress or discomfort for the women in this study. In addition, the inability for the self to influence the body is constructed as unique to pregnancy and childbirth. The difficulty women express accepting that their selves cannot influence their bodies suggests that throughout most of life, the self does influence the body.

Sarah describes her self losing control over her body during pregnancy.

I guess that was one of the hardest things particularly early on, but maybe even more so towards the middle when your body really, when you make that jump kind of. I don’t know, it was about four months, five months, just the whole sense of losing control over your body and nothing you can do is really going to stop this process from happening. I felt good and I had always exercised beforehand so I was able to continue to do that which helped a lot, but of course despite that you’re still gaining weight and all. So that middle part I remember feeling depressed a little bit and anxious, you know, what am I going to look like when this is over, and all of that. But then once I passed a certain point it mattered less somehow. . . . But I remember at first I was worried about it, and then when things actually started happening I could see my body changing and I was like, what’s gonna happen to me?

In Sarah’s narrative, not having the ability to influence one’s body is constructed as unique to childbearing. Sarah states that she lost control over her body during pregnancy, which implies that she had control over her body before pregnancy. The pregnant body in this context is an active subject that performs its own activities regardless of the self’s

wishes. The self is a passive, powerless subject that does not have the ability to influence the body.

Elizabeth also describes the inability of the self to influence the body. In Elizabeth's narrative, her self actually interferes with her body's activities during labor by trying to exert control over the body. When asked to describe what laboring with an epidural was like, Elizabeth explains:

I could relax more but I knew what was going on. But, I guess it being my first time I wanted to feel the pain. Does that make sense? I don't know. I wanted to feel more of the pain. I guess I wanted to experience it. So I was ready. With each contraction I was like, "okay, bring it on" type of thing. And then when the epidural came, my energy was solely focused, I was no longer focused on breathing and I have to, okay let's wait for this next contraction. I was then focused on, "oh, I'm going to see my baby soon. I'm so excited." And I became more, just getting excited, thinking of a name and letting my body do what it was already doing, but I wasn't mentally focused on it anymore. [It sounds like maybe you were trying to control it?] I was absolutely trying to control it. Absolutely. I was trying to control it and felt like I could push along my contractions, which I knew I had no control over it. After the epidural, I allowed my body to completely do, which maybe to some extent I was getting stuck at five centimeters because I was trying to control it and my body wasn't relaxing enough.

Not only is the self unable to control the body, but the self interferes with the body by trying to exert control. The body in this context is an active subject that is contracting and dilating on its own. The self is a passive, powerless subject in that the self does not have the ability to control the pace of the body's activities despite its attempts to do so. At the same time, the self is an active subject in that it interferes with the body's activities by trying to control the body.

Interestingly, the self interferes with and slows down the exact bodily activities that it is trying to speed up. Elizabeth's cervix gets "stuck" at five centimeters dilation for a few hours during the time that Elizabeth's self is trying to exert control over the body. Twenty minutes after she gets the epidural and stops focusing on her body's activities,

her cervix dilates to ten centimeters. The body in this context is a defiant body; the body refuses to comply with the self's wishes until the self stops trying to get the body to behave in a certain way.

Body Influences Self

Some of the narratives in this study also construct the body influencing the self. In these narratives, the body is an active subject and the position of the self is negotiated throughout the narratives. In some narratives the self is an acted upon object while in others the body activates the self, pushing the self to become an active subject.

Jasmine constructs her body influencing her self during labor.

I remember saying, it seems depressing to be my sharpest memory about immediately after giving birth, but I remember being on the couch and nursing him, and it was like eight or nine at night and people were still there, we were kind of partying. And me saying "if someone told me that I had to do that again tomorrow I'd shoot myself right now." And like, 100% meaning it. That's how hard it was. I couldn't have done it again. I would rather have died right there and left him motherless. I couldn't do that again. And I thought about it, I've thought about that statement periodically between the past four months and I still, I remember meaning it. Like, truly, truly, honestly would have ended my life rather than do that again. . . . It was like my body knew that that's exactly how much I could take and that's exactly how much it gave me and I did it and that was enough. That was it.

In Jasmine's narrative, the body acts upon the self during labor. Jasmine's body is an active subject in that it not only produces the labor, but it gives the labor to the self. The self is also an active subject that needs to handle the labor. Where the body creates the labor and passes it off to the self, it is the self that actually labors and gives birth to the child. This construction of the self rather than the body as the active agent that labors and gives birth also contradicts the biomedical view of birth that emphasizes female passivity (Davis-Floyd 2001; Hahn 1987; Martin 1992).

The body and the self also have an intimate relationship in this narrative, whereby the body knows the self. The body here has its own internal knowledge and it knows what the self can handle. The body also has a bit of compassion toward the self, as the body only gives the self as much as the self can handle.

Jasmine defines herself as the recipient of her labor in more depth. Earlier in the same interview, Jasmine states that she asked her body to give her a break from contractions and her body momentarily stopped contracting. I refer back to that scenario later and ask Jasmine if this means that she was separate from her body. She replies:

I think in a way yeah. Because when my labor started, I didn't say "labor start now." It just began. And so in a way, I was sort of out of control and there was something happening to me, started by who knows what. But then I do think it can be influenced by, then once you realize that it's there you can accept it and embrace it and make it work. You know, I need a break, I need a break. Let's take this break. But, you know . . . I couldn't just say, "well I have the day off, let's start labor now." It just, it really did happen *to* me.

Jasmine constructs labor as something that happens to the self. She states that her self and body are separate because her self does not have control over her body. Rather, the bodily activities of labor are constructed as starting by something else and happening to Jasmine's self. At the same time, the self and the body are related in that the self must accept and embrace the body's activities. The self and the body then work together to get through labor.

Annie also constructs her body influencing her self, but in Annie's narrative the body communicates with the self. In describing her pregnancy, Annie states:

It was like you could feel your body communicating with you. When I would get angry I would feel my heart beating really fast and it was like my body saying, "you can't do this." It was like your body was constantly speaking to you. Telling you "a little more of this, a little less of that, don't yell, calm down, eat some more fiber."

The body in Annie's narrative is an active subject in that it communicates its needs to Annie's self. The self is also an active subject because it can choose to comply with or ignore the body's requests. Although the body influences the self by giving the self directives, the self ultimately decides whether or not it will comply with the body's demands.

A few of the narratives in this study suggest that the body should influence the self but in these particular narratives, the body does not influence the self. Isabel describes the relationship between her self and her body during the pushing stage of her labor:

You know at one point I looked at Jenny and I was like "I can't do it anymore. I need help because I don't have any more pushing in me. My body stopped giving me the urge." I was like "I'm not getting any help body-wise."

In Isabel's narrative, pushing is a collaborative effort between the body and the self. The body gives the self an urge to push and the self pushes. Once Isabel's body stopped giving her the urge to push, she could no longer push. The expectation in this narrative is that the body influences the self. When the body stops influencing the self, the self can no longer perform its activities.

The variety of self/body relationships constructed by women in this study parallel the multiple and varying perspectives noted by academicians. In one sense, the self is expected to maintain control over the body, but in the context of pregnancy and childbirth, the self is often constructed as lacking that ability. Pregnancy and childbirth in this context are sometimes constructed as unique in that the self "loses" its previous ability to control the body. For the women in this study, the expectation that the self maintains control over the body during pregnancy and childbirth was often communicated to the women by their healthcare providers. Following the prescription of agency within the biomedical model, the self is at fault for any malfunctions of the body.

The body is also constructed as an entity that influences the self in these childbearing narratives. Labor contractions and the urge to push are often constructed as originating within the body and subsequently “given” to the self to deal with and work through. In these scenarios, the body maintains the upper hand, as the self is at the mercy of the body.

The Holistic Self

This dissertation has focused primarily on the ways that women differentiate between concepts of body, mind, emotions, and self in their childbearing narratives and the various relationships they construct between these components. While the bulk of the narratives do differentiate and relate these various concepts, some of the narratives integrate all four components without making much distinction between body, mind, emotions and self. These narratives construct and convey childbearing as it is experienced by the “whole” person, weaving body, mind, emotions and self together. I refer to this as the “holistic self” because holism resists the division of the whole into its parts. While one could retrospectively divide these narratives into the components of body, mind, emotion, and self, the narratives are not told in this fashion.

For example, Kristy describes how she felt during contractions.

I felt, like I said, it was like the pain. It's not like a pain that you can explain. It's not like, you know, a broken arm. It wasn't the pain that was so bad, it really wasn't. I think I could have handled it. But I couldn't make my body, my heart was racing, my blood pressure, and they kept telling me, “you need to calm down.” And I couldn't get control. And I don't know what it matters, if you have high blood pressure, I don't know the medical reasons, but they were really concerned. “You need to get your blood,” you know, “you need to calm down. You need to relax.” But I think because I was feeling a little bit of pain that it was freaking me out. And I was thinking, “it's going to get worse, it's going to get worse. What am I going to do?” You know, I was probably just psyching myself out but I couldn't get control of that. So when I got the epidural it was like the pain went away. You could still feel, you know, the harder contractions, but they were nothing.

Kristy's narrative integrates body, mind, emotion, and self in such a way that all four components are interrelated and interconnected. Kristy describes her bodily activities such as her heart racing, her mental state of "psyching" herself out, her emotional reaction of feeling "freaked out," and the inability of her self to gain control over all of these activities. In Kristy's narrative, all of these things are happening at the same time and it is the combination of body, mind, emotion, and self all acting at once that make up her experience.

Isabel describes a similar experience that occurs immediately before her midwife ruptures her membranes.

So [the midwife] was like, "I'm going to break your water to speed up the process." And I was like, "okay." This point was like a turning point in the whole thing. Cause I was like, "I'm really nervous." I was like, "no, I don't know." I totally, my whole body changed. I got really nauseous. And [the midwife] was like, "your heart rate is going up." And I'm like, "I'm really nervous." And she's like, "because I'm going to break your water?" And I'm like, "yeah, because I know it's going to make the contractions really hard and I'm just totally, they're hard but I'm grooving. I don't really want them any harder." She's like, "well, I hate to say it, but you've gotta go there." Because after sixteen hours I got comfortable with how hard it was. And I was like, "okay, this is going to push me into transition and I don't know." So anyway, [the midwife] is like, "you can't go back honey. You've gotta go through that." So I'm like, "okay, bring it on." So she burst my water and then [the contractions] start coming, like they were two minutes apart. It's about four in the afternoon, two minutes apart, really, really strong, lasting about two minutes and I couldn't do anything. I was actually like peeing all over the place and I was just going out of my mind.

Like Kristy, Isabel describes her body, mind, emotions, and self all acting at the same time with little distinction between these components. Isabel describes physical changes in her body, her emotional state of nervousness, and her self going out of her mind. It is particularly interesting to note that most of this excerpt reports Isabel's state before her midwife actually ruptures her membranes. In most of this narrative, it is the knowledge of impending physical changes that instigates the activities of Isabel's body, mind,

emotions and self. In Isabel's narrative, body, mind, emotions and self are all acting simultaneously and are interconnected.

Another distinguishing feature between these narrative excerpts and the rest of the narratives in this study is the speed and intensity with which these parts of the childbirth story were told. At these points during the interviews, Kristy and Isabel both spoke very quickly and with heightened energy and intensity. The delivery of the narratives in this way portrayed a sense of chaos, as if everything was firing at once in a manner that felt out of control. This is similar to Morse and Mitcham's (1998) observations during their interviews with severe burn victims when describing experiences of agonizing pain.

Summary

This chapter begins by exploring women's constructions of childbearing in relation to the self. Many of the women in this study construct childbearing as influencing or changing the self, as it marks a transition to the status of mother or adult. Some women also construct pregnancy and childbirth as changing the magnitude of their self, resulting in either a loss or enhancement of the self. Additionally, childbearing is also perceived as an experience that influences one's view of their self as either empowered or disempowered. Finally, some women construct childbearing as having no influence on their self whatsoever.

This chapter also demonstrates that a variety of relationships can be constructed between the self and the body. The self is constructed as separate from the body, or "disembodied" in some of the narratives, yet women expressed discomfort with this self/body separation. The self is also constructed as influencing the body through the constructions of the self as responsible for the body's activities, the self having limited control over the body, and the self having no control over the body. The body is

constructed as influencing the self by acting directly upon the self or communicating with the self.

This chapter concludes with a discussion of the holistic self, or the construction of the body, mind, emotions and self as integrated and interrelated. Holistic narratives of the self describe the body, mind, emotions and self all acting at the same time to make up one's experience. These narratives make no distinction between these various components, but construct them as integrated components of the whole person.

CHAPTER 7
CONCLUSIONS AND FUTURE RESEARCH

Negotiated Concepts

Body, Mind, Emotions and Self as Negotiated Concepts

This dissertation has explored the variety of ways that women construct body, mind, emotions and self in the context of their pregnancy and childbirth narratives. Chapters three through seven each began by demonstrating that women's narratives address individually the concepts of body, mind, emotions and self. These sections demonstrate that pregnancy and childbirth can be constructed as activities that take place in each of the realms of body, mind, emotions, and self individually. Chapters four through seven then examine the variety of relationships between the mind, emotions and self on the one hand and the body on the other. Each chapter then explores the multiple ways that each concept is constructed and negotiated in relation to another. Overall, this research demonstrates that the meanings and interrelationships between body, mind, emotions and self are negotiated throughout the narratives.

Throughout this dissertation, we see that for every reality that is constructed there is a counter-reality. That is, each time a particular notion is established, it is followed by narratives that refute that notion. For example, in chapter five we see that childbearing is often constructed as an emotional experience only to find that childbearing is also constructed as non-emotional. Chapter four demonstrates that mind and body are viewed as separate in one context, influencing each other in another, and integrated and inseparable somewhere else.

Much of the data not presented in this dissertation create a variety of other relationships between the concepts of body, mind, emotions and self. For example, the women in this study also construct multiple relationships between mind and emotion, mind and self, and self and emotion. These relationships were not reported elsewhere for the sake of managing the complexity of this project. Nevertheless, the body, mind, emotion and self relationships reported in this project are not exhaustive of the relationships created throughout women's childbearing narratives.

The variety of ways that the body, mind, emotions and self are constructed in these narratives demonstrate the socially constructed nature of these concepts and the somewhat arbitrary boundaries between them. That the body, mind, emotions and self can be constructed in so many different ways perhaps generates more questions than it does answers. Which construction is the right construction? Which body is the true body? What is the real relationship between the body and mind, body and emotions, and body and self?

According to the social constructionist perspective, these questions are irrelevant, as individuals live according to whatever reality they construct. James Holstein and Jaber Gubrium (2000) argue that the self we construct through social interaction is, for all practical purposes, "the self we live by." It follows then that the socially constructed body, mind and emotions are the true body, mind, and emotions to the reality constructor.

That a single individual can construct the body, mind, emotions and self in so many different ways throughout a single narrative demonstrates that these are negotiated concepts. A certain component becomes salient at different times and is often constructed in relation to another component. In addition, which component an

experience takes place within is a matter of interpretation. Throughout this dissertation, we see the same experience being located in different realms by different women. For example, many women report having high blood pressure, but the causes and meanings of high blood pressure are different for different women. Victoria's narrative in chapter six locates high blood pressure in the realm of the body and constructs the self as responsible for lowering the body's blood pressure. In an excerpt that is not reported elsewhere in this dissertation, Maria constructs her high blood pressure as a response to her heightened emotions that resulted from the terrorist attacks of September 11, 2001. High blood pressure in this context is a physical manifestation of emotion. In chapter six, Isabel speaks of high blood pressure as one component among many that made up her experience immediately before her midwife ruptured her membranes. Whether a woman locates high blood pressure in the realms of body, mind, emotion and/or self is a matter of individual choice and interpretation. In this sense, body, mind, emotions and self are negotiated realms of experience.

Experience and Representation

This research is further complicated by the possible gap between interpretations of lived experience and representations of experience. The women in this study were asked to represent their experiences of being pregnant and giving birth by using words in an interview setting. The words that were available to these women through their language set "conditions of possibility" (Foucault 1977) for how they could articulate their experiences in that setting. In articulating their childbearing experiences, women reconstructed their pregnancies and childbirths within the parameters set by language. Women articulated their experiences as primarily occurring within one or two of the realms of body, mind, emotions and/or self at any given point throughout the narratives.

Which realm an event occurred within and the relationships between these realms were negotiated throughout the narratives, but body, mind, emotions and self were present and distinct in all of these narratives. The question then is do these concepts enable women to adequately portray their experiences? Do the socially constructed concepts of body, mind, emotions and self shape women's experiences or their articulations of their experiences?

I turned to my participants to seek answers to these questions. My participants concluded that pregnancy and childbirth encompass body, mind, emotions and self and that these concepts enabled them to craft cohesive stories. However, they agreed that these concepts fall short of adequately representing their experiences of pregnancy and childbirth.

The first agreed upon conclusion is that the whole woman experiences pregnancy and childbirth. I asked this question directly in follow-up conversations because near the end of my research I went back and reread each interview as a whole. In looking at each narrative as a whole, pregnancy and childbirth are constructed as experiences that involve the "whole person," including the four components of body, mind, emotions and self. Though I never asked specifically about any of these realms, all four of them came up in every interview in this study. Therefore, according to the women in this study, pregnancy and childbirth are physical, mental, emotional and self-encompassing experiences.

In follow-up conversations, women emphasized that one or two components of body, mind, emotions and self might become more salient at certain points during pregnancy and childbirth, but even when one is more salient than the others, the other

components still play into the situation. Sarah provided an example during our follow-up conversation that she encountered during her second pregnancy. Sarah noticed one day that she had varicose veins forming on her leg. Upon this recognition, she began to focus on the bodily changes that were happening with her veins. This bodily change elicited an emotional reaction that was related to Sarah's concept of self. In addition, her mind was at work, making sense of her bodily changes and rationalizing these changes as acceptable and worthwhile because the end result is that she will have another child. Sarah concluded and other women agreed that while pregnancy and childbirth encompass body, mind, emotions and self, these components are not equal all of the time. An individual's focus shifts at times from one concept to another, and the other three contribute to help make sense of the one that is being focused upon.

The second point that was initially made by Annie and subsequently agreed upon by other women in this study is that the experience of pregnancy and childbirth is greater than the sum of its parts. Annie argued that simply compounding the physical, mental, emotional and self-related components of childbearing does not give justice to the magnitude of the experience of being pregnant and giving birth. Additionally, simply including another component such as spirituality does not help convey the grandiosity these women associate with childbearing. The women in this study concluded that the English language simply does not contain adequate concepts for conveying their childbearing experiences.

The third agreed upon conclusion is that in the lived experience of pregnancy and childbirth, body, mind, emotions and self are all acting at once in a way that is pragmatically inseparable. It is only in reflecting on or representing the experience

through language that these concepts are distinguished and compartmentalized. In this sense, the terms body, mind, emotion and self are narrative resources that women retrospectively draw upon to define their experiences. These concepts provide women with resources that enable them to compartmentalize their experiences into the separate realms of body, mind, emotion and self and subsequently negotiate the contents of and boundaries between these concepts. Women's experiences of pregnancy and childbirth, however, are not so neatly compartmentalized.

Concepts and Legitimation

Nikolas Rose argues that research projects that focuses on language and discourse “are most instructive when they focus not on what language *means* but what it does” (1998:178, emphasis in original). Rose instructs researchers who use a social constructionist perspective to focus on the mechanisms of power, relations of ruling and control over the mind that is *accomplished* by language and discourse. Rose's contentions coincide with Michel Foucault's theories of language, discourse and power. Referring to the contemporary discourse of the criminal justice system, in which the human subject is no longer physically punished but rather is reformed and rehabilitated, Foucault writes:

This discourse provided . . . a sort of recipe for the exercise of power over men: the “mind” as a surface of inscription for power, with semiology as its tool; the submission of bodies through the control of ideas; the analysis of representations as a principle in a politics of bodies that was much more effective than the ritual anatomy of torture and execution. (1977:102)

Following Foucault and Rose's insights into power inequalities embedded in language, this section examines the social and political implications of the existence and persistence of the concepts of body, mind, emotion and self. I first examine the concepts

of body, mind, emotion and self in the context of the biomedical model of childbearing and then explore these concepts in the context of social science critiques of biomedicine.

Legitimation and Biomedicine

Many social science researchers have concluded that the biomedical model of pregnancy and childbirth focuses primarily on the body at the exclusion of mind, emotions and self (Davis-Floyd 2001; Hahn 1987; Martin 1992). This conclusion is verified and upheld by obstetricians and medical students (Davis-Floyd 1987; Newton 1987). If these conclusions are correct, the conceptualization of body, mind, emotions and self as separate components of the human being legitimizes the biomedical model of childbirth's exclusive focus on the body. An individual or institution can only focus on the body in isolation from mind, emotions and self within the context of a legitimizing discourse that constructs these concepts as separate, unrelated components of the human being. The existence of the concepts themselves that compartmentalize the human being into distinct and unrelated components legitimizes the biomedical model of childbearing's focus on the body at the exclusion of mind, emotions and self. In this sense, body, mind, emotion and self are legitimizing concepts that validate and perpetuate the biomedical model of childbearing.

The biomedical model's emphasis on the physical body at the exclusion of mind, emotions and self assists in the functions and daily operations of the biomedical institution and has broader implications for childbearing women and their babies. In terms of the everyday functioning and perpetuation of the medical industry, the isolation of the body from the rest of the individual reflects Max Weber's (1998/1930) notion of "practical rationalism." The goal of the medical institution in the United States as a profit-driven industry is to serve the greatest number of people in the least amount of

time. Isolating the body from other components of the human being enables the medical institution to meet this goal. As Chris Cosans (2001) points out, the biomedical practice of viewing and treating the body as a machine eases the institution's task of treating individual patients because individual difference and subjectivity is irrelevant.

The isolation of the body from other aspects of the human being along with medical practitioners' "authoritative knowledge" (Jordan 1993, 1997; Starr 1982) of the body also ensures a continuing base of biomedical consumers. This is particularly relevant in the case of childbearing as opposed to other contexts in which the expertise of medical professionals is sought, such as in the case of illness. Childbearing is not an illness and much research and demographic calculations indicate that biomedicine is unnecessary for the management of low-risk, healthy pregnancy and childbirth (World Bank 1999; World Health Organization 1997, 1999) and actually *increases* the risk of maternal and fetal mortality (Rooks 1997). Nevertheless, 98% of childbearing women in the United States give birth in hospitals with the assistance of biomedical healthcare providers (Boston Woman's Health Book Collective 1998). The isolation of the body from other facets of the human being, the notion that pregnancy and childbirth are, above all, physical experiences, and the perception of biomedical expert and authoritative knowledge of the inner workings of the human body ensure a continuing consumer base for healthcare providers who work within the biomedical model of childbearing.

Legitimation and Critiques of the Biomedical Model

The concepts of body, mind, emotions and self also legitimize social science critiques of the biomedical model of childbearing. The critique that the biomedical model focuses solely on the body-as-machine at the exclusion of mind, emotions and self employs these same concepts and dichotomies that are critiqued within the biomedical

model. It is possible that these critiques are overly simplistic. While there is a great deal of evidence to support the notion that laboring women's bodies are viewed as machines, and therefore objectified (Davis-Floyd 1987, 1992, 2001; Hahn 1987; Martin 1992) they are viewed as machines *at work*. Uterine contractions and cervical dilation are activities that take place within an active body. To what extent, then, is the body viewed as both a passive object and an active subject in the theory, discourse and practice of biomedicine and how are these two seemingly contradictory definitions negotiated?

Critiques of the biomedical model also charge that pregnant and birthing women are robbed of their subjectivity and personhood, and are viewed as passive beings throughout most of labor and birth. There is a great deal of empirical evidence to support this perspective (Davis-Floyd 1992; Hahn 1987; Martin 1992). However, logically speaking, the woman has to become an active subject at some point during a vaginal delivery, as she is called upon to push the baby out of her body. While it may be true that in the most medical of scenarios she is instructed to push only upon doctor command and the need to push is determined by a machine that measures uterine contractions, the act of pushing necessarily requires the woman to become an active subject.

The question then is not whether the woman is viewed as active or passive within the biomedical model of childbirth, but to what extent is she viewed as active, to what extent is she viewed as passive, and how are these (seemingly) contradictory definitions managed and negotiated in the practice of the biomedical management of labor and birth? Future research should look beyond either/or dichotomous concepts in its critical analyses of biomedicine to uncover the ways that women are viewed as both active subjects and passive objects and how the concepts of body, mind, emotions and self are

managed and negotiated in healthcare providers' narratives of births, in reference texts, and in the everyday practice of contemporary obstetrics.

Practical Implications

Healthcare Providers and Childbearing Women

This research has practical implications for the care and treatment of childbearing women. This project has demonstrated that women perceive pregnancy and childbirth as experiences that encompass body, mind, emotions and self. It is the whole woman rather than her parts that becomes pregnant and gives birth. At the same time, different women construct body, mind, emotions and self differently, and express greater concern over certain components at different times throughout pregnancy and childbirth.

This information is useful for healthcare providers in two ways. First, as many other researchers have argued, the reductionist view of the childbearing woman as a body-machine that is purportedly embedded in the biomedical model of childbirth is inconsistent with women's views of themselves throughout childbearing. Women view themselves as whole selves, consisting of a mind, emotions and self as well as a body. Women's desires to be afforded more agency and have greater emphasis and acknowledgment of their mental and emotional experiences during childbearing often result in women's dissatisfaction with their childbirth experiences (Campero et al. 1998; Fowles 1998). Women's dissatisfaction with their birthing experiences and perceived lack of social support are consistently found to be strong predictors of postpartum depression (Johnstone et al. 2001; Marshall 1995; Oweis 2001) and post-traumatic stress symptoms (Czamocka and Slade 2000; Soet 2002), which are linked to low levels of breastfeeding (Field et al. 2002; Galler et al. 1999) negative perceptions of infants (Cohn et al. 1990; Whiffen and Gotlib 1989), and lower levels of intellectual development in

children (Brennan et al. 2000; Sharp et al. 1995). Healthcare providers who are trained within the biomedical model of childbearing could improve the care they provide to pregnant and birthing women by placing more emphasis on the woman as a whole person and focusing more attention on the mental and emotional components of childbearing.

Healthcare providers could also attend to women's individual definitions of the relationships between their bodies, minds, emotions and selves. As we have seen throughout this project, not all women define these relationships the same way. How a woman defines these components of her self may impact the type of care that she will be most satisfied with. Healthcare providers could investigate women's perceptions of these different realms and tailor their care accordingly.

This research also has implications for childbearing women. The women in this study construct a variety of relationships between body, mind, emotions and self, and some of these components are more important to some women than to others. Childbearing women can explore their own perceptions of these relationships and determine which aspects are most important to them before selecting a healthcare provider. Each woman can then make an informed choice about selecting a healthcare provider that will attend to the needs that she deems most important.

For some of the women in this study, the greatest concern for giving birth is feeling that her physical body and the body of her child are safe. For some of these women, physical safety means having advanced medical technology easily accessible for the event that a problem should arise. Women who perceive the body and medical technology in this way will benefit from giving birth in hospitals where medical technology is abundant. For other women, feeling physically safe means avoiding

medical technologies that are known to increase the risk of cesarean, which increases the risk of fetal and maternal mortality. These women benefit from giving birth in out-of-hospital settings where certain medical technologies are not readily available and healthcare providers are prepared to assist women in giving birth without medical interventions. It is important for women to determine what their own needs are and carefully select healthcare providers that will meet those needs.

Models of Healthcare for Childbearing Women

The disruption of the categories of body, mind, emotions and self also creates a space for the creation of new models of healthcare for pregnant and birthing women. Scott Sharpe (1999) points out that current healthcare debates surrounding childbearing employ dualistic concepts with the biomedical model on the one hand, encompassing medicine, technology, hospitals, the public sphere, paternalism and masculinity and the midwifery model on the other hand, encompassing nature, home, the private sphere, autonomy and femininity. He argues that this polarity limits women's childbearing choices in both models of care, with women in the biomedical system unable to refuse certain medical technologies and women in the midwifery model unable to utilize certain medical technologies. In addition, many feminist groups and activists have resisted embracing the midwifery model of care and the home birth movement due to their concern that this association will reinforce women's association with the natural, private and feminine and further strengthen women's subordinate status in a society that values technology, the public sphere and masculinity (Pringle 1998).

The disruption of the binary concepts that lie at the heart of this debate creates a space for the development of new models of childbearing that are all encompassing, focus on the whole woman, and are tailored and individualized to meet each woman's

unique needs. This type of healthcare model is likely to improve women's satisfaction with childbearing, thereby improving the overall physical and psychological health of women and their babies.

As stated earlier, the disruption of these concepts also provides a space for new evaluations of current models of care that examine the constructions and negotiations of concepts to evaluate the extent to which one definition or another is used in theory, discourse and practice. Research on midwives indicates that midwives utilize and negotiate biomedical and natural discourses throughout their work narratives (Foley and Faircloth 2003). Future research could focus on the similarities and differences between midwives and obstetricians in their constructions and negotiations of body, mind, emotions and self; subjectivity and objectivity; and nature and biomedicine/technology. This research could also extend beyond narratives to include text analysis and participant observation.

Beyond Childbearing

Body, Mind, Emotions and Self in Other Contexts

The insights gained from this dissertation can be generalized beyond the experiences of pregnancy and childbirth. Robbie Davis-Floyd states,

As individuals within a society shape birth, so shall they shape social life. The core values and beliefs of both individual women and the wider society in which they live condense into visible, focused form in childbirth, where their perpetuation is either assured or denied. (1992: 307)

Davis-Floyd argues that childbirth can be viewed as a microcosm that represents an entire society's way of life. Therefore, research on childbearing lends insights into the ideologies and practices of a society at large.

While writing this dissertation, I noticed that the ways that the women in this study construct body, mind, emotions and self also applied to the process of writing a dissertation. Writing a dissertation is not solely an intellectual endeavor. Rather, my whole self—body, mind, emotions and self—have been involved in this process, with different components becoming more salient at different times. Throughout the first stages of writing, I engaged in the “mental work” of conceptualizing the dissertation. My emotions and perceptions of self during this phase were also salient as I felt fear and anxiety that I would not be able to accomplish my goals. As the dissertation progressed, my physical body became tired and my hands and wrists began to ache from writing and typing. Like the women in this study, I constructed my dissertation writing experience as encompassing body, mind, emotions and self. At some points a particular component would become more salient while at other times everything was firing at once.

I also constructed a variety of relationships between my body, mind, emotions and self throughout this dissertation process. When fear and self-doubt were salient, I felt physical manifestations of these emotions in my body in the forms of increased heartbeat and nausea. I also did certain things to my body such as exercise, eat certain foods, take vitamins and drink coffee for the sole purpose of stimulating my mind. These are just a few of the body/mind/emotion/self relationships that I constructed throughout the process of writing this dissertation.

In this way, the insights this dissertation provides about the body, mind, emotions and self can also be applied to an educational endeavor and therefore extend beyond pregnancy and childbirth. Social scientists have begun to address some of these issues in the areas of health and illness (Gadow 1980; Garro 1992; Williams and Bendelow 1996),

education (Roth and Bowen 2001), pain (Bendelow and Williams 1995; Good 1992; Morse and Mitcham 1998) and emotion (Hochschild 1979, 1983; Williams 2003; Williams and Bendelow 1996). The further development of these ideas within these substantive areas and their exploration in other realms of social life such as work and employment, parenting, and politics can contribute to our broader theoretical understanding of the human individual and its relationship to society. In addition, this research could provide a point of comparison to see the ways that childbearing is both similar and different from other social experiences.

Concepts and Inequalities

The multiple ways that the concepts of body, mind, emotion and self are socially constructed and negotiated that have been demonstrated throughout this project contributes to broader theories of social inequalities. Many social theorists have argued that domination by one group over another relies on either/or dichotomous thinking that is embedded in Western thought and culture (Ani 1994; Collins 2000; Glen 1999; Hawkins 1998; Lorber 1993; Ortner 1974; Said 1993). Dualistic concepts such as mind/body, reason/emotion, culture/nature, man/woman, self/other are viewed not just as different and oppositional but as intrinsically hierarchical. This dualistic conceptual thinking, it is argued, lies at the root of contemporary systems of domination. In terms of gender, childbearing is a central component of the male/female dichotomy as women are purportedly associated with the “lesser” realms of body, emotion and nature as a result of their reproductive capacities (Firestone 1971; Ortner 1974).

Much interdisciplinary research and theory has focused on disrupting this dualistic conceptual thinking by demonstrating the socially constructed nature of these concepts. One method of reaching this broader objective is to demonstrate the socially constructed

nature of the categories that are assumed to represent natural or biological differences between people, such as sex (Fausto-Sterling 2000; Lorber 1993; Petersen 1998), race (Davis 1991; Omi and Winant 1986; Rasmussen et al. 2001), ethnicity (Pilkington 2002; Said 1979) and sexual orientation (Greenberg 1990; Kamano and Khor 1996; Ringer 1994). A second method of obtaining this objective is to demonstrate the socially constructed nature of the categories that each group is associated with such as nature/culture (Fausto-Sterling 2000; Hawkins 1998), mind/body (Ani 1994), and emotion/reason (Williams 2003).

This project has sought to disrupt some of this dichotomous conceptual thinking by demonstrating the negotiated and fluid relationships between mind and body, reason and emotion, and subject and object. In addition, this project has aimed to demonstrate that the individual is not concretely divided into the separate components of body, mind, emotions and self. Rather, body, mind, emotions and self are merely concepts that are used to make sense of human experience. The goal of this project is not to attempt to align women more with culture, mind and reason than nature, body and emotion as some feminist theorists have advocated (Firestone 1971; Ortner 1975) but to demonstrate the existence and contribute to the development of a continuous rather than dichotomous worldview.

APPENDIX A
PARTICIPANT HEALTHCARE AND CHILDBIRTH DESCRIPTIONS

Aimee

Aimee gave birth in a hospital with an obstetrician. She received epidural anesthesia and gave birth vaginally with vacuum extraction.

America

America gave birth in a birth center with a midwife. She gave birth vaginally with no medical interventions. America became pregnant again after the interview and gave birth to her second son at home with a midwife.

Annie

Annie gave birth in a hospital with a Certified Nurse Midwife. She gave birth vaginally with no medical interventions.

Cindy

Cindy gave birth in a birth center with a midwife. She gave birth vaginally with no medical interventions throughout her birth. Cindy was given pitocin after her birth to manage bleeding.

Elizabeth

Elizabeth gave birth vaginally in a hospital with an obstetrician. She received pitocin and epidural anesthesia.

Francis

Both of Francis' births took place in a hospital with an obstetrician. She gave birth vaginally with an epidural both times. Francis also received morphine during her first birth.

Isabel

Isabel planned to give birth in a birth center. After 36 hours of labor, she transferred to a hospital where she gave vaginal birth with vacuum extraction and epidural anesthesia.

Jasmine

Jasmine gave birth at home with a Licensed Midwife. She gave birth vaginally with no medical interventions.

Kristy

Kristy gave birth in a hospital with a Certified Nurse Midwife. She gave birth vaginally with pitocin and epidural anesthesia. Kristy was pregnant with her second child during the interview.

Maria

Maria gave birth in a hospital with an obstetrician. Her labor was induced with pitocin. She gave birth vaginally with the use of epidural anesthesia.

Meka

Meka gave birth in a hospital with an obstetrician. She gave birth vaginally with morphine and her contractions were induced with pitocin.

Rebecca

Rebecca gave birth in her home with a midwife. She gave birth vaginally with no medical interventions. Rebecca gave birth to her second child at home after the interview.

Sarah

Sarah gave birth in a hospital with an obstetrician. She gave birth vaginally with vacuum extraction and epidural anesthesia.

Seva

Seva gave birth to her third son in her home with a midwife. She gave birth vaginally with no medical interventions. Seva's first two children were born in a hospital with an obstetrician.

Susan

Susan gave birth to both children in a hospital with an obstetrician. She gave birth both times by cesarean section. The first birth was a cesarean because her baby was breech. Susan's doctor recommended that she give birth by cesarean for her second birth because her first had been a cesarean. Both of Susan's children were conceived using in-vitro fertilization.

Teresa

Teresa gave birth in a hospital with an obstetrician. Her labor was induced with pitocin and she received epidural anesthesia. After laboring for two and a half days, Teresa gave birth by cesarean.

Tracy

Tracy gave birth to her second child in a hospital with an obstetrician. She gave birth vaginally with an epidural. Her first birth took place in a birth center that was affiliated with a hospital.

Victoria

Victoria gave birth in a hospital with an obstetrician. She gave birth vaginally with an epidural.

APPENDIX B
INTERVIEW GUIDE FOR PRELIMINARY INTERVIEWS

- Tell me about your pregnancy.
- Tell me about your birth.
- Overall, how did you feel about the care you received?
- What role did your partner play in your pregnancy and childbirth?
- If you had the opportunity to trade places with your partner and have him go through the pregnancy and birth, would you?
- Was this your first pregnancy?
- What is your race?
- What is your social class?

APPENDIX C
INTERVIEW GUIDE

- Tell me about your pregnancy.
- What was it like being pregnant?
- How did you feel during your pregnancy?
- If you had to describe pregnancy in just a few words, how would you describe it? Why?
- Tell me about your birth.
- What was it like giving birth?
- How did you feel while you were giving birth?
- If you had to describe birth in just a few words, how would you describe it? Why?
- Where did you plan to give birth? Why did you choose to give birth at (location)?
- Is there anything about your birth that you wish you had done differently?
- Who else was present at your birth? What did they do?
- What was it like after you gave birth?
- How did you feel after you gave birth?
- How did you feel about yourself after you gave birth?
- How did you feel about your baby after you gave birth?
- If you had to describe the initial postpartum period in a few words, how would you describe it? Why?
- What role did (the father) play in your pregnancy and birth?
- Do you think your partner's experience of pregnancy and childbirth was any different from yours? Why/Why Not? In what ways?

- Let's say it was possible for you to switch places with your partner and him go through the pregnancy and birth instead of you – would you do that?
- What did you do to prepare for your birth?
- Did you read any books or pamphlets about pregnancy or childbirth while you were pregnant? What did you read? How did they prepare you for pregnancy and childbirth?
- Did you take any childbirth education classes? What topics did they cover? How did they prepare you for birth?
- Did you do anything else to prepare for birth (talk to others who had given birth)?
- What is your social class?
- What is your race?
- What is your current relationship with the father of your child?
- How old are you?
- How old were you when you found out you were pregnant?
- How old were you when you gave birth?
- Was this your first birth? (If no, how many?)
- Where did you give birth?
- What type of insurance did you have at the time? What did it cover?
- What is your current level of education?
- Are you currently employed? Were you employed before the birth of your child?

LIST OF REFERENCES

- American College of Nurse-Midwives. 2003. "What is the Difference Between a Nurse-Midwife, Midwife, and Doula?"
<http://www.acnm.org/focus/thinking/difference.cfm> Retrieved 2/20/04.
- Ani, Marimba. 1994. *Yurugu: An African-Centered Critique of European Cultural Thought and Behavior*. Trenton, NJ: African World Press.
- Arms, Suzanne. 1994. *Immaculate Deception II: A Fresh Look at Childbirth*. Berkeley, CA: Celestial Arts.
- Barber, Jennifer S. 2001. "The Intergenerational Transmission of Age at First Birth among Married and Unmarried Men and Women." *Social Science Research* 30(2):219-247.
- Bartky, Sandra Lee. 1990. *Femininity and Domination: Studies in the Phenomenology of Oppression*. New York, NY: Routledge.
- Beck, Ulrich and Elisabeth Beck-Gernsheim. 1995. *The Normal Chaos of Love*. Cambridge, MA: Polity Press.
- Bendelow, Gillian and Simon J. Williams. 1995. "Pain and the Mind-Body Dualism: A Sociological Approach" *Body & Society* 1(2):83-104.
- Berger, Peter L. and Thomas Luckmann. 1966. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. New York, NY: Anchor Books.
- Beutel, Ann M. 2000. "The Relationship between Adolescent Nonmarital Childbearing and Educational Expectations: A Cohort and Period Comparison." *The Sociological Quarterly* 41(2):297-314.
- Blumer, Herbert. 1969. *Symbolic Interactionism: Perspective and Method*. Berkeley, CA: University of California Press.
- Bordo, Susan. 1993. *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley, CA: University of California Press.
- Boston Women's Health Book Collective. 1998. *Our Bodies, Ourselves For the New Century*. New York, NY: Touchstone.
- Bourdieu, Pierre. 1990. *The Logic of Practice*. Cambridge, MA: Polity Press.

- Brennan, Patricia A., Constance Hammen, Margaret J. Anderson, William Bor, Jake M. Najman and M. Gail. 2000. "Chronicity, Severity, and Timing of Maternal Depressive Symptoms: Relationships with Child Outcomes at Age 5." *Developmental Psychology* 36(6):759-781.
- Butler, Judith. 1999. *Gender Trouble: Feminism and the Subversion of Identity*. New York, NY: Routledge.
- Campero, Lourdes, Cecilia Garcia, Carmen Diaz, Olivia Ortiz, Sofia Reynoso and Ana Langer. 1998. "'Alone, I Wouldn't Have Known What to Do': A Qualitative Study on Social Support During Labor and Delivery in Mexico." *Social Science & Medicine* 47(3):395-403.
- Chalmers, Beverley and Wendy-Lynne Wolman. 1993. "Social Support in Labor—A Selective Review." *Journal of Psychosomatic Obstetrics and Gynecology* 14(1):1-15.
- Charles, Nickie and Marion Kerr. 1986. "Food for Feminist Thought." *Sociological Review* 34(3):537-572.
- Charmaz, Kathy. 2002. "Qualitative Interviewing and Grounded Theory Analysis." Pp. 675-694 in *Handbook of Interview Research: Context and Method*, edited by Jaber F. Gubrium and James A. Holstein. Thousand Oaks, CA: Sage.
- Charmaz, Kathy. 2000. "Grounded Theory: Objectivist and Constructionist Methods." Pp. 509-535 in *Handbook of Qualitative Research, Second Edition*, edited by Norman K. Denzin and Yvonna S. Lincoln. Thousand Oaks, CA: Sage.
- Chernin, Kim. 1981. *The Obsession: Reflections on the Tyranny of Slenderness*. New York, NY: Harper and Row.
- Cicourel, Aaron. 1974. *Cognitive Sociology: Language and Meaning in Social Interaction*. New York, NY: Free Press.
- Cohen, Nancy Wainer and Loise Estner. 1983. *Silent Knife: Cesarean Prevention and Vaginal Birth after Cesarean*. New York, NY: Bergin and Garvey.
- Cohn, Jeffrey F., Susan B. Campbell, Reinaldo Matias, and J. Hopkins. 1990. "Face-to-Face Interactions of Postpartum Depressed and Non-Depressed Mother-Infant Pairs at 2 Months." *Developmental Psychology* 26(1):15-37.
- Collins, Patricia Hill. 2000. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York, NY: Routledge.
- Corea, Gena. 1985. *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*. New York, NY: Harper and Row.
- Cosans, Chris. 2001. "The Embodiment of Birth." *Theoretical Medicine* 22:47-55.

- Coulter, Jeff. 1986. "Affect and Social Context: Emotion Definition as a Social Task." Pp. 120-134 in *The Social Construction of Emotions*, edited by Rom Harre. Oxford: Basil Blackwell.
- Cuthbertson-Johnson, Beverley, David D. Franks and Michael Dornan. 1994. *The Sociology of Emotions: An Annotated Bibliography*. New York, NY: Garland.
- Czamočka, Jo and Pauline Slade. 2000. "Prevalence and Predictors of Post-Traumatic Stress Symptoms Following Childbirth." *British Journal of Clinical Psychology* 39(1):35-51.
- Davis, James F. 1991. *Who is Black? One Nation's Definition*. University Park, PA: Pennsylvania State University Press.
- Davis-Floyd, Robbie. 2001. "The Technocratic, Humanistic, and Holistic Paradigms of Childbirth." *International Journal of Gynecology & Obstetrics* 75(S1):S5-S23.
- Davis-Floyd, Robbie. 1992. *Birth as an American Rite of Passage*. Berkeley, CA: University of California Press.
- Davis-Floyd, Robbie. 1987. "Obstetric Training as a Rite of Passage." *Medical Anthropology Quarterly* 1(3):288-317.
- de Beauvoir, Simone. 1989/1952. *The Second Sex*. New York, NY: Vintage Books.
- Descartes, Rene. 1901. *A Discourse on Method: Meditations and Principles*. London: Everyday Paperbacks.
- Douglas, Jack D. 1985. *Creative Interviewing*. Beverly Hills, CA: Sage.
- Drobnic, Sonja. 2000. "The Effects of Children on Married and Lone Mothers' Employment in the United States and (West) Germany." *European Sociological Review* 16(2):137-157.
- DuPleissis, Helen M., Robert Bell and Toni Richards. 1997. "Adolescent Pregnancy: Understanding the Impact of Age and Race on Outcomes" *Journal of Adolescent Health* 20(3):187-197.
- Earle, Sarah. 2003. "'Bumps and Boobs': Fatness and Women's Experiences of Pregnancy." *Women's Studies International Forum* 26(3):245-252.
- Eisenberg, Arlene, Heidi E. Murkoff and Sandee E. Hathaway. 1996. *What to Expect When You're Expecting*. New York, NY: Workman Publishing Company.
- Ellis, Carolyn and Leigh Berger. 2002. "Their Story/My Story/Our Story: Including the Researcher's Experience in Interview Research." Pp. 849-876 in *Handbook of Interview Research: Context and Method*, edited by Jaber F. Gubrium and James A. Holstein. Thousand Oaks, CA: Sage.

- Faircloth, Christopher, Craig Boylstein, Maude Rittman and Mary Ellen Young. 2004. "Disrupted Bodies: Experiencing the Newly Limited Body in Stroke" *Symbolic Interaction* 27(1):71-87.
- Fausto-Sterling, Anne. 2000. *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York, NY: Basic Books.
- Featherstone, Mike. 1991. "The Body in Consumer Culture." Pp. 170-196 in *The Body: Social Process and Cultural Theory*, edited by Mike Featherstone, Mike Hepworth and Brian Turner. London: Sage.
- Featherstone, Mike and Mike Hepworth. 1991. "The Mask of Ageing and the Post-modern Life Course." Pp. 371-389 in *The Body: Social Process and Cultural Theory*, edited by Mike Featherstone, Mike Hepworth and Brian Turner. London: Sage.
- Field, Tiffany, Maria Hernandez-Reif and Larissa Feijo. 2002. "Breastfeeding in Depressed Mother-Infant Dyads." *Early Childhood Development and Care* 172(6):539-545.
- Firestone, Shulamith. 1971. *The Dialectic of Sex: The Case for Feminist Revolution*. New York, NY: Bantam Books.
- Foley, Lara and Christopher A. Faircloth. 2003. "Medicine as Discursive Resource: Legitimation in the Work Narratives of Midwives." *Sociology of Health & Illness* 25(2):165-184.
- Foucault, Michel. 1980. *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. London: Harvester.
- Foucault, Michel. 1977. *Discipline and Punish: The Birth of the Prison*. New York, NY: Vintage Press.
- Foucault, Michel. 1977. *Power/Knowledge*. New York, NY: Pantheon.
- Fowles, Eileen R. 1998. "Labor Concerns of Women Two Months After Delivery" *Birth* 25(4):235-240.
- Franklin, Donna L. 1988. "Race, Class and Adolescent Pregnancy: An Ecological Analysis" *American Journal of Orthopsychiatry* 58(3):339-354.
- Freidson, Eliot. 1970. *The Profession of Medicine*. New York: Dodd Mead and Co.
- Freund, Peter. 1990. "The Expressive Body: A Common Ground for the Sociology of Emotions and Health and Illness." *Sociology of Health and Illness* 12(4):452-477.

- Friedrich, William N., Theresa M. Jaworski, John E. Huxsahl and Brad S. Bengtson. 1997. "Dissociative and Sexual Behaviors in Children and Adolescents with Sexual Abuse and Psychiatric Histories." *Journal of Interpersonal Violence* 12(2):155-171.
- Gadow, Sally. 1980. "Body and Self: A Dialectic." *Journal of Medicine and Philosophy* 5:172-185.
- Galler, Janinia R., Robert H. Harrison, Antonia M. Biggs, Frank Ramsey and Victor Forde. 1999. "Maternal Moods Predict Breastfeeding in Barbados." *Journal of Developmental and Behavioral Pediatrics* 20(2):80-87.
- Garfinkel, Harold. 1967. *Studies in Ethnomethodology*. Englewood Cliffs, NJ: Prentice Hall.
- Garfinkel, Harold and Harvey Sacks. 1970. "On the Formal Structures of Practical Actions." Pp. 337-366 in *Theoretical Sociology: Perspectives and Developments*, edited by John C. McKinney and Edward A. Tiryakian. New York, NY: Appleton-Century-Crofts.
- Garro, Linda C. 1992. "Chronic Illness and the Construction of Narratives." Pp. 100-137 in *Pain as Human Experience: An Anthropological Perspective*, edited by Mary-Jo Delvecchio Good, Paul E. Brodwin, Byron J. Good and Arthur Kleinman. Berkeley, CA: University of California Press.
- Giddens, Anthony. 1992. *The Transformation of Intimacy: Love, Sexuality and Eroticism in Modern Societies*. Cambridge, MA: Polity Press.
- Giddens, Anthony. 1984. *The Constitution of Society*. Cambridge, MA: Polity Press.
- Gillespie, Clark. 1992. *Your Pregnancy Month by Month: A Comprehensive Guide and Personal Diary from Conception to Birth*. New York, NY: Harper-Perennial.
- Giugliani, Elsa R. 1994. "Breastfeeding: How and Why to Promote it." *Journal of Pediatrics* 70(3):138-151.
- Glaser, Barney G. and Anslem L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, IL: Aldine.
- Glen, Evelyn Nakano. 1999. "The Social Construction and Institutionalization of Gender and Race: An Integrative Framework." Pp. 23-63 in *Revisioning Gender*, edited by Myra Marx Ferree, Judith Lorber and Beth B. Hess. Thousand Oaks, CA: Sage.
- Goer, Henci. 1999. *The Thinking Woman's Guide to a Better Birth*. New York, NY: Perigee.
- Goer, Henci. 1995. *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*. Westport, CT: Bergin & Garvey.

- Good, Byron J. 1992. "A Body in Pain – The Making of a World of Chronic Pain." Pp. 29-48 in *Pain as Human Experience: An Anthropological Perspective*, edited by Mary-Jo Delvecchio Good, Paul E. Brodwin, Byron J. Good and Arthur Kleinman. Berkeley, CA: University of California Press.
- Greenberg, David F. 1990. *The Construction of Homosexuality*. Chicago, IL: University of Chicago Press.
- Gubrium, Jaber F. 1986. "The Social Preservation of Mind: The Alzheimer's Disease Experience." *Symbolic Interaction* 9(1):37-51.
- Gubrium, Jaber F. and James A. Holstein. 2002. *Handbook of Interview Research: Context and Method*. Thousand Oaks, CA: Sage.
- Gubrium, Jaber F. and James A. Holstein. 2001. *Institutional Selves: Troubled Identities in a Postmodern World*. New York, NY: Oxford University Press.
- Gubrium, Jaber F. and James A. Holstein. 1997. *The New Language of Qualitative Method*. New York, NY: Oxford University Press.
- Hahn, Robert A. 1987. "Divisions of Labor: Obstetrician, Woman, and Society in *Williams Obstetrics*, 1903-1985." *Medical Anthropology Quarterly* 1(3):256-282.
- Hanna, Barbara. 2001. "Adolescent Parenthood: A Costly Mistake or a Search for Love?" *Reproductive Health Matters* 9(17):101-107.
- Hanson, Lars A., Marina Korotkova, and Esbjorn Telemo. 2003. "Breast-feeding, Infant Formulas, and the Immune System." *Annals of Allergy and Asthma Immunology* 90(6 Supplement 3):59-63.
- Haraway, Donna J. 1991. *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York, NY: Routledge.
- Hawkins, Ronnie Zoe. 1998. "Ecofeminism and Nonhumans: Continuity, Difference, Dualism, and Domination." *Hypatia* 13(1):158-197.
- Hegel, Georg Wilhelm Friedrich. 1948/1802. *Early Theological Writings*. Chicago, IL: University of Chicago Press.
- Helman, Cecil. 1990. *Culture, Health and Illness*. London: Wright.
- Hochschild, Arlie Russell. 1983. *The Managed Heart: The Commercialisation of Human Feeling*. Berkeley, CA: University of California Press.
- Hochschild, Arlie Russell. 1979. "Emotion Work, Feeling Rules and Social Structure." *American Journal of Sociology* 85:551-75.

- Holstein, James A. and Jaber F. Gubrium. 2003. *Inner Lives and Social Worlds: Readings in Social Psychology*. New York, NY: Oxford University Press.
- Holstein, James A. and Jaber F. Gubrium. 2000. *The Self We Live By: Narrative Identity in a Postmodern World*. New York, NY: Oxford University Press.
- Holstein, James A. and Jaber F. Gubrium. 1995. *The Active Interview*. Thousand Oaks, CA: Sage.
- Iovine, Vicki. 1995. *The Girlfriends' Guide to Pregnancy*. New York, NY: Pocket Books.
- Jacobs, Sheila C. 1997. "Employment Changes Over Childbirth: A Retrospective View." *Sociology* 31(3):577-590.
- Jaggar, Alison M. 1989. "Love and Knowledge: Emotion in Feminist Epistemology." Pp. 145-171 in *Gender/Body/Knowledge: Feminist Reconstructions of Being and Knowing*, edited by Alison M. Jaggar and Susan R. Bordo. New Brunswick, NJ: Rutgers University Press.
- James, Veronica and Jonathan Gabe. 1996. *Health and the Sociology of Emotions*. Oxford: Blackwell.
- James, William and Carl Lange. 1922. *The Emotions*. Baltimore, MD: Wilkins and Wilkins.
- Johnstone, Stuart J., Phillip M. Boyce, Anthea R. Hickey, Allen D. Morris-Yates, and Meredith G. Harris. 2001. "Obstetric Risk Factors for Postnatal Depression in Urban and Rural Community Samples." *Australian and New Zealand Journal of Psychiatry* 35(1):69-74.
- Jordan, Brigitte. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Prospect Heights, IL: Waveland.
- Jordan, Brigitte. 1997. "Authoritative Knowledge and Its Construction." Pp. 55-79 in *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, edited by Robbie E. Davis-Floyd and Carolyn F. Sargent. Berkeley, CA: University of California Press.
- Kamano, Saori and Diana Khor. 1996. "Toward and Understanding of Cross-National Differences in the Naming of Same-Sex Sexual/Intimate Relationships." *NWSA Journal* 8:124-141.
- Kerbo, Harold R. 1991. *Social Stratification and Inequality: Class Conflict in Historical and Comparative Perspective*. New York, NY: McGraw-Hill.

- Keys, Jennifer Lynn. 2003. *Emotion Work in Women's Abortion Experiences*. Ph.D. Dissertation, State University of New York, Albany, New York.
- Kitzinger, Sheila. 1990. *The Crying Baby*. New York, NY: Penguin Books.
- Kitzinger, Sheila. 1992. "Birth and Violence Against Women: Generating Hypotheses from Women's Accounts of Unhappiness after Childbirth." Pp. 63-80 in *Women's Health Matters*, edited by Helen Roberts. New York, NY: Routledge.
- Krakow, Irving. 2002. *Why the Mind-Body Problem Cannot be Solved! Some Final Conclusions in the Philosophy of Mind*. Lanham, MD: University Press of America.
- Kristeva, Julia. 1982. *Powers of Horror: An Essay on Abjection*. New York, NY: Columbia University Press.
- Lamaze, Fernand. 1984/1970. *Painless Childbirth: The Lamaze Method*. Chicago, IL: Contemporary Books Inc.
- Lamaze International. 2001. "Lamaze for the 21st Century." <http://www.lamaze.org/About/documents/Lamaze21stCentury.pdf> Retrieved 3/06/04.
- Langer, Ana, Lourdes Campero, Cecilia Garcia and Sofia Reynoso. 1998. "Effects of Psychosocial Support During Labour and Childbirth on Breastfeeding, Medical Interventions, and Mothers' Wellbeing in a Mexican Public Hospital: A Randomised Clinical Trial." *British Journal of Obstetrics and Gynaecology* 105(10):1056-63.
- Lawler, Jocalyn. 1991. *Behind the Screens: Nursing, Somology and the Problem of the Body*. London: Churchill Livingstone.
- Leder, Drew. 1990. *The Absent Body*. Chicago, IL: University of Chicago Press.
- Lee, Meng-Chih. 2001. "Family and Adolescent Childbearing." *Journal of Adolescent Health* 28(4):307-312.
- Longhurst, Robyn. 1999. "Pregnant Bodies, Public Scrutiny: 'Giving' Advice to Pregnant Women." Pp. 78-90 in *Embodied Geographies: Space, Bodies and Rites of Passage*, edited by Elizabeth Kenworthy Teather. London: Routledge.
- Longhurst, Robyn. 1998. "(Re)presenting Shopping Centres and Bodies: Questions of Pregnancy." Pp. 20-34 in *New Frontiers of Space, Bodies and Gender*, edited by Rosa Ainley. London: Routledge.
- Lorber, Judith. 1993. "Believing is Seeing: Biology as Ideology." *Gender & Society* 7:13-22.

- Loseke, Donileen R. 2001. "Lived Realities and Formula Stories of 'Battered Women.'" Pp. 107-126 in *Institutional Selves: Troubled Identities in a Postmodern World*, edited by Jaber F. Gubrium and James A. Holstein. New York, NY: Oxford University Press.
- Lowe, Claudia. 1992. "Childhood Sexual Abuse and Birthing Women." *Midwifery Today and Childbirth Education* 36:35-38.
- Lupton, Deborah. 1998. "Going With the Flow: Some Central Discourses in Conceptualising and Articulating the Embodiment of Emotional States." Pp. 82-99 in *The Body in Everyday Life*, edited by Sarah Nettleton and Jonathan Watson. London: Routledge.
- Lynch, James J. 1977. *The Broken Heart: The Medical Consequences of Loneliness*. New York, NY: Basic Books.
- MacCormack, Carol. 1977. "Biological Events and Cultural Control" *Signs* 3:93-100.
- Maguire, Jessica P. 2002. *Ecstatic Pain and a Labor of Love: Emotion Praxis and the Midwifery Movement*. Ph.D. Dissertation, Ohio State University, Columbus, OH.
- Mannheim, Karl. 1936. *Ideology and Utopia: An Introduction to the Sociology of Knowledge*. San Diego, CA: Harvest.
- Marshall, Harriette and Anne Woollett. 2000. "Fit to Reproduce? The Regulative Role of Pregnancy Texts." *Feminism and Psychology* 10(3):351-366.
- Marshall, Mary Ellen. 1995. *Women's Psychological Adjustment to the First Experience of Childbirth*. Ph.D. Dissertation, California School of Professional Psychology, Los Angeles, CA.
- Martin, Emily. 1992. *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston, MA: Beacon Press.
- Marx, Karl and Friedrich Engels. 1947. *The German Ideology*. New York, NY: International Publishers.
- Maternity Center Association. 2001. "Types of Maternity Caregivers." <http://www.maternitywise.org/mw/topics/caregiver/types.html> Retrieved 2/27/04.
- Mead, George Herbert. 1934. *Mind, Self, and Society from the Standpoint of a Social Behaviorist*. Chicago, IL: University of Chicago Press.
- Merleau-Ponty, Maurice. 1962. *The Phenomenology of Perception*. London: Routledge and Kegan Paul.
- Midwives Alliance of North America. 2003. "Direct-Entry Midwifery State-by-State Legal Status." <http://www.mana.org/statechart.html> Retrieved 2/27/04.

- Mills, C. Wright. 1959. *The Sociological Imagination*. New York, NY: Oxford University Press.
- Mitford, Jessica. 1992. *The American Way of Birth*. New York, NY: Penguin Books.
- Morse, Janice M. and Carl Mitcham. 1998. "The Experience of Agonizing Pain and Signals of Disembodiment." *Journal of Psychosomatic Research* 44(6):667-680.
- Musick, Kelly. 2002. "Planned and Unplanned Childbearing among Unmarried Women." *Journal of Marriage and the Family* 64(4):915-929.
- Newton, Michael. 1987. "Commentary on Hahn's *Divisions of Labor*." *Medical Anthropology Quarterly* 1(3):283-287.
- Norr, Kathleen L., Carolyn R. Block, Allan Charles, Suzanne Meyering and Ellen Meyers. 1977. "Explaining Pain and Enjoyment in Childbirth." *Journal of Health and Social Behavior* 18:260-275.
- Oakley, Ann. 1986. *The Captured Womb: A History of the Medical Care of Pregnant Women*. Oxford: Basil Blackwell.
- Oakley, Ann. 1981. "Interviewing Women: A Contradiction in Terms." Pp. 30-61 in *Doing Feminist Research*, edited by Helen Roberts. London: Routledge & Kegan Paul.
- O'Brien, Mary. 1981. *The Politics of Reproduction*. New York, NY: Routledge & Kegan Paul.
- Omi, Michael and Howard Winant. 1986. *Racial Formation in the United States: From the 1960s to the 1990s*. New York, NY: Routledge.
- Ortner, Sherry. 1974. "Is Female to Male as Nature is to Culture?" Pp. 67-87 in *Woman, Culture and Society*, edited by Michelle Zimbalist Rosaldo and Louise Lamphere. Stanford, CA: Stanford University Press.
- Oweiss, Arwa Issa. 2001. *Relationships Among the Situational Variables of Perceived Stress of the Childbirth Experience, Perceived Length and Perceived Difficulty of Labor, Selected Personal Variables, Perceived Nursing Support and Postpartum Depression in Primiparous Jordanian Women Living in Jordan*. Ph.D. Dissertation, Widener University School of Nursing, Chester, PA.
- Page, Lafern. 1993. *Menopause and Emotions: Making Sense of your Feelings when Your Feelings Make No Sense*. Vancouver: Primavera.
- Panuthos, Claudia. 1984. *Transformation Through Birth: A Woman's Guide*. South Hadley, MA: Bergin & Garvey.

- Pavlov, Ivan. 1927. *Conditioned Reflexes: An Investigation of the Physiological Activity of the Cerebral Cortex*. London: Oxford University Press.
- Peterson, Alan. 1998. *Unmasking the Masculine: "Men" and "Identity" in a Skeptical Age*. London: Sage.
- Peterson, Gayle. 1981. *Birthing Normally: A Personal Growth Approach to Childbirth*. Berkeley, CA: Mindbody Press.
- Pilkington, Andrew. 2003. *Racial Disadvantage and Ethnic Diversity in Britain*. Brasington: Palgrave Macmillan.
- Pollner, Melvin and Jill Stein. 2001. "Doubled Over in Laughter: Humor and the Construction of Selves in Alcoholics Anonymous." Pp. 46-63 in *Institutional Selves: Troubled Identities in a Postmodern World*. New York, NY: Oxford University Press.
- Pringle, Rosemary. 1998. *Sex and Medicine: Gender, Power and Authority in the Medical Profession*. New York, NY: Cambridge University Press.
- Radosti, Sue. 1999. "The Dynamics of Trauma in Childbirth." *Special Delivery* 22(1):2-15.
- Rasmussen, Birgit Brander, Irene J. Nexica, Eric Klinenberg and Matt Wry. 2000. *The Making and Unmaking of Whiteness*. Durham, NC: Duke University Press.
- Reinharz, Shulamit. 1992. *Feminist Methods in Social Research*. New York, NY: Oxford University Press.
- Reinharz, Shulamit and Susan E. Chase. 2002. "Interviewing Women." Pp. 221-238 in *Handbook of Interview Research: Context and Method*, edited by Jaber F. Gubrium and James A. Holstein. Thousand Oaks, CA: Sage.
- Ringer, Jeffrey R. 1994. *Queer Words, Queer Images: Communication and the Construction of Homosexuality*. New York, NY: New York University Press.
- Rooks, Judith Pence. 1997. *Midwifery and Childbirth in America*. Philadelphia: Temple University Press.
- Rose, Nikolas. 1998. *Inventing Our Selves: Psychology, Power, and Personhood*. New York, NY: Cambridge University Press.
- Roth, Woff-Michael and G. Michael Bowen. 2001. "Of Disciplined Minds and Disciplined Bodies: On Becoming an Ecologist." *Qualitative Sociology* 24(4):459-481.
- Rothman, Barbara Katz. 1991. *In Labor: Women and Power in the Birth Place*. New York, NY: W.W. Norton & Company.

- Ruane, Sally. 1996. "Maternal-Baby Unbonding: Rituals for Undoing Nature." Pp. 133-156 in *Health and the Sociology of Emotions*, edited by Veronica James and Jonathan Gabe. Oxford: Blackwell.
- Rudolfsdottir, Annadis Greta. 2000. "'I Am Not a Patient and I Am Not a Child': The Institutionalization and Experience of Pregnancy." *Feminism & Psychology* 10(3):337-350.
- Said, Edward. 1993. *Culture and Imperialism*. New York, NY: Alfred A. Knopf.
- Said, Edward. 1979. *Orientalism*. New York, NY: Vintage.
- Sanders, Clinton R. 1993. "Understanding Dogs: Caretakers' Attributions of Mindedness in Canine-Human Relationships." *Journal of Contemporary Ethnography* 22:205-226.
- Scarry, Elaine. 1985. *The Body in Pain: The Making and Unmaking of the World*. New York, NY: Oxford University Press.
- Scheper-Hughes, Nancy and Margaret Lock. 1987. "The Mindful Body: A Prolegomenon to future Work in Medical Anthropology." *Medical Anthropology Quarterly* 1:6-41.
- Sears, William and Martha Sears. 1994. *The Birth Book: Everything You Need to Know to Have a Safe and Satisfying Birth*. Boston, MA: Little, Brown and Company.
- Schutz, Alfred. 1971. "On Multiple Realities." Pp. 207-259 in *Collected Papers I: The Problem of Social Reality*, edited by Maurice Natanson. The Hague: Martinus Nijhoff.
- Schutz, Alfred. 1970. *On Phenomenology and Social Relations*. Chicago, IL: University of Chicago Press.
- Sharp, Deborah, Dale F. Hale, Susan Pawlby, Gesine Schumaecker, Helen Allen and R. Kumar. 1995. "The Impact of Postnatal Depression on Boys' Intellectual Development." *Journal of Child Psychology and Psychiatry* 36(8):1315-1336.
- Sharpe, Scott. 1999. "Bodily Speaking: Spaces and Experiences of Childbirth." Pp. 91-103 in *Embodied Geographies: Spaces, Bodies and Rites of Passage*, edited by Elizabeth Kenworthy Teather. New York, NY: Routledge.
- Shilling, Chris. 1993. *The Body and Social Theory*. London: Sage.
- Simkin, Penny. 1991. "Just Another Day in a Woman's Life? Women's Long-Term Perceptions of Their First Birth Experience. Part I." *Birth* 18(4):203-210.
- Simkin, Penny. 1986. "Stress, Pain, and Catecholamines in Labor: Part 1. A Review." *Birth* 13(4):227-233.

- Simon, Robin W., Donna Eder, and Cathy Evans. 1992. "The Development of Feeling Norms Underlying Romantic Love Among Adolescent Females." *Social Psychology Quarterly* 55:29-46.
- Simonds, Wendy. 2002. "Watching the Clock: Keeping Time During Pregnancy, Birth as Postpartum Experiences" *Social Science & Medicine* 55:559-570.
- Smith, Dorothy E. 1987. *The Everyday World as Problematic: A Feminist Sociology*. Boston, MA: Northeastern University Press.
- Smith, Dorothy E. 1978. "'K' is Mentally Ill: The Anatomy of a Factual Account." *Sociology* 12:23-53.
- Smith, Pam. 1992. *The Emotional Labour of Nursing*. Basingstroke: Macmillan Educational Books.
- Soet, Johanna Eastman. 2002. *Prevalence and Predictors of Women's Experience of Trauma During Childbirth*. Ph.D. Dissertation, Georgia State University, Atlanta, GA.
- Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York, NY: Basic Books.
- Tavris, Carol. 1992. *The Mismeasure of Woman*. New York, NY: Touchstone.
- Thomas, William I. and Dorothy Swain Thomas. 1928. *The Child in America*. New York, NY: Alfred A. Knopf Inc.
- Thompson, L.M. 1993. "Treating Diseases, Not Patients." *Southern Medical Journal* 86(7):803-807.
- Turner, Bryan S. 1992. *Regulating Bodies: Essays in Medical Sociology*. London: Routledge.
- Turner, Bryan S. 1984. *The Body and Society: Explorations in Social Theory*. Oxford: Basil Blackwell.
- Upchurch, Dawn M. Lee A. Lillard and Constantijn W. A. Panis. 2002. "Nonmarital Childbearing: Influences of Education, Marriage, and Fertility." *Demography* 39(2):311-329.
- Warren, Carol. 2002. "Qualitative Interviewing." Pp. 83-102 in *Handbook of Interview Research: Context and Method*, edited by Jaber F. Gubrium and James A. Holstein. Thousand Oaks, CA: Sage.
- Weber, Max. 1998/1930. *The Protestant Ethic and the Spirit of Capitalism*. Los Angeles, CA: Roxbury Publishing Company.

- Wentworth, William M. and John Ryan. 1994. "Introduction." Pp. 1-17 in *Social Perspectives on Emotion*, edited by William M. Wentworth, John Ryan and David D. Franks. Greenwich, CT: JAI Press Inc.
- Wentworth, William M. and David Yardley. 1994. "Deep Sociality: A Bioevolutionary Perspective on the Sociology of Emotions." Pp. 21-55 in *Social Perspectives on Emotion*, edited by William M. Wentworth, John Ryan and David D. Franks. Greenwich, CT: JAI Press Inc.
- Werbel, James. 1998. "Intent and Choice Regarding Maternal Employment Following Childbirth." *Journal of Vocational Behavior* 53(3):372-385.
- Wertz, Richard W. and Dorothy C. Wertz. 1977. *Lying-In: A History of Childbirth in America*. New York, NY: Schocken Books.
- Whiffen, Valerie E. and Ian H. Gotlib. 1989. "Infants of Postpartum Depressed Mothers: Temperament and Cognitive Development." *Journal of Abnormal Psychology* 98(3):274-279.
- Whorf, Benjamin L. 1956. *Language, Thought, and Reality*. Cambridge, MA: MIT Press.
- Wiles, Rosemary. 1994. "'I'm Not Fat, I'm Pregnant': The Impact of Pregnancy on Fat Women's Body Image." Pp. 33-48 in *Women and Health: Feminist Perspectives*, edited by Sue Wilkinson and Celia Kitzinger. London: Sage.
- Williams, Simon J. 2003. *Medicine and the Body*. Thousand Oaks, CA: Sage.
- Williams, Simon J. and Gillian Bendelow. 1998. *The Lived Body: Sociological Themes, Embodied Issues*. London: Routledge.
- Williams, Simon J. and Gillian Bendelow. 1996. "Emotions, Health and Illness: The 'Missing Link' in Medical Sociology?" Pp. 25-54 in *Health and the Sociology of Emotions*, edited by Veronica James and Jonathan Gabe. Oxford: Blackwell Publishers Ltd.
- Wolf, Naomi. 2001. *Misconceptions: Truth, Lies, and the Unexpected Journey to Motherhood*. New York, NY: Doubleday.
- Wolf, Naomi. 1990. *The Beauty Myth*. New York, NY: William Morrow.
- World Bank. 1999. "Safe Motherhood and the World Bank: Lessons From 10 Years of Experience." www.worldbank.org/html/extdr/hnp/population/tenyears/text.pdf Retrieved 10/27/03.
- World Health Organization. 1999. "Reduction of Maternal Mortality: A Joint WHO/UNFPA/UNICEF/World Bank Statement." www.who.int/reproductive-health/publications/reduction_of_maternal_mortality Retrieved 3/05/04.

- World Health Organization. 1997. "Care in Normal Birth: Report of a Technical Working Group." www.who.int/reproductive-health/publications/MSM_96_24/ Retrieved 3/05/04.
- Wu, Zheng and Lindy MacNeill. 2002. "Education, Work, and Childbearing after Age 30." *Journal of Comparative Family Studies* 33(2):191-213.
- Young, Iris Marion. 1990. *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory*. Bloomington, IN: Indiana University Press.
- Zborowski, Mark. 1952. "Cultural Components in Response to Pain." *Social Issues* 8:16-30.
- Zerubavel, Eviatar. 1997. *Social Mindscapes: An Invitation to Cognitive Sociology*. Cambridge, MA: Harvard University Press.
- Zhang, J., J. W. Bernasko, E. Leybovich, M. Fahs, and M.C. Hatch. 1996. "Continuous Labor Support From Labor Attendant For Primiparous Women: A Meta-Analysis." *Obstetrics and Gynecology* 88(4 part 2):739-744.
- Zola, Irving. 1966. "Culture and Symptoms: An Analysis of Patient's Presenting Complaints." *American Sociological Review* 31:615-630.

BIOGRAPHICAL SKETCH

Shannon Krista Houvouras grew up in Ann Arbor, Michigan. After high school, she attended Washtenaw Community College, where she received an Associate of Arts degree in the humanities and social sciences. She completed her Bachelor of Arts degree in sociology at the University of Michigan in 1998. Shannon then moved to the University of Florida for her graduate work. She completed her Master of Arts degree in Sociology in 2000 and her Doctor of Philosophy degree in sociology in 2004. Her areas of specialization are gender, social psychology and the sociology of health and illness.