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Managing Motherhood Online: Authority, Assemblage, and Fetal Personhood

Juliet Rose Mallouk
Bard College

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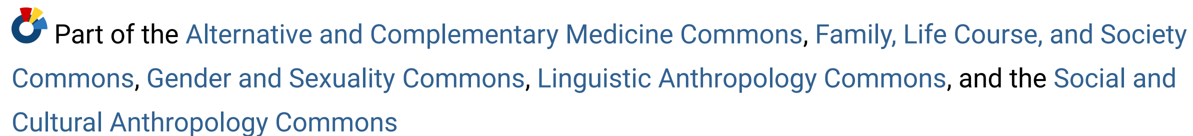

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Managing Motherhood Online:

Authority, *Assemblage*, and Fetal Personhood

a senior project submitted to

the Division of Social Studies of Bard College

By Juliet Mallouk

Annandale-on-Hudson, New York
May 2017

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Introduction

This project began with a series of questions. How do we understand the pregnant body? When and how do we consider mother and the fetus to be separate subjects, patients, or individuals? At what point does one distinguish a singular pregnant body conceptually from the idea of one person *carrying* another, and what does this distinction do? In formal politics as well as common parlance, characterization of fetal personhood, or the recognition of the fetus as a social body, is a familiar rallying point in discussion of women's agency and the state's control of the body. This is particularly evident in the rhetoric of abortion politics in the United States, where pro-life and pro-choice camps contest the importance of what is differentially referred to as a "baby" (pro-life) or, for example, "bundle of cells," (pro-choice) in contrast to a "woman" or "mother." However, the positionality of fetal life and death transcends discussion of abortion, and it is for this reason in particular that it deserves to be discussed as a key element of what pregnancy means for women in the United States.

This past fall, when my sister told me she was pregnant, I was immediately excited. Already during our first conversation on the subject we, two staunchly *pro-choice* women steeped in Feminist ideology from a young age, were talking about the future, remembering our own childhoods, and (perhaps half-)joking that the "baby" should be raised as a girl, no matter its sex and/or genital morphology. Afterward, I noticed the instance of using what I would normally call pro-life language, and felt a strange sense of guilt and confusion—why would I call a part of my sister's body a baby? It is worth noting that in this instance I participated in collapsing the future and the present. I also began to consider at what point I might consider the entity to be alive—did it matter whether we were talking about a fetus, or an embryo, a blastocyst or zygote

or even unfertilized gametes? How should I consider the relationship between the biological events of development and the coming to be of a person? More recently, these distinctions have become central to my understanding. Since this time, I have come to consider the play between the rhetoric of rallying points about identity in pregnancy and controversy of agenda as a fruitful area of cultural study, rather than a personal inconsistency.

While *pro-life* and *pro-choice* politics are ostensibly opposed, my own kind of casual complicity, which I've recognized is common, suggests that the American culture of pregnancy is more nuanced—perhaps in this case, in favor of a paradigm wherein the fetus as a social being that has a life and can die—or be killed. The quotidian language we use to describe pregnancy simultaneously attempts to assert and announces the instability of our categories of life, death, and identity.

This project is neither an analysis of the political valence of pro-life and pro-choice stances, nor a description of medical practice. It is about the way in which people speak about their own experience with pregnancy and, as we shall see, the complex and sometimes ambiguous shift into, and inhabitancy of, motherhood. As a discursive analysis, my research draws on the words women share on online forums, and the ways in which the *speech communities* that arise from the practice of this sharing engage with and create understandings of the nature of the state of pregnancy and the relational identities of mother and baby. In order to illustrate the project at hand, I would like to introduce some key terms and themes, before discussing the content of the following chapters.

Speech patterns in American English are widely heterogeneous. One key term of this research, which will attempt to illustrate the body of participants in the study and their discursive practice, is the *speech community*. Though the ethnographic material of this project is a

collection of written words, the affective and informal quality of the writing, as well as the environment in which it is communicated, has much in common with spoken language. Thus while I do not analyze the sonic and phonic qualities of utterance, the qualia of *speech* are nonetheless relevant to the study, and I regard textual language to be infused with social meaning. Like oral communication, informal writing on support groups and forums signifies participation in a *community* through linguistic signs. In the case of these websites and groups, such meaning is also communicated through paralingual indices such as affective punctuation. As "on-screen discourse" that has the ability to evoke "vocal intensity and bodily movement," (Papailias 2016:8) the casual writing of the medium carries a transubstantiative property that brings people together through language.

In contrast with attempts to define a *speech community* that posited its stable character and homogeneity, more recent scholarship on the topic has focused on the knowledge and practices of the people who participate in said *communities*, and the dynamics at play within and between them. Marcyliena Morgan argues that the concept of a *speech community* "assumes that when people come together through discursive practices, they intend to behave as though they operate within a shared set of norms, local knowledge, beliefs, and values. It means that they are aware of these things and capable of knowing when they are being adhered to and when the values of the community are being ignored" (Morgan 2004:22). Morgan posits a conception that constitutes a group practice, but does not limit participants to acting through or understanding only that practice. In the past, disillusionment with *the speech community's* apparent implications of homogeneity and Western self-regard led to significant criticism of the term. Much of the progress that has afforded scholarship on *speech communities* traction as a result focuses on the negotiation and cultural and/or sociopolitical nature of such a group's parameters (Morgan

2004). For the purposes of this study, we can understand *speech communities* through the discursive interactions of participants and in the ways these actions create meaning. Reading *culture as a text* (Geertz 1973), through text, I will use the term to show how social information is communicated in language that is specific to the group. In this case, the text does not stand for or indicate community but rather constitutes a community in itself.

The communities that surface in this project exist under, and act upon, the dominant orders of hegemonic discourse highlighted by both general trends in secularity and medical rhetoric. Following the Gramscian notion that "hegemony can never be singular," but "has continually to be renewed, recreated, defended, and modified" (Williams 1977: 112), I argue that the *speech communities* of online pregnancy forums focus on creating and using types of language that belong to them, or that distinguish their experience from an often-dominant view from outside the group. These distinctions perform the very real function of asserting the self-representation of the *community* and the individuals who constitute it, and particularly their relationship to the motherhood role, while incorporating some aspects of dominant ideology, and very much resisting others.

The relationships between various posters on thematically organized online pregnancy forums occupy a special category by virtue of participants' experiences, their inclusion in the *speech community*, and the qualities of Internet technology that particularize the kinds of informal, written communication it affords. In one portion of this project, I focus on communications surrounding public mourning after a miscarriage, which provide a special kind of support that comes out of unique markers of speech that allow participants to pay testimony to one another and validate the qualities they perceive in the act of loss. I also draw on the framework that Penelope Papailias describes in her analysis of online viral memorials, in which

she argues that the "performative force of the witnessing/mourning assemblage" creates a kind of "mass participation" (Papailias 2016:2). Memorializing online in this context is focused on "witnessing" because it involves, in contrast to passive spectatorship, the forming of an intersubjective network through which people participate by testifying to and responding to a public act (Papailias 2016). Because the Internet lacks clear temporal and spatial bounds, narrative testimony is replaced by "assemblages" in which authority is afforded by "*authorship"*[emphasis added]—of comments on memorial videos rather than a monolithic or contained narrative (Papailias 2016: 6).

Although only part of this analysis of online pregnancy forums is focused on a practice of mourning or memorializing, the function of the online *assemblage* at hand is marked by what Papailias describes in her work as "continuous, connective, and emergent," as well as "multiple" "temporalities," (6) which allow actors to situate themselves within the intersections of their interactions with an event—or online response, post, or publication. In this work, the unique *assemblage* often constitutes a *speech community*, wherein the technology of the web allows users to bridge the private and public spheres, in order to seek help that will directly affect the material and physical qualities of their lives and bodies. The productive interactions that give responses on the forums some qualities of speech create an ongoing dialogue that is constitutive of *speech communities*. As comments on posts on The Bump and the What to Expect websites occur out of time with original posts, yet may be tied together by common themes or experiences, they constitute a unique *temporality* while maintaining collective and interior practices.

The online communities about which I will speak are based in shared experience and support, which occurs through a kind of collapse of the distinction between the categories of

public and private, in which an affective interiority is made possible by virtue of the Internet. As Papailias describes, online *assemblages*, though not necessarily immaterial, do not follow the rules of shrines that one might find on a roadside or other non-Net locations, but are rather made up of gestures by people who would otherwise be "unrelated strangers" (Papailias 2016: 6). Support groups and interactive question-and-answer forums like those found on the What to Expect and The Bump websites create a similar kind of *assemblage*, sometimes through language that constitutes a *speech community* and always in a mode that bridges spheres. These groups are places where people meet rather than plan to meet.

The question of the public nature of sharing the internet is ultimately bound to what we understand of the "public," the function of technology in supporting or challenging this understanding, and the ways in which materiality informs or participates in the social imaginary found in this kind of public. Citing Francis Cody's review of seminal literature on *publics*, Laura Kunreuther illustrates how scholars Habermas and Anderson describe political subjects as emerging in the "public sphere" (Habermas 1989; Cody 2011: 39; Kunreuther 2014: 240) by virtue of the technology of print and other media, and participating in a new kind of "functioning liberal democracy" (Kunreuther 2014: 240). Kunreuther asserts, however, that this public can be both personally passionate and politicized, as it is made up of "intimate subject[s]" (240). The convergence of self-narratives and mediation of the voice, in Kunreuther's project, speaks to the ways technology can facilitate affective relations that destabilizes the notion of a non-personal *public*. Kunreuther describes this phenomenon as a *public intimacy* (Kunreuther 2014).

In the context of online pregnancy forums, women share information about their private, domestic, personal, embodied lives on a platform with an unlimited number of viewers. Though most posters use pseudonyms, they cast no doubt over the fact that they are talking about their

own lives and bodies, often including medically privileged information. These women have a sense that they are speaking to an audience, which is comprised of people who are in or have experienced similar life situations, who can offer them advice, as well as help in the form of validation. The support of these *assemblages*, though they may be elusive in form, is a kind of *public intimacy*, in that interior and personal thoughts, feelings, stories, and worldviews are shared through an imaginary of belonging and boundedness in an otherwise public place.

The sense of place and its connection to material is also central to understanding the way this network functions. Writing on the Internet facilitates a kind of copresence that is mediated by and connected to the body, but nevertheless indexes qualities of bodily experience through punctuation and explanation more than other sensory modes (Papailias 2016: 8). When communicating on the Internet, one occupies a special temporality, spatiality, and materiality. Simultaneously near and far, women on the pregnancy forums can communicate intimately and instantaneously from across the globe. They can also access content written years ago, by someone who has witnessed or engaged with something they have missed. They may choose to disengage with their own or others' previous posts. One can reply to someone who is deceased without knowing it. There is an anxiety when communicating online that one can't know who the other *really* is, as in the narrative of "Catfishing," the perceived dangers of craigslist housing or job solicitation, online dating, or wire transfer scams. Sincerity is not omnipresent online. However, online communication among the groups in this analysis is marked by an earnestness, which is conveyed by the sense of belonging and particular knowledge contained with in one speech community, through linguistic and paralinguistic signs. Posters tend trust each other enough to share their stories of fear, joy, and heartbreak and, in doing so, form a collective mode of language, which has a special kind of meaning within the group. The posters treat each other's

authorship as authority, so that while their usernames are often pseudonymous and they usually don't have a connection outside of the support group or question-and-answer format, their public intimacy creates a kind of copresence, in which one or more person's body or life can be affected by the actions or statements made by another. While the body's materiality is indexed by written words, it is not absent from the considerations or actions of the posters on these forums. In fact, interactions between technologically mediated bodies and modes of agency and control are central to this study.

Medical Anthropology

Concerns with the body, on these websites, are also fundamentally tied up with concerns about how the body lives, within and without the culture of the speech community. My engagement with medical anthropology will primarily concern scholarship that critiques the medical emphasis on pregnancy and childbirth or otherwise relates to the relationship between the entities of mother and her relationally opposed baby, fetus, or embryo.

Cultural perspectives on health and wellness are central to the context of this work. Though one's physical form is in many ways notably absent from the Internet, it is also plays a great role in my analysis, as discursive representations of the body speak to its ideological containment, and the expression of its boundaries. Scholarship in medical anthropology tends to oppose the Cartesian mind/body dualism in favor of perspectives of an integrated subject, for whom ailment of the body and mind are entangled and whose ailments are constructed as a social fact (Eisenberg 1977; Scheper-Hughes 1994). The consideration of the bodies of the women in this study follows on the premise that they act and create meaning on the different planes or frames of analysis (Lock and Scheper-Hughes 1987). At one level of experience, we will

consider the "individual body" or "lived self" of the mindful body-self (Lock and Scheper Hughes 1987:8), which occurs phenomenologically. In such a consideration of the body, the first-person perspective is considered to constitute a consciousness and lifeworld that may pre-objectively define life experience (Good 1994; Scarry 1985). The personal body, in medical anthropology, in intrinsically tied up with the "social body" in which the physical and symbolic qualities of the body play out in the interpersonal realm through the "constant exchange of meanings between the 'natural' and social worlds" (Lock and Scheper-Hughes 1987:7). The individual and social bodies represent two ways of considering the self, while maintaining the simultaneity and entanglement of these modes of acting and understanding.

This analysis occurs at the distinction made between the categories of the self and other. Mothering, insofar as I understand it comes out in this work, is largely formed out of a process of imaging the child as something that relates to the self, so that a specific kind of care can be enacted; to consider the child while isolating it from social meaning would make no distinction of such a being from the mother. Physical boundaries, though they may be negotiated, ambiguous, contested, or otherwise fraught, provide the beginning of a network through which action can begin to be read, as it forms on an Internet *assemblage*. In the case of this study, difference between websites and sections within one website show changes in discourse regarding the closeness or externalization of a fetus, baby, or perceived entity.

The premise of *managing motherhood* relies on the notion of the personal or social bodies with a "body politic." In discussing the concept of the "body politic," Lock and Scheper-Hughes describe the "regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality… in sickness and other forms of deviance and human difference" (Lock and Scheper-Hughes 1987:8). The "body politic" is based in the rhetoric and modes of

control of Foucauldian panopticism, which posits regulation of the subject as working through an imaginary structure that affords total surveillance by a central source that coerces compliance (Foucault 1977). These "three bodies" form the foundation for a fluid but nevertheless distinct scholarly consideration of the ways power is enacted on and through the body of the subjects at play for the women who participate in this analysis. In attempting to understand the political mode of the body, this project will analyze themes of choice and individuality in the context of the pervasiveness of medical narratives and the often-clinical context that influences pregnant women and new mothers. Though it is not a discussion of hospital practice, we see nonetheless that women engage with modes of medical authority, notably within the rubric of the Real Answers format of The Bump website and in discussions of tension that women cite feeling with regards to their healthcare provider.

Within medical anthropology, biomedical practice often garners criticism for reinforcing the isolation of the individual body by effectively denying the relation between its personal and sociopolitical qualities, or for delegitimizing phenomenological experience when ailment or *illness* (what the patient suffers) does not fit into a *disease* model (as can be diagnosed by a doctor) (Eisenberg 1977; Scheper-Hughes 1994). Though pregnancy is not spoken about as a disease, it is seen as a *condition* that warrants medical intervention and sets women who bear children apart as *patients* during such a period. Drawing on Michael Taussig's 1980 essay, "Reification and the Consciousness of the Patient," I argue that women on these websites and online forums are subject to such a Marxist understanding of reification, or "the thingification of the world, persons, and experience," by which the aforementioned entities are submitted de facto to commodity structure and capitalist ideology (Lukács 1971; Taussig 1980:3). In the face of being reified as patients, these women seek out and use the community of the online forum to

resist and take control of their own narratives. Taussig's work situates the acts of medical practice within a construction of reality that ignores modes of social living and obscures both the doctor's positionality and enforces compliance based on the "use-value power embodied in the healing process" (Taussig 1980:11). He also shows how reification of the patient is afforded in the hospital by a split in subjective and objective ordering, and the dominant influence of treatment based on an ordering of bodies as "*a priori* objects beholden to only their own force and laws dutifully illuminated for us by professional experts such as doctors" (Taussig 1980:5). My work does not analyze the category of being a patient per se, but rather draws on Taussig's sense that the implicit politics and ideology of medical practice are obscured as bodies are taken out of their social and historical context. In contextualizing the comments, interactions, and stories of individual writers, I attempt to show both the ways in which power in medicine is structured to create subjugated patients and, importantly, the modes of deviance and resistance by which assemblages on The Bump and What to Expect, among others, define themselves in reference to their social worlds and babies.

Similarly, the struggle to reconcile one's meaning in the face of prescriptive medical practice is also connected in scholarship to the practices of the construction of the disease category, the function of diagnosis, and the notion of *medicalization*. In such an iteration, the control of the reified body functions through the process of assessment, in which the discomfort of a person's illness or ailment is first identified as deviant and then reintegrated into a manageable state by the naming and diagnosing of the disease (Eisenberg 1977; Conrad 1992; Martin 1987; Scheper-Hughes 1994). Once safely in the disease category, once-ailments can be treated. Though this treatment can occur through healing metaphors and the phenomenon of *meaning* that *mends* (Moerman 1991), it is most commonly remarked upon in a critique of

clinical Western biomedicine that perform interventions such as medication and surgery. This critique plays into scholarship of *medicalization*, wherein life experience is considered to be claimed for the medical domain (Conrad 1992; Scheper-Hughes 1994). Medicalization as a concept formed over time throughout the 20th century, and is succinctly defined as a "process whereby more and more of everyday life has come under medical dominion, influence, and supervision" (Zola 1983:295). The emphasis in this statement on the "more and more" speaks to the general idea that the practice threatens the lay realm or alternative forms of social meaning by its mode of control. Similarly, anthropologist Nancy Scheper-Hughes argues that as problems with an individual are transformed into a diagnosis, the embodied and lived experience is devalued in the face of the overproduction of illness and emphasis on pivotal, primordial role of healthcare providers (Scheper-Hughes 1994).

Literature on the treatment of pregnancy and childbirth that follows from medicalization narratives often involves a lamentation of the loss over time of midwife-based facilitation of the gradual and non-discrete process of pregnancy and birth, and toward distinctly male scientific regime of medicine (Martin 1987; Rothman 1982). Pregnancy is understood to be medicalized by entrance into the category of a medical *condition*. While it is not a "disease," pregnancy is nevertheless understood to be pathologized, and creates a category of reified *patient* in biomedical practice (Rothman 1982). Similarly, Rothman argues that a second patient is created (and subjugated by its externalized identity) at birth. Scholars like Emily Martin and Barbara Katz Rothman criticize medical practice for not allowing women to participate in their own birth experiences in ways that provide them meaning or agency (Martin 1987; Rothman 1982). Part of this critique comes from the perception that biomedical healthcare provided to women in labor or shortly after birth is centered around intervention and the need for specialized medical care.

Additionally, doctors are contrasted to midwives, and criticized for opposing a "natural" state (in the case of pregnancy) or process (as in childbirth). Arguments about the medical model often criticize the practice for over-management, and for subjugating women's bodies within a male paradigm of biomedicine that characterizes them as inherently deviant or otherwise ripe for exterior management (Lock and Scheper-Hughes 1987; Martin 1987). This project describes a revision to the medicalization model that (re)imagines the way pregnant women and new mothers ascribe meaning to medical events, while still maintaining a critical attitude toward the engulfment of biomedical practice. As the following chapters will show, the unique communities that arise online present themselves as occupying both resistance and compliance, as well as a kind of self-assertion that relies on the support and *public intimacy* of the group. As "symptoms" of a pregnancy "condition" are appropriated into the discourse about one's life experience, they come to fulfill a validating role, through the assertion of individual *choice*, or in describing the reality of one's own claim to motherhood after a miscarriage.

Chapter Overview

Chapter One of this project will explore the discursive tactics of The Bump pregnancy website within the context of new understandings of medical treatment, mothers' agency, and the use of technology. This chapter problematizes the power structure put forth by earlier medicalization narratives, and examines other approaches to the birth experience, especially through a framework of the assertion of individual choice. The unique organization of The Bump as an online *assemblage* provides users with different interactive options. While posters can respond to each other's questions, they can also 'bump' responses up, bringing them to the forefront of conversation by rearranging them spatially on the webpage. Additionally, advice is

given by both fellow users, who usually post based on shared experience, and the more expert editors of the website. While a disclaimer prevents editors' advice from being taken as medical fact or guidance, the responses they provide appear aligned with a biomedical paradigm, especially with regard to posters' concerns about choices surrounding perinatal practice.

Notably, much of the discussion on the interactive portion of the website is concerned with issues of health. Not everyone describes health in the same way, but several trends come to the forefront of my analysis of the related discourse. The first of these is the relationship between health and "natural" modes of prenatal care or childbirth. In this context, women contrast natural and technological ways of giving birth that evoke primarily late 20th-century ideals of a "*return to"* practices that assist the mother in asserting her own agency, provide a (more) meaningful rite of passage, and assist in the social bonding between mother and baby. Mothers of The Bump provide their own rational for giving birth, for example, without an epidural or Pitocin stimulation, in an upright or squatting position, on their own time, or assisted by a midwife in their home or a birthing center, among other things. However, they also participate in more traditionally medicalized forms of the birthing practice. Their claims focus on providing support for options they consider healthy, in terms of limiting stress on the body and providing social support or meaning, rather than following one proscribed procedure.

Interestingly, the mode of discourse on The Bump is marked by a decisive respect for another person's *choice*. Though women step in on question-and-answer forums to give advice, and play a role in determining which advice is the most spatially visible on the page, their wording is marked by a distinct disavowal for the act of trying to convince someone of what they may think is best. The refusal to make a choice for another person provides a special kind of *witnessing* in which one's own authorship defers to the original poster in a thread. Additionally,

views on birth practices are seldom phrased staunchly enough to appear dogmatic or self-important. Women on this forum situate their views in their own experience seemingly to safeguard against intruding on another person's lifestyle or wishes. Many of them even speak from the experience of undergoing natural childbirth (usually meaning without anesthesia or induced labor) as well as the full-scale interventions of biomedical practice, in order to compare and contrast the two types of practices in the form of advice. While to some degree many are choosing sides on a debate of nature vs. technology, the primary importance of their explanations still falls under the priority of the original poster's choice and wishes, and within the framework of a working definition of what health or wellness means to them. Though tension sometimes exists between individuals' strong views and their desire to give helpful advice, the community of the website tends ultimately to supports women's' practices based less on what they are than the independent quality of choice by which they come about. The discursive practices at play in this chapter illustrate a unique attitude toward the pregnancy and birth experience that somewhat complies with and somewhat resists the biomedical paradigm.

Though Chapter Two includes information on preparing for pregnancy, it most notably introduces the theme of the identity of the fetus, whereupon fantasies of prenatal personhood and resultant relational motherhood identities occur. In this chapter, we will explore the ways in which the speech communities of miscarriage forums and online rhetoric create and affirm the role of motherhood for many women who have lost their children or have trouble getting pregnant. This chapter describes practices in which women assert social roles or positions that they feel have been denied them by dominant thought and practice, including in their perinatal medical treatment and interaction with their doctors. In this chapter, an elusive definition of pregnancy and motherhood is facilitated by the *speech communities* enacted on and afforded by

forums of the What To Expect website, which are both more intimate and democratic than those of The Bump. This chapter also investigates views on the instance of conception in an attempt to define fetal death and locate its importance for women who are involved with it. The strength of *witnessing/assemblages* in this contexts allows women to create and assert their own realities though mourning narrative and online practice. The support of the group functions to legitimize the grief of lost potentialities. Through the technologically mediated and Internet-specific mode of communicating with the dead, stories of personal loss come to create actors out of miscarried or deceased “angel babies.” Mourning practices rely on the elusive materiality of the Internet and the modes of communication of material and of hope it affords.

The third chapter of this project assesses the validity of treating motherhood as a normative project for women. This section will attempt to apply the themes of discourse found in the first two chapters to the relationship between mother and baby that we can find online in medically mediated form of communication in 2017. Chapter Three will show the ways in which women fear or embrace the categories of “good” or “bad” motherhood, (Roberts 1995) and how this concept enacts on their own decisions and self-representation, especially in the context of The Bump’s message boards on breastfeeding. This chapter will also show how hegemonic paradigms of gender inform one’s perception of oneself, the ways in which women may be made to feel guilty or “bad” as a mother, and the function of group message boards in mediating such a perception.

Chapter One: Interactive *Author*ity

Introduction: The Bump

The notion that language enforces a kind of symbolic domination (Bourdieu 1991) that is nevertheless contested by the work of counter-hegemonies (Williams 1977) or centrifugal linguistic forces (Bakhtin 1981), is central to the form of *speech community* that one finds on The Bump. The website, which self-describes as providing "first-time millennial parents" with information on pregnancy, birth, and babies,[i] fosters a display of linguistic heterogeneity in terms of register and relatability. The website is the third in a series by the same creators that all follow a traditionally heteronuclear, first-comes-love logic—from "The Knot" (marriage) to "The Nest" (home-making and décor) to "The Bump." Its design relies on a centripetal, unifying social model, yet the site makes appeals to the young with clean, unfussy graphics, apps and active social media presence, and words like "lowdown," that skew hokey but are clearly contrived to hit a millennial mark. The premise of the website is reconciliation; it brings the opinions of "experts, editors and peers" together to provide "Real Answers" to individual questions, grouped by topic or trimester.[ii] The Bump is comprehensive. Its scope ranges from news about pregnancy-related topics to listicles about pregnancy myths to a guide to specific markers, arranged by trimester. This chapter will focus on a special locus within the site: the Real Answers section, which constitutes a discrete *assemblage*, wherein the relationship between status, autonomy, and the group is negotiated through language.

Expertise

The “Real Answers” section of The Bump website is characterized by engagements between people with different enactments of expertise. The answers are promoted as “real” based on their very interactive nature. “Real Answers” is set up to facilitate direct responses to specific and often personal questions. In gaining and providing responses, posters create and engage in unique relationships. Their interactions with one another produce a sense of closeness, as their bodies and discourse are linked through the Internet in the form of *assemblage*. As people are grouped based on certain topics that they may search for, browse, or write about, the social milieu of the website comes into focus based on participatory practice as well as the editorial and operational qualities of the site.

The “Real Answers” categories of expert, editor, and peer present a simultaneous distinction and fluidity between kinds of authority on the page. Medical doctors or closely affiliated medical professionals are the most prominent experts on the site. Though they may consider factors brought in by other (peer) respondents, they only respond directly to original posts, and their responses are formatted to rest at the top of the page. Here one MD replies to a “mom’s” question about whether or not she can opt out of using a catheter after getting an epidural while she’s in labor:

1 FEATURED ANSWER

SARA TWOGOOD, MD
Assistant Professor of Clinical Obstetrics and Gynecology at Keck Medicine of USC

It is a choice and you should ask your doctor about it during a prenatal visit. I always prefer to have these discussions in the office before my patient is in labor ... it makes it easier for her to ask thoughtful questions and gives me time to answer. An epidural limits sensation from the waist down. That means sensation to your bladder is limited too. You can't sense when your bladder is full which may cause over-distension (which can lead to long term bladder problems and in some cases can obstruct the baby from descending). Nurses place the catheter after the epidural is already working so it shouldn't cause discomfort. Most women won't be able to urinate normally if they opt out of a catheter and try to use a bed pan. If your epidural is light, such as with a walking epidural, you may be able to urinate without problems though.

This answer should not be considered medical advice and should not take the place of a doctor's visit or consultation with your physician or other healthcare provider.

Figure 1.1: Expert Answer from a medical doctor on The Bump's Real Answers page. Accessed 23 April 2017.

Though a disclaimer prevents this and other expert comments from being taken as medical advice, doctors' credentials are clearly listed on the site underneath their photo, full name, and distinction as an MD. Expert answers are always *featured answers* (along with official Bump editorial answers), which means they are displayed with an orange banner at the top of the page regardless of the movement of peer answers. This banner is decorated with a stethoscope, tying the categories of "expert" and "medical doctor" (or sometimes nurse) together in one fell swoop. The disclaimer about medical advice does little to discredit the post. Written in faint gray, it is presumably provided based on the legal protection of the doctors and the creators of the website—and sends mixed messages to users. Despite the prominence on the page, the overtly medical labeling and symbology, and the feature of this type of answer, all of which give

credit and weight to this kind of response, users are asked to disregard its practical meaning. Expert posts undoubtedly provide valuable information to those who frequent “Real Answers.” At the same time, they do more to accrue symbolic power and determine the use-value of the information being spread, based on the biomedical standards of legitimacy, and its presumed authority. The editorial decision to feature these answers stratifies the overall conversation based on the presence of this authority, which also constitutes a type of instruction. Even as medical doctors deny the responsibility to treat readers as their own patients, they teach them about what kinds of information are correct and participate in the creation of a hierarchy.

Featured Real Answers can also include posts by the editorial staff of The Bump or other informational websites. In this case, the social positioning and iconography are slightly different: a B symbol on the orange banner takes the place of the aforementioned stethoscope, and the official label of “The Bump Answer” that accompanies it indexes editorial authority within the context of the site. Expert answers from elsewhere that are deemed credible simply share the banner of and “Expert Answer,” with otherwise relatively little variation. Yet these sorts of posts regularly cite medical literature, and reference original posters and the wider audience of non-expert viewers to information about side effects and (scientifically proven) reports on the sensations of a certain kind of pregnancy or birth experience. Responses by medical doctors and editors are both specially marked (in orange) beside the posts they answer in the list under a certain topic, like “Labor & Delivery”. This creates a distinction between expert (MD and editorial) and all other posts, as it provides a sort of filter for browsing. The special orange color that marks this distinction singles these posts out as providing the answers that are presumably most useful from the editorial perspective.

However, while the primacy of these posts seems intentional, the actual language used in them, especially in those written by medical doctors, seldom draws a stark contrast. Though the doctors primarily draw on their medical training and experience with other people's bodies, their advice also bolsters the original poster, often providing comprehensive reassurance in the form of explanations for standard interventions. Though posts by "moms" are relegated by design to the "additional answers" section below a featured post once one has been created, the language used sometimes transcends the categories of status that the website promotes spatially. Boundaries in this section initially appear fixed, but in analyzing the site it becomes clear that modes of credibility are pluralistic and engaged in both a mutual reinforcement and competition.

One clear example of this is the sometimes-ambiguous designation of expertise. Though Real Answers bases its delegation of "Featured Responses" to "experts," many "moms" in the additional responses provide sound reasoning and support, often using references to their own knowledge. Two categories stand out in this vein. Firstly, the women who respond in the "moms" section are sometimes technically qualified experts in their own right. Women in this peer-oriented rank sometimes identify themselves as nurse practitioners, midwives, or scholars of such practices. I consider many more to hold valuable knowledge gained through their own independent research, which provides its own kind of support. This group, consisted of "moms," interests the question of the setup of the response section as a whole. The apparent inconsistency that promotes one birth-oriented nurse but not another (see *Fig. 2.1*) seems to be linked to their affiliation with the website; those who choose to speak as a peer lack a page describing their expertise in The Bump's expert directory, though it could also be related to their formal education or status within their field.

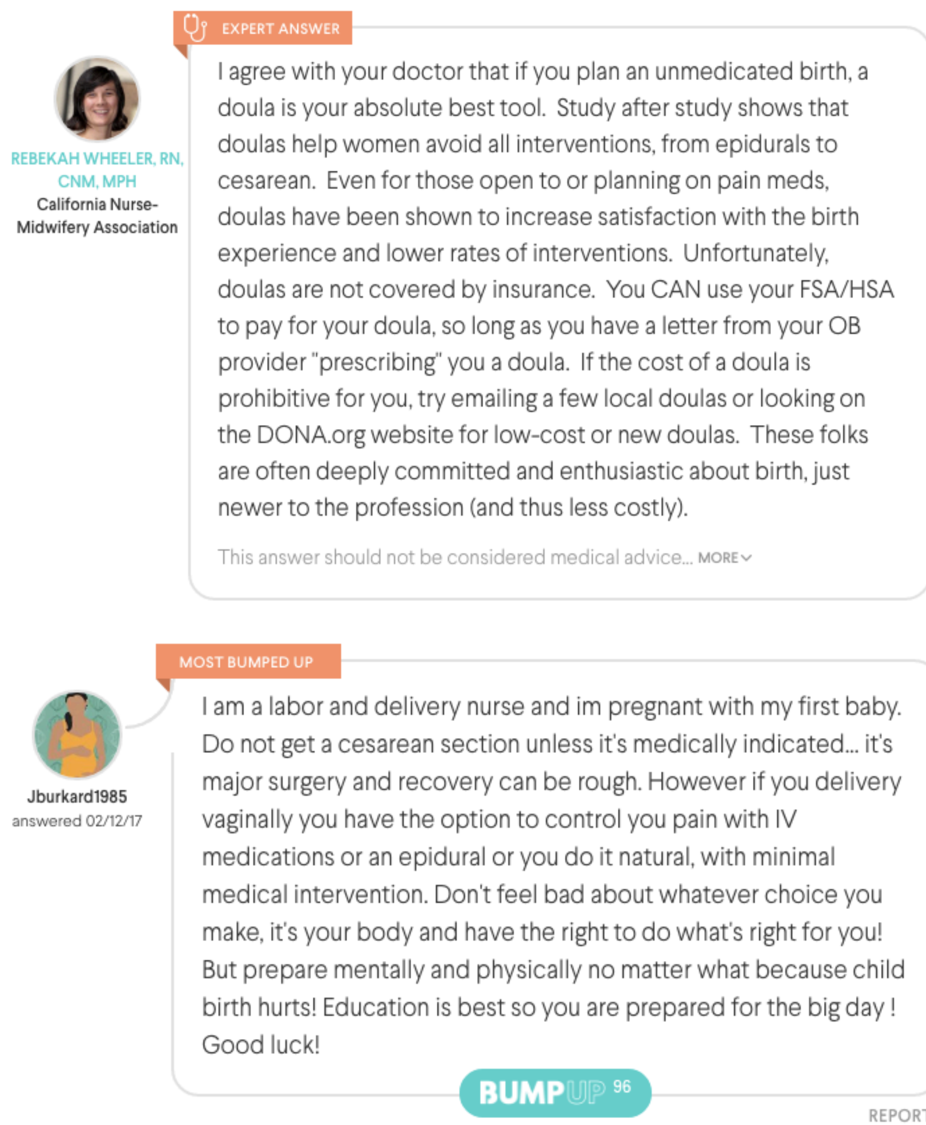

Figure 2.1: Comparison of the treatment of nurse expertise based on mode of interaction with the website. Accessed 22 April 2017.

Figure 2.1 compares the visible prominence and credibility afforded two posts by medical nurses. The first nurse, who is identified by her full name and picture, presents her advice alongside her official designations as a Registered Nurse, Certified Nurse Midwife, and her Master's degree in Public Health, with a link provided to her education and relevant work experience. The second woman writes under a username, yet she identifies herself with two credentials in her post—her status as a "labor and delivery nurse" and as "pregnant with [her]

first baby." As is clear from the example the second nurse gives, women often refer explicitly to their own status as mothers or moms-to-be when citing the credibility of their responses. Though this position is the ostensible rationale for the inclusion of peer response and constitutes the majority of the community, it is less formally promoted than those that might fit stricter tropes of the biomedical birthing practice. Nevertheless, its importance and the notion that one can be access status in multiple ways lead into the analysis of the unique power structure.

The Bump as Assemblage

1 EXPERT ANSWER | 14 MOM ANSWERS

Figure 1.3: Expert and Mom answers listed in Real Answers. Accessed 29 April 2017.

Peer responses on Real Answers are invariably called "mom answers" (see *Figure 1.3*). The website creates a dichotomy between these and "expert answers," highlighting the singular and preeminent nature of the latter in orange. "Mom answers" are edited to appear secondary, and are identified as non-"expert" by omission. There are also many more of them. Part of their presentation as lay advice seems to rely on their abundance. However, the dates of the posts show that responses often occur after an expert has posted. These posts can verify, challenge, ignore, or otherwise affect each other, including the reading, if not the spatialized legitimacy, of expert answers. Questions garner more traffic when they present popular or exciting topics, but additional answers are also contingent on the activity of the community that forms around the original posts. Commenters congregate in threads where they feel their perspective or experience is relevant and important to the topic at hand, and their answers take the form of a shifting and expansive *assemblage* with a unique practice of providing direct support to one another's authorship.

Though the nature of the first post in *Figure 1.2* is automatically afforded prominence, the second also achieves visibility status through the interactions from her peer posters. The Bump Real Answers section provides a unique mode of communication; though one can comment to provide an answer to a post, it is also common practice to "Bump Up" a peer post so that it will appear higher on the Answers page. The more "Bumps" a post gets, the closer to the original post at the top of the page it will be. It will also most likely be read first by those who come to the website to browse questions similar to their own. This practice creates a category of spatial credibility that transcends traditional narrative chronology. Online *witnessing/assemblages*, as defined by Penelope Papailias in her work on viral memorials, are marked by the "mass participation in a sprawling intersubjective network" (Papailias 2016:2) that Internet engagement affords. Unlike the Greif & Loss forum of the What to Expect website, which we will examine in detail in the following chapter, Real Answers on the bump is not dedicated to mourning. Yet it may exhibit a type of community interaction that is common among people sharing and influencing each other's stories. This section of the website provides a kind of *assemblage* in which would-be strangers influence each other's life choices. Papailias notes that the "mediated witnessing" that characterizes this kind of a group/interaction "makes the past continuous with the present" as time is spatialized within the database (Papailias 2016:2). The display of posts on Real Answers doesn't follow a linear temporality; though the date of each post is listed, they are much more likely to be displayed in relation to one another, as an evolving conglomerate wherein life stories are intertwined. This phenomenon is most evident in the "mom" or peer comments, whose configuration is often based on the comparable experience between and among individuals. The instance of pregnancy or the category of being a "mom," as well as birthing choices and interactions with medical management, allows women to

comment on each other's relevant situations, forming social communities regardless of physical location.

The *witnessing* category of a comment or a "Bump" provides a form of *public intimacy*, as its expressive mode of multivalent temporality allows women to find each other's posts when they become relevant to one's specific life story. The double entendre of the website's name, which refers to both the "baby bump" that forms during pregnancy and the action of promoting a specific comment or response to a question, speaks to the unique relationship to the physical body that this *assemblage* promotes. This kind of record of informal writing about what occurs in the body affectively produces a sense of closeness and relation. Feedback about specific bodies seems to connect these women in a network of familiar (or complementary, or contradictory) sensation, so that the focus on the physical comes to inhabit the online interactions. Even the semi-formality of expert posts, which read as inviting and constructive but draw on more distant forms of experience, do not compare to the kind of intersubjective sharing that the seemingly earnest and informal "mom answers" create. While expert/editor answers may be involved in the process, they do not *witness* in the same way.

The particular action of the "Bump" allows for peer engagement to have an effect not only on the original poster, but for those who create responses as well. If one part of a record or response feels especially helpful or salient to a "mom" peer, she can "Bump" the post, providing a second kind of feedback that gives support both to that response and the question posed by the original poster. This kind of sprawling simultaneity relies on time in terms of specific life history and connection, creating a web-specific, non-linear temporality. This phenomenon establishes *public intimacy* by reconciling the various types of distances between posts with an affective connection that brings the sensations, emotions, and social positions of women together, based

on the state of pregnancy that is occurring or has occurred in their body. As "the Bump" refers to both the form of participation and the content of these posts, so interwoven words and experiences constitute the community. The nature of the answers on the post set the parameters for claims to belonging as well as expertise. The mode of collective *authorship* that marks the Real Answers discourse is thus concerned with practicing one's own as well as others' authority, while maintaining a distinction between the two based on the unit of the individual.

Choice and Advice

The Real Answers portion of The Bump website is, first and foremost, a place to share opinion. Though participants are situated within a group, they present views that mesh to varying degrees. Because advice is often given from the perspective of experiential credibility, it is often infused with a subtle superiority. This tendency is tempered by one consistent buffer: a statement that defers the matter of *choice* to the individual who initially asked the question. Comments or answers, in this context, engage in the rhetoric of help and contribute to the construction of an interwoven experiential state but do not challenge the *authorship* of the original poster, for whom such responses presumably matter the most. The comments on Real Answers effectively establish an ideology of individual choice as defined by collective effort.

This phenomenon is particularly evident in the context of questions about birth and delivery. This area is subtly marked by a debate around medical management, and various ways of understanding "health." Comments on this forum distinctly prioritize *health* as going hand in hand with either various uses of "technology," or engagement with "natural" childbirth. These categories engage with existing literature in medical anthropology by exemplifying a relatively recent revision to the medicalization narrative, in which a person's needs are understood to take

precedence over adherence to specific rules about the inherent controls of the medical institution (Taylor 1995; O'Dougherty 2013). Though the isolation of the individual is a major criticism of biomedicine (Foucault 1977; Scheper-Hughes 1994:230), the personal body and, more specifically, its enacted agency or choice, has long been a focus of medical anthropology, notably in the context of birth processes and interactions.

Medicalization and the Primacy of the Individual

In the 1980s, fundamental theorists of the medicalization of childbirth argued that the natural process, along with menstruation and pregnancy itself, had been taken into the realm of medical management, subjugating women's status and effectively taking them out of their own birth experience, with the use of technological interventions like drugs and tools used in C-sections (Martin 1987; Rothman 1982). The rhetoric of technology was fundamentally opposed to the natural processes in which the self and the body were understood to be inherently integrated. In her 1987 book, *The Woman in the Body,* Emily Martin describes a metaphorical cultural understanding of women's bodies as machines and doctors as supervisors or even owners of those machines—rather than more equal maintenance care workers or "mechanics" (Martin 1987: 57). Martin situates women's bodies within a Marxist construction of the alienation of labor by highlighting the disconnect women feel between the "self" and "body" (Martin 1987: 71). Additionally, she cites the "involuntary" status of the uterus and technology the doctor uses (including forceps, epidurals, external monitors, and the incisions of C-sections, among others) as constructing the birth experience as something that happens to a woman, denying her agency in her own act (Martin 1987: 78). This metaphor of machine, and the all-encompassing biomedical power it seems to represent, was part of a late-20th century

construction that participated in an ideological divide between technology and nature. In this context, the "natural" was generally indicative of an integrative health that considered the body as social and political as well as individual. Agency, in *The Woman in the Body*, depended on the idea that a woman had control over the physical processes of her body. Though Martin's focus offers a powerful critique of biomedical practice by ostensibly calling for an integration of social and physical meaning, the focus on the specifics of technology and the clear-cut distinction between autonomy and exterior force lack an integrative understanding of the body or the self as a locus of tension and activity (Scheper-Hughes 1994), where the boundaries of the self are both porous and unfixed (Kristeva 1982; Moore 2009:429).

Early midwifery models, insofar as theorists considered them a natural, and therefore integrative, alternative to biomedical birth, were generally preferred based on criteria that can be found in arguments on The Bump's Real Answers forum. These include a respect for the timing of birth to the woman's body, as opposed to the drug-induced labor that comes as a result of the arbitrary parameters of concise labor (Rothman 1982; Rothman 2007: 65), and the maintenance of the physical connection between the mother and baby (Rothman 2007: 74). Barbara Katz Rothman criticizes the medical approach for creating two patients out of the mother and baby by pitting their perceived "needs" against one another, for example the "need" for the mother "to rest," which leads to the mother and baby being physically separated in the perinatal period. In her kind of alternative midwifery model, the "family" rests together (Rothman 2007: 74). Rothman's work in particular includes a historical description of the politics of medical care that highlights a shift away from midwife-based facilitation of the gradual and non-discrete process of pregnancy and birth, and toward distinctly male scientific regime of medicine that makes a problem out of it (Rothman 2007). By the measure of these anthropologists, the macro-level

systematized problem of disease-making ensures that, while many obstetricians and gynecologist doctors may be women or may have lived experiences of birth, they also act from a perspective that marks female bodies to be subjugated, violently managed, and otherwise denied power. Additionally, proponents of natural birth and/or midwifery oppose certain regulatory factors like clinical tools, doctor-led methods for pushing and delivery in favor of counting on the "sufficiency of nature over the supremacy of technology" (Cheyney 2001). Studies on midwifery often cite the kind of power, performance, and guidance birth attendants perform as emphasizing the role women play in the ritual of childbirth, which serves to ease the stress of the rite of passage for the mother, help her bond with the child, and give her a sense of control (Cheyney 2001, Rothman 2007). In this context, midwifery is often contrasted with through arguments that it places agency ("back") with the mother and her body.

The question of power and powerlessness seems to underlie many of the concerns with technologically mediated medical births on The Bump. The group gives no singular definition of agency, yet to some extent the concept seems pervasive in several ways through the rhetioric of individual power and choice. In one instance a peer poster, who also identifies herself as a labor and delivery nurse, comments: "Just like it's your choice to have an epidural or not, the nurses/doctors/midwives cannot force you to have an indwelling catheter… The other option is use of a bedpan every hour or two hours since you won't be able to walk to the bathroom." In this example, the poster sides with the logic of the adequacy of care provided by a traditional biomedical approach, implying that the management of the physical body should be taken over by medical instrument (the catheter) when continence is no longer in the patients' control. However, this position also presents the overall "choice" as the paramount factor in the decision, in which epidural, catheter, and bedpan are all options for treatment that preserve this essential,

patient-driven, and thus *healthy* practice. In another post, a peer "mom" encourages someone unsure about her birth experience: "You can absolutely cope with the pain... anyone can... without an epidural you can keep moving, walk and squat through the pain. Labor will progress faster and more naturally without an epidural as well, and you will damage less as you know when to push and when to stop! Your recovery will be so so so much faster without an epidural too! Goodluck!" This approach offers a more traditional support of "natural" birth, in which voluntary physical movement and the democratic notion that "anyone" has the ability to withstand the pain of childbirth without anesthetic assist the seemingly innate qualities of the birthing body. Though these instances present slightly different types of response of support, they both assert "choice" is the primary ideological locus by which power is either asserted or taken away. These and many more comments refer to the general belief that control over the birth decisions should (and ultimately does) rest with an individual. However, the key marker found these comments, as well as many provided by expert doctors and midwives, that differentiate them from Martin and Rothman's work, is the implication that control is not automatically sacrificed along with "natural birth." An odd position seems to arise in which natural and technological approaches to birth are rhetorically somewhat distinct, yet not entirely opposed; rather, as the category of *health* follows the development of a person's will or narrative, both "nature" and "technology" can participate in supporting it. The differences in the imagination of health as a concept are reconciled through a focus on decision, rather than opinion on specific intervention, and come to form the leading ideology for the group.

Building on this earlier critique of medicalized childbirth, related scholarship has since problematized this very distinction that feeds a narrative that denies the use of certain kinds of tools, diagnoses, and interventions. On one hand, the medicalization model is a comprehensive

criticism of medical practice. Anthropologists like Emily Martin provide an important framework for understanding the power dynamics at play in the treatment of women's bodies. Many posts in the group are influenced by proponents of natural childbirth, an emphasis on midwifery, or sources that deal more directly with these specific critiques of the biomedical practice or gaze, such as the now pervasive, Netflix-ready film *The Business of Being Born.* However, the field of study has changed since The Woman in the Body, with numerous social scientists questioning whether the specific treatment of mothers can be held responsible for their feelings of suffering or powerlessness (O'Dougherty 2013; Lazarus 1994; Taylor 1995). As "traditional" biomedical practices are less and less seen to oppose "natural" measures that may be taken when attending a woman's birth, much of the inherent violence of Martin's machine model seems less convincing. In the age of The Bump, individual choice takes precedence over the use or refusal of an epidural.

Furthermore, some scholarship has warned of a risk in drawing a false dichotomy between "natural" or "technological" tools or interventions, as there is in calling a birth that uses biomedical technology "unnatural." The construction that links "nature" to "health," as well, is challenged in a study of "Baby-Friendly Hospitals" in Slovenia, where breastfeeding was promoted under a UNICEF initiative based on the equation with natural birth and health, to the extent that women who were unable to follow this prescribed care were left feeling guilty, ashamed, and worthless—because of self-judgment and that of others in the hospital (Drglin 2005). The critique of a "baby-friendly" agenda considers mothers' feelings about their ability to care for a child as a fundamental aspect of health, that may allow for technological interventions like the use of formula based on its role in supporting the mother—and not just the child.

In recent years, anthropologists have characterized women's struggle with the surgical context of C-sections along the lines of asserting their own agency. In her analysis of the surgical (C-section) births of middle-class Brazilian women, Maureen O'Dougherty argues that there are radically different ways to be active in giving birth, and that most choices the women she studies makes are simultaneously partially resistant and partially compliant (O'Dougherty 2013: 46). The cultural climate in which agency exists, for O'Dougherty, is a mediator that situates women's actions within the dynamic atmosphere of their lives, which include different forms of interactions and limitations. Rather than focusing on a machine model or factory metaphor to describe the experiences of women giving birth, O'Dougherty listens to the conceptualizations the women iterate in their life stories and finds that they contain both justifications and critiques of the widespread use of C-section in Brazil. Women overwhelmingly use the active voice in their descriptions of their bodies and their births, whether or not they were unable to deliver vaginally and/or were kept from that process but the assumptions or (perceived) violations of the their doctors.

Similarly, on The Bump, women who consider scheduled C-sections may feel affirmed or reassured, especially if they feel daunted or powerless at the thought of vaginal delivery. Though C-sections are much less common in the United States than they are in Brazil, there are enough comments in the group to show that the procedure, along with other "intervention"-style pregnancy or birth conditions, does not seem to automatically make a woman feel less like a mother, or any less bonded to her children (O'Dougherty 2013: 54). In lieu of complete bodily control, women again state their ability to assert their form of *choice*, in order to attain a kind of security. This treatment reinforces the notion that some medical moves such as diagnosis articulate a kind of support that women feel enables them to self-label and thus understand and

live with their reaction (Taylor 1995). In many ways the biomedical doctors on The Bump, or about which Bump commenters speak, seem to embrace a narrative of patient-driven (or at least influenced) guidance, in which forms of diagnosis and treatment bolster a woman's ability to manage her own experience. Feelings of legitimacy can be derived from self-labeling and narrative choice even in the context of coercive decision-making.

This (re)articulation does not wish to ignore earlier critiques of the biomedical childbirth practice. However, on the Internet in 2017, it seems there is a call for nuance in the way women narrate their birth experiences—in terms of individualized health, but not, primarily, as a noncompliant act against their medical care. The matter of *choice*, as centered on the individual, arises largely in the context of assertion. Participants on Real Answers are generally informed, and inform one another. The reconciliation of their different opinions regarding specific pregnancy and birth practices functions through the assertion of the primacy of individuality, suggesting that the *choice* on the part of the mother is an iteration of specific American values. While these arguably stem from the same tradition that marks the separation of patient and doctor categories, they also provide each Internet user on "Real Answers" with a sense of possessing a distinct identity based on the separate quality of their private and continuous existence.

Implications for Fetal Personhood

Interestingly, this quality of the *assemblage* establishes the personhood of the mother based on her unique mode of interaction rather than overt concern for the integrity of the child. Though a woman and her child, in the study of birth and motherhood, are often shown to be politically opposed (Dubow 2010; Duden 1993; Roberts 1995; Roberts 1997), the setup of Real

Answers accords the experiential qualities of giving birth value, and posits the relational aspect of the positions of mother and baby in a way that does not obscure the former. As we will see in the subsequent chapters, this iteration is not the case for every assemblage; rather, this position seems particularly related to The Bump's interactive question-and-answer format, which allows women to offer one another advice for easing the troubles and dangers of pregnancy and birth. Though in some sense biomedical conduct is advised on the website in the form of "expert" advice, the collective ability to regulate the criteria by which authority and expertise gain traction presents a unique challenge to the legitimacy of traditional biomedical claims and the notion that submission and obligation are endemic to American birth practice. The support of The Bump's *public intimacy* practices provide a kind of care that effectively integrates the personal and social lives of participants, even as they locate their agency within their (singular) selves.

The implication in the assertion of choice on the part of the mother is paramount in this construction, as it shows that the baby at the time of birth has a distinct social and personal body. Mothers' individual ideation of their own bodies during labor and delivery creates two kinds of bodies, which are fundamentally separate. Within the *assemblage* of Real Answers, mothers speak about their own bodies as enacting health, engaging with and challenging medical models in congruence with the way they imagine themselves and the entities they contain. Giving birth, in the context of Real Answers, is also an exercise in asserting *author*ship—over the experience, and in the realm of discursive practice. The pull of these mothers within the biomedical model in many ways seems to constitute a unique practice of self-containment that nevertheless comes about by group practice. The following chapter will explore a somewhat different approach to personhood, focusing on implications of pregnancy and the formation of (relational) fetal identity.

Chapter 2: Fetal Life and Death

Introduction: The Forum

In this chapter we turn to the specificity of the forum as an interactive *assemblage*, mainly located in the discourse surrounding pregnancy loss on the What to Expect website. Whattoexpect.com, or What to Expect as I will also refer to it, is an offshoot of Heidi Murkoff and Sharon Mazel's bestselling pregnancy guidebook, *What to Expect When You're Expecting*. The book, originally published in 1984, gives an explanation of the "symptoms" of pregnancy through time, with one chapter dedicated to each of the nine months of pregnancy (Mazel and Murkoff 1984). *What to Expect When You're Expecting* was purportedly based off of Murkoff's own experience with her first pregnancy, and spurred a series of 13 subsequent *What to Expect* books that focus on the perinatal period and early parenting. While the What to Expect website[iii] describes *What to Expect When You're Expecting* as a "guide that would help parents sleep at night," the work was also criticized in more recent years for focusing on the complications that could arise during pregnancy, essentially promoting fear and obsessive attention to problems (Kantor 2005). Nevertheless, its format easily transitioned into a website that combines (updated) information of the type found in the original guide with articles that tackle specific questions.

Some of the online guidance comes in the form of an inspiring narrative, often accompanied by a cheery stock photo or portrait of Murkoff. The electronic signature that the author shares—a carefully etched but informal *heidi*—includes neither last name nor capital letters, perhaps as an echo to the mythical origins of the project (giving advice with no mention of gaining capital), an emphasis on the intimacy between the author and the viewers and participants, simply a statement about Murkoff's appropriately feminine and maternal

approachable nature, or all of the above, draws the connection between the iconic work of 1984 and the current mission of the site. This mission is echoed by the whattoexpect.*org* foundation, a charity that also carries Murkoff's face and brand, dedicated to providing free education about pregnancy and other resources to low-income mothers. While neither the foundation nor the original book is a site of my research, both projects situate the What to Expect (.com) website as something that provides support to women by focusing on their questions and, importantly, giving them a place to ask them of each other. Putting the question of Murkoff's involvement aside, the website seems to promote a sense of community or rather, because of its size and popularity, a conglomerate of related communities, in which people can coordinate to find and start local support groups in their areas, or participate in the forums according to their particular interest. This is additionally promoted by the existence of "Den Mothers", who apply (or are nominated!) to be official volunteers for the website, essentially to "welcome visitors" and monitor the tone of conversation so that it stays friendly. The current Den Mothers' biographies, which are posted publicly, evoke announcements at a debutante ball, except that the emphasis on marriageability and high social class is replaced by descriptions of respectable maternal nature and upstanding membership in society. The role of mother is listed before all else, followed by wholesome or admirable hobbies like knitting or exercise, and sometimes the mention of a job. The Den Mothers do not have a large discursive presence, but rather serve as monitors and ambassadors of the larger What to Expect agenda.

Most forum posters on What to Expect are seeking advice from people they believe to have practical knowledge of childbearing, and whose perspectives often seem to align better with theirs than with that of a healthcare provider. Posts are usually addressed to anyone and everyone who can provide guidance, care, and reassurance. Though the posts are public, the forum for a

given subject is technically a group in itself that one may join, and thus the audience of posters is also usually limited to people who may have experienced the same problems. In the Greif & Loss section of the forum, for example, the distinct rhetoric surrounding miscarriage creates a kind of linguistic community, with certain terms, like *angel baby* and *rainbow baby,* that inform participants' approach to pregnancy and/or perinatal child loss. We will explore these terms in more detail later on in the chapter.

In some ways, the format of the What to Expect website is similar to The Bump. It also provides an overview of the "symptoms" of the condition of pregnancy, interspersed with articles and general Q&A type questions to which the editors or other community members respond. However, there are significant differences in the presentation and the kind of interactions that take place in each site. In the context of What to Expect, this chapter focuses on thematically specific pregnancy threads and the ways online groups provide emotional and medical support through the terms they use to describe perinatal child loss or discontinuation of pregnancy. Blog posts, Facebook groups, and commercial enterprises will also serve to corroborate the content of What to Expect, for which the centrality of the fetus and its relationship to identity is a major concern.

What is Fetal Death? Conception and Confusion

As scholars such as Margaret Lock and Sharon R. Kaufman have argued, the boundary between life and death is not fixed. Even singular consensuses on what we consider "death" (such as brain death) are never immobile categories (Lock 2002). Medical definitions of death, while generally established, do not negate the often-contradictory understandings of its instance that define hospital culture (Kaufman 2005: 28). One need only perform a survey of relatively

recent changes in cultural conceptions of fetal life to show that they belong to the same category. As Sara Dubow argues in her book Ourselves Unborn, the American definition of fetal life was not always located in our reliance on conception at all, but rather, until the late 19th century, in *quickening*, or the first instance in which a pregnant woman experiences the movement of a fetus (Dubow 2010). We can apply the argument that the "moment of death" is defined in conjunction with a temporally situated medical mode, and the motives contained therein (Lock 2002), to show that the medical practice and parlance may be capable of co-opting and defining fetal life, and by the same hand the possibility for fetal "death."

Popular ideation of contemporary pregnancy, regardless of political "camp," generally allows that pregnancy begins at conception. However it is worth noting that even among popular US-based destinations for FAQs about pregnancy, tension exists within the simultaneity of pregnancy and fertilization.

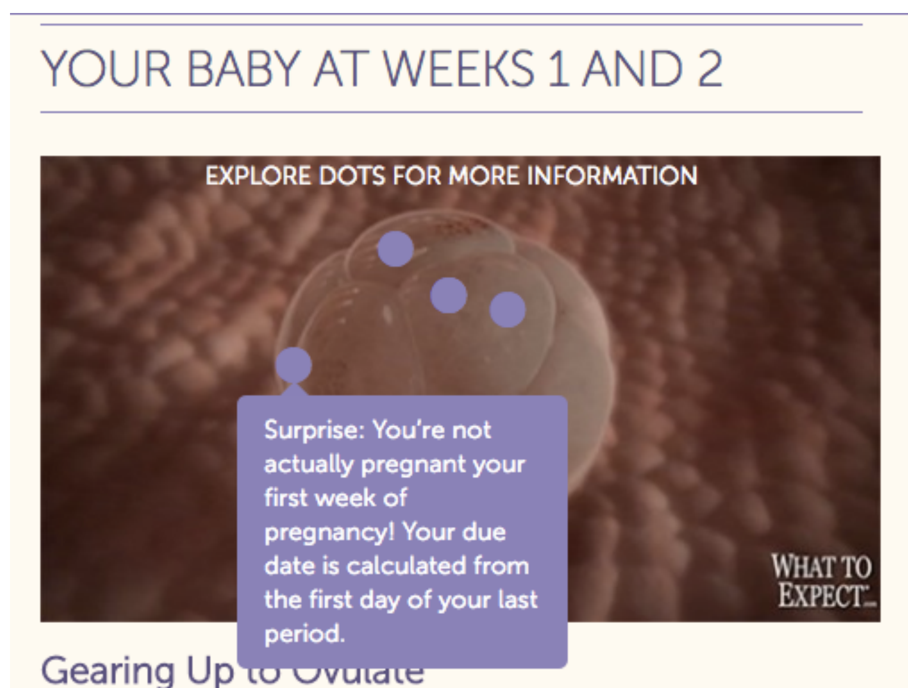

Figure 2.1: Image from whattoexpect.com showing the breakdown of the beginning of pregnancy. Accessed March 5 2017.

As the What to Expect website explains, the start of a contemporary biomedical pregnancy in the US is calculated from the first day of a person's last menstrual period. The contradictory statement that a woman is "not actually pregnant" during the "first week of pregnancy," shows the instability of this claim, and situates pregnancy as a social condition that does not necessarily depend on the strictly biological interactions between egg and sperm. I bring this to light not to iterate a dichotomy between the social and biological body, but to show that in this instance the boundaries of this kind of understanding of *life* is a negotiation between the consideration of both of these aspects of a person. Furthermore, the website contends with what may come across to readers as a somewhat arbitrary starting point by directly addressing an assumed confusion:

> How can you call this your first week of pregnancy if you're not even pregnant? It's extremely hard for your practitioner to pinpoint the precise moment pregnancy begins (i.e. when sperm meets egg). While there's no mistaking the start of your period, the exact day of ovulation can be hard to nail down. What's more, sperm from your partner can hang out in your body for several days before your egg comes out to greet it. Likewise, your egg can be kept waiting for up to 24 hours for some tardy sperm to make their appearance. So in order to give all pregnancies some standard timing, most practitioners use the first day of your last menstrual period as the starting line of your 40-week pregnancy. Still confused? Think of it as a head start — you're clocking in roughly two weeks of pregnancy before you even conceive!

The website distinguishes the "precise moment pregnancy begins (i.e. when sperm meets egg)" as synonymous with "conception," and yet, still not synonymous with the "first two weeks of pregnancy" (see *Figure 2.1*). The meeting (or "greet"-ing) of egg and sperm is at once a definitive starting point of the pregnancy condition, and also presented as too elusive to be

considered a reliable marker of that state with respect to time. Furthermore, the "first two weeks of pregnancy" is necessarily a retroactive distinction for a pregnant person to include in their "standard" forty weeks, as one cannot possibly know on the first day of a menstrual period if, sometime in the next two weeks, fertilization will occur. One only knows one has been pregnant thanks to an estimation that follows some kind of pregnancy diagnosis, whether it occurs as is a self-labeling experience or is doctor-directed.

In her famous 1991 essay, "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles," Emily Martin cites Ludwik Fleck's notion of "'the self-contained' nature of scientific thought" (Martin 1991:492; Fleck 1979:38). Fleck describes this as:

> The interaction between what is already known, what remains to be learned, and those who are to apprehend it, go to ensure harmony within the system. But at the same time they also preserve the harmony of illusions, which is quite secure within the confines of a given thought style. [Fleck 1979:38]

Martin elaborates on this phenomenon to describe the way outdated imagery that promoted certain gender-stereotypical understandings of the egg and the sperm come together in fertilization (Martin 1991). Though our discussion of conception is not necessarily fixed on this relationship, Martin's treatment of social conventions about gender that influence the practice of biological science is central to how we investigate the issue of pregnancy. Her instrumentalization of Fleck's "self-contained" nature shows how deeper scientific understanding may both break with and re-iterate traditional metaphors. "Endowing egg and sperm," she argues, "with intentional action, a key aspect of personhood in our culture, lays the foundation for the point of viability being pushed back to fertilization" (Martin 1991:500). What to Expect's language does not usually follow the same gendered stereotypes that Martin found

over two decades ago, preferring instead a more neutrally valence concept of "meeting." However, gametic personification is nevertheless evident, and continues to create the possibility for instantaneous "babies" who can *live* and *die* inside women, even as their conception is practically understood as occurring in an obscure window of time. Medically situated understandings of the beginning of life are mediated by biomedical culture in a way that seems as fraught as Margaret Lock's "moment of death" (Lock 2002).

For What to Expect, "Your Baby at Weeks 1 and 2," (see *Figure 2.1*) exists only in the possibility of an ovum "greeting" a sperm—yet a woman's life already belongs to the category of pregnancy. Upon discovering their pregnancies, women on the site immediately begin discussing their own (changing) health, as well as that of their "baby." The website, alongside others like The Bump and more, often serves to identify which "symptoms" of pregnancy are normal, and which may present a danger to a mother or child. This is done in conjunction with the standard of the number of weeks one has been pregnant.

It is an ideological challenge to disentangle the intent of the language used on the What to Expect forums. While in the pregnancy section it is fairly clear that the entities about which women speak are unborn fetuses, they are nevertheless most commonly referred to as "babies." I find this term interesting particularly because it is unclear whether or not this is a reference to the future or a statement about the present. Time is central to the process and progress of pregnancy, but often seems almost warped, especially with regards to the intense emphasis on preparation for a (postnatal) baby.

The collapse of these categories is most obvious in forums that focus on miscarriage. In these discussions, babies are often named before birth, and reminders, like clothes bought for a baby shower, due dates, and anniversaries, often serve to perpetuate the instance of miscarriage

past the time of the event, sometimes during the what would have been the time of pregnancy, and beyond. Depending sometimes (but not always) on how far along a pregnancy was, miscarriages and stillbirths will often be conflated or compared to one another. Sometimes posters lose one "baby" shortly before, and one shortly after birth, and these two instances come to represent one event. Of note in these kind of posts is the inconsistent relationship between a fetus and a pregnant body. As one member writes:

> In April of 2015 I gave birth to a baby boy... In December 2015 he passed away from chronic aspiration. January 2017 I found out that I was pregnant again.. I missed being a mom and really wanted another baby and so did my husband. At 7 weeks and 3 days we got the baby's heart beat it was 154. February 27 I found out that my baby had died the same day we got the heart beat however, I had a missed miscarriage meaning the baby was still inside of me. It had been 5 weeks.

This poster distinguishes between being pregnant and having "the baby" "still inside" of her body. She goes on to voice her concern about the types of bleeding she was having following the miscarriage, stating that she was worried about it because she and her husband were trying to conceive immediately following the event, due to their understanding, based on the advice of a friend with no apparent medical training or specialized knowledge, that one is most fertile following a miscarriage. From her post we can see a type of fluidity that marks these forums, in which the transitions between conception, the fetal state and pregnancy, and birth or motherhood, sometimes overlap, are muddled, and depend on more than just placement of a fetal entity or symptoms like heartbeat.

Terms of Loss and Redemption: Sunshine, Angel, and Rainbow Babies

One of the most particular marks of What to Expect's Greif & Loss, The Bump's miscarriage/pregnancy loss, and the Facebook group Miscarriage Mamas, is the use of the term *angel baby* to describe the pregnancy that has been lost. The term *sunshine baby*, another instance of retrospective categorization, is a baby who was born to a mother before the *angel baby*, while a healthy child born after a miscarriage, stillbirth, or neonatal death (and the creation of the angel baby category) is known as a *rainbow baby*. Though I experience a kind of clash of ontologies in attempting to describe the phenomenon of the *angel baby*, I also recognize that the paradox that I find in the category is, in fact, central to its existence.

Women on these forums particularly use these terms to address the ways they have been undermined by doctors, dominant discourse, and sometimes their peers. The insistent equation between "babies" that are both living and dead is a exercise in validation. Women often cite experiencing emotional pain, or otherwise perceive their miscarriage experience as being exacerbated by a general assumption it's something they should "get over." Threads of rainbow baby stories in particular participate in creating and maintaining fluid categories under the umbrella of grief, in which the particular themes of loss and emptiness are key. The support of the forum allows women to mourn for something they could not perhaps effectively grieve if it was not understood and a kind of "baby." Moreover, the slippage between particularly the *angel babies* and *rainbow babies* shows not only that one's life is defined by the death of another, but also that many women share a wish to effectively replace a baby who died, while simultaneously remembering the first as a separate entity. The *angel baby* thus belongs to a special category among the community. It is neither alive nor dead, and yet in some ways it is both.

Figure 2.2: Profile picture of the Miscarriage Mamas Facebook group. Accessed 28 March 2017.

Although depictions of the *angel baby* seem overtly related to the Christian imagery of an angel, and mimic the iconography of *The Last Sleep* of Victorian postmortem photography, two things set it apart. The angel baby is sometimes but not always considered a religious figure. A woman who has lost a baby might feel that her *angel baby* is praying for her; more than a few posts mention this phenomenon. However, for the majority of participants, "angel" seems more akin to the positive and vaguely celestial words like "sunshine" and "rainbow" that describe other babies in a similar category. The special kind of religion, spirituality, or belief that seems to be at play in recognizing and mourning angel babies doesn't overtly have much else to do with the doctrine of Christianity, with the exception of members sometimes "sending prayers" to others on the forum alongside or in lieu of another mystical entity: *baby dust*.

When parents (primarily mothers) read and respond to each other's stories, they offer not only sympathy and advice but also consolation in the form of hope. One common example of this is the instance of one member "sending baby dust," to another—essentially wishing them good luck in conceiving again and carrying to term. Instances of sending baby dust are often

accompanied by respondent's own stories of *rainbow babies*. The strange materiality that the "dust" seems to have is difficult to parse out, not least because of the casual quality with which it is "sent" but also by the sort of negation the Internet creates out of physical matter, even when used metaphorically. Yet within the rubric of the community and the prevalence of casual prayer, it seems like a wish with some valence, that has the capacity to create or place some kind of special conception-inducing matter within a person or perhaps between two.

The celestially bound, quasi-religious nature of the *rainbow baby* imaginary is also found in the elusively concrete nature of its materiality, as discourse about *rainbow babies* is bound up with the quality of "stickiness" attributed either to *dust* or to the baby itself.

Mommyof2boys1217:
Thank you!! yes if i end up pregnant again it will be my rainbow baby God willing. Just praying for a sticky one! I didn't want one originally either and waited a whole day without it but when the doctor ruptured my amniotic sac the contractions that came afterwards were super intense!! I couldn't stay still and couldn't take the pain any longer so i asked for the epidural before it got worse. I was induced also! It was easier for me to push with the epidural because I wasn't distracted by the contractions. So i was pushing as hard as i could too lol

Praying my rainbow baby sticks!!!

Figure 2.3: Stickiness mentioned on the What to Expect Greif & Loss Forum. Accessed 29 April 2017.

As *Figure 2.3* shows, a popular signoff and focus of *rainbow baby* posts on the miscarriage forum is the assignment of a "sticky" quality to such a "baby." Though I initially understood "stickiness" to refer to successful implantation in the uterus, the term is used in a much broader context. There is certainly a concern with spatial placement (of the fetus in the body) in the usage, however, such an explanation ignores the concern with viability that seems central to fetal

"life" in conceptualizing its loss. Rather, "stickiness" only partially references the material quality of adhering to the body, and comes rather to represent both the wish for tenacity, in the form of a continued pregnancy, and the precariousness of such a condition. Tempered by the experience with perinatal loss that an *angel baby* signifies, current or hopeful carriers of *rainbow babies* are familiar with the elusive promise the category signifies.

Baby dust, as well as the *rainbow baby* itself, is characterized as "sticky," which creates an ambiguous distinction between the two categories. As the *rainbow baby* exists in a state of promise and unknowability, its identity melds with that which is thought to bring it about. The impermanence and fluid movement suggested by words like *dust* and *rainbow* also show that it is difficult to define. This phenomenon relates to Susie Hatmaker's work on *mattering*, in which she defines "things" by their "capacity to affect and be affected" in a physical sense, even as their materiality is somewhat ambiguous (Hatmaker 2014:21). Hatmaker's description of the environmental pollution of coal ash sheds some light on the instance of "baby dust" because both "things" are simultaneously impalpable and known to exist. Coal ash, as she describes, "is the unseen, never fully representable excess of the dreams and desires," and constitutes a physical reality by virtue of its unknown quality. Similarly, the category of baby dust, though it may occur in heterogeneous, inconsistent, dissimilar, or indefinable iterations, carries qualities in terms of social and political meaning for those who use the term. In fact, the very lack of specificity in its constitution speaks to its significance as an important influence; the flexibility and renegotiation of such a category allows it to serve the needs of many different voices in this pregnancy loss *speech community.* In contrast to dominant discourse about the knowability of the physical, "baby dust," along with related terms, provides an alternative category of affective

relation and ambiguity that not only forms ties within the *assemblage,* but also allows its "mamas" to build knowable realities and identity out of invisibility.

Someone to Mourn

The *angel baby* categories speak to the frustrations of people who wish to mourn their miscarriages as deaths, and furthermore create and participate in discursive communities that use this mourning as an important sociocultural ritual. People who feel that others don't think their miscarriage matters react by insisting that it does, using the terms of fetal life and death to do so. In an article called, "Why miscarriage matters when you're pro-life[iv]," a Christian author, who does not openly identify as "pro-life" yet seems to belong to a community that does, laments the differential treatment of abortion and miscarriage. She claims that there is an inconsistency in the pro-life argument in the sense that abortions "deserve to be grieved," while a miscarriage "deserves to be gotten over. And quickly." The author argues that the politicization of abortion creates a system of thought in which aborted babies are real "people" with tragic deaths, while the loss of "miscarried babies" is conceptualized as part of God's plan, and road bumps in one's life. Her story reads as though she is upset that she has not been allowed to grieve her miscarriage as the death of a person, while those who would console her devoutly attest to the value of aborted life, which begins at conception. This question of grief begs the question: is one allowed to grieve for a miscarriage, and if so, how?

Those involved with the specific practice of mourning their miscarried "babies" in funeral or other formal rituals do not necessarily express this inconsistency, but do note that they had to overcome some kind of adversity in accomplishing that goal, especially when it came to requesting their human remains that would normally be discarded as medical waste from the

hospital[v]. Heaven's Gain, a ministry with an online business selling "small baby caskets and burial products for families suffering the loss of a child through miscarriage, stillbirth, or infant death," specializes in first, second and third trimester caskets[vi].

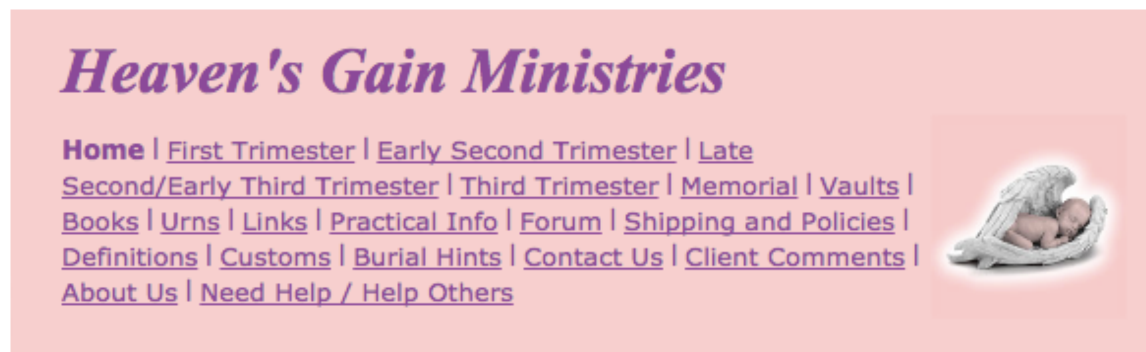

Figure 2.4: Heaven's Gain Ministries, Offering Caskets for First Trimester "Babies." Accessed 5 March 2017.

While the consistency of their definitions of child death, in which life begins at conception regardless of whether a baby "dies" by abortion or miscarriage, would satisfy our "why miscarriage matters" writer, the obvious allusion contained in the phrase "Heaven's Gain," accompanied by an image of a small but distinctly personified baby asleep in angel's wings, may pose a problem. The positive spin on miscarriage necessarily relies on the imagined continuation of a some kind of existence, for the baby as an angel in heaven.

The predicament of this specifically Christian, overtly pro-life practice can be overcome, for some, by imagining a continuation, or a validation that one's unborn baby was *a real person*. Though this practice appears most clearly through religious rhetoric, the *speech community* that uses *angel baby* and related terms seem to practice a similar reverence for the sacred, while often retaining an otherwise secular approach, suggesting that the phenomenon has more to do with a reading of fetal identity than notions of responsibility regarding the intentional termination of a pregnancy. Outside of the context of abortion, the lines between pro-choice and pro-life are not so easily drawn, and political creed is overshadowed by the issue of externalization wherein the

act of processing a miscarriage, as well as an abortion, is also one of separation, even when the slippage between a first-trimester fetus and an infant death is considerably more fraught.

There is no singular way in which people deal with human death, and the definition of life even outside the womb is hard to pinpoint. Because the category of death has already been shown to be ambiguous and partially constructed by medical influence, abortion and miscarriage may be included in or excluded from a “death” narrative.

Some treatment of death may include mourning, but what exactly “mourning” means is culturally specific. As Beth A. Conklin illustrates in a study of Amazonian cannibalism, understood as a funerary practice rooted in mourning, those who are still alive grieve a dead person by externalizing, depersonalizing, and objectifying them so that they can be eaten. The eating of the flesh is understood as a process by which a past person is transformed into something that is harder to miss (Conklin 2001: 237). Following Conklin’s logic, one might wonder whether the category of fetal personhood can be understood as part of a mourning process in which a ‘subject’ is first realized and then phenomenologically externalized (from a pregnant or formerly pregnant woman) in order to manage the potential emotional disruption of miscarriage, stillbirth, neonatal death, and abortion. However, this line of thought relies on the implicit assumption that such a disruption would be inevitable, ignoring cases in which a pregnancy might end without emotional impact or ideological separation from another entity. Nancy Scheper-Hughes’ discussion of the *anjinhos* of postcolonial Brazil, shows that we may understand emotional responses as culturally specific in a way that destabilizes the Western heuristic of grief-stricken mourning (Scheper-Hughes 1992: 183). Rather than psychologizing the ontology of people who aren’t compelled to mourn by feeling sadness for their child’s deaths, Scheper-Hughes calls (in part of her argument) for a recognition of both the legitimacy of the

these women's feelings, and the apparent cause of their lack of sadness and grief. The special position that *anjinhos* occupy for Brazilian women shows the possibility for a subject that is neither squarely dead nor alive (Scheper-Hughes 1992: 185). My investigation of the fetal subject builds on the particular quality of potential existence that the *anjinhos* seem to illustrate. The instance of an ideological clash even in the slippage between fetuses and "babies" speaks to the kind of mourning or processing we may expect from the voluntary or involuntary termination of a pregnancy. I do not argue that the clay angels of Heaven's Gain or the angel babies of the What to Expect Greif & Loss forum are *anjinhos*, but rather that they may exist in a special position, which is grieved, especially by those who believe life begins at conception, but in a particularly positive light. The specific treatment of a fetal "body" occupies multiple definitions, as such an entity can be simultaneously understood as a diagnosable object and a social body that can be "dead" or "alive."

One intrinsic aspect of ritual, described by Roy Rappaport, is the imposition of "unambiguous distinctions upon ambiguous differences" (Rappaport 1979:186). Additionally, Rappaport describes the liminal period as a kind of "time between times" (Rappaport 1979:186). While childbirth is often treated as a ritual in itself, I wish to focus here on the entire pregnancy as illustrating this phenomenon. Treating both the mourning of angel babies and the occurrence of pregnancy itself as kinds of (related) ritual and rites of passage, we may understand that the "time between times" of the pregnancy is a liminal period in which one is ideologically (and in some ways physically) separated from the group, into which one is reintegrated as a non-pregnant person, after undergoing childbirth. The particular, marked relationship to time that everything from the instance of fetal "life" and "death" to the ambiguous starting point of pregnancy illustrated in this chapter distinguishes the pregnancy period and something *betwixt*

and between (Turner 1964), in which the completion of childbirth and the viability of a healthy child is the focus of the project from the beginning, whenever that really is. When the ritualistic structure or expectation of the process does not end in childbirth, however, a different kind of reintegration ritual needs to take place. The mourning of *angel babies*, through recognition of peers on online forums, or funerary burial in a Heaven's Gain casket, speaks to the complete transformation of a formerly pregnant person, who names the externalized and effectively reified *angel baby* in order to constitute or support her maternal identity. Thus these subjects define themselves as mothers based on their fetal death experience.

The care enacted by the miscarriage *speech community* occurs through linguistic participation in such an experience, so that the *community* occurs through the multivalence and inclusive directionality of its authorship. The use of *angel baby* categories is sometimes defined, perhaps for newer users/viewers and/or in a unifying or legitimizing move, but it is mostly implied by regular usage and active participation; because the terms are by definition elusive, each iteration varies the form and mothers in the community can find locate particular modes of caring and validation within an intersubjective array of linkages.

Mourning online in this context is distinctly a function of the *assemblage*, in which the loose boundaries around time and space provide a space for the *public intimacy* of grieving together. As Papailias argues in the context of online mourning, there is a particular quality about both the intensity and the structure of grieving online that seems to break down the boundaries between people (Papailias 2016). Treating the assemblage as a community that links the body's physical qualities and its position in society to the relationship with the group, in a sense encountering temporally spaced linkages allows people to *witness* to grief with their whole selves, in terms of their life history and experience with loss. Insofar as it is a way of enacting

copresence while spaced out over time and space, mourning on the Internet through shared stories and affective speech also has a connection with a kind of mediumship by which people can access the reality of their *angel babies*. The crisis of lost fetal life is addressed by constant engagement with the continuation of a potential future; in creating a fetal personhood identity, women on the forums also engage in a continued relationship, fed by other living mothers. The communal quality of grieving their dead "babies" allows women to care both for such an entity and each other, as a system of support that links imaginaries and physical instances of bodies via the technology and possible formations of the Internet. In this instance, the melding of private and public spheres through grief and fluent interiority creates personalized memorial relationships, between posters on What to Expect, as well as their *rainbow babies* or reified fetal entities. Angel babies transcend time and space in way that references similar qualities of the intangible internet inhabiting a milieu of existence that suits their mothers' mode of community. In many ways, they *live* within such a speech community, and problematize clear-cut notions of the distinction between life and death.

Chapter 3: The Motherhood Role

Part I: Visual Markers of Identity

While the first chapter of this project described the relationship between new mothers and medical practice, and the second defined mothering as relational to a category of personified fetus, this chapter will attempt to situate mothers on online forums in terms of the way they regulate identities between themselves, in distinguishing good, real, or otherwise respectable motherhood from deviance, and rearticulating such categories.

The research of this chapter draws on findings that transverse sites already described. However, I wish to draw special attention to the message board "communities" of The Bump pregnancy/parenting forums for the unique references to maternal criteria that they exemplify. Message boards on The Bump[vii] constitute a community in which a consistent individual identity is maintained not only through linguistic self-identification, but also in membership details that mark one's distinguishing characteristics, including self-curated (if not generated) images, GIFs, and personalized statistics that support claims to mothering (see *Figure 3.1*). These message boards share a similar relationship to temporality to The Bump's Real Answers section, and the kind of mutual support, *witnessing*, and modes of intimacy relate to the What to Expect forums. At the same time, certain markers are unique to this *assemblage* and show a tendency to a define motherhood consistently, in terms of personal details that relate both to the sense of belonging within a group and a person's children.

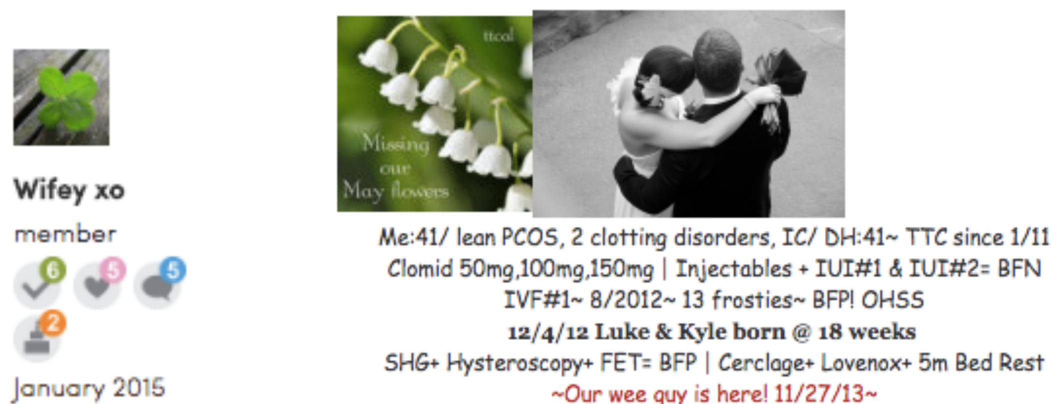

Figure 3.1: A member's website statistics next to a portion of her post signature. Accessed 30 April 2017.

As Figure 3.1 shows, each "member" in a given community is tagged with certain categories, called "badges," that label an individual's past (inter)actions on the site. Badges listed in response threads include "Answers," referring to direct responses to questions, "Love Its," or complimentary action by others on one's responses, "Comments," or replies in a message thread, and one's "Anniversary," which refers to the amount of time one has been a member of a community on The Bump, rather than to marriage their child's birth. More badges, often earlier versions of a specific badge with lower number criteria, are listed on the "Activity Pages," of specific members. Member mommaashley12's Activity Page, for example, shows that she "earned" separate badges for 5, 25, 100, 250, and 500 "Love Its," respectively. Similar to the "Bump" quality of the website's Real Answers section, these forums are set up to allow for non-linguistic feedback on one another's post. However, in the case of the interaction provided by "Love Its," a post not overtly more visible or spatially prominent based on the amount of positive attention it garners. Instead, the "member" gains a mark on her identity that refers to her belonging and standing within a group, so that the individual is more explicitly credited—hence the language of reward in the form of a "badge." In contrast to the relatively anonymous threads

that mark discourse on the What to Expect forums, personal identity is central to userdom in the context of legitimatizing authorship and presence within the community.

While badges are assigned based on qualities ascribed by the website, members also regularly use automated signatures on their posts. As is evident in Wifey xo's signature, these often give explicit details both on a person's medical history, with regards to pregnancy, birth, and motherhood, and list the birth and/or age of the baby as a product of such a process, along with meaningful images that speak to a specific presentation on identity, such as, in Wifey xo's case, a wedding photo beside an image that laments "missing our May flowers," presumably referring to "Luke and Kyle" who were "born @ 18 weeks" in December and would have been due in May. As in the case of the *angel babies* of What to Expect pregnancy loss forums, these "May flowers," along with the (viable) birth of the "wee guy" born the following year, define the user as a mother, and as a participant in her group (in this case, based on the topic of parenting following a pregnancy loss).

Figure 3.2: Automatically updated GIFs in a member's signature.

Additionally, the relationship between qualities of the website and participation takes the form of including banners from various websites (including The Bump) in a personalized signature that depends on the unique relationship between pregnancy and time as well as the

unique nonlinear mode of interaction common to these online sites. The remnants of self-updating image calendars (and the lack of congruity between them) in this type of signature show that certain iterations of time can reoccur or be revived based on new access or interaction. The way these personalized labels create legitimacy for their curators, especially as they accompany every post, is a way of crediting their belonging with a standard (though group-specific) recognition of motherhood practice.

Members in the community of The Bump message boards relate to each other on a personal basis in sharing not only their tales of experience, but engagement with it in the form of photos of their children and inquiries about each other. Participants will often identify themselves by their relationship to the others in terms of time and contact, for example as newcomers. Veteran users who are more fully integrated sometimes apologize for not responding to others with more frequency, and "check in" on one another. While the interaction displays a *public intimacy* that relies on a dispersed, variable, and leaky audience, it is not only "intimate" but also personally specific, so that individuals are accountable for their participation and actions, in a way that reads as similar to social media interactions. Even in contrast to the Facebook group Miscarriage Mamas, members of The Bump message boards speak to each other based on a familiarity that transcends the relative obscurity of their pseudonyms. In this case, the imagined community of the *public* is in some ways more concrete, though it remains officially unbounded based on its web location and the inviting interface that allows new members to search for groups.

Within this group, members do not usually join to ask one question or for an instance of advice and support. Rather, it is pronounced by continuous interactions between individuals, who

sometimes introduce themselves with the intent to integrate. As one newcomer to the Parenting After A Loss community message board writes:

> I've been meaning to join in over here on PAL for a while. I had my sweet rainbow girl, Leila, in June. I'm Ashley, from Alabama. I like to take lots of pictures of my baby, travel, and read. So great to see some familiar faces. Congrats to all of you on your sweet rainbows! Look forward to participating on this board and getting to "know" everyone.

This member's participation in speech conventions like the "PAL" abbreviation and the use of "rainbow" as an adjective initiate her insider status, while her reference to her daughter and claim to seeing "familiar faces" establishes her inclusion within the mothering group. By placing the word "know" in quotation marks, she also refers to her own knowledge of the tension that exists between the affective proximity and elusive quality of such an online community. In a sense, this member is enacting her own inclusion in the group while also referencing the intention of her post. The description of mothering, insofar as we can take it to mean participation in the motherhood role, relies on self-regulation based on the recognition of linguistic standards within the group.

Regulation, Legitimacy, and Judgment

The legitimation of discourse, as defined by Pierre Bourdieu, relies on the practice of correction, which moves from dominant speakers to dominated ones (Bourdieu 1977). In this iteration, social difference is enacted through language by the comparison of an utterance to the standard of the highest authority. In the context of The Bump's message boards, the regulation of language is evident in the form of conventions followed by the *rainbow baby* speech community, as well as the prevalence of specific abbreviations and inclusion of signatures. It seems largely to

follow a path largely based in self-limitation and recognition of convention, rather than the kind of discipline enacted by formal indoctrination.

The relational aspect of fetal and maternal qualities is often shown this context by anxiety about the perceived pathology or deviance of one's own mothering, and the underlying notion that some degree of regulation is involved in the category. As Dorothy Roberts argues in her work on motherhood and crime, the social pressure to enact an ideal of motherhood is also a practice in creating of two dichotomous categories: the "good," mother, who upholds and perpetuates the traditional constructions of caretaking and self-sacrificing roles, and the "bad" or deviant mother who can or will not (Roberts 1995:100). The threat of "bad" mothering is regulated in the context of The Bump forums, while, to some extent, the validity of such a category is also challenged.

Women of The Bump message boards often worry about being bad or inadequate mothers based on biologically deterministic criteria, such as what they believe should be innate characteristics of their bodies or selves. One example of can be found on breastfeeding threads, in which women often cite feeling "sad," "frustrated," "overwhelmed," and "guilty" because of they are unable to or have trouble with breastfeeding their newborns. The struggle is marked by the sense that these women feel they *should* be breastfeeding, based on the assumption that it is the healthiest option for their baby, and that formula should be used as a last resort. Members cite guilt, in this context, as arising from the difficulty of the task, paired with the notion that they don't live up to their own expectations of care in mothering. These women also cite the concern of being judged by "others" for not breastfeeding, implying that this kind of pressure has bearing on their decisions to breast or bottle-feed. One member describes wanting to "quit" trying to breastfeed due to a painfully plugged (and possibly infected) milk duct:

> I want to stop and just formula feed, but I feel guilty. I feel like a crappy mom. He is using formula half of the time anyway, I don't know why I feel so bad. I think that it's pressure from others. I lasted breastfeeding with my daughter for about 2 weeks and was judged big time for my decision to formula feed.

Many similar posts hint at the threat of judgment from others and the pressure to follow the prescription that "breast is best," even when nursing may be nearly impossible due to pain or other complications like the baby's lingual morphology. In the context of breastfeeding, women often work toward "good" motherhood through perseverance, participating in a model of self-sacrifice, at times replete with the blood of martyrdom. Anxiety over "quitting" this practice is also a kind of distress about the possibility of enacting a deviant form of new motherhood, in which one might be able to alleviate personal bodily pain but gives up the claim to the role as an effective caretaker, and incurs "judgment." The Bump's breastfeeding message boards are filled with comments from mothers seeking to manage the pain of sore or bleeding nipples or breasts in order to continue the practice and avoid feeling guilty or "like a crappy mom." In some cases the reported shame regarding formula use is a strong enough deterrent that members do not "quit" until the pain or extreme difficulty becomes debilitating.

Members tend to turn to the group precisely when this happens. While it is not always particularly clear where the reported judgment is coming from, the hope that the group will sanction one's decision to modify or discontinue the breastfeeding practice seems to exclude it from the general trend. Repeated emphasis on "no judgment" implies that breastfeeding groups or threads provide exceptionally accepting spaces. This is perhaps the result of the shared experience of the community, as well as the nature of identities formed on such an *assemblage*. As other women's profile pages often include information about their relevant life history and pregnancy stats, and past comments are available to another online viewer, they may become

relatable by virtue of implied experience. Similarly, the relatively pseudonymous quality of such profiles allows one's perceived identity to be specifically contextualized by her participation in the forum. The accessibility of a member's badges or other markers of her participatory qualities provide the basis for an accountability to others in the group. Belonging to such a specific discourse about parenting includes setting the parameters for the kind of mentions of behavior that may be condoned.

As such, support takes the form of a somewhat generous regulation that does not do away with the concept of "good motherhood" so much as it modifies the category's specific conditions in order to reconcile them with other priorities. For many members, the idea of discontinuing breastfeeding is not conceivable unless the difficulty or suffering is intense, even if the baby is well-fed and has no problems with previously pumped breast milk or formula. Those who do reframe their choices in terms of what is best for the child, that is, the paramount importance of care for the child is rearticulated in a way that also benefits the mother. For example, a post in the November 2017 Moms thread "breastfeeding?" describes one member's rationale in deciding to try pumping and bottling her breast milk when she writes, "I was in so much pain, my son wasn't getting enough to eat and eventually I broke out the pump, hooked it up, and cried for the first 2 weeks of using it because I felt like a failure as a mom and as a woman." The crisis that this member describes speaks to the paramount importance that she placed on breastfeeding and her understanding that it would be a practice in enacting the motherhood role. However, as she cites not only her own pain but also her wish to provide her child with nutrients as reasons for using the pump, she begins to shift the status of these mothering qualities, prioritizing a type of care that recognizes the importance of feeding her baby over the method she chooses to do so. Though she initially feels "like a failure as a mom," she is eventually able to reconcile her new

motherhood practice with her beliefs of what a mother should be, based at the nexus of care and the underlying value of keeping her baby fed. In the place of "breast is best," she asserts that "*fed* is best [emphasis added]," overriding claims to the primacy of one kind of feeding over another. "Pumped milk," as she concludes, "vs straight from the boob milk vs formula, they are all best."

Enacting good motherhood through the best care possible is also an issue for women who do not plan to breastfeed. A Formula Feeding thread in the Bump's breastfeeding message board finds one first-time mom committed to her plan to feed her child with formula after delivering in a "baby-friendly hospital" worrying that her lactation consultant will push her to breastfeed. The discussion that follows involves a play between the primacy of individual (as exemplified by the discussion of choice in Chapter One's "Real Answers") and anxiety about what is best for the baby. Members who post in the thread are worried about being "harassed" by Lactation Consultants and otherwise undermined in their decision to choose breastfeeding. The notion that good motherhood can take many forms, and be enacted through the use of assistive technology like baby formula, is established within the message board community through discussion of interactions with such forms of harassment or judgment. Members in the Formula Feeding thread support each other by advising them to "be clear about the choice [they're] making" and not "let anyone try and make that decision for [them]." The assertion that there is nothing wrong with formula feeding empowers both the argument of choice and the decisions of mothers who might read such comments. Though these women are still concerned with enacting modes of care, they challenge a certain normative model of motherhood that "baby-friendly" medical practice might promote in favor of making their own "choices" and "decisions." In this case, concern for the baby's source of nutrition, rather than suffering or struggling, is the primary claim to effective mothering.

In a way, The Bump message boards present a problem for the question of *choice*, in that they do not seem to distinctly prioritize the well-being of either the baby or the mother. Rather, the rhetoric is repeatedly marked by assertions that what is good for the mother should also be good for the baby. The two categories are intertwined so that mothers are able to assert themselves as belonging to a legitimate category largely through their struggles with adapting to motherhood, and in the practice of asking for each other's opinions.

Of course, there are exceptions. Instances when the attempt to paint one's activity as an example of good motherhood is questioned by the group, as well as subtle and not-so-subtle checks on a woman's autonomy which may occur if she does not adequately prove that she has a baby's best interests in mind. Notably on the breastfeeding forums as well as in discussions about pregnancy, most women are generally focused on mothering that accommodates their well-being. However, uncertainty about how a woman's actions may affect her offspring come through in questions and answers, especially in the context of drinking alcohol or taking recreational drugs. Though "judgment" is usually spared on this front within the forum, the need to ask for uncritical advice carries an implication that such topics are generally judged.

Additionally, based on the website one uses, similar questions may garner different responses. On The Bump breastfeeding message boards, for example, one thread openly discusses drinking alcohol while breastfeeding. Though members check in because they are concerned with the effect it might have on the baby, they react relatively calmly to the question and reply with practical responses, including having a drink after pumping their breast milk and/or putting the baby down for the night. In similar threads on The Bump's pregnancy messaging boards, members discuss how little alcohol might affect the growing fetus when taken in moderation. The messaging boards are generally less regulatory in this sense than The Bump's

Real Answers section. In the context of "Real Answers," responses to questions about drinking or smoking during pregnancy are generally met with an assertion that the relaxation, relief from anxiety or nausea, or other pleasant effect a mother might have from such a vice is never worth the harm it might cause a baby; gentle warnings that hint one must be a pathological or otherwise "bad" mother for suggesting such a practice pepper the responses of peer and expert commenters alike. In deploying such a call for respectability in the name of health, as well as contrasting the health of mother and baby, such responders incur a rubric based on the assumption of the primacy of biomedical or otherwise site-sanctioned knowledge. On the contrary, members of The Bump message boards continue in the vein of melding their needs and identities with their new babies. As What's To Expect's community of creation of prenatal "babies" in the context of pregnancy loss, so do the message boards of The Bump incorporate their (postnatal) babies into their lives by including in their discursive and *witnessing* practices a discussion of the melding of their bodies with their children.

As is evident from the personalized signatures with which The Bump message board members decorate their comments, fetal and postnatal children are similarly integrated into not only the life story but also the very identity of an actor within the group. This phenomenon occurs to an even greater extent in the context of threads that deal with the fusion of bodily identities. The message boards show a collapsing of the categories of fetal and maternal identity specifically through concerns with blood alcohol content, or otherwise related to the issue of regulation. Therefore, much like Chapter Two, the unique *assemblage* of the group links the community through discussion of the particularities of bodies, and also by the linkage of those bodies to others (in this case children). As the categories of blood and milk collapse through a transubstantiation of caring matter, such material drifts online through comments, threads, and

identity markers along with the detailed medical history that characterizes the bodies of so many members. In the mixing of bodily and discursive elements, the women of the forum engage affectively to support, challenge, and define each other, as such definitions incorporate their relational identities with their pregnancies, fetuses, babies, disappointments, fears, and hopes. They manage motherhood together, in a conglomerate of practice, and find themselves online in affective modes that blend with their bodily lives.

Epilogue

This past winter, when I went to visit my sister during the most difficult part of her pregnancy, I found myself worrying about her. She had constant migraines that could only be alleviated by drinking caffeine, but she refused to drink too much because of her fear that it would incur harm to her fetus, or, as we nicknamed it shortly after, "Figgy." Speaking to my sister about her pain became qualified by her determination to care for this separate entity, which now had a (temporary) name and produced visible and tangible effects in her body. I sensed she was exercising tremendous self-control, but she asserted that consideration for "Figgy" took primacy over her immediate well-being because she was "going to be a mother." She also mentioned that she had gotten into the habit of checking and discussing her symptoms online on pregnancy websites, because she did not feel that her doctor cared enough about her well-being to seriously address the problem of her chronic migraines. The unique compliance/resistance she enacted in terms of the general "health," for the baby called into question the parameters of motherhood, and gave her a similar claim to that identity as others who have a different relationship to it in time.

This morning, I happened across the Facebook post on the wall of a close friend who died in January. Her mother had written "I miss you, Lovie," incurring reactions of hearts and sad faces on the post. Though there were no comments, I felt deeply affected by the sentiment. I was both moved to feel sadness for the mother, and reminded of how much I missed my friend. I found myself wishing I had the means to address her directly, and thought I had a sense of why her mother would choose to use the medium as intercessor. I thought briefly of writing a message to my late friend's extant Facebook myself, but decided to write to her mother instead. I

found myself still filled with questions, and wanting to share in the experience of mourning online, specifically with the mother of someone I cared, and in fact still care, about.

As my sister seeks out advice from pregnant peers, and I engage with a grieving mother online, I wonder about the mode of assemblage and the breadth of the motherhood role that comes along with it. These two instances seem to me to show, in a sense, the scope of the motherhood role, as both my pregnant sister and a woman who can no longer speak to the daughter that positions her within the maternal category. In the context of this discussion of assemblage on online groups and forums, I feel that motherhood, as mediated by self-labeling in conjunction with hegemonic or normative practice, can be engaged as an effect of choice as well as through the collective practice of *witnessing*. Stories of conception, birth, and mourning all engage diverse forms of claiming the identity.

Such an array leads to my curiosity about the process of and ritual surrounding becoming a mother when one does not conceive, carry, or give birth to the "baby" with whom one might share a relational identity. This project begs the question of the way in which adoptive mothers, stepmothers, mothers who use a surrogate, and so on, may undergo similar or dissimilar transitions into the mothering role. Future research might engage with the transfer from birth-mothers to adoptive mothers, in exploring the ways constructions about biological obligation might inform such interactions, and how such relationship might also be managed in online *assemblage*. Similarly, because the project focuses on a generally cisgendered and heterosexual experience, a fruitful continuation of study might include an analysis of how people who can and do give birth (but are not women) might engage with the role of motherhood and navigate through such a gendered category, in the context of online engagement.

What seems clear from this research is the need for interactive engagement and the way women are creating it for themselves, often in the face of socially or culturally inadequate medical or otherwise dominant practice. In enacting collective narratives, the women of these online loci are also challenging the modes of power that seek to characterize their experience.

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