THE EMBODIED EXPERIENCES OF PREGNANCY

THE EMBODIED EXPERIENCES OF PREGNANCY:

LEARNING, DOING, AND ATTACHING MEANING TO PREGNANT BODY

IN DIFFERENT SOCIAL CONTEXTS

By

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Abstract

This dissertation investigates the socially and physically embodied experience of pregnancy. Analyzing qualitative interviews with 42 culturally diverse women of different ages and social classes, I explore the meaning women attach to pregnancy and its impact on their relationship with others.

Theoretically, this research is grounded in the intersection of the sociology of the body and the sociology of pregnancy and childbirth. Focusing on women's embodiment of pregnancy I reinstate the importance of the physical component of pregnancy within the literature on pregnancy and childbirth, which predominately deals with social pregnancy rendering the physical body an "absent presence". At the same time, I seek to reiterate the importance of social interactions in the field of sociology of the body which, concentrating on physical body, often neglects the social meanings attached to physiological transformation. I contribute to both fields of study demonstrating that treating physical as real is as wrong as analyzing social experiences of pregnancy without mentioning physical bodies.

My major argument is that the meaning that pregnant women and people around them attach to pregnancy is constantly re-negotiated in social interactions. I claim that despite the physiological transformation that women undergo during pregnancy, the pregnant body is not socially pregnant until it is defined as such during interactions with others.

Situating women's experiences in the context of North American medicalized culture of pregnancy, this dissertation also examines how women's journey to motherhood is shaped by their social context and what effect the medicalization of pregnancy have on women's embodiment of motherhood.

I conclude this dissertation exploring the role of social context in shaping the embodied experiences of pregnancy and reflecting on the dynamics of social and physical in the study of pregnancy and transformations of corporeal yet socially positioned bodies.

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Chapter One: Introduction

Over the past few decades the sociological study of pregnancy has covered various aspects of women's lives. Initiated as a criticism of overmedicalization of women's reproductive health and inspired by the attempt to deconstruct the presumed natural link between womanhood and childbearing, it has recently shifted to the detailed analysis of the personal experiences of pregnancy and their impact on women's selves. Unfortunately, like a pendulum, sociological interest has moved from one side to another without stopping in the middle in a way that would allow researchers to combine physiological and sociological understandings of pregnancy as an embodied experience. Studying pregnancy, sociologists tend to emphasize the changes in expectant mothers' identities and roles but pay little attention to the physiological experience of pregnancy and bodily changes associated with the transition to motherhood. The growing, corporeal, maternal body has played a somewhat insignificant role in their works. Often it is even completely absent from sociological analyses of pregnancy.

In this dissertation my aim is to investigate the socially and physically embodied experience of pregnancy. Incorporating women's physical experience into the analysis, I explore the meaning women attach to pregnancy and its impact on their relationship with others. I show that during pregnancy the combination of physical and physiological changes experienced by expectant mothers with the social change associated with transition to motherhood facilitates a new development in women's relationships with their own bodies and with people around them. Although research on the experiences of pregnancy traditionally deals primarily with visible transformation of the body during pregnancy, here I demonstrate that other physiological changes, which are often invisible to others, can lead pregnant women to reconstruct their view of themselves and their relationship with others. Finally, I suggest that it is impossible to fully understand the experiences of pregnancy without recognizing the role of the pregnant body in facilitating the meanings that women attach to their transition to motherhood.

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Situating women's experiences in the context of North-American medicalized culture of pregnancy, this dissertation also explores how women's journey to motherhood is shaped by their social context. I show that the effects of medicalization on the expectant mothers are manifold: it influences women's experiences of pregnancy, alters their relationship with others and even has an impact on how pregnancy is envisioned and talked about. At the same time, I demonstrate that it would be wrong to perceive medicalization of pregnancy as having *only* a negative impact on women's childbearing experiences – although some women feel pressured to conform to medically designed norms of pregnancy, others can benefit from adherence to those norms.

My major argument is that the meaning that pregnant women and people around them attach to pregnancy is constantly being re-negotiated in social interactions. The journey to motherhood is associated with changes women experience inside their bodies and facilitates a change in the social relationships of expectant mothers with their families, friends, co-workers, and even complete strangers. I show that moving from one social circle to another, expectant mothers and people around them are constantly re-defining the meaning of pregnancy and the same body in different situations can be perceived as "pregnant" or "not pregnant", labeled as "good" or "bad". Therefore, I claim that despite the physiological transformation that women undergo during pregnancy, the pregnant body is not pregnant until it is socially defined as such during interactions with others.

Theoretically, this research is grounded in the intersection of the sociology of the body and the sociology of pregnancy and childbirth. Sociology of the body, although a relatively new field of study, has successfully demonstrated the usefulness of the analysis of embodiment in the context of personal experiences of people undergoing a physical transition (Waskul and Vannini 2006a). Although the process of embodiment had received significant attention among medical sociologists (Charmaz and Rosenfeld 2006; Turner 1996), inexplicably little has been written about the embodiment of pregnancy (but see Bailey 2001; Davidson 2001). The lack of physical bodies in the study of

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pregnancy reflects what Chris Shilling (2003) has called "the absent presence" of the body in sociology – although the body is present conceptually, the physical experiences of the actual bodies are missing from sociological analysis. In this work I seek to introduce the pregnant body in the analysis and focus on the process of pregnant embodiment and its effect on the experiences of pregnancy among expectant mothers.

At a more general level, this research is situated within the sociology of health and illness. Since pregnancy is so tightly associated with medicine and health, it is impossible to understand the construction of the meaning of pregnancy without contextualizing it in the medicalized environment of the North American culture surrounding women's reproductive experiences. Indeed, the majority of sociological studies on pregnancy have been criticizing the overmedicalization of pregnancy, seeking to demonstrate the oppressive nature of medicalization and the many negative effects of medicalized culture on women's experiences of pregnancy and childbirth (Arditti, Klein, and Minden 1989; Davis-Floyd 1994; Katz Rothman 1993; Oakley 1980). In this dissertation, however, I take a different approach to understanding the impact of medicalization on women's transition to motherhood. Lock and Kaufert (1998) introduced the concept of "pragmatic women" to suggest that women's choice to use or reject the use of medical services and technologies should be understood as a pragmatic decision made in a particular cultural context, rather than simply the result of the oppressive nature of medicalization. Borrowing the concept of "pragmatic women" from those researchers, I adopt their view and allow pregnant women to construct their own meaning of medicalization of pregnancy. I demonstrate that although the experience of pregnancy is always shaped by medicalization, some women find it useful to rely on biomedicine while others resist medicalization. I further show that the differences between these women are rooted not in their personal proneness to oppression but rather constructed through their own experiences of pregnancy and through their interactions with others.

Finally, since I focus on women's understanding of their experiences of pregnant embodiment, I draw on a sociological tradition that gives primacy to the meaning-making activities of social actors – symbolic interactionism. Following the theoretical premises of symbolic interactionism, I explore the meaning-making process through which the body of a woman becomes defined as pregnant and treated as such by expectant mothers and people around them. The interactionists' paradigm encompasses a set of assumptions both about the nature of social interactions and about how best to study social reality. Ultimately, it is hardly possible to understand the embodiment of pregnancy and the meaning-making process formed in social interactions without relying on women's personal narratives about their journey to motherhood. Therefore, it seemed as the most logical and appropriate methodological choice to use a qualitative study design relying on the analysis of semi-structured individual interviews with expectant mothers.

Seeking to understand the changing meaning of pregnancy in different social contexts, I interviewed 42 women from different cultures, age groups, and social classes. Among my interviewees there were married and unwed mothers, teen mothers and older women, first-time mothers and women who had given birth before. Some of the respondents came from well-established families while others had difficulty trying to make ends meet. I talked to women who defined themselves as religiously observant of Christian, Jewish and Muslim faiths as well as to women who did not hold any religious beliefs. Some of them were new immigrants to Canada while others belonged to well-established, white Canadian families. During the time of the interview those women were either pregnant or had given birth to a child in the previous 12 months. Discussing with women their pregnancies, I had the opportunity to explore how women made sense of their planned and unplanned pregnancies, how they experienced the pregnant embodiment, what changes pregnancy brought into their lives and how it affected their relationships with others.

Analyzing narratives of mothers who shared with me their experiences of pregnancy and their adjustment to it, I found that although tremendously different,

women's experiences of pregnancy were similar in their constantly changing nature – moving from one social context to another women often had to redefine the meaning of their pregnancy and reclaim their selves and their identities in communication with others. I also found that women redefine the usefulness (or the damages) of biomedical discourse and medical advice on pregnancy based on their own personal needs and views of their transition to motherhood. A similar approach was demonstrated by women in negotiating their body image during pregnancy and assessing their own bodies vis-à-vis other pregnant bodies or non-pregnant sexualized bodies. Finally, I found that although pregnancy is a physiologically apparent, visible transformation, it, nevertheless, may lack any special meaning until it was socially defined as "pregnancy". Sometimes it is the labelling of the body as "pregnant" rather than physiological transformations associated with carrying a child that gives a woman the status of a pregnant woman.

Drawing on these findings, I reflect on theoretical and methodological implications of this research in the conclusion. Specifically, I consider the limitations of the sociological study of the body which, emphasizing the corporeal body, often fails to grant importance to the social setting in which we attach the meaning to bodily processes. At the same time, I conclude that it seems improper to continue researching the experiences of pregnancy without actually recognizing the physiological processes women undergo during their transition to motherhood. Finally, I reflect on the role of biomedical discourse in the writings of feminist researchers studying pregnancy and call for a change in the widely-used medicalized language which we unconsciously employ when talking about pregnancy.

Thesis Outline

Following this introduction, I set out the context for this research by presenting a literature review, which summarizes the major insights from the sociology of pregnancy and childbirth, sociology of the body, and sociology of health and medicine. In this chapter I emphasize the relevance of those fields of study to my research and identify substantive gaps in sociological scholarship which this dissertation attempts to fill.

Chapter three provides the theoretical basis for this research. Focusing on interactions between individuals and the meanings constructed through those interactions, which are attached to social and physiological phenomena, this chapter relies on the theoretical legacy of Cooley (1922), Mead (1934), Schutz (1962), Berger and Luckmann (1966) and highlights the theoretical insights of the interactionists' study of embodiment incorporated in my analysis.

In chapter four I describe the methodology employed in this research. I provide details on data collection and analysis highlighting some difficulties that I encountered while conducting the study and identifying how my personal identity as a woman and a mother shaped my access to the interviewees, influenced the context of conversations with women, and was reflected in the analysis.

In the second part of this dissertation I present my findings. Following the chronological course of pregnancy, in chapter five I demonstrate how women detect their bodily transformation and how they attach to them the meaning of pregnancy. Chapter six is devoted to women's reflection on the advice given by pregnancy experts and the entrance of women into the pregnancy club – the community of mothers and women who have given birth and who willingly share their wisdom with first-time mothers-to-be. In chapter seven I move on to demonstrate how women negotiate their body image contextualizing their experiences in the growing industry of maternity fashion and the expanding consumer market for pregnant women. Finally, the last chapter in the findings section focuses on the role of social context in facilitating the social response to pregnancy. I demonstrate that, depending on the social context, a pregnancy can be praised, perceived as disruption, or remain unrecognized by others.

In the concluding part of this dissertation I summarize my findings and reflect on the implications of this research for the study of pregnancy and the body. Noting some of the limitations of this research, I also highlight its contribution to sociology and suggest a number of directions for further sociological inquiry.

Chapter Two: The Embodied Experiences of Pregnancy in Medicalized North American Culture

In this chapter I summarize the three fields of sociological inquiry on which I built my analysis: (1) medicalization of pregnancy and childbirth; (2) experiences of pregnancy, and (3) sociology of the body. Both the literature on medicalization and on the experiences of pregnancy greatly contribute to our understanding of the transition to motherhood. At the same time, neither of those areas acknowledges the role of pregnant embodiment on the experiences of pregnancy. In this chapter I attempt to fill this gap by introducing the concept of embodiment into the literature on the experiences of pregnancy and situating it in the medicalized context of North American culture of pregnancy.

I start with the medicalization of pregnancy and childbirth – one of the most dominant topics in the feminist academic literature on women's reproductive health. I show how medicalization of pregnancy has not only changed the way we *treat* pregnancy, but also the way we *think* and *talk* about it. Then I move to discuss the experiences of pregnancy. In this section I show how, seeking to establish grounds for sociological study of pregnancy, researchers often neglected the embodied aspect of this experience. I then move to the sociology of the body which provides very useful insights into the experience of embodiment. Focusing mainly on the works of Bryan Turner (1996; 2004), Arthur Frank (1991) and Chris Shilling (2003), I show that, similar to other sociological inquires, the physicality of the pregnant body was rendered a status of "absent presence" by sociologists (Shilling 2003) - although researchers talk about the pregnant body, the body itself plays little role in their theorizing. I summarize each section, identifying theoretical and empirical gaps and situating my research within this literature.

The Medicalization of Pregnancy

The medicalization of pregnancy as a specific example of the medicalization of women's reproductive health in general is one of the most well-researched topics in feminist scholarship in the sociology of health and illness (Arditti, Klein, and Minden 1989; Bourgeault, Benoit, and Davis-Floyd 2004; Brubaker 2007; Brubaker and Dillaway 2009; Conrad and Schneider 1980; Davis-Floyd 1994; Fox 1994; Hartley 2003; Katz Rothman 1993; Kaufert and Lock 1998; Kohler Riessman [1983] 2003; Lane and Cibula 2000; Lorber and Moore 2002; Lupton 2000; Martin 2001; Oakley 1980). According to Conrad, medicalization is "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (2000: 324). In his view, there are at least three levels on which medicalization can occur: (1) the *conceptual* level, when medical vocabulary has been adopted to define a problem as medical; (2) the *institutional* level, when organizations approach a problem as medical; and (3) at the level of *interactions* where the problem is defined and/or treated as medical in the context of provider-patient communication (Conrad and Schneider 1980). Those levels are easily reflected when applied to women's experiences of pregnancy: (1) although pregnancy is not an illness, it is treated at a conceptual level as a medical condition by physicians, nurses, and an overwhelming majority of the general public (Davis-Floyd 1990; Katz Rothman 1993; Oakley 1980); (2) institutionally, pregnant women are expected to access prenatal care and to give birth in hospital; and (3) not only the interactions between care provider and a woman but also plenty of other social encounters define pregnancy as a "medical" condition (Brubaker and Dillaway 2009; Oakley 1980; van Teijlingen 2005)[1].

In this section I intend to show how pregnancy has become heavily medicalized. I also demonstrate the negative implications of the medicalization of pregnancy. At the same time, following some scholars (Brubaker 2007; Gruenbaum 1998; Lock and Kaufert

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[1]It should be noted that midwifery ideology does not treat pregnancy as illness. Rather, midwives have more natural and holistic approach to pregnancy and childbirth (Bourgeault 1999; Brubaker and Dillaway 2009; Davis-Floyd 1992; van Teijlingen 2005). Nevertheless, especially in the places where midwifery was institutionalized one cannot ignore the existence of some similarities between institutionalized experiences of women in obstetrical and midwifery care (Brubaker and Dillaway 2009).

1998), I argue that medicalization should not be treated exclusively as a negative phenomenon. Rather, it should be considered within a specific social context and with respect to women's personal health needs (Lock and Kaufert 1998).

It is hard and often impossible to identify the theoretical or technical distinction between research on the medicalization of pregnancy and research on the medicalization of childbirth. The majority of studies dealing with either topic typically involves inquiry into both, following the initial entrance of women into maternity care and demonstrating how women's reproductive experiences are shaped by obstetrical culture over the course of their pregnancy, during and after delivery of a child, or during termination of pregnancy (Brubaker and Dillaway 2009; Davis-Floyd 1990; Featherstone 2001; Katz Rothman 1993; Martin 1984; Oakley 1980; Rudolfsdottir 2000). Since the focus of my dissertation is on pregnancy, and, more specifically, on the *embodiment* of pregnancy, in this section I summarize primarily the medicalization of prenatal care. At the same time, I contextualize women's medicalized experiences in prenatal care in a larger body of literature dealing with the medicalization of childbirth and women's reproductive health in general.

Transforming pregnancy into a medicalized experience

As medical sociologists and other scholars have documented, the victory of medicine over other, alternative forms of healing has been the result of a number of social and historical factors. Those factors include the professionalization of medicine, the political influence of medical professionals, the fascination of general culture with science and medical discourse, and the government's need to regulate people's health and bodies and to maintain patriarchal order in our society (Foucault 1975; Freidson 1970; Illich 1976; Katz Rothman 1998; Lupton 2000; Turner 1992; 1994; Witz 1992).The transformation of pregnancy and childbirth from a woman-centered, midwife-assisted experience into a medically regulated field was not much different from the entrance of medical professionals into other domains of people's lives. Seeking to gain political and social power, physicians came to replace midwives at the bedside of women starting first

with trend-setting wealthy families. The rise of biomedical discourse and the popularity of medical science, the struggle for political and professional dominance, and, finally, the willingness of some women themselves to medicalize pregnancy and childbirth transformed childbirth (and pregnancy) into a medicalized condition, an "illness" requiring constant medical supervision in a relatively short period of time (Davis-Floyd 1990; 1992; Katz Rothman 1989; Kohler Riessman [1983] 2003).

The shift dramatically changed the experiences of birthing women. It changed the very "physics" of birth: redesigned from a sitting/squatting position, which was used by midwives and was perceived as more convenient for labouring woman, to having women lay in a supine position. The latter was perceived as more modest and more convenient for a physician, who had to attend a woman's birth but at the same time to make sure that his physical and visual contact with a laboring woman's body was managed within professional boundaries (Davis-Floyd 1990; Featherstone 2001). It also changed the process of birth with the physician becoming an active agent while the birthing woman left in the role of a passive recipient of medical treatment (Davis-Floyd 1990; Kohler Riessman [1983] 2003). Finally, it changed the nature of birth, which ceased to be a part of women's worlds managed for women and by women in a community setting.

In this struggle for professional dominance, physicians succeeded in excluding midwives from providing care for laboring women[2]. Nurses and nurse-midwives had become professions subordinate to medicine. As such, not only laboring women, but also women caring for laboring women had become supervised and controlled by medical men (Witz 1992). Women's bodies, which were constructed by biomedicine as deviating from the normative, male bodies, were perceived as even more pathological and doomed to fail during pregnancy and childbirth (Davis-Floyd 1992; Martin 2001).

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[2] In some communities, however, midwives often continued to provide care for women even after the rise of obstetrical care (Bourgeault 1996; Mason 1988). For instance, in Canada, the Aboriginal midwifery continued to exist for some time. Also, women belonging to remote communities and secluded religious communities had been using services of neighbor (lay) midwives and formally trained midwives (Biggs 2004).

To control the potentially dangerous process of bringing new life into society, the birth process became hospitalized and the period of pregnancy, leading to the process of labour, were introduced into medicine and labeled prenatal care. Women's knowledge of their own bodies was replaced by scientific evidence, medical wisdom, and various technological devices allowing physicians to look "inside" women's bodies and follow the development of the fetus (Davis-Floyd 1990; Katz Rothman 1993). The interest in birthing women was replaced by interest in the growing fetus and obstetrical care was slowly transformed into care for the fetus (Featherstone 2001; Katz Rothman 1989; Mutman and Ocak 2008).

Implications of medicalization on pregnancy

The medicalization of pregnancy changed the experience of the transition to motherhood in at least three different aspects: (1) it contributed to women's loss of autonomy over their bodies[3]; (2) it changed the way we think and talk about pregnancy; (3) it placed moral responsibility on women to nurture a healthy fetus by constant monitoring of their bodies. One of the direct consequences of the medicalization of pregnancy, which has so often been criticized by feminist scholars, is the loss of women's autonomy over their own bodies and the transfer of control into the hands of physicians both during pregnancy and during labour (Davis-Floyd 1992; Katz Rothman 1993; Kohler Riessman [1983] 2003; Martin 1984; Oakley 1980). The introduction of the various technological devices assisting medical men in prenatal care allowed physicians to observe and to monitor the process of child development "trapped" in a woman's body for nine months (Katz Rothman 1989). Once the link between the welfare of an unborn child and the pregnant woman's behaviour, nutrition, and even mood was firmly established by biomedicine, it became easy to argue for the routine introduction of prenatal care into medical practice (Katz Rothman 1998).

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[3] Although here I discuss the social implications of the medicalization of pregnancy which predominately had a negative impact on women's lives (reflective of the literature), some scholars argue that women can draw upon medicalization to address their health needs (Lock and Kaufert 1998). I discuss this point introducing the concept of "pragmatic women" in the following section of this chapter.

The dominance of the medical profession over the reproductive health of women, however, is not limited to prenatal care and labour. With the introduction of assisted reproductive technologies and genetic counseling, physicians are increasingly taking an active role in defining who is to be born and who is not (Arditti, Klein, and Minden 1989; Katz Rothman 1993). Moreover, physicians have come to garner a crucial role in decisions about various legal issues surrounding abortion as well as Caesarian sections and other medical interventions sometimes required during the delivery of a child (Bordo 1993; Katz Rothman 1993; 1998).

In all too many human societies women have roles subordinate to men and their reproduction is controlled by the patriarchal order of their communities (Katz Rothman 1998; O'Brien 1989). Lacking an active, physiological role in reproduction, men historically have employed various forms of regulation of women's sexuality. Publically acknowledging the familial relationship to a child by giving him/her the father's last name, or restricting women's ability to reproduce to a structure of nuclear, patriarchal families are just two examples of the successful attempts of men in western societies to regulate women's reproductive work (Katz Rothman 1989; O'Brien 1989). The difference between those traditional forms of social regulation of women's bodies and the social control brought about by medicalization lies mainly within the *rationalization* of regulation over women's bodies before, during, and after pregnancy: since women are responsible for carrying children – the future members of the society – their bodies should be "protected" and/or excluded from any activity that can be physiologically harmful to the process of reproduction.

Researchers have demonstrated how, based on this logic, women were denied employment in potentially hazardous environments, forced to undergo compulsory treatment in cases of alcohol or drug abuse, and were defined as "deviant mothers" if they did not conform to prenatal regulations (Callahan and Knight 1992; Maher 1992; Toscano 2005). Envisioning childbearing as a physiological process, which brings everything consumed by mother to the womb where a child is developing, our society

denies women the very basic right of ownership over her own body, considering the welfare of an unborn child to dominate over women's rights and their bodies (Bordo 1993; Copelton 2004; Katz Rothman 1989; Wakschlag et al. 2003). Moreover, if for any reason a woman demonstrates her inability or unwillingness to sacrifice her personal needs and to devote her body to the unborn child by maintaining a healthy pregnancy, she is stigmatized as unworthy of motherhood or even criminalized for fetal endangerment (Brooks-Gardner 2003; Callahan and Knight 1992).

Paradoxically, although the pregnant body is perceived as being "naturally" designed for having children, pregnancy guides and self-help literature often picture the woman's body as being in need of "cleansing" before pregnancy. The spontaneous, unplanned pregnancy is commonly presented as potentially dangerous and women are advised to prepare themselves for pregnancy by reducing imbalanced food consumption, increasing vitamin intake, and eliminating caffeine and alcohol from their diet *before* they conceive a child (Copelton 2004; Marshall and Woollett 2000; Upton and Han 2003). Ultimately, the instructions on the "cleansing" of the body and the assessment of potential risks of improper behaviour during pregnancy is assessed by biomedicine. For instance, many self-help books and pregnancy guides are filled with advice from medical specialists on foods that can cause harm to fetal development (Copelton 2004; Elliott 2003; Holcomb 2009). The media often announces the latest research findings related to prenatal health and women are expected to be responsible for educating themselves about pregnancy by constantly updating their knowledge of potential dangers and hazards to pregnancy (Copelton 2004; Root and Browner 2001).

The general social expectation is that the "responsible" pregnant woman should take on the duty of closely monitoring her food consumption in order to provide a nurturing environment for her unborn child (Brooks-Gardner 2003). As was suggested by Foucault (1975) and others (Turner 1992) self-regulation is the most effective way of controlling populations and women often engage in myriad disciplining practices to control their bodies' appearance and behaviour (Bartky [1988] 2003; Bordo 1993).

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During pregnancy, however, the regulation of female bodies increases dramatically: not only women themselves are expected to constantly monitor their bodies but the regulation of pregnant bodies is also enforced by maternity care providers, general public and government officials (Brooks-Gardner 2003; Marshall and Woollett 2000). For instance, maternal care providers usually schedule monthly visits with expectant mothers during which they assess women's physiological and social state. Family, relatives, friends and even complete strangers routinely invade expectant mothers' privacy by touching, advising, or policing them (Bailey 1999; Warren and Brewis 2004). It is not uncommon for pregnant women to be denied alcohol in public or to be advised on improper food consumption practice (Bailey 1999; Root and Browner 2001). Children's social services often monitor pregnant women who are considered to pose a "risk" to their unborn children, planning to apprehend the child after the delivery. Finally, in some jurisdictions women may still be forced to undergo compulsory drug treatment during pregnancy (Callahan and Knight 1992). In all those cases, the justification for societal intervention into the private life of a woman is explained by potential "risks" that a woman's actions may cause to the health and development of an unborn child.

The medicalization of pregnancy has become a normalized experience. Moreover, it is hard to envision a pregnancy without contextualizing it in a medicalized environment. Whereas pregnant bodies appear in media, they are usually pictured receiving obstetrical care and/or giving birth in hospitals. Similarly, the vast majority of self-help books and pregnancy guides deal with medicalized pregnancy and pay little attention to the social and emotional aspects of the transition to motherhood (Houvouras 2006; Marshall and Woollett 2000). Everything consumed is routinely assessed by expectant mothers as a "good" or "bad" food choice influencing the health of their unborn children (Copelton 2007).

Struggling to regain autonomy over their bodies, in the past decades some women have begun to fight to get their bodies back and have achieved some significant victories in the reproductive terrain. For instance, the legitimization of midwifery (which is now

institutionalized in most Canadian provinces and territories) as well as the accessibility of the home birth option has given some women more control over the birthing process. It was perceived by many as a feminist struggle over women's reproductive autonomy (Bourgeault 2000; Davis-Floyd 1992). Women also have more control over their bodies in deciding on medical interventions during pregnancy and labour and the use of reproductive technologies. At the same time, on a daily basis women are bombarded with new research findings on nutrition risks during pregnancy, which they are expected to monitor in order not to endanger their unborn children (Copelton 2010). The rise of IVF and assisted reproductive technologies has also greatly increased the use of medical interventions in initiating pregnancy (Gregory 2007). Finally, researchers have questioned the common assumption that such medically designed procedures as genetic screening, sex selection for the conceived child, or scheduled Caesarian sections indeed assist women in making an informed choice about their pregnancy (Bourgeault et al. 2008; Hoskins and Holmes 1989; Katz Rothman 1993).

According to Peter Conrad (2005) medicalization is a reversible process. Some conditions, previously perceived as medical, have been successfully demedicalized and normalized in our culture. The most common example of demedicalization is the normalization of homosexuality, which no longer has the label of a medical condition (Conrad, 2005). At the same time, Renee Fox (1994) suggests that we ought to distinguish between *structural* medicalization (the result of structural changes in the health care system and the formal authority of physicians) and *cultural* medicalization (changes in our perceptions of "health" and "disease" with respect to a particular condition)[4]. In her opinion, structural demedicalization does not automatically change our cultural perceptions about a medicalized condition. The difficulty in changing the cultural perceptions about a particular condition lies in the nature of cultural medicalization. Cultural medicalization means that our very language, what and how we think, are medicalized. Usually, it is a slow process of re-shifting the way of thinking about any

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[4] This distinction is similar to the one made by Conrad and Schneider (1980) between conceptual and institutional medicalization noted earlier in this chapter.

particular phenomenon and attaching to it a medical label. Foucault (1975), for instance, demonstrated that our perceptions and discourses on human body, etiology of disease, and the ways of treating sickness have changed due to medical knowledge and power. Cultural medicalization does not happen with the introduction of a change in government legislation; it often takes years for people to adjust to a new way of thinking about a particular condition in medical terms. At the same time, once medicalized, the medical nature of a condition is taken for granted and it is hard to accept that there may be some other way to explain the phenomenon (i.e., religion, fate, etc.) (Turner 2004). Therefore, cultural medicalization is not simple to change – it requires structural change but it also requires the change in our ways of thinking about a particular phenomenon.

Using the distinction between cultural and structural demedicalization proposed by Renee Fox (1994), we can, for example, suggest that the institutionalization of midwifery (in some jurisdictions) has lead to a (partial) structural demedicalization of pregnancy. At the same time, analyzing the content of pregnancy guides and self-help books as well as watching TV-shows featuring episodes on pregnancy and labour in the medicalized context of a hospital environment, the majority of us still perceive pregnancy culturally as a medical condition. Moreover, even though in the past few decades women have achieved more authority over their bodies and many women can now choose between conventional, medical care and midwifery care and home birth, most people still think about childbirth in medical terms (Brubaker and Dillaway 2009; Gillespie and Strauss 2007). Ultimately, even in the example provided here, women who choose midwifery care would still be given the option to undergoing various medical procedures (i.e., ultrasounds, blood tests, pap smears, etc.). Finally, the very language we use to discuss pregnancy is filled with medical terminology which divides pregnancy into trimesters, calculates weeks of gestation, and uses medically established timelines and tests rather than women's own personal knowledge of their bodies. Therefore, it is safe to argue that although some important steps had been made on the way to demedicalizing

pregnancy, we are far from reaching the point where women can choose between medical and natural pregnancy and childbirth (Brubaker and Dillaway 2009).

Pragmatic women in the era of medicalization

Not all researchers agree that the medicalization of women's reproductive health is necessarily negative (Brubaker 2007; Lock and Kaufert 1998). It appears that some women do not consider medicalization as oppressive in nature and use its fruits for their own, personal needs (Boddy 1998; Brubaker 2007; Gruenbaum 1998). For instance, the anthropological essays collected in the volume edited by Margaret Lock and Patricia Kaufert (1998) demonstrate that women do not always see reproductive technologies as oppression – sometimes they find it helpful to use the technology brought about by medicalization:

> *women's relationships with technology are usually grounded in existing habits of pragmatism. For by force of the circumstance of their lives, women have always had to learn how they may best use what is available to them. If the **apparent** benefits outweigh the costs to themselves, and if technology serves their own ends, then most women will avail themselves of what is offered (Lock and Kaufert 1998, emphasis in original).*

As those researchers note, medicalization and its effect on women's lives should be understood in the cultural, political, and historical contexts in which the introduction of women to medicalization of reproductive health has occurred (Boddy 1998; Gruenbaum 1998). For instance, while middle-class North American women see medical intervention as disempowerment, rural Sudanese Muslim women observed by Ellen Gruenbaum (1998) define the lack of access to medical services as disempowering. Lacking access to prenatal and maternity care in the absence of medical services, experiencing disease and malnutrition, many women birthing children in low income countries would prefer hospitalized, medically supervised birth over natural birth. As a result, often they would have difficulties to understand the desire of white, middle-class western women to have their babies at home (Lock and Kaufert 1998). A similar argument is made by Sarah Brubaker (2007), who analyzed birthing experiences of black

teens in the U.S. According to Brubaker, with few exceptions, feminist scholarship failed to include in their criticism of medicalization the dimensions of race and class (2007:531). Yet, many poor and black women in the U.S. are denied the use of reproductive technologies and do not necessarily share the need of middle-class women to control the process of labour and childbirth. Some of Brubaker's teen respondents, for example, embraced medicalization since it allowed them to demonstrate their good mothering skills and to normalize their pregnant identity by receiving conventional medical care during pregnancy (Brubaker 2007).

Undoubtedly, the desire of marginalized pregnant women to receive conventional, medical prenatal care can be linked to the cultural medicalization of childbirth – the common use of medical technologies during pregnancy and hospital birth does have an effect on how women visualize their birthing experiences and their prenatal care and what they consider to be "safe" labour and birth. At the same time, looking at the experiences of pregnant women in prenatal care, it is important to understand *their own* perception of the medicalization of pregnancy: how do they see it and why do they choose to receive/deny medical assistance. In other words, in order to understand women's experiences of pregnancy it is important to give them the opportunity to talk about the medicalization of their experiences (or the lack of thereof) without a preconceived perception of universally oppressive nature of medicalization of pregnancy and childbirth. Finally, analyzing women's experiences in the world of reproduction in the context of presumed dichotomy of "medicalized" versus "natural" pregnancy and childbirth does not allow us to actually capture women's experiences and places unjustifiable limits on the analysis of women's journey to motherhood[5]. Therefore, although I acknowledge the importance of contextualizing women's reproductive experiences within the culture of medicalized pregnancy and demonstrate the importance of the cultural context throughout my analysis, I devote the next section to the discussion

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[5] In fact, some researchers argue that there is no real "dichotomy" between the medical and natural childbirth and women's definitions of what is considered to be "natural" birth vary significantly (Brubaker and Dillaway 2009).

of women's experiences of pregnancy which often are beyond their encounters with prenatal care.

Experiences of Pregnancy and the Absence of the Body

Although sociologists often deconstruct grand narratives and question dominant ideologies, they themselves, are not immune from the influence of social forces when they choose to focus their attention only on the social aspects of a particular issue. In the study of pregnancy, the research exploring women's experiences comes up against the naturalized, physiological perceptions of pregnancy and childbirth. In this section I show that focusing on the "sociological" nature of pregnancy, feminist scholars have been very effective in deconstructing the automatic link between pregnancy and women's physiology, perhaps too much so. I demonstrate that seeking autonomy from the physiology which confines women to childbirth, they detached the experiences of pregnancy from pregnant body, leaving the embodied experience relatively un-researched (but see Bailey 2001; Davidson 2001; Young 1984). Here I argue that pregnancy cannot be understood without bringing the physiological nature of this process back into women's personal experiences. Following Barbara Katz Rothman (1989), I suggest that such a disembodied view of pregnancy mirrors the patriarchal, capitalist notions of reproduction which needs to see the "product" of masculine labour (of planting a child inside a woman's body) and serves to deny women the legitimacy to claim that they have the emotional, social and physiological ties to their unborn children. In highlighting the limitations of this literature, I conclude by calling for an investigation of pregnancy as an embodied experience, which, even when invisible to others, makes pregnancy real for expectant mothers.

Redefining pregnancy as a social and cultural act

For many years the oppression experienced by women living in patriarchal societies was explained by their "natural," physiological roles of mothers, carers, and nurturers (Katz Rothman 1989; 1998; Oakley 1981). Being a woman meant to be confined to the domestic role. Therefore, many early feminist saw reproduction as

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oppressive and called on women to cease bearing children because it provided the justification to deny women roles equal to men's social roles (Oakley 1980; Phoenix and Woollett 1991a; Rabuzzi 1988).

Of the many "stages" and levels of motherhood, pregnancy is probably the most manifested act of mothering: women not only nurture their children, they host them inside their bodies and share with them their own flesh (Katz Rothman 1998). Evidently, a baby cannot be born without growing inside a woman's body which, for some scientists, further emphasizes the connection between women's physiological and the social roles of mothers (see Rabuzzi 1988).

It is this link between women's physiology and their cultural roles as "mothers of society" that many feminist researchers sought to deconstruct in their works. They claimed that the connection between physiology and the social roles of mothers should not be seen as automatic since the fact that women give birth to children does not explain how and why they have become oppressed and unrecognized for this work and underrepresented in other social spheres. Some feminists even suggested that, on the contrary, women's oppression is the result of men's attempt to gain control over reproduction (Katz Rothman 1989; O'Brien 1989; Oakley 1980). Reducing the role of women to the mechanical role of the incubator (in which, a child, the man's product of labour, is growing), men often denied women equal rights to the child. Moreover, pregnancy itself has come to be seen as lacking *social* meaning, and was perceived as purely mechanical process of a female body transforming man's seed into a child (Katz Rothman 1989).

Subsequently, the criticism of feminist researchers studying pregnancy and childbirth was first and foremost directed towards the introduction of social factors into the mechanical scheme of pregnancy and childbirth. Ann Oakley, for instance, was one of the first sociologists to note that "having a baby is a biological and cultural act (1980:5)." Arguing against the biomedical notion of pregnancy she demonstrated that in addition to the physical transformation that women undergo during pregnancy, they also experience

a social transformation. Analyzing women's experiences of childbirth she concluded that pregnancy is not simply a process of the "production of babies", but rather, a life changing event that should be studied in context of women's lives. She also demonstrated how women's personal lives, skills, and experiences are completely disregarded by maternity care providers treating pregnancy as a standardized, "universal" experience. Her findings indicated that social support and the recognition of women's personal circumstances during pregnancy and after childbirth could have a crucial role for satisfactory experiences of the journey to motherhood (Oakley 1992).

The works of Barbara Katz Rothman (1989; 1993; 1998) show how pregnancy affects women's lives and how women develop a social and not just a biological relationship with their children even prior to giving birth. She describes how women learn to adjust to their pregnant bodies and how they engage in social relationships with their unborn babies: everything from eating to sleeping is synchronized between the mother and the fetus (Katz Rothman 1989). Despite this presumably natural link of a mother to her child, Katz Rothman shows that society often intrudes in these relationships, seeking to "protect" the fetus from its mother, to "own" the product of her body (as in the cases of surrogate motherhood), and to advise her on the termination of her pregnancy due to the questionable quality of the sought product of pregnancy, when the results of medical screening for genetic disorders are uncertain (Katz Rothman 1993).

In the past few decades, the research on the social nature of pregnancy has flourished in sociology and feminist studies (Bailey 1999; 2001; Balin 1988; Borve 2007; Brubaker and Wright 2006; Davidson 2001; Draper 2003; Earle 2000; 2003; Elvey 2003; Grenier and Burke 2008; Hockey and Draper 2005; Houvouras 2006; McMahon 1995; Messias and Dejoseph 2007; Miller 1978; O'Dougherty 2008; Smith 1991; 1999; Warren and Brewis 2004; Werkmann 1994; Wiles 1994). The majority of those studies focus predominantly on the social aspects of the transition to motherhood, such as changes in women's relationship with others and transformation of their identities (Bailey 2001; Earle 2000; McMahon 1995; Miller 1978; Smith 1991;1994), paying little attention (if at

all) to physiological changes associated with pregnancy. For instance, emphasizing the importance of the social transition to motherhood, most researchers suggest that pregnancy should be regarded as a rite of passage during which women acquire new social roles and form new relations with others (Brubaker and Wright 2006; Coleman and Cater 2006; Hockey and Draper 2005; Martin 2003; McMahon 1995; Messias and Dejoseph 2007). Whereas the physical pregnant body is mentioned, it usually appears in the context of social change and is paid little attention to the body as a subject for sociological inquiry.

One of the areas of study in which the physical pregnant body is mentioned in passing explores the experiences of expectant mothers in the workplace and the effect of pregnancy on workplace relations (Borve 2007; Masser, Grass, and Nesic 2007). The workplace is usually constructed as body-less or absent of women's bodies. The growing body of a pregnant woman, which manifests its femininity via visible signs of pregnancy has been perceived as threatening the usual social order. Therefore, expectant mothers often report uneasiness with their growing bodies in a workplace environment (Borve 2007).

The pregnant body is also mentioned in the context of transforming the relationship of expectant mothers with their social surrounding (Bailey 1999; Davidson 2001; Longhurst 2001). For instance, some women report that once their pregnancy is visible, it affects their communication with friends and strangers who perceive expectant mothers as "pregnant" and often forget about other social roles women continue to play despite the fact that their bellies are growing (Bailey 2001; Warren and Brewis 2004). A pregnant body becomes a social body, which can be touched and advised by others and many pregnant women experience a loss of control over their bodies during pregnancy, triggered by both, rapid physical transformation and social intrusion into their personal lives (Marshall and Woollett 2000; Warren and Brewis 2004). Finally, the pregnant body is mentioned in the context of changing relationship with a partner where the contrast is

drawn between purely "social" transition experienced by fathers and the embodied experience of a mother carrying a child (Draper 2003; Houvouras 2006).

Although the aforementioned studies sometimes note the physiological, corporeal pregnant body, the focus of researchers' attention predominantly concerns the social factors associated with women's transition to motherhood. The body itself plays not much of a role in sociological analysis and usually simply serves the function of an object exemplifying changing social relationships. Without taking away the importance of social change experienced during pregnancy, my goal in this dissertation is to introduce into the field of the study on pregnancy the embodied experience of pregnant women. In what follows, I summarize the scarce research available in this field, demonstrating that even those studies that specifically deal with embodied experiences of pregnancy do not really introduce the physical body of pregnant women into their analysis.

The embodied experiences of pregnancy

In light of the rich scholarship on the experiences of pregnancy it is odd how underdeveloped is its analysis of pregnancy as an embodied experience. Only a few researchers have dealt with this issue as central to their focus of interest and showed how pregnancy changes the experiences of women with their bodies (Bailey 2001; Davidson 2001; Draper 2003; Young 1984).

One of the researchers exploring the embodied experience of pregnancy is Lucy Bailey, who interviewed middle-class pregnant women living in England (Bailey 1999; 2001). She found that pregnant women experienced changes in their sensuality, shape and the amount of social space that they are allowed to take (Bailey 2001). Some women, for instance, reported changes in their sexuality, feeling that their bodies are fulfilling maternal roles and thus should not be regarded as the object of sexual desire. Some of her respondents also felt more feminine due to pregnancy – the ultimate manifestation of "womanliness" (Bailey 2001). A similar tendency to shift to a "mothering" representation of the body was noted by Bailey in women's relations to their changing body shape – she suggested that fulfilling their roles of mothers pregnant women tended to worry less

about their body shape which is inconsistent with the norms of slender western femininity. Finally, women were also allocated more space by others, both, due to their growing bodies and due to the need to give more social space to a becoming mother. Bailey suggested that the above changes led expectant mothers to experience their femininity as an embodied experience. At the same time, she claimed that the bodily changes were often not reflected in the self-identity of pregnant women, which was constructed separately from their pregnant embodiment (Bailey 2001). Bailey explained women's resistance to link the embodied experiences of pregnancy to the changes in their identity as part of their fear of being denied other social roles and being reduced to simply "a body" (Bailey 2001). Drawing on the works of Frank (1991) and Connel (1987), Bailey demonstrates how women renegotiated their femininity and the use of their bodies at this particular point in time.

The issue of space allocated to the pregnant body has also been investigated by other feminist scholars studying pregnant embodiment (Davidson 2001; Draper 2003; Longhurst 2001). Robyn Longhurst (2001; 2005), for instance, demonstrated that during pregnancy women often feel obliged to change the spaces they occupy in society, hiding their (potentially) leaking bodies from the public eye. According to Longhurst, pregnant women "constantly threaten to expel matter from inside – to seep and leak – they may vomit (morning sickness), cry (pregnant women tend to be constructed as 'overly' emotional…), need to urinate more frequently, produce colostrum which may leak from their breasts, have a 'show' appear, have their 'water break', and sweat with the effort of carrying the extra weight of their body. But perhaps, even more than these leakages, they constantly 'threaten' to split their one self into two or more (2001:84)." The potential leakage of the body is perceived as a threat for the social order in our society and also is constructed as a shameful act. Therefore, she claims, her respondents reported a preference to withdrawal from public spaces into more private spheres of the social world where they do not fear the breach the social norms by their constantly threatening pregnant bodies. Similar findings were reported by Davidson (2001) who showed that

expectant mothers often feel "out of place" in public, fearing that their bodies will manifest their unstable, potentially leaking nature.

Focusing their attention on pregnant bodies, researchers usually investigate the visible stage of pregnancy when the changes in women's bodies are apparent to others. Exploring the experiences of bodily changes associated with enlarged breasts, growing bellies and changing body shape, pregnant women often look for recognition of their bodies as pregnant once they begin showing (Earle 2003; Longhurst 2005; Wiles 1994). Being visibly pregnant also allows them to re-introduce their bodies to society as not "just fat" but as "pregnant" (Earle 2003; Wiles 1994).

Although the changing shape of the pregnant body catches the public eye and the attention of researchers, other aspects of pregnant embodiment, which are not easily detectible by the public eye, remain insignificant in the analysis of pregnant embodiment (but see Young 1984). Various other symptoms associated with pregnancy (i.e., tiredness, breast tenderness, leg swelling) are not a part of sociological investigation of the embodied experience of pregnancy. Yet, the invisible part of pregnancy is no less crucial for women's pregnant embodiment than the enlarged body attracting the attention of others. Iris Young (1984) is one of the few researchers who described the process of embodiment associated with pregnancy which can often be invisible to others. She recalls:

> *As my pregnancy begins, I experience it as a change in my body, I become different from what I have been. My nipples become reddened and tender, my belly swells into a pear. I feel this elastic around my waist, itching, this round, hard middle replacing the doughy belly with which I still identify. Then I feel a little tickle, a little gurgle in my belly, it is my feeling, my insides, and it feels somewhat like a gas bubble, but it is not, it is different, in another place, belonging to another, another that is nevertheless my body (Young 1984:48).*

In fact, myriad physiological changes can be experienced by pregnant women long before the ability of others to document those changes and to label them pregnancy:

we often associate nausea and vomiting, extreme exhaustion, sore nipples and swollen belly with the first signs of pregnancy which usually appear in the very beginning of the journey to motherhood. The lived, feeling body, pictured by Iris Young (1984) in the quote above is often absent in sociological analysis of the embodiment of pregnancy. Instead, researchers tend to concentrate almost exclusively on visible changes associated with pregnancy and analyze their impact on the self-identity of pregnant women (Bailey 1999; 2001; Earle 2003; Longhurst 2001; 2005; Wiles 1994).

This tendency to forget about the invisible pregnancy can be partially explained by our cultural perceptions of the pregnant state. As Katz Rothman (1989) noted, in past decades we have witnessed a cultural shift in which pregnancy has become evaluated based on its *product* (i.e. healthy baby) rather than on the *work* involved in it (i.e. being pregnant). Therefore, she suggested, we adopted the understanding of pregnancy as "expecting a child" rather than the previously used "being with the child". As a result, we tend to neglect the invisible work of the pregnant body and de-emphasize the connection between the mother and her unborn child focusing exclusively on the visible, touchable, scientifically-measured results. The mechanized, technocratic model of pregnancy and birth, which is so common in our society, cannot incorporate the emotional, invisible, immeasurable experiences of expectant mothers. Moreover, in a sense it seriously threatens the biomedical model of pregnancy and birth, allowing women to introduce their personality into the seemingly mechanical process of babies production.

To summarize, I want to highlight the tremendous contribution of sociologists to the study of pregnancy, especially to the social aspects of the transition to motherhood. Here I showed that introducing the social experiences of pregnancy into the medically dominated universalistic field of pregnancy and childbirth, feminist scholars have allowed women's personal experiences to be heard and recognized. Because of this effort, socio-economic, cultural, and individual factors surrounding pregnancy and childbirth have been taken into consideration not only in social sciences but also in

biomedical and psychological research[6]. Inevitably, however, focusing their attention on social aspects of pregnancy and the transformation of self-identity, scholars have neglected the embodied experiences of pregnant women. Whenever pregnant bodies appear in the analysis, they usually tend to be visibly pregnant and mostly concerned with social relations which are detached from their ever-present physiological experiences of pregnancy. In the last section of this chapter, I show that the failure of sociologists to value the embodied experience of people is not a unique feature of the field of sociology of pregnancy and childbirth. Briefly summarizing the works of Turner (1992; 1996), Frank (1991) and Schilling (2003), I demonstrate that in other areas of sociological inquiry human embodied experiences do not receive the attention they deserve from scholars.

The Sociology of the Body and Embodied Experience

In the past several decades the study of the body has dramatically expanded not only in the field of sociology, but also in other terrains of the social sciences and humanities (Sweeney and Hodder 2002; Twigg 2006). Informed by insights from feminist theory, cultural theory, post-structuralism, theories on consumption, ageing, the disability movement, the sociology of health and illness, anthropology and various other disciplines, the enterprise of studying the body encompasses researchers from different academic disciplines working with different, and sometimes even contradictory, theoretical agendas (Sweeney and Hodder 2002; Twigg 2006). This theoretical diversity has resulted in rich empirical scholarship developed by the researchers studying the body. For instance, medical sociologists had looked into the lived experience of sick and disabled bodies (Charmaz and Rosenfeld 2006; Frank 1991; Williams, Gabe, and Calnan 2000). Post-structuralist researchers have documented how gender and cultural norms are being inscribed on human bodies (Butler 1999; Foucault 1978). Scholars have also shown how the dominant discourses on sexuality, consumerism, and gender are transforming

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[6] See, for example, Bissell (2000), Breheny and Stephens (2008), Lee (2008), Musick (1993), Oken et al. (2008), Pogarsky, Thornberry and Lizotte (2006), Stevens-Simon and Sheeder (2005).

and are being transformed by human bodies (Collier 2001; Featherstone 1991; Twigg 2006). Finally, researchers have demonstrated how bodies have become commodified and used as a resource for personal expression and the development of self and identity (Giddens 1991; Sweeney and Hodder 2002).

Despite different ways to approach the study of the body, researchers working on this subject are usually concerned with a similar task – they seek to explore the complexity of the relationship between individual bodies and society (Sweeney and Hodder 2002). In other words, they seek to understand the process of human embodiment. As Turner argues, the embodiment is:

> *not a static entity but a series of social processes taking place in the life course. Embodiment is a life process that requires the learning of body techniques such as walking, sitting, dancing, and eating. It is the ensemble of such corporal practices, which produce and give a body its place in everyday life ... Embodiment is the mode by which human beings practically engage with and apprehend the world. (Turner 2004:71)*

That is, the bodies form a society but at the same time, society is inscribed on human bodies (Merleau-Ponty 1962; Shilling 2003). The understanding of this dialectical relationship is often at the core of sociological interest in the human body (Turner 1996). It is also the topic of this last section of the literature review which is aimed at demonstrating the importance of incorporating the embodied experience into the study of the sociology of pregnancy.

Resolving the dualism of mind/body

One of the most important contributions of the sociology of the body to the general field of sociological inquiry is its attempt to challenge the commonly held analytical distinction between body and mind (Shilling 2003; Sweeney and Hodder 2002). Studying social reality, sociologists do not feel comfortable dealing with human flesh and the physical materiality of the human body, thus neglecting to include the study of real bodies in their analysis (Shilling 2003; Sweeney and Hodder 2002; Turner 1996). According to Shilling, however, the uneasiness of sociologists with "real bodies" is a

relatively recent phenomenon. He shows that the founders of sociological theory invested a lot of interest in exploring the role of physical bodies in forming society and put a significant effort in understanding the social meanings attached to the individual body. Evidently, the works of Emile Durkeihm (1995 [1912]), Karl Marx (1970 [1846]) and Max Weber (1985 [1904-5]), the "founding fathers" of sociology, all include references to lived, embodied experiences (Sweeney and Hodder 2002). It is only later that sociological theory tends to neglect the role of the body in society and leave little space for real bodies in sociological theory (Shilling 2003; Sweeney and Hodder 2002) granting them their absent presence:

> *The body is present as an item for discussion, but absent as an object of investigation. At most, we sometimes get a sense that there is an absent 'other' lurking behind social constructions. Even then, however, we receive little idea about what this bodily 'other' actually is (Shilling 2003:87).*

Analyzing the role played by the body in sociological theory, scholars note that it has rarely become the actual focus of sociological analysis (Evans and Lee 2002; Shilling 2003; Turner 1992). Moreover, even when the bodies are present in the sociological analysis, researchers do not provide theoretical explanations linking the acting bodies in a social order or explaining how the bodies are organized into societies (Frank 1991; Turner 1996). One of the exceptions was a theory developed by Bryan Turner, who proposed a structural model which explores the relationships between bodies and society. According to this model, bodies are connected to social systems in four interrelated areas: (1) the reproduction of the population; (2) the restraint of the body's desire; (3) the regulation of populations in space; and (4) the representation of bodies (Turner 1996). These social tasks explain the social interest in human bodies and assist in classifying studies of bodies under different categories (Shilling 2003).

A categorically different approach to theorizing the management of human bodies was developed by Arthur Frank (1991). Unlike Turner's structuralist approach, the work of Frank deals primarily with the agency of human bodies and the "action problems" faced by human bodies. He emphasized the importance of the embodied experiences of

humans and identified four different types of body usage that may be employed by individuals: (1) the disciplined body, (2) the dominating body, (3) the mirroring body and (3) the communicative body. To each of these ideal body types he links the medium of activity: (1) the disciplined body is mediated through regimentation and can be manifested through regulating activities; (2) the dominating body uses force and demonstrates its strength; (3) the mirroring body manifests consumption activity through visible adoption of consumerist practices and (4) the communicative body is a medium of recognition of the body that is "in process of creating itself" (Frank 1991).

Applied to the study of pregnancy both these models help to categorize women's experiences of pregnancy and to situate them in a larger social context. For instance, adopting Turner's structural approach it becomes apparent that pregnant women cannot be left without tight social control as they go about reproducing – as some feminist scholars noted, it is the role of women in reproducing the world that was often perceived by men as threatening to the social order (O'Brien 1989). Similarly, the threat of women's sexuality has often been at the core of the aim to restrain human desire and to locate it within heterosexual nuclear, male-controlled families (Turner 1996). Finally, the regulation of the population in space as well as self-representation among pregnant women had to incorporate self-disciplining practices employed by expectant mothers themselves and combined with institutionalized practices of the criminalization of women's bodies that do not adhere to regulatory norms of pregnancy. Everything that is being consumed by pregnant women (food, air, cosmetic products, clothing, etc.) is evaluated as good or bad by women themselves or by people around them.

The model developed by Arthur Frank was successfully employed by Lucy Bailey (2001) in her analysis of women's embodied experiences of pregnancy. She demonstrated how expectant mothers engage in disciplining their pregnant bodies and how they change their consumer practices to shop for the baby (rather than themselves). Finally, following Frank (1991), Bailey claims that the communicative body is represented through the

pregnant body which nurtures another body and engages in selfless activity oriented towards the creation of another human being.

Although both models are helpful for understanding the social relationship between pregnant women and others, according to Shilling (2003) those theories do not incorporate the actual, embodied experience into their theoretical analysis. Shilling notes that even though the Frank's theory does so more than Turner's, it still does not explain how and why people choose different acts of body usage and cannot shed light on the linkage between structure and agency (Shilling 2003:86). Real, breathing and walking bodies, in Shilling's view, are missing from sociological analysis and have yet to be incorporated into the theoretical enterprise.

The absence of the body from the field of social theory is a problem for sociology in general. According to Shilling, functionalists, feminists, socio-biologists, and constructionists – have all fallen short in introducing real bodies into their analysis. Although his critique is oriented towards sociology in general, here I only wish to summarize his argument about the failure of social constructionists to incorporate real bodies into social theory. This task seems imperative to me, since this dissertation is theoretically rooted in symbolic interactionist and a social constructionist approach[7]. In doing so, I primarily focus on the criticism of the works of Michel Foucault, who has been identified by Shilling and many others as a groundbreaking theorist in the constructionist view of the body (Shilling 2003; Sweeney and Hodder 2002; Turner 2004).

Constructionist theory and the body

Social constructionists working in the field of sociology of the body are usually interested in exploring the ways through which social meanings are inscribed on human bodies. Researchers working under this theoretical umbrella often perceive the bodies as

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[7] I treat social constructionist theoretical enterprise as a logical derivative from symbolic interactionist theory (Meltzer, Petras and Reynolds 1975). In the following theoretical part of this dissertation I will fully explore the links between the two approaches and demonstrate the interconnectedness between them.

constructed socially rather than containing a number of well-defined biological features. Some of the most influential writings on the body in a constructionist tradition has been produced by Michel Foucault (Shilling 2003; Sweeney and Hodder 2002; Turner 1992). As Foucault shows, human bodies do not have biologically determined roles but rather, they are constructed through social discourses (Foucault 1975; 1978). Therefore, it is impossible to see the biological body. We can merely assume a biological entity under the shell of social meanings ascribed on the body. Contextualizing his research on bodies in different historical times, Foucault's major interest was to locate the governing of human bodies and the effect of power and operation of social institutions on human bodies (Rabinow 1984). Looking at the discourses on sexuality, punishment, the birth of the formal medical knowledge, and the transformation of disciplinary systems, Foucault documented the linkages between the daily practices of bodies and the organization of power in society (Rabinow 1984).

The works of Foucault have had tremendous influence on theories about the bodies. They challenged traditional, naturalistic approaches treating bodies as biological entities and demonstrated the crucial role of social mechanisms in the creation, organization, and regulation of human bodies. Nevertheless, as Shilling notes, Foucauldian analysis has its own limitations:

> *On the one hand, there is a real substantive concern with the body as an actual product of constructing discourses… On the other hand, Foucault's epistemological view of the body means that it disappears as a material or biological phenomenon (Shilling 2003:70).*

A similar critique of Foucauldian bodies was voiced by Bryan Turner who suggested that Foucault tends to focus on regulatory, external to the body, powers and pays little attention to the embodied experiences of individual bodies (Turner 1996). Additional criticism of the works of Foucault was raised around the issue of human agency in response to regulatory powers (Lock and Kaufert 1998). It seems that Foucauldian bodies have little ability to resist or negotiate the dominant discourses and can only be seen as passive acceptors of social discourses.

The disappearance of the material body in researcher looking at meanings inscribed on the body is not unique to Foucault and post structuralist analysis. In the earlier sections of this chapter I showed that analyzing the experiences of pregnancy researchers often tend to forget about the *physical body,* focusing exclusively on the *meaning* this body bears for women and for others. Often it seems that the identity change experienced by pregnant women is only driven by their *knowledge* of the fact of their pregnancy and is completely dissociated from what is actually happening inside their bodies.

Similar criticism was levelled by Shilling towards the works of Michel Foucault. In his opinion, Foucault did not overcome the problem of the "absent presence" of the body in sociological theory. Interested in discourses and forms of regulation of the human body, he did not uncover the "real" human body on which those discourses are inscribed (Shilling 2003; Turner 2004). This gap, however, can be explained by the theoretical differences in the view of the body adopted by Foucault and taken up by other sociologists: for Foucault there is no "natural" body. Rather, the natural is the construction of social, while Shilling and Turner tend to believe that the materiality of the human body cannot be denied (Shilling 2003; Turner 2004).

This epistemological difference between social constructionists and scholars studying the body is especially evident in the works of Bryan Turner (1996; 2004). Arguing against the constructionist view of the body and, more generally, identifying limitations of social constructionism in the field of medical sociology, Turner suggests that the constructionist paradigm, although very helpful in analyzing some social phenomena, falls short in explaining the reality of the embodied human experience. In his opinion, social constructionism reduces the real experiences of the body to cultural texts and leaves little space to understand human embodiment (Turner 2004). Unlike social constructionist scholars, who see reality as socially constructed and thus refuse to treat any phenomenon as "true" or objective, Bryan Turner believes that there are some conditions that are more socially constructed than others:

> *Psychological conditions such as anorexia, bulimia, and hysteria are inherently fuzzy, but there are some conditions, such as heart disease, to which constructionist argument does not apply. One can represent heart disease by X-rays, photographs, and anatomical pictures. Heart disease is fact that is not open to dispute (Turner 2004:39).*

In his opinion, such phenomena as tuberculosis, heart disease and the vulnerability of humans to sickness demonstrate that despite culturally ascribed meanings, there are some material facts that cannot be explained away by social constructionists. So the human embodiment cannot be reduced to the cultural scripts and socially constructed representations. Therefore, he concludes that social constructionism is limited in its ability to contribute to the field of medical sociology and the study of the body because of its incapacity to explain human vulnerability, materiality of the human body, and interconnectedness of human experiences throughout human history (Turner 2004).

Following Turner's (2004) and Shilling's (2003) argument it seems that social constructionist analysis cannot overcome the problem of the absent presence of the body in sociological theory – the inability of constructionists to "admit" the real matter under the meanings inscribed on the body makes it impossible to explore the embodied experience of the body. Despite my recognition of the considerable contribution of the criticism posed by Turner and Shilling against the absence of the body in social constructionist theory, in this dissertation my objective is to demonstrate that constructionist approach can and should be employed in the study of the body. While, as Turner himself notes, the social constructionist theoretical camp includes a variety of different theoretical directions which manifest significant differences in their assessment of social reality[8], one of the arguments which can be presented against Turner's criticism concerns his tendency to define a particular social phenomenon as "real" or "not so real". Although these definitions are imperative for Turner's analysis, for some constructionists

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[8] In the next chapter I briefly summarize the constructionist theory and show theoretical and methodological diversity of this school of thought.

debates about the 'reality" of any social phenomenon lies outside of their scope of interest: since human ability to assess any phenomenon is limited to socially produced knowledge incorporated by individuals through social interactions, there is no social phenomenon that can be taken for granted as "objective" reality (Berger and Luckmann 1966; Maines 2000). Therefore, some constructionists, rather than trying to assess the *reality* of social reality, prefer to concentrate their efforts on examining the ways in which this reality is actually constructed (Holstein and Miller 2003; Maines 2000; Spector and Kitsuse 2003).

It is the constructionists' ambivalence with respect to the "reality" of the human body that makes sociologists theorizing the body uncomfortable with constructionist argument. Seeking to re-introduce the body into the field of social theory, scholars emphasize the importance of treating bodies as material entities with "real" objectively-documented feelings, pains, and characteristics (Evans and Lee 2002; Thomas and Ahmed 2004; Turner 1996). In this dissertation, however, I seek to demonstrate that incorporation of the lived experience of the human body does not necessarily require the application of an objectively-valid label on the body, categorizing it as "sick", "healthy", "pregnant" or "not pregnant". I show that sometimes it is impossible to give an objective definition to (presumably) real, visible conditions of pregnancy. Rather, it is the social interactions and the attachment of meanings to this body that makes the body pregnant and renders to it its objective status of pregnancy.

My Research Within Sociological Literature: Summary

In this chapter I reviewed the existing literature on the sociology of pregnancy and childbirth, medicalization of pregnancy and the study of the body. I showed that those fields provide a firm foundation on which this research is built. I demonstrated that feminist research on medicalization of pregnancy has been very helpful in emphasizing how the introduction of biomedicine into the field of pregnancy and childbirth has dramatically changed women's experiences of the journey to motherhood.

It would be wrong, however, to define the medicalization of pregnancy as a solely negative phenomenon. When we assess the impact of medicalization on individuals, it becomes apparent that there are women who embrace medicalization and choose to actively use its fruits for their reproductive needs. In addition, even in a medicalized culture of pregnancy, which characterizes our society, women can experience their pregnancy differently, sometimes welcoming and sometimes resisting medical advice. Therefore, contextualizing women's experiences in a medicalized culture of pregnancy, *this dissertation seeks to uncover how expectant mothers make pragmatic choices with respect to medical advice and how they negotiate their resistance or acceptance of the medical view of pregnancy.*

The second part of the chapter dealt with the literature on the experiences of the journey to motherhood. I showed that over past few decades sociologists have been primarily interested in the social nature of pregnancy and have shown little interest in the embodied aspect of this experience. The lack of bodies in the study of pregnancy is the theoretical gap which this dissertation seeks to fulfill. Unlike the well defined and designed material-based bodies of some scholars studying the body, however, the bodies presented in this research are being materialized through the meaning women attach to them. I show that without the special meaning attached to any physiological feature it cannot be defined as constituting pregnancy or the lack thereof. *My theoretical contribution to the study of the body, therefore, is to re-establish the importance of social interpretations given to the physiological phenomenon which is often evident in the works of symbolic interactionist scholars.* It is their invaluable contribution to the theoretical and methodological basis of this dissertation that I am about to present in the following chapter.

Chapter Three: Symbolic Interaction and the Embodied Experience

In this chapter I lay out the theoretical foundation on which this research is built. Based on epistemological premises of symbolic interactionist tradition, this dissertation is also informed by a phenomenological theoretical approach and relies on social constructionism. As I am about to show, those three theoretical approaches are tightly linked with each other and complement each other in my analysis. Throughout this chapter I demonstrate that these theoretical perspectives best situate the lived experiences of pregnant women, their embodiment of pregnancy, and the meanings they attach to their constantly changing bodies and selves. The purpose of this chapter, therefore, is to summarize the major postulates of symbolic interactionism, phenomenology, and social constructionism and to show how they contribute to our understanding of the construction of meaning via social interactions and how they help to explore the process of embodiment. I start with the classics of symbolic interactionism focusing on the works of Charles Cooley (1922) and George Mead (1934) and then move on to summarize the theoretical contributions of the phenomenological approach (Schutz 1962; 1964) and social constructionism (Berger and Luckmann 1966). I treat social constructionism and phenomenology as variants of the symbolic interactionist tradition. While there are some differences between the three in terms of the focus of their interest, their common epistemological foundation and interest in the micro and generation of meaning bring them under the same theoretical rubric (Denzin 1985; 1992; Reynolds and Herman-Kinney 2003). Over the course of this chapter I intend to show the relevance of those perspectives to the case in study.

In the second part of this chapter I specifically deal with the contributions of symbolic interactionism and its variation to the sociology of the body and the study of embodiment (Waskul and Vannini 2006a). Focusing on the typology of the symbolic

interactionist bodies proposed by Waskul and Vannini (2006b), I show how useful it is for the analysis of the experience of embodiment which is presented in this dissertation.

The Theoretical Core of Symbolic Interactionism

Deriving its philosophical roots from pragmatism and Darwinism, the interactionist perspective assumes that (1) any knowledge is evolutionary; (2) interactions with environment are crucial for realizing one's potential; and (3) "truth" is socially constructed (Meltzer, Petras, and Reynolds 1975). In other words, the main premise of the interactionist perspective is that humans simultaneously create their environment and are shaped by it (Ritzer 2000).

These assumptions are easily noticeable in the works of Cooley (1922) and Mead (1934) who have become known as the founders of the symbolic interactionist perspective. Seeking to understand the relationships between social actors, both Cooley and Mead looked at the role of social interactions in forming the individual and his/her environment. For instance, Cooley (1922) described human existence as an intersection of two roads: one transmits biological traits and the other "comes by way of language, intercourse, and education" (p. 4). Exploring the origins of social transmission, Cooley established a link between a child's development of language, imaginary play and the creation of self (Collins 1994).

Although Cooley (1922) and Mead (1934), as well as their followers, placed the utmost importance on the social aspects of the formation of self, their interest in the development of the child and the meaning children attach to their actions shows how vital the physical, corporeal body was for their theoretical assumptions. The process of embodiment often became the focus of their analysis and helped them to emphasize the importance of social environment in facilitating human development. Cooley noted, for instance, that simple imitation of the actions manifested by children copying the adults, which is purely mechanical in small children, is transformed over the course of a child's

development into the intentional action that is meaningful to others and to children themselves. Describing a development of his own child he recalled:

> *At two and a half he had learned, for instance, to use a fork quite skillfully. The wish to use it was perhaps an imitative impulse, in a sense, but his methods were original and the outcome of a long course of independent and reflective experiment. His skill was the continuation of a dexterity previously acquired in playing with long pins, which he ran into cushions, the interstices of his carriage, etc. (Cooley 1922:22)*

The physical, repetitive action of a child is slowly transforming into the social, meaningful act under the influence of the social environment in which the child develops. It is evident, therefore, that not only our mental abilities but also our physical bodies are shaped by societal influence. This transformation, according to Cooley, is only possible due to our ability to observe others and imagine their perspective. The process, known as *looking-glass self*, involves the ability (1) to imagine ourselves as we are seen by others; (2) to imagine the judgment of this appearance; and (3) to reflect back on the meaning of this judgment for ourselves (Cooley 1922).

Similarly to Cooley (1922), Mead (1934), too, noted how children engage in role-taking while playing games. He suggested that through this activity the concept of "generalized other" is being developed: the child learns to understand what behaviour is expected in what situation. At the same time, Mead's primary interest was in the interpretation of actions of communication. Those actions, interpreted by a socially influenced mind, nevertheless, were made by and in reference to the actual, human body. The body to which we attach the meaning constructed in our interaction, is vividly present in Mead's accounts:

> *The hand is responsible for what I term physical things, distinguishing the physical thinking from what I call the consummation of the act... with the human animal the hand is interposed between the consummation and the getting of the object to the mouth. In that case we manipulate a physical thing... Contact constitutes what we call the substance of such a thing. It has color and odor, of course, but we think of these as inherent in*

the something which we can manipulate, the physical thing…
(1934: 184-185)

Thus, for Mead the physical world provides a myriad possibilities for interpretations but it does exists in addition to the mind, busy in processing it and making meaning of it via social interactions. As Bryan Turner (1992) noted, this part of Mead's theory was largely overlooked by interactionists who often prefer to concentrate on the production of meaning and neglect Mead's link to the body which physically and neurologically contributes to the interpretive process. Turner, however, suggests, that Mead's interest in the human body is evident in his analysis of gesture and the link between the physiological processes and the creative thinking inspired by it (Turner 1992:35). At the same time, the gesture or a physical object of any kind is meaningless for Mead without an interpretive process which takes place during social interaction (Mead 1934:185). Only through communications with others we learn to interpret the physical world around us. Individuals develop the sense of self by interpreting the expectations of others as to the behaviour which would be appropriate to a particular situation. The development of self, therefore, is the ability to perceive oneself as an object, which, in turn, can only be developed through communication. The work of mind, too, is dependent on one's ability to converse and communicate, to be able to become a "me" in response to "I".

To summarize, symbolic interactionism pictures individuals who are active, meaningful and responsive to their social world. It is only through the communication with the social world that the individual can develop. At the same time, early interactionists did include in their analysis the presence of corporeal body. Moreover, they provided detailed explanations to the process of embodiment. They convincingly demonstrated how society shapes the body through social interactions and how physiological functions of the body serve, simultaneously, to interpret the world and to be interpreted by it.

Although in the beginning of its scholarly tradition symbolic interactionism was seen as a small fraction of sociologists coming against structure-based, functionalist dominant tradition (Mullins 1973), it later became tremendously popular among sociologists (Denzin 1992; Fine 1993). Rather than seeing it as one, well-defined sociological school, I prefer to envision symbolic interactionism as an integral part of the interpretive theoretical umbrella under which there are other sociological perspectives that share the common theoretical premises with symbolic interactionism even though they might be somewhat different in their focus of interest[9]. Among them are phenomenological tradition and social constructionism – two other theoretical perspectives that informed this research.

Social Phenomenology

Social phenomenology, which some scholars consider closely interlinked with both symbolic interactionism and social constructionism, is the philosophical and sociological tradition that was formulated by Alfred Schutz (1962; 1964) who was in turn predominantly influenced by Husserl's philosophy and the philosophical school of German idealism (Agger 1993). According to social phenomenologists, a person has an active role in shaping and reproducing the world. Therefore, the society is never externally defined, but exists via human interpretations, as both intersubjective and objective reality (Agger 1993). Consistent with the interpretive tradition of symbolic interactionism, the constructionist perspective and social phenomenology perceive that "*human beings actively create and interpret social reality*, which is conceptualized as a moving structure of interpenetrating, dialectical forces subject to transformation (Agger 1993: 285, emphasis in original)".

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[9] There is a great theoretical and methodological diversity among the scholars who consider themselves symbolic interactionists. For instance, some scholars include under the interactionist umbrella the dramaturgical approach and ethnomethodology (Meltzer, Petras, and Reynolds 1975). Others consider sociology of emotions and social constructionism to be a part of the interactionist camp, too (Denzin 1985; Fine 1993). Finally, even under the definition of symbolic interactionism there are two separate methodological schools – Iowa and Chicago, which use different methodological applications and have a slightly different focus of their analysis (Fine 1993; Meltzer, Petras, and Reynolds 1975).

According to Schutz (1962), the taken-for-granted world is no more than the intersubjective reality interpreted by individuals through a set of categories which he called "typifications". Our socialization since the early childhood provides us with a tool kit to make sense of the world around us. Although it is impossible to learn the world (or about the world) apart from our socialization, we are taught to accept it as real and existing independently of us. For Schutz, therefore, "knowledge is socially rooted, socially distributed and socially informed (1962: XXIX)". It is only through our lived experience in the world that we make sense of it and make it real. As Crotty (1998) suggests, simply put, phenomenology means to overcome the tendency to treat the familiar objects as we are used to and to try and get "back to things":

> *The 'things themselves', as phenomenologists understand the phrase, are phenomena that present themselves immediately to us as conscious human beings. Phenomenology suggests that, if we lay aside... the prevailing understanding of those phenomena and revisit our immediate experience of them, possibilities of new meanings emerge* (Crotty 1998:78).

This exercise in understanding the real meaning of things is what, in Crotty's opinion, distinguishes phenomenology from symbolic interactionism. While interactionists grant culturally shared meanings utmost importance in understanding any object, for phenomenologists culture is both liberating and confining: on the one hand, it provides us with possibility to "name" objects and to grant them social meaning via social interactions; on the other hand, it restricts our ability to see the "real" behind taken-for-granted meanings which we learned to attach to objects around us over the course of our socialization (Crotty 1998).

In phenomenological tradition, the corporeal body can be seen as an integral part of the analysis. Ultimately, it is only through the corporeal body that we can grasp the meaning of the outside world around us. On the other hand, sometimes the phenomenological body is hidden and rendered less importance than the analysis of the work of mind and the process of making sense of the world (Shilling 2003).

Social Constructionism

Relying on the phenomenology of Schutz (1962), but at the same time inspired by symbolic interactionist tradition, Berger and Luckmann (1966) examined the process of construction of meaning in their groundbreaking book the *Social Construction of Reality*. Linking the process of typification (described by Schutz) to the attempt to make sense of social reality around us, Berger and Luckmann demonstrated how, objectifying the world we construct social institutions as real, existing before and after us. This process of socialization happens over the course of social interactions which enable the production of meaning granted by individuals to the social reality around them (Pfohl 2008).

Similarly to symbolic interactionism, the school of social constructionism incorporates a lot of traditions, methodological approaches and theoretical variations (Gubrium and Holstein 2008)[10]. Although I tend to treat constructionist perspective with a loose approach allowing various theoretical and methodological traditions to get incorporated under the theoretical umbrella of constructionism, for the purpose of conducting this research I could place myself among the sociologists who consider themselves interactional constructionists (IC) (Marvasi 2008). According to Marvasi, "the key feature of IC's approach to understanding social life is an uncompromising attention to the construction process as it is enacted in concrete settings... for IC analysts social objects and their texts ultimately are realized in everyday practice (2008:315)." Marvasi notes that the Median influence on the interactional constructionists forces them to investigate the meaning which individuals attach to social processes and social interactions. Therefore, unlike other practitioners of constructionism, who (potentially) can focus in their research on generation of meaning in newspapers and documents, the IC scholars tend to capture the production of meaning investigating social interactions. Consequently, their methodological framework requires them to place their attention on

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[10] For instance, scholars working under constructionist paradigm tend to differentiate between "strict" and "soft" versions of constructionism, as well as identify many different constructionisms, which include Foucauldian approach, discursive constructionism, narrative inquiry, claims-making, and interactional (Gubrium and Holstein 2008).

the individuals themselves and not on the products of their work (Marvasi 2008:317). In addition, IC scholars see structural conditions similarly to the view employed by interactionists – for them social structure and social conditions are enacted in everyday practice and not socially determined. Finally, another distinctive feature of IC school of thought is the attention paid to the variations in generations of meanings attached to the same social setting and the analysis of "discourse in practice" (Marvasi 2008).

Although the theoretical traditions summarized above are not always possible to separate into distinct sociological schools in my analysis, the theoretical and methodological insights taken from them are firmly incorporated into this research. The generation of meaning during social interactions with others and with one's own body is what had become the focus of my analysis. Exploring the meaning that pregnant women attach to their pregnant bodies, I often rely on the combination of interactionist, phenomenological, and constructionist arguments. I focus on the interactions between pregnant women and people around them in order to understand the meaning making process of pregnancy happening within and outside the pregnant body. I also constantly refer to the social context in which expectant mothers live their pregnancy and experience their changing bodies. As Waskul and Vannini (2006b) note, symbolic interactionism and its theoretical allies have informed their own interpretivist framework for understanding human body and the process of embodiment. In the following section of this chapter I briefly present the "bodies of symbolic interactionism" (Waskul and Vannini 2006b) and highlight which of them are especially relevant for this work.

The Body and Embodiment in Symbolic Interactionism

Similarly to the position taken in this chapter, Waskul and Vannini see interactionist tradition as a loose construct incorporating under the interpretive paradigm various theoretical traditions including symbolic interactionism, dramaturgical approach, phenomenology, socio-semiotic interactionism, and the narrative framework (Waskul and Vannini 2006b). In their edited volume on the body and embodiment in symbolic interactionism they offer a rich empirical collection of the analysis of the body, consistent

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with interactionist tradition, and provide a theoretical framework for conceptualizing bodies of symbolic interactionism (Waskul and Vannini 2006a).

Waskul and Vannini (2006b) identify five distinctive conceptualizations of human bodies inspired by pragmatist philosophical tradition and consistent with interactionist ontology. According to them, the interactionist body is always social and constructed through social interactions. Therefore, it is often impossible to distinguish between the body of a person, his/her self, and interactions which facilitate the construction of self – the body is inseparable from the process of embodiment (Waskul and Vannini 2006b:3). While all five conceptualizations of human bodies summarized by Waskul and Vannini share this vision of the body, they are slightly different in providing the answer to "*how* and by *what means*" the process of embodiment is experienced (Waskul and Vannini 2006b:3-4). In what follows I briefly summarize this typology:

- The Looking-Glass Body: Reflexivity as Embodiment - drawing mainly on Cooley's (1922) looking-glass self but also on the works of Mead (1934) the looking-glass body is embodied through the process of reflexivity. As Waskul and Vannini note, "when we gaze upon bodies of others we necessarily interpret what we observe. Similarly, others imagine what we may be seeing and feeling, thus completing the reflections of the looking-glass. Obviously, this looking-glass body is not a direct reflection of other's judgments – it is an *imagined* reflect built on the cues gleaned from others." (2006b: emphasis in original)

- The Dramaturgical Body: Body as Performance – this framework for understanding the body is based on the works of Ervin Goffman (1958; 1963; 1972) and the dramaturgical school. As Waskul and Vannini suggest, "the dramaturgical body is embedded in social practices... people do not merely "have" a body – people actively *do* a body. The body is fashioned, crafted, negotiated, manipulated and ritualized in social and cultural conventions." (2006b:6 emphasis in original)

- The Phenomenological Body: Body as Province of Meaning – inspired by the legacy of Schutz (1962; 1964) and Merleau-Ponty (1962), phenomenological body uncovers

the meaning of the world through the detailed description of the lived experience. Quoting Waskul and Vannini, "we have a body that serves as a fundamental corporeal anchor in the world: we also experience ourselves through numerous "bodies of meaning"... meaning is comprised *in* embodied action and the body is interpreted *by* frameworks of meaning." (2006b:9, emphasis in original)

- The Socio-Semiotic Body: Body as Trace of Culture – deriving its roots from post-structuralist tradition and the cultural studies, the socio-semiotic body is a reflexive agent and an active self which is engaged in "practical meaning-making (semiosis) occurring in an exo-semiotic field inevitably informed by power relations." (Waskul and Vannini 2006b:10)

- The Narrative Body: Body as Story – this body is situated around the stories we tell about ourselves and to ourselves as well as the stories others tell about our bodies and their own bodies. Embedded in this process is contextualization of the story in the "site of discursive struggle between narratives of the self and institutional discourses which frame our (embodied) subjectivity (Waskul and Vannini 2006b:12)."

Evidently, the similarities between the bodies of symbolic interactionism cannot be ignored – each conceptualization places the utmost importance on the interactions of individuals and interpretations given to those interactions through the process of embodiment. Therefore, the self and the body are always social, fluid and constantly changing their meaning. What shifting from one approach to another is the focus of the attention and a slightly different vision of the process of human embodiment. At the same time, Waskul and Vannini (2006b) note that the presented typology is more of an "ideal-type" categories which are often closely interwoven in interactionists' analysis, informing each other and contributing to the understanding of each other.

The Bodies of Symbolic Interactionism in My Analysis: Summary

In the theoretical foundation of this research, which heavily relies of the interpretive tradition, it is possible to identify four of the presented frameworks for conceptualization of the body – the looking-glass, the phenomenological, the

dramaturgical, and the socio-semiotic (constructionist) bodies. These bodies coincide with interactionist, phenomenological, and constructionist traditions on which this research relies and become a useful tool for exploring the meaning of pregnant embodiment.

Generation of meaning which expectant mothers attach to pregnancy, the interpretive process of their experience of embodiment, and the contextualization of these experiences in social reality, which is, simultaneously, constructed and being reconstructed by expectant mothers, is what makes all three theoretical perspectives presented in this chapter essential for my analysis. Those perspectives influence the analysis of the body, which is sometimes presented as the reflection of women on their socially constructed selves during pregnancy and sometimes oriented towards the understanding of women's negotiation with others, the presentation of their bodies and selves to others, and their repositioning of self in their social worlds.

Throughout this dissertation, I show that my conversations with pregnant women highlighted the looking-glass self constructed in the social interactions between women and people around them. Going to work, announcing their pregnancy to their family and friends, and participating in brief encounters with strangers, expectant mothers often reflected on what others might have thought about their pregnancy, their bodies, and their suitability to mother a child. These interpretations were reflected in their personal view of pregnancy and the meaning that they attached to the transition to motherhood.

Focusing on women's actions in response to interpretations that they gave to the pregnant embodiment, I often highlighted their work of *doing* pregnancy. I showed how their social status as mothers was often dependent on their ability to perform pregnancy and to demonstrate their successful performance of pregnancy to people around them. Therefore, in my analysis I incorporated the meaning-making process of the dramaturgical body. It allowed me to demonstrate how women performed pregnancy and enacted it with their bodies.

The process of embodiment of pregnancy and the knowledge that pregnant women acquired before getting pregnant about their own bodies and the transition to motherhood was put to test when they experienced this transition through their own bodies. Often, their personal experiences of pregnancy had shaken the taken-for-granted assumptions, forcing them to reinterpret their knowledge about the body and about their pregnancy. This transition, experienced in the North American context of heavily medicalized and institutionalized pregnancy, sometimes had transformed their personal experiences and sometimes transformed the very reality of what we tend to call pregnancy.

Chapter Four: Research Methodology

When researchers are interested in depicting the meaning-making process, the most appropriate form of sociological inquiry is qualitative methodology - the only method that allows accurate exploration of the meaning that people attach to the world around them (Pawluch and Neiterman forthcoming). As Herbert Blumer (1969), the founding father of the qualitative methodology in sociological research, noted, if the empirical world of social actors is constructed in the process of social interactions, one can only study it through close examination of these interactions. Therefore, seeking to understand the meaning that women attach to pregnancy and to explore their relationship with their pregnant bodies, I adopted the methodological approach of qualitative inquiry. Using individual, semi-structured interviews as the tool of data collection, I attempted to capture women's experiences of pregnancy and to present them on the pages of this dissertation. I start with describing my initial interest in the experiences of pregnancy and show how it was transformed into the research inquiry. Following the chronology of the project I describe the investigations that formed the pilot phase of my project and then move on to the more formal stages of data collection and analysis. I summarize the chapter reflecting on the role of my personal identity (as pregnant woman, a mother, an immigrant, and a student) on data collection and analysis.

The Birth of the Research Project

In many ways being an immigrant is similar to being an ethnographer. Coming to another country, an immigrant starts to observe the "others" learning to understand their language and culture. At first, (s)he is merely an observer, unfamiliar with local customs, conventions and traditions. Slowly, however, the initially distant observer is transformed into a participant in the local life – the rules and interactions in the hosting society become meaningful and easily recognizable.

The benefit of being a newcomer to a field of study is the ability to see the taken-for-granted reality of others in a novel light. This is probably why, starting my Master's

degree in McMaster University soon after my arrival in Canada, I noticed how disruptive my visibly pregnant body was to some within the local academic community. Walking on the campus and attending class after class, I was amazed to notice that I was the only pregnant woman around. It was quite a surprise since during my previous academic studies in Israel four other students from my department were also expecting their first child. Wandering in the labyrinths of halls and doors of McMaster, I soon realized that my lonely and disrupting second pregnancy was a very different experience from my first journey to motherhood. And, although it could have been partially accounted for by the greatly decreased amount of severe nausea in my second pregnancy, it felt different mainly because of my local "otherness" and the way people around me related to my visibly pregnant body. In Canada, people were less eager to touch my body and to give advice. At the same time, reflecting on my pregnancy in Israel I could not recall as many books, websites, guides, prenatal nutrition classes and other sources of information for pregnant women as were available in Canada. I also started to notice how often the covers of popular magazines would feature stories about pregnant celebrities and how dominant was the voice of maternity fashion in Canada.

It was, therefore, my initial reflection on the differences in my personal experiences of pregnancy that led me to the field of my study. When designing my research project, I was planning to understand how pregnant women experience pregnancy, how they respond to their changing bodies and what roles popular media and the medical advice given in popular media have on shaping the experiences of expectant mothers. Interested in the experiences of women and their understanding of the discourse that is taking place in media, I opted for a qualitative inquiry, collecting data mainly through interviews but also documenting information available in popular media that specifically targets pregnant women and new mothers. The meaning that women attach to their transition to motherhood can only be fully understood via personal interactions with expectant mothers. Thus, I chose personal, semi-structured interviews as the primary

method of data collection, relying on text and media analysis as a secondary source that could help to contextualize women's experiences of pregnancy.

Piloting the Project: Media Data Collection

Over the course of my Master's studies, I conducted a number of pilot projects that dealt with the analysis of media discourse on pregnancy. My personal experience of pregnancy as well as my journey through obstetrical and midwifery health care services provided me with easy access to the seemingly endless information guides and brochures on pregnancy distributed (or recommended) in the offices of health care providers. In the office of my obstetrician, for instance, after each visit I received a package with a free magazine for pregnant women and a lot of flyers and booklets about health, nutrition and exercise during pregnancy. Two years later I was expecting again, and this time I chose a different path of maternity care that was unknown to me previously. Instead of traditional obstetrical care, which I experienced first in Israel and later in Canada, I decided to have a midwife and signed up at a local midwifery clinic. In the office of midwives, along with a folder full of resources for prenatal care, I was introduced to bookshelves with plenty of guides on pregnancy that I was welcomed to borrow. Registering for birth in a local hospital, I received a full bag of information and instructions on pregnancy, labour, birth, and postpartum. Finally, released from the hospital with my newborns, each time I carried home another bag filled with useful (and not so useful) information on breastfeeding, postpartum and child development.

Although I did not purposely collect and classify this information, it became a first step on my way to the data collection for this study. Reading the material offered in various maternity care settings, I learned which issues were being discussed and which issues were absent from media. Subsequently, I turned my attention to the Internet, where (almost) each popular magazine for pregnant women has its own website containing information about pregnancy and birth. For instance, popular Canadian magazine *Today's Parent* has its own website, which not only features about 217 articles on pregnancy but also has its own forum communities for expectant mothers

(http://www.todaysparent.com/). Similarly, the websites for magazines *Canadian Parents* (http://canadianparents.com/), *Fit Pregnancy* (http://www.fitpregnancy.com/) and *Parents* (http://www.parents.com/pregnancy/), as well as the Johnson & Johnson–sponsored Baby Centre (http://www.babycenter.ca/), all have their own sections of articles related to pregnancy and feature an online community or a forum for expectant mothers.

Before starting the interviews, I spent a considerable amount of time studying the content of the websites and learning about pregnant women's concerns and problems that they experience over the course of their journey to motherhood. It was through this preliminary data collection, for instance, that I learned how popular it is to discuss exercise during pregnancy and how often expectant mothers are advised to modify their weight. It also led me to believe that maternity fashion has become an important trend in the pregnancy community - each website features its own section on clothing, including intimate and outdoor apparel. Although I read articles from all the above websites, for this thesis I systematically collected the content of just two sources - Today's Parent and Baby Centre, which, after cross-referencing information in magazines and forums, seemed to be the most popular among Canadian women. The popularity of those websites was later confirmed by my participants who mentioned them more often than other sources when asked about the Internet websites that they used. The table of contents for these websites is attached in Appendix 1.

I did not engage in deep and thorough content analysis of these websites. Nevertheless, over the course of this project they helped me to situate women's experiences in a larger social context. During the individual interviews, I often heard in women's statements the ideas of the pregnancy experts quoted in those websites and information brochures. Sometimes my interviewees argued with the experts and sometime they would adopt their advice. Regardless of their personal position, however, it was clear that women were familiar with the discourse on pregnant body and health that takes place in media and that their personal experiences of pregnancy were often

shaped by those discourses and in response to them. This fraction of data, therefore, served me as a context in which the personal experiences of pregnancy were analyzed.

Data Collection: Interviews

My interest in the meaning that women attach to their experiences of pregnancy and their changing bodies led me to seek the opportunity to talk to expectant mothers. For that purpose, I sought to conduct individual, semi-structured interviews with pregnant women or women who gave birth to a child in the previous 12 months. I assumed that 12-months postpartum women would still have a very vivid memory of their pregnancy and therefore, could talk about the changes they experienced with their bodies. Those postpartum months could also give them a chance to reflect on the transition that happened to their bodies and how it was different from their postpartum experiences. Finally, many Canadian women are able to take a maternity leave from work to take care of their newborns for 12 months. Thus, the 12-months postpartum period seemed to be a good option to meet with women and to talk to them about their experiences.

Planning the interviews, I designed an interview guide (see Appendix 2) that would help me to navigate through women's experiences of pregnancy. Key questions included in the interview guide covered three major themes: (1) the experience of the transformation of the body during pregnancy (including physiological changes and body image); (2) changes in relationships with others (family, friends, co-workers and strangers) during pregnancy; and (3) social construction of pregnancy (medical advice, images of pregnant women and maternity fashion). I also asked women what Internet resources and pregnancy guides they used while being pregnant. The semi-structured nature of the interviews allowed me to use those key themes as anchors that helped me to navigate through women's pregnancy experiences. Rather than asking the set of key questions in a strict order, I consulted the guide to make sure that my participants and I covered all areas of my inquiry. For the most part, our interviews were more of a conversation than the scientific model of question-and-answer. Sometimes, however,

when the conversation would slow, it was really helpful to stimulate the discussion by going back to the prepared questions.

Finding participants

In my initial research design I planned on recruiting participants for my study via maternity care providers' offices, such as physicians, obstetricians and midwives. I printed out one-page flyers (see Appendix 3) inviting women to participate in my research and giving them a brief explanation about the research aim and the process. My other recruitment strategy was to gain access to prenatal classes available to expectant mothers in the Hamilton area. There, I was hoping to give a brief (one to two minute) presentation about my study and leave flyers with information about the research and contact numbers.

Both of these strategies failed. Although I had easy access to maternity care providers' offices and left approximately 150 flyers in midwife and obstetrical offices, as well as 10 family practices across Hamilton, only two women responded to my advertisement, of whom only one agreed to be interviewed. A similar situation occurred in prenatal classes - obtaining the permission of the Hamilton Public Health Department to come into the classes and do a presentation about my research, I visited five facilities, gave a brief presentation and handed out the flyers. Although the majority of the women voiced real interest in my research during my presentation, only two actually contacted me and only one found time for the interview.

I believe that my failure to recruit pregnant women using those two strategies can be explained by my limited ability to interest women in participation. To protect their privacy I could not ask for their personal information and had to wait for their response (via phone or email). I can imagine how hard it was for women (who, probably, were simultaneously managing work, home and pregnancy) to find the time to get interviewed and how easily my flyer could get lost in their purses and bags. Desperately waiting for someone to call, I could still understand how I, too, could have lost such a flyer and how

my good intentions to participate could have been buried under the piles of laundry, undone homework and an uncooked dinner.

After failing to recruit women via my carefully designed recruitment strategies, I decided to use a snowball sampling. Here, I had much more success. I asked my friends, relatives, co-workers and fellow students to advertise my study to pregnant women or new mothers that they knew in their personal circles. I sent them my flyer via email hoping that they would distribute it among the women they knew. I also left flyers about my study in my sons' daycare and school and in community centres that we often visit. In just a month, I had close to 30 respondents who were willing to give me an interview either in person or on the phone. Some of these women resided in Hamilton and some of them were living in other parts of Ontario. Each one of those women recruited via friends and fellow students had found the time to talk to me and to discuss her experiences.

My initial reluctance to use a snowball sampling was mainly due to the fear that using my personal networks would result in a sample over-represented by women who are middle-class, white, and married - a key flaw in the existing literature on women's experiences of pregnancy and childbirth. Therefore, I was eager to find a way to gain access to younger mothers, older mothers, poor mothers, immigrant mothers, and mothers of three and more children whose experiences of pregnancy might be remarkably different from the well-researched population of white middle-class first-time mothers. Often I specifically asked my friends to advertise my research to "marginalized" mothers. My personal networks helped me to gain access to immigrant mothers (especially of Jewish and Russian descent), religious mothers (mostly Christian-Orthodox and Jewish-Orthodox), and mothers of three and more children. Finally, to get access to financially disadvantaged women and younger mothers, I started to offer a $5 gift certificate to Tim Horton's as a thank-you gesture for participation. Mainly due to this incentive, I was able to conduct 10 interviews with teenage mothers studying in a residential facility in southern Ontario. I also offered the gift certificates to immigrant women participating in prenatal classes specifically designed for newcomers and recruited two more participants.

Using those strategies I was able to conduct interviews with 42 women from different cultural and social backgrounds. The age of the women ranged from 15 to 42. About two-thirds of them were married while the rest were single and/or had partners. Close to one-third had identified with the low-income families and about one-half considered themselves to be a cultural or visible minority. Half of my respondents were first-time mothers and the rest had one to three children. Table 1 presented in Appendix 4 summarizes the characteristics of my participants. To protect my participants' identity I used pseudonyms and erased all the information that could be used to identify them. Where possible, however, I tried to give each woman a name that would reflect her belonging to a particular culture, and provide a brief description of her family status and type of employment. One of my participants, a woman named Anna, was interviewed twice over the course of my research. She was one of my first respondents, and she contacted me in the concluding phase of the research, when she was pregnant again with her third child. The rest of the participants were interviewed just once over the course of their pregnancy or in postpartum. The timing of the interview ranged from the seventh week of pregnancy until twelve months postpartum.

The interview process

In a sense, the interview process often started long before we sat down and discussed the experiences of pregnancy. Recruiting women to participate in my study, I had to explain the purpose of my research. Going over the letter of information (see Appendix 5), my participants and I would already start the conversation about the experiences of pregnancy. In a similar manner, the interview would rarely be finished when it was formally concluded - once I turned off the recorder, we often continued talking about our children, our experiences of pregnancy, and my speculations about the anticipated findings. Therefore, in addition to recording the interviews (to which all but one woman agreed), I also kept notes on "before and after" communication, which helped me later during the analysis.

The majority of the interviews were conducted in person but some of the participants preferred to talk on the phone. Usually I offered women both options, letting them choose. When interviews were conducted over the phone, it was mainly due to geographical restrictions (some women lived outside of the driving distance) or personal constraints (time constraints and the ability to engage in housework while talking on the phone). Although phone interviews restricted my ability to meet the woman and to record her body language during our conversations, telephone interviews had three positive features that the in-person interviews lacked: (1) it helped women to preserve their relative anonymity; (2) it lessened the intrusion of the researcher into the woman's life (the majority of women, while talking to me on the phone, continued with their daily routines of nursing, cooking, taking care of children, and doing household chores); and (3) it seemed to be a more natural way of talking (it is more common for women to talk on the phone than to formally participate in the structured interview). Of course, from time to time phone conversations would be interrupted - a crying child or a neighbour knocking on the door are just two examples where the interview had to be stopped and rescheduled. However, it was much easier (and more convenient) to reschedule the phone interview than a personal meeting. One time we rescheduled our conversation to the next morning and another time the woman called me back in 15 minutes once she soothed her crying child.

When I received a message from a woman who agreed to participate in my study, we scheduled a conversation via phone or email so I could go over my letter of information, let her know about the interview length and structure, as well as discuss the issues of anonymity and potential harms and benefits. Each participant would then sign a consent form (or give a verbal consent over the phone). At this time I also asked women if they would be willing to be recorded, if they wanted to receive a transcript of the interview (that they could correct and send back to me or just save for their personal records), and if they wanted a summary of the study results. All but one woman agreed to be recorded during the interview and all were interested in receiving the summary of the

study results. About half of my participants indicated they were interested to receive a transcript of their interview, but mostly to include it in their pregnancy diaries. All of my respondents were computer accessible and email was the preferred choice for later correspondence.

The interviews usually lasted from 45 to 90 minutes, with vast majority taking more than one hour. I started the interview by asking women to talk about their first response to pregnancy - how did they find out about it and what were the first signs given by their bodies that they were pregnant. We also talked about physiological changes experienced during pregnancy, including cravings, changes in diet, body posture and movement. Over the course of the interview, I would usually ask women to reflect on their personal experiences during pregnancy but also to render their opinion about the social construction of pregnancy. For example, I would ask how the appearance of pregnant celebrities in the media affected them personally and how, in their opinion, it changed the way people think about pregnancy in general. It was common for women to present themselves as being very different from what they assumed the average pregnant woman would be. At the beginning of my research I focused primarily on the body image during pregnancy. I found that although women were concerned with their changing bodies, their major concern was navigating through myriad suggestions, advice and comments on the management of a successful pregnancy. Therefore, I modified my research guide, and started to ask women how they manage to navigate their pregnancy in terms of expert advice - how do they choose whom to listen to and whom to ignore and why. Finally, towards the end of the project I felt that I reached theoretical saturation - during the last five interviews I mainly confirmed previous findings and found no more new insight. At this point I stopped the interview process and moved to the analysis.

The Data Analysis

Although in this chapter, for the purpose of clear presentation, I analytically drew lines between the interview process and the analysis, during the course of the project the first part of analysis was done simultaneously with the data collection process. After each

interview I wrote a memo, reflecting on the interview and highlighting the major themes and questions that came up during the conversation. Those answered (and unanswered) questions would then be explored during the next interviews, sometimes clarifying an issue and sometimes finding that further investigation was required. In that way, I started to indentify the major themes arising from the project long before the data collection was finished. Moreover, the second half of data collection was structured mainly around already well-established analytical themes.

The second phase of data analysis started after I finished the data collection. Once the last interview was over, I began transcribing the interviews, starting from the first one. The transcription process proved to be a very efficient way to refresh my memory about the interview with each woman and to re-examine the emergence of the major themes resulting from our conversation.

Upon completion of the transcription phase[11] I transferred the transcripts into NUD*IST 6, a software for qualitative data analysis, and started coding the interviews. Following the suggestions of Richards (2005), I first started with a free coding scheme, coding each interview under different nodes that included the quotes about a particular topic. Once this process was completed, I started to categorize nodes under a tree structure, combining similar topics or inter-related themes under one subject. For instance, the tree nodes formed a category "reactions of others to pregnancy" under which there were "family" (where I collected the reaction to pregnancy coming from family members), "friends," "workplace," and "strangers." In a similar manner, under the "workplace" node, there were nodes for management and co-workers as well as a node for support and for a negative reaction to the pregnancy. As a result, the initial, long list of free nodes was reduced and re-designed into separate themes and categories.

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[11] Once the transcription phase was completed I also emailed my participants who wished to receive a transcript of their interview, asking their permission to send the transcript via email or to the desired mailing address. Although initially many women indicated their willingness to receive the transcript, only one participant actually voiced her interest to get the file. After receiving her consent, it was sent to her via email.

In this dissertation I present four major themes that arose from the analysis: (1) the ambiguity of the state of pregnancy (which is discussed in the next chapter); (2) the entrance into a pregnancy "club" (chapter 6); (3) negotiations around the body image (chapter 7); and (4) the impact of social context on the meaning attached to pregnancy (chapter 8). Before moving on to the presentation of the results, however, I want to briefly reflect on the impact my other social roles (i.e., those of a woman, a pregnant woman, a mother and an immigrant) had on data collection and analysis.

Reflecting on My Role as a Researcher

As Denzin and Lincoln (1998) suggest, the identity of the researcher may have a crucial impact on the study design and implementation. Starting from the access to the field (which may be easier for some people than for others due to their age, gender and social status) and working in it while getting to know people and engaging with them in daily conversations, it is often more important for a researcher to be able to "engage in sociable behaviour" than to follow "any scientific canons of research" (Shaffir 1991:73). Consequently, I consider it very important to reflect on my other social roles that had their impact on my entry into the field of study and facilitated (or made it more difficult) to gather the research data and to analyze it.

At the beginning of this chapter, tracing the birth of this research project I showed how my personal experiences of pregnancy in academe triggered my interest to turn to sociological inquiry in order to understand the pregnant embodiment. It was my "otherness" and my unfamiliarity with the local culture, rather than anything else, that led me to this research project. Over the course of the project it became abundantly clear how my other social roles facilitated my access to the field and made the process of gathering data easy and enjoyable. For instance, over the course of my Canadian pregnancies, I learned the art of navigating through the maternity health care system, in both obstetrical and midwifery settings. This experience was invaluable in discussing it later with my participants and relating to their negative and positive comments about the system. My own experiences of pregnancy and childbirth gave me credibility not only of

a researcher, but also of a mother to engage with my participants in conversations about pregnancy and child rearing. On a number of occasions, upon completion of the interview, the first-time expectant mothers asked me questions about my personal experiences of labour, birth and breastfeeding and I was happy to share with them my personal story of pregnancy. Finally, accompanied by my newborn child or my older children, I had comfortable access to such facilities as women's shelters, and community centres for mothers with young children.

At the same time, this familiarity with the field of my study could have potentially harmed my research. Since I have personal pregnancy experiences, I could easily have overlooked the differences in women's perceptions of pregnancy. Therefore, during the interviews and over the course of the data analysis I constantly reminded myself to be aware of the voices of the women in order to capture their (rather than my own) experiences of pregnancy. Especially when women's voices contradicted my personal reflections, I made sure to document their opinions, seeking to understand the underlying logic of their individual dynamics. This was a study about women (and not about me), about their experiences of pregnancy and my role as the researcher was to document this process and to render it sociological explanation. Thus, during the course of data collection I often used my status as a mother and a pregnant woman to gain access to participants. Over the course of data analysis, however, my voice was never singled out. When present at all, it would simply be just one more, a 43rd voice of the diverse group of women who contributed to this study.

Chapter Five: Naming, Claiming and Reclaiming

In discussing the medicalization of pregnancy, scholars typically build their argument by exemplifying various ways of control exercised by medical practitioners over pregnant women. Close and continuous monitoring of pregnancy, slowly expanding over the past hundred years from the curious gaze of a physician to a deeply penetrating technological eye via ultrasound, fetal monitoring and other devices, allows one to vividly illustrate how, increasingly, pregnant women have come to lose control not only over their bodies but also over the life of the person growing inside them (Davis-Floyd 1990; Katz Rothman 1993; Kohler Riessman [1983] 2003; Oakley 1980; Tan 2004). Focusing on the physical examples of medicalization, however, we often forget about the role medicalization plays in changing our understanding of pregnancy and the pregnant body. Thus, thinking about the birth process, people almost inevitably picture a labouring woman in the hospital. Similarly, discussing pregnancy, people usually talk about "trimesters" and "due dates," which transform pregnancy into a process with scientifically established timelines. The culture of pregnancy and childbirth remains heavily medicalized despite years of feminist struggle, legalization of home birth and establishment of legitimate midwifery care in most Canadian provinces. It further proves that medicalization of ideology is a very powerful process and demedicalization of culture is much slower than the structural changes demedicalizing a particular condition (Clarke et al. 2003; Conrad 2005; Fox 1994; Zola 1994).

Analyzing medicalization and the control it imposes over our bodies, scholars tend to neglect the interpretation lay individuals give to a phenomenon that has been medicalized. Yet, as Lock and Kaufert (1998) argue, even when cultural norms encrypt certain images and beliefs about a condition, the actual experience may be different from the dominant representation. In this chapter I demonstrate how women's understanding of pregnancy challenges the dominant belief that pregnancy is an event, which starts on medically calculated - or at least calculatable - day of conception and ends with the birth of a child. I show that in women's personal narratives, pregnancy is not just shaped by

medical discourse but is also attuned to their emotional and physiological experiences. Reflecting on their personal feelings and interacting with others, they construct their own pregnancy "timelines" that do not necessarily correspond to the medicalized definition of pregnancy. Finally, I show how physical and social aspects of pregnancy are interwoven, one contributing to the development of the other, and how both shape the embodied experience of the journey to motherhood.

Following the natural course of pregnancy, I start this chapter from the beginning of pregnancy and monitor the change experienced by women until they enter the postpartum period. I purposely decided to exclude women's experiences of labour and childbirth for two reasons. First, I see pregnancy as a continuous, prolonged event that changes women's bodies and transforms their interactions with others. Childbirth, on the other hand, is a (relatively) short event during which a woman interacts with a limited number of people. Since my interest is in the change in interactions of women with their bodies and with others, to include in the research an additional focus - childbirth - seemed unwarranted. Secondly, childbirth has already been thoroughly examined by researches who contributed tremendously to our understanding of this event (see, for example Brubaker and Dillaway 2009; Davis-Floyd 1990; Hewison 1993; Mansfield 2008; O'Reilly 2004; Oakley 1980). In the first part of this chapter I demonstrate how women acknowledge their pregnancy and how they name their bodies "pregnant". The second part of the chapter deals with the renegotiation of pregnant women's roles and responsibilities in their interactions with others. Here I show how women claim (or resist to claim) their status of "being pregnant" and how others respond to this claim. Finally, moving to postpartum period, I demonstrate that for some women, pregnancy does not end with the delivery of the baby since the meaning that the women give to pregnancy is often attached to social transformation (*sharing* their bodies with someone). I conclude this chapter reflecting on the role women play in redefining the biomedical discourse on pregnancy.

Naming the Body Pregnant - Personal Acknowledgement

In the context of maternity care the length of pregnancy is usually calculated from the first day of the last menstrual period. Based on this date, it is common to identify the approximate date of conception and to calculate the due date for delivery of a child. Although some women claim that they know their day of conception, women's knowledge of their own bodies does not receive legitimacy in the medical discourse (Oakley 1980). Instead, family physicians and obstetricians prefer to rely on more scientific methods of confirmation of pregnancy and due date, such as laboratory testing (for confirmation of pregnancy) and ultra-sound (for confirmation of the due date) (Crook 1995; Davis-Floyd 1992; Marshall and Woollett 2000; Oakley 1980). Even the pregnancy test available without prescription in pharmacies is not considered to be a competent tool for identifying pregnancy (Marshall and Woollett 2000). Only the confirmation of pregnancy by a maternity care provider has the authority to name the changing body of a woman a "pregnant body."

In this sense, pregnancy is no different from other medical conditions - only a health professional has the right and authority to attach a 'sick" label to a person and to define the sickness as a specific disease (Charmaz 1991; Conrad 2005; Lupton 2003). However, in order for a person to consult a physician, s/he, first and foremost, needs to detect a dysfunction of the body and to associate it with a possible illness. Similarly, before receiving a scientifically valid label of pregnancy, women have to attribute the changes in their bodies to pregnancy, and, subsequently, to assume that they might be pregnant. In this section of the chapter I demonstrate how women acknowledge their pregnancy, how they interpret the signs given by their bodies and how they attach them to pregnancy or detach them from it. Influenced by the cultural representation of pregnancy, we often assume that women are waiting to get pregnant and they are eager to confirm their pregnancy immediately. In what follows I show how diverse the initial response to pregnancy is.

Planned pregnancy

Typically, women who were planning on having a child recognize when they are pregnant right away. Some of the women I interviewed were using ovulation tests to improve their chances of getting pregnant. Others were checking their temperature to increase the chances of conception. In both cases, the home pregnancy test was usually used by women right after the first signs of the suspected pregnancy:

> *I kind of knew [I was pregnant] before I took the test because I was monitoring my ovulation and kind of had a sense... I was taking basal temperature and then I confirmed it with a pregnancy test. I just knew [I was pregnant] based on the temperature, that was it. (Beverly, 34-year-old married mother of one, last trimester of pregnancy)*

In cases where fertility treatment was involved, the confirmation of pregnancy came even more quickly:

> *Well... my partner is a woman, and we went to a fertility clinic and it was all very clinical. And we went there for insemination on the 1st of [the month] and went for a follow up pregnancy test on 15th which is when we got the confirmation [of pregnancy]. And then we got back 2 days later and got another confirmation and... I can't remember now if it was then or maybe a week later that we got the early ultrasound, but basically it was pretty much boom, boom, boom, and within two weeks I knew I was pregnant. (Amanda ,35-year-old mother of one, living with her partner)*

Trying to conceive a child or using fertility treatment, women demonstrated a pragmatic approach to assisted reproduction technology. Similar to the perceptions of "pragmatic women" depicted by Lock and Kaufert (1998), my interviewees were neither passively consumed by the available technologies nor actively resisting the domination of medicalized world of fertility. Reflecting on Beverly's decision to use the basal temperature measurements, it is possible to speculate that it helped her to take control over her reproductive body. In the case of Amanda, "giving in" to the dominant culture of assisted reproduction meant also "resisting" the conventional structure of the patriarchal nuclear family. For both women, however, their personal needs more than anything else

defined the decision to use medicalized tools for conception and/or detection of pregnancy.

Planning their pregnancy, women often needed to rely on scientifically designed tools to confirm their pregnancy or to detect their ovulation. Even when women "felt something" or "suspected something" and even when they could pinpoint the day of conception on the calendar, medically established timelines for ovulation/conception/confirmation had constantly taken priority in the calculations of their care providers. Although some women claimed to be able to read their bodies well enough to detect the exact moment of conception, they rarely argued with maternity care providers about the expected delivery date. Nevertheless, they were sure that their detection of conception was more accurate than the one calculated using scientific measures. But the women's own dates of conception were unconfirmed scientifically and thus not valid within a medical discourse on pregnancy. Yet, they were real and felt real to the women themselves. Moreover, for some women pregnancy had started even before they conceived a child. When I asked Jenna how she found out that she was pregnant, she responded:

> *First of all, we were planning from the beginning. I sat on a special diet and stopped eating the stuff that are not healthy and started taking folic acid and the first month we didn't get pregnant but the second month we did. And I stopped eating fast food and other stuff that are not healthy. And then I did the test and there was a confirmation that I am pregnant. (Jenna, 33-year-old married mother of two, immigrant)*

In today's medical discourse, women have to prepare for pregnancy and to plan it ahead of time. They are expected to "clean" their bodies through special diets and make them suitable for pregnancy by taking prenatal vitamins and folic acid. Following the medical advice, Jenna and her partner started to prepare themselves for pregnancy before the planned conception. For Jenna, therefore, the pregnancy began from the preparations of her body to carrying a child, rather than from a confirmation of her pregnancy.

Being ready to have a child gave some women the opportunity to listen to their bodies, to expect physical changes and to recognize those changes as the signs of pregnancy. Although the most common sign of pregnancy is the absence of a menstrual period, women told about many other ways their bodies responded to conception. Breast tenderness, headaches, feeling of being bloated, intense emotions and a general feeling of "something happening" were interpreted by women as the signs of pregnancy.

Unplanned Pregnancy

Unlike planned pregnancy, which was recognized almost immediately, the unplanned conception was often delayed to be named "pregnancy" by women. The majority of teenage mothers who participated in my study, for instance, had unplanned pregnancies and were interpreting the signs given by their bodies as "something else," not pregnancy:

> *Actually, I was starting to gain weight and I was working, so I was thinking, what's going on? I can't fit in my workpants anymore… What the heck is going on? But then I was like, ah, whatever, I am just getting fat. And after that I started to feel sick and my mom said to me you are pregnant, and I [thought], like, no, no way, but I took a pregnancy test and surely enough within couple of seconds I was positive… I did have a period for the first 3 months. It wasn't actually a period, more like spotting. (Lisa, 19-year-old mother of one)*

Similar to Lisa, the majority of other teenage mothers did not associate their bodily changes with pregnancy. Even when they got well-recognized symptoms of pregnancy, such as the absence of the menstrual period, nausea and vomiting, they did not define themselves as pregnant. Sometimes, the girls suspected pregnancy but they needed a push from their mother or other older woman to name the condition as pregnancy:

> *I started being very tired and I started sleeping a lot and one lady that was living in the [residence] … said that I have to check myself out. And she noticed that my body got bigger and changed… And one of the nurses told me that I was pregnant. And that was that…I had an idea that I was pregnant but I just ignored it and I waited for my period for one month and it did not come and I*

*waited more, and then I started to realize that I might be pregnant
and I knew that I have to check myself out that it was 3 months that
I didn't have my period. But then the lady on the side told me that I
had to get checked and that pushed me. (Rebecca, 19-year-old
mother of one, immigrant)*

Not expecting pregnancy, Rebecca decided to wait to accept the news about
being with child. She prolonged the period of uncertainty, probably trying to prepare
herself for acknowledging her pregnancy, which, in turn, would require changing her life.
Whereas Rebecca does not name her body "pregnant," her neighbor does. This "naming
process" initiated by someone else makes it impossible to ignore pregnancy any longer
and transforms it into a reality, an actual event.

A similar strategy of postponing the naming of pregnancy was demonstrated by
Michele. Although she was planning the pregnancy, she did not expect it to occur so
quickly and was waiting with the pregnancy test until she was psychologically ready for
the news:

*I think first thing that I noticed is that I was very tired and I am
usually very energetic… My sister was pregnant pretty much at the
same time and she was telling me how she felt and she actually
told me that she is very tired. And I was thinking that I was feeling
the same thing. And she was saying that maybe I am pregnant, too.
But I was working on my comprehensive exam and I didn't do the
[pregnancy] test right away because I was thinking that if I found
out that I was pregnant, I would be too distracted. So I kind of
postponed doing it and by the time I did the test I wasn't that
surprised by the results, I kind of felt that I am pregnant already.
And I also was planning to get pregnant so it wasn't a big surprise
for me. (Michele, 31-year-old married mother of one)*

According to Michele, it is the confirmation of pregnancy by test that makes it
real. From the abstract "maybe" of unconfirmed bodily changes, the scientific proof of
the test transformed the pregnancy into a definite fact that would fill her with emotions
and require her to take on new responsibilities. Therefore, during the tense time of her
academic studies, she decided to postpone the confirmation of pregnancy until she
finished off her duties as a student.

So far, I have demonstrated that in contrast to the biomedical discourse setting strict timelines for ovulation, conception and birth, the personal experiences of women differ significantly from the very beginning of pregnancy. For some, pregnancy starts with an expectation to conceive while for others the labeling of their body as "pregnant" is postponed until they are emotionally ready to accept the new social status associated with being a pregnant woman. Living in a culture that heavily medicalized women's reproduction, even those women who feel pregnant need a scientific confirmation in order to validate the pregnancy label that they assigned to their bodies. Confirming their pregnancy scientifically (i.e., using the pregnancy test or during an appointment with a maternity care provider) they initiate the cycle of medicalized pregnancy. For some women, the test becomes a tool to face the reality of the unexpected pregnancy. For others it proves that they correctly read their bodies' signs and that pregnancy had indeed started. Ultimately, however, confirmation of pregnancy by biomedical tools serves as the final and most definitive step in the process of naming the body as "pregnant". In what follows I demonstrate how, once the body is named as pregnant, its meanings, roles and responsibilities are re-negotiated by women themselves and by people around them. I also show how, over the course of this process, women's personal experiences differ from, yet correspond to, the biomedical model of pregnancy.

Claiming the Body Pregnant –

Entering the Social World as Pregnant

Once the body was labeled pregnant, the social status of a woman changes to a "pregnant woman." Acknowledging her pregnancy, a woman is expected to take on a new role, that of an expectant mother. This role calls for redefinition of her relationship with her own body (due to physiological changes of pregnancy) and with her social circle (partner, family, friends, co-workers and even complete strangers). In this section I explore how pregnant women and others interpreted their bodily changes and how the new role of a pregnant woman was negotiated in social interactions. Finally, I

demonstrate that the medicalized model of childbearing constantly served as a context in which women and people around them made sense of pregnancy.

While medical discourse divides pregnancy into three trimesters, the division that emerged from women's narratives suggested a more personalized approach to pregnancy stages. In their narratives, the women divided their pregnancy into two stages - before and after showing. I start with demonstrating how women negotiate their new status of being pregnant when their bodily changes are still invisible to others and then move on to show how public recognition of pregnancy shaped expectant mothers' experiences in communication with their families, friends, and in their workplaces.

Pregnant and not showing

The beginning of pregnancy was often described as an unpleasant experience. Some women felt nauseated, others were disturbed by smells. Many women also talked about the changes in their personal diets - sometimes following prenatal guidelines and sometimes simply responding to their body demands, women had to change their diets to exclude previously favorite foods and drinks:

> *I started to dislike the smell of coffee which is really unusual for*
> *me and also I was tired and I felt sick and I never felt sick [before].*
> *I was nauseous and I was really, really hungry and I couldn't stop*
> *eating and nothing seemed to fill me and it was really weird*
> *because it was a change from barely eating to eating all the time.*
> *(Deena, 33 years old and married, second trimester of pregnancy)*

Those physical transformations made women constantly aware of their changing bodies, which had to be fed, clothed and treated differently. Often invisible to others, nausea, hunger, sore breasts, headaches or tiredness were nevertheless ever-present in women's daily experiences. While symptoms of pregnancy varied significantly among pregnant women from feeling absolutely nothing to severe nausea and headaches, the vast majority of my interviewees did experience fatigue and tiredness in the beginning of their pregnancy. Despite the invisibility of this condition, some women saw it as a legitimate reason to renegotiate household chores between them and their partners. For example, the inability to associate her fatigue with some visible, physical evidence (such

as growing belly), led Geena's husband to underestimate the extent of the effect of pregnancy on her body:

> *During my fatigue he [my husband] was struggling with the*
> *change when he was required to do more [chores]. And we talked*
> *about it. Because during this time women feel the most terrible and*
> *we don't have anything physical to show. And we complain and*
> *don't have anything physical to show and it made sense to me that*
> *that was a frustration for him but that was a reality for me...And*
> *[later] he was reading a chapter from one of my parenting books*
> *that was dedicated to the father and the chapter described how*
> *hard [a] woman's body is working during this period. And I came*
> *home one day and he sat me down and apologized for not*
> *understanding it. [Because] a woman really works hard during*
> *this time even though she lays there on the couch and looks like*
> *she is doing nothing, her body is working. (Geena, 26 years old,*
> *married, last trimester of pregnancy)*

Being unable to observe and/or feel the change in women's bodies during pregnancy, men often feel alienated from the pregnancy experience and do not define pregnancy as "real" (Draper 2003). In negotiating household chores, however, Geena wanted to legitimate her pregnancy and her status of a pregnant woman even though she did not have "anything physical to show." In this account she contrasts a visibly static position (of lying down on the couch) with the hard yet invisible work of the pregnant body growing a baby. During the interview Geena discussed the tension her tiredness brought into her relationship with her husband. However, once her fatigue was confirmed by pregnancy experts as "real," through the text he read, her right to renegotiate house chores was legitimized and she received support, understanding and an apology from her husband.

Experiencing changes that are invisible to others, some women chose to announce their pregnancy to family members. When significant others were informed about the woman's pregnancy, she also could claim or expect to be treated as pregnant. Married women tended to receive more help from their partners and extended families. Teenage unmarried mothers received support from their mothers, teachers and boyfriends.

As they adjusted to pregnancy, women had to rearrange their daily routines to meet the needs of their bodies. In addition to monthly scheduled appointments with maternity care providers, some women had to change other aspects of their daily lives - eating habits, resting patterns, physical exercise and social activities were often altered due to pregnancy. Ultimately, this change was more dramatic for first-time mothers who were novices in the pregnancy experience. Women with children, on the other hand, often could not change their routines drastically due to lack of personal time or the fear that this may have a negative impact on their children. For instance, comparing her first and second pregnancies, Helen says:

> *It was the same [fatigue] my first trimester but because I didn't*
> *have a child at home I could come home [from work] and crash.*
> *And then because of that I could rest a little bit and then I could*
> *stay up until 9 and do the treadmill or exercises. And now because*
> *I have home responsibilities I cannot do that anymore. The thing I*
> *do remember is that with my first pregnancy between my first and*
> *second trimester it was just like a snap – I was not tired anymore.*
> *And this time it is more gradual change. I am still tired and I am*
> *trying to go to bed before 10. (Helen, 37-year-old married mother*
> *of one, last trimester of pregnancy)*

Being pregnant with her second child, Helen struggled to adjust to pregnancy while continuing to fulfill her mothering duties and care for her young daughter. Consequently, she had less rest and felt more tired throughout her second pregnancy. While the division of household chores between pregnant women and their partners was often regarded as fair, women had difficulties reassigning to their husbands the time spent with children. This could partially be explained by the general absence of fathers in the daily care of their children - many pregnant women who already had children were responsible for the provision of care to their kids. However, the reluctance to renegotiate child care can also be explained by societal expectations placed on mothers to provide a stable and stress-free environment for their children (Douglas and Michaels 2004). Since having another child joining the family is considered to be a stressful event for the older sibling(s), mothers are expected to smooth this transition by spending more quality time with the older children. Therefore, on many occasions pregnant mothers improvised how

to continue their daily routines despite feeling sick, tired or nauseated. One woman, for instance, played with her son while lying down on the floor trying to get at least some form of rest. Another pregnant mother had to get up half an hour earlier to accommodate her morning sickness and vomiting before taking her kids to school.

Not all women I interviewed, however, experienced sickness, nausea or fatigue. For some women the beginning of pregnancy was a smooth transition with little physical or emotional evidence of a change. Knowing about the pregnancy but being unable to feel it made some women a bit anxious to "experience" pregnancy. Therefore, often women were happy when their pregnancy became visible to others and they started to feel the baby kicking.

Pregnant and showing

Pregnant women are public bodies (Warren and Brewis 2004). Being responsible for the baby they carry, pregnant women can be either praised for doing "good work" or be scrutinized and punished for endangering their children with immoral or harmful behaviours (Brooks-Gardner 2003; Upton and Han 2003). The elasticity of the boundaries of pregnant bodies can be easily evident in the moral and judicial dilemmas of pregnant drug users, abortion debates, cases of unwanted medical interventions during labour and delivery, and other instances where the personal boundaries of the pregnant body might be breached due to the [presumed] danger to the fetus (Callahan and Knight 1992; Featherstone 2001; Warnock 2002). Although a small number of women who participated in my study resisted these societal perceptions about pregnancy, the vast majority of women did consider pregnancy to be a special time in their lives. They enjoyed the special attention that they received from others. Showing off their bellies, women also showed off their intentions of being a good mother - by wearing appropriate clothes, participating in conversations with others about their pregnancy, listening to welcomed and unwelcomed advice, and following through with myriad dietary and exercise regulations. These pregnant women did believe that their pregnancy entitled

them to be treated specially. And even when they did not play their pregnancy card, they expected others to acknowledge their special status.

For many women "showing" and quickening were the crucial points of their pregnancy that made it real to them and to others. While previously the status of pregnancy should have been claimed by the woman herself (who would usually announce the news to family and friends), at the more advanced stage of pregnancy being with child would be noticeable by others as well and would usually be received with praise and excitement[12]:

> *Well, I liked a lot of things ... I guess I liked getting a lot of special attention, and people are usually excited about you being pregnant and they are happy. And it is exciting to have people excited. And it doesn't bother me at all, I liked when people ask [about the baby] and I don't mind people touching my belly. (Beverly, 34-year-old married mother of two)*

Being visibly pregnant was a welcomed stage yet for another reason - it was a public labeling of the transforming, growing, heavier body as "pregnant body" (the important issue that will be fully addressed in chapter 7). Finally, for many women showing coincided with quickening, which allowed them and people around them to witness the birth of a new life inside their bodies.

Quickening

Barbara Katz Rothman (1989) notes that pregnancy is not just a condition; it is a physical and social relationship between a mother and the child inside her. Quickening was often regarded by women as the start of an intimate relationship with their babies, which reassured them that their changing bodies had been working hard on the development of a new life. The vast majority of women reported that feeling the baby inside was the most enjoyable experience of pregnancy. It provided them with a sense of purpose of the change they had been undergoing during the first months. It also gave

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[12] In the next chapter I show that some pregnant women (middle-class, married in their early 30's) are valued socially more than others (i.e., teenage mothers, older mothers). Nevertheless, even teenage mothers who participated in my study talked about social support and praise they received from others.

them a way to directly communicate with their baby. Even those few of my interviewees who did not enjoy the experience of pregnancy liked quickening:

I didn't like the feeling of being pregnant all that much... I did like the movement of the baby but I mostly liked it because it reassured me that the baby was fine, the baby was okay. I also liked when it was visible from the outside that the baby is kicking and I could share it with my husband, which was nice. (Debra, 34-year-old married mother of two)

Although Debra did not have nausea or any medical complications during both of her pregnancies, she did not regard pregnancy as a pleasant experience. Rather, she looked at this process as a necessary step required for obtaining a child. Unlike the majority of my interviewees, Debra did not enjoy the intimacy between herself and her fetus and felt relieved once the baby was born. Paradoxically, when the baby did manifest his presence by moving and kicking, Debra did like the feeling. Aside from the reassurance that the baby was fine, it was also Debra's way to communicate the feeling of carrying her child to her partner and to make the pregnancy real not only to herself but also to the people around her.

Resisting the body loss

Only a handful of women who participated in my study did not like the experience of public pregnancy. Even women who felt sick and nauseous were still looking forward to showing off their pregnant bellies and getting social recognition of their new status of expectant mothers. However, some women resisted accepting the pregnancy label, claiming that once their status of pregnant women had been acknowledged by others, they received special treatment that they did not like. Miranda was one of those women. When I asked her what she liked about being pregnant, she replied:

Nothing. I like not getting my period but other than that nothing... I just think that pregnancy is sort of an uncomfortable stage and it draws a lot of attention to you and I don't like it... You don't breathe as well anymore and you don't walk as good. You kind of feel that you lose a part of identity...It drives me crazy when people treat me as a pregnant woman, because in some way you

*feel like you are not capable anymore, it is like you are ill. I know
this is not their intention but it drives me crazy. Like neighbours
shoveling my sidewalk or my mother carry stuff for me or people
are commenting, "Oh, you must be having baby very soon". It sort
of puts you in a category of other human beings. When you are
pregnant it affects how mobile you are and what can you do, and I
guess I feel like I am not as independent and people also feel that
they can make comments on you and your body .... [They] do stuff
for you and help and I don't need the help. I know that I am
pregnant but I am still the same person... I do my best to hide my
belly but at this stage it is pretty much impossible. (Miranda, 42-
year-old married mother of one, last trimester of pregnancy)*

It is apparent that for Miranda being pregnant was also associated with loss - a
loss of personal freedom, independence and part of her identity. Her pregnancy grants her
a lot of public attention that she does not appreciate receiving. In addition to the
unwelcomed attention, Miranda was also bothered by some physical aspects of pregnancy
that affected her mobility and the usual use of her body. She insisted that she was "still
the same person" despite her changed physical shape and her pregnancy. Pregnancy is
hard to hide in public – at her workplace, her neighbourhood and even on the streets
Miranda was surrounded by people who interpreted pregnancy as a special status - they
did not see Miranda as the same person. For them, Miranda was a pregnant woman and,
therefore, she should be treated differently and taken care of.

Pregnant in the workplace

While Miranda did not appreciate people's attention to her pregnancy, the
majority of women did consider it important, especially in the context of negotiation of a
possible new set of responsibilities at work. More than half of my interviewees (27
women) worked until very late in their pregnancies. They worked as academics,
professionals, administrative assistants, educators, care providers, bookkeepers, nurses,
receptionists, social workers and waitresses. Some of the occupations demanded
considerable physical effort. For instance, three of my participants were working with
mentally unstable clients who would routinely get violent and aggressive during the day.
Those women felt justified negotiating a reassignment to mild cases as their pregnancy

progressed. Similarly, four of interviewees were nurses who worked in a hospital. Their responsibilities included heavy lifting (i.e., lifting a patient), long hours standing and a potentially infectious environment. Due to the nature of nursing work requiring the effort of a team, for some nurses it was really hard to renegotiate their duties and responsibilities. For instance, Maria, a nurse in a ward requiring significant physical abilities, was not feeling well during her pregnancy. Due to medical complications in pregnancy her obstetrician provided her with a letter stating that she could only perform light duties at her workplace. Nevertheless, the letter did not have an effect on her working conditions:

> *All the girls I worked with were really happy for me. But when [I brought a letter requiring] light duties, it was all on paper only. And in reality I didn't have any light duties. Because [we are] all short of staff and my manager would never close the rooms, no matter what happens. So she didn't have nurses and she would put me to work. And what can I do? I didn't want to get fired and there was nothing I could do. There was no light duties [where I worked]. All I could do is to work... I think those women who complain about special treatment feel themselves pretty good. Because I wouldn't mind to get special treatment since I hardly could work. (Maria, 31-year-old married mother of two, immigrant)*

For Maria, getting recognition that she was pregnant was essential for easing the pressure and physical demands at her job. While women usually described their management as supportive and listening, Maria was denied the possibility of getting special treatment because of her medically complicated pregnancy. Being in a position where she was required to work despite her difficulty to manage heavy duties and an intense workload, Maria was angry at other pregnant women who complained about receiving special treatment during their pregnancy. Claiming her special status (i.e., light duties at work) due to pregnancy and being denied it, she had little empathy for Miranda and women like her who resist increasing social attention during pregnancy. This difference in women's preferences, however, can hardly be attributed to differences in opinions - physiological changes related to pregnancy (i.e., some women feel discomfort

while others don't) as well as social interactions that require women to negotiate their special (or not special) status with others in the context of their daily lives make women redefine the effect that pregnancy has on their bodies and selves.

This complexity of the physiological and social conditions that form women's experiences of pregnancy and lead them to claim (or not to claim) a recognition of their special status is often missing from the accounts of feminist scholars. While some women feel absolutely nothing during pregnancy, others may require extensive medical attention. Moreover, for some women such procedures as ultrasound or genetic screening (commonly used examples of medicalization of pregnancy) serve as reassurance of the baby's well-being and in no way would be defined by them as oppressive patriarchal measures used to control and regulate women's bodies[13].

To summarize, adjusting to pregnancy means renegotiating social status and daily activities. For some pregnant women, changing their diet and daily routines required a drastic adjustment. Others went through a smoother transition, changing some of their daily activities but leaving most unaltered. All women, however, felt that their pregnancies had changed them by limiting their physical abilities (being less mobile and active, getting tired more easily) and/or by changing their social status (receiving special treatment from their families, co-workers and strangers). While some women did not appreciate the change in their social status, the majority of women did enjoy it - they regarded pregnancy as a stage when they are different, and, therefore, should be treated as such. The women's definition of different, however, had little similarity to the one given by a biomedical discourse regarding the pregnant body as prone to potential risks and, therefore, in need of constant medical supervision (Oakley 1980). The "special needs" of their pregnant bodies were constructed in the context of their daily lives and interactions with their families, friends and others. The stages of pregnancy, too, were constructed around personalized, intimate experiences of "being tired", "showing", or "feeling the baby kicking" and were qualitatively different from the structured

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[13] The latter argument can be, for example, found in Arditti et al. (1989) and many others.

scientifically calculated trimesters. Moreover, as I show in the next section, for many women the end of pregnancy was also defined through personal experience and not a scientifically prescribed "end."

Reclaiming the Body in Postpartum

In the previous section of this chapter I demonstrated that during pregnancy women's physical and social status is usually changing (at least) to some degree. The growing body changes the way it walks, sits, sleeps and moves around. Women have to adjust to those changes along with planning their lives in accordance to what their bodies are like during pregnancy. For instance, towards the end, women might feel uncomfortable about leaving their homes fearing that they might give birth in public (Longhurst 2001). Frequent urination may alter the usual shopping routes of expectant mothers. At night, women have to find a way to fall asleep in a position that would be comfortable for them and the baby inside (Katz Rothman 1989). All those disruptions are assumed to end with the delivery of the baby - once the baby is out, the woman is not considered pregnant anymore. Instead, those women enter a postpartum stage, where they are required to (successfully) adjust to their role of mother and to get physically and emotionally back to normal. How women deal with this requirement and when they stop seeing themselves as pregnant is the topic of the final section of this chapter.

The majority of women (36) who participated in my study had already had the experience of giving birth by the time the interview took place. Some of them had just given birth for the first time in their lives while others, although still pregnant, had had this experience previously. The birth of a child was marked as a pleasant event among all my respondents. However, the effects that this event had on their bodies were experienced remarkably differently. For Debra, for instance, the birth of her child signaled a relief from the unwelcomed duty to host her baby inside her body for the period of nine months. She recalled:

It was so strange to me, especially with my first pregnancy, to have something inside my body. And I remember the night I gave birth to [my son] I kind of felt relieved because I felt that now my body

is mine again, which I was happy about - not sharing the space.
Which maybe sounds mean because I am the mother and he is my
child and this is how they come to the world but yes, that is how I
felt. I just didn't like to share my own body, so I was happy when
pregnancy was over. (Debra, 34-year-old married mother of two)

For Debra, therefore, the right to reclaim her body was a long awaited event and she reclaimed the rights to her body the minute her child was born. The majority of my participants, however, did not share these feelings. On the contrary, in their narratives the birth of the child was associated with the loss of their special status. As Chelsea, a 31-year-old first-time mother, remarked:

After pregnancy women are not needed anymore. I remember that
after I came home I had some [medical complications] and I
couldn't find any information about it and I remember I was
saying to my husband that if hospital would send us with just one
page summary of what is going to happen, that would really help a
lot. (Chelsea, 31 years old and married)

The loss of the status of pregnant that follows the birth was also conveyed by Louisa:

I think for the postpartum body the recovery time and how much
time is required [to recover] is not discussed to a proper extent at
all. I was certainly not ready to what was happening. Once you
had the baby, your job is done, and all the attention is paid to the
baby and not to you. And I felt it right away once giving birth. I
had fever and shaking and I wasn't paid attention from maternity
care providers. (Louisa, 27-year-old married mother of one)

Both Chelsea and Louisa described that they were not prepared for the physical changes that happened postpartum. Most first-time mothers actually complained of inadequate information provided postpartum by maternity care providers. But, as Chelsea and Louisa commented, new mothers also lose their special status of pregnant women - their "job is done" and they are "not needed anymore." The immediate transformation from being special to being alone and stuck at home trying to deal with a newborn baby is a central motif in the narratives of first-time mothers describing their postpartum experiences.

These findings hardly come as a surprise. The feminist researchers often blame biomedicine for concentrating its attention solely on the needs of the fetus and constructing the needs of pregnant women *versus* the needs of their babies. This is reflected in the provision of maternity care oriented to monitor the fetus while ignoring women and their experiences (Callahan and Knight 1992; Davis-Floyd 1994; Katz Rothman 1989; Parry 2006). What I found surprising in the narratives of women about their postpartum experience is their resistance to part ways with the label of pregnancy. Although the majority of women I interviewed were happy to deliver a baby and become their "old selves" again, some women claimed that they did not feel like their old selves, and therefore, even after delivering the baby, they can't be seen as "not pregnant".

Unlike the biomedical model that identifies pregnancy as a stage in which the baby is inside a woman's body and postpartum as the stage after the baby is out, my interviewees had their own understanding of pregnancy. For them, pregnancy was an embodied experience changing their lives and their bodies. Feeling the baby inside and experiencing body transformations that they associated with pregnancy (i.e., swollen legs, puffy face, nausea, fatigue, etc.) was defined as being pregnant. Although some women talked about them growing a new life inside their bodies, being pregnant for them meant first and foremost moving and feeling differently than their normal non-pregnant state and being seen differently by others. The delivery of the baby did not always stop those feelings. One woman told me that during the first week postpartum she woke up every night feeling a sudden emptiness of her belly - after having the baby inside for such a long time she still "felt pregnant" even after giving birth.

In addition, sometimes women regarded the level of personal autonomy as the indicator of them still being pregnant. For instance, when I asked Michele about the end of pregnancy and her postpartum experience, she replied:

I felt like it [the pregnant body] was a new body, like it was unfamiliar. And I didn't really feel like myself. After I had my baby I felt like I got my body back... But then again, it is not really back when you are breastfeeding because you are really around the

*clock and, also, your body is still not yours. Because I used to be
really flat and now I have huge boobs and I feel like it is really
different and I still need to find a special bra that I can wear and
before I did not have this issue. So I still feel like my body is not my
own and I still feel very attached [to the baby] because we are
trying to have her to take a bottle so I can go out for a few hours
but yesterday I went out shopping and I got a call from my
husband that I had to come home because she is not taking a
bottle. So you still have this feeling of being attached and your
body is still quite not yours because it is still so important in
someone else's life where before it was only important in your own
life. (Michele, 31-year-old married mother of one)*

For Michele, being pregnant and having a baby was a continuous event, which
was different from "before" by the level of autonomy that was given to her own body.
Whereas before her body was important only for herself, once she got pregnant, had her
daughter and started nursing, her body became "attached" to her daughter. Reflecting on
her pregnancy and postpartum experience, Michele linked the end of pregnancy to having
her "body back" and she was uncertain whether she had it back three months after birth.
On the one hand, she felt that she got her body back once she had her child. On the other
hand, she didn't feel like herself because constant breastfeeding disrupted her autonomy
and made her feel physically and emotionally different.

Like Michele, Anna was uncertain about the end of her first pregnancy and the
beginning of the next. She had her children close together and, during this time, she
participated in two interviews - one six months postpartum and another one six months
later while she was expecting her second child. During her first interview, like Michele,
she still felt tethered to her child due to frequent breastfeeding, and she was unable to
leave the house even for a short period of time without her daughter. When I met with her
six months later, at the end of her second pregnancy, she said:

*I feel like I have been pregnant non-stop. I can't remember when I
was myself and when I had my body to myself last time. It is like I
was pregnant all this time. (Anna, 33-year-old married mother of
two, last trimester of pregnancy)*

Anna, too, linked her pregnancy to the inability to have her body exclusively to herself. She did not experience morning sickness or vomiting and in general felt very well through her pregnancy. During her interview she joked that if she didn't feel the baby and see her body growing, she would not know that she was pregnant. At the same time, the quote above demonstrates that she was conscious of sharing her body with her children and she felt somewhat constrained by the lack of autonomy of her body. For Anna being pregnant meant sharing her body, being a body for someone else (Frank 1991). Therefore, nursing her newborn child and attending to the needs of her infant she could not reclaim her body for her personal use and continued to see it as pregnant.

While biomedical discourse defines pregnancy as a physiological state during which the fetus resides inside the woman's body, women themselves often look at the pregnancy as the state of being different, of being linked emotionally and physically to the child they nurture. Whether this nurturing happens inside of their bodies (as in pregnancy) or outside (as during the first months of breastfeeding), the link between the body of a woman and her child does not cease to exist after the delivery. Therefore, some women still feel pregnant when they had their baby delivered since they were not able to regain control over their bodies. This is especially evident when women decide to breastfeed and spend half of their day nursing their newborn child (Schmied and Lupton 2001).

Chapter Five: Summary and Conclusion

In this chapter I have demonstrated that women's personal experiences of pregnancy are qualitatively different from the biomedical discourse that sets up universal timelines, calculates ovulation and gestation, divides pregnancy into trimesters, and sets times for "normal" labour and delivery. When women's bodies are considered to be defective machines, the deviation from the medically established norm is considered to be dangerous and thus requires constant medical supervision and intervention (Davis-Floyd 1992; Katz Rothman 1989; Martin 2001). Although only a few of the women who participated in my study had sufficient knowledge, authority and willingness to openly

question medical discourse, the personal stories of my interviewees revealed that they constructed their pregnancy cycles differently from the medically established norm. In doing so, they often unknowingly resisted the acceptable labels and questioned scientific guidelines. I showed that unlike maternity care providers who start their calculations from the first day of the last menstrual period, my respondents identified their pregnancy based on their personal expectations and readiness to define themselves as pregnant. For some women, preparations for pregnancy signaled their readiness to bear a child even before they got pregnant. Others waited for signs given by their bodies that something had changed. Feeling tense, bloated, tired or having sore breasts was seen by those women as no less legitimate signs of pregnancy than the absence of menstruation - the conventionally recognized, externally observable sign. Still, other women delayed defining their bodies as pregnant and ignored all the signs waiting for the right time to acknowledge that their life was about to change. Those women could misinterpret the signs given by their bodies until they were emotionally ready to deal with the change.

The change, which some women were not ready to accept, was not limited to the physiological transformation that women undergo during pregnancy. Women's social statuses and roles were simultaneously changing while their bodies adjusted to changes in diet, mobility and shape. In the second part of the chapter I showed how women's roles and responsibilities were renegotiated during pregnancy. Some women were the active agents of those negotiations and had demanded to be treated specially at home and at work. Yet others were forced to accept the label of "pregnant woman" even when they resisted it. I also showed that unlike maternity care providers, who identify pregnancy cycles as equally divided trimesters of gestation, my interviewees personalized their pregnancy, dividing it into the time of invisible and visibly recognized pregnancy. Often, they found it hard to manage their pregnancy during the invisible stage, since others did not see the physical changes that made them feel tired and exhausted, nauseated and sick. Once they started to show, however, the vast majority of my interviewees were happy to get public recognition and validate their own feelings and sensations as legitimate and

real. Similarly, women were looking forward to feeling the baby inside. In addition to the possibility of making sure that their baby was okay without any external technological assistance, women also had the chance to share these experiences with their partners and family members. Quickening, therefore, was often regarded as the beginning of the relationship between the woman and her child.

Finally, I showed that similar to the beginning of pregnancy, the end of it is given to personal interpretations among women. For some women pregnancy did not end right after the delivery of the baby; rather it continued into the postpartum period. Since women often defined pregnancy as sharing their bodies with a child and considered personal autonomy as the essential form of getting their body back, they continued to feel pregnant even after the baby was born: constant breastfeeding for the first months postpartum made their bodies physically tied to their children.

Noting the changes in their bodies, women learned to attach meaning to the physical transformation that they experienced. Sometimes they labeled it "pregnancy," attaching a specific meaning to the physiological changes that they observed within their bodies. On other occasions they tended to name the physical transformation as something else, postponing attaching the meaning of pregnancy to their changing bodily routines. This practice is reflected in the meaning-making process of "phenomenological body" (Waskul and Vannini 2006b). On the one hand, women label their bodies as pregnant based on the widely recognized signs associated with pregnancy (such as absence of the menstrual period or nausea). On the other hand, as long as the label of "pregnancy" has not been attached to the body, the physiological transformations experienced by women are meaningless. Finally, for some women it is the absence of the link between the label of "pregnancy" and the presumed necessity to experience physical transformation associated with pregnancy that makes them anxious about the reality of their status of being with child. It is through this process of navigation between feeling (or the absence of feeling) "something" and attaching the meaning of "pregnancy" to the physical feelings that women label their bodies as pregnant.

In conclusion to this chapter I would like to point out the interconnectedness of physical and social transformations over the course of pregnancy. Due to the universality of the scientific discourse on pregnancy, maternity care providers and the general public tend to miss the personal meaning women attach to the changes attributed to pregnancy. For those women, the meaning of pregnancy cannot be summarized by the weeks of gestation; they attach meanings to their changing bodies. Nausea, vomiting, tiredness, boosts of energy, quickening, and "showing" mark the completion or initiation of another step on the journey to motherhood. Being pregnant also means being treated differently and *sharing* one's body with somebody else. That is why, unlike medical discourse identifying the clear end of pregnancy as once the baby is born, women get ambivalent in postpartum, vacillating between the feeling that they can reclaim their bodies and yet recognizing that they continue to share them with their newborns. Maternity care providers and the general public do not share this confusion - for them the interest in the pregnant body ceases once the baby is born and the body of a mother no longer interrupts the sight of the baby. Once the product of labour is received, medical practitioners have less interest in the body that produced the baby (Katz Rothman 1989). No wonder that some women feel lonely, alienated and depressed in the postpartum period, when they have to recover and to take care of the baby on their own (Oakley 1980).

The tendency to concentrate on the baby, regarding the mother as merely an incubator, is a common practice in our patriarchal society (Katz Rothman 1989). The role of women and their bodies in nurturing their children and communicating with them is often left out of the medical discourse. It often seems that biology does the work leaving women passive witnesses to the creation of new life (Katz Rothman 1989).

Consequently, when pregnancy is defined as a purely biological event, its social aspects are disregarded and minimized as not important. For instance, pregnancy guides and books routinely describe the physiology of pregnancy among heterosexual, middle-class white couples expecting their first child (Dworkin and Wachs 2004; Upton and Han

2003). Women who do not fit these categories are left to assume that their experiences will be similar to the ones described in books.

Resisting biological determinism, feminist scholars often take the opposite side - they tend to overlook physical pregnancy while exploring the social context in which pregnancy occurs. In their accounts the development of a new identity during pregnancy is seen as a purely social phenomenon with little mention of the physical transformation women undergo during pregnancy (Bailey 1999; Brubaker and Wright 2006). Finally, when researchers do touch upon physical transformation, they tend to concentrate on the "visible" pregnancy, demonstrating how the changing body shape (breasts and bellies) changes interactions with others (Bailey 2001; Earle 2003; Longhurst 2001; 2005). As a result, the first half of pregnancy, which is invisible to others but, nevertheless, very real to pregnant women themselves, remains unnoticed and unrecognized as pregnancy. This chapter showed that pregnancy starts long before others see the pregnant belly and label a woman as pregnant. It also showed that the social status of a woman changed simultaneously with her body - addressing the body's needs, women renegotiate their daily routines, social circles, their roles and responsibilities. Simultaneously, defining a body as pregnant, women, maternity care providers and others interpret the physical transformation happening with women's bodies as the symptoms of pregnancy. In the chapters that follow, I further explore how pregnancy changes women's understanding of their bodies and their interactions with others. The next chapter is devoted to women's responses to pregnancy experts. It shows how women choose and interpret prenatal advice and how social interactions define the way women treat experts' advice. Chapter 7 uncovers women's attitudes toward body image during pregnancy. I summarize the results section showing how the meaning attached to the pregnant body has to be renegotiated in social interactions and changes in different social contexts.

Chapter Six: Joining the Pregnancy Club

In the previous chapter I showed how the acknowledgment of pregnancy leads a -woman to a new path in her life - a journey to motherhood. The journey of pregnancy is simultaneously constructed by our society as a passive and active process. Social presentation of pregnancy and childbearing lead us to assume that nurturing a growing life does not require conscious activity on the part of women –biology does its job inside the body with women having little control over the process. At the same time, during pregnancy we expect women to engage in extensive preparations for motherhood. Over the course of nine months women are expected to acquire or maintain a healthy lifestyle, monitor every change happening within their body, and get a thorough education on pregnancy, childbirth and their future role of mothers. A variety of widely available pregnancy books and guides as well as magazines and websites targeting expectant mothers clearly illustrate how common the assumption is that women should *learn* and *do* pregnancy (rather than simply *be* pregnant).

Reorganizing their lives around pregnancy, women are expected to follow experts' advice on how to maintain a healthy pregnancy. In addition to maternity care providers, however, women also receive information on pregnancy and childbirth from books, pregnancy guides, media, relatives, friends and even complete strangers. All these people form a community of pregnancy experts who have their own beliefs and notions of how to nurture a child. It is commonly suggested in the feminist literature that the pregnancy advice given by experts serves to further regulate and control pregnant bodies (Upton and Han 2003; Warren and Brewis 2004). Considerably less attention has been paid to women's decision-making processes in seeking out advice, selecting, interpreting it and applying it to their everyday life (but see Copelton 2004).

In this chapter I show that the social context within which women seek and receive advice from the pregnancy experts shapes the interpretation they render to it. I suggest that once pregnancy is acknowledged, either because it was announced by an

expectant mother or through the labelling of her body as "pregnant", women enter a new community, which some of my interviewees called the "pregnancy club". This club consists of people working in pregnancy "industry", women who have already given birth and includes everyone else who is willing to share their wisdom and give advice to expectant mothers. As I will show in this chapter, *being* pregnant gives women the privilege to enter this club while *learning* and *doing* pregnancy (i.e., seeking the information on pregnancy and motherhood and accepting the new role of an expectant mother) establishes the status of a woman within the club. Moreover, because of skin colour, age, marital status and income some women receive a privileged position in this club while others struggle to get included in the community. Consequently, for some women doing pregnancy and being praised for their efforts is much easier than for others. Finally, I claim that although belonging to this club adds to the totality of social control imposed on women during pregnancy, we should recognize the benefits women receive from participation in this community life. Joining the pregnancy club means that expectant mothers are the recipients of an endless amount of information about pregnancy, which can in turn generate feeling of self-worth, empowerment and recognition of good mothering skills.

I start this chapter defining the pregnancy club and describing how pregnant women join it through informal communications with others and how age, skin colour and social status are interpreted as markers of a privileged or underprivileged position within this club. I then move to demonstrate how women's position in the pregnancy club shapes their communication with formally recognized pregnancy experts (in this case mostly maternity care providers)[14]. I show that compliance with medical advice, personalization of the advice, and even resistance to the advice given by pregnancy experts are all different paths of *learning* and *doing* pregnancy. I summarize this chapter

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[14] I want to emphasize that the analytical division that I make throughout this chapter between formal (maternity care providers) and informal (everybody else) pregnancy experts does not necessarily mean exclusively belonging to one particular category. That is, a family physician sharing the story of her own pregnancy can belong in two categories. An experienced mother can often be recognized as a better expert on pregnancy than a young male physician just starting his medical practice.

with a call to reconsider women's compliance with advice given by pregnancy experts as pragmatic personal choices rather than passive acceptance of medical dominance over their bodies.

Entering the Pregnancy Club

Recognized as pregnant, women automatically receive a new social status - that of an *expectant mother*. When the pregnancy is invisible to others and known only to a limited number of friends, co-workers and relatives, those informed about the pregnancy form a circle of people who share the experience of pregnancy with the expectant mother. Once the pregnancy becomes visible, however, even interactions with complete strangers are performed in the context of pregnancy. As I noted in the previous chapter, pregnancy does not only change the shape of the body but also transforms the content and the character of communication with other people. Deena, a first-time mother, noted:

> *I found that now more people who have children approach me in a different way from what they used to. It is like I joined the club that I didn't know existed. They ask me about my pregnancy and tell me their stories about being pregnant or having a newborn or what we should do... which sometimes is nice and sometimes you don't really need the advice. So, I am really feeling like I've joined a new club. (Deena, 33 years old and married, second trimester of pregnancy)*

Joining the pregnancy club was a common theme in women's narratives. The information that was not shared with Deena before (or maybe was ignored by her), such as personal stories about pregnancy and childbirth, becomes a central topic of discussion in social encounters with pregnant women. For some of them, like Deena, the existence of this club was a surprise. Others - more experienced mothers - knew about this community and actively used it to gather information about the body changes they associated with pregnancy, and sought out the advice and support of other women.

Although the pregnancy club was pervasive in women's narratives, it is difficult to assign a clear definition to this community. My interpretation of women's narratives suggests that *any* social interactions concerning pregnancy and mothering could be

defined as communication between the members of the pregnancy club. Therefore, anyone who approached an expectant mother with a discussion concerning children and pregnancy could potentially be defined as the member of her own pregnancy club. Usually, the core of a woman's pregnancy club consisted of female relatives and friends who had already experienced pregnancy and motherhood. Those women would support the expectant mothers, provide them with guidance and welcomed or unwelcomed advice. At the same time, since membership in the pregnancy club is manifested through the content of social interactions, sometimes men, co-workers and even complete strangers became members of the woman's pregnancy club. Every time they shared their personal experiences of childrearing or pregnancy they would become the members (even if only for a brief moment). Consequently, since social interactions of pregnant women with people around them constantly touched upon the subject of pregnancy and children, it was often impossible to clearly define the boundaries between the members of pregnancy club and people outside of this community. Unlike online pregnancy clubs and communities that establish a clear criteria (usually the due date) for signing up and belonging to a particular virtual club or virtual community[15], the pregnancy clubs of real life did not declare specifically who had a right to belong to the pregnancy club. The intersection of the (presumably) private experience of pregnancy and public role of a working woman contributed to a feeling of the absence of boundaries between the body of a woman and her social self, as described by Debra:

> *Being pregnant cuts through your personal life and usually you don't have it [where I work]. And I remember how I went to a conference and I was visibly pregnant and it was so rare. And I remember couple of [other pregnant] women among thousands of women, I remember smiling at these women and they were smiling back at me and of course it was weird to be pregnant in this environment... I remember I was standing in a line for coffee and a*

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[15] Almost every website featuring information for pregnant women has online forums or chat rooms called "club" or "community" where expectant mothers can discuss their concerns, talk about their problems and share their worries and excitement. Usually those communities are formed around weeks of gestation or trimesters (see, for instance, *Today's Parent* website http://todaysparent.com/community/index.jsp) or the expected date of birth (see BabyCenter website, http://www.babycenter.ca/community/birthclubs/ or Canadian Parent site, http://www.canadianparents.com/pregnancy).

woman approached me and said, "oh, last year I was like that."
(Debra, 34-year-old married mother of two)

Sometimes, belonging to the pregnancy club was manifested through an action (that is, telling a story about pregnancy or giving pregnancy advice) and sometimes it was assumed based on the interpretation of the visible motherhood (that is, being pregnant, or being in the company of a child). Even then, however, the acknowledgement of belonging to the same community (of mothering women) usually occurred. Meeting other pregnant women in a child-free, professional environment, Debra identified them as the members of her club when she noticed their pregnant bodies. Their shared smiles, at the same time, served as an act of recognition of their shared tie of pregnancy, which distinguished just them among "thousands" of other women and confirmed their belonging to one community.

Benefits of membership

While the contours of the pregnant body become an immediate signifier of membership in the pregnancy club, non-pregnant individuals have to be recognized as members of this mothering community based on their actions, that is, on their previous experience as mothers/parents. Consequently, those lacking the experience of motherhood do not belong in to the club and, sometimes, this puts a strain on communication with them. As she continued her story, Debra pointed out the exclusiveness of the pregnancy club:

> *And basically it [pregnancy and motherhood] breaks the ice with the women who had children; it makes it a little awkward with the women who don't have children... I have one colleague who doesn't have children. When we have a social event we talk about kids, and I don't know what to say to her, because she doesn't have kids and I don't want to blub about kids because I don't know whether she didn't want to have kids or she couldn't have kids. With men I usually don't chat about kids. Although I remember there was one colleague and he talked about how he and his wife [were] having kids... and how she pumped her breast milk and he fed the baby and he sounded like a really active parent. Sometimes, although it is really rare, the men would jump in and start talking about that (Debra, 34-year-old married mother of two).*

Although mothering and pregnancy are assumed to be women's terrain (Phoenix and Woollett 1991b), Debra told how, apparently, it is the parenting experience and the ability to share it with other (mostly) women that established the boundaries between her pregnancy club and all other people. Paradoxically, despite the fact that parenting is acquired through learning and doing, it is the assumption that all women are mothers by nature that facilitates communication with mothers and creates tension in communication with all other women. Mothering (and belonging to the club) can become a shared topic with all women who mother (or mothered) regardless of their age, social status or occupation while the absence of this experience is often assumed to be an unwanted consequence rather than a personal choice.

Blurred boundaries between public and private life that researchers attribute to the appearance of the pregnant body in a public sphere (Bailey 2001; Davidson 2001; Longhurst 2001) did not necessarily cause tension in the relationships of women with their friends and co-workers. On the contrary, the majority of women talked about the support they received from their coworkers and friends. For instance, one woman, who was afraid to tell her boss that she was pregnant, not only received encouragement and support from her boss but also got to hear the boss's personal story about being a young mother 20 years prior. Another woman enjoyed her new status of being spoiled by her co-workers who treated her as special and made her feel very comfortable at her workplace. Similarly, when I asked Madeline about her relationship with co-workers she replied:

> *Everyone I am working with are mothers and they are all older than me. So they all act like mothers to me. They have been very, very nice. They would offer me tea... I work with good people. At my job, luckily, we have no issues [with pregnancy]. It is a small office, and we know each other very well. My co-workers are all women. I think that because they have been there before, they know what annoyed them and they wouldn't do it. And I am pretty sure if there would be a couple of people younger than me or a couple of guys, maybe, they would feel differently [less supportive of pregnancy]. (Madeline, 31 years old and married, third trimester of pregnancy)*

In Madeline's story, her pregnancy not only enabled her to be invited into a pregnancy club that she discovers at her workplace, but also transformed the formal (albeit very friendly office) into a "community of mothers". Essentially, because of her pregnancy, previously established relationships with those women as co-workers were transformed into mother-daughter type relationships where the presumed universal experience of pregnancy and motherhood blurred the professional boundaries and made them less visible and less felt. As many other interviewees did, Madeline assumed that these feelings cannot be shared by all women - only those who nurtured their natural instincts of mothering through the personal experience of motherhood could empathize with her and be a part of this newly formed community at her workplace.

As I demonstrated thus far, being publically recognized as pregnant, women automatically entered into a pregnancy club. Discussing with others their experiences or receiving welcomed and/or unwelcomed advice from others (sometimes complete strangers), women were labeled as the members of a new community, that of mothers. As I show in the next section, however, not all women received the same status within their pregnancy club - while some women were praised for their mothering effort and received a lot of useful information and support from the members of their club, other women were marginalized within their pregnancy club and struggled to get praised for their mothering efforts.

The privilege to belong

When they received the privilege of belonging to the pregnancy club, women also had to accept the responsibility of doing pregnancy, and doing it right - following the advice given to them by pregnancy experts, demonstrating their readiness to sacrifice their well-being for the sake of their children, and sharing their happiness and excitement with others. As I am about to show in this section, however, for some women entrance into the pregnancy club was much easier than for others.

<u>Exclusive membership</u>

Many women, especially first-time mothers, received a lot of useful information by communicating with members of their pregnancy club. At the same time, the relationship inside the community of mothers should not be idealized. Pregnant women often complained about the ease with which the members of their pregnancy club gave them unwanted advice or commented on their looks, appearance or behaviour. Nevertheless, the majority of my interviewees enjoyed their membership in the pregnancy club, which also allowed them to share the excitement about the baby with others:

> *Everyone was pretty excited when I was pregnant and everyone was supporting me, and made fuss about the belly, and touched it, and commented on how cute it was. I was absolutely fine with it. When I am not pregnant, I have more strict boundaries but when I was pregnant I didn't mind. Most people commented that I was so big and some people said that I have twins. I actually preferred when people said that I was big than them saying that I was small. Because for me [being] small [meant] something was wrong with the baby but most people said to me that I was too big... I remember one time I was at work and I was rubbing my belly and someone said to me "Don't rub your belly, that is not good for the baby" and I didn't like it because it was an unwanted advice. [But usually] I loved the attention towards my pregnancy and people got so excited from it that I got excited, too. (Chelsea, 31-year-old married mother of one)*

Jane Balin (1988) suggests that during pregnancy women's social status is elevated to a sacred position that symbolically marks their rite of passage on the journey to motherhood. Chelsea clearly emphasized the difference between her usual (pre-pregnancy) state and the changed social boundaries that came with her pregnant body. Although she was sometimes bothered by unwelcomed advice, she enjoyed people's attention and her status as "pregnant". Being married and in her early thirties made Chelsea a suitable mother in the eyes of others and associated her pregnancy with people's excitement. The comments of others and their interest in her pregnancy reinforced the recognition of her elevated social position and the breach of the boundaries

of her personal space highlighted once again people's special interest in her pregnancy and thus in her.

The position that women are granted upon their entrance into the pregnancy club is not static - they can move up and down the social ladder of mothering based on their effort to learn and do mothering. At the same time, some women (usually white, middle-class, married mothers in their 30s) are given a head start while others (women of color, working-class, single, younger or older) would usually receive underprivileged positions and would have to work hard to move up the social ladder of mothering. While women like Chelsea benefited from their participation within the pregnancy club and received support and advice from other people, women who did not fit in the category of normative motherhood struggled with the stigma of being an unworthy mother and had limited access to information and support that was available to more privilege women in the mothering community. In what follows I show how the presumed inability of younger mothers to raise a child negatively shaped their interactions with the members of their pregnancy club.

Marginalized membership

Unfortunately for unmarried and/or young women, their deviation from the norm usually negatively affected their communication with others. Teen mothers, for instance, would often receive negative comments from strangers and, therefore, only felt safe and supported in their close circle of female relatives and friends. Rarely were they invited to join the larger community of women who had given birth. On rare occasions older women (strangers, teachers or family friends) gave them advice and praised pregnant teens for their adherence to prenatal guidelines. Overall, however, the members of the pregnancy club of young mothers commented negatively on their pregnancy and, knowing this, pregnant teenagers tried to avoid (potentially) unpleasant conversations:

> *Some people would ask how far along I was and what I was having and the others would just stare at me or ask how old I was. Some people just ask because they are nosy... Usually I just ignored them. I didn't really care. I got enough support at home, and*

somebody loved me and I really didn't care. (Catharine, 19-year-old mother of one)

Catharine was supported by a close circle of her female friends, mother and sisters throughout her pregnancy. She also attended prenatal classes where she met other young mothers. Bearing a child in a society that does not value the mothering skills of teens, she, like many other teen mothers, mostly talked about her pregnancy in the small pregnancy club of her close family and friends. In this club she was praised for her efforts, supported and loved. There she also received informal information about pregnancy and childbirth. Whereas she would be engaged in social interactions with others, uninvited members of her pregnancy club, the comments of others would stigmatize her body as inappropriate for nurturing a child. Seeking to exclude those strangers from having membership in her club, she, as the majority of other teens, quietly ignored with voiceless resistance the embarrassing label of deviant mother. Monica, a friend of Catharine, recalls:

> *A lot of strangers said I was too young to be pregnant, and some people that I know said that, too. "Or, you are too young to be pregnant." And they would give me these dirty looks. It really didn't bother me a lot though. It is their opinion, why would I care? I would just ignore them. I don't need to explain. (Monica, 16 years old, in her second trimester)*

By refusing to communicate with others or by being excluded from informal communication with other mothers, young mothers didn't receive the social support that other women constantly received from more experienced mothers in their pregnancy club. The lack of social interactions (or at least positive ones) with the larger community of mothers reduced their access to the informal wisdom of mothering. Among my interviewees only teen mothers shared the bond of marginalized membership in the pregnancy club[16]. Based on the samples from the literature, however, it would be only

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[16] Although sociological literature suggests that older mothers would experience social exclusion from the pregnancy club, too, it was not corroborated by my findings. Partially, this can be due to the small size of my sample—only two women out of 42 were 40 years old or older and they both were praised and supported in their communities. Another explanation is that these women defined themselves as belonging

logical to assume that other "deviant" mothers, such as women with addictions, HIV-positive, on social assistance and without adequate housing would share similar experiences of being recognized as a good mother only by a small number (if at all) of relatives and friends.

Seeking to expand the pregnancy club

While some women were negatively judged by the members of their pregnancy club due to their questionable value as mothers, others struggled to get even recognized as members of the pregnancy club because of their lack of social ties to the community in which they experienced pregnancy. Being an immigrant and having difficulties communicating in English significantly limited the participation of some women in the life of the pregnancy club. This was especially evident in the case of Jasmin, a very recent immigrant from the Middle East:

> *I have been in Canada for only two months and I really don't know anyone besides my family. Maybe because it is winter, people don't really see me pregnant and they don't talk to me about pregnancy. In my country it was different, people would come up to you, they would rub your belly, they would ask you questions. And here, nobody cares. Again, maybe [it happens] because I have been here for such a little time and I don't know anyone. I wouldn't mind to have somebody to touch my belly, really. (Jasmin, 26 years old and married, in her third trimester of pregnancy)*

For Jasmin, people's attention to her pregnancy gave her a public recognition of her elevated social status. Lacking this attention she limited the number of interactions with others concerning her pregnancy and, therefore, she feels that no one "cares" about her expecting a child. Unlike some women, Jasmin wanted to be touched and to experience people's excitement about her baby. She was eager to meet other pregnant women and share her experiences with the members of a pregnancy club but she had not received an invitation. In sharp contrast to the cultural norms of her home country, where pregnancy marks a woman's body as public even more boldly than it does in Canada,

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in middle-class category, which, according to Gregory (2007) has recently become more tolerant of older mothers.

Jasmin experienced her pregnancy in isolation from other women and the public eye, which was unable to see her belly under the layers of winter clothes. Seeking to belong to a community of mothers, she started to attend prenatal classes offered to immigrant women, but her lack of English language skills still placed a constraint on interactions with others.

To summarize, in academic discourse the attention paid to the pregnant body is usually presented as unwanted attention, as a form of social control over pregnant bodies and a breach of personal boundaries (Upton and Han 2003). Although to some extent women's narratives reflect this notion and some women indeed found themselves bothered by the unwanted attention, here I showed that, at the same time, entering the pregnancy club can be a beneficial experience for women. Sharing advice and experiences, women become more knowledgeable about the process of pregnancy and childbirth. The community of other women grants recognition to an expectant mother, inviting her to be a part of the club. Those (mostly) women do not only give advice to a new member; they also provide support, understanding, sharing the excitement about pregnancy and demonstrate to a pregnant woman how rewarding the experience of motherhood can be.

Unfortunately, those women who do not fit the category of "good" mothers often receive little support from other women. Moreover, they are commonly stigmatized by the members of the pregnancy club, who protect not only their own children, but children in general and, therefore, view deviant mothers as a threat to babies and the social status of mothers. Younger or older mothers, as well as those failing to demonstrate their readiness to sacrifice themselves for the sake of their children find themselves marginalized within the community of people forming their pregnancy club. Usually, except for a limited number of female relatives and friends, they have little recognition for their mothering work. In the situation where their pregnancy is discussed in interactions with others, they would more often be stigmatized by others than being praised. Dealing with this, they have to adjust their actions and experiences to

demonstrate to others and to themselves their value as good mothers. Usually, this is done by doing pregnancy - learning to be a mother while acquiring knowledge about motherhood and making sacrifices for a child. This process consists of both informal communication and more formal demonstration of mothering skills in the context of women's interaction with their maternity care providers. What I am about to show in the next section, however, is that women's informal position (within the pregnancy club) is reflected in the interpretation they render to their prenatal care. I demonstrate that some women are empowered by following prenatal guidelines on nutrition and exercise while other choose to negotiate with pregnancy experts and even to resist the advice altogether. Finally, I show that women's actions within the formal terrain of prenatal care are intrinsically linked to their status within the informal position at the pregnancy club.

Learning and Doing Pregnancy

Pregnancy is a journey to motherhood. Both pregnant women and people around them see pregnancy as a temporary condition which, after a fixed period of time, will lead to the birth of a baby and will transform a pregnant woman into a mother. The popular literature on pregnancy tends to emphasize the connection between pregnancy and mothering, in many cases demanding expectant mothers to demonstrate devotion and readiness to sacrifice themselves for the sake of their soon-to-be-born children (Copelton 2004; Warren and Brewis 2004). While the connection between pregnancy and mothering is tight, taking care of a pregnant body and nurturing an unborn child are constructed as completely unknown tasks that have to be learned by an expectant mother. Not only are women depicted as being unfamiliar with their bodies and the processes inside them; they are also thought to have no idea what is "safe" or "not safe" during pregnancy. The articles on nutrition, for instance, often emphasize potential dangers of incompetent food consumption during childbearing. The titles "Is It Safe?" (Moore 2006), "Should You Go Organic?" (Desjardins 2006), and "How Much Water?" (Desjardins 2005) asking pregnant women to constantly monitor their consumption and link even the most basic and familiar food habits to potential dangers they may bring to the fetus. Reading articles

on pregnancy, pregnant women learn that nothing can be safely consumed during pregnancy without a thorough check and examination. Food guides and charts that are widely available on the Internet and through the offices of maternity care providers usually specify the exact portions of foods that women should eat during pregnancy. Despite the fact that women are often constructed as naturally designed for motherhood (Douglas and Michaels 2004; Phoenix and Woollett 1991a) the thoroughness with which pregnancy experts calculate the number of calories and the amount of exercise suitable for pregnant women leaves little space for women's "natural" instincts in deciding what is good for their yet-to-born babies. This inconsistency is not exclusive to pregnant women. As Glenn (1994) notes, it is also present in the motherhood ideology:

> *Motherhood ideology certainly encompasses multiple contradictions. Mothers are romanticized as life-giving, self-sacrificing, and forgiving, and demonized as smothering, overly involved, and destructive. They are seen as all-powerful-holding the fate of their children and ultimately the future of society in their hands - and as powerless - subordinated to the dictates of nature, instinct, and social forces beyond their ken." (p. 11)*

In the previous section of this chapter I suggested that some women are more likely to be defined suitable for motherhood based on characteristics such as age, marital status, level of income and skin color. For instance, we generally assume that married, middle-class, white, educated women between ages 25 and 35 are fit for motherhood while teenage, older, poor or single women are not (Phoenix and Woollett 1991b). The latter are stigmatized as unable to provide a nurturing environment for their children. As I will demonstrate here, when these marginalized women respond to their presumed inability to mother, they usually choose different strategies to do pregnancy that include compliance with pregnancy regulation, the personalization of experts' advice and resistance to the regulation of pregnancy. I show, however, that rather than being a passive response to social regulation of pregnant bodies the chosen strategies were negotiated based on women's interactions within the pregnancy club and often empowered women to think more highly of their abilities to mother.

Deciding to comply

Fighting the stigma of deviant mothers, teenage girls who participated in my study were eager to demonstrate how devoted they were to the welfare of their unborn children during pregnancy. Of 10 young girls who participated in my study, all were enrolled in prenatal care, attended prenatal classes and did their best to adhere to strict instructions for prenatal nutrition given to them by maternity care providers. As soon as those young mothers realized that they were pregnant, they ceased to go out and party with their friends assuming this behaviour to be inappropriate for future mothers. Girls who used to eat greasy foods, drink alcohol, or smoke refrained from those activities while they were pregnant. These teenaged young women were eager to change their diet and engage in a healthier and adult-like lifestyle. Following the advice of their physicians, they tried to balance their diets and nutritious food:

> *I only ate healthy because of the baby. I knew I had to keep the baby healthy and for that I had to eat healthy. Before I used to smoke and eat greasy foods to get more weight. And I quit right after I knew that I was pregnant. I started to be very healthy and I was so proud of myself cause I didn't know that I could do that and that it is possible until I actually did it (Lindsey, 15-year-old mother of one).*

By changing her lifestyle Lindsey answered to societal pressure, and also demonstrated to herself that she can be a good mother. Being stigmatized means dealing not only with stigma during social interactions; it also means dealing with internalized stigma. Women who do not fit the western norm of motherhood (i.e., teenage, older or poor mothers) are usually aware of their deviant social status and find ways to cope with the stigma of being an unfit mother (Friese, Becker, and Nachtigall 2008; Gillies 2007; Werkmann 1994). The eagerness with which young women who took part in my study followed pregnancy regulations, in a sense, was their way to demonstrate to themselves and everybody else that they could in fact be trusted to be good mothers. This is why Lindsey felt pride and self-confidence once she saw that she was capable of changing her lifestyle and complying with prenatal regulations - she proved to everybody that, despite her young age, she is fit for motherhood.

Therefore, allowing their bodies to be controlled and regulated by experts' advice on pregnancy was an empowering experience for these young mothers, rather than an oppressive experience. These findings are consistent with the study results of Sarah Brubaker (2007) who interviewed African American teen mothers in the United States. Looking at the birth choices of young mothers, she showed that young poor black women did not consider hospitalized birth as a loss of control over their reproductive choices (a common representation provided by white middle-class women in feminist literature). Rather, young mothers saw their engagement in obstetrical care as demonstration of their good mothering abilities. They also felt more relaxed about transferring the decision-making about their pregnancy and childbirth to their maternity care providers, who, in their opinion, had more knowledge and authority than they had as teenagers. That way they, simultaneously, followed the norm and freed themselves from the potential wrongdoing.

Lost in experts' advice

Prenatal nutrition guidelines are not constructed as "recommendations" or "advice". Usually the rhetoric on pregnancy nutrition uses strict negative adjectives representing certain foods as "harmful," "not safe,"and even "no-no foods." For instance, Sara Moore (2006), the author of "Is It Safe?" an article featured on *Today's Parent's* website, claims:

> *Camembert is a no-no, while cough medicine might be OK when you're pregnant... Everyone's got advice: how much milk to drink, whether exercise is OK, what to name the baby.... Of course, you get to decide what and who you will listen to. There are, however, some advisories you shouldn't ignore. These include recommendations on what foods, medications and chemicals are safe during pregnancy.*

She then lists recommendations on which foods should be avoided and which should be consumed in moderation. On a similar note, the BabyCenter website features a long list of "is it safe?" questions under the food and drink safety section of the website (Babycenter CA, 2009). Alongside the commonly known harms of alcohol, caffeine, and

cigarettes, the links invite women to inquire about herbal teas, sushi, barbequed food, cheese, peanuts, pizza, raw eggs, and prewashed salads (Babycenter CA 2009). The potential damaging effects of "bad" food choices can range from preterm labour and low birth weight to severe defects in the development of the fetus, causing permanent brain damage and other harms. Therefore, pregnant women come to the realization that everything should be consumed with caution, in moderation, and under strict regulation of daily or weekly recommended portions.

In addition to avoiding some foods, women also have to make sure that they consume enough "healthy" foods since too little calcium, protein, iron, vitamins and minerals can also harm the baby and delay its development. For many mothers those regulations can be quite confusing. Yet, the fear of endangering the child forces many women to follow them religiously:

> *I took prenatal classes because I didn't know many things… I didn't know, for example what I could and couldn't eat. Like, lunch meats because of the preservatives and I couldn't eat tuna and I couldn't drink soda, and there were just so many restrictions about what I can and cannot eat and luckily for me there wasn't a lot of things that I absolutely had to have but it was hard because… like I used to have lunch meats for lunch and I had to change that… I think there should be more information and I took all the information from the prenatal classes and I know that there are a lot of girls who do not take prenatal classes and I think that it is much harder to find this information, what is good for you and for your baby… When I got there [to prenatal classes it was because] I was concerned with the health of the baby. (Brenda, 20-year-old mother of one)*

For Brenda, prenatal classes provided an opportunity to get the knowledge and information necessary to navigate through prenatal nutrition guidelines. She was concerned with her ability to nurture a healthy baby. The information she got at prenatal classes provided her with the tools to ensure that her child would not be endangered and that she would create a healthy and loving environment for nurturing him. She acknowledged that the change was hard, since she had to alter her previous eating habits and drastically change the way she ate. Nevertheless she was fairly satisfied with her

choice to get to prenatal classes and to receive the available information. Not once during the interview did she came back to what she defined as "preaching" about the help of prenatal classes.

So far I have shown how deciding to adhere to prenatal nutrition guidelines and to follow the advice of their maternity care providers often enabled young first-time mothers to feel empowered. Partially, it helped them to overcome negative stereotypes about young pregnant women and, partially, it helped them to reduce anxiety about potential dangers their bodies can cause to their unborn children – a topic commonly raised in medicalized discourse on pregnancy and childbirth (Katz Rothman 1989). Although those young women did follow the advice of maternity care provides and demonstrated submission to the dominant medical discourse on pregnancy, like several other feminist scholars (Brubaker 2007; Brubaker and Wright 2006), I oppose the definition of these women as "oppressed" or "submissive" to dominant ideologies. Lacking a respectable position in the pregnancy club, these women would also often miss out on informal advice and the respect of other mothers. This, in turn, would only strengthen their reliance on formal advice. Moreover, engaging in pregnancy work and demonstrating their readiness to make sacrifices in foods and behaviours, at the very least, provided them with reassurance that they could be good mothers. In some cases it could also offer them a better social position within the pregnancy club and grant them the privileged status of being a "good" mother.

Personalizing experts' advice

Although some women found it helpful to follow the formal and informal advice of medical experts on pregnancy, the majority of my interviewees found it either confusing or resisted the advice altogether. In addition to the nutrition charts available on the Internet, in pregnancy magazines or via the offices of maternity care providers, there are also charts on expected weight gain, level of recommended exercise and daily calorie intake. Some women found it extremely confusing to navigate through this information

while others resisted the tone in which the advice was given. Deena, for instance, commented:

> *You asked me about what annoys me and it really annoys me when people are saying, oh, you shouldn't be eating that. So, if they see me eating cream cheese on a bagel and people monitor everything for you... like you shouldn't be eating this and that... And I believe that it is okay if it's in moderation. Like, you probably shouldn't be eating that every day, but occasionally it is okay. [And people don't know that you don't eat it every day] and look at you and they think that you are a horrible person because you don't think about your baby... I am not following those orders, and if once a month I want to have a bagel with cream cheese, I will have it! And if I want to go to Tim Horton's and have a donut I will do that! (Deena, 33 years old and married, second trimester of pregnancy)*

Prenatal eating regulations, while established in a professional community, are usually widely spread through informal channels of communication. In this sense, the social control over pregnant women is not only enacted in direct communication between women and their maternity care providers but also in informal communication with lay people who take on a role of "pregnancy expert" and then monitor women's behaviour and compare it to publicly available regulations. Deena, a white, well-educated first-time mother, however, resists following these regulations and redefines the guidelines on nutrition as suggestions, rather than strict rules. Personally assessing her food habits and desires, she follows her own interpretation of those "orders". Although she is profoundly annoyed by the possibility of being labelled as a "horrible" mother by other people, her privileged status in the community of mothers allows her to negotiate her food intake and to personalize it to fit her own needs.

Navigating through experts' advice

Moderation is the keyword that some women (mostly white, middle-class, married) emphasized in their adherence to the nutrition norms. Although familiar with nutrition guidelines, they selected the range of "exceptions" that they allowed themselves to make. In the following quote, Leah, similar to Deena, explains her interpretation of

nutrition guidelines. Unlike Deena, Leah is not worried about being labelled as a "horrible person" – in her third pregnancy, married and employed as a professional, she feels protected from stigmatization:

> *I would like to say that I watch what I eat. I am trying to eat okay and do exercise but I am thinking, ah, I am gaining weight anyway, why don't I have extra desert... I didn't watch my weight at all during pregnancy, I only weighed myself at my midwife's and I think that if she would tell me that I was gaining too much I would be concerned. But I don't weigh myself at all. And if I want to have an ice cream at night, I will have it... [As about no-no foods] I am a big sushi eater and I have avoided eating the raw fish even though some practitioners say that this is fine and I tried to avoid eating lunch meats. [With] caffeine, I know, you shouldn't drink a lot but especially with my third pregnancy I was tired and I had to drink some, but I was trying not to drink too much. I was trying to avoid alcohol, so some things I've been avoiding. Not to say that I never had a glass of wine over the Christmas dinner or something but for the most part, I am aware of the things that you really shouldn't do...Definitely, with the first one you do everything exactly right, you do everything according to the book. And this time, midwife would say don't worry that much about it [and I wouldn't]. (Leah, 35-year-old married mother of two, last trimester of pregnancy)*

Food intake during pregnancy consists of two potential harms: (1) the possibility of consuming potentially harmful foods, and (2) the possibility of over consuming[17] and, as a result, gaining too much weight, which can also harm the baby. In Leah's account, those two dangers were linked with each other: she talked about her weight gain and also about the foods that she decided not to consume and the ones she consumed in moderation. Assessing her weight gain, her job stress and her general eating habits, Leah constructed her own pregnancy diet trying to avoid some things while allowing others. Expecting her third child, she felt sufficiently empowered to alter prenatal guidelines

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[17] There is also, of course, a danger of not eating enough. Although this poses concerns for many women in developing countries (Ashdown-Lambert 2005), it is rarely discussed in pregnancy resources available in the western world and, when it is, usually it is linked to eating disorders. Occasionally pregnant women are reminded to regimen their calcium intake or folic acid, but usually taking prenatal vitamins makes up for not consuming enough.

without threatening her mothering identity – a luxury not experienced by teen mothers struggling to redeem themselves as good mothers in the eyes of others.

Like Leah and Deena, most educated, middle-class women who participated in my study constructed their pregnancy diet allowing some deviation from the norms in prenatal nutrition guidelines. In doing so, they did not necessarily actively resist the guidelines, but rather tried to adjust diet recommendations to their personal lifestyle. According to Denise Copelton (2010), who reported similar results from her study of 55 white middle-class pregnant women in the U.S., pregnant women who deviated from the norm often felt guilt and used neutralization techniques to explain/justify their nutritional deviance. Unfortunately, Copelton does not specify whether she interviewed only first-time mothers or included in her sample women in their second (plus) pregnancy. My findings indicate that previous pregnancy experience made a big difference in the attitude that women expressed toward the nutrition guidelines and other advice given by pregnancy experts. As I demonstrate in the following section, experienced mothers often directly challenged the experts' advice and juxtaposed their personal authority (of an experienced mother) against the authority of pregnancy experts (usually constructed as medical doctors).

Challenging the experts

Not all women can openly challenge experts' advice. In the beginning of this chapter I showed that some women, who, due to their age, marital status, or income level, are considered by many to be unfit for motherhood, have little means and motivation to resist experts' advice on pregnancy. Voicing their opposition to prenatal care, they risk being stigmatized or even penalized for not following prenatal regulations. On the other hand, women who had previously given birth and (presumably) demonstrated that they can be "good" mothers, have more authority and power to challenge the advice given by maternity care providers or to follow their own, personally set regulations. For instance, when I asked Beverly, a married middle-class mother of two, to comment on prenatal nutrition guidelines, she responded:

I pretty much abandoned all those regulations of what we need [to eat] and what we do... I believe that I know myself enough to know what is reasonable and what is not. I don't listen to everything that is out there. I think I was probably more influenced by that during my first pregnancy because I just wanted to make sure that I am doing the right thing, and gaining the right amount of weight and doing this and doing that but this time I am not, I really don't care, I think I have a good sense of what my body needs. (Beverly, 34-year-old married mother of one, last trimester of pregnancy)

Beverly considered that she acquired enough knowledge to understand her body and its needs from her previous experience of pregnancy and childbirth. While dominant discourse on pregnancy presupposes universality in the development of pregnancy and, therefore, suggests universal maternity care (including relatively universal regulations), Beverly valued her own personal experience and the knowledge of her body. Treating pregnancy as absolutely detached from the previous experience of a woman is highly common in medical discourse on pregnancy (Marshall and Woollett 2000). Beverly, however, adopted a more holistic approach and relied on her body and senses to navigate her to healthy pregnancy.

While medical practice detaches previous women's experience from pregnancy, the ideology of midwifery sees pregnancy in a more holistic sense, similar to the perception of Beverly (Hewison 1993). Although only a small number of women who participated in my study used the services of midwives, their experiences in maternity care were significantly different from the dominant (medical) care. It was especially evident in the case of prenatal nutrition guidelines and weight gain. For instance, Amanda saw her midwife as relaxed and supporting, paying little attention to her weight gain:

I read a lot about not eating too much and the ranges of healthy weight gains. And I was certainly concerned that I would become one of these you know gigantic women that are sort of balloons... But I also had a midwife and she was very relaxed about the weight gain. In fact, I think [during our] first or second meeting I forgot to weigh myself, and she said, 'It is okay, you don't have to weigh yourself'. And it was nice to have this health care professional who was just relaxed about that and that was just enormously freeing... I think that if I would have a doctor, I would

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*probably be more anxious about things. She [my midwife] never
gave me a hard time about anything. I think it was pretty
empowering kind of thing. (Amanda, 35-year-old mother of one,
living with her partner)*

In Amanda's account her weight gain is presented as an insignificant detail of her
journey to motherhood. Other women who used the services of midwives also reported a
more relaxed approach to nutrition guidelines and weight gain during pregnancy. Overall,
women who received prenatal care from midwives felt more at ease resisting medical
guidelines on pregnancy and were more likely to be encouraged to listen to their own
bodies. Physicians, on the other hand, were usually described as more concerned about
the weight gain than were midwives. This is especially evident in the story of Mary, a
married mother of four who negotiated the label of "normal" weight gain with her
physician:

*I don't think that you can control your body. I think that if a
woman is hungry during pregnancy, it means that a baby is hungry
as well and she has to eat. You shouldn't of course go crazy and
overeat, but you certainly shouldn't stay hungry. And then,
whatever you gain, you gain... You can't control this. My mom, for
example, gained more during pregnancy than I did. And I gained
50 lbs or maybe more. My doctor during my prenatal visits said
that this is too much, that they add here [in Canada] only 8-12 kg,
which I don't understand how, because most women here [in
Canada] are overweight. But this is what I was told, that I gained
too much... The doctor would say all the time that it is too much
and that I gained weight too fast. But I didn't worry. I said to him
that I always gain too much weight [during pregnancy] and he
shouldn't worry about it. I couldn't starve anyways. But I guess he
was still concerned that it is not good for me and for the baby.
(Mary, 38-year-old married mother of four, immigrant)*

In Mary's account, the role of the doctor and patient in prenatal care were
somewhat reversed: the doctor seemed concerned and Mary tried to calm him down and
explained that *for her*, it was the normal progress of pregnancy. Moreover, Mary
redirected the power dynamics in her medical encounter. Instead of being a passive
recipient of the advice given by an expert, a common model of communication between
an immigrant female patient and a male doctor, she becomes an expert on the subject of

her body. Her presumed social marginality (being an immigrant) becomes the source of her expertise in her body (which she sees as culturally different from the Canadian standards) and legitimizes her resistance to adhere to her doctor's advice. Therefore, she meets her doctor's concern with calm indifference.

Some experienced mothers, like Mary and Beverly, challenged the universality of the guidelines that, in their opinion, could not reflect the needs of their bodies. Others resisted accepting the guidelines altogether, relying on other sources of information which, in their opinion, were more reasonable to follow. For instance, Donna, a first-time mother who worked in academe, followed her friend's advice and was "eating by the book" rather than following the directions of her maternity care provider:

> *I was trying to eat healthy but I was really looking differently at it.*
> *Because I think I had a different view of what does it mean to eat*
> *healthy. My friend sent me a book and I really followed this book,*
> *especially first time around. And there were things like I had to get*
> *60-80 g protein per day, and it was really hard. And I was trying to*
> *follow it. Like I had to eat liver, according to this book, 3-4 times a*
> *day, and I ate healthy. And I was lucky that this system aligned*
> *with my personal favourite foods... I ended up gaining a lot,*
> *because I was trying to eat a lot of meat. But I didn't care about*
> *my weight because I cared about my baby. And I gained 40 pounds*
> *the first time [during her first pregnancy]... But this book I think*
> *was really good and I followed it all the time. For instance, the*
> *book said that if you have headaches, it means that there is not*
> *enough Vitamin B6. So, I would consume more Vitamin B6. I*
> *didn't have problems with my legs, because I was having*
> *something for that as well. So, what I liked about the book that it*
> *helped to prevent problems during pregnancy using diet. And even*
> *today I am on 8-9 supplements to increase [breast] milk supply. I*
> *really think that this book* [Healthy Mothers, Healthy Babies] *is my*
> *bible. (Donna, 40-year-old, married mother of two)*

When professional knowledge becomes publicly available it inevitably changes the power dynamics between lay people and experts. In the case of pregnancy, formally established medical knowledge is usually spread as informal advice through many channels of communication - in personal encounters, pregnancy books and other texts available in magazines and on websites. As I showed earlier, when professional

knowledge becomes common knowledge, it can often assist society in regulating pregnant bodies via the everyday enactment of control, which is usually taken voluntarily by lay people. Paradoxically, it also helps women to resists the experts' advice given to them directly in communication with their health providers. As Donna pointed out, the book that she chose to follow clearly links health in pregnancy to mother's food intake and is based on a medical perspective on pregnancy. At the same time, it enabled Donna to become an expert in her own pregnancy and to challenge the status of "knower" in direct communication with her health care provider. When the advice given in the book does not coincide with the norm, Donna abandons the norm and follows her nutrition "bible" exclusively.

Finally, some women actively resisted the norms established by pregnancy experts. They openly challenged the validity of the restrictions and chose to follow their instincts and their previous experience, criticizing the rhetoric used by medical experts:

I had a fairly good diet to begin with and then I ate a lot of crap. I complemented my diet with a lot of sugar and cookies. You know what, you suffer enough! I am hungry all the time. It is not that I go four times a day to McDonalds because it is fun. My body doesn't register that it is full, it just keeps going. I am hungry all the time. I eat very well, because I eat very well normally... All women are different ... Now [pregnant] women like to weigh themselves and I don't think it is a really positive focus for women... I wish we would pay less attention to it. And the same [problem is] with food. Europeans are eating unpasteurized cheese. And if you had two glasses of alcohol, [people here say], you are killing your baby. And I think we pay too much attention and put too much pressure on women [placing restrictions]. If you want to have a cigarette, go and have a cigarette! ... Babies survived all kind of things in utero, like famine and what not. And two cigarettes won't kill any baby. I am not suggesting that [pregnant] women should drink Pepsi all the time, but I think we should be calmer about it... Such books as "What To Expect" are just damaging. These books completely disregard 30–40 years of experience that women had before they got pregnant. For me it is the other women who could help you to find out that you are not alone and they feel the same as you feel. (Miranda, 42-year-old married mother of one, last trimester of pregnancy)

Unlike other women who do not openly challenge the regulation imposed on pregnant women, Miranda actively resisted the norm. Being a mother and a maternity care provider, Miranda feels sufficiently empowered to resist regulations established by medical experts. Moreover, being well versed in the feminist literature on women's reproductive experiences, Miranda explicitly links resistance to prenatal regulations to women's ability to understand their own bodies. She seeks to reinstate women's rights to own their bodies and to make their own choices during pregnancy. Therefore, over the advice of medical experts on pregnancy she prefers the advice of experienced mothers who share the wisdom and knowledge of pregnancy and childbearing.

Chapter Six: Summary and Conclusion

As much as Miranda's opinion is provocative and challenging, she proposes a very real alternative to the advice of medical experts. My interviewees stated that they often relied on the advice of their mothers, sisters, female friends and co-workers, and even men who told them about their wives' experiences of pregnancy. Becoming members of a pregnancy club, women simultaneously accepted the responsibility of being a mother and gained access to mothering wisdom shared by the members of the club. Sometimes women valued the advice and sometimes they found that it violated their privacy. But all of them indicated that the wisdom of pregnancy was constantly shared in interactions with other women. Receiving a legitimate position within the club, women could take on an informal, holistic approach to pregnancy. Even those women who were marginalized in the pregnancy club had the opportunity to receive informal advice from their mothers, sisters, relatives and friends. It seems that concentrating on social control enacted through the informal advice given to pregnant women by people around them, scholars overlook the benefits that belonging to the pregnancy club gives to pregnant women (but see Brubaker and Wright 2006; Oakley 1992; Rudolfsdottir 2000). Rarely do researchers demonstrate how informal advice allows women to resist the medical dominance and to alter, personalize or deny the advice given by maternity care providers. Instead, many researchers focus exclusively on analyzing the medicalized approach to

pregnancy, and thereby downplay the interpretations women give to the medically centered discourses.

This chapter also attempted to show the influence of women's position within the pregnancy club on their experiences of motherhood. I showed that the initial position at the pregnancy club not only affected women's informal interactions with others but also shaped their interpretation of formal medical advice. Choosing to closely follow the experts' advice, poor and younger mothers seek acceptance inside the community of mothers and proved to others and to themselves their worthiness as mothers. The privileged status of some women (middle-class and white and/or experienced mothers) allowed them to resists formal and/or informal advice given by medical experts on pregnancy. I further demonstrated that although women are depicted as mothers by nature, they also have to learn and do pregnancy. Some women are socially perceived as better mothers than others. Doing pregnancy (and doing it right), however, allows women to move up the ladder of socially valued pregnancy. This is why following the experts' advice can be as empowering for some women as resisting the very same advice is for others.

Learning to be pregnant and doing pregnancy is exemplified in the body work that, based on the categorization provided by Waskul and Vanini (2006b), can be reflected in the "dramaturgical body" or the "body as performance." Interacting with the members of their pregnancy club, women learn about managing their bodies while pregnant. This learning, however, is an enacted experience. Women have to translate what they learned about pregnancy into their actions. Doing pregnancy does not stop at getting the right type of exercise and eating right. Presumably every activity of a woman can and should be changed during pregnancy -women should think positively, reflect on their future role as mothers, be more careful walking, refrain from running, listen to calm music, read the right books. Reorganizing their life around pregnancy they have to embody the learning process. Their performance, in turn, is judged by the members of the pregnancy club and becomes a method of evaluation of women's mothering skills not

only for the people around them, but also for the expectant mothers themselves. Being pregnant, therefore, triggers a new set of actions and bodily practices, which are learned in social interactions with others and encrypted on the changing body of a pregnant woman.

Finally, I want to emphasize the elasticity of the boundaries of the pregnancy club. Since membership in this club is based on the experiences of mothering that are shared in personal interactions, it is impossible to construct clear-cut categories of who is "in" and who is "out". A stranger, approaching an expectant mother on the street or in the line at a grocery store, who shares with her a smile, advice and a personal memory of her own childbearing, suddenly becomes a member of the pregnancy club and then, after this brief encounter, may disappear from this club forever. A co-worker who, after hearing the news about pregnancy, may give a piece of advice or tell a story, can also become a member and then leave the club and stay in the pregnant woman's strictly professional circle for some time. Sharing their advice and feelings towards the woman's pregnancy, the members of the pregnancy club would often violate the personal space of expectant mothers, touching them and advising them on what to do. At the same time, however, they simultaneously supported women and, often unconsciously, gave expectant mothers the power to view their pregnancy as their personal life experience rather than universally standard process of having a child.

Chapter Seven: The Beauty of Pregnancy

Pregnancy transforms women's bodies and women's selves (Bailey 1999). It also alters their relationships with others and changes the social roles of expectant mothers (Balin 1988; Brubaker 2007). While scholars from all disciplines agree that pregnancy leads to a change in the woman's perception of self and significantly transforms her pre-pregnant body, they often part ways in assessing the role of pregnancy in woman's life course. One of the differences in the vision of pregnancy among feminist scholars and traditional biomedical discourse is the degree to which pregnancy is detached from women's previous social and bodily experiences. In contrast to the medical and obstetrical model that envisions pregnancy as a discrete and contained experience separable from women's previous lives, the feminist and midwifery literature insists that pregnancy should be understood within the context of women's lives, their selves, and their previous experiences (Davis-Floyd 1992; Earle 2000; Katz Rothman 1998; Oakley 1980).

Although feminist scholars have criticised medical discourse for separating pregnancy from women's previous life experiences, a similar trend can be found in the feminist literature itself. For instance, the literature on the body image and femininity that thoroughly examines women's attitudes towards weight gain and other bodily changes has taken little interest in the pregnant body (Kaw [1993] 2003; Morgan [1991] 2003). Similarly, researchers studying pregnancy have paid a lot of attention to medicalization and the development of self during pregnancy but rarely have they analyzed the transformation of body image during pregnancy (but see Earle 2003; Longhurst 2005; Wiles 1994). It seems that women's adherence to the beauty norms inscribed on their bodies from the early childhood years suddenly disappears during pregnancy and all the practices associated with the "beauty work" (such as dieting, for instance) are completely forgotten during the nine months of pregnancy.

So far I have shown that pregnancy changes women's lives and requires them to renegotiate their social status in communications with others. I demonstrated that

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expectant mothers redefine their relationship with others and accept (or resist to accept) their new role of being pregnant. I also showed how joining the community of mothers women learn and do pregnancy and take on the new set of bodily practices and behaviours which allow them to perform the role of a "good" mother. In this chapter I intend to explore how women experience their bodies during pregnancy and how they construct their body image on the journey to motherhood. This topic is essential for our understanding of the experience of pregnancy for a number of reasons. First of all, the pregnant body is a growing body. In western culture, however, the movement towards a bigger body (and especially, among women) is considered to be a negative event. Women are expected to seek smaller bodies, achieving the ideal slim shape through dieting, physical exercise, and adherence to consumerist feminine practices (Bartky [1988] 2003; Bordo 1993; Findlay 1996; Morgan [1991] 2003). Therefore, the transition to a bigger body may become a form of personal distraction for an expectant mother.

Secondly, the shape of the pregnant body is markedly different from the perceived ideal of femininity - in a sense it is a grotesque[18] body (Bakhtin 2005): instead of a flat abdomen and small hips it features large forms and a pregnancy bulge; the enlarged and leaking breasts are profoundly different from the firm and sexualized breasts idealized by Western culture (Giles 2004; Longhurst 2001; Young [1992] 2003). Finally, the physical and emotional connection between a woman and her fetus constantly blurs the boundaries between the two bodies (Young 1984). How women come to terms with their changing bodies and how they perceive them, therefore, becomes a central part of the analysis of the experiences of pregnancy.

The third justification for inquiring about the role of body image in pregnancy is rooted in the emerging public interest in pregnant body. The early 1990's signified a

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[18] I borrow this term from Mikhail Bakhtin's who saw a grotesque body as "a body in the act of becoming. It is never finished, never completed; it is continually built, created, and builds and creates another body... the essential role belongs to those parts of the grotesque body in which it outgrows its own self, in which it conceives a new, second body... Eating, drinking, defecation and other elimination, as well as copulation, pregnancy, dismemberment, swallowing up by another body – all these acts are performed on the confines of the body and the outer world, or on the confines of the old and new body." (Bakhtin 2005:92-93)

major shift in the visibility of pregnant bodies in public, availability of maternity fashion and establishment of consumerist culture around pregnancy and childbirth (Earle 2003; Jette 2006; Longhurst 2005). Instead of being a private, hidden event, pregnancy has become a public celebration and pregnant bodies - often naked - appear on the covers of popular magazines and in the public arena. Situating women's experiences in a larger social and cultural context, in this chapter I show the mixed reactions of women towards this social change.

I begin this chapter by describing women's responses to the public representations of pregnancy and the postpartum period. I show that women see the effect of media on the experiences of pregnancy as combining positive and negative features. That is, they were happy to note that pregnancy has become a celebration of femininity and more visible in public, but at the same time, they were concerned about the unrealistic expectations that the emerging body image placed on pregnant and postpartum women. In the second part of this chapter I demonstrate how women constructed their own body image during pregnancy. I show that, overall, they were fond of the pregnant body shape but disliked other symptoms of pregnancy, such as swelling and stretch marks. I also demonstrate that women felt that their ability to control their bodies was rather limited. I emphasize the role of women's social networks in facilitating women's feelings towards their bodies. Finally, I move to the analysis of women's experiences in postpartum and show that postpartum bodies are often perceived as dissatisfying and in need of fast repair. I conclude the chapter linking women's attitudes towards their pregnant and postpartum bodies to the discourse on motherhood and the role of women's bodies as producers and not seducers while pregnant.

Canonization of Pregnant Body in Media

As with any other social phenomenon, it is hard to identify the beginning of the shift in public attitudes towards pregnancy and the pregnant body. Some scholars and journalists attribute the change to the appearance of a very pregnant and nude Demi

Moore on the cover page of Vanity Fair magazine in the early 1990's (Earle 2003; Longhurst 2005; McLaren 2003). Others link the transition to the fast expansion of consumer market and maternity fashion for pregnant women (Longhurst 2005). What is evident, however, is that the pregnant body has become more visible recently in the public sphere. Expectant mothers are often featured in magazines and TV shows, where pregnant celebrities readily pose for photographs and happily smile at cameras documenting their journey to motherhood. The Parents website, for instance, informs women of the new industry of maternity photography and invites women to celebrate their growing bodies:

In 1991, a very pregnant Demi Moore appeared nude on the cover of Vanity Fair. With that iconic cover, a sea change occurred in how pregnancy is portrayed in print. Pregnancy is no longer something to be hidden underneath a muumuu, but something to be celebrated in all its glory. (Shinseki 2004)

Since Demi Moore, many others celebrities have posed pregnant for the cameras. Entering the public sphere, pregnant bodies have also become the bodies that are expected to adhere to the norms of femininity – to be dressed and taken care of according to the rapidly growing beauty industry surrounding pregnancy.

Consequently, in the past couple of decades maternity clothing has been transformed into maternity fashion which is advertised by pregnant models. For instance, the article featured in Parents magazine "Gotta Have It: Best Products for Moms to Be" shares information on "sexy lingerie for Mamas-to-be" explaining that " you should enjoy every second -- or at least almost every second -- of your pregnancy, you gorgeous thing (Parents 2008)." The articles on the website of Today's Parent magazine advise pregnant women on "Maternity Wear Essentials," "Dressing for Two," and "Fabulous Fall Maternity Wear" (Todays' Parent 2010). Pregnancy, the authors suggest, could and should be stylish:

There is definitely a trend among moms-to-be to flaunt their curvaceous tummies, and several maternity lines offer clothes designed to hug the belly beautiful with carefully tailored garments that flatter the expectant mom's physique... You're getting these

super-sheer, wrappy, sexy dresses worn over a pair of jeans and
they just look great...You don't have to give up your personal style
to make room for your growing belly. (Todays' Parent 2010)

There are cosmetic products targeting pregnant women, as well as services such as pregnant belly casting and pregnancy portraits. As with the non-pregnancy beauty industry, however, the representations of pregnant bodies in the media feature products for predominantly white, middle-class, married and not too big women leaving the needs of older, single, poor and disable women not only unmet, but also completely ignored. Unfortunately, however, the canonization of a particular feminine form by media has been noted to affect all women regardless of their class, age, and body size (Bordo 1993). In what follows I demonstrate how women who participated in my study negotiated their body image and how they responded to the establishment of a beauty industry around pregnancy.

Dealing with media images

The feminist literature on body image has often demonstrated how women's bodies are controlled through fashion and canonization of ideal femininity (Bartky [1988] 2003; Bordo 1993). At the same time, researchers have shown that during pregnancy women feel exempted from following the beauty norms. Although they are exposed to various other forms of social control, during pregnancy women are not expected to adjust their bodies to the standards of feminine beauty (Bailey 2001; Upton and Han 2003). While previously pregnant bodies were invisible and hidden from the public eye, in the past decades pregnancy shape is featured on every magazine stand of a grocery store and glowing pregnant celebrities canonize the new feminine body image, that of pregnancy. As Geena notes, it is hard not to notice the pregnant body featured in the public arena:

Certainly these days - and I hate reading the tabloids - but
certainly you see them and you see this all the time, who is
expecting and what. I mean, you just see those things around and
you are aware of them but I don't really think that I have a good
understanding of the source of those changes... And you can't
avoid [seeing those] magazines, you just line up at your store and
you are forced to look at them, on the news, on the radio, you hear
about it, and you see it. I don't feel any need to align myself with

*that but you really cannot ignore it. (Geena, 26 years old and
married, in her third trimester of pregnancy)*

The majority of women, like Geena, were well aware of all the pregnant images
advertised in media. Overall, however, they did not see those images as a negative
phenomenon, putting pressure on them to look good during pregnancy. More often than
not, expectant mothers expressed ambivalent feelings towards the new trend:

*I think it is like anything with the media. We seem to find
pregnancy beautiful now. And the pregnancy clothes are out there
and it is really nice and the media has made something out of
pregnancy that can be celebrated and beautiful. I guess, we have
that mentality now that pregnancy is beautiful and we can show it
off. But then there is something negative to it. Because only if you
have a certain bump you will be looked upon that way and we still
see that some people put more revealing maternity clothes than
others. (Deena, 33 years old and married, second trimester of
pregnancy)*

Similarly to Deena, many women found that the increased social value attached to
pregnancy made it possible for them to celebrate their own transition to motherhood.
Comparing themselves to their mothers, who often hid their pregnant bellies under the
layers of clothes, my interviewees felt free to show off their bellies. They saw pregnant
bodies as attractive and beautiful and many attributed this social change to the new media
attention. Moreover, despite Deena's observation that media features only a certain type
of pregnancy, with a few exceptions, expectant mothers saw the celebration of the
pregnant shape as allowing for physical and social diversity. For instance, women noticed
that some celebrities gain more weight than others during pregnancy, yet, they still look
beautiful and their bodies are still perceived as attractive. Similarly, the majority of
women who gained a lot of weight during pregnancy still saw themselves as beautiful and
attractive and did not feel the need to hide their bodies. Young women who participated
in my study also noted that the images of pregnant celebrities made pregnancy more
acceptable among the teenage population. Although previously young women who got

pregnant felt pressure to hide their pregnancy, teen mothers who shared with me their stories were usually proud to demonstrate their growing bellies:

> *I have seen the girls who think that it is cool to be pregnant. Like I was the first one from my group [of friends] to get pregnant and now 4 or 5 of my friends have babies. It seems that after I had my daughter everybody was getting pregnant. But teen girls are really having more babies now… probably they get influenced easily by media, they see everyone is having a baby and think it is cool. I think people just do it. I don't know why I got pregnant, but people just do it. (Audrey, 17-year-old mother of one)*

Like Audrey, the majority of expectant mothers who participated in my study did not see media as influencing their perception of their pregnancy or self. The positive effect of the greater visibility of pregnancy was often noted by my respondents as affecting *all* expectant mothers.

At the same time, the negative aspects of the newly emerging image of pregnancy (which was usually summarized as putting pressure to look a certain way and increasing pregnancy rate among teen girls) were always constructed as having an effect on *someone else*, but not the woman herself. For instance, teen mothers suggested that, generally, pregnancy had become more desirable among teens due to the popularity of this topic in media. At the same time, their own pregnancies were always presented as accidents that had nothing to do with the increasing popularity of pregnancy among teens. On the same note, women often saw other women, but not themselves as affected by the images of the "ideal" pregnancy – with a few exceptions they did not feel pressure to look a particular way during pregnancy. On the contrary, they completely dissociated themselves from the pregnant celebrities, linking the pregnant looks to the differences in social circumstances of their personal world and the glamorous life of famous people. The pregnant body, therefore, was presented as celebrated but not pressuring to look a certain way. Overall, the visibility of pregnancy in media made the pregnancy desirable and attractive but did not constrain women to feel that the pregnant shape had to take a particular form.

The postpartum bodies in media

Although the greater visibility of pregnant celebrities was often seen as resulting in a positive change in social views of pregnancy, the postpartum bodies of movie and TV stars were a source of anxiety and annoyance. The reappearance of celebrities soon after birth on the covers of magazines featuring bodies identical to their pre-pregnancy shape was an issue about which participants had much to say. Advertising diet and exercise routines for postpartum bodies, the ads intended to demonstrate how, in just a short period of time, new mothers could return to "normal" after giving birth. Exploring the discourse on the postpartum body, feminist researchers note how, during this period, social control over the body shapes tightens (Dworkin and Wachs 2004; Upton and Han 2003). As Dworkin and Wachs (2004) claim, ironically, the postpartum talk on "getting the body back", which for some is associated with feminist slogan referring to owning your body and being in control of it, is used to signify the return to constant self-regulation in eating and exercise practices that is believed to be an effective tool in controlling women's bodies commonly used by societies (Bartky [1988] 2003).

Unlike celebrities' pregnancies, which were mostly assessed positively by pregnant women, the postpartum slim bodies of famous mothers were met with fury and frustration:

> *I definitely think that the impact of media is huge. I am actually quite glad that to be pregnant is to be sexy and I am grateful for that. But I think that [there is a] negative part to it as well. After giving birth, you know, you see those celebrities and they are back to their weight after three months. And she is like "Or, this is because I am running after my newborn", [and] I am thinking, like, "bullshit"! The only time that I read [gossip magazines] is when I am in a cottage and I remember how I read an article about Gwyneth Paltrow and how she admitted that it took her nine months to take off her baby weight and she actually did work hard on it. And I think it was the only celebrity [who told about that]. And I read it and thought "Thank you for that!" You actually validated that you do need to work hard on it and it takes time. And that is where I think the media ... does it wrong, [featuring] those women who after 4-6 weeks of having a baby are back to*

*super skinny. (Helen, 37-year-old married mother of one, second
trimester of pregnancy)*

The dissatisfaction of women with postpartum bodies of pregnant celebrities was
often voiced in their personal narratives. The immediate return to the pre-pregnant body
was perceived as unrealistic yet pressuring to bounce back immediately after birth. As
Jennifer suggests, many women felt that the slim bodies of supermodels only a few
weeks into the postpartum period set up social expectations for "normal" women that
they felt unable to fulfill:

> *It is frustrating, to see them [celebrities] and to know that they
> have their body back to normal so quickly and then people who do
> not understand [how hard it is] think "Oh, why can't you do it as
> quickly?" and it is frustrating because people do not understand
> that this is unrealistic (Jennifer, 40-year-old married mother of
> three).*

Unrealistic or not, the pressure to look good after giving birth was felt by all of
the participants despite considerable differences in their ages, ethnic backgrounds and
social statuses. Knowing that this quick transition back to normal is often impossible to
achieve, the women nevertheless constantly compared themselves to celebrities, who,
having the arsenal of financial resources, nannies, masseuses, personal trainers, and
dieticians, managed to canonize the slim postpartum bodies causing regular women to
feel anxiety and dissatisfaction with their unruly postpartum shape.

To summarize, the emerging public visibility of the pregnant body had a dual
effect on pregnant women. On the one hand, the majority of my respondents associated
the greater visibility of pregnancy with representations of the pregnant body as attractive.
They enjoyed the fact that pregnancy is being portrayed as a beautiful time in a woman's
life when she can celebrate her body and show off her belly. On the other hand, women
raised concerns about the effect these idealized images may have on women who do not
"fit" the ideal, although they claimed that they themselves were not bothered by this.
They assumed that the images may be affecting other women negatively (i.e. younger,
richer, first-time mothers) but dissociated themselves from the (possible) negative effects
of these images. All of this, however, changed in the postpartum period, during which

women did feel pressure to bring their bodies back into shape as quickly as celebrity mothers appear to do it. Claiming that the expectations to bounce back within just a few weeks are unrealistic, they were frustrated and annoyed by the images and the expectations they generated.

Overall, however, women paid little attention to pregnant celebrities. Rather, their expectations towards their bodies during pregnancy and postpartum were more attuned to their previous experiences, their personal attitudes towards their bodies, and the comments that they received from their family members and friends. In what follows I show how women's perceptions of their bodies were altered during pregnancy and how they responded to this transition. I start with women's attitudes towards their pregnant shape and how they were often altered in communications with others (predominantly partners, family, and friends). I summarize the chapter reflecting on the tension my respondents felt towards their postpartum bodies.

The Pregnant Body Image

The attitudes of women towards their bodies during pregnancy have often been described in the academic literature as negative rather than positive. Although researchers rarely dealt directly with pregnant women's perceptions of their body image during pregnancy, the consensus seems to be that women are dissatisfied with their body shape that they find unattractive and inconveniently adding on extra weight (Martin 1984; Pond 1986; Stenberg and Blinn 1993). This has been especially well documented among pregnant teens, who often experienced dissatisfaction with their growing bodies and felt that they are not physically attractive during pregnancy (Brubaker and Wright 2006; Stenberg and Blinn 1993; Werkmann 1994).

Women who participated in my study, however, did not express dissatisfaction with their pregnant shape as such. They liked the look of a pregnant shape. They looked forward to being seen as pregnant and to highlighting their own pregnancy bulge:

> *I liked showing off my belly. I got a really big belly and that where*
> *most of my weight was, so there was no hiding it, really. I think I*
> *had more trouble with it in the beginning where you just look more*

like you gained 5 pounds rather than looking like you are
pregnant. Because I didn't mind to have a big belly - during
pregnancy you're supposed to have a big belly. (Michele, 31-year-
old married mother of one)

Michele, as many other women, took pride in her pregnant shape. Once she was

defined as pregnant, she was no longer seen as simply gaining weight and looking fat –

the pregnancy shape distinguished her from women unable to control their flesh.

Therefore, for her, as for most other women, the showing off was marked as a pleasant

experience rather than a negative one.

The pregnant shape was often perceived as attractive and beautiful. Still, it would

be incorrect to state that women were satisfied with their pregnant bodies. Although the

vast majority of them did enjoy the curve of pregnancy, the other "markers" of pregnancy

were not met with enthusiasm and positive attitude – swollen legs, bigger hips, stretch

marks and heaviness in the end of pregnancy made women uncomfortable and

dissatisfied with their bodies:

I think that I was expecting [myself] to be a healthy model of
pregnancy with moderate weight gain. You know, gaining in all the
"right" spots. Towards the end of the pregnancy I was surprised
by how my body has changed. I gained weight in the places I didn't
expect to gain... The waist and the back... I thought I was going to
have just this belly in the front. I was hoping I am going to stay the
same with just a big beach ball at the front. It didn't work that
way. My hips got bigger, my legs were swollen, my face was puffy
and... it was just an overall puffiness... I looked like a Michelin
man with a big belly (laughing). (Anna, 33-year-old married
mother of two)

Talking about their favourite time during pregnancy, a majority of women

indicated that the second trimester was the most enjoyable time. While the beginning of

pregnancy was regarded as plain weight gain and the end of pregnancy was often

experienced as a very uncomfortable stage due to swelling and bloating, the time in the

middle was defined as pleasant. The women started to be recognized as pregnant, yet,

they had not grown so large as to not enjoy their growing bellies.

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Labeling the body pregnant and not fat

Being identified as "pregnant" rather than fat was important to expectant mothers. Pregnancy provided a social permission to get bigger. Once the woman was defined by others as pregnant, she felt more comfortable with her changing shape. This experience was not unique to the women who participated in my study. Similar findings were reported by Sarah Earle (2003) who interviewed expectant mothers in the United Kingdom. Likewise, the overweight women in the United Kingdom studied by Rose Wiles (1994) felt more social acceptance towards their bodies during pregnancy when they were "allowed" to gain weight and to be big. Robyn Longhurst (2005) described how New Zealand women make statements about their pregnant identity through different styles of clothing. *Looking* pregnant, therefore, was often no less important than *being* pregnant in the perception of pregnant women towards themselves. Many women, struggling to control their weight and appearance before they got pregnant, were especially concerned with their body image in the first trimester of pregnancy. When the pregnancy bulge was still invisible (or not defined as pregnancy by others) the fear of being seen as "letting go" or "being fat" was often expressed by expectant mothers:

> *I think what I had an issue with is that when I came back to [work] I was already pregnant but it was this stage of pregnancy when you don't look pregnant, you just look fat. And I didn't see my colleagues for three months. So, there was a little bit of embracement there, I have to admit... I think that what bothered me that people who would not ask [if I am pregnant] but during a conversation they would look at my breasts and bump. I felt that it bothered me, that they might as well ask... And I had three colleagues they had those conversations among themselves and kept staring between my boobs and my waist. And at that point I became very self conscious because I am thinking "Oh, are they thinking that I became fat during this summer?" And I was going, like "Oh, what are they thinking, what are they thinking?" So, I would rather answer a direct question. (Helen, 37-year-old married mother of one, second trimester of pregnancy)*

When I asked women about their body image during pregnancy, many of them responded to my questions talking about weight gain. Gaining too much or just the right

amount of pounds was closely associated with body image during pregnancy and women's satisfaction or dissatisfaction with their shape. Feelings towards their bodies were often constructed in response to the projections of the feelings of other people towards women's bodies. Sharing the news about pregnancy with their partners right away also symbolically marked the point at which women felt that they had social permission to get bigger.

While all women in my study reported having the support and affection of husbands, partners, and boyfriends towards their growing bodies, sometimes even their positive attitude was not sufficient in helping women to redefine their bodies as beautiful. For instance, despite her boyfriend's reassurance that she still looks beautiful, Catharine could not come to terms with her growing body. Rapidly growing from size 3 to 16 during pregnancy, she was not convinced that she still looks attractive:

> *I was always small, and when I met my boyfriend I was small. So, I look totally different [now], and I don't like it. When I was pregnant I didn't wear any makeup and I was so big and I didn't like it... My boyfriend said [that] he doesn't care but I know he did... During pregnancy I felt totally different... everything was bigger and felt differently. I felt heavy and I just felt so much baggage. (Catharine, 19-year-old mother of one)*

Catharine is one of the few women who were dissatisfied with the *look* of their bodies during pregnancy. During the interview, she came back to this theme on number of occasions. In her opinion, pregnancy did not simply change her body image – it changed her body to the point of being unrecognizable to others. Being young and interacting with her fellow teen friends Catharine felt that her new body did not fit social expectations. Although she was not told that she is too big *verbally*, she felt people looking at her *differently* and felt uneasy about it.

The role of social networks

The role of social networks in women's attitudes towards their bodies was subtle in most cases. Asked about their partners, families and friends, women would usually talk about being supported by all of them and being praised about their bodies' looks.

Nevertheless, since the issue of body image was often a sensitive topic for some women before pregnancy, on number of occasions women carried on this baggage with them on their journey to motherhood.

For Deena, for example, excessive body weight was always a potential threat as the history of excessive weight gain ran in her family. Gaining weight during pregnancy she felt rather uneasy about this process. The comments of her mother noticing her weight gain, made her worried even more:

> I had my birthday on the weekend and my mom started saying "Ah, it's too bad that you are having my hips because your pregnancy went into your hips." And you already feel self-conscious about that. Because that is not what I imagined and when I used to think about pregnancy I always seemed to imagine the models that you see that are pregnant and all you can see is a straight basketball in the stomach and nothing else. And when you get pregnant and you start to gain weight everywhere, you start to think, "What's the hell?" So, I guess I am kind of aware of it [body image] all the time but I guess that my workout will help me out with that [gaining too much]. (Deena, 34 years old and married, second trimester of pregnancy)

What caused the most anxiety in relation to body image (even though it helped women tremendously with their other concerns) was to have pregnant girlfriends or other pregnant women around them. As much as expectant mothers enjoyed sharing their feelings and receiving information from other pregnant women, they (often unconsciously) compared their bodies to the bodies of their pregnant girlfriends. Unfortunately, sometimes this comparison was not for their benefit:

> My sister-in-law and I were pregnant at the same time and I didn't like comparing our pregnant bodies and I didn't enjoy it. My body was quite large and I got a lot of comments about it being large and amazement about me being large. But my immediate family and my friends were very supportive. My in-laws, they didn't mean it negatively, it was really natural to compare it because there were two pregnant women at the same time. Sometimes it would get under my skin a little bit because she and me, we have very different bodies. And actually the comments I got were that I wasn't as large as she and you wouldn't be annoyed about that but I didn't appreciate the comments. And I think that I got bothered

because I didn't appreciate the comparison in general, because it was sort of viewed that her pregnancy was right and my pregnancy was wrong just from the comments were made by my in-law family. Looking back at this, I don't believe that it was necessarily true but that how I felt at that time. (Louisa, 27-year-old married mother of one)

Similarly to Louisa, many other pregnant women felt uncomfortable being compared to their pregnant girlfriends. Sometimes they would be perceived as gaining too much weight; on other occasions the comparison would reveal that they did not gain as much. Regardless of the results, however, the majority of women did not feel comfortable to be compared to other pregnant women. Louisa, in my opinion, pinpoints quite precisely the reason for this – for many women being "other" (bigger or smaller) meant deviating from the norm.

Being just the "right" size was important to all my interviewees. When this size did not correspond to socially acceptable norm of femininity (i.e., being too thin or too big), women worked hard before pregnancy to come to terms with their deviating bodies and to get used to having a different from the norm body. This process of adaptation to their body size was not easy – it had always required a lot of hard work and a lot of self-convincing. It is quite understandable, therefore, that for many of them the growing pregnant bodies caused a disruption in their body image. As I am about to show in the next section, majority of women defined pregnancy as the time when they have to postpone the concerns about their body weight until the end of pregnancy and to worry first and foremost about nurturing their unborn children. At the same time, spending considerable amount of time over the course of their lives engaging in "beauty work" and constantly controlling their weight gain, some of my interviewees could not simply forget for nine months the everyday practice of measuring and controlling their bodies. They perceived other pregnant bodies as unpleasant reminder of the hard work that was expecting them in the very near future.

Weight gain as motherly sacrifice

Although women did raised concerns about their body weight during pregnancy, I was surprised how little importance was granted to the body image in women's narratives. It was defined as egoistic, especially by the first time mothers, to care too much about weight gain and body shape. Since it was the growing life inside the body that initiated the change in the physical shape, women often shifted their concern from their own personal fitness to the health of the baby nurtured inside them:

> *During pregnancy [the concern about the body image was] really not there. I was just focused on being healthy and exercising and being as mobile as possible. I looked at this [transformation] as at training for this big physical labour event. And I guess I just really appreciated what my body was doing - this weird way that human beings go about reproducing, That women's body adjust so much, that your spine moves, and I don't even want to think about what happened to my intestines, where did they go [during pregnancy]. So, I kind of became very relaxed [about my body image and weight gain]. And sort of peaceful, particularly when I was getting into my third trimester and I realized that I am not that big. (Amanda, 35-year-old mother of one, living with her partner)*

For Amanda, being pregnant does not only change her body, it also changes the way she thinks about her body and the functions of this body. Before pregnancy, she was somewhat concerned with her appearance. Living with her female partner who is a slim woman, Amanda admitted occasionally comparing her body to the body of her partner and being motivated to lose weight in order to look better. During pregnancy, however, the attractiveness of the body was not part of her concern. She switched her body to the production mode, concentrating on her health and the heath of her baby. Preparing herself to the marathon of motherhood, she was training her body "adjusting" to a change, getting enough exercise, and making sure that she is mobile enough.

The switch in the function of body as sexualized/attractive and (therefore) slim to maternal/productive and (therefore) big, was often described by my interviewees, especially by those who experienced their first pregnancy. As Jenna notes, carrying for

the baby puts aside the personal concerns and dissatisfaction leaving women little space to worry about their appearances:

> *When I am not pregnant, my body image is important to me but*
> *when I am pregnant it is not as important, because everything is*
> *for the baby. (Jenna, 33-year-old married mother of two,*
> *immigrant)*

"Giving up" to the growing bodies was not merely the demonstration of maternal sacrifice – women often felt that they have little control over their changing shape. Being pregnant not only signified social permission to gain weight but also inability to manage the growing body. For instance, Anna tried to control her weight gain in the beginning of her pregnancy but soon she realized that she is doomed to fail:

> *I think I am less concerned [about my weight gain] not because I*
> *stopped caring but because I understand that this is out of my*
> *control and there is nothing I can do now... Maybe I will worry*
> *about it later [when I give birth] and maybe when I will breastfeed*
> *I will try to lose more weight. (Anna FU, 33 year-old married*
> *mother of two, last trimester of pregnancy)*

The rhetoric of personal responsibility for the body during pregnancy is often presented in the media and pregnancy guides. As I showed in previous chapters, pregnant women are expected to engage in scrupulous body work, to monitor their every bite and movement in order to make the nurturing of their unborn child as safe as possible. The language that is used in media assumes that being in charge of your body weight gain is a matter of personal choice and the ability to control one's own body. Consequently, the success in this enterprise is a demonstration of a woman's readiness to sacrifice her desires for the welfare of her children.

Unlike pregnancy experts, suggesting that expectant mothers are in charge of their bodies, the women who took part in my study did not perceive their bodies as manageable and easy to control. Although many of them tried to follow the advice of pregnancy experts on nutrition and exercise, they did not associate those efforts with an exercise of control over their bodies. On the contrary, vast majority of them denied any ability to regulate their bodies and regarded their weight gain and mobility during

pregnancy as the matter of luck rather than personal choice. For instance, Abigail, who had given birth to her third child, told me that she looked nice during all her pregnancies. At the same time, she did not attribute it to her lifestyle:

> *It felt nice that I didn't gain much. But it is silly... [You see that] like it is your achievement but you then realize this is not something you did. And [during] the third pregnancy it was different. I felt like I am not lucky anymore and I felt like I am gaining too much weight but then in the end I was fine. (Abigail, 36-year-old married mother of three, immigrant)*

It is evident that Abigail did not associate her weight gain with her personal efforts to maintain healthy weight. It is a matter of "being lucky" rather than personal choice. This was also the perception of the majority of other pregnant women. Sometimes they attributed their weight gain to their genetic makeup, comparing their own bodies to the bodies of their mothers and sisters who had had children before. In any case, however, even when the control over the body weight was somehow exercised (reducing ice cream at night or eating less cookies if weight is increasing too fast), the attempts to manage weight gain were rare among my respondents. Usually, women put little effort in managing their weight and preferred to flow with their natural course of pregnancy and gaining extra pounds rather than struggling with their bodies. In this sense, the story of Claire about her battle with her body during pregnancy stands out from the rest of the narratives:

> *It [the body image] was really important to me. During my first pregnancy I felt so bad and so terrible [due to nausea] that I didn't even think about it [weight gain] and I gained 30 kg and I thought that it is all just a baby and I will lose everything once I had the baby. But then I had the baby and the weight stayed there. And this time around I was really watching myself and I also had not been feeling well but I didn't want to eat anything and I even lost 3-5 kg in the beginning [of my pregnancy]. But during the last two months I started to gain lots of weight, like a kg per week, and then my belly grew so big that it [watching weight] wasn't important [anymore]. I was trying not to eat after 6 or not to eat sweets and not to eat ice cream. But I didn't have the motivation to watch myself towards the end of the pregnancy. (Claire, 32-year-old married mother of two, immigrant)*

Before pregnancy, Claire used to diet and she was always watching closely her calorie intake. After her first baby was born, Claire had some difficulty losing her weight. She was breastfeeding for a year and could not be on an aggressive diet that she would usually sit on to lose weight fast. This experience led her to try and regulate her body weight during her second pregnancy. In the beginning, she was happy with her strategy – although she felt as sick and nauseated as the first time around, she was able not to gain a lot of weight and even managed to lose it thanks to vomiting. She also set rules on her eating habits (not to eat after 6 or limit ice cream) that made her feel that she is managing and controlling her body. Ultimately, however, Claire lost the battle over her weight gain since despite her efforts, her body started gaining pounds rapidly towards the end.

To summarize, the body image in pregnancy was often constructed by pregnant women as beautiful and dissatisfying at the same time. Vast majority of them really adored the pregnant shape of their bodies, highlighting the belly curve and proudly celebrating their pregnancy. At the same time, other pregnancy "signs" such as weight gain, swelling, stretch marks were, understandably, met with little enthusiasm. The women also believed that they had little control over their bodies. Although many of them tried to eat healthy and exercise regularly, they attributed their body weight gain and other changes to pure "luck" rather than to their personal efforts. Moreover, worrying about the body image was often perceived as selfish and improper. The sacrifice of the personal body for the health and the needs of the tiny baby growing inside it made women less concerned with their shape and postponed the worries about personal appearance to the postpartum period. In a sense, having a baby inside protected women from the pressures to look appealing, as the baby, and not the woman, was "ruling" the pregnant body.

Getting the Body Back

This attitude toward the body drastically and rapidly changed during postpartum. Once the baby was out, the pressure to get back to "normal" was immediately felt by most women. In the previous chapter I showed that for some women pregnancy did not

end immediately after having a baby and the constant breastfeeding of the first months still closely linked the woman's body to her infant, not allowing her to feel physically separated from her newborn. Nevertheless, even when women did not feel personal autonomy and still experienced their bodies as shared with their babies through breastfeeding, they were anxious to immediately get back to their previous shape. Andrea, quoted below, gave me the interview when she was three months postpartum. Pregnant with her first baby, she envisioned herself very big during pregnancy. Despite her worries, however, her pregnancy weight gain was rather moderate. Therefore, it was especially surprising for her that she did not get back to her previous shape soon after birth:

> *During postpartum it [the body image] became more of an issue. Sometimes during pregnancy I would go to my midwife and I would weigh myself I would be shocked that during two weeks I gained so much weight and I couldn't believe it. Especially because I didn't feel it... But afterwards [in postpartum] when I started going back to the gym, I remember the feeling that something was just moving around and then I realized that it was my stomach and I never had that before. I tried my old clothes and nothing still fit. I obviously ate too much during pregnancy because I had the weight in other areas. And I was hoping that I would lose weight and it is hard because people are coming over and you want to look nice... I did have that expectation about being able to get back to my weight after six weeks. And I ended up buying some clothes because I couldn't fit in any of my clothes...Once in a while I go to the closet and I try something on and I mean, I know I am getting smaller but they [old clothes] still don't fit.(Andrea, 34-year-old married mother of one)*

Comparing her pregnancy experience with her postpartum struggle to get back to her normal shape, Andrea cannot identify her postpartum body as her pre-pregnant body. As she finds out during her workout in the gym, this new body does not only *look* different but it also *feels* different. While during pregnancy she did not notice weight gain and simply observed with amazement the growing number of pounds on the scale, during postpartum the extra pounds added up preventing her from wearing her old clothes. Moreover, once the baby is out, Andrea also loses social acceptance to be big - having

people over puts even more pressure on her to get back to her normal weight. The process of getting back to her previous clothes is too slow for her to be satisfied with her post pregnancy shape.

While the unborn babies protect pregnant women from societal pressure to have a slim and a fit body and granting them permission to get bigger, the newborn child does not have the same effect. Being (or perceived as being) physically separated from a woman's body, a newborn is no longer a part of woman's body. A body of a woman, therefore, is expected to come back to its pre-pregnant shape erasing pregnancy from its surface and regaining control over it (Dworkin and Wachs 2004; Upton and Han 2003). In this sense, pregnancy is not seen as a continuous part of woman's lifecourse. Rather, it is often constructed as a disrupting event, which is detached from woman's previous life experience and should also be erased from her body in postpartum.

Women are expected to regain control over their bodies in postpartum and they seem eager to do that. Upton and Han (2003) attribute this need to the experience of "body loss" during pregnancy but also to the shifting social responsibility over the body of a woman: "*the postpartum body is scrutinized, but the onus for control and change rests on the individual. Pregnant bodies are public bodies. Postpartum bodies are often not* (Upton and Han 2003:689)."

Not all women who shared with me their stories about pregnancy experienced the loss of control over their bodies during pregnancy and not all of them found this experience disturbing. Nevertheless, the vast majority of women was eager to get back to their pre pregnant shape. Beverly notes:

> *I would say, absolutely, for me postpartum period is much, much harder than pregnancy period. Because right now it is obvious that you are pregnant, people are excited and happy and you get a lot of attention and it is wonderful. Postpartum, in a couple of weeks you just look like you have an extra 10 pounds on you and you cannot get rid of them and the things are just sitting there. The clothes don't fit properly and maternity stuff are too big and your regular clothes too small and you are trying to find those in-between sizes and I went last time and bought a whole bunch of stuff that were bigger than my own size because I got tired of*

trying to fit in my regular clothes and not being able to. Because I think that has an effect on woman's self esteem, feeling that things are too tight and not fitting properly and you know, feeling the fat that is on your body. So, definitely, for me the postpartum period is much harder. (Beverly, 34-year-old married mother of one, last trimester of pregnancy)

Being 38 weeks pregnant at the time of the interview, Beverly is dichotomising between her big pregnant body, which causes excitement and positive attitude from others and the unattractive postpartum body, which looks jut fat and flabby. As many other women who had given birth before, Beverly chooses to buy a new set of clothes for the liminal postpartum body, since she feels that that her attempts to fit into her old clothes would only add more negative feelings to her view of her body. In a sense, for many expectant mothers this decision also signified women's resistance to accept their postpartum bodies as their old bodies – instead of seeking to regain control over big and unruly postpartum body in order to fit it in its pre-pregnancy form, women defined it as different and requiring its own set of clothing.

The postpartum bodies were often described as bringing dissatisfaction to the experiences of pregnancy and postpartum. As I showed in the beginning of this chapter, reflecting on their need to get back to their shape right after birth, many women blamed media for creating false social expectations and placing on women unrealistic timelines to be their "old selves" again:

I think that when I saw pictures of pregnant women [in media] I felt it was kind of gratifying. You think I look like that too, even if you don't really look like that (laughing). But where I do see a problem is when those celebrities that just had their children and after couple of weeks they got their body back and that what came as a surprise for me. Because I didn't realize that it would take long to get your body back, and that sort of a message that comes from media. It is kind of fun to be pregnant when you are pregnant but it is not fun when you already had your baby. (Michele, 31-year-old married mother of one).

As Upton and Han (2003) note, in the past decade there was formed a big consumer market for postpartum bodies advertising special diets, workout videos and

how-to guides for women who just gave birth. Moreover, new developments in cosmetic surgery offer a "mommy makeover" or a "mommy tuck surgery" which promises women to combine liposuction, cellulite treatment, breast augmentation, tummy tuck and stretch marks removal all in one package[19]. Bombarded with messages about the appropriate post pregnant body, my respondents identified them as "annoying" and "bothering". The postpartum body, therefore, unlike the pregnant body, was seen by many women as unattractive and dissatisfying, in need of physical repair and major work to get it back to "normal" (that is, without any signs of the experiences of pregnancy). Nevertheless, it was a real body that, although needed repair, could not be fixed in just four weeks, as it often was presented by media. Realistically, taking care of the newborn baby, struggling to get enough sleep and to learn how to breastfeed (for the first time mothers) or how to introduce the new baby into their old lives (for all mothers) was more important than the quest for the perfect postpartum body. At the same time, smiling and slim Hollywood mothers meeting the women on the magazine stands of groceries stores, kept reminding them that our postmodern mothers, in addition to the traditional mothering tasks, have yet one more responsibility – to look sexy and attractive, to be "yummy mommies" who did not let themselves "go" after giving birth (Douglas and Michaels 2004).

Chapter Seven: Summary and Conclusion

In conclusion, I would like to point to the significant differences in women's attitudes towards their bodies during and after pregnancy. I showed that the pregnant shape was often perceived by women as attractive and beautiful, and even when their bodies did demonstrate some unpleasant "signs" of pregnancy (such as swelling, puffiness, or stretch mark), overall, the pregnant bodies were viewed with affection. The postpartum body, on the other hand, was a source of dissatisfaction for many women who felt pressure to erase the experience of pregnancy from their bodies and to "bounce back" as soon as possible. Imagining how others perceive their bodies and reflecting those perceptions on their body image, the women who participated in my study renegotiated

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[19] For advertisement of plastic surgeons see Docshop.com (2009)

their pregnant body image through the looking-glass process of embodiment (Waskul and Vannini 2006a). That is, their new body image was a reflection of what, the women believed, others saw when they assessed the pregnant and pospartum bodies' shape and weight. The pregnant body was almost always perceived as beautiful while the postpartum body was seen as dissatisfying.

The differences in the attitudes toward the pregnant and postpartum bodies cannot be explained by the images advertised by media – both, postpartum and pregnant body featured by media are slim and fit with no excess of fat. Nevertheless, pregnant women are little affected by the images of pregnant celebrities posing in media, yet, they are bothered and annoyed by the slim postpartum bodies.

It seems to me that women's attitudes towards their bodies during and after pregnancy can only be explained by acknowledging the role of the discourse on motherhood on women's experiences of pregnancy. Seeing pregnancy as a transition to motherhood, women learn to sacrifice their bodies and their selves for the sake of the baby, and, to demonstrate their readiness to give up their personal ambitions for the wellbeing of their children, expectant mothers present themselves as fit for motherhood (Douglas and Michaels 2004; Marshall and Woollett 2000; Messias and Dejoseph 2007; Phoenix and Woollett 1991c). Moreover, hosting a baby inside the body, women "give up" their bodies to the baby and, therefore, have little control (and little interest to control) their growing bodies[20]. Demonstrating mother-like behaviour women are encouraged to feed their bodies properly and to provide nurturing and safe environment for the growing life inside them (Copelton 2010). The productive role of a nurturing body leaves little space to worry about the sexualized image of the body with particular amount of pounds and inches and precise and concise forms. The pregnant body is, therefore, seen as beautiful and attractive, but it is also more productive than entertaining – to control its physical appearance through diet or hunger is to threaten its capacity to nurture a child. And, since the quest for the perfect body is often associated with harming bodily

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[20] Here I only refer to the physical attractiveness. As I demonstrated earlier, women are expected to completely transform their eating habits during pregnancy and to constantly monitor what they eat.

practices such as aggressive dieting, hunger, exhausting physical activity, or cosmetic surgery (Bartky [1988] 2003; Bordo 1993; Findlay 1996; Morgan [1991] 2003), pregnant women are allowed to take detour from the quest and to devote themselves to their growing child. The longer the detour, however, the harder the return to the quest for the ideal body in postpartum since the ideal feminine body is the young, sexualized body with a complete absence of the remotest remnants of pregnancy and childbearing.

Chapter Eight: Pregnant Bodies in Social Context: Natural, Disruptive and Unrecognized Pregnancy

In the previous chapters I demonstrated the significance of the role of social interactions and the social context in which those interactions occur for understanding the meaning that women attach to their transition to motherhood. I showed that from the very first signs of the manifestation of pregnancy in the body, over the next nine months and well into the postpartum period, women learn to understand their bodies and their selves in unison with their own expectations of what the pregnancy should be and in response to the perceptions about pregnancy of their significant others. Situated in a particular context, interactions with others define the socially appropriate behaviour for a pregnant woman and guide her in accepting the new role of "being pregnant". Relying on the clues received in social interactions with friends, relatives and various formal and informal experts on pregnancy, women engage in behaviours and practices allowing them to demonstrate their role as "good" mothers. For some this means following the medicalized advice on pregnancy while for others the goal is to resist these messages and/or to accept an alternative set of behaviours. The social position and such personal characteristics as age, number of children, class, and marital status would usually define the context in which the interactions with others would occur. I explored how some women struggle to have their mothering skills socially valued while others, privileged women, would be automatically assumed to have a set of skills and characteristics suitable for motherhood.

Throughout this dissertation I pointed out that the existing sociological literature on the experiences of pregnancy and motherhood predominantly deals with white, middle-class women (Bailey 1999; 2001; Dworkin and Wachs 2004; Earle 2000; 2003; Longhurst 2001; 2005; Marshall and Woollett 2000; Upton and Han 2003; Warren and Brewis 2004). The experiences of other, socially marginalized mothers have received considerably less attention (but see Brubaker and Wright 2006; Gillies 2007; McMahon 1995). Scholars commonly assume that pregnancy is experienced by *all* women in a

similar manner[21]. Therefore, many researchers tend to make overarching generalizations based on the existing research which, they believe, applies to *all* expectant mothers. Among sociologists, it is usually the norm to limit generalizations to women who belong to the social class represented in their sample. Even when researchers acknowledge the influence of class on the experiences of pregnancy, they look primarily at social class as a constant characteristic affecting the experiences of pregnancy and rarely engage in the analysis of its role in facilitating differences in the social contexts in which women experience their transition to motherhood (but see McMahon 1995).

In the preceding chapters I demonstrated that situating women's experiences of pregnancy in social contexts reveals remarkable differences in women's personal experiences of the journey to motherhood. I claimed that only by exploring the meaning that women attach to pregnancy during social interactions it is possible to understand the embodied experience of becoming a mother. I showed that by leaving the social context out of the analysis scholars are unable to capture the variability in the experiences of motherhood. Here I intend to show that overlooking the importance of social context in facilitating the construction of the meaning of pregnancy, sociologists do not only ignore the experiences of marginalized mothers but also do a disservice to the well-studied, white, middle-class women. Analyzing the experiences of pregnancy among privileged women they tend to capture women's transition to motherhood "in general". For instance, including in their sample only first-time mothers or not mentioning if women had previous birth experiences at all, scholar leave us to assume that this factor is insignificant for women's experiences of pregnancy (Bailey 1999; 2001; Copelton 2010; Earle 2003). In a similar manner, looking at women's changing communication with relatives and friends, scholars tend to neglect the context in which the interactions

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[21] In fact, this tendency is not unique to the sociology of pregnancy. Feminist scholars often criticized the research projects focusing exclusively on the binary gender structures and/or the intersection of gender with class and/or race (Bredstrom 2006; Hankivsky and Christoffersen 2008; Hankivsky et al. 2010). Instead, they suggest incorporating into the health research the paradigm of intersectionality that would allow to accommodate the diversity of women's identities and social worlds and analyze the impact they have on women's health.

occurred, which presumes the constant nature of such communication and transforms a social context into a negligible circumstance (Bailey 2001; Draper 2003; Longhurst 2001; 2005). As I am about to show in this chapter, however, even the experiences of the well-studied, middle-class and white population of pregnant women are not fully captured without examining them within a particular social context.

Focusing exclusively on the experiences of white, middle-class women, in this chapter I explore how people surrounding pregnant women interpret their pregnancy and how their interpretations are constructed in different social contexts. I demonstrate that even when pregnancy is presumably socially expected (as in the case of married, middle-class women) moving from one social situation to another, expectant mothers can be praised for their pregnancy or cause social uneasiness and tension. I show that the value that the society grants to pregnancy is constantly negotiated in social situations leaving little importance to class and age as the sole predictors of the social attitudes towards pregnancy. Based on the interpretations given by the pregnant women to the social encounters with others, I explore how the same pregnant bodies receive different meanings in different social contexts. I start this chapter defining the meaning of "natural" pregnancy and describing how women of a certain class and age regard themselves and are regarded by others as potentially "good" mothers. Next, I show that even what is typically considered to be an "acceptable" pregnancy can become problematic should it be manifested in a certain social context. I demonstrate that in some situations the pregnant body that is usually seen as destined to mother disrupts social order and becomes unwelcomed by others. Following this section, I move to demonstrate that when pregnancy is not socially expected even the changing shape of the pregnant body has little effect on the reluctance of others to label the woman's body as pregnant. Showing that sometimes pregnancy remains unrecognized by family, friends and co-workers while strangers and other people can easily spot it, I reinstate the importance of social labelling and the process of naming the body as "pregnant" over the physical evidence of pregnancy.

Born to Mother

It is a widely accepted belief that since the introduction of the birth control pill women had become more involved in planning their pregnancies. While in past decades women could not freely choose when to get pregnant, today there is the possibility of planning pregnancies and adjusting childbearing to individual's personal goals, careers, and lives (Gregory 2007). As I demonstrated in the previous chapters, pregnancy experts often encourage women to plan their pregnancies ahead, cleaning their bodies and preparing them to bear children by improving their diet, modifying their exercise, taking prenatal vitamins and folic acid, and reducing (or better eliminating at all) alcohol and cigarette consumption (see for instance Babycenter UK 2007; Elliott 2003; Holcomb 2009).

Of course, trying to get pregnant is considered socially appropriate only if a woman has achieved a certain social status – that is, she is married, not too young (but also not too old), with sufficient family income to raise a child, and a stable household (Gregory 2007). While getting pregnant before achieving those conditions raises the possibility of questioning the worthiness of a woman as a mother (and her level of responsibility), delay in childbearing among women who are socially defined as "fit" to have a child is also regarded as improper[22].

It is commonly assumed that among married, middle-class women of the normative childbearing age, pregnancy is socially expected and encouraged. The majority of my participants who belonged in this category knew that their pregnancy would be met with acceptance and indeed excitement. Debra, for example, notes:

> *I always felt that I looked old enough and I wore a wedding ring
> and I felt like the society approved of me being pregnant... I was
> always among women of my age, and my class, and we all were
> married house owners. And we were talking about our bodies*

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[22] For instance, women who choose not to have children or women who are unable to conceive continue to be negatively stigmatized in our society, albeit less so now (Friese, Becker, and Nachtigall 2008; Gregory 2007; Miall 1994).

*being celebrated and that would not necessarily apply to younger
mothers. (Debra, 34-year-old married mother of two).*

Debra got pregnant with her first child at the age of 32 and after 2 years of marriage. As she notes, she and her friends celebrated their pregnancies and felt that the society praised them for a decision to carry a child. Knowing that this social acceptance of pregnancy is due to her social status which she nicely summarizes by highlighting the visible signifiers of her "appropriateness" to have a child (age, wedding ring, and a house), Debra admits that her experience of pregnancy can be remarkably different from the experiences of young, teenage mothers.

Debra's recognition of being privileged to become a mother is not surprising. While marginalized women are often stigmatized for their decision to mother a child and defined as unworthy of motherhood, the white, middle-class population of women in their late 20's and early 30's is constantly constructed as the model of ideal mothers in our culture (Douglas and Michaels 2004; Marshall, Godfrey, and Renfrew 2007; Phoenix and Woollett 1991a). As I mentioned, self-help books, pregnancy-guides, magazines, and Internet articles available to pregnant women take on the white, middle-class and married expectant mothers as the *model* or an *ideal type* of the pregnant woman and of the mother.

Despite the fact that the pregnancy among middle-class women is commonly celebrated by people around them and by a larger society, my findings reveal that even those privileged women have their own, socially prescribed norm for reproduction. In what follows I show how, depending on the context in which women find themselves, their pregnancies would be perceived as problematic, disrupting social order or remain ignored altogether. I start with demonstrating how others problematize (presumably) socially acceptable pregnancy due to social circumstances in which it was announced to others. I then move on to demonstrate how the socially acceptable pregnant body, moving from one social context to another, could have been suddenly perceived as disrupting or unrecognized as pregnant at all.

Redefining socially (un)acceptable pregnancy

Being ready to have a child does not only mean to be of an appropriate age and colour. Social class, sufficient income, and a respectable social position often define women's right to mother, too. As I demonstrated in Chapter 5, once a woman would name her body as pregnant and announce the news to others, the social value of her pregnancy would be negotiated in the social encounters.

Families and friends often played a crucial role in legitimizing (or delegitimizing) a woman's pregnancy. This process of evaluation was never final – the change in social circumstances or the change in women's behaviour could have called for "reassessment" of pregnancy and re-validation of it by others. For example, young teen mothers who would initially be defined by others as "deviant" could have been later praised for their efforts to stick to prenatal guidelines. Similar upward transition (from being stigmatized to socially praised) was experienced by Brenda, a university student, who got pregnant during her last year of an undergraduate degree and gained legitimacy to be pregnant once she finished her studies:

> *Or, they [family] were happy. I mean, at first they were at shock because we were students. I mean, I was a student and he [my fiancé] was working. But then I finished my school and my family was great and so supportive and he [my fiancé] was great from the beginning. (Brenda, 20-year-old mother of one, engaged).*

In this account, Brenda constructs the reaction of her family to her pregnancy around her status of a student. That is, her being a student comes as an explanation to the initial shock that her parents expressed upon hearing the news about her pregnancy. Therefore, once her degree was completed and she was no longer a student, her family had become "great and supportive" signifying to her that she is socially accepted and her pregnancy, although not really desirable at this stage of her life nevertheless will be celebrated by her family and (thus) socially valued.

While Brenda moved up the ladder of socially valued motherhood, the change in social circumstances of Anna's pregnancy moved her down the same ladder. A stay-at-

home mom from a family with middle to upper income, Anna got pregnant with her third child very soon after giving birth to her second. As she notes, the news about her pregnancy was not met with "celebration" and excitement:

I knew that the majority of people will be really surprised that I am doing it again. I... think they were surprised negatively but I don't even want to think about it. And I think that a lot of people judge me... His [husband's] parents, for example. Like, his mom when she was talking to him on the phone said "So, I hope this time it is the last time [you have a child]"... I didn't say anybody that I was pregnant. I didn't want people to judge me and I saw when my friend got pregnant with her 4th child, she was really pissed that people would come and say, "Are you crazy? Why did you get pregnant again?" And she was shocked at that reaction of people. And I know that if I will get pregnant one more time, I won't hear even one positive comment. (Anna FU, 33-year-old married mother of two, last trimester of pregnancy)

Media often defines family income as a crucial tool for assessing the readiness of a woman to have another child – ultimately, single mothers, welfare mothers and working-class mothers are believed to become a burden on society's shoulders and (therefore) should limit their childbearing (Byfield 1999; Douglas and Michaels 2004). Although Anna's family income is not threatened by another child, she nevertheless feels that her pregnancy is defined as deviant. Having two little ones too close to each other and having more children than is typically expected in her social network, made Anna feel that she was being socially reprimanded for her decision (the presumption being that it was indeed her decision) to have another child. This experience was remarkably different from the pregnancy with her second child that was discussed during our first interview. At that time, Anna was happy to share the news with others and her pregnancy was praised and celebrated. This time around, she kept it secret and was not eager to announce the news to her friends and relatives.

As some scholars note, in past decades parenting children among middle-class mothers had become a professionalized enterprise (Douglas and Michaels 2004; Phoenix and Woollett 1991a). In addition to providing children with financial and family stability,

to be a suitable mother nowadays also means to constantly read parenting books, consciously adopt and follow a particular parenting ideology and/or practices, enrol children into a number of extra-curricular activities, and to designate special "quality time" with the kids (Glenn 1994; Phoenix and Woollett 1991b; 1991c). As a result, to mother a child "properly" requires a lot of time and effort and the ability to be a good mother has become transformed into a myth and a goal that most women will never be able to achieve (Douglas and Michaels 2004). This physical, emotional, and financial investment into children's education, which, according to Hays (1998), became a basis for the "ideology of the intensive mothering", leads to a constant psychological dissatisfaction of women with their mothering practices and abilities (Phoenix and Woollett 1991b) and serves to continue confining women to mothering, leaving out the fathers from equally participating in their children's lives.

Considering the enormous amount of effort and time required to raise just one child, not surprisingly, families with an above average number of children (which, for the most part, are managed by the underprivileged women) are perceived to be unable to provide a suitable environment for their children's successful development (Douglas and Michaels 2004; Munn 1991). As one of my interviewees told me, her friend had nicely summarized the decision to have only two kids – "I have just two kids because I have two hands – one kid is going to be holding my right hand and the other one left", she said.

The professionalization of motherhood transformed the presumably natural instinct of women to mother into a growing enterprise of education on childrearing, adoption of a particular ideology of parenting, participation in various children's activities, financial investment and thorough planning of children's future, and myriad other duties and responsibilities that constitute the successful model of contemporary parenting. Analyzing the social implication of the professionalization of motherhood, researchers often point out that it further marginalizes the experiences of poor mothers who, due to insufficient income and/or full-time work outside the house are unable to invest in their children's future to the extent that is done by the middle-class mothers

(Phoenix and Woollett 1991b; Speier 2004). As the case of Anna demonstrates, however, even middle to upper level of income cannot suffice to raise more than two children according to the new standards of mothering.

It seems that self-regulation of one's reproductive activity has become a signifier of socially praised mothering. When middle-class women do not demonstrate control over their reproduction and exceed the socially established limit on the ideal family size, the value of their mothering work is questioned. As Nicole notes, having more children than socially prescribed automatically questions women's ability to provide sufficient care to their children:

> *Middle-class parents are responsible and that is why they shouldn't have a lot of kids. I think the assumption is that you cannot provide adequate care and you cannot handle a large number of kids. Like, three is too much - if you have a job, you don't give them enough attention. How can you give attention to three kids [if you are working]? And if my husband is working and earning a lot of money and I am a stay-at-home mom, I think that three kids is a cut off for me, that's the top (Nicole, 37-year-old married mother of three).*

Nicole, having just given birth to her third child, and coming from the family with middle to upper income, links the need in self-controlling reproduction to responsible parenting. According to Nicole, the proper care that women have to provide to their children requires so much emotional and physical attention that *no* mother is capable of raising more than three kids, even when she is not working outside of home. Nicole clearly dichotomizes between the elevated sense of responsibility that she believes is manifested by women who are coming from the families with sufficient income and the lack of such self-control among working-class women whose reproductive choices (the assumption being made that they do make these choices) are irresponsible and endangering the welfare of their children.

To summarize, once women announced the news about their pregnancy to others, the social circumstances in which the announcement was made defined the pregnancy as either socially acceptable and desirable or problematic and deviant. The reaction of

family members, friends, and the women themselves to their pregnancy usually marked the body of a pregnant woman as worthy of social appraisal or social reprimand. At the same time, being a "good" mother was in no way a static category - as women's social circumstances would change, they could switch the categories of "good" and "deviant" mothers. Even among middle-class married women – the ones who are routinely assumed to be socially expected to mother, having too many kids or having kids too soon after each other was perceived as improper childbearing and was socially condemned.

At the same time, the pregnant body of a woman does not own a label of "socially valued" or "deviant". Moving from one social context to another, women often have to negotiate the value of their pregnancy in communications with others. In the remainder of this chapter I demonstrate how, depending on a social context, pregnant bodies which would be otherwise perceived as socially valued would disrupt the social order or would not be perceived as pregnant at all.

Pregnancy as Socially Disruptive

As I noted above, the pregnant body does not receive a permanent label of "acceptable" or "improper". Rather, in each social context the meaning of pregnancy is renegotiated by women. In communication with their friends and relatives, for instance, the topic of pregnancy would often come up during conversations, and, every time the women would be reassured over and over again that their pregnancy was regarded as a positive transition and marked with celebration and excitement. On the other hand, at social events, pubs, clubs and some other public places pregnant women often felt that their bodies disrupt social order and that they are out of place.

Although in previous chapters I demonstrated that in the past decades pregnancy has become increasingly visible in the public sphere and much more acceptable, there are some places where pregnant women are still rarely welcomed. For instance, places with loud music, serving alcohol and having the designated places for smokers usually do not meet pregnant women with enthusiasm. Becoming pregnant women would cease to be

visiting pubs and clubs, as those places would be considered inappropriate for a pregnant woman. Sometimes the women would make this decision independently, as in the case of the teen mothers who participated in my study. On other occasions, the denial of this social life would be initiated by others around the expectant mothers. One of my interviewees, for instance, told that once her friends knew that she was pregnant, they stopped inviting her to go out, assuming that *she* (and not them) would feel uncomfortable to go clubbing:

> *[When I was pregnant my relationship with] my friends who are*
> *still single and don't have kids received a new dynamic. I know*
> *that if they would go out to the club or some place at night there*
> *were some times when I wasn't invited where I would've been*
> *beforehand. I think that was just the case of thinking that I*
> *wouldn't want to go out because I couldn't drink. So there was that*
> *kind of hesitation. (Andrea, 34-year-old married mother of one)*

Pregnancy, therefore, marked the bodies of women as different, so different that they often could not engage in their previous social life – some of the activities that they could have engaged in before pregnancy (i.e., clubbing or having a social drink at a pub) became defined as "improper" for pregnant women. Instead, the pregnant women were expected to engage in mother-like behaviours (reading, TV-watching, and educating themselves about pregnancy and childbirth). Consequently, accepting the new role of a pregnant woman, expectant mothers would often have to redefine their appearance in different social situations and reconsider which of them are no longer appropriate.

Disrupting professional image

While young teen mothers usually described how their bodies would be commonly stigmatized by people around them, the pregnancy of middle-class, appropriate age, married women was generally met with enthusiasm by their families and friends. It was, therefore, especially apparent to them that in particular social situations their bodies caused a disruption of a usual social order. One of those instances was described by Debra, who was looking for a job while being visibly pregnant. In the beginning of this chapter I quoted Debra's narrative about the celebration of her

pregnancy by her immediate circle of relatives and friends. Once she was interviewed for a job, however, her pregnancy was perceived differently. Applying for a permanent position that she was expecting for a long time, Debra decided to send her resume to the prospective employer even though she was already pregnant. If she would get hired, she hoped to begin her employment in the new workplace with a maternity leave and after a year to start her professional duties. Being uneasy about her decision to apply for a job while pregnant, she did not mention to her prospective employer her pregnancy prior to the in-person interview. Showing up for the job talk while being visibly pregnant, she felt as if she caused a disruption in a strict professional environment by her (presumably) unprofessional, maternal body:

> *When I went for an interview it was horrible. The pregnancy was like an elephant in the room because I couldn't bring the pregnancy up and they by law cannot talk about it. And when I was giving my job talk, it was just terrible. And then, after having my job talk, in the end, I said that after I am back from my maternity leave I will do this, and will do [that], because I felt that I have to address it [my pregnancy]. But it was an awful day and I never felt relaxed, it was just awful. I [know that I] don't need to apologize for having a child but, in a way, I do feel sheepish, especially applying for a job and being visibly pregnant. (Debra, 34-year-old married mother of two).*

Coming for a job interview while pregnant, Debra feels that she threatens the structure of the interview by appearing pregnant in front of the people who are about to hire her. Her pregnancy is felt as physically present, and not just as a small disruption, but as an "elephant" - in a sense, it is more visible than Debra herself and her skills and professional abilities, which she planned to demonstrate during her job talk. Trying to make sense of her "sheepish" attitude towards her pregnancy in the eyes of others, Debra explained that her pregnancy seems to put a shadow on her professionalism – since pregnant women are often defined as first and foremost "pregnant" and only secondary as "women", she was afraid that her pregnancy will be defined as "unprofessionalism" and as a lack of dedication to her career.

Debra was certainly not alone in worrying about the reaction to her pregnancy at her workplace. In male dominated white collar positions, women are expected to fulfill the role of men and to hide the "abnormalities" of their womanly and sometimes leaking bodies (Borve 2007; Longhurst 2001). Many women in my study feared that their pregnancy will signify a lack of professionalism to their employer, especially when they were employed in male-dominating sectors[23]. Therefore, celebrating their pregnancies within the context of the private sphere, those women often delayed the uncomfortable conversation about pregnancy with their employers and rarely mentioned the news to their colleagues.

Disrupting a body-absent culture

Not only the professional environment is a male-dominated environment, it is often a body-absent environment in which bodies are simply functioning as the carriers of the minds of intellectuals. The structure of academe, for example, often caused women to feel anxiety about their professional identity while being pregnant lecturers, professors, and presenters.

The feminist researchers often pointed out that contrary to male, rational, mind-ruled bodies, the female bodies are socially constructed as ruled by nature, as unpredictable and illogical (Davis-Floyd 1990; Glenn 1994). The "natural" substance of female bodies and the potential dangers of the unpredictable nature are believed to be especially explicitly evident over the course of the woman's pregnancy and childbirth (Davis-Floyd 1990). That is why the important component of the ritual of birth of western countries is the attendance of a (preferably) male physician whose mind is rational enough to take control over the situation (Davis-Floyd 1990).

The degree to which my participants believed they were ruled by nature during their pregnancy varied significantly. Some women claimed that over the course of

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[23] Women who worked in a women-dominated sector, on the contrary, were usually quite excited announcing their pregnancy at work. Since at those workplaces maternity leaves were more common, they did not associate their pregnancy with unprofessionalism and received support from their coworkers and employers.

pregnancy they became "hormonal", easily irritated and commonly had mood swings. Others did not notice any changes in their behaviour and had difficulties to believe that during pregnancy women become more emotional.

Regardless of their perceived proneness to the mood swings during pregnancy, however, the vast majority of my respondents claimed that pregnancy did not affect in any way their professional performance. Moreover, when their co-workers would joke about the effect of pregnancy on their professionalism, the expectant mothers would usually be annoyed and even offended by the remarks. Struggling to maintain the identity of a professional woman who is in charge of the body which is (believed to be) ruled by nature, the pregnant women were often concerned that, in the eyes of others, their mind is dominated by their body and, therefore, their professional skills are questionable. As Donna, a professor in a department dominated by male presence notes, the fear of being perceived by others as unprofessional was haunting her once her pregnancy became visible:

> I was afraid to lecture. I was afraid that my students will laugh at me and that I will lose my authority in the classroom. I thought that instead of listening to what I have to say they will be looking at my belly. And it was not so. So they did look at my belly in the beginning of the class but then they forgot about it... I think that all women should work a little bit harder to get to the same level of status as male professors but for pregnant women it is even more difficult. (Donna, 38-year-old married mother of two).

Similarly to Donna, the majority of women who were visibly pregnant and continued to work in the male-dominated professional sectors were anxious to maintain the image of a professional. Although all of them had won the battle over their professional status, it was an uneasy task which required a lot of investment in the professional performance. For instance, similarly to the New Zealand women studied by Longhurst (2005), my respondents would choose the apparel that would highlight their professional identity. Talking with others about their expectations for maternity leave, they would discuss the possibility of working on collaborative projects while being at home with the newborn. Lecturing in front of their students, they would not mention their

pregnancy, making the change not announced and thus socially unrecognized as pregnancy. Switching the social attention from their changing bodies to calm and rational minds, the women tried to minimize the disruption their pregnancy caused in the professional environment.

While most women felt uncomfortable when their pregnant bodies disrupted the social context, Amanda, another member of academe, found this experience quite pleasant:

> *I had nice new pregnancy clothes that were sort of professionally looking. And then I was pretty subtle and I didn't wear a lot of baby-doll kind of things. I was wearing kind of well fitting things. I am sure [my] students kind of were looking at me trying to decide, whether I was [pregnant]or I wasn't. And the people in my department knew at that point [that I was pregnant]. But then the things progressed and I remember particularly well when I was much more pregnant [around] 8-9 months, we went to a party and I wore this pink shirt and it felt so nice to walk into this kind of academic surrounding just looking extremely pregnant and very fertile. And I really enjoyed the contrast between [myself] and this very professional environment. Not that I was unprofessional, but I wasn't going to feel apologetic about it. (Amanda, 35-year-old mother of one, living with her partner)*

As many other middle-class working women who took part in my study, Amanda chose the attire that would signify her professional identity and mark her body as (even though) pregnant but (nevertheless) professional. As many others, coming to work every day, she made an effort to make her pregnancy less visible and not to breach the "professional boundaries" teaching classes to students. Her appearance at the academic party in pink, therefore, was a rare occasion on which she did question the boundary of professional and personal in academic surrounding. Wearing pink, often associated with a "girlish" color, and disrupting the black and white structure of the party, she felt that her sexuality and fertility were challenging the body-absent professional environment unsettling by her visibly pregnant body.

To summarize, the disruption posed by the pregnant body to the social context was usually interpreted by women as caused by their position of being "out of place", whether it was due to physical attributes of the place (i.e., pub or club which serves alcohol drinks) or the absence of physical attributes (such as the professional environment in which the body should not dominate the mind). While the vast majority of my interviewees sincerely believed that their pregnancy did not affect their professional performance, responding to the common cultural belief about the unruly nature of pregnant bodies, and using particular clothing and managing discussion around particular topics, the women had to learn again the art of "performing professional". This time, however, this task was harder than usual as they had to demonstrate their professional identity taking control over the unruly pregnant body. Mastering their performance, they minimized the social disruption caused by their pregnant bodies and made the pregnancy less visible to others. Furthermore, as I am about to show, sometimes their performance of the professional role was so successful that it completely obscured the pregnant shape from the eyes of others and made their bodies not recognizable as pregnant. In the next section I demonstrate that when the pregnancy was *not* expected by others, even the very visible bodily changes did not trigger the public recognition of pregnancy.

Unrecognized Pregnancy

Pregnancy is one of the physical states of the body that is hard to hide. So far I have described how the bodies that are defined as naturally suitable to mothering occasionally would disrupt the usual social order when they were spotted in specific social contexts. In this section I show how in some familiar social contexts pregnant bodies would be unrecognized as pregnant even when in other social surroundings people easily notice pregnancy.

Perceived as one of the physiological conditions that can easily be noticed by others (at least in its second half), pregnancy is believed to be marked by some visible body changes (i.e., enlarged breasts or growing belly) that cannot be mistaken and could

only be identified as pregnancy. As such, pregnancy is used to demonstrate the "real" physical condition which exists beyond the construction of meaning attached to it in the course of social interactions (see, for example Evans and Lee 2002). In what follows I demonstrate that despite its visibly changing shape, sometimes the pregnant body is not perceived as pregnant by people because they do not expect this body to be pregnant. Therefore, even though this body *looks* pregnant it is not *identified* as pregnant in particular social contexts.

One such situation was described by Leah, who was expecting her third child during the time of the interview. Being a lawyer and working in a professional environment, Leah's pregnancy was not recognized by her co-workers even when it was physically apparent. While strangers and her friends did notice her pregnant belly, the coworkers were shocked to learn that she is expecting again:

Leah: This time I had weird experience [with my pregnancy]. Because I don't know, [maybe] people didn't expect me to get pregnant third time but I had a weird experience of people just not noticing, not until just now [38 weeks], and I kind of look at them thinking, are you serious? I see you every day, how could you not see it? But, I guess, [it is because of] the way I carry [the baby] and [also because] I wear suits… And some people may not necessarily notice if they are not looking. And there are some weird comments, like "Oh, I didn't notice, I thought you are just getting fat." And this is not a nice thing to say to a pregnant woman.
Elena: Why do you think this was happening? You said you always carried pretty similar. Yet, this time people did not notice?
Leah: I think, it was the context. A lot of that happened in court. And I had a lot of male lawyers and they just don't notice that kind of thing and men don't notice weight gain as much as women do. And the weirdest thing about this pregnancy, I had more people comment to me late in my pregnancy that they didn't even realize I was pregnant. And I mean it is really hard to miss. Also, I think people just hesitated because it would feel really uncomfortable to be mistaking. And I don't think that this is common to see pregnant women in that court… Also, once you go over two kids, there is this idea of "What, are you having another one?", and I do get the comment "Oh, you are always pregnant" and I guess people just

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don't believe that professional women can have three kids. (Leah,
35-year-old married mother of two, last trimester of pregnancy)

As I demonstrated in the previous section, when women worked in a professional
environment, they used a number of the techniques that minimized the disruption caused
by their visible pregnancy. Working mostly among men, Leah maintained her
professional identity by wearing professional type of clothes (such as suits) and
continuing to run from one court room to another with her pre-pregnancy speed. Keeping
up with her usual level of professionalism, therefore, she was not identified as pregnant
until very late in her pregnancy. Moreover, when her body changes were spotted by
others, they were interpreted as gaining weight and not being pregnant.

Leah provides an additional explanation for her co-workers' reluctance to notice
her pregnant belly. Reaching a fairly clear limit of two kids (which are presumed to be
the norm for a professional woman like Leah) she is not expected to get pregnant
anymore. Therefore for strangers, who do not know Leah, her pregnancy was readily
apparent. Her coworkers, on the other hand, did not identify the changing body of Leah
as pregnant even when it was getting bigger and taking a distinct maternal shape.

In the previous section of this chapter I described how in a professional
environment the pregnant body can be perceived as disrupting the usual social order.
Leah's story, however, indicates that in some social situations the very *idea* of labelling
body as pregnant can be so disrupting that people ignore the presumably apparent
physical signs and do not recognize pregnancy, mistaking it for some other body change.

Another instance in which the pregnancy went unnoticed for a prolonged period
of time was described by Anna. Breastfeeding her newborn child, Anna did not use birth
control although she and her husband did not plan on having more children. After six
months of breastfeeding she did get pregnant and was going to break the news to her
husband. Anna's husband, however, was not looking forward to his wife's pregnancy.
Despite his support and affection to Anna during her previous pregnancy, he repeatedly

mentioned his unwillingness to have more children. Due to his reluctance to talk about another child she could not come around and announce to him her pregnancy:

> *I was going to talk to my husband about [having more kids] but every time I wanted to talk about it, he was asking me to postpone the conversation because he was not yet ready to discuss it. And meanwhile I got pregnant and he still was not ready to talk about another child and he did not want to talk about it. And I did not want to break the news when he had those feelings about another child. And at some point I felt that I cannot wait anymore because other people already noticed me getting bigger. Interestingly, he did not notice it... Maybe he thought that I am just getting fat... Anyway, he thought that I am joking when I said that I am pregnant. And I showed him the picture from the ultrasound and he asked me "What is that?" and I said this is the picture of your[new] child and he was thinking that I am joking. And after that we had a conversation for 30 minutes and I tried to convince him that this wasn't a joke but he was in complete denial. He thought we are finished with the kids and that we have maximum kids that he can handle (Anna FU, 33-year-old married mother of two, last trimester of pregnancy).*

Waiting for a right moment to break the news, Anna was already four months pregnant when she told about her pregnancy to her husband. Even after announcing her pregnancy, however, she was not defined by him as pregnant. Being so remote from the possibility of having another child Anna's husband did not name her body as pregnant despite her growing belly and enlarged breasts.

These two stories coming from women experiencing pregnancy in different situations (Anna is a stay-at-home mother and Leah is a working professional) serve to demonstrate how, on some occasions, pregnant bodies are not identified by others as pregnant even when the change in the shape of the body is easily apparent. When women are expected *not* to get pregnant, their pregnant bodies are not necessarily interpreted as pregnant. Rather, others can identify them as gaining weight or not changing at all, despite an evident difference in their shape. Moreover, as I showed in Chapter 5, sometimes even the pregnant women themselves (who do not only see but presumably also feel the change) do not recognize their pregnancy if it is perceived as disrupting their

lives. This is why many teen mothers were reluctant to label their bodies as pregnant even when the physical markers associated with pregnancy had clearly manifested themselves.

These findings challenge the position of some sociologists, who claim that in the study of the body, social constructionist arguments often fail to account for the materiality of the human body. In their opinion, presenting the body as socially constructed does not explain the physical transformations that manifest themselves in the flesh (Evans and Lee 2002; Shilling 2003; Turner 2004). The stories of Leah and Anna demonstrate that although pregnancy transforms the female body physiologically, those physiological changes do not in themselves render the labeling of the body as pregnant. Rather, it is the social context and social interactions that grant the label of "pregnancy" to those physiological changes.

Chapter Eight: Summary and Conclusion

To summarize, in this chapter I demonstrated that the meaning of pregnancy and its social value is negotiated in a social encounter. Once a pregnant body is labelled as pregnant, others often attach a social value to this pregnancy. For instance, the pregnancy of young, teenage mothers, women of colour, immigrant women and other marginalized mothers are, in general, less socially valued that the pregnancy of white, middle-class married women (Shandy and Power 2008; Werkmann 1994). Furthermore, the experiences of socially marginalized mothers are also rarely explored by sociologists, who, reaching out to their social networks, investigate predominantly middle-class motherhood. Both culturally and in academic discourse those mothers are considered to be a "norm" of pregnancy. Therefore, while pregnancy among marginalized women is depicted as "polluting population", the journey to motherhood of white, middle-class married women is socially praised and valued. Throughout this chapter I showed, however, that the labels of "good" and "deviant" pregnancy should not be simply regarded as the markers of belonging to a social class. The process of assessment of pregnancy (and of a pregnant woman) as socially valued or lacking value is happening in interactions with family, friends and strangers. Consequently, expectant mothers can be

assessed differently in different social encounters. Many young mothers who would be routinely stigmatized by strangers, for example, talked about support they received from their families (predominantly mothers) who reassured them that they are going to succeed on the journey to motherhood. Similarly, middle-class women who "fit" the profile of perfect mothers would be defined as "problematic" if they disrupted the usual social order by appearing in public places that are deemed inappropriate for pregnant women or if the women would demonstrate behaviours that signify irresponsibility. Finally, I have shown that in some social contexts even the visibly pregnant body remains unrecognized as pregnant despite its markedly different physical shape.

Analyzing women's embodied experiences of pregnancy, I showed how by managing their bodies' performance they built their image in response to the perceived effect that their pregnancy has on others. That is, when they believed that their pregnancy is seen by others as disrupting their professional identity, they would try to demonstrate to others that they are in control of their "unruly" bodies. The embodiment of the imagined response to their pregnancy manifested by others is what Waskul and Vannini summarized as the looking-glass body in which a process of embodiment is manifested through reflexivity (2006b). Assuming that others perceive their appearance in a particular social context as disrupting, the women would adopt the techniques of the presentation of self that would obscure their pregnancy and make it less noticeable. As I showed in the end of this chapter sometimes they would be assisted by a social context which would make their pregnancy unrecognizable without any significant effort on their behalf.

In some cases, pregnant body is identified as pregnant; in others it is not. Sometimes non-pregnant body is mistakenly defined as pregnant and in virtually all situations the meaning that is attached to pregnancy is constructed during social encounter. In the context where pregnancy is expected, the pregnant body will be labeled as socially valued; the pregnancy will be praised and celebrated. In some other contexts the same body may be perceived as being "out of place" and create tension. Finally, in

some places, the body would not be perceived as pregnant at all, until it was verbally identified as such by the participants of the social encounter. Therefore, although pregnancy is manifested physically, it is the social interactions, rather than the growing belly itself, that defines it as pregnant and defines what pregnancy is.

Chapter Nine: Discussion and Conclusion

When I started my research journey I wanted to understand the process of the embodiment of pregnancy and how social and physical experiences are interwoven in pregnant embodiment. Over the course of this study I came to realize that despite its real and distinct physical features, pregnancy is also a socially constructed process which can be best understood in the context of the social interactions through which pregnant women attach meaning to their experiences. Drawing on women's narratives I showed that starting from the very beginning of their journey to motherhood, women and the people around them attach various meanings to the physiological transformations related to pregnancy, and they interpret the changes associated with pregnancy within the context of their lives.

Summarizing in just one sentence the major argument of this study, I would say that the embodiment of pregnancy, rather than being a fixed physical condition, is a continuing readjustment of the body and self to a myriad of social situations in which women interact with others during pregnancy. The physical body and the meaning attached to it are constantly changing during pregnancy. The process of pregnant embodiment is experienced differently in different social contexts. The combination of physiological transformations of the body (which can be different from one pregnancy to another and also over the course of one pregnancy) with changing social situations requires women and people around them to reconstruct the meaning they attach to the pregnancy and to recreate the mosaic of pregnant embodiment. Constantly renegotiating the social value of their pregnancy in different social contexts, women cannot simply *be* pregnant, they have to *do* pregnancy through the process of learning about pregnancy, discussing it with others, accepting or resisting medical advice on pregnancy, and managing such activities as eating, dressing, walking, or exercising.

The bodies presented in this research, rather than being purely physical, were the bodies on which the meaning of the physical transition is inscribed through the process of

social interaction and introspection (Waskul and Vannini 2006b). Throughout my dissertation I argued that the physical state of the body is meaningless (or at least is not perceived as pregnancy) until women attach the label of pregnancy to it. One could claim, of course, that eventually *any* pregnancy should result in parting ways with the fetus and therefore, will be socially validated as pregnancy and as a physical condition. I would argue, however, that the birth of the child is only a *product* of pregnancy and it is not necessarily related to experiencing pregnancy, feeling and embodying it[24]. This dissertation focused on this process of pregnant embodiment during which a woman acknowledges her being with child and rearranges her life in order to adapt to this change.

In Chapter 5, I showed how women acknowledge their pregnancy and announce it to others. I demonstrated that unlike the biomedical discourse, which identifies clear physical markers for the beginning of pregnancy and its end, the meaning that women attach to the physical changes associated with pregnancy is rooted in their personal circumstances. I highlighted in particular how the labelling and the treatment of the woman's body as pregnant sometimes begins before pregnancy and sometimes is postponed until women feel emotionally ready to engage in pregnancy work. Finally, I demonstrated that unlike medical discourse which perceives pregnancy as a process of *producing* a child, pregnant women define pregnancy as *sharing* their bodies with a new human being. Therefore, they do not always look forward to parting with the pregnancy label in the postpartum period. Many women feel that their bodies are still closely attached to their newborn children during postpartum, especially during first months of breastfeeding, but this extension of the physical relationship is rarely acknowledged in the medical or sociological literature. Katz Rothman (1989; 1993) emphasized the significance of social relationship between the mother and her unborn child that is developing during pregnancy. I showed how the physical relationship of pregnancy can

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[24] We hear occasionally, for example, how women who did not know that they were pregnant gave birth to a child. For instance, there is a TV show featuring women who did not know that they were pregnant up until late in the pregnancy.

be extended to the postpartum period. These findings led me to conclude that the physical connection of the body of a mother and her newborn child, as well as the meaning that women attach to this connection, make the pregnancy real for mothers and for others and contribute to the process of the embodiment of pregnancy.

I also highlighted in Chapter 5 how women negotiate their new social roles while pregnant, sometimes resisting and sometimes adopting the biomedical discourse on pregnancy. Similarly to women depicted in the collection of readings edited by Lock and Kaufert (1998), my interviewees pragmatically used the biomedically designed tools for detection of pregnancy and followed medical advice when it fit their needs or helped them to renegotiate their social responsibilities with people around them.

The adaptation to the change in the social life of expectant mothers over the course of their pregnancies was explored in Chapters 6 and 7. Moving to the examination of the shifting social roles of pregnant women, in Chapter 6, I described the various ways in which women learn about "doing" and actually "do" pregnancy, concentrating on their reconciliation with their changing physical bodies in Chapter 7. I showed that acknowledging pregnancy and making it known to others, expectant mothers are invited to join a *pregnancy club* – a community of parents who share informal wisdom on pregnancy and childbirth. Throughout Chapter 6, I explored how the membership in this community allowed women to benefit from informal advice and feel empowered as mothers. In the context of social interactions in which others praised their pregnancy, expectant mothers could discover how their social status has risen to a "sacred" level (Balin 1988), allowing them to be treated as special should they demonstrate their willingness to sacrifice their needs for the sake of their children. This new social status of being a sacred body protected women from dissatisfaction with their growing bodies and allowed them to maintain a positive body image until they enter the postpartum period. Revealing their readiness for mothering sacrifice and constantly readjusting their bodies, women learned to perform pregnancy, adapting to the most challenging changes in their diet, level of activity, and physical needs of their bodies. Judged by their performance of

pregnancy and demonstration of their mothering abilities, the women would often benefit from the social praise and recognition of their status as mothers validated in the course of social interactions with the members of their pregnancy club.

These findings challenge the position of many scholars who claim that the increased public attention to pregnancy has a predominantly negative effect since it enhances the social control over pregnant bodies and further strengthens social regulation of women in our society (Bordo 1993; Brooks-Gardner 2003; Earle 2003; Upton and Han 2003). I showed that while women are indeed being constantly monitored by the members of their pregnancy club, receiving advice from other expectant mothers would helped them to acquire the skills to master the performance of pregnancy. Also, they would often feel empowered and able to challenge or question their maternity care providers who presumably have the exclusive, scientific, medically proved and (therefore) dominant knowledge about pregnancy. Although the content of the encounters with others was usually rooted in medicalized views on pregnancy, receiving information about pregnancy in informal communication with others, women could challenge their social position in the context of the patient-provider encounter. As a result, while the participation of women in the pregnancy club can potentially increase the conceptual or cultural medicalization of pregnancy, it can also reduce the medical power at the institutional level and in social interactions with maternity care providers. I showed that the vast majority of my interviewees rather than resisting or accepting medicalization, pragmatically used the medicalized discourse on pregnancy if and when it fitted their personal, individual needs.

At the same time, I noted that not all women can and want to challenge the distribution of power in prenatal encounters with their maternity care providers. The entrance to the pregnancy club is segregated by the social status of pregnancy. White, middle-class, married women would usually receive automatic membership while young, poor, immigrant and other marginalized mothers often only had a rather limited participation in this community life. Consequently, expectant mothers from different

social contexts tended to adopt different ways of doing pregnancy. All pregnant women joining the pregnancy club were expected to engage in "pregnancy work" – to read and learn about pregnancy and to embody the new status through the right ways of consuming food and behaving. For marginalized mothers, however, this journey was much harder than for privileged women. Working their way up the ladder of socially valued motherhood they started at the low place of unworthy, stigmatized mothers and had to demonstrate to other and to themselves that they can be trusted to nurture a child. As a result, while privileged women, who are routinely praised in social interactions, could challenge the advice given by their maternity care providers and people around them, the marginalized mothers, such as teen moms, did not have confidence to do so. Receiving praise and support from only limited numbers of people in their pregnancy club (mainly from their mothers and close female relatives), they had neither social status, nor sufficient knowledge to resist medical advice.

Nevertheless, it would be wrong to assume that marginalized mothers are doomed to experience their pregnancies in the oppressive context of medicalized motherhood. As I repeatedly noted, pragmatic women from a wide variety of social contexts may *choose* to adopt the medical model of pregnancy if it helps them to better perform pregnancy. I showed that the young mothers who participated in my study, similarly to young black American mothers depicted by Brubaker and her colleagues (Brubaker 2007; Brubaker and Wright 2006), embraced medicalization since it helped them to receive the social recognition of "good" and "responsible" mothers.

Chapter 6 and 7 emphasized the process of learning and doing pregnancy. Focusing on the physical change of the pregnant body and on the adaptation to the role of mother in social interactions, this part of my dissertation captured the embodiment of pregnancy as a continuous reconsideration of the familiar regimens of eating, exercising, walking and entertaining the body. Engaging in social interactions with members of their pregnancy club, expectant mothers constantly learn how their performance of pregnancy is assessed by others and, if needed, re-adjust it to fit the social expectations. As Waskul

and Vannini (2006b) note, the significance of embodiment reflected in the dramaturgical body is rooted in the action of people rather than in simple acknowledgement of "having a body". Adopting the role of being pregnant, women are expected to manage their bodies in certain ways and, doing so, they enact their pregnancy and render it the social value of being a "good" or a "bad" mother. Being pregnant, therefore, is not merely a physical condition. It is also a constant work of performing pregnancy – acting and re-enacting it in every social interaction. The successful performance of pregnancy is socially praised and women are valued for it and granted a label of "good" mother. The failure to perform pregnancy, on the other hand, results in stigmatization and the labelling of a woman as a "bad" mother.

Finally, in the last chapter of my findings, I demonstrated that the labels of "bad" and "good" mothering are never a static marker of the pregnant body. Moving from one social context to another, women renegotiate the social value of their pregnancy with people around them. Consequently, the meaning of pregnancy and its social significance are constantly changing, labelling presumably the same pregnant body as "natural" and acceptable in some situations while stigmatizing it or finding it disrupting or "out of context" in others.

This latter argument seeks to challenge the usefulness of the stereotypical marking of pregnant bodies as "socially acceptable" or "marginalized" which is commonly found in sociological literature on the experiences of pregnancy (Brubaker 2007; Dworkin and Wachs 2004; Gillies 2007; Upton and Han 2003). While the social position within the social structure has, indeed, significant effect on the experiences of pregnant embodiment, treating the bodies as simply belonging to a social class without examining how the class is enacted in a particular social context can misrepresent women's actual experiences. As I noted previously, the experiences of motherhood among working class and marginalized mothers were predominantly overlooked by researchers studying pregnancy (but see Brubaker 2007; Gillies 2007; McMahon 1995). I showed in Chapter 8, however, that even the experiences of the well-studied middle-

class and white population of pregnant women are not fully captured without examining them within a particular social context. Focusing exclusively on the women who presumably have been socially praised for carrying a child, I showed that even within this category of middle-class women, the pregnant body can be experienced as disrupting the usual social order, being unrecognized as pregnant, or perceived as "out of context" by others.

Overall Contributions to the Literature

Treating pregnancy as an embodiment and exploring how physical and social changes are interwoven in women's experiences of pregnancy, this research contributes to sociological literature by re-instating the importance of the body in the research on pregnancy. In the beginning of this dissertation I claimed that over the past decades the sociological view of pregnancy and motherhood had moved towards examination of a social change, leaving little space (if any at all) to the physiological changes of the pregnant body (Bailey 1999; 2001; Copelton 2004; Lahman 2009; McMahon 1995; Messias and Dejoseph 2007; Werkmann 1994). Adopting the concept of embodiment and applying it to the study of pregnancy, I demonstrated how social change is often triggered by the physical change even though the physical change can only become significant after it has been granted a meaning in the context of social interactions and/or personal introspection.

This latter point also calls to reconsider the importance of the meaning-making process in the study of the physical body, a fast-growing sociological enterprise. While some scholars claim that the reality of the physical condition cannot be treated simply as a social construction (Evans and Lee 2002; Shilling 2003; Turner 1996; 2004), this dissertation shows that, even when physical changes do occur, they can be meaningless and (therefore) invisible or misinterpreted until people attach to them a particular label in a social context. Treating physical as real, therefore, is as wrong as analyzing social experiences of pregnancy without mentioning physical bodies.

Examining the embodied experiences of pregnancy, in which physical is interwoven with social, and the meanings granted to the changing pregnant body are negotiated and labelled in social interactions, my major contribution to sociological literature is in setting up the analytical bridge between the sociology of the body and the symbolic interactionist perspective on the study of social life. Following scholars who demonstrate the applicability of the interactionist theory to the study of the body and embodiment (Waskul and Vannini 2006a), I show that physical transformation can only be fully understood within social interactions in which the meanings to this transformation are attached. Some scholars working under the interpretive paradigm have already shown that the experiences of chronic illness and disability can only be fully assessed in the social context (Charmaz 1995; 2000; Frank 2001). Contributing to the literature on health and illness experiences, this dissertation explores the formation of new social roles in a relatively short period of time (nine months of pregnancy) due to a temporary physical change (pregnancy). Moreover, my findings demonstrate that such physical transformations as pregnancy require constant renegotiation of meaning in social contexts. Therefore, it challenges the presumption that could be easily drawn from the existing sociological literature on the experiences of pregnancy and motherhood that there is a fixed, new identity that women acquire during pregnancy (Bailey 1999).

My contribution to the sociology of pregnancy is in the examination of the transition to motherhood as a social act. I showed that to be valued as good mothers, women are required to engage in pregnancy work. Many sociologists explored how women experience pregnancy (Bailey 2001; Borve 2007; Earle 2000; Lahman 2009; McMahon 1995). I showed how women are also expected to perform pregnancy and how they are being evaluated for this performance. In their interactions with the members of their pregnancy club women acquire skills to do pregnancy. Being a good mother means to be willing to learn pregnancy and to do it in a socially accepted way.

This research also makes a contribution to the study of pregnancy and childbirth by bringing into the literature the voices of mothers coming from different social and

cultural backgrounds. As I mentioned in the introduction to this thesis, the experiences of pregnancy among marginalized mothers has been largely ignored by sociologists (but see Brubaker 2007; Gillies 2007; McMahon 1995). Moreover, when researchers did inquire into the experiences of pregnancy among women of colour (Brubaker 2007; Brubaker and Wright 2006), working-class women (Gillies 2007), and teen mothers (Brubaker 2007; Werkmann 1994), they would usually examine just one segment of the population, making it difficult to render a comparative view on the experiences of pregnant embodiment (but see McMahon 1995). Offering the analysis of the experiences of pregnancy among white women and women of colour, younger and older women, as well as women expecting their first child and the experienced mothers, this research demonstrated that social context plays a pivotal role in the embodiment of pregnancy. It also showed that there is no pregnancy with a fixed social value – virtually every pregnancy can be praised or stigmatized in social interactions.

Limitations and Promising Areas for Future Research

As I noted above, the diversity in culture, social status, and social position of my participants helped to demonstrate the importance of social context in forming women's experiences of pregnancy. At the same time, this diversity also placed some limitations on the ability to automatically apply the findings emanating from this study to a larger population of women. For one, all women who participated in my study spoke at least some English and were integrated into a dominant society. Learning that every experience of pregnancy can be different and that the social situation in which the pregnancy is experienced has a tremendous role in shaping the pregnant embodiment, I believe that women who live in rural areas, in relatively closed communities, or those women largely excluded from the social life of their community would have different experiences of pregnancy. For instance, all young mothers in my study were enrolled in an educational facility for teen moms and were engaged in receiving prenatal and newborn care. I would assume that the experiences of pregnancy among teenage mothers who do not attend any school and do not receive prenatal care would be qualitative

different from the voices of teen mothers heard in this study. Although the past few years has marked a growing interest in the experiences of young mothers among sociologists (Arai 2009; Bonell 2004; Brubaker 2007; Brubaker and Wright 2006; Werkmann 1994; Woollett 1991), the embodiment of pregnancy among teen mothers is still an under-researched area. At the same time, the examination of the pregnant embodiment among teen mothers could become a fascinating field for the sociologists interested in the study of the body. It would allow exploration of the physical transformation related to pregnancy in the context of adaptation to a physiologically changing adolescent body, and management of the stigma of being a pregnant teen.

Conducting this research I aimed to understand the process of pregnant embodiment. As with any other research project, however, the more I discovered about the experiences of pregnancy, the more questions have become unanswered. For instance, I had relatively little data available on the role of women's partners and families in contributing to the process of pregnant embodiment. The few available studies suggest that comparing women's embodied experiences of pregnancy with the experiences of their partners can be invaluable in the understanding of pregnant embodiment and requires further examination (Draper 2003; Ivry and Teman 2008).

Examining the experiences of pregnancy, I emphasized the role of a social context in shaping the meaning of pregnancy and attaching to it a social value. I showed how the performance of pregnancy is evaluated by people around expectant mothers and labelled as "good" or "bad" mothering. Further investigation of performing pregnancy in different social contexts could help to explore how women negotiate the advice of others and how they adjust the performance of pregnancy to different social situations.

My findings also call for a deeper examination of the role of prenatal care settings and maternity care providers on women's experiences of pregnancy. According to a recent report on the maternity experiences of Canadian women, 32.2% of the respondents reported their maternity care providers as the most useful source of information on pregnancy, while 22.3% considered the most useful advice as coming from books (on

pregnancy) and 17.1% relied mainly on their previous birth experiences (Bartholomew et al. 2009). While these percentages reflect women's perceptions about the usefulness of the received information, they do not capture the changing dynamics in communication between pregnant women and their maternity care providers and the meaning-making processes in their interactions. Future research exploring the enactment of power in the context of provider-patient interactions between expectant mothers and different maternity care providers can shed light on how the informal medical advice is being used by women in formal prenatal care settings.

My personal future research destination inspired by conducting this study is the analysis of women's experiences in the postpartum period. The findings of this study indicated that for many women the postpartum period is not perceived as discontinuity of pregnancy since the postpartum body continues to be shared with the child through breastfeeding and physical contact. Postpartum bodies have been largely overlooked by sociologists (but see Baker et al. 2005; Remennick 2008; Upton and Han 2003). Though postpartum women are mentioned in the literature, it is almost exclusively done so in the context of medical and psychological scholarship analyzing postpartum depression (Benoit et al. 2007; Cooper et al. 2003; Daniel 2008; Dennis et al. 2009; Goulet, D'Amour, and Pineault 2007; Patel, Rodrigues, and DeSouza 2002; RNAO 2005). Those few researchers who do inquire into the postpartum period suggest that the postpartum body is under great pressure to normalize itself as soon as possible and to re-assert self-control over its size and shape (Dworkin and Wachs 2004; Upton and Han 2003). My research findings indicated that the postpartum body is typically not able to meet these expectations and to return to its pre-pregnancy shape, especially when it continues to be shared with the newborn through breastfeeding. The reasons for tightening social control around postpartum bodies and how we can explain the reluctance of our society to treat postpartum bodies as maternal bodies will be the subject of my future research of maternal embodiment.

Appendix 1: Websites

Todays Parent – Pregnancy

Website address: http://www.todaysparent.com/pregnancy/index.jsp

Content (Please note that some articles are listed in more than one category):

Preconception – 22 articles

Pregnancy – 224 articles

Prenatal nutrition – 43 articles

You and your newborn – 72 articles

Labour and delivery – 92 articles

Becoming a parent – 92 articles

Baby Center – Pregnancy

Website address: http://www.babycenter.ca/

Content (Please note that some articles are listed in more than one category):

Prenatal health - 23 articles

Complications in pregnancy - 14 articles

Naming your baby – 23 articles

Fetal development - summaries for each month of pregnancy

Fitness – 16 articles

Grief and loss – 17 articles

Pregnancy dilemmas (includes articles of food safety) – 71 articles

Having another baby – 5 articles

Labour and birth – 15 articles

Looking good – 16 articles

Nutrition – 8 articles

Travel – 22 articles

Twins – 14 articles

Work – 11 articles

Appendix 2: Interview Guide

Demographic Profile:

Age: ___ Social Class (self-definition): upper/middle/low

Ethnicity or cultural belonging: _____

First Pregnancy? Yes/No   Weeks of gestation: ___ Children (how many and ages) ____

Key questions:

1. Tell me about the changes you experienced with your body since you found out that you are pregnant?

Probes: What are the signs your body gave you that it is changing? Were there physical signs? Emotional signs? How early in pregnancy did you feel that your body is changing? Was it a pleasant or an unpleasant change?

2. What are the aspects of your life (i.e. health, beauty, motherhood, partnership) in which your body image concerns you the most?

Probes: Is body image important to you during pregnancy? Was it important to you before pregnancy? Are you concerned with gaining extra weight? With changing shape of your body?

3. What do you have to say about the pregnant body image promoted by media?
Probes: Do you have any comments/thoughts about the discourse on the body image during pregnancy? Do you find that indeed this topic has become of interest for pregnant women or it remained unchanged? How do you think it changed the way we think about our bodies during pregnancy and after having a baby?

4. If there is something we forgot to talk about?

Appendix 3: Recruitment Flyer

Are you Pregnant?

Volunteers are needed for a study on

The Pregnant Body Image:
How We Construct It, See It, and Experience It in Everyday Life

We are looking for volunteers who are pregnant or gave birth to a child in the past 3-4 months.

Volunteers to do what?

We would like you to participate in an interview of approximately 60 minutes. The questions will be largely open-ended. You will be asked about the body image during pregnancy, its impact on pregnancy and on your life. You will also be asked to share your opinion about media resources you have used during pregnancy and their role in forming the body image.

What are the risks?

For some women answering questions related to the body image may cause emotional discomfort. In that case, you may choose not to answer a question or stop participating completely.

What are the benefits?

There are no direct benefits for participating in this study. We are hoping to learn more about the body image during pregnancy and its impact on the well-being of pregnant women.

Whom to contact?

If you would like to participate please contact Elena Neiterman @ (905) 628-0188 or neitee@mcmaster.ca or Dr. Bourgeault @ (905) 525-9140 ext. 27414

This study has been review by, and received ethics clearance through, the McMaster University Research Ethics Board (MREB)

Appendix 4: Participants

Pseudonym	Age	Weeks of pregnancy	Other children
Abigail	36		8 and 6 years; 6 months
Amanda	35		4.5 months
Andrea	34		3 months
Anna	33		11 years; 6 months
Anna FU	34	34 weeks	11 and 1 years
Audrey	17		7 months
Beverly	34	36 weeks	3 years
Brenda	20		3 months
Catharine	19		12 months
Chelsea	31		5 months
Claire	32		3 years; 3 months
Debra	34		2 years; 1 month
Deena	33	26 weeks	
Donna	38		1 year; 2 months
Geena	26	37 weeks	
Helen	37	30 weeks	3 years
Jane	28	24 weeks	4 and 1.5 years
Jasmin	26	20 weeks	
Jenna	33		1.5 month
Jennifer	40		6 and 2 years; 5 months
Jessica	28	18 weeks	
Jessie	24	29 weeks	
Judith	34	28 weeks	8, 5 and 2 years
Kimberly	18		4 months
Leah	35	36 weeks	5 and 3 years
Lindsey	15		1 month
Lisa	19		1 year
Louisa	27		3 months
Madeline	31	28 weeks	
Maria	31		7 years; 3.5 months
Mary	38		18, 16, 5 years; 3 months
Michele	31		2 months
Miranda	42	35 weeks	4 years
Monika	16	26 weeks	
Natalie	33		6 and 4 years; 3 months
Nicole	37		6 and 3 years; 7 months
Rachel	31	8 weeks	3 years (died)

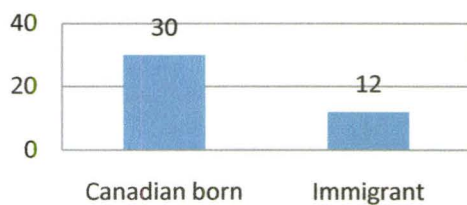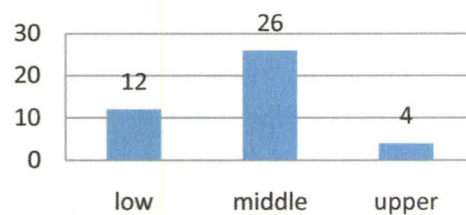|			
Rebecca	19	13 weeks	
Sam	19		1 year
Susan	18		5 months
Vanessa	29	24 weeks	
Vicky	19		2 months

Age of Participants
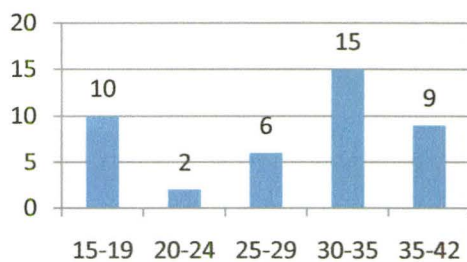
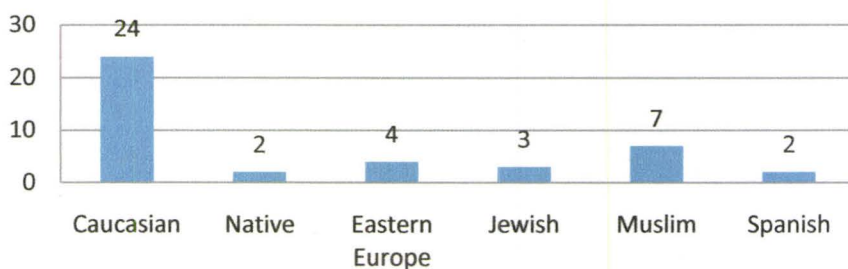## Total number of children (pregnancy is not included)
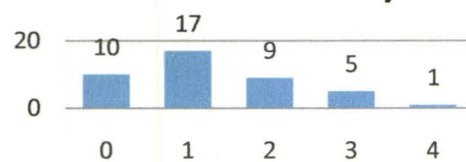
Born in Canada and Immigrants

Self-reported Level of Income

Self-reported Ethnicity/Culture

Appendix 5: Letter of Information

April 2008

Letter of Information

The Pregnant Body Image:
How We Construct It, See It, and Experience It in Everyday Life

McMaster
University

Inspiring Innovation and Discovery

Investigator:	Elena Neiterman
	Department of Sociology
	McMaster University, Hamilton, Ontario, Canada
	Tel: (905) 628-0188; **email**: neitee@mcmaster.ca
Faculty Supervisor:	Dr. Ivy Lynn Bourgeault
	Department of Sociology/Health, Aging & Society
	McMaster University, Hamilton, Ontario, Canada
	Tel: (905) 525-9140 ext. 23832; **email**: bourgea@mcmaster.ca

Purpose of the Study

The purpose of this study is to capture the construction of the pregnant body image in media and to understand how the body image changes during pregnancy and what impact these changes have on psychological and physiological well-being of pregnant women.

Procedures involved in the Research

We would like to invite you to participate in an interview examining the role the body image plays during pregnancy. We would like to know your opinion about the importance of the body image during pregnancy based on your personal experiences and your knowledge of the pregnancy related media. The interview should take approximately 60 minutes and can be conducted in person or on the phone. The questions will be largely open-ended and will include the following areas:

- *The changes you experienced with your body since you found out that you are pregnant.*
- *What are the aspects of your life (i.e. health, beauty, motherhood, partnership) in which your body image concerns you the most?*
- *How often do you read pregnancy media and what can you say about the pregnant body image promoted by media?*

With you permission, the interview will be recorded and transcribed. Your personal information will be kept confidential and once the interview is transcribed, the audio file will be erased.

Potential Risks:

For some women, the issue of the body image can be a challenging topic, thus, there is a possibility that there may be some discomfort associated with answering some of the questions during the interview. You do not need to answer questions that make you uncomfortable or that you do not want to answer.

Potential Benefits

In doing this research we hope to learn more about the importance of the body image during pregnancy. Upon completion of the study we hope to have some insights about the importance of the body image during pregnancy and its impact on the well-being of expectant mothers. The research will not benefit you directly. We could, however, provide you with a transcript of your interview should you want to include it in your personal records/dairy.

Confidentiality:

Anything that you say or do in the study will not be told to anyone else. We will not be asking to provide your name in the interview and will be using a pseudonym on any transcripts and publications resulting

from the study. All study materials will be kept locked in Elena Neiterman's personal filing system in home office. The audio files will be destroyed upon transcription and the transcribed files will be kept on Elena Neiterman's personal computer and a back-up CD both secured by a password. Once the study has been completed, the transcripts of the interviews will be deleted, the CD will be destroyed and all the written materials will be shredded.

Participation:
Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you. In case of withdrawal, any data you have provided to that point will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Follow Up:
If you are in your first or second trimester of pregnancy we would like to invite you to participate in a follow up interview which can be conducted approximately three months after the first interview. We want to conduct a follow up interview to see if there are any differences in your perception towards the body image and will be asking questions similar to the ones you are going to answer in the initial interview. You may choose not to participate in a follow up interview and still be a part of the study.

Information About the Study Results:
You may obtain information about the results of the study by contacting Elena Neiterman at (905) 628-0188, neitee@mcmaster.ca or Dr. Bourgeault by contacting her at (905) 525-9140 ext. 23832 or email her at bourgea@mcmaster.ca. Once the study is completed, we can email you the brief summary of preliminary findings at your request.

Information about Participating as a Study Subject:
If you have questions or require more information about the study itself, please contact Dr. Bourgeault at (905) 525-9140 ext. 23832 or email her at bourgea@mcmaster.ca .

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:
McMaster Research Ethics Board Secretariat, Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services; E-mail: ethicsoffice@mcmaster.ca

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CONSENT

I have read the information presented in the information letter about a study being conducted by Elena Neiterman and supervised by Dr. Bourgeault. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study.

Please indicate, with your initials, your agreement or disagreement to each of the following requests:
1. Do you agree to the recording of the interview?   YES _____ NO _____
2. Do you wish to be contacted for a follow up interview? YES____ NO _____
3. Do you wish to receive a transcript of your interview? YES____ NO _____
4. Do you wish to receive a summary of the results emanating from the study? YES_____ NO____

If you wish to receive a copy of the results of your interview transcript, please provide email/mail address

_____

I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

_____   Name of Participant

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