Normative practices and normative identities: A critical feminist investigation of pregnancy ultrasound

Bethany Riddle

Follow this and additional works at: https://dsc.duq.edu/etd

Recommended Citation

This Immediate Access is brought to you for free and open access by Duquesne Scholarship Collection. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Duquesne Scholarship Collection.
Normative practices and normative identities:
A critical feminist investigation of pregnancy ultrasound

A Dissertation
Presented to the Faculty
of the Psychology Department
McAnulty College and Graduate School of Liberal Arts
Duquesne University
in partial fulfillment of
the requirements for the degree of
Doctor of Philosophy in Clinical Psychology

By
Bethany Riddle

January 13, 2005

Suzanne Barnard, Ph.D. (Director)
Leswin Laubscher, Ph.D. (Reader)
Fred Evans, Ph.D. (Reader)
Name: Bethany Riddle

Title: Normative practices and normative identities: A critical feminist investigation of pregnancy ultrasound

Degree: Doctor of Philosophy in Clinical Psychology

Date: January 13, 2006

APPROVED: ____________________________________
Suzanne Barnard, Ph.D.
Director

APPROVED: ____________________________________
Leswin Laubscher, Ph.D.
Reader

APPROVED: ____________________________________
Fred Evans, Ph.D.
Reader

APPROVED: ____________________________________
Russell Walsh, Ph.D.
Department Chair

APPROVED: ____________________________________
Francesco Cesareo, Ph.D.
Dean, McAnulty College and Graduate School of Liberal Arts
Acknowledgements

Dissertations don’t happen in a vacuum. I wrote this one, but it doesn’t quite feel fair to say that it’s mine. I owe too many people too many thanks for their contributions.

I would first like to thank my participants for their willingness to share so much about their experiences. Without them, there definitely would not have been a project.

The psychology department at Duquesne has given me the rare opportunity to pursue a project that is well outside the bounds of what most departments would consider to be a psychological investigation. Faculty members have not only granted me permission, they have given me their enthusiastic endorsement. Specifically, I would like to thank the following members of my committee and others: Suzanne Barnard, who has been a consistent source of rigorous, feminist scholarship; Fred Evans, who has expanded infinitely my understanding of Foucault and other philosophers; Leswin Laubscher, whose scholarship terrifies me in its brutal honesty and inspires me to be more honest in my own; Paul Richer, whose theoretical and methodological challenges have added a greater dimension of rigor and depth to this project; and, Russ Walsh, who has never failed to ameliorate my moments of panic (and there have been many), in part, I suspect, because his coping style is so eerily similar to mine.

I would like to thank the following friends and colleagues and mentors for invaluable conversations about feminism, postmodernism, psychoanalysis, politics, agency, and resistance that have directly shaped my thoughts on these matters: Jenn Jamieson Bortle, Scott Bortle, Paula Caplan, Nancy Chubb, Norma Coleman, Lisa Cosgrove, Dennis Debiak, Jackie Grimesey, Lynn Harper, Kara Jackson, Claudette Kulkarni, Anita Landreau, Sarah Langer, Deborah Luepnitz, Sipho Mbuqe, Michael
Miller, Akiko Motomura, Andrea Nelken, Linda Pasqualino, Rong-bang Peng, Deb Pollack, Scott Pytluk, Jill Richards, Debra Roth, Kathryn Schmidt, Jonathan Slavin, Peggy Stubbs, and Amy Verdun.

I would like to thank my mom who is the first critical feminist that I ever met and who, often without knowing it, has encouraged me to pursue only the most rigorous forms of scholarship. I would like to thank my dad for his consistent and quiet support of all of my harebrained endeavors, the pursuit of a Ph.D. not being the least of them.

Lastly, I would like to thank Jenny Hwang for providing support for this dissertation that extends far beyond the reaches of what a partner is expected to do. Language cannot capture it, but I will try. Thank you for taking me to the beach when the writing got to be too much, for picking up the slack at home when it was not, for reading many, many drafts of this project and never failing to provide clarity (or at least reassurance), for talking with me about Judith Butler and Stuart Hall over dinner while the leftover ravioli on the stove grew cold, for challenging me academically and emotionally, for taking me seriously but not too seriously, for love and patience and kindness and trust and humor.
Abstract

Pregnancy ultrasound has gained popularity in recent decades. In the U.S. and other industrialized countries, it is an expected part of the medical monitoring that accompanies pregnancy. Most scientific, medical and popular opinions of pregnancy ultrasound consider it to be unequivocally beneficial. However, following feminist researchers who note the potential for the ultrasound to act as a form of surveillance, medicalize the body of the woman while simultaneously removing it from the picture, and sediment the reality of pregnancy, I took as my starting point the idea that it is important that we investigate technologies that are taken for granted as normal because of the potential for such technologies to contain ideological frameworks that are masked by beliefs about neutrality.

I completed semi-structured interviews with three pregnant women. The interviews were transcribed using a combination of notation systems drawn from conversation analysis and discourse analysis. I used a modified Foucauldian discourse analytic approach to analyze the interview narratives. Starting with a critique of the ways in which the subject category ‘woman’ has been constructed within philosophical, medical, and psychoanalytic discourse, I completed a series of steps including free associating to the texts, itemizing the nouns, identifying the subjects and subject categories, and identifying rights and responsibilities of central subjects. This led to an identification of six dominant discourses within which experiences of ultrasound and subjectivity can be conceptualized: scientific, maternal, biological, familial, gendered, and visual. Throughout the dissertation, I incorporated a reflexive autoethnographic
component in order to identify and illustrate the ways in which normative discourses are written on the body, both in privilege and in marginalization.

The analysis paved the way for two parallel examinations concerning how ultrasound is positioned as a normative technology and how certain subjectivities are positioned as normative within the context of the dominant discourses that I identified, allowing for a closer examination of how it is that ideological frameworks are inscribed upon the bodies of those who participate. That is, while a number of feminist projects have focused on the ways in which women’s bodies are objectified by medical procedures, my emphasis concerns the ways in which the body of the woman, the body of the fetus, and others, are subjectified by linguistic utterances that close off possibilities of doing and of being.
Table of Contents

Chapter One: Introduction

   Feminist critiques of ultrasound p. 4
   Reproducing norms p. 9
   Identifying subjectivities p. 18

Chapter Two: Unmethod:
   Gaining approval, gathering data, and locating the narratives p. 22

   The proposal p. 23
   The IRB and regulatory mechanisms: Problems of regulatory oversight p. 26
   Scratching our heads: Making revisions to the IRB proposal p. 31
   Soliciting participants p. 37
      First interview: Heather p. 40
      Second interview: Emily p. 45
      Third interview: Joanne p. 52
   Turning the text into written form p. 57

Chapter Three: Analysis, Part I: Getting my bearings p. 64

   Before the analysis p. 68
   Systematic itemization of objects p. 73
   Individuals meaning units: Nouns and a whole lot more p. 74
      Words by which we refer to the fetus p. 74
      Words that serve to caution p. 75
      Words that imply an action that is foolish p. 76
      Official sounding words p. 77
      Words that denote a normative movement/response/action p. 78
      Pronouns p. 80
      Temporal words or groups of words p. 80
      Words related to quantity p. 82
   Free associating to the text p. 83
      Emily p. 84
      Joanne p. 88
      Heather p. 91

Chapter Four: Analysis, Part II: The emergence of positionality p. 97

   My new wallpaper: Locating central subjects p. 101
   Dancing with norms: Identifying rights and responsibilities p. 104
      Woman p. 110
      Mother/wife p. 114
      Partner/mother p. 118
      In pregnancy and during ultrasound p. 120
Man p. 124
Boyfriend/father p. 126
Husband/father p. 127
Medical professional p. 129
Doctor p. 129
Sonographer p. 136
Midwife p. 140
The fetal image p. 141
Researcher p. 144

Chapter Five: Results: The identification of dominant discourses p. 147

Scientific discourse p. 148
Scientific knowledge is precise p. 149
Doctors have access to that knowledge… p. 150
…and patients do not p. 152
Maternal discourse p. 155
Every (white, able-bodied, heterosexual) woman wants to be a mother p. 157
Motherhood is natural p. 158
Motherhood is transformative p. 159
What pregnant women can do, should do, and should feel p. 161
Pregnancy supersedes everything else and implies an off-limits heterosexuality p. 163
Biological discourse p. 164
Biological links are the most legitimate p. 165
Hormones drive behavior p. 165
The ticking of the biological clock p. 166
(Hetero) Sex (ual Intercourse) is natural p. 167
Familial discourse p. 169
The standard heterosexual family unit p. 170
Family members look alike p. 173
Parents have specific responsibilities in regard to their children p. 177
Gendered discourse p. 178
Gender is foundational to identity p. 178
Girly-girls and Barbie-lovers p. 182
That’s hysterical p. 186
Visual discourse p. 187
The male gaze p. 188
The legitimacy of visual stimuli p. 189
I feel so much better now p. 191
For your viewing pleasure p. 192
Seeing is believing p. 193

Chapter Six: Discussion p. 197

The pull of normalizing discourses p. 200
The discursive foreclosure of possibilities p. 207
Negotiating normative discourses and identifying countermovements p. 215
Areas for further investigation p. 219

Chapter Seven: Epilogue: Reflections on the final stages of the project p. 222

References p. 226

Appendixes p. 241
  Appendix A p. 242
  Appendix B p. 243
  Appendix C p. 328
  Appendix D p. 413
  Appendix E p. 416
Bette: Is that our baby?

Doctor: That’s your baby. Those are her fingers.

B and Tina: Ohhh.

D: Very well-formed, yeah.

B: Oh, it’s like she’s waving at us, look.

D: She’s showing you her profile.

On Showtime’s popular new series “The L Word,” the first television series to focus on the lives of a group of lesbian women, Tina and Bette, a lesbian couple who recently split up due to Bette’s infidelity, are in the process of forging a new relationship as future co-parents of the fetus that Tina is carrying. As viewers, we have followed Tina’s pregnancy from pre-conception dilemmas about locating a sperm donor to present. By many accounts, Tina’s character serves to expose implicit assumptions about normative identity. As a lesbian carrying a fetus that has developed from Tina’s ovum and the sperm of an African American sperm donor, Tina challenges expectations about normative heterosexuality and racial identity. Visibly pregnant, and looking as though she is well into her second trimester, Tina has been shown having sex with both a girlfriend, Helena, and her ex-partner, Bette, exposing presumptions about the heterosexual, monogamous, desexualized body of the pregnant woman.

In the above scene which aired on April 17, 2005, Bette has accompanied Tina to an ultrasound appointment. Bette and Tina are captivated by the image on the screen, an
image which is interpreted by the physician. Both Bette and the doctor imply a fetal subjectivity that is, by all lucid accounts, a fantasy. Bette, in noting that “it’s like she’s waving” (emphasis mine), gives voice to the fact that the fetus is not really waving, but the doctor goes further in saying, “she’s showing you her profile.” These comments attribute to the fetus an agency, calling her into personhood and the beginnings of a sedimented identity position. Fiction, yes, but a good illustration nonetheless of the enactment of the technology that we call pregnancy ultrasound.

Pregnancy ultrasound has gained popularity in the past few decades, and it is now widely regarded as an expected part of prenatal medical monitoring (Browner & Press, 1995). Currently, pregnant women in the U.S. and other industrialized countries who have access to health care and who choose to be monitored by a physician during their pregnancy anticipate that they will have at least one ultrasound as part of their routine medical care (Rapp, 1997). Because pregnancy ultrasound is a technology that has become a routine, and thus taken for granted, part of pregnancy, it has achieved the status of what I call a ‘normative’ technology.

The ultrasound procedure involves the transduction of ultrasound waves through the uterus of the woman. The goal of the ultrasound is to procure a good fetal image in order to monitor fetal position in the womb, establish accurate dating, and diagnose miscarriages or ectopic pregnancies (Lazarus, 2003; Mitchell & Georges, 1998). Additionally, it is often used to ascertain the sex of the fetus (Cartwright, 1995). Although it is more frequently performed on women who have identified complications or who fit into a higher risk group on the basis of previous history of structural or chromosomal abnormalities or “advanced” maternal age (Munim & Khowaja, 2004), it is
commonly used as a screening tool for pregnant women who have no complications with their pregnancies.

Most scientific, medical and popular opinions consider pregnancy ultrasound to be unequivocally beneficial. It is thought to be a purely scientific venture and as such is afforded all of the perks that go along with that, including a hegemonic status as an objective and impartial procedure. As well, it is particularly appealing to both women and medical doctors because it is considered to be noninvasive in that it does not involve any physical threat to the body of the woman (Cartwright, 1995). Researchers who work from this perspective advocate both an expansion of the use of ultrasound as a screening tool and a refinement of the technology that is currently being utilized (Goldberg, 2004; Lazarus, 2003).

Although some research has found support for the diagnostic effectiveness of ultrasound in high risk pregnancies (Munim & Khowaja, 2004), there is little evidence that it provides any benefit to either the woman or the fetus in low risk or unselected populations (Baillie, Hewison, & Mason, 1999; Raynor, 2003). Researchers have provided evidence to challenge the accuracy of ultrasound for predicting date of delivery (Hutchon, 1998), fetal abnormalities (Raynor, 2003), fetal weight (Dudley, 2005; Ott, Doyle, & Flamm, 1986), and fetal sex (Harrington, Armstrong, Freeman, Aquilina, & Campbell, 1996; Watson, 1990). Although many women rely on a doctor’s interpretation of the ultrasound scan for their due dates, Hutchon (1998) notes that, “when precisely calculated, menstrual dates may be more accurate in predicting the onset of spontaneous labour than the scan date alone” (p. 435). Although many women trust that the
ultrasound will reveal fetal abnormalities, Raynor (2003) notes that, “a normal sonogram may lower the likelihood of an anomalous child by as little as 17%” (p. 886).

In addition to the above, a number of concerns in regard to prenatal ultrasound remain underresearched, and these include the prevalence of false positives with regard to fetal abnormalities (cited as 5.2% in one retrospective study of 12,339 women (Spencer, K., Spencer, C. E., Power, Dawson, & Nicolaides, 2003)), the “effect of operator expertise on the diagnostic accuracy of ultrasound” (Raynor, 2003, p. 885), and the psychological impact of the procedure on women who participate (Baillie, Hewison, & Mason, 1999; Garcia, Bricker, Henderson, Martin, Mugford, Nielson, & Roberts, 2002).

Despite the limited available data on ultrasound screening, and despite the number of research findings that indicate its potential drawbacks, pregnancy ultrasound is becoming more and more popular. Women rarely question the need for the ultrasound and assume both its necessity and its value. In fact, most women not only participate willingly in the procedure, they eagerly anticipate it and request it. This combination of factors – the increased demand for the ultrasound in the absence of evidence that supports its utility – provides stimulus for inquiry around what is happening – and why – that makes this procedure so desirable. All of this makes pregnancy ultrasound a particularly interesting topic of inquiry.

**Feminist critiques of ultrasound**

As pregnancy ultrasound has gained popularity, feminist researchers have begun to challenge the status of the ultrasound procedure as neutral, harmless, or helpful through investigations of the ways in which it is performed and experienced. Researchers
note the potential for the ultrasound to act as a form of surveillance (Balsamo, 1999), one that medicalizes the body of the woman (Gross, 2000; Martin, 1998) at the same time as it removes it from the picture altogether (Kember, 1999; Michaels, 1999; Stabile, 1998). Some feminists focus on how it acts to sediment the reality of the pregnancy (Grosz, 1994; Weir, 1998), while others emphasize the ways in which it functions to reduce the woman’s body to “parts and pieces” (Balsamo, 1999, p. 232).

The impetus for the sonogram is often cited as medical, but the sonogram has a number of “nonmedical” effects. The pleasure that women receive from viewing the image is observable in what happens both during and after the ultrasound is performed. Women are eager to view the image and to gain information about the fetus, including general characteristics of “sex, age, size, physical normality, and personality” (Mitchell & Georges, 1998, p. 106). Following the ultrasound, women and their partners often display their ‘baby’s first picture’ (Mitchell & Georges, 1998) on the refrigerator or on the Internet, include the sonogram in the baby’s scrapbook, or play a copy of a video sonogram for friends and family. There is something powerful and pleasurable in the image, specifically, and the drive for this visual pleasure is so great that a market has opened up for ‘recreational’ sonograms. Services are offered by a number of stores (with catchy names such as Baby Insight, Fetal Fotos and, my personal favorite, Womb with a View (Baby Insight, 2003; Fetal Fotos, n.d.; Womb with a View, 2004)) that provide packages to expectant mothers with options such as “video of complete ultrasound with background music of your choice,” “10 wallet sized color photos,” and the invitation for guests to “share the experience in our home theater setting” (Baby Insight, 2003).
In the absence of an interpretation, the ultrasound beams that scan the fetus and are reflected back onto the transducer to create an image mean little. People “frequently do not recognize anything in the blur” (Mitchell & Georges, 1998, p. 105) and must rely on a medical interpretation of it. Although medical and expert knowledge is often taken for granted as objective truth, an examination of the interpretation of ultrasound images indicates that the ‘findings’ have a great deal to do with cultural norms. That is, interpretations of ultrasound images can be seen to reflect ideological frameworks rather than ‘true’ facts.

One salient example of this is the way in which fetuses are gendered. The barely formed fetus is sexed (and, by extension, heterosexed) within normative models of masculinity and femininity. The fetus is “inscribe[d]” as a “properly social human being – that is, one invested with a normative sexual identity” (Cartwright, 1995, p. 225). Male fetuses whose hands are in proximity to its penis are read as masturbating. Female fetuses whose face is pointed away from the ‘camera’ are read as shy (Cartwright, 1995). The inscription of normative sexual identity at the fetal level allows us to continue with a series of enormous and fantastical pretenses about how human beings should fit within the categories we have constructed.

Normative gendered behavior is perpetuated at the maternal level as well. The interpretation of the sonogram is constructed by cultural presuppositions about the woman’s body in pregnancy, including the ways in which it is viewed as a problem or an

---

1 The most fantastical pretense of all may be the idea that there are two discrete sexes. Despite the fact that the prevalence rate of infants born with ambiguous genitalia is approximately 1 in 2000 births (the same prevalence rate as cystic fibrosis), and more common if slighter forms of variation are considered (Blackless, Charuvastra, Derryck, Fausto-Sterling, Lauzanne, & Lee, 2000), the condition is rarely discussed. Despite the fact that a number of researchers have pointed out that, “A body’s sex is simply too complex. There is no either/or” (Fausto-Sterling, 2000, p. 3), the binaries don’t seem to be moving.
obstruction. Existent research on ultrasound points to the ways in which the woman’s body is positioned as something that ‘gets in the way’ of a ‘good’ fetal image. That is, in cases in which fetal sex is difficult to determine, “technicians [attribute] blame to the maternal body” (Cartwright, 1995, p. 227). For example, obese women are told that the image is difficult to see, reminding them that “their bodies are an obstacle to prenatal diagnosis” (Mitchell & Georges, 1998, p. 112).

Specific expectations about the woman’s maternal role are advanced during the ultrasound, conveyed to women by sonographers’ comments regarding appropriate maternal behavior. Mitchell and Georges (1998) note, “The sonographers’ accounts of the ultrasound image are infused with a powerful script on ‘natural’ behavior for pregnant women and mothers” (pp. 111-112). Pregnant women are referred to as ‘mom,’ and distinctions are made between ‘nice’ patients (those who show more concern for fetal health than fetal sex) and patients who are cause for concern. Indeed, women who have had more than a few pregnancies, are adolescents or are in their forties, or are from “different races” (Mitchell & Georges, 1998, p. 112) frequently find themselves to be under additional scrutiny.

The sonographer’s interpretation of the screen has a powerful effect on the woman’s knowledge of her pregnancy. These blurry pictures come to take on a particular ‘truth’ status for the pregnant woman or the pregnant woman and her partner, sedimenting a woman’s knowledge about the reality of the presence of the fetus. Women who have been interviewed about their experiences of pregnancy ultrasound have noted that the technology serves to make their pregnancies feel more ‘real.’ Oftentimes, this is explicitly connected to the interpretation of a visual image. For example, one woman
noted that although she initially could not decipher anything in the image, “After they told me what to look for, then I knew I was really pregnant” (Rapp, 1997, p. 43).

The process of the ultrasound simultaneously makes the most internal (and invisible) part of the woman’s body visible and positions it as conspicuously out of the picture. With the ultrasound, the woman’s body is positioned as a container (Rapp, 1997). Her subjectivity is obscured in favor of a fetal subjectivity. The sonogram acts to visually dislocate the body of the fetus from the body of the woman (Mitchell & Georges, 1998) in its concern with “sharpening the focus on the fetus rather than on pregnant women” (Rapp, 1997, p. 44).

In consonance with critical feminist readings of ultrasound that problematize its status as a neutral technology, Sawicki (1991), following Foucault, argues that new reproductive technologies (including ultrasound) serve a disciplinary or regulatory function. The body of the woman, whether she is positioned as potential obstruction, invisible container, or naturally maternal being, is regulated and monitored. She is expected to embody a particular identity. From Sawicki’s perspective, the body of the woman is “controlled through a set of discourses and practices governing both the individual’s body and the health, education and welfare of the population; namely, the discourses and practices of ‘biopower’” (p. 67). The body of the fetus is disciplined as well, interpellated by the discursive call of a normative gender identity before its internal organs have fully formed.

Following the work of those theorists who have investigated the ways in which the ultrasound acts as a form of surveillance, medicalizes the body of the woman, exposes it while simultaneously removing it from the picture, requires an expert interpretation,
sediments a woman’s knowledge of her pregnancy, acts to discipline the body of the
woman in Foucauldian fashion, and inscribes both the fetus and the mother as particular
kinds of subjects, it is my contention that the ultrasound is not simply neutral or benign
but rather is constructed as such by a web of discourses that protects, maintains, and
perpetuates its status. That the ultrasound is taken for granted as a normal part of
pregnancy – as a given – is precisely what allows both its impetus and its effects to go
unnoticed. And, that the body of the woman is taken for granted as a particular kind of
subject is precisely what allows for its inscription and reinscription as container, potential
obstacle, invisible subject, and object in need of medical scrutiny.

Reproducing norms

The expectation that women will embody a particular kind of subjectivity is
apparent across a number of disciplines. There is an abundant amount of literature that
points to the ways in which the category ‘woman’ has been positioned as ‘other’ in
relation to a masculine ‘norm,’ as ‘absence’ in relation to a masculine ‘presence,’ and as
‘body’ in relation to a masculine ‘mind’ (Bayer & Malone, 1996; Bordo, 1987; Mills,
1996; Tavris, 1992). These binaries (norm/abnorm, presence/absence, mind/body)
underpin our conceptualizations of what a woman is and what a woman should be. This
positioning is hidden behind theoretical fortresses that posture as indifferent to
ideological frameworks. It is concealed behind declarations of neutrality and objectivity.
Much in the way that it itself is positioned as neutral, pregnancy ultrasound resides within
a broader sociohistorical framework in which the discourses that work to constitute the
body of the woman as a particular kind of subject are taken for granted as value free. These discourses are only apparent when we examine them explicitly.

Disciplines such as philosophy, psychology, and medicine are fairly preoccupied with the ‘problem’ of woman, obsessed with making sense out of and controlling her mysterious subjectivity. Central to making sense out of the problem of woman is the issue of the woman’s sexuality, including her stance as a (potentially) reproducing subject. The body of the woman – whether she was pregnant, is pregnant, is not yet pregnant, or is never intending to become pregnant – is marked as a maternal one. Assumptions about the ever-present possibility of the woman’s maternal status are inseparable from assumptions about the woman’s normative heterosexual status. Women are expected to embody a particular kind of subjectivity that is all at once maternal, heterosexual, and feminine. We are continually – unrelentingly – positioned within these normative, and highly constrictive, models.

A number of feminist theorists have problematized the ways in which women are tied to a bodily existence within a binary framework that privileges rationality (Bayer & Malone, 1996; Bordo, 1987). The mind/body dualism has permeated philosophical studies in Western culture for thousands of years. The mind has been granted a privileged status in relation to the body, and this is traceable back to Plato who divided the realm of the spiritual from the realm of the physical, speaking distastefully of the confining body. For Plato and for Augustine who followed him, the body was “the locus of all that which threatens our attempts at control” (Bordo, 1999, p. 60). Plato provided instruction for transcending the bodily appetites for the betterment of the soul which for him was explicitly connected to reason. Descartes is typically credited with advancing
the mind/body dualism in contemporary Western philosophy. Thousands of years after Plato, he articulated a philosophy premised on the distinction between two kinds of substance, mental and physical, asserting that the rational mind and the physical body were wholly distinct systems that co-existed (Descartes, 1641/1996).

In all cases, men were considered to have privileged access to the realm of the mind or the rational while women were relegated to a bodily existence. While all individuals were vulnerable to slipping into the realm of the irrational and being overtaken by “the passions,” only those with a privileged status (namely educated, white men) had the capacity to transcend their bodily existence. Women, persons of color, slaves, and less-educated members of society were not believed to have been endowed with this capacity (Bordo, 1999). Thus, women as a category have been tied to their bodies, a type of existence that has been largely viewed as unsettling and unacceptable within a culture that privileges rationality.

In the field of medicine, women’s bodies are widely regarded as more passive, more complicated and more temperamental than men’s bodies. In Martin’s (1992) critical reading of medical texts, she discusses popular medical metaphors that demarcate women as ‘other,’ exposing the ‘truth’ status of a number of medical metaphors as heavily influenced by cultural presuppositions about the woman’s body. For example, she notes the general (and inaccurate) conceptualization in medicine of understanding the woman’s reproductive functioning as ‘passive’ (the egg) in relation to an ‘active’ (sperm) male. She as well notes the understanding of menstrual blood as breakdown or as failed reproduction. In short, she notes the ways in which the woman, in her sexuality and in her reproductive functioning, is regarded as troublesome, problematic and passive, and
she argues that these beliefs do not reflect value-neutral truths but rather are constructed by language and metaphor.

In noting the constructedness of the ‘field’ of ‘sexuality,’ Foucault highlighted the constructedness of the woman’s sexuality as aberrant and exposed the ways in which ‘sexuality’ has been taken up as “both an object of analysis and target of intervention” (1976/1978, p. 26). As Dreyfus and Rabinow (1982) note, following Foucault, the problem body calls out for us to make sense of it much more than the unproblematic body. Bodies in need of figuring out “are known in infinitely more detail than are…healthy individual[s]” (p. 159). Indeed, careful examinations have been undertaken in an effort to make sense out of those bodies that seem to be causing all of the trouble.

In the field of psychoanalysis in particular, efforts have been made to make sense out of – indeed, to ‘know’ – women’s “aberrant” sexuality. Women’s psychosexual development was perplexing to Freud, and he puzzled for years over it. He posited that prior to the Oedipal stage, girls and boys were just the same. That is, they were both boys (Moi, 1985). Initially, he asserted that during the Oedipal stage, “Things happen in just the same way with little girls, with the necessary changes” (1920/1966, pp. 413-14). He later changed his mind, noting that things could not happen in just the same way because girls, in lacking a penis, would necessarily have an Oedipal resolution that would be both less powerful and less complete (Freud, 1925/1961). For Freud, women’s sexuality was doomed to be incomplete, and this was based on a conceptualization of their genitals as lack or as absence. Without the phallus, the Oedipus complex could not be fully resolved.2

2 Freud argued that girls would not accept the (presumed) loss of the phallus without an attempt at compensation through the procurement of a baby. For Freud (1924/1961) then, pregnancy has a phallic
Irigaray challenges Freud’s notion of a psychosexual drive theory that is based upon a phallic economy. She asks, “...why, if stages there be, is there no question, for example, of a vulvar stage, a vaginal stage, a uterine stage, in a discussion of female sexuality?” (1974/1985, p. 29). She does not pose this question naively. She understands quite well that “the feminine occurs only within models and laws devised by male subjects” (1977/1985, p. 86, emphasis original). In a culture that only contemplates male sexuality, women’s sexuality only makes sense relationally. Or, perhaps more accurately, it does not make sense at all. Irigaray argues that woman is rejected and/or excluded from the Symbolic order (Van Buren, 1995), that is, from linguistic representation. This is explicitly connected to a “specular logic” (Moi, 1985, p. 133) that positions women as “an absence or negation of a male norm” (Moi, 1985, p. 132). Moi, in her reading of Irigaray, writes, “The Freudian theory of sexual difference is based on the visibility of difference: it is the eye that decides what is clearly true and what isn’t...when he looks at the woman, Freud apparently sees nothing” (p. 132, emphasis original).

In Irigaray’s reading of Freud, she notes that his conceptualization of the woman’s genitals as absence or lack exemplifies a specular logic that excludes the woman from representation. For Irigaray, this exclusion has a productive power – it produces the feminine as that which “must be excluded for that economy to operate as internally coherent” (Butler, 1993, p. 38). The gaze does not merely serve to dominate

significance: “Renunciation of the penis is not tolerated by the girl without some attempt at compensation. She slips – along the line of a symbolic equation, one might say – from the penis to the baby. Her Oedipus complex culminates in a desire, which is long retained, to receive a baby from her father as a gift – to bear him a child. One has the impression that the Oedipus complex is then gradually given up because this wish is never fulfilled. The two wishes – to possess a penis and a child – remain strongly cathected in the unconscious and help to prepare the female creature for her later sexual role” (pp. 178-9).
but actively constitutes a particular kind of subjectivity, one that is produced as unintelligible and external in order that the system might continue to work (Butler, 1993). In this regard, the feminine is not so much positioned within the secondary term as much as she is “excluded in and by such a binary opposition” (Butler, 1993). In this way, Irigaray goes beyond arguments that focus exclusively on the ways in which women have been tied to a bodily existence and positioned within the less-privileged term of various binaries, arguing instead that each term of the binary is, necessarily, masculine. The feminine occurs as external to the binary and is subsequently produced as the feminine through it.

Although Foucault never wrote a history of women’s bodies as he had planned,\(^3\) he did discuss directly the relationship between the “hystericization of women” (1976/1978, p.146) and the medicalisation of women’s bodies. His work on the constitutive role of discourse is certainly appropriable to a discussion of the relationship between the productive power of discourse and the gendering of subjects, even if he did not discuss at great length how his conceptualization of biopower can be extended to women’s bodies.

In Volume I of the *History of Sexuality*, Foucault (1976/1978) touches briefly on the ways in which women’s bodies are hystericized, noting that the hysterical woman is one who is “thoroughly saturated with sexuality” (p. 104). He argues further that the body of the mother is the most hysterical of them all: “the Mother, with her negative image of ‘nervous woman,’ constituted the most visible form of this hystericization” (p. 104). In so doing, he draws attention to the ways in which the woman in her

---

\(^3\) Sawicki (1991) notes that “had [Foucault] proceeded according to his original plan, he would have written a volume in the *History of Sexuality* entitled *Woman, Mother, and Hysteric*” (p. 67).
reproduction is simultaneously unapproachable (as Oliver (1993) notes, “All…
prohibitions are directed against the maternal body. It is what is off limits” (p. 56)) and
something to be analyzed and discovered.

Perhaps one illustration of the cultural preoccupation with making sense of
mothers rests in the proliferation of theoretical perspectives about motherhood within
psychology. Psychoanalytic perspectives that have grown out of classical
psychoanalysis, in particular, have emphasized the role of the mother (not the father) in
the development of the psychological health of the child. However limited in its
conceptualization of psychosexual development, insofar as the classical, Freudian view
prioritized the development of the ego within a triadic (mother-father-child) structure, it
at very least allowed for the influence of more than one parent figure of more than one
gender. In contrast, object relations and ego psychology perspectives in particular have
placed much more emphasis on the importance of the mother-infant bond for the eventual
individuation of the child and the development of its ego (Mitchell & Black, 1995),
zeroing in on the potential impact of the mother’s pathology on the developing child and
in so doing prescribing nearly unattainable standards of childrearing. Without necessarily
intending to, this has created undue pressure on women to perform their role adequately.
For example, Bowlby (1969) articulated an attachment theory which postulated that “the
kind of bonds infants forge with their mothers determine the kinds of relationships they
will have with other people for the rest of their lives” (Warner, 2005, p. 92).

---

4 In addition to positioning female development as subordinate to male development and not allowing any
room for healthy homosexual development, the classical model has been critiqued for advancing a
universalizing model of human development premised on a nuclear family that is specific to a
sociohistorical time period and class structure. Contemporary dynamic thinkers who draw on classical
perspectives are currently revisiting the Oedipal story and examining its appropriability (Heineman, 2004).
Ego psychologists prescribed a particular kind of maternal presence that, in retrospect, can be seen to demand a superhuman kind of attunement: “Exquisitely sensitive to her infant’s nonverbal messages, the ‘good’ mother empathically divines the needs of her baby with near clairvoyant accuracy, relying on her capacity to regressively revive herself this early communication that, Spitz felt, is lost to most adults. She senses why her infant is crying, a mystery to others, and is able to respond correctly” (Mitchell & Black, 1995, p. 43). Although object relations theorists such as Winnicott perhaps sought to ameliorate this pressure by arguing that a ‘good enough mother’ (and not a perfect one), was all that was required – and was, in fact, preferable – for adequate adjustment on the part of the infant, the demands placed upon the mother are no less great.

In fact, for Winnicott, the ‘good enough mother’ is one whose entire existence is presumed to center around the needs of the infant. He argues that an adequate environment for an infant requires a “primary maternal preoccupation” (Mitchell & Black, 1995, p. 125), a state of mind in which the mother (or expectant mother) will become completely absorbed with thoughts of the baby to the point that her own subjectivity will be subsumed and displaced by a fetal subjectivity. Winnicott believed that a woman’s propensity to nurture an infant came about as a result of a biological predisposition: “The mother is prepared in the last trimester of the pregnancy for this deeply biological, evolutionarily honed function by her natural absorption with the baby…she becomes increasingly withdrawn from her own subjectivity, from her own interests in the world, and more and more focused on the baby’s movements, on the baby’s vitality” (Mitchell & Black, 1995, p. 125, emphasis mine).
Influenced by psychoanalytic theories about the importance of the intrapsychic development of the ego and the role of the mother in facilitating that development, theories on the etiology of psychological disturbances have targeted the mother as primarily responsible for those disturbances. Drawing from Fromm-Reichman’s (1948) development of the term “schizophrenogenic mother,” Bateson articulated a double-bind theory of schizophrenia which postulated that the etiology of schizophrenia was directly related to the expression of the mother’s conflicting emotions to the child (Bateson, Jackson, Haley, & Weakland, 1956). Following Kanner’s (1943) work on the relationship between the cold and aloof mother and the autistic child, Bettelheim (1967) popularized the term “refrigerator mother,” advancing a theoretical perspective which postulated that the development of autism in children is largely a result of the mother’s icy demeanor.

Although the specific theories that I name here have been challenged and refuted, feminist theorists note that mother-blaming perspectives continue to strongly influence both theoretical perspectives and clinical interventions (Caplan, 1990; Goldner, 1985; Luepnitz, 1988; Tavris, 1992). Contemporary feminists note that the pressure on women to mother their children in very specific ways is no less prevalent today and the threat of failure no less widespread (Warner, 2005). Again, the cultural construction of the mother as a particular kind of subject, one who embodies a normative, yet wholly unattainable, femininity and (hetero)sexuality and who will act in very particular ways in accordance with that subject position, creates an impossible set of demands. Worse yet, the idea that the specific role of the mother is a cultural construction is very nearly always covered over to some degree, creating a situation in which impossible demands are coupled with the belief that those demands are ‘normal’ or ‘natural.’
Identifying subjectivities

Identification is constructed on the back of recognition of some common origin or shared characteristics with another person or group, or with an ideal, and with the natural closure of solidarity and allegiance established on this foundation. In contrast with the ‘naturalism’ of this definition, the discursive approach sees identification as construction, a process never completed, always ‘in process.’ (Hall, 1996, p. 2)

I began this project with a general appreciation for postmodern perspectives on language and with a specific appreciation for a Foucauldian conceptualization of discourse. Rather than viewing language as a tool that we use for naming objects, from a postmodern perspective language has a performative role. That is, in speaking, we do not simply describe something that is already there, we constitute it as such. As Gergen (2001) writes, “language is world constituting; it assists in generating and/or sustaining certain forms of cultural practice” (p. 806). We are born into linguistic structures that both precede and postdate us. Within their present-day context, these structures are easily and often taken for granted as truth rather than as constructions that are sociohistorically specific.

Practices are normalized and reified discursively. In The History of Sexuality: Volume I, Foucault (1976/1978) takes on the project of investigating how categories and practices become reified by examining the “discursive explosion” (p. 17) that has occurred with regard to sex. Foucault articulates one story about the ways in which ‘sexuality’ and the discourses that surround it have come to gain a particular scientific
status, meaning, and/or truth in Western culture. ‘Sexuality’ provides us with an example of the ways in which ‘knowledges’ are discursively constructed and perpetuated. Our attempts to locate the truth about sex have resulted in an explosion of discourses around sex that are taken up as truth.

Categories and practices are sedimented as legitimate through a discursive repetition of their legitimacy. Butler writes, “If a performative provisionally succeeds...then it is not because the intention successfully governs the action of speech, but only because that action echoes prior actions, and accumulates the force of authority through the repetition or citations of a prior and authoritative set of practices” (1997, p. 51, emphasis original). That is, a speech act gains legitimacy when it is cited over and over again and not because it has identified some ‘truth.’ The more an assertion is repeated (especially when it is repeated by those whose speech is perceived to be ‘legitimate’ (e.g., doctors, psychologists)), the more it gains a ‘truth’ status, even in the face of evidence to the contrary. This perspective provides support for the ways in which ultrasound has been perpetuated as a necessary or normal part of pregnancy in the absence of supporting evidence. And, it provides support for the ways in which particular kinds of identities are discursively perpetuated and reinscribed through the ultrasound procedure.

Following Butler and others, I believe that it is not only practices that are sedimented in language but also identities which are inscribed through the linguistic positioning of subjects as particular kinds of subjects. Said another way, the performative function of language has implications at a bodily level as bodies are constituted in language; they are shaped and formed within a particular set of discursive
practices. Subjects are constituted within a framework in which some bodies come to matter more than other. Bodies are linguistically constituted through exclusionary practices that render some bodies more intelligible than others. That is, some bodies are recognizable, intelligible, visible, while others are not. Individuals who are white, male, heterosexual, educated, healthy, young, upper-middle class, are taken for granted as ‘normal.’ These bodies are afforded a particular privilege. They are seen to be more important. Their materiality is deemed to be legitimate. Their status is protected and perpetuated by a high degree of visibility which has the effect of affording it a privileged invisibility.

For Butler, following Althusser, bodies are interpellated. Subjects are ‘hailed’ into being. Existence is solicited of one by an other and this is a discursive solicitation: “There is no way to protect against that primary vulnerability and susceptibility to the call of recognition that solicits existence, to that primary dependency on a language we never made in order to acquire a tentative ontological status” (1997, p. 26). We are called into being through a process in which we are named and recognized (as when others say, “Hey, Bethany…”) and in which we turn to recognize ourselves in others who are like us (as when I say, “That person is a lesbian like me”). We make sense of our existence through what others call us and through our observation of others who are ‘like’ us. There is no simple ‘being,’ no assumed ontological status: “‘being’ belongs in quotation marks, for ontological weight is not presumed, but always conferred” (Butler, 1993, p. 34). The subject comes into a material being discursively, within language: “everything, including materiality, is always already in language” (Butler, 1993, p. 68).
When I began this project, I knew that I was interested in critiquing the ultrasound from a feminist perspective. I took as my starting point the idea that it is important that we examine critically those technologies that are taken for granted as neutral or benign because the impetus for – and the effects of – technologies that are considered to be benign are often the most insidious. Initially, I was concerned with looking at the role of both the discursive and the visual in: constructing expert knowledges; regulating and disciplining bodies; positioning women as maternal and heterosexual subjects/objects of a masculine gaze; and, gendering, racing, and classing fetuses in utero. Through the process, I began to notice the ways in which subjectivities are constructed through chains of signifiers that both reinforce and imply one another.

Assumptions regarding the woman’s status as a potentially reproducing subject are inexorably linked with expectations about normative femininity, heterosexuality, and motherhood – categories that are infused with beliefs about the woman’s status as ‘other,’ ‘problem,’ ‘passive,’ ‘abnormal,’ etc. – and these assumptions are inseparable from other highly restrictive normative categories such as race, class, age, and disability status. In this investigation, the interrelationship between chains of signifiers revealed the highly contingent status of subjectivity, and the investigation of women eventually gave way to a fuller investigation of the ways in which the discourses that surround the ultrasound not only reinforce the subjectivities of the mother and the fetus but also act in subtle ways to constitute and reinforce the identities of everyone involved.
There is no method to discourse analysis in the way we traditionally think of an experimental method or content analysis method. What we have is a broad theoretical framework concerning the nature of discourse and its role in social life, along with a set of suggestions about how discourse can best be studied and how others can be convinced findings are genuine. (Potter & Wetherell, 1987, p. 175 (emphasis original))

In a traditional method section of a research report or dissertation, the researcher would provide information about the method that had been utilized, including details of the population that had been studied, the instruments that had been used, and the experimental procedures that had been undertaken (Bordens & Abbott, 2005; Pyrczak, 2003). The method section would follow logically from a testable hypothesis that had already been developed and clearly articulated.

There is no such clarity with a discourse analytic approach. With a discourse analytic approach, every step is tirelessly interrogated (to the point that one yearns for clarity at various junctures). Every movement counts, every moment is an opportunity for reflection and self-reflection, every inflection is cause for closer examination and interrogation. What we have here, then, is an Unmethod, a series of steps which has not been anticipated and which will not give way to a luscious clearing of p<.05, or even to themes that have been identified through careful coding. If the idea that we make it up as we go along seems too much to bear, the reader may wish to turn back now.
I begin with a discussion of the dissertation proposal. As the first major step of the dissertation project, the proposal is integral to the construction of that project. I follow that with a discussion of the IRB proposal as this, too, turned out to be important to the development of the steps that would ultimately be created. Lastly, I discuss the specifics of participant recruitment, the emergence of the narratives, and the development of the transcriptions that were used in the analysis.5

The proposal

There are four steps listed in the student handbook regarding the path of the dissertation, and they are: 1. The Proposal; 2. The IRB Proposal (if human participants are to be used); 3. The Progress Report Meeting; and, 4. The Defense. The project must be laid out clearly during the proposal meeting for one Director and at least two Readers who comprise the Dissertation Committee. After the meeting, the decision of whether or not to pass the proposal is made by the committee. In the event that the proposal is passed, the committee may request: 1. substantial revisions to the proposal, 2. minor revisions to the proposal, 3. no changes to the proposal but an intention to include some revisions in the dissertation, or, 4. no revisions at all. After the proposal is passed, the student moves on to the second stage of the process and submits an IRB proposal for the inclusion of human participants in the project.

The path to the proposal for me included many drafts of highly theoretical material, meetings with Suzanne in which she politely suggested that I find a more specific topic to research than “the history of the term ‘woman,’” and genuine attempts

5 I include a brief discussion of the progress report meeting and a general discussion of the structure of the defense at Duquesne in Chapter Seven.
on my part to integrate material from my courses into a coherent and interesting project. The production of the written proposal included moments of frustration which gave way to moments of excitement which gave way to moments of clarity which gave way to frustration again. I felt good about the draft that eventually went to readers – not because it was any great piece of work, exactly, but because I felt that I had exhausted my capacity to think even a little bit more clearly about the project.

The proposal meeting was the most formal activity in which I’ve ever participated in my time as a graduate student at Duquesne. Neither classes nor supervision nor meetings nor comprehensive exams had prepared me for one-and-a-half-hours of what felt in moments to be unrelenting feedback. Others may not have this experience. Colleagues I’ve spoken with have not had this experience. One’s experience of the proposal meeting seems to be largely dependent on several major factors including the composition of the committee and the nature of the project and also, I suspect, minor factors including time of day, time of year, and degree of health (or illness) of some of the members of the committee and the student. In my case, I had scheduled a proposal meeting in mid-December, right in the middle of finals and flu season on what was nearly the shortest and darkest day of the year. I do not imagine that this contributed positively to the collective mood of the committee. I did my best to remain attentive to the barrage of (thoughtful and interesting, yes they were) suggestions, but by the end of the meeting my focus was beginning to wane as feelings of self-deprecation took over.

One of my readers commented that he thought that it was not necessary for me to self-identify as a lesbian, noting that it felt “gratuitous” to him. This comment took me by surprise. Indeed, I felt exposed and ashamed as well as insulted. I had thought that I
had articulated clearly my reasons for locating my own subject position, but a part of me bought into the idea that this level of self-disclosure was somehow unseemly. I went home and located the definition of gratuitous in the dictionary (“unnecessary, unwarranted, or unjustified”), consoling myself by tapping into my own ire and the ire of my friends. It is fitting that this issue – the issue of what factors contribute to when (and when not) one locates oneself or is located by others as a particular kind of subject – would arise in the proposal meeting as it will become absolutely central to the project. Although somewhat painful at the time, this single comment served to constitute the project in a way that no other comment has as it immediately sparked my desire (both the pain and pleasure that that term holds) for clarity on this issue. Why had I felt it necessary to expose myself in this way? We’ll let this question hang there for the moment.

By external measures, the meeting was a success. One committee member asked for one change to be included directly in the proposal, but other than that the committee approved my proposal on the condition that I include their suggestions into the body of the dissertation. However, my internal experience of the meeting was more severe, and by its end and in the days that followed, I felt entirely wrung out. It took me several weeks to relocate my motivation and draft a letter outlining the suggestions to be included in the finished dissertation.

The four steps that lead to the successful completion of a dissertation project look quite neat on paper, but in reality they are infused with uncertainty and bewilderment for many of us who undertake them. The steps seem to imply a simple expansion of the proposal, but the gap between the proposal meeting and the progress report meeting is
cavernous. This seems to be especially true of qualitative projects. In that they do not necessarily begin with a discrete hypothesis, qualitative projects oftentimes do not know where they are going until they actually get there. As well, qualitative projects such as mine, in which the scientific method is critiqued from the inside out, do not fit well within the confines of a rigid dissertation structure. I will discuss these issues further in the section below on the IRB proposal as this is another stage of the research that is fraught with difficulties for researchers who question traditional definitions of research.

The IRB and regulatory mechanisms: Problems of regulatory oversight

Following the approval of my proposal, the next step was to request permission from the Institutional Review Board (IRB) to recruit and interview pregnant women. Working under FDA regulations, the IRB functions to review and monitor research projects in order to protect research participants from ethical oversights; additionally, the IRB affords protections to the researcher. In the U.S., regulations to protect human participants went into effect in 1974 (IRB History, n.d.) in response to heinous ethical violations committed by physicians and administrators in research projects such as the Nazi medical experiments, the Tuskegee Syphilis Study, the Jewish Chronic Disease Hospital Study, and the Willowbrook Study, to name a few. According to a governmental website:

[T]he purpose of IRB review is to assure, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of humans participating as subjects in the research. To accomplish this purpose, IRBs use a group process to review research protocols and related materials (e.g., informed
consent documents and investigator brochures) to ensure protection of the rights and welfare of human subjects of research. (Food and Drug Administration, n.d.)

Because of a history in the U.S. and elsewhere of egregious ethical oversights, the IRB is indispensable to the regulation of ethical research. Researchers have demonstrated over and over again that human participants are at risk of being seriously harmed in research studies. Therefore, it is absolutely crucial that institutions such as hospitals and universities have in place a system of formal regulatory oversight to ensure that researchers do not abuse their positions of power.

However, as with any situation in which one group is appointed to regulate the activities of another group, the perpetuation of subtle and normalizing forms of regulation are unavoidable. Members of the IRB are afforded a position of power by virtue of their position as a group – appointed by and sustained within a ‘University’ – that has been charged with protecting the interests of others and by the individual statuses of its various members. The IRB is (and, I should add, researchers are, as well) largely composed of individuals who have been afforded privileges on the basis of their race, gender, educational level, occupation, and various other markers of identity. This group then has the task of determining which level of protections and surveillance to provide to those who would participate in research. This creates a dilemma. Even when members of the IRB act out of genuine concern for those who would participate in research (and I believe that in most cases they do), the existent power structure demands that certain forms of research on certain types of people are in need of extra scrutiny, extra protections, extra
oversight; the safeguards put into place to ‘protect’ the ‘other’ then act to monitor, constrain and reinscribe the other as ‘other.’

Qualitative research endeavors are often deemed to be in need of closer scrutiny because they directly challenge the positivist-empiricist theoretical framework within which an IRB functions. The IRB exists within a larger, modernist structure in which ‘research’ has been constructed within a perspective that “accepts the belief that some can reveal information (whether truth, constructions, negotiated perspectives, or even new possibilities) for others” (Cannella, 2004, p. 238). The IRB is not prepared to deal with qualitative research endeavors that question the imperialist function of research at its roots. As with the larger structure of RESEARCH, it is not equipped to consider the nuances of forms of research that don’t begin with a discrete hypothesis and plan to follow a predetermined path. Critiques of this modernist definition of research have been attempted by few (e.g., postcolonial thinkers and some feminist thinkers) (Cannella, 2004, p. 236), and most of us who attempt research projects that sit outside of this definition make do by molding our descriptions of our projects to approximate the confines of what is already available, furiously shaving off the corners of our square pegs in order to fit them into the existent round holes.

In retrospect, it is not surprising that my particular project, as a qualitative project that is intimately concerned with language and that critiques both motherhood and normative identity, raised a number of red flags for many of the committee members. However, it was surprising to me at the time. Before submitting anything to the IRB, I was informally told by one preliminary reviewer that my proposal could probably be submitted for an expedited review because, although I was planning to interview
pregnant women (a group that is considered to be a vulnerable population), the designation of pregnant women as a vulnerable population was intended in large part to offer protections from potentially harmful medical procedures. As a group, the cognitive abilities of pregnant women are not compromised to the point that they aren’t able to consent to interviews, and thus an expedited review could be thought to be appropriate for a physically noninvasive project such as mine which sought only to interview women.

In order for a proposal to be approved for an expedited review, all three preliminary reviewers must agree that a full board review is not necessary. On the advice of my first reviewer, I prepared my proposal for an expedited review and submitted it to my second reviewer. The second reviewer expressed concern about the project because, in addition to seeking pregnant women, I had mentioned in my proposal that I would make efforts to maximize my potential of including minority individuals in the research. Specifically, in my section on recruitment, I wrote:

I hope to recruit participants by posting flyers in places that pregnant women will have access to, including physicians’ offices. These flyers include a brief description of the project, a request for participation, and my contact information so that individuals who wish to participate may contact me directly (see attached “Flyer”). I will be contacting physicians’ offices in the Pittsburgh area that are committed to serving underserved populations, including persons of lower socioeconomic statuses, persons of color, and members of the Lesbian, Gay, Bisexual and Transgender (LGBT) community. I hope to maximize my potential of including minority participants in this research, and my rationale for this is twofold. First, I hope to challenge the overrepresentation of non-minority
individuals in psychological research at an empirical level. Second, given that
one of the aims of my project is to investigate the ways in which pregnancy
ultrasound acts to perpetuate normative identities, I believe that it will be helpful
to talk with individuals whose identity is already, in some ways, ‘nonnormative.’
Whether this happens on a conscious level or not, I believe that there are ways in
which individuals who hold what is considered to be a minority status of one kind
or another are more attuned to the ways in which normative identities are
perpetuated and, in talking about their experiences, will provide narratives in
which identifiable points of rupture will emerge. (Riddle, 2003a)

In a phone conversation I had with this second reviewer shortly after he’d read the
abstract, he expressed his discomfort with the above section in which I articulated my
decision to maximize my potential for including minority participants in the research. He
told me that he was particularly concerned about the recruitment of individuals of lower
socioeconomic statuses as he had concerns about their capacity to consent to the research.
In the end, he said that my decision to recruit minorities (or, in my words, to “maximize
my potential of including minority participants”) who were also pregnant was what
tipped his decision in favor of a full board review rather than an expedited one. Both my
first and second reviewers seemed to be completely perplexed about my decision to try to
recruit minorities at all given that I had not mentioned it earlier in the abstract and despite
what I felt was my clarity on this issue. We agreed to let it go to the full board and see
what changes they suggested.
Scratching our heads: Making revisions to the IRB proposal

I prepared the proposal for the full board review. It was reviewed on February 4, 2003 and was approved contingent upon revisions. Some suggestions by the full board were minor and easy to alter. These suggestions involved the clarification of subject selection, a change to the title of the investigation, and a change to the consent form so that possible benefits of the research, including implications for future research, were made clear to participants. Other suggestions revealed more fundamental misunderstandings of the research. According to my first reviewer, the proposal as a whole had generated a great deal of confusion among IRB members. The members of the full board agreed that:

The relationship between the effects of medical technology and the various minority statuses of participants needs to be explained in the abstract. A number of board members could not comprehend how vastly different minority persons (such as racial minority and sexual minority) could provide data that cohere in a way that valuable conclusions could be drawn. A significant number of board members did not understand the overall goal of the research. The goal and its relation to method (subject selection, subject interview, and interview analysis) should be clarified. (P. Richer, personal communication, February 2003)

Members of the IRB were confused by my project and, in all honesty, I was confused by their confusion. I will concede that perhaps I could have articulated the goals of the project in a clearer manner, but I had a hunch that other things were in play. Although I felt fairly defensive about making revisions to a project that felt as though it
was as clear as it was going to get, I also realized that if twenty-odd people were
confused by my research then there was a significant disjoint between my own clarity on
the project and its comprehensibility to others. Although it was discouraging, this
situation presented me with a chance to investigate more fully what was happening.

The first major development that occurred with regard to my IRB submission –
the decision by my initial reviewers that the project was to be reviewed by the full board
– seems to me to illustrate the ways in which bodies that are ‘non-normative’ or
problematic in some way require more surveillance, closer scrutiny, better monitoring. I
had named my decision to include not only women (whose bodies have long been
considered to be a problem in relation to a male norm (Bayer & Malone, 1996; Bordo,
1987, Mills, 1996, Tavris, 1992)), and not only pregnant women (whose bodies, in this,
the apex of their reproductive career, have been considered to be particularly perplexing
(Ussher, 1991, 1992)), but also to make efforts to include women who sit on the margins
of normalcy by virtue of various markers of difference such as race, sexual orientation,
and socioeconomic status.

Once the project got to the full board, the emphasis from reviewers was on the
project’s incomprehensibility. I was to make revisions in light of the fact that “a
significant number of board members did not understand the overall goal of the
research.” It is striking to me that the response to the project was one of confusion.
Members of the IRB did not say, ‘This project is bad,’ and they did not say, ‘This project
is dangerous.’ They did not say, ‘This project is unethical,’ or even, ‘This project makes
us angry.’ They said simply, ‘We do not understand what it is that you are trying to do;
we are confused by your project.’
As I write this, in March of 2005, I am reminded of a conversation I had with my brother about a month ago in which I stated my desire that his two children – my nephew, age eleven, and my niece, age seven – be present at my (same-sex) wedding in a couple of months. I told him that I really hoped they could be there, and he responded that he and his wife had talked it over several times and were concerned about my niece (the younger child) in particular. His words: “We think she’ll be confused.” I challenged his belief by providing rational evidence to refute this claim, but these efforts fell (predictably) flat. In spite of some very persuasive, empirical evidence, my brother (and millions of other Americans) continues to maintain that gay marriage is a situation that is confusing to children.

In a culture in which rationality is deeply privileged, an appeal to ‘confusion’ leveled at a particular person or situation carries considerable weight and oftentimes reveals a larger structure in which certain movements, certain bodies, certain ways of being are more intelligible than others. The heterosexual matrix – and the production of a field of intelligibility in which only heterosexual couples are knowable – creates a situation in which the idea that two people of the same sex could love one another deeply stretches beyond the limits of intelligibility. To be deemed one who is ‘confusing’ is to be deemed one who is not recognizable within the bounds of intelligibility is to be

---

6 I cited research indicating that children raised by same-sex couples turn out ‘as good’ as children raised by heterosexual couples (Stacey and Biblarz, 2001); I talked about personal experiences with children who know same-sex couples and who do not seem to be even slightly disturbed; I attempted to argue that if children can understand that two people of the opposite sex can love one another and make the decision to be together through a commitment called marriage then surely they can understand that two people of the same sex could do so as well.

7 Accusations in regard to “confusion” drive a number of the conservative family organizations. Randy Thomasson, President of the Campaign for Children and Families, argues that gay marriage would "give children very confusing role models" (cited in Fikes, 2005); Peter LaBarbera, Executive Director of the Illinois Family Institute – in a move that pits minorities against one another – argues that with the legalization of gay marriage, “Confusion over civil rights will increase: ‘Gay marriage’ activists are selfishly equating their misguided cause with the noble civil rights movement, insulting African Americans and confusing children” (LaBarbera, 2004).
deemed one who does not truly exist. Indeed, according to Butler, “If we are not recognizable, then it is not possible to persist in one’s own being, and we are not possible beings; we have been foreclosed from possibility” (Butler, 2004, p. 31).

This foreclosure is deeply painful. The reality of the situation in this current political climate is that a push for an acknowledgement of oneself as a gay person can result in a literal estrangement. As such, I constantly walk a fine line between honesty (being ‘myself”) and dishonesty (not being ‘myself” too much). Revealing oneself in full has the potential to result in a painful and literal alienation from loved others (oftentimes families of origin for LGBT people) and can have concrete consequences, but restraining oneself from revealing that ‘self” very much can produce a feeling of profound alienation from both oneself and others. The tensions that exist around how much or how little to reveal are often emphasized by well-meaning individuals who note the complications of outing oneself in a heterosexist culture. What feels most important for me to note here is that it is impossible to emphasize, in language, how much it all hurts.

Though the revisions that the IRB suggested did not carry as much emotional weight as my experiences with my family, their comments were quite disconcerting, and even a bit painful. In my project, I had articulated a desire to create a space in which voices that are not often asked to speak would be asked to share their stories, and I did so out of a very personal investment. When the suggested revisions came back, I felt terribly misunderstood and, even more troubling, at a loss to articulate my position more clearly. Wearily, I approached the revisions determined to at least figure out a way to persuade the reviewers about the viability and ethicality of the project, if not its overall value.
In my revisions, I was to consider the fact that “a number of board members could not comprehend how vastly different minority persons (such as racial minority and sexual minority) could provide data that cohere in a way that valuable conclusions could be drawn” (italics mine). I believe that my difficulties arose in large part because I had dared to question an invisible (white, heterosexual, able-bodied, etc.) norm without explicitly defining my project as one which was concerned with a discrete category of persons. That is, in my proposal, I made the decision to pull for ‘difference’ without promising any kind of containment of that difference. People seem to see the value, and even ethicality, of focusing a research project on either ‘no group/everyperson’ or on ‘a particular group.’ In the former scenario, when markers of difference are not named, we can keep up the pretense that they are not really that important. In the latter scenario, when only one very particular marker of difference is named, we can maintain the fantasy that a unified group exists and can thus imagine a way in which people’s experiences logically cohere.

I don’t think that I would have run into any of these problems if I had decided to either let the subjectivity of my potential participants go unnamed or chosen a specific population based on one marker of identity (i.e., “African Americans,” “lesbians”) and made an investigation of that specific population central to the project. But I did something different. I called attention to myself. I said that I would like to try to include individuals who sit on the margins, and I did so without articulating a way in which I would make everything okay. I pulled for an uncontained, unbridled difference, without promising to pull it back together in a rational, unified or logical way and I did so outside the bounds of a (currently accepted) model that sees individuals’ racial/ethnic identity,
sexual orientation, social class, physical disability as discrete markers (Arredondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996; Sue & Sue, 1990) to be studied separate from one another. I believe that the confusion around my challenges to this serves to cover over a catastrophic sense of alarm.

With some resignation, I revised my proposal to reflect my belief in the importance of making attempts to include women who have been marginalized on the basis of various markers of subjectivity. I emphasized my belief that anyone who is marked as such will already challenge normative expectations of mothering. I also touched upon the ways in which research projects that focus on one ‘group’ often minimize other kinds of oppression (e.g., feminist projects, while challenging patriarchy and prioritizing gender discrimination, have been criticized for being white-centered and heterosexist; research on lesbians and gay men have been critiqued for being white-centered; research projects that examine specific cultural and ethnic minorities often privilege a heterosexual development (Fine & Gordon, 1995; hooks, 1989)):

This project is neither focused on drawing conclusions about any one particular minority group (e.g., African Americans, lesbians), nor is it aimed at drawing conclusions about similarities and/or differences between various minority groups. Instead, it is focused on exposing cultural expectations about normative behavior that are reflected in supposedly neutral medical interventions. Individuals are marked within various cultural categories, including race and sexual orientation. Although individuals are marked in different ways depending upon their individual ‘non-normative’ statuses (and some individuals are ‘double-marked,’ e.g., as both a racial and sexual minority), individuals whose identity is
marked as non-normative already challenge normative expectations of mothering and reproduction. On a concrete level, lesbians pose challenges to normative models (e.g., marriage, motherhood) simply by attempting to participate in them. Research projects that have focused on the experiences of individuals who are positioned within one minority identity category (e.g., race, sexual orientation) have sometimes worked to obscure the importance of investigating the ways in which other persons are marginalized. In this project, I hope to keep at the forefront of the research the various identity positions that are excluded from the ‘norm.’ (Riddle, 2003b)

The IRB accepted the revisions, and I closed the door on this part of the project. With my formal approval in hand, I set out to recruit participants for the research.

Soliciting participants

Initially, I did not foresee any difficulties with finding participants for this research. I had recruited participants for research projects before (Cosgrove & Riddle, 2003), and I hadn’t had any problems. In late March of 2004, I spoke with physicians at Metro Family Practice, a local-area practice that is known for serving communities of color, the LGBT community, and individuals of lower-income status, about posting a flyer on the bulletin board in their waiting room. I also went to Magee Women’s hospital and approached the department that serves lower-income women, including women who are enrolled in WIC (Women, Infants, and Children), a federal program that supports low-income women and children up to age five. I was given permission to post flyers at both locations.
When I hadn’t received any responses by mid-May, I redesigned my flyer to include a picture of an ultrasound. I approached the Wilkinsburg branch of Magee Women’s Hospital, a local clinic that primarily serves the African American community. I received permission to post my flyer there. I also located the e-mail of the contact person for a local parenting group for lesbians called Families Like Ours (FLO), and I e-mailed her about posting a flyer in a location where members of the group would have access to it. She e-mailed back to let me know that she would forward my e-mail to members of the listserv. Following this, I received two e-mails from women on the listserv who indicated that they would be willing to participate in my research. However, both women were not pregnant at the time and thus were not eligible to participate.

In mid-July, when I hadn’t received any responses from potentially eligible participants, I began talking with various friends and colleagues to brainstorm locations in which I could post flyers that might yield participants. I e-mailed a colleague who teaches in the School of Nursing at Chatham College who offered to circulate my flyer at her doctor’s office and at Chatham. I spoke with a friend who had a contact at Magee, and I contacted this friend’s colleague at her encouragement. I received an encouraging e-mail in return, but this ultimately did not lead to any participants. In July, I re-posted my flyer at Metro Family Practice, and I also posted it on bulletin boards at the East End Food Co-Op, in Oakland adjacent to the Hillman Library at the University of Pittsburgh, and at the Midwife Center.

I received my first phone call from a potential participant in late July. This woman said that she would be very interested in participating in the project, and it became clear that she would be eligible to participate as she was pregnant and reported
that she was not having any complications with her pregnancy. As well, she identified herself as a lesbian. She told me that she had not had an ultrasound yet as she was early in her pregnancy but that she had a doctor’s appointment scheduled for mid-August, anticipated that she would have her first ultrasound in late-August, and asked if it would be okay to schedule the interview after that. I told her that this would be fine. She said that she would contact me after her doctor’s appointment – sometime in mid- to late-August – and we agreed that I would contact her later in the summer if I hadn’t heard from her.

I received a second phone call in early August from a woman who had seen my flyer at the Midwife Center. She was also eligible to participate as she was pregnant, reported that she was not having any complications with her pregnancy and had already had three ultrasounds. We scheduled an interview for the following day at the Psychology Clinic. On August 3, I conducted my first interview with the participant to whom I refer as “Heather.”

When I had not heard back from the woman who had phoned me about participating in July, I followed up with her by phoning and leaving a message on her answering machine. I identified myself, reminded her about the project, and asked her to phone me if she was still interested in participating. She did not return my call.

The month of August passed without any more calls from potential participants, and in September I began to brainstorm other ways of recruiting. I spoke with the chair of the IRB again to discuss my options. We discussed the possibility of placing an ad in a local newspaper and making attempts to obtain participants through more informal routes such as by word of mouth. After receiving the go-ahead for these minor changes
to my recruitment procedure, I placed an ad in a local newspaper aimed at the LGBT
community. The description of my project in the ad was similar to the description on the
flyer. I stated that I was interested in interviewing pregnant women who had not had
complications with their pregnancies about their experiences of ultrasound and that I was
particularly interested in the experiences of women who would identify as sexual or
racial minorities. At this point, I also e-mailed the contact person for FLO again, and she
again circulated my e-mail to the listserv.

On September 27, I received an e-mail from a woman who expressed her interest
in the project. I e-mailed her a more specific description of the project, including the
details important to her eligibility to participate. She met these criteria, and we scheduled
an interview for the following week. This is the participant to whom I refer as “Emily.”
After our interview, we had an informal conversation about my research and I let her
know that I was still looking for another participant. She told me that she had a number
of colleagues who were pregnant and offered to let them know about the project. On
October 2, I received an e-mail from another potential participant. She was also eligible
to participate. Several days later, I conducted an interview with this third and final
participant to whom I refer as “Joanne.”

First Interview: Heather

Heather called me on August 2, 2004 to express her interest in participating in my
project. She told me that she had seen a flyer at the Midwife Center during one of her
appointments there. I offered her the option of meeting either at the Psychology Clinic at
Duquesne or at a location that would be convenient for her. She opted for the Clinic, and
we scheduled an interview for the following afternoon. Heather is a Caucasian, heterosexual woman in her early thirties. At the time of the interview, she was at thirty-five weeks gestation. Although she told me on the phone that she was not having complications, at the time she was being monitored by a physician as a result of the detection by the midwives of the presence of two large uterine fibroids. At the time of our meeting, Heather had had three ultrasounds.

I arrived at the building for our interview approximately thirty minutes early. The Psychology Clinic is on the ninth floor of the building, and I entered at the first floor entrance. Prior to taking the elevator up to the Clinic, I stopped for a cup of coffee at the coffee machine on the first floor. As I walked down the hallway toward the elevators, I passed a pregnant woman. Given the rarity of seeing a visibly pregnant woman on a traditional undergraduate campus, I wondered if it was Heather. I glanced and smiled weakly at her as I passed by, and I pushed the button for the elevator up to the ninth floor. Once I reached the Clinic, I said hello to the administrative assistant, checked that the room that I had reserved was available, and unpacked my bag in the main office so that I could photocopy the consent form.

Heather arrived at the Clinic about five minutes after I had arrived and as I was in the midst of talking with the administrative assistant and getting ready to photocopy the consent form. She had arrived about twenty minutes early for the interview. She was, indeed, the same person that I had passed in the hallway, and when she came in to the Clinic and introduced herself to the administrative assistant (to whom I was standing in proximity), I commented, “I wondered if that might be you.” She nodded and said that she had wondered when she saw me (perhaps because of the way that I had looked at her
a bit too carefully) if I would be the person who would be interviewing her. I told her that we could probably start a bit early if that was okay with her but that I would need a few minutes to get my things together. She said she was ready to start at any time. I showed her the waiting room and then took about five or ten minutes to photocopy the consent form, organize my materials including the taping equipment, and arrange the room for our interview.

There are about eight therapy rooms at the Psychology Clinic that are shared by student therapists, and they are all fairly minimalist in their decor. Each room contains a couch and several chairs with wooden frames and mauve-colored cushions; the couches, in their sturdiness, resemble those found in college dorm common areas. Each room also contains a short table on which rests a box of tissues and a small tape recorder, one or two end tables with lamps, and a plant or two. The room that I had reserved is the smallest room. It is my favorite room at the Clinic and was the room that I always reserved when I was seeing clients there. In addition to my comfort level with the space, I also chose this room specifically because I thought that a smaller space might be better in terms of sound quality of the recording. This room sits on the western side of the building and overlooks downtown Pittsburgh. On sunny days in the afternoon and early evening, the blinds are typically drawn as the sun produces a bright and uncomfortable glare.

Before getting Heather from the waiting room, I arranged the furniture so that the chairs and couch were facing one another, giving her the option of sitting on either the couch or one of the chairs. I set my recording equipment on the short table in the center of the room and tested it by pressing record, speaking into the recorder, and listening
back on the headphones. I arranged a second (60-minute) blank tape next to the recorder in the event that the interview was lengthy enough to require a second tape. I pulled my yellow legal pad and pen from my bag and set them on the table as well. I set the two copies of the consent form on top of my legal pad. I (carefully) set my coffee next to the recording equipment. After arranging the blinds to minimize the amount of light coming into the room, I went to the waiting room to get Heather.

When Heather came into the room, I thanked her again for agreeing to participate and asked if she’d been able to find the building without any trouble, and she told me that she had. At thirty-five weeks, she was nearing her due date and she moved with some awkwardness and lowered herself carefully onto the couch. She had been carrying a water bottle, and she set it down on the table in front of her. At that point, I repeated the information that I’d told her over the phone: I told her that I would be asking her some questions about her pregnancy, some specific questions about her ultrasounds, and some general questions about the medical care that she had received in her pregnancy and at other times in her life. I told her that I would be audiotaping the interview.

After she signed both copies of the consent form, I co-signed them. I then explained again that I would be asking her some questions and that while most research in psychology is quantitative, my project was different in that it is qualitative. I had been yammering on about my feminist perspective and my interest in a more depthful approach to understanding women’s experiences of their pregnancies when she interrupted me and said, “Uh, I’m sorry but I don’t know what qualitative and quantitative are.” I felt jarred by this and realized that I had shifted into more technical language with realizing it. I felt caught off guard, but I was glad that she had felt
comfortable enough to point this out to me. Had she not interrupted me, I would have
gone unchallenged in my belief that I was adequately explaining my research
perspectives to her. After she interrupted me, I made an attempt to minimize my use of
technical language. I explained that qualitative is generally concerned with language and
that quantitative is generally concerned with numbers. I told her that as a feminist
researcher, I was generally interested in women’s experiences in the context of a culture
that does not always value them. After this introduction, and as our conversation started
to get a bit interesting, I told her that perhaps I’d better start the audiotape.

Our interview followed from my interview guide, and in addition to the questions
that I had planned to ask, I asked a number of other questions that arose spontaneously
from our discussion as I had anticipated that I would. Heather seemed to me to be an
unusually forthcoming and candid participant. She described in detail and with great
animation her negative experiences of doctors, her positive experiences of her
ultrasounds, her relationship with her boyfriend, her current and anticipated difficulties
with her boyfriend’s children, her fears about balancing career and motherhood, and her
experiences growing up in a family that valued traditional gender roles. Heather
exhibited a wide range of emotional experiences. For most of the interview, she was
animated and somewhat outspoken, and her speech was punctuated at times by moments
of laughter. In contrast to this, at the point during the interview in which she described
her hopes for her child, her tone shifted, and she became quiet and was moved to tears.

The interview was a long one, and I believe this was in part due to my efforts to
extend our conversation in my desire to have plenty of interview material to analyze, in
part due to the fact that Heather was almost to term and had a number of very rich
experiences to share, and in part due to Heather’s extraverted personality. During the interview, in addition to engaging Heather in conversation, I jotted down notes of comments that were interesting to me on my legal pad; as well, I kept a close eye on the tape recorder to make sure that the tape was continually spooling. The flow of the interview was interrupted twice by me when I flipped over the first tape about twenty-eight minutes into the interview and changed the tape about fifty-six minutes into the interview. There were two instances toward the end of the interview during which time Heather’s phone rang (she ignored the calls) and these seemed to distract us only minimally.

Following the interview, I thanked Heather for her time and encouraged her to contact me if she had any questions. I walked her to the waiting room and shook her hand. I asked her if she knew how to get home, and she told me that she did. After Heather left, I returned to the room, rewound each of the tapes, and listened to make sure that the conversation had been recorded. Following that, I packed up my bag with my recording equipment and notes and left the Clinic.

Second interview: Emily

Emily e-mailed me on September 27, 2004 to express her interest in participating in the project. She had heard about it through an e-mail that I had sent to the contact person of a local lesbian parenting group. Emily said in her e-mail that she would be able to do the interview if I could meet her at her place of work during lunchtime. We scheduled an interview for September 29, 2004. Emily is a Caucasian, lesbian woman in her mid-thirties. At the time of the interview, she was at twelve weeks gestation. She
had been artificially inseminated and was initially monitored by doctors at the fertility clinic where the insemination had taken place; at the time of the interview, she was being monitored by her regular Ob/Gyn and had had two ultrasounds.

Emily told me that there was no office area that she could count on being free for an interview and suggested that we meet at her place of work and then walk to a local coffee shop. We made plans to meet at the entrance of her place of work at twelve-thirty in the afternoon. After I had agreed to the arrangement, I started to worry that the noise level in a coffee shop might interfere with the recording; I was also concerned about whether conducting the interview in a small, enclosed, and crowded public space would interfere with Emily’s willingness to speak freely about her experiences. As I am familiar with the area near where she works, I was aware that there are several picnic tables close by and wondered if it might make sense to do the interview there as long as the weather was good. With these concerns in mind (concerns that often accompany research in which the researcher enters the space of the participants), I packed up my backpack and went.

Prior to meeting Emily, I had decided that I would use two tape recorders during the interview. Given my difficulty recruiting participants, I wanted to have two recordings in the event that one of the tape recorders failed to record the conversation. I also thought that it might be helpful to have two recordings so that in the event that specific sections were indecipherable, a second recording could be consulted. For the first interview, I had borrowed a Sony Walkman professional stereo cassette-corder (WM-D3). This device, a walkman-sized audio recorder with a detachable microphone, retails at around $250 and came highly recommended as reliable and dependable for
recording interviews (J. Hwang, personal communication, August, 2004). For the second interview, I used this same machine again and also used my own Sony cassette-corder (TCM-929), a portable audio recorder with a built-in microphone that I had bought several years prior for about $30. Before leaving for the interview, I made sure that I had in my backpack the two audio recorders, the detachable microphone, plenty of audiotapes, extra batteries, my notepad, pens, the consent forms, and my interview questions. I wince as I commit the details of my interview preparations to text as they reflect a surplus of privilege, the classist concerns of a student conducting a dissertation project.

I arrived at Emily’s building about ten minutes prior to the interview, glad to see that it wasn’t raining. I waited at the entrance of the building next to a row of metal detectors. I wasn’t sure what Emily looked like or how far along she was in her pregnancy, so I stood just inside the metal detectors trying to make myself look nonchalant yet approachable to each woman of childbearing age who passed by. My deportment (in combination with the fact that there really weren’t very many people hanging around the metal detectors) must have clued Emily in, because she approached me unhesitatingly about two minutes after our arranged time, asking, “Are you Bethany?” I nodded and asked in return, “Emily?” She nodded and stretched her hand toward me. We shook hands and headed outside together. She suggested a specific coffee shop that she thought would be convenient, and at that point I told her about my concerns about the noise level. I mentioned that I had thought that we could sit at one of the picnic tables, and she said that that would be fine.
The outdoor area where Emily and I sat for the interview is a small, developed area with grass, symmetrical trees, and about eight picnic tables that sit as a kind of small oasis within a predominantly urban area. There are several main roads and large buildings adjacent to the picnic area. Conducting an interview in a ‘natural’ setting brings its own specific set of concerns, and in addition to my initial concerns about rain, I was also concerned about other factors that had the potential to impact the interview. I was worried that the wind might blow my papers, or that passers-by might distract our conversation, or that urban noise such as traffic or construction might interfere with the audio recording. As it turned out, the setting was remarkably peaceful. The air was calm, our picnic table was far enough from others so as to feel private, traffic noises were at a minimum and, somewhat remarkably for this particular area of Pittsburgh, there was no construction that day.

I set my backpack on the bench beside me and began unpacking my equipment. As I pulled out my materials, we talked informally, and this seemed to be partly a function of the fact that I was entering Emily’s space and not the other way around. With Heather, I had done my pre-interview preparations in private. With Emily, she was sitting with me as I unzipped my backpack, arranged my papers, and put the audiotapes into the recorders. During our initial conversation prior to the formal interview, and in the context of my impetus for specifically recruiting sexual minorities in the research, I outed myself to her, saying with some degree of self-consciousness, “As a lesbian, I am really concerned to include lesbians and/or bisexual women in this research.”

After I had arranged my interview paraphernalia, I repeated to her the information that I’d previously shared with her in an e-mail. I told her that I would be asking her
some questions about her pregnancy, the medical care she’d received during her pregnancy and at other times in her life, her experiences of the ultrasounds specifically, and some other general questions about herself and her experiences. I gave her the consent form and asked her to read it carefully, ask me any questions that she might have, and sign both copies, one for her and one for me. She read through the form and said that she didn’t have any questions, and I co-signed them. At that point, I told her that I would be using two tape recorders – a detail that was probably already apparent as they were both sitting on the picnic table – as one sometimes picks up sounds that the other does not.

As with Heather, I followed the interview guide fairly closely, although in many instances Emily anticipated questions that I had been planning to ask. Also as with Heather, our conversation did not follow the interview guide in an entirely linear fashion. Emily was much more reserved than Heather and maintained a fairly quiet and calm demeanor for the duration of the interview. Although I experienced her to be both forthcoming and genuine, her responses had a conciseness to them, and at times I felt as though I was pulling for more information.

Emily described her experiences of the insemination process, various medical providers, and the two ultrasounds that she’d had. We also discussed her ideas about raising a child, her thoughts on gender identity, and her experiences growing up in a family in which traditional gender roles were maintained and expected. Throughout the interview, Emily’s experiences as a lesbian came up again and again and seemed to be central to all of her experiences. The fact that the setting in which she’d been inseminated was “definitely like a heterosexual environment” (line 41) came up almost
immediately, and Emily’s implicit awareness of heterosexism in various settings came up throughout our discussion.

This interview was the shortest one, and I think that this was due to several factors. Emily was quite reserved, and her responses to my questions were generally concise and to the point. Also, Emily had been experiencing morning sickness nearly every day, including on the day of our interview, and had mentioned that following the interview she’d need to get home and get something to eat to counter her nausea. I remember feeling that I didn’t want to keep her longer than necessary. Also, after I’d completed the interview with Heather, I was somewhat overwhelmed with the amount of data I had from that interview, and I did not feel any pressing need for additional data.

At the end of the interview with Emily, I asked her if she had any questions for me, and she responded that she did not. I briefly looked over my questions to make sure that I hadn’t omitted anything, saw that I hadn’t, and then turned the tape recorder off. As I was packing up my bag, she asked me, “How did you get interested in ultrasound?” I told her that I’d done some research on women’s experiences of PMS (Cosgrove & Riddle, 2003), that I’d always been interested in women’s health in general, and that I had done a project on ultrasound for a research class that had focused on visual method and I’d found it to be interesting.

She seemed curious about all of this and responded with the question, “What have you found so far?” I told her that despite the fact that the ultrasound is generally seen as a strictly medical procedure, it can have a number of non-medical effects. I recounted how she had remarked during the interview that seeing the heartbeat was comforting and gave her the sense that the fetus “really was alive” (line 402), and told her that many
women feel that the ultrasound seems to make their pregnancies more real. I also remarked that I was interested in how ultrasounds work to shape women’s experiences of their pregnancies and that some research indicates that while the process can be positive for many women, it can also be a negative experience for some women if abnormalities are found or if a woman doesn’t feel that she has a good relationship with her doctor.

At that point, Emily commented that a friend of hers had had an ultrasound in which a possible fetal abnormality had come up, and she described to me her friend’s experience of a number of medical professionals rushing into the room to view the ultrasound. Emily commented something to the extent of, ‘It was like all these people were looking at the inside of her body.’ Then she remarked that having an ultrasound for a medical problem (e.g., a cyst) is different than a pregnancy ultrasound because everyone expects that a pregnancy ultrasound will be wonderful and no one has that expectation with other medical ultrasounds.

Emily asked when I would be done with the project, and I told her that I would hopefully be defending the dissertation in either the spring or the fall. She said that she’d be interested in reading it. At that point, I told her that I was still looking for one participant, and I asked her if she would mind letting people know about my project if that felt okay to her. She told me that she had several colleagues who were pregnant and that she would pass along my e-mail to them.

During the conversation that followed the ‘formal’ interview, Emily was much more animated and talkative about her thoughts and experiences. As well, I felt freer in sharing my impressions with her. Following this conversation, I lamented the fact that I hadn’t gotten this exchange on tape, but in retrospect I think that this development is
informative. Although I had invited Emily to ask me questions at the end of the interview, the structure of the interview is such that it is assumed that the interviewer asks the questions and not the other way around, and it seems to be very difficult for people to break a conventional pattern of an interview, even when they are invited to do so. It was only in the absence of a formal structure that a spontaneous and engaged conversation took place, and this tells us about the ways in which the formal interview structure acts to constrict the voices of the participant and of the researcher.

Third interview: Joanne

Joanne contacted me via e-mail on September 30, 2004 to express her interest in participating in the research. She had heard about my project through Emily with whom she works. Joanne told me in her e-mail that we could meet during her lunch hour at her place of work. We scheduled an interview for the following week, on October 5, 2004. Joanne is a Caucasian, heterosexual woman in her late thirties. She was born with spina bifida, a neural tube defect which limits her mobility. At the time of the interview, she was at twenty-four weeks gestation. Although Joanne told me that she had not had any complications with her pregnancy, because of her physical disability and because she was almost forty years old she was being seen by a group of physicians who specialize in monitoring high-risk pregnancies.\(^8\) At the time of the interview, Joanne had had four ultrasounds.

\(^8\) Although both Heather and Joanne indicated that they were not having complications with their pregnancies, both were referred for ultrasounds early as a direct result of specific and complicating concerns (for Heather, fibroids; for Joanne, age and spina bifida). And, in fact, my third participant Emily also received additional monitoring as she had been inseminated. This changes the trajectory of these women’s experiences and as well changes the trajectory of this research. It highlights the large number of complicating factors, if not true medical complications, that can impact the level of monitoring that one receives. While typical complications include things such as bacterial vaginosis, bleeding, blighted ovum,
Joanne and I exchanged a few e-mails in which I informed her of the specifics of her participation in the interview and in which we coordinated our meeting time and place. Joanne told me that because of her limited mobility, she would be unable to travel for the interview. She let me know that she could arrange for us to meet in an office at her place of work during lunchtime. The first interview had taken place in a setting with which I was familiar, the second in a public location which, although it was close to Emily’s place of work, was relatively neutral, and this third one was at Joanne’s place of work. It is worth noting here that, of my three participants, Joanne seemed to me to be most at ease during the interview. This may have been due to Joanne’s extraverted personality, or it may have been due to the fact that I was more comfortable with the interview process because I had already conducted two interviews, or it may have been due to the fact that the interview took place at Joanne’s workplace. Quite possibly, it was a result of a combination of all three factors.

After having some difficulty finding a place to park and locating Joanne’s office, I arrived at Joanne’s place of work about five minutes before our scheduled time. Joanne’s office is located on the top floor of a large building, and the stairs that lead up to her office area are quite narrow. I felt as though I was walking into someone’s attic. The office area itself is small, and Joanne was the first person that I encountered. I said, “I’m looking for Joanne,” and she said, “That’s me, you must be Bethany.” We shook hands,
and she walked me to the room that she had reserved for us. She told me to make myself comfortable, and she went to get her lunch as she planned to eat while we talked.

The room where we met was a medium-sized conference room with a large conference table in the center surrounded by chairs. The table and chairs took up most of the space in the room. The area around the table was somewhat cluttered with several boxes, books, papers, office supplies, and a small table with a microwave, coffee maker, and phone. It struck me at a typical example of an all-purpose room that resides in a non-profit agency. While Joanne was getting her lunch, I sat down in one of the chairs at one corner of the table. I set up my two tape recorders and arranged my notepad and consent forms. Joanne came back several minutes later with her lunch and began to sit down across from me. Knowing that the distance between us might impact the recording, I asked Joanne if she would mind sitting in the chair next to me at the corner of the table so that the tape recorder could pick up our conversation better. She agreed without hesitation.

Joanne immediately struck me as friendly and talkative. I thanked her for agreeing to participate, told her again that I would be asking her some questions about her pregnancy and the ultrasounds that she’d had during her pregnancy, as well as some general questions about the medical care that she’d received during her pregnancy and some general questions about her experiences. I gave her the consent forms to sign and asked her to ask me any questions she had and then sign two copies, one for her and one for me. Joanne read through the consent forms and told me that she didn’t have any questions.
As with the other interviews, I followed the interview guide fairly closely, deviating from it in some moments to ask follow-up questions. Joanne was forthcoming and talkative. She laughed often and easily. She was easy to talk to in that she offered her thoughts and experiences unhesitatingly. By that same token, there were moments in which I felt that it was hard for me to finish a sentence or question because she was so eager to talk that she sometimes interrupted. There were some moments in which I was unsure if she had really heard a specific question or comment of mine, but through the course of the interview it became apparent through her remarks that she was listening to me and that it was simply her style was to anticipate a question or comment with her own comments.

As with Emily’s discussion of her experiences as a lesbian – the nonnormative category in which she is positioned – Joanne’s experiences as a woman with a physical disability came up almost immediately and seemed to be central to Joanne’s experiences in pregnancy and otherwise. Joanne told me within the first minute of the interview, “I have a neural tube defect” (line 14), and much of the interview was focused on the meaning of this in various situations.

Joanne and I discussed her experiences with the doctors in the maternal/fetal medicine group, including the increased amount of monitoring that she had undergone to that point as a result of her disability and her age (late thirties). She discussed with me the decision-making process that she and her husband had gone through prior to her pregnancy. She was forthcoming about describing how difficult it was to find doctors who were supportive of the idea of her getting pregnant, and as well she was forthcoming about describing people’s negative reactions to her pregnancy. As well, Joanne shared
with me her ideas about raising a girl. The only time during the interview that Joanne seemed at a loss for what to say was when I asked her for her ideas about why she considered herself to be feminine. Joanne noted, “That’s a really hard question, I’m stumped there” (lines 900-1).

In an effort to connect with Joanne – as her experience of feeling ‘outside the norm’ in relation to her experiences as a woman with spina bifida resonated deeply with my own experiences as a lesbian – I came out to Joanne early in the interview (within the first fifteen minutes). This was one of those moments during which Joanne interrupted me and, following this self-disclosure, I felt extremely self-conscious. This was a moment in which not only was I making myself vulnerable by identifying myself as a lesbian but also I was also doing so in violation of the typical conventions of an interview structure. I was still feeling haunted by my proposal and wondered if the self-disclosure was gratuitous. I was heartened that this move seemed to be a productive one. At one point later in the interview when Joanne was talking about her experiences of feeling “shoved into” (line 1320) a particular category, she noted, “you would probably understand that same kind of concept” (lines 1315-6). At other points, I regretted the self-disclosure, in particular when Joanne noted that she and her husband are both “conservative” (line 1029) and “very religious” (line 1031). In these moments, I felt not only self-conscious but also quite unnerved, concerned about whether Joanne was judging me thorough a religious lens as well as uneasy about whether I had impacted Joanne’s ability to talk freely.

The interview with Joanne took approximately forty-eight minutes. As the interview was ending, and after I had asked Joanne if she had any questions for me, she
asked me, “[D]id you feel like you got everything you needed?” I was a little thrown by this question as it seemed to be a moment during which Joanne challenged the conventions of the interview.

After I turned off the tape recorder and was packing up, Joanne and I continued to talk about ultrasounds, and Joanne made some spontaneous comments that were quite rich with regard to her experiences of the procedure, providing more support for the idea of the formal interview structure as constrictive. Joanne remarked that she felt that the ultrasound served to change her relationship with the fetus, noting “You do feel a connection.” I asked her if she would mind if I wrote that comment down, and she said that she wouldn’t. She continued, “To me, it wasn’t just a medical procedure, I guess it’s your first picture of your baby, it was very exciting that way.” When I noted that I thought that that was interesting, she commented, “I wouldn’t have thought to say anything about that [in the interview] because that was normal for me.” This comment in particular seems to highlight the ways in which normative procedures, and the experiences that feel “normal” in regard to those procedures, are so taken for granted that commenting on them seems unnecessary or redundant.

**Turning the text into written form**

Producing smooth conversation is a highly skilled art which only appears to be natural and unproblematic because we are so practiced at it. (Potter and Wetherell, 1987, p. 23)
Parker suggests a series of steps for the analysis of texts. He recommends that the researcher first “turn the text into written form” (Parker, 1994a, p. 96), a stage more widely known in qualitative research as “transcribing.” But there’s a difference between “turning the text into written form” and “transcribing,” for the latter implies that there is an unmediated relationship between words as they are spoken and words as they appear fixed on the page for the researcher and the reader. In contrast, the former acknowledges that the act of fixing spoken words to paper involves a turning of sorts, a twisting of sounds and meanings and phrases.

In the early summer of 2004, I met with Leswin, one of my readers, to discuss my early thoughts on method. Although I didn’t tell him this, at the time I was in a near-panic about whether or not I would ever find any pregnant women who would be willing to talk with me. We met in the late morning at a local coffee shop. We sat outdoors. As we talked, the sun gained momentum and strength as it does in the early summer, beating down on my brow and causing me to squint helplessly. The backs of my knees became damp and stuck to the cheap plastic white chair. Most of the details of the conversation escape me now, but when we talked about the interviews, he told me that he did not feel that transcriptions were necessary. In fact, I remember him saying specifically, “If I were directing you, I would encourage you not to transcribe at all.” Hmm. I responded with something about as unformulated as, “Well, I’m going to because I want to,” but in the last eight months or so I have thought of his comment often and wondered about what has motivated me to commit words to the page, turning them into immovable objects, stuck for all of eternity without any hope of ever shifting, and his to let them float freely in the
air, never-fixed, always-shifting, wandering and dissipating and dispersing eventually into nothingness. Of these two fates, which is the better?

Both of these options have serious drawbacks, but in the end I chose to follow my desire to fix the narratives to the page, trusting that my reasons would become clearer as I worked through the project. In fact, my purposes did become more evident as I considered seriously Parker’s (1994a) notion that a written text “allows us to bring into focus connotations that normally just twinkle on the margins of our consciousness” (p. 94). Although I desired a fixed text, as I reviewed various notation systems, I found myself uncomfortable with some systems, most notably in conversation analysis, that seem to imply that there is a way to precisely translate spoken word into written word and emphasize accuracy in transcription. As though each phoneme can be harnessed and squarely placed where it belongs. As though there is a right way to do it.

The issues around transcription highlight the difficulties in navigating the relationship between an “objective” reality (the utterances as they are precisely spoken) and a “subjective” reality (the conversation as it is mediated by our perspectives and biases). Whether there is or is not an existent or ‘true’ objective reality becomes a largely moot point when considering that that reality is always mediated and thus entirely inaccessible. The impossibility of uncovering a reality in its true or pure form renders a search for it to be not only a waste of time but also dangerous because we run the risk of convincing ourselves (and others) that we have located an unmediated version of events and then privileging that version over all others.9

---

9 Or, as Judith Butler (1993) has called it, specifically with regard to her explication of the impossibility of capturing a version of ‘sex’ that is unmediated by gender, a search for an unmediated version of events becomes a kind of fantasy or fiction: “If gender is the social construction of sex, and if there is no access to this ‘sex’ except by means of its construction, then it appears not only that sex is absorbed by gender, but
There is an inherent danger in transcribing conversations, for one cannot help but take for granted the fixed words as a tangible reality. The potential for the words to become ‘truth’ is unavoidable. With my transcriptions, then, I can only hope to attempt to minimize these reifications by reminding myself and any readers (over and over and over again) that although the “transcriptions” of these interview texts are my attempt to, in part (yes, I must admit, I have a desire to), represent as faithfully as I can the interactions that occurred between myself and each of my participants, the decisions that I made with regard to the representations of sounds make these written transcriptions of the interview texts my version of events and nothing more.

Immediately prior to conducting the first interview, I settled on a formal notation system. I used a combination of notation systems drawn from conversation analysis and discourse analysis (Poland, 2002). My main goal was to produce texts that were faithful to the conversations as I saw them, yet readable. I attempted to capture enough details to give myself and any readers a flavor of the conversation without prioritizing the minutia of the verbal utterances. In the transcriptions, I indicated short and long pauses, nonlinguistic utterances such as laughing and coughing, points of emphasis, points of interruption and overlapping speech, unclear and/or indecipherable speech, held sounds, and some of my own descriptions of speech quality (see Appendix A for full transcription notation system).

I completed the transcriptions within a week or two of each of the interviews, and I completed the transcription of each interview prior to conducting the next interview. In other words, I interviewed my first participant, Heather, on August 03, 2004, and I

---

that ‘sex’ becomes something like a fiction, perhaps a fantasy, retroactively installed at a prelinguistic site to which there is no direct access” (p. 5).
completed the transcription within a few weeks and prior to my interview with Emily. I interviewed Emily on September 29, 2004 and completed that transcription within a few days and prior to my interview with Joanne. I interviewed Joanne on October 05, 2004 and completed that transcription within a week.

Heather’s interview was the longest interview, taking approximately eighty minutes to complete. Emily’s interview was the shortest interview, taking approximately thirty-seven minutes to complete. Joanne’s interview lasted approximately forty-eight minutes. Each minute of talk resulted in about twelve minutes of transcription time; therefore, it took approximately one hour to transcribe five minutes of interview text. Altogether, the interviews took approximately thirty-three hours to transcribe.

The first interview was the most labor-intensive to transcribe given that it was the longest and the quality of the recording was the worst of the three. Most of the interview was audible, but because I had placed the recorder in between Heather and me on a table that was perhaps slightly too low to pick up all of the sounds, there were some instances in which words or groups of words were inaudible. This happened in moments in which Heather’s and my comments overlapped and also in moments in which one of us spoke softly. Because only one tape recorder had been used, a second recording was not available for cross-referencing. In cases in which I had difficulty understanding a particular exchange, I employed several strategies: I listened to the exchange several times, paying attention to specific sounds and as well paying attention to the context in which the exchange occurred. If I was still unable to understand the exchange, I asked a colleague to share with me her impressions of the exchange with the hope that an outside perspective might give new insight. In most instances in which words were inaudible, I
was able to make sense of the exchange by using these strategies. However, there were seventeen instances in which words or short groups of words remained inaudible (lines 558, 594, 598, 602, 616, 698, 993, 1015, 1115, 1346, 1460, 1549, 1632, 1929, 1971, 2047).

The second and third interviews were much easier to transcribe because the quality of the tapes was much better. In both settings, the tables on which I had placed the recording equipment were taller. Additionally, I had asked Emily and Joanne to sit in particular places (closer to the microphone) in order to maximize the quality of the tape recording, something I hadn’t done with my first participant as I had believed that the microphone would capture sounds within a wider radius. In both interviews, both tape recorders produced audible recordings of the interview. With each interview, I listened to the beginnings of both tapes and chose the one that seemed to be of better quality to transcribe, retaining the others as back-ups. In addition to rewinding a tape several times and utilizing a colleague’s ear, there were several times that I consulted a back-up tape when speech was inaudible, and this clarified the dialogue in several instances. In the second transcription, there are two moments in which I could not decipher the speech (lines 421, 839). There were as well two moments in the third transcription (lines 1016, 1081) in which speech was indecipherable.

Although tedious at times, completing the transcriptions gave me a chance to revisit the conversations and familiarize myself with some of the nuances of the exchanges. Throughout the process of transcribing, I had moments in which I remembered feelings and experiences that I’d had during the interviews and moments in which I became aware of things that I had not noticed during the interviews. As I
completed the transcriptions, I was able to notice moments in which I had colluded with participants and moments in which I had challenged their statements. The sections of interview that were most difficult to transcribe involved moments in which I broke with my role as interviewer and revealed some piece(s) of information about myself. It was during these moments that I felt quite self-conscious and vulnerable, and it was these exchanges that were particularly difficult to commit to paper.

Following the completion of the transcriptions, I felt a wave of relief at having finished the initial phase of the project. Participant recruitment had been difficult, and I looked forward to the easier days that were sure to lay ahead, the yellow brick road that would glisten as I effortlessly skipped along. I envisioned days of sipping coffee at my desk and pondering the narratives, rigorously analyzing the interview texts in light of engaging theoretical perspectives, culling insightful nuggets of wisdom from the likes of Butler and Foucault and deftly applying them to salient passages of text. These delightful fantasies soon gave way to the stark reality of dissertation research, the fits and starts, the long pauses, and the sharp realization that there is no yellow brick road after all, only a cold, grayish road that the writer is impelled to lie brick by brick on her own.
Chapter Three
Analysis: Part I: Getting my bearings

Analysis of discourse is like riding a bicycle compared to conducting experiments or analysing survey data which resemble baking cakes from a recipe. (Potter & Wetherell, 1987, p. 168)

When I started working on this project, I had a very circumscribed knowledge of the kinds of methodological considerations that I would run into, the types of contradictions that I would encounter, and the specific method that I would utilize to analyze the data. I felt fairly confident in my understanding of the differences between a qualitative and a quantitative approach, yes; somewhat confident in my understanding of the difference between a phenomenological approach and a postmodernist approach, it is true; and, less confident in my understanding of the differences between the various postmodernist approaches that are concerned with language, such as grounded theory (Swann & Ussher, 1995), rhetorical analysis (Lay, Gurale, Gravon, & Myntti, 2000), discursive psychology and Foucauldian discourse analysis (Willig, 2003).

Mainstream psychology sits within a positivist-empiricist framework in which experiences of sense perceptions are privileged as the only admissible route to knowledge about the human. In consonance with this, an objective reality, one which exists apart from humans and which is thought to be able to be observed as long as emotions and personal prejudices are kept at bay, is perceived to exist. Consequently, most researchers in psychology utilize quantitative approaches. Efforts are aimed at minimizing bias and bolstering the validity of the research through the manipulation and precise measurement of carefully controlled variables (Henwood & Pidgeon, 1994). The emphasis in
psychology has been on factoring out the subjectivity of the research participants and the researchers (Fine, Weis, Weseen, & Wong, 2000).

Although it would be incorrect to exactly contrast qualitative approaches with quantitative approaches because of the extensive differences between qualitative approaches due to their varying relationships with mainstream psychological literature, theoretical backdrops, and one another (Henwood & Pidgeon, 1994; Parker, 1994b), it is perhaps the case that some broad commonalities can be said to exist between qualitative schools of thought. We might say that a qualitative researcher will “never build her account directly, or only from quantitative data” (Parker, 1994b, p. 1) or that she is particularly “sensitive to the complexities of behaviour and meaning in context” (Henwood & Pidgeon, 1994, p. 227) or that she seeks “to understand what people do and think on a large scale by exploring individuals’ lived experiences” (Jaffée, Kling, Plant, Sloan, & Hyde, 1999, p. 423)

Although a number of qualitative approaches share an appreciation for an investigation of individuals’ lived experiences, qualitative perspectives that are influenced by phenomenology privilege those experiences as foundational. There is little concern for the ontological grounding of the subject; rather, the consciousness of the participants, and their status as “‘free agents’” (du Gay, Evans & Redman, 2000, p. 2), is presumed and goes largely unquestioned. The methods that arise from this perspective, then, are usually aimed at capturing those experiences; there is a sense that the interviewer will be able to identify something that is ‘authentic’ through the interview data.

In contrast, a postmodern or poststructuralist perspective looks carefully at the
ways in which language acts to constitute reality. Following Henwood and Pidgeon (1994), I took as a starting point for this project the notion that “representations of the world, and specifically linguistic representations (called discourses), do not merely reflect an objective reality, but reflexively construct both objects and subjects (p. 233). Dominant discourses work to enable and constrain what can be said and by whom. In my concern for language, I found that I gravitated time and time again to Foucauldian discourse analytic approaches that view language as beyond the control and intentions of the speaker or speakers. Following a perspective that Foucault outlines in the Discourse on Language (1971/1972), a discourse analytic approach emphasizes the disorderly and chaotic nature of language, the diversity of meanings, and “the different contradictory ways of speaking that govern what we do” (Parker, 1994a, p. 93). From this perspective, language is viewed as something that we can neither possess nor get behind, as something we can neither order nor encapsulate. An analysis of language from this perspective, then, looks to address “the ways in which language is so structured as to produce sets of meanings – discourses – that operate independently of the intentions of speakers, or writers” (Parker, 1994a, p. 92). It holds that meanings are not static and neither are the individuals who convey them. All of this has important implications for research as from this perspective none of us – researchers and participants alike – are ever in charge of the meanings that are produced.

In parallel to this, as this is a feminist project, I was concerned with investigating women’s experiences within a culture that often dismisses them, and I was concerned with investigating women’s bodies within a context that often problematizes them. As with the wide variation that exists between qualitative approaches, feminist research is
not a homogeneous category. Although “[q]ualitative methods…dovetail nicely with feminist research goals” (Jaffee et al., 1999, p. 424), not all feminist approaches are qualitative, and not all qualitative approaches are feminist.

According to Fine and Gordon (1995), feminist approaches share a consideration for the ways in which power asymmetries structure gender relations, the relationships between gender and other factors such as race, social class, disability status, age, and sexual orientation, the meanings of social experiences as women express them, and a consideration for the context in which those experiences occur (p. 3). Burman (1994) notes the ways in which feminist methodologies are outgrowths of specific philosophical perspectives. The first school of approaches, perhaps most widely known as ‘feminist empiricist’ approaches (or standpoint theory), is primarily considered with the ways in which research has excluded women, and the overarching goal of these types of research projects is simply to include more women. The second school of approaches, known broadly as the ‘feminist separatist’ approaches (or difference theory), emphasizes the differences between women’s experiences and dominant paradigms of knowledge. The third schools of approaches, known by various names including feminist relativism, feminist postmodernism, feminist poststructuralism, or feminist deconstructionism (Burman, 1994), in parallel to a discourse analytic approach, views language as constitutive and explicitly challenges the presumption of a stable identity, and it does so with specific regard for the ways in which gender is constructed. I see my project to be consonant with this third school of thought, and I place a strong emphasis on appropriating robust discursive perspectives for feminist aims.
In consonance with a consideration of the productive power of language in specific regard to the discursive construction of gender, I have been concerned with locating myself as a subject in this research. More traditional psychological perspectives – and even many qualitative perspectives – assert that ‘good’ research seeks to minimize the influence of the researcher, but from my perspective, attempts to do so merely serve to further obscure already existent power relations. I am positioned within a larger social field, and my status as a young, white, lesbian, psychologist-in-training is not an aside. Further, I hold a privileged position as researcher and am situated within a field of power relations that positions my self and my research as ‘legitimate’ and as having ‘access’ to particular ‘expert knowledges.’ My role as researcher, along with other aspects of my subjectivity, cannot be considered aside from the enabling and constraining aspects of discourses. As part of my method, then, I have included some elements of reflexive autoethnography as a way of keeping my subject position in the foreground (Ellis & Bochner, 2000).

Before the analysis

Because I had been wrestling with a number of theoretical and methodological concerns with regard to the project, after I transcribed the interviews the dissertation hit a bit of an impasse. I wasn’t sure what to do next. I had been eager to find participants, interview them, and get the interviews onto paper so that I could analyze the exchanges. But my method was only loosely structured at this point. I had an idea that I would be concerned with investigating the details of the conversations with an eye on both the larger context in which identity positions are constituted discursively and the specific
ways in which the ultrasound image and its interpretation positions women, fetuses, and doctors within particular roles. But I wasn’t sure how to further articulate this or where to begin with regard to the analysis.

I read more. Mostly about discourse analysis. I re-familiarized myself with different versions of discourse analytic method, noting the differences between discursive psychology and Foucauldian discourse analysis. At every turn, I felt drawn to the latter. Both discursive psychology and Foucauldian discourse analysis exist within a larger framework that challenges the notion that language can provide direct access to either an internal emotional state or an external reality. Language is viewed as productive in that it acts to construct both social realities and internal experiences. Discursive psychology and Foucauldian discourse analysis don’t exactly contradict one another in their basic assumptions; rather, the differences seem to be a result of where the emphasis is placed.¹⁰

Whereas discursive psychology emphasizes the constructedness of conceptual thought (Willig, 2003), Foucauldian discourse analysis emphasizes “the availability of discursive resources within a culture – something like a discursive economy – and its implications for those who live within it” (Willig, 2003, p. 171). From a Foucauldian perspective, the subject positions that are available within a particular sociohistorical period are constructed discursively. By extension, our very subjectivity – or identity – is constructed discursively. Following Foucault, this subjectivity is constructed within a particular field of power relations in which “[d]ominant discourses privilege those

¹⁰ Some discourse analysts, including Potter and Wetherell challenge the distinctions between discursive psychology and Foucauldian discourse analysis, and Wetherell has argued for a synthesis of the two (in Willig, 2003). However, following Burr (1995) and Willig (2003), I have found an articulation of the differences and similarities to be quite useful. That said, I encourage readers to bear in mind (in consonance with a critical perspective on language), that the differences between the two are, as always, constructed.
versions of social reality which legitimate existing power relations and social structures” (Willig, 2003, p. 171).

I revisited a chapter by Ian Parker called “Discourse Analysis” (1994a) in a book entitled, *Qualitative Methods in Psychology: A Research Guide*. In this chapter, Parker uses a Foucauldian form of discourse analysis to investigate the text on a tube of toothpaste, walking the reader step by step through each phase of the analysis. In arguing that language is held together by particular discourses, Parker (1994a) advocates an identification and naming of those discourses through a series of sequential steps including the following: “free associate to a text” (p. 97), “systematically itemize ‘objects’ that appear in this text” (p. 97), “refer to these ways of speaking as objects, our objects of study, the discourses” (p. 98), “systematically itemize the ‘subjects’ (the categories of person) who appear in this text” (p. 98), “reconstruct, as a device to explore differential rights to speak within discourse, what each type of person may say within the framework of rules presupposed in the text” (p. 98), “map the different versions of the social world which coexist in the text” (p. 99), and “choose an appropriate terminology to label the discourses” (p. 101). After reading through this chapter, I was fairly well convinced that an approximation of this method was the one that I wanted to use to analyze my own texts.

Completing the transcriptions of the interviews had allowed me to begin to notice nuances of my interactions with my participants and the ways in which our dialogue emerged with respect to our subject positions. By repeatedly reviewing the details of the exchanges, I had begun to notice the larger context (the discourses) in which our exchanges occurred. Although Parker outlines several steps to be completed prior to the
identification of the discourses, I found myself beginning to notice the larger discourses that held together the interview texts during the transcription stage. Preliminary discourses that jumped out at me during this stage included biomedical, psychological, rationalist, gendered, (hetero)sexual, familial/relational, religious, temporal, developmental, racial and visual. I jotted down these preliminary impressions and set them aside.

Parker (1994a) suggests free associating to the text after turning it into written form and then – in consideration of Foucault’s assertion that discourses form the objects of which they speak – systematically itemizing those ‘objects’ by looking for nouns in the text. I decided to reverse those two steps in the hopes that the identification of the nouns would serve to shake loose some associations.

I was somewhat concerned about this ‘itemization of objects,’ worrying that the act of locating all of the nouns in approximately eighty-five pages of text would result in mass confusion instead of more clarity. As well, I was concerned that pinning down certain parts of speech might truncate the fluidity of the texts. I wondered if it might be useful to apply Parker’s version of analysis only to sections of transcripts that were most relevant to my project, deciding preliminarily to focus my energy on only those sections of interview transcript in which participants and I discussed the ultrasound procedure specifically.

Shortly thereafter, I began the process of identifying the most relevant sections of transcript. I went through each transcript and marked sections in which each participant

---

11 It may be the case that the discourses began to emerge for me during this stage of “turn[ing] the text into written form” (Parker, 1994a, p. 96) because I had completed transcriptions of live interviews rather than analyzing a text that was already written. In the example that Parker gives in his chapter (1994a), the analyst would not need to spend much time dwelling with that text as it is already in written form.
and I discussed the ultrasound. In some cases, these sections were easily identifiable; there were many pages in each transcript during which we talked about the ultrasound directly. In other cases, either the participant or I would make a passing reference to the ultrasound or would engage in a brief exchange about some topic only peripherally related to ultrasound. One difficulty that became apparent was that the conversations were not linear, and therefore references to previous experiences were made within the context of different discussions altogether. Another difficulty that I encountered was that even sections of transcript in which the ultrasound was not even mentioned in passing were undeniably interesting and, I had a hunch, related, as throughout each of the texts we touched upon various aspects of identity and/or subject positions.

It did not take me long to realize that my attempts to isolate particular sections for the purpose of the analysis was not going to work, mostly because it contradicted so many aims of my project, and I abandoned it quickly. I was back to where I had started. And so, despite some reservations, I moved ahead with the identification of the nouns in the transcripts in their entirety. This movement required a double leap of faith which, in retrospect, is largely in consonance with, and serves as a kind of parallel process to, the overall aims of the project. First and foremost, I had to trust that isolating specific parts of speech might serve to shake loose some associations and thus might have a kind of productive power. Second, and no less important, I had to trust that my movements with regard to language would not be permanent. That is, I had to have faith in the notion that while all linguistic movements are productive, at no times are they irreversible.
Systematic itemization of objects

In identifying the nouns, I had to make a decision regarding which grammatical perspective I would follow. In middle school, I had learned to take as truth the idea that a noun is a ‘person, place, or thing,’ and that it is one of the eight major parts of speech, the others of which are verbs, pronouns, adverbs, adjectives, conjunctions, prepositions and interjections. I had not known at that time that the parts of speech are a source of much debate and that grammarians from different schools of thought view parts of the sentence differently. That is, I was unaware of the fact that I had learned grammar from a specific perspective called a traditional perspective.

Therefore, I had taken for granted the idea that a noun is always a noun, a verb is always a verb, etc. It wasn’t until I began trying to locate nouns in my transcripts that I began to see some problems with this. For example, in my interview with Heather, I was not sure what to do with her sentence, “I took three pregnancy tests” (line 47). It was obvious that ‘tests’ was a noun, but what about the word ‘pregnancy’? On its own it was a noun, but when preceding the words ‘tests’ it appeared to be acting as an adjective. Through moments like this one, I stumbled upon an entirely different perspective of grammar, a structural perspective, which views parts of speech in the context of the structure of the sentence.

At this point, I had to make a decision about which perspective I would take in identifying nouns. Although a structural perspective is ostensibly more in line with my own perspective in that parts of speech are examined with explicit consideration of the context, I decided to take a more traditional approach in identifying the nouns in the transcripts because I did not want to omit any nouns that happened to be acting as
adjectives at particular points in a sentence. I proceeded, then, to identify any word that could be classified as a noun irrespective of its location in the text but with an awareness of the ways in which it might be acting as a noun modifier. When I shined the spotlight on the nouns, I began to notice the sheer redundancy with which words are utilized. I began to bang up against the same words over and over again, and this process seemed to precipitate the shaking loose of a series of associations.

**Individual meaning units: Nouns and a whole lot more**

Identifying the nouns in the transcripts was useful insofar as it drew my attention to specific words, but I found as I moved through this part of the analysis that I was unhappy limiting myself to nouns alone. The bridge between the identification of the nouns and the completion of the free associations included a stage during which I jotted down my impressions of all kinds of words including, but not limited to, nouns. Some of the words that my participants and I used jumped out at me for their vagueness, others for their exactitude. I was particularly attuned to words that had a gendered quality or that were evocative of adherence to a norm. I noticed that some words implied a temporality, others were related to quantity, and others signaled a kind of danger. In the sections that follow, I have somewhat arbitrarily and very much subjectively grouped these words according to images that were conjured for me.

**Words by which we refer to the fetus**

Because this project is concerned with the development of subjectivity, I was particularly attuned to the words that my participants used in reference to the fetus. Not
surprisingly, all of my participants referred to the fetus as a **baby**. In contrast, I was cognizant of wanting to refer to the unborn child as a fetus rather than a baby in order to distinguish an unborn child from a very young child, in part because I wanted to challenge the idea that a fetus has a subjectivity that is equivalent to that of a baby, particularly in light of criminal cases in which fetuses have been at center stage in concern for legislation around abortion (Dorf, 2003). This was a political decision, and in moments during which I used the word fetus with participants, I felt quite self-conscious.

Emily used the term **gestational sac** to refer to the embryo during the sixth week of development. She noted, “I actually had an ultrasound in the sixth week, um, when it was not even a baby yet, just a gestational sac” (lines 169-171), implying that at this point in its development, the fetus is a baby now. At one point during our conversation, Heather used the word **child** to refer to the fetus (“I never really thought about at twelve weeks how formed that child is” (lines 804-5)) and said that “he was very much a little person,” adding to the advancement of the fetus as an independent entity.

**Words that serve to caution**

I was attuned to words – articulated by either myself or my participants – that indicated the presence or anticipation of some kind of difficulty, danger or failure. After discussing with Heather her disbelief about her pregnancy – and her hesitation to make a prenatal appointment – I asked Heather, “So when did you finally break down and go see somebody?” (lines 102-03). I am struck by my choice of the word **break down**, and have an immediate association to a breakdown as a kind of a failure (e.g., cars break
down and need to be fixed, people break down and need to see psychologists). Similarly, I used the word catastrophes (line 273) to inquire about Heather’s preparation for the pregnancy, which is an odd word choice on my part given that this was a planned pregnancy. Heather noted, “They warned me that it would probably be a little later (xxxx xxxx) I would feel the baby move because of the fibroids” (lines 1345-7).

Warning signals danger. Joanne also used the word warning, and she did so in reference to the fact that during an ultrasound for a previous pregnancy in which she’d had a miscarriage, the sonographer had not given her any verbal indication that something was wrong before telling her “your uterus is empty” (lines 529-30).

Words that imply an action that is foolish

Joanne noted that she and her husband wanted to make sure that they were informed about the risks to her and the fetus before making the decision for her to try to get pregnant, specifically noting that they wanted to make sure that they “weren’t just going off half-cocked and doing whatever” (line 213). Whatever the etiology of this colloquialism, there is the obvious reference to male genitalia which could be read as a masculinist assumption concerning the foolishness of committing to an undertaking without the benefit of a full phallus. Joanne made later reference to she and her husband as “two stupes” (line 636) because they were having difficulty identifying the fetus in the ultrasound picture.

Heather used the word ridiculous several times. She noted that a doctor thought that it was “ridiculous” (line 198) to use iodine for a strep throat, that thinking about plastic surgery was something that she considered to be “ridiculous” prior to pregnancy
(line 1425), and that having different rules for different sexes is “ridiculous” (line 1791). She told me that when she has suggested homeopathic remedies to doctors they have told her, “Nonsense, you need [something else]” (lines 2057-8). When we discussed her concerns about the health of the fetus, Heather noted that her mind “does all kinds of goofy things” (lines 1102-3).

Emily noted that her primary care physician was “sort of clueless” (line 964) initially about lesbian health care issues. She as well noted that after a period of time, and after which she suspected he’d participated in some training experiences in regard to lesbian health care, he began lecturing her about particular issues. She noted that she thought that this was “sort of funny” (line 979).

Official sounding words

Emily’s transcript is riddled with official sounding words, most notably in the section during which she described the insemination. She noted that she underwent various tests (line 67), completed “checklists, all of these lists” (line 85), and was required to track her “hormone levels” (line 103). She made reference to the Fertility Clinic (line 193) where she underwent a number of procedures. In a different section of the transcript, Emily noted the steps that she and her partner, April, were planning to undertake in order to ensure that April would be granted the status of legal parent. She noted that April had spoken with an attorney in regard to “guardianship papers” (line 216). In our discussion of the ultrasound, Emily and I repeat the word procedure five times in the span of a few seconds:

R: Uh-huh (.5). Okay, and um (.) so, how did you come to the decision to have an ultrasound?
P: Um, it was just part of their procedure
R: It was part of their procedure? Was it specific to (.) you because you had had some problems with cysts before?
P: No
R: (overlapping) Or no, it was just part of their procedure
P: (overlapping) I don’t thi-, I think it was just part of their procedure
R: (overlapping) in terms of artificial insemination
P: Or, I, I don’t know, I mean, it just se-, it seemed like it was part of their procedure for everyone that got pregnant there (lines 316-27)

Joanne as well used the word procedure (line 744) to describe the ultrasound. She noted, “I kind of knew what the procedure was, so it wasn’t too, I didn’t have a lot of expectations over it” (lines 744-6). When we were talking after the interview, she told me, “To me it wasn’t just a medical procedure. I guess it’s your first picture of your baby. It was very exciting that way.”

Words that denote a normative movement/response/action:

The word natural came up several times in the narratives. For Heather, it came up in regard to the process of conception (line 20), the pregnancy itself (line 1425) and the process of the birth (line 878). For Emily, the only time the word naturally came up was when she discussed her surprise at the progression of her and April’s plans to have a child. That is, she used it to identify something that she had not anticipated. She noted, “It just never occurred to us that was gonna, that would sort of naturally progress” (lines 706-7).

The word normal came up several times for Heather, in the context of her feelings about motherhood (“it’s kind of normal to me”(line 325-36)), the ways in which symptoms that are consistent with having fibroids are not dissimilar from experiences that would not indicate the presence of fibroids (“all kinds of things that could be blown off as normal” (lines 727-28)), in regard to a particular type of ultrasound that takes a
standard or average amount of time (“I think a normal ultrasound takes about twenty minutes” (lines 955-6)), in regard to her desire to return to her pre-pregnancy bodily state (“I want to be normal-sized again” (lines 1391-2)), in regard to her stomach returning to its pre-pregnancy size (“you hear things about your stomach never going back to normal” (lines 1414-5)), in regard to her concerns about sex following the birth (“I mean, you wonder, like, okay, is sex going to be normal after this” (lines 1455-6)), in regard to her feelings about her body and the impact of the changes to her body on her relationship with her boyfriend (“[Y]ou know, with the fibroids, I was big fast and grew out of my clothes quickly and so just not feeling normal has, has taken a certain amount of stress on the relationship” (lines 1619-1623)), and in regard to her sexuality/sexual attractiveness (lines 1926-7).

Joanne used the word normal as well to describe the process of conception (line 8), the preparations she and her husband were making for the baby (line 47), the assumption that people with spina bifida wouldn’t have children (“that’s just normal based on the culture and how it was” (lines 1281-2)), and to describe her feelings of anticipation with regard to the baby (“I’m a little nervous about all the normal stuff that all moms are nervous about” (lines 1361-2)).

Heather mentioned a regular M.D. in contrast to a homeopathic M.D. (line 197), and the word “regular” seems to have a function that’s similar to that of the words normal, natural, customary, usual, typical. It acts to position those things that aren’t “regular” as outside of a normative structure. Indeed, Joanne used the word to position herself as outside the norm when she noted, “I rarely go to the doctor any more than the regular person” (lines 1232-3), as though she herself is not a regular person.
Pronouns

When Joanne described to me her experience of her first ultrasound, she used second-person pronouns at several points. In response to my question about her experiences of the ultrasounds, she noted that although the experiences had been “great,” she’d been nervous because of her experience of an ultrasound that she’d had with a previous pregnancy in which she’d miscarried. She reported, “[T]hey’ve all been great, um, the first one was very nervewracking ‘cause you’re nervous” (lines 402-3). The use of a second-person pronoun to describe a first-person experience seems to serve several purposes. It presumes a commonality of experiences among people (perhaps a hope that others would have the same experience), and it deemphasizes the pain and anxiety around a particular experience. Joanne shifted to a first-person pronoun with the comment that followed: “I was very nervous ‘cause I had already had a miscarriage” (lines 403-4).

Temporal words or groups of words

Emily told me that she had a history of endometriosis, pointing to a record or pattern of experiences in the past. History is a word that is used often in medical settings (e.g., “Please get me that patient’s history”). A history, or past, is gathered for use in the future. In many cases, it predisposes a different kind of treatment. In fact, as Emily and I talked about the different tests that she’d had done – including the ultrasound at twelve weeks – I made the assumption that these were all related to her history of endometriosis. In fact, most of them were not.

There were several instances in which either Heather or I used the temporal phrase at this point (lines 106 (P), 668 (P), 1151-52 (P), 1284 (P), 1313 (P), 1356 (R),
1358 (P), 1430 (P), 1777 (P)) to indicate a specific juncture or moment in time. My association to the phrase is that it gives the impression that there is a way in which one can precisely pinpoint or fix a moment in time. I also have an association to a phrase that I have been trained to use when conducting intakes with individuals seeking therapy: “What made you decide to seek therapy at this point?” This has always made me somewhat uncomfortable because it seems to indicate that there is a way in which moments can be isolated and harnessed.

Nevertheless, I asked Emily about the moment that her expectations had shifted in regard to her decision to have a child. Similar to a point in time, a moment typically indicates a very discrete period of time; oftentimes people have difficulty pinpointing moments where a shift in their attitude occurs. However, Emily was clear that the birth of her niece was a “big part” (line 717) of her change in attitude about her own plans to have a child.

The repeated mention of months, dates, and holidays indicates a particular way in which our activities are structured, one in which we are at all times located with a reference to a past, present and future. In line 33, Heather mentioned that she and her boyfriend had decided that they would try to conceive in November. This is the first of a series of words in her narrative that denotes a temporal discourse. Throughout the interview, Heather mentioned specific months and dates. References to particular times of the year as marked by the Gregorian calendar conjure up different images of specific weather patterns, typical activities, and rituals which are largely dependent on the location (in time and geography) of the region. For example, November (in Pittsburgh, PA, USA) conjures up images of the beginning of the winter and preparations for
Thanksgiving, while January (line 66) conjures up images of the dead of winter and the collective hope that the Steelers will advance to the Superbowl.

Holidays in particular (because they exist both in our memories and in our future planning) structure our daily activities, either literally or in retrospect. Heather mentioned that she and her boyfriend first seriously considered the possibility that she might be pregnant after New Year’s (line 63). I wondered whether this indicated that she and her boyfriend were too busy with holiday responsibilities prior to New Year’s to take action, or if it was the case that New Year’s was the most logical marker by which Heather could convey a particular time period to me.

As with Heather and Emily, for Joanne (and for most pregnant women), time seemed to be divided up into weeks where major milestones are thought to occur at specific junctures despite the enormous individuality between women’s experiences. In my interview with Joanne, the word week(s) came up fifteen times (lines 342, 380, 381, 384, 394, 450, 647, 663, 665, 668, 769, 776, 780, 794, 795), mostly in reference to events (including ultrasounds) that had occurred at particular lengths of gestation.

Words related to quantity

Emily used the phrase a lot to quantify various tangible and intangible qualities or actions. In twenty-four instances, she used the word to describe things such as: the number of tests (lines 19, 28, 97) and ultrasounds (lines 33, 345) she’d had done; the number of problems she’d experienced (line 162); a particular quantity of: pain (line 273); confidence (line 318); fear (line 405); comfort (line 437); and, self-confidence (line 920); the demeanor of medical professionals (i.e., aggressive and conservative (lines 164-
tangibles such as friends (line 207) and legal work (line 211); factors related to time (lines 293, 614, 754, 812); how much she liked the doctor (line 203); and, how much her partner was interested in picking donor characteristics (line 52). I used the word twice myself, in reference to the amount of preparation that Emily had done (line 220) and in regard to the number of shifts that have occurred in recent years around general attitudes toward gays and lesbians (line 710). In almost every instance, the word is used to identify a large yet unspecified extent, amount, or number, and I was struck by the ways in which the repetitive use of particular words can lull one into the sense that their use depicts something accurate, even in the case in which their meaning is unspecified.

**Free Associating to the text**

After identifying the nouns and identifying specific words that lent themselves to rich associations, I moved onto the stage of analysis in which I completed more systematic free associations for each of my participants. I began with Emily because I felt her narrative to be particularly compelling; I believe that this stems at least in part from the fact that she identifies as a lesbian. Her experiences of confronting heterosexism in medical settings, and her descriptions concerning what it is like to live in this world as a woman with a nonnormative sexual orientation, resonated deeply with me. I followed this by writing down my associations to Joanne’s narrative, a narrative which was also compelling to me because Joanne also identified herself to be outside of a normative structure. Lastly, I completed my associations to Heather’s narrative. The free associations eventually gave way to an identification of specific subject categories and the discourses that constitute them. In this section, I include those free associations in
which I reflect on the moments of connection and disconnection, as well as moments of misunderstanding, that I experienced with each of my participants.

Emily

The inquiries that I made during my interview with Emily seemed to be strongly influenced by my positionality as a lesbian. This issue seems to be salient with regard to both the questions that I asked during the interview itself and my analysis of conversation. For example, when Emily told me that her decision to have a child was affected by the birth of her sister’s child, I immediately asked her, “Is this your sister who’s a lesbian?” In part, I believe I felt that this was important to ask as we had recently touched on the cultural shift in which it has become increasingly acceptable for openly gay and lesbian couples to parent children. In part. The other part is that I have a strong personal investment and interest in this, and my impetus to ask the question came from my own desire to know of lesbians who choose to have children.

As well, there were other experiences that Emily discussed with which I identified. Emily mentioned that prior to her becoming pregnant, she and her partner had made the decision to settle in Pittsburgh as they decided that it is a “good place to raise a family” (line 128). She told me that she and her partner had bought a house together previously and that recently they had bought a bigger house in a different school district. This kind of planning – with an emphasis on mobility and a consideration for house size and school district prior to the conception of a child – clearly betrays a class privilege. It resonates with me very strongly as I suspect that my partner, Jenny, and I will make such arrangements as well; indeed, we have already had conversations about these types of
issues. I felt connected to Emily in her concerns and feelings about plans for a child. I was also aware of the level of privilege that this kind of planning implies.

Perhaps because I felt such an investment in Emily’s experiences, the places in which we differed in our reactions to similar experiences felt jarring at times. For example, Emily noted that her partner, April, initially was not allowed to accompany her into the ultrasound room. In recounting this, Emily did not seem to be particularly angry about this. In contrast, I believe that this situation would have enraged me. I was also somewhat surprised when Emily reported that she had not put a lot of thought into the legal issues around securing her partner’s presence at the birth, as legal rights such as this one concern me a great deal.

There were other moments during the interview in which I felt waves of regret and self-consciousness, either for not pursuing a particular line of questioning or for taking the conversation in what seemed to be an irrelevant direction or for confusing information that Emily had already provided or for self-disclosing a piece of information about myself. For example, Emily commented, in the context of a discussion about the morning sickness that she’s experienced, that she was “really regretting that decision” (line 148-9) to carry a child. When she made this comment, she laughed, and I laughed along with her. She brought it up again with regard to my question about how much she’d done in preparation of becoming a mother (“I’ve been so sick, that’s been hard” (line 223)). In retrospect, I feel as though I colluded with Emily in her laughter, and I wish that I had pushed this issue more and questioned her about her feelings of regret.

I felt unsettled about the exchange in which I confused the number of siblings that Emily had with the number of siblings that her mom had:

R: Uh-huh, you’re one of eight, so
Specifically, I was worried that Emily would wonder if there were other places in which I had misheard her, and I believe that this worry arose from two places: my genuine concern for Emily’s feelings and my concern, as an interviewer, for the impact that this might have on Emily’s willingness to share information. In this moment, I was reminded of the conflict of interest around protecting our participants and getting what we want.

And, I felt very self-conscious during the exchange in which Emily described how she and her partner got a dog as a kind of dry run for parenting, and I interjected that Jenny and I had recently gotten a dog as well and had been thinking of it similarly:

P: No, I’m one of three
R: Oh, okay
P: My MOM is one of eight
R: Oh, your mom’s one of eight, okay (lines 723-27)

P: Um, but, ah (laughs) we actually got a DOG about a year and a half ago?
R: Um-hmm
P: and it was sort of like our experiment, you know
R: Um-hmm
P: to see, ah, how this is gonna work out
R: Uh-huh
P: and, um, so we’ve already been sort of MORE tied down than we were before
R: Uh-huh, uh-huh
P: you know (laughs) which is, I know nothing compared to a kid
R: Uh-huh
P: but it was sort of like our first step toward (.)
R: (overlapping) well, it’s funny
P: (overlapping) xxxx xxxx xxxx
R: that you say that because actually my partner and I just got a dog
P: Oh (laughs)
R: (laughs) about five weeks ago, yeah, and we’re like, “This is like a microcosm of like what it’s like
P: Yeah
R: maybe to have a child” because (. ) they’re not like cats
P: (laughs)
R: they need you (. ) to come home (laughs)
P: Right, exactly
R: Right (lines 825-50)
Reading through the transcript after the fact, my self-revelation seems to be both appropriate and benign, but at the time I felt extremely exposed. I had wanted to tell Emily about this experience as a way of joining with her, but I felt embarrassed to be taking up her interview time with my own stories. In part, I believe that my discomfort is around ‘breaking’ with my researcher role. I was also aware of feeling embarrassed about noting that dogs are “not like cats” (line 846) – which was a direct reference to my own experience as I have two cats – because of the stereotype that lesbians have cats. I worried that she would think that I was making an assumption that she had cats or knew about cats because she was a lesbian.

I continued to feel self-conscious when I commented to Emily, “Well, maybe tell me about the experience of parenting a dog” (line 853) as I was horrified to notice how tangential the question seemed to be, but I couldn’t seem to do anything about it. In retrospect, this detour gave way to some interesting comments about normality. For example, Emily discussed people’s perceptions of the legitimacy of her very small dog (“[S]ome people don’t consider him, like, a real dog” (line 864)), her tendency to obsess about something and then eventually “go back to normal” (line 875), her sense of wanting to train her dog by taking him to different classes before coming to the conclusion that “now he’s just sort of a normal dog and does normal dog things” (lines 877-8), and her sense of idealizing the dog initially before coming to the conclusion that “it was sort of a realization of like, you have, like, in your, in your mind, you have, like, the perfect dog that you’re going to have and then you have the reality which is not a perfect dog” (lines 890-5).
Joanne

I liked Joanne immediately and felt particularly connected to her in her experiences of feeling marginalized as a woman with a physical disability. At the same time, I knew almost nothing about spina bifida going into the interview, and there were moments during which I felt self-conscious about the gaps in my knowledge. My experiences (of Joanne and of the interview) vacillated the most during this interview in comparison with the others. There were moments in which I felt connected with Joanne, and there were moments that felt quite tender to me. I also had some moments of feeling guarded against Joanne. As with the other interviews, I noted moments of misunderstanding in which Joanne and I seemed to miss one another.

I felt confused during a conversation that we had about folic acid. Prior to the interview, I knew that women who plan to get pregnant are advised to take folic acid as there is evidence that it is preventative of neural tube defects, but I wasn’t clear in my conversation with Joanne if she herself was prescribed folic acid because of her own neural tube defect or solely for preventative purposes in regard to the fetus:

R: Okay (.4) And, um, did you plan to become pregnant?
P: Yes we did
R: And did you do anything in preparation of that?
P: Um, I was actually on prescription strength folic acid because I have a neural tube defect
R: Uh-huh
P: so I had to take, ah, extra, um, folic acid ‘cause it’s, it’s a preventive tool for neural tube defects, eh, but you have to be ON it when you get pregnant
R: (overlapping) Uh-huh
P: so I was on that and um
R: so you were on that (. ) prior anyhow?
P: Ye, well, as soon as we decided we wanted to try to get pregnant, the
R: (overlapping) Uh-huh
P: doctor put me on it
R: Okay (lines 10-26)
I hesitated to clarify my confusion, and I suspect that this is because I was afraid to show my ignorance in regard to neural tube defects. I felt stuck in this moment because I didn’t want to ask Joanne to ‘educate’ me about this matter, and I also didn’t want to show my ignorance. This seems to be one example of how conversations can get closed off. This is a case where I, as an able-bodied person, occupy a normative category, and felt embarrassed by my lack of knowledge, and, prior to the conversation, my lack of even knowing that I lacked knowledge. In another moment, I fought this stuckness and attempted to open up a conversation about how Joanne’s disability has impacted her pregnancy by noting, “I don’t know much about [spina bifida]” (line 123). This felt moderately successful, and I think it did open up the conversation a bit, but I felt self-conscious in this moment for presuming that it was Joanne’s responsibility to educate me.

Joanne was the oldest of my participants, and this may have contributed to my sense of feeling young and inadequate in moments. I felt very young, informal, and somewhat unprofessional in the moment that I responded, “Cool” (line 346) to Joanne’s description of the ways in which her group of doctors meets once a week to share information about patients. I was relieved when, later in the interview, Joanne remarked in regard to the ultrasound, “it was really cool ‘cause she showed us every little thing” (lines 489-90).

After I transcribed the interview, I noticed a moment in which I believe I had misunderstood Joanne. When I initially reviewed Joanne’s comment about the surprise of the sex of the fetus in which she said, “either way, whether you find out early or you find out when you have it, it’s still a surprise, either way” (lines 714-6), I thought that she
meant that regardless of any knowledge of the sex, the individual person would be a surprise. I reflected that this was a thoughtful comment that challenges the idea that knowledge of the sex can provide access to some knowledge about the subjectivity of the fetus. But then, in further reflecting on it, I think that what she meant by this comment was that the surprise (of having either a boy or a girl) either comes during the pregnancy or during the birth and that once the sex has been revealed the surprise is over.

Joanne cut me off several times during the interview and this annoyed me somewhat. This occurred during the following exchange:

R: Uh-huh, Is there anything that (. ) the doctors could have done differently to prepare you for the?
P: (overlapping) I don’t think so
R: (overlapping) experience? No
P: No
R: No (lines 747-52)

It is probably difficult to tell from the transcript on its own (it is easier to hear on the tape), but this was one of several times that I felt that I wasn’t able to fully ask my question because Joanne began providing an answer halfway through. I had moments of wondering whether Joanne even understood an entire question. In later exchanges, it appeared by her answers and other comments she provided that she did.

My heart sunk when Joanne commented, “we’re conservative” (line 1029) and went even deeper when she remarked, “we’re very religious” (line 1031). I not only felt uncomfortable in that I’d come out to her (and most likely would not have done so if I’d known that she was a religious conservative), I also felt scared. In the presence of religious conservatives, I have the experience of feeling targeted and vulnerable and hated, and it is only in retrospect that I can recognize how intense this fear was. At the time, I was more in touch with the ways in which I felt compassion toward Joanne,
particularly in what seemed to be her sincere hopes for her child to be good to people (line 1044), care for others (line 1045), be well-adjusted (line 1053), be hopeful about her future (line 1051), and be able to make decisions (line 1052).

It was following Joanne’s comment that she was conservative that we had a conversation about how difficult it is to find a competent and compassionate physician as someone who occupies a minority position, and this felt very tender to me:

P: I’m glad that I was able to find somebody (.) pretty quick, and my pri-, and like, my primary care was just an accident, he, I wasn’t looking for anyone who had worked with women with disabilities, so
R: Um-hmm
P: he was just a (. ) he was just a great doctor (laughs) so and
R: Just lucked out on that (laughs)
P: (overlapping) Yeah, I did, I did (laughs) kind of did
R: (overlapping) happens sometimes (lines 1245-53)

That we were able to continue maintain a connection even after identifying at seemingly opposite ends of the political spectrum (i.e., religious conservative and lesbian) assuaged my concerns somewhat.

Heather

Of the three women that I interviewed, Heather was perhaps the most outspoken in regard to her negative experiences of – and resistance to – mainstream medical care. In many ways, she showed the most nuanced appreciation for the ways in which individuals (and women in particular) are mistreated by the medical profession. This was a thread that ran through the interview; we touched upon it in regard to several of Heather’s experiences, including her decision to use a group of midwives to follow her pregnancy as an alternative to mainstream medical care.
As with the other interviews, my feelings shifted during my interview with Heather, and I experienced vacillating moments of closeness, distance, confusion, and frustration. In moments, there are ways in which my subjective stance is exposed in the questions that I ask. In the following exchange, Heather articulated for me the ways in which her experiences of physicians have been negative. She attributed this in part to the fact that she has found that physicians have been dismissive of her experiences of her body:

P: (.) and just had very negative experiences all around, like, ya-
ya-you know, I’ve lived with my body my entire life, if I tell you something is hurting and WHY it’s hurting
R: Um-hmm
P: At least LISTen to me
R: Um-hmm
P: don’t totally dismiss it and that’s what I was running into-(lines 130-134)

I felt very connected to Heather as she recounted how she had been sent home by a physician who did not believe that she had strep throat. I had a similar experience when I was an undergraduate and had diagnosed myself with an ear infection on the basis of how it felt to me (the same as any other semi-annual ear infection I’d had during the first eighteen years of my life). I remember distinctly the nurse’s irritation and condescension at my presumption that I would know not only what was wrong with my body (an ear infection), but also what kind of treatment I should receive (Amoxicillin).

Because of my own critical perspective on mainstream medical care, I felt very open to hearing about Heather’s decision to look into midwives. In particular, I felt joined with her as she discussed a perspective on health care that shows an appreciation for the experiences of the individual (lines 209-39), a perspective which stands in stark contrast to a blanket approach to women’s health care (i.e., everyone should give birth in
a hospital, HRT is appropriate for all women, C-sections should be mandated for women who have had them previously rather than allowing the option of a vaginal birth) that is being prescribed by large and bureaucratic managed care companies and which is looming particularly large right now with the George W. Bush administration.

I wondered at several points during the interview if Heather’s decision not to marry her boyfriend might also be an act of resistance. I perceived this decision as a choice given that Heather is a highly educated, Caucasian, heterosexual woman with a planned pregnancy, but I never asked her about it directly because I didn’t want to make a normative assumption about her marital status (that is, I didn’t want to ask her, “Why aren’t you married?” because asking such a question would presume that marriage was the expectation). Upon reflection, I realized that my decision not to ask the question did not protect me from my racist, classist, and heterosexist assumptions after all. On the contrary, they seem to be more apparent than ever. As I write this section of the analysis, I find myself making the slip over and over again (I have done this at least ten times) of typing the word “husband” in place of “boyfriend” and then correcting it. I don’t imagine that I would make this slip if Heather was an adolescent, African American woman with an unplanned pregnancy. There’s a certain level of legitimacy that Heather demands based on her race, her age, and her educational status. Her status as unmarried and pregnant positions her on the margins of legitimacy, and my slip seems to be my unconscious effort to pull her back into the legitimate space in which I feel she belongs on the basis of the other categories that she occupies.

There were some moments during which my subjective stance seems apparent in the interview questions that I posed. For example, in line 399, following Heather’s
discussion of beginning law school just prior to her due date, I asked her, “[H]ow’s that gonna go?” I was aware during the interview of the ways in which this resonated with my own contemplations of (and anxiety around) balancing a career and children.

I felt some distance from Heather at several points during the interview. I’m not sure that this is a negative thing, but it did mark a shift. That is, in moments in which I felt more connected to Heather around similar experiences that I perceived that we’d had, I felt that the two of us were joined in some way against a more powerful force. At other times, I became aware of my role as researcher/psychologist-in-training (and my own place within that larger power structure). This happened during moments in which I found myself to be critical of some of Heather’s comments. For example: she informed me that she had been told by a doctor that she had a “listening problem” and not a “hearing problem” as had been previously diagnosed (lines 168-69), and I found myself wondering (as a psychologist-in-training) if this might be true; she told me that if you put iodine on a strep throat it will cure it in about a day (lines 186-93), and I found myself wondering (as someone who receives mainstream medical care) if this really is helpful; she described how she does an annual fast to clean out her body (lines 248-58), and I immediately perceived the possibility (again, as a psychologist-in-training) of this behavior to be eating-disorder related.

I felt some moments of frustration with Heather, particularly in regard to her level of denial at being pregnant. In fact, it irritated me that Heather was so surprised to be pregnant given that she and her boyfriend had been trying to get pregnant and given that she’d had both physical (e.g., missing her period, gaining weight) and technological (e.g., three positive pregnancy tests) clues of a pregnancy. I first noticed my irritation at the
point during the interview at which I asked Heather about whether she’d had other experiences of being similarly surprised (lines 261-66).

In contrast to this, I felt some tenderness for Heather, particularly as she was describing her feelings about her child being born. Heather said, “[T]he idea of him actually coming out of me and leaving being that close is upsetting to me” (lines 1749-52). As she told this to me, it was apparent that she had strong feelings about it as her eyes became teary and her voice became quieter.

There were moments in which it is unclear to me, in retrospect, if Heather and I were talking about the same thing or if I misperceived her statements. One of those moments happened around our discussion of birth control (lines 278-82). I perceived Heather’s statement of “I KNOW (laughs) I’m using birth control” (line 281) to mean that she was vigilant about her use of birth control when she was trying to avoid a pregnancy, but when I read through the transcript, I realized that I’m not entirely sure that that was the meaning that she had intended. Another moment of confusion occurred when I tried to clarify Heather’s skepticism with regard to her pregnancy. She told me, “I’ll plan to avoid something I guess is the answer to that, but not to DO something” (lines 301-03). I didn’t understand what she meant then, and I don’t understand it now.

We had another moment of confusion during our discussion of gender roles. I had asked Heather about her ideas or concerns about raising a boy in contrast to raising a girl. I was trying to get at her ideas about normative gender, and was wondering whether she had thoughts about how she would either challenge gender roles (e.g., encouraging a recognition of sexism, etc.) or accept them. She responded, “At this point I think things are pretty equal” (lines 177-8). I understood this to mean that she thought that sexism
had been eradicated, but when I listened to and transcribed the conversation afterwards –
and listened more carefully to her comments about children being punished or given
privileges on the basis of individual behavior – I realized that it may have been the case
that Heather thought that I was implying that children should be treated differently.

The central purpose of the identification of objects and a reflection of the “chains
of connotations” (Parker, 1994a, p. 97) raised in the free associations is to make way for
the identification of discourses. It is important to remind ourselves of that at this point in
particular as we are at risk of misplacing the overarching lens of the analysis within the
minutia of linguistic detail. Parker recommends that an itemization of subjects and a
reflection on the rights and responsibilities of those subjects be completed prior to the
identification of discourses, and in the next section I will identify the central subjects of
the analysis and reflect on the movements that they exhibit.
Positioning, as we will use it, is the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines. There can be interactive positioning in which one person positions another. And there can be reflective positioning in which one positions oneself. However it would be a mistake to assume that, in either case, positioning is necessarily intentional. One lives one’s life in terms of one’s ongoingly produced self, whoever might be responsible for its production. (Davies and Harré, 1990, p. 48)

I am identified by various markers of difference. I am a lesbian, a doctoral student, a white woman, an American. I am a sister, an aunt, a partner, a daughter. These markers position me as a person with a racial and sexual and gender identity, with a professional identity, with a national identity, with relational identities. These are markers by which others have referred to me and by which I refer to myself. As I have said before and will say again, these markers not only describe but construct my subjectivity and my very personhood. They allow the possibility of my very existence.

Markers of difference exist within a discursive economy, within a system of linguistic practices that is specific to a particular sociohistorical and sociocultural period (Foucault, 1971/1972). We don’t often notice them but rather take for granted our categories of personhood as natural or normal. It is only when we begin to examine the ways in which these categories hang together within the context of a larger framework – one which permits certain ways of being and disallows others – that we can begin to
expose those categories as constructions and are able to create the possibility of something different.

We have perhaps arrived at the most important part of the project, the moment at which we examine explicitly the following: our subject categories; the movements that we are allowed/not allowed to make within the confines of those subject categories, i.e., the rights and responsibilities that accompany those subject categories; and, the discourses that work to create and sustain the legitimacy/illegitimacy of those movements. This brings us closer to the possibility of saying something meaningful about the larger discursive structure in which our identities come into being and in which the technology of pregnancy ultrasound is situated.

We reside within the confines of a discursive economy in which specific groups of people are permitted to do some things and expected to do others, while other groups of people face entirely different sets of expectations altogether. One of the most salient examples of this is gender, and the cultural expectations placed upon individuals who find themselves members of the category we call ‘women’ differ greatly from the expectations placed upon individuals who find themselves members of the category we call ‘men.’ This idea is neither novel nor radical; it has been asserted and re-asserted in feminist literature (perhaps most notably in postmodernist feminist literature in which the linguistic positioning of men and women as ‘having’ particular qualities or attributes has been explicitly challenged as constitutive of those attributes (Butler, 1992, 1993, 1999)); moreover, our cultural fantasy of two dichotomous sexes has itself been torn apart by feminists, biologists, historians, and cultural theorists (Fausto-Sterling, 2000; Nestle, Howell, & Wilchins, 2002).
Despite those efforts, in the name of the normalcy of two dichotomous sexes it is common practice to surgically alter the genitals of infants born with external genitalia that are smaller (penises) or larger (clitorises) than “normal” in an effort to normalize them. In the manner of scientific precision, there are charts – with measurements down to the centimeter – for determining appropriate genital lengths. The practice of surgically altering genitally ambiguous neonates and fitting them into one of two acceptable boxes gained widespread medical acceptance after a twin study by a renowned Johns Hopkins physician seemingly “proved” that a healthy baby boy could be successfully reared as a girl. The findings of the study have subsequently been refuted (Diamond, 1997), and David Reimer, whose “success story” was chronicled in a series of articles by John Money and who eventually went public with his ordeal (Colapinto, 2000), suicided in May of 2004 after years of painful, invasive and unethical medical and psychological “research.”12 The presence of transgendered and intersexed individuals perhaps highlights the inadequacy of our binary gender system most explicitly, but it is my contention that all of us – even those of us who feel that we are in possession of a static gender identity – are constrained by a rigid system in which our very existence is predicated upon our identification with one sex or the other (Butler, 1993, 1999).

There are so many examples of the ways in which the expectation of normative gender identity is communicated that I hesitate to spend much time on this at all; I am confident that the reader can conjure up several examples on the spot from her or his own life of either experiencing first-hand, or bearing witness to, the pressures and expectations that are associated with being either male or female. Because normative gender identity

12 Butler (2004) writes, “It is difficult to know what, in the end, made life unlivable or why this life was one he felt was time to end…It is unclear whether it was his gender that was the problem, or the ‘treatment’ that brought about an enduring suffering for him” (p.74).
functions at the level of a fantasy, none of us can measure up to the standards of our assigned gender all the time (or perhaps ever). Some of us – those of us who find ourselves sitting on the margins of masculinity or femininity more often than not – feel this pressure more than others. For myself, I have innumerable memories of not quite fitting into my assigned role. I clearly remember being disappointed at a first-grade birthday party when I found out that all of the boys had received matchbox cars and all of the girls had received Barbies in their goody bags; I distinctly recall being ostracized from my third grade class because I had dared to speak a shocking truth: my favorite colors were blue and orange (not pink and purple, as was the case with the other girls); and, I remember feeling quite caught out when I wanted a paper route in the fifth grade and my mother’s initial response was that “those are for boys.”

These examples illustrate both my discomfort and the discomfort of those around me with the movements that I made which served to transgress my assigned role. As a girl, I was expected to prefer girl things such as pink and purple and Barbie. As a girl, these were my responsibilities, and I often did not meet them. Importantly, as a girl, I was also allowed to do other activities that were discouraged for boys; for example, I loved playing Cabbage Patch dolls and singing to the soundtrack of Annie, both of which were activities that people in my life seemed to feel were consistent with my role. As a girl, these were my rights, and I was able to take advantage of them.

I have started with gender and some examples of the ways in which our existence as male or female demands a dance with normative expectations, but our existence is also marked by various other categories that have their own sets of normative expectations. We are marked with a racial, cultural, sexual, and class identity; we are marked as having
specific and particular relational identities (e.g., mother, father, brother, sister, wife, husband, aunt, uncle); we are marked as having specific and particular professional identities (e.g., teacher, student, doctor, lawyer, mechanic, drug-store clerk).

These categories are constructed by the rights and responsibilities that are associated with them. The movements we are allowed to make within the confines of a particular category – the normative movements – are specific to our sociohistorical and sociocultural context. We don’t think about these norms very often – in fact they become rather invisible – not because they don’t exist or because there are relatively few movements associated with categories of personhood or even because they are subtle, but because so many of us spend such an inordinate amount of time performing behaviors that are consistent with our roles that we lose sight of the ways in which those movements exist within a larger structure of rigid expectations and constraints. It is only when we begin to look explicitly at those movements that we can start to get a sense of how often they occur, how infrequently they are investigated, and how difficult they are to transgress.

My new wallpaper: Locating central subjects

After completing the free associations, I set out to identify the subjects – the persons and categories of persons – in the transcripts. I approached this by going through each of the transcripts individually and identifying all references made by either the participant or me to all subjects (e.g., April, Dr. Medeiros) and subject categories (e.g., mother, sister). I did this by first sitting with the list of nouns from Heather’s transcript and highlighting in green marker any subjects or subject categories. I then transferred the
results of this search – in large, bold letters – to my wall-sized post-it notes. At the initial identification of a subject or subject category, I added it to the list and noted the line number on which it appeared; for each subsequent reference, I simply noted the line number next to the subject category. I found forty-one subjects in Heather’s transcript. I repeated this process with Emily’s transcript (red) and Joanne’s transcript (purple), tallying thirty-five and twenty-six subjects, respectively.

At the completion of this step, I had created six post-it notes with words such as “girl, doctor, father, lesbian, cousins, twins, patient, sonographer, specialist, child, homeopath, woman, man, girlfriend, physician” written on them. My office is small, and it was as though the subjects of the analysis truly surrounded me. The list of subjects for each participant is included in Appendix D. Subjects are in the order in which they first appeared in the transcript. Numbers that follow categories of subjects indicate the line of the transcript on which the reference appears. Except in cases in which references were made to subject categories in plural tense only, the subjects are listed in singular tense, although references in the transcripts might be in either singular or plural. In my list of subjects, I included references to any subject categories made by either the participant or me, even if they did not refer to an actual person (e.g., “he acts like a grandmother”), because all references point to a category of persons, whether metaphorical or literal.

Following the identification of all of the subjects and subject categories in each of the transcripts, I narrowed down the list to the subject categories that were most salient to my project, thinking of them as the central subjects. During this step, I sought to identify the main subjects that are involved in ultrasound technology, including the pregnant woman, her partner or husband or boyfriend, the doctor or medical professional, the
sonographer, and the fetus. This process was more difficult than I had initially anticipated, as I was already beginning to notice the problematic nature of identifying discrete categories of personhood. In Emily’s interview, the pregnant woman is not just a pregnant woman, she is also a lesbian; however, all lesbians referenced in the transcript are not pregnant. In Joanne’s transcript, the pregnant woman is a pregnant woman with a disability.\textsuperscript{13} In all of the transcripts, the categories of mother and woman overlapped in moments, as did mother and wife. This ‘problem,’ however much it complicated the analysis, is not really a problem after all as it forces a recognition of the idea that categories of identity are never discrete. In addition to overlapping and diverging from one another in moments, they exist in as much as they imply and are implied by one another.

Somewhat unsatisfactorily, then, and with increasing awareness about the attention that must be paid to the overlap between categories, I identified a list of the following central subjects. They are included below with notes regarding the transcripts in which they appeared:

- Woman (all transcripts)
- Mother/Wife (all transcripts)
- Partner/Mother (Emily)
- In pregnancy and during the ultrasound (all transcripts)
- Man (all transcripts)
- Boyfriend/Father (Heather)
- Husband/Father (Joanne)

\textsuperscript{13} This observation highlights a number of invisible norms (in this case, specifically, an invisible heterosexual norm and an invisible able-bodied norm) where facets of identity (e.g., race, sexual orientation, able-bodied status) are assumed to accompany other things unless articulated otherwise.
Medical professional

Doctor (all transcripts)

Sonographer (all transcripts)

Midwife (Heather)

The fetal image (all transcripts)

Researcher (all transcripts)

Following the identification of the central subjects, I set out to identify the rights and responsibilities associated with each of these categories.

Dancing with norms: Identifying rights and responsibilities

After deciding which categories of subjects seemed to be most central to the project, I next faced the task of going through each of the texts and identifying the rights (what is allowed) and responsibilities (what is expected)\(^\text{14}\) of the subjects central to the analysis. Following Parker (1994a), I decided that the rights and responsibilities of categories of subjects could be most clearly investigated through an examination of specific movements on the parts of those subjects in the context of the texts. I decided to go ahead and identify all of the actions – what people actually did – of particular subjects. I decided that I would include each and every movement, both those that seemed to be consistent with the expectations of identification with a particular category as well as those that seemed to transgress them. I made the decision to include the most subtle and

\(^{14}\) By rights and responsibilities, I mean those expectations that we have for ourselves – as well as those that others have for us – within the context of social norms. That is, rights and responsibilities refer to socially sanctioned movements, while resistant movements or countermovements refer to those movements that serve to challenge normative expectations.
banal of movements with the belief that even the most seemingly inconsequential movements point to a larger discursive structure. These movements are included in Appendix E.

The process of identifying the specific movements of categories of subjects in the transcripts involved an entry into a strange world in which a flashlight was shone on even the smallest of movements and in which I ostensibly became privy to a kind of knowledge to which others did not seem to have access. As with the identification of subjects, I decided that I wanted to be able to see these movements, to have them surround me as I had done with the subject categories, and this stage of the analysis found me again at my oversized post-it notes. When I had finished locating all of the movements of all of the central subjects, I had filled eleven post-it notes with tiny print.

To me, the view of what I was doing was (relatively) straightforward, but friends who saw my office at this stage gave consistent feedback: “This is bizarre.” “How can you possibly decipher any of this?” “What does it mean?” Jenny was baffled by the strange conglomerate of tiny print and numbers, underlines and parenthetical symbols, and asked how I was making sense of the information. I explained that the post-it notes were clear to me because I had spent so much time with each of the transcripts (at least thirteen read-throughs apiece) and felt very familiar with them; I took several minutes to show her my interpretation of the words, pointing out the various subject categories, their movements, and my system for identifying the line numbers on which those movements were articulated.

An interesting insight emerged from this. The process of interpreting an indecipherable – in fact, quite blurry – visual to others seemed to parallel the process of
the expert interpretation of the ultrasound image. There I was, the expert (researcher/doctor), removing what was internal (words/image) and abstracting it for external scrutiny, placing it in flat image (wall/screen), zooming in and out, dissecting and diagnosing parts and pieces, quantifying measurements (counting nouns and subjects/taking fetal bone lengths) in order to place them into a text (dissertation/report) without ever asking these women (research participants/patients) their opinions of my reading.

The process of identifying the rights and responsibilities of subject categories was not without difficulty, and a number of problems emerged as I worked through this stage. Some of these problems I was able to resolve. Others, I was not, and the unresolved problems will remain an uncomfortable background dissonance for the rest of the project. It is my belief that the problems that emerged should not be dismissed or considered to be limitations of the work, but instead should serve to highlight some of the complexities involved.

Prior to this stage, guided by Parker’s method (1994a), I had identified the nouns, the objects of our discourses. During this stage, where I was looking to identify the movements, I decided to prioritize verbs as they most directly denote some activity on the part of someone or -thing. In thinking about these movements, I had implicitly settled on an identification of active verbs, those verbs that describe the very noticeable movements made by people and categories of people. For example, doctors perform tests, administer checklists, give instructions, examine patients, etc. Lesbians in the midst of the insemination process monitor their cycles by checking their morning urine, schedule doctor’s appointments, consider state laws with regard to second-parent adoption, etc.
The first problem that arose: I knew that I wanted to identify movements in the broadest sense of the word, but I quickly ran into the unanticipated problem of identifying what exactly would count as a movement: Would a feeling count? Would a thought? What about an attitude? Would the articulation of something that is not done count as a movement? Should there be any delineation between movements typically considered to be passive (i.e., listening) and those considered to be active (i.e., walking)? And, what about the problem of accounting for all of the movements that were implied by the movements which were directly articulated?

Part of what I was bumping up against was the distinction between active, passive, and linking verbs. In common grammatical parlance, active verbs are used to describe the performance of an action by a subject, passive verbs are used to describe some action being performed on the subject, and linking verbs are used to describe a state of being (Jerz, 2004). Predictably, I was not satisfied with the idea that subjects are ever static, even when it seems as though a state of being is simply being described. With respect for the idea that “[a]ll language, even language which passes as simple description, is constructive and consequential for the discourse analyst” (Potter & Wetherell, 1987, p. 34), I settled on the broadest definition of ‘movements,’ allowing for the inclusion of descriptive statements with the notion that a description of one’s state of being must be considered to be a movement if we take seriously the notion that language is constitutive.

A second dilemma that I encountered was a problem of temporality. When I initially approached the interview narratives, I anticipated – incorrectly – that my participants’ stories would unfold in a chronological manner, at least with regard to their
responses to specific questions or their telling of specific events. What I found instead
was that my participants’ narratives jumped from past to present to future, and they
seemed to be held together by experiences that shared similar characteristics rather than
by moments in time. I found myself growing frustrated as I grappled with participants’
propensity to interject experiences that were out of time with the narratives that they were
recounting.

For example, when I asked Emily about what she had done in preparation of
becoming a mother, she noted that she and her partner had bought a different house in a
different school district, had read books, and had socialized with friends who had
attended meetings for lesbian parents (lines 200-208). She then noted, “[W]e have a lot
of legal work to do which we haven’t started yet but, well, actually we have because
April’s already talked to the attorney” (lines 210-213). Within this excerpt, Emily
switched from a past tense to a future one and then back to a past again. In another
example, Heather recounted an experience in which she had a case of strep throat which
got undiagnosed by a doctor who wouldn’t take her symptoms seriously (lines 146-
199). In addition to changing tenses several times, in the middle of this narrative she
briefly recounted her experience of being told that she has a listening problem (lines 164-
173). As I scrutinized each of these excerpts and others, I found myself feeling
increasingly self-conscious about the disjointed quality of the individual movements that
I identified, and I worried that this would be perceived as a limitation of my ability to
solicit a cohesive narrative, of my participants’ ability to recount one, or of my method of
analysis.
Upon reflection, it seems as though the disjointed quality of the narratives is neither a reflection of limitations of my interview structure nor of the ability of my participants to tell their stories nor of my methodological decision to focus on the specific movements within the narrative. If anything, it draws attention to the fictive quality of a cohesive narrative. During this stage in which the temporal became a ‘problem,’ my initial attunement to temporality (including the words we use that act to confine us to particular locations, see pp. 79-81) became clearer. It became apparent to me that my perturbation with the disjointed quality of the interview narratives betrayed my own investment in a rational, cohesive and chronological narrative that does not actually exist. Following Ricoeur’s (1983) assertion that “time becomes human to the extent that it is articulated through a narrative mode, and narrative attains its full meaning when it becomes a condition of temporal existence” (p. 52, emphasis original), I began to see the ways in which so much of what we take for granted as fact – including the generally unquestioned factuality of temporality – is mediated in the telling. Importantly for this project, the oft-unexamined relationship between time and narrative in psychology (Ricoeur notwithstanding) points to a kind of factualism, a privileging of a narrative apart from an examination of the ways in which it has been constructed. Thus, the ‘resolution’ to this problem came in the form of tolerating the disjoined nature of the narratives with an increasing awareness of how uncomfortable this feels.

The third problem, to which I’ve already alluded, concerned my continued awareness of the ways in which categories blur into one another and overlap. Certain categories just cannot get away from other categories. The category ‘woman’ implies the category ‘mother’ and the category ‘wife.’ Movements made by ‘women,’ then, are
inexorably linked to movements made by mothers and movements made by wives.

Isolating the movements made by particular subjects (e.g., ‘women’) is impossible as one’s identity is never one thing or another, but is always predicated upon other identities. This doesn’t mean that we can’t look for the movements associated with specific categories of identity (e.g., ‘mother’), it just means that to do so without recognizing the interconnectedness of these categories would be gravely incomplete. For now, I will suspend a more complete discussion of this issue in order to examine specific movements associated with specific categories. I will return to these issues in the Discussion section.

**Woman**

Identifying the rights and responsibilities attributed to members of the category “woman” is complicated in a cultural context in which we move through the world within the confines of a binary model in which gender is a fundamental piece of one’s personhood. For individuals who are identified or who identify as women, all movements are movements made as women. This realization initially made me nauseous, for how could I possibly make manageable any discussion of the rights and responsibilities attributed to women? After some initial panic, I realized that one way to do this is to focus on the movements that are most explicitly identified as gendered, and I will do so in this section. In the interviews, these movements most often were articulated to be in contrast to the movements allowed by individuals who reside within the confines of the category men, and I will discuss this below.
I asked each of my participants the question, “Do you consider yourself to be a woman?” in order to initiate a more explicit conversation about the rights and responsibilities attributed to people on the basis of their gender. Each of my participants answered quickly and affirmatively, and in each interview I followed this question with “Could you say why?” Heather stated immediately that she considers herself to be a woman on the basis of the body parts that she possesses (“I have all the parts that make me a girl” (lines 1908-10)) as did Emily (“I have all, you know, all the physical parts of a woman” (lines 524-5)).

Joanne, after noting, “that’s a hard question” (line 859) and “there’s so much involved in that” (lines 859-60), identified a number of movements to confirm her existence as a woman, including being a girly-girl (line 862), liking a lot of girly stuff (line 862), being “flowers and bows” (line 863), and being nurturing and enjoying taking care of things and people (lines 864-6). She specifically identified this nurturing behavior as a “female” or “womanly kind of thing” (lines 868-9).

Heather and Emily each brought up the word “feminine” shortly after identifying with feeling like a woman. Both articulated a complex relationship to femininity, including a simultaneous desire to identify with and disassociate from the term. Two comments that were made included, “[I]nternally, I feel pretty feminine” (line 547) and, “I don’t think of myself as feminine” (line 547), comments which may seem unremarkable at first but become more interesting when we consider that they were articulated by the same participant (Emily) within a span of approximately thirty seconds. The full exchange looks like this:

R: Um-hmm (.8) Um, all right, I’m gonna start to, like, digress a little bit and ask you some GENERAL questions, ah, Do you consider yourself to be a woman?
Emily went on to describe some movements that she felt were associated with femininity that did not fit with her experience of herself, and these included wearing make-up (line 552), doing her hair (line 552), wearing high-heeled shoes (line 554), and being compelled to express a sexually suggestive female energy (lines 570-5). She also associated being warm, nurturing and motherly with the word feminine (lines 567-8), qualities she perceived as more “internal” qualities and which she seemed to believe were consonant with who she is.

Heather noted that she doesn’t always consider herself to be feminine (line 1811), and she went on to say that whether or not she feels feminine “depends on the situation”
Heather told me that she observed “very specific gender roles” as a child. Some of the responsibilities of women included raising the kids and making dinner, putting on lipstick, and dressing up and looking pretty. She noted that she sometimes enjoys doing more feminine things including “dresses and hair fixed and make-up done” and putting on “the smile”, qualities that she associated with being “the good girlfriend”. She as well noted that she doesn’t want to do that all the time, remarking, “I don’t want to go to the gym with my make-up fixed” and “I’m not gonna clean the house in a dress...or get fixed up for him to come home”.

When I asked Joanne if she considered herself to be feminine, she said that she did and then remarked that she felt that this went along with feeling like a woman, noting, “I think the woman thing and the feminine thing go hand in hand, I don’t really see them as really separate”. As with Heather and Emily, she noted a complex relationship with femininity, telling me that although she enjoys “looking like a girl”, she does not consider herself to be “overly girly” and wanted to disassociate herself from those qualities. Her difficulty in locating herself in relation to models of femininity is apparent in the following comments:

P: I like, you know, LOOKing like a girl and I like, um, you know, girly stuff (laughs) you know, I’m ve-, I’m pretty. I’m not overly girly, though, like I’m not sissy girly, like I don’t like you know, frou-frou laced stuff and I’m not, I don’t dress like that and I’m not, you know, but I’d say I’m pretty feminine, ag-, yeah, I don’t know how to describe that, that’s a really hard question. I’m stumped there
Movements identified to be associated with women and femininity – and which also implied a kind of normative heterosexuality – were articulated to be in opposition to movements identified to be associated with men and masculinity. Joanne noted, “My husband’s not exactly Mr. Nurturing” (lines 869-70) and “my husband doesn’t seem to worry about whether he’s thin or fat or whatever” (lines 918-9). Heather noted, “it’s a more feminine thing to primp to go to the mall then, you know, masculine, where it’s more masculine to just, you know, throw your clothes on and look grubby and go do what you need to do” (lines 1851-1855).

**Mother/wife**

I asked each of my participants whether or not she expected that she would become a mother, and the responses to this question provided some information about the movements associated with the category “mother.” Again, I’ve collapsed these two categories here (mother and wife) because within the context of the transcripts there was a great deal of overlap in my participants’ descriptions of the movements associated with wives and those associated with mothers (particularly in Emily’s narrative). All of my participants were aware on some level of the “responsibilities” associated with mothers and wives. As well, each of my participants identified movements associated with mothers that could be said to transgress those normative expectations.

Heather told me that she “figured that [she] would have children at some point” (line 1635), a movement of anticipation that is consistent with the belief that the desire for motherhood is innate and universal (as Morse (2000) notes, “it is commonly believed that everyone expects and wants to produce at least one child” (p. 291)). Heather said
that her expectation that she would become a mother might have been influenced by her surroundings as a child. She noted that she “grew up in a family that was kind of traditional” (line 31).

Joanne as well reported that she expected that she would become a mother but reported that she did not consider it to be a given. She noted, “I think I always wanted to be a mom, or wanted to have children, but I think had I not gotten pregnant, I would’ve been okay with that, too” (line 22). Following that, she told me, “I didn’t get married until I was thirty-three” (lines 1149-50), and then described a series of movements (saving money, buying a house, getting a dog to get practice taking care of a living being (lines 1152-5)) that she had made prior to her pregnancy. Joanne noted feeling pressure to get pregnant before she turned forty, describing this as a “time limit” (line 1167) and a “window” (line 1179). She noted that she and her husband had “risked it” (line 1191) this time in that she was close to forty and that a second pregnancy “would be a little nervewracking” (line 1193).

When I asked Emily about whether she expected to become a mother, she responded, “No, I definitely did not want to be a mother” (line 642). She then noted, “I did not ever want to get married, I never wanted to have kids” (lines 644-5). Emily expanded on these statements by noting that as a child she observed the women in her life who were mothers and wives, witnessed the expectations that came with those roles, and decided that that was something that she didn’t want for herself. Movements that Emily associated with motherhood included not having a career (line 651), taking care of other people at the expense of your own needs (lines 653-4), never doing anything for yourself
(line 654), and always putting your children and husband first (lines 656-7). She also noted:

P: I didn’t want to be a WIFE because to me being a wife meant, you know, just not even having a self, really
R: Um-hmm
P: just giving yourself completely up to other people
R: Um-hmm
P: Um, and to me that was what wa-, was being a mother was, too
R: Um-hmm
P: so I didn’t want that at all (lines 658-67)

Emily’s idea that a woman could not be a mother or wife without forfeiting a self is a powerful one, and, of course, it reflects the lived reality of psychoanalytic articulations of just such an erasure of subjectivity. As a child, Emily perceived a split between being a woman who maintained a self (movements associated with maintaining a self included things such as going to college (line 669) and having a career (line 670)) and one who did not and became a mother/wife. She noted, “where I grew up…there was no conception of, like, a woman who worked and had a career and also had children, that just didn’t exist in our world, and so I think, growing up, it just never occurred to me that that could actually happen” (lines 672-7).

The possibility that two lesbians could choose to have a child was also nonexistent. Emily noted that it was only after witnessing other lesbian couples successfully undertake parenting that she was able to consider that possibility for herself, going so far as to identify it as part of a natural progression (line 707) that she had not anticipated. Much like Joanne’s comment that having children wasn’t considered to be an option for women with spina bifida (line 1277-8), lesbians as well have been excluded from the possibility of parenting until recently. Joanne identified advances in medicine
as primarily responsible for the changes in attitudes toward women with spina bifida

becoming pregnant, but Emily noted a societal and generational shift:

P: so (laughs) and it occur-, you know, I saw other people, um, you know other lesbian couples
R: (overlapping) Uh-huh
P: (overlapping) having children
R: Um-hmm
P: and, you know, saw that that could work
R: Um-hmm
P: I think that, like, my sister, ah, works with HRC?
R: Um-hmm
P: the Human Rights Campaign? And, um, there, ah, the people who are in their early twenties who work there that she knows, it just seems, like, obvious to them that they are going to have kids
R: Uh-huh
P: like, they just don’t even seem to even question it
R: Uh-huh
P: to them it’s like, it’s they’re, they’re gay, they’re gonna have kids, and they’re gonna be a couple and that’s just part of what they think is gonna happen
R: Uh-huh
P: And, I think that for April and me, we’re in our, we’re both thirty-four
R: Uh-huh
P: It just never ocCURred to us that was gonna, that would sort of naturally progress (lines 683-707)

Each of my participants had different relationships to the discursive construction of women’s natural propensity toward motherhood. Although Heather believed that being a mother is “something you do, you’re born with the ability to do” (lines 309-10), she identified a number of active movements that she had done to prepare for becoming a mother, including getting the crib together (line 306), washing clothes (line 307), taking a birthing class (line 308), and reading books (line 308).

When I asked Joanne about what she’d done in preparation of becoming a mother, she noted “normal stuff” (line 47) including taking a baby class (line 44) and getting the baby’s room ready (line 47). In contrast to Heather, Joanne felt that because she and her
husband hadn’t spent much time around small children it would be helpful for them to “bone up” on their childrearing skills (line 62).

Emily named a number of movements that she and her partner had made in preparation of becoming mothers but downplayed them somewhat. When I initially asked her what she’d done in preparation of becoming a mother, she responded, “Well, like what?” (line 198). She then noted that she and her partner had bought a different house in a different school district (line 200-1), read a number of books (line 205), familiarized themselves with the community of lesbian parents (line 210), were preparing to do “a lot of legal work” (line 211), had talked about names (line 215), and had put “in motion” the process of obtaining guardianship papers and a second-parent adoption (lines 216-7).

Partner/Mother

It was only through the process of breaking down the rights and responsibilities of various categories of subjects that I realized that there were four mothers active in the narratives – each of my participants and the partner of my lesbian participant, Emily. It’s not that I didn’t realize that when two women have a baby they’re both mothers, it’s just that the significance of that piece of information escaped me until I began to sift through the movements of various categories of subjects.

As the same-sex partner of a woman who is pregnant (in contrast with an opposite-sex partner), some of April’s movements are restricted; as well, she bears the responsibility to make a number of additional movements that opposite-sex partners don’t have to make. As the lesbian partner of a pregnant woman with a planned pregnancy,
April made the decision with Emily to have a child (line 128) and participated in discussions about which one of them would carry a child (line 136-7). April helped to choose the donor (line 45) according to certain characteristics (line 47-53). In fact, Emily noted, “she seemed to be a lot more into picking characteristics and stuff like that so I just let her pick the guy” (lines 52-3). Similar to the movements of opposite-sex partners of pregnant women, prior to the pregnancy April helped to prepare for the birth of the child by making the decision to raise a family in a particular geographic location (line 128) and familiarizing herself with a community of parents (line 210). Following the conception of the fetus, Emily participated in sharing the news with family (line 242) and reading books (line 232) to prepare for the baby.

April experiences fewer rights than would typically be afforded to an opposite-sex partner of a pregnant woman. During Emily’s first ultrasound appointment, April was not immediately allowed to accompany Emily into the room. Emily reported, “April wanted to come in and see it, and they were, like, ‘Okay, well, she can come in but she, you have to wait ‘til we do this other stuff first and then we’ll go get her’” (lines 1018-21), and Emily said that she was not sure about April’s right to accompany her during the birth of the baby (lines 1034-8). As a lesbian, and without any legal relationship to either Emily or the fetus, April faces a number of responsibilities to ensure her legal status as mother to the child when he or she is born. Emily said, “we have a lot of legal work to do” (line 211), and then noted that April has already “talked with the attorney” (line 213) in preparation for the completion of guardianship papers and the second-parent adoption (line 216-7), all movements that are necessitated by a legal system in PA and in most of
the U.S. that does not recognize any legal relationship between two women or between a
woman and the biological child(ren) of her partner.\(^\text{15}\)

When I asked Emily for her thoughts about raising a girl or a boy, and perhaps in
particular with regard to the fact that they’re a lesbian couple, Emily noted, “April
actually probably wants a boy more…’cause she’s more rough and tumble” (lines 464-7).
This comment highlights a binary gender system in which the association between
masculinity and males is so powerful that it is even the case that a woman who associates
more with masculinity desires a boy because the presumption is that a boy will be more
masculine.

**In pregnancy and during the ultrasound**

With regard to pregnancy ultrasound specifically, and reproductive medical care
in general, women are frequently asked to submit their bodies to procedures that are

\(^{15}\) Of course, legal marriage between same-sex couples is currently in limbo in many places. As of this
writing, September 29, 2005, Massachusetts is the only state to legally recognize gay marriage. Lawsuits
are currently pending in the following states: California, Connecticut, Florida, Maryland, New Jersey, New
York, and Oregon. Domestic partnership laws in the following states provide limited rights to same-sex
couples: California, the District of Columbia, Hawaii, Maine and New Jersey; and, Vermont licenses civil
unions which provide all of the rights and responsibilities of marriage to same-sex couples at the state level
but provide none of the federal protections (Human Rights Campaign, 2004). Regarding second-parent
adoption, the law varies from state to state and, in some cases, from county to county: “In some states,
such as Massachusetts, New Jersey, New York and Vermont, second-parent adoptions are available
statewide as a result of favorable appellate court decisions. In other states, such as Wisconsin and
Colorado, judges are precluded from granting them because of appellate courts’ restrictive interpretations of
the adoption laws. And in still others states, such as Florida, Utah and Mississippi, there are general
statutory prohibitions against adoption by gay and lesbian parents. But in the majority of states…there are
no appellate court decisions or statutes that address second-parent adoption, which often means that
second-parent adoptions may be granted in some counties but not in others” (Cooper, 2001). An
unprecedented set of decisions handed down by the California Supreme Court in August, 2005, conferred
the legal rights and responsibilities of parenthood on the partners of lesbians who had become inseminated,
holding that when two individuals decide to have a child together, the nonbiological parent has the same
legal status as the biological parent, becoming the only state to provide full legal parental status to a
nonbiological parent in the absence of adoption proceedings (Grossman, 2005). The discrepancies between
states (a person can be legally married or a legal parent in one state but not in another), coupled with a legal
system that is constantly in flux (indeed, rights could be granted or taken away at virtually any moment),
marks this situation – and, indeed, the identity positions of those involved – as impossibly tenuous.
oftentimes invasive. Each of my participants described moments of acceptance and resistance with regard to these demands but on the whole, and not surprisingly, each described their excitement about participating in the procedure and expressed few hesitations about submitting their bodies to the demands of medical professionals.

As with many lesbians, Emily’s pregnancy began via artificial insemination. Unlike Heather and Joanne, who described the conception of the fetus as occurring “naturally” and “normally,” respectively, Emily underwent an insemination process during which she was monitored by physicians and asked to undergo various medical tests. Although fertility problems were not an issue, her position as a patient began several months earlier than the pregnancy itself.16

For Emily, the process of conceiving involved a careful tracking – by self and others – of her bodily functions. She was asked to: undergo “a lot of tests” (lines 97) that had to be done “on certain days” (line 98) and to track her ovulation cycle (lines 98-99) and hormone levels (line 103). This tracking involved Emily getting up in the middle of the night in order to obtain her second urine of the morning (lines 106-7). She described the process prior to conceiving as “very regimented” (line 109). She summarized the experience far better than I could in, commenting: “once you entered the Center for Reproductive Endocrinology, it was like you were a cog in the wheel” (lines 82-4). She followed this observation by noting, “It was a little bit intimidating at first but then, they seemed like they knew what they were doing and you just, like, did whatever they told you to do” (lines 91-3). One thing that Emily was told to do was have an

16 Although many lesbians could conceive without any reproductive assistance, the potential for a donor to successfully assert his parental rights makes home insemination legally risky. Lesbians’ pregnancies are frequently medicalized because those who choose to be inseminated in a medical environment in order to circumvent legal issues are oftentimes grouped with women who have fertility problems.
ultrasound at six weeks in order to ascertain whether the embryo had implanted in the right place (lines 338-9).

Heather was asked to undergo an emergency ultrasound when her regular provider, a midwife, could not locate the fetal heartbeat with a Doppler. Heather was not told explicitly that there were grave concerns about the viability of the fetus but figured it out on her own anyway. She told me, “[The midwife] was trying to stay calm but you could sense that there was something. It just seemed a little fishy…you don’t send somebody for a surprise ultrasound” (lines 577-84).

At the hospital, Heather was first asked to preregister (line 649) by filling out paperwork indicating personal data and insurance information (line 650-1). She and her boyfriend waited in the waiting room (line 652), responded to questions about why they were there (line 654), and observed as hospital personnel listed a diagnosis of “placenta previa” on the form (line 655). When she was brought in for the ultrasound, she was asked to lay back on the table (line 663) for the procedure. The sonographer who conducted the ultrasound pointed out the fibroids (lines 691-2) and fetal body parts (line 688) while Heather watched the monitor and asked questions. Heather reported a favorable impression of the sonographer due to her emphasis on getting pictures of the fetus (lines 699-702).

When I asked Joanne if she could tell me about her experiences of the ultrasounds she’d had, she emphasized the ease with which the procedures had occurred. Without noting just exactly who “they” were, she first noted, “[T]hey always ask you if you have to pee, which is good” (lines 465-6). She reported that after peeing, she was brought in and asked to lie down on a table (line 476). She noted that, per the staff’s request, she
pulled up her shirt and pulled her pants down below her belly (lines 479-80). Joanne evaluated the staff as “pretty great” in large part because “it’s not required for it to be a big, long, drawn-out process” (lines 482-3).

Foucault (1975/1977) observed that “no detail is unimportant” (p. 140) because he believed that bodies were made docile through a “discipline of the minute” (p. 140). As with the careful, deliberate and regimented movements of the soldier (p. 135), so, too, do the movements that the woman makes in monitoring her reproductive functioning work to produce “practiced, bodies, ‘docile bodies’” (p. 136), bodies which are useful and intelligible (p. 136), open to coercion (p. 169), and “offered up to new forms of knowledge” (p. 155). That the ultrasound procedure is oftentimes quick and easy, is an expected part of pregnancy for many women, and involves the performance of detailed bodily movements, marks it as a disciplinary procedure as Foucault articulates it (Sawicki, 1991).

The above examples illustrate moments during which Joanne, Emily, and Heather accepted medical recommendations without much of a thought. All three regarded ultrasound as part of the picture, so to speak, of pregnancy. When asked how she came to the decision to have an ultrasound, Joanne reported, “I didn’t really come to it…when you’re in a high-risk pregnancy they do it right away” (lines 365-9) and Emily said, “[I]t was just part of their procedure” (line 318). Because Heather had undergone an emergency ultrasound, I asked if she had been planning to have an ultrasound, and her response was, “I assumed you were supposed to at some point in time” (lines 1047-50).
Man

The specific rights and responsibilities attributed to men as a category came up most directly following the question I asked to my participants in regard to whether they considered themselves to be women as well as the question regarding whether they anticipated altering their parenting practices depending upon the sex of the child they were having. Joanne knew she was having a girl, Heather knew she was having a boy, and Emily didn’t know the sex of the fetus yet, so I altered the questions accordingly.

When I asked Joanne how she felt about raising a girl, she noted that she would feel “really comfortable” about raising a child of either sex (lines 933-5). She noted that she had “leaned towards” (line 940) having a boy because of concerns about constraints to her level of physical activity, saying, “I kind of thought having a boy might be easier with my husband, ‘cause then, they’d do more boy stuff” (lines 945-6). Joanne then noted, “it’s gonna be kind of hard to say ‘cause, you know, what if she’s kind of a tomboy girl?” (lines 964-5). The identification of the “tomboy girl” serves to mark a gender expression that is just outside the norm for young girls, but still within an acceptable range, particularly during prepubescent years.

Joanne then identified specific activities (e.g., football, volleyball, soccer, swimming, ballet lessons) and commented on their level of appropriateness for either boys or girls. She remarked, “if she wanted to participate in sports and stuff we’d be into that, you know, but if she wanted to take ballet lessons, we’d be into that, too” (lines 976-8). With regard to a girl, Joanne drew the line at football: “[N]ow if she wanted to play football, I’d be, like, no, you’re not doing that, ‘cause that’s a little dangerous” (lines 994-5). Joanne noted the ways in which gender expression is more constrained for males,
commenting, “I think my husband would have a hard time if it was the other way around, now, if we were having a boy, ballet lessons would not be in the cards” (lines 981-3). She continued, “I think there’s a lot more leeway for girls than there are the other way around” (1000-02).

Heather noted that there were “very specific gender roles” (line 1824) in her house such that men “get to work around the house” (line 1820-1) and “wear whatever they wanted out of the house” (lines 1827-8). She noted that it’s more masculine to “throw your clothes on and look grubby and go do what you need to do” (lines 1854-5). In spite of that, when I asked about whether Heather had any concerns about raising a boy in contrast to a girl, she noted, “Not really, I think at this point things are pretty equal” (lines 1777-8), following that by saying, “I don’t see a reason for separate rules” (lines 1781-2). The only difference she identified was that “men tend to be physically stronger” (lines 1778). This is one of the places that I felt that we were not on the same page, as in retrospect it feels as though Heather thought that I was implying that there should be separate rules based on gender when, in fact, it’s the opposite; I was wanting to know if she saw systemic sexism to be a problem such that she would work to try to counter it.

Heather did note that she felt as though there was an advantage to the fact that the baby would be male in light of the difficulties she and her boyfriend were having with his adolescent daughter. She noted, “I think she’ll be able to bond better with a boy than if we had a girl because then not only would she have to deal with not being the baby any more, she’d also have to deal with not being the only girl” (lines 1032-5).
When I asked Emily if she anticipated any differences in raising a boy in contrast to raising a girl, she, too, identified anticipating characteristics and movements that were sex-dependent. She noted, “I think April probably wants a boy more and I probably want a girl more, you know, ‘cause she’s more rough and tumble and I’m more into, like, traditionally feminine kind of things” (line 464-8). In this case, gender roles are highlighted even more explicitly because the expectant parents are women with differing relationships to the expectations associated with femininity and masculinity. That is, even though both future parents are women who experience different attributes associated with masculinity and femininity, the male/female binary is still played out with an emphasis on masculinity being assigned to male bodies\textsuperscript{17} and femininity being assigned to female bodies. Emily went on to note that she has been in a caretaker role for children of both sexes and doesn’t anticipate any concerns about the sex of the baby. She also noted that neighbors of hers (a lesbian couple) have a thirteen-year-old son and have been having a difficult time with him since “the hormones kicked in” (line 485).

Boyfriend/Father

Heather identified a number of movements that her boyfriend had made in regard to his role as her boyfriend and as a father (of both his own two children and in anticipation of the birth of his third child). As a part of a heterosexual couple, he participated in the conception of the child through intercourse (line 20-22) after deciding with his girlfriend that they would try to have a baby (lines 33-4). In preparation for this child, he participated in a birthing class with his girlfriend (line 308), joked with his girlfriend about the size of her stomach (line 532-3), accompanied her to the ultrasound

\textsuperscript{17} in relation to the anticipated new person, but not in relation to April herself
appointments (lines 586-7, 932, 1133), waited with her in the doctor’s office (line 1149),
participated in discussions about what will change after the baby is born (line 1521),
inadvertently hurt his girlfriend’s feelings through comments he was making (line 1550-
2), and participated in a conversation with her about these comments (line 1554).

She noted that he attempts to set up boundaries with his other two children (line
384), tries to please his daughter (line 1577), and is attempting to complete a number of
projects before the birth of the baby, including finishing the nursery (line 1578-9).
Heather noted that their relationship has changed as her pregnancy has progressed, saying
that they used to go swing dancing (1588), an activity that they can no longer enjoy
because it is painful to her.

In regard to gender roles, Heather noted that her boyfriend “understands…gender
roles” (lines 1831-2) which she has found that “other people over the years have not”
(lines 1835-6). She noted that he will spend a lot of time getting ready to go to the mall
(“he’ll get a pair of jeans and get a shower and cologne and all this stuff” (lines 1840-1)),
and will good-naturedly accept her comments that he is “acting like a girl” (lines 1845-6).

**Husband/Father**

Joanne commented about a number of movements that her husband had made in
regard to her pregnancy. As a part of a heterosexual couple conceiving a child through
intercourse, Joanne’s husband had a role in the conception of the child. In preparation for
the conception, he had participated in discussions with his wife about conceiving a child
(line 22-3) and accompanied her to medical appointments in order to procure information
(line 210-1). In preparation for the birth of the child, Joanne’s husband took a baby class
with her (line 44), helped to get the room ready (line 47), accompanied his wife to several ultrasound appointments (line 471), attempted to provide reassurance (line 528), made the decision with his wife to find out the sex of the fetus (line 677), expressed some disappointment in the sex of the fetus (line 679), teased his wife about her worries about major fetal deformities (line 810), and enjoyed the increase in the size of his wife’s breasts (line 850).

In noticing that she tends to be more nurturing, and in labeling that a “female” or “womanly” thing (line 868), Joanne drew a contrast between her actions and those of her husband in saying, “my husband’s not exactly Mr. Nurturing” (lines 869-70). She went on to note that he is item-oriented as opposed to people-oriented (lines 884-5), and doesn’t worry about his weight (918-9). She reflected that she had anticipated that he would do “more boy stuff” (line 946) if they were expecting a boy. This parallels the assertion made by Heather in regard to her boyfriend’s daughter being better able to bond with a boy. Both of these comments point to the relational assumptions that are made on the basis of knowledge of the sex alone, as though this gives us access to personality characteristics. This exposes and further produces a binary framework in which women, femininity, and heterosexuality imply one another and are implied by one another. Or, as Butler (2004) notes, “The very attribution of femininity to female bodies as if it were a natural or necessary property takes place within a normative framework in which the assignment of femininity to femaleness is one mechanism for the production of gender itself” (p. 10).
Medical professional

My participants each spoke of a number of medical professionals who had provided treatment to them during their pregnancies and prior. They all spoke of doctors (specialists, obstetricians, gynecologists, general practitioners) and sonographers, and as well Heather spoke about her experiences with homeopathic physicians (who had treated her while she was growing up) and midwives. In this section, I break down the movements of medical professionals into three categories: doctors, sonographers, and midwives.

Doctor

The movements associated with doctors (from the perspectives of the participants) drew attention to their role as overseer and coordinator of medical interventions, provider of information, and decision-maker with regard to medical procedures. Each of the participants had their own set of concerns and reservations about physicians – Heather because of the negative experiences she’d had in the past as a patient, Joanne because of her disability, and Emily because she is a lesbian – and each brought their own unique perspective about the interventions they experienced, including the ultrasounds. Heather, Emily, and Joanne all described movements performed by various physicians that they appreciated and movements that they found to be unhelpful.

Emily spoke of her relationship with three doctors – the surgeon who’d removed the cysts from her ovaries, the specialist with whom she worked through the process of becoming inseminated, and her obstetrician. Their movements overlap as well as diverge, and I include them under the general heading “doctor.” Emily noted right away
that her insemination specialist fit a particular stereotype. She remarked, “the doctor, Dr. Medeiros, was really, he was good, I mean, you know, he’s a doctor so he’s sort of remote” (lines 38-9). Emily described movements that indicated his role as overseer of the insemination process. She noted that he administered checklists (line 85), gave instructions (line 93), made sure everything was going okay (line 167), made sure that the sac was implanted in the right place (line 174), checked for multiple births (line 176), and released Emily to her obstetrician after locating the fetal heartbeat (line 187). She later noted how minimal her relationship with this doctor was, remarking that she only talked with him twice (line 305). She experienced the relationship as analogous to a business relationship:

P: So he was sort of, like, you know, um (.) ah, overseeing everything and coordinating everything and making decisions, but (.) I rarely even saw him and (.) you know, I just really thought of it as more of a business relationship, honestly (laughs), you know what I mean? Like, he was in the business of getting me pregnant and that was pretty much how I thought of it. (lines 309-15)

In the early part of our conversation, Emily noted that the Center for Reproductive Endocrinology and Fertility was “definitely, like, a heterosexual environment” (line 41), a comment which made immediate sense to me, even in the absence of further description. Later in the conversation, she articulated more fully what that particular “heterosexual environment” looked like. Part of it concerned pervasive assumptions about normative heterosexuality. Emily noted, “you’re always sort of explaining yourself” (lines 948-9) because “they’re always asking about your husband” (line 951). A second factor concerned the exclusion of Emily’s partner from the first part of the first ultrasound appointment, a movement that Emily attempted to make sense of within the confines of the normative heterosexual model:
P: Um (.) we-, I mean, it was kind of we-e-ird during my first ultrasound at Dr. Medeiros’ office, um, you know, and April wanted to come in and see it, and they were, like, “Okay, well, she can come in but she, ah, yo-, you have to wait ‘till we do this other stuff first and then we’ll go get her”

R: Um-hmm

P: you know? But it was, it felt sort of weird, it wasn’t like, I think if, if she had been MALE it would have been, i-, it probably would have felt

R: Uh-huh

P: and I don’t know if it was them or if it was me

R: Uh-huh

P: that felt kind of weird about it (lines 1017-29)

In talking about her experience of her obstetrician, Emily spoke with some degree of affection in regard to his efforts to procure and disseminate information. She noted the efforts that he’d made to familiarize himself with health issues pertaining to lesbians after she had come out to him, describing him as “sort of clueless” (line 964) initially, a factor that she tolerated because she liked him (line 967-8). She then described his clumsy efforts to relate to her:

P: so, when I went back to him in December to talk about this it seemed like he must have gone to some seminar on lesbian health recently?

R: Uh-huh

P: because he gave me a whole, like, lecture on lesbian health issues?

R: Uh-huh

P: which was just really funny because, like, two years beforehand, he’d been clueless and now, it just seemed like he was le-, lecturing ME, so it was sort of funny

R: Uh-huh

P: Um (.) but, um, you know, I thought, “Well, MAYbe by my coming out to him, then, you know maybe he’s gotten more interested in it, maybe, you know, he’ll be better, a better doctor to other patients (lines 970-84)

For Heather as well, the movements made by her physician highlight his role as overseer and coordinator of medical procedures and provider of information. During her first (emergency) ultrasound appointment (during which she found out for the first time that she had fibroids), the doctor entered the room after the sonographer had begun to
perform the ultrasound. After getting out the “jelly and stick thing” (line 717), he looked at the screen (line 719) and questioned Heather’s absence of knowledge about her fibroids, commenting to her, “You didn’t know you had fibroids?” (lines 719-20), a detail which irritated me greatly, prompting me to ask Heather, “How would you know?” Heather’s initial response was one of self-blame: “I guess I should have noticed that I was getting thicker in the middle” (lines 723-4).

Heather’s description of her physician’s efforts to provide her with accurate information indicates an emphasis on the disbursement and procurement of knowledge. Heather described her physician as “very good at explaining and giving a lot of detail” (lines 750-2). She also noted that “he will give you all of the information you ask for” (lines 752-4). Secondary to that was a consideration of how that information was disseminated. Heather described how her doctor’s presentation of information alarmed her during both her first and second ultrasound. During the first ultrasound, he began by telling her that she had uterine “tumors” (line 772), a word often associated with cancer. In recounting it, Heather joked to me, “benign is a good word to start with for me” (lines 776-7). During the second ultrasound, he began by “giving [her] the history of Down’s syndrome” (line 763-4) because the ultrasound had revealed one marker for Down’s syndrome.

Joanne, as well, prioritized a provision of information by her doctors. Within the context of a consultation she and her husband had had prior to her getting pregnant (line 215), the doctor provided information about what she could do to prevent a neural tube defect (lines 218-9), the risks involved due to Joanne’s age (line 219), and the implications a pregnancy might have on Joanne’s level of mobility (lines 224-6). When I
asked about how Joanne perceived her relationship with her doctors, she noted that
they’re very informative overall (lines 338-41), describing how they meet each week with
one another in order to keep “up to date” (line 344) on each of the patients and provide
information to one another in regard to specific issues (lines 350-2). Joanne noted that
she and her husband had specifically sought out doctors who would provide them with
information:

P: ‘cause my husband and I wanted to make sure that we were
   informed, you know
R: Uh-huh
P: that we weren’t just going off half-cocked and doing whatever
   (lines 210-3)

The role of Joanne’s doctors in overseeing her medical care was apparent in their
specific movements. Joanne reported that various doctors put her on folic acid and a
prenatal vitamin (lines 25-7), diagnosed her hernia (lines 310-1), ordered the ultrasound
(lines 368-9), and monitored her medications (line 1224). For Joanne, there seemed to be
an emphasis on the doctor as a “checker” and a “watcher.” The doctors were concerned
to monitor fetal weight because of the potential impact of a high fetal weight on her
breathing; as well, Joanne had hypertension that the doctors wanted to monitor. She
noted three times that the doctors were “keeping an eye on” (lines 135, 146-7, 184) the
fetal weight and her high blood pressure, and she noted twice that they were “watching”
these things (lines 144-5, 146-7).

Despite Joanne’s strong emphasis on the importance of the physician’s
knowledge, she commented, “[I]f I had to pick one thing, I was looking for somebody
who was going to be supportive of me getting pregnant” (lines 233-6). Prior to finding
the group of doctors she ultimately chose to work with, she described a different doctor’s
practice as “very negative” (line 281) in response to her desire to get pregnant as a woman with a disability. Joanne noted that when she was younger, the general attitude was that “it was kind of assumed that you wouldn’t have children” (line 1279) and remarked, “they didn’t even know if spina bifida children could have, even, have children” (lines 1282-4). She noted a shift toward an acceptance of women with disabilities choosing to become pregnant, and attributed this shift to “advances in medicine” (line 1288). She drew a parallel between my experiences as a lesbian and her experience of being disabled in that we both occupy places in groups that are not considered to be a part of the mainstream. Although Joanne noted that she’s been “really lucky” (line 1308-9) in that her experiences with discrimination have been minimal, she noted a heightened awareness of the ways in which she is marginalized on the basis of her disability, noting the ways in which minority individuals are oftentimes shoved aside:

P: you know, that I haven’t had that, but I think, I think it all comes from that same thing that years ago (.) you know, disabled people were, you know, you wanted to put them away, you know, you really didn’t want them involved in the regular, you know, and (.) you would probably understand that same kind of concept (laughs)
R: Um-hmm
P: I mean, it’s, it’s a hard thing when you’re kind of the little GROUP and they don’t really want you to be a part, and I think that (.) w-, women with disabilities got shoved into that kind of category
R: Um-hmm
P: where it’s like, ‘cause people would rather not think about that, you know, because then they have to face their own (.) fear about it and I think that that’s what happened and so, years ago, THAT’S what people did, it was like, “Oh, no, you don’t want to have CHILDren,” you know, so (.) they just sort of shoved you aside (lines 1311-28)

Each of my participants spoke of tolerating pain for longer than necessary due to medical misdiagnoses. Emily told me about her experience of a surgery to remove cysts from her ovaries. In addition to describing the surgery as “sort of traumatic” (line 265)
because the surgeon “just treated you like you were an inanimate object” (lines 266-7), she also described how the doctor had put her on an incorrect dosage of hormones following the surgery which resulted in her experiencing depression (lines 275-6). She was only put on the correct dosage after she consulted her gynecologist at the encouragement of a friend (lines 278-296).

Joanne described her experience of being dismissed by a physician when she complained about a pain in her side. According to Joanne, she was told by the physician that “pregnant women get pains and aches all the time” (lines 303-4). He also admonished her that she couldn’t “be flustered about every little thing and hysterical about every little thing” (lines 304-5). The pain that she had experienced was only discovered to be a hernia during a subsequent appointment with a different physician.

Heather described an experience of being ill when she was in college. Because she’d had strep throat each year, she was familiar with the symptoms. She told the physician that it was “incredibly likely” that she had strep throat (line 147) and was told, “I don’t think so, why don’t you go home for a couple of days and then come back and we’ll do a culture” (lines 150-1). Despite then telling the doctor, “I really think I have strep throat and I’m gonna get worse,” she was persuaded to go home. When she returned several days later, a throat culture confirmed the diagnosis.

These three examples have commonalities that are striking. All are examples of the ways in which women were persuaded to accept a physician’s initial (mis)evaluation and tolerate pain even when they were aware that something was wrong. And, in each of the examples, each of the women found a way to resist that initial evaluation and procure appropriate medical treatment. For Emily and Joanne, it came in the form of visiting
different doctors. For Heather, it meant returning to the same doctor. Following these experiences, women made sense of them in different ways and had different emotional reactions. Emily’s resistance was quiet: she had not liked the doctor; he had put her on the wrong dosage of hormones, and she was depressed as a result; a friend encouraged her to see a different doctor, and she actively sought one out; this doctor listened to her and put her on the correct dosage of hormones. Joanne was more outspoken about the doctor’s mistake. In commenting on the experience of being told that she couldn’t be hysterical about every little thing, she noted, “I felt like I hadn’t been hysterical about every little thing” (lines 306-7). She also said, “it turned out that he really should have paid more attention to me” (lines 313-4). Of the three, Heather perhaps felt the impact the most, noting that the experience of not being listened to was just one of many “very negative experiences” (line 130) she’d had with mainstream medical providers. Upon returning to the doctor and receiving a throat culture that confirmed the diagnosis she’d suspected, she noted that she “did the ‘I told you so thing’” (line 158). In describing how she pointed out how she was right and the doctor was wrong (an accurate assessment of the situation), Heather commented that that “was probably not the right way to be” (line 159).

Sonographer

While the responsibilities of the doctor position her or him as overseer and coordinator of medical decisions and provider of information, the sonographer plays a much more active role in the administration of the ultrasound. Joanne described in detail the process whereby the sonographer prepared her for and conducted the ultrasound. She
noted that the sonographer asked Joanne if she had to empty her bladder (lines 465-6),
brought her into the room for the ultrasound (line 476), laid her down on the table (line
476), asked her to pull up her shirt and pull her pants down below her belly (lines 479-
80), and provided information while conducting the ultrasound (483-4). Joanne said that
in the later ultrasounds, the sonographer measured different parts of the fetus (lines 443-
4) and pointed out fetal body parts that were more easily recognizable, including hands
and feet (lines 500-02). Joanne also noted that the sonographer let Joanne listen to the
baby’s heart beat (lines 791-2), a part of the ultrasound that Joanne described as
reassuring. Joanne said that following each ultrasound, the sonographer would leave the
room to get the report (lines 505-6).

Heather also noted that the sonographer pointed out fetal body parts (lines 687-9),
took fetal bone lengths and measurements (line 978), and went in and out of the room to
consult with the doctor (lines 712-3, 988-9, 1175-6). During one appointment, the
sonographer found the heartbeat quickly (lines 964-5), and during another she had
difficulty locating the fetal heartbeat because the fetus was curled up in a ball (lines 961-
2) which caused Heather some anxiety. Heather also noted that the sonographer pointed
out the fibroids in Heather’s uterus (lines 691-2), asked Heather questions about the
fibroids (lines 694), and conducted a longer ultrasound (without Heather knowing the
reason for it) because she had noted a light calcification of the heart (lines 973-4) which
is one of the markers for Down’s syndrome.

Perhaps because Emily was not as far along in gestation as either Heather or
Joanne (or because she was generally more introverted, or because I didn’t press her for
more information, or because the emphasis on her ultrasounds was in ascertaining
implantation of the embryo and not fetal health), her description of the sonographer’s role was much briefer. She, too, emphasized the location of the fetal heartbeat during the second ultrasound (line 365) as central to the experience, as something which was “really great” (line 366).

All of my participants described their perceptions of the sonographer’s level of skill. Emily noted that the sonographer who conducted the two ultrasounds during her pregnancy was gentle and fast (line 376) and “seemed to know what she was doing” (lines 378-8), in contrast to ultrasounds that she’d had previously which were painful and uncomfortable (lines 388-9), took a long time (line 391), and were conducted by sonographers who did not seem to have a lot of experience (lines 381-2).

In the later ultrasounds, part of the sonographer’s role is to ascertain fetal sex and provide that information if it is desired. Both Joanne and Heather had decided to find out the sex of the fetus. Emily was too early in her gestation but was planning to find out through subsequent ultrasounds. Joanne described the moment matter-of-factly: “[S]he said, ‘Do you want to know?’ and we said, ‘Yeah,’ and she said it was a girl” (line 677-8). Heather, who had seen ultrasounds before when she’d assisted her mother (who was a medical assistant), was able to ascertain the sex without the sonographer’s help: “He was not shy and I’m like, ‘He’s a boy!’ And she’s like, ‘You’re right!’” (lines 1021-3).

Both Joanne and Heather emphasized particular personality features of the sonographers as part of their evaluation of their skills. Joanne noted that the sonographers who conducted her ultrasounds were “easygoing” and “nice” (line 571), talked to her “the whole time” (line 573), and displayed some level of excitement in regard to the procedure (line 578). Joanne noted, “they were real good about being as
excited as you were and making you feel like you were probably like the only one they were seeing today” (lines 582-4). She contrasted this with an experience she’d had during a previous pregnancy which had resulted in a miscarriage in which the sonographer was too “cold” (line 533) and “clinical” (line 539). Heather positively evaluated the sonographer who conducted the first and second ultrasound, noting that she maintained an emphasis on the fetus (lines 701-2) and was friendly (line 944). She contrasted this with her experience of the sonographer who conducted her third ultrasound and whom she described as “a little crabby” (line 1146). Heather noted that this sonographer insisted that Heather remain in a reclined position despite her discomfort (lines 1213-4) and quickly left the room after completing the ultrasound and didn’t return (lines 1173-80).

For both Heather and Joanne, part of the evaluation of the sonographer’s ability included the degree to which they were able to provide good pictures of the fetus. Heather noted that the sonographer “pointed out the positive things” (lines 708-9) and “took some cute pictures” (line 711). During the third ultrasound, which Heather did not evaluate positively, she noted that she “didn’t really get to see the baby, didn’t really, you know see much of anything…I asked her about, you know, are you gonna be able to get us any pictures and that kind of stuff and she’s like, ‘Well, we’ll see,’” (lines 1172-8). Joanne, in describing her experiences of the sonographers noted, “they were all great, they printed me pictures, I have pictures from all of them and they printed me the video from the last two” (lines 508-10).
**Midwife**

Heather sought out a midwife to follow her during her pregnancy and deliver the baby. She had initially wanted someone to do a home birth (lines 203-4), but after doing some research, she learned that midwives who are accredited in Pennsylvania are not licensed to do home births (lines 212-3). Heather noted that midwives who are licensed by the state (line 220) must “pass certain courses” (line 222) and “have certain qualifications” (lines 222-3). She assessed midwives to be a “balance” (line 238) between traditional medical care and completely natural childbirth in that they maintain a more natural approach to childbirth but refer patients for supervision by a physician when complications arise (line 235) which is what happened in Heather’s case when one of the midwives that Heather sees was unable to detect a fetal heartbeat (line 540-1).

I asked Heather to describe for me what happened during her first appointment with the midwives. She told me that the midwife did a blood draw to test for syphilis as required by state law (lines 496-9), did blood typing (line 514), blood count (line 515) and “any other type of testing that you opt for” (lines 515-6). She said that the midwife completed a pelvic exam (line 518), took her blood pressure (line 521), completed a breast exam (line 522), and attempted to listen to the fetal heart tones with the Doppler (lines 523-4). Heather told me that the midwife who conducted the exam looked visibly worried when she was not able to get a heart tone (lines 549-50). At that point, the midwife encouraged Heather and her boyfriend to go and get an ultrasound that day (lines 569-71).

Following her ultrasound appointment, Heather had a number of questions about the fibroids which she had been too overwhelmed to ask the physician. She phoned the
midwives the following day and left what she called a “horrible, crying message” (line 851). She told me that they called her back and were “very understanding” (lines 853-4), showed a willingness to talk about her situation (line 854), provided reassuring information about the locations and size of the fibroids (line 863), and made attempts to “get answers for what…they didn’t have the answers for” (lines 854-7).

The fetal image

Before its birth, the child is…always-already a subject, appointed as a subject in and by the specific familial ideological configuration in which it is ‘expected’ once it has been conceived. (Althusser, 1971/2000, p. 34)

The movements attributed to the image of the fetus are perhaps the most interesting of all because they are performed by something that is not yet an independent person, indeed, not yet a person at all. Before it is a person in the world with others, the fetus is regarded by others. That regarding occurs linguistically and, with the advent of the ultrasound, visually as well. Thus, it may be said that these movements provide a unique opportunity to examine the ideological frameworks in which they occur.

In all of the narratives, development – in regard to both general growth and to the development of the functionality of bodily mechanisms – was emphasized. Emily noted that the ultrasound and the Doppler heart monitor were used to ascertain whether or not the embryo had implanted at the right place (line 174) and had developed a detectable heartbeat (line 409). The importance of the development of a detectable fetal heartbeat was articulated in Joanne’s (line 791) and Heather’s (line 523-4) transcripts as well.
In her narrative, Joanne noted that the fetus was gaining weight (line 135) and also noted concerns about the potential for the fetus to get too big (line 128). Heather emphasized the development of specific body parts such as lobes of the brain (line 688), heart (line 710), and hand (line 813). Heather’s comment regarding the position of the fetus in the womb (head down (lines 1198-9)), followed by her relief in knowing that “he’s right” (line 1199), highlights the emphasis on normal development. This was further underscored by her and the doctor’s shared wish for the fetus to “[stay] in the same percentile” (line 1267).

Not surprisingly, and consistent with the literature (Cartwright, 1995; Mitchell & Georges, 1998), the development of fetal sex was emphasized. Because my participants were at various stages of their pregnancy (Emily was early in her pregnancy, Joanne midway through, and Heather almost to term), their relationships to the sex were at different stages as well. Emily’s was one of anticipation; she noted that she and her partner were, “hoping to see the sex of the baby” (line 440). Joanne and her husband had found out that she was having a girl, and Joanne remarked that she had asked the sonographer to double check the accuracy of this assessment at one point in order to prepare for a baby shower:

P: it was a girl so, and then when I went my la-, this last time, I said to her, you know, ‘cause we’re getting ready for a big baby shower and, I said to my, you know, I said to her, “Can you just make sure it’s a girl again because (. ) if it’s not, we have serious problems, ‘cause I’ve purchased a lot of girl items” (lines 688-93)

Heather found out that she was having a boy during her second ultrasound, and she articulated her belief that this piece of information – in consonance with the naming
that would transpire as a result – was crucial to her perception of the fetus as real. She noted:

P: we had talked about it and I wanted to know the sex of the baby and (. ) my boyfriend agreed
R: Uh-huh
P: (. ) for me-e-e, that’s a bi-i-g (. ) identifying factor, ‘cause now I can name you (. ) a-a-nd once you have a name (. ) you’re (. ) even MORE real. (lines 919-25)

Heather’s comments emphasize a cultural belief in gender as a prerequisite for human intelligibility. That is, when we wonder about the sex of a fetus, we are not merely wondering about some characteristic of that future person, we are wondering about an aspect of personhood that is fundamental to that human’s existence. As Butler notes, “When we ask, what are the conditions of intelligibility by which the human emerges, by which the human is recognized, by which some subject becomes the subject of human love, we are asking about the conditions of intelligibility composed of norms, of practices, that have become presuppositional, without which we cannot think the human at all” (Butler, 2004, p. 57).

Indeed, in both Joanne’s and Heather’s narratives, fetal movements were interpreted through the lens of a subjective agency. Joanne noted that in the later ultrasounds, she could observe the fetus sucking her thumb (line 501-2) and as her pregnancy progressed has noticed that she has been kicking harder (line 776). In addition to movements such as curling up into a ball (line 961), Heather talked about whether or not the fetus would cooperate with the ultrasound (line 927). In remembering the moment that she found out the sex, she noted, “He was not shy” (line 1021).
Researcher

As the researcher, I juggled a number of responsibilities. By going back and observing my actions prior to, during, and after the interview, I can be seen to be making a number of movements that are consistent with my role as researcher. Prior to each interview, I explained the purpose of the research, obtained oral and written consent, and set up the tape recorders. During the interviews, I asked questions from the semi-structured interview guide I had constructed as well as off the top of my head. At different times during the interviews, I asked for examples (Heather, line 137), challenged contradictory statements (Emily, 556-7), and interrupted my participants in order to redirect conversations. I encouraged particular paths of conversation while discouraging others. In seeking additional information, at various moments I restated information, asked for clarity, and paused for more information.

I made efforts to look professional and knowledgeable while minimizing information of which I was unaware, as when Heather brought up a specific case involving a breech baby born in Pittsburgh (lines 223-5) and discussed her fibroids, when Joanne discussed her neural tube defect (lines 14, 218-9) and when Emily discussed the cysts that she’d had removed from her ovaries (lines 22, 271, 320, 505). That is, although I had little knowledge regarding the specifics of each of these situations, in an effort to look legitimate I attempted to maintain a knowledgeable stance even as I was asking for more information about things about which I knew little.

Early in one of the interviews, an interesting moment occurred which highlighted my role as researcher. Prior to the interview, as I was setting up the taping equipment, I had talked with Joanne informally about her experiences. During this conversation, the
fact that she had had a prior miscarriage came up. However, even though I already knew the answer to the question, I asked Joanne, “[H]ave you been pregnant before?” as if I did not already have this information. I believe that this was a function of the formality of the interview situation and that my question arose from a pull to get an official answer to this question. Somewhat strikingly, Joanne seemed to understand her role as well and did not seem at all surprised when I asked her a question that she knew I already knew the answer to. She responded without hesitation.

As a researcher, I attempted to put my participants at ease, and this was guided by both a genuine concern for my participants’ comfort as well as a desire to elicit more information. In an effort to open up conversation, I followed the norms of social exchange such as laughing along with participants in moments and trying to maintain an empathic and open stance. At times, I felt genuine connections with each of my participants and felt moved to disclose some part of my own experience or identity. With Heather, the self-disclosure was relatively minor, as I indicated that I am the kind of person who typically prepares for the worst. With Emily and Joanne, I disclosed my identity as a lesbian.

To this point, I have identified the categories of personhood that seem to me to be central in regard to a research project that is concerned with investigating ultrasound from a discourse analytic perspective. As well, I have outlined a number of movements that individuals make within the confines of various identity positions. These steps have been important to the project because they pave the way for the next step, which is the identification of the discourses in which these categories of personhood have been (and
continue to be) constructed and which surround the technology of pregnancy ultrasound.

In the next section, the Results section, I will discuss these discourses explicitly.
Chapter Five
Results: Identification of dominant discourses

[Discourses] naturalize the things they refer to…in such a way that it appears perverse and nonsensical to question that they are really there. (Parker, 1994a, p. 103)

The identification of the central subjects of the analysis, those identity positions by which we define ourselves and by which we are defined by others on the basis of factors such as gender, sexual orientation, occupation, relational status, etc., pave the way for an examination of the discourses in which those subject categories reside. In this section, I “name” the discourses that seem to be in play here, pointing to a larger structure in which “mothers,” “doctors,” “fetuses,” “researchers,” etc., come to be constructed as they are. The discourses that I will name here come about largely as a result of my own personal position, and in naming them as I do, I participate in a reification of sorts, something that troubles me because I run the risk of further sedimenting the very discursive constructions that I hope to disrupt. In light of this, it seems important to note again that the discourses that I name here reflect my version of dominant discourses and not an objective reality from which I am separate, and I name them in order to examine more closely a larger structure in which some things come to be taken for granted as “normal.” With that in mind, I have identified six discourses that seem to be central to the narratives, and these are:

- scientific
- maternal
- biological
In this section, I will discuss some of the assumptions that comprise, contribute to, and surround these larger discourses by providing examples from the transcripts of my conversations with Emily, Joanne and Heather that seem to illustrate them.

**Scientific discourse**

[All scientific knowledge is always, in every respect, socially situated. Neither knowers nor the knowledge they produce are or could be impartial, disinterested, value-neutral, Archimedean. The challenge is to articulate how it is that knowledge has a socially situated character denied to it by the conventional view, and to work through the transformations that this conception of knowledge requires of conventional notions such as objectivity, relativism, rationality, and reflexivity. (Harding, 1991, pp. 11-12)]

Initially, I identified two discourses and named them ‘medical’ and ‘rationalist’ discourse, but I made the decision to collapse them under the term scientific discourse because they largely overlap. Scientific knowledge presupposes rationality, and medical discourse is situated within a scientific and rational framework. The physician is assumed to be logical, rule-following, even-headed, and unemotional. Within a scientific discourse, the doctor is assumed to have the upper hand as he or she is believed to have
access to scientific knowledge. Scientific knowledge is privileged as legitimate, truthful, and accurate. People are expected to adhere to recommendations from those who have access to this form of knowledge.

As well, and in consonance with a discourse that presupposes the existence of an external truth, preciseness (of measurement, of movement) is privileged. In Western culture, pregnancy has taken on the look and feel of a medical event, as babies are most often delivered in a hospital with the mother receiving medical care during the event. Even though the ultrasound sometimes feels personal and emotional for pregnant women, it is largely seen as a medical procedure and its medical-ness is usually seen to be primary.

*Scientific knowledge is precise*

In describing the process by which she was monitored prior to the conception of the fetus (and during the early months of pregnancy), Emily noted that she felt as though she was a “cog in a wheel” (line 84). She noted that she was required to undergo “lots of tests” (line 97) and that these tests were to be done “on certain days” (line 98), that she was required to track her menstrual cycle for ovulation (lines 99-102) and hormone levels (line 103) by obtaining her second urine of the morning (line 107). The amount of surveillance in conjunction with an authoritative knowledge about that surveillance is at once coercive and enticing. Patients often go along with recommendations prescribed by those who seemingly have access to this type of authoritative knowledge. Emily commented, “It was a little bit intimidating at first but then, they seemed like they knew what they were doing and you just, like, did whatever they told you to do” (lines 91-3)
In her narrative, Joanne noted the process by which the fetus is measured, saying that in “the later ones, they’re measuring the baby, like, they’re measuring all the different things, and, one of the things, they couldn’t see in the last, second to last one, I had was the size of her spine” (lines 443-6). Although fetal measurements are sometimes incorrect (Raynor, 2003; Spencer, et al., 2003), the calculation of the measurements denotes a kind of scientific precision and these measurements are usually presumed to be accurate. Joanne noted the importance of going along with scientific/medical recommendations, telling me that she would not have gotten pregnant “if [my primary care physician] said, ‘I think you’re crazy’” (line 1215). She added, “cause I trust him a lot” (line 1216), highlighting the amount of faith that people often place in medical doctors.

Doctors have access to that knowledge...

There was an emphasis on the physician’s access to particular forms of knowledge, to the point that, in the narratives, doctors were evaluated primarily on their ability to provide such knowledge. Joanne noted that she and her husband “wanted to make sure that [they] were informed” (lines 210-1) about potential risks. She also described her attempts to find a physician who was knowledgeable (line 253-7). Joanne also noted that one of the qualities that she appreciated about the sonographer was that she was “very informative” (line 483-4). And, in regard to her primary care physician whom she’d been seeing for a period of time before getting pregnant, she commented, “it wasn’t like he was uninformed or anything” (lines 1219-20).
In her first mention of her physician, Emily noted that he was “good” (line 38). She immediately qualified that with, “you know, he’s a doctor, so he’s sort of, um, remote, you know” (lines 38-9). This is an example of a normative expectation (and acceptance) of doctors as distant or remote. At a different time, I asked Emily if her doctor could have done anything different to prepare her for the ultrasound. In spite of her feelings about his remoteness, she could not imagine that he could have done anything different, and she emphasized the ways in which he was competent (“I, I knew what to expect” (line 492)).

At another point, Emily noted that she didn’t have very much contact with her physician, noting that she had worked mainly with the staff. She saw the doctor’s role as one in which his responsibilities included oversight, coordination of care, and decision-making. She described her relationship with her doctor as more of a business relationship:

R: Um-hmm (.4) Um (.4) any other ways that you have to describe your relationship with your physician?
P: Well, with Dr. Medeiros, I only really, actually, the, there’s a, the Clinic, I think when I only talked to him maybe twice
R: Uh-huh
P: It was really his staff that did everything
R: Uh-huh
P: So he was sort of, like, you know, um (.4) ah, overseeing everything and coordinating everything and making decisions, but (.4) I rarely even saw him and (.4) you know, I just really thought of it as more of a business relationship, honestly (laughs), you know what I mean? Like, he was in the business of getting me pregnant and that was pretty much h-, how I thought of it (lines 302-15)

During the second ultrasound, when the fetus was screened for Down’s and came up with one marker, Heather looked to the doctor to provide reassurance of the health of the fetus, (which he did, in fact, provide): “[A]s much as a doctor can say, ‘He’s fine,’ he said, ‘He’s fine.’” (lines 1007-08). In this case, Heather is aware that the scope of the
doctor’s knowledge is limited (“as much as a doctor can say”), but nevertheless she looks to him to provide information that she does not have access to. The power of the physician to provide reassurance is highlighted by Heather’s comment, “I left there feeling pretty good” (line 1010), particularly in light of how anxiety-provoking the experience was.

When I asked Heather what she thought the doctor might have done differently (and for me, looking from the outside, it seemed as though the doctor could have been much more sensitive to Heather’s feelings), I was startled to hear her say, “I don’t think there’s anything he could have done without knowing me better” (lines 894-5), which again seems to indicate that the problem lies with her. However, and interestingly, she did note that the response of the midwives, including their provision of concrete information and an empathic stance, were extremely helpful to her but she is unable to bridge that to an expectation of those things from the doctor. She noted later, in regard to my question about the doctor’s mannerisms, “He’s always been fine” (line 1242).

...and patients do not

Emily mentioned several times during the interview that she was unclear about the purpose of the ultrasound. When she was talking about her first ultrasound, she said, “I think they wanted to make sure it was actually implanted at the right place and, ah, they might have been checking for multiple births, I’m not really sure” (lines 173-7). When I asked Emily how she had come to the decision to have an ultrasound, she noted that “it was just part of their procedure” (line 318). She again indicated that she was unsure about the purpose of the ultrasound when I asked if she was being monitored more
carefully as a result of her history of cysts. She responded, “I don’t thi-, I think it was just part of their procedure” (lines 323-4) and then, “[I]t seemed like they just wanted to make sure it was actually implanted in the right place” (lines 338-9).

It is somewhat surprising to me the degree to which women (and men) entrust physicians to perform medical procedures/assessments without a clear understanding of their purpose, and I am no exception to this. It was around this time that I had a conversation with a friend about the purpose of pap smears. This friend and I – both advanced graduate students – both seek out routine gynecological exams without a clear sense of the purpose of the procedure. I have an idea that it a screening for pre-cancerous cells but don’t know what particular type of cancer it is supposed to detect and if it serves any purpose beyond that. I do it because the expectation is that women will have an annual gynecological exam.

Both Joanne’s age (almost forty) and disability status put her in ‘high-risk’ groups. For these reasons, she is perceived to be at greater risk and consequently requires more surveillance. This is apparent in her description of the number of ultrasounds that she has had (four at the time of the interview and anticipating more (lines 388-95)) and comments such as, “I go [to the doctor] more frequently probably than other women” (lines 318-9). The “probably” here indicates that she is not entirely sure about the level of monitoring that she’s receiving and why.

As with Emily, Joanne did not actively make the decision to have an ultrasound and noted that they “do it right away” with individuals who are in high-risk pregnancy groups. As with both Heather and Emily, some of the specific purposes of the checking are vague to Joanne:
R: Okay (. ) And, um, how did you come to the decision to have an ultrasound?
P: (. ) The first, well, I didn’t really come to it, I mean, when I, as soon as they, um, determine that you are pregnant
R: Uh-huh
P: and you come for your first appointment, when you’re in a high-risk pregnancy (. ) they do it right away
R: Okay
P: just to make sure everything’s, you know, good, and then I’ve had them frequently (. ) leading up
R: Um-hmm
P: ’cause they’ll kee-, and they’ll keep doing them (. ) pretty frequently ’cause they want to make sure everything’s (. ) good because I’m in a high-risk group
R: Okay
P: they’ll keep checking the baby pretty frequently.
(lines 363-378)

Joanne described the process whereby the image was interpreted to her in the moment (“they show you everything” (line 504)) and then after the fact (“then when they’re done then you usually have to wait while they go ahead and get the report” (lines 504-6)). The production of a report, which is typically considered to be an official and detailed account of something, gives the interpretation a kind of legitimacy.

Heather noted that she believed that the ultrasound was a standard procedure for pregnant women. When I asked if she had planned on having an ultrasound, she noted, “I assumed that you were supposed to at some point in time just to check on it.” She further reiterated, “I just assumed that pregnant women got ultrasounds” (line 1077-8) and “almost everybody you talk to gets them now” (line 1080).

I was startled by Joanne’s comment, “I can’t really say I’ve had any bad, eh, pregnancy experiences” (lines 1352-3). This is one moment in which I am struck by the benefits of qualitative research – in the context of the entire interview, this comment cannot be taken at face value given that Joanne has already named two very negative pregnancy experiences, one with a previous pregnancy (when the tech told her that her
uterus was empty) and one with this one (when the doctor dismissed her complaints of pain which turned out to be a hernia). One possible way to make sense out of this contradiction is through a discursive approach, noting that experiences that are inconsistent with a dominant discourse are minimized and, ultimately, covered over.

### Maternal discourse

We can talk about a man ‘mothering’ a child, if he is this child’s primary nurturing figure, or is acting in a nurturant manner. But we would never talk about a woman ‘fathering’ a child, even in the rare societies in which a high-ranking woman may take a wife and be the social father of her wife’s children. In these cases we call her the child’s social father, and do not say that she fathered her child. Being a mother, then, is not only bearing a child—it is being a person who socializes and nurtures. It is being the primary parent or caretaker. So we can ask, why are mothers women? Why is the person who routinely does all those activities that go into parenting not a man? (Chodorow, 1999, p. 11)

The discourse that I’ve labeled ‘maternal’ concerns assumptions about women’s relationships to motherhood. Motherhood is purported to be a natural event, and caring for a baby is believed to be something that women just know how to do. Women are expected to want to become mothers (above all else), and women who choose not to have children are considered to be selfish and are often told so directly.18

---

18 The assumption that ‘women’ want to become mothers presupposes a particular kind of ‘womanhood.’ Women who are white, able-bodied, heterosexual, and married are assumed to want to become mothers, while women who do not fit into these identity categories are not (Morse, 2000; Woolett & Marshall, 2000). I will discuss this further below.
Motherhood is believed to be transformative experience. In popular discourse, motherhood is purported to be a blissful experience, causing the woman to be happier, more fulfilled, more emotionally available, and generally more of a person than she was prior to the birth of the child. This discourse is reflected in the plethora of articles published in the last year or so chronicling “Hollywood’s Baby Boom” (People, 2005) which describe a number of celebrities’ (Julia Roberts, Gwyneth Paltrow, Britney Spears) unconflicted and ecstatic transformations as a result of their child or children being born. And, although accounts of postpartum or postnatal depression from celebrities such as Brooke Shields might seem to stand in stark contrast to this discourse as they entail a difficult and painful post-birth experience, in fact these act to reify the normative maternal discourse further in setting up a contrast between the “normal” experience of the happy mother and the “abnormal” experience of the depressed woman who is in need of psychological intervention and medical treatment in order to recover.19

The pregnant body is one which is surrounded by a number of prescriptive, and oftentimes contradictory, discourses, creating somewhat of an impossible situation. Women are expected to simultaneously have “that glow” while also battling morning sickness, hormonal shifts and swollen feet. There are specific things that pregnant women are expected to do (take prenatal vitamins, go to the doctor for regular check-ups, gain a particular amount of weight) and expected not to do (smoke, drink, lift heavy things). Perhaps most interesting, the pregnant body all at once implies both a hypersexualization and a hyposexualization; that is, the pregnant body implies an off-

---

19 I do not intend to be dismissive of the legitimacy of women’s experiences of postpartum depression and the usefulness of the available treatment options for many women who become depressed following the birth of their child(ren), but I do hope to note that the health/illness split (whereby health is the norm and illness is the abnorm) is a false one; the expectation that a woman will have a specific and joyful experience of motherhood may in fact contribute to some women’s experiences of depression (Stoppard, 2000).
limits sexuality that is presumed to reside within the confines of a pervasive heterosexuality.

Every (white, able-bodied, heterosexual) woman wants to be a mother

Emily and Joanne challenged often unspoken assumptions about who should become a mother. Unlike Heather, who “figured that [she] would have children at some point” (line 1635), Emily clearly asserted that when she was growing up she definitely did not want children. Joanne felt that she wanted children but was aware of the fact that this was something that was not “expected” of a woman who has spina bifida.

Joanne and I had a number of conversations about her decision to become pregnant. Early in the interview, she described to me her difficulty finding a doctor who would work with a woman with disabilities:

P: Um, well, because I have spina bifida, I had to, um, look for a high-risk pregnancy group ‘cause I’m over forty
R: Um-hmm
P: Well, gonna be forty, I’m not over forty
R: Um-hmm
P: and, ah, and because I have the spina bifida, um, I wanted a doctor who’d worked with women with disabilities before?
R: Uh-huh
P: which is not easy to find, I might add (laughs)
R: Um-hmm
P: Really, really difficult, actually (lines 97-107)

As with Emily, Joanne is within a ‘first-generation’ of a particular group to have children. Initially, she attributed this to increased longevity due to medical advances, noting, “My generation of spina bifida children are the first group that are old enough to have lived really long enough to have children” (lines 192-6). She later noted that social factors are in play as well when she remarked that the possibility of someone with spina bifida having children “was not well discussed” in previous generations:
but, ah, OTHER than that I don’t think there’s been any other
um, impacting things, you know, when I was younger, it
was not well (. ) ah, discussed to have childr-, yo-, yu know,
that, it was kind of assumed that you wouldn’t have children

Joanne attributes the social changes (more acceptance of the possibility of
someone with spina bifida having children) to medical advances, believing that medical
advances have acted as a kind of precursor to social movement. I wonder if the two are
perhaps not more reciprocal and if some cultural shifts in attitudes have acted as a
precursor to the initiation of more research on such medical conditions and pregnancy
which have in turn provided more research which has allowed for more shifts. I also
wonder about how the potential for economic gain might drive the proliferation of certain
forms of research, including those that capture demographics of people who have not
“traditionally” been expected to have children.

Motherhood is natural

Heather seemed a bit caught off guard when I asked her what she had done in
preparation of becoming a mother. Although she described concrete movements she had
made including getting the crib together, purchasing clothing, taking a birthing class, and
reading books, and as well had discussed previous experiences she had had in taking care
of younger cousins, she still ascribed to the idea that motherhood is just something you
know how to do. She remarked, “to me it just seems like something you DO, you’re born with the ability to DO it” (lines 309-10).

As with Heather, Emily seemed a bit caught off guard by my question about whether she had done anything in preparation of becoming a mother. She responded, “Ah, well, like what?” (line 198), to which I responded, “Anything goes” (line 199). Following that, she told me that she and her partner had bought a bigger house in a different school district (line 200-1), read about twenty-five books (line 205), familiarized themselves with the community of lesbian parents in Pittsburgh (line 207-11), and thought about and began to set in motion the legal work that they anticipate will need to be completed, including guardianship papers and second-parent adoption papers (lines 211-7). Additionally, she told me that because she had been so sick, a good amount of the preparation that she had done was emotional: “I’ve been dealing with how to handle, you know, working and also being sick so that’s been most of my emotional work” (lines 235-8). As with Heather, there was a discounting of the movements that she had made with regard to her preparations, in particular with regard to the intangible movements (the “emotional work”).

Motherhood is transformative

Another strong belief that we hold onto with regard to motherhood is the idea that it is or will be a transformative experience for the woman who gives birth. Emily illustrated this discourse when she talked about how having a baby changed her sister’s temperament dramatically:

P: and then, um, when the BABY came, my sister, my youngest sister was always sort of the irresponsible one?
R: Um-hmm
Although I was skeptical that Emily’s sister’s transformation from irresponsible younger sister to never-yelling mother was as dramatic as she described, I nevertheless felt enticed by the idea of young parents who suddenly “shape up” following the birth of their child(ren). At the same time, I wondered in this moment if there were perhaps some parts of a rosy picture that we did not want to acknowledge. Indeed, following the above excerpt, Emily went on to note that she’s seen that there are “bad parts,” too:

**P:** And I’ve gotten to see, too, you know, there are bad parts of that, too, but, um, you know, just seeing what that relationship is like, you know, a really positive example of that relationship, you know?

**R:** Uh-huh, bad parts of being a mother, is that what you meant?

**P:** No, I mean, the, seeing the, seeing the GOOD parts of it

**R:** Uh-huh

**P:** have really, you know, I think, um, it really made us want to have a kid (lines 783-91)

This is one moment in which we seem to misunderstand one another as my follow-up inquiry was intended to open up more of a conversation about the all-too-often unspoken negatives of being a mother, but I think that it’s more than that. In the above exchange, I could have worked harder to clarify what I meant and to understand more of what Emily meant when she said “bad parts.” The fact that I did not may illustrate some reluctance on my part to discuss the negative experiences.

There’s a parallel between the romanticization of pregnancy and the romanticization of motherhood. With pregnancy and motherhood, an idealistic image has
been enacted in which the beauty and fulfillment of the pregnancy/motherhood will override the physical, mental and emotional strain. Emily described a romantic notion of pregnancy prior to becoming pregnant herself. She noted that, at the time of her sister’s pregnancy, she was focused on the beauty of the pregnancy and the proliferation of life and hadn’t realized that her sister was, in fact, miserable:

P: And, um, you know, just seeing, I think, I wanted to be pregnant after seeing my sister be pregnant
R: Uh-huh
P: like, my sister just looked so beautiful when she was pregnant, even though, like, talking to her now I realize she was miserable a lot of the time
R: Uh-huh
P: at the time I didn’t really th-, I didn’t SEE that, you know, I just thought, Oh, she looks so beautiful, and it just was so wonderful, like, I just was, like, so wrapped up in the fact that she was making life, you know
R: Um-hmm
P: and it just seemed so fantastic (lines 749-61)

What pregnant women can do, should do, and should feel

There were moments in which discursively-perpetuated expert knowledges were apparent in regard to both permissible and expected movements of pregnant women. Heather told me that she had a cup of coffee on the morning of the third ultrasound, noting, “they say it’s okay as long as you don’t drink a ton of it” (line 1129). She also told me that she felt uncomfortable on a particular incline during the third ultrasound but was quick to attribute the problem to herself: “[E]ven though a pregnant woman’s supposed to be fine on a five percent incline, it kills me” (lines 1161-2).

When Joanne told me that she hadn’t gained any weight during her pregnancy, I had a reaction of concern that was immediate. My system went into high-alert, and I thought, rather dramatically, ‘You haven’t gained weight and you’re five months pregnant?!?!.’ (This was similar to the concern I felt about Heather’s decision not to visit
a doctor for a number of years.) Again, this points to the strong (and oftentimes unidentified) pull to do what is “normal” and the immediate concern that arises when confronted with something that is outside the bounds of normalcy.

When I asked Heather about the physical changes she had noticed in her first three months of pregnancy, she responded by telling me about the changes that she had not noticed. Perhaps there is no better illustration than this of the ways in which we fit our experiences within a larger discursive structure as it betrays an unrelenting awareness of what we should be doing or experiencing, i.e., what’s ‘normal.’ In the following excerpt, Heather attempted to make sense of her experiences as a pregnant woman by contrasting them with what she might have experienced:

R: Uh-huh (.) So besides your stomach (.) feeling bigger did you notice any physical changes (.) in those first few months?
P: I was not sick, I was n-o-o-o-t particularly tired
R: (overlapping) Uh-huh
P: I mean, I was a little bit tired but nothing that winter blahs wouldn’t account for.
R: Um-hmm
P: Um (.2) yeah, no, my hair didn’t change, my nails didn’t change, all of those things they sa-a-a-y, no breast enlargement
R: Uh-huh
P: Nothing, you know, you’re just like (.) I’ve gained a little weight, that’s weird (laughs) (lines 89-101)

As with Heather, Joanne made sense of bodily changes and experiences in terms of the available discourses about pregnancy. When I asked Joanne about bodily changes that she’d noticed, she first reported that her right hip had been hurting and that her breasts had gotten bigger, and then added, “those are pretty much the only big changes that I’ve noticed, that, my feet aren’t swelling, I’m not having any kind of, um, other, you know, stuff” (lines 839-41). As with Heather, the normative discourses regarding the
changes that women are supposed to experience are so persuasive that Joanne made sense of her experiences with specific regard for that larger structure.

**Pregnancy supersedes everything else and implies an off-limits heterosexuality**

In our conversation about Heather’s feelings about how her body looks to others, she described a conversation in which she had asked her boyfriend how a particular outfit looked. She told me that she asked him, “Does it look good? Does it look bad?” (line 1551) and his response was, “Well, you look pregnant” (lines 1551-2). In this example, the pregnant appearance of the body overrides everything else. In a way, the pregnancy acts to desexualize the appearance of the woman.

In contrast to this, Heather described a situation in which she felt that her pregnant appearance seemed to have a hypersexualization effect. She recounted a situation in which she perceived a grocery store bagger to be flirting with her. In this instance, she remarked that during her pregnancy and beforehand she has noticed men noticing her. While her comment, “I predominantly notice men just because I’m heterosexual” (line 1902-3), served to open up a space for more than one kind of sexuality – and I appreciated Heather’s awareness of her own sexuality as a particular kind of sexuality and not the only one that exists – I was also aware of the ways in which the masculine gaze is not only reserved for self-identified heterosexual women.

In this moment, I was initially reminded of a work colleague, a lesbian therapist who became inseminated several years ago. Prior to her pregnancy, her clients presumed that she was a lesbian, but after the insemination, they shifted their assumption and assumed that she was straight. I also have as association to my own awareness of who
“looks” at me, an awareness that does not necessarily have any reciprocity. In fact, the kind of interaction that Heather described – in that it did not seem to be reciprocal (she noted, “I find it bizarre” (line 1936)) – denoted much more of a voyeurism – perhaps structured by a patriarchal unconscious (Sturken & Cartwright, 2000) in which Heather’s status as both a sexual being and maternal figure is highlighted.

**Biological discourse**

Biological discourse encompasses any presumption that privileges the body in its ‘pure’ biological form. Biological discourse – in parallel to rational, scientific, or medical discourse – proliferates in Western culture, as illustrated by research that seeks to locate the etiology of any number of variations of human development (e.g., schizophrenia, gayness, PMS). Biological discourse is intimately concerned with genes, hormones, chromosomes, and cells as foundational. In the biopsychosocial model of psychological illness (APA, 2000), the “bio-” comes first, betraying a belief in the biological as primary to the genesis of the human subject.

A number of observable biological presumptions surround pregnancy, childbirth, and parenthood. There is a presumption of the legitimacy of the links that exist between parents and their biological offspring. Other biological presumptions concern the idea that hormones are responsible for driving behavior and a (somewhat delusional) belief in the concrete existence of the ‘biological clock.’ Because biology is privileged as something that is ‘pure’ or unaltered, factors that are biological are privileged as ‘natural.’ The act of conception itself is believed to be a biological event, and consequently the copulation of two heterosexual subjects for the purposes of conceiving a
child is considered to be natural, thus rendering other forms of sexual contact – and other forms of conception – to be unnatural or artificial (Tiefer, 2004).

**Biological links are the most legitimate**

I misunderstood a comment that Emily made with regard to her and April’s decision that Emily would carry the child. Emily remarked, “April’s adopted, so she liked the idea of having a genetic link to someone” (lines 140-1), and I assumed that this meant that she had a desire for either her (April) or Emily to carry a child, rather than adopting, so that one of them would have a genetic connection to the child. In fact, it was not until after the interview, when I looked closely at Emily’s next remark (“but when it really came down to it, I was really the one who wanted to experience pregnancy and childbirth and she really didn’t want to” (lines 143-5)), that I realized that what Emily had meant by this comment was that even though April wanted to have a genetic connection to the child, in the end it seemed that Emily was the more likely person to carry the child because of her desire to experience pregnancy and childbirth.

**Hormones drive behavior**

The idea that hormones are responsible for behavior is a cultural assumption, one that seems to be invoked more often in regard to the behaviors of women and adolescents. As Tavris (1992) notes, regarding women’s behavior, researchers “enthusiastically seek physiological differences in…hormonal changes that supposedly account for women’s (but not men’s) moods and abilities. Their assertions are more likely to make the news than is the evidence that contradicts them” (p. 24). She also
notes, “Large-scale studies of normal adolescent males and females show that turmoil is only one way, and not the most common way at that, for getting through the teenage years” (p. 38).

Emily indicated an acceptance of a biological discourse when she commented, in regard to the son of a lesbian couple that she and her partner know, “it’s sort of like once the hormones kicked in, you know, they’ve had a much harder time with him” (lines 485-6). Heather as well made a reference to the ways in which hormones have impacted her thoughts and behaviors. In regard to her worries about the humanness of the fetus and in noting her desire to know that “it’s a baby in there and not, you know, something from Alien” (1098-9), she commented, “I know that sounds cra-a-zy but (. ) my mind does all kinds of goofy things (. ) it, I think it’s (. ) the hormones” (1101-2).

The ticking of the biological clock

Joanne noted that she was aware of a time clock in terms of her capacity to get pregnant. She told me, “I didn’t get married until I was thirty-three so I, you know, I started wondering if I would have children ‘cause that’s, getting, you know, up there” (lines 1149-51) and “then we decided that we really wanted to try and then we were on a time limit because I did, I wanted to do it before I was forty” (lines 1166-8). Joanne also noted, “I kind of risked it this time with being close to forty, and over forty would be a little nervewracking” (lines 1191-3). This intersects with idea that dramatic things occur at particular moments that can be harnessed, as though the risk of pregnancy increases exponentially on one’s thirty-fifth or fortieth birthday, as though there is a pivotal moment at which your fertility completely goes to hell.
Heather told me that her skepticism in regard to her pregnancy was partially due to the fact that she had some concerns about her fertility given that she was in her thirties. She attributes her skepticism to her awareness of the “statistics” that are available with regard to women’s fertility:

P: but, yeah it wasn’t, I just really didn’t think it would happen
R: Uh-huh
P: Well, also, because, you know, you read all the statistics, your fertility starts to decline at twenty-EIGHT
R: Uh-huh
P: blah, blah, blah
R: Uh-huh
P: and so, I’m like, OH-kay, you know
R: Um-hmm
P: (...) it’s gonna take some time (laughs) (lines 290-99)

An identification of the ways in which these biological factors are discursively mediated is not to deny that biological change occurs, but it is to point out the ways in which these changes are emphasized to occur in the same way and at the same time for everyone and to highlight the ways in which context and individual variation are obscured.

(Hetero) Sex (ual Intercourse) is natural

Heather responded, “Naturally” (line 20) to my question, “How was the fetus conceived?” (lines 19-20). Naturally has several definitions, the most salient of which are “through inherent nature” and “according to nature; by natural means; without artificial help” (Lexico Publishing Group, LTD, 2005). In thinking about the word naturally, I wondered about its opposite, and it occurred to me that there are two (perhaps overlapping) binaries in play here. The binary of natural/unnatural positions the subordinate term of the binary as “in violation of a natural law; deviating from a
behavioral or social norm” (Lexico Publishing Group, LTD, 2005) in contrast to something which is “through inherent nature.” The binary of natural/artificial positions the subordinate term as “made by humans” in contrast to that which is “without artificial help” (Lexico Publishing Group, LTD, 2005).

Even though Heather’s use of the word naturally here seems to stand in contrast to that which is artificial, I have an immediate association to the word “unnatural.” In popular discourse, homosexual sex is positioned as unnatural in contrast to heterosexual sex, even though sexual activity between animals of the same sex occurs in nature and has been well-documented (perhaps the most highly publicized case in the past few years has been the story from the New York Aquarium of two male African black-footed penguins, Wendell and Cass, who appear to have mated for life (Cardoze, 2002)). In regard to Heather’s comment, I have an association to a question regarding its opposite term: If sperm is inserted into the vagina via artificial insemination or via any other means than an erect penis, is this more appropriately deemed “unnatural” or “artificial”?

In response to my question about how the fetus was conceived, Joanne noted, “normally” (line 8) and then added, “there was no extra stuff involved” (line 9). Again, this marks heterosexual sexual intercourse as the norm. Joanne later noted that if she and her husband were to have a second child, they “would probably decide to do something else, some alternative” (lines 1195-6). Emily responds “artificial insemination” (line 9) to my question about how the fetus was conceived, contrasting both Heather’s response (“naturally”) and Joanne’s response (“normally”).
Familial discourse

The belief is that culture itself requires that a man and a woman produce a child, and that the child have this dual point of reference for its own institution into the symbolic order, where the symbolic order consists of a set of rules that order and support our sense of reality and cultural intelligibility. (Butler, 2004, p. 118)

In parallel to a number of other discourses, the family comes into existence as a result of movements that are discursively perpetuated as natural or legitimate, and this includes both who is allowed to be a member of that family unit and what his or her responsibilities are within that unit. The construction of the nuclear family presupposes a normative heterosexuality such that the unit consists of a heterosexual couple and their ((preferably biological) children) and such that members of the opposite-sex pair perform movements that are appropriate to their gender.

The heterosexual family unit is perceived to be so foundational to the societal structure that recent court decisions legalizing gay marriage have caused many to decry the fall of Western civilization itself. Indeed, the idea that two individuals of the same sex could love one another and desire to commit to spending a lifetime together is so terrifying (to some) that individuals actually perceive a threat to their own existence, providing strong support for the idea that language is constitutive of reality and that ontological weight is constructed through a process of exclusion, through a constitutive outside, through “a set of foreclosures” (Butler, 1993, p. 8).

In addition to the privileging of the heterosexual unit, parents are expected to perform specific responsibilities in their roles as parents, and these are observable in
relation to their (unborn) children as well as in relation to their spouses, medical
professionals and other family members.

The standard heterosexual family unit

The idea that children will grow up in the context of a nuclear family in which
two heterosexual parents rear children until they “leave the nest” and form their own
heterosexual units is a sociohistorically-specific ideal that is perpetuated as a universal
norm. In a moment of subtle perpetuation of a normative nuclear family, Joanne, as an
aside to a comment about her feelings about the differences between raising a boy and a
girl, noted, “I have a brother and my parents raised us, obviously” (line 937, emphasis
mine).

Emily noted almost immediately that the hospital was “definitely like a
heterosexual environment” (line 41). She noted instances in which she had to explain to
the doctor who April was, and she described a situation in which April was excluded
from the beginning part of one ultrasound. She described the paperwork that indicated a
place for her to provide the name of a spouse and the confusion with which her provision
of “April” was met. She noted that she had the feeling that no one had ever come out to
her physician because of comments he’d made to her.

Emily mentioned to me that it had been “exciting” for her and April to tell their
families about her pregnancy (lines 242-3), and she did not equivocate about this. Even
still, I immediately wondered about how supportive Emily’s family had been about her
sexual orientation and her relationship with April. In an effort not to make an assumption
(that a minority sexual orientation is a problem or at least a potential source of conflict or
difficulty for families or origin), I did not ask Emily any questions about how she had come out or what the process had been like for her. However, as with my decision not to ask Heather about her marital status, not asking the question did not protect me from my assumptions and fantasies.

In part, I wanted to ask about Emily’s family’s reaction to her gayness because I wondered how much work she and her family had done to this point that was possibly getting covered over by the present joy of her pregnancy. There is a pain in coming out that gets covered over after a few years or decades of emotional work. Recently, I came across a copy of Modern Bride magazine in which a lesbian wedding was featured. The photo spread included a picture of the two brides with their flower girls and attendants, and I wondered, “How much kicking and screaming occurred behind the scenes in the years leading up to this picture?” What became apparent to me is the way in which there’s a whole level of pain that I did not (or we did not) attend to, perhaps in this interview more so than in the others.

Before traveling with Jenny last November to spend Thanksgiving with my parents, my siblings and their spouses, and their children, I made the decision to behave as any newly-engaged person would. The trip would be the first time that we would see my family after having become engaged, and in the days prior to the trip I resolved to act as “normally” as possible, discussing our plans, our future, our lives together. I was aware that this would not be easy given my brother and sister’s resistance to telling their children – ages ten and seven, and ten and six respectively – about our plans in concern
for the dreaded confusion that it might cause. In spite of this, I resolved to “be myself” as much as possible.

We had an early flight. The alarm went off just before dawn on the Wednesday before that Thanksgiving, and I awoke with an unsettled feeling in my stomach. On autopilot, I made a pot of coffee, showered, gathered and packed last-minute belongings, and rechecked the flight schedule. Bleary-eyed from lack of sleep, and with fifteen minutes to spare before we were to depart for the airport, I sat at the edge of the bed and unsuccessfully fought back the churning in my stomach as it gave way to great, heaving sobs and paralyzing grief. The grief was a combination of a profound awareness of my own isolation, of feeling that I did not belong within a family unit that was supposed to be my own, of weariness at clawing for scraps of recognition of the legitimacy of my self and my relationship and of the emergence of the sickening prospect that I was about to inflict this pox on those around me, causing a circle of pain that extended to those who would struggle to out themselves as the niece or nephew, sister or brother, father or mother of a lesbian.

This was a low point. It eventually gave way to other feelings, including tentative joy, both my own and that of others. In the end, my sister decided to bring her daughters to our wedding, and five months after Thanksgiving, I phoned her to ask about meal options for her two girls. A simple conversation: I inquired about whether my oldest niece would prefer to have a kid’s meal or an adult meal, and we decided that it would be

---

20 I should note here that this situation was preceded by several years of resistance to introducing Jenny as my girlfriend or partner, resistance that was fueled by my sister’s pediatrician’s observation that “perhaps the children are too young” and which I met (heart in my throat) with both the provision of statements from major medical and psychological associations in the U.S. regarding gays and lesbians as well as my own desire to be able to live an honest existence with my nieces and nephew, allowing myself some small measure of peace in the knowledge that, after the fact, no one would be able to say that they “didn’t know” (Laubscher & Powell, 2003).
easiest to give each of them the option to have a plain, cheese quesadilla. A simple conversation, and one which in its banality threatens to cover over a paralyzing grief that had been endured prior.

When Emily and I discussed her ideas about any differences between raising a boy versus raising a girl, I added to my question “particularly as a lesbian couple” (line 462). Although I did so tentatively and perhaps not so eloquently, this is a case where I did name an assumption that I had about the ways in which childrearing is necessarily complicated by the presence of same-sex parents. Specifically, I am thinking about the ways in which psychological literature in general has lagged behind in its articulation of family models that do not adhere to a ‘traditional’ structure (Heineman, 2004). Given that Emily’s lesbianism was not central to the explicit goals of the interview, I probably would not have asked Emily about this if I had not disclosed to her my own status as a lesbian as I feel that it might have put her on the spot unfairly. As it was, I did feel somewhat uncomfortable posing this question to her.

Family members look alike

Emily told me about how she and her partner had come to the decision to choose a specific sperm donor. She told me that they had chosen the donor primarily on the basis of his consent for his identity to be released when the child is eighteen and secondarily on a number of characteristics (mostly physical but also temperamental) that she called “quirks” (line 64) (e.g., red hair, freckles, being over six feet tall, playing rugby). She identified her discomfort with the process (“it’s like eugenics” (line 65)), but we didn’t
discuss it more specifically, and this is perhaps due to my own discomfort as much as Emily’s.

Race of the donor was notably absent from our conversation. Emily emphasized the “quirks” that came up with regard to characteristics, and these imply something more trivial. I don’t have any idea if Emily’s partner is white or not, but based upon the fact that race was absent from our discussion – and knowing that her partner has red hair and freckles – I made the assumption that she was. Built upon the basis of my assumption of the whiteness of Emily’s partner, I also made an assumption regarding the whiteness of the donor. This is a clear illustration of white as the invisible norm.

There’s a lot to say here, much of it having to do with the level of white privilege evidenced in a number of assumptions about family structure. In cases in which a couple (opposite-sex or same-sex) desires to parent a child together who will not be the biological offspring of both of them, decisions must be made regarding characteristics of that child – this is true in cases of both adoption and donor insemination. In regard to these “characteristics,” race is arguably the stickiest.

Couples with the economic and class privilege to access adoption and insemination options are disproportionately white, and the preference for lighter-skinned children is overwhelming. On one private agency website, children available for domestic adoption are divided into two categories: “Caucasian, Latino and Asian” babies comprise one category, while “African-American” babies comprise a second (Adoptions from the Heart, 2003). Fees for adopting African American children are subsidized “because of the great need for families to adopt children of African-American heritage”

---

21 I should note here that I have avoided writing about this until the very last minute, right before this draft is getting ready to go to the progress report meeting.
(Adoptions from the Heart, n.d.). Demand for light-skinned children is evident in regard to donor insemination as well. California Cryobank, one of the largest cryobanks in the country, imports sperm from Denmark under their Nordic Donor program, providing couples with the best odds of conceiving a blonde and blue-eyed child (California Cryobank, 2003).

Jenny and I have had a number of conversations about both adoption and insemination, many of them in regard to race. It is likely that if one of us gets pregnant it will be me, and she has made it clear her hesitations about parenting a white child as a Korean American woman. Discussing donor characteristics has led to conversations about whether or not it will be important to either of us for the donor to be Asian, or specifically, Korean. Discussions about adoption have gone a similar route, and the potential for us to adopt a child from an Asian country is appealing for a number of reasons, including an anticipated acceptance from our families and a perception that we will be able to blend in more easily.

Families in which members look alike are afforded a privileged level of invisibility, and families in which the children look much different from both of the parents are highly visible. Many couples indicate their desire to have a child who “looks like” them, oftentimes enacting a white privilege and covering over a large degree of implicit racism and homophobia. Indeed, Jenny and I have discussed the level of visibility we will have if we adopt or one of us gives birth to a child who looks nothing like either one of us. When we are out in the world, Jenny and I do not appear to most people to be a couple, and there are particular situations in which I would not want to draw attention to the fact that we are, usually out of a perceived threat to our safety. As a
white person, I have the racial privilege to pass as the adoptive parent of a child of virtually any race, but Jenny does not possess this racial privilege and she will be quite visible as the parent of a non-Asian child, a perception which has the potential to out all of us as a gay family unit. Whatever the race of the child, Jenny will be marked as raced – something which is not new for her – but I, in my white privilege, and from a white perspective, will most likely be able to avoid this marking in most cases. If we adopt an African American child, I will potentially be raced in a way that I have not experienced before, identified as a gay, white adoptive parent in the black community, subjectified in a way that I am usually able to avoid, marked within a context of race relations between blacks and whites in which I will have to confront my own role within the context of this country’s ugly history of slavery and oppression.

These things are difficult to commit to paper as I would rather not think about them. They highlight the intersection of an overwhelming degree of race, class, and heterosexual privilege. They reveal my own racism and race privilege, classism and class privilege, and internalized homophobia that I would rather mask as something more benign but which are evident in the assumptions that I would prefer to attribute to other people. They reveal the ways in which the particulars of subjectivity which Emily referred to as “quirks” – and which during the interview I did nothing to challenge or elicit further conversation about – cover over an impossible and interlocking degree of entitlement that was left completely untouched.
Parents have specific responsibilities in regard to their children

When I asked Joanne about what she had done in preparation of becoming a mother, she told me that she had read some books (line 41) to get “boned up” on stuff (line 43), was getting the baby’s room ready (line 47), and was planning to take a parenting class with her husband (line 56). She noted that she and her husband were doing “normal” stuff (line 47) and, indeed, the steps that she described are in consonance with what an expectant mother is ‘supposed’ to do. She later remarked that she is nervous about “all the normal stuff that all moms are nervous about” (line 1362-3) and then noted, “I think that’s pretty standard” (lines 1368-9).

I found Emily’s responses to my question about what she wants for her child to be somewhat off-putting. Emily told me that, among other things, she hopes for her child to be involved and active (lines 917-8), to have self-confidence (line 920), to care about people and the world (lines 920-22), to not be selfish (line 924), and to have a sense of responsibility for the world and not just for him- or herself (lines 926-7). I am left with the feeling that there is a lot of pressure for the child to be a particular kind of person.

Heather described her feelings of frustration with another pregnant woman who spoke of wanting to keep her future child close. Heather told me that the woman had said, “I want to keep him and hold him and hug him and, you know, I-, he is never gonna love another woman as much as me and, in fact, I hope he’s gay” (lines 1762-4). I was initially startled by this. On reflection, I think that it is related to the idea that the love of a man for another man (or woman for another woman) lacks a particular depth, predicated on the heterosexist assumption that the “love between a man and a woman” is
the highest level of love that one can achieve against which all other love relationships are comparatively less-than.

Gendered discourse

Gendered discourse concerns the specific responsibilities that are assumed of men and women within the confines of a binary system of gender, including the presumption of a normative masculinity (for men) or femininity (for women) and a normative heterosexuality, or opposite-sex sexual orientation, for all. Underlying these roles concerns the larger, culture-bound assumption that gender is foundational to and a prerequisite of one’s identity. Gendered discourse also encompasses the construction of “woman” as demanding, irrational, unstable, and prone to hormonal disruption at any time.

Gender is foundational to identity

Emily and I discussed her anticipation in regard to finding out the sex of the fetus. Although Emily said that she and her partner don’t have a preference for a boy or a girl, she commented, “I’m hoping to get to see the sex of the baby, you know, so, we’re excited about that” (lines 440-2). In regard to the sex, she also commented, “[W]e don’t like the surprise, [we] want to know things, so” (lines 453-5). Following this comment, we discussed the anticipated differences between girls and boys (lines 464-88). Again, as with Heather (pp. 13-14), Emily perceived the sex of the fetus to be foundational to its identity, illustrating the belief that “knowing” the sex of the fetus will provide some clues
about important and foundational aspects of her or his identity including personality, mannerisms, interests.

Joanne noted that she and her husband chose to find out the sex of the fetus out of a desire for knowledge (“we wanted to know” (line 668)) that would allow them to prepare for the baby. Joanne said that she “wanted to plan the room and stuff to fit whichever sex it was” (lines 703-6), noting that because they are having a girl she had purchased a lot of “girl items” (line 693). She also noted that she wanted to keep the preparations “within reason” (line 708). Although I did not ask her exactly what she meant by this comment, for me it conjured up an image of an attempt to avoid an outlandish femininity (e.g., a pink room filled with frills and lace) in favor of a more sensible or tempered one. Again, this points to gender constraints being set into place before the fetus is even born. That she wanted to keep things “within reason” is yet another reference to the privileging of a rational order.

Following her comment regarding her desire to fit the room to the appropriate sex, Joanne did note, “I don’t really know why because we’re doing Winnie the Pooh, which is pretty multi (laughs) either one” (lines 710-1). She also noted that she requested that the sonographer confirm the sex at a subsequent visit: “I said to her, ‘Can you just make sure it’s a girl again because if it’s not, we have serious problems, ‘cause I’ve purchased a lot of girl items” (lines 690-3). Although spoken somewhat tongue in cheek by Joanne (“we have serious problems” (line 692, emphasis mine)), efforts to loosen the constraints of normative gender are considered by many to be no less than catastrophic.

These gender constraints are appealing, and they can be difficult to resist. Several years ago, Jenny and I traveled to Long Island for a baby shower for Jenny’s former
internship training director. Jill and her husband were expecting a girl. Jenny and I walked into a BabyGap to pick out a gift. The store is divided into sections by age (Toddlers, Infants, and Newborns) and further divided within those sections by gender (Girls and Boys). We headed to the newborn/infant girl section. We examined the tiny clothes (0-3 months, 3-6 months, 6-12 months) for the more androgynous-looking items, simultaneously aware of our political and personal opposition to constrictive gender roles and our desire not to offend our intended recipients by bestowing a gift upon them that would imply the possibility of a less-than-normative child.

As we browsed, I found myself increasingly drawn to the tiny pink outfits, the little flowers, the miniature bows. I struggle to resist this gender-coding, but at times I find these little girl outfits to be adorable, even in spite of my awareness of how constrictive this hypernormative femininity felt to me as a child. This happened a few years ago, too, when I was buying baby clothes for a friend’s new baby daughter. At the time, I was doing research on the social construction of PMS and the relationship between experiences of menstrual distress and constructions of femininity (Cosgrove & Riddle, 2003). I purchased some pink and white clothes for the baby, wrapped them in a pink and white package, and tacked a pink and white bow on the top. My roommate at the time was bewildered by my actions, but not more so than I was.

Gender as a prerequisite for subjectivity came up around Heather and her boyfriend’s desire to know the sex of the baby in order to provide the baby with a name that would act to sediment his identity: “I wanted to know the sex of the baby and my boyfriend agreed, for me, that’s a big identifying factor, ‘cause now I can name you and once you have a name you’re even more real” (lines 920-5). This remark points to the
idea that a sex must be known before an identity can be ascertained and a name given which will sediment that identity. Bodies that are marked as normative within the confines of the male/female binary are legitimized as real bodies. (Of course, those bodies that fall outside of that framework are perceived to be outside the domain of intelligibility.)

For Heather, finding out the sex of the fetus had an impact on how she perceived the familial relationships would be restructured, particularly in regard to her boyfriend’s daughter:

R: (.2) Did you have any (. um, hopes about what the sex of the fetus would be?
P: No, didn’t make any difference, I look at it now and I do think it’s better it’s better that it’s a boy because of his DAUGHTER
R: Um-hmm
P: and I think (. sh-, she’ll be able to bond better with a boy than if we had a girl because (. then not only would she have to deal with not being the BABY any more (. she’d also have to deal with not being the only girl (lines 1027-35)

Heather’s idea is that her boyfriend’s daughter will be better able to bond with a boy because she won’t feel so displaced, and at the time I was not sure what to think about this. Part of me agreed. Another part of me thought that maybe it wouldn’t matter, and another part of me thought that it might actually be more difficult for a daughter to cope with the birth of a half-brother because the father-son bond might be a stronger one. I later realized that all of these musings were predicated on the idea that the sex of the baby is so fundamental that relationships will be able to be anticipated on the basis of this factor alone.

Joanne told me that when she and her husband found out that they were having a girl, she sensed that her husband was “a little disappointed” (line 679). Again, as with both Heather and Emily, Joanne felt that the sex of the child would make a difference in
the type and quality of relationships that would develop. She noted that she was happy to be having a girl, but also reported, “I kind of thought having a boy might be easier with my husband ‘cause, then, they’d do more boy stuff” (lines 945-6). Again, it is as though something about the identity of the fetus is accessible through knowledge of the sex. In this, there is an acceptance of gender norms and perpetuation of the construction of gender as foundational.

**Girly-girls and Barbie-lovers**

When I asked Joanne about whether she considered herself to be a woman, she answered in the affirmative and, while noting that “there’s so much involved in that…question” (lines 859-61), mentioned a number of stereotypically feminine activities. She noted that she considers herself to be “kind of a girly-girl” (line 862), is into “a lot of girly stuff” (line 862), is a “flowers and bows” (line 863) kind of person, considers herself to be “very nurturing” (line 864), enjoys “taking care of things and taking care of people” (lines 865-6), and doesn’t like to change the oil and other “stuff like that” (lines 873-4).

When Emily and I discussed her expectations about the sex of the fetus, she commented that she probably has a slight preference for a girl because she’s “more into, like, traditionally feminine kind of things” (line 468) and that her partner probably has a slight preference for a boy because she’s “more rough and tumble” (line 467). This is a case where normative gender roles are articulated and accepted (i.e., boys are more rough and tumble, girls are more feminine), despite the fact that both expectant parents are women and one has more “boy” (read: masculine) characteristics and one has more “girl”
(read: feminine) characteristics. My assumptions are in play here, too: despite the fact that she did not specify the sex, when Emily commented that she teased her partner about getting a “Barbie-lover” (“she’s going to get a Barbie-lover, you know, she’s gonna hate it” (lines 470-1)),²² I assumed that the “Barbie-lover” of her imagination would be a girl.

I noticed that a number of contradictions came up during our conversation about Emily’s feelings about her femininity and about being a woman. When I asked Emily if she considered herself to be a woman, she answered in the affirmative and initially attributed her sense of being a woman to a combination of physical parts and an internal sense of femininity. As with Heather, Emily brought up the word “femininity” before I asked about it specifically. However, while Emily attributed her sense of womanhood in part to her internal feelings of femininity, Heather reported, “I don’t know that I necessarily always feel feminine” (line 1810-11).

I was surprised, given Emily’s statement that she feels internally feminine, that when I told her that my next question was around her experiences of femininity, Emily reported that she does not, in fact, feel feminine:

R: Uh-huh, Okay, and you sai-, mentioned the word feminine and actually my next question is, Do you consider yourself to be feminine and it sounds like you do
P: I don’t really
R: You don’t really?
P: I mean, I don’t think of myself as feminine
R: Okay
P: Um (. ) no. I would say not.
R: You would say not, um, would you, could you give me, maybe, some examples of why not?
P: Ah, well, I don’t wear make-up, I don’t do my hair
R: Uh-huh
P: Ah, I don’t wear high-heeled shoes, um, you know, I don’t, ah (. ) you know, I just don’t think of myself that way
R: Okay (. ) but now, you mentioned, I thought you mentioned that you sort of feel internally feminine
P: Yeah, I mean, um, as opposed to masculine

²² Indeed, this is something I can relate to as Jenny and I have similar conversations regarding, “What are we going to do if we have a girl who wants to wear pink all the time?”
Emily made the distinction between being “internally feminine” and “externally feminine.” She said that she does not feel that she is externally feminine in that she doesn’t wear make-up, do her hair, or wear high-heeled shoes, but she feels strongly that she is internally feminine. There is a distinction here between an embodied (external) femininity and a natural (internal) femininity, and it appears that there may be room for movement with regard to the former but not the latter. That is, within a binaried understanding of gender, although we might entertain the idea that gender roles are, at least in part, learned, we have a much more difficult time considering that they are constructed – and further produced in the repetition of that construction – from the ground up. That is, for Butler, “the very attribution of femininity to female bodies as if it were a natural or necessary property takes place within a normative framework in which the assignment of femininity to femaleness is one mechanism for the production of gender itself” (2004, p. 10).

Emily expanded on her ideas about femininity, noting, “When I think of feminine, well, I mean, there’s warm and nurturing and, ah, motherly, but also, um, sort of a strong sense of needing to express outwardly sort of, ah, a female energy that would be, almost like, sexually suggestive or attractive” (lines 567-75). What Emily seems to identify here is the implied and powerful relationships between the terms woman, feminine, heterosexual, and mother.

Although Joanne did not spontaneously use the word feminine (as Emily and Heather had), as with both Emily and Heather she indicated that the terms ‘woman’ and
‘feminine’ imply one another. When I asked whether or not she considered herself to be feminine, she said that she did and then noted, “I would have to say this is kind of, kind of the same thing” (lines 893-4). She also noted, “I think the woman thing and the feminine thing just kind of go hand in hand, I don’t, I don’t see them as really separate” (lines 924-6).

As with Emily and Heather, Joanne struggled to answer the question and reported that she found that she enjoyed some aspects of femininity and wanted to self-identify as feminine, but not too much:

P:  Um (.) I would have to say (.3) this is kind of, kind of the same thing, I, I like (.) I like, you know, LOOKing like a girl and I like, um, you know, girly stuff (laughs) you know, I’m ve-, I’m pretty (.) I’m not overly girly, though, like I’m not sissy girly, like I don’t like (.) you know, frou-frou laced stuff and I’m not, I don’t dress like that and I’m not, you know, but (.) I’d say I’m pretty feminine, ag-, yeah, I don’t know how to describe that, that’s a really hard question (.) I’m stumped there

R:  Um-hmm, you’re doing pretty well

P:  Yeah?

R:  Yeah

P:  Okay, good (laughs)

R:  (laughs)

P:  I was starting to get nervous, like, I don’t think I’m answering this well

R:  It’s a hard question, I mean, I think-

P:  Yo-, you know, it’s very difficult because (.) What is FEMinine, that’s a really hard question (lines 893-911)

Heather’s description of why it is that she considers herself to be a woman invokes a tautology of sorts. She remarked, “I consider myself a woman based on gender,” (lines 1808-9) implying that her gender is what gives her her sex. Of course, the term gender was developed to highlight the socialization of the sexes. From this perspective, your sex, as the ‘preceding’ factor, is what “gives” you your gender. What I think that Heather identifies here is the way in which the terms have become
interchangeable with “gender” coming to replace “sex” as the foundational term, covering over the whole reason that it was developed in the first place. Indeed, Heather referenced her specific body parts as evidence of her womanhood (“I have all the parts that make me a girl so therefore I am a girl” (lines 1809-10)). For Heather, this indicated an open-and-shut case of womanhood, but of course I must note here my association to transgendered and intersexed individuals for whom it does not all fit together so neatly.

Immediately following this comment, Heather anticipated my next question and remarked, “I don’t know that I necessarily always feel feminine” (line 1810-11).

Although Heather sees the ways in which gender is constructed (“there were very specific gender roles” (line 1824)) and acknowledges the fluidity of her femininity (when I asked her if she considered herself to be feminine, she noted, “It depends on the situation” (line 1817)) and of her boyfriend’s masculinity, she is quick to point out that, at a default level, feminine is associated with women and masculine is associated with men. That is, while she noted that she tells her boyfriend that he is “acting like a girl” (line 1841) when he takes a long time to get ready to go the mall, she was quick to point out, “it’s not that I am in any way compromising his, you know, masculinity” (line 1848-9).

That’s hysterical

There were moments in which Heather seemed to feel that some of her expectations about her medical care might be either excessive or specific to her personal needs, and this seems to indicate at least a tacit acceptance of the notion that women are demanding, unreasonable, irrational, hysterical. For example, when discussing the ways in which her doctor presented information to her (she recounted two examples in which
he presented potentially frightening information, the first in regard to the fibroids, the second in regard to the fetus’ level of risk for Down’s syndrome) she remarked, “He doesn’t always do it in the order I want” (752-3). She described herself as “flustered” (line 880) when the doctor told her that fibroids are tumors and, following her experience in which she left the hospital with little clarity about the specifics of the fibroid diagnosis, she remarked that she had worked herself into a “tizzy” (line 845) and had left a “horrible, crying message” (line 851) for the midwives. She further remarked that she had “freaked” (line 881) herself out and that she went “nuts” (line 903). Again, there seems to be a way in which she held herself accountable for what seems to be the doctor’s mishandling of the situation. She remarked (somewhat punitively of herself) that she “just needed to accept” (line 888) the medical information.

**Visual discourse**

It may seem odd, initially, to consider a visual discourse. The visual is, after all, a sense in its own right. But it is not only that. As a facet of the ontological weight that we consider to be open to disruption, the visual is as well constructed in language. Then, the ‘truth’ or ‘fact’ of the visual is observable to be largely a function of how we talk about it. In the narratives, the legitimacy of visual stimuli for locating ‘fact’ (and the bolstering of the legitimacy of that fact through the expert interpretation of the medical professional) became apparent. In that it is assumed to provide access to some kind of truth, the presence of the visual stimuli (the sonogram) can serve to sediment the reality of the fetus, assuage worries about health problems or potential health problems, and counter fantastical images of alien beings in the womb.
One way to think about the ultrasound procedure is to conceptualize it as an enactment of the psychoanalytic concept of the gaze. As Sturken and Cartwright (2000) note, “the gaze is not the act of looking itself, but the viewing relationship characteristic of a particular set of social circumstances” (p. 76). This visual can be interpreted from multiple (and oftentimes overlapping perspectives): it can be seen as a disciplinary gaze as Foucault articulates it (1975/1977), as a colonizing gaze as Fanon articulates it (Bhaba, 1983/2001), as a masculine or patriarchal gaze as Rose (1986/2001) articulates it. In regard to the ultrasound, the visual can be seen to be invested with a voyeuristic desire on the part of looker. What I am most concerned about in this section, however, is the relationship between the visual and discursive such that language is dominated by metaphors that prioritize the legitimacy of visual stimuli for procuring accurate information.

The male gaze

How women view themselves at some times can be thought to be a reflection of an internalization of those normative models in which the terms heterosexual, feminine, and maternal imply one another and coalesce to form the “woman.” Heather and I discussed her concerns about her changing appearance and the impact of those changes on her sexual relationship with her boyfriend following the birth of her child. In addition to concerns about the impact of limited resources (e.g., time, desire) on their relationship, she is concerned that “he’ll not find [her] attractive” (lines 1506-07). When I asked Heather if she had noticed if the ultrasound had changed her experience of how she saw
her body, she remarked, “I stopped looking at myself as negatively, like I was getting fat, this is annoying” (line 820-1).

As Heather articulated it, the ultrasound provided her with a different way of seeing herself. Rather than seeing herself as “getting fat,” she began to see view herself as providing nourishment for the fetus. It can perhaps be noted that in both of these cases, whether seeing her appearance negatively as someone who is “getting fat” or positively as someone who is expanding in the service of a fetus, Heather seems to view herself within the confines of a normative femininity or maternal status, illustrating the ways in which “women often have been presented in ways that emphasize their status as sexual beings or maternal figures” (Sturken & Cartwright, 2001, p. 76).

She also identified herself as the “looker,” and at one point in our conversation, in regard to broken capillaries in her legs, she noted regarding her boyfriend, “He’s not a detail person so he’s not gonna notice them anyway, I mean, that’s gonna be a ‘me’ thing” (lines 1543-4). Heather’s awareness of her perception of the impact of her pregnancy on her level of attractiveness or sexuality can be seen to illustrate a way in which she is looking at herself “through the implied gaze of others” (Sturken & Cartwright, 2000, p. 81).

The legitimacy of visual stimuli

Emily noted that the doctors at the specialized clinic “don’t release you to your OB until they actually see the heart beat” (lines 186-7). This denotes a visual regulation that is so powerful that the word “release” (whose primary meaning is “to set free from confinement, restraint, or bondage” (Lexico Publishing Group, LTD, 2005)) is used to
describe the process whereby Emily is transferred from one physician to another. It is only upon observation of a visual stimulus that this release is initiated.

Joanne noted the number of ways in which her doctors kept visual tabs on a number of factors related to the progression of her pregnancy. One of the ways that she described this surveillance was through the use of the term “keeping an eye on,” an informal term that denotes a casual kind of surveillance. She also used the term “watching” which denotes a more purposeful and deliberate visual regulation. Initially she included herself within the group that was monitoring the baby’s growth (apparent in the use of a first-person collective pronoun): “we’re keeping an eye on the baby’s weight” (line 135). In subsequent descriptions, in which she described the oversight of a number of physical factors, she disappeared from the role of observer (apparent in the use of a third-person collective pronoun): “I have really small hips and had a dislocated hip when I was born, so, um, probably will deliver Cesarean because it’d be a little risky to try anything different, um, and I have high blood pressure and they’re watching that but so far I haven’t had any problems from any of these, it’s just, they’re things they’re keeping an eye on and watching” (lines 140-7),” “mine is kind of a rare case of spina bifida, so, they’re just kind of keeping an eye on it” (lines 175-6), “I have high blood pressure so they’re watching that” (lines 144-5) and, in regard to hip placement, high blood pressure, and weight gain, “they’re watching all those things” (lines 161-2).

In another example of the ways in which the visual image has a particular legitimacy, Heather told me that her concerns about complications during pregnancy (which had been fueled by books she had read) faded after she saw the sonogram image: P: it was just still, like, okay, this is really weird (.) like (.) you know, of course you read all those books, you know, that talk about blighted ovums and all this other stuff, and like
I feel so much better now

When Emily and I discussed the ultrasound specifically, she noted a number of reactions that she’d had to the procedure. Initially, she noted that the ultrasound was “thrilling” in that it acted to confirm the human existence of the fetus: “[O]f course it was thrilling, you know, after all this time, to see, you know, to actually, ‘cause you know it’s there but to actually see it is pretty exciting” (lines 361-3). There are two (perhaps overlapping) things here: there is the idea that the ultrasound is thrilling (as related to visual desire) and there is a way in which that thrill is connected to the confirmation of the existence of the fetus. Emily noted as well that the ultrasound alleviated some of her fears about the potential for a miscarriage:

Prior to the first ultrasound, Joanne felt some anxiety due to the fact that she had not had any bodily experiences to confirm the existence of the pregnancy. She noted, “it’s a little nervewracking ‘cause that early you can’t feel anything so you’re not really sure” (lines 406-7). She said that she wondered, ““What if something happened and I
didn’t know?’” (line 409). Joanne noted that the movement of the fetus reassures her that everything’s okay, noting, “you live for that” (line 412). She also noted that the ultrasound provided reassurance prior to the time when she could feel the movement of the fetus. She reported:

P: Um, well, like, I said before, it’s the same thing I said before which is, it’s a little nervewracking when you don’t feel the baby because you do worry
R: Uh-huh
P: like, I worried, like I’d be good right after my doctor’s appointments ’cause they’d le-, let you hear the baby’s heartbeat, so you’d know, “Okay, everything’s okay”
R: Uh-huh
P: but then, like, that’s like, you know, four weeks ‘til the next one (laughs) and it’d be like, at three weeks, you’d be like, “I hope everything’s all right” (laughs) (lines 786-96)

Joanne’s experience is consistent with research on ultrasound which has found that “anxiety reduction following normal ultrasound examination is likely to reflect increased anxiety in anticipation of the procedure which is subsequently dissipated by receipt of normal results” (Baillie, Hewison, & Mason, 1999, p. 150).

For Heather, too, the pull of the ultrasound was related to the anticipated reassurance and comfort that the visual would provide. She remarked, “I wanted to check and see everything was okay” (line 936-7) and “I’m a visual person and for me to see the baby and see he’s okay gives me just a great deal of comfort” (lines 1056-7).

For your viewing pleasure

Joanne noted that she was pleased that she was given a video to take home, and she remarked, “it’s nice because now they give you a video, you get to take it home and watch it sixty-two thousand times” (lines 455-8). The images were such an important part of the experience that the staff was evaluated, in part, on their willingness to
reproduce images for Joanne and her husband: “they were all great, they printed me
pictures. I have pictures from the all of them and they printed me the video from the last
two” (lines 508-10).

There is a pleasure in viewing the image of the fetus, apparent in this comment
made by Heather: “I’m having fun ‘cause I’m gettin’ to see him” (line 947), and also in
her actions with regard to the hard copies of the images. She noted that she had scanned
the images into the computer and e-mailed them to out of town family (lines 1306-09),
keeps them upstairs in a file (line 1311), and plans to get them laminated at Kinko’s
(lines 1313-4). She also noted that she pulls them out periodically in order to remember
how big the fetus was earlier in the pregnancy (as one would do with old baby pictures)
and as a source of comfort regarding his present health:

P: that way they won’t, like, do weird things (. ) I’ll get there
eventually (laughs) but ye-, yeah, I pull them out and look at
them periodically, like before coming in today, actually
R: Uh-huh
P: ‘cause I didn’t remember necessarily when I had go-o-one
and, I was thinking how big he was in relation to the fibroids
and I couldn’t remember if he was the size of the grapefruit or
the size of the orange
R: Uh-huh
P: the first time around
R: Uh-huh
P: it-, it’s just, it’s nice to SEE them, it’s very comforting to me, I
mean, even though I feel him moving around all the time now
R: Uh-huh
P: you know, so I know he’s OKAY in there, but, I, I like having
the pictures (lines 1316-1331)

Seeing is believing

With ultrasounds done very early in the pregnancy (as they are done
increasingly), the visual confirmation of the pregnancy oftentimes occurs before any
noticeable bodily changes would indicate the presence of a fetus. As Joanne noted, “the
first, you know, the first one’s really nervewracking ‘cause you’re waiting to see if’
there’s something and is it okay” (lines 420-4). The ‘something’ here seems to stand in contrast to a ‘nothing,’ drawing my attention again to the presence/absence binary that Irigaray (1974/1985) lucidly unpacks. Joanne further conjured up this presence/absence binary when she noted that, during an ultrasound for a previous pregnancy in which she had miscarried, she was able to tell that something was wrong because of the sonographer’s failure to comment on the screen, “in the other one, she just wasn’t saying anything, she didn’t say, ‘Here it is,’ or ‘Here it’s not,’” (lines 609-11). That is, in this case, nothing is something and not just the absence of something.

As well, and in support of prior research, she indicated that seeing the pictures contributed to the sedimentation of her pregnancy: “I saw the pictures of the baby so I was happy ‘cause it became real and, I don’t know if that makes sense in a way but it really wasn’t real prior to that” (lines 783-86). She remarked later, “I don’t tend to believe that things are real until I see them” (line 1105-6), drawing attention to the ways in which the visual provides confirmatory evidence for the reality of an experience. As well, and in parallel to Heather’s assertion that she is a “visual person” (line 1056), Joanne’s comment – including her emphasis on the “I” – indicates that she believes that her experience is unique, obscuring the ways in which visual stimuli are culturally privileged as confirmatory.

Following the idea that dominant discourses work to “naturalize the things they refer to” (Parker, 1994a, p. 103), in this section I have identified six dominant discourses that work to position the ultrasound as a normal part of pregnancy and that work to position some bodies as natural or normal, two overlapping assertions that I have striven
to keep central to this project from the outset. In so doing, I sought to identify those ways of speaking about the world which we take for granted but which act insidiously to obscure the ways in which the world, and those things in it, come into being as they are through the ways in which we describe them.

The ultrasound is taken for granted as a normal part of pregnancy – and women accept and actively seek this technology – in the context of scientific discourses that grant an authoritative position to doctors and medical providers, privilege scientific knowledge and precision of measurement, and endorse the notion that some have access to a privileged knowledge about others. In fact, challenges to the precision of the ultrasound for locating particulars of fetal development have been advanced (Baillie, Hewison, & Mason, 1999; Dudley, 2005; Harrington, Armstrong, Freeman, Aquilina, & Campbell, 1996; Hutchon, 1998; Ott, Doyle, & Flamm, 1986; Raynor, 2003; Watson, 1990). Not surprisingly, these have not had much impact – if any – on the belief that doctors will be able to locate a particular kind of knowledge through the procedure of ultrasound.

Maternal, biological, familial and gendered discourses overlap in their positioning of bodies as particular kinds of bodies, and these discourses are reiterated and reinscribed through the procedure of the ultrasound. When we examine them closely, discursively perpetuated beliefs – including the idea of behaviors or states of existence as “natural” (e.g., heterosexual sex, motherhood, the nuclear family), and including the privileging of an underlying level of existence (e.g., biological as primary, gender as foundational) – are exposed to be culturally-driven beliefs rather than true facts. The overlap of normative discourses is observable in the chains of signifiers that are evoked in the citation of just one term. Regarding the ultrasound, then, the interpellation of the fetus as a particular
subject (e.g., “it’s a girl”) initiates a domino effect, for “being” a “girl” is inseparable
from a presumed femininity, a presumed heterosexual status, the anticipation of a
presumed maternal status.

Subjects are interpellated within a cultural framework in which the legitimacy of
visual stimuli is privileged. In this culture, and in the ultrasound procedure, “seeing is
believing.” This “seeing,” of course, is legitimated through a process whereby the image
is interpreted by an expert. In identifying a visual discourse, I have drawn attention to the
“ubiquity of visual metaphors” (Jay, 1993, p. 1) that structure, indeed construct, how we
“see” the world. In parallel to the positivist-empiricist belief in the idea that sensory
experience is the only admissible route to knowledge (and that knowledge can be
revealed through observable phenomena), a dominant visual discourse contains the belief
that an experience can be legitimated, a sex can be revealed, and an identity can be
located in the procurement of a visual image.
Chapter Six
Discussion

Before we are loved and held by mothers and others, before birth, and sometimes
years before our conception, we have already been the subject of talk. In some
families, a male or female child has been long awaited—or dreaded. In others, a
child may be conceived as a replacement for a lost baby or relative. Parents rich
and poor, sick and well, imagine all manner of things for their children. These
expectations—along with cultural conversations about the value of children, male
and female, born in and out of wedlock to parents young and old, straight and
gay—cannot fail to affect children’s subjectivity, the way they will say “I am.”
(Luepnitz, 2002, p. 177)

Despite its appearance as such, pregnancy ultrasound is not a neutral technology.
It is one in which ideological frameworks are apparent; indeed, they are inscribed on the
bodies of those who participate. Ultrasound sits surrounded by chains of signifiers that
presuppose and thus act to construct what the doctor would do, what the woman would
do, who the fetus would be. Having achieved the status of a normative technology,
pregnancy ultrasound has come to be taken for granted as a normal part of pregnancy.
But that is only because it has been positioned as such by those discourses that act to
normalize it and to normalize us. Technologies are normalized – and existences are
normalized – through the “reiterative and citational practices by which discourse
produces the effects that it names” (Butler, 1993, p. 2, emphasis mine). We might say,
then, that pregnancy ultrasound is particularly secure in its position as a normative
technology because it sits at the convergence of a number of interlocking discourses.
The discourses that surround pregnancy ultrasound – those ways of organizing the world that structure how not only how we make sense of it, but also who we are in relation to it and what we may do in it – work to reinforce a particular set of norms. Regarding ultrasound technology, there are a number of overlapping discourses in play – discourses such as scientific, maternal, biological, gendered, familial, visual – that “[lock] together alarmingly” (Parker, 1994, p. 100) in their concern for the identification of the fetus as a healthy, viable subject.

Much of the feminist literature on ultrasound (most notably, radical feminist literature) emphasizes the ways in which the body of the woman is objectified through the process of the ultrasound. Whether medicalized, eliminated from view, seen as an obstacle, or dismissed in her phenomenological experiences of her pregnancy, the woman’s body is considered to be rigidly controlled and monitored by a procedure that makes visible that which is not typically visible. Although I see some utility in those arguments that view women’s bodies to be objectified by medical procedures that have emerged within the context of patriarchal structures, I have a different emphasis and am much more concerned with the ways in which women’s bodies – indeed, all bodies involved – are subjectified by linguistic utterances that close off possibilities of doing and of being.

I am not the first person to point out the relationship between the ultrasound and the situation of bodies within discursive frameworks. Weir (1998) and Zalewski (1997), among others, challenge the notion of the autonomous body and highlight the ways in which discourses can be viewed as signifying practices. The collective work of Cartwright (1995), Rapp (1997), and Sawicki (1991) is probably the most closely aligned
with my project; these theorists most explicitly touch upon the relationship between ultrasound technology, dominant discourses, and the interpellation of subjects, and it is their work that has most directly provided the impetus for this particular project.

Rapp (1997) directly points out the ways in which women and fetuses are “embedded and represented in social and power-laden discourses” (p. 39) and the ways in which “sonography bypasses women’s multifaceted embodiment and consciousness, providing independent medical knowledge of the fetus” (p. 39). Cartwright (1995), in her emphasis on the ways in which the medical interpretation of the ultrasound image is influenced by beliefs about “gender, sexuality, and cultural identity” (p. 222), recommends “an intensified focus on the class, race, and gender politics of bodily regulation and surveillance demonstrated by these techniques” (p. 220).

Most closely aligned with my project, Sawicki’s (1991) work directly advances a Foucauldian understanding of reproductive technologies (including, but not limited to, pregnancy ultrasound), noting that “new reproductive technologies represent the most recent of a set of discourses (systems of knowledge, classification, measurement, testing, treatment and so forth) that constitute a disciplinary technology of sex” (p. 83). She applies Foucault’s model of biopower to new reproductive technologies, noting that NRTs fit this model in that they do not operate violently but rather by “producing new objects and subjects of knowledge, inciting and channeling desires, generating and focusing individual and group energies, and establishing bodily norms and techniques for observing, monitoring, and controlling bodily movements, processes, and capacities” (p. 83).
The ultrasound both mirrors and reproduces discursively constituted beliefs about practices, disciplinary fields, and technologies. The discourses that surround the ultrasound – and work through it – beckon us toward particular subjectivities. Because the procedure of the ultrasound is hardly given much of a thought and is more or less taken for granted as a normal part of pregnancy, this positioning can easily remain unexamined unless we make serious efforts to expose it. This whole dissertation is an effort to do just that: to expose those ways of thinking and speaking about the world and about ourselves as constitutive of that world and of those selves. In this section, this last section of the dissertation, I will discuss the subjectification of bodies within the context of the dominant discourses that I identified in the previous section, including a discussion of the possibility of resistance – what I refer to as countermovements – with regard to those dominant discourses. I will also discuss potential areas for further investigation.

The pull of normalizing discourses

A Foucauldian understanding of the relationship between power, knowledge and pleasure provides unique insight in regard to the ways in which pregnancy ultrasound operates, why it has become so popular and what systems of power and knowledge it perpetuates. From a Foucauldian perspective, the ultrasound can be understood as a form of bio-power in that it is surrounded by a web of knowledge, power and pleasure that perpetuates the identities of everyone involved in the service of ensuring a healthy population for the state. According to Foucault, bio-power came about following a shift from a time in which a sovereign was entitled to enact an absolute power over its citizens by means of torture and execution in order to emphasize the omnipotence of the state to
one in which punishment was aimed at reform and justice. Reform also served the state, but it did so in a different way. Instead of demonstrating the almighty power of the sovereign, the aim of reform and justice was to make the citizens of the state more useful to that state. That is, the “lives, deaths, activities, work, miseries and joys of individuals were important to the extent that these everyday concerns became politically useful” (Dreyfus & Rabinow, 1982, p. 139). Thus, in contemporary society, according to Foucault, power operates through both a discipline and normalization of infinitesimally small details of the subject’s actions (micropolitics) and a focus on the health and well-being of the subject. Bio-power operates through a state intervention in biological issues, such as “reproduction, disease, work, or pain” (Dreyfus & Rabinow, 1982, p. 140).

For Foucault, sexuality emerged as the “central component in a strategy of power which successfully linked both individual and the population in the spread of bio-power” (Dreyfus & Rabinow, 1982, p. 168). ‘Sexuality’ was constructed as “an area of investigation” (Foucault, 1976/1978, p. 98) and became reified through the “discourses of truth” which took charge of it (Foucault, 1976/1978, p. 98). Specifically, sexuality was produced through the confession which brought together several factors in play: “the body, knowledge, discourse, and power” (Dreyfus & Rabinow, 1982, p. 169). Foucault considers and ultimately rejects the repression hypothesis with regard to sexuality, claiming (in contrast) that sexuality is produced and bio-power is spread not through a restriction of but through a production of discourse (Dreyfus & Rabinow, 1982).

Bio-power is not a violent power but rather is one that appears to be benevolent. It works not forcefully but by “creating desires, attaching individuals to specific identities, and establishing norms against which individuals and their behaviors and
bodies are judged and against which they police themselves” (Sawicki, 1991, p. 68).

Everyone participates in an enactment of bio-power by participating in disciplinary and normalizing practices aimed at ensuring the ‘betterment’ of the individual. Individuals participate not because they are violently coerced by someone or -thing which is invested with a greater power. They participate because they have some investment23 in participating in these practices and because there is some pleasure in them. For Foucault, power, knowledge and pleasure are intertwined and actively reinforce one another. Knowledge is not some objective truth but something which is constructed discursively within a field of power relations. There is pleasure in knowledge and so we seek it. In this pleasure, we actively construct knowledge (Dreyfus & Rabinow, 1982).

For Irigaray (1977/1985), this discursive knowledge is a masculinist knowledge – “The sexes are now defined only as they are determined in and through language. Whose laws, it must not be forgotten, have been prescribed by male subjects for centuries” (1977/1985, p. 87) – and this pleasure is a masculinist pleasure – “Feminine pleasure has to remain inarticulate in language, in its own language, if it is not to threaten the underpinnings of logical operations. And so what is most strictly forbidden to women today is that they should attempt to express their own pleasure” (p. 77).

She continues, “If there is such a thing – still – as feminine pleasure, then, it is because men need it in order to maintain themselves in their own existence” (1977/1985, p. 96). The production of the feminine as external to “man’s discourse” (Irigaray, 1977/1985, p. 88) occurs again and again, continually marking woman as “‘not-all’” (p.

---

23 Investment is a term that Foucault likely would not have been comfortable with as it implies a purposive action that contradicts his notion that subjects are formed in language. My use of it here is a result of my particular appropriation of a Foucauldian perspective for theorizing the ways in which subjects come to find themselves drawn to particular practices, a reading which challenges a thin subject in favor of a more depthful one.
Woman is produced as woman, as a particular kind of subject – one that is passive, absent, other – who has a particular kind of subjectivity – one that is feminine, heterosexual, maternal. In this production, chains of signifiers coalesce to form a norm that postures as largely untouchable.

Butler (1993), of course, dares to touch on those chains of signifiers all the time, as when she writes, “the initiatory performative, ‘It’s a girl!’ anticipates the eventual arrival of the sanction, ‘I pronounce you man and wife’” (p. 232). She then notes that “the peculiar pleasure of the cartoon strip in which the infant is first interpellated into discourse with ‘It’s a lesbian!’” (p. 232) comes as a result of its disruption of the heterosexualizing law, a law in which “being a girl” means embodying a particular kind of subjectivity. She goes on to note, “Femininity is…not the product of a choice, but the forcible citation of a norm, one whose complex historicity is indissociable from relations of discipline, regulation, punishment” (p. 232).

Each of my participants attributed to the fetus that they were carrying a subjectivity within that heterosexualizing law, interpellating that fetus as human by identifying it within a normative model, anticipating that fetus as an intelligible subject who would come to embody a particular identity. To do so, each of my participants made reference to a constitutive outside – to a lack, to an Other, to what it would not be – in order to construct an anticipated “positive” identity, exemplifying the idea that “[a]bove all, and directly contrary to the form in which they are constantly invoked, identities are constructed through, not outside, difference” (Hall, 1996, p. 5).

When I asked about any anticipated differences between raising a boy and a girl, Joanne noted, “so much depends on the girl” (lines 963-4). She followed this by asking,
rhetorically, “what if she’s kind of a tomboy girl?” (line 965), asserting that this “would be fine” (line 965-6). While this ostensibly points to an acceptance of an identity outside of a norm, it draws attention to “the tomboy girl” as an aberration. Joanne also noted, “if we were having a boy, ballet lessons would not be in the cards” (lines 982-3), a situation that she believes indicates the additional amount of “opportunities” that exist for girls (line 989). I view it differently. A boy in “drag,” in drawing attention to the disjoint between gender and femininity, or gender and masculinity, exposes the contingent status of gender most explicitly (Butler, 1999). Men in drag are particularly disruptive because, in what appears to be a refusal to be a “real man,” they mock an ideal masculinity.

Heather recounted the story of a woman who had recently had a baby boy and had told her that she hoped that her child would never leave her. Specifically, she remarked, “He’s gonna be with me forever, I want to keep him and hold him and hug him and, you know, he is never gonna love another woman as much as me and, in fact, I hope he’s gay” (1761-4). This perverse wish for a male child’s homosexual identity illustrates a normative heterosexual Oedipal model in which masculinity and femininity necessitate one another for the sedimentation of one’s individuation, predicated on the development of an ego. The assumption that a gay child will stick around comes out of the assumption that a gay person’s love relations will be much weaker. Relatedly, his identity seemingly will be less “real.”

Emily, in positioning herself as the more “feminine” one in her relationship, and in noting that her partner tends to be “more rough and tumble” (line 467), told me that she jokes with her partner that she’ll “hate it” (line 471) if their child turns out to be “a Barbie-lover” (line 471). Although her trepidation seems to imply a resistance to rearing
a hyperfeminized child, there is a way in which this, too, illustrates both a binary and a resignation to that binary. The pressure on gay and lesbian couples to affirm their children’s identities within a sexist and heterosexist binary structure is enormous, reflected in the desire of many gays and lesbians to prove to the world that they, too, can raise “normal, well-adjusted” (read: straight) children. This is observable in research reports that defensively cite statistics that indicate that children of gay and lesbian parents are no more likely to be homosexual than their peers (Clarke & Kitzinger, 2004; Stacey & Biblarz, 2001).

As I have said previously, the chains of signifiers that position some bodies and some movements as ‘norm’ and others as ‘abnorm’ actively work to constitute our world and our selves. Identities come into being through a reference to what they are not. In prioritizing discursive construction as I have – in claiming that discourse is formative of subjectivities – I run the risk of advancing a number of unhelpful (and I believe inaccurate) ideas about how it is that bodies come to “matter” (Butler, 1993), walking on the edge of a cliff of discursive construction that at any time I could allow to subsume this project. I do not wish to elevate DISCOURSES – those frameworks of linguistic utterances – to a level that renders them responsible for the movements of the subject in a top-down fashion (as though they are headless puppeteers running the show) but rather hope to emphasize how subjectivities are formed within a linguistic context. Butler (1993) notes that “To claim that discourse is formative is not to claim that it originates, causes, or exhaustively composes that which it concedes; rather, it is to claim that there is no reference to a pure body which is not at the same time a further formation of that body” (p. 10).
Discourses normalize ways of doing and ways of being by reinforcing institutions (e.g., medicine, the family) that operate to “constrain what can be said, who can say it and how people may act and conceive of their own agency and subjectivity” (Parker, 1994, p. 103). As this is a critical feminist project, I view these discourses from a lens that is explicitly concerned with the ways in which women’s subjectivity is viewed as a problem to be addressed. All of the discourses that act to construct the ultrasound as ‘normal’ – and all of the discourses that act to place individuals within constrictive, normative models – are themselves undergirded by beliefs about the woman’s body that are predicated on a number of binary fictions. Said another way, the discourses that constitute the ultrasound as benign – or even as helpful – are the very same discourses that reduce the woman to container, to object of medical scrutiny, to maternal-heterosexual-feminine subject.

The discourses that I “named” – scientific, maternal, biological, familial, gendered, and visual – overlap in their understanding of the woman as, among other things, a hormonally-driven mystery that is in need of extra scrutiny and a mothering-driven being whose pregnancy has been long-anticipated. Across discourses, women are positioned as heterosexually-driven and femininity-embracing. Even in cases in which they meet the call of such hailing, their subjectivity is always somewhat perplexing. For Irigaray (1977/1985b), this is because femininity is produced through a phallic economy and excluded from linguistic representation. For Butler (1993), the production of woman as external occurs in the service of the continued operation of that economy as coherent.

Normative discourses close off possibilities – of doing and of being – by restricting allowable movements – indeed, by restricting even the possibility of those
movements. In regard to the ultrasound, possibilities are closed off for the woman, her partner, the doctor, the sonographer, and the fetus. The foreclosure of possibilities is observable in several ways. It is observable in those moments in which possibilities are unimaginable, and it is observable in those moments in which experiences that challenge a norm are positioned as exceptional. It is observable in the vulnerability that arises as a result of breaking from a particular subject position, and it is observable in the confusion with which that transgression is frequently met.

The discursive foreclosure of possibilities

Each of the women whom I interviewed described horrible experiences with medical professionals. Heather described an experience she’d had when she was younger in which a physician had dismissed her (accurate) self-diagnosis of strep throat. Regarding her experiences with her pregnancy, she told me that the physician who diagnosed her fibroids gave her very little information about how detrimental they would be to her health or the health of the fetus. The experience left her shaken. She went home and frantically tried to find more information via the Internet in the middle of the night. At another point, this same physician alarmed her by presenting her with information about Down’s syndrome outside of any context, leaving her initially unsure about the chance of the fetus’ risk. She also described a negative experience with her third ultrasound in which she’d been forced to wait for an hour and a half and in which the sonographer had kept her on an uncomfortable incline, given her less information than she’d hoped for, and left the room with an indication that she’d come back and never did.
Joanne described an experience with a previous pregnancy in which a sonographer had broken the news to Joanne that she’d miscarried by stating, “Your uterus is empty” (lines 529-30). This experience was upsetting to Joanne because of the matter-of-fact demeanor of the sonographer. Another experience with her current pregnancy involved a physician’s comment to her that she was “hysterical” (line 305) when she complained about a pain in her side. That pain turned out to be a hernia. She also described negative experiences with health care providers she had approached when she had initially sought information about any risks she might face with a pregnancy. She told me that several health care providers were very negative about even discussing a possible pregnancy, telling her that they hadn’t provided “that” (line 282) kind of care and asking her if she was sure that she wanted to “go that route” (line 284).

Emily told me about her experience of having cysts removed from her ovaries by a surgeon who treated her like “an inanimate object” (line 267). Following the surgery, he prescribed the wrong dosage of hormones, inducing a hormonal imbalance that resulted in depression. She as well described several examples of the ways in which she and her partner had been discriminated against as a lesbian couple. She told me that she has had to educate some doctors who have been uninformed about lesbian health issues (line 938).

I found each of my participants to be unusually thoughtful and articulate. All of them, in their own ways, brought a critical perspective to the health care treatment they’d received in their pregnancies and prior. And yet, for each of them, their ability to question their medical providers, or imagine a different kind of experience, was circumscribed. Although they each caught moments in which they recognized the ways
in which these negative experiences (their own movements and the movements of their medical providers) might have been different, their reflections on their experiences – and their recourse to self-blame, minimization, and outright dismissal – indicate a tacit acceptance.

Although Heather initially noted that she had felt dismissed by the doctor who had treated her in college and had ignored her suggestion that she probably had strep throat, she then indicated that her subsequent pointing out to the doctor that she’d been correct, and telling him, “I told you so” (line 158) was “probably not the right way to be” (line 159). When Heather described the negative experience she’d had with the physician who had sent her home with very little information about fibroids, she indicated to me that she felt that she had overreacted in her emotional response, telling me, “I had worked myself into such a tizzy” (line 845) and describing her behavior as “nuts” (line 903). Although she articulated clearly that the concrete information that the midwives provided to her about fibroids helped to alleviate her anxiety, when I specifically asked her what she thought the doctor could have done differently, she told me, “I don’t think there’s anything that he could have done without knowing me” (lines 893-4). When I asked again later in the interview about things that the doctor might have done that would have been helpful to her, she told me, “He’s always been fine” (line 1243).

In regard to Heather’s experience of the third ultrasound, she indicated to me that the discomfort that she’d felt during the process during which the sonographer had extracted amniotic fluid was her fault because “a pregnant woman’s supposed to be fine on a five percent incline” (line 1161-2). Although she described a number of concrete things that the sonographer had done that were unhelpful, when I asked about what could
have made the experience better, she minimized what seemed to me to be the more salient factors and instead attributed the problem to her own behavior, telling me, “I think not having coffee would have been a factor” (line 1220).

Joanne seemed to be able to see a bit more clearly the ways in which the medical professionals who mistreated her were at fault. In regard to the sonographer, she told me, “her exact words were, “Your uterus is empty,” which I thought was a HORrible thing to say” (lines 529-30). In regard to the physician who dismissed her complaints of pain, she commented, “it turned out that he really should have paid more attention to me” (lines 313-4). And, in regard to the professionals who were not interested in helping a woman with disabilities to get pregnant, she attributed the problem to them, noting, “they were VERY negative” (line 281).

Although it’s a bit more subtle, Joanne’s other remarks do indicate a way in which she minimizes the degree to which these experiences were negative and questions the validity of her own reactions. After noting the sonographer’s cold demeanor, she indicated that this experience may have been an exception (“that was just one girl in the whole ultrasound department” (line 560)), excused the sonographer’s actions on the basis of her age (“she was very young so I’m wondering if she just didn’t KNOW what to say (lines 562-3)), and drew attention to her emotional reaction, indicating that it was a problem (“I had got myself so flustered from that comment” (lines 566-7)). In regard to the physician who had not only overlooked a medical problem but whose comments clearly point to a misogynistic attitude – “[P]regnant women get, you know, pains and aches all the time, you can’t be flustered about every little thing and hysterical about
every little thing” (lines 303-5) – Joanne noted mildly, “I wasn’t real impressed with him” (line 299).

Although Joanne recognized the ways in which the collective cultural attitude (including the attitudes of many medical professionals) toward women with disabilities bearing children continues to be negative, she chose to focus on the changes that have occurred, noting “it was more negative when I was younger but the advances in medicine have really changed that attitude” (lines 1287-9). She also emphasized own her role, noting, “I’ve never really let my disability stop me from doing anything so if that’s your attitude, I think it’s much different” (lines 1344-7), drawing attention to the autonomous subject and obscuring systemic issues.

When Emily noted that the physician who had removed several cysts from her ovaries had put her on the wrong dosage of hormones, she emphasized the fact that the dosage was wrong for her in particular: “so the doctor that did that put me on an incorrect dosage for ME of, um, hormones” (lines 275-6). When Emily described the situation with her current physician who knew very little about lesbian health issues, she described it as “sort of funny” (line 954) that he was “clueless” (line 964), a relatively benign reflection on an egregious situation. In reflecting on the situation in which her partner, April, had not been allowed in the room during the beginning of her first ultrasound, although she began to say that she felt as though the situation would have been different if April had been male (1023-4), she quickly second-guessed this hypothesis: “I don’t know if it was them or if it was me” (line 1027).

When Jenny and I went shopping for engagement rings, we were overlooked by a number of jewelers who could not fathom that we were planning to marry one another.
Our efforts to try on rings that looked like engagement rings on the hand on which it is traditionally worn resulted in fielding questions such as, “What’s the ring for? Just for fun?” and “Which one of you is getting married?” Even bold responses on our part such as, “We both are” could not disrupt the unyielding assumption that a commitment to love and to cherish belongs only to a man and a woman. Particularly disorienting to us was the gushing joy of one jeweler who emphasized what a coincidence it was that we were both getting engaged at the same time.

Planning for our wedding was a perpetual coming out. And out, and out, and out. It was a continual self-identification, a continual assertion of, “I am here,” in spite of the fact that very few people were saying, “Here you are.” Every different task and every new vendor brought the same familiar stirrings of anxiety, the same concerns about being misunderstood, discounted or worse. I experienced an anxious response prior to and during each of these errands. My sweaty palms and churning stomach frequently alerted me to the unspoken dangers, sometimes before I was even willing to acknowledge that they were there.

We were misrecognized by so many people on so many different occasions that we were enormously grateful for the scraps of recognition that we did receive. We bought our wedding bands at a jeweler where the salespeople with whom we worked were so consistently affirming that we wondered if they’d attended a mandatory diversity training in the spirit of capturing the emerging gay wedding demographic. During one of those visits, the saleswoman lifted out a tray of simple bands from behind the display cases and began asking us about what kinds of bands we were thinking about: What metal? What width? Did we want to have matching bands? When would we need them?
I was so comfortable that I took off my coat, and I found myself only thinking about whether I preferred a plain band or a milgrain one. Jenny told me afterwards that she felt similarly at ease. We left the store in a cloud of relief. On the way home, both of us had the same reaction, and we used the same words to describe it. We noted, “It was so nice to be treated like a normal couple.” This, of course, parallels Emily’s willingness to forgive moments of discrimination – minimizing institutional and personal affronts to her and her partner’s subjectivity – as soon as she felt even the smallest degree of recognition.

When I began this project, I had a sense that it was important to identify myself as a particular kind of subject – to identify the level of privilege I have been granted on the basis of race and class and physical ability, and to locate my position outside of that privilege on the basis of gender and sexual orientation. But I wasn’t sure exactly what motivated this level of self-identification, and in moments in which I was asked to explain it, I wavered in my belief that it was important. Through the process of completing this project, it has become more apparent to me that identifying my own subjective stance provides a clear way to illustrate how it is that normative discourses are written on the body, both in privilege and in marginalization. It also feels important for me to identify myself as a particular kind of subject because to fail to do so would be to affirm my existence within a normative space that I do not occupy and to respond to a calling that is, in fact, incorrect.

The argument that I make here in regard to locating myself as a particular subject does not come without a cost. For example, the assertion that I have a “coherent identity-position” (Butler, 1993, p. 113) as a “lesbian” necessitates a rejection of heterosexuality.
This movement is not necessarily any less rigid than accepting and asserting a heterosexual identification. Or, according to Butler (1993), “a radical refusal to identify [as heterosexual] suggests that on some level an identification has already taken place” (p. 113, emphasis mine). Indeed, my efforts to participate in the heterosexual institution of marriage – but as a lesbian – indicate an identification that can appear to be disruptive but which can have the effect of buttressing a normative model. Asserting my identity as “not-me” in contrast to a heterosexual norm can have the unfortunate effect of inadvertently reifying that model as norm.

This brings us to the question of resistance. If it is the case, as I have argued, that pregnancy ultrasound has achieved the status of a normative technology – by which I mean that it is taken for granted as something that pregnant women do and is surrounded by normative discourses that act to construct and reconstruct the subjectivities of those who are involved – then what is one to do? For if it is the case, as I have also argued above, that one cannot avoid this type of subjectification by simply refusing a normative identity, for to refuse it is to participate in a reification of its status as norm, then where is the possibility for a different possibility?

Postmodern arguments about the nature of resistance are most tricky, and no less so when we apply them to sociohistorically-specific phenomena such as pregnancy ultrasound. From a radical feminist perspective – one which maintains that technological advances work to objectify the body of the woman within a patriarchal model – a prescription for resistance takes the form of a refusal of ultrasound technology altogether (Sawicki, 1991). In viewing the ultrasound within a framework in which discourses work to normalize technologies and subjectivities, I am arguing something different. Much in
the way that it is problematic to identify oneself outside of a normative model and call it
a day, it would not seem to be enough to simply refuse a technology that has become
normalized. In the next section, I discuss more fully the difficulty in identifying resistant
movements with regard to normative discourses.

**Negotiating normative discourses and identifying countermovements**

My point is not that everything is bad, but that everything is dangerous, which is
not exactly the same as bad. If everything is dangerous, then we always have
something to do. So my position leads not to apathy but to a hyper- and
pessimistic activism. (Foucault, 1983, p. 256)

Throughout this dissertation, I have identified and emphasized – over and over
again – the ways in which my participants and I inadvertently participate in normative
models, even in moments in which we try so hard not to. Even in situations in which we
think we’ve successfully circumvented a normative discourse, alas, we find upon
reflection that we’ve only worked to sediment it further. This is discouraging, to say the
least, but I think that there is some hope here.

Regarding resistant movements from a postmodern perspective, perhaps the first
thing to address concerns the ways in which the idea the we are constituted in language
leads some to believe that this means that there is little we can do. The arguments go
something like this: If we take as our starting point the idea that the subject is
constructed in language, how can we possibility theorize resistance? If the subject is
dead – if there is no foundational ontological starting point – then where is there any hope for transgression? (Butler, 1992)

The theoretical debates within and outside of postmodern theory about whether we can resist, and, if so, what it is that allows for resistance – those questions rife with concern about warding off an impending nihilism – betray the fact that it is already occurring, observable in the slightest movement with which I put pen to paper and try to figure it out. For Butler, the constituted character of the subject is not a liability, is not a limitation. For Butler (1992), “the constituted character of the subject is the very precondition of its agency” (p. 12) because the subject is “never fully constituted, but is subjected and produced time and again” (p. 13) marking her as a “permanent possibility” (p. 13).

Hall (1996) takes it further in unpacking those moments in which discursive productions allow for a challenge to a normative positioning. Agreeing with Butler in his argument that subjectivities are “points of temporary attachment to the subject positions which discursive practices construct for us” (p. 6), he also sees identities as shifting and fluid, rather than static and fixed. This shifting, according to Hall, is directly tied to the ways in which we respond to the discursive call of subjectivities, to the always-moving relationship between interpellation and psychic investment. A resistance, then, entails a working of that contingency, an investment (however temporary) in a counternormative position, a disruption of a system in which a signified concept is inscribed (Derrida, 1972/2000, p. 89).

That I continue to identify the ways in which what might seem to be a resistance (e.g., my identification as a lesbian) is not so clearly a resistance – or is not only a
resistance – is tedious, yes, but I do not do so just to be tiresome or difficult or pessimistic but rather in the service of a continual examination and reexamination of what might be dangerous. Following Foucault’s idea that “the ethico-political choice we have to make every day is to determine which is the main danger” (Foucault, 1983, p. 256), I have spent this dissertation fixating on these moments of danger in an effort to expose them. Consequently, I have perhaps neglected to illustrate clearly those moments in which the possibility of resistance comes into view.

To consider the question of what allows for the possibility of resistance, it may be helpful to look at those moments in which the social order is disrupted, to consider those moments in which the subject is called in one direction, yet goes in another, or to ponder those moments in which rigid chains of signifiers (e.g., woman-mother-feminine-heterosexual) are broken. In fact, it seems to be the case that all of my participants challenged a normative model of motherhood by simply choosing to become mothers – Heather as an unmarried woman, Emily as a lesbian, and Joanne as a woman with a disability.24 Given the ubiquity of maternal discourse, it is unusual to make the claim that becoming a mother is a transgressive movement for a woman, but that is because of the chains of signifiers with which maternal discourse is invested and those assumptions upon which it is predicated. Thus, and perhaps this much is already clear, it is not correct to simply say that movements are transgressive without invoking a discussion of who is performing those movements.

We might be able to identify resistant movements as those which entail an investment in a precarious position. There were many uncomfortable moments for me

---

24 Similarly, my decision to get married – or a heterosexual couple’s decision not to get married in political opposition to the exclusionary practices of marriage as it now stands – entails a resistance.
during the writing of this dissertation. I was uncomfortable drafting a dissertation proposal in which I identified myself as a lesbian, I was uncomfortable locating my racial and class privilege, and I was uncomfortable about breaking with my researcher role by sharing information about myself with participants, however benign and inconsequential that information might have been.

Each instance of discomfort or difficulty on my part or on the part of my participants might be an indication that a normative structure has been challenged, that that movement sits outside the bounds of intelligibility. Those instances during which movements are met with confusion – when someone can’t even comprehend what it is that someone is talking about25 – also indicate the presence of the possibility that a normative model has been challenged. It is in these moments that we have the greatest possibility of hope for disrupting sedimented categories of identity.

As with subjectivity, and as with normative discourses, resistance is also contingent. It is not a once and for all. It is not as though once we’ve discovered a resistant movement we can capture it, for the social field is constantly changing. The movements that will serve to counter expected movements, or move against the anticipated rights and responsibilities of specific subjects as they are located within dominant discourses, are always-shifting. This marks everything – always – as a “permanent possibility” (Butler, 1992, p. 13).

---

25 One of my favorite examples of this: In an interview with Irigaray (1977/85), the interviewer comments, “I don’t understand what ‘masculine discourse’ means,” and Irigaray responds, “Of course not” (p. 140).
Areas for further investigation

Throughout this dissertation, I have prioritized the ways in which dominant discourses act to normalize practices, technologies, and subjectivities, noting how it is that they close off possibilities of doing and being. But if normative discourses foreclose possibilities, so, too, does my identification and discussion of those discourses obfuscate other ways of looking at this situation. In prioritizing discourses, I have made a choice to put them at center stage and in so doing have overlooked other ways of looking at things. This is not to say that I have made an error but rather to acknowledge the idea that any time we choose to prioritize one way of looking at a particular situation or phenomenon, we are at risk of obscuring other ways of viewing it.

Each time that I read through an observation that I have made or work through another section of this project, I notice one more thing that have neglected to discuss, I identify one more thing that I probably could have talked about but didn’t. Again, this is not to say that I necessarily should have done anything differently, but rather to look at the utility of exposing those gaps in my investigation as a potential source of richness for future endeavors. My initial discussion of psychoanalysis at the beginning of this project emphasizes the ways in which particular psychoanalytic models have come into being within a cultural context in which women, and particularly mothers, are viewed as ‘other.’ While perhaps accurate, this covers over the utility of psychoanalytic models for theorizing the depth of the subject, limiting a discussion of the ways in which these models can be used to conceptualize the relationship between interpellation and psychic investment (Hall, 1996). Thus, one potentially different avenue would be to utilize psychoanalytic theory to ground a more depthful investigation of gendered subjectivities.
I briefly touched upon the political implications of ultrasound for abortion politics when I articulated my own skittishness with using this term “baby” to refer to an unborn child. However, I avoided a fuller discussion of the ways in which ultrasound is currently being used by anti-abortion groups, some of whom are lobbying for federal monies to supply their organizations with high-tech machinery in order to discourage women from having abortions (O’Keefe, 2003), and I have avoided a discussion of the very real possibility for this to extend to legislation that threatens abortion rights across the board, including a bill in Michigan that recently passed which would require doctors to offer ultrasounds to women who are considering abortion (Heinlein, 2005). There seems to be a wide open space for a more explicitly political discussion of ultrasound.

I have included only very limited reflections on the economic investments in play with regard to the propagation of ultrasound technology, noting in the introduction that several stores have opened up which offer pregnancy ultrasound outside of a medical setting and noting that ultrasound is a technology that is reserved for the class-privileged. There are a number of directions that one could go in regard to this. Martin (1992), for example, illustrates the relationship between production and reproduction by noting the ways in which “metaphors of production inform medical descriptions of female bodies” (Martin, 1992, p. xiv). Irigaray (1977/1985), in a feminist appropriation of Marx, notes that “Marx’s analysis of commodities as the elementary form of capitalist wealth can thus be understood as an interpretation of the status of woman in so-called patriarchal societies” (p. 172). A discussion of ultrasound technology that is centrally concerned with the reproductive value of women within a capitalist patriarchy could be another direction in which one might go.
Rather than viewing these gaps in the project as restrictions, an acknowledgement of their presence provides us with yet one more way in which to notice how it is that possibilities are foreclosed in the prioritization of one thing or another, demanding an attention to those points of suture in which we identify ourselves as particular kinds of subjects and an unrelenting appreciation of the idea that “in the very struggle toward enfranchisement and democratization, we might adopt the very models of domination by which we were oppressed” (Butler, 1992, p. 14). This ultimately leaves us with, to paraphrase Foucault (1983), so much to do.
Chapter Seven
Epilogue: Reflections on the final stages of the project

I might try to tell a story about what I am feeling, but it would have to be a story in which the very “I” who seeks to tell the story is stopped in the midst of the telling. The very “I” is called into question by its relation to the one to whom I address myself. This relation to the Other does not precisely ruin my story or reduce me to speechlessness, but it does, invariably, clutter my speech with signs of undoing. (Butler, 2004, p. 19)

The dissertation is a unique piece of work, distinguished from other comprehensive pieces of work including articles, books, or research reports because it is typically the final hurdle over which one must successfully vault before the conferment of the doctoral degree. In the past few weeks, as I’ve been in the process of completing my final revisions, friends and colleagues have asked me, “Are you a doctor, yet?” a question that reminds me that the completion of this project will move me into a different subjective space, one which will mark me as “doctor” or “psychologist” and will position me as a person who is invested with the authority to assess, diagnose, regulate, monitor, and authorize.26

In Chapter Two, I talked about my experiences of the proposal meeting and the submission of the project to the IRB for approval, the first two formal stages of the dissertation. I contrasted the level of formality of the proposal meeting with other

---

26 Officially, I will not be a Ph.D. until I finish my predoctoral internship in July of 2006, but people often forget this, perhaps because the dissertation is the final requirement for most doctoral programs or perhaps because even in programs such as mine where an internship is required, it is unusual to complete the dissertation prior to the internship. In most cases, but not mine, the dissertation marks the very end.
interactions I have had with faculty members, and I noted the ways in which the IRB process served to mirror the mechanisms by which subjects are normalized, bodies are marked, and movements are overseen by a regulatory body. These were the places in which it perhaps seems most apparent the ways in which this project has been constructed within the confines of a University system in which it is a requirement for a degree, shaped by the comments of various authorities in and outside of the psychology department. The progress report meeting marked these things for me as well.

Different departments have different procedures in regard to the final stages of the dissertation. At some Universities, the defense is a formal one in which committee members rigorously question the student and afterwards may demand substantial revisions. At Duquesne, the last big hurdle is the progress report meeting. The defense is a formality of sorts as once the dissertation has been approved at the progress report meeting and final revisions have been agreed upon, a bound, completed, and final copy of the dissertation is submitted to the department. The defense is an open defense, and oftentimes friends and family members are invited. Post-defense celebrations of beer and pizza and wings at local restaurants such as the Church Brewworks or the Sharp Edge are commonplace and are usually arranged beforehand. Although the defense is largely a formality, as no one gets to this last stage of the dissertation and is denied the degree, it is a ritual without which the degree cannot be granted.

The progress report meeting is the setting for the final formal approval of the dissertation from the director and the readers. I was eager to arrange the progress report meeting as I was eager to know what changes I would be required to make prior to receiving the final stamp of approval on the project, something which for so long had
seemed to be so elusive. I was eager to receive feedback from committee members in regard to this project that had taken up so much space in my head (in my body) and which had demanded such a high degree of emotional energy. I was very much looking forward to this meeting as I was eager to have my project read and for the panel of experts to tell me how it was.

As it turned out, the first reader who arrived for our one o’clock meeting had forgotten about our appointment because he had left his diary at school over the weekend and as a result had not read the dissertation in its entirety. The second reader arrived a few minutes late but fully prepared for our appointment. We waited for my director, the third doctor, for twenty minutes, after which time we began without her, cobbling together a meeting in large part based on the comments of the one reader who’d read all the way through the dissertation. An incomplete meeting, a project that had not been (could not be) read fully, an image – a part of me – that had been carelessly dismissed without full consideration.

The progress report meeting was my final ultrasound, the one that I had looked forward to the most, the one in which the group of medical professionals would tell me whether the baby was viable and would schedule a delivery date for me. I had consulted my doctor at various junctures, I had scheduled the final appointment, and as far as I was concerned the sonographers had had plenty of time to carefully read the image. I had hoped that they would be able to provide me with a report to legitimate the existence of the project – and of myself as a new subject – in response to my cautious, “How is it?”

But things did not go as planned. The head doctor didn’t show and one of the sonographers hadn’t read the image carefully enough to tell me for sure whether it was
really okay. Although he told me that based on what he had read so far it seemed as
though everything would be fine, the fact that his reading was based on an incomplete
knowledge left me feeling uneasy. As it turned out, I did not get any pictures to take
back to family and friends, to laminate at Kinko’s, and to put on the refrigerator. I could
only tell them that as far as the doctors could tell from what they saw everything seemed
to be fine but that I would have to wait a little while longer for the full report.

The failure of the experts in this instance opens up the space to consider, yet
again, our reliance on experts to tell us who we are and who we will become and that we
are okay and, perhaps more importantly, the ways in which that reliance is predicated on
a pleasure that comes from gaining access to an authoritative knowledge. My experience
of the progress report meeting is another example of the ways in which any authoritative
venture contains a meshwork of feeling, desire, disappointment, disillusionment, and
human subjectivity, factors which go unspoken in the large majority of research projects.
It feels important to speak them here, to leave the reader, last of all, with the notion that
although authoritative knowledge is constructed as important and untouchable, it is only
positioned as such because it sits behind rules and regulations, signed by those who have
the power to sign it and deem it to be an academic truth. This dissertation will sit behind
my name, Bethany Riddle (Ph.D.), and I will say, This is MY dissertation when I am
asked to point to it. It will serve as a means to sanction me as one who then will be
invested with the authority to stamp and validate and confer on others, will grant me a
privileged access to the very knowledge that I know to be constructed, and will position
me as a more legitimate knower. It is a position that I will accept with a strange mixture
of hesitation and delight.
References


Cardoze, C. (2002, June 10). They’re in love. They’re gay. They’re penguins…and


Munim, S., & Khowaja, N. (2004). Effectiveness of early pregnancy ultrasound in


Riverhead Books.


APPENDIXES

Appendix A: Transcription notation system
Appendix B: Interview transcripts
Appendix C: Nouns
Appendix D: Subjects and subject categories
Appendix E: Rights and responsibilities of subjects
Transcription notation system

Short Pauses (less than one second) – dot in parentheses
Pause longer than one second – dot + number in parentheses (lengths in seconds)
Laughing/coughing – action indicated in parentheses
Emphasis – caps
Emphasis of I – underlined
 Interruptions – hyphens
Overlapping speech – hyphens and parenthetical (overlapping)
Garbled speech
Unclear words – bracketed + question mark if guessing what word is
Indecipherable – x’s indicate words that cannot be deciphered at all; number of x’s corresponds to number of words
Held sounds – with hyphens separating word(s)
Researcher’s descriptions – double parentheses
Identifying details omitted – underlined

** names and other identifying details in transcripts have been changed
R: All right, so we should be good to go. So (.), let’s see (.), I’m gonna ask you, I have some questions. This is a semi-structured (.) interview…

P: Okay.

R: …so I have some questions that I’d like to ask you but (.) I don’t mind at all if we diverge from those, and I kind of expect that we will.

P: Okay.

R: So (.) I have some stuff written down but (.) we probably won’t go in this order (.) and I may ask you other questions that I haven’t written down.

P: Okay!

R: Okay (laughing)

R: Um (.) so let’s start (.) maybe like a little bit chronologically because I’m interested as well in your experiences prior to pregnancy.

P: Um-hmm

R: so if you don’t mind telling me, How was the fetus conceived?

P: (.2) Naturally

R: Um-hmm

R: Intentionally (laughs)

R: Uh-huh. And (.)

P: It was kind of bizarre because, like I said, I’m thirty-two

R: Uh-huh

P: I’d never been pregnant, to the best of my knowledge

R: Uh-huh

P: and took precautions to make sure that happened.

R: And the what?

P: and took precautions to make sure that I didn’t become pregnant.

R: Okay.

P: You know, so (.) and (.) we decided in November that, okay, we’re gonna try to have a baby.

R: Um-hmm

P: Now I’m thirty-two, he’s FORty-two

R: (overlapping) Um-hmm

P: so, I mean, we-, we’re looking at, okay, probably gonna take six months, all this stuff he’s like, no, (gotta get pregnant?)

R: (laughing)


R: (overlapping) WOW

P: Yeah.

R: Uh-huh. So it happened faster than you thought it would.

P: Yeah.

R: Would you say you were surprised by that?

P: Surprised enough that it took (.) I took three pregnancy tests

R: (overlapping) Uh-huh

P: and was three months pregnant before I ever went to the doctor

R: (overlapping) Wow

P: not believing the tests were accurate

R: Uh-huh

P: because (.) you know what, even if you get the FAINTest pink line (.) the extra line (.) yeah, you’re pregnant!

R: Uh-huh
P: Yeah, I didn’t know that.
R: Wow.
P: I just figured, Oh, okay, you know, a-h-h, the test’s a little screwed up or something, you know.
R: Uh-huh. So when did you first (.) think that you might (.) be pregnant, when did you first start-?
P: Ah, it was after New Year’s.
R: Uh-huh
P: Um ( .) so ( .) it was probably like the first or second week of January ‘cause I’ve also never been late
R: (overlapping) Uh-huh
P: in my life
R: (overlapping) Uh-huh
P: and I’m like ( .) this is a little weird but, you know, I’m getting older ( .) maybe ( .) something’s UP with that
R: Um-hmm
P: so we took a test and ( .) it had the little faint pink line and I’m like ( .) you know, I showed it to him, I’m like, you know the other line’s so much BRIGHTer and ( .) I-I don’t think this counts, we’ll wait another two weeks and we’ll take aNOTHer one
R: Uh-huh
P: you know, we take another one and it comes out the same way ‘cause it was the same manufacturer and I’m like ( .) a-h-h-h, you know, we’re not pregnant, um, I just missed a period
R: (overlapping) Um-hmm
P: big deal (.2) and we’re just continuing life as normal
R: (overlapping) Um-hmm
P: like ( .) you know, then I took the third one and, at the same time, my stomach is growing
R: Uh-huh
P: you know, we take another one and it comes out the same way
R: (overlapping) Um-hmm
P: ‘cause it was the same manufacturer and I’m like ( .) a-h-h-h, you know, we’re not pregnant, um, I just missed a period
R: Uh-huh (.2) and we’re just continuing life as normal
P: I was not sick, I was n-o-o-o-t particularly tired
R: Um-hmm
P: I mean, I was a little bit tired but nothing that winter blahs wouldn’t account for.
R: Um-hmm
P: Um (.2) yeah, no, my hair didn’t change, my nails didn’t change, all of those things they sa-a-a-y, no breast enlargement
R: Uh-huh
P: Nothing, you know, you’re just like (.2) I’ve gained a little weight, that’s weird (laughs)
R: Uh-huh (.2) So when did you finally break down and go see somebody?
P: Ah, March first
R: Uh-huh
P: a-a-and ( .) so I go in and at this point we had decided, you know, we’re pregnant, ‘cause I’d also called and made the appointment about ( .) two or three weeks before that
R: Um-hmm
P: (overlapping) and
R: so did you go see a physician at that time, were you thinking about seeing a midwife?
Appendix B; Transcript 1

113  P: No, I went, um, to the midwives straight away
114  R: (overlapping) Uh-huh. That was your plan prior?
115  P: Well, I didn’t really HAVE a plan, which was probably
116                because I was thinking I had six months (laughs)
117  R: (laughs)
118  P: (laughing) before I had to worry about all this (.2) um (.) so (.)
119                didn’t really give it a lot of thought I don’t like doctors
120  R: (overlapping) Uh-huh
121  P: I have a-a-a, an aversion to them I grew up, ah, being treated
122                by a homeopath
123  R: Uh-huh
124  P: which was very different from the standard (.) um (.)
125                mainstream medical care
126  R: (overlapping) Uh-huh
127  P: that you get when you go to a doctor which I DID end up
128                doing after that doctor retired
129  R: Um-hmm
130  P: (. and just had very negative experiences all around, like, ya-
131                ya-you know, I’ve lived with my body my entire life, if I tell
132                you something is hurting and WHY it’s hurting
133  R: Um-hmm
134  P: At least LISTen to me
135  R: Um-hmm
136  P: don’t totally dismiss it and that’s what I was running into, so-
137  R: Can you give me an example of that, actually-
138  P: Ah-
139  R: of a negative experience that you had-
140  P: (overlapping) Oh, okay.
141  R: with a doctor?
142  P: Strep throat
143  R: Okay
144  P: I used to get it on an annual basis every February
145  R: Uh-huh
146  P: (. I went to a NEW doctor (. when I went to college and said,
147                It’s incredibly likely that I have strep throat beCAuse (. every
148                OTher February I’ve had it (laughs)
149  R: Um-hmm
150  P: and they said (. oh I don’t think so, why don’t you go home
151                for a couple of days and then come back and we’ll do a culture
152  R: Um-hmm
153  P: and I said, I-I-I really think I have strep throat and I’m gonna
154                get worse (. and so (. couple days go by, I come back, guess
155                what, I have strep throat, well, I was also (. TWENty, I think,
156                nineteen or twenty
157  R: Um-hmm
158  P: and you know, did the “I told you so” thing which was
159                probably N-O-O-O-o-t the right way to be
160  R: (overlapping) Uh-huh
161  P: with the doctor (. but (. i-i-it just led to an adversarial
162                relationship where-
163  R: With that ONE particular doctor?
164  P: With THAT one, um (. I’ve been told (. as a CHILD I was
165                told that I have a, ah (. mild hearing loss?
166  R: Um-hmm
P: I went to a hearing specialist (.) when I was in my mid-
twenties (.) and was told that I don’t have a peer-, hearing
problem, I have a LISTening problem (laughs)
R: Um-hmm
P: so, I-I-I, ja-, you know, yes, I add this frustration to my life for
my own entertainment, (laughs) you know and i-it’s those type
of things, I also don’t necessarily like, um, antibiotics being
shoved at me
R: Um-hmm
P: those type of things, and when ASKED about homeopathic
remedies (.) a lot of doctors become very deFENsive
R: (overlapping) Uh-huh
P: when they don’t know about them, and that’s fine if you don’t
know just SAY
R: (overlapping) Uh-huh
P: that but don’t (.) disMISS it as something that doesn’t WORK
R: (overlapping) Um-hmm
P: when in my own personal experience it’s worked
R: (overlapping) Um-hmm
P: very well, I mean, ah, to go back to the strep throat thing (.) if
you put iodine on your throat which (.) I don’t recommend
doing unless (.) you know, you’re under the care of a
homeopath (laughs)
R: Um hmm
P: because it’s poisonous?
R: (overlapping) Um-hmm
P: But (.) it’ll cure it in about a day
R: Um-hmm
P: and it’s aMAzing
R: Um-hmm
P: (.2) But yep, so (.) in LOOKing for somebody who was going
to care for me in my pregnancy I actually just wanted
somebody to come to my house
R: Um-hmm
P: and so I could have the baby a-a-nd I knew that wouldn’t be a
doctor
R: (overlapping) Right
P: so I started looking around at MIDwives (.) and researching
Pennsylvania law for them and accreditation
R: (overlapping) Um-hmm
P: and things like that (.) and NObody who is accREdited (.) will
do a home birth anymore i-i-in
R: (overlapping) Is that right?
P: (overlapping) the Pittsburgh area
R: I didn’t know that. I don’t know MUCH about midwives,
actually
P: Yeah
R: Uh-huh
P: and, um, so they ARE licensed by the state
R: (overlapping) Um-hmm
Appendix B: Transcript 1

222 P: ...and um, have to (.), you know, pass certain courses and have
223 certain qualifications like um, Did you hear about the lady in
224 Bloomfield that did the breech baby that died?
225 R: YES, I did.
226 P: Ye-, she is NOT (.) a-an accredited midwife
227 R: Uh-huh
228 P: (.) and actually that patient was going to the midwives I see
229 R: Uh-huh
230 P: and was told, “You have to go to the DOCtor.”
231 R: Um-hmm
232 P: And I’m oKAY with that with, you know, if something like
233 that happens, it’s a breech baby
234 R: Right
235 P: you do need a medical intervention at that point
236 R: (overlapping) Right, yeah
237 P: but it’s not the first place (you go?) but yeah, so, that’s why I
238 picked the midwives for, you know, kind of a balance between
239 the two
240 R: Um-hmm, um-hmm (.7) Okay, just to back up a little bit, so
241 you had, this was the first pregnancy?
242 P: Um-hmm
243 R: and it happened really fast, a little faster than you intended
244 (laughing)
245 P: (laughs)
246 R: had you done anything prior in preparation (.) of becoming
247 pregnant?
248 P: (.3) just started eating a little bit better um (.) I did about a ten-
249 day fast in um (.) October (.) no, I’m sorry, September, it was
250 September (.) and (.) I like to do that ANYway on a ANnual
251 basis
252 R: (overlapping) Uh-huh
253 P: just, I feel like it cleans out my body.
254 R: Uh-huh
255 P: You know, some people think it’s crazy not to eat for ten days
256 (laughs)
257 R: Uh-huh
258 P: but (.) it, it feels good to me, so (.) and (.) I-I-I didn’t really
259 start taking vitamins, I don’t, I always took vitamins
260 R: Um-hmm
261 P: I just don’t take the prenataals and it was (.) it was really more
262 of a joke, I HATE to say that, but it was like, Yeah, right,
263 we’re gonna get pregnant right away (laughs)
264 R: (laughs) Uh-huh, uh-huh (.2) I’M curious, have you had
265 experiences like that in the past where things have, like, taken
266 you by surprise or was this kind of (new?)?
267 P: Um-
268 R: Like, do you tend to be a planful person? Be-because some
269 people prepare for the worst. Like, I imagine (.) myself (.) in
270 that situation, I’d probably think, Oh, as luck would have it I’d
271 probably get pregnant right away, so-
272 P: Yeah
273 R: I’d imagine I’d prepare for (.) (laughs) all catastrophes
274 P: Well, see, when not, trying to NOT be pregnant
275 R: Uh-huh
276 P: I did plan for all (.) possible scenarios
277 R: Uh-huh
P: So it was like, Okay, you know, okay, sure you’re using birth control or whatever (laughs)
R: Uh-huh
P: like, I KNOW (laughs) I’m using birth control
R: (laughs) Right, right
P: It was THAT type of thing, but with THI-I-I-S, it was just, okay, let’s just take it as it comes
R: (overlapping) Um-hmm
P: if it doesn’t, you know, happen for a little bit
R: (overlapping) Um-hmm
P: then we’ll go see what else is going on
R: (overlapping) Um-hmm
P: but, yeah it wasn’t, I just really didn’t think it would happen
R: Uh-huh
P: Well, also, because, you know, you read all the statistics, your fertility starts to decline at twenty-EIGHT
R: Uh-huh
P: (.) it’s gonna take some time (laughs)
R: Uh-huh
P: you know and it just, yeah (.) Yeah, no (.5) I’ll plan to avoid something I guess is the answer to that (.) but not (.5) to DO something.
R: Okay (.) Uh-huh (.) U-u-um, have you done anyth-i-i-ning in preparation of becoming a mother?
P: (.) Um (.2) Other tha-a-an, like, getting the (.) cri-i-b together
R: (overlapping) It just, yeah, not that I couldn’t possibly
P: (.2) Other tha-a-an, like, getting the (. ) cri-i-b together
R: LEARN something (. ) but I was the oldest of the cousins in the area,
P: washing the clothes (.) not really, nothing like um (. ) a-a-, I mean, we took a birthing class, I’ve read some books (. ) but (. ) to me it just seems like something you DO (. ) ya-you’re born with the ability to (. ) DO it.
R: Um-hmm (.) So you feel like (. ) (you don’t really need the extra) (. ) preparation? (. )
R: that would be, like, I don’t know (. ) unnecessary?
P: (overlapping) Uh-huh
R: (overlapping) Uh-huh
P: we had a very large extended family growing up,
R: Uh-huh
P: A-a-and (. ) s-o-o (. ) I spent a lot of time (. ) WATCHing the younger kids
R: (overlapping) Uh-huh
P: that ranged down to, let me think, the youngest one i-i-is eleven years younger than me (. ) and so (. ) it’s kind of normal to me, I’ve worked at day cares
R: (overlapping) Um-hmm
P: I’ve, you know (.2) you know, treat them like little people and they tend to act like little people
R: (laughs) Uh-huh
P: (laughs) you know?
Appendix B; Transcript 1

R: Uh-huh (.3) But yeah, so how are you feeling, it sounds like you’re feeling pretty CALM, do you have any feelings about (. what it’s gonna be like or expectations? P: Um (.2) as far as (.) I’m calm about (.) having the baby and the ability to CARE for the baby R: Uh-huh P: The things that cause me anxiety are my boyfriend has two other children R: Um-hmm P: And, um, one is an adult he’s (. just turned nineteen R: Um-hmm P: his daughter is Fifteen (. a-a-and she lives with us forty percent of the time R: Um-hmm P: And she’s going through that special thing fifteen-year-old daughters do R: Uh-huh P: which is, “I want ALL of dad’s attention,” R: (overlapping) Um-hmm P: and now the new BAby’s co-o-o-ming a-a-and (.) she’s not so KE-E-EN on it, she was at first, and then she went home to her mother and (.) then she wa-, and then she wasn’t as keen on it anymore (laughs) R: Uh-huh P: Yeah, she came back, “Well, it’s only a HALF brother.” (. Oh (. KAY R: Uh-huh P: We’ll get PA-A-St that, you know, and it-it’s those types of things that cause stress in the household R: Uh-huh P: (. um (. that’s what I worry about because, ‘cause I don’t like having (. anXIETY around (. It would be better to be (. just kind of mellow R: (overlapping) Um-hmm (. So (. you’re sort of anticipating a shift in the family dynamic? P: Ye-e-ah, I-I mean it’s been (. RISing throughout the pregnancy R: Uh-huh P: Bu-u-ut (. she’s been acting out more and more (. Um, getting caught with a boy behind the BUILDing, you know, like, just, not GOOD things R: (overlapping) Um-hmm P: and because of the dynamic between m-y-y-y boyfriend and his ex-wife R: (overlapping) Um-hmm P: (. which (.) is pretty NEGative (.) her mother will do just about anything to turn her against her father R: (overlapping) Um-hmm P: and so (. that inCLU-U-UDES (. a lot of bad behavior with boys or school R: (overlapping) Um-hmm P: or whatever and it’s like, you know, and so she comes over to our house and we’ll try to set up some boundaries and, you know, that results in an explosion and so she le-e-eaves, and it’s like, R: (overlapping) Um-hmm
P: we’re gonna have a BABY here
R: Um-hmm
P: that just does not need that type of STUFF
R: Um-hmm
P: so (.) THAT causes some anxiety (.) um (.) I start (.) law school, my freshman year, on the twenty-second, er, twenty-third
R: (overlapping) Uh-huh
P: of this month, yeah (laughs)
R: And when are you due?
P: September fourth
R: Uh-huh (laughs) how’s that gonna go?
P: you’re pregnant for nine months? (.) Eh, you’re not, it’s ten months
R: Uh-huh
P: Yeah, I didn’t KNOW that (laughs) (.) and, um, so (.) when we did the math out we figured November or December’d be just fine
R: Why do they say that you’re pregnant for nine months? It really isn’t exactly nine months, is it?
P: No (.), no, because I’m (.) THIRTY-five weeks, I’ll be thirty-six on Friday.  That’s nine months.  I’m still due to go for another (.) four weeks
R: Uh-huh
P: So I don’t know where they got nine months
R: Um-hmm
P: But, um-
R: What is a full term gestation, it’s (.) thirty-eight to forty-two?
P: Um, thirty-seven
R: (overlapping) thirty-seven
P: to forty-two, I think, or forty-three (.) something in that range
R: Yeah, I’ve never done the math, but I’ve heard other people say, too, that it doesn’t quite work out
P: Yeah (.) so-o-o that was not necessarily the, we-, the best (.) excuse me, planning, and I, I, realize that you’re first year of school kind of your most stressful but, then again, I don’t want to put it off for another year
R: (overlapping) Um-hmm
P: ‘cause my job is computer related?
R: Um-hmm
P: and, a lot of it’s going off shore, so I pretty much expect to, i- i-i-f I did leave on my own would be laid off
R: (overlapping) Um-hmm
P: for next year (.) so (.) going to school seems like a good (laughs) idea (.) um (.) but the-, THOSE are the things that I’m, like, anxious about, n-o-ot (.) raising the baby or caring for him
R: (overlapping) Um-hmm
P: or the BIRTH or anything like that, it-it’s all gonna HAPpen
R: (.?) Okay (.) a-a-and, you said you ha-, you have a fibroid?
P: I actually have two
R: Uh-huh
P: One is the size of a grapefruit
R: (overlapping) Uh-huh
P: the other is the size of an orange
R: Uh-huh (.) and can you tell me some about that, I don’t kn-o-o-o-ow TOO much about that?
P: (.) they are, um, generally benign tumors in your uterus (.) They’re not quite sure why they’re caused
R: Uh-huh
P: but-
R: Did they develop during your PREGnancy or they were there (.) before?
P: I don’t know
R: You don’t know
P: I don’t know, they said that they may have been there PREviously
R: (overlapping) Um-hmm
P: and just got (.) um (.) they GRE-E-EW as a result of the pregnancy because (.) when you’re pregnant (.) there’s an increased blood flow and estrogen
R: (overlapping) Um-hmm
P: (.) and that type of stuff
R: (overlapping) Um-hmm
P: mine are both in the wa-a-all
R: Which are (.) pretty much the best ones I could get for the baby
P: Um-hmm
R: (.) ’cause they’re the least possibility of deGENerating (.) of um (.) getting in his GROWTH’s way
P: (.) and that type of stuff
R: (overlapping) Um-hmm
P: u-u-um (.) they caused a lot of anxiety for me when I first found out about it
R: (overlapping) Um-hmm
P: because (.) I had never met anybody with them, I’d never heard anything aBOUT them (.) and (.) ya-you go looking on the Internet at (.) different information and what you keep seeing is hysterectomy (laughs)
R: Um-HMM
P: (.) and that’s a pretty scary THING (laughs)
R: When did you find out-, how did you find out?
P: Uh, I went to my first apPOINTment, u-u-mm (.) in March (.) a-a-and (.) they, you know, do all the standard first appointment STU-U-UFF, and then she’s like, “Oooh, we can listen to your HEART tones” and I-I-I-
R: What do they do at a-, I’m sorry to interrupt you, what do they do at a first appointment
P: (overlapping) Oh
R: at the Midwife Center?
P: a-a-ah, at the birth center, at your first appointment i-i-is, um, a blood draw?
R: Uh-huh
P: Because by state law you are required to be tested for syphilis
R: Okay
P: which I find kind of aMUsing (laughs) but, that's a whole different
R: (overlapping) that seems very
P: (overlapping) story (laughs)
R: arbitrary to me. Why syphilis, and um…?
P: I'd imagine it's an old law on the books because, you know, years ago when you got MARRied and they did blood work up
R: (overlapping) that's TRUE, isn't it?
P: You ONLY got tested for
R: (overlapping)
P: syphilis, and, so I'd imagine it's something on the books from the THIRties (laughs) () and
R: Okay
P: so, you get that, they do yo-o-our, um () blo-o-od typing, they do your, um, blood count and any other type of, um () testing that you OPT for
R: Um-hmm
P: Um () based on when you had your last pap smear they do one of those () ah, they do blood pressure a-a-and () a-a-ah, breast exam, I'm trying to think, eh, of a-a-anything e-e-lse they do () Oh, and then they listen to, um, the baby's HEARTbeat with the Doppler
R: Um-hmm
P: now () wh-e-en I layed back on the ta-a-ble I was a lot thin- (laughs) ner than I am now
R: Uh-huh
P: and there was just this mound of belly
R: Um-hmm
P: and my boyfriend and I had kept laughing about it, you know, saying, "It's not a baby, it's a TUmor," but, you know, or maybe it's TWINS or something
R: (overlapping) Right
P: like that () because we had not clue about the fibroid at the time (laughs)
R: (overlapping) Right
P: the time (laughs)
R: (laughs)
R: (overlapping) Right
P: and so () um () we're laying there, you know, I'm doing my thing, she's doing the DOPpler and () she's not getting a HEART tone
R: Um-hmm
P: a-a-and, I don-, do you know any of the midwives?
R: No, I don't, I don't.
P: Okay, um, I was with Laura who has red hair if you ever see her
R: (overlapping) Right
P: and () she's HORrible about hiding what's going ON () so it's really funny, you can see on her face that she's gettin’ really worried
R: Uh-huh
P: so, looking a little stressed out
R: Uh-huh
P: (laughs) 'cause she's not finding a heart beat
Appendix B; Transcript 1

R: Uh-huh (.) Did you know she wasn’t finding a heart beat beFORE, or could you tell from her facial expression-?
P: Well, you can hear it as she moves
R: (overlapping) Oh (xxxx xxxx xxxx xxxx)
P: (overlapping) it across your belly, it’s just like, um (.2) played out through
R: (overlapping) Um-hmm, um-hmm
P: a-a-a little box
R: Um-hmm
P: It’s kind of cool (.2) and, um (.2), you know, after it comes to be that, um, she was trying to get a heart beat, you know, off the fibroid (laughs)
R: Uh-huh
P: (.) But at the time that she’s not getting it she’s like, you know, “We-e-Ill, maybe, you should see if you can go over to the ultrasound place toDAY. How would you feel about going there toDAY?” (laughs)
R: (laughs) Uh-huh
P: “Because you’re looking a little large for gestational age, we need to”
R: (overlapping) Uh-huh
P: you know, get a good DATE on you” and all this other stuff
R: So sh-, it sounds like she was trying to stay calm but you could sense
P: (overlapping) Yeah
R: that there was something
P: It just (.) seemed a little fishy
R: (overlapping) Uh-huh
P: that it was, like, Okay, you don’t send somebody for a surprise ultrasound (laughs)
R: Uh-huh
P: And, um (.2) so fine, so I called my boyfriend and we went over for the ultrasound
R: (overlapping) Uh-huh
P: that DAY, and THAT’s when I found out about the fibroids and that’s when I had my first ultrasound
R: Okay (.4) okay, well, that was nice segue, so, um,
P: (laughs) Oh-
R: (laughs)
P: (laughs) (xxxx xxxx xxxx xxxx)
R: So (.2) um (.2) this is a little bit different because you went for a medical reason and not (.2) as kind of a standard monitored by a physician?
R: (overlapping) Um-hmm
P: (xxxx xxxx xxxx xxxx) as sort of a standard part of, ah, being
R: ultrasound (xxxx xxxx xxxx)?
P: My mom was a medical assistant
R: (overlapping) Uh-huh
P: for an OB for years
R: Uh-huh
P: and, so, I had SEEN ultrasounds before
R: Uh-huh
P: And (.2) so, I was, was pretty much, just, ac-ac-actually (.)
expecting to see a dead baby
R: Um-hmm
P: Because she couldn’t get a HEART beat a-a-and I was, you know (. .) a LITtle freaked out
R: Yeah
P: And, um (. .) the girl who was there, she was very good, she was (xxxx), so she kept (xxxx xxxx xxxx), and all of when she first started LOOKing, you know, they go to the BIG part, and the big part at that point in time was ALL FIBroid
R: (overlapping) Okay, uh-huh
P: Because (. .) to put it into perspective (. .) the grapefruit (. .) the orange (. .) the baby, based on the size he is in the picture
R: (overlapping) Um-hmm
P: is about the size of the orange
R: Um-hmm
P: so he’s, kind of, like (. .) under the other guys (laughs)
R: (overlapping) Right
P: a little bit
R: Uh-huh
P: And, um (. .) yeah, and so, I’m seeing these, like, MASSes, and it’s like (. .) I don’t remember ultrasounds being THIS bad
R: Uh-huh
P: I mean the last time I saw one was about fifteen YEARS ago,
but
R: (overlapping) Uh-huh
P: it was just still, like, okay, this is really weird (. .) like (. .) you know, of course you read all those books, you know, that talk about blighted oovums and all this other stuff, and like
R: (overlapping) Um-hmm
P: eugh, you know, what is this (. .) and then we see the baby (. .) and, it was like (. .) everything was okay and then I didn’t care about the rest of it (laughs)
R: Uh-huh
P: And, um-
R: Well, tell me what, Can you tell me, actually, like what you remember from, like, backing up a little bit
P: Um (. .) We went in and they had to get me, um, preregistered so I had to fill out the little paperwork form about (. .) where I c-a-ame from and (. .) what my insurance was and all that, we’re sitting in the waiting room, er – we were at —— and (. .) you know, everybody was very FRIENDly
R: Uh-huh
P: and, you know, they’re like, “Oh, why are you HE-E-EERE?”
R: Uh-huh
P: a-a-and (. .) they brought me in pretty quickly ‘cause they were about to close up
R: Uh-huh
P: a-a-and so (. .) you know, you just (. .) lay back on the TAble
and then (. .) the g-i-i-i-rl that does the ultrasound (. .) is just very JOvial, ver-r-ry friendly, very LIGHT and (. .) so that kind of helped, I remember that because I mean
R: (overlapping) Uh-huh
P: you know, at, at this point I know my blood pressure was 
(R: (laughs) through the
P: ) Right (. ) Was this a medical doctor or
R: (overlapping) No this is the
P: (overlapping) the sonographer?
R: Right (. ) I hadn’t met with the doctor yet
P: the sonographer (. ) I hadn’t met with the doctor yet
R: Okay
P: and, um (. ) yeah, then she just started DOing it
R: (overlapping) um-hmm, um-hmm
P: ( . ) so
R: and so you saw the-
P: (overlapping) so then
R: (overlapping) fibroids
P: So then, I saw the fibroids, first
R: (overlapping) Uh-huh
P: and didn’t realize what they were
R: Okay
P: and um (. ) she started TELLing us, “Okay, yeah, no, this is go-
o-o-d, like, these are the lobes of his BRA-A-AIN” and she
just, you kno-
R: Did she tell you that they were fibroids immediately or
P: ( . ) Ah, yes, yeah, she did, she said, “Oh, you’ve got some big
fibroids,” and I said, “What’s a fibroid?” (laughs)
R: Uh-huh
P: She said, “You didn’t know you HAD them?”
R: Uh-huh
P: And I said, “No-
(R: (overlapping) “No, that’s why we’re here” (laughing)
P: (overlapping) “No (xxxx xxxx), I don’t know what a fibroid
IS, even (laughing) (. ) you know just like, “Oh, okay, we’ll
just take a look at that, I’m gonna take some pictures, we’ll
take some pictures of the BAby,” and she kept focusing on the
BABY
R: Um-hmm
P: which (. ) was the right thing to do with ME
R: Um-hmm
P: so I didn’t freak out
R: Um-hmm
P: and (. ) um (. ) you know and she (. ) pointed out, like, the
positive things, like, with the baby, that you could see the
(leaflets) in the HE-A-A-ART (. ) and that um (.2) you know,
took some cute PI-I-ICTures, you know (. ) that type of thing (. )
and then she said, “O-o-okay, I’m going to go look at a couple
of these with the DOCtor and then he’s gonna come in and
talk to you. ”
R: Um-hmm
P: And so (. ) um, that’s when Dr. THOMas came in (. ) and um
(. ) he ah (laughs) he gets out the, like, jelly and the stick thing
(R: (overlapping) Um-hmm
P: and he starts looking, and he’s like, “You DIDn’t KNOW you
had FIBroids?” (laughs) (.2) And I’m like, “No” (laughs)
R: I’m just curious, How could you KN-O-OOW, like (. ) [would
you KNOW]?
P: (overlapping) I DON’T know (. I-I guess I should have
noticed that I was getting THICKer in the middle (. ’cause (.)
they were pretty SIZEable (. but (. eehh (. I don’t see how
you would know OTHERwise (. supposedly it’s painful
menstruA-Ation, it’s, um (. all kinds of things that could be
blown off as NORmal
R: Um-hmm
P: You know, there-, okay, so I have bad cramps, eh
R: Right
P: Um (. it really, the only way I’d think you’d know is (. you
know, regularly visiting the doctor, and, ah (. getting an
ultrasound eventually
R: Um-hmm
P: (. or being in such excruciating pain, ’cause I have one
girlfriend who had them afterwards, who had a ton of fibroids
and has had a lot of the, ah, I forget what they’re called,
myectomies or something?, where you just cut out the fibroids
R: (overlapping) Um-hmm
P: and sew up the uterus? And (. you know, another lady I work
with just had a hysterectomy because of them (laughs)
R: Um-hmm
P: Because she was in SO much pain
R: Um-hmm
P: (. but (. they didn’t BOTHer me, if they were there
R: Um-hmm (. Okay, so you came in and
P: he expla-a-ained (. you know, what a fibroid is, that, you
know, “Yes, it is a TUmor, it’s non-cancerous,” but, he’s, he’s
ver-r-ry good at explaining
R: Uh-huh
P: and giving a lot of detail (. he doesn’t always do it in the
ORDER I want (laughs) but um (. he will give you all of the
information you ask for
R: Okay (. What order does he give it in and (. what order
would you rather have? (laughs)
P: Well, it depends
R: Uh-huh
P: and, um, that’ll actually come up with the second ultrasound
(. where he (. walked in and (. you know, started giving me
the history of DOWN’S syndrome
R: Uh-huh
P: (laughs) I was like, eehh, “Why are you giving me the history
of DOWN’S syndrome?”
R: Uh-huh
P: You know, and he should have started with the, you know,
“The baby’s FINE (. However, he has ONE SINGLE
MARKER that could potentially be conSIDered for Down’s
syndrome."
R: (overlapping) I see
P: Right (. You know, so for me, that-, that’s a little helpful,
like, he starts with, “You have uterine TUMORS, that’s what a
fibroid is.” I’m like, tumor equals cancer equals DEAD
(laughs) you know
R: Right
P: and (. yeah (. so (. beNIGN i-i-is a good word to start with
for me (laughs)
R: (laughs)
P: But, you know, so (. ) he looked at THOSE and, um (. ) at that point I was SO FLUStered (. ) I didn’t ask a lot of questions R: Um-hmm
P: I just said (. ) Okay, I have fibroids and he says the baby’s gonna be FINE (. ) and I saw pictures of the baby so I was HAPpy (. ) ‘cause (. ) it became REAL and, I don’t know if that makes SENSE (. ) in a way (. ) but it really wasn’t REAL prior to that R: Um-hmm
P: It was, I’m just gettin’ FAT (laughs) you know, what is this (. ) weird (. ) you know (. ) ‘cause I had NOTHing else to go with it (. ) and we hadn’t told anybody at that point either (.2)
R: What do you think (. ) made it more REAL (. ) about the experience?
P: It’s seeing it
R: Uh-huh
P: a-and (. ) you know, being able to hear the heart beat (. ) and (. ) seeing how well-formed he was, a, a conversation we had when we left the ultrasound was actually about abortion R: Um-hmm
P: ‘cause I was twelve weeks pregnant
R: Um-hmm
P: and we had no inTENtion of having a abortion, I mean, eh, I personally don’t agree with it for ME R: Um-hmm
P: Um (. ) but I never really thought about (. ) at twelve weeks (. ) how FORMED that child is R: Um-hmm
P: and how many women just g-o-o-o get an abortion because, you know, you don’t notice anything, you don’t SEE anything, you don’t FEEL anything (. ) and, eh, he’s the size of an ORANGE (laughs) you know R: Um-hmm
P: I-i-it’s (. ) yeah, he was very much a little PERson (.7) Yeah, I mean, like, he had a HAND, you know, that we saw R: Um-hmm
P: his PROfile, it was just R: Um-hmm
P: Yeah, I mean, it was very weird, it made it very real R: Um-hmm (.8) Did it change your experience of your body at all?
P: I stopped looking at myself as (. ) negatively (. ) like, I was getting FAT, this is annoying R: Uh-huh
P: You know, it was (. ) he’s gettin’ bigger, that’s GOOD R: Uh-huh
P: You know (. ) he’s GROWing, that means he’s oKAY (. ) you know, I-I did worry a LOT with the fibroids R: Like, you said that [tape cuts off – Side B of tape inserted] Okay (. ) um, soo you said there were questions that, like, you didn’t ask a lot of questions that first time
P: (overlapping) Um-hmm
R: because you were too (. ) stunned
P: Yeah
R: Were there questions you thought of afterwards
P: (overlapping) Um-hmm
that you might have asked?
Yeah (.) and that’s when I was up at two o’clock in the morning looking on the Internet for information
(overlapping) Uh-huh
on fibroids
Uh-huh
and finding out that there were, like, the different t-y-y-ypes and the different loca-a-ations and what can ha-a-a-a-pen with them and, you know, all of these other things
(overlapping) Uh-huh
about (.) I had myself worked up into such a TIZzy by-y-y (.)
the next morning that I was totally not functional
Uh-huh
just ’cause (.) I didn’t have any answers
Um-hmm
and so I called Midwa-, Midwives and you know (.) left this (.)
horrible, crying message (laughs)
Um-hmm
and they (.) called me back and they were very, um,
understanding and wanted to ta-a-a-lk and discuss and get answers for what needed, you know,
Um-hmm
that they didn’t have the answers for
Um
so that made me (.). feel BETter? I mean, I still worried but (.).
it felt better
And what were some of the things (.) that, that you found out that alleviated your anxiety?
Um, the location of the fibroids (.) the actual size
Uh-huh
Um-m-m (.) the-e (.) where the placenta was attached
Um-hmm
and HOW it was attached (.) because, like, if the fibroid was IN the uterus (.) and the placenta had attached over the fibroid
Um-hmm
well, if that fibroid dies so does the baby
Um-hmm
(.) with (.). them being in the WA-A-ALL (.) the placenta’s actually attached over the wall
Oh, okay
so (.). it’s better.
Uh-huh
Um (.2) you know, the fact that none of them are on top of my, um, cervix (.) you know, still allows for a natural birth,
Um, whi-i-ich lowers risk
Uh-HUH
(.) Ah (.). I’m trying to remember (.) what also I freaked myself out with (laughs)
Um-hmm
(.) You know, um, postpartum hemorrhaging (.). it’s still a risk
Um-hmm
It’s going to be a risk
Um-hmm
I just needed to acCEPT it
Um-hmm
(.) you know
R: (.) so (.) Wh-what do you think (.) w-would have been helpful for (.) the doctor to have, at the sonogram, to maybe alleviate your anxiety?
P: I don’t think there’s anything that he could have done without knowing me.
R: Okay, uh-huh
P: You know, I mean, the fact that I walked away with know-, the knowledge that it was not CANcer (.) helped
R: Right
P: You know
R: Right
P: Um (.2) but (.2) yeah, I think that (.) i-it would make a big deal (. ) to me and that I would go nuts and (. ) look up all this stuff on the Internet ‘cause not everybody’s going to do that?
R: Uh-hmm
P: You know, some people do do more of a FRE-E-AK and, you know, just
R: Uh-huh
P: you know
R: Okay (.11) Okay, so how, um, so ya-,you went for the sonogram, and then
P: Um-hmmm
R: You were REALLY anxious and so then you called the Midwife Center and then (.) you felt (.) that helped a lot, and then when did you go ba-a-ack (.) for your (.) second (.) sonogram?
P: For my second sonogram? That was at, ah, twenty weeks (. ) and you can do it ANY time between eighteen and twenty weeks and I wanted to put it at the very end (. ) because we had talked about it and I wanted to know the sex of the baby and (. ) my boyfriend agreed
R: Uh-huh
P: (. ) for me-e-e, that’s a bi-i-g (.) identifying factor, ‘cause now I can name you (.) a-a-nd once you have a name (. ) you’re (. ) even MORE real.
R: Uh-huh
P: A-a-and, I mean, if he HADn’t cooperated (. ) then, you know that would have been okay, too
R: Uh-huh
P: I mean, that’s just the way it works
R: Uh-huh
P: but (. ) um (. ) so, yeah, we went in at twenty weeks a-a-and, um, that was an optional ultrasound
R: Uh-huh
P: that, generally, ah for me it was kind of (. ) NECessary just ‘cause of the fibroids, I wanted to check and see everything was okay
R: Uh-huh
P: with all THAT stuff
R: Uh-huh
P: and so we go in, and (. ) you know, got the same girl as last time
R: Uh-huh
P: (. ) she’s (. ) very friendly and all that, like I said, and (. ) we start LOOKing at him, she’s just TAKing different PIctures
and, you know, part of me in my head is saying, this is taking a long time but I’m having fun ‘cause I’m gettin’ to see him

R: Uh-huh

P: and, um-

R: How long does it take?

P: It depends, I ended up with a Level Three ultrasound

R: Uh-huh

P: which is something where they’re looking for, ah, birth defects

R: Uh-huh

P: (...) and, um, I think a NORMal ultrasound takes about twenty minutes

R: Um-hmm

P: I think I was in there for an hour and a half (laughs)

R: Um-hmm

P: (...) OH, I was freaked out at first because, um, I remember this now (laughs), the baby was all curled up in a ba-a-all and she’s taking pi-i-ictures (...) and I’m not hearing a heart beat

R: Um-hmm

P: a-a-and (...) last time when she did it she got a heart beat real quickly

R: Um-hmm

P: and she didn’t this time and I was like (...) he’s DEAD and (...) I’m TERRible about jumping to bad conclusions (...) it’s something I DO

R: Um-hmm

P: and (...) so, um, but anyway, the heart beat was THERE and everything was fine and, um, sh-e-e-e was taking pictures of the HEART at (...) and, um, there was a light calcification (...) in there and that is actually one of the markers for Down’s syndrome

R: Um-hmm

P: and, ah, you know that’s what led to the LONGer ultrasound where they take BONE lengths and different (...) measurements, I think there’s something with the back of the NECK a-and all kinds of stuff

R: Um-hmm

P: (...) a-and, they look at all of that together and determine (...) where the (...) what’s the likelihood

R: Right, right

P: And, um, so (...) you know, they did that but, I, I didn’t know what they were DOing at the time

R: Um-hmm

P: so that’s when she, she left to go talk about things with the (...) DOCTOR (...) and the fibroids had stayed the same size (...) and he came back in and started giving me the history of DOWN’S syndrome (laughs)

R: Wow

P: (laughing) and I was just like, [xxxx xxxx xxxx], you know, and, you know, he said it’s very unlikely and all of this stuff and we talked about amniocentesis and he said, pretty much it came down to, he’s like, “What would you do differently if you knew?”

R: Um-hmm

P: and (...) I said (...) NOTHing, I have a baby

R: Um-hmm
P: and he said, “Then it isn’t worth the risk” (.) because there is a risk associated with
P: having that test done
P: So, you know, we opted AGAINST it, you know, he said, it, it, ya-you know, really, as much as a doctor can say, (.) “He’s fine”? He said, “He’s fine.”
P: Uh-huh
P: (. and so (.).) I left that one, um (.).) feeling pretty GOOD overall
R: How did you, when did you (.).) um, find out the sex? Can you tell me about that moment?
P: (overlapping) It was at that ultrasound, well, he was, um, she was moving around the thi-ing (.) and (.) it was right there on the screen
P: He was (.) not shy and I’m like (overlapping) he’s a BO-O-Y! And she’s like, “You’re right!”
P: (overlapping) it’s better it’s better that it’s a boy because of his DAUGHTER
P: and I think (.). sh-, she’ll be able to bond better with a boy than if we had a girl because (.).) then not only would she have to deal with not being the BABY any more (.).) she’d also have to deal with not being the only girl
R: (overlapping) Um-hmm
P: anymore, so (.).
P: Uh-huh
P: You know, so, it, it wa-, it was easy with a boy, it was like we had that picked out and
R: (.6) So prior to the Fibroids, though, had you planned on having an ultrasound at all during your pregnancy?
P: I assumed that you were sup-
R: (overlapping) Uh-huh
P: posed to at some point in time
P: Uh-huh
P: just to check on it
P: Uh-huh
P: (. Um, I found out from the midwives it’s totally optional
R: Right
Appendix B; Transcript 1

P: a-a-nd (.) didn’t realize that, um (.) I probably would have elected to do it anyway (.) just for (.) I’m a visual person and for me to (.) see the baby and see he’s okay

R: Um-hmm

P: gives me just a great deal of comfort (.2) tha-a-at (.) the risks I’ve seen associated with ultrasound (.2) are sketchy in potential anyway

R: Um-hmm, um-hmm

P: so

R: Why do you think yo-o-u-u (.) like where do you think you came to that assumption that (.) this is what women do when they’re pregnant is have an ultrasound

P: Ah, my mom working with the OB

R: Uh-huh

P: that (.) I SAT, you know, li-, I had been filing for them (.) at points in time and if somebody was coming in for an ULTRAsond

R: Uh-huh

P: [they’d] ask if I could sit and watch it

R: Uh-huh

P: 'cause I thought they were cool

R: Uh-huh

P: And so (.) um (.) I was just assumed that pregnant women got ultrasounds (laughs)

R: Uh-huh

P: (.8) Yeah, and (.2) almost everybody you talk to gets them now,

R: Uh-huh actually (.2) I, I was surprised that they had the eLEcitive 3-D ones (.2) they don’t have 3-D at, um, ________ which is fine

P: I don’t need a 3D (laughs) I just want to see that he’s okay

R: Right

P: But, yeah, I mean, there are people in my office who-o-o, you know, have gone in for elective ones

R: Uh-huh (.2) so what was, tell me again, what was it that, your primary reason, besides thinking this was part of the monitoring, what for you personally, for having an ultrasound done?

P: Ah (.2) seeing him,

R: Uh-huh

P: (laughs) I just want to see that he’s okay

R: Uh-huh

P: But (.8) yeah, I mean, there are people in my office who-o-o, you know, have gone in for elective ones

R: Uh-huh (.2) so what was, tell me again, what was it that, your primary reason, besides thinking this was part of the monitoring, what for you personally, for having an ultrasound done?

P: (.2) it’s a baby in there and not, you know, something from ALien

R: (overlapping) Uh-huh

P: That it, ah, I, I know that sounds cra-a-zy but (.2) my mind does seeing that he was okay, and just (.2) visual confirmation that (.2) it’s a baby in there and not, you know, something from

R: ALien

P: (laughs) to be quite honest

R: (laughs)

P: but (.8) Yeah, I, I, I don’t tend to believe things (.2) are real (.2) until I see them

R: Uh-huh

P: You tell me you’re going to give me ten bucks on Tuesday? If Tuesday comes and goes and I have ten bucks in my hands,
fine, if n-o-o-ot? (laughs) Oka-a-y (.) you know, I’m not gonna
hold my breath, it’s th-, it’s the same type of thing
R: Um-hmm (.5) I had a question I (was wondering? can’t
remember?)
P: (overlapping) I’m sorry
R: (overlapping) I’m not, no it’s okay (xxxx xxxx xxxx)
P: (laughs) ’cause I was, like, yammering
R: Well tell me ab-, maybe we’ll come back to it, can you tell me
about your THIRD ultrasound?
P: Okay
R: Okay
P: Um, my-y THIRD one (.) wa-a-s at (.) it was July fifteenth and
I don’t remember how far along I was at that point but I, I was
um (.) probably thirty-two weeks, something
R: Um-hmm
P: Um (.) and (.) we had had a ROCKY morning (.) it just, I had
be-e-en (.) not SLEEPing well, it was just one of those days
that just wasn’t going right? a-a-and, he ordered me COFFEE,
which, I didn’t WANT, but, every once in a while I drink
coffee even though, you know, I mean, they say it’s okay as
long as I don’t drink a TON of it
R: Uh-huh (your boyfriend?)
P: Uh-huh, uh-huh, he bought, he bought me coffee, so (.) like,
I’m not in the mood for it, and then we get to the
ULTRAsound place and (.) you have to have a full bladder to
have an ultrasound
R: Uh-huh
P: so now I’ve had COFfee (.) and I have a very full bladder that
wants to be empty because (.) it’s full
R: Uh-huh
P: a-a-and, we had to wait about an hour and a half after our
appointment time
R: Uh-huh
P: (.) which we hadn’t had to DO before (.) and we get a different
girl
R: Uh-huh
P: (.) She’s a little crabby (laughs) as I’m probably a little
crabby, too to be honest
R: (overlapping) Uh-huh
P: because now I’ve been WAITing an hour and a half and I’ve
got a very full bladder (.) and, you know, I’m not feeling so
good ‘cause I probably should have e-e-aten, you know (.) at
this point, and I didn’t bring food with me because I didn’t
plan on BEing here this long
R: Right
P: (.so-o, um (.) we go in the room and it’s HOT, now,
everything’s hot to me these days, she could’ve had the air
conditioning CRANKED and it was hot
R: Um-hmm
P: and the bed was, um, reclined pretty far on its back
R: Um-hmm
P: (.) and even though a pregnant woman’s supposed to be able
to be fine on a five percent incline? it kills me
R: Uh-huh
P: and I’m not sure if it’s ‘cause of the fibroids, having extra we-
e-i-ght or whatever but (.) it cuts off that vein and I get hot,
then I get nauseous, and (. ) so far I’ve been lucky and just
stopped it there (. ) so (. ) she’s trying to get amniotic FLUID
levels and (. ) I’m needing to sit up
R: Um-hmm
P: because I can’t stay in that position and (. ) it just, it was just
NOT a good combination of personalities or events or
whatever and (. ) didn’t really get to see the baby, didn’t really,
you know (. ) eh, see much of anything, like she just did, click,
click, fibroids and, you know some measurements on the baby
and (. ) a couple of pockets of amniotic fluid and kind of
walked out of the ROOM, I’m like, okay, and I asked her
about, you know, are you gonna be able to get us any pictures
and that kind of stuff and she’s like, “Well, we’ll see”
R: Um-hmm
P: She never came BACK (laughs) the doctor came back in, and,
I still, you know, got belly out, like all jellied and all this stuff
figuring, okay, they’re gonna do more or something
R: Um-hmm
P: and they didn’t and, you know, I’m mean, that’s oKAY which,
he said, “Everything’sFINE, he’s in the forty-fourth
perCENtile,” you know, gives you an estimated, he gives you
the current weight
R: (overlapping) size?
P: (overlapping) and estimated weight. Um-hmm
R: Uh-huh
P: and um (. ) you know (. ) pretty much (. ) yo-, you can have
birth at the Midwife Center and everybody’s happy
R: Uh-huh, uh-huh
P: so we left and (. ) you know, it, it, it wasn’t a good note to
LEAVE on, it was just kind of, like, we-e-eird, like, I want the
other girl back, I like her (laughs)
R: Uh-huh
P: (. ) but it was very nice to, you know, hear, you know, his he-e-
a-ad’s do-o-wn, he’s, he’s right
R: Um-hmm
P: he’s good to go
R: Um-hmm (. ) Um-hmm
P: Yeah
R: and how long was that, that was a long WAIT for the
ultrasound
P: Yeah
R: how long did the ultrasound actually take?
P: Ah, the ultrasound itself? I think it was about twenty minutes
R: Uh-huh, yeah (. ) and how did the, um, the-e woman respond
when you said that you wanted to change position, when you
were uncom-, when you were uncomfortable
P: E-e-h-h, I mean (. ) she goes, “Well, you need to be in the same
position for, to, to get the, ah, amniotic FLUID and (. ) she
didn’t offer to move the thing up, she offered to get me some
water , but, it was kind of like, if I have to, you kn-, you know
what I mean? It was just
R: Um-hmm (. ) What do you think (. ) could have made the
experience better? (. ) (laughs) besides having the nice girl
back
P: Um (. ) I think not have coffee would have been a factor,
R: Really?
P: Yeah, because coffee raises my body temperature
R: Uh-huh
P: a-and it also makes me have to, it fills my bladder
R: (overlapping) Right
P: (overlapping) faster, and so, having been taken on time (.) or not having the coffee, or, you know, something like that ‘cause, you know, we’re both sittin’ there and I’m like, I gotta go to work, you know, we booked THE FIRST appointment for a reason
R: Yeah
P: you know, what’s going on here?
R: Um-hmm
P: and it’s fine if they come out and say, “You know, look, we have an emergency or something,” but you never get that, you just get the, you know, “Oh, we’ll call you in a few minutes,” it’s like
R: Um-hmm
P: come on, em (.) so I, I think those things would have made it (.3) better
R: (.3) And how about the doctor himself?
P: He’s always been fine
R: Uh-huh
P: I really can’t-
R: Did he give you information in the wrong order on the third one?
P: No, no, no there was nothing really to say on the third visit
R: Uh-huh
P: you know, um, he (.) yeah, he gave us the size, talked a little about circumcision and, um, what they do with that (.) and who would do that and how they do that
R: Um-hmm
P: you know, all that type of stuff, and, yeah, the fibroids, that, since they’ve stayed the same size, that’s a good thing
R: Um-hmm
P: and, I would have to have twice as big fibroids for there to be a worry
R: Uh-huh
P: about the uterus not falling properly
R: Uh-huh
P: so it was comfort, um, yeah, the fact that, you know, the baby’s growing just fine (.4) is a good thing (.4) he seemed to, ah, thi-, this was funny ‘cause the baby’s full size is supposed to be, like, seven pounds and twelve ounces or something
R: Uh-huh
P: if he stays in the same percentile
R: Uh-huh
P: and, I was like, oh, that’s good, the doctor started laughing, and I’m like, “Oh, what’s up?” and, um (.) he said a lot of women get upset when you say a seven-pound baby, they want the ten-pounder, and I’m like, I don’t want a
R: (overlapping) really? (laughing)
P: ten pound (laughing) baby (.) I know, SEVEN (.) (laughs) We could go with six, that’s okay, too
R: Um-hmm
P: you know, as long as he’s doing fine (laughs) and, so I thought
that was a, a strange thing to hear that women want large
babies
R: Uh-huh
P: you know but
R: I haven’t heard that
P: Yeah (. ) me neither, he, he seems to, you know, say they want
bigger ones (. ) and, at this point I’ve been told that I don’t
need any more ultrasounds
R: Uh-huh
P: unless I go past date
R: Unless you go past date
P: Um-hmm
R: and then they’d do another ultrasound?
P: Um-hmm, yeah, just to check that he’s okay in there, there’s
no fluid and all that (.6) and because he’s bigger it’s easier for
the midwives to feel for position?
R: Um-hmm
P: instead of just feeling fibroids
R: (.2) Right (.8) I remember what I was going to ask you
P: Okay
R: did you, um, did you get pictures from your ultrasound? Did
you get hard copies?
R: (overlapping) from of any of the
P: (overlapping) the first and second, yes
R: the first and the second?
P: Um-hmm
R: And what did you do with them?
P: A-a-ah, actually, I scanned them all in ‘cause none of our
family lives in Pittsburgh
R: Uh-huh
P: and e-mailed them to everybody (laughs)
R: Uh-huh
P: and I’ve got them upstairs in a file
R: Uh-huh
P: at this point, and, I keep saying I’m going to go to Kinko’s and
get them laminated
R: Uh-huh
P: that way they won’t, like, do weird things (. ) I’ll get there
eventually (laughs) but ye-, yeah, I pull them out and look at
them periodically, like before coming in today, actually
R: Uh-huh
P: ‘cause I didn’t remember necessarily when I had go-o-one
and, I was thinking how big he was in relation to the fibroids
and I couldn’t remember if he was the size of the grapefruit or
the size of the orange
R: Uh-huh
P: the first time around
R: Uh-huh
P: it-, it’s just, it’s nice to SEE them, it’s very comforting to me, I
mean, even though I feel him moving around all the time now
R: Uh-huh
P: you know, so I know he’s OKAY in there, but, I, I like having
the pictures
R: something about the visual
P: Um-hmm
R: (being able to picture it?)
P: Yeah
R: When did you first feel him move?
P: A-ah
R: Do you remember if it was before the first ultrasound?
P: Eh, no
R: (overlapping) or after?
P: (overlapping) after both
R: (overlapping) After
P: after the first two
R: Oh, really, uh-huh
P: Um-hmm, and they (.) they warned me that it would probably
be a little later (xxxx xxxx) I would feel the baby move
because of the fibroids
R: Um-hmm
P: (.2) and at first I questioned it, like, eh, is this him moving or
is this (.) you know, actually g-a-a-s, you know
R: Right
P: because that’s (.) kind of what it feels like
R: Uh-huh
P: and (.) then he got stronger and bigger and (.) now you
definitely know he’s moving (laughs)
R: Uh-huh (.2) What other, um, bodily signs do you have at this
point, now, that you’re pregnant?
P: Okay, at this point, um, I have the linea negra. (.2) I have-
R: You have the what? I’m sorry
P: The line on the belly?
R: Oh
P: Linea negra
R: okay
P: U-um (.2) my breasts have DEFINITely gotten bigger and, um,
the areola’s darker and bigger
R: Uh-huh
P: U-um (.2) let’s see, SWELLing, lots of swelling (.2) and, ah, my
feet actually can fit in FLIPflops or men’s shoes (laughs)
R: Uh-huh
P: and I can’t wear any rings or my wristwatch
R: Uh-huh
P: anymore, ah, there’s itching on my belly
R: Uh-huh
P: (.2) U-um, let’s see, I, I had acne at one point
R: Um-hmm
P: which was not fun (laughs)
R: Uh-huh
P: Um (.2) let’s see, I, I still don’t know anything about the hair
and nail thing that (.2) women talk about
R: Um-hmm
P: (.6) ah, no real (.2) na-a-ausea (.2) occa-a-asional food aversion,
where I’ll smell something? And it’s like, “Get that away from
me”
R: Um-hmm
P: Cigarette smoke, in particular, it’s, it’s repugnant
R: Um-hmm
P: (.6) I mean, it, my sense of smell has gotten a lot better (.6)
but that, that’s about it
R: Um-hmm, so, how do you feel about all those changes?

P: Um (.) most of them don’t bother me, ah, it’s (.) it, eh, the thing that’s getting me at point is (.) I want to be normal sized again

R: (overlapping) Um-hmm

P: ‘cause (.) eh, for me this is HUGE

R: Um-hmm

P: it’s bigger than I’ve ever been in my life

R: (overlapping) Um-hmm

P: I’m normally, like, a size three or four (laughs)

R: Um-hmm

P: and (.) this is just stra-a-a-nge

R: (overlapping) Um-hmm

P: a-a-and (.) my mother has a weird neurosis (.) about her weight a-a-and is not very helpful or supportive (laughs) right now with it. Like ((mocking tone)), “You’re gaining weight,” you know, “are you gonna be able to take it off?” Okay, I’m just gonna hang up on you now (laughs)

R: Uh-huh

P: You know, I, I’m feeding the BABY, it’s the GOOD thing to do (laughs)

R: Uh-huh

P: Um, you know, I do wonder what I’ll look like afterward (.) you know, you hear things about your stomach never going back to normal or

R: (overlapping) Um-hmm

P: Um (.) you know, stretch marks and things like that and I know that, you know, in the end if it’s bugging me enough (.) I can just go have it fixed

R: Um-hmm

P: (.2) which I, you know, if somebody had asked me about cosmetic surgery (.) prior to being pregnant? (.) I would have (.) said, you know, why would I do that?

R: Um-hmm

P: that’s ridiculous but (.) you know, it is a natural part of life and it’s something your body does do naturally but if I’m gonna sit there and look at my stomach and be unhappy (.) yeah, I, I, I see it as a better thing to just get it fixed (then?)

R: (.3) Uh-huh

P: I don’t have any stretch marks (.) that (.) I can see at this point

R: Um-hmm

P: Apparently they can show up AFTER you have the baby

R: Um-hmm

P: which I thought was very unfair (laughs)

R: (laughs)

P: (laughing) So, you know, I’m, like, trekking along, I’m like, he-he, not (even?) good enough I-

R: I don’t know who you can send the complaint to (laughs)

P: (.) I’m like, wait a minute, they can come afterwards, what’s that about so, you know, I, I mean, I wonder about that, I wonder how I’ll lo-o-ok

R: (overlapping) Um-hmm

P: I mean, you know, I, I, I, I spent the majority of my life looking one way
Appendix B; Transcript 1

R: Um-hmm
P: and now (. ) it’s, it’s going to be different whatever it is (.15)
but I don’t see it as, like, I’m not upset with the baby for it?
R: Um-hmm
P: it, you know, it’s, you know, it was my choice, I did it
R: (laughs)
R: Um-hmm
P: you know (.8) yeah, I mean, I guess women have done this
over and over again so (. ) it can’t be that horrible
R: Um-hmm
P: you know, I mean, you wonder about, like, okay is SEX going
to be the normal after this
R: Um-hmm
P: you know (. ) that’s BIG (laughs)
R: Right
P: It’s always a (xxxx xxxx xxxx) I never really gave thought
R: Uh-huh
P: to how big the baby was and then with this third ultrasound,
actually, they gave me the measurements o-o-f the
circumference of his HEAD, and his arms and his torso? So I
drew a little picture?
R: (overlapping) Uh-huh, uh-huh
P: with the measurements I had? (. ) and (. ) yeh, first of all, like,
how do you fit in there? (laughs)
R: Uh-huh (laughs)
P: you know? And second of all, like, how are you gettin’ out?
R: (laughs)
P: you know, like, wa-a-ait a minute, because, it, ah, you know, I
don’t know how you (. ) it, it’s BIG
R: Yeah
P: Ten centimeters is (. ) Did it do something?
R: Oh, no, I heard something, I thought maybe it was the tape.
I’m gonna change it now actually, I’m just gonna put in
another tape
P: Oh, okay
R: I’m sorry to interrupt you [side A of second tape inserted]
Okay, I’m sorry
P: But um (. ) yeah, the size, like-
R: Yeah, you said you drew the picture and you were
P: Yeah, I mean, ten centimeters is four inches which, I, I realize
they’re equivalent
R: Um-hmm
P: but, eh, four inches is way bigger than ten centimeters in my
head (laughs)
R: Um-hmm
P: and it’s like, so yeah, that, that was kind of interesting
R: Um-hmm
P: to, actually, you know, get the, the size on that
R: Um-hmm, um-hmm, right (.3) What are your worries about
sex afterwards?
P: U-u-um
R: Let me slide over here
P: (overlapping) Yeah
R: (overlapping) the sun’s getting
P: (overlapping) oh, the sun?
Appendix B; Transcript 1

R: (overlapping) in my eyes, yeah
P: Tha-a-t (.) you know, it’ll be too big, it’ll be, um, unenjoyable for either one of us, that, ah, you know, he’ll, like, not find me attractive
R: Um-hmm
P: and those type of things and (.2) that there won’t be time for it or there won’t be desire for it
R: Um-hmm
P: Um, because, you know, like I said, I’m gonna be in school (.) he’s gonna continue working full-time (.) and be in school
R: Um-hmm
P: a-a-and we have a baby, and we have his daughter (laughs) and that it’s just gonna, you know, life’s gonna (.3) kind of take over the relationship
R: Um-hmm
P: so, you know, it, it’s those type of things
R: (.3) Um-hmm, is this something that you and your boyfriend talk about, some?
P: Some, yeah
R: Um-hmm
P: you know we’ve talked about that, um, he’s like, “You’re gonna look FINE”
R: Um-hmm
P: You know? He’s like, “I’ve been through this before”
R: Um-hmm
P: (laughs) You know, and I’m like, “Yeah, but she was eightTEEN”
R: Um-hmm
P: You know, she was eighteen and, I think, twenty-four when she had their kids
R: Um-hmm
P: so (.) you know, I think her body might have been a little more resilient then, I kind of wonder now, like, eh, ‘cause I can see, like, in my ankles, ‘cause they swell, they have little broken capillaries now
R: Uh-huh
P: which again, if they really bugged me, they have those little lasers that take them away
R: Uh-huh
P: But, you know, do I really want to go get my leg lasered
R: Uh-huh
P: You know, and (.4) he’s not a detail person so he’s not gonna notice them anyway, I mean, that’s gonna be a me thing
R: Uh-huh
P: Um (.4) yeah, he, he can be reassuring in some ways, in other ways, it’s funny, like, being pregnant? I, I feel rather, ah, unattractive just ‘cause you’re kind of pregnant (without being all xxxx xxxx) stuff, I’ll ask him how I look in something and he’s like, “Well, you look pregnant” (.3) and I’m like “No, eh, does it look good? Does it look bad?” “Well, you look pregnant”
R: Um-hmm
P: and so we had to have a LONG conversation about “Okay, look, you know I realize that I’m pre-e-egnant but, ‘This outfit
looked better than that outfit,’ can you help me there?” you
know? (laughs)
R: Um-hmm
P: (.2) I guess for a worry for AFTERward is I look at, like, the clothes I wore before? a-a-nd (. ) we’d go to clubs or whatever (he’d) wear a skirt or, ah, you know, um, halter top
R: Um-hmm
P: or, ah, belly shirt or something, and, I’m like, Hmm, are these clothes all going to GoodWILL?
R: Right
P: are th-, eh, you know, are these gonna fit me, you know, what, what’s (. ) gonna happen?
R: Um-hmm
P: (.16) Um, but, yeah, that, that’d be (. ) what I worry about afterward
R: Um-hmm (. ) And how has, um, your relationship with your boyfriend changed (. ) through your pregnancy? Or has it?
P: It’s changed, um (. ) like I said, his daughter is, um (.2) VYing for attention in a lot of ways and that’s created certain disharmony
R: It’s wh-, oh, created (. ) disharmony in-
P: Yeah, because he tries to (. ) please her, and then we’ve got, like, nineteen projects going on in the house, like, he was supposed to build a nursery that didn’t happen
R: Um-hmm
P: which is FINE, I mean, I don’t really care
R: Um-hmm
P: Um (. ) I’d rather have him do something fun with me, but for HIM (. ) he’s rather build that nursery because he sees that as a chore in his head that he needs to get done
R: Um-hmm
P: And (.2) we haven’t had a lot of fun, where, you know, I fall ASLEEP all the time, we used to go swing dancing all the time and (. ) then my joints started to hurt
R: Um-hmm
P: and this was pretty early on, this was only four months in
R: Um-hmm
P: where, you know, before being pregnant we would switch partners and that would be fine
R:Um-hmm
P: a-a-and (. ) then once I was even that much pregnant I didn’t like dancing with other men because if they didn’t (. ) if they didn’t know what they were doing and couldn’t lead well?
P: Um-hmm
R: A-a-and (.3) I think, eh, we, we had some tension THERE because, ya-, you know, it would be comparisons with his ex-
R: Um-hmm
P: of, “Well, she could do that” and I finally, went, “Oh, well, you know what, with her first pregnancy, you know, she was FOURTEEN years younger than me

R: Um-hmm

P: come on” (laughs)

R: Um-hmm

P: It’s not the same thing

R: Um-hmm

P: you know, and with the fibroids, I was big fast

R: Um-hmm

P: (.2) and grew out of my clothes quickly (.2) and so (. ) just not feeling normal (. ) has, has taken a certain (. ) amount of stress on the relationship

R: Um-hmm

P: you know, and, like, having sex is (. ) you know, either PAINful or AWKward or the baby’s on my sciAtic

R: Yeah

P: or, you know, and it’s like, “Okay, well this just isn’t fun”

R: (laughs) you know

P: (.13) okay (.10) ((shuffling papers)) so a lot of this we’ve covered, but I’m, I’m looking now at, at what I have written down (xxxx xxxx xxxx) Whe-e-n you think back to your experience growing up, did you expect (. ) that you would (. ) become a mother?

R: Uh-huh

P: I-I-I figured that I would have children at some point (. ) a-a- and, had you asked me this at, like, twelve or sixteen or something? I would have assumed it would happen in my very early twenties

R: Uh-huh

P: I would not have thought that I would’ve waited ‘til my thirties.

R: Um-hmm

P: person I was in my twenties and I think that (. ) I had to work through some of my own things and

R: Um-hmm

P: grow up a bit to, you know, get a little more stable (laughs)

R: Um-hmm

P: and, yeah, but, no, I always thought I’d have kids and, actually, getting (. ) being over thirty was starting to (. ) get to the point where I was like, “Huh, I wonder if I’m going to” because, well, I got married, I was twenty-seven, I got divorced when I was twenty-y-ni-i-ne

R: Um-hmm

P: and we got divorced because I (. ) initiated that

R: Um-hmm

P: and so, actually, it was right before my twenty-ninth birthday and af- after a number of, thinking a number of things, like, “Okay, well, thought I was gonna have kids with him, not gonna have kids with him because that’s just not the right thing to do

R: Um-hmm

P: so what am I gonna do?” and I had decided that, at thirty-two, if I wasn’t with somebody who I was going to have children with

R: Um-hmm
P: I was gonna go get a popsicle (laughs) you know, just, pick a
guy that way
R: Um-hmm (.7) So what was the feeling to you, thinking back,
of being a mother in your (.) early twenties, or in your
twenties? (. ) Or why did you assume that?
P: Oh, um (. ) because, I guess, my family is very, um (. ) kind of
typical, I wasn’t supposed to, like, move out and go to
college
R: Um-hmm
P: (laughs) I was supposed to stay home and (. ) maybe go to
junior college, ma-a-a-ybe go to college but I was supposed to
stay home and I was supposed to marry a boy from back home
R: Uh-huh
P: Which, oddly enough, um, he is from back home but we met
here
R: (overlapping) your boyfriend now?
P: Yes, our parents live, like, seven-tenths of a mile from each
other, it’s really weird
R: Uh-huh
P: but, you know (laughs)
R: Where are you from?
P: ________________
R: Uh-huh
P: And, um (. ) so I was (. ) supposed to stay there and be a good
girl because that’s what the girls do, the BOYS are allowed to
go away and do stuff
R: Uh-huh
P: but the girls, you stay home and you have babies and (. ) you
know, you stay with the family
R: Um-hmm, you stay with the what?
P: The family
R: The family, uh-huh
P: a-a-and, so, being raised that way, I just pretty much assumed
I would do that
R: Uh-huh (. ) Do you remember when it occurred to you that (. )
you might not do that?
P: (. ) Um (.4) I, I don’t know that it was any specific thing, I, I
had a lot of tension with my parents through my teenage years
so I knew I wanted to move out
R: Um-hmm
P: and (. ) I just wanted to go some place else, I wanted to see
something else
R: Um-hmm
P: I just (3) just watching everybody doing the same thing, like,
you’d people graduate that, you know, you were friend with
who were older than you, and now they’re twenty and they’re
still drinking in the park?
R: Um-hmm
P: And it’s like, “A-, aren’t you gonna do something else?” I, I
go home NOW and there are people who I run into that I went
to grade school with who are, like, “Why’d you move?”
R: Um-hmm
P: And they’re doing the exact same thing as they were back then
(laughs)
R: Um-hmm
And, I, I, I don’t know that it was anything specific but it was just, I wanted to get out.

I almost joined the Marines to do it (laughs)

And um (.) glad I didn’t do that (laughs)

I kind of asked you this before a little bit, but what are your ideas about motherhood? And what will it be like when the baby comes?

My ideas about motherhood like-

What do you do as a mother?

Eh, I think what I want is to give him everything he needs to leave me

I think that’s what you do as a parent

is (.) you-u (.) you just do the best you can and then you, you let them live their own life

you let them (. ) grow and experience and have fun and do all that type of stuff and ((tearing)) I get a little upset about this because I see so many people who just want to control their kids and HOLD them and they, they, you know, I mean, the idea of him actually coming out of me and leaving being that close is upsetting to me in a way, because (.) I can protect him right now, I have control over EVERYTHING (laughs)

you know, I mean, I, I, I did, I sat with a woman last year who just had a baby boy and she said, you know, “He’s gonna be with me forEVER, I want to keep him and hold him and hug him and, you know, he is never gonna love another woman as much as me and, in fact, I hope he’s gay.”

you know, I mean, I, I, I, I did, I sat with a woman last year who just had a baby boy and she said, you know, “He’s gonna be with me forever, I want to keep him and hold him and hug him and you know, he is never gonna love another woman as much as me and, in fact, I hope he’s gay.”

and, I was like, how warped is that?

I mean, you know, it’s oka-, it’s her kid, I’m not gonna say that to her but it’s like, No, I, I want to give him all the tools he needs to go out (.) and whatever he wants

What are your ideas about raising a boy?

Um (.) I’m not sure, what do you mean? Like versus raising a girl or (.) would I do anything differently between the two sexes?

Yeah, yeah, or do you have specific ideas or concerns or things about parenting a boy (.) versus a girl?
P: Not really, I, you know, I think at this point things are pretty equal, I mean, boys do tend to be physically stronger (. ) girls tend to mature a little faster
R: Um-hmm
P: but (. ) ou-, outside of that, no, I don’t see a reason for separate rules
R: Um-hmm
P: You know, I, I think that actually causes hardship in families
R: Um-hmm
P: having grown up with separate rules (laughs)
R: Um-hmm
P: you know, my fourteen-year-old brother, and, I was eighteen, had the same curfew (laughs)
R: Uh-huh
P: I look back and I think that’s a little ridiculous
R: Uh-huh
P: you know, I, I, I think things should be done that are age-appropriate to the child and each child individually, you know, if I catch him smoking pot a-a-and, you know, let’s say he has a sibling who’s not doing that, well, guess what
R: Um-hmm
P: You’re gonna, you know, not necessarily be afforded the same privileges (laughs)
R: Um-hmm
P: ‘cause, you know, you’re doing something you’re not supposed to be doing (laughs)
R: Um-hmm (.7) okay, um, I have some questions that are a little unrelated, but a little bit related, Do you consider yourself to be a woman?
P: Yes
R: Do you know why or-, why you have that feeling?
P: Um (.4) well, I consider myself a woman based on (. ) g-, gender, I mean (. ) I, you know, I have all the parts that make me a girl so therefore I am a girl (. ) Um, I don’t know that I necessarily always consider myself feminine
R: that was the next question (laughs)
P: (laughs) Ah-
R: Do you consider yourself to be feminine?
P: at ti-
R: That was the next question
P: Oh, okay, at times, it depends on the situation
R: Uh-huh
P: Um (. ) and I’d say THAT stems from my childhood, what is determined to be feminine and masculine because, ah, men get to work around the house (. ) women raised the kids and made dinner (laughs)
R: Right
P: you know, there, there were very specific gender roles
R: Um-hmm
P: and, you know, women put on the lipstick and dressed up and looked pretty and, you know, men could wear whatever they wanted out of the house
R: Um-hmm
P: and, you know, there’s times when, and, I-, I’ll laugh at my boyfriend with this because he actually understands these
gender roles, I don’t know if it’s something specific to the
(Italian) community in _________
R:  Um-hmm
P:  that he can understand it, and other people over the years have
NOT, but, yo-, you know, where I’ll get, you know, he’ll say,
“Okay, we’re gonna go, you know, to the mall” and I’ll put on
a pair of sweats and a t-shirt
R:  Um-hmm
P:  and he’ll get a pair of jeans and get a shower and cologne and
all this stuff, I’m like, you know, “Okay, we’re gonna go, you know, to the mall”
R:  Okay
P:  and he’ll get a pair of jeans and get a shower and cologne and
all this stuff, I’m like, you know, “Okay, we’re gonna go” (laughs)
R:  Uh-huh, so wait, when you said he understands, what do you
mean he understands, like, different gender roles or-
P:  Eh, yes, like I was saying, like, me saying he was acting like a
girl
R:  Okay
P:  it’s not that I am in any way compromising his, you know,
masculinity or questioning it or anything, it’s just (.) based on
what I think is feminine versus masculine, it’s a more
feminine thing to primp to go to the mall
R:  Uh-huh
P:  then, you know, masculine, where it’s more masculine to just,
you know, throw your clothes on and look grubby and go do
what you need to do
R:  Um-hmm (. 5) So what are times when you feel more
feminine?
P:  Um, dresses and hair fixed and make-up done and
R:  Um-hmm
P:  you know, going through that type of, you know, out to dinner
event of, you know (.) I’ll make a joke that, you know, like,
okay, it’s my job to be the good girlfriend now
R:  Um-hmm
P:  you know, put on the smile and the hair and the, you know
R:  Um-hmm
P:  and all of that type of stuff, and, I, I like doing that sometimes,
I think it’s fun
R:  Um-hmm
P:  but I don’t like doing it all the time
R:  Okay
P:  yeah, like, when do you not like doing it, do you have any idea?
P:  Yeah, like, I don’t want to go to the gym with my make-up
fixed
R:  Uh-huh
P:  that to me is funny, I mean, it’s fine that people want to do it,
my mom does it, I, I find it amusing
R:  Uh-huh
P:  you know, I’m not gonna go out and go running, you know, all
fixed up, do my nails, all that stuff (.) When it’s apPROpriate
in my mind (.) I’ll do that, you know (.) I’m not gonna clean
the house in a dress, regardless of what happened on ‘Leave it
to Beaver’
R:  Okay
P:  (.6) or even, like, get fixed up for him to come home
R:  Um-hmm
P:  you know, I’ve heard of women doing that, like, they’ll spend
the day all grubby and, “Uh-oh the husband’s coming home
and” (.) you know, gotta get all pretty and stuff,
R:  Um-hmm
P:  it’s like, okay, you know, well, if I’m cleaning the kitchen, would you rather have me finish cleaning the kitchen or spend an hour putting on make-up
R:  Um-hmm
P:  you know? (laughs)
R:  (.6) How has your, sort of, feeling about your femininity changed through you pregnancy, or has it?
P:  (.) Um (.4) I don’t know if my feelings about my femINInity have changed, feelings about my atTRACtiveness have changed
R:  Um-hmm
P:  (.) Um (.4) but, no, I still feel the same feminine-wise (.6) I think it IS strange, eh, re-, regarding attraction though, the different types of ways people react to you, and I, I, I predominantly notice men just because I’m heterosexual
R:  Um-hmm
P:  and ((cell phone ringing)) there are men who (.) um (.4) react TO ((participant turns cell phone off)) pregnant women
R:  Uh-huh
P:  which I think is interesting, I’m like, “I’m PREGnant, obviously with another man’s child because I don’t KNOW you” (laughs)
R:  (laughs) They can react and that you get the sense that they’re atTRACted to you or what?
P:  Yeah, like, I, I mean I was at, um, the GROcery store the other day and the bag boy was commenting on the food I was buying
R:  Um-hmm
P:  and, you know, how much he’d like to come to dinner at MY house
R:  Uh-huh
P:  and I’m like, okay, I’ve had people do this before and generally they’re trying to pick me up
R:  Uh-huh
P:  this is a little WERID (.4) I’ve obviously got a very large belly (laughs)
R:  (laughs)
P:  you know, so, I, I find it strange where before, like, as a thin, normal person, you know, non-pregnant
R:  Uh-huh
P:  I’d be like, oh, okay, you know (.4) bag boy tried to (xxxx) me today, you know, okay
R:  Uh-huh
P:  whatever
R:  how interesting
P:  Yeah
R:  Uh-huh
P:  Yeah, I find it bizarre now and, like, just, why would you do that? (laughs)
R:  Uh-huh (.14) Oh, let’s see, I asked a lot more questions than I had, which is good, um, okay, I have a few last questions
P:  Okay
R:  Um, do you feel like your gender has impacted your health care in any way (.4) either during your pregnancy or at other times?
P: I think, in general, from what I’ve researched, that there has been substantially less research done on women’s health issues than men’s.
R: Um-hmm
P: like, I (.) what was I reading the other day, something about more research has been done on male breast cancer than female breast cancer
R: Um-hmm
P: in the past fifty years, and, eh, eh, you know, the incidence of male breast cancer is pretty low
R: Um-hmm
P: that to me is kind of (.) ridiculous
R: Um-hmm
P: (.) um (.) so I see THAT kind of thing, I think (.) you know, like, the fact that they don’t know anything about fibroids
R: Um-hmm
P: really (.) and I’m, the more I’m talking to women the more I’m finding out these are common
R: Um-hmm
P: and (.) how can you guys not know something about it and how can yo-o-u, you know, up until I think ten years ago, they, the normal thing to do for fibroids, a hysterectomy
R: Um-hmm
P: eh, you know, that just doesn’t seem right in my head (.) and (.5), I, I would say that that’s more or less (.) it for, like, women’s health-related, like, things,
R: Um-hmm
P: I mean, the (xxxx xxxx xxxxxxx) the whole drug company, medical profession but that, but that’s both sexes
R: Uh-huh
P: (.2) you know
R: Well, go ahead and tell me your issue
P: (overlapping) Oh, well, I really think the drug companies are a major factor in what doctor’s (.) prescribe as treatment
R: Um-hmm, um-hmm
P: and that (.) is very upsetting to me, like, these commercials for like, “Ooh, go ahead and tell your doctor that you need Prilosec”
R: Um-hmm
P: Well, I don’t even know what Prilosec IS, but I bet a lot of people walking their doctor’s office and say, “I think I need Prilosec”
R: Um-hmm
P: and they get their free sample
R: Um-hmm
P: and, you know, maybe it does make ‘em feel a little better, maybe it’s ‘cause it’s in their head, maybe ‘cause it really works, whatever, but, I just see it as harmful to not allow your body to do what it’s meant to do
R: Um-hmm
P: and keep interfering with it
R: Um-hmm
P: and that, that’s why so many kids have, you know, asthma
now and allergies and (. ) excuse me, and people get sicker all
the time
R: Um-hmm
P: I have one girlfriend, I swear she’s on a different antibiotic
every week
R: Um-hmm
P: and (. ) that, that’s kind of my issue (laughs) you’re destroying
your immune system
R: Um-hmm (. ) I’m curious, how did you grow up, let’s step
back a little bit, but you said you grew up in a family that
valued homeopathic (. ) medicine
P: Um-hmm
R: and so this is something that you kind of grew up with, do you
think that shaped (. ) your perception of doctors of how did you
come to-
P: Well, my mom actually worked for a homeopathic doctor
R: Oh
P: He was an M.D.
R: Uh-huh
P: And, um, I thought that’s how all doctors were
R: I see, uh-huh
P: and, you know, and I had my grandmother who, you know,
makes witches brew on the (. ) stove,
R: Uh-huh
P: we used to call it,
R: Uh-huh
P: but it made you BETter, you know,
R: Uh-huh, uh-huh
P: I don’t know what she put in there (laughs) and, you know
what, the stuff HE gave me (. ) made me better
R: Uh-huh
P: and when I started going to a traditional doctor, I was
probably, I’m trying to think, thirteen or fourteen years old
R: Uh, uh-huh
P: and the stuff he gave me-
R: What made you swi-, or, why did you make the switch?
P: Ah, the doctor my mom worked for retired
R: Okay
P: and, you know, this was the next guy she went to work for
R: Uh-huh
P: (. ) a-a-and the stuff he gave me didn’t work for me
R: Um-hmm
P: or it didn’t work WELL, or it made me sicker at first or,
R: Um-hmm
P: you know, and I’m like, this should-, it just didn’t make sense
in my head and I would, you know, like I said, ask them about
these other things, like, well, what about the pills that (xxxx)
under your tongue?
R: Um-hmm
P: You know, and as a kid, you don’t remember what they are,
R: Right
P: what they were
R: um-hmm
P: and they would sa-a-a-y, “We don’t know what you’re talking
about,”
R: Um-hmm
P: you know, or, “No, that’s, you know (.) “nonsense, you need
this”
R: Um-hmm
P: I’m like, but that stuff WORKED (laughs)
R: Um-hmm
P: and so, I stopped going to doctors all together (.) beca-a-use I
just didn’t feel they were helping me
R: Um-hmm, um-hmm, have you seen a doctor since then?
P: Uh-huh
R: I mean, for your pregnancy, but
P: for my pregnancy
R: Uh-huh
P: bu-u-ut the last time I saw an actu-a-al do-o-ctor (.) prior to the
pregnancy was probably (.) um, early college
R: Um-hmm
P: twenty years old, so twelve years ago
R: Um-hmm
P: Yeah (.) and I just didn’t feel that they (.) added any value to
me
R: Um-hmm
P: (.10) and honestly, you know, I haven’t been sick (laughs)
R: (.10) What’s your family’s, I’m just curious, your family’s
tradition with, you said your mom worked for
P: (overlapping) a homeopathic ((cell phone ringing))
R: (overlapping) a homeopathic physician, 2082
P: Um-hmm
R: but your grandmother was also familiar with homeopathic
medicine, too?
P: I just think that she had all the old wives tales, um, you know,
like, just, women from years ago who put mud on a b-, bee
sting type of thing,
R: Uh-huh, uh-huh
P: and, you know, (may have adapted her mom to) (.) that type of
thing
R: Uh-huh (6) all right, and, Do you think that, um, I had asked
about if you felt like your gender impacted your health care at
all, do you feel that there are any other factors about you, what
makes you an individual, like your race or your sexual
orientation or socioeconomic status that’s impacted the health
care that you’ve received?
P: Um
R: either in your pregnancy or before
P: I would sa-a-ay (.) sometimes male doctors will talk down to
females
R: Uh-huh
P: and will actually talk to the male WITH you, even though it
has nothing to do with hi-, them
R: Uh-huh
P: Ah, yeah, socioeconomic, ah (.) the fact that I’m able to afford
a good health plan and pay the, ah (.) ah, whatever it is, it’s
not the co-pay, it’s the, ah, deductible, that thing
R: Uh-huh
P: I think DOES afford me better health care, I’m not stuck going
to a clinic if I don’t want to, and I can say I don’t want to go to
that person if I don’t want to
R: Uh-huh
P: and (.) yeah, I, I, I think that does give you certain (.). edge on (.).
R: (.).
P: being able to pick a good provider (.). and, um (.6), I, I do (.).
R: think my childhood and dealing with a homeopath growing up (.). has had (.). a big impact on it just ‘cause (.) I saw that stuff (.).
P: work, and I know that in some cases scientific trials have said (.).
R: that Echinacea, you know, has no active thing (.).
P: that could possibly make you better (.).
R: Uh-huh
P: Makes you better (laughs)
R: Um-hmm
P: Makes me better (.).
R: Um-hmm
P: at least, I’m not gonna say it’s gonna make everybody better (.).
R: Um-hmm
P: but it’s made me better (.) and if it’s in my head, so be it, then (.).
R: I’m better, a-a-and, those antibiotics would make me sick (.).
P: Um-hmm
R: and (.) so maybe that’s in my head, too, I don’t know (.2) but (.).
P: I’m not (.) adverse to-o-o hearing something out (.). as long as (.).
R: there can be a reason for it (.).
P: you know, it’s like, um, I took Group b strep test for being (.).
R: Um-hmm
P: Group b strep?
R: Group b strep? Uh-huh
P: Um-hmm, and I’m waiting to find out if it’s gonna be positive (.).
R: Um-hmm
P: If it’s positive, that means that I could potentially transmit it to (.).
R: Um-hmm
P: the baby (.).
R: Um-hmm
P: and I need to look at what risks are associated with that before (.).
R: I determine if I’m going to take the antibiotics or not (.).
P: so, I’m not, like, so against them that I wouldn’t take them (.).
R: Um-hmm
P: but, you know (.11)
R: Um-hmm (.). okay, do you have any other (.). thoughts (.) that or (.). any questions for me (.). that (came to mind) that you (.).
P: maybe haven’t had a chance to say? (.).
R: No, just, I, I mean, I guess, um, for me the ultrasounds were a (.).
P: very positive experience (.).
R: Uh-huh
P: you know (.3) it, it was (.). it (.). being able to see him and hear (.).
R: his heart beat and name him (.). makes me feel closer to him (.).
P: (.11) yeah, that’d probably be it (.).
R: Well, that’s a good note to end on (.).
P: Yeah (laughs)
R: Um, so, I’d like to ask you some questions about (.) generally your experience of your pregnancy and also more specific questions about your experience of doctors and ultrasounds?

P: Um-hmm

R: and so I’d like to just start with, um, just first some questions about your pregnancy, so-

P: Um-hmm

R: if I could ask you, How was the fetus conceived?

P: Ah, artificial insemination.

R: Okay. Can you tell me a little bit more about it and describe (.) the process for you?

P: Um, well, we went through, um, the, ah _______ hospital, there’s the Center for Reproductive Endocrinology and Fertility

R: Um-hmm

P: and, ah, we went through them, um () and because of um, I have a history of, ah, endometriosis?

R: Um-hmm

P: and so I had to have a lot of tests done, um,

R: Um-hmm

P: just to make sure that everything was working correctly ‘cause I had, had some, um, cysts removed from my ovaries about four years ago?

R: Um-hmm

P: so there wa-, there was some concern () that everything was going to be working okay

R: Um-hmm

P: Um, so I had a lot of tests done, actually they were pr-, pretty painful, and, um, some of them did involve ultrasound, so-

R: Uh-huh

P: I, I mean, I’ve had ultrasound before for my endometriosis

R: Uh-huh

P: so I’ve actually had a lot, about, probably a lot more ultrasounds than most people have had

R: Uh-huh

P: just because of that. Um, so, the tests were painful but (.) brief, which was good (laughs) and, um () I mean, it’s (), the doctor, Doctor Medeiros was really, he was good, I mean, you know, he’s () a DOctor, so he’s sort of () um, remote, you know, but the staff was really great, um, and, ah, I mean, there was definite-, it was definitely like a heterosexual environment

R: Um-hmm

P: I think we were probably the only lesbian couples there that I could tell, it seemed really really straight, um () that really just didn’t BOTHer me, um (.3) and, ah, we picked a donor from, um, __________ and, um, we picked someone based on the fact that we wanted someone who would co-, allow his identity to be released when the child was eighteen

R: Uh-huh

P: um, that was really the only criteria I had, ah, my partner () was a lot, she seemed to be a lot more into picking characteristics and stuff like that so I just let her pick the guy

R: Uh-huh

P: And, um, so, because she has red hair and freckles she chose somebody who has red hair and freckles
R:  Uh-huh
P:  and she plays rugby so she chose somebody who likes rugby
R:  Uh-huh
P:  and, um (.) so that, and that was fine with me, my only
criteria, actually I did have a criteria, that he had to be at least
six feet tall
R:  Uh-huh
P:  (laughs) so, um, I don’t know, these weird quirks come out
when you start picking, it’s like eugenics, but
R:  Uh-huh
P:  um, so, we picked him and, um (.2) and, even after all the tests
and the worrying, um, I actually conceived in the second
month (.) that we tried it.
R:  Um-hmm
P:  So, it worked really well.
R:  So you (.), you did, like, two tr-, er, two
P:  (overlapping) well, yeah,
R:  (overlapping) trials and then
P:  there was two, there was two months, I mean, every month
you try twice,
R:  I see, uh-huh
P:  yeah, two consecutive days (.2) um (.) and it was, I mean, it
was just very, like, I mean to me there was no, like, roMANtic
aura about it, it was, like, it was very, very medical
R:  Um-hmm
P:  you know, and it was, once you entered the Center for
Reproductive Endo-, Endocrinology, it was like you were a
cog in a wheel, and you’re given, they have, they have all
these checklists, all of these lists, exactly what to do and when
to do it and it’s just very, um (.2) MEDICAL, I mean, it’s not,
you know, eh, you know, there’s sort of this aura of, like,
BABy making and BABies as being, I, I guess romantic, but it
wasn’t like that at all.
R:  Uh-huh
P:  It was a little bit intimidating at first but then, they seemed like
they knew what they were DOing and you just, like, did
whatever they told you to do.
R:  Uh-huh
P:  (laughs) so
R:  What, what were some of the things that they asked you to do?
P:  Um, well, I had to have lots of tests and they had to be done
on certain days, you have to make sure that you’re always
tracking the days of your period
R:  Uh-huh
P:  Um, and then, you have to track your cycle in terms of, um (.)
you know, checking to see you’re, when you ovulate, it’s, you
always have to tracking your hormone levels and stuff like
that
R:  Um-hmm
P:  so, you have to, you know, get up in the middle of the night to
pee so that you use your second urine of the morning (laughs)
R:  Uh-huh
P:  in order to pee on the sticks, and, um (.2) just very regimented
(.2) and that was prior to conceiving?
P:  (overlapping) Prior to conceiving,
R:  (overlapping) Uh-huh
Yeah

Uh-huh, how long did that period last?

Um, I think we first went to see him in February and we first tried to conceive in June

Um-hmm

so it seemed like it took a long time, but I guess it was only a few months

Uh-huh

(cause we’d been thinking about doing it for five years so

That was my next question, so how long had you been considering-

Well, five years ago we decided, neither one of us is actually from Pittsburgh?

Um-hmm

and five years ago we decided th-, that we wanted, that this would be a good place to raise a family, and like, so

Um-hmm

we bought a house here five years ago

Um-hmm

um (and we just, in January bought a bigger house in a different school district, um, and decided this was the time

Um-hmm

so

(.8) Did you have any discussion of which one of you would carry a child?

Yeah, we thought about it for a long time

Uh-huh

Um, April’s adopted, so she liked the idea of having a genetic link to someone?

Uh-huh

but when it really came down to it, I was really the one who wanted to experience pregnancy and childbirth and she really didn’t want to

Uh-huh

so, um, which, I’ve had like twenty-four-hour-a-day morning sickness for the last month so, I’m really regretting that decision (laughs) but, um

(laughs)

(.2) but you know, that was how we decided.

Uh-huh, and so, How far along are you, now?

I’m in my twelfth week.

In your twelfth week?

Um-hmm

(.4) and so you’ve had, already two ultrasounds

Yeah

in your pregnancy?

Yeah

Uh-huh

Yeah, at Doctor Medeiros’s office, they, um, I think because they’re used to dealing with people who have lots of problems

Uh-huh

in their pregnancy? Um, I think they’re a lot more aggressive and conservative, maybe, than, I guess ’cause they’re sort of opposite, they’re like a lot more aggressive in their treatment and in their, um, making sure everything’s going okay.

I see, uh-huh
P: So I actually had an ultrasound in the sixth week
R: Uh-huh
P: Um, when it was (.) not even a baby yet, just a gestational sac
R: Uh-huh
P: s-o-o (.), they, I think they wanted to make sure it was actually implanted at the right place?
R: Uh-huh
P: and, ah, they might have been checking for multiple births,
R: and how many more ultrasounds are you thinking you’ll probably have?
R: Uh-huh
P: I think I’ll probably have at least one more
R: Uh-huh
P: Um (.), you know, probably around week nineteen or twenty
R: I haven’t talked to my doctor about it yet, but
P: and I had one in week eight (.) um, where we, we actually,
R: because they (.) Doc-, Doctor Medeiros’s office, they don’t release you to your OB until they actually see the heart beat?
R: Uh-huh
P: So we saw a heart beat at week, week eight and then I was released from him to go to my OB
R: Uh-huh (.12) So you have, like, a specialized doctor, and then a regular OB?
P: Yeah, although I’m done with the Fertility Clinic now
R: Uh-huh
P: so I’m (.) not dealing with them anymore
R: Okay (.). Um, have you done anything in preparation of becoming a mother?
P: (.4) ah, well (laughs) like what?
R: Anything goes (laughs)
P: Um, well, we bought a different house in a different school district
R: Uh-huh, that would count, probably (laughs)
P: Yeah (laughs) yeah, um, you know, we’ve done a, a, you know, we’re, ________
R: we’ve probably read twenty-five books, you know
P: Um-hmm
R: Uh-huh
P: Um, we have a lot of friends who are parents who have gone to FLO meetings
R: Um-hmm
P: um, so we’re familiar with the community of parents, you know, and, um (.4) we-e-e-e have a lot of LEGal work to do,
R: um, which we haven’t started yet but, well, actually we have
P: because April’s already talked to the attorney
R: Um-hmm
P: Um, we need to talk about names, um, and then we’ll have to do all of the, you know, guardianship papers and then the adoption (.) you know, so we’ve started all of that in motion.
R: Um-hmm, um-hmm
P: You know
R: Well, that sounds like a lot of prep, actually
P: Yeah
R: Yeah, um, how about emotionally, or
P: Um (.) well, I’ve been so sick that’s been hard, (laughs) you know
R: Um-hmm
P: I mean, at first we were really excited and we were, like, you know, we have all these books about, you know, week by week, sort of looking every week to see, like, you know, it’s a lima bean, or whatever, you know
R: Right
P: Um (.) but now it makes me sick just to even look at the books so I really (laughs) haven’t been doing that, April has been but, um
R: Um-hmm, um-hmm
P: mostly (.) I’ve been dealing with how to handle, you know, working and also being sick
R: Um-hmm
P: so that’s been most of my emotional work
R: Um-hmm
P: at the time
R: Um-hmm
P: We’ve also, you know, been telling our families, you know, and so, that’s been exciting
R: Um-hmm, um-hmm (. 9) u-u-um, so my next question is, Have you experienced any complications in your pregnancy?
P: No
R: Besides all the work that you did prior and then the morning sickness, but other than that no?
P: No
R: All right, now I want to ask you some more specific questions about the medical care that you’ve had
P: Um-hmm
R: Did you choose your physician or was this somebody who was assigned to you, and so, that, I guess that would be (.) for both your OB/GYN and the specialist.
P: My OB I’ve had for a number of years as my gynecologist
R: Uh-huh
P: and then when I told him I wanted to get pregnant, he refer-, he referred me to Dr. Medeiros’ office
R: Uh-huh
P: so I picked both of them
R: Um-hmm (. And how did you go about choosing physicians?
P: Um, well, ah, my OB, um, someone had recommended him when I was at the, I had had my surgery (. ) my surgery was really, um, sort of traumatic because I had this really terrible surgeon, um, a-a-and he was like, just treated you like you were an inanimate, you know, object, you know.
P: Uh-huh. And tell me again, when did you have that surgery?
P: Four years ago
R: Four year ago
P: I had to have cysts removed from my ovaries
R: Uh-huh
P: so I was in a, just a lot of pain and I couldn’t take it anymore
R: Okay
P: So, um (. ) so the doctor that did that put me on an incorrect dosage for ME of, um, hormones
R: Uh-huh
P: And I was depressed and, ah, so a friend of mine recommended that I go see Doctor Med-, um, ah, Schwartz, as my gynecologist, to talk to him about it
R: Uh-huh
P: and, ah, he spent like forty-five minutes with me, he’s, he was just really (.) he’s funny, you know, I went and told him, like, ‘cause of the, ‘cause of the hormones I was in, like, a horrible mood all the time
R: Uh-huh
P: and I went and I told him, you know, like, “I hate everyone,” and he was like, “Well, probably they’re not crazy about you, either” (laughs)
R: (laughs)
P: So, I thought that was very funny
R: Uh-huh
P: And, um (.) so I liked him a lot, he took a lot of time with me
R: Uh-huh
P: And, um (.) so I liked him a lot, he took a lot of time with me and after a couple of days I felt much, much better
R: Um-hmm
P: And he’s been (.) well I changed, I changed health care provi-, I mean, I changed HMOs once, so I had to go to so-, I didn’t really go to him for a while but then I changed back, and so, um, he’s been sort of (.) with me ever since
R: Um-hmm (.4) Um (.) any other ways that you have to describe your relationship with your physician?
P: Well, with Dr. Medeiros, I only really, actually, the, there’s a, the Clinic, I think when I only talked to him maybe twice
R: Uh-huh
P: It was really his staff that did everything
R: Uh-huh
P: So he was sort of, like, you know, um (.) ah, overseeing everything and coordinating everything and making decisions, but (.) I rarely even saw him and (.) you know, I just really thought of it as more of a business relationship, honestly (laughs), you know what I mean? Like, he was in the business of getting me pregnant and that was pretty much h-, how I thought of it
R: Uh-huh (.5). Okay, and um (.) so, how did you come to the decision to have an ultrasound?
P: Um, it was just part of their procedure
R: It was part of their procedure? Was it specific to (.) you because you had had some problems with cysts before?
P: No
R: (overlapping) Or no, it was just part of their procedure
P: (overlapping) I don’t thi-, I think it was just part of their procedure in terms of artificial insemination
R: Or, I, I don’t know, I mean, it just se-, it seemed like it was part of their procedure for everyone that got pregnant there
R: Uh-huh. It’s early to have an ultrasound
P: Yeah
R: Like, much earlier than I’ve heard, ‘cause I know that people are routinely (.) being (.) sort of, referred for ultrasound, but
P: Yeah
R: Did you say six weeks?
P: Yeah
R: Uh-huh
P: six weeks
R: Uh-huh
P: Yeah, I mean, it seemed like they just wanted to make sure it
was actually implanted in the right place
R: Uh-huh
P: So
R: Okay, and can you tell me about, um (.) what the experience
(.) both experiences were like?
P: They were actually pretty good, I mean, ’cause I have had a
lot of ultrasounds, and a lot of internal ultrasounds, which I
find really uncomfortable
R: Um-hmm
P: And I’ve had people who weren’t very good at them (laughs)
R: Uh-huh
P: Before
R: Uh-huh
P: and so, the two that I had at his office were actually really
good
R: Uh-huh
P: the person was very skilled and gentle and, um, it didn’t take
forever
R: Uh-huh
P: and, um, you know, I felt a lot of confidence in what they
were doing
R: Um-hmm
P: and, um, and of course it was THRILLing, you know, after all
this time, to SEE, you know, to actually, ’cause you know it’s
there but to actually see it (.) is pretty exciting
R: Um-hmm
P: I mean, the second time when I got to see the heartbeat, that
was really great (.) and unfortunately April couldn’t be there
for the second one, she was out of town
R: Um-hmm
P: um, ’cause, I think she would have loved to see the heartbeat.
She was disappointed that she didn’t get to see it, but um
R: Um-hmm
P: Ah, they were really positive because I’ve had (.) negative
ones before
R: Uh-huh (.) what, ah, were some of the things that made (.) a
difference between the experiences?
P: Um, well, she was gentle and fast
R: Uh-huh
P: there were two things (laughs) and, ah, just seemed to know
what she was doing
R: Uh-huh
P: You know, where, you know, I’ve had people before when
I’ve thought, they haven’t done this before? (laughs)
R: Uh-huh (.6), um, and, um, before the ultrasound, it sounds like
you’d had some experience, but, what were your expectations
in terms of the ultrasounds-
R: Um
P: (.3) Hmm, well, I knew that it could be painful, and, they
were uncomfortable
R: Uh-huh
P: and I knew that it could take a long time
R: Uh-huh
P: so I was really just hoping it wouldn’t
R: Um-hmm, um-hmm
P: I was prepared for the worst
R: O-, okay (.5). Ah, could you tell me a little bit more, you said
it was thrilling, can you just tell me a little bit more in your
words about what felt so great about it?
P: Um, well, seeing the heartbeat I think was the really thrilling
one
R: Uh-huh
P: and that was, just, knowing that it really was aLI-I-IVE, you
know
R: Uh-huh
P: I mean, because I think, I’ve had a lot of fear, you know, that
something’s going to go wrong, or
R: Uh-huh
P: um, you know, that, I’d have a (. ) um, miscarriage, and it just
seemed like once I saw the heartbeat it seemed, like then it
seemed less likely (. ) it’s like a little more secure
R: It seemed (.) once you saw the heartbeat it would be less likely
that you’d have-
P: Yeah, I’d be less likely to have a miscarriage or that there’s-
R: Uh-huh
P: it seemed like there’s, it was like one more hurdle, like
something wasn’t gon-, this was one thing that wasn’t gonna
go wrong
R: Uh-huh
P: (.4) and just seeing the heartbeat, like knowing that it was
alive and it was really there and
R: (. ) Um-hmm. What could you see that, um, xxxx xxxx?
P: (overlapping) It’s just a blob
R: Uh-huh
P: it was just a blob but you could actually, like, SEE, um, you
know, just, you could see like a movement
R: Uh-huh
P: you could see the movement of the heartbeat and then, um, she
turned on the sound so I could actually hear, like, you know
R: Uh-huh
P: the heartbeat
R: (.6) Are you looking forward to the next one?
P: Oh, yeah
R: Yeah
P: yeah
R: Uh-huh
P: Well, I’m hoping that the next one’ll probably be external
instead of internal, so I’m expecting it to be a lot more
comfortable
R: Right, right
P: And, um, I’m hoping to get to see the sex of the baby
R: Uh-huh
P: you know, so, we’re excited about that
R: Okay (.4) So you’re planning to find out the sex?
P: Yeah
R: And do you have any hopes, either you or your partner, about
P: (overlapping) No
R: (overlapping) which one?
P: No
R: (.3) Um, did you, have you talked about like, what, making the decision to decide to know the sex beforehand?
P: Eh, we’ve always wanted to know we’re just,
R: Uh-huh
P: you know, we’re not, we don’t like the surprise
R: Okay
P: We want to know things so (laughs)
R: (laughs) Uh-huh
P: Yeah
R: Um, what are your thoughts about, like, raising a baby, if you think about raising a boy or raising a girl, if there are differences, do you have thoughts about that?
P: U-u-um
R: Particularly maybe as a lesbian couple, or, I don’t know if that makes a difference
P: (laughs) I think April actually probably wants a boy more and I probably want a, a girl more
R: Uh-huh
P: Um, you know, ‘cause she-e-e’s more rough and tumble and I’m more into, like, traditionally feminine kind of things
R: Uh-huh
P: and so, you know, and I always joke around and say she’s going to get a Barbie-lover, you know, she’s gonna hate it, you know
R: Um-hmm
P: and so um (.) you know (.I, I just, you know (.I’ll go (.you know when I was younger I took care of, ah, my cousins or I took, you know, babysat during the summers and I certainly loved, you know, the little boys I took care of just as much as I loved the little girls so, you know,
R: Uh-huh
P: so I don’t know, I don’t really have any concerns about that
R: Uh-huh, uh-huh
P: Um, our neighbors, we have neighbors who are a lesbian couple and they have a thirteen-year-old son
R: Uh-huh
P: And, um, it’s sort of like once the hormones kicked in, you know, they’ve had a much hard-, much harder time with him
R: Uh-huh
P: but
R: Uh-huh (.10) Um (.), okay, going back to the-e-e experience of (.the ultrasounds? Do you think there’s anything that your doctor could have done differently to prepare you?
P: I, I knew what to expect
R: Uh-huh
P: ‘cause I’d just had them so many times
R: Uh-huh, and there wasn’t too much different about the ultrasound, the pregnancy ultrasound, versus other ultrasounds-
R: (overlapping) No
R: you had, except for they turned out to be (. more comfortable for you?
P: Yeah, it was more comfortable (. and exCITing, you know, as whereas beFORE, when I had ultrasounds, it was (. really upSETting, and diff-, you know,
R: Right
First of all to realize there were cysts there

want to see how, 'cause then (.) I kept having them to see
how much bigger they were getting

and how many more there were, so, it was like, every time I
had it it was worse and worse (laughs), and like they were,
so this was actually, like, a GOOD thing

this was different

Um-hmm (.8) Um, all right, I’m gonna start to, like, digress a
little bit and ask you some GENeral questions, ah, Do you
consider yourself to be a woman?

(.) Um-hmm

(overlapping) Yup

(overlapping) and, Could you say why?

U-u-um (.4) well, I mean, PHYSically, u-um, I would say I’m
a woman, I have all, you know, all the physical parts of a
woman

so I would say that, um (. ) inTERnally, I feel pretty feminine

Um-hmm

Um (.) I don’t really fee-e-el, um, like I’m-, you know, have
like, these masculine traits that can’t somehow come out (.)
Um, I work in a place that’s all women and where strength in
women is encouraged and is a good thing

Um-hmm

Um (.) so, you don’t have to sort of, UM, be something you’re
not

Um-hmm

and in my family it’s always been, ah, you know, strong
women are encouraged

Um-hmm

um, so I don’t have any, you know, any kind of, like, gender
dysphoria or any kind of feelings like that

Uh-huh, Okay, and you sai-, mentioned the word feminine and
actually my next question is, Do you consider yourself to be
feminine and it sounds like you do

I don’t really

You don’t really?

I mean, I don’t think of myself as feminine

Okay

Um (.) no. I would say not.

You would say not, um, would you, could you give me,
maybe, some examples of why not?

Ah, well, I don’t wear make-up, I don’t do my hair

Uh-huh

Ah, I don’t wear high-heeled shoes, um, you know, I don’t, ah
( . ) you know, I just don’t think of myself that way
Okay ( . ) but now, you mentioned, I thought you mentioned
that you sort of feel internally feminine

Yeah, I mean, um, as opposed to masculine

As oppo-

I CERtainly would not say I’m masculine
Okay, okay, so maybe the words don’t quite fit (.)
(overlapping) Yeah, I don’t,
(overlapping) to you
yeah, I don’t feel like either one of those words really fits me
Uh-huh, uh-huh, okay (.) What do you think about when you
think of, um, feminine?
Um, when I think of feminine, well, I mean, there’s warm and
nurturing, and ah, motherly
Uh-huh
Um, but also, bu-, and, but also, um (.) sort of a strong sense
of, um (.) needing to express outwardly (.) um (.) sort of, ah,
a female energy
Um-hmm
Um, that would be, almost like, sexually suggestive or
attractive
Um-hmm, okay, and what about when you think of
masculine?
Um (.) I think of masculine, I think of sort of aggressive, um
(.5), I mean (laughs), just to digress a second
(laughs) Yeah, that’s good, I like that
Um, one of my sisters is also a lesbian
Um-hmm
and her partner, um, has recently become transgendered?
Um-hmm
and, um, I’ve had transgendered friends before (.) who I’ve
felt, felt were very MASculine
Um-hmm
and, you know, and it seemed really obvious they were
transgendered from the time they were children
Um-hmm
and, my sister’s partner has such a feminine energy to me
Um-hmm
I mean, he’s S-O-O-O, um (.2) he’s s-o-o, nurturing and, I
have a three-year-old niece and he’s so kind to her and, like,
spends all of this energy on her and just, like, loves children
and he’s just, so, to me, very, very feminine
Um-hmm
I mean, not feminine in that he, like wears, I mean, like, the
other things I said about, like, wearing make-up or, like,
having this, um, sort of feminine sexual energy, not like that
Um-hmm
but just like, his persoNALity is just so warm and nurturing
Um-hmm
Um, and we always used to call him Grandma, because he
was, like, he’s like twenty-five
Um-hmm
and, um, and he’s so, ah, like, cautious, you know, and just
like all these things that I think of as grandmotherly
Um-hmm
and so it’s really weird to me, that on the INside he feels
masculine, you know
Um-hmm
and, um, so, anyway, but, I’ve been, I’ve been thinking about
this a LOT
Uh-huh
P: like, what it means, like to be feminine or be masculine or,
617 you know, and, you know, it’s pretty obvious I guess that (.)
618 what people see on the outside is not necessarily what you feel
619 like on the inside
620 R: Um-hmm
621 P: so, um, so to ME, it’s hard for me to THINK of him as
622 masculine because I don’t really think of many positive
623 attributes as masculine (laughs) attributes
624 R: Uh-huh, uh-huh
625 P: um (.) and so (.) you know, to me he just isn’t masculine
626 R: Uh-huh
627 P: except that he kind of looks like a twelve-year-old boy
628 R: Uh-huh, uh-huh
629 P: so
630 R: Is he in the process of transitioning?
631 P: Um, well, I guess he’s going to start taking some hormones
632 and I think that he’s going to have surgery, um, like, breast
633 reduction surgery
634 R: Uh-huh, uh-huh (.4) Um, all right, I think we have, like, five
635 more minutes on the tape so I’ll just leave, make sure it’s,
636 yeah, it’s still spinning
637 P: Okay
638 R: Okay, um, when you think back to your experiences growing
639 up, did you expect that you would become a mother?
640 P: No
641 R: No
642 P: No, I definitely did NOT want to be a mother
643 R: You did NOT want to be a mother?
644 P: (overlapping) I did NOT. I did not ever want to get married, I
645 never wanted to have kids
646 R: Uh-huh
647 P: Um, I think because, um, it, my mom is one of eight kids and
648 in their family women, it’s like their husbands are also their
649 children?
650 R: Um-hmm
651 P: and it just seemed to me, none of them had, like, careers, it
652 just seemed like all the wives in our FAMily, um, they always
653 were taking care of other people, they never thought about
654 themselves, they never got to do anything for themselves
655 R: Uh-huh
656 P: Um, it was always about other people, I mean, it was always
657 about their children or their husbands or, um (.) and so looking
658 back on it, I think, well, no wonder (laughs) you know, I
659 didn’t want to be a WIFE because to me being a wife meant,
660 you know, just not even having a self, really
661 R: Um-hmm
662 P: just giving yourself completely up to other people
663 R: Um-hmm
664 P: Um, and to me that was what wa-, was being a mother was,
665 too
666 R: Um-hmm
667 P: so I didn’t want that at all
668 R: Um-hmm
669 P: and I always knew that I wanted to, um, go to college and
670 have a career?
671 R: Um-hmm
P: and where I grew up, in rural Ohio with, in a working class family, and so, there was no conception of, like, a woman who worked and had a career and also had children

R: Uh-huh

P: that just, didn’t exist in our world, and so I think, growing up, it just never occurred to me that that could actually happen

R: Uh-huh, uh-huh

P: and so, it wasn’t until, um, like I said, like, five years ago that April and I both went, “Hey, you know, we really want to have a kid”

R: Uh-huh

P: so (laughs) and it occur-, you know, I saw other people, um, you know other lesbian couples

R: (overlapping) Uh-huh

P: (overlapping) having children

R: Um-hmm

P: and, you know, saw that that could work

R: Um-hmm

P: I think that, like, my sister, ah, works with HRC?

R: Um-hmm

P: the Human Rights Campaign? And, um, there, ah, the people who are in their early twenties who work there that she knows, it just seems, like, obvious to them that they are going to have kids

R: Uh-huh

P: like, they just don’t even seem to even question it

R: Uh-huh

P: to them it’s like, it’s they’re, they’re gay, they’re gonna have kids, and they’re gonna be a couple and that’s just part of what they think is gonna happen

R: Uh-huh

P: And, I think that for April and me, we’re in our, we’re both thirty-four

R: Yeah, there’s been a lot of shifts in, like, five or ten years, even

P: Yeah

R: there’s a big difference

P: Yeah, yeah

R: So, can you think of, like, maybe a mom-, the moment that it shifted for you?

P: Um, part of, a big part of it was when my sister had her baby, my niece just turned three in July

R: Is this your sister who’s a lesbian?

P: No

R: (overlapping) No, okay

P: (overlapping) I have, I have a younger sister

R: Uh-huh, you’re one of eight, so

P: No, I’m one of three

R: Oh, okay

P: My MOM is one of eight

R: Oh, your mom’s one of eight, okay
P: Yeah, um, no, I have a younger sister who’s in a straight relationship, she’s married, er, she has a husband, and they have a three-year-old and as soon as the baby was born, April and I were both, like, “Yeah, this is DEFinitely gonna happen for us,” you know, we really hadn’t thought about it before then, but as soon as Jordan was born we knew it was gonna happen.

R: Uh-huh

P: You know, we just loved her so much and we just KNEW we wanted to be parents.

R: Uh-huh, uh-huh

P: So

R: Uh-huh, can you say even more about that?

P: U-u-um (.) we just think she’s wonderful, it’s like, you know, even when she’s ba-a-ad, to us, she’s not bad (laughs) you know?

R: (laughs)

P: It’s like, she’s, to us, she’s just such an angel no matter what she does.

R: Uh-huh

P: And, um, you know, just seeing, I think, I wanted to be pregnant after seeing my sister be pregnant.

R: Uh-huh

P: like, my sister just looked so beautiful when she was pregnant, even though, like, talking to her now I realize she was miserable a lot of the time.

R: Uh-huh

P: at the time I didn’t really th-, I didn’t SEE that, you know, I just thought, Oh, she looks so beautiful, and it just was so wonderful, like, I just was, like, so wrapped up in the fact that she was making life, you know.

R: Um-hmm

P: and it just seemed so fantastic.

R: Um-hmm

P: and then, um, when the BABY came, my sister, my youngest sister was always sort of the irresponsible one?

R: Um-hmm

P: like, dropped out of college, didn’t really know what to do with her life and then she got pregnant and, um, and then, to a, with, with this guy that she’d been seeing for just a couple of months, and we were all, like, “Oh, my God,” but then after she had the baby, she’s like the most wonderful mother ever.

R: Uh-huh

P: like she’s just the most patient, patient person, like she never, ever, ever would yell at, at my niece.

R: Uh-huh

P: you know, never.

R: Uh-huh

P: she never loses her patience, and um, so just seeing their relationship, you know, has, yo-, you can BE the baby’s aunt, but you’re still not her mother.

R: Uh-huh

P: you know?

R: Right.
P: And I’ve gotten to see, too, you know, there are bad parts of
that, too, but, um, you know, just seeing what that relationship
is like, you know, a really positive example of that
relationship, you know?
R: Uh-huh, bad parts of being a mother, is that what you meant?
P: No, I mean the, seeing the, seeing the GOOD parts of it
R: Uh-huh
P: have really, you know, I think, um, it really made us want to
have a kid
R: Uh-huh
P: and my sisters really wanted us to have a kid, too (laughs), so
my sisters, ah, really wanted it
R: so she can be an aunt
P: yeah, uh-huh, yeah
R: Ah, let me change this tape, I think we’re gonna
[P: [Side B inserted]]
R: Okay, so actually that (.) made me think of a question, um
P: Okay
R: in terms of, like, you seeing all the changes that happened to
your sister
P: Yeah
R: after having her child? And, are there things that you’re
anticipating (.) will happen (.) with you in terms of your
personality?
P: Um (.) I know that there WILL be, I’m not really sure what
they ARE yet?
R: Um-hmm
P: Um, I’m no-, I’m already sort of a homebody, I just like to
sort of stay home and be with a fe-, few, you know, close
friends, I don’t really go out (.) a lot, um (.) so, I’m not like
anti-, I’m not anticipating a HUGE change in lifestyle like
that?
R: Um-hmm
P: Um, I do like my leisure time, I do like my aLONE time
R: Um-hmm
P: so I think it’s gonna be hard to, um, you know, to find that,
and I love to read and do things that are sort of, um (.) QUIET
(.) things like that to do, so I think that might be more difficult
with a child
R: Um-hmm
P: Um (.) so I know our lifestyles will change
R: Um-hmm
P: Um, but, ah (laughs) we actually got a DOG about a year and
a half ago?
R: Um-hmm
P: and it was sort of like our experiment, you know
R: Um-hmm
P: to see, ah, how this is gonna work out
R: Uh-huh
P: and, um, so we’ve already been sort of MORE tied down than
we were before
R: Uh-huh, uh-huh
P: you know (laughs) which is, I know nothing compared to a kid
R: Uh-huh
P: but it was sort of like our first step toward (.)
R: (overlapping) well, it’s funny
P: (overlapping) xxxx xxxx xxxx 839
R: that you say that because actually my partner and I just got a 840
dog
P: Oh (laughs)
R: (laughs) about five weeks ago, yeah, and we’re like, “This is 843
like a microcosm of like what it’s like
P: Yeah
R: maybe to have a child” because (. ) they’re not like cats
P: (laughs)
R: they need you ( . ) to come home (laughs)
P: Right, exactly
R: Right
P: Right ( . ) yeah, and, you know, yo-, you can’t just, like,
LEAVE them for the weekend or, so
R: Well, maybe tell me about the experience of parenting a dog
P: (laughs)
R: with your partner and how that’s been, like
P: (laughs) u-u-um, well, we got a shih tzu, ‘cause that’s what I
(. ) we’re both allergic to dogs, so shih tzus don’t shed
R: Uh-huh
P: and so, and my s-, my, ah, April really wanted a small dog
R: Uh-huh
P: I, I really kind of like German Shepherds, that kind of dog
R: Um-hmm
P: but she likes small dogs, so we got this shih tzu (. ) and, um, so
(.) some people don’t consider him, like, a REAL dog
R: Um-hmm
P: ‘cause he’s (. ) really small, but, um (.2) it’s been, I mean, it’s
been pretty good, eh, like at the beGINning I was really into,
like, training him and, you know, taking him to, like
Obedience classes and Agility classes and (laughs) all this
kind of stuff
R: Um-hmm
P: um, but, um (.2) you know, eventually, I, I get that way, I get
very, eh, you know, um, obsessed about something and then
R: Um-hmm
P: it actually, sort of, it wears off and I go back to normal, so
R: Uh-huh
P: um, so now he’s just sort of a normal dog and does normal
dog things
R: Uh-huh
P: so (laughs)
R: So did that experience maybe tell you more about (. ) what you
think you might be like as a parent?
P: Um, maybe because, um, I, I, you know, at first I thought he
was sort of perfect
R: Uh-huh
P: you know, like he could do no wrong and then I, I started to
realize that he did have some behaviors that other people
might find kind of obnoxious
R: Um-hmm
P: you know (laughs) and so, it was sort of the realization of like,
you have, like, in your, in your mind, you have, like, the
perfect dog that you’re going to have
R: Um-hmm
and then you have (..) the, the reALity which is not a perfect
dog
but you still love him anyway, you know, it isn’t like I would
give him up, you know
so
(.3) Well, actually, that kind of leads me to another question,
um, kind of related, Are you things that you think about that
you want for your child?
Yeah, ah, well I want really good education
for him or her
Um-hmm
Um, so we’re, you know, we have to decide whether we want
public school or private
school or um, we were living in _____ so we moved out of

Um, 'cause we didn’t want to send [them] to the public school
there
Um (.2) I would definitely want them, um (.2) to be involved
and active, you know, in something, you know
Um-hmm
Um, I want them to have a lot of self-confidence
Um-hmm
you know, and also to really care about other people
Um-hmm
and to care about the world and not be selfish
Um-hmm
Um, and to have, like, a sense of responsibility
Um-hmm
towards, sort of, the WHOLE world, and not just (..) towards
themselves
Um-hmm
Um, so I guess those are the major things
Um-hmm, um-hmm, okay (..) um, all right, and I’m wondering
now if you have ever felt if certain parts of what makes you
you, like your gender, sexual orientation, race or income status
have ever affected the medical care that you’ve received
Um
either, like, in your pregnancy or beforehand
Hmm, I mean, I’ve had to do some education of doctors
Um-hmm
you know, like, you know when you go, like, my first doctor’s
appointment with the, eh, Dr. Medeiros, with the (.)
endocrinologist?
Uh-huh
Ah, I went into his office and, and he was like, “Oh, is your
husband coming in?”
Uh-huh
and I was, like, “No,” and I had to explain the whole thing,
you know, and, and, um, so it’s sort of, it seems like you’re
always sort of explaining yourself
Appendix B; Transcript 2

950 R: Um-hmm
951 P: they’re always asking about your HUSband
952 R: Um-hmm
953 P: or they’re always expecting something DIFFerent, um, and,
954 um, it was sort of funny ‘cause, eh, you know, in my, my OB,
955 who I really like (. ) I really don’t think had any, like, any, kind
956 of, I don’t think anybody had maybe even ever come out to
957 him, it just seemed
958 R: Uh-huh
959 P: like he was totally clueless, and, um, what was funny was that
when I went back to him in December, um-
960 R: so you, like, you felt like you were the first person to come out
961 P: (overlapping) Oh, yeah
962 R: (overlapping) to him
963 P: Yeah, I mean, it just seemed like he was sort of (. ) clueless
964 about it
965 R: Uh-huh
966 P: Um, but, you know, I’m okay with that, so (. ) ‘cause I liked
967 him, so I just thought (. ) that he could handle it
968 R: Uh-huh
969 P: so, when I went back to him in December to talk about this it
970 seemed like he must have gone to some seminar on lesbian
971 health recently?
972 R: Uh-huh
973 P: because he gave me a whole, like, lecture on lesbian health
974 issues?
975 R: Uh-huh
976 P: which was just really funny because, like, two years
977 beforehand, he’d been clueless and now, it just seemed like he
978 was le-, lecturing ME, so it was sort of funny
979 R: Uh-huh
980 P: Um (. ) but, um, you know, I thought, “Well, MAYbe by my
981 coming out to him, then, you know maybe he’s gotten more
982 interested in it, maybe, you know, he’ll be better, a better
983 doctor to other patients
984 P: that come after me” so (laughs)
985 R: What were some things that he was clueless about, do you
986 remember specifically?
987 P: U-u-u-um (.3) well, I had put down on the FORM, I had put
down sp-, under spouse I put April’s name
988 R: Uh-huh
989 P: and, I think that we just di-, he didn’t even look at the name,
990 he just looked at “spouse”
991 R: Uh-huh
992 P: and he expected something? And, um, and I just, and he, you
993 know (.2), i-, it just seemed like he was really was like, “Huh”
994 (laughs) you know? Like he just was like, “Hmm” like it ju-, it
995 just never occurred to him before
996 R: Uh-huh
997 P: Uh-huh. What were things that you would have wanted him to
998 know maybe?
999 R: so
1000 P: Um, well, like, he asked me questions about, like, venereal
1001 disease and stuff that didn’t really apply
1002 R: Um-hmm
P: I mean, we’ve been together for thirteen years, we’re a monogamous lesbian couple?

R: Um-hmm

P: and, you know, it was sort of, you know, those are, you know, those kind of questions don’t really apply to us

R: Uh-huh

P: you know, so, I guess that kind of thing

R: Uh-huh

P: Yeah

R: Um-hmm, okay. Um, anything else? Any other, maybe, examples?

P: Um, I mean, it was kind of weird during my first ultrasound at Dr. Medeiros’ office, um, you know, and April wanted to come in and see it, and they were, like, “Okay, well, she can come in but she, ah, yo-, you have to wait till we do this other stuff first and then we’ll go get her”

R: Uh-hmm

P: you know? But it was, it felt sort of weird, it wasn’t like, I think if, if she had been MALE it would have been, i-, it probably would have felt

R: Uh-huh

P: and I don’t know if it was them or if it was me

R: Uh-huh

P: that felt kind of weird about it

R: Uh-huh

P: so

R: Uh-huh

P: I just felt, kind of, off

R: Um-hmm, and have you thought about, like, in terms of the birth and what, do you have anything in place for her to be there or, How does that, I don’t know how that works in Pennsylvania right now (laughs)

P: I haven’t really thought about that

R: Uh-huh

P: I mean, I, you know, she went with me to my first, um, my first prenatal visit with my OB?

R: Uh-huh

P: We went in, ah, September, and, ah, so she went with me to the visit, you know, and she sat there through the whole thing

R: Um-hmm

P: you know, and, um, you know, we both asked him questions so, you know, he’s very aware that she’s my partner and she has questions and she’s gonna be part of it all, so

R: Um-hmm, um-hmm

P: Yeah

R: Um-hmm

P: So, I guess that’s, that would be, how I, I’m preparing him (laughs)

R: Uh-huh

P: is that she’s there already

R: Uh-huh, okay. Um, are there anything, is there anything that you want to tell me that we didn’t touch upon that might be important

P: Umm

R: even if it’s only peripheral?

P: (.3) I can’t really think of anything
Okay. Do you have any questions for me?

Um, no

Okay, um, I’m just gonna look over my questions one more time, I think that’s probably everything I have.

Yeah, okay.
R: So I have two recorders because (.) sometimes one picks up
things that the other doesn’t so (.) um, so I’m just gonna ask
some questions first
P: ‘kay
R: just about your pregnancy
P: Sure
R: Um, how was the fetus conceived?
P: (.) Um, nor-, n-, normally, my husband and I (.2) there was
no-o-o extra stuff involved (laughs)
R: Okay (.4) And, um, did you plan to become pregnant?
P: Yes we did
R: And did you do anything in preparation of that?
P: Um, I was actually on prescription strength folic acid because
I have a neural tube defect
R: Uh-huh
P: so I had to take, ah, extra, um, folic acid ‘cause it’s, it’s a
preventive tool for neural tube defects, eh, but you have to be
ON it when you get pregnant
R: (overlapping) Uh-huh
P: so I was on that and um
R: so you were on that (.) prior anyhow?
P: Ye, well, as soon as we decided we wanted to try to get
pregnant, the
R: (overlapping) Uh-huh
P: doctor put me on it
R: Okay
P: and, and a prenatal vitamin I was already on before I got
pregnant
R: Uh-huh (.) and, um how long did you try
P: (overlapping) Um, two months
R: (overlapping) before you got pregnant?
P: we tried
R: Uh-huh
P: (.) With this pregnancy, I should say
R: Okay (.3) And have you been pregnant before?
P: I had one miscarriage
R: Uh-huh
P: Last year
R: Uh-huh (.6) Okay, and have you done anything in preparation
of becoming a mother?
P: Other than reading? (laughs)
R: (laughs)
P: Kind of read and, you know, kind of get boned up on that stuff
and we’re taking a baby class, my husband and I
R: Uh-huh
P: and, ah (.) that’s pretty much all we’ve done so far and, ah,
and normal stuff like gettin’ the baby’s room ready and all of
that kind of stuff
R: Okay
P: ‘cause we’re pretty far in now so (.)
R: Um
P: you kind of wait to do that stuff ‘til you’re pretty far in
R: Uh-huh
P: so you know nothing will happen (laughs)
R: And, wh-, ah, what’s the baby class on?
P: Um, Parenting 101, it’s just a basic parenting class
R: Uh-huh
P: Like how to take care of an infant, really
R: Uh-huh
P: ‘cause we’re not around small children very frequently
R: Um-hmm
P: right now, so we thought we’d bone up
R: Uh-huh
P: (laughs)
R: And how’s that going
P: (overlapping) Well, we on-, we
R: [so far?]?
P: haven’t even had our first one yet, it’s, ah, not ‘til November, so
R: Uh-huh, um-hmm (.2) And, um, have you experienced any
difficulties in your pregnancy?
P: (overlapping) Um, I was,
R: (overlapping) with this pregnancy
P: I was very sick, as far as, like, morning sickness, it lasted, it
wasn’t morning sickness, it was every day all day sickness
R: Uh-huh
P: And (laughs) ah, it lasted really long, I actually, ah, haven’t
gained any weight since I got pregnant
R: Really
P: My weight’s all shifted, you know, and the baby’s gaining a
lot of weight
R: Uh-huh
P: but, ah, I haven’, I’ve actually lost weight, so, um, hopefully,
about the five month mark I finally started being
able to keep down more meals than I was getting rid of
R: Uh-huh
P: and so, that’s improved. Other than that, I haven’t had any,
ah, anything else.
R: Okay Um, and can I ask you some about the medical
and, I guess, technological care that you’ve received
P: Um-hmm
R: in your pregnancy?
P: Um-hmm
R: Um, did you choose your physician?
P: I did, um-hmm
R: Okay, and how did you go about deciding?
P: Um, well, because I have spina bifida, I had to, um, look for a
high-risk pregnancy group ‘cause I’m over forty
R: Um-hmm
P: Well, gonna be forty, I’m not over forty
R: Um-hmm
P: and, ah, and because I have the spina bifida, um, I wanted a
doctor who’d worked with women with disabilities before?
R: Uh-huh
P: which is not easy to find, I might add (laughs)
R: Um-hmm
P: Really, really difficult, actually
R: Um-hmm
P: and I finally went with, um, a group in the city, ah, actually at
______, that is, um, a high-risk pregnancy group,
maternal/fetal medicine group
R: Uh-huh
P: and that’s who I went with
R: Uh-huh
P: I decided that I thought I could get the best (.)
R: (overlapping) Yeah
P: (overlapping) care from them
R: Uh-huh (.3) So can you t-, actually tell me about the spina
P: bifida a little bit
R: Um-hmm
P: and how that impacts your pregnancy and
R: (overlapping) Um, yeah, there’s a-
R: (overlapping) I don’t know much about it, so
P: there’s a few things, um, because I also have a curvature with
R: that, a curvature of my spine?
P: Uh-huh
R: Um-hmm
P: so, there’s not a lot of room, so they’re a little concerned about
R: the baby getting too big
P: Okay
R: Um-hmm
P: because then I wouldn’t be able to breathe as well
R: Um-hmm
P: which is typical of all pregnant women but would be (.) a little
R: more complicated with me
P: Uh-huh
R: Um-hmm
P: so, we-, we’re keeping an eye on the baby’s weight, I may end
up going, ah, early
R: Uh-huh
P: instead of, eh, you know, ah, later
R: Uh-huh
P: I have really small hips and had a dislocated hip when I was
born, so, um, probably will deliver Cesarean because it’d be a
little risky to try anything different
R: Um-hmm
P: Um, and I have high blood pressure so (laughs) they’re
watching that but so far I haven’t had any PROBLEMS from
any of these, it’s just, they’re things they’re keeping an eye on
and watching
R: Um-hmm
P: Um (.4) and those are most of the complications, um, the wa-,
the ambulatory walking could get (.) tougher as I get heavier
R: Right
P: depending, so, you know, ‘cause your balance, your center of
balance, gravity, gets thrown off so, depending on how heavy
I get
R: Um-hmm
P: that would determine how (.) difficult it is, so it’s actually
been, (laughs) a blessing that I haven’t really gained a lot of
weight because so far (.4) I feel pretty good and I’m already six
months so
R: Um-hmm
P: feeling, like, and I’m walking fine and doing okay, so they’re
watching all those things, but those are the things generally,
now THAT’S in my specific case, ‘cause other spina,
different, there’s different types of spina bifida
R: Okay
P: and different levels of that?
R: Uh-huh
Um, ah, MOST, a good portion of spina bifida children or adults are in wheelchairs and don't really walk

Um-hmm

or ha-, so, my s-, case is a lot different than a lot of others, I don't have a shunt and I don't have any kind of mental, ah ()

not disability but, you know, I'm not slower, like, than anyone

Um-hmm

so it's, it's a lot different, mine is kind of a rare case of spina bifida, so, they're just kind of keeping an eye on it

Um-hmm

you know, makin' sure that, you know, I don't, but, you know, my hips hurt more probably than other women, you know, like I've been getting walking, I notice I get a pain, more pains on my side

Um-hmm

but other than that it hasn't been too bad, so they're just kind of keeping an eye on it

Okay (.) And what do you (.) look for, like, in looking for (.) a doctor who would work with disabilities,

(overlapping) Um, I really would have

(overlapping) women with disabilities?

liked to have found somebody who had actually worked with somebody who had had spina bifida?

Um-huh

But, um, MY generation of spina bifida CHILDren (%) are the first group that are old enough to have lived really long enough

Um-huh

to, ah, HAVE children

Um-hmm

and most of them don't want to have, most of them don't have children

Um-huh

Um, so, it was kind of hard to find somebody (laughs) that had already done that (%) but they knew a lot about spina bifida (%) and they knew a lot about, um, ALL the different issues, I mean, when I me-, ah, before I even got pregnant I went and met with them and talked to them about what the, you know, what the risks were to me

Um-hmm

to even do-, do it

Um-hmm

'cause my husband and I wanted to make sure that we were informed, you know

Um-huh

that we weren't just going off half-cocked and doing whatever

Right

and, um, they were great, we had a consultation with them, and they sat down and went over everything I just told you

Um-huh

Um, all the things we could do to help prevent a neural tube defect, um, all the risks involved in my age, um, and then all the things that they thought could go, you know, could go wrong or could be bad, and all of them ended up being, u-um,

inconvenient to me more than detrimental, they weren't, they
were inconvenient things, like, towards the end you might not be able to walk as much, you might have to be in a wheelchair

R: Uh-huh

P: or you might have to stay in bed or,

R: Uh-huh

P: like, things but that after would go right back to the same

R: Right, right

P: so, no permanent damage, as it were and that’s why we decided to, to kind of go with that, that was really what we were looking for in a doctor, I was really looking for mostly, if

R: Uh-huh

P: I was looking for somebody who was going to be supportive of me getting pregnant

R: Um-hmm

P: not, um, because unfortunately, um, when you’re disabled, that can be a real problem

R: Um-hmm

P: even from strangers (laughs)

R: Um-hmm

P: like, you know, “Oh, you’re having a baby, was it an accident?” (laughs) so, I wanted to find someone who would be supportive and would not, um, be like, “Oh, we think it’d be best if you just didn’t go there, or didn’t do that,” you know

R: Um-hmm

P: “No, it wasn’t an accident” (laughs) so, I wanted to find someone who would be supportive and would not, um, be like, “Oh, we think it’d be best if you just didn’t go there, or didn’t do that,” you know

R: Um-hmm

P: and they were great, I mean, I can’t, really can’t fault them there, so I was really happy to find somebody

R: Okay, all right, so just to be clear, so you were looking for somebody who would be informed

P: Um-hmm

R: that was one part, about risks to you

P: Right

R: and the fetus

P: Um-hmm

R: but also maybe even more importantly somebody who would be

P: (overlapping) supportive

R: (overlapping) supportive of your decision

P: (overlapping) Right, exactly

R: (overlapping) to get pregnant. Okay, okay, all right, I’m a lesbian,

P: (overlapping) Those were my two main things

R: so I, this resonates with me somewhat (.) particularly in terms of the, like, “Oh, that’s weird, why would you do that” like, kind of vibe

P: (overlapping) Yeah, yeah, yeah, and it’s

R: (overlapping) that people give, so when I look for health care providers-

P: it’s really hard, ‘because initially I went (.) and looked closer

R: Um-hmm
P: for a doctor, and um, I went to a couple (. ) different places to find out that even
worked with women
R: Um-hmm
P: and they were VERY negative, like very, “O-o-oh, no, we
really (. ) haven’t done that, and, Are you sure you wanna
R: Um-hmm
P: go that route?” and so I, I know, I was, like, you know
what, I’m looking for someone who’s gonna be behind me,
like, I don-, I don’t need anyone (. ) being negative, there’s
plenty of that out there (laughs)
R: Um-hmm
P: I don’t really need that, so I, I went with a whole different
thing, and then when I thought of these, this group, and it’s the
maternal/fetal medicine group, and there’s, like, twelve
doctors, I think
R: Uh-huh
P: (. ) and of the, I’ve s-, of the twelve, I think I’ve seen seven so
far?
R: Uh-huh
P: and of the seven I’ve seen, SIX of the seven I really liked
R: Uh-huh
P: there was only one, I wasn’t real (. ) impressed with him, he’s
was an older gu-, gentleman and, ah (. ) he kind of went the
whole, like, um (. ) you know, I had, like, a pain, and, ah, he
said (. ) I said, “I don’t know what this pain is, I’m getting this
bump, this pain,” he’s like, “OH, pregnant women get, you
know, pains and aches all the time, you can’t be flustered
about every little thing and hysterical about every little thing,"
and (. ) I felt like I hadn’t really BEEN hysterical about every
little thing
R: Uh-huh
P: and so I was kind of, like, “Okay,” well the next time I went to
the doctor, I had a, a different one, and I asked her about it,
well, it turns out I have a hernia (laughs)
R: Wow
P: so it turned out that he really should have (. ) paid a-, more
attention to me,
R: Uh-huh
P: but, ah, other than him, eh, they’ve all been really great and
real supportive and really encouraging and, you know, every
wee-, every time I go, I, I go frequent-, more frequently
probably than other women
R: Um-hmm
P: and, ah, so it’s been kind of interesting t-, for him to say, for
them to say, “Oh, you seem like you’re doing really good,” I
really, like I said, I haven’t had very few problems, all things
considered
R: Uh-huh
P: which is (. ) great so
R: Uh-huh, uh-huh, okay (. ) Um, all right, so I was going to ask
how you’d describe your relationship with your physician, so,
do you have a regular physician or you just see
P: (overlapping) I hav-
R: (overlapping) one in the practice?
P: I see whoe-', they like you to see as many because when you
go to have the baby it could be any of them who are on
R: Okay
P: so you really need to, kind of, be familiar with all of them
R: Uh-huh
P: But like I said, all of them have been great excep-, except that
one so-o, I would have to say, overall they’re all really (.)
good
R: Okay
P: Very informati-, and they get together, I mean, this particular
group get together and discuss (. every patient every week
R: Uh-huh
P: with all of them so they’re all up to date on every patient so
that
R: Cool, um-hmm
P: you’re never, and that’s kind of good to because (. if someone
doesn’t know as much about (. high blood pressure
R: Uh-huh
P: as somebody else (. there might be information
R: Right
P: you can get from them, so I’m really happy with it,
R: Uh-huh
P: yeah,
R: Uh-huh
P: a lot, so,
R: Okay
P: and then I also have a primary care doctor as well
R: Uh-huh
P: and he’s great, too, and he’s real supportive as well,
R: Uh-huh
P: so
R: Okay (. And, um, how did you come to the decision to have
an ultrasound?
R: (. The first, well, I didn’t really come to it, I mean, when I, as
soon as they, um, determine that you are pregnant
R: Uh-huh
P: and you come for your first appointment, when you’re in a
high-risk pregnancy (. they do it right away
R: Okay
P: just to make sure everything’s, you know, good, and then I’ve
had them frequently (. leading up
R: Um-hmm
P: ‘cause they’ll kee-, and they’ll keep doing them (. pretty
frequently ‘cause they want to make sure everything’s (. good
because I’m in a high-risk group
R: Okay
P: they’ll keep checking the baby pretty frequently.
R: So when did you have the first one?
P: I think I had the first one at (. ten weeks
R: At ten weeks?
P: Um-hmm
R: And when was the next one?
P: Ah, oh geez, ah, probably (. six weeks later
R: Okay
P: So sixteen (. and then I had another one at nineteen (.5) and
then (. twent-t-ty (. two, so I’ve had [um, three]
R: So you’ve had four?
P: Oh, would that be four? (laughs)
R: (laughs) That’s four
P: That’s four, sorry (laughs)
R: And then, so, you’re just kind of expecting to have them
P: (overlapping) Yeah
R: (overlapping) every few weeks?
P: Pretty frequently
R: Okay, and how has the experience, of, um, well, you’ve had a
few (. ) maybe you can describe-
P: (loudly) Um, they’ve all been good,
R: Um-hmm
P: I’ve had different (. ) techs different times
R: Uh-huh
P: Um, they’ve all been GREAT, um, the first one (. ) was very
nervewracking ‘cause you’re nervous, I was very nervous
‘cause I had already had a miscarriage and so
R: Okay
P: It’s nerve-, it’s a little nervewracking ‘cause (. ) it ear-, that
eyou can’t feel anything so you’re not really sure,
R: Uh-huh
P: “What if something happened and I didn’t know?” (laughs)
R: You know?
R: Uh-huh
P: You live for that kind of, like, now the baby’s moving
R: Uh-huh
P: actually right NOW the baby’s moving
R: Uh-huh
P: And, ah, I really like that because it’s much more relaxing
‘cause your like, “Oh, she’s moving, she’s okay,” it’s a girl,
by the way
R: Okay
P: (clears throat) Um, so (. ) yeh, the first, you know, the first
one’s really nervewracking ‘cause you’re waiting, and, to see
if there’s something (laughs)
R: (overlapping) So you had your first
P: (overlapping) and is it okay
R: ultrasound before you had had ANY, like-
P: I had just done pre-, like a test, like a regular,
R: Uh-huh
P: little
R: (overlapping) but no, like,
P: (overlapping) test
R: feeling in your body
P: Right
R: that you were pregnant at all
P: No,
R: Yeah
P: Well, I was feeling sick, still (. ) I, I started feeling sick pretty
much right away
R: Okay
P: But, ah, you know, you still never know with that so (laughs)
like, maybe I’m just sick, but ah, so that was kind of neat and,
R: um, and then the other ones have all been, um, I’ve had to
P: have a couple of extra, I’ve had a couple of extra ones, or one
extra one because the later ones, they’re measuring the baby,
like, they’re measuring all the different things and, one of the
thin-, things they couldn’t see, in the last, second to last one
I had, was the size of her spine

R: Um-hmm

P: and, it couldn’t get a good shot, she wasn’t laying right

R: Um-hmm

P: and so then I had to come back a few weeks later for that again

R: Um-hmm

P: and the next one they got it, so

R: Um-hmm

P: But it’s nice because now they give you a video, you get to take it home

R: Okay

P: and watch it sixty-two thousand times (laughs)

R: Uh-huh, so which one do you have a video from with the? 

P: Um, the last two

R: The last two

P: Um-hmm

R: And, um, can you tell me just as much as you can about the experience of going in and what happens?

P: Yep, ah, went in, and, ah, they always ask you if you have to pee, which is good (laughs)

R: Um-hmm

P: and you usually do

R: Uh-huh

P: and then, ah, and then ah, my husband was with me the first, well, my husband was with me for ah, two of the four

R: Uh-huh

P: And, ah, a girlfriend was with me for one, and then my mother was with me for the last one

R: Uh-huh

P: and, ah, they bring you IN, and, ah, lay on the table very, I mean they’re pretty great, like, you don’t have to, it’s so nice ‘cause they don’t make you, like, change into a GOWN and do all that anymore, it’s just, like, “Pull up your shirt, pull your pants down below your belly and”

R: Uh-huh

P: so it’s pretty it’s not required for it to be a big, long, drawn-out process, and the girl was really nice, um, and she was very informative, like, while she was doing it, showin’ us, you know, every single thing what it was, and, “here’s this,” and “here’s that,” and you know,

R: Um-hmm

P: And, ah REALLY GREAT, I mean, I haven’t really, I mean, she was good and it, it was really cool ‘cause she showed us every little thing and, of course, sh-, I, I don’t know what everyone else has said, but your looking at and you’re like, “I have no idea what I’m looking at” (laughs)

R: Um-hmm

P: It’s like, looks like nothing to me, at first-, especially the first, the first ones are really hard because they don’t look like anything, pretty much,

R: Um-hmm

P: It’s just, like, “Sure, it’s a baby,” y-, y-, you know, and,

R: Um-hmm
Appendix B; Transcript 3

500 P: but now th-, these later ones, they’re cool ‘cause they got
501 HANDS and LEGS and you can see them sucking their
502 THUMBS, and, you know, it’s really neat
503 R: Um-hmm
504 P: And, ah, they show you everything, and then when they’re
505 done then you usually have to wait while they go and get the
506 report
507 R: Um-hmm
508 P: and print that and, ah, and they were all great, they printed me
509 pictures, I have pictures from all of them and they printed me
510 the video from the last two
511 R: Um-hmm
512 P: and, ah, so all of them were really good
513 R: Uh-huh
514 P: all of the experiences were good
515 R: Uh-huh
516 P: with th-, with that. I actually had a BAD experience with (.)
517 with m- with my miscarriage one
518 R: Um-hmm
519 P: that I had, yeah, I (. um, the girl who did my, um, ultrasound
520 for that particular (. I was bleeding and I came in
521 R: Um-hmm
522 P: and, ah, they did, ah, the ultrasound and (inward breath) she,
523 ah, she said to-, she went sh-, she didn’t say ANYthing the
524 whole time she was doing the ultrasound which (. is a tip-off’
525 ‘cause that’s unusual and then she LEFT and I said to my
526 husband, “This is not good, like, something’s wrong”
527 R: Um-hmm
528 P: and he said, “No-o-o, I’m sure it’s fine,” and she came back in
529 and she said, um (laughs) her exact words were, “Your uterus
530 is empty,” which I thought was a HORrible thing to say
531 (laughs)
532 R: Uh-huh
533 P: like, just, I mean, that’s so, like, kind of cold, you know? And
534 I was like, “O-oh,” and, and she’s like, “So here’s the report”
535 (laughs) and I was like, “Okay,” and of course then I burst out
536 crying and I was all upset and (. so that was a very bad
537 experience I had
538 R: Uh-huh
539 P: ‘cause I thought she was a little (. too clinical
540 R: Uh-huh
541 P: to be (. like that’s a hard thing, that’s your baby
542 R: Right
543 P: and, you know, you want it, and it’s, you’re excited, and to
544 just say, “Oh, sorry, your uterus is empty,” just wasn’t, you
545 know, I thought a little more (. heartfelt (. feeling would’ve
546 been nice (laughs)
547 R: Um-hmm
548 P: (overlapping) but I have-
549 R: (overlapping) and this (. was a different group of doctors or
550 the s-?
551 P: same group
552 R: same group?
553 P: but, now, the ultrasound is through the hospital, I mean, like,
554 you go
555 R: Okay
P: 'cause they’re at the hospital
R: Um-hmm, right
P: so there’s a whole ultrasound department
R: Right
P: so that was just one girl in the whole ultrasound department
R: Uh-huh
P: and she was very young so I— (.), you know, I’m wondering if
she just didn’t KNOW what to say (laughs)
R: Um-hmm
P: so, but, you know, in retrospect, I was a little like, eh, I was,
she’d been a little, ‘cause I had got myself so flustered from
that comment that it was really hard
R: Yeah
P: but the other ones I’ve had have all been really, really good
R: Um-hmm
P: and ( .) easygoing, very nice people
R: Um-hmm
P: talk to you the whole time, you know
R: Um-hmm
P: and I LIKED it that I never felt like it was just routine for
them, like,
R: Uh-huh
P: you know what I mean? Like, they were excited for you and
didn’t seem like it was just like, “Oh, God, another one, here’s
another spine, another leg, anoth—”
R: Um-hmm
P: you know? It, they were real good about being ( .) as excited
as you were and making you feel like you were probably like
the only one they were seeing today
R: Uh-huh
P: which is nice
R: Uh-huh
P: very nice
R: (.2) So you must have been really nervous to go in for your
first ultrasound
P: Yes
R: with this pregnancy
P: Yeah
R: after that experience
P: Yeah
R: And what was different, like, you said it wa—, there was kind
of a tip-off to you that things were wrong because she wasn’t
saying anything
P: Right
R: what did you notice about the first ultrasound with this
pregnancy
P: (overlapping) Well, she right away said,
R: (overlapping) that was different, a different tip-off?
P: “Okay, there it is, see the little heart? See the—“ (laughs) you
know?
R: Uh-huh
P: Like, right away, it was, “Here it is,” you know,
R: Uh-huh
P: and in the other one ( .) she wasn—, just wasn’t saying anything
R: Um-hmm
P: she didn’t say, “Here it IS,” or “Here it’s NOT,” or, you know, “Uh-oh,” or
R: Um-hmm
P: (laughs) I mean, nothing, no warning
R: Um-hmm
P: so (. ) I could tell right away (. ) okay, well, there’s the baby, I could see it
R: Um-hmm
P: you know, so I knew right away that things were better
R: Um-hmm
P: with this one
R: Um-hmm
P: and, ah, and plus I hadn’t-, I wasn’t bleeding so I knew (. ) nothing was actually probably wrong
R: Um-hmm, um-hmm
P: so (. ) that was helpful, too, but (. ) she was, I mean, she was great, the first girl was great and she, you kn-, the first one is never very long ‘cause (. ) there’s not a lot to see
R: Um-hmm
P: um (. ) so you do it real quick and they print you the pictures and she was really funny ‘cause she handed us the photo and she’s like, “There’s your picture,” you know, and we’re like, “Okay,” and she left the room and my husband and I are staring at the photo
R: Um-hmm
P: like two stupes, we’re like, ((flips blank piece of paper over to motion looking at a sonogram)), you know, she comes in, I go, “Can you tell us what we’re looking at, exactly?” (laughs) She’s like, “Oh, I’m sorry, sure,” so then she explained to us which way it went, and which was the head and, you know, which was, you know, and, ah, so she was really great ‘cause it was really nice because then we had had something solid and we felt really good
R: Um-hmm
P: that we knew everything was (. ) going okay
R: Um-hmm
P: so, and now, once you get past that twelve week mark, you feel pretty (. ) secure
R: Uh-huh
P: like, it’s gonna be okay, or
R: Uh-huh
P: everything’s gonna work out (laughs)
R: Uh-huh
P: I mean it can go wrong but (. ) you feel better
R: Uh-huh
P: after it’s over
R: (. ) Um, and which, at which ultrasound did you find out the sex?
R: U-um (.2) the third one
R: The third one?
R: Uh-huh
P: Yeah
R: Uh-huh
P: The twenty-, I think it was like twenty-two weeks?
R: Uh-huh
P: Or twenty (. ) twenty weeks, which-, whichever one that was, like, around there
R: Uh-huh
P: Nineteen, twenty weeks, and, ah, and we wanted to know, she asked us if we wanted to know
R: Uh-huh, uh-huh
P: She said, “Would you like to know,”
R: (overlapping) Had you talked about it before?
P: Yeah,
R: Uh-huh
P: we, we did want to know, so, we, um, she said, “Do you want to know?” and we said, “Yeah,” and she said it was a girl, and I think my husband was a little disappointed (laughs)
R: (laughs)
P: but, ah, he got over it, and, ah, you know, he was laughing and, an-, he sa-, “Ah,” ‘cause he was so convinced it was a boy, I don’t really know why ((breath inward)) and I kept saying to him the whole time, “I know you’re pretty convinced it’s a boy, but you DO realize, right, that it could be a girl?” (laughs)
R: Um-hmm
P: and it was, it was a girl so, and then when I went my la-, this last time, I said to her, you know, ‘cause we’re getting ready for a big baby shower and, I said to my, you know, I said to her, “Can you just make sure it’s a girl again because (.) if it’s not, we have serious problems, ‘cause I’ve purchased a lot of girl items”
R: Um-hmm
P: and she checked, and she goes, “Still a girl,” I said, “Okay, then,”
R: Um-hmm
P: so (.) yeah, we wanted to know
R: Um-hmm
P: (.2) a LOT of people don’t want to know, but
R: (.2) What do you think about it, like, how come you want to know
P: Um, I wanted to know ‘cause I wanted to plan (.) the room and stuff to fit
R: Uh-huh
P: whichever sex it was
R: Uh-huh
P: I mean, you know, within reason
R: Um-hmm
P: and, ah, I don’t really know why because we’re doing Winnie the Pooh, which is pretty (.) multi (laughs) either one
R: Right
P: but, ah, I, we, you know, we looked at a bunch of different things and, ah (.) and we really just we-, we figured, either way, whether you find out (.) early or you find out when you have it, it’s still a surprise, either way
R: Um-hmm
P: so we kind of just thought, Oh, it’d be nice so that we could plan for it right
R: Um-hmm
P: and know what we’re, you know, and, ah, so we decided, Oh, let’s just, we want to know, so we just decided
R: Um-hmm
P: No bi-, no big (.) decision, kind of, it was just like, Oh, yeah let’s, let’s find out
R: Uh-huh, uh-huh
P: so (.) we did
R: Okay (.) Ah, I don’t know if you’ve answered this already, but did you have any expectations about what the ultrasound would be like?
P: Um (.) no, I don’t think I really did
R: Um-hmm
P: ‘cause (.) I’ve had ultrasound before for other stuff
R: Um-hmm
P: like, for kid-, my kidneys and stuff, so (.) I kind of knew what it would be like
R: Um-hmm
P: the ultrasound, per se
R: Um-hmm
P: Um, and then, you know, I figured it’d be pretty
R: Um-hmm
P: I-, I’ve gone with girlfriends when they’ve had them, so
R: Uh-huh
P: I kind of knew what the procedure was, so it wasn’t too
R: Okay
P: I didn’t have a lot of expectations over it
R: Uh-huh, is there anything that (.) the doctors could have done differently to prepare you for the?
P: (overlapping) I don’t think so
R: (overlapping) experience? No
P: No
R: No
P: It was pretty, I mean, they, you know, they tol-, told us exactly what to expect, um, you know, as far as, this is what’ll happen, you’ll go in, they pretty much prepared us like that
R: Um-hmm
P: Um (.) so I felt pretty prepared for it
R: Um-hmm
P: I didn’t feel like I was going in blind or anything
R: Um-hmm, And at what point did you notice, like, movement from the baby, like,
P: (overlapping) actually, jus-
R: (overlapping) separate from,
P: like, you mean, like, i-, i-
R: (overlapping) like, kicking,
P: personally? Yeah
R: Yeah
P: Um (.) JUST, let’s see, I’m six months now, I’d say two weeks ago
R: Uh-huh
P: So (.) not that long ago, and I think it’s ‘cause it’s my first baby, and you’re not sure, you’re like, “Oh, is that the baby? Was that the baby?”
R: Uh-huh
P: (laughs) and ah, I-, but I started noticing it, but my husband couldn’t feel it, and then LAST week (.) she’s kicking harder
R: Um-hmm
P: and he could feel it
P: so (.) just in the last, probably, last two weeks
R: Okay, and so you had all of the ultrasound prior to feeling
P: Yeah
R: the baby kick?
P: Yeah
R: So how was that?
P: Um, well, like, I said before, it’s the same thing I said before
which is, it’s a little nervewracking when you don’t feel the
baby because you do worry
R: Uh-huh
P: like, I worried, like I’d be good right after my doctor’s
appointments ’cause they’d le-, let you hear the baby’s
heartbeat, so you’d know, “Okay, everything’s okay”
R: Uh-huh
P: but then, like, that’s like, you know, four weeks ‘til the next
one (laughs) and it’d be like, at three weeks, you’d be like, “I
hope everything’s all right” (laughs)
R: Uh-huh
P: I’d start getting worried, I mean, I think when you have a
miscarriage, too, you worry
R: Uh-huh
P: more, and I worried, like, that things, you know, something
was wrong and, you know, or (.) I know when we went for our
(.) when we went for our (.2) when we went for our FIRST
ultrasound (.) I was nervous as far as, “What if we go for the
ultrasound and we find out (.) our baby doesn’t have any legs”
(laughs)
R: Um-hmm
P: and my husband’s like, “Oh for God’s sake,” and I’m like,
“You don’t understand,” so we went, and of course, you
know, he’s like, “Look, honey, it has legs,” I’m like, “Oh,
good” (laughs)
R: Uh-huh
P: but, I think you (.) just deal with those fears as you go along
and when you can’t feel the baby I think you (.) worry more
R: Um-hmm
P: ‘cause you, you’re like, waiting, ‘cause you’re like, “What if
it’s in there and something’s wrong and you don’t know”
R: Um-hmm
P: ‘cause you can’t really tell
R: Um-hmm
P: you know (.) AND they’re all just general fears, I think,
R: Um-hmm
P: you know, it’s always nicer now because now if I feel
nervous, sometime, like, within the next three hours, I feel her
moving around, I’m like, “Okay, everything’s okay,” so I
THINK you relax a little more
R: Um-hmm
P: you know, than you do when you (.) don’t feel them
R: Um-hmm, um-hmm (.) Okay (.5) Are there other changes
that you (.) like, have in your body, like,
((inward breath))
P: you said being sick
R: (overlapping) Yeah
P: (overlapping) Okay (.5) Are there any other changes that you notice?
P: Other than my right hip’s been kind of hurting, and, um, and I feel like I’m turning into Pamela Anderson in the breast area.

R: Um-hmm

P: Ah, those are pretty much the only BIG changes that I’ve noticed, that my feet aren’t swelling, I’m not having any kind of, um, OTHer, you know, stuff, um, I can’t eat lettuce no matter what I do, I’ve tried a million times to eat, you know, l-e-, like, I can eat OTHer stuff but the MINute I eat lettuce, a half hour later I’m (. ) running for the bathroom.

R: Um-hmm

P: So (. ) I’ve quit eating lettuce, pretty much

R: Um-hmm

P: And, ah, and then, like I said, my, ah, my breasts have really, the-, they hurt, and they’re, you know, I’ve had to buy a bigger BRA and (. ) my husband’s pretty happy about it, but (laughs)

R: Um-hmm (.5) Okay (. ) I’m gonna shift gears a little bit

P: Okay

R: Ah, do you consider yourself to be a woman?

P: (. ) YEAH

R: Yeah

P: Yeah

R: Um, could you say why?

P: Um (. ) that’s a hard question, um (.3) I, I don’t know, there’s so much involved in that, like, that’s hard fo-, kind of a hard question to answer, you know, I think I’m (. ) I tend to be (laughs) kind of a girly-girl, like I like a lot of girly stuff and, you know, I’m kind of (. ) flower and bows kind of (laughs) you know, I’m like that and I’m (. ) I’m really very nurturing and I like, um, I like taking care of things and taking care of people.

R: Um-hmm

P: and, um, and I think that’s GENerally a female, a womanly kind of thing ‘cause I noticed, you know, my husband’s not exactly Mister Nurturing, eh,

R: Um-hmm

P: when he’s, you know, hanging around (. ) and, ah (. ) you know, I’m Miss, ah, I-don’t-want-to-change-the-oil-you-change-the-oil (laughs) like I would never do stuff like that

R: Um-hmm

P: so I think, but I think it’s more about being nurturing, I, I really like THAT aspect of being a woman

R: Uh-huh

P: and, um, you know, I like, I’m ver-ry (. ) people oriented as opposed to (. ) ITEM oriented, um, I, you know, if I see something I worry about, you know, like, w-, you know, we drive, my husband and I drive past, you know, flood victims’ (. ) homes and I say, “Oh, I hope the-., those people have a place to LIVE,” and he says, “I wonder how bad their house was damaged” (laughs)

R: Um-hmm

P: like we just totally think different and, ah (. ) so I think that’s all part of it

R: Um-hmm (.3) Okay, um, do you consider yourself to be feminine?
P: YES, oh yeah

R: Again, can you say why?

P: Um (.) I would have to say (.3) this is kind of, kind of the same thing, I, I like (.3) I like, you know, LOOKing like a girl and I like, um, you know, girly stuff (laughs) you know, I’m ve-, I’m pretty (.3) I’m not overly girly, though, like I’m not sis-sy girly, like I don’t like (.3) you know, frou-frou laced stuff and I’m not, I don’t dress like that and I’m not, you know, but (.3) I’d say I’m pretty feminine, ag-, yeah, I don’t know how to describe that, that’s a really hard question (.3) I’m stumped there
R: Um-hmm, you’re doing pretty well
P: Yeah?
R: Yeah
P: Okay, good (laughs)
R: (laughs)
P: I was starting to get nervous, like, I don’t think I’m answering this well
R: It’s a hard question, I mean, I think-
P: Yo-, you know, it’s very difficult because (.3) What is FEMinine, that’s a really hard question
R: Um-hmm
P: You know, I mean, I, I don’t know, I mean, like, I like to (.3) do my HAIR and I like to put MAKE-up on and I like to LOOK good all the time and (.3) [or at least as much as possible] (laughs) and, you know, I worry about my WEIGHT and I worry about whether I’m THIN enough and I think that’s all pretty feminine, my husband doesn’t seem to worry about whether he’s (.3) thin or fat or whatever
R: Um-hmm, um-hmm
P: And, ah, you know, I worry about, you know, EATING right and, ah, you know, all that kind of stuff so, you know, I guess, I guess that’s all part and parcel to it, you know, and (.3) all together with the oth-, I, I think the woman thing and the feminine thing just kind of go hand in hand, I don’t (.3) I don’t see them as really separate
R: Um-hmm (.11) Okay, I’m gonna turn this actually
P: Go ahead

[Tape removed, side B inserted]
R: Um, all right, actually, well actually so, like, in line, with, like being a woman and being feminine, like, how do you feel about raising a girl?
P: Oh, I feel really comfortable about it
R: I-, but, you know what? I felt really comfortable about raising a boy as well
R: Uh-huh
P: Um (.) I have a brother and my parents raised us, obviously, and, ah, so I felt like I was prepared to do either,
R: Um-hmm
P: you know, and actually, I, I actually leaned towards, um, hoping it was a boy a little bit because (.3) because of my disability I worry a little bit about how much stuff I’m going to be able to do
R: Um-hmm
P: and so I kind of thought having a boy might be easier with my husband, ‘cause, then, they’d do more BOY stuff
Appendix B; Transcript 3

R:  Um-hmm
948  P:  and I wouldn’t have to necessarily always be (laughs) you
949    know, involved, and now, we’re having a girl which is great,
950    too, because my mom was great and I probably will pattern
951    my mothering skills after her
952  R:  Um-hmm
953  P:  she was a great mom
954  R:  Um-hmm
955  P:  is a, she is a great mom, she’s not dead () and, ah (laughs)
956    and, so, I feel pretty comfortable, you know, do-, raising. I just
957    feel good about raising a girl, I don’t think we’ll have any
958    problem in, you know, with that
959  R:  Uh-huh
960  P:  so
961  R:  Uh-huh, can you say more about that, like, maybe differences
962    in, like, raising a girl versus a boy for you?
963  P:  Um () ((outward breath)) I, you know, I k-, it so much
964    depends on the girl, like I-, it’s gonna be hard to say ‘cause,
965    you know, what if she’s kind of a tomboy girl? Which would
966    be fine, you know
967  R:  Um-hmm
968  P:  Um () so, you know, what my idea is () could be really
969    different from her idea is (laughs) of what she wants to be but,
970    I mean, you know, I’m sure we’ll do all the stuff that, you
971    know, m-, my parents did, you know, get her involved, I
972    mean, but we’re pretty good, like, we, my husband and I both
973    like sports a lot, so
974  R:  Um-hmm
975  P:  I mean, I’m much more obviously a spectator than a
976    participant, but, so I don’t think, you know, if she wanted to
977    participate in sports and stuff we’d be in-, into that, you know,
978    but if she wanted to take ballet lessons, we’d be into that, too,
979    so
980  R:  Um-hmm
981  P:  so, I think, you know, now () I think my husband would have
982    a hard time if it was the other way around () now, if we were
983    having a boy () ballet lessons would not be in the cards
984  R:  Um-hmm
985  P:  I don’t, I don’t think so, anyways, ‘cause he’d be, like, are you
986    kidding? (laughs) so, I think there’s a little more stereotyping
987    with boys than there are with girls
988  R:  Um-hmm
989  P:  there seem to be more opportunities for girls to do () MORE
990    than boys to do more, you know, and I don’t think that I’m
991    totally aAGAINST that
992  R:  Uh-huh
993  P:  per se, but I, I just think, you know, if our girl wanted to play
994    soccer, now if she said she wanted to play football, I’d be,
995    like, no you’re not doing that, ‘cause () that’s a little
996    dangerous (laughs)
997  R:  Uh-huh
998  P:  but if she said s-, you know, she wanted to play volleyball or
999    () s-, I SWAM and my husband () played volleyball and so
1000  P:  () I think there’s a LOT more leeway for girls
1001  R:  Uh-huh
1002  P:  than there are th-, the other way around
Um-hmm, um-hmm

so (.) I think it’ll be EASier because there are so many more opportunities (.) for girls that and we’re pretty open to (.) pretty much anything as far as whatever she’d want to be

Um-huh

doing

Uh-huh

you know, so

What do you think about when you think about just raising a child, be it a boy or a girl, what do you want for her

Um

when she grows up or even

I, I really want

(xxxxx xxxxx xxxx?)

I, w-, well, I-, you know, first of all (.) I think, one of the most important things is (.) and one of the things that my husband and I are ABsolutely together on is that we inSIST that, you know, our child (.) be able to listen to people and make decisions and, on her own, like, I don’t like group think (laughs) you know, I want her to be able to THINK for herself

(xxxxx xxxxx xxxx?)

I hope she’ll be successful but success is, um, POPular

and make decisions and if those decisions aren’t, um, POPular

Well, that’s too bad, like, it’s still your-, you still have to make up your mind what you think, and, ah, we’re both (.) like that and we really want to make sure that, you know, she, she has that, and, um, you know, we’re, we’re conservative so the, ah, we hope that she would (laughs) you know, follow that as well and we’re very religious we, we have a (.) really good spiritual church and, and, ah, we would hope that she would be involved in that, you know, [being aware] that you can’t (.) make her do that so I don’t, I don’t know but (.) those are the things we hope for her, you know?

(xxxxx xxxxx xxxx?)

and I hope she’ll be successful but success is, um (.2) success is relative

and what is successful? I mean, I’m an administrative assistant and I feel successful and I don’t really have an ambition to be anything-, some great, you know, career, like, I don’t think career is being successful, so, to me successful is being, um (.2) good to people and it’s your personality and it’s your caring for others, and (.) those are the things that I would prefer that she have over y-, being ultra intelligent or (laughs) you know, some great doctor or whatever, although being a great doctor would be fine (laughs)

so, but I think for us that’s the thing, we, we just want her to be well-adjusted and, and um, hopeful about her future, and (.) um, able to make decisions (.) on her own we, you know, I don’t like, um (.) and I hope th-, I think for us that’s the thing that we’re both most nervous about is that we can help raise her to have those things and be that, and, and not be influenced necessarily by (.) a ton of other stuff, you know,
P: you know what I mean, because there’s so much now and the
Internet and the TV and, I mean, there’s just so much
bombarding your kid every day that we just want to make sure
that, you know, we’re, we’re being, we’re influencing her as
well and that she can, you know, look at everything and make
decisions and, you know, we’re kind of opposed to ah, the
everybody WINS thing, you know
R: Um-hmm
P: like with children, you know, “Who’s the winner?” well, there
IS a winner and it’s, it’s difficult and I think that for us, we
want to make sure that (.) she doesn’t come out of school with
this attitude like, everybody wins because sometimes you get a
job and, you don’t get the job (laughs)
R: Uh-huh
P: and I-
R: So, wait, could you, I don’t know if I understand that, what’s
the everybody wins attitude?
P: Um, I don’t know, I mean a lot of my girlfriends have kids in
school and it’s this whole, like, they have, they have a
PUMPkin carving contest and
R: (overlapping) Oh, okay
P: (overlapping) Everybody brings their pumpkin and, there is no
winner
R: (overlapping) Everybody gets a xxxx xxxx
P: (overlapping) Everybody gets a blue ribbon
R: Okay
P: And I think that’s really hard for children because I think
children innately know there’s a winner
R: Um-hmm
P: like, you know, I have my girlfriend, her little boy was, you
know, he’s like, “But who won mom?”
R: Um-hmm
P: and she’s like, “Oh, EVERYbody won,” you know and she
said and for DAYS she said, for like THREE days he kept
saying to he-, and finally she said he came to her and he said,
“You remember that pumpkin that had the snowman?” and
she’s like, “Yeah,” and he goes, “I think THAT one won,” he
had to FINISH it and I think children really need that and I
think in our, especially in our public schools we’re, we’re
lacking that, because we went away from that into this whole
thing and I don’t, I think it’s really bad for children
R: Um-hmm
P: so, WE’RE hoping that we can (.) make her understand that (.)
you know, sometimes you lose and when you lose (.) it’s
important that you learn how to lose (.) WELL
R: Um-hmm, do you know what made you think of that, I’m not
sure how we got (.) to that?
P: Um, you s-, were saying d-, did I have (.) ner-, was I nervous
about raising children?
R: Yeah, okay
P: and I, I want to make sure that those are the thing, main things
R: Okay
P: that I instill in her
R: Okay
P: that she, that those things, sorry we might have got a little off
track (laughs)
R: No, no, no, it’s FINE, I was just wondering how we got there
xxx
P: Yeah, it, ’cause I think those are the things we’re nervous
about is, is just being, you know, like, I’m not worried about
taking care of her basic needs and gettin’ her up and dressed
and, you know
R: Um-hmm
P: I worry a little bit about working, um, and spending enough
time, being able to spend enough time at home, I’d LOVE to
quit
R: Um-hmm
P: I’d quit in a heartbeat tomorrow if I,
R: Um-hmm
P: if I could afford it
R: Um-hmm
P: and, ah, and we’ve done a lot of, you know, juggling and
budget moving trying to see how we could do it
R: Um-hmm
P: and I probably may tr-, be able to try to work LESS
R: Um-hmm
P: but not totally (.) quit
R: Um-hmm
P: so (.) so you WORRY, like as a working mom that’s a
concern, you know, am I going to be able to do it all (laughs)
R: Um-hmm
P: you know, but other than that, those are the kind of concerns,
we’re mor-, mostly worried about (.) how she’ll turn out in the
END (laughs)
R: Um-hmm
P: Will she be a well adjusted adult? So, and I hope that she will
so
R: Okay, okay, um, when do you think back to your experience
growing up, did you expect that you would become a mother?
P: I think I always knew I, I wanted children
R: Uh-huh
P: You know, um, we, I didn’t get married until I was, um, thirty-
three, so (.) I, you know, I started wondering if I WOULD
have children ‘cause that’s getting’, you know, up there, and
then we’ve married and, and, ah, we decided at fir-, at first we
couldn’t afford to even really think about having a kid and
when we, ah, bought our house and everything (.) and then we
got a dog to make sure we could take care of a dog and do that
well (laughs)
R: Um-hmm
P: and we DID, we remember to feed her and take her out and
everything
R: Yeah
P: and plus it’s, it’s (.) it’s an interesting thing when you get a
dog because (.) it’s very tying down and y-, it really IS a
responsibility and we-e, so it really was, kind of, good
preparation for thinking about having a baby
R: Uh-huh
P: and, ah, and then we decided that we really wanted to try and
(.) then we were on a time limit because (.) I did-, I wanted to
do it before I was forty
R: Um-hmm
P: so,
R: Um-hmm
P: you know, but yeah, I think I always (. ) wanted to be a mom, or wanted to have children, but I think had I NOT gotten pregnant, I would’ve been okay with that, too,
R: Um-hmm
P: you know, especially at this age,
R: Um-hmm
P: I think if I would’ve, if we couldn’t have gotten pregnant, ’cause we had a window and we’re like, “If we’re not pregnant by this certain time (. ) then we’ll have to decide what we want to do,” maybe we would adopt or do something else
R: Um-hmm
P: Um, but, ah, since we did we didn’t have to worry about it (laughs)
R: Um-hmm
P: But I think I’d like to have more than one and I-, we may look into adopting a second one
R: Um-hmm
P: ‘cause I don’t know that I’d want to (. ) try to (. ) do it again
R: Um-hmm
P: since (. ) I kind of risked it this time with being close to forty
R: Um-hmm
P: and over forty would be a little nervewracking,
R: Um-hmm
P: so, I think, if we decide to have another one we would probably decide to do something else, some alternative
R: Um-hmm, um-hmm (.9) all right, and, um (. ) yeah, I wonder if you could talk a little bit more about things that have impacted your health care, in pregnancy or (. ) before then, [even, some you] had talked some about
P: (overlapping) Umm
R: having a disability and how hard it is to find (. )
P: Yeah
R: someone who’s sensitive to that
P: Yeah, that was probably the biggest thing, I don’t really know that, um, anything else has really impacted, I mean, my doctors, since they’ve been so supportive it’s been very helpful (. ) with, um (. ) preparation to get pregnant, like,
R: Um-hmm
P: my pri-, before I (. ) got anyone else, I just had my primary care physician, and he was GREAT,
R: Um-hmm
P: you know, and he gave me, I mean, we talked about it and decided whether he thought it would be even feasible to think about ‘cause, you know, if he said, “I think you’re crazy” and, you know, ‘cause I trust him a lot,
R: Um-hmm
P: and, um, and he knew my situation and I had been going to him for a long time, so, it wasn’t like he was uninformed or anything,
R: Um-hmm
P: and, ah, he suggeste-, he was great, he was like, “Yeah, do it,” (laughs) ye-, I was like, “Okay” (laughs) but, ah, he was great, too, about making sure that all of the medicine that HE had me on for maintenance stuff, like my blood pressure
R:  Um-hmm
P:  and everything would, um, would transfer over to, um, being,
   once I would get pregnant so I wouldn’t have to switch
R:  Okay, um-hmm
P:  So, so he was really great about that and
R:  Um-hmm
P:  most of my other stuff is pretty much just maintenance, like, I
   rarely go to the doctor any more than (. ) the regular person
R:  Um-hmm
P:  so, um, unless something’s wrong
R:  Um-hmm
P:  colds, flus, whatever
R:  Um-hmm
P:  so I can’t, I can’t say that there was anything else, really (. )
   OTHER than the fact that (. ) I’ve had to really look for a good
   doctor
R:  Um-hmm
P:  but once you find that, that’s great,
R:  Um-hmm
P:  I’m glad that I was able to find somebody (. ) pretty quick, and
   my pri-, and like, my primary care was just an accident, he, I
   wasn’t looking for anyone who had worked with women with
   disabilities, so
R:  Um-hmm
P:  he was just a (. ) he was just a great doctor (laughs) so and
R:  Just lucked out on that (laughs)
P:  (overlapping) Yeah, I did, I did (laughs) kind of did
R:  (overlapping) happens sometimes
P:  Yeah, I’ve referred him to a number of people ‘cause he is-s
   really good
R:  Uh-huh
P:  but, ah (.) you know, other than that I don’t think there’s been
   anything else (. ) um (. ) I have FREquent urinary tract
   infections and I did worry (. ) about that as far as getting
   pregnant
R:  Um-hmm
P:  um, if that would be an issue
R:  Um-hmm
P:  um (. ) which they do have me on, like, a, a low (. ) dose
R:  antibiotic all the time
R:  Um-hmm
P:  while I’m pregnant so that keeps that from happening and, um,
   it’s better to be on the antibiotic (. ) then it is to be off of it
R:  Um-hmm
P:  and take the chance, so, I’m on that as well, I feel like I take
   twenty-six pills a day
R:  Um-hmm
P:  but, that’s all right, I’m getting used to it (laughs)
R:  Um-hmm
P:  but, ah, OTHer than that I don’t think there’s been any other
   (. ) um, impacting things, you know, when I was younger, it
   was not well (. ) ah, discussed to have childr-, yo-, you know,
   that, it was kind of assumed that you wouldn’t have children
R:  Um-hmm
P: eh, you know, and that’s just (. ) normal, based on (. ) the
culture and how it was and, they didn’t know if spina bifida
children could have, even, have children, like,
R: Um-hmm
P: it was kind of a (. ) unknown kind of thing
R: Um-hmm
P: SO, I would have to say it was more negative when I was
younger (. ) but the advances in medicine have really (. )
changed (. ) that (. ) attitude
R: Um-hmm
P: and, um, and I’M really lucky as well because (. ) here, where I
work, um, everyone’s really supportive as well,
R: Uh-huh
P: so, that’s been really nice because, um, I actually am on a
listserv with disabled parents,
R: Um-hmm
P: and, um, a-, from all walks of life, and from all over the c-,
world actually, and it’s very interesting because they have
good tips, you know,
R: Um-hmm
P: and stuff, but they’ve had very bad experiences, a lot of them
R: Um-hmm
P: now a LOT of them are in wheelchairs or have other
disabilities but, um, have had very negative, not just from the
medical f-, community but, ah, people they work with,
strangers (laughs)
R: Umm
P: and I’ve not really HAD that much of a that, so, I’m really
lucky,
R: Um-hmm
P: you know, that I haven’t had that, but I think, I think it all
comes from that same thing that years ago (. ) you know,
disabled people were, you know, you wanted to put them
away, you know, you really didn’t want them involved in the
regular, you know, and (. ) you would probably understand that
same kind of concept (laughs)
R: Um-hmm
P: I mean, it’s, it’s a hard thing when you’re kind of the little
GROUP and they don’t really want you to be a part, and I
think that (. ) w-, women with disabilities got shoved into that
kind of category
R: Um-hmm
P: where it’s like, ‘cause people would rather not think about
that, you know, because then they have to face their own (. )
fear about it and I think that that’s what happened and so,
years ago, THAT’S what people did, it was like, “Oh, no, you
don’t want to have CHILdren,” you know, so (. ) they just sort
of shoved you aside
R: Um-hmm
P: and I think that, still, a lot of places they have to deal with that
(. ) living in a big city makes a difference
R: Um-hmm, um-hmm
P: a lot of these women like out (. ) you know, in rural areas and
that’s a much different thing,
R: Right
P: so
Appendix B; Transcript 3

R: Right, um-hmm (.3) all right, I think we’ve covered (.)
1338  everything I have, do you have anything else that you-
1339  P: No, it’s been, like I said, it’s been a pret-, it’s been a pretty
1340  good experience for me ((knocking at the door)) can you hold
1341  on one second?
1342  R: Yup ((tape turned off while Joanne gets the door))
1343  P: I think I’ve had a really good experience and, um, I think for
1344  me it’s different, too, with my disability because I’ve never
1345  really let my disability stop me from doing anything?
1346  R: Um-hmm
1347  P: so, if that’s your attitude, I think it’s much different
1348  R: Um-hmm
1349  P: you know, so (.) all in all, I’d say m-, my experiences have
1350  been really good with being pregnant, the doctors I’ve had
1351  have been great, the ultrasounds have all been good, th-, the
1352  people have been very great, um, I can’t really say I’ve had
1353  any bad, eh, pregnancy experiences
1354  R: Um-hmm
1355  P: so I’m
1356  R: Um-hmm
1357  P: pretty happy (laughs) with the way it’s going
1358  R: Um-hmm, good
1359  P: and I hope it continues, so (laughs) that’s good
1360  R: Right
1361  P: you know, it, it’s a little nervewracking, you know, I’m a little
1362  nervous about (. ) all the normal stuff that all moms are
1363  nervous about, deLIVering a baby is nervewracking, you
1364  know (. ) being PREGnant is fine but thinking about actually
1365  HAVING the baby (laughs) is (. ) a little nervewracking
1366  R: Um-hmm
1367  P: but (. ) the actual process of having a baby, I should say, I’m a
1368  little nervous about that, but other than that, I think that’s
1369  pretty standard.
1370  R: Um-hmm, um-hmm
1371  P: you know, for most moms
1372  R: Right
1373  P: and, um,
1374  R: Right
1375  P: so, hopefully, it’ll all (. ) PAN out in the end
1376  R: Um-hmm, um-hmm
1377  P: so (. ) I thought this was a pretty painless interview
1378  R: Good
1379  P: (laughs)
1380  R: (laughs) Do you have any questions for me?
1381  P: (laughs)
1382  R: Are they usually painful? (laughs)
1383  P: (laughs) No, really?
1384  R: Are they usually painful?
1385  P: Oh, no, I, I wasn’t sure how it would be, really,
1386  R: Yeah
1387  P: you know, you asked some very thought-provoking questions
1388  R: Um-hmm
1389  P: and I thought that was good
1390  R: Um-hmm
1391  P: and, did you feel like you got everything you needed?
R: YEAH, I did, I always, it always happens that I’ll go back and I’ll say, “Oh, why didn’t I ask THIS” and it’s always, but that’s okay because (overlapping) yeah, it happens (overlapping) that’s how it goes, you know? Yeah but that’s interesting, it will be interesting for me to see, like, and that will be part of my project, too, Yeah like, what were the places where I could have followed up but didn’t, what was going on there, and stuff, it’s all good, but yeah, I thought this was really great Great, glad you enjoyed it, Yeah, but, ah, I’ll turn this off Okay [After the interview, we talked a little more about the ultrasound as I was packing up. Joanne remarked: “And you do feel a connection” “To me, it wasn’t just a medical procedure, I guess it’s your first picture of your baby, it was very exciting that way” “I wouldn’t have thought to say anything about that because that was normal for me”]
questions - an expression of inquiry that invites or calls for a reply (in reference to my interview questions)
interview - a conversation in which facts or statements are elicited from another
questions (2)

stuff - unspecified material (in reference to my questions)
order - sequence or arrangement of successive things (in reference to interview); questions (2)

bit - to a small degree; somewhat (in reference to chronology of questions)
experiences - events or a series of events participated in or lived through
pregnancy - the condition of carrying offspring within the body
FETUS - in humans, the unborn young from the end of the eighth week after conception to the moment of birth

kind - rather; somewhat
knowledge - specific information about something (in reference to P’s not having knowledge of prior pregnancies)
precautions - caution practiced in advance; forethought or circumspection (in reference to birth control)
precautions (28)

November - the 11th month of the year in the Gregorian calendar
BABY - a very young child; an infant (in reference to P and boyfriend’s plan to have a baby)

months - a unit of time corresponding app. to one cycle of the moon's phases; abt. 30 days or 4 weeks; stuff (9)

December - the 12th month of the year in the Gregorian calendar

tests - a procedure for critical evaluation; a means of determining the presence, quality, or truth of something (modified by pregnancy (17))
months (39)
DOCTOR - a person trained in the healing arts and licensed to practice (in reference to a physician)
tests (46)

line*2 - a thin continuous mark (in reference to the line on the pregnancy test)
test (46)

New Year’s - the first day of a calendar year; the first day of January

week - a period of seven days (in reference to period of time when P first thought she might be pregnant)

January – the 1st month of the year in the Gregorian calendar

life - the interval of time between one's birth and the present (in reference to regularity of P’s menstrual cycle - “never been late in my life”)

test (46); line (56)

line (56)

weeks (65) (in reference to length of time that P and boyfriend planned to let pass before taking another pregnancy test)

way - a state or condition (in reference to the results of the follow-up pregnancy test)

manufacturer - a person, an enterprise, or an entity that manufactures something

period - A menstrual period

life - Human existence, relationships, or activity in general; normal - the usual or expected state, form, amount, or degree

stomach - the abdomen or belly

stomach (86)

changes - transformations or transitions from one state, condition, or phase to another; months (39)

first - the ordinal number matching the number one in a series (modified by March - the 3rd month of the year in the Gregorian calendar)

point - a specific moment in time

appointment - an arrangement to do something or meet someone at a particular time and place; weeks (65)

PHYSICIAN - a person licensed to practice medicine; a medical doctor; time - a number representing a specific point on a continuum; MIDWIFE - a person, usually a woman, who is trained to assist women in childbirth; Midwives – in reference to the midwives at the Midwife Center
Appendix C; Nouns in transcript 1

plan - a scheme, program, or method worked out beforehand for the accomplishment of an objective

plan (114)

months (41)

lot - a large extent, amount, or number (in reference to thought); thought - the act or an instance of deliberate or extended thinking; DOCTORS (53)

aversion - fixed, intense dislike; repugnance

HOMEOPATH - practitioner of homeopathy

medical care - professional treatment for illness or injury

DOCTOR (53) (in reference to contrast between a doctor and a midwife)

DOCTOR (53) (in reference to the homeopathic doctor that P saw growing up)

experiences (16) (in reference to “negative experiences” of doctors)

body - the entire material or physical structure of an organism, especially of a human or animal; life (68)

example – an illustrative instance

experience (16)

DOCTOR (53)

strep throat - an infection of the throat, often epidemic, caused by hemolytic streptococci and characterized by fever and inflammation of the tonsils

basis - an underlying circumstance or condition (“an annual basis”); February – the 2nd month of the year in the Gregorian calendar

DOCTOR (53); college - an institution of higher learning that grants the bachelor’s degree in liberal arts or science or both; strep throat (142)

February (144)

home - a place where one lives; a residence

couple - a few; several; days - the 24-hour period during which the earth completes one rotation on its axis

culture - an examination of the growing of microorganisms, tissue cells, or other living matter (in reference to diagnosis for strep throat)

strep throat (142)

couple (151); days (151)

strep throat (142)

thing - an act, deed, or work (in reference to “the ‘I told you so’ thing)

way - an individual or personal manner of behaving, acting, or doing

DOCTOR (53)

relationship - a particular type of connection existing between people related to or having dealings with each other

CHILD - a person between birth and puberty (in reference to P’s personal experience)

loss - the deficiency of an amount

SPECIALIST - a physician whose practice is limited to a particular branch of medicine or surgery, especially one who is certified by a board of physicians; mid-twenties - the time of life between 20 and 30

problem*2 - a state of difficulty that needs to be resolved
frustration - the condition that results when an impulse or an action is thwarted by an external or an internal force; life (68) entertainment - something that amuses, pleases, or diverts (used sarcastically: “I add this frustration to my life for my own entertainment (171-72)); type - a particular variety; a sort of things – circumstances; antibiotics - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi, bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms type (173); things (173) remedies - something, such as medicine or therapy, that relieves pain, cures disease, or corrects a disorder; lot (119) (in reference to doctors); DOCTORS (53)

experience (16)

thing (173) (modified by strep throat (142))
iodine - a poisonous halogen element having compounds used as germicides, antiseptics, and food supplements; throat - the portion of the digestive tract that lies between the rear of the mouth and the esophagus and includes the fauces and the pharynx care - attentive assistance or treatment to those in need (189) HOMEOPATH (122)
day (151)

M.D. - medical doctor
antibiotics (174)
erythromycin - an antibiotic obtained from a strain of the actinomycete
pregnancy (17)
house - a structure serving as a dwelling for one or more persons, especially for a family
BABY (36)
DOCTOR (53)

MIDWIVES (112)

law - a set of rules or principles dealing with a specific area of a legal system (modified by Pennsylvania - a state of the eastern United States); accreditation - the state of being supplied with credentials or authority; authorized (212) things (98) birth - the emergence and separation of offspring from the body of the mother (modified by home (150))
area - a roughly bounded part of the space on a surface; a region (modified by Pittsburgh - a city of southwest Pennsylvania) MIDWIVES (112)

state - one of the more or less internally autonomous territorial and political units composing a federation under a sovereign government
courses - education imparted in a series of lessons or class meetings
qualifications - qualities, abilities, or accomplishments that make a person suitable for a particular position
or task; LADY - a woman, especially when spoken of or to in a polite way
BABY (36) (in reference
to the delivery of a baby)
MIDWIFE (113)

PATIENT - one who receives medical attention, care, or treatment

DOCTOR (53)

BABY (36) (in reference to the position of the baby as breech; in the case of either an actual and/or
hypothetical situation)

intervention - interference so as to modify a process or situation; point (106)

place - an area with definite or indefinite boundaries
Midwives (113); balance - a harmonious or satisfying arrangement or proportion of parts or elements

bit - a small degree

pregnancy (17)

preparation - a preliminary measure that serves to make ready for something

bit (15)

fast - the act or practice of abstaining from or eating very little food; October - the 10th month of the year
in the Gregorian calendar; September - the 9th month of the year in the Gregorian calendar

basis (144)

body (131)

PEOPLE - living humans; days (151)

vitamins*2 - any of various fat-soluble or water-soluble organic substances essential in minute amounts for
normal growth and activity of the body and obtained naturally from plant and animal foods

prenatals - (abbr. for prenatal vitamins) vitamins taken before birth/during pregnancy

experiences (16); past - the time before the present; things (173)

kind (25)

PERSON (255)

PEOPLE (255)
situation - the combination of circumstances at a given moment; luck - the chance happening of fortunate
or adverse events

catastrophes - great, often sudden, calamities; complete failures; fiascos

scenarios - outlines or models of expected or supposed sequences of events

birth control – a contraceptive technique
Appendix C; Nouns in transcript 1

278
279
280  birth control (278)
281
282  type (173); thing (173)
283
284
285  bit - a brief amount of time
286
287
288
289
290
291  statistics - numerical datum (in reference to statistics on fertility)
292  fertility - the condition, quality, or degree of being Capable of initiating, sustaining, or supporting
293  reproduction
294
295
296
297
298  time - an interval separating two points on this continuum; a duration
299
300
301  answer - a spoken or written reply, as to a question; a correct reply (in response to my question)
302
303
304  preparation (246); MOTHER - a woman who conceives, gives birth to, or raises and nurtures a child (my
305  question is in reference to the two latter)   crib - a bed with high sides for a young child or baby
306  clothes - articles of dress; wearing apparel; garments
307  class - education imparted in a series of lessons or class meetings (“birthing class”); books - printed or
308  written literary works
309  ability - a natural or acquired skill or talent (in reference to mothering a child)
310
311  preparation (246)
312
313
314
315  cousins - relatives descended from a common ancestor, such as a grandparent, by two or more steps in a
316  diverging line   area (215)
317
318  family - a fundamental social group in society typically consisting of one or two parents and their children;
319  two or more people who share goals and values, have long-term commitments to one another, and reside
320  usually in the same dwelling place   lot (119); time - a nonspatial continuum in which events occur in
321  apparently irreversible succession from the past through the present to the future   KIDS - children
322
323
324  years - the period of time during which Earth completes a single revolution around the sun, consisting of
325  365 days, 5 hours, 49 minutes, and 12 seconds of mean solar time. In the Gregorian calendar the year
326  begins on January 1 and ends on December 31 and is divided into 12 months, 52 weeks, and 365 or 366
327  days  (326) normal - the usual or expected state, form, amount, or degree  (327) day cares - provision
328  of daytime training, supervision, recreation, and often medical services for children of preschool age, for
329  the disabled, or for the elderly  (328) PEOPLE (255)  (329) PEOPLE (255)
330
331
332  feelings - affective states of consciousness, such as that resulting from emotions, sentiments, or desires
Appendix C; Nouns in transcript 1

expectations - something expected; eager anticipation

BABY (36)

ability (310); BABY (36)

things (173); anxiety - a state of uneasiness and apprehension, as about future uncertainties;
BOYFRIEND - a favored male companion or sweetheart  CHILDREN (164)

ADULT - one who has attained maturity or legal age

DAUGHTER - one's female child

percent - a percentage or portion; time (299)

thing (158)

DAUGHTERS (343)

DAD - father; a man who begets or raises or nurtures a child; attention - observant consideration; notice

BABY (36)

home (150); MOTHER (305)

HALF-BROTHER - a brother by one parent, but not by both

type (173)

things (173); stress - a stimulus or circumstance causing mentally or emotionally disruptive or upsetting
condition occurring in response to adverse external influences; household - a domestic unit consisting of
the members of a family who live together

anxiety (338)

kind (25)

shift - a change from one person or configuration to another; dynamic - an interactive system or process, especially one involving competing or conflicting forces (modified by family (319))
pregnancy (17)

more*2 - a greater or additional quantity, number, degree, or amount

BOY - an immature or inexperienced man, especially a young man; building - something that is built, as
for human habitation; a structure   things (173)
dynamic (366); BOYFRIEND (339)

EX-WIFE - a woman who was formerly a particular man's wife

MOTHER (305)

FATHER – a man who begets or raises or nurtures a child

lot (119); behavior - the manner in which one behaves/conducts oneself

BOYS (371); school - an institution for the instruction of children or people

house (204); boundaries - something that indicates a border or limit

explosion - sudden, often vehement outburst

BABY (36)
Appendix C; Nouns in transcript 1

389 type (173); stuff - specific talk or actions
390
391 anxiety (338) law school - a graduate school offering study leading to a law degree
392 year (325)
393
394 month (41) (in reference to starting law school)
395
396 fourth - the ordinal number matching the number four in a series (modified by September (250))
397
398 months (41) (in reference to the duration of pregnancy)
399
400 months (41) (in reference to the duration of pregnancy)
401
402 math - use of mathematics; November (35); December (44)
403 months (41) (in reference to the duration of pregnancy)
404 months (41) (in reference to the duration of pregnancy)
405 weeks (65) (in reference to length of P’s gestation)
406 Friday - the sixth day of the week; months (41)
407 weeks (65)
408
409 months (41)
410
411 gestation - the period of development in the uterus from conception until birth; pregnancy
412
413 range - an amount or extent of variation
414 math (405); PEOPLE (255)
415
416 year (325)
417 school (381); kind (25)
418 year (325)
419 job - a position in which one is employed
420
421 lot (119); off-shore - located or based in a foreign country
422
423 year (325); school (381)
424 idea - a plan, scheme, or method; things (173)
425 BABY (36)
426
427 birth (213)
428 fibroid - a fibroma (a benign, usually enclosed neoplasm composed primarily of fibrous tissue) or myoma (a tumor composed of muscle tissue) occurring especially in the uterine wall
429 grapefruit - a large, round fruit, having a yellow rind and juicy, somewhat acid pulp (in reference to size of fibroid)
430 orange - a round fruit, having a sweetish, acidic juice (in reference to size of fibroid)
tumors - abnormal growths of tissue resulting from uncontrolled, progressive multiplication of cells and serving no physiological function; uterus - a hollow muscular organ located in the pelvic cavity of female mammals in which the fertilized egg implants and develops

pregnancy (17)

flow - to circulate (modified by blood - the fluid consisting of plasma, blood cells, and platelets that is circulated by the heart through the vertebrate vascular system, carrying oxygen and nutrients to and waste materials away from all body tissues; estrogen - any of several steroid hormones produced chiefly by the ovaries and responsible for promoting estrus and the development and maintenance of female secondary sex characteristics (461) supply - an amount available or sufficient for a given use; uterus (477); fibroid (438) (462) type (173) (463) variety - the quality or condition of being various or varied; pendulums - a body suspended from a fixed support so that it swings freely back and forth under the influence of gravity (464) wall - An investing part enclosing a cavity, chamber, or other anatomical unit issues - problems or concerns

wall (464)

ones - a single person, unit or thing; BABY - an unborn child; a fetus

growth - the process of growing, developing; way - space to proceed

type (173); stuff - matter of concern

lot (119); anxiety (338)

Internet - an interconnected system of networks that connects computers around the world via the TCP/IP protocol; information - a collection of facts or data hysterectomy - surgical removal of part or all of the uterus thing (98, 173)

appointment (108); March (104)

stuff (390) (modified by appointment (108))
tones - the quality or character of sound (modified by heart - the chambered muscular organ in vertebrates that pumps blood received from the veins into the arteries, thereby maintaining the flow of blood through the entire circulatory system) appointment (108)

Midwife Center - a local organization of midwives

center - a place where a particular activity or service is concentrated (modified by birth (213) (in reference to Midwife Center)) draw - an act of causing to flow forth (modified by blood (459)
law (210) (modified by state (220)); syphilis - a chronic infectious disease caused by a spirochete (Treponema pallidum), either transmitted by direct contact, usually in sexual intercourse, or passed from mother to child in utero, and progressing through three stages characterized respectively by local formation of chancres, ulcerous skin eruptions, and systemic infection leading to general paresis (501) kind (25) story - an account or recital of an event or a series of events syphilis (499) law (210); books - a set of prescribed standards or rules on which decisions are based years (325) blood work-up - one or more tests of the blood, esp. for detecting disease or drug use blood typing - the process of identifying an individual's blood group by serologic testing of a sample of blood; blood count - the determination of the number of red blood cells, white blood cells, and platelets in a definite volume of blood; type (173); testing - a procedure for critical evaluation; a means of determining the presence, quality, or truth of something pelvic - (abbr. of “pelvic exam”) an examination in which the cervix is checked pap smear - a test for cancer, especially of the female genital tract, in which a smear of exfoliated cells is specially stained and examined under a microscope for pathological changes blood pressure - the pressure exerted by the blood against the walls of the blood vessels, especially the arteries; breast exam - a procedure in which the breasts are examined for abnormal growths BABY (471) heartbeat - a single complete pulsation of the heart; Doppler - ultrasound that utilizes the Doppler effect to measure movement or flow in the body and esp. blood flow table - an article of furniture supported by one or more vertical legs and having a flat horizontal surface mound - a pile; a raised mass; belly - the stomach BOYFRIEND (339) BABY (36) (in reference to the fetus); tumor (446) TWINS - two offspring born at the same birth clue - a slight indication; fibroid (438) time (111) thing (158); Doppler (524) tone (491) (modified by heart (491)) MIDWIVES (112) LAURA - name of a specific midwife; hair (96) face - the surface of the front of the head from the top of the forehead to the base of the chin and from ear to ear heartbeat (524)
heartbeat (524)
facial expression - a gesture executed with the facial muscles

belly (529)

box - a container typically constructed with four sides perpendicular to the base and often having a lid or cover
kind (25)
heartbeat (524)
fibroid (438)
time (111)

place (237) (modified by ultrasound - the use of ultrasonic waves for diagnostic or therapeutic purposes, specifically to image an internal body structure, monitor a developing fetus, or generate localized deep heat to the tissues)
age - a length of time (in reference to gestational)
date - a particular point or period of time at which something happened or existed, or is expected to happen (in reference to due date); stuff (390)

ultrasound (570)

BOYFRIEND (339)
ultrasound (570)
day (151); fibroids (438)
ultrasound (570)
segue - an act or instance of moving smoothly and unhesitatingly from one state, condition, situation, or element to another

reason - the basis or motive for an action, decision, or conviction; kind (25)

part - a portion, division, piece, or segment of a whole

PHYSICIAN (111)

ultrasound (570)

MOM - mother; medical assistant - a person trained to assist medical professionals

OB - abbr. for obstetrician, a physician who specializes in obstetrics; years (325)

ultrasounds (570)

BABY (471)
heartbeat (524)

GIRL - an immature or inexperienced woman, especially a young woman

part (598); point (106); time (111); fibroid (438)

perspective - a mental view or outlook; grapefruit (441) (in reference to size of fibroid)

orange (443) (in reference to size of fibroid); BABY (36) (in reference to the fetus); size - the physical dimensions, proportions, magnitude, or extent of an object; picture - a visual representation or image

size (621); orange (443) (in reference to size of fibroid)

kind (25); GUYS - persons of either sex (in reference to fibroids)

bit (15)

masses - unified bodies of matter with no specific shape

ultrasounds (570)

time (111); years (325)

books (308)

ovums - the female reproductive cells or gametes of animals; eggs; stuff (390)

BABY (471)

rest - the part that is left over after something has been removed; remainder

bit (15)

form - a document with blanks for the insertion of details or information (modified by paperwork - work involving the handling of reports, letters, and forms) - insurance - coverage by a contract binding a party to indemnify another against specified loss in return for premiums paid - waiting room - a room, as in a railroad station or physician's office, for the use of people waiting

placenta previa – a condition in which the placenta is implanted in the lower segment of the uterus so that it is adjacent to or obstructs the internal opening of the cervix; form (650)

baby (471)

bit (15)

form (526)

GIRL (615); ultrasound (570)
Appendix C; Nouns in transcript 1

point (106); blood pressure (521)

roof – part of an idiom “go through the roof” - to grow, intensify, or rise to an enormous, often unexpected degree

DOCTOR (53)

SONOGRAPHER - a specialist in the use of ultrasound

SONOGRAPHER (674); DOCTOR (53)

fibroids (438)

lobes - a subdivision of a bodily organ or part bounded by fissures, connective tissue, or other structural boundaries; brain - the portion of the vertebrate central nervous system that is enclosed within the cranium, continuous with the spinal cord, and composed of gray matter and white matter. It is the primary center for the regulation and control of bodily activities, receiving and interpreting sensory impulses, and transmitting information to the muscles and body organs. It is also the seat of consciousness, thought, memory, and emotion

fibroid (438)

look - the act or instance of looking; pictures - visual representations or images painted, drawn, photographed, or otherwise rendered on a flat surface

BABY (471)

thing (158)

things (98); BABY (471)

heart (491)

pictures (700); type (173); thing (173)

couple (151)

DOCTOR (53)

DR. THOMAS - name of a specific doctor

jelly - something, such as a petroleum ointment, having the consistency of a soft, semisolid food substance;

thing - an inanimate object (modified by stick - something slender and often cylindrical in form)

fibroids (438)
Appendix C; Nouns in transcript 1

- middle: the middle part of the human body
- menstruation: the process or an instance of discharging the menses; kinds: a particular variety; a sort; things (173)
- cramps: spasmodic contractions of the uterus, such as those occurring during menstruation or labor, usually causing pain in the abdomen that may radiate to the lower back and thighs
- way: a manner or method of doing
- doctor (53)
- ultrasound (570)
- pain: an unpleasant sensation occurring in varying degrees of severity as a consequence of injury, disease, or emotional disorder; suffering or distress; GIRLFRIEND: a female friend; ton: a large extent, amount, or number (737) fibroids (438) lot (119)
- myectomies: excision of a portion of muscle; fibroids (438)
- uterus (447); LADY (224)
- hysterectomy (484)
- pain (736)
- fibroid (438)
- tumor (446)
- lot (119); details: individual parts or items; particulars
- order: a condition of logical or comprehensible arrangement among the separate elements of a group
- information (484)
- order*² (753)
- ultrasound (570)
- history: a chronological record of events, as of the life or development of a people or institution, often including an explanation of or commentary on those events; Down’s syndrome: a congenital disorder, caused by the presence of an extra 21st chromosome, in which the affected person has mild to moderate mental retardation, short stature, and a flattened facial profile (763) history (761) (764) Down’s syndrome (761)
- BABY (471)
- marker: a genetic marker; Down’s syndrome (761)
- tumors (446)
- fibroid (438); tumor (446); cancer: The pathological condition characterized by any of various malignant neoplasms characterized by the proliferation of anaplastic cells that tend to invade surrounding tissue and metastasize to new body sites
- word: a sound or a combination of sounds, or its representation in writing or printing, that symbolizes and communicates a meaning and may consist of a single morpheme or of a combination of morphemes
point (106); lot (119); questions (2)

fibroids (438); BABY (471)
pictures (700); BABY (471)

sense - something sound or reasonable

point (106)
real (784)
experience (16)

heartbeat (524)
conversation - the spoken exchange of thoughts, opinions, and feelings; talk
ultrasound (570); abortion - any of various procedures that result in termination of pregnancy and
expulsion of an embryo or of a fetus
weeks (65)

intention - a course of action that one intends to follow; abortion (797)

weeks (65)
CHILD (164) (in reference to the fetus)
WOMEN - adult female humans; abortion (797)

size (621); orange (443)

PERSON (255)
hand - the terminal part of the human arm located below the forearm, used for grasping and holding and
consisting of the wrist, palm, four fingers, and an opposable thumb
profile - a side view of an object or structure, especially of the human head

experience - the feeling of emotions and sensations as opposed to thinking; involvement in what is
happening rather than abstract reflection on an event; body (131)

lot (119); fibroids (438)

questions (2)

lot (119); questions (2); time (111)

questions (2)
morning - the first or early part of the day, lasting from midnight to noon or from sunrise to noon; Internet (483); information (484)
fibroids (438)
types (173)
locations - a place where something is or could be located; a site
things (98)
morning (837)
answers - a correct reply, as to a question; a solution, as to a problem
Midwives (113)
message - a usually short communication transmitted by words, signals, or other means from one person, station, or group to another
answers (848)
answers (848)
things (98)
anxiety (338)
location (842); fibroids (438); size (621)
placenta - a membranous vascular organ that develops in female mammals during pregnancy, lining the uterine wall and partially enveloping the fetus, to which it is attached by the umbilical cord
fibroid (438)
uterus (447); placenta (865); fibroid (438)
fibroid (438); BABY (471)
wall (466); placenta (865)
wall (466)
fact - knowledge or information based on real occurrences
cervix - a neck-shaped anatomical structure, such as the narrow outer end of the uterus; birth (213)
risk - the possibility of suffering harm or loss; danger
postpartum hemorrhaging - hemorrhage from the birth canal in excess of 500 milliliters during the first 24 hours after birth; risk (879)
DOCTOR (53); sonogram - an image, as of an unborn fetus or an internal body organ, produced by ultrasonography; anxiety (338)

fact - an event known to have happened or something known to have existed [I’m not satisfied with this definition]; knowledge (27); cancer (773)
deal - an indefinite quantity, extent, or degree; stuff (476); Internet (483)

people (255); freak - behave or cause to behave irrationally and uncontrollably, with enthusiasm, excitement, fear, or madness

sonogram (892)

Midwife Center (495); lot (119)

sonogram (892); sonogram (892); weeks (65)

time (111)

weeks (65); end - the point in time when an action, an event, or a phenomenon ceases or is completed

sex - either of the two divisions, designated female and male, of the property or quality by which organisms are classified as female or male on the basis of their reproductive organs and functions; BABY (36)

factor - one that actively contributes to an accomplishment, result, or process

name - a word or words by which an entity is designated and distinguished from others

way (732)

weeks (65)

ultrasound (570)

kind (25)

fibroids (438)

stuff (9)

GIRL (615)

time (111)

pictures (700)
part (598) (in reference to part’s of woman’s self); head - the seat of the faculty of reason; intelligence, intellect, or mind; time (299)

ultrasound (570)

birth defects - a physiological or structural abnormality that develops at or before birth and is present at the time of birth, especially as a result of faulty development, infection, heredity, or injury

ultrasound (570)

minutes - a unit of time equal to one sixtieth of an hour, or 60 seconds

hour - one of the 24 equal parts of a day; half - one of two equal parts that together constitute a whole

BABY (471); ball - a spherical object or entity

pictures (700); heartbeat (524)

time (111); heartbeat (524)

time (111)

conclusions - the result or outcome of an act or process

heartbeat (524)

pictures (700)

heart (491); calcification - hardening, as of tissue, by impregnation with calcium or calcium salts

markers (768) Down’s syndrome (761)

ultrasound (570); lengths - The measurement of the extent of something along its greatest dimension (modified by bone - the dense, semirigid, porous, calcified connective tissue forming the major portion of the skeleton of most vertebrates) (978) measurement - the dimension, quantity, or capacity determined by measuring (979) back - the part or area farthest from the front; neck - the part of the body joining the head to the shoulders or trunk (980) kinds (727); stuff (9)

likelihood - the state of being probable; probability

(98)

things (98)

DOCTOR (53); fibroids (438); size (621)

history (761); Down’s syndrome (762)

stuff (9)

amniocentesis - a procedure in which a small sample of amniotic fluid is drawn out of the uterus through a needle inserted in the abdomen. The fluid is then analyzed to detect genetic abnormalities in the fetus or to determine the sex of the fetus

BABY (471)
Appendix C; Nouns in transcript 1

1000 risk (879)
1001 risk (879)
1002
1003 test (49)
1004
1005
1006 DOCTOR (53)
1007
1008
1009
1010
1011 sex (920)
1012 moment - a specific point in time
1013
1014 ultrasound (570)
1015
1016 ultrasound (570)
1017 thing (718)
1018 screen - the phosphorescent surface on which an image is displayed, as on a television, computer monitor, or radar receiver
1019
1020
1021
1022 BOY - a male child
1023
1024
1025
1026 hopes - wishes or desires; sex (920)
1027 fetus (19)
1028 difference - the magnitude or degree by which one quantity differs from another of the same kind
1029 BOY (1023); DAUGHTER (343)
1030
1031 BOY (1023)
1032 GIRL - a female child
1033 BABY - the youngest member of a family or group
1034 GIRL (1033)
1035
1036
1037
1038 thing (173)
1039 trouble - difficulty; GIRL (1033); name (924)
1040
1041
1042 BOY (1023)
1043
1044 fibroids (438)
1045 ultrasound (570); pregnancy (17)
1046
1047
1048 point (106); time (299)
1049
1050
1051
1052 Midwives (113)
1053
1054
1055 PERSON (255)
BABY (471)

deal (903); comfort - a condition or feeling of pleasurable ease, well-being, and contentment; risks (879)

ultrasound (570)

assumption - the act of taking for granted; WOMEN (807)

ultrasound (570)

MOM (603); OB (605)

points (106); time (299)

ultrasound (570)

WOMEN (807)

ultrasounds (570)

3D - 3D ultrasound

people; office - a place in which business, clerical, or professional activities are conducted

reason (596); part (598)

ultrasound (570)

confirmation - something that confirms; verification

BABY (471)

Alien - a popular movie about creatures from outer space released in 1979 and inspiring several sequels

mind - the human consciousness that originates in the brain and is manifested especially in thought, perception, emotion, will, memory, and imagination; kinds (727); things (158); hormones - a substance, usually a peptide or steroid, produced by one tissue and conveyed by the bloodstream to another to effect physiological activity, such as growth or metabolism

things - entities, ideas, or qualities perceived, known, or thought to have their own existence

bucks - dollars; Tuesday - the third day of the week

Tuesday (1108); bucks (1108); hands (813)

breath - the air inhaled and exhaled in respiration (part of idiom: “I’m not gonna hold my breath”); type (173); thing (173) question (2)
Appendix C: Nouns in transcript 1

1112
1113
1114
1115
1116
1117
1118
1119
1120
1121
1122
1123
1124
1125
1126
1127
1128
1129
1130
1131
1132
1133
1134
1135
1136
1137
1138
1139
1140
1141
1142
1143
1144
1145
1146
1147
1148
1149
1150
1151
1152
1153
1154
1155
1156
1157
1158
1159
1160
1161
1162
1163
1164
1165
1166
1167

*ultrasound* (570)

**fifteenth** - the ordinal number matching the number 15 in a series (modified by **July** - the 7th month of the year in the Gregorian calendar)

**point** (106)

**weeks** (65)

**morning** (837)

**days** (151)

**coffee** - the beverage prepared from the seeds of any of various tropical African shrubs or trees of the genus Coffea

**coffee** (1127)

**ton** (737)

**BOYFRIEND** (339)

**coffee** (1127)

**mood** - inclination; disposition

**place** (237) (modified by **ultrasound** (570)); **bladder** - any of various distensible membranous sacs, such as the urinary bladder or the swim bladder, that serve as receptacles for fluid or gas

**ultrasound** (570)

**coffee** (1127); **bladder** (1134)

**hour** (958); **half** (958)

**time** (111) (modified by **appointment** (108))

**GIRL** (615)

**hour** (958); **half** (958)

**bladder** (1134)

**point** (106); **food** - material, usually of plant or animal origin, that contains or consists of essential body nutrients, such as carbohydrates, fats, proteins, vitamins, or minerals, and is ingested and assimilated by an organism to produce energy, stimulate growth, and maintain life

**room** - an area separated by walls or partitions from other similar parts of the structure or building in which it is located

**days** (151); **air conditioning** - an air conditioner or system of air conditioners

**bed** - a piece of furniture for reclining and sleeping, typically consisting of a flat, rectangular frame and a mattress resting on springs; **back** (980)

**WOMAN** (807)

**incline** - an inclined surface; a slope or gradient

**fibroids** (438); **weight** (101)

**vein** - any of the membranous tubes that form a branching system and carry blood to the heart

**levels** - a relative degree, as of achievement, intensity, or concentration (modified by **amniotic fluid** - the fluid within the amnion that surrounds the fetus and protects it from injury)
position - the arrangement of body parts; posture
combination - the result of combining; personalitites - the totality of qualities and traits, as of character or behavior, that are peculiar to a specific person; events - something that takes place; an occurrence

(1172) BABY (471) click - a brief, sharp sound
click (1173); fibroids (438); measurements (979); BABY (471)
couple (151); pockets - a pouch in an animal body; amniotic fluid (1167); kind (25)

room (1154)
pictures (622);
kind (727); stuff (9)

DOCTOR (53)

belly (529); stuff (9)

percentile - a value on a scale of one hundred that indicates the percent of a distribution that is equal to or below it

weight (101)

size (621)
weight (101)

birth (213); Midwife Center (495)

note - the sign of a particular quality or emotion

kind (25)
GIRL (615)

head - the uppermost or forwardmost part of the body of a vertebrate, containing the brain and the eyes, ears, nose, mouth, and jaws

wait - the act of waiting or the time spent waiting

ultrasound (570)

ultrasound (570)
ultrasound (570); minutes (956)

WOMAN (807)

position (1170)

position (1170); amniotic fluid (1167)

thing (718)

water - a clear, colorless, odorless, and tasteless liquid, H2O, essential for most plant and animal life and the most widely used of all solvents; kind (25)

experience (16); GIRL (615)

coffee (1127); factor (923)

coffee (1127); body temperature - temperature of the body; normally 98.6 F or 37 C in humans; usually measured to obtain a quick evaluation of a person's health
Appendix C; Nouns in transcript 1

bladder (1134)
time (111)
coffee (1127)
work - a job; employment; appointment (108)
reason (596)
emergency - a serious situation or occurrence that happens unexpectedly and demands immediate action
minutes (956)
things (173)

DOCTOR (53)
information (484); order (10)
one (471)
visit - the act or an instance of visiting a person, place, or thing
size (621)
circumcision - the surgical removal of part or all of the prepuce
type (173); stuff (390); fibroids (438)
size (621); thing (173)
fibroids (438)
worry - a source of nagging concern or uneasiness

uterus (447)
fact (877)
BABY (471); thing (173)
BABY (471); size (621)
pounds - unit of weight equal to 16 ounces; ounces - a unit of weight in the U.S. Customary System, an avoidupois unit equal to 437.5 grains
percentile (1186)

DOCTOR (53)
lot (119)
WOMEN (807); BABY (36)
ten-pounder - a ten-pound baby

pound (1265); BABY (36)

thing (98); WOMEN (807)
BABIES (36)
ones (471); point (106)
ultrasounds (570)
date (576)
date (576)
ultrasound (570)
fluid - a continuous, amorphous substance whose molecules move freely past one another and that has the tendency to assume the shape of its container; a liquid or gas
MIDWIVES (112); position (1179)
fibroids (438)
pictures (622); ultrasound (570)
hard copies - printed copies, especially of the output of a computer or word processor
first - the one coming, occurring, or ranking before or above all others; second - one that is next in order, place, time, or quality after the first
family (319); Pittsburgh (215)
upstairs - the part of a building above the ground floor; file - a container, such as a cabinet or folder, for keeping papers in order
point (106); Kinko’s - a store that specializes in office tasks such as printing, faxing and copying
things (158)
today - the present day, time, or age
relation - reference; regard; fibroids (438)
size (621); grapefruit (441)
size (621); orange (443)
time (111)
time (299)
pictures (622)
visual - a picture, chart, or other presentation that appeals to the sense of sight, used in promotion or for illustration or narration
Appendix C; Nouns in transcript 1

1336  ultrasound (570)
1337  two - the second in a set or sequence
1338
1339  BABY (471)
1340  fibroids (438)
1341  first - the beginning; the outset
1342  gas – flatulence
1343
1344  kind (25)
1345
1346  signs - something that suggests the presence or existence of a fact, condition, or quality
1347  point (106)
1348  point (106); linea nigra - the linea alba in pregnancy, which then becomes pigmented
1349
1350  linea nigra (1358)
1351
1352  breasts (99)
1353  areola - a small ring of color around a center portion, as about the nipple of the breast or the part of the iris
1354  surrounding the pupil of the eye
1355  lots (119)
1356  feet - the lower extremities of the vertebrate legs that are in direct contact with the ground in standing or
1357  walking; flipflops - backless, often foam rubber sandals held to the foot at the big toe by means of a thong;
1358  MEN - adult male humans; shoes – a durable covering for the human foot, made of leather or similar
1359  material with a rigid sole and heel, usually extending no higher than the ankle  (1370) rings - a small
1360  circular band, generally made of precious metal and often set with jewels, worn on the finger; wristwatch -
1361  a watch worn on a band that fastens about the wrist  (1372) belly (529)
1362  acne - an inflammatory disease of the sebaceous glands and hair follicles of the skin that is marked by the
1363  eruption of pimples or pustules, especially on the face; point (106)
1364  fun - a source of enjoyment, amusement, or pleasure
1365
1366  thing (173) (modified by nail (97) and (1378) hair (96)); WOMEN (807)
1367
1368  nausea - a feeling of sickness in the stomach characterized by an urge to vomit; aversion (121) (modified
1369  by food (1152))
1370
1371  smoke - the vaporous system made up of small particles of carbonaceous matter in the air, resulting mainly
1372  from the burning of organic material, such as wood or coal (modified by cigarette - a small roll of finely
1373  cut tobacco for smoking, enclosed in a wrapper of thin paper) sense - any of the faculties by which
1374  stimuli from outside or inside the body are received and felt, as the faculties of hearing, sight, smell, touch,
1375  taste, and equilibrium; smell - the sense by which odors are perceived; the olfactory sense  changes (90)
1376
1377  thing (173); point (106)
kind (25)

life (68)

three - the cardinal number equal to 2 + 1; four - the cardinal number equal to 3 + 1 (modified by size (621))

MOTHER (305); neurosis - any of various mental or emotional disorders involving symptoms such as insecurity, anxiety, depression, and irrational fears weight (101)

BABY (471)

things (98); stomach (86)

normal (83)

stretch marks - shiny lines on the skin of the abdomen, breasts, thighs, or buttocks that are often lighter than the surrounding skin and are caused by the stretching and weakening of elastic tissues as a result of pregnancy or obesity; things (1105) end – (part of idiom: “in the end”) eventually; ultimately

cosmetic surgery - surgery that modifies or improves the appearance of a physical feature, irregularity, or defect

part (598); life (83)

body (131)

stomach (86)

thing (158)

stretch marks (1416); point (106)

BABY (36)

complaint - an expression of pain, dissatisfaction, or resentment

minute (956)

majority - the greater number or part; a number more than half of the total; life (68)

way (79)

BABY (471)
choice - the act of choosing; selection

WOMEN (807)

sex - sexual intercourse

thought - the act or an instance of deliberate or extended thinking; a meditation

BABY (36); ultrasound (570)

measurements (978)

circumference - the size of something as given by the distance around it; head (1198); arms - upper limbs of the human body, connecting the hand and wrist to the shoulder; torso - the human body excluding the head and limbs; trunk (1465) picture (622)

measurements (978); first (1349)

second - one that is next in order, place, time, or quality after the first

minute (956)

centimeters - a unit of length equal to one hundredth of a meter

tape - a cassette tape

tape (1477)

size (621)

picture (622)

centimeters (1476); inches - A unit of length in the U.S. Customary and British Imperial systems, equal to 1/12 of a foot

head (946)

kind (25)

size (621)

worries (1258)

sex (1455)

sun - the radiant energy, especially heat and visible light, emitted by the sun; sunshine

sun (1499)

eyes - organs of vision or of light sensitivity
Appendix C; Nouns in transcript 1

1503  type (173); things (173); time - a period at one's disposal
1504  desire - wish or longing
1505  school (381)
1506  school (381)
1507  BABY (36); DAUGHTER (343)
1508  life (83); kind (25)
1509  relationship (162)
1510  type (173); things (173)
1511  BOYFRIEND (339)
1512  KIDS (322)
1513  body (131)
1514  ankles - the slender section of the leg immediately above the foot
1515  capillaries - the minute blood vessels that connect arterioles and venules; these blood vessels form an intricate network throughout the body for the interchange of various substances, such as oxygen and carbon dioxide, between blood and tissue cells
1516  lasers - any of several devices that convert incident electromagnetic radiation of mixed frequencies to discrete frequencies of highly amplified and coherent ultraviolet, visible, or infrared radiation; used in surgery to cut and dissolve tissue
1517  leg - a limb or an appendage of an animal, used for locomotion or support
1518  PERSON (255) (modified by detail (752))
1519  thing (158)
1520  kind (25)
1521  stuff (don’t know – out of context)
1522  conversation (796)
1523  outfit - a set of clothing, often with accessories
1524  outfit (1556)
1525  worry (1258)
clothes (307); clubs – nightclubs
skirt - the part of a garment, such as a dress or coat, that hangs freely from the waist down; halter-top - a garment for women that ties behind the neck and across the back, leaving the arms, shoulders, and back bare
shirt - a garment for the upper part of the body, typically having a collar, sleeves, and a front opening (modified by belly (529))

Goodwill - an institution set up to provide help to the needy

relationship (162)
BOYFRIEND (339); pregnancy (17)
DAUGHTER (343)
attention (349); lot (119); ways (159)
disharmony - something not in accord; a conflict
disharmony (1575)

projects - an undertaking requiring concerted effort; house (204)
nursery - a room or area in a household set apart for the use of children

fun (1376)
nursery (1579)

chore - a routine or minor duty or task; head (946)

lot (119); fun (1583)
time - frequently, repeatedly (used in the idiom “all the time”)
time (1588); joints - points of articulation between two or more bones, especially such a connection that allows motion

months (41)

partners - either of two persons dancing together

MEN (1368)

job - a specified duty or responsibility

arm (1464); joints (1589)

tension - mental, emotional, or nervous strain

comparisons - the act of comparing or the process of being compared; a statement or estimate of similarities and differences; EX-WIFE (375)

pregnancy (17)
years (325)
thing (173)
fibroids (438)
clothes (307)
normal (83); stress (360)
relationship (162)
sex (1455)
BABY (471)
fun (1583)
lot (119)

experience (16, 818)
MOTHER (305)
CHILDREN (164); point (106)
twenties - the time of life between 20 and 30
thirties - the time of life between 30 and 40
PERSON (255); twenties (1638)
things (173)
bit (15)
KIDS (322)
point (106)
birthday - the anniversary of one's birth
number*2 - a collection of things; several (part of idiom “a number of”); things (98)
KIDS (322)
KIDS (322)
thing (158)

CHILDREN (164)

popsicle - ice cream or water ice on a small wooden stick (slang for penis)
GUY - a man; a fellow; way (159)
feeling (333)
MOTHER (305); twenties (1638)
twenties (1638)
family (319); kind (25)
Appendix C; Nouns in transcript 1

1671 college (146)
1672 home (150); junior college - an educational institution offering a two-year course that is generally the equivalent of the first two years of a four-year undergraduate course; college (146)
1673 home (150); BOY (371); home (150)
1674 home (150)
1675 BOYFRIEND (339)
1676 seven-tenths - seven out of ten equal parts; mile - a unit of length equal to 5,280 feet or 1,760 yards (1,609 meters), used in the United States and other English-speaking countries
1677 GIRL (615); GIRLS (615); BOYS (371)
1678 stuff (390)
1679 GIRLS (615); home (150); BABIES (36)
1680 family (319)
1681 family (319)
1682 family (319)
1683 way (732)
1684 place (237)
1685 thing - a turn of events; a circumstance
1686 lot (119); tension (1607); PARENTS - one who begets, gives birth to, or nurtures and raises a child; years (325)
1687 PEOPLe (268); friends - a person whom one knows, likes, and trusts
1688 park - an area of land set aside for public use
1689 home - the place, such as a country or town, where one was born or has lived for a long period; PEOPLe (268) grade school - a school for young children; usually the first 6 or 8 grades
1690 thing (158)
1691 kind (25); bit (15)
ideas (433); **motherhood** - the state of being a mother

BABY (36)

motherhood (1728)

MOTHER (305)

PARENT (1703)

life (83)

fun (1583)

type (173); **stuff** (390)

PEOPLE (255)

KIDS (322)

idea - something, such as a thought or conception, that potentially or actually exists in the mind as a product of mental activity

control - authority or ability to manage or direct

life (83)

stuff (390)

WOMAN (807); **year** (325)

BOY (1023) (modified by BABY (36))

WOMAN (807)

KID (322)

tools - something regarded as necessary to the carrying out of one's occupation or profession

WOMAN (807)

sexes (920)

ideas (433); **concerns** - a troubled or anxious state of mind arising from solicitude or interest

things (173); BOY (1023); **GIRL** (1033)

point (106); things (173)

BOYS (1023)

**GIRLS** (1033)

reason (596)

rules - a regulating principle or precept; a regulation or bylaw governing procedure or conduct in a body, organization, institution, or proceeding
hardship - extreme privation; suffering; families (319)

rules (1782)

BROTHER - a male having the same parents as another or one parent in common with another
curfew - a regulation requiring certain or all people to leave the streets or be at home at a prescribed hour

things (158)

CHILD*2 (164)
pot - marijuana

SIBLING - one of two or more individuals having one or both parents in common; a brother or sister

privileges - special advantage, immunity, permission, right, or benefit granted to or enjoyed by an

individual, class, or caste

questions (2)

bit (15)

WOMAN (807)

feeling - intuitive awareness

WOMAN (807)
gender - the condition of being female or male; sex; sexual identity, especially in relation to society or
culture; parts - an organ, member, or other division of an organism GIRL*2 (1033)

question (2)

situation (270)

childhood - the time or state of being a child

MEN (1370)

house (204); WOMEN (807); KIDS (322)
dinner - the chief meal of the day, eaten in the evening or at midday

gender roles - the pattern of masculine or feminine behavior of an individual that is defined by a particular
culture and that is largely determined by a child's upbringing

WOMEN (807); lipstick - a small stick of waxy lip coloring enclosed in a cylindrical case

MEN (1370)
house (204)
times (111)

BOYFRIEND (339)
gender roles (1824)

community - a group of people living in the same locality

PEOPLE (255); years (325)
mall - a large, often enclosed shopping complex containing various stores, businesses, and restaurants

usually accessible by common passageways sweats - A sweatsuit; t-shirt - a short-sleeved, collarless

shirt
Appendix C; Nouns in transcript 1

jeans - pants made of jean, denim, or another durable fabric; shower - a bath in which the water is sprayed on the bather in fine streams from a showerhead, usually secured overhead; cologne - a scented liquid made of alcohol and various fragrant oils (1841) stuff (390); GIRL (615)

gender roles (1824)

GIRL (615)

masculinity - the quality or condition of being masculine

thing (158); mall (1837)

clothes (307)

times (111)

dresses - a one-piece outer garment for women or girls; hair (96); make-up - cosmetics applied especially to the face

type (173)

event (1172) (modified by dinner (1822)); joke - something said or done to evoke laughter or amusement

job (1602); GIRLFRIEND (737)

smile - a pleasant or favorable disposition or aspect; hair (96)

type (173); stuff (390)

fun (1583)

time (321)

idea (1749)

gym - athletic facility equipped for sports or physical training; make-up (1858)

PEOPLE (255)

MOM (603)

nails (97); stuff (390)

mind (1101)

house (204); dress (1858); Leave it to Beaver - sitcom popular in the 1950s

home (150)

WOMEN (807)

day - the period of light between dawn and nightfall; the interval from sunrise to sunset; HUSBAND - a man joined to a woman in marriage; a male spouse stuff (390)

kitchen - a room or an area equipped for preparing and cooking food

kitchen (1889)

hour (958); make-up (1858)

feeling (1807); femininity - the quality or condition of being feminine
pregnancy (17)
feelings (1807); femininity (1894)
feelings (1807); attractiveness - the quality of arousing interest; being attractive or something that attracts
attraction - the quality of attracting
types (173); ways (159); PEOPLE (255)
MEN (1370)
MEN (1370)
WOMEN (807)
MAN (1370); CHILD (164)
sense - a vague feeling or presentiment
grocery store - a marketplace where groceries are sold
day (151); bag BOY - person, often young and often presumed to be male, who bags groceries for customers at grocery stores; food (1152)
dinner (1822)
house (204)
PEOPLE (268)
belly (529)
PERSON (255)
bag BOY (1914)
today (1318)
questions (2)
questions (2)
gender (1809); health care - the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions
research - scholarly or scientific investigation or inquiry; WOMEN (807); issues (466) (modified by health - soundness, especially of body or mind; freedom from disease or abnormality MEN (1370)
day (151)
research (1945); breast cancer - cancer of the breast; one of the most common malignancies in women in the US; breast cancer (1949)
Appendix C; Nouns in transcript 1

1950  
1951  years (325)  
1952  breast cancer (1949)  
1953  
1954  
1955  
1956  kind (25); thing (173)  
1957  fact (877); fibroids (438)  
1958  
1959  WOMEN (807)  
1960  
1961  
1962  GUYS (625)  
1963  years (325)  
1964  thing (158); fibroids (438); hysterectomy (484)  
1965  
1966  head (946)  
1967  
1968  WOMEN (807); things (173)  
1969  
1970  drug company - a company that makes and sells pharmaceuticals  
1971  medical profession - the body of individuals who are qualified to practice medicine; sexes (920)  
1972  
1973  
1974  issue (466)  
1975  
1976  
1977  
1978  issue (466)  
1979  drug companies (1971)  
1980  factor (923); DOCTOR (53); treatment - administration or application of remedies to a patient for a disease or injury  
1981  
1982  commercials - a paid advertisement on television or radio  
1983  DOCTOR (53)  
1984  Prilosec - a trademark used for the drug omeprazole  
1985  
1986  Prilosec (1985); lot (119)  
1987  PEOPLE (255); DOCTOR (53); office (1089)  
1988  Prilosec (1985)  
1989  
1990  sample - a part of anything presented for inspection, or shown as evidence of the quality of the whole  
1991  
1992  
1993  head (946)  
1994  
1995  body (131)  
1996  
1997  
1998  
1999  KIDS (322); asthma - a chronic respiratory disease, often arising from allergies, that is characterized by sudden recurring attacks of labored breathing, chest constriction, and coughing; allergies - an abnormally high sensitivity to certain substances, such as pollens, foods, or microorganisms; PEOPLE (255) (2002); time (321)  
2000  
2001  
2002  
2003  GIRLFRIEND (737); antibiotic (174)  
2004  week (65)
Appendix C; Nouns in transcript 1

2005 kind (25); issue (467)
2006 immune system - the integrated body system of organs, tissues, cells, and cell products such as antibodies that differentiates self from nonself and neutralizes potentially pathogenic organisms or substances
2007 bit (15); family (319)
2008 medicine - the science of diagnosing, treating, or preventing disease and other damage to the body or mind
2009 kind (25)
2010 perception - insight, intuition, or knowledge gained by perceiving; DOCTORS (53)
2011 MOM (603); DOCTOR (53)
2012 M.D. (197)
2013 DOCTORS (53)
2014 GRANDMOTHER - the mother of one's father or mother
2015 witches' brew - a potent or fearsome mixture; stove - an apparatus in which electricity or a fuel is used to furnish heat, as for cooking or warmth
2016
2017 stuff (9)
2018 DOCTOR (53)
2019 years (325)
2020 stuff (9)
2021 switch - a transference or shift
2022 DOCTOR (53); MOM (603)
2023 GUY (1667)
2024 stuff (9)
2025 first (1349)
2026 head (946)
2027 things (718); pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing tongue - the fleshy, movable, muscular organ, attached in most vertebrates to the floor of the mouth, that is the principal organ of taste, an aid in chewing and swallowing, and, in humans, an important organ of speech KID (322)
2028
2029 stuff (9)
2030
2031 DOCTOR (53)
2032 years (325)
2033 stuff (9)
2034 switch - a transference or shift
2035 DOCTOR (53); MOM (603)
2036 GUY (1667)
2037 stuff (9)
2038 first (1349)
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
Appendix C; Nouns in transcript 1

2061 DOCTORS (53)
2062
2063 DOCTOR (53)
2064
2065 pregnancy (17)
2066 pregnancy (17)
2067
2068 time (111); DOCTOR (53)
2069 pregnancy (17); college (146)
2070
2071 years*2 (325)
2072
2073 value - worth in usefulness or importance to the possessor; utility or merit
2074
2075
2076
2077 family*2 (319)
2078 tradition - a mode of thought or behavior followed by a people continuously from generation to
2079 generation; a custom or usage; MOM (603)
2080 PHYSICIAN (111)
2081
2082 GRANDMOTHER (2022)
2083
2084 medicine (2011)
2085 old wives’ tales - superstitious belief or story belonging to traditional folklore
2086 WOMEN (807); years (325); mud - wet, sticky, soft earth, as on the banks of a river; bee sting - a sting
2087 inflicted by a bee type (173); thing (158)
2088
2089 MOM (603); type (173)
2090 thing (173)
2091
2092 gender (1809); health care (1941)
2093 factors (923)
2094 individual - a person distinguished from others by a special quality; race - a local geographic or global
2095 human population distinguished as a more or less distinct group by genetically transmitted physical
2096 characteristics; sexual orientation - the direction of one's sexual interest toward members of the same,
2097 opposite, or both sexes (2095) socioeconomic status - one’s position relative to that of others in regard
2098 to social and economic factors; health care (1941) pregnancy (17)
2099 DOCTORS (53)
2099 FEMALES - a woman or girl
2100
2101 MALE - a man or boy
2102
2103
2104 fact (877)
2105 health plan - health insurance; insurance against expenses incurred through illness of the insured
2106 co-pay - a copayment; a fixed fee that subscribers to a medical plan must pay for their use of specific
2107 medical services covered by the plan; deductible - a clause in an insurance policy that exempts the insurer
2108 from paying an initial specified amount in the event that the insured sustains a loss; thing (718)
2109 (2109) health care (1941) clinic - a facility, often associated with a hospital or medical school, that is
2110 devoted to the diagnosis and care of outpatients PERSON (255)
2111
2112 edge - a margin of superiority; an advantage
2113 PROVIDER - one that makes something, such as a service, available
2114 childhood (1819); HOMOPATH (122)
2115 impact - the effect or impression of one thing on another; stuff (9)
trials - an instance of the act or process of testing, trying, or putting to the proof as part of a series of tests or experiments

Echinacea - the roots, seeds, or other parts of any of several coneflowers of the genus Echinacea, used in herbal medicine; thing (718)

head (946)

antibiotics (174)

head (946)

reason (596)

strep test - test for an infection of the throat, often epidemic, caused by hemolytic streptococci and characterized by fever and inflammation of the tonsils (modified by Group b - the Lancefield group of usually beta-hemolytic streptococci that comprises all strains of a species of the genus Streptococcus (S. agalactiae) and that includes the causative agents of certain infections (as septicemia, pneumonia, and meningitis) especially of newborn infants) (2138) strep (2135) (modified by Group b (2136)) (2139) strep (2135) (modified by Group b (2136))

BABY (36)

risks (879)

antibiotics (174)

thoughts (119)

questions (2)

chance - an opportunity

ultrasounds (570)

experience (16)

heartbeat (524)

note (1194)
questions - an expression of inquiry that invites or calls for a reply
experience - events or a series of events participated in or lived through; pregnancy - the condition of carrying offspring within the body questions (1); experience (2); DOCTORS - a person trained in the healing arts and licensed to practice (in reference to a physician); ultrasounds - the use of ultrasonic waves for diagnostic or therapeutic purposes, specifically to image an internal body structure, monitor a developing fetus, or generate localized deep heat to the tissues (5) questions (1) pregnancy (2)

FETUS - in humans, the unborn young from the end of the eighth week after conception to the moment of birth artificial insemination - introduction of semen into the vagina or uterus without sexual contact
bit - to a small degree; somewhat
process - a series of actions, changes, or functions bringing about a result

hospital - an institution that provides medical, surgical, or psychiatric care and treatment for the sick or the injured; Center for Reproductive Endocrinology and Fertility - group in Pittsburgh that specializes in women’s reproductive issues

history - an established record or pattern of behavior; endometriosis - a condition, usually resulting in pain and dysmenorrhea, that is characterized by the abnormal occurrence of functional endometrial tissue outside the uterus tests - a procedure for critical evaluation; a means of determining the presence, quality, or truth of something
cysts - an abnormal membranous sac containing a gaseous, liquid, or semisolid substance; ovaries - the usually paired female or hermaphroditic reproductive organ that produces ova and, in vertebrates, estrogen and progesterone (23) years - the period of time during which Earth completes a single revolution around the sun, consisting of 365 days, 5 hours, 49 minutes, and 12 seconds of mean solar time. In the Gregorian calendar the year begins on January 1 and ends on December 31 and is divided into 12 months, 52 weeks, and 365 or 366 days (25) concern - a troubled or anxious state of mind arising from solicitude or interest tests (19)
ultrasound (3)

ultrasound (3); endometriosis (17)

ultrasounds (3); PEOPLE - a living human(s)
tests (19)

DOCTOR (3); DR. MEDEIROS - name of a specific doctor
DOCTOR (3)
staff - the personnel who carry out a specific enterprise
environment - the totality of surrounding conditions
couples - two people united, as by betrothal or marriage
donor - one that contributes something (in this case, sperm)
Reproductive Services - name of an agency concerned with fertility services
fact - knowledge or information based on real occurrences
identity - the distinct personality of an individual regarded as a persisting entity; individuality; CHILD - a son or daughter; an offspring

criteria - a standard, rule, or test on which a judgment or decision can be based; PARTNER - a person, other than a spouse, with whom one cohabits; often used to describe the spouse-equivalents of same-sex couples; the term has been shortened from domestic partner (52) lot*2 - a large extent, amount, or number (53) characteristics - a feature that helps to identify, tell apart, or describe recognizably; a distinguishing mark or trait; stuff - unspecified material; GUY - a man; a fellow hair - any of the
Appendix C; Nouns in transcript 2

368

cylindrical, keratinized, often pigmented filaments characteristically growing from the epidermis of a mammal; freckles - a small brownish spot on the skin, often turning darker or increasing in number upon exposure to the sun (56) hair (55); freckles (55) rugby*2 - a game played by two teams of 15 players each on a rectangular field 110 yards long with goal lines and goal posts at either end, the object being to run with an oval ball across the opponent's goal line or kick it through the upper portion of the goal posts, with forward passing and time-outs not permitted criteria*2 (51)

feet - a unit of length in the U.S. Customary and British Imperial systems equal to 12 inches (0.3048 meter)

quirks - a peculiarity of behavior; an idiosyncrasy

eugenics - a science that deals with the improvement (as by control of human mating) of hereditary qualities of a race or breed
tests (19)

worrying - a source of nagging concern or uneasiness

month - a unit of time corresponding approximately to one cycle of the moon's phases, or about 30 days or 4 weeks

trials - an effort or attempt

months (69); month (69)

days - the 24-hour period during which the earth completes one rotation on its axis

aura - a distinctive but intangible quality that seems to surround a person or thing; atmosphere

Center for Reproductive Endocrinology (14)
cog - a tenon projecting from a wooden beam designed to fit into an opening in another beam to form a joint; wheel - a solid disk or a rigid circular ring connected by spokes to a hub, designed to turn around an axle passed through the center (85) checklists - a list of items to be noted, checked, or remembered; lists - a series of names, words, or other items written, printed, or imagined one after the other (87) aura (80)

BABY - an unborn child; a fetus; BABIES (88)

first - the beginning; the outset

things - an act, deed, or work

lots (52); tests (19)
days (78)
days (78); period - a menstrual period

cycle - an interval of time during which a characteristic, often regularly repeated event or sequence of events occurs

levels - a relative degree, as of achievement, intensity, or concentration (modified by hormone - a substance, usually a peptide or steroid, produced by one tissue and conveyed by the bloodstream to another to effect physiological activity, such as growth or metabolism); stuff (55)
night - the period between sunset and sunrise, especially the hours of darkness

urine - the waste product secreted by the kidneys that in mammals is a yellow to amber-colored, slightly acid fluid discharged from the body through the urethra; morning - the first or early part of the day, lasting from midnight to noon or from sunrise to noon sticks - something slender and often cylindrical in form
Appendix C; Nouns in transcript 2

period - an interval of time characterized by the occurrence of a certain condition, event, or phenomenon
February - the second month of the year in the Gregorian calendar
June - the sixth month of the year in the Gregorian calendar
time - an interval separating two points on a continuum; a duration
months (69)
years (23)
question (1)
years (23)

Pittsburgh - a city of southwest Pennsylvania
years (23)
place - an area with definite or indefinite boundaries; a portion of space; family - a fundamental social
group in society typically consisting of one or two parents and their children
house - a structure serving as a dwelling for one or more persons, especially for a family; years (23)

January - the first month of the year in the Gregorian calendar; house (130)
school district - a geographic district, the public schools of which are administered together; time - a
number representing a specific point on a continuum, reckoned in hours and minutes
discussion - consideration of a subject by a group; an earnest conversation; one - a single person or thing; a
unit CHILD - an unborn infant; a fetus
time (118)

APRIL - P’s partner; idea - something, such as a thought or conception, that potentially or actually exists
in the mind as a product of mental activity link - a connecting element; a tie or bond
one (136)
pregnancy (2); childbirth - the human act or process of giving birth; parturition

morning sickness - nausea and vomiting upon rising in the morning, especially during early pregnancy
month (69)
decision - the act of reaching a conclusion or making up one's mind

week - a period of seven days
week (153)
ultrasounds (4)
pregnancy (2)

DR. MEDEIROS (38); office - a place in which business, clerical, or professional activities are conducted
PEOPLE (34); lots (52); problems - a situation, matter, or person that presents perplexity or difficulty

pregnancy (2)
sort - somewhat; rather (part of idiom, “sort of”)
Appendix C; Nouns in transcript 2

- **treatment** - administration or application of remedies to a patient or for a disease or injury; medicinal or surgical management; therapy

- **ultrasound (4); week (153)**

- **BABY (88); sac - a pouch or pouchlike structure in a plant or an animal, sometimes filled with fluid**

- **place (128)**

- **births - the circumstances or conditions relating to an event, as its time or location**

- **ultrasounds (4)**

- **one (136)**

- **week (153)**

- **DOCTOR (3)**

- **one (136); week (153)**

- **DR. MEDEIROS (38); office (161)**

- **OB - abbr. for obstetrician, a physician who specializes in obstetrics; heartbeat - a single complete pulsation of the heart**

- **heartbeat (187); week*2 (153)**

- **OB (187)**

- **DOCTOR (3)**

- **OB (187)**

- **preparation - a preliminary measure that serves to make ready for something**

- **MOTHER - a woman who conceives, gives birth to, or raises and nurtures a child**

- **house (130); school district (133)**

- **library - a place in which literary and artistic materials, such as books, periodicals, newspapers, pamphlets, prints, records, and tapes, are kept for reading, reference, or lending; APRIL (140); LIBRARIAN - a person who is a specialist in library work**

- **books - a printed or written literary work**

- **FRIENDS - a person whom one knows, likes, and trusts; PARENTS - one who begets, gives birth to, or nurtures and raises a child; a father or mother meetings - an assembly or gathering of people, as for a business, social, or religious purpose (modified by FLO - abbr. for Families Like Ours, a network of lesbian parents in the Pittsburgh area)**

- **community - a group viewed as forming a distinct segment of society; PARENTS (207)**

- **work - physical or mental effort or activity directed toward the production or accomplishment of something**

- **APRIL (140); attorney - a person legally appointed by another to act as his or her agent in the transaction of business, specifically one qualified and licensed to act for plaintiffs and defendants in legal proceedings**

- **names - a word or words by which an entity is designated and distinguished from others**

- **papers - an official document (modified by guardianship - one who is legally responsible for the care and management of the person or property of an incompetent or a minor) adoption - the act of adopting, or state of being adopted; voluntary acceptance of a child of other parents to be the same as one's own child**

- **prep – abbr. for preparation (196)**
first (91)
books (205); week (153)
week (153); sort (165); week (153)
lima bean - the seed of the any of several varieties of a tropical American plant (Phaseolus limensis) (in reference to the fetus)
books (205)
APRIL (140)

work (211)
time (133)

FAMILIES (128)

question (1)
complications - a secondary disease, an accident, or a negative reaction occurring during the course of an illness (pregnancy) and usually aggravating the illness (pregnancy)
work (211); morning sickness (147)

questions (1)
care - attentive assistance or treatment to those in need

PHYSICIAN - a person licensed to practice medicine; a medical doctor

OB/GYN – abbr. for obstetrician (187)/gynecologist, a physician specializing in gynecology;
SPECIALIST - a physician whose practice is limited to a particular branch of medicine or surgery, especially one who is certified by a board of physicians
(256) OB (187); years (23);
(257) GYNECOLOGIST - a physician specializing in gynecology
DR. MEDEIROS (38); office (161)

PHYSICIANS (253)

OB (187)
surgery*2 - a surgical operation or procedure, especially one involving the removal or replacement of a diseased organ or tissue
SURGEON - a physician specializing in surgery
object - something inanimate; in opposition to something that is living
surgery (264)
years (23)
years (23)
cysts (22); ovaries (22)
lot (52); pain - suffering or distress

DOCTOR (3)
Appendix C; Nouns in transcript 2

276 dosage - the amount of a therapeutic agent; hormones - a synthetic compound that acts like a hormone in
277 the body
278 FRIEND (207)
279 DR. SCHWARTZ - the name of a specific doctor
280 GYNECOLOGIST (257)
281 minutes - a unit of time equal to one sixtieth of an hour, or 60 seconds
282 hormones (276)
283 mood - a state of mind or emotion; time (118)
284
285 lot (52); time (118)
286
287 dosage (276); hormones (276)
288 couple - a few; several; days (78)
289
290 HMOs - abbr. for Health Maintenance Organization, group insurance that entitles members to services of
291 participating hospitals and clinics and physicians; while - a period of time
292 relationship - a particular type of connection existing between people related to or having dealings with
293 each other; PHYSICIAN (253)
294 DR. MEDEIROS (38)
295 Clinic - abbr. for Center for Reproductive Endocrinology and Fertility (14)
296 staff (40)
297
decisions (149)
298
299 relationship (302) (modified by business - a specific occupation or pursuit)
300 business (312)
301
302 decision (149); ultrasound (4)
303 part - a portion, division, piece, or segment of a whole; procedure - a manner of proceeding; a way of
304 performing or effecting something part (318); procedure (318)
305 problems (162); cysts (22)
306
307 part (318); procedure (318)
308 part (318)
309 procedure (318)
310 terms - as measured or indicated by (part of idiom, “in terms of”); artificial insemination (9)
311
312 part (318); procedure (318)
313 ultrasound (4)
314
315 PEOPLE (34)
316 ultrasound (4)

Appendix C; Nouns in transcript 2

weeks (153)

weeks (153)

place (128)

experience (2)

experiences (2)

lot (52); ultrasounds (4); lot (52); ultrasounds (4)

PEOPLE (34)

two - the second in a set or sequence; office (161)

PERSON (34)

forever - a seemingly very long time

lot (52); confidence - trust or faith in a person or thing

time (133); heartbeat (187)

APRIL (140)

one (136); town - a city

heartbeat (187)

ones (136)

things (96)

difference - a noticeable change or effect; experiences (2)

things (96)

PEOPLE (34)

ultrasound (4)

experience - active participation in events or activities, leading to the accumulation of knowledge or skill;

expectations - belief about (or mental picture of) the future terms (325); ultrasounds (4)
FETUS - in humans, the unborn young from the end of the eighth week after conception to the moment of birth, as distinguished from the earlier embryo

time (118)

worst - that which is most bad or evil; the most severe, pernicious, calamitous, or wicked state or degree

bit (10)

words - discourse or talk; speech

heartbeat (187)
one (136)

lot (53); fear - a feeling of agitation and anxiety caused by the presence or imminence of danger; a feeling of disquiet or apprehension

miscarriage - the premature expulsion of a nonviable fetus from the uterus

heartbeat (187)

heartbeat (187)
miscarriage (408)
hurdle - an obstacle or difficulty to be overcome

thing (96)

heartbeat (187)

blob - a soft, amorphous mass

blob (422)
movement - the act or an instance of moving; a change in place or position

movement (425); heartbeat (187)
sound - vibrations transmitted through an elastic solid or a liquid or gas, with frequencies in the approximate range of 20 to 20,000 hertz, capable of being detected by human organs of hearing

heartbeat (187)
one (136)

one (136)

lot (53)

sex - the property or quality by which organisms are classified as female or male on the basis of their reproductive organs and functions; BABY (88)
Appendix C; Nouns in transcript 2

443  sex (440)
444
445  hopes - something that is hoped for or desired; PARTNER (51)
446
447  one (136)
448
449  decision (149); sex (440)
450
451  surprise - something, such as an unexpected encounter, event, or gift, that surprises
452
453  things - a piece of information
454
455  thoughts - a product of thinking; BABY - a very young child; an infant
456
457  BOY - a male child; GIRL - a female child
458  differences - the quality or condition of being unlike or dissimilar; thoughts (458)
459
460  couple (43) (modified by LESBIAN - a woman whose sexual orientation is to women)
461  difference (460)
462  APRIL (140); BOY (459)
463  GIRL (459)
464
465  kind - rather, somewhat; things (96)
466
467  Barbie-lover - person who loves Barbie dolls
468
469  COUSINS - a relative descended from a common ancestor, such as a grandparent, by two or more steps in
470  a diverging line  summers - the usually warmest season of the year, occurring between spring and
471  autumn and constituting June, July, and August in the Northern Hemisphere, or, as calculated
472  astronomically, extending from the summer solstice to the autumnal equinox  477 BOYS (459); GIRLS
473  (459)
474  concerns (25)
475
476  neighbors*2 - one who lives near or next to another
477  couple (43) (modified by lesbian (462))  SON - one's male child
478
479  hormones (103)
480  time - an interval, especially a span of years, marked by similar events, conditions, or phenomena
481
482  experience (2)
483  ultrasounds (4)
484  DOCTOR (3)
485
486  times (133)
487
488  ultrasound (4); ultrasound (4) (modified by pregnancy (2))
489
490
491
492
493
494
495
496
497
498
ultrasounds (4)
cysts (22)
time (133)
thing (96)
bit (10); questions (1)
WOMAN - an adult female human

WOMAN (518); parts - an organ, member, or other division of an organism
WOMAN (518)

traits - a distinguishing feature, as of a person's character
place (128); WOMEN (518); strength - the state, property, or quality of being strong
WOMEN (518); thing - a particular state of affairs; a situation
sort (165)

family (128)
WOMEN (158)

gender dysphoria - a feeling of incongruence between one’s feelings of one’s gender and one’s sex organs
kind (468); feelings - an affective state of consciousness, such as that resulting from emotions, sentiments,
or desires word - a sound or a combination of sounds, or its representation in writing or printing,
that symbolizes and communicates a meaning and may consist of a single morpheme or of a combination of
morphemes; question (1)

examples - one that is representative of a group as a whole
make-up - cosmetics applied especially to the face; hair (55)
shoes - a durable covering for the human foot, made of leather or similar material with a rigid sole and
heel, usually extending no higher than the ankle
words (542)

words (542)

sense - an intuitive or acquired perception or ability to estimate

energy - strength of expression; force of utterance; power to impress the mind and arouse the feelings; life; spirit

sort (165)

second - a brief interval of time; a moment

SISTERS - a female having the same parents as another or one parent in common with another; LESBIAN

PARTNER (51)

FRIENDS (207)

time (486); CHILDREN (48)

SISTER (591); PARTNER (207); energy (572)

NIECE - the daughter of one's brother or sister or of the brother or sister of one's spouse

energy - exertion of vigor or power; CHILDREN (48)

things (455); make-up (552)

energy (572)

personality - the pattern of collective character, behavioral, temperamental, emotional, and mental traits of a person

GRANDMA – grandmother

things (96)

inside - inward character, perceptions, or feelings
Appendix C; Nouns in transcript 2

611 612 613 614 lot (52)
615 616 617 618 PEOPLE (34); outside - outward aspect or appearance
619 inside (610)
620 621 622 623 attributes*2 - a quality or characteristic inherent in or ascribed to someone or something
624 625 626 627 kind (468); BOY (459)
628 629 630 process (11)
631 hormones (276)
632 surgery (264); breast - either of two milk-secreting, glandular organs on the chest of a woman; the human
633 mammary gland surgery (264)
634 635 minutes (282); tape - audiotape, a relatively narrow magnetic tape used to record sound for subsequent
636 playback
637 638 experiences (2)
639 MOTHER (197)
640 641 642 MOTHER (197)
643 644 645 KIDS – children (48)
646 647 MOM - mother (197); KIDS - children (48)
648 family (128); WOMEN (518); HUSBANDS - a man joined to a woman in marriage; a male spouse
649 CHILDREN (48)
650 651 careers - a chosen pursuit; a profession or occupation
652 WIVES - a woman joined to a man in marriage; a female spouse; family (128)
653 PEOPLE (34)
654 655 656 PEOPLE (34)
657 CHILDREN (48); HUSBANDS (648)
658 659 WIFE*2 (652)
660 self - the total, essential, or particular being of a person; the individual; one's own interests, welfare, or
661 advantage
662 PEOPLE (34)
663 664 MOTHER (197)
college - an institution of higher learning that grants the bachelor's degree in liberal arts or science or both
career (651)
Ohio - a midwestern state in north central United States in the Great Lakes region
family (128); (modified by working class - the socioeconomic class consisting of people who work for wages, especially low wages, including unskilled and semiskilled laborers and their families); conception - the ability to form or understand mental concepts and abstractions; WOMAN (518)
(674) career (651); CHILDREN (48) world - a realm or domain
years (23)
APRIL (140)
KID - CHILD (645)
PEOPLE (34)
couples (43) (modified by LESBIAN (462))
CHILDREN (645)
SISTER (581); HRC - abbr. for Human Rights Campaign, an organization devoted to promoting the legal and social rights of LBGT individuals
Human Rights Campaign (690); PEOPLE (34)
twenties - a decade or the numbers from 20 to 29
KIDS - CHILDREN (645)
KIDS - CHILDREN (645); couple (43); part (318)
APRIL (140)
sort (165)
lot (52); shifts - change in attitude, judgment, or emphasis; years (23)
difference (375)
moment - a specific point in time
part*2 (318); SISTER (581); BABY (458)
NIECE (594); July - the seventh month of the year in the Gregorian calendar
SISTER (581); LESBIAN (462)
SISTER (581)
MOM - mother (197)
SISTER (581)
relationship - a romantic or sexual involvement; HUSBAND (648)
three-year-old - child of three years; BABY (458); APRIL (140)

PARENTS (207)

angel - a kind and lovable person

SISTER (581)
SISTER (581)
lot (52); time (118)

BABY (458); SISTER (581)
SISTER (581); one (136)

college (669)
life - the physical, mental, and spiritual experiences that constitute existence
GUY (55); couple (296)
months (69); God - a being conceived as the perfect, omnipotent, omniscient originator and ruler of the universe, the principal object of faith and worship in monotheistic religions
BABY (458); MOTHER (197)
PERSON (34)
NIECE (594)

patience - the capacity, quality, or fact of being patient
relationship (302); BABY (458); AUNT - the sister of one's father or mother
MOTHER (197)

parts (318)
relationship (302)
example (551)
relationship (302)
parts (318); MOTHER (197)
parts (318)

KID - child (48)

SISTERS (581); KID - child (48)
SISTERS (581)
AUNT (778)
tape (635)

question (1)
terms (325); changes - transformation or transition from one state, condition, or phase to another
SISTER (581)

CHILD (48); things - a turn of events; a circumstance
terms (325)
personality (602)

sort (165); homebody - a person who seldom goes anywhere; one not given to wandering or travel
sort (165); home - a place where one lives; a residence
FRIENDS (207); lot (52)
change (801); lifestyle - a way of life or style of living that reflects the attitudes and values of a person or group
time*2 (118)

things (96); sort (165)
things (96)
CHILD (48)
lifestyles (813)
dog - a domesticated carnivorous mammal (Canis familiaris) related to the foxes and wolves and raised in a wide variety of breeds; year (23) half - one of two equal parts that together constitute a whole

sort (165); experiment - a test under controlled conditions that is made to demonstrate a known truth, examine the validity of a hypothesis, or determine the efficacy of something previously untried
KIDS – children (48)
sort (165); step - one of a series of actions, processes, or measures taken to achieve a goal
PARTNER (51)
dog (825)
weeks (153)
microcosm - a small, representative system having analogies to a larger system in constitution, configuration, or development
CHILD (48); cats - a small carnivorous mammal (Felis catus or F. domesticus) domesticated since early times as a catcher of rats and mice and as a pet and existing in several distinctive breeds and varieties
home (811)
weekend - the end of the week, especially the period from Friday evening through Sunday evening
experience (2); dog (825)
PARTNER (51)
toy poodle - the smallest of a breed of dogs originally developed in Europe as hunting dogs, having thick curly hair of varying color, and classified by shoulder height into standard, miniature, and toy varieties (857) dogs (825); toy poodles (856)
APRIL (140); dog (825)
kind (468); Rottweilers - any of a German breed of dog having a stocky body, short black fur, and tan face markings; kind - a particular variety; a sort; dogs (825)
dogs (825); toy poodle (856)
PEOPLE (34); dog (825)
beginning - an early or rudimentary phase
classes*2 - education imparted in a series of lessons or class meetings
kind (862); stuff (55)
way - an individual or personal manner of behaving, acting, or doing
sort (165); normal - the usual or expected state, form, amount, or degree
sort (165); dog (825)
things (96) (modified by dog (825))
experience (2)
PARENT (207)
sort (165)
behaviors - the actions or reactions of a person or animal in response to external or internal stimuli;
PEOPLE (34) kind (468)
sort (165); realization - the act of realizing or the condition of being realized
mind - the human consciousness that originates in the brain and is manifested especially in thought, perception, emotion, will, memory, and imagination
dog (825)
reality - the quality or state of being actual or true
dog (825)
kind (468); question (1)
kind (468); things (532)
CHILD (48)
education - the act or process of educating or being educated
school - an institution for the instruction of children or people under college age
school (909)
school (909)
lot (52); self-confidence - confidence in oneself or one's own abilities
people (34)
world (676)
sense - a capacity to appreciate or understand; responsibility - the state, quality, or fact of being responsible
sort (165); world (676)
people (34)
things (96)
parts (318)
gender - the condition of being female or male; sex; sexual identity, especially in relation to society or culture; sexual orientation - the direction of one's sexual interest toward members of the same, opposite, or both sexes; race - a local geographic or global human population distinguished as a more or less distinct group by genetically transmitted physical characteristics; status - position relative to that of others (modified by income - the amount of money or its equivalent received during a period of time in exchange for labor or services, from the sale of goods or property, or as profit from financial investments)
care (251) pregnancy (2) education (904); DOCTORS (3) DOCTOR (3) appointment - an arrangement to do something or meet someone at a particular time and place; DR. MEDEIROS (38) ENDOCRINOLOGIST - physician who specializes in the diagnosis and treatment of conditions affecting the endocrine system office (161) HUSBAND (648)
Appendix C; Nouns in transcript 2

946  thing (532)
947  sort (165)
948  sort (165)
949  HUSBAND (945)
950  sort (165); OB (187)
951  kind (468)
952  December - the 12th month of the year in the Gregorian calendar
953  PERSON (34)
954  sort (165)
955  December (960)
956  seminar - a meeting for an exchange of ideas; a conference; health - a condition of optimal well-being
957  (modified by LESBIAN (462))
958  lecture - an earnest admonition or reproof; a reprimand
959  issues - a matter of public concern (modified by health (971) and LESBIAN (462))
960  years (23)
961  sort (165)
962  DOCTOR (3); PATIENTS - one who receives medical attention, care, or treatment
963  things (455)
964  form - a document with blanks for the insertion of details or information
965  SPOUSE - a marriage partner; a husband or wife; APRIL (140); name (215)
966  name (215)
967  SPOUSE (990)
968  things (455)
questions (1); venereal disease - a sexually transmitted disease
stuff (55)
years (23)
couple (43) (modified by LESBIAN (462))
sort (165)
kind (468); questions (1)
kind (468); thing (96)
examples (551)
kind (468)
ultrasound (4); DR. MEDEIROS (38); APRIL (140)
stuff - talk or actions
sort (165)
kind (468)
kind (468)
terms (325)
birth - childbirth (144); place - in the appropriate or usual position or order (part of the idiom, “in place”)
Pennsylvania - a state of the eastern United States
visit - the act of visiting in an official capacity, such as an inspection or examination; OB (187)
September - the ninth month of the year in the Gregorian calendar
visit (1041); thing (96)
questions (1)
PARTNER (51)
questions (1)
questions (1)
questions (1)
recorders - one, such as a tape recorder, that makes recordings or records

things - an object or entity that is not or cannot be named specifically; other - the remaining one of two or more questions - an expression of inquiry that invites or calls for a reply

pregnancy - the condition of carrying offspring within the body

FETUS - in humans, the unborn young from the end of the eighth week after conception to the moment of birth, as distinguished from the earlier embryo

HUSBAND - a man joined to a woman in marriage; a male spouse

stuff - unspecified material

preparation - a preliminary measure that serves to make ready for something

folic acid - a B vitamin that is essential for cell growth and reproduction

tool - any instrument of use or service; neural tube defects - any of various congenital defects of the brain and spinal cord, such as spina bifida, resulting from incomplete closing of the neural tube in an embryo

DOCTOR - a person trained in the healing arts and licensed to practice (in reference to a physician)

prenatal vitamin - any of various fat-soluble or water-soluble organic substances essential in minute amounts for normal growth and activity of the body and obtained naturally from plant and animal foods that are recommended for women to take prior to birth and/or conceiving

months - a unit of time corresponding approximately to one cycle of the moon's phases, or about 30 days or 4 weeks

preparation (12) (40) MOTHER - a woman who conceives, gives birth to, or raises and nurtures a child

kind*2 - rather, somewhat; stuff (9)

class - education imparted in a series of lessons or class meetings (modified by BABY - a very young child; an infant); HUSBAND (8)

stuff - talk or actions; BABY - an unborn child; a fetus; room - an area separated by walls or partitions from other similar parts of the structure or building in which it is located

kind - a particular variety; a sort; stuff (47)

now - the present time or moment

kind (43); stuff (47)

class (44) (modified by BABY (44))

class (44)
INFANT- a child in the earliest period of life, especially before he or she can walk

CHILDREN - a person between birth and puberty

one - a single person or thing; a unit; November - the 11th month of the year in the Gregorian calendar

difficulties - a laborious effort; a struggle; trouble; pregnancy (34)
pregnancy (34)
morning sickness - nausea and vomiting upon rising in the morning, especially during early pregnancy
morning sickness (74); every-day-all-day-sickness

weight - a measure of the heaviness of an object

lot - a large number or amount or extent; weight (78)

mark - a point reached or gained

meals - the food served and eaten in one sitting

attentive assistance or treatment to those in need

pregnancy (5)

PHYSICIAN - a person licensed to practice medicine; a medical doctor

spina bifida - a congenital defect in which the spinal column is imperfectly closed so that part of the meninges or spinal cord protrudes, often resulting in hydrocephalus and other neurological disorders

flush (98) group - an assemblage of persons or objects gathered or located together; an aggregation (modified by pregnancy (5))

spina bifida (97)

DOCTOR (25); WOMEN - an adult female human; disabilities - a disadvantage or deficiency, especially a physical or mental impairment that interferes with or prevents normal achievement in a particular area

group (98); city - a center of population, commerce, and culture; a town of significant size and importance
group (98) (modified by pregnancy (5))
group (98) (modified by medicine - the science of diagnosing, treating, or preventing disease and other damage to the body or mind)
Appendix C; Nouns in transcript 3

care (90)  
spina bifida (97)  
bit - a small portion, degree, or amount (97)  
pregnancy (5)  
things (2); curvature - a curving or bending, especially an abnormal one (124); spine - the spinal column of a vertebrate (124)  
lot (81); room - a space that is or may be occupied (5)  
BABY (47)  

WOMEN (104)  

eye - watchful attention or supervision; BABY (47); weight (78)  

hips - the laterally projecting prominence of the pelvis or pelvic region from the waist to the thigh; hip (140)  

high blood pressure - hypertension; a common disorder in which blood pressure remains abnormally high  
problems - a situation, matter, or person that presents perplexity or difficulty (135)  
eye (135)  

complications - a secondary disease, an accident, or a negative reaction occurring during the course of an illness and usually aggravating the illness  
walking - the action of one that walks  

balance - the ability to maintain bodily equilibrium; center - a point or place that is equally distant from the sides or outer boundaries of something; the middle  
gravity - the natural force of attraction exerted by a celestial body, such as Earth, upon objects at or near its surface, tending to draw them toward the center of the body  

blessing - something promoting or contributing to happiness, well-being, or prosperity; a boon; lot (81)  
weight (78)  
months (30)  

things*2 - a matter of concern  

case - a set of circumstances or a state of affairs; a situation  
types - the general character or structure held in common by a number of people or things considered as a group or class; spina bifida (97)  
levels - a relative degree, as of achievement, intensity, or concentration  

portion - number or amount; CHILDREN (60) (modified by spina bifida (97))
ADULTS - one who has attained maturity or legal age; wheelchairs - a chair mounted on large wheels for the use of a sick or disabled person

case (163); lot*2 (81); OTHERS - the remaining one of two or more

shunt - a passage between two natural body channels, such as blood vessels, especially one created surgically to divert or permit flow from one pathway or region to another; a bypass; kind (49)

(173) disability (104)

lot (81); kind (43); case (163); spina bifida (97)

kind (43); eye (135)

hips (140); WOMEN (104)

pain - an unpleasant sensation occurring in varying degrees of severity as a consequence of injury, disease, or emotional disorder; pains (181) side - the left or right half of the trunk of a human or animal body

kind (43); eye (135)

DOCTOR (25); disabilities (104)

WOMEN (104); disabilities (104)

spina bifida (97)

generation - a group of individuals born and living about the same time; CHILDREN (60) (modified by spina bifida (97)) group - a number of individuals or things considered together because of similarities

CHILDREN (60)

CHILDREN (60)

kind (43)

lot (81); spina bifida (97)

lot (81) issues - problems or concerns

risks - a factor, thing, element, or course involving uncertain danger; a hazard

HUSBAND (8)

consultation - a meeting between physicians to discuss the diagnosis or treatment of a case

things - an act, deed, or work; neural tube defect (14)

risks (206); age - the length of time that one has existed; duration of life

things - a circumstance or turn of events

things (220); end - the point in time when an action, an event, or a phenomenon ceases or is completed; the conclusion wheelchair (169)
bed - a piece of furniture for reclining and sleeping, typically consisting of a flat, rectangular frame and a mattress resting on springs

things (220)

damage - harm or injury to property or a person, resulting in loss of value or the impairment of usefulness

DOCTOR (25)

thing (2)

problem (145)

STRANGERS - one who is neither a friend nor an acquaintance

BABY (47)

accident - an unexpected and undesirable event; not planned

accident (244)

part - a portion, division, piece, or segment of a whole; risks (206)

FETUS (7)

decision - the act of reaching a conclusion or making up one's mind

LESBIAN - a woman whose sexual orientation is to women

things (162)

terms - in relation to; with reference to (part of the idiom, “in terms of”)

kind (49); vibe - a distinctive emotional atmosphere; sensed intuitively

PEOPLE - humans considered as a group or in indefinite numbers

providers - one that makes something, such as a service, available (modified by health care -the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions) home - a place where one lives; a residence; city (109)

DOCTOR (25); couple - a few; several

couple (277); places - a business establishment or office

WOMEN (104)
route - a means of reaching a goal
plenty - a full or completely adequate amount or supply; there - that place or point
thing - a means to an end; group (98)
group (98) (modified by medicine (111))
DOCTORS (25)

GENTLEMAN - a man
pain (180)
pain (180)
bump - a raised or rounded spot; a bulge; pain (180); WOMEN (104)
pains (180); aches - a dull, steady pain; time - an interval separating two points on this continuum; a duration thing*2 (162)
thing (162)

kind (43); time - a number representing a specific point on a continuum, reckoned in hours and minutes
DOCTOR (25); one (68)
hernia - the protrusion of an organ or other bodily structure through the wall that normally contains it; a rupture
attention - observant consideration; notice
time (309)
WOMEN (104)

problems (145); things (220)

relationship - a particular type of connection existing between people related to or having dealings with each other; PHYSICIAN (94) PHYSICIAN (94)
one (68); practice - the business of a professional person
BABY (44)
kind (43)
Appendix C; Nouns in transcript 3

337
338  one (68)
339
340
341
342  group (98); PATIENT - one who receives medical attention, care, or treatment; week - a period of seven
343  days
344  date - in or into accordance with current information, styles, or technology (part of the idiom, “up to date”);
345  PATIENT (342)
346
347  kind (43)
348  high blood pressure (144)
349
350  information - knowledge derived from study, experience, or instruction
351
352
353
354
355
356
357
358  PRIMARY CARE DOCTOR - a physician, such as a general practitioner or internist, chosen by an
359  individual to serve as his or her health-care professional and capable of handling a variety of health-related
360  problems, of keeping a medical history and medical records on the individual, and of referring the person to
361  specialists as needed
362
363  decision (263)
364  ultrasound - the use of ultrasonic waves for diagnostic or therapeutic purposes, specifically to image an
365  internal body structure, monitor a developing fetus, or generate localized deep heat to the tissues
366
367
368  appointment - an arrangement to do something or meet someone at a particular time and place
369  pregnancy (5)
370
371
372
373
374
375
376  group (193)
377
378  BABY (47)
379  one (68)
380  one (68); weeks (342)
381  weeks (342)
382
383  one (68)
384  weeks (342)
385
386  one (68)
387
388
389
390
391
392  kind (43)
weeks (342)

experience - events or a series of events participated in or lived through
few - an indefinitely small number of persons or things
techs - abbr. for technicians, one whose occupation requires training in a specific technical process; times
one (68)

miscarriage (36)

kind (43); BABY (47)

BABY (47)

GIRL - a female child
way - incidentally (part of the idiom, “by the way”) 
one (68)

ultrasound (364)
test - a procedure for critical evaluation; a means of determining the presence, quality, or truth of something; a trial
test (426)

body - the physical part of a person

kind (43)
oones (68)
couple*2 (277); ones (68)
one (68); ones (68); BABY (47)
things (2)
things (2); one (68)

size - the physical dimensions, proportions, magnitude, or extent of an object; spine (125)

shot - a photographic view or exposure
Appendix C; Nouns in transcript 3

- **weeks** (342)
- **one** (68)
- **video** - a videocassette or videotape, especially one containing a recording of a movie, music performance, or television program; **home** (275)
- **times** - one of several instances
- **one** (68); **video** (455)

**experience** (396)

- **HUSBAND** (8)
- **GIRLFRIEND** - a female friend; **one** (68); **MOTHER** (40)
- **one** (68)
- **table** - an article of furniture supported by one or more vertical legs and having a flat horizontal surface
- **gown** - a robe or smock worn in operating rooms and other parts of hospitals as a guard against contamination
- **shirt** - a garment for the upper part of the body, typically having a collar, sleeves, and a front opening; **pants** – trousers; **belly** - the stomach; the womb; the uterus
- **process** - a series of actions, changes, or functions bringing about a result; **GIRL** - an immature or inexperienced woman, especially a young woman
- **thing** (2)
- **idea** - something, such as a thought or conception, that potentially or actually exists in the mind as a product of mental activity
- **ones** (68)
- **BABY** (47)
- **ones** (68)
- **hands** - the terminal part of the human arm located below the forearm, used for grasping and holding and consisting of the wrist, palm, four fingers, and an opposable thumb; **legs** - a limb or an appendage of an animal, used for locomotion or support
- **thumbs** - the short thick digit of the human hand, next to the index finger and opposing to each of the other four digits
report - a written document describing the findings of some individual or group

pictures*2 - a visual representation or image painted, drawn, photographed, or otherwise rendered on a flat surface  
video (455)

experiences (396)

experience (396)

one (68) (modified by miscarriage (36))

GIRL (483); ultrasound (364)

ultrasound (364)

time (304); ultrasound (364); tip-off - an indication of an otherwise unknown fact or probability

HUSBAND (8)

uterus - a hollow muscular organ located in the pelvic cavity of female mammals in which the fertilized egg implants and develops  
thing - a thought, a notion, or an utterance

kind (43)

report (506)

experience (396)

thing (220); BABY (47)

uterus (530)

group (99); DOCTORS (25)

group (99)

group (99)

ultrasound (364); hospital - an institution that provides medical, surgical, or psychiatric care and treatment for the sick or the injured

hospital (553)

department - a distinct, usually specialized division of a large organization (modified by ultrasound (364))

GIRL (483); department (558) (modified by ultrasound (364))
retrospect - a review, survey, or contemplation of things in the past

comment - a statement of fact or opinion, especially a remark that expresses a personal reaction or attitude

ones (68)

PEOPLE (272)

time (304)

God - a being conceived as the perfect, omnipotent, omniscient originator and ruler of the universe, the principal object of faith and worship in monotheistic religions; one (68); spine (125); leg (502)

one (68); today - the present day, time, or age

ultrasound (364)

pregnancy (5)

experience (396)

tip-off (524); things (220)

ultrasound (364)

tip-off (524)

heart - the chambered muscular organ in vertebrates that pumps blood received from the veins into the arteries, thereby maintaining the flow of blood through the entire circulatory system

one (68)

BABY (47)
things (220)

one (68)

GIRL (483); one (68)

lot (81)

pictures (509)

photo - abbr. for photograph, an image, especially a positive print, recorded by a camera and reproduced on a photosensitive surface picture (509)

room (47); HUSBAND (8)

photo (631)

stupes - stupid people

head - the uppermost or forwardmost part of the body of a vertebrate, containing the brain and the eyes, ears, nose, mouth, and jaws

mark (84)

ultrasound (364)

sex - the property or quality by which organisms are classified as female or male on the basis of their reproductive organs and functions one (68)

one (68)

weeks (342)

weeks (342)

weeks (342)

weeks (342)
GIRL (417)
HUSBAND (8)

BOY - a male child

GIRL (417)

GIRL (417)

shower - a party held to honor and present gifts to someone (modified by BABY (47))

GIRL (417)

problems (145); lot (81)

items - a single article or unit in a collection, enumeration, or series (modified by GIRL (417))

GIRL (417)

lot (81); PEOPLE (272)

room (47)

stuff (9)

sex (658)

reason - within the bounds of good sense or practicality (part of the idiom, “within reason”)

Winnie the Pooh - children’s cartoon character

one (68)

bunch - a considerable number or amount; a lot

things (2)

surprise - something, such as an unexpected encounter, event, or gift, that surprises; way - a course of

conduct or action

kind (43)

decision (263); kind (43)
Appendix C; Nouns in transcript 3

expectations - the act of expecting; ultrasound (364)

ultrasound (364); stuff (9)
kidneys - either one of a pair of organs in the dorsal region of the vertebrate abdominal cavity, functioning to maintain proper water and electrolyte balance, regulate acid-base concentration, and filter the blood of metabolic wastes, which are then excreted as urine; stuff (9)

ultrasound (364)

GIRLFRIENDS (473)

procedure - a series of steps taken to accomplish an end

expectations (729)

DOCTORS (25)

experience (396)

point - a specific moment in time; movement - the act or an instance of moving; a change in place or position

BABY (47)
thing (531)

BABY (47)

DOCTOR (25)

appointment (368); BABY (47)

heartbeat - a single complete pulsation of the heart

weeks (342)

one (68); weeks (342)

miscarriage (36)

ultrasound (364)

ultrasound (364); BABY (47); legs (502)

HUSBAND (8); God (579)

honey - sweetheart; dear; used as a term of endearment; legs (502)

fears - a feeling of agitation and anxiety caused by the presence or imminence of danger; a feeling of
disquiet or apprehension  BABY (47)

there (287)

hours - one of the 24 equal parts of a day

changes - a transformation or transition from one state, condition, or phase to another

body (431)

changes (829)

hip (140); kind (43)

Pamela Anderson - an actress known for her large breasts

area - a division of experience, activity, or knowledge (modified by breast - either of two milk-secreting,
glandular organs on the chest of a woman; the human mammary gland)

changes (829)
feet - the lower extremity of the vertebrate leg that is in direct contact with the ground in standing or walking
stuff (9); lettuce - the leaves of L. sativa, used especially in salads
matter - regardless of (part of the idiom, “no matter”); times (309)
stuff (9); minute - unit of time equal to one sixtieth of an hour, or 60 seconds; lettuce (841)
half-hour - a period of 30 minutes; bathroom - a room equipped with facilities for taking a bath or shower and usually also containing a sink and toilet
lettuce (841)
breasts (837)
bra - abbr. for brassiere, a woman's undergarment worn to support and give contour to the breasts;
HUSBAND (8)
gears - direction (part of the idiom, “shift gears”); bit (119)
WOMAN (104)

question (3)
kind (43)
question (3)
kind (43); girly-girl - a very feminine girl; lot (81); stuff - unspecified activities
kind (43); flower - a plant that is cultivated or appreciated for its blossoms; bows - a knot usually having two loops and two ends; kind (43)
things (2)
PEOPLE (272)

kind (43); thing (218) (modified by FEMALE - a member of the sex that produces ova or bears young);
HUSBAND (8)
Mr. Nurturing

Miss I-don’t-want-to-change-the-oil-you-change-the-oil; stuff (47)

aspect - a particular status or phase in which something appears or may be regarded; WOMAN (104)

HUSBAND (8); homes (275) (modified by victims - one who is harmed by or made to suffer from an act, circumstance, agency, or condition (modified by flood - an overflowing of water onto land that is normally dry) (883) PEOPLE (272) place - an area with definite or indefinite boundaries; a portion of space;
house - a structure serving as a dwelling for one or more persons, especially for a family

part (256)

kind*2 (43)
thing (218); GIRL (483)
stuff (9)
Appendix C; Nouns in transcript 3

stuff (9)

question (3)

there (287)

question (3)

question (3)

hair - any of the cylindrical, keratinized, often pigmented filaments characteristically growing from the epidermis of a mammal; make-up - cosmetics applied especially to the face; time (304)

weight (78)

HUSBAND (8)

kind (43); stuff (47)

part and parcel - (idiom) a basic or essential part

thing (162) (modified by WOMAN (104))

thing (162); kind (43); hand in hand - (idiom) in cooperation; jointly

WOMAN (104)

GIRL (417)

BOY (683)

BROTHER - a male having the same parents as another or one parent in common with another; PARENTS - one who begets, gives birth to, or nurtures and raises a child; a father or mother

BOY (683); bit (119)

disability (104); bit (119); stuff (47)

kind (43); BOY (683)

HUSBAND (8); stuff (47) (modified by BOY (683))

GIRL (417)

MOM - abbr. for mother (40)

skills - proficiency, facility, or dexterity that is acquired or developed through training or experience
Appendix C; Nouns in transcript 3

404

MOM (950)

MOM (950)

GIRL (417)

problem (145)

differences - the quality or condition of being unlike or dissimilar

GIRL (417); BOY (683)

GIRL (417)

kind (43); GIRL (417) (modified by tomboy - a girl considered boyish or masculine in behavior or manner)

idea (492)

idea (492)

stuff (47)

PARENTS (938)

HUSBAND (8)

sports - physical activity that is governed by a set of rules or customs and often engaged in competitively;

lot (81)

SPECTATOR - an observer of an event; PARTICIPANT - one that participates, shares, or takes part in something

sports (973); stuff (47)

lessons - a period of instruction; a class (modified by ballet - a classical dance form characterized by grace and precision of movement and by elaborate formal gestures, steps, and poses)

HUSBAND (8)

time - difficulty (part of the idiom, “hard time”); way - progress or travel along a certain route or in a specific direction BOY (683); lessons (978) (modified by ballet (978)); cards - likely or certain to happen (part of the idiom, “in the cards”)

stereotyping - a conventional, formulaic, and oversimplified conception, opinion, or image

BOYS (683); GIRLS (417)

opportunities - a favorable or advantageous circumstance or combination of circumstances; a chance for progress or advancement; GIRLS (417) BOYS (683)

GIRL (417)

soccer - a game played on a rectangular field with net goals at either end in which two teams of 11 players each try to drive a ball into the other's goal by kicking, heading, or using any part of the body except the arms and hands. The goalie is the only player who may touch or move the ball with the arms or hands;

football - a game played by two teams of 11 players each on a rectangular, 100-yard-long field with goal lines and goal posts at either end, the object being to gain possession of the ball and advance it in running or passing plays across the opponent's goal line or kick it through the air between the opponent's goal posts (998) volleyball - a game played by two teams on a rectangular court divided by a high net, in which both teams use up to three hits to ground the ball on the opposing team's side of the net (999) volleyball (998)

(1000) lot (81); leeway - a margin of freedom or variation, as of activity, time, or expenditure; latitude;

GIRLS (417) (1002) way (982)

opportunities (989); GIRLS (417)

1006
CHILD (60); BOY (683); GIRL (417)

first - the beginning; the outset; one (68)

things (162); one (68); things (162); HUSBAND (8)

CHILD (60); PEOPLE (272)
decisions (263); groupthink - the act or practice of reasoning or decision-making by a group, especially when characterized by uncritical acceptance or conformity to prevailing points of view
decisions*2 (263)

mind - the faculty of thinking, reasoning, and applying knowledge

church - a congregation; a building for public, especially Christian worship

things (162)
success*2 - the achievement of something desired, planned, or attempted

administrative assistant - a person employed to handle correspondence, keep files, and do clerical work for another person or an organization

ambition - an eager or strong desire to achieve something, such as fame or power; career - a chosen pursuit; a profession or occupation career (1042)

PEOPLE (272); personality - the pattern of collective character, behavioral, temperamental, emotional, and mental traits of a person caring - close attention; painstaking application; OTHERS (171); things (162)

DOCTOR (25)

thing (162)

future - a prospective or expected condition, especially one considered with regard to growth, advancement, or development decisions (263)

thing (162)

things (2)
ton - a great quantity; stuff (47)

Internet - an interconnected system of networks that connects computers around the world via the TCP/IP protocol; TV - abbr. for television, a receiving set for an electronic system transmitting transient images of fixed of moving objects together with sound over a wire or through space by apparatus that converts light and sound into electrical waves and reconverts them into visible light rays and audible sound
Appendix C; Nouns in transcript 3

KID – abbr. for children (60); day - the 24-hour period during which the earth completes one rotation on its axis (1063) decisions (263); kind (43) thing (220)

CHILDREN (60); winner - one that wins, especially a victor in sports or a notably successful person

school - an institution for the instruction of children or people under college age

attitude - a state of mind or a feeling; disposition

job*2 - a regular activity performed in exchange for payment, especially as one's trade, occupation, or profession

attitude (1069)

lot (81); GIRLFRIENDS (473); KIDS (1063)

school (1068)

contest - a struggle for superiority or victory between rivals

pumpkin - the large pulpy round fruit of this plant, having a thick, orange-yellow rind and numerous seeds

blue ribbon - an emblem, badge, or rosette made of blue ribbon that is awarded as the first prize in a competition

CHILDREN (60)

CHILDREN (60); winner (1066)

GIRLFRIEND (473); BOY (683)

MOM (950)

days*2 (1063)

pumpkin (1079); snowman - a figure of a person made of packed snow

CHILDREN (60)

public schools - an elementary or secondary school in the United States supported by public funds and providing free education for children of a community or district

thing (220); CHILDREN (60)

CHILDREN (60)

thing (2); things (2)

track - away from one's objective, train of thought, or a sequence of events (part of the idiom, “off track”)

things (2)
needs - something required or wanted; a requisite

bit (119)
time*2 (304); home (275)

heartbeat - an instant; tomorrow - the day following today

lot (81)
budget - an itemized summary of estimated or intended expenditures for a given period along with proposals for financing them

MOM (950)
concern - a troubled or anxious state of mind arising from solicitude or interest

kind (49); concerns (1137)

end - eventually; ultimately (part of the idiom, “in the end”)

ADULT (169)

experience (396)
MOTHER (40)
CHILDREN (60)

CHILDREN (60)
first (1017)
KID (1063)
house (885)
dog*2 - a domesticated carnivorous mammal (Canis familiaris) related to the foxes and wolves and raised in a wide variety of breeds
dog (1155)
responsibility - something for which one is responsible; a duty, obligation, or burden; kind (43)
preparation (12); BABY (44)
time limit - a time period within which something must be done or completed

MOM (950)

CHILDREN (60)
Appendix C; Nouns in transcript 3

1174
1175
1176  age (219)
1177
1178
1179  window - an interval of time during which an activity can or must take place
1180  time (309)
1181
1182
1183
1184
1185
1186  one (68)
1187  one (68)
1188
1189
1190
1191  time (458)
1192
1193
1194
1195
1196  one (68)
1197  alternative - a proposition or situation offering a choice between two or more things only one of which
1198  may be chosen
1199  bit (119); things (220)
1200  health care - the prevention, treatment, and management of illness and the preservation of mental and
1201  physical well-being through the services offered by the medical and allied health professions; pregnancy
1202  (5)
1203  disability (104)
1204
1205
1206
1207  DOCTORS (25)
1208  preparation (12)
1209
1210  PRIMARY CARE PHYSICIAN – primary care doctor (358)
1211
1212
1213
1214
1215
1216
1217
1218  situation - the combination of circumstances at a given moment; a state of affairs
1219  time - an interval, especially a span of years, marked by similar events, conditions, or phenomena
1220
1221
1222
1223
1224
1225
1226
1227  medicine - an agent, such as a drug, used to treat disease or injury
1228  stuff (47) (modified by maintenance - the work of keeping something in proper condition; upkeep); blood
1229  pressure - the pressure exerted by the blood against the walls of the blood vessels, especially the arteries. It
1230  varies with the strength of the heartbeat, the elasticity of the arterial walls, the volume and viscosity of the
1231  blood, and a person’s health, age, and physical condition
stuff (47); maintenance (1225)

DOCTOR (25); PERSON - a living human

DOCTOR (25)

stuff (47); maintenance (1225)

DOCTOR (25); PERSON - a living human

colds - a viral infection characterized by inflammation of the mucous membranes lining the upper
respiratory passages and usually accompanied by malaise, fever, chills, coughing, and sneezing; flus -
influenza, any of several diseases caused by bacteria or viruses and marked especially by respiratory
symptoms fact - knowledge or information based on real occurrences

DOCTOR (25)

PRIMARY CARE - primary care physician/doctor (358); accident (244)

WOMEN (104)

disabilities (104)

DOCTOR (25)

kind (43)

number - an indefinite quantity of units or individuals; PEOPLE (272)

urinary tract infections - any infection of any of the organs of the urinary tract

issue (203)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)

antibiotic - a substance, such as penicillin or streptomycin, produced by or derived from certain fungi,
bacteria, and other organisms, that can destroy or inhibit the growth of other microorganisms. Antibiotics
are widely used in the prevention and treatment of infectious diseases (modified by dose - a specified
quantity of a therapeutic agent, such as a drug or medicine, prescribed to be taken at one time or at stated
intervals) (1265) time (304) (1268) antibiotic (1265)

chance - a risk or hazard; a gamble

pills - a small pellet or tablet of medicine, often coated, taken by swallowing whole or by chewing; day
(1063)
listserv - an automatic mailing list server; PARENTS (938)

walks - of varying personal qualities and experiences; life - human existence, relationships, or activity in general
world - the earth with its inhabitants
tips - helpful hint, pieces of information

stuff (9); experiences (396); lot (81)
lot (81); wheelchairs (169)
disabilities (104)
community - a group of people having common interests; PEOPLE (272)
STRANGERS (241)

thing (220); years (38)
PEOPLE (272)

kind (49); concept - a general idea derived or inferred from specific instances or occurrences

thing (220); kind (43)
group (193); part (256)
WOMEN (104); disabilities (104)
kind (49); category - a specifically defined division in a system of classification; a class

PEOPLE (272)

fear (813)
years (38); PEOPLE (272)
CHILDREN (60)

lot (81); places - a locality, such as a town or city
city (109); difference (961)

lot (81); WOMEN (104); areas (837)
thing (220)

experience (396)
second - a unit of time equal to one sixtieth of a minute
experience (396)  
disability (104)  
disability (104)  
attitude (1069)  
experiences (396)  
DOCTORS (25)  
ultrasounds (364)  
PEOPLE (272)  
experiences (396) (modified by pregnancy (5))  
stuff (9); MOMS (950)  
BABY (44)  
BABY (44)  
process (483); BABY (44)  
MOMS (950)  
end (223)  
interview - a conversation, such as one conducted by a reporter, in which facts or statements are elicited from another  
questions (3)  
questions (3)
part (256); project - an undertaking requiring concerted effort

places - points or moments

there (287); stuff (9)
Subjects and subject categories

Heather:

FETUS (19)
BABY (36, 206, 224, 233, 335, 336, 351, 388, 434, 471, 525, 532, 610, 639, 701, 702, 709, 767, 782, 783, 870, 999, 1034, 1057, 1098, 1172, 1174, 1263, 1264, 1271, 1274, 1279, 1346)
PHYSICIAN (111, 599, 2081)
MIDWIFE (112, 113, 209, 216, 226, 238, 543, 850, 1293)
HOMEOPATH (122, 189, 2115)
CHILD/KID (164, 322, 339, 805, 1530, 1635, 1648, 1658, 1659, 1663, 1748, 1768, 1794, 1821, 1909, 2000, 2050)
SPECIALIST (167)
MD (197, 2018)
LADY (224, 741)
PATIENT (228)
MOTHER (305, 352, 377, 603, 1067, 1404, 1634, 1669, 1732, 1875, 2016, 2037, 2080, 2089)
COUSINS (316)
BOYFRIEND (339, 374, 531, 586, 922, 1131, 1517, 1572, 1681, 1831)
ADULT (341)
DAUGHTER (343, 347, 1030, 1512, 1573)
FATHER/DAD (349, 378)
HALF-BROTHER (356)
BOY (371, 381, 1023, 1030, 1032, 1043, 1677, 1690, 1761, 1771, 1776, 1778, 1914, 1929)
TWINS (533)
LAURA (545)
MEDICAL ASSISTANT (603)
OB (605, 1067)
GIRL (615, 664, 941, 1033, 1035, 1040, 1144, 1196, 1218, 1690 (x2), 1693, 1773, 1776, 1779, 1810 (x2), 1842, 1846)
GUYS (625, 1667, 1963, 2039)
SONOGRAPHER (674, 675)
DR. THOMAS (716)
GIRLFRIEND (737, 1862, 2004)
WOMEN (807, 1065, 1077, 1161, 1209, 1271, 1278, 1379, 1452, 1760, 1763, 1805, 1808, 1821, 1826, 1885, 1906, 1945, 1960, 1969, 2086)
MEN (1370, 1597, 1820, 1827, 1903, 1905, 1909, 1946)
EX-WIFE (1609)
Appendix D

PARENT (1703, 1739)
FRIEND (1710)
BROTHER (1788)
SIBLING (1796)
HUSBAND (1886)
GRANDMOTHER (2022, 2083)
MALE (2102)
FEMALE (2100)
PROVIDER (2114)

Emily:

DOCTOR (3, 38, 39, 183, 275, 491, 940 (x2), 984
FETUS (8, 387)
PEOPLE (34, 162, 330, 348, 355, 381, 618, 653, 656, 662, 692, 772, 864, 888, 922, 961)
DR. MEDEIROS (38, 161, 186, 259, 304, 941, 1018)
PARTNER (51, 445, 583, 591, 840, 855, 1047)
GUY (55, 798)
BABY (88, 171, 441, 458, 717, 730, 763, 770, 778)
APRIL (140, 205, 213, 366, 464, 680, 703, 730, 859, 990, 1018)
MOTHER (197, 664, 720, 727, 770, 779, 787)
LIBRARIAN (203)
PARENT (207, 211, 738, 882)
PHYSICIAN (253, 262, 303)
OB/GYN, OB, GYNECOLOGIST (255, 257, 258, 263, 280, 954, 1041)
SPECIALIST (256)
SURGEON (266)
DR. SCHWARTZ (279)
BOY (459, 464, 478, 627)
GIRL (459, 465, 478)
LESBIAN (462, 483, 684, 719, 972, 976, 1007)
COUSINS (475)
SON (483)
WOMAN (518, 524, 525, 531, 532, 538, 648, 675)
SISTER (581, 591, 690, 717, 719, 722, 728, 750, 752, 763, 764, 793, 794, 802)
FRIENDS (585, 812)
NIECE (594, 718, 773)
GRANDMA (604)
MOTHER/MOM (639, 642, 643, 647)
HUSBAND (648, 657, 729, 945, 951)
WIFE (652, 659 (x2))
JORDAN (734)
AUNT (778, 795)
ENDOCRINOLOGIST (942)
Appendix D

SPOUSE (940)
PATIENTS (984)

Joanne:

FETUS (7, 258)
HUSBAND (8, 45, 210, 470, 471, 526, 633, 679, 775, 808, 851, 870, 882, 918, 946, 972, 981, 1018)
DOCTOR (25, 104, 186, 232, 277, 292, 310, 549, 747, 790, 1047, 1048, 1207, 1233, 1241, 1250, 1350)
MOTHER/MOM (41, 473, 950, 953, 955, 1136, 1146, 1172, 1362, 1371)
BABY (44, 47, 55, 80, 128, 135, 243, 333, 378, 412, 414, 443, 498, 541, 616, 690, 761, 772 (x2), 773, 782, 788, 791, 805, 814, 1164, 1363, 1365, 1367)
INFANT (58)
CHILD/KID (60, 168, 192, 196, 199, 1012, 1020, 1060, 1066, 1075, 1084, 1085, 1095, 1098, 1106, 1147, 1151, 1153, 1173, 1279, 1283 (x2), 1327)
PHYSICIAN (94)
WOMAN (104, 132, 179, 188, 279, 303, 319, 854, 877, 924, 931, 1274, 1320, 1333)
ADULT (169, 1143)
STRANGER (214, 1306)
LESBIAN (266)
PEOPLE (272, 571, 700, 866, 884, 1020, 1044, 1233, 1254, 1305, 1313, 1323, 1326, 1352)
GENTLEMAN (306)
PHYSICIAN (329)
PATIENT (342, 345)
PRIMARY CARE PHYSICIAN/DOCTOR (358, 1210, 1246)
GIRL (417, 519, 560, 627, 678, 685, 688, 691, 693, 695, 894, 932, 949, 957, 962, 964, 965, 987, 990, 993, 1003, 1005, 1012)
GIRLFRIEND (473, 742, 1075, 1087)
BOY (683, 685, 935, 941, 945, 946, 962, 983, 987, 990, 1012, 1087)
FEMALE (869)
BROTHER (937)
PARENTS (938, 971, 1295)
SPECTATOR (975)
PARTICIPANT (975)
TOMBOY (965)
Appendix E

Rights and Responsibilities of Subjects

Emily

**Pregnant woman (lesbian):** *pre-pregnancy:* conceive fetus (by artificial insemination) (9); go to hospital (12-14); have a lot of tests done (19); [had cysts removed from ovaries (22)]; had a lot of painful tests done involving ultrasound (28-9); participate in a heterosexual environment (41); be only lesbian couple (43); pick a donor (45); choose criteria/characteristics of a donor (46); have tests (67); worry (68); conceive (68); [did two trials (74)]; participate in very medical process (80); become “cog in a wheel” (84); complete checklists specifying what to do/not do (85); endure intimidation (91); do whatever you are told to do (93); track the days of your period/your cycle, check ovulation and hormone levels (99-103); get up in the middle of night/obtain second urine (106-7); pee on stick (109); endure regimented process; plan for five years (127); choose good place to raise family (128); buy house (130); buy second house in different school district (133); decide it is time (133); discuss who would carry child “for a long time” (130); desire to experience pregnancy and childbirth (144); desire genetic link (140-1); *during pregnancy:* have constant morning sickness (147-8); regret decision (148-9); have ultrasounds (159); endure aggressive and conservative treatment (164); see heartbeat (189); get released from CREF to OB (192); experience excitement (226); follow development of fetus with books (227); locate size of fetus with metaphor (228); get sick looking at books (231); deal with being sick and working (236); tell families (242); take referral from OB to CREF (259); choose both physicians (261) [experience being treated like an object (267); have cysts removed from ovaries (271); endure a lot of pain (275); experience incorrect dose of hormones, endure depression (278); talk with friend and medical professional (278-80); endure horrible mood (284-5); consult with doctor for a long time (293); experience correct dose of hormones (295); change HMOs (299) and change back (300)]; have ultrasound as part of procedure (327); [experience discomfort of internal ultrasounds (345)]; experience confidence in what they were doing (358); experience thrills at seeing it (361); see the heartbeat (369); anticipate painful, uncomfortable, and lengthy ultrasound (388-91)

**prep to be a mother:** buy different house in different school district (200); read lots of books (203); go to FLO meetings (208); be familiar with community of parents (210); begin/continue planning legal work (211); talk to attorney (213); talk about names (215); do guardianship papers (216); plan for adoption (217); endure sickness (223); hope that pregnancy ultrasound wouldn’t take a long time (393); prepare for worst (365); experience thrills at seeing heartbeat and knowing that it was alive (402); endure fear that something would go wrong (405); fear of miscarriage (409); experience sense of security at seeing heartbeat (410); have sense of going through hurdle (415); experience fetus as “blob” with heartbeat/movement (424-7); hearing heartbeat (428); look forward to next one being external (432-6); look forward to seeing the sex (440); experience excitement about seeing the sex (442); make decisions that will lead to knowledge (455); notice desire for sex of fetus (464-5); [be rough and tumble (467); be into traditionally feminine things (468); joke around about Barbie-lover (471); babysat for cousins (475-6); cope with hormones of child (485)]

**Woman/(lesbian):** be in possession of physical parts (524); feel internally feminine (527); have masculine traits that come out (530); work with all women where strength is
encouraged (532); don’t have to be something you’re not (534-5); experience family
where strong women are encouraged (538); don’t experience any gender dysphoria (540-
1); don’t think of self as feminine (547); don’t wear make-up (552); don’t do hair (552);
don’t wear heels (554); feel feminine as opposed to masculine (558); feel as though
words don’t fit (561); feminine: warm (567); nurturing (568); motherly (568); having
female energy that is sexually suggestive/attractive (572-5); kind (594); loves children
(595); personality is warm and nurturing (602); cautious/grandmotherly (607-8); think
of these things a lot (613-4); outside doesn’t necessarily match inside (618-9); feminine
contrast masculine which doesn’t have many positive attributes (623); go to college
(669); have a career (670); don’t work/ have career an children (672); have children as
lesbian woman (684); work with HRC (694); take for granted that you will have children
(694); don’t question whether or not you will have children (697); experience
pregnancy/raising children as “natural progression” (706-7); experience shifts when niece
is born (735); love niece (737); experience desire to be parents (738); desire to be
pregnant after seeing sister pregnant (750); come to realization about sister being
miserable (754)
**Mother/wife:** take care of other people (653); don’t have career (651); don’t think about
self or do anything for self (653-4); look after children or husbands (656-7); not having a
self (660); giving self up completely to other people (662-4); make life (759); change
personality from irresponsible to patient (772); never yell (773); never lose patience
(777); have bad parts, too (783); want to have a kid (793); anticipate/have changes to
personality (807); not anticipating huge in lifestyle (813); as she is already a homebody
(810); who like to stay home (811) and be with a few close friends (811-2); anticipate
having difficulty finding time for leisure ((816), time to be alone (816), time to read
(819), and time to do quiet things (819); be tied down (832); anticipate perfection in the
object you’re parenting initially (883) and eventually come to realize that the reality is
not perfect (894); love that object in spite of imperfections (897); have hopes for child
that include: good education (904), good school (908-9), involvement and activity (917-
8), self-confidence (920), caring (922), not being selfish (924), sense of responsibility
(926)
**Lesbian:** educate doctors (938); explain yourself all the time (949); hear questions (and
respond to questions) about your husband (951); cope with expectations counter to
personal experience (953); come out (962); assess whether people can handle it (967-8);
get lectured (979); consider impact of coming out on others (982-6); fill out forms with
heterosexual language (989); list partner as spouse (990); cope with non-applicable
questions (1003-4); cope with having partner excluded from procedure (1019-21);
questions self/second guess reaction (1027-9); think about/not think about legalities
regarding partner at birth (1038); include partner at prenatal visit (1040-1); make doctor
aware of partner (1047-8); prepare doctor with partner’s presence (1052)
**Fetus/baby:** develop from gestational sac (171); implant in the right place (174); grow
(228-9); present with heartbeat (409); move (425); develop sex (440)
**Medical professional (M.D.):** do tests (19); make sure everything is working correctly
(21); perform painful tests (36); remove cysts from ovaries (22); be remote (39);
administer checklists (85); give specific instructions (93); deal with people who have lost
of problems in their pregnancy (162); be aggressive (164); be conservative (165); make
sure everything’s going okay (167); make sure sac is implanted in the right place (174);
check for multiple births (176); [specialist: release woman to ob (187) when s/he sees heartbeat]; make referrals (259); treat person like inanimate object (266-7); put woman on incorrect dosage of hormones (275-6); be relatively removed from process (305); oversee everything (309-10); coordinate everything (310); make decisions (310); in business of getting women pregnant (313); have procedure (318); make sure embryo is implanted in the right place (338-9); be educated by patients (938); inquire about husband (944-5); have expectations regarding normative role (953); be clueless (959); go to seminars (971); provide info/give lectures (974); get interested in specific health care issues (983); become better doctor (984); review contact information on forms (993); ask (sometimes non-applicable) questions (1003-4); receive questions from lesbian partner

**Sonographer/tech:** be unskilled at performing ultrasounds (348); be “really good” at performing ultrasounds (352-3); be skilled (355), gentle (355, 376), brief (355-6, 376); have confidence in one’s ability (358-9); get heartbeat (365); know what you’re doing (378-9)/not know what you’re doing (381-2); administer painful (388), uncomfortable (389) and long (391) ultrasound; exclude partner from procedure (1019-21)

**Partner:** choose donor (45); choose criteria/characteristics of donor (47-53); pick the guy (53) based on physical characteristics (56) and hobbies (58); make decision to raise a family (128); discuss who would have child (136-7); desire genetic link (140-1); talk with the attorney (213); read books (232); tell family (242); had to be out of town for ultrasound (367); would have loved to have seen second one/heartbeat (369); be disappointed (370); [discussed decision to find out sex (431)]; want a boy (464); be rough and tumble (467); hate having a Barbie-lover (471); not have it occur that pregnancy would naturally progress (706-7); decide it’s definitely going to happen (730-1) having not thought about it prior (734); love niece (737); want to be a parent (737-8); think niece is wonderful (742) even when she’s bad (743); got a dog as an experiment (825); make decision about public versus private school (908-9); moved (911); wanted to come in and see first ultrasound (1019); accompany partner to first prenatal visit (1043-4); ask doctor questions (1046); be part of it all (1048)

**Man/boy:** donate sperm (45) with intent to release identifying information (48); be “rough and tumble” (467); have hormones kick in (485) eliciting difficulties (486); [masculine: aggressive (578); not having positive attributes (622-3); get looked after by wives (657); be spouse of woman (993-5); have right to accompany partner to ultrasound (1024)

**Researcher:** set up interview (1); ask questions (throughout); tape recording interview; make acknowledging comments (throughout); repeat participant’s words (throughout); provide specifically supportive comments (220); laugh along with participant/mirror responses (throughout); follow interview guide; diverge from interview guide; disclose lesbian status (prior to the interview); challenge contradictory statements (556-7); check status of tape (634-6); insert own opinion (710); miss participant in moments (783-9); feel connected to participant/feel disconnected from participant; be judgmental; be empathic; self-disclose (840-1); feel exposed/vulnerable; change tape (797); ask participant for questions (1056-8); look over questions (1064); end interview (1065-6)
Appendix E

Joanne

**Pregnant woman (with disabilities):** pre-pregnancy: have sex with husband (8); plan to become pregnant (11); take prescription strength folic acid (13); take extra folic acid as preventative tool for neural tube defects (16-8); take prenatal vitamin (27); try to get pregnant for two months (30-2); had miscarriage (36); prep to be mother: read (43); get “bond up” on stuff (43); take baby class (44); do “normal” stuff (47); get baby’s room ready (47); wait to do stuff until you’re pretty far it (52); experience morning sickness (75); haven’t gained weight (77-8); lose weight (83); during pregnancy: choose physician (94); look for high-risk pregnancy group due to age and disability (97); wanted doctor who’d worked with women with disabilities previously (102-3); had difficulty finding doctor who’d worked with women with disabilities (105-7); chose high-risk pregnancy group in the city (109); keeping an eye on difficulties in ambulatory walking (150); [most spina bifida children in wheelchairs (169), don’t walk (169), have shunt (172), have mental/physical disability (172-3)]; have rare case of spina bifida (175); having pain in hips (179) and side (180); talk with doctors about the risk of pregnancy (205-6); got informed (210-1); didn’t go off “half-cocked” (213); had consultation (215); decided to pursue pregnancy based on information obtained (231); looked specifically and primarily for doctor who would be supportive of pregnancy (235-6); respond to questions from strangers (243-6); looked closer to home initially, not in city (274-5); called a couple of places and had negative experiences (278-81); looking for someone who would be “behind me” (285); has seen seven of twelve doctors in group (294); had good experiences with all but one (299); reported pain (301); reported pain again (310); go more frequently than other women (319-20); have primary care doctor in addition (358); didn’t come to decision to have an ultrasound (365); had ultrasound right away (369) and then frequently thereafter (372); had ultrasounds at ten weeks (380), sixteen weeks (386), nineteen weeks (386), and twenty-two weeks (387); expects to have them every few weeks (392-4); had different techs at different times (400); was nervous for first ultrasound because of miscarriage (403-4); worry whether something has happened (409); live for baby’s movement (412); wait to see if there’s something (421-2); had “regular” test (426); was sick (426) and wondered if it was pregnancy or not (439); had extra ones (442); come back later for follow-up ultrasound (450-1); watch video “sixty-two thousand times” (458); go in (465); pee (468); bring people for support (470-4); get on table (476); don’t change into gown (478-9); pull up shirt and pull down pants below belly (479-80); have no idea what you’re looking at (492); usually wait while they get the report (505-6); take home pictures and video (508-10); had bad experience with miscarriage ultrasound (516-7); observe techs mannerisms (523-6); burst out crying (535-6); want baby (543); reflect on tech’s mannerisms/motivations (562-3); got self flustered from comment (566-7); saw baby (616-7); knew right away things were better from techs mannerisms and own perception of image (619) in addition to bodily experiences (not bleeding) (623-4); stare at photo (634) and feel like “two stupes” (636); found out sex at third ultrasound (659); wanted to know sex (668); discussed finding out sex previously (675); tells husband fetus could be girl (685); get ready for baby shower (689-90); ask for double check on sex (691); purchase girl items (692-3); plan the room to fit the sex (703-6); desire to plan for it right (718-9); was aware of procedure (744); didn’t have a lot of expectations (746); noticed movement about five and a half months (768-9); wondered whether movement was baby (772-3); worry (788); feel reassured
after doctor’s appointment (791-1); hear baby’s heartbeat (791-2); worry that something
drastically wrong (805); deal with fears as you go along (813); worry more when you
can’t feel the baby (814); notice changes: hip hurting (855), breast enlargement (836-7),
no swollen feet (840), can’t eat lettuce (841) so quit eating it (846), bought bigger bra
(849-50)
**Woman/girl:** into girly stuff (862); flowers and bows (863); like to take care of things
and people (865-6); notice contrast between self and husband (869-70); doesn’t want to
change the oil (873-4); likes nurturing aspect of being a woman (877); people-oriented as
opposed to item-oriented (879-80); think totally different from husband (887); see
feminine and woman as the same thing (893-4); [feminine: looking like a girl (894); not
being overly girly (896) or sissy girly (897); don’t like frou-frou laced stuff (897);
[getting nervous about answering the question (907-8); questions difficulty of the
question (910-1); like to do hair (914), put make-up on (914), look good all the time
(915); worry about weight (whether thin enough) in contrast to husband who does not
worry about weight (916-8); worry about eating right (921); sees woman and feminine as
inseparable (926)]; feel comfortable about raising a girl (933); leaned towards hoping it
was a boy because of disability (941-2); will pattern mothering skills after own mom
(950-1); anticipate possibility of tomboy girl (965); like sports (977); [girl: participate in
sports (977); take ballet lessons (978); experience less stereotypes (986); have more
opportunities (989); play soccer (994); not play football (994-5); play volleyball (998);
[swam (999)]; have more leeway (1000); have more opportunities (1004-5); open to girl
being what she wants to be (1005-6); wants child to: listen to people (1020) and make
decisions (1021), think for herself (1022); is conservative (1029) and hopes that child
will be as well (1032-3): hopes she’ll be successful (1037); is administrative assistant (1040-
1); feel successful (1041); doesn’t have ambition for career (1042); wants child to be:
good to people (1044), have good personality (1044); care for others (1045), not
necessarily be ultra-intelligent (1046) or a “great doctor” (1047), be well-adjusted (1051),
be hopeful about future (1051); nervous about raising her with regard to outside
influences (1054-6); want to influence her (1061); opposed to “everybody wins” thing
(1064); talks to friend about parenting (1087); believes it’s important to learn how to lose
well (1102); not worried about taking care of child’s basic needs (1118); worried about
being working mom (1121); have desire to quit (1125) but doesn’t have financial
resources (1127); juggle budget (1129-30); might try to work less (1132); always knew
she wanted children (1147); got married at thirty-three (1149-50); bought a house (1154);
got a dog as preparation for baby (1154-5; 1163-4); decided to try to get pregnant with
awareness of “time limit” (1166-7); would have been okay with not getting pregnant
(1173-4); may adopt second child (1186-7), consider some alternative (1196); talked with
primary care physician (1213); put trust in primary care physician (1216); saw pcp over
long period of time and established relationship (1218-9); rarely go to doctor more than
“regular” person (1232-3); had to look for a good doctor (1240-1); found someone quick
(1245); lucked out on pcp (1246); referred doctor to a number of people (1254); worked
about UTIs (1258-60); takes low-dose antibiotic (1264-5); takes many pills a day (1271);
feels like hse’s getting used to it (1274); coped with assumption that she wouldn’t have
children (1279); on listserv with disabled parents (1294-5); receives tips (1298-9); have
not had any negative experiences overall (1308); feels/perceives being shoved into a kind
of category (1320-1); doesn’t let disability stop her from doing anything (1344-5); holds
Appendix E

421

determined attitude (1347); nervous about delivering baby (1363); experiences interview as painless (1377)

Fetus/baby: get too big (128); gain weight (135); get checked frequently (378); move (412, 414); get measured (443); lay right (448); have body parts like hands, legs (501); suck thumb (502); be seen (616); develop sex (658); be checked (691); kick harder (776); be felt (778); have heartbeat (791); have legs (805); be delivered (1363)

Medical professional (M.D.): put patient on folic acid and prenatal vitamin (25-7); concerned about baby getting to big (127-8); keeping an eye on baby’s weight (135); watching high blood pressure (144-5); keeping an eye on and watching (146-7); keeping an eye on it (184); know about spina bifida and other issues (202-3); talked with patient about risks (205-6); gave consultation (215); went other everything (216); provided specific information (218-30); supportive of pregnancy (235-6); negative about pregnancy (281-84); tells patient that she’s flustered and hysterical (304-5); diagnosed hernia (310-1); should have paid more attention (313-4); be supportive (317); be encouraging (317); see all patients (332); provide information (341); meet to discuss patients (342); determine your are pregnant (366); order ultrasound right away for high-risk pregnancy (368-9); make sure everything’s good (371); do ultrasounds frequently to check baby (374-8); told patient what to expect (753-4); prepared them (755); let patient hear baby’s heartbeat (791-2); supportive (1207); helpful with preparation (1208); great (1211); gave patient information and feedback (1222); monitor medications so that pre-pregnancy meds could transfer over to pregnancy (1224)

Sonographer/tech: measure the baby (443); measuring different parts in the later ones such as size of spine (444-6); get a good shot (448); give a video to take home (455-6); ask if you have to pee (465-6); bring you in (476); lay you on the table (476); don’t make you change into gown (478-9); be nice (483); give information (483-4); point out parts verbally (485-6); show you everything (504); go and get report (505-6); printed patient pictures from all (509) and video from most recent (509-10); didn’t say anything the whole time (523-4); left the room (525); said “your uterus is empty” (529-30); gave report (534); from patient’s perspective, was cold (533) and clinical (539); didn’t do something heartfelt (545); talk to you the whole time (573); act like it isn’t routine for them (575-6); make you feel like you’re the only one they’re seeing that day (583-4); right away pointed out parts (602-4); didn’t say anything (609); do it real quick (630); print you the pictures (630); hand you the photo (631); leaves the room (633); apologizes (639); explains parts of photo/rotation of photo (640); asked if they want to know the sex (671, 677-8); told sex (678); checks sex again and reports same result (695); lets patient hear baby’s heartbeat (791-2)

Husband: have sex for conception of fetus (8); decided with wife for her to get pregnant (22-3); take baby class (44); get baby’s room ready (47); make sure to be informed (210-1) and not going off “half-cocked” (213); go with wife to some of the ultrasounds (471); say that everything is fine/provide reassurance (528); stare at ultrasound photo with wife (633-4) “like two stupes” (636); decide to find out sex (677); disappointed with sex (679); laughing about results (681); got over it (681); was convinced it was a boy (682); couldn’t feel kick (775-6); could feel kick (778); says, “Oh, for God’s sake” (808); says, “Look, honey, it has legs” (810); enjoys wife’s larger breasts (850); likes sports (972-3); would not want ballet lessons for boy (981-3); played volleyball (999); with wife, wants child to be able to listen to people and make decisions on her own (1018-21); is
conservative (1029), religious (1031), goes to spiritual church (1031-2); opposed to “everybody wins” thing (1063-4); talks with wife about child-rearing; does juggling and budget-moving (1129-30)

**Man/boy:** not Mr. nurturing (869-70); is item-oriented as opposed to people-oriented (884-5); doesn’t worry about weight (918-9); would do boy stuff with a boy (945-6); would not be allowed to take ballet (983); experience more stereotyping (986-7); experience less opportunities (989-90) and leeway (1000-2)

**Researcher:** explain tape recorders (1-2); set up interview (2-3); ask questions; give affirming comments; challenge; clarify; restate; follow up; pause for more information from participant; ask about neural tube defects and spina bifida specifically as I don’t know much about it; probe; laugh; choose not to laugh; self-disclose; feel uncomfortable; feel inadequate; concern self with participant’s comfort level; monitor tape recorders; change tapes; interrupt; endure/choose not to endure interruptions; empathize; feel angry (303-6); follow interview guide; diverge from interview guide; choose not to self-disclose; think of ways in which answers support/challenge research; ask for specific information; feel cornered, nervous, anxious, betrayed (1029-31); feel vulnerable (1392-1403)
Heather

**Pregnant woman:** pre-pregnancy: conceived fetus “naturally” and “intentionally” (20-1); previously, took precautions to prevent pregnancy (28); made decision to have baby (33-4); planned for long time before conceiving (38-9); conceived quickly (39); took three pregnancy tests (47); waited three months to go to the doctor (49-50); didn’t believe tests were accurate (52); used tests with pink line (54); doubted validity of tests (59-60); had not had late periods previously (66); attributed missed periods to age (70-1); showed test to boyfriend (74); used the same manufacturer (80); continued life as normal (83); took a third one (85); noticed stomach growing (86); decided to call someone (88); during pregnancy: changes noticed: not sick (91), not particularly tired (91), a little bit tired but could have been winter bl abs (93-4), hair didn’t change (96), nails didn’t change (96-7), all of those things they say didn’t happen (97), no breast enlargement (97); thought it weird to have gained weight (100-1); went to midwives (104) after deciding was pregnant (106) and calling beforehand to make appointment (107-8); went to midwives straightaway (113); hadn’t had plan (115); started looking at midwives (209); started researching PA law (209-10); picked the midwives for balance between the two (237-9); started eating better (248); did ten-day fast (248); [does fast on annual basis (250-1)]; didn’t really start taking vitamins (258-9); [when not trying to get pregnant, planned for all possible scenarios (276)]; knew she was using birth control (281); plans to avoid something but not to do something (301-3)]; decide to take it as it came (284); didn’t think it would happen (290); read stats about declining fertility and “blah, blah, blah” (292-5); prep to be a mother: get the crib together (306); wash clothes (307); took a birthing class (308); read some books (308); believe you’re born with the ability to do it (309-10); feeling calm about ability to care for baby (335-6); anxious about boyfriend’s children (338-9); lives with boyfriend and his daughter lives there 40% of time (343-4); anticipating shift in family dynamic (367-9); tries to set boundaries with boyfriend’s daughter (384); feels as though baby doesn’t’ need that type of stuff (390); planning to start law school in about one month (392-4); questions length of pregnancy (400-2); did the math (405); didn’t do best planning (422-3); doesn’t want to put off law school for another year (424-5); expects to be laid off (429-30); has fibroids (438); doesn’t know when they developed (452); caused a lot of anxiety (478); did search online and found most information was about hysterectomies (482-4); went to first appointment (488); got blood draw (497); had pelvic done (518); had blood pressure taken (521); had breast exam (522); had heartbeat of fetus listened to (523-4); laid back on table (526); watches midwife’s expression during Doppler (548-50); listen to Doppler (557); called boyfriend (586); went over for the ultrasound (586-7); [had seen ultrasounds previously as mom was a medical assistant (603-7)]; was expecting to see a dead baby (608-10); sees these masses (629); has read books about blighted ova (636-7); saw the baby (639) and felt everything was okay and didn’t care about the rest of it (640-1); went in (649); filled out paperwork with insurance information for preregistration (650-1); waited in waiting room (652); noticed woman put placenta previa on the form (656); laid back on the table (663); had ultrasound with questions about fibroids (719-20); should have noticed she was getting thicker in the middle (723-4); asks questions about Down’s syndrome (763-4); equates tumors with cancer and death (773); got flustered (780); didn’t ask a lot of questions (780); saw pictures of the baby (783); was happy (784); feels it became real (784); doubts self and experience (784-5); hadn’t told anybody (790); hearing the
heartbeat (795); seeing how well-formed the fetus was (796); had conversation with boyfriend about abortion (796-7); had no intention of having an abortion (801); doesn’t agree with it for her (801-2); don’t notice/see/feel anything (808-9); stopped looking at self as negatively (820); worried a lot about the fibroids (826); looked up information online at 2am (836-7); found out specific information about fibroids (841-3); got self into non-functional tizzy (845-6); called the midwives (850); left a horrible, crying message (850-1); spoke with someone on phone (853-5); found out information that alleviated anxiety (863-75); needs to accept risks (888); doesn’t believe there’s anything doctor could have done differently without knowing her (894-5); walked away with knowledge that it was not cancer (879-8); went nuts and looked up information (903-4) (attributes problem to self); went for second sonogram (917); made decision to put it at the end of window of time so she and boyfriend could find out fetal sex (918-21); planning to name him to sediment identity (923-4); went in at twenty weeks for optional ultrasound (933); wanted to check to see that everything was okay (936-7); went in (941); got same girl (941); started looking at him (944-5); having fun getting to see him (947); was there for one and one half hours (958); was freaked out at first (960); didn’t hear heartbeat (962); [jumps to conclusions (968)]; didn’t know what they were doing at the time (985-6); listened to history of Down’s syndrome (989-90); talked about possibility of amnio (995); responded to doctor’s question (999); opted against it (1006); left feeling good (1010); sees it’s a boy (1023); reflects on sex and thinks it’s better that it’s a boy (1029-30); were having trouble picking out a girl’s name (1040); have picked out a boy’s name (1043-4); assumed you were supposed to have ultrasound (1047-51); found out it’s optional (1053); probably would have elected to do it (1055-6); see self as visual person (1056); has taken in information about risks (1059-60); [did filing for mom’s OB (1069-71); watched ultrasounds (1073) after asking permission (1073)]; talked to many people who’ve had ultrasounds (1080); felt surprise at 3D ones (1081-2); wanted visual confirmation that fetus was not from Alien (1097-99); dismisses mind as crazy due to hormones (1101-2); doesn’t believe things are real without visual proof (1105-6); went for third ultrasound around thirty-two weeks (1121-3); had had rocky morning (1125); hadn’t slept well (1126); drinks coffee but not a “ton” of it (1129-30); took coffee from boyfriend (1132-3); drinks coffee (1137); waits 1½ hours for appointment (1140-1); am crabby (1146-7); should have eaten (1151); hadn’t brought food (1152); hadn’t planned on being there that long (1152-3); go in the room (1155); feels uncomfortable even though pregnant woman’s supposed to be fine on a 5% incline (1161-2); speculates about reasons for discomfort on a 5% incline (1164-7); needing to sit up (1168); speculated about reason for negative experience (1171-2); asks about pictures (1176-7); expects more (1182); receives information from doctor (1185-1192); desired other tech (1195-6); feels good with knowledge received (1198); upon reflection, names ingestion of coffee as factor central to discomfort (1120); booked the first appointment for a reason (1130-1); wondered what was going on (1233); asks doctor what’s funny (1270); discusses size of baby with doctor (1272-5); reflects that it seems strange that women want large babies (1277-9); scanned in pictures from ultrasound for family outside of Pittsburgh (1306-7); e-mailed them (1309); keeps them upstairs in file (1311); planning to go to Kinko’s to have them laminated (1313-4); pulls them out to look at periodically (1317-8); pulled them out to look at prior to interview (1318); has trouble remembering when fetus was size of what in relation to the fibroids (1321-3); initially questioned whether movement
as fetus (1349-50); noticed presence and absence of physical changes such as: linea nigra (1258), larger breasts (1364), larger and darker areola (1365), swollen feet, hands and fingers (1367-70), itchy belly (1372), acne (1374), no changes to hair or nails (1378-9), no real nausea (1381), occasional food aversion (1381-2), aversion to cigarette smoke (1385), sense of smell better (1387); feels desire to be normal sized again (1391-2); receiving nonhelpful/nonsupportive feedback from mother (1405); responds to mother (1410); hear things about permanent changes (1414-7); considers plastic surgery (1418-9); wouldn’t have considered it prior to pregnancy (1422-3); thinks it’s unfair that stretch marks appear after pregnancy (1434); anticipates looking different (1446); not upset with baby (1447); chose pregnancy (1449); wonders about whether sex will be normal (1455-6); drew a to-scale picture of baby (1464-5); realizes 10cm.=4in. but seems different (1485-8); in terms of sex, worries about attractiveness (1504), time constraints (1506), desire (1507); going to be in school (1509); discuss feelings with boyfriend (1521); sees broken capillaries (1534-5); feels unattractive (1547-8); asks boyfriend about attractiveness (1549-50); had a long conversation (1554); asks for help (1556); [goes to clubs (1560)]; wonders if clothes are going to Goodwill (1563-4); doesn’t care about projects (1581); prefers to spend time together and do something fun (1587); falls asleep all the time (1587-8); used to go swing dancing all the time but stopped because joints hurt too much (1588-9); switch partners (1593-4); didn’t like dancing with other men (1597-8); felt some tension (1607); challenged boyfriend (1611-3); feels stress from not feeling normal (1621-3)

**Mother:** watched younger cousins (321-2); worked at day cares (326); treat them like little people and they’ll act like little people (328-9); figure would have children (1635), assumed in early twenties (1637-8); worked through things (1643-4); grew up (1646); got more stable (1646); began to wonder if would have children (1650-1); got married (1651); got divorced (1651-2); decided she would “get a popsicle” (1666); desire to give him everything he needs to leave (1734-5); let them live their own life (1742); let them brow, experience, have fun (1744); gets upset (1746); can protect him now (1754-5) and anticipates that that will change (1757-8); wants to give him tools (1769-70); thinks separate rules cause hardship in families and won’t do separate rules (1784); will allow privileges based on behavior (1795-9)

**Woman (girl):** dislikes doctors (119); was treated by homeopath growing up (121-2); lived with body whole life (131); reports experiences of pain (131-2); felt dismissed by doctors (136); got strep throat annually; went to new doctor (146); reported likelihood of strep (147); insisted on likelihood of strep (153-4); went home (154); came back (154); did the “I told you so” thing (158); (dismisses self for doing that); went to hearing specialist (167); asks doctors about homeopathic remedies (176-7); puts iodine on throat (187-9); bring up iodine to regular M.D. (197); was supposed to stay home and maybe go to junior college (1675-6); marry a boy from back home (1677); boyfriend is from back home (1679); was supposed to stay there and be a good girl (1689-90); assumed she would follow rules (1698-9); experience tension with parents (1703); wanted to move out (1704); watched everyone do the same thing (1709); goes home (1714); asks and responds to questions (1713-5); wanted to get out (1722); almost joined Marines (1724); mature faster (1779); grew up with separate rules (1786); considers self woman based on body parts (1808-10); doesn’t always consider self feminine (1810-1); raise the kids (1821); make dinner (1821-2); put on lipstick (1826); dress up (1826); look pretty (1827);
laughs about this (1830-1); put on sweats to go to the mall (1837-8); says, “you’re acting like a girl” (1841); doesn’t compromise masculinity (1848-9); primp to go to the mall (1851); dresses (1858); hair fixed (1858); make-up done (1858); at dinner event, will joke about job to be good girlfriend (1860-2); puts on smile and hair (1864); enjoys sometimes but not all the time (1866-9); doesn’t go to gym with make-up on (1871-2); mom goes to the gym with make-up on (1874-5); finds it amusing (1875); doesn’t do nails and stuff to go running (1877-8); does it when it’s appropriate (1878); doesn’t clean the house in a dress (1879-80); doesn’t get fixed up for him to come home (1883); some women get all pretty (1885-7); questions role (1889-91); noticed changes in feelings about attractiveness (1897-1898); feels same feminine-wise (1900); notices men noticing because she’s heterosexual (1903); went to grocery store (1913-4); noticed bag boy trying to pick her up (1920-1); has researched and found less research done on women’s health issues (1944-6); read about breast cancer (1948-50); feels it’s ridiculous (1955); talks to women about fibroids (1958-61); questions research focus (1967-9); gets upset by conflict of interest with drug companies (1980-5); sees it as harmful not to allow your body to do what it’s meant to do (1995-6); observes and questions asthma and allergy epidemics (2000-2); observes and questions girlfriend who routinely takes antibiotics (2004-7); thought that’s how all doctors were (2020); watched grandmother make witches’ brew (2022-3); went to traditional doctor and age 13 or 14 (2032-3); asked him about homeopathic remedies (2046-8); stopped going to doctors all together (2062); watched grander who learned from woman who put mud on bee stings (2085-7); experienced male doctors as talking down to her (2099-10) and talking with males you’re with (2103); can afford good health care (2109); can chose provider (2109-11); saw homeopathic stuff work (2116-7); became familiar on research on Echinacea (2117-8) and has different personal experience (2122-4); will take in information (2131-3); took Group B strep test (2135); waiting for results (2140-1); will research risks and benefits of antibiotics (2146-7)

**Fetus/baby:** grow (473); grow around fibroids (473-4); have heartbeat (523-4); be in picture (621); is under the other guys (625); develop parts such as lobes of brain (688) and heart (710); get pictures taken (701); be fine (764); have markers for Down’s syndrome (767-9); be well-formed (796); be formed (805); be size of orange (809-10); be little person (812); have hand (813); have profile (815); get big (823); develop sex (920); cooperate (927); curl up in a ball (961); have light calcification (973); not be shy (1021); have head down (1198); be right (1199); be in particular percentile (1267); move (1328); get fed (1410); be on sciatic (1626)

**Medical professional (M.D.):** don’t listen to her (134); said you probably don’t have strep, go home (150-4); do a culture (151); have/participate in adversarial relationship (161-2); diagnose mild hearing loss (164-5); questions previous diagnosis (167-9); prescribe antibiotics/”shove them” at patient (173-4); get defensive (177); dismiss homeopathic remedies (182); recommend/advocate erythromycin (198-9); don’t go to house (203-7); deliver breech babies (230); intervene (235); do ultrasound (603-7); get out jelly and stick thing (717); question participant about knowledge of fibroids (719-20); explains information (750); gives a lot of detail (752); doesn’t necessarily give it in the right “order” but gives all formation patient wants (752-4); gives history of Down’s syndrome (760-1); should have started with “the baby’s fine” (766-7); says patient has tumors (772); couldn’t have done anything without knowing patient (894-5); discusses
things with sonographer (988-9); came in (990); gave history of Down’s (990-1); said it’s unlikely and other stuff (994); discusses amniocentesis (995); asks what patient would do differently (996-7); said it isn’t worth the risk (1001); said “he’s fine” as much as he could (1007-8); came in (1180); gave current and estimated weight and size in percentiles (1185-9); has always been fine (1243); talked about circumcision (1250-1); talked about fibroids (1254-5); laughs (1269); tells patient what most women want in terms of weight (1270-2); checks that he’s okay in there with ultrasound (1291); gave measurements (1462-4); prescribes drugs with influences from drug companies (1980-1); give free samples (1991); give meds that won’t work (2041); says, “we don’t know what you’re talking about” (2054-5); says, “you need this” (2057-8); male doctors talk down to females (2099-100) and talk to the male you’re with (2102); do scientific trials (2117); give Group b strep test (2135)

Sonographer/tech: was very good (615); went to big part/fibroid (617-8); does the ultrasound (664); started doing it (677); points out fetal body parts (687-9); points out fibroids (691-2); takes pictures of the baby (700-1); focuses on baby (701-2); pointed out the positive things (708-9); point out body parts (709-10); took some cute pictures (711); went to talk to doctor (712-3); ask patient about fibroids (694); look at him (945); take pictures (945); looked for birth defects (953); got a heartbeat quick (964-5); didn’t get heartbeat quick (967); took pictures of heart (972-3); took bone lengths and different measurements (978); left to talk with doctor (988-9); moved around the thing to determine sex (1017-8); says, “You’re right” (1023); try to get amniotic fluid levels (1167-8); did “click, click, fibroids” (1173-4); got some measurements on the baby (1174); got a couple of pockets of amniotic fluid (1175); walked out of room (1175-6); said, “Well see about pictures” (1178); didn’t come back (1180); told patient she needed to be in same position (1212-3); offered to get water (1214-5); gave measurements of circumferences of head, arms, torso (1463-4)

Midwife: is accredited, won’t do home birth (212-3); get licensed by state (220); pass certain courses (222); have certain qualifications (222-3); inform patient, “you have to go to a doctor” (230); offer balance between home birth and doctor (238-9); did standard first appointment stuff (489-90); prepare patient to listen to heart tones (430-1); do blood draw to test for syphilis (496-9); do blood typing (514), blood count (515), and other type of testing that you opt for (515-6); do a pelvic based on last pap smear (518-20); do blood pressure (521); do a breast exam (521-2); listen to the baby’s heart with Doppler (523-4); does Doppler and doesn’t get heart tone (540-1); shows on fact that she’s getting worries (549-50); tries to get heartbeat off of fibroid (565-6); recommends patient goes to ultrasound place that day (569-71); says purpose is to get a good date (576); tries to stay calm (577); returned call from patient’s message (853); wanted to talk and get answers for what they didn’t know (854-7); gave answers (861); inform patient that ultrasounds are optional (1053); deliver babies at center (1191-2); feel for position (1293)

Homeopath: treat patients (121-2); give specific remedies (176-7); put iodine on throat (187-9); did ultrasounds (1067-71); gave stuff (2030); retired (2037); gave pills under tongue (2047-8)

Boyfriend: decided with girlfriend to try to have a baby through heterosexual intercourse (33-4); continuing life as normal (83); took a birthing class (308); has two other children (338-9); try to set up some boundaries (384); joke that it’s a tumor or twins (532-3); went with girlfriend to ultrasound (586-7); went in (649); had conversation about abortion
went in for second ultrasound (932); opted against amniocentesis (1006); didn’t see sex at first (1026); ordered coffee for girlfriend (1127); brought girlfriend coffee (1132); get to ultrasound place (1133); wait for 1½ hours (1149); sat there (1229); had booked first appointment (1230); talk with girlfriend about anticipating life after baby is born (1521); says, “I’ve been through this before” (1524); doesn’t notice details (1543-4); says, “you look pregnant” (1550-2); had a long conversation about comments he was making to girlfriend (1554); tries to please daughter (1577); has different projects going on including nursery (1578-9); sees projects as chores (1584-5); used to go swing dancing (1588); compares girlfriend with ex (1608-9); has sex (1625); understands gender roles that some others don’t (1831-2); spends time getting ready to go to the mall (1840-1); acts “like a girl” (1841)

**Man/boy:** will bond better than girl with half-sister (1032-3); leads in dancing (1598); lead well/don’t lead well (1597-1604); go away and do stuff (1690-1); tend to be physically stronger (1778); at age 14, had same curfew as 18-year-old sister (1788-9); wok around the house (1820-1); wear whatever they want out of the house (1827-8); be masculine (1848-9); react to pregnant women (1905-6); comment on food Heather was buying (1914)

**Researcher:** set up interview; prior, explain differences between qualitative versus quantitative research; obtain consent; clarify; interrupt; finish sentences; ask for examples (137); question participant’s judgment (167-9); desire connection (223-5); desire to look knowledgeable (223-5); pass judgment regarding vitamins (261); wonder about participant’s temperament character (268-71); self-disclose minor amount (268-71); collude with participant (401-13); get annoyed with participant during analysis (461-3); jog memory (960-1); challenge participant (1246-7); shift position (literally) (1497); encourage discussion of sex; judge participant (1537-8); dislike participant’s boyfriend; not understand initially (1666) (1843-4); probe