Conceiving subjectivity: embodiment and constructions of self in pregnancy

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A thesis submitted for the degree of Doctor of Philosophy in Sociology

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January 2024

Acknowledgements

As with all things in life, completing this project would not have been possible without the symbolic "village" around me. I want to thank the following people especially:

First, the participants who donated their time and stories to this project. While I hope this project might, in some small way, provide a platform for pregnant people's voices, I am very aware that the goal of this project has been my educational qualification. I am incredibly grateful for them joining me on this learning journey and sharing their thoughtful and personal stories. Their contribution was invaluable. I feel a special acknowledgement should go to the first participants of this study, who did not hold back in sharing their stories while I stumbled through a newly learned interview method. Rest assured, later interviews were much smoother.

Second, I would also like to thank my supervisors and mentors, Dr Michael Halewood and Professor Mike Roper. Their continued support, feedback, and unwavering attempts to keep pulling me through this long process have successfully managed to get me to the end! When I started this project, I remember sitting in Mike's office, listening to them in wonder as they debated theoretical ideas and offered numerous ideas on the direction to head with this project. I now feel as though I've come full circle as I prepare for my viva, now the one expected to have these conversations. Their positive and faithful guidance has built my confidence as a researcher and writer, and I'm incredibly grateful for their seemingly endless understanding and nudges.

Last but certainly not least, I would also like to my family. My husband, the ever-cromulent Dr Ed Packard, became my coach master, assuring me throughout, sometimes with memories of his own PhD, that it was possible to make it to the end. He also held me to account, ensuring I never slept in while there was writing to be done and took our daughter on fun weekends out so that I could stay home, writing. I hope everyone in the world finds someone in life who is willing to keep their promises to proof and feedback on an entire PhD thesis. Thank you – this thesis is better for it. My daughter, Norah Jean Haaker-Packard, arrived halfway through data collection and gave me – quite literally – an entirely different perspective. Her inspiration and (sometimes welcome) distractions have given new meaning to what I have tried to achieve. At the very least, I hope I am a mother for whom she feels proud. And finally, my parents, Ron and Kathy Haaker, whose immense appreciation for education set me on this journey. For better or worse, the word "can't" was never uttered when I was growing up, and my aspirations to continue my education clearly reflect their unwavering support in this endeavour. I am now finally happy to answer my mother's question, "Did you get anything done on it?".

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Abstract

This doctoral research project investigated pregnant people's experiences of pregnancy. First, it examines the feminist literature on the medicalisation of the pregnant body and overviews the development of models of subjectivity used to understand the maternal subject. Taking a qualitative, interpretivist stance, grounded in feminist epistemologies, this research addressed questions related to how pregnant people navigate their bodily boundaries and how this, in turn, informs their sense of self. Using Wengraf's (2004) Biographical Narrative Interview Method, this research collected twenty unstructured narrative interviews, three diaries, and ethnographic materials. Drawing on relational models of pregnant subjectivity, this thesis explores discourse, the body, and agency within its analysis. First, it argues that medicalised and natural bodies form key discourses for pregnant bodies, both of which relegate the pregnant subject as a passive, non-agentic actor. Next, it examines the bodily experience of pregnant subjects, noting how a corporeal "knowing" of their pregnant subjectivity helps to construct and de-construct a foetal other, further recognising the ways in which pregnant people feel both distinct and connected to their foetus. Finally, it also examines how participants used their pregnant bodies as site of agency and power to challenge dominant discourses of gender. Throughout these explorations, the role of others continually arises as a key influence in shaping pregnant subjectivity, whether that is in providing support to challenge dominant discourse, recognise and feel a distinct corporeal other, or assert agency. From these insights, pregnant forms of embodiment help to reveal the intersubjective nature of the body, self, and others.

Chapter 1: Introduction

When does the story of pregnancy start? This is a question which has plagued politics, medicine, and law, with far-reaching, sometimes disastrous consequences. While the debate to determine the precise point rumbles on, this PhD project sought to ask this very question to the most knowledgeable ones on this topic: pregnant people. Using narrative interviewing, this research collected and analysed narratives of pregnancy, as told while pregnant. Rather than focusing on the social challenges faced by those who are pregnant, this project focused on the ways pregnancy surreptitiously brought the body to the fore in conversations about power, kinship, and the roles of individuals. The ambiguity of the pregnant body being two and/or one raises critical questions about personhood and individuated embodiment. Moreover, the very physical-ness of pregnancy – a situation where the boundaries of the body are negotiated and not fixed – challenges the underlying assumptions of the biomedical understanding of bodies and its link to identity. Additionally, the liminality of pregnancy and its rapid and constant changes offer a unique model for thinking of all bodies as unfinished. The pregnant body, "with all [its] attributed conceptual liabilities and somatic messiness", therefore, acts as a critical case study of broader ideas about the connection between body, self, and identity (Gottlieb, 2000, p. 58). Maher (2004, p. 2) similarly described pregnancy as "a critical tool for feminist thinking and as a locus for new forms of subjectivity". Thinking through what knowledge can be gleaned from pregnant embodiment, this research sought further explorations of subjectivity and how lived experiences are negotiated. Such an exploration sheds light on how the body becomes a site for constructing difference, practising norms, and asserting agency.

While the project aimed to explore how bodily boundaries are negotiated, within this thesis, there are two stories: the re-telling of the experiences of my pregnant participants, using a psychoanalytic approach that gave participants the space to construct and tell their story, deciding what was important to their story, how the story flowed, and where it started and

ended. In addition to this, there is also the telling of my journey as a PhD student, researching pregnancy while (unexpectedly) also becoming pregnant in the process. The former tells about how personhood is constructed, where social discourses shape these processes, and the importance of the body in making sense of the social world. It describes how the body becomes a site for agency and feelings of powerlessness. The latter is a developing plot of my own development, learning how to research and the surprising ways in which we can embody research. These stories intersect with each other at times and undoubtedly influence each other.

1.1. Background Context

Pregnancy, and by extension, embryos and foetuses, have gained increasing visibility in the public domain to the point that they have become subject to fervent contestation over their meanings and ontologies. These discussions involve not just the unborn but also the rights and responsibilities of those carrying the foetus. New reproductive technologies, including abortion methods, ultrasound imaging, in vitro fertilisation (IVF), prenatal practices, screening tests, embryonic stem cell research, and the legal disputes that arise from these technologies, have debated the cultural significance of the foetus and reflected the values and beliefs of Western concepts of what it means to be human. From this body of literature, pregnancy has been defined as not just simply a biological process but, as Hartouni (1997, p. 30) described, a "historically specific set of social practices, an activity that is socially and politically constructed and conditioned by relations of power, and that differs according to class, race, history and culture".

Much of the existing work on pregnancy has focused on the ways that the medical treatment of the pregnant body is conceptualised as a machine (Aristarkhova, 2005), foetal container (Bordo, 2004), and, more generally, an object for the medical gaze (Shaw, 2012), thereby

leaving the pregnant woman struggling to claim any subjectivity during their pregnant state. The pregnant body remains an "indeterminate position as part object, part subject", a mere shadow of a figure that seems to disappear in the numerous discourses that try to account for them (Baraitser, 2009, p. 4). Beyond focusing on the pregnant body, research has also explored how foetal imaging bifurcates pregnant women into two bodies and two selves (Oakley, 1984; Petchesky, 1984). Notably, some research has pointed out that "although biomedicine may exert influence on how women understand and attempt to address problematic embodied subjectivities, women do not enter into medical interactions as deterministically medicalised subjects" (Lorentzen, 2008, p. 75). Instead, such subjectivities are performed as a result of a variety of knowledges, and the extent to which women accept such medical truth claims is variable. It is clear that women can use the technological power of medicine to configure their bodies in a particular way by medically naming their bodies (albeit larger social structures highly influence such configurations). The fact that women seek medical care under biomedicine's promise to normalise their bodies signifies that women's reproductive organs are a complex interplay between what is going on in the body, instruments used to measure the pregnant body, and the materiality of their bodies.

Articulating the pregnant subject's agency, desires, and choices has thus attracted the attention of many feminists and academic researchers; however, this is usually done from a perspective that relies upon rhetoric and discourse rather than materiality. Foucault's concept of biopower has often been utilised to illustrate how medical discourses, as a site of disciplinary power, shape the experiences of pregnancy (e.g. Lee and Jackson, 2002; Shaw, 2012). For example, Martin's (1987) study of twentieth-century gynaecological texts revealed how the description of the uterus effectively mechanised it and conceptualised it as something that could be controlled. In particular, the uterus was (and largely still is) measured for its progress during labour with the objective clearly to "control the exact movements of the worker so as to increase

production" (Martin, 1987, p. 59). Oakley's (1993, p. 138) survey of pregnant women similarly noted this disjuncture between measurements of the uterus and pregnant women's experiences, concluding that the "real expert – the mother – loses her right to knowledge and control" the progress of her pregnancy. This echoes the rhetoric used by biomedical experts interviewed by Ettorre (2000), who described a clear distinction between the objective knowledge of pregnancy (the "scientific") and the behavioural processes of pregnant women (the "social"). These studies meticulously document how medical knowledge and procedures override the wishes of those who are pregnant, noting how medical discourse creates a frame to not only understand the body but also control the process and outcomes.

Gendered knowledge is also employed to produce compliance in medical power relations. Women, in particular, face additional scrutiny and stigma related to reproductive choices. There can be societal expectations that women should prioritise motherhood, and those who choose not to become mothers may face criticism for not conforming to traditional gender roles. For example, women who choose not to reproduce were found to be measured against the idealised visions of motherhood and labelled as "flawed" or incomplete" (Wager, 2000). Some individuals who choose not to have children may face misconceptions or stereotypes, such as being perceived as selfish, irresponsible, or lacking in nurturing instincts. Morell (2000, p. 318) explained that "…self-respecting other-than-mothers inherit the psychological task of re-definition". Thus, pregnant bodies not only galvanise medical views of the body but also act as a significant indicator of femininity and, more broadly, of one's commitment to gendered expectations. Browne's (2022, p. 32) work on miscarriage also noted how dominant discourses of what is "natural" bodily functioning, "particularly in relation to that fabled entity 'the female body'", contributes to the production of a normative womanhood, resulting in "womb teleologies" which not only outlines an "organic purposefulness" for the female body but also outline the correct circumstances under which pregnancy and birth must occur. Feelings of

"failure" to properly reproduce, then, are not only confined to those who choose not to reproduce, but also those whose femininity is questioned, such as teens, transwomen, or even migrants.

Flowing from the gendered, medicalised knowledge of the pregnant body also comes the ways in which pregnant people are encouraged to perform pregnancy in particular ways, resulting in choice rhetoric. The choices that personally confront each pregnant woman outside the doctor's offices and in the privacy of her own home encourage her to conform to particular reproductive processes, even when no one is looking. The feminist criticism that has examined these sets of choices has been concerned with reproductive politics: both the right to reproduce and not to reproduce and, even further, how power and control are maintained during reproductive practices. This includes discussions about the significance of making pregnant bodies visible within popular culture, technological restraints that have engaged the pregnant body, and how (and when) motherhood is negotiated. These discussions track how pregnancy – once a corporeal state experienced and overseen by women alone – has increasingly been scrutinised and refigured as corporeality requiring regulation by public institutions. These discussions, however, privilege the ability to control material processes to the extent that they largely ignore any explorations of the relationship between body and subject. For example, Akrich and Pasveer (2004, p. 63) explored how medical practices surrounding childbirth have a performative effect on women's experiences. They found that narratives of birth deployed two main actors: the body (or, more specifically, the uterus) and the "embodied self" or the "I" of their narratives. As medical practice took over during childbirth, birthing mothers increasingly spoke in terms which separated their embodied selves from their bodies. Women reported focusing on the medical instruments used to measure the progress of their labour (rather than the changing sensations of their bodies). Even the most basic instruments, such as a watch used to time the space between contractions, emphasise the uterus as an object working in isolation

from the woman. In a sense, the pregnant person's own bodily sensations and reactions were ambiguous to the uterus's workings.

1.2. The Theoretical Framework

This research aimed to bring questions of subjectivity to the fore. This research was completed in the UK, a neo-liberal state whose everyday life and politics are underpinned by a post-industrial market which holds a strong belief in individualism, emphasising personal responsibility and meritocracy. Grosz (1994) and Shildrick (1997) discuss the effects of this philosophy in detail, noting how individuality also lends itself to a valuing of self-containment and autonomy. Shildrick (1997) wrote that this belief bounded the Self in skin, revolting that which "leaks" and "flows" through this boundary. Pregnancy, in particular, poses a particular challenge for these beliefs, as it is appoint where the body is physiologically both two bodies and one body at the same time. Consequently there remains a tension in medical and legal discourses of how to describe and manage reproduction, with lingering questions of who bears rights and responsibilities during pregnancy. As will be further described in chapter 3, the unborn body and the pregnant body are anomalies according to these accepted norms of individuation and contained embodiment. While seemingly singular and contained from one aspect, the pregnant body quite clearly becomes (at least) two bodies from a different view. Due to this ambiguity, the pregnant subject has often been described as an "unknown thought" (Bollas, 1987), unspeakable, or "unthematizable" (Baraitser, 2009, p. 6). Paes de Barros (2004, p. 90) further elaborated, "The reality of the maternal body – its biological contingencies, its vast capacity for radical change, its evident sexuality and utility – make it truly…the inexpressible Real". The pregnant body, both two and one body, has challenged ideas of subjectivity and left the pregnant body as an object of study.

Efforts to understand and map the interior of the pregnant body have led to a shift in how the pregnant body is conceptualised. Before the seventeenth century, a woman would have stagnation or a "fruit" that could eventually emerge as a child, but no such thing as a secondary being or "foetus" (Martin, 2010). The eighteenth century became a critical turning point as medical science began its dissection and isolation of the female body. According to Gelis's (1991) analysis of early modern attitudes toward pregnancy, foetal narratives arose in a concerted effort to construct the "chain of life". He wrote, "Surgeons seized every opportunity to perform autopsies on the corpses of aborted babies…the aim was clear: to reconstruct the chain from the first days and weeks of life to full term" (Gelis, 1991, p. 219). The emergence of the foetus, complete with its own life history, had an adverse effect on the pregnant body: as Clark (1995, p. 147) put it, "pregnant bodies [were] erased to make way for the one true person – the fetus [sic]". In conceiving of the pregnant body in this manner, the medical gaze established a stark distinction between a person and their pregnancy, positioning the pregnant body as a condition that required medical examination and the foetus as needing medical attention. This evolution in the medicalisation of the pregnant body only further pushed a frame of a pregnant person as a subject of gestation rather than gestating subjects. This re-conceptualisation encouraged the separation between the foetus and the pregnant body, moving from one to two bodies. Therefore, concepts of pregnant subjectivity and embodiment inevitably imply notions of foetal subjectivitivation and embodiment.

In 1984, Iris Marion Young (1984, p. 45) pointed out that not much work had been done on the pregnant woman "*as a subject*" (emphasis in original) or on "the mother as a site for its proceedings". Young's (1984) close examination of her own pregnancy revealed how a pregnant subject is "decentred, split or doubled" and spurred a whole area of feminist research on pregnancy. Although more research has been done on and with pregnant people since this time, much of it tends to focus on social experiences of parenthood, new reproductive

technologies which engage with the pregnant body, and the impact these have on reproductive politics. Consequently, the pregnant body has often served as a backdrop for theorising rather than as a central focus. Maher (2002) added that the foetal body, as a construct, serves an even more limited function, particularly within feminist critiques, appearing only as competition to pregnant subjectivities. Meanwhile, pregnant people have been compared to "containers" for the developing foetus, having "compromised", split subjectivity, or with a "condition for which she must take care of herself".

The oscillations between being two and one at the same time highlight pregnancy as a partially unconscious bodily project (that is, without necessarily an intentional subject behind every change and every movement). This project seeks to build on this feminist work, but rather than conceiving the pregnant subject as having compromised subjectivity, this research pushes for further explorations of pregnant subjectivity and further interrogation of embodied processes. Specifically, as written in the first research proposal, the project aimed to "explore how pregnant people construct and negotiate the limits of foetal bodies in relation to themselves." Rather than assuming pregnancy to be either a doubled, split, or a compromised state of being, this research has sought to understand better the gestating subject and the ways a subject enacts their body as a powerful site for acknowledging, if not actively constructing, identity, difference, and agency. As part of this, it examines the sensory and physical aspects of being pregnant and how these sensations are used to help construct their bodily boundaries while also constructing the bodily boundaries of others; it examines how medical discourses are internalised not only through their choices, but also in their emotions and the physical reactions that accompany this; and, finally, how the pregnant body is used to challenge and experiment with new bodily forms that stretch the limitations of what it means to be feminine.

In keeping with a feminist approach to examining everyday experiences, this project took a phenomenological approach. Welman and Kruger (1999, p. 189) wrote that "phenomenologists

are concerned with understanding social and psychological phenomena from the perspectives of people involved", seeking to place participants' voices at the centre of research. This approach rejects the idea that the world can be understood objectively and independently from immediate experience. The aim of phenomenology, thus, is to go "back to the things themselves" and immerse oneself in the "various provinces of meaning" (Vandenberg, 1997, p. 7). Research on pregnancy has favoured a phenomenological approach, with seminal work like Oakley (1979, Kristeva (1983), and Young (1984) showing the value of the pregnant person's perspective for uncovering the depth and richness of the subjective experiences associated with pregnancy. In the five decades since these pioneering works carved out a new area of research into pregnancy and maternity, feminism, medicine, and reproductive rights have changed significantly. As Oakley (2019, p. v) wrote, "'Oppression' was the language of the 1970s, a time when feminist activists and academics in Europe and North America were stitching together an analysis of the structures, systems and ideologies of women's confinement to a special place in a man's world." While this work remains important, research is time-limited in that its findings are not subject to the test of time. The medical experience and social expectations of pregnant people today have changed considerably. Thus, this research examined what experiences continue to endure and what disappears upon further investigation.

Moreover, and perhaps more importantly, this research takes the view of what Browne (2022, p. 16) described as a "here and now of pregnancy", in which gestation is not looked at as simply a transition to a potential future as parent and child, but rather how the experience and bodily transformation shape subjectivity regardless of the outcome of pregnancy. Previous work has already extensively covered the logical pitfalls of rights-based approaches, which look at pregnancy as a state of becoming and conceptualise the foetus as a separate individual with a claim to rights. While necessary for advancing the reproductive rights of pregnant people, this viewpoint often adheres to the singular argument that the pregnant person must be the only

person and, therefore, someone with undeniable rights. Such an argument gives little validation to pregnant people's varied experiences of constructing and disassembling personhood and foetal bodies throughout their pregnancy, nor does it explain how pregnant people make sense of these experiences without risking bodily autonomy or impeding their reproductive rights. In examining the lived experiences of pregnant people, this research sought to learn more about the complexities of subjectivity and how it might give space for a more liminal, changing state of being. Thus, a phenomenological approach is reflected in its qualitative design that uses diaries and interviews to try and understand the pregnant person's point of view. In short, it assumes that pregnant people are the experts of their experiences and the multifaceted interplay between themselves and any foetal other.

Finally, a feminist approach also reflects upon the positionality of the researcher. The debates surrounding the politics of reproduction, the formation of personhood and self, and the ways in which bodies are constrained by society have long been an interest of mine. I was raised within an Irish Catholic family in the United States, so the answers to some of these questions were heavily influenced by political, religious, and medical debates but rarely referenced the voices of those who are pregnant. As a Masters student, I learned about the work of Irigaray, a psychoanalyst who argued for the concept of "sexual difference," challenging traditional notions of gender and highlighting the need for a re-evaluation of the role of women in philosophy, language, and culture (Irigaray, 1980). Irigaray's text "misused" and played with language, focusing on tactile, simultaneous, plural and fluid meanings, gives me a springboard for thinking about life experiences that do not seem to fit the mould, including pregnancy. At the start of data collection, I had never been pregnant. However, I became pregnant halfway through the research. While friends joked that I took my work a little too seriously, it also gave me insight into the importance of the historical situation of the individual. While previous feminist literature has mainly focused on ideas of alienation from the body and split

subjectivity, it is also true that parental rights have changed significantly, impacting the ways we can interact with our bodies and embody our identities. Becoming a pregnant researcher on pregnancy encouraged me to pay closer attention to my participants' stories – if for no other reason than wanting to make sense of my experience – and pushed me to think through the specific political and social context of my pregnancy.

1.3. Methodology and key findings

This research project used Wengraf (2004) biographical narrative interview method (BNIM). This participant-led method elicits narratives using a psychodynamic and sociobiographic approach. The underpinning assumption is that the "narrative expression", or telling of a story, reveals something about both the "inner" and "outer" worlds of a person. In other words, stories simultaneously tell about unique and individual experiences while also being one in which society has its own telling of the same experience. BNIM aims to explore one's situated subjectivity – that is, the way one's sense of self is formed from the social processes going on around us, as well as the internal feelings and reactions to those processes, including searching for a balance between the interview situation, the thoughts and emotions portrayed within the story, and the story itself.

The BNIM interview begins with a single, carefully constructed question: "Please tell me the story of your pregnancy, from the moment you found out you were pregnant until now; begin wherever you want to begin; I won't interrupt, I'll just take some notes for afterwards." Following this initial narrative, sub-sessions then probe for particular incident narratives (PINs), which are asked using the participants' exact words in the same order in which the participant recalled them. For example, "You said [words from the initial narrative]. Do you remember anything else about that particular moment?" The interviews themselves are

somewhat prescriptive and draw from a psychoanalytic method of elicitation (Wengraf 2001). Following these interviews, the interviewer takes time to record free association writing. Within this project, these writings were used to help re-contextualise the interviews at the time of analysis.

This method was chosen for three reasons. First, this method has a principle of conceptual openness, fitting in with the phenomenological theoretical framework of the researcher. There is no prior hypothesis being "tested" or even a pre-written interview schedule to follow. There is also an emphasis on the "Gestalt" of the interview, allowing the participant space to tell their story without interruption, clarification, or re-direction. Given the intent of wanting to explore a body whose ambiguity, as mentioned earlier, is commonly described as "unknown", "unthemizable", and "inexpressible", this method allowed for the words and narratives of those experiencing pregnancy, rather than the questions of the researcher, guide the shape of the data and subsequent analysis. This participant-led method allowed participants to decide and share which aspects of their lives were most meaningful to them at the time of telling. Second, this focus on life narratives and the ability to expand and rewrite stories within sub-sessions also gave scope to explore the evolution of individuals' experiences and perspectives as their pregnancy progressed. Often, stories are expected to have a clear beginning, middle and end, and interview questions are set up to encourage this structure. The openness of this method gave participants control over not only the content of the stories but also the temporal perspective. Rather than making assumptions about when a pregnancy started and ended, participants could begin, end, and move around events and emotions based on their perceptions of their gestating bodies. Finally, it also allowed for analysis of the interconnectedness between their personal experiences, societal influences, and individual choices. The primary focus of this method was not to examine a specific kind of story but to explore the lived experience, using the events, feelings, and thoughts that are important to the individual. These tellings

delved into the rich details of the broader context of their personal experiences and reflected on decision-making processes. Overall, the method was well-suited not just to a feminist, phenomenological approach but also to prioritise participant voices and viewpoints over the researcher's expectations.

1.4. The Thesis Structure

The thesis follows a traditional format, starting with a literature review, moving to methodology, and ending with a discussion of the findings. Table 1 below gives a quick snapshot of the chapters, their purpose, and the key arguments within each chapter.

Chapter	Title	Broad purpose	Key arguments
1	Introduction	An overview of the project, including the research intention and questions, a summary of the thesis structure, and notes on terminology.	
2	Literature Review on the Medicalisation of Pregnancy	A literature review looking at the increasing medicalisation of pregnancy over the past 150 years.	• Support for pregnancy has shifted from female-led midwifery to the medical man to “diagnose” and “treat” pregnancy • Advances in technology have sought to map the interiors of the body without inference from the pregnant subject. • Social expectations have increasingly expected pregnant people to take part in these processes actively
3	Literature Review on the Maternal Subject	A literature review exploring the theoretical lenses used to examine pregnancy, explicitly focusing on subjectivity.	• Conceptual developments in feminism have influenced thinking on the maternal subject • Ideas on pregnant subjectivity have moved from an absent subject to a split subject to intersubjectivity • Overlaying work on the subject is gendered knowledge, moving from maternalism to postmaternalism
4	The Research Story	An explanation of the biographical narrative interview	• This qualitative, multi-method project included narrative interviews, free association

		method, the ethical review process of this project, and the analysis strategy used.	writing, diaries, and ethnographic materials • BNIM offered a participant-led method to explore personal narratives • Ethical approval was granted by the HRA, with key ethical considerations including the vulnerability of the participants, consent procedures, and researcher safety
5	The Socially Constituted Self	A chapter covering empirical findings examining how key dominant discourses of pregnancy, including the medicalised self and the natural self.	• Two key discourses, medicalised pregnancy and natural pregnancy, frame experiences • While knowledge and language are essential aspects to reproducing these discourses in everyday life, so is the local context • When these frames do not consider the body-in-historical-situ, it sparks resilience or distress
6	The Socially Constructed Body	A chapter covering empirical findings examining the way personhood is constructed during pregnancy.	• Bodily sensations, including knowing, feeling, and seeing, all contribute to building the image of another • Pregnant subjectivity relies upon bodily knowledge of another • An expanded application of corporeal generosity explores the role of corporeality in constructing a pregnant body
7	The Agentic Person	A chapter covering empirical findings examining how participants write counter-narratives which lead them to challenge dominant discourses on femininity.	• Counter-narratives of the pregnant body allowed women to challenge typical feminine ideals • Counter-narratives included challenging food habits and capabilities • Even in counter-narratives, social support is sought to push new narratives
8	Conclusion	A chapter summarising the key findings and suggestions for further research.	

Table 1: A summary table of the thesis

This table gives an at-a-glance view of the thesis, highlighting the key debates and arguments explored within each chapter.

The following two chapters provide historical background to the research on pregnancy. Withycombe (2015) writes that there are two "neat" models used to describe pregnancy discourse over the past two hundred years: "pregnancy as illness" and "pregnancy as foetal containment". Consequently, the literature review is divided into two chapters focusing on these discourses. The first chapter, Literature Review on the Medicalisation of Pregnancy, gives a historical account of the medicalisation of pregnancy, exploring medical advancements and the impact these have had on the experiences of pregnant people. The more prominent theme of this chapter is the distribution of power in pregnancy, from being an experience primarily confined to the private sphere and supported mainly by other women to an experience performed within the public sphere, where women have a declining sense of power and medical science structures experience. The second literature review chapter, Literature Review on the Maternal Subject, explores the development of feminist work on pregnancy and examines theoretical understandings of pregnant subjectivity and embodiment. The themes within this chapter focus on foetal personhood, split subjectivity, and the declining visibility of the pregnant subject.

Chapter 4, The Research Story, explains the Biographical Narrative Interview method and its psychoanalytic approach in more detail. It critically discusses storytelling as a research method, focusing on the role of the voice of the participants and what is elicited from narrative interviews. It also describes the ethical review process, noting the key ethical considerations. Finally, it explains the analysis strategy of the project and how free association writing taken during the interviews helped to triangulate and focus the analysis.

Chapters 5, 6 and 7 comprise the findings and discussion. Each focuses on a different aspect of the self, as indicated in their titles. The Socially Constructed Body explores foetal personhood and how participants crafted otherness within their bodies. The Socially Constituted Self examines popular discourse of pregnancy, including medicalised pregnancies and natural pregnancies. Medicalisation is covered within the literature review, and this chapter introduces the reaction to this discourse: a de-medicalised script of "naturalness" and critically explores what this means to participants. The final analytical chapter, The Agentic Person, looks at the imaginative, sometimes funny, ways women navigated cultural scripts that did not fit with their own experiences and produced counter-narratives to these discourses. These three analytical chapters build a larger picture of the self, examining how the pregnant self is constructed, fits into discourse, and sometimes challenges it.

The conclusion summarises the key concerns of the thesis, reflects on the political debates around pregnancy, and makes suggestions for further research. Keeping in mind the goal of this project was to obtain a PhD for educational purposes, this conclusion chapter pulls together both the knowledge I generated as a student and a pregnant subject and where this knowledge fits within the broader research landscape around pregnant experiences.

1.5. Notes on Terminology

The terminology used in pregnancy is often contested and imbued with cultural meaning. There is sometimes a preference to use highly medicalised terms, which usually broadly help pinpoint the time of gestation and development of the foetus. The foetus starts in embryonic development, moving quickly to foetal development, approximately ten gestational weeks. Some of the terms used include:

- Zygote, which refers to a fertilised egg cell before implantation,
- Blastocyst: a collection of cells which has reached the uterus,

- Embryo, describing approximately 1-10 gestational weeks,
- Foetus, which is approximately 10 gestational weeks to birth,
- Neonate, or newborn, once born.

Even medical terminology, however, does not always have concrete meanings. For example, medical researchers at Philadelphia's Children's Hospital have announced a move toward human trials of EXTrauterine Environment for Neonatal Development (EXTEND). This device provides extracorporeal support to premature infants (De Bie *et al.*, 2023). This ground-breaking research states that it "re-thinks a premature baby as premature fetus [sic]" and provides an extra-uterine environment to continue foetal development (The Children's Hospital of Philadelphia, 2017). The device works by removing a foetus from the pregnant person and immediately transferring it into a fluid-filled bag with specialised valves that mirror the flow of nutrients through a placenta. Hooton and Romanis (2022) point out that within UK law, one is not "birthed" until a breath of air has been taken, meaning the foetus transferred to an extrauterine environment would not be considered a "baby" (based on current legal precedent, barring any future challenge to this).

The vocabulary of pregnancy is significant because it reflects cultural norms. Undoubtedly, most participants in this study referred to their (developing) "baby" or "child" during pregnancy. It was an infrequent occurrence for participants to use medical terminology. When this did happen, it was done in jest or emphasise the earliness of the pregnancy (e.g. one participant who cooed "Look at that little blastocyst!" when looking at an image of a 7-week scan). As expanded on in Chapter 5, using the terms baby or child helped construct a person – specifically a child – which was foundational for building an identity as a parent. The phrasing to describe their foetus often reflected ownership, such as "it's my baby" or "my body, my baby". The use of possession is interesting, as it seems to have at least two meanings. On the one hand, it is perhaps a recognition of the corporeal work of pregnant people and may signify something which is tangible and easily recognised by others (e.g., "it is the product of my

work"). However, it also alludes that the child is specific and personal to them, an abstract thought whose shape can only be known to those "carrying" the child or those invited to help refine or add to this construction (e.g., "it is my thought"). Sometimes, participants outwardly recognised the complicated nature of this terminology, with one participant very pointedly clarifying that it was "still my body, my choice" while describing how the foetus, with its own personality reflected in its movements, displayed some of her husband's traits. Therefore, the use of "baby" or "child" works on multiple levels: in part, it helps make sense of the bodily sensations of a second body, or the generational work of gestation. However, "baby" and "child" also construct parenthood, reacting to social expectations of how parents should describe their families. Thus, "baby" and "child" were words used mainly by my participants who were anticipating birth.

However, describing a foetus as a baby or child is often politicised, fuelling the fight over reproductive rights. For example, the reversal of Roe v Wade precedent in the US on 24 June 2022 triggered 14 states to pass so-called "foetal heartbeat laws", legislation which place restrictions on abortion after six weeks, or the point at which a sound likened to a heartbeat can often be heard using ultrasound equipment. While the laws use medical terminology (e.g., "foetal" heartbeat), the Supreme Court hearing to enact these laws chose to use other terms to further construct personhood. Scott G. Stewart, the general solicitor for Mississippi, argued that scientific knowledge had grown about "what we know the *child* is doing and looks like" (emphasis added) and claimed that we now know that foetuses are "fully human" even "very early" in gestation ('Dobbs v Jackson Women's Health Organization', 2021). Samuel Alito, one of the Supreme Court Justices, similarly argued in his opinion that the right to an abortion was different from other privacy rights. He wrote, "What sharply distinguishes the abortion right from [other healthcare and reproductive] rights [is that]: Abortion destroys what has been called

in this case an 'unborn human being'" (Samuel Alito, 2022, p. 31). Within these political contexts, terms like foetus and baby are manipulated to call on social values for political gain.

Within this thesis, I switch between the terms foetus and baby or child. For example, in chapter two, which covers existing literature exploring the medicalisation of pregnancy, I have referred to the "foetus" to fit within the medical context of the chapter. However, in chapters five, six, and seven, which contain an analysis of participant narratives, I often use the terms baby or child to reflect the typical word choices of my participants. This indicates a change in my own vocabulary because of this research. Prior to writing this thesis, I would have probably only ever referred to the "foetus" to emphasise my belief in pregnant people's bodily autonomy. The term foetus, of course, signifies a stage of development, so it reflects an understanding of a foetus as a "potential person" and "becoming" rather than the "being" of a child with clear rights that could compete with the rights of a pregnant person. However, having now listened to the perspectives of others who are pregnant and experienced pregnancy myself, I feel that my (admittedly, perhaps incessant) use of "foetus" as a political safeguard may have actually discounted the perspectives of pregnant people. Given the occasional clarifications from participants to re-assert "my body, my choice" phrases into the descriptions of their pregnant bodies, I fear not acknowledging and using terms like "baby" and "child" may perhaps have the unintentional effect of weaponising the feelings pregnant people have of "knowing" their child and constructing their identity. Therefore, I now interchange foetus, baby and child as a way to validate how participants may feel and describe their pregnancies and de-politicise the nature of the words, regardless of whether the pregnancy ends in a live birth.

While the terms of foetus, baby, and child are quite clearly politicised, I must also address the term "pregnancy" itself. Participants were a self-selected group responding to a call for participants asking for stories of those currently pregnant. Within this research, I did not independently confirm the pregnancy of my participants but instead focused on the story of

pregnancy being told. Throughout history there are numerous examples of pregnancy which many may not medically be considered a pregnancy, from Queen Mary I, whose famous pregnancy portrait was likely a phantom pregnancy, to Mary Toft, who was rumoured to have birthed rabbits (please see Seligman (1961) for an account of this lurid tale). Chapter two expands on these discussions by recounting the developments in tools used to confirm and monitor pregnancy, re-telling folklore of pregnancy, and examining the changing value of reproductive loss. It should be noted, again, that the focus of this research was not on a "factual" relaying of events or a strictly medicalised understanding of pregnancy but on the telling of the story of pregnancy. Additionally, not all participants experienced birth (and indeed, there is at least one story which ended in reproductive loss). Any form of pregnancy, regardless of whether it resulted in birth or not, held value for this research examining pregnant embodiment and subjectivity. As noted earlier, this research responds to a body of literature that explores the gestating subject at the centre of its research focus rather than examining birth or parenthood, and therefore, it made no assumptions about the trajectory or result of pregnancy.

Finally, it should be noted I have tried to used gender-neutral terms throughout, except when speaking directly about my participants (all of whom identified as women). Pregnancy has historically been considered a women's issue, and gender certainly plays a crucial role in the performance of pregnancy. The alignment between the female body and structural discrimination of women is undoubtedly influenced by the social expectations that surround reproduction. However, more current research, such as the ESRC-funded project led by Sally Hines, Pregnant Men: An International Exploration of Trans Male Experiences and Practices of Reproduction, addresses gender within pregnancy, arguing that gender is no longer viewed as a binary and, therefore, renders terms like "pregnant women" to be exclusionary (ESSL, 2017). As such, I have tried to ensure terminology is gender-neutral, using terms like pregnant people instead of pregnant women. However, the participants of this research all identified as

mothers-to-be and women. Therefore, within the findings, I refer to pregnant women to reflect the realities of my participants. Within the conclusion, I reflect on the broader political context and again try to maintain more gender-neutral terms to make the point that these debates affect everyone who experiences pregnancy, not just those who identify as a specific gender. Further research on pregnancy for trans people may help to further elaborate on differences and what can be further learned on pregnant embodiment.

This introduction has introduced the topic of pregnancy, with a specific note on the calls from existing literature to examine the gestating subject as a subject in their own right rather than viewing pregnancy solely as a transition to another mode of being. It also outlines the structure of this thesis, including the broad ideas conveyed within each chapter. Finally, it makes final points around terminology, including why terms like foetus, baby and child are used interchangeably and the use of gendered terminology in some parts of this thesis. The next chapter examines how the pregnant body has increasingly become medicalised, providing some historical context that contextualises discussions within the analytical chapters.

Chapter 2: Literature Review on the Medicalisation of Pregnancy

On 13 May 2021, Mr Justice Holman (2021) delivered a ruling on the case An NHS Foundation Trust vs An Expectant Mother [2021] EWCOP 33 that gave permission for a hospital to enforce hospital care for an expectant mother's labour and birth, using restraint if need be. Based on a search of the British and Irish Legal Information Institute database, court-appointed pregnancy care and birth are rare; at the time of writing, there are approximately 17 cases spread over the past eight years where this has happened. Such cases usually arise out of concerns for the pregnant person's mental health and capacity to make judgements about their own care. However, this trend of medicalisation, particularly where a person is deemed unable to make "appropriate" decisions during pregnancy, is relatively new. Prior to the 1900s, few pregnant people in the Western world had any contact with medical practitioners during pregnancy, and medical practitioners would have only been contacted as a last resort during birth. By the end of the twentieth century, however, this shifted to medical care being the standard for all pregnancies to the point where, much like this case, it is even forced upon those who are pregnant who may otherwise refuse such care. This chapter explores some of the features of this shift, focusing on the introduction of novel medical interventions that drastically changed the pregnancy experience, including the development of the at-home pregnancy test, the increase of foetal monitoring, and the progression of foetal imaging. In examining these medical advances, this chapter places medicalisation as a historical process which overlays cultural practices onto pregnant bodies, shaping and influencing the way individuals relate to and understand their bodies. It also critically examines how medicine has mapped the interior of a pregnant body, providing cultural frames to interpret and understand the pregnant body.

In addition to shaping society's beliefs and imagination about how pregnancy is experienced, the trend toward medicalisation has also had several implications for power dynamics within the healthcare system and society at large. Among these are three important features: first, it

gives recognition to specialist doctors for having greater knowledge about pregnancy, thus having more authority over decisions made during pregnancy and birth; second, it standardises care, limiting the number of choices that are available to individuals, and finally, it pathologises normal processes, framing experiences of pregnancy in terms of risk rather than a bodily process. All of these factors were seen in the above-referenced case heard in the Court of Protection. In this case, an NHS trust asked for a court-ordered treatment for a 21-year-old pregnant woman suffering from an extreme ("long term and deeply seeded") form of agoraphobia, who had expressed a preference for a home birth and had declined the majority of routine, antenatal care throughout her pregnancy. A consultant psychiatrist, testifying on behalf of the NHS trust, speculated that her routine appointments were most likely missed due to her agoraphobia, a condition that was unlikely to substantially change before birth. This, he reasoned, amounted to a lack of capacity to make decisions under the Mental Health Act 2005. Additional testimony from doctors explained that the scans performed at her home showed no concerns for foetal development or the mother's health. The issue, in this case, was complicated: the pregnant woman had no preference over the mode of delivery (she was not opposed to medical intervention). However, she had a preferred location. The location, however, impacts the mode of delivery; it is not possible to have a Caesarean section at home, nor can a home birth be done at a hospital.

Mr Justice Holman (2021) explained his ruling was, thus, a decision about best interests. The judge's verdict explained this is not supposed to debate medical intervention's comparative advantages and disadvantages. Nevertheless, he described in detail the relative risk of requiring urgent medical care during pregnancy and labour, noting that approximately 10% of home births require a transfer to the hospital, with 1-2% of those requiring an emergency, blue-light transfer. Weighing up the relative risks of home birth and her apparent ability to make a decision about going to a hospital, the judge decided the woman should have a court-ordered care plan

which required her to attend a hospital for a planned birth. Her options once at the hospital were induction for vaginal delivery or Caesarean section, with no option to wait for spontaneous labour unless this happened before the scheduled date. The transfer to the hospital would be enforced if she did not voluntarily go to the hospital, and a mental health nurse would be stationed outside her room during delivery.

The case was complicated and received substantial comment and critique. The charity Birthrights (2021) argued that despite the time and space to have a full discussion with the woman about these issues, the woman's voice was silenced: she was referred to solely as "an expectant mother", rather than "P" (for anonymous person) or initials which are normally used in court documents, and she was never actually asked if would go voluntarily to the hospital in the event of an emergency. Butler-Cole (2021), a solicitor writing for Promoting Open Justice in the Court of Protection, pointed out that only the risks of requiring urgent medical care during a home birth were considered, while the risks of induction and Caesarean section were never weighed on balance. Similarly, the Perinatal Mental Health (PMH) Midwives UK (2021) noted that there were significant risks with forced hospital births, including how birth trauma can impact the bond between parents and babies and influence decisions about future pregnancies. They also noted that substantial resources exist in midwife-led care, which can facilitate the wishes of mothers preferring homebirths. Gutteridge (2021), a midwife and psychotherapist, opined that the judge may have "create[d] a precedent that any woman who has an anxiety disorder and requests birth outside of the regular menu of choice may be subjected to strong-arm maternity care."

A postscript to the judgement explained that the woman went into spontaneous labour before the planned delivery date, received anti-anxiety medication, and, although initially resistant, willingly took an ambulance to the hospital, delivering a healthy baby vaginally. This case serves as a vivid illustration of how pregnancy is framed through a medical lens, profoundly

affecting the experience of pregnancy. Refusal to receive medical care during pregnancy can be read as a statement on the person themselves and their decision-making capacity and, as it happened in this case, may result in a social force to submit to medical care. These social expectations are, at least partly, influenced by beliefs about the relative safety of and risk to foetal bodies. The next chapter further explores those conceptual debates surrounding the ontology and meaning of foetal and pregnant bodies. First, this chapter will look at the progress of medical knowledge, focusing on key events and technology that served as a turning point for significant social practices in pregnancy. This is not a strictly linear history, and advances and changes in cultural practices were not instantaneously applied uniformly across all areas. Accordingly, this chapter is arranged thematically, first exploring how pregnancy is confirmed and acknowledged, then moving to how the body is monitored throughout pregnancy, then looking at how the interiors of the pregnant body were visualised, before finally addressing how pregnancy is pathologised as a medical condition.

2.1 Diagnosing pregnancy

Al-Gailani and Davis (2014) trace the discussion of medicalisation back to the 1970s, where it grew out of a broader, sociological interest in the growth of professional power as a function of social control and, specifically, theorisations on the authority and practices of medicine on everyday life. However, reliance on medical authority over reproduction has been an ongoing process, with significant changes happening in the 19th and 20th centuries. Cox (2023) notes that between 1801 and 1901, the population in the United Kingdom exploded from 10.8 million to nearly 37 million, with millions of labouring and pregnant bodies behind this population explosion. Anxieties around the viability of national expansion led to what Pickstone (2000) labelled as a ‘productionist’ political economy, which assumed the need for a large and healthy population to keep a supply of industrial labour and military. An increasing focus on child and

maternal welfare saw the emergence of new public health campaigns and appeals from a range of sources, including policy-makers, charities, medicine and science, to ensure the health of a growing, working population. This same period saw an expansion in the knowledge, teaching and practice of obstetrics, at least as represented in the number of texts and manuals available on pregnancy care, and a supplanting of the female midwife by the man-midwife, or accoucheur, to oversee pregnancy and birth (Hanson, 2004; Fox, 2022). Pregnancy, or at least the product of pregnancy, had a cultural value that contributed to wider social needs.

Confirming pregnancy, therefore, had an important social value attached to it. Quickening, or the point at which a pregnant person can feel the movements of an embryo or foetus, had long been considered a pivotal point in pregnancy. For many women, these first sensations of movement signalled splitting into two parts: parent and child (Root and Browner, 2001; Nash, 2012a). However, quickening has had many meanings throughout history, from the ensoulment of a foetus to determining the legality of termination or abortion (Sekaleshfar, 2009). This particular point, usually 16 to 20 weeks into a pregnancy, was identified in Aristotle's (1684 [note: this is an author who used the philosopher's name as the pen name for books on sex and midwifery which were particularly popular in early modern Britain]) Experienced Midwife, who wrote it was this stage that separated an embryo from the foetus and conscious thought willed the foetal body to move.

However, not all women experience quickening, and distinguishing quickening from other bodily movements may require prior experience to accurately identify foetal movements from other bodily sensations. Therefore, other more reliable and efficient methods for confirming pregnancy were sought, resulting in a range of tests with urine. Ancient Egyptians, for example, used cereal grains like a modern-day pregnancy test, which the women would urinate on. If seeds sprouted after a week, it would indicate she is pregnant (Braunstein, 2014). A similar test on grains was found in tenth-century Arabic medical texts (Ghalioungui, Khalil and Ammar,

1963). Modern experiments tested this theory, finding the method to be accurate in 70-85% of cases (Henriksen, 1941; Ghalioungui, Khalil and Ammar, 1963). In the Middle Ages, surgeons, nicknamed "piss prophets", would analyse the colour, clarity, and granules in urine to determine whether a woman was pregnant (Burstein and Braunstein 1995). The first laboratory test for pregnancy, which aimed for higher validity and reliability, was produced in the 1920s (Olszynko-Gryn, 2014). Initially, mice and rabbits were injected with a potentially pregnant person's urine; then, the animal was dissected to see if the ovaries had been stimulated to produce eggs. From this practice, the phrase "the rabbit died" became a euphemism to refer to pregnancy. These animals were later traded for the much more efficient toad, which would lay its eggs and, therefore, did not require dissection. Toads also laid eggs within twelve hours of injection, making this the fastest pregnancy test to date. Davis (2017) told the story of how thousands of South African toads were imported to Edinburgh throughout the 1930s and 1950s. Even in the height of the Second World War, a shipment of toads was permitted to sail from South Africa, along the coastline of Europe, into the Thames to a London hospital, demonstrating just how vital a pregnancy confirmation was, for at least those who could afford such a test. All of these tests produced a result based on the presence of human chorionic gonadotropin (hCG), the hormone produced after implantation. Eventually, this hormone was isolated and, in 1976, the at-home pregnancy test was introduced. This test boasted a 97% accuracy and could be determined within two hours for just $10.

While the methods for pregnancy testing have come a long way, the social value behind "knowing" a pregnancy is something that wields a certain kind of power. These modern pregnancy tests were labelled as a feminist breakthrough, which allowed women privacy, convenience, and control over the experience of confirming their pregnancy. Oakley (1976, p. 502) noted the importance of these products because they were "available over-the-counter, so that we are not dependent on medical super-structures for confirmation of the outcomes of our

own reproductive choices". However, Layne (2009) made the argument that at-home pregnancy tests were not the tool of freedom that it is often purported to be; she argued that it reduced the role of a woman's voice and instead re-focused attention on medicalised knowledge of the body. While at-home pregnancy tests now have increased accuracy to 99%, there is, however, still room for error – for that 1% chance of a false negative. For example, sometimes pregnancy tests cannot pick up pregnancy as quickly as women begin to feel pregnant, especially if pregnancy is felt, or "known", in the "two week wait", luteal phase of pregnancy between ovulation and her expected period. A woman may, therefore, feel pregnant (and, physiologically, be pregnant) but have a negative reading. Conversely, the pregnancy test also picks up chemical pregnancies, where there is an early miscarriage or molar pregnancy. A woman may know she is not pregnant and yet may be holding a positive test result. In all of these scenarios, "pregnant" becomes a status given and confirmed by others, using tools bypassing knowledge about one's own body. Duden (1993) made a similar point, noting the development of pregnancy tests took the knowledge and power of confirmation of pregnancy out of the hands of those who are pregnant. Even where pregnancy is not suspected, National Health Service (NHS) guidance in the UK recommends pregnancy tests on all people with uteruses of child-bearing age upon admittance through their emergency services or before planned surgery. Once a pregnancy is identified, a change in status requires further medical testing; for example, the NHS procedure to diagnose a miscarriage is done with two blood tests, taken 24 hours apart, to show a drop in pregnancy hormone levels (National Health Service, 2022b).

2.2. Monitoring Pregnancy

After testing and confirming pregnancy, monitoring the foetus became the next important step to ensure that one was, in fact, still pregnant. Small *et al.* (2020) traces the history of foetal

monitoring back to at least the 17th century, when Phillipe Le Goust first described foetal heart tones in his poetry, describing the heart of the foetus beating “like the clapper of a mill”. He was a colleague of Marsac, who is largely credited with having first discovered the foetal heartbeat (Pinkerton, 1969). Marsac’s observation, however, seemed to go unnoticed until 1818, when Swiss surgeon Francois Mayor reported the presence of foetal heart sounds when he placed his ear on the maternal abdomen. Just a year later, when René Laënnec invented the stethoscope in 1819, it was used by his pupil Jacques Alexandre de Kergaradec to listen for the ‘splashing’ of the foetus in the amniotic fluid (Hanson, 2004). Instead, Kergaradec discovered the foetal heartbeat, writing, “It seemed to me that I was hearing the movements of a watch placed very close to me” (Small *et al.*, 2020). He suggested auscultation, or listening to the heart, to be of value in the diagnosis of twins and in determining foetal lie and presentation.

The obstetricians of the time were slow to respond to Kergaradec’s observations and recommendations. However, one hospital, the National Maternity Hospital in Dublin, adopted this use, and listening to the foetal heart was described as a standard part of their evaluations. The primary use was to diagnose foetal death, which permitted the use of instruments to remove the foetus in pieces and bring the labour to an end in the hope of saving the life of the woman. To convince other clinicians of the value of Kergaradec’s findings, Evory Kennedy published guidelines in 1833 for foetal distress and recommended auscultation for monitoring the foetus (O’Sullivan, 2006). The text contained many anecdotal examples of cases where auscultation was beneficial. Building upon this, Von Winkel established criteria in 1893 for foetal distress based on irregular heart rates (Sartwelle and Johnston, 2016). By the turn of the twentieth century, monitoring foetal heart rate became widely adopted to help assess the progression of pregnancy.

There was, however, debate over the best way to hear a foetus. Many believed vaginal stethoscopy to be the best way to confirm foetal life. Meanwhile, Laennec’s stethoscope, when

pressed directly to a pregnant abdomen, was deemed to be a less invasive choice (Freeman, Garite and Nageotte, 2003). The invention of the fetoscope, a foetal stethoscope, was first used in the 1920s at the Chicago Lying-In Hospital, eventually taking over as the preferred tool for foetal monitoring until electric foetal monitors took their place in the 1960s. Small *et al.* (2020) noted that the use of such inventions often preceded the research to support the effectiveness of such inventions. For example, she stated that in 1973 over 50% of pregnant women in high-income countries were monitored using electronic monitoring tools, three years prior to the first randomised controlled trials (RCTs) on the effectiveness of electric foetal monitoring. By 2007, this number had risen to 90%, with the assumption that such tools benefitted outcomes for pregnant and birthing people. Hindley, Hinsliff and Thomson (2006) also found that, despite pregnant people valuing the ability to autonomously make decisions about their pregnancy and labour, electric foetal monitoring created an environment that relegated them to a more passive role and more likely to place midwives' choices above their own. Interestingly, a recent Cochrane review analysing the RCTs for continuous monitoring during labour and birth found no significant difference in a range of outcomes (Alfirevic *et al.*, 2017). The one area of difference, however, was in the likelihood of having a Caesarean or assisted birth. In this example, foetal monitoring equipment gave insight into foetal heart rate, with the underlying assumption this explained something about foetal distress. As Small *et al.* (2021) pointed out, however, this meta-narrative of detecting foetal distress overrides the distress of the pregnant person. Small's work, exploring how midwives perceived foetal monitoring systems during maternity care, examined how these tools helped shift power dynamics to those deemed to have the most medical experience. One midwife in Small's (2020, p. 198) study explained, "Often times there's already this explosion of things that need to happen and…my whole room just [goes] into chaos because of that thing [the foetal monitoring system] in the corner!" The

medical technology, then, works on two levels: to position pregnant individuals as passive to medical decisions but also to create a hierarchy of power within the medical setting.

Monitoring within pregnancy was not just for the foetus but also for the pregnant person. Cultural pressures standardised certain behaviours, which were then assimilated into categories of "disease" and "treatment" by the medical profession. A good example of this process is the so-called "insanity of pregnancy", or puerperal insanity, a diagnosis which flourished in the nineteenth century (Theriot, 1989). Looking at the mental health hospital admissions in the UK during the nineteenth century, Loudon (1988, p. 78) found between 5-20% of female hospital admissions were for puerperal mania. Symptoms included:

> 'highly excitable', 'elated', 'irritable', 'furious madness', or 'wildly incoherent, raving and very difficult to control'. Extreme restlessness, often leading to violence, was associated with a total inability to sleep and usually a refusal to eat… Even women of highly respectable backgrounds (clergymen's wives, for example) were apt to produce an astonishing barrage of aggressively obscene and erotic remarks which left everyone wondering where on earth they could have heard such things…. And the baby was often in danger from 'a homicidal tendency'…

Theriot (1993, p. 18) noted that most patients themselves did not identify their behaviour as insane but were brought to medical attention by a family member or close friends. Upon further prompting about the cause of symptoms, patients would report symptoms that occurred around a child's birth or a specific point in their reproductive cycle. Their "subjugated knowledge" led to the trends within medicine and research that responded to these self-reported symptoms and causes, thereby creating medicalised subjectivity in turn. This also created one of the earliest specialities within medicine, specifically those who understood and treated diseases of the womb (Marland, 1999).

2.3. Visualising Pregnancy

The emerging speciality of obstetrics and gynaecology fuelled further interest in mapping the interior of the pregnant body to better understand the foetal body within. Gelis (1991) analysed discourses of early modern medicine and explored how the developmental model arose in a concerted effort to construct the "chain of life". He wrote, "Surgeons seized every opportunity to perform autopsies on the corpses of aborted babies…the aim was clear: to reconstruct the chain from the first days and weeks of life to full term" (Gelis, 1991, p. 219). This was seen as holding the key to understanding life and improving medicine, so it became crucial to collect bodies, and specifically foetuses, in which to study. In one particularly stark example of this, Withycombe (2018) recounted the story of Dr J Stolz, a physician who, in 1866, attended the miscarriage of a 16-year-old woman. The pregnant woman delivered a five-month-old foetus, which the doctor wrapped in flannel before giving remedies to the mother. When he turned back to the foetus, he was surprised to see it "gasping for breath, making regular inspiratory movements". He took the living foetus back to his office, where he was joined by two friends, Drs Jenner and Booths, who watched the foetus breathe for one hour and forty minutes before expiring. Withycombe (2018) pointed out that physicians were only able to remove foetal remains with the permission of the family. In a time when women were trying to limit family size and had little access to effective birth control, miscarriage was sometimes seen as a comfort. Consequently, foetal remains were not conceptualised as infants but much more akin to specimens, leading women to allow physicians to take foetuses with them for preservation and study. In the early 1900s, Franklin P. Mall began building a collection of these human embryological specimens and put out a call to physicians to hand over any specimens they had collected and preserved throughout their careers. In a few short years, he was able to amass 500 jars and piece together the full range of stages of foetal development. This research led to discoveries, such as when the heart could beat, or hair grew, ultimately leading to the

personification of the foetus. The emergence of the foetus, complete with its own life history, had an adverse effect on the pregnant body: as Clark (1995, p. 147) wrote, “pregnant bodies [were] erased to make way for the one true person – the fetus [sic]”. Withycombe (2015) noted the history of this knowledge, which changed the cultural context which changed the status of foetuses, is therefore paradoxically rooted in women’s permission to preserve and study foetal remains.

Other images of the living foetus, taken through less invasive methods, were also explored in the late twentieth century. Obstetricians began producing new images of pregnancy using X-rays, gathering and studying detailed pictures of the interiors (Jauniaux, 2014). Throughout the first half of the twentieth century, obstetricians studied x-rays of the pelvis and foetal skeleton to better predict where difficulty in pregnancy and birth would occur. This, of course, led to disastrous results; Alice Stewart and her research team at the University of Oxford quickly identified that radiation from X-rays correlated with an unusually high incidence of childhood cancers, and obstetric X-rays were quickly abandoned thereafter. In 1956, however, Scottish obstetricians developed the first commercial ultrasound, an image using ultrasonic waves to picture tissue density. Oakley's (1984, p. 155) study on ultrasound devices found them to be “revolutionary because, for the first time they enable obstetricians to dispense with mothers as intermediaries, as necessary informants of foetal status and lifestyle”. A perhaps latent, but nonetheless evident, consequence of visualising and studying the pregnant body without the input of the voice of the pregnant subject. Oakley went on to argue that women’s bodily experience was marginalised and devalued, and foetal-centric technology became the equivalent to uncovering the natural and true “facts” of the pregnant body.

Other feminist critiques argued that the foetal images today are different from those of the past in very significant ways, particularly in how they now focus on the foetus alone, just like ultrasound imaging. In 1990, Swedish photographer Lennart Nilsson, using a high-tech

scanning electron microscope, introduced the public to a 7-week-old foetus for the first time (Chambers, 2009). In the image, all traces of the female body, including the amniotic sac and placenta, disappeared. Stabile (1992) argued that these images, alongside now common ultrasound images of the foetus, have continued to switch the focus from the gestating body to foetal personhood. The importance of this critique is about recognition of subject status of the foetus, which is created through these images of active gestation, which bypass the pregnant subject. Stabile further wrote that this erasure of the pregnant subject has given rise to disputes over abortion and even child support and custody. Hartouni (1997) brings up more extreme examples where the female subject had fallen into the background of decision-making, citing examples where brain-dead or comatose women on life support have been kept alive long enough to give birth. The very human images produced through ultrasounds and microscopes have thus informed not only medical discourse but also legal discourses, which fundamentally change the experience and understanding of pregnancy. Instead of a bodily process for a pregnant subject, these images also indicate a second person, which requires medical treatment and consideration.

Compiling 103 illustrations of pregnancy, Newman (1996) argued that images of the pregnant body and the foetal body have not changed that drastically, and instead, medicine continues to draw on the same gendered knowledge that existed before medical advances. Comparing anatomical drawings and figures to religious images, she argued such illustrations do not represent a significant shift in conceptualisation of the foetus. Duden (1999), however, contested this conclusion, pointing out that such images must always be interpreted within their specific historical and social context, and what is more significant than the images themselves is how they are collectively deciphered. Moreover, images, and the way images are used, have changed since the thirteenth century. While thirteenth-century drawings depicted a miniature adult, the first “photographic” appearance of the unborn came about in the 1950s, revealing a

child with a large head, tiny body, and translucent skin (Shrage, 2002). By the 1980s, ultrasound scans became regular, accompanied by a heartbeat and two-dimensional images. Nevertheless, Newman's (1996) study recognised that the often fuzzy or unrealistic ultrasound images require an “expert” technician to assist in an “accurate” reading of the blurry images, ultimately applying the appropriate cultural meaning for the pregnant woman and, importantly, humanising the image by labelling the otherwise unrecognisable body parts or describing the motions of the foetus. The pregnant woman was thus “read” by medical technology and experts as bifurcated, with two individuals acting independently, thereby establishing both mother and foetus as two separate entities, unconnected as illustrated by their visual individuality.

While medical research collected and studied the foetal body in an effort to see inside the pregnant body, there still remained some artistic depictions of the outer, pregnant body, which placed the pregnant subject at the centre of the illustration. In early modern Europe, reproduction and pregnancy were often considered to be the duty, or even a calling by God, of women. Motherhood, therefore, was the main task for elite women to carry on the family bloodline. When a woman was unable to bear children, it was generally considered to be the “fault” of the woman failing in her duty, so announcing pregnancy was particularly important for women. In early modern England, pregnancy portraits were often commissioned, displaying an almost exaggerated pregnant belly and other symbolic imagery, such as a hand cradling the belly or a rose held in front of the belly. Hearn's (2020) unique analysis of pregnancy portraits showed that early images of pregnancy were highly influenced by Christianity as the dominant discourse of the social world. Images of pregnancy were often likened to the Visitation, the famous scene where Mary was visited by an angel and asked to carry God’s son into the world. These images often bore religious symbols or were posed in ways that mimicked the Visitation scene. However, portraits and other artistic images of pregnancy largely disappeared by the seventeenth century, with pregnancy even edited out of images. Confirming a sitter was

pregnant could only be ascertained by looking at the age of the children and when the portrait was painted. This curious retraction of pregnancy into more private spheres denoted a social change: it was deemed inappropriate for a woman to appear pregnant in official portraits or other images (Hearn, 2020). It was not until the twentieth century that pregnancy stopped being airbrushed out, led mainly by key female artists producing and sharing self-portraits as a way of making sense of their pregnant bodies. Then, in August 1991, the American magazine Vanity Fair featured Annie Leibovitz's photograph of Demi Moore, heavily pregnant and nude, appearing next to the caption "More Demi Moore" on the front cover. This watershed moment reintroduced the public to the pregnant body, but with reservation: the image was deemed so inappropriate that many newsstands refused to stock it or, conversely, put a black plastic cover over the image. However, it started another cultural shift to a more visible pregnant body. Within just a couple of decades, Demi Moore's pose has been reproduced by several other celebrities, including Serena Williams and Beyonce, and tabloids now feature a "bump watch" as a standard part of magazines. Longhurst (2001, pp. 33–34) noted the picture marked a sharp contrast to the historical tradition of confining the pregnant body to the private sphere. In a single image, fertility was reframed as a "fashionable spectacle" (Tyler, 2001). Now, weekly "soft news" is decorated regularly with gestating celebrities, while tabloids keep a close "bump watch" on high-profile personalities. The meaning of this powerful, modern iconography of pregnancy is not without debate – while some hail it as a breakthrough for the pregnant subject to be recognised and celebrated, others feel these images refine the pregnant subject to a passive position, simply an object of the societal gaze. Longhurst (2000a) writes that while these images of pregnancy open up the debate about the multitude of subject positions for the pregnant subject, these images also position motherhood as a glorious and beautiful thing, harkening back to historical images of pregnancy as "doing your duty".

2.4. Pathologizing Pregnancy

The focus of the gaze on the pregnant body and visualisation of the foetus had a two-fold effect on the pregnant subject: first, it attracted the medical gaze to the reproductive organs, encouraging them to be studied out of context of the pregnant body. Second, it identified specific organs, namely the uterus, as fundamental and specific to reproduction, devaluing the role of other parts of the body during pregnancy. By the twenty-first century, pregnancy could be identified, monitored, and imaged entirely through medical technology and, importantly, without input from the pregnant subject, thus relegating the pregnant body to a passive object of study. Foucault's concept of the medical gaze has often been employed to illustrate how medical practices, as a site of power, shape the experiences of pregnancy (for example, see Lee and Jackson (2002) or Shaw (2012)). Foucault traced how visualisations and representations of the body in Western medicine profoundly affected power dynamics between physicians and their patients. Foucault argued that the medical gaze objectifies patients, reducing them to their physical symptoms or diagnostic categories. This objectification can depersonalise the patient and focus solely on the medical aspects, neglecting broader social, psychological, and cultural factors. This, Foucault argued, was rooted in how the body was studied. Dead bodies were anatomised, providing granular detail to images of specific body parts. The clinician then became the privileged reader of these images, with highly localised knowledge which rendered "the body of the patient [as] the epistemological terrain on which the new theories of 'life' were founded" (Shaw, 2012, p. 113). Shaw (2012) argued the use of medical instruments, imaging technologies, and laboratory tests in the treatment of the pregnant body extended the reach of the gaze into the interior of the pregnant body, influencing diagnostic practices. The study of the inanimate images of the foetal body disempowered the pregnant subject, leaving the pregnant subject without a voice or subject status. By utilising the concept of the medical gaze, Shaw (2012) highlighted how medical knowledge and practices contribute to the exercise of

power and the construction of social norms during pregnancy, which have a lasting impact on how pregnant people view their bodies. For example, Akrich and Pasveer (2004, p. 63) explored how medical practices surrounding childbirth have a performative effect on women's experiences. They found that narratives of birth deployed two main actors: the body (or, more specifically, the uterus) and the "embodied self" or the "I" of their narratives. As medical procedures took over during childbirth, birthing mothers increasingly spoke in terms which separated their embodied selves from their bodies. Women reported focusing on the medical instruments used to measure the progress of their labour rather than the changing sensations of their bodies. In one example, one woman relayed the contradictory instructions given by her doctor to stop pushing during involuntary contractions and to push when she was not contracting. Even the most basic instruments, such as a watch used to time the space between contractions, emphasised the uterus as an object working in isolation from the pregnant person, leaving the internal bodily sensations insignificant to the uterus's workings.

Beyond disconnecting the pregnant subject from their pregnant body, the medical gaze also re-imagines the pregnant body as a machine, able to move and work without the intention of a subject. Martin's (1987) study of twentieth-century gynaecological texts revealed how the description of the uterus effectively mechanised it and conceptualised it as something that could be controlled. In particular, the uterus was (and largely still is) measured for its progress during labour with the objective clearly to "control the exact movements of the worker so as to increase production" (Martin, 1987, p. 59). Oakley's (1993, p. 138) survey of pregnant women similarly noted this disjuncture between measurements of the uterus and pregnant women's experiences, concluding that the "real expert – the mother – loses her own right to knowledge and control" the progress of her own pregnancy. This echoes the rhetoric identified by Ettorre (2000) in interviews with biomedical experts, who described a clear distinction between the objective

knowledge of pregnancy (or "scientific" knowledge) and the behavioural processes of pregnant people (or "social" action).

However, the pregnant body is not simply a passive object of the medical gaze. Notably, Lorentzen (2008, p. 75) has pointed out, "Although biomedicine may exert influence on how women understand and attempt to address problematic embodied subjectivities, women do not enter into medical interactions as deterministically medicalised subjects". Instead, such subjectivities are performed as a result of a variety of knowledges, and the extent to which women accept such medical truth claims is variable. Rothman (1998, p. 18) reasoned that these medical methods are "an ideology of our time" and reveal more about the values and belief system of society than it does about the experiences of pregnant bodies. Pregnant people, through this process of medicalisation, equally became active participants in the production of optimum pregnancy (and foetal) health. Ettorre (2000, p. 246) called this 'reproductive asceticism', when pregnant people strictly monitored and controlled their bodies in line with medical expectations for the sake of their foetuses. Shaw (2012) notes that society is so well-conditioned to see pregnancy as a condition to manage that certain events, such as the absence of menses, bleeding, or even movements of the foetus, are carefully documented and taken back to the doctor for further examination. The weight of expert knowledge about the impact of the pregnant woman's lifestyle on the future health and well-being of children prompts individuals to self-regulate their conduct during pregnancy. Through the wide dissemination of health promotion information, pregnant people are continually encouraged to act responsibly in order to promote "normal" foetal development. Raphael-Leff's (1991) psychoanalytic work with pregnant people discussed the anxiety dreams which often surface during pregnancy, such as giving birth to monstrous babies or suffering a miscarriage, and how such fears arose from doing something "wrong" while pregnant. Steyn (2000) similarly found that Western women are increasingly terrified and nervous about labour and birth and suggested that such fears are

focused on the loss of control. Whereas in the past, women were expected to submit to labour, now women have come to expect some level of control over the process. As Raphael-Leff (1991, p. 137) put it, the pregnant woman herself typically "wants to be treated as an adult person on a creative mission, an active, cognisant participant in a strange, exciting experience not merely a dumb container who comes to the 'workshop' for a service checkup".

Women can use the technological power of medicine to configure their bodies in a particular way through the power of medically modifying their bodies (albeit larger social structures highly influence such configurations). Women seeking medical care under biomedicine's promise to normalise their bodies signify that women's reproductive organs are a complex interplay between what is going on in the body, the instruments used to measure the pregnant body and the materiality of their bodies. Johnson (2014) noted that the smartphone revolution has brought a whole new aspect to monitoring the pregnant body: it has allowed women themselves to track their health and become "expert patients" by consuming a vast range of health information. One NHS trust, for example, published a list of "useful apps", including ones which help count kicks, track your food and sleep, check the expected development of the foetus that week, and provide medically-approved information "from preconception through to your child going to school age 5" (National Health Service, 2020b). From this focus on "checking" the body and standardising the experience, a "choice rhetoric" arose seemingly as a compromise to satisfy the inherent idea that the individual is a "free agent" who exercises her rational capacity to make an autonomous decision – as long as that decision is one which manages the risks of pregnancy and safeguards the health of the foetus. The choices that personally confront each pregnant woman outside the doctor's offices and in the privacy of her own home encourage her to conform to very specific reproductive processes, even when no one is looking.

However, these "choices" also refer to a set of social expectations for pregnant women. Bennett (cited by Earle and Letherby (2003, p. 2)) sardonically offers a short list of all of these rules for pregnant women:

> Want to have a child? Well don't do it too early. Don't leave it too late. Don't do it before you're nicely settled. Don't have an abortion. Don't have an unwanted child. Don't be a single parent. Don't miss out on the joy of childbirth. Don't think you can do it alone. Don't let your children be reared by strangers. Don't sponge off the State. Don't have a child for selfish reasons. Don't be childless for selfish reasons. Don't end up in barren solitude. Don't expect fertility treatment to work.

Longhurst's (1999) critical account documented how others, including strangers, supervise the behaviour of pregnant women to chastise them for breaking the "rules". She noted that these rules are what was deemed as "proper and natural behaviour" for pregnant women, which included an assessment of how antagonistic a woman was to the foetus. Recent years have seen a plethora of newspaper and magazine articles, books, and television programmes devoted to telling women their choices and which of those choices are the best ones to make, utilising medical knowledge to promote them as the best choice. The ramifications for women who do not follow these suggestions, however, can be extraordinary: Bordo (2004, p. 83) quoted a full-term, pregnant woman who decided to have a drink with dinner, explaining that the rest of her dinner party "tried to make [her] feel like a child abuser". Bordo (2004) went on to explain pregnant women are expected to create a kind of environment for the foetus that is not expected of the father, the state, private industry, or anyone else that is a part of the foetus's "environment" – whether it is those that affect the mother's well-being or those that impact the foetus directly through, for example, physical abuse, second-hand smoke, or inadequate healthcare coverage. The social discourse that targets the habits of pregnant women as the sole causes of foetal abnormalities places a duty of care is placed squarely on the shoulders of women rather than implicating the entire network that aids foetal development. Pollitt (1995, p. 172) pointed out that no government or healthcare service offers the support needed to make

it possible for women to abide by this extensive (unwritten) list of societal expectations, citing examples such as landlords evicting pregnant women, obstetricians refusing to care for uninsured women, or drug treatment programmes rejecting drug-addicted, pregnant women. As Nettleton (1997, p. 212, emphasis in original) wrote, "Individuals are recruited to take care of themselves, but the techniques that are deployed by the "experts" of human conduct must in turn invariably shape how individuals come to think about themselves".

Gendered knowledge about who should become pregnant and how is important to produce compliance in medical power relations. For example, women who chose not to reproduce were found to be measured against the idealised visions of motherhood and labelled as "flawed" or "incomplete" (Wager, 2000). Pollitt (1990, p. 280) also criticised depictions of pregnant women as self-indulgent, undisciplined, and animalistic, noting the foetus is framed as "innocent" while childless women are "guilty" of indulging their "whims". Even when the choice was made to be voluntarily childless, they still dealt with the stigma as a "failed" woman. Some research has found some of these attitudes are changing, but the underlying goal to reproduce remains. Moore *et al.* (2013), for example, observed that while research in the 1970s primarily found discourse framed childless women as "deviant", more recent research since 2000 has seen a shift to more positive depictions, which pointed to social structural obstacles "preventing" the choice to become a parent. Even as attitudes change, women remain framed as essentially reproductive beings with an implicit assumption they should monitor their reproductive bodies and become pregnant at some point, even when that choice does not suit their own desires.

When women choose to become pregnant, the options available to them of how to experience the pregnancy may still be limited. Petchesky (1984, p. 685) wrote, "The 'right to choose' means very little when women are powerless … women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions which

they themselves create but under social conditions and constraints which they, as mere individuals, are powerless to change." The "choices" that Petchesky identified are not only made under particular social conditions but often only acknowledged within favourable social conditions. To put it another way, social exclusion remains a determining factor of women's access to healthcare and, therefore, the reproductive "choices" that are available to them. For example, Earle and Letherby (2003, p. 5) note that, in the United Kingdom, almost twice as many of the poorest women will give birth to a stillborn or premature baby when compared with women in other social class groups, a trend that is repeated throughout the world. Even the choice to terminate a pregnancy or request sterilisation is not routinely available "on demand"; other times, such options can be forced. In both cases, such a treatment must be approved by (at least) two medical professionals, supported by family members, and performed within specific timeframes in certain settings, those "favourable social conditions", which may not reflect a woman's actual social environment.

2.5. Concluding Thoughts on the Medicalisation of Pregnancy

The medicalisation of pregnancy and birth, where aspects of pregnancy and childbirth are increasingly defined and treated as medical conditions, is met with both criticism and celebration of progress. While this process has the capacity to deprive patients of a voice, identity, and choice, it also undoubtedly improved outcomes for pregnant people and their babies. Medical advances, particularly those since the 1940s, significantly brought down maternal deaths (Chamberlain, 2006). As Figure 1 shows, the introduction of antibiotics and handwashing after the Second World War had a revolutionary impact on the maternal death rate. Cox (2023) explained that simple procedures like washing hands before attending a birth were basic but essential ways of improving welfare. Several factors contribute to the continued medicalisation of pregnancy, including the advent of prenatal care and routine medical check-

ups to diagnose and monitor pregnancy health, technological advances which provide detailed assessments of health and influence decision-making during pregnancy, the standardisation of care with guidelines and protocols that establish hierarchies of power and knowledge, and a focus on risk management that has led to increased surveillance and intervention. All of these factors shift the cultural perceptions of pregnancy as a condition which requires medical expertise and treatment to safeguard the health of the mother and baby.

Figure 1: General Register Report of annual death rate per 1000 total births from maternal mortality in England and Wales (1850-1970) (University of Essex and UK Data Service, 2007)

Accordingly, these breakthroughs have significantly shaped experiences of pregnancy and family life. Therefore, no exploration of pregnancy would be complete without first examining the medical discourse, which creates an interpretive frame for the understanding and fundamentally defining experience of pregnancy. Within these medical frames, two key trends have had a particular influence: the technologisation of pregnancy and the visualisation of pregnancy. Technology in pregnancy encompasses a wide range of developments, starting with efforts for a more valid and quicker pregnancy test to more specialised equipment, usually used by medical practitioners, to monitor and explore the foetus. Visualisation of the foetus follows these technological advancements, with a focus on exploring the internal pregnant body and

pinpointing more specific physiological developments of the foetus. While medicalisation has brought significant advances in maternal and foetal health, it has also been critiqued for potentially contributing to over-medicalisation, unnecessary interventions, and the disempowerment of pregnant individuals.

The necessity of medicalisation of pregnancy is well documented and debated. There is a risk that relying only upon the medical model of pregnancy has the unintended consequence of narrowing the understanding of pregnancy. Indeed, as Matus (1995, p. 6) has pointed out, medical discourse can sometimes appear "more open, exploratory and less ideologically obedient than fictive imaginings". It is necessary to stress that medical science, although it strives for truth claims and has undoubtedly influenced (both positively and negatively) the understanding of pregnancy, is not value-free, nor indeed the only frame which exists for making sense of reproduction. Rothman (1998, p. 18) argued that these medical methods are complicit in reiterating and encouraging particular cultural norms. Scientists are not detached observers; they (re)produce and normalise cultural values and make choices about what is significant and what is left out. Lippman (1995, p. 12) similarly called medical experts "storytellers" who use body matter to "construct their explanations, their stories, for the conditions that interest them". It has been repeatedly argued that the experience of the pregnant woman, including her internal sensations, mood and environment, has been disregarded in lieu of scientific concepts, such as sex hormones, DNA and metamorphosing cells (e.g. (Martin, 1987; Oakley, 1993; Ettorre, 2000; Bordo, 2004). The next chapter further explores some of the ontological debates arising from a medicalised understanding of pregnancy and further explores the implications of the visualisation and treatment of two bodies.

Chapter 3: Literature Review on the Pregnant Subject

Pregnancy is a profound and transformative experience that transcends the physical realm and delves into the complex realm of subjectivity. The previous chapter explored the processes which turned the pregnant subject into a medicalised subject. However, the term "pregnant subjectivity" encapsulates the multifaceted dimensions of a pregnant person's experience, encompassing not only the physiological changes but also the psychological, emotional, and social aspects of this transformative journey. This chapter seeks to unravel the conceptual developments on subjectivity during pregnancy, exploring how conceptual turns within feminism have also sparked new conversations about the pregnant subject. There is a challenging aspect to this discussion, however, in that it begins by talking about the pregnant subject and ends by talking about the maternal subject. Some view this conceptual slippage between pregnancy and maternity with a critical eye, arguing it invokes essentialist arguments that examine the maternal subject instead of the pregnant subject will inherently equate women with reproduction. Wading fully into the argument, I acknowledge implicit connections made by discussing both the pregnant subject and maternal subject in the same chapter. This chapter, however, draws heavily from psychoanalytic theory, for which sexual difference is said to be core to the Western symbolic order. Within this thought, the maternal is not defined by biological sex; instead, it is symbolic of a value system which, according to psychoanalyst and theorist Irigaray, is unspoken and unwritten. Irigaray (1993, p. 12) argued that to change the symbolic order, we need to activate and express the feminine through psyches and bodies, declaring that “women’s exploitation is based upon sexual difference; its solution will only come about through sexual difference”. The problem, of course, is that the West already has symbolic meanings for male and female, father and mother, which reflect a whole organisation of binary oppositions represented within bodies, values and psyches. The language within feminist thought is often debated, rejected, and reclaimed, with these decisions rooted in

popular discourses associated with these Western ideas of sexual difference. In providing a theoretical history of the pregnant subject, I aim to give a fuller discussion of these theoretical developments, and I hope it becomes clear that sexual difference in this sense is not based on essentialist arguments of biological difference but on symbolic representations whose meanings change and shift across time and space.

To invoke the pregnant body in discussions of subjectivity is still, to some extent, profoundly political and hotly contested. This may be, at least in part, due to the difficulty in engaging in arguments on the role and expectations for women within society. Beyond this, however, is the debated interpellation of foetal subjectivity. Existing research on pregnancy often explores social activities and interactions, critically discussing power, agency, and identity. This literature has examined the role of medicalisation in rearranging power dynamics and shaping the experience of pregnancy. Overlaid onto this are the conclusions of how these medicolegal discourses reflect Western neo-liberal values of individuality and meritocracy. This line of inquiry often focused on the pregnant body as an object of research, merely a backdrop to theorising rather than the central focus. As mentioned in the Introduction, Young's (1984) account of her own pregnancy was conducted to fill a void in literature which studied the cultural framing of pregnancy rather than listening to the pregnant subject. Similarly, Maher (2004) called for further theorisation on new forms of embodied subjectivity that could allow for intersubjectivity rather than simply placing foetal and pregnant subjectivity at odds with one another. These debates raise critical questions for reproductive politics: who has rights and responsibilities in reproduction? Who has the right to reproduce and not reproduce? And even further, how is power and control maintained during reproductive practices? Sorting through these debates about subjectivity has a significant impact on the very real experience of pregnancy, as the stance on these debates affects the visibility of pregnant bodies within popular

culture, the role of technology that engages with the pregnant body and how (and when) parenthood is negotiated.

Meanwhile, public focus has centred much more on embryos and foetuses to the point that they have become subject to fervent contestation over their meanings and ontologies. New reproductive technologies, including abortion methods, ultrasound imaging, *in vitro* (IVF) fertilisation, prenatal practices, screening tests, embryonic stem cell research, and the legal disputes that arise from these technologies, have debated the cultural significance of the foetus and reflected the values and beliefs of Western concepts of what it means to be human. As the previous chapter demonstrates, changing understandings of the pregnant body position the pregnant subject within a specific cultural and historical context. What is considered "human" or, conversely, "non-human" is, therefore, a constructed subject position that some scholars have sought to unpack. This chapter draws upon this work, done mainly by feminist scholars, who sought to understand foetal and parental subjectivities in the pregnant body. This work identifies four key areas: the disappearance of pregnant subjectivity, phenomenological accounts of split subjectivity, theorisations using a relational approach of intersubjectivity, and post-maternalism, or the harkening back to a caring, interdependent subject. These four theoretical narratives have shifted over time, developing as feminism moved through waves of thinking and changed its stance on what a gendered body is.

3.1. Feminism and the Body

Feminists have held a wide range of reactions and attitudes to the body, significantly influencing how some lived experiences, like pregnancy, are thus conceived. Grosz (1994, pp. 15–19) outlined three key feminist conceptualisations of the body, primarily aligned with first, second, and third-wave feminism. These provide a valuable framework to situate how the

theorisations of the pregnant subject have progressed with feminist thought. While these typologies are by no means exhaustive of the various feminist stances, they nevertheless signpost clear conceptual developments and critiques of how feminism has tackled the problem of the body.

Grosz starts with "egalitarian feminism", a category which includes thinkers like Simone de Beauvoir (or, at least, some of Beauvoir's earlier writing). This early wave of feminist thinking regarded the specificities of the female body (e.g. menstruation, pregnancy, maternity, lactation, etc.) as a limitation on women's rights within a patriarchal culture. Nature and culture, thus, are pitted against each other and bodies, accordingly, are "regarded as a limitation on women's capacity for equality" (Grosz, 1994, p. 15). In this view, achieving equality requires modification and transformation of the body and the reproductive capacity of the body is posed as something to be managed if not completely rejected. Importantly, this means that, as Grosz (1994, p. 16) argued, "maternity must be overcome" to achieve equality. A rational, autonomous self is idealised, embracing a more humanist approach to understanding subjectivity.

The next major category of Grosz's feminist typology is "social constructionism", which includes thinkers like Julia Kristeva, Nancy Chodorow and other psychanalysts. This group is much more positive about the body and is more interested in examining the different meanings and values awarded to bodies than it is about controlling the body. In this line of thought, the body is regarded as precultural, naturalistic, and a material upon which culture inscribes meaning. While equality remains a key goal (like egalitarian feminists), the way to achieve this is focused on modifying social orders or conceiving of a world without these structures. Within this group, there is no striving to overcome biological function; rather, the task is to ascribe new meanings and value to a wider range of bodies and bodily functions. The major conceptual development by this group is the distinction between sex and gender, noting that inequality is

experienced because of cultural meanings, not because of inherent, biological inferiority. This conceptual splitting between social roles and the biological was an extremely persuasive argument to begin shifting attitudes toward women and achieving more equality. This conceptual splitting, however, also gave rise to essentialist arguments. As Fuss (1989, pp. 2–3) pointed out, "essentialism is essential to social constructionism", not only throwing the essentialist/constructionist binary into question but also pointing out that the "natural is produced by the social". Nevertheless, the project of this pool of thought aimed to minimise biological differences and instead focus on a new, more equal gender structure.

The final group Grosz described is "sexual difference", which includes thinkers like Luce Irigaray, Judith Butler, and Monique Wittig. Within this thought, the body is central to understanding subjectivity and is no longer considered an "ahistorical, biologically given, acultural object" but a social and discursive object (Grosz, 1994, p. 18). Feminists of sexual difference are concerned with the lived body and unpacking systems of signification and exchange. In some ways, this builds on social constructionists as they look for new meaning in old categories of gender but extends this to question sex as well, noting that "the body codes the meanings projected onto it in sexually determinate ways" (Grosz, 1994, p. 18). These thinkers avoid the pitfalls of essentialist arguments by noting that the body is an interweaving of culture and nature, and they valorise the differences between members of the same sex. There is no universalist or uncritical acceptance of irreducible differences between the sexes, but an exploration of what sexed bodies are and could be.

Grosz's classification of feminist thought on the body is particularly useful, as each category has contributed an influential way of understanding the pregnant subject and their experiences and is a reminder that there is no universal model for understanding subjectivity. These theorisations also highlight broader concerns about subjectivities beyond the pregnant subject: understandings of embodiment and relationality, debates of singularity and multiplicity,

valuing of affectivity and thought, structures for norms and desires, and transitions between identities. The theoretical work on the pregnant subject thus represents the importance of thinking psychosocially and exploring both internal and external worlds and how these modalities co-produce each other. These categories also point to the difficulties of language in speaking of pregnant subjectivity, highlighting the earlier point about speaking of the pregnant subject and the maternal subject. The following overview of theorisation on the pregnant subject is, thus, not intended to be definitive but to clarify the historical development and the number of differing, perhaps even oppositional, views of the pregnant body, even when all views are informed by feminist thought.

These classifications are a simple metaphor to help explore basic, historical developments in thought, however these typologies have been subject to various criticisms. First and foremost, each category simplifies a multi-faceted movement. While it may encompass some of the mainstream ideas and values, it does not depict a full picture of the various communities and what has been called “fringe feminism”. Importantly, this typology also primarily focuses on the evolution of white feminism, writing a narrative of feminism which ignores more global movements fighting for varying ideals of gender equality. Hemmings (2011) critiqued the popular “story” of feminism which uses the waves metaphor as its storyline, and how it falsely presents a unified narrative of activism. Her analysis explored the narratives formed around feminist action, raising up some characters while villainising others. She suggested these stories gave the impression of a cohesive story while actually they simplified overlapping, complicated histories. She wrote she strived to “[experiment] with how we might write stories differently, rather than writing different stories” (Hemmings 2011, p. 16). Secondly, this typology implies a linear trajectory with clear boundaries across each category. However, feminist movements are often pulled in many directions and influence each other, blurring and blending across time and space. This also suggests that types of feminism may be in conflict

with each other, or even have a generational disjuncture (if seen as a chronological development). Consequently, this model fails to show where these ideas develop in conjunction or in contrast to each other. Again, this has been heavily critique; for example, Roth's (2004) exploration of feminists of colour, specifically Black and Chicana activists, show how these groups preceded, both in collaboration and confrontation to, the mainstream, white feminism of the 1960s and 1970s. She describes the different methods taken up by these groups, including community-based organisation which brought issues of class and race to the fore. Her analysis of the work of these groups showed how feminism not only sought to address a much wider range of concerns, but also challenged the idea that white, middle class feminism (of "first wave" feminism) was the "start" of feminism. Despite these criticisms, however, these typologies help to demonstrate that current thinking has a past and present, and that thinking on the body and subjectivity is not a historical aberration but influenced by and connected to a larger movement. This chapter has used these typologies to help guide an understanding of how ideas on the pregnant subject have changed and been influenced by different movements of feminism. While such categories bear the limitations of presenting a simplified and discreet ideas, it has been used here as a tool to better appreciate that there are many and differentiated models of subjectivity in relation to pregnancy, and that these have evolved in line with the wider evolution of feminist thought. In short, this model provides a (albeit rough) blueprint to organise theoretical ideas around pregnant subjectivity and critical points and concepts introduced by new thinkers.

3.2. Disappearance of Pregnant Subjectivity

The first of these models looks specifically at the way subjectivity is denied or unrecognised. Beauvoir addresses this concern directly, exploring the ways that patriarchy systematically rejects the work of creation involved in pregnancy. Her descriptions of pregnancy are

complex and nuanced, exploring not only the biological processes of pregnancy, but also the subjective experiences of the pregnant person. In one particularly descriptive passage, she describes pregnancy as follows:

> Often it no longer seems marvellous but rather horrible that a parasitic body should proliferate within her body; the very idea of this monstrous swelling frightens her… pictures of swelling, tearing, haemorrhage, will haunt her.

While there is an acknowledgement of the corporeal challenges of being pregnant, the somewhat horrific image presented by Beauvoir (1949, p. 336) when she described the scene that would unfold when a newly married woman would come to find out she was pregnant, gives a wholly new image of the pregnant subject. This account of pregnancy reflected existentialist anxiety about the loss of autonomy and agency. Beauvoir (1949, pp. 551-552) later further described this experience in a way which brings to the fore the ways in which she considers the subjectivity of the pregnant person:

> She experiences it both as an enrichment and a mutilation; the fetus [*sic*] is part of her body and it is a parasite exploiting her; she possesses it and is possessed by it; it encapsulates the whole future and in carrying it, she feels as vast as the world; but this very richness annihilates her, she has the impression of not being anything else

In this passage she goes beyond the biological processes of pregnancy and begins to reflect on the subjectivity of the pregnant subject and the difficulty that exists for a pregnant person to be recognised as a gestating person. For Beauvoir (1949, p. 46), the body is of central importance as it is “one’s gasp in the world”. In her later work, Beauvoir goes as far as to reject calls to motherhood, arguing that if one is to maintain one's status as a masterful and speaking subject, one must refuse that which obliterates female subjectivity: maternity.

Beauvoir's critique of maternalism can be understood within the broader context of her exploration of women's oppression and the ways in which patriarchal norms and structures contribute to the subjugation of women. Beauvoir argued that maternalism contributed to the instrumentalisation of women, reducing the experience of pregnancy to a mere biological

process. As pregnancy positions a person as both an agent and site of activity, Beauvoir's concern lay in the threat of being defined only in relation to the latter and, in effect, being denied a voice.

While Beauvoir has been challenged for a negative view of maternity, she nevertheless remains hugely influential. Some, like Zahra (2022), have debated the meaning of Beauvoir's work, noting that Beauvoir is actually unpacking a patriarchal value system which does not class gestation as giving life but instead as reproducing life, an important distinction in terms of awarding value. By exposing these cultural values, Zahra (2022) argued that Beauvoir left space for new cultural meanings of motherhood. Zerilli (1992) similarly pointed out that Beauvoir's work did not advance, but rather unsettle the modern, masculine-speaking subject by questioning a woman's desire for motherhood. Her basic point that pregnancy leads to a non-speaking subject status has been reflected in a wide array of literature on pregnancy. The medicalisation of the pregnant body, described in the previous chapter, and the increasing detail of the images that came from medical technologies led to new social practices which feminist authors have long argued visually and discursively erase the pregnant subject (e.g. Franklin, 1991; Stabile, 1992; Duden, 1993; Mehaffy, 2000; Betterton, 2002). Rather than a clear intertwined image of both the foetus and the pregnant subject, images increasingly focus and add further detail to the foetal body specifically, effectively editing out any pregnant subject. Feminists like Beauvoir were highly influential in unpacking medicalisation and gendered expectations' effect on the pregnant body and pregnant subject. Their work helped to explain why viewing pregnant bodies purely for their future selves and reproductive capacities is problematic.

The exploration of how the pregnant subject is relegated to a passive position has inspired other feminist work also looking for the nuanced ways that the pregnant subject is silenced and even erased. This work has recognized the concept of foetal subjectivation, where the foetus is

interpellated an identity and subjectivity separate from the pregnant person. The harsh consequences of this rhetoric around being two are outlined in Bordo's (2004, pp. 81–82) exhaustive list of United States' cases in which pregnant women were legally prosecuted for harm to the other "individual" (that is to say, the unborn) within them:

> In 1989, a Florida judge sentenced twenty-three-year-old Jennifer Johnson to fifteen years' probation on her conviction of delivering illegal drugs via the umbilical cord to her two babies. A Massachusetts woman who miscarried after an automobile accident in which she was intoxicated was prosecuted for vehicular homicide of her fetus. A Connecticut woman was charged with endangering her fetus by swallowing cocaine as police moved to arrest her. A Washington judge sent Brenda Vaughan to jail for nearly four months to protect her fetus because a drug test, taken after she was arrested for forging a check, revealed cocaine use. In 1990, a Wyoming woman was charged by police with the crime of drinking while pregnant and was prosecuted for felony child abuse…

Bordo (2004, p. 87) contends this ideology of "woman-as-foetal-incubator" renders foetuses as "super-subjects", allotting them rights that have never been granted to anyone else in society. It is as though all the subjectivity of the pregnant body were drained away and deposited into the foetus alone. Browne (2022, p. 5) similarly warns against the fetocentric thinking that fetishes foetal subjectivitivation at the expense of the gestating subject. Even words like "carrying" or "expecting", she argued, shift the gaze from the pregnant subject to the foetus. It is important to note here that the point is not to argue that foetuses are simply an extension, or even appendage, of the pregnant subject; instead, it is to emphasise the ontological conceptualisation of the foetus as a separate, independent entity, which has arguably rendered the woman as a container of the foetus, has been constructed by advances in modern medicine.

Scholarship on surrogacy can also view pregnancy through the lens alone of what is to be, using a patriarchal understanding of the pregnant body as a "host" to an imagined future child. Browne (2022, p. 10) made this point with a reference to Ergas (2012) and argued that "recent discourse and jurisprudence on commercial surrogacy routinely ignores the lived experience and situation of pregnant surrogates and has reinforced the idea of pregnancy as a "service"

whose value lies solely in the expected child as a "product"". Berkhout (2008) similarly found that the norms and practices of commercial surrogacy have failed to enhance the autonomy of the surrogate or expectant mother, relying on legal structures to make decisions rather than allowing either party the ability to speak on their own desires. There is some evidence that surrogates sense of self is reinforced through an "act of altruism" (Ferolino *et al.*, 2020). The experience of surrogacy and relinquishment carried personal meanings for the individual. Nevertheless, such meanings are largely individual, and at a wider social level, surrogacy and parenthood remain processes where the focus is often on the foetus as the eventual "outcome" of pregnancy. In contrast, pregnancy is relegated as a transitional moment, leading to a new subject status. Much of this body of work focuses not on the lived experience of pregnancy but on how larger social structures interpret and treat pregnant people, affecting the pregnant subject in turn.

3.3. Split Subjectivity

Western notions of subjectivity divide mind and body and represent them as different entities, with the mind taking precedence and viewed as being able to exert control over the flesh (Grosz, 1994; Shildrick, 1997). Within this Western philosophy, individuality, self-containment and autonomy are valued, and one's own body is primarily viewed as entirely separate from others' bodies. Shildrick (1997) wrote that this belief had bounded the Self in skin and revolted that which "leaks" and "flows" through this boundary. In Western cultures, the unborn body and the pregnant body are anomalies according to these accepted norms of individuation and contained embodiment. While seemingly singular and clearly contained from one aspect, the pregnant body quite clearly becomes (at least) two bodies from a different view. This de-centring, splitting and doubling of women is the key ontological supposition made within medical, legal, and popular discourse where women are treated as "containers" for the

developing foetus; without an intentional will behind bodily movements, the focus shifted to the foetal body.

In the 1980s, a new wave of feminist scholars began analysing their own pregnancies, taking a phenomenological account of their lived experiences. Their accounts, however, wrote the pregnant subject back into these understandings of pregnancy. While they noted the alienation of the body – the unintentional movement and shifting boundaries of the body, and the public recognition of a potential child-to-be – they also recognised their own, sometimes indescribable, intentions and desires throughout their pregnancies. Kristeva (1980, p. 237) gave this description of her pregnancy:

> Cells fuse, split, and proliferate; volumes grow, tissues stretch, and body fluids change rhythm, speeding up or slowing down. Within the body, growing as a graft, indomitable, there is an other. And no one is present, within that simultaneously dual and alien space, to signify what is going on. "It happens, but I'm not there." "I cannot realize it, but it goes on." Motherhood's impossible syllogism.

Kristeva's (1980, p. 238) imagery of the "radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and other, of nature and consciousness, of physiology and speech" was highly influential on Young's (1984) phenomenology of pregnancy. She similarly described:

> As my pregnancy begins, I experience it as a change in my body, I become different from what I have been… I feel a little tickle, a little gurgle in my belly, it is my feeling, my insides, and it feels somewhat like a gas bubble, but it is not, it is different, in another place, belonging to another, another that is nevertheless my body… Only I have access to these movements from their origin (Young, 1984, p. 48)…

The impossible syllogism and split subjectivity described by Kristeva and Young presents a challenge to the humanist idea of a stable, intentional subject behind the body, giving space for new conceptions of the subject. Young (1984, pp. 50–51) admitted that "Certainly there are occasions when I experience my body only as a resistance, only as a painful otherness preventing me from accomplishing my goals…" but then later added that "contrary to the

mutually exclusive categorisation between transcendence and immanence that underlies some theories, the awareness of my body in its bulk and weight does not impede the accomplishing of my aims". Young explained that the everyday, instrumental actions of the observing, willing, and acting "I" is phenomenologically located in the head. However, sometimes, this shifts the eyes to the body, causing a greater sensory continuity with surroundings. Pregnancy, she argued, allows her to simultaneously experience the phenomenological "I" and the body, a dual location. While the pregnant subject moves through space with intention, the pregnant body can sometimes be surprised, grounding the subject in the physical space they inhabit and reminding them of their materiality.

Kristeva (1980), however, went further with the idea of split subjectivity and argued that there is not an adequate discourse for pregnancy. She noted there are two dominant Western discourses of pregnancy and maternity: religion, which makes motherhood sacred and a "natural" duty, and medical science, which objectifies the pregnant body and locates it within nature as something to be studied. Kristeva (1986, p. 297) described the pregnant subject's location as "the threshold between nature and culture, biology and language", confounding boundaries of the self and other and offering a feminist critique of the male, speaking fully intentional subject. By insisting that the pregnant body operates between nature and culture, Kristeva tries to counteract stereotypes that reduce pregnancy to nature. She pointed out that even if the pregnant subject is not the intentional agent of the body throughout pregnancy and birth, the pregnant subject nonetheless never ceases to be primarily a speaking subject. Reflecting on these layers of duality of the pregnant subject, she described its dual location as "two-in-one", recognising the other within, which served as a valuable model for all subjective relations. Like the pregnant body, each is what Kristeva called a subject-in-process. Subjects-in-process always negotiate the other within; in other words, it negotiates the return of the

repressed self. Like the pregnant body, no one is ever the wholly singular, intentional subject of their own experience.

Research on pregnancy often reflects these sentiments. For many women, the first sensations of movement, or "quickening", signal splitting into two parts (Root and Browner, 2001; Nash, 2012b). Women have described these sensations as strange or "weird" because they are so different from the sensations of their non-pregnant state (Nash, 2012a). Schmied and Lupton (2001) found women struggled to articulate their experiences, often remarking, "I don't know how to put it into words" or "I can't explain it". Young (1984, p. 49) similarly wrote, "In pregnancy I literally do not have a firm sense of where my body ends and the world begins. My automatic body habits become dislodged; the continuity between my customary body and my body at this moment in broken". She argued that as the foetus grows within a pregnant body, these changed contours affect not only how the pregnant subject thinks of themselves but their relationship with the material world. This splitting of the pregnant body spanned beyond the emergence of a "foetal body" and has also been argued to shape women's experience of their own pregnant bodies. Even when speaking of the foetal body within, women from Nash's (2012a) interviews found there to be a divide between those who viewed their foetuses as "part of me" and those who thought of them as separate bodies. Still others, as Warren and Brewis (2004, p. 223) found, described their pregnancy as a "foreign invasion", stating that their body "no longer belongs to them". Kristeva went on to argue that, in pregnancy, a woman is lost and cannot be placed; from this, she described the abject, which she explained as

> an extremely strong feeling which is at once somatic and symbolic, and which is above all a revolt of the person against the external menace from which one wants to keep oneself at a distance, but of which one has the impression that is not only an external menace but that it may menace us from the inside. So it is a desire for the separation, for becoming autonomous and also the feeling of an impossibility of doing so-whence the element of crisis which the notion of abjection carries with it (in Oliver, 2002, p. 374).

In other words, an existential crisis is caused by the loss of distinction between subject and object, self and other, and exists on a location before entering the cultural, or symbolic, order. In thinking of a pregnant subject, the abject is a reminder of the unstable borderline between parent and child, in which the pregnant person is simultaneously a subject, body (and object), and abject.

3.4. Intersubjectivity

Some feminist scholars have sought to counter narratives of the disappearance of the pregnant subject or split pregnant subject with a relational account of pregnant identities and embodiment (see, for example, Petchesky, 1987; Maher, 2002; Ruhl, 2002; Hird, 2007). These models of pregnant subjectivity aim to provide a configuration that shows a subject which is not individuated as (at least) two subjects but who are intertwined and interembodied. It borrows from the idea of Kristeva's "two-and-one" but positions the pregnant subject as unique, part of an ethics of corporeal generosity that "gifts" life (and subjectivity) to another. Like ideas of split subjectivity, it makes a clear case for the presence of the pregnant subject and aims to present the foetal subject as co-constructive with the pregnant subject. However, unlike ideas of split subjectivity, this model does not rely upon an exercise of will or intention in order to be recognised as a subject. This relational model informs what Hird (2007) argued is a "materialist" approach to pregnancy, which recognises the increasing blurring of bodies. Coole and Frost (2010, p. 22), recognising the impact of changing assumptions about the body and its categories, reflected,

> It is becoming evident that changes in living matter are rendering obsolete many of the conventional ethical categories used to evaluate them. As scientists succeed in bridging species, artificially creating and extending human and animal life, and manipulating and synthesizing genes to create new life forms, they muddle the concepts and boundaries that are the ground for much ethical and political thinking.

As such, a relational approach to thinking about the self and body is a particularly productive model for exploring these blurred boundaries and new ways of incorporating ideas of intersubjectivity.

Defining intersubjectivity, however, has its challenges. Irigaray, a French feminist philosopher and theorist, sees intersubjectivity as imperative to understanding the lived experience. As Irigaray (2000, p. 110) explained, “Beyond transforming our relationship with the truth, the mystery of the other would allow us to enter into a philosophy, and not only an ethics, of love, into thinking of subjectivity as intersubjectivity”. However, she notably critiques the shortfalls of language in describing this experience. One such critique involves the use of the pronoun "I" and the way language reflects and reinforces gendered power dynamics. Irigaray critiqued what she calls "phallogocentrism," which refers to the dominance of male-centred perspectives in both language (logocentrism) and culture. She argued that, historically, language has been shaped by male experiences and that women's voices have been marginalised or suppressed. In her critique, Irigaray suggested that the pronoun "I" is not neutral but reflects a male-centric perspective. She contends that language, including the use of "I," often serves to reinforce the masculine subject as the norm, while the feminine is positioned as the "Other" or as lacking in comparison (Irigaray, 1974). Central to Irigaray's work is the concept of "sexual difference", which explored the idea that feminine experiences and subjectivity should be recognised in their own right, challenging traditional patriarchal norms (Irigaray, 1993). She questioned the adequacy of existing linguistic structures to represent women's experiences and argued for creating a more inclusive and pluralistic language to better capture the diversity of women's identities. Irigaray advocated for an "écriture féminine" or "feminine writing," suggesting a form of expression that disrupts traditional linguistic structures and opens up new possibilities for representing feminine experiences. This involves moving away from linear, hierarchical language toward a more fluid and diverse mode of expression. Critical explorations of

intersubjectivity, therefore, undoubtedly include Irigaray's effort to evade the erasure of the other and her broader call for a focus on connection.

Irigaray's work on intersubjectivity differs from Kristeva's "between subjectivities" in that it explores ideas of the self which focus on connection to others, rather than framing ideas of subjectivity around individuation from others. This fusion requires, as she calls it, a "third term", or "intermediary", that creates "a synthesis that is neither one nor the other" (Irigaray, 1993, p. 20). She used a range of imagery to explain this, including love, air, muscousity, and, perhaps most provocatively, the placenta. For Irigaray, the placenta is a site of interaction, not just a simple connection between two. In an interview with Hélène Rouch, Rouch explained that the placenta "modif[ies] the maternal metabolism, transforming, storing, and redistributing maternal substances for both her own and fetus' benefit" (Irigaray, 1993, p. 39). The placental economy, therefore, like the physical organ itself, both prevents and permits access between the self and others, constantly negotiates boundaries, and offers a metaphor for exchanges which both differentiate and fundamentally connect figures.

Other feminist scholars, such as Hird (2007) and Maher (2002), have continued to use the placenta to help explain a relational model, critiquing other models that focus on individuation. Hird (2007, p. 6) pointed out that Beauvoir conceived of pregnancy as the "unilateral transaction from mother to child", where parental and biological "gifting" through the placenta jeopardises pregnant people's integrity as individuals. Quoting Beauvoir, Hird (2007, p. 6) stated that Beauvoir described the pregnant person as "'victim to the embryo/fetus [*sic*]', as the fetus 'absorbs her autonomy; [the] individuality of the female is opposed by the interest of the species, it is as if she were possessed by foreign forces – alienated'". However, Hird went on to argue that modern ideas of subjectivity are predicated on the notion of autonomy. Of course, pregnancy, birth, and feeding are not conducted with autonomous individuals but dependent individuals (or, in the words of Beauvoir (1974 [1949]), a "parasite"). Hird (2007) turned to

Diprose's idea of "corporeal generosity" instead to describe the interdependence of maternal/foetus/child relations. Highlighting work like Young's (1984) phenomenology, she described how bodily boundaries are in flux and questions the dominance of individuality as the basis for thinking about embodiment. She used examples such as the sharing of DNA, blood and nutrients through the placenta and, later, breastmilk. She succinctly explained the implications for understanding subjectivity as follows:

> The necessary symbiotic relationships and their constant gifting invites fundamental questions about the individual autonomy of all people specifically, and living and non-living matter more generally. That is, we are not autonomous individuals who subsequently interact: we interact, gifting things calculable and incalculable, and this ongoing process creates our individuality, to be recreated with every encounter.

One such example of the blurring of boundaries lies in foetal and maternal microchimerism (FM and MM, respectively). FM and MM refer to the uni- or bilateral exchange of mitochondrial DNA across the placenta. While most foetal cells would disappear from maternal tissue within the first weeks post-gestation, Chan and Nelson (2013) found evidence of foetal cells in maternal tissues up to three decades after birth. Peterson *et al.* (2013) even found evidence of foetal microchimerism in cases of miscarriage and termination, both in the once-pregnant individual and in subsequent children of that pregnant individual. Foetal mitochondrial DNA seems to play a role in the somatic healing of a pregnant individual; this DNA has been found to migrate to parental tissues with damage or disease to help repair tissue (Boddy *et al.*, 2015). It is also thought this tissue may make some types of cell therapies more effective (Chan and Nelson, 2013). This sharing of genetic material and nutrients across the placenta represents a somatic gift between the foetus and the parent.

Fanin (2014) developed these ideas further, arguing that this materialist perspective offered more than just a metaphor for ways of being. She argued that the placenta provides a temporal structure to a theory of becoming. Examining Irigaray's (2014, p. 13) work, she reflected on the point that people are "submerged in a world that he partly produces and from which is he

is not separable", and that the placenta acts as a relation between-two. As such, the placenta is understood as an enclosure, or barrier, between exchanges. Fanin (2014) pointed out that the material placenta, as an organ in reproduction, is a temporary connection and argued that as a mediating passage, the placenta's materiality helps explain how relationships are negotiated, and boundaries change. Honing in on this materialist perspective, Fanin (2014, p. 302) suggested it is the agential capacities of matter which can offer what the placenta does rather than what it represents.

However, there is still something to be gleaned about representation and the placenta; Maher (2002, p. 96) argued for using the placenta as a way to "begin thinking through the impasse of pregnant representation". In this exploration, Maher (2002) examined how, within imagery, the pregnant subject has been cast as an object rather than a subject of their gestation. Drawing on the critique by humanist feminists on the disappearance of pregnant subjectivity, she agreed that the pregnant body is signified as a single subjectivity, matched by its expanding and malleable body. Nevertheless, the very material site of the placenta both signifies and is signified by multiplicity. She explained,

> the pregnant body presents visually as a singular and unified body, it has the visual contours of bodily integrity that underpin the possibility of a unified subject… The protrusion of the belly seen in pregnancy does not constitute a break in the integrity of the body. Instead, a process of retracing the edges can be seen, a gradual transformation in a still-unified corporeal space. In this way, the pregnant body participates in the production of bodies as sites on which particular Western requirements of subjective identity can be located. Yet, it also acts as a subversion of this signified meaning (Maher, 2002, p. 102).

Maher (2002) argued for new ways of thinking about the pregnant subject *and* its representation, making the case that the placenta provides a material, corporeal site on which to do this. The placental economy thus provides a material and representational model of a relational subject that produces and is produced through a relationship between-two.

3.5. Postmaternalism

Theorisations about the pregnant subject undoubtedly allude to maternal differences in what "mothering" or "feminine" means on a broader cultural level. Thus far, I have aimed to keep the language on the pregnant subject rather than the maternal subject, not least to recognise my own understanding of gender within my historical and social context. Many theorists, such as Kristeva and Beauvoir, confront mother/child relationships directly, and this is an essential underpinning to their understanding of the social order. At times, I have quite carefully chosen language which reflects diverse bodies rather than assuming pregnancy necessitates a maternal subject, not least to avoid some of the essentialist assumptions which align a pregnant body with a female body. In choosing to write inclusively, I hope it also opens the discussion of how the pregnant subject can help unpack understandings of subjectivity more broadly; understanding the pregnant subject helps to understand humanity and what value maternity has within society. This section on the maternal subject aims to explain how "maternal" has a range of meanings and applications without reducing the maternal subject to a pregnant subject or vice versa. It also recognises the importance of gender in the lived experience and the constantly negotiated boundaries of the body. These discussions, therefore, would not be complete without some recognition of who a maternal subject is and what meanings are associated with it.

As (Bar-Haim, 2021, p. 7) explained, maternalism is an imaginary and fantasised set of emotions and qualities (love, tenderness, care, maturity) underpinning social relationships. Bar-Haim's (2021) work exploring the development of maternalism explores how some of these values were conceived and attributed to the mother, which was often held as the pivotal influence for a child's healthy development. Maternalism, therefore, became the blueprint for developing the welfare state (and potentially other social structures, including healthcare). Ruddick (1980, 1989) described "maternal thinking" as tied up with reproduction and social

reproduction, which aimed to ensure a child's growth, preservation, and acceptability. Shifting the focus from maternal labour to maternal thinking, she sought to expand ideas of maternity to include the kind of care and dependency experienced across genders. Maternal thinking, however, is impacted by social barriers, which sometimes make maternal thinking impossible (as in the case of extreme poverty, for example), and thus society repeatedly fails mothers in this aim. Maternal thinking, she argued, is invariably tied up in issues of power and powerlessness. Utilising the capacities of the body for the interest of the parent and the child will maintain some level of power. However, Ruddick (1980, p. 343) acknowledged that "women are socially powerless in respect to the very reproductive capacity that might make them powerful… Children confront and rely upon a powerful maternal presence only to watch her become the powerless woman in front of the father, the teacher, the doctor, the judge, the landlord…" Therefore, this figuration of the maternal subject is both philosophical and political in nature and predicated on a mode of being that nurtures and socialises. As (Ruddick, 1989, p. 12) declared, "Throughout, I aim to articulate distinct ways of thinking about the world – for example, about control, vulnerability, "nature," storytelling, and attentive love".

Postmaternalism, introduced by Stephens (2012), is a relatively new term which describes public anxiety over the values associated with "maternity" and the maternal subject. She distinguishes it from maternalism, which values, even celebrates, an ethics and duty of care. While postmaternalism may in some ways seem like a reaction to relational models which prioritise ideas around dependency, exchange, and relationship, it is also built upon the work that critiqued motherhood as an oppressively medicalised social institution and ideology. Stephens (2012, p. x) explained, "Postmaternal thinking refers to a process where the ideals intimately bound with the practices of mothering are disavowed in the public sphere and conflicted in the private." She went on to argue there is a cultural hostility to the idea of dependence, as this challenges neoliberal, Western values of individuality, autonomy, and

meritocracy. Care and nurturing, accordingly, are often outsourced, which Stephens (2012, p. 7) argued "can be seen as a kind of unmothering of society as a whole. The postmaternal, therefore, becomes a fantasy of self-sufficiency" and a devaluing of what menstruation, pregnancy, lactation, and maternity have to offer understandings about the self and others. Stephens (2012, 2015, 2018) argued for a return to maternalism and reorganisation of society, which uses maternity as a model for ways of thinking and being. In her work, she argued for a fundamental shift in the organisation of society to embrace the ideals and ethics of the maternal subject.

Postmaternalism, however, is not so easily defined. Bartlett (2016) pointed out that postmaternalism arose in the late twentieth century, alongside postfeminism and postmodernism, situated within a historical period which has questioned "grand narratives" about meaning and categories (Bartlett, 2016). She questioned the idea that "post" simply means what comes after and instead explores the more radical feminist thought within peace politics and environmentalism. Bartlett's (2016) analysis of feminist texts pointed to the multiple understandings of "traditional" maternity, bringing in indigenous and queer voices to question what "family" means in the context of maternity. She pulled in, for example, ecofeminists whose promotion of collective living reshapes not only the roles within a family but also where families live and the social practices of family. By examining the fringes of feminism, Bartlett (2016) suggested that postmaternalism embraces a postmodern way of thinking, harkening back to a definition of maternity that is more diverse than what Stephens means. While Bartlett fundamentally agreed with Stephens that the maternal subject should be recognised and promoted, she questioned Stephens's methods, suggesting these reflect a slippery slope to essentialist ways of thinking about the maternal subject.

Similarly critical of postmaternalism, Baraitser (2009) offered a different conceptualisation of maternity, which does not frame care as an essential trait or a form of female suppression. She

calls this "maternal alterity" the listening out for the "call" of many others, "signalling the multiple histories of collective childcare practices" and, from a more materialist perspective, the connections between subjects and complex processes that join them. In doing so, she seeks to validate *who* can be a maternal subject. Focusing intensely on her own phenomenological, mundane, everyday interactions of pregnancy and motherhood (Baraitser, 2009b, 2012, 2013, 2014), Baraitser (2016, p. 394), as she puts it, "overmines" these experiences to avoid figuring the maternal subject exclusively within the parent/child relationships. She explained she was

> Concerned with thinking maternal ethics as an encounter a mother may have with an irreducible otherness in the figure of the child, who remains resistant to the effects of that encounter, and therefore may call forth what we could then, with more surety, name as a 'maternal subject'.

Drawing on the psychoanalytic analysis of mothering, she discussed postmaternalism as a psychosocial phenomenon exploring the love/hate relationships held toward maternal figures post experiences of mothering. In this understanding, it is possible to hold both maternal and postmaternal subject positions simultaneously while also analysing "the mother" as a public imagining. These individual and collective definitions of the maternal subject, therefore, allow for a more fluid understanding of maternity beyond the superficial social practices of mothering.

3.6 Black Feminist Scholarship

The scholarship on pregnant subjectivity demonstrates how pregnancy offers a unique and critical point for exploring the differing and blurring boundaries of self and other. Alongside this scholarship, however, also sits a critical view of how racialisation further develops these ideas in exploring the role of the body in subjective experience. Patricia Hill Collins (1994) discusses the pregnant subject primarily in the context of her broader analysis of race, gender, and social inequality. While she did not focus extensively on pregnancy alone, her insights into

the experiences of Black women and the concept of intersectionality provide important perspectives on pregnancy and maternity. Specifically, her work has allowed scholars to explore how race intersects with gender, giving rise to concepts like obstetric racism (Davis 2018). Davis (2020) explained that obstetric racism examines how "racial hierarchies have led to differential practices, tasks and clinical decisions… [and] structure Black value as it is constituted in the engagements of Black women within biomedical and healthcare infrastructures". This theoretical framework uses the experience of women of colour to explore how these experiences shape the identities and situated knowledge for women of colour. Davis (1982) also addressed how race impacted the experience of reproduction, noting that "voluntary motherhood" espoused by feminists throughout the nineteenth century did not apply evenly to all women, and reproductive justice was needed to address the ways that medicine systematically discriminated based on race and class. The experience of reproduction, including who can reproduce, how they reproduce, and when they can reproduce, is not equal. For example, within the UK, where this study takes place, Black women are 43% more likely to experience miscarriage compared to white women (Quensby *et al*. 2021). The most recent government report on maternal death also shows that Black women are four times more likely to die when compared to white women, and two times higher when compared to women from Asian backgrounds (MBR Race UK, 2020). The disparity extends to assisted reproduction as well, with Black patients less likely to have a baby following fertility treatment compared to mixed and white women (Human Fertilisation and Embryology Authority 2021). Patterns such as these are repeated around the world, where women of colour experience disempowerment and poorer health outcomes (Brantley 2023). Simmons (2021, p. 313) points out these experiences are inextricably tied to the pregnant subject's past, including "intersubjective and intergenerational ties". Her work exploring the narratives of Black pregnant women examined the ways in which experience was lived with and through generational memory. She coined the

term “Black relationality” to describe the way time is deconstructed and a connectedness is formed to family histories. Importantly, she points out that the statistics of health outcomes alone do little to explain the subjective experience of pregnancy for women of colour; instead, experience of trauma and loss, felt across generations, helps to bring understanding to the embodied experience. By situating the pregnant experience within the wider context of community and history, it gives new insight into the relationship between the pregnant subject and their foetus and builds a new intergenerational and relational framework in which to understand the pregnant subject.

3.7. Concluding Thoughts on the Pregnant Subject

Pregnancy is a catalyst for profound shifts in identity and self-perception. The pregnant person may grapple with questions of autonomy, bodily sensations, and the renegotiation of relationship roles. Moreover, the transformation of a parental identity with a pre-pregnant self also gives rise to a complex interplay of identities. Therefore, theory exploring pregnant subjectivity is diverse and sometimes even contradictory in how to describe this transformation. In examining the pregnant body, it is, therefore, prudent to explore how these different theorisations conceive of the pregnant subject and pregnant body.

Historically, the coding of corporeality with femininity led to essentialist arguments that women were “naturally” able to conceive, nurture, and care for a child. Grosz's (1994) outline of the different reactions to this argument includes three key typologies: egalitarianism, social constructionism, and sexual difference. All typologies critique equating reproduction with women, albeit in different ways. Feminists, from an egalitarian point of view, outright reject motherhood and seek to “overcome” the body in the pursuit of equality. Social constructionists, however, made the critical step to split the biological from the social, noting that inequality did

not sit within biological differences but in systems of representation that did not equally value both sexes. Finally, proponents of sexual difference built on the ideas of social constructs but also embraced the diversity within each sex, noting the multiple and diverse ways of "being feminine". Given the importance of bodily experience in understanding subjectivity and the lived experience, this valuable overview of the various feminist views of the body helps contextualise the maternal subject's multiple and diverse thoughts.

Who the maternal subject is, however, adds another layer to these theoretical developments. Maternalism, or the imagery of the mother as a caring, nurturing, and dependable figure, plays a key role in inspiring early critiques, such as those by Beauvoir. Beauvoir's work represents early reactions to maternalism, which recognises and fiercely rejects the disappearance of the maternal subject, deprived of a voice and agency. Work that has explored the shift of attention to the foetus, paving the way for its subjectivity, draws from this body of thought. However, other feminists, like Kristeva, explained this as a split subjectivity, or two-in-one, focusing on how intention creates a subject. While the pregnant subject is no longer deprived of a voice, this view of the pregnant subject also views it as a subject-in-process. Irigaray then theorised about between-subjectivities, a form of intersubjectivity that no longer considers the pregnant subject as a becoming but as a being. However, this shift away from a singular vision of a maternal figure inspired yet another movement. Stephens's (2011) term postmaternalism aimed to explain the anxiety over subjectivity, which is based on care and development. In an attempt to ensure postmaternalism did not revert to essentialist arguments of the maternal subject, Baraitser (2009a) proposed "maternal alterity", which allowed for both maternal and postmaternal subjectivities to co-exist and expand these ideas of the maternal figure. Black feminist theory has added the critical stance of how embodied experiences are tied to history and community, further establishing a complex, relational framework in which to understand embodied subjectivity.

In this chapter and the previous chapter, I have explored the historical and social context of pregnancy and the pregnant subject. Understanding the differences in the experience of the pregnant subject requires an appreciation for how processes like medicalisation influence the pregnant subject and acknowledgement of the various forms of which one understands subjectivity and the body. Tracing ideas about the pregnant subject and putting this into the context of the developments within feminist thought has also helped me to assemble the foundations upon which my own theoretical framework for this project is built. As previously mentioned, within this project, pregnancy serves as a critical case study of subjectivity, not simply an object of study of pregnant experiences. Works like Baraitser (2009a) provide useful models for thinking about the range of pregnant people's subjectivities, discourses, and experiences and how these forms may be found simultaneously. The next chapter explains the methods used to gather accounts and how this method reflects a psychoanalytic approach.

Chapter 4: The Research Story

This chapter outlines the methodology and ethical considerations for this doctoral research project. The chapter first explains the methods employed throughout this research, namely Wengraf's (2004) Biographical Narrative Interview Method (BNIM). This multi-method approach used narrative interviews, diaries, and reflective field notes, which prioritised the voices of participants as experts on the topic of pregnancy. Below, this chapter outlines the underpinning philosophies, strategies, and design this research adopted, including a detailed summary of the data collection, sampling procedures, and analysis. Further discussion also provides an overview of the ethical approval process and resulting procedures for ethical considerations.

Previous chapters have summarised work exploring the medicalisation of pregnancy, including the development of diagnostic and visualisation technologies and guidelines that help standardise care. A body of philosophical work, explored in chapter two, has also analysed pregnant subjectivities through the telling of individual stories of pregnancy. For example, Young's (1984) influential auto-ethnography explored her personal narrative of pregnancy. She highlighted the relationship between the self and the body and how the shifting boundaries surprised, challenged, and shaped her sense of self. She also importantly explored how the medicalisation of pregnancy alienated herself from her body. Raphael-Leff (1991) also examined stories of pregnancies. As a psychoanalyst, many of her participants were clinical patients of her psychoanalysis practice, whom she got to know intimately through their two-to-five weekly sessions over the course of two-to-seven years. Her data, consequently, contained not just single interviews with participants but an in-depth understanding of a woman throughout her pregnancy and even into the first years of motherhood. Other research on pregnancy has also used semi-structured interviews, such as Longhurst's (2001, 2007) work. Her cross-sectional approach interviewed women and asked them to draw symbolic maps of

their lifeworlds to explore the spaces pregnant women occupy. Still others, including Petchesky (1987), Pollitt (1990), and Bordo (2004), have done qualitative content analysis of various literature, including foetal imaginings, legal proceedings, and "self-help" books directed at pregnant women. Pregnancy is a well-researched topic, examined on both macro- and micro-levels. Research has explored how individual experiences position the pregnant subject in larger social structures of power and how this positioning is perceived and internalised by the individual.

The guiding research question, as set out in the very first research proposal written for this project, was "to explore how pregnant women construct and negotiate the limits of foetal bodies in relation to themselves." The specific objectives of this aim were to:

- Evaluate the change in how pregnant bodies are described and felt throughout pregnancy, with a particular focus on how medicalisation may impact this experience,
- Assess the factors and processes that contribute to the construction of a foetal body,
- Investigate any disjuncture between the sense of self and bodily boundaries.

As outlined in the introduction, pregnancy was chosen as a case study, a particular lived experience which provides an opportunity to examine how bodies – and specifically a rapidly changing body – impact one's sense of self, boundaries, and lived experience. As Young (1984, p. 48) noted, "Reflection on the experience of pregnancy reveals a body subjectivity that is dc-ccntcrcd, myself in the mode of not being myself. As my pregnancy begins, I experience it as a change in my body, I become different from wht I have been." I chose to study pregnancy not because it was a unique human experience, totally different from any other way people relate to and live within their bodies, but because of pregnancy's extraordinary opportunity to bring the body to the fore for the individual in a way very few other life experiences do. Importantly, as Young's (1984) work shows, individuals feel and notice this change. Maher (2002, p. 2) similarly wrote, "It is worth taking a closer look at the pregnant body itself for what it can suggest about new models of embodied subjectivity". My research focuses on pregnancy was,

therefore, not to draw conclusions about gestation specifically but to learn what can be gleaned about the connection between body and self more broadly, to examine how the body becomes a corporeal site for agency and identity, and how boundaries between self and other are constructed.

4.1. Research Approach

At the start of the project, I had never undertaken a qualitative research project and had never experienced pregnancy or known many who had been pregnant. My undergraduate project, looking at the role of religion in gender divisions in the household, used a quantitative approach, while my Master's dissertation was a theoretical analysis of Irigaray and Butler's work on the pregnant body. Consequently, this project into pregnant subjectivity was exploratory in numerous ways. Not only did the research question ask to examine forms of embodied subjectivity during pregnancy, a bodily experience I had very little experience of, but I was also experimenting with a new approach to and way of doing research.

Silverman (2006, p. 45) warned that qualitative research is often disregarded as a minor method, done at the early stages of research as exploratory to help guide later, more valid and reliable research. However, Silverman (2006) went on to argue that qualitative research offers scope to gain a deeper understanding of everyday life and, importantly, gives a method to systematically slow down and ask "so what?" questions. While qualitative methods undoubtedly have the opportunity to gather rich, "thick" descriptions of social life (Geertz, 1973), this research also sought to unpick the underpinnings interpretations of pregnant embodiment. Thus, I sought a very specific approach to qualitative research, best categorised as an abductive research strategy. An abductive strategy provides an alternative to more limiting inductive or deductive strategies; inductive strategies are usually concerned with

“what” questions and describe social phenomena, and deductive strategies seek to explain social phenomena by asking “why” questions. On the other hand, an abductive approach seeks to grasp the whole picture and can use both inductive and deductive strategies together. Abduction uses social actors’ accounts, language, and interpretations in the context of their everyday lives to construct wider theoretical insights (Blaikie, 2010). Blaikie (2000, p. 116), heavily influenced by hermeneutics, phenomenology, and symbolic interactionism, described abductive research as “derived from quotidian concepts and meanings, from socially constructed mutual knowledge". He understood mundane, everyday life as taken-for-granted, relegated to the background, largely unarticulated knowledge known only as people engage in social activities with each other. Therefore, these meanings, embedded in language and which produce people’s social realities, are not private but intersubjective and dependent on social action. In a social world that is already understood and defined by social actors, research, Blaikie concluded, needs to tackle those interpretations, not re-interpret them again on behalf of participants (as in inductive strategies do) or present an objective reality (as in deductive strategies do).

This strategy is also distinctive from other types of qualitative research, as Blaikie (2000, p. 116) explained through its:

- “View of the nature of social reality (ontology)
- The origin of answers to ‘why’ questions; and
- The manner in which those answers are obtained (epistemology).”

To understand more about the social world, an abductive strategy requires researchers to gain an “insider” perspective and learn how social actors construct and reconstruct their lives. An abductive strategy, accordingly, lends itself to an ontological basis of interpretivism. Interpretivism is a philosophical and methodological approach to research that emphasises the importance of understanding social phenomena from the perspective of the individuals involved. Rather than adhering to the idea that there is a singular truth, or law, about why people

act or behave in particular ways, interpretivism allows for varied experiences and understanding of social reality. In short, social reality is the product of social actors, produced and reproduced as a part of everyday social life. Thus, this research aimed to examine the perspectives of pregnant people by gathering unstructured, rich narratives of their pregnancy to further explore their changing and varied perspectives. This approach considers that every pregnancy is unique and individual yet recognises that these experiences result from wider social structures and patterns.

4.1.1. Feminist Approach

This project also identified with a feminist methodological approach in that it sought to examine the power dynamics and relationships which produce gendered knowledge. As noted in Chapter 3, there are multiple understandings of what a feminist approach means, especially since issues of pregnancy and motherhood can sometimes slide down a slippery slope to more essentialist arguments. Postmaternalism, for example, is a care-focused form of feminism which aims to embrace the association between femininity and a duty of care. It bears similarities to Gilligan's (1982) ethics of care in that it places value on interdependency and interconnectedness. While these approaches rightfully critique the undervalue of what many see to be more traditional feminine values, this kind of feminist approach has also been critiqued for reducing the maternal subject to necessary experiences of pregnancy as a formative experience of the maternal subject, limiting the multiple and various ways maternity is formed and experienced (Bartlett, 2016). It also suggests normative ways of "doing" maternity, which may not always reflect the maternal subject's diverse and sometimes contradictory emotions and habits. Other forms of feminism, however, offer an alternative way forward. Baraitser's (2009a) "maternal alterity" allows for multiple histories and transformations of the maternal subject, where the maternal subject is "called into being"

through relationships with one that has come to be recognised as a child. Baraitser (2009a, p. 28) wrote,

> I want to return to the mother-child relationship itself to probe the complexity of a specifically maternal ethics. To do so requires understanding maternal ethics as less to do with an unstinting commitment or caring attentiveness towards an other, and more to do with the way otherness is always at work, structuring, infecting and prompting human subjectivity.

Her rejection of care as the fundamental basis for understanding the maternal subject leaves room for exploring the processes of both creating and recreating a child-other. It is this perspective of maternal alterity which I drew on to examine experiences of pregnancy.

Achieving this feminist outlook, therefore, required a method with enough structure to answer the research question but also unstructured enough to allow participant their voice and views to explore the diverse narratives of pregnancy. Earle and Letherby (2003) also pointed out that a feminist methodology acknowledges the researcher's subjectivity, making reflexivity vital. The reality is that researchers researching the same topics will not all produce the same findings because “we all speak from a particular place, out of a particular history, a particular experience, a particular culture, without being contained by that position” Hall (1992, p. 258). As McDowell (1992, p. 409) argued, “We must recognise and take account of our own position, as well as that of our research participant, and write this into our research practice”. Reflection, then, was another important aspect for the choice of methodology.

4.2. Research Methods

On my supervisor's advice, I attended intensive training with Tom Wengraf to learn his Biographical Narrative Interview Method in April 2017 in London. Wengraf's (2004) Biographical Narrative Interview Method (BNIM), derived from Rosenthal’s Quatext “mix of methods”, is a form of unstructured interviewing that allows participants to decide what is

meaningful to them and how they make sense of their experience. This method aims to examine the lived experience and the told story. The distinction between these tellings is important: the former alludes to the individual's emotional, biographical subtext, while the latter explores the sociocultural domain, which provides the words, discourses, and subject positions that help make sense of reality. There are similar interviewing styles, such as Hollway and Jefferson's (2012) free association interview, which also aims to tap into the subconscious, inner world of the participants. These methods explore one's situated subjectivity – that is, the sense of self formed from social processes, as well as the internal feelings and reactions to those processes (Wengraf, 2004). BNIM does this by gathering participants' biographical narratives centred around a story they tell and the researcher's free association writing, taken after each interview. These different data sources then allow an analysis of three different aspects of the interview: the story told, the thoughts and feelings portrayed within the story, and the interview situation. Analytical conclusions, then, have the potential to balance these three aspects of the interview. The chosen method, BNIM, not only followed a more feminist approach of a more unstructured and reflective method but also gave a holistic understanding of the subject.

This method offered a systematic way to explore how pregnant people made sense of their bodies in a way which considered both the social constructs related to pregnancy and the internal processing of these discourses. Importantly, however, this method allows participants space to share their stories how they would like it to be told. Rather than devising a series of questions or topics to be asked by an interviewer, the participant leads the direction of the interview. Even the subsessions use the words as they were phrased by participants in the order they were told. Too often, pregnancy and the way it is experienced is used as a circumstance to defer to another, more "knowing" individual. This is done in two ways: one, more structured interviews will use questions that rely upon operationalisation processes to test already established concepts and hypotheses. Wengraf (2001, p. 61) has a useful visualisation of this

spectrum, with highly structured interviews on one side, designed to test theory or hypotheses, while unstructured interviews sit on the opposite end, used for building models and theory. He goes on to say the operationalisation process works downward from theory, adjusting the language of the interview questions to match the conceptual framework. This process also introduces power inequality within the interview, as Wengraf (2001, p. 112) explained,

> One of the prejudicial assumptions and mythologies of many research interview interactions is that of the 'conversation' where each partner participates equally. Indeed, together with the researcher's idea that he or she 'should run' the interview, the model of the conversation where there can be unrestricted participation by the interviewer can – despite the best intentions of both – turn into that of the strongly structured and strongly controlled pedagogic interrogation.

Therefore, reliance on a structured interview introduces a power dynamic where the interviewer is thought to "know" what needs to be discussed. Second, the unconscious biases researchers hold will necessarily shape the research question, directing and signalling certain kinds of responses from participants. Schostak (2007) explains these processes in meticulous detail, noting that biases about social life and even the materiality of life, including bodies, shape the language of research questions, what is ignored, and what is counted as valid data. Again, in this circumstance, power is introduced into the interview setting through the decisions of what to ask about and what not to ask about. In asking pregnant people for their stories with minimal interruption, I hoped to open the possibility for a different kind of interaction within my research, allowing participants the space and words to shape the narrative and what was meaningful to them, as well as to avoid setting up an interview situation in which I, as the researcher, maintained a clear sense of power or knowledge over the participant.

While unstructured interviews seemed an obvious choice to explore the range of pregnant people's experiences, I still wanted to capture some details on everyday experience. These minute details are sometimes lost in an interview alone, as often "these experiences are part of day-to-day life, rendering them indistinguishable and harder to recall on the spur of the

moment" (Kenten, 2010, p. 10). Diaries are argued to be capable of capturing this "ever-changing present" (Plummer, 2001, p. 48). To successfully encapsulate the transformative nature of pregnancy, then, would require something that both interviews and diaries can offer: the possibility for an external, verbal exploration and a more private and personal method of writing. Zimmerman and Wieder (1977) wrote about a "diary: diary-interview method" whereby diaries are kept for a period of time and then reviewed before intensive interviewing. These entries then informed interviews and allowed researchers to "get into the field" and maintain a more naturalistic approach at times when it was impossible for the researcher to be in the field themselves. The diary fills in the gaps of daily activities, emotional responses to everyday interactions, and the nature of relationships between people. Diary writing, as Corti (1993) noted, can last for any length of time, but explained that solicited diaries typically last for just a few weeks due to the time commitment required of the diarists. Diaries are then used to inform an intensive interview at the end of the diary writing period, whereby researchers can expand upon the diary entries, fact-check, and involve the participant in data analysis. In this sense, diarists could be described as "surrogate observers" in a participant observation study. Alaszewski (2006) lists several purposes of diaries, but the diary, in the case of Zimmerman and Wieder's (1977) diary: diary-interview method, serves a very specific function as a record of fact (according to the instructions accompanied by the diary) which can later be further interrogated and explored. Corti (1993) explained that this method is "considered to be one of the most reliable methods of obtaining information" as it allows participants to capitalise on recall, record more information about daily life, and feel more comfortable revealing details. I decided to ask participants to take part in narrative interviews using a BNIM format and/or keep a diary; participants could then determine if they wanted to take part in either or both methods.

4.3. Data Collection

This research project was a qualitative, longitudinal, multi-method study. All but one participant took part in an initial BNIM interview. Follow-up interviews, where applicable, took place approximately every eight weeks until birth. Upon becoming pregnant myself in the autumn of 2018, I also kept a diary and asked a colleague to do a narrative interview with me, thereby producing some ethnographic materials as well.

Following ethical approval of the project by the Health Research Authority (HRA) in November 2017 (a process detailed in a following section on ethical considerations), a "call for participants" was placed in Ipswich GP waiting rooms and the Ipswich Hospital waiting rooms (see appendix A). As participants contacted to take part, a date was arranged for a face-to-face initial meeting and interview. In this initial meeting, participants were given a participant information sheet (see Appendix B) and asked to sign a consent form (see Appendix C). Participants who opted to complete a diary alongside the interviews were also given a diary with a basic prompt (see Appendix D) and could opt-in to receive a text message or e-mail reminder to write in their diaries.

Data was collected from November 2017 to October 2020, resulting in twenty interviews, three diaries, nineteen post-interview free association writings, and ethnographic materials. While most interviews were conducted face-to-face, three participants chose to conduct one or more interviews over the phone or via Zoom. Interviews usually lasted approximately 60 minutes, although this varied; one participant's interview was 46 minutes and ended so the participant could get to another appointment, while the longest interview lasted 3.5 hours. Diaries also varied in length: the shortest diary, kept by a participant who experienced miscarriage, was only three entries, while the longest diary contained 24 entries.

4.3.1. The Sample

The initial aim was to recruit up to 15 participants, as outlined in the ethics form for the Health Research Authority. The need to outline a specific number of participants was a requirement of ethical approval, so I looked specifically at what the recommended number was for qualitative research: Creswell (1998, p. 64) stated five to 5-25 participants are needed for a phenomenological, qualitative study, while Morse (1994) stated at least six. On the other hand, Emmel (2013) argued that there is no ideal sample number when selecting cases for qualitative research. Instead, he argued that the sample should depend on whether the study's purpose has been achieved. A survey by Mason (2010) on the sample size of qualitative PhD projects found that even sample size numbers of 20, 30 and 40 were most popular, suggesting that the final sample size (at least at the PhD level) is not wholly data-driven, but instead dictated by other constraints, such as limited time or resources. For the purposes of giving the ethical review board a number, I outlined a maximum sample of 15 participants; however, I noted that should data saturation be reached before this number, no more participants will be sought. I used theoretical sampling, where analysis started as data collection was ongoing. As major themes began to be explored, further participants were recruited until no new information was being gathered.

In line with the timeframe approved by the HRA, twelve months was allotted for data collection. However, I became pregnant halfway through data collection and took an intermission from study for twelve months. Following advice from my supervisors, I completed a diary and asked a colleague to conduct a narrative interview with me, joining the study as a participant-researcher. Upon returning from my intermission, I then carried on data collection for another six months, at which point I had recruited ten participants, including my own data. I had intended to stop data collection at ten participants, however I received an urgent message from friend who knew someone “who had a story to tell”. Initially, I had planned to conduct an

interview but not include the data in my PhD study, as I had already completed a report for the HRA to confirm data collection was complete. This further participant, however, was a first-time mother who experienced their pregnancy during the first lockdown of the COVID pandemic in 2020. The interview brought new ideas to light and specifically hit on issues with the guidelines used by hospitals to limit those who could be present during medical appointments, ultrasounds, and birth. Intrigued by the new experience relayed in this interview, I reached out to a friend of mine who was also pregnant in this lockdown, and she also agreed to take part. Both of the interviews have been included in this write-up.

In total, I recruited twelve participants, including myself as a participant-researcher. Participants were aged 26-38. Eleven lived in Suffolk, where recruitment materials had been posted, and one lived in London. All but one of the participants were university-educated, and all held professional occupations (according the NS-SEC classifications), including teacher, office manager, personal trainer, business administrator, nurse, and sports coach. All participants were also white/Caucasian. As part of the ethical approval process, I also listed eligibility criteria that participants needed to be at least 18 years old and fluent in English. Simply put, as a PhD project without additional resources, there was no capacity to expand the participant pool outside these parameters. To ensure a sufficient number of participants, the research was open to anyone at any point in their pregnancy, as well as first-time parents or those who have had children in the past. Of the twelve participants, seven were first-time parents, four already had one child, and one was unknown. Most participants joined after the 12-week scan during their second trimester, although three joined earlier. Two participants were pregnant during the first pandemic lockdown in 2020, while all others experienced the entirety of their pregnancies before the lockdowns began.

This study, as an exploratory study, sought participants willing to share their stories of pregnancy. As such, the sample was largely white, middle class, cis women. While certainly

not representative of the wider population, these stories still offer a useful exploration of pregnancy narratives. Lawson (2004, p. 62), whose research also leaned toward white, middle class, and cis women, makes a key point about representativeness in samples, which is that the "critical question to be asked about any sample is not whether they do or do not represent the general population from which they are drawn, but whether the characteristics on which they vary matter". The critical demographics of social class, sex, and race certainly affect experiences of pregnancy, however this research is not intended to make grand statements about these social patterns, but rather look in depth and in detail at cases of pregnancy. In this case, this sample had advantages – this relatively homogenous group offered a stable social context in which these individual stories are contextualised. This group also provided a well-educated, articulate group who readily reflected on their experiences, and used words, analogies, and context which I, as the researcher, felt a broad, shared understanding of their meaning.

The sample size, while typical of many qualitative research projects and in keeping with other similarly-scaled projects, nevertheless raises some concerns about representativeness and generalizability. Emmel (2013) wrote that qualitative research can combat this through purposive and theoretical sampling. Purposive sampling means participants were selected because they possess certain features that the researcher wishes to investigate, as with the final two participants who experienced pregnancy during lockdowns. Theoretical sampling refers to a process of choosing the cases while analysing the data so that data continues to generate or build on a theory. As mentioned earlier in this chapter, this method and the study's exploratory nature were aimed at theory-building, not hypothesis-testing. Therefore, concerns about generalizability and representativeness (as they relate to probability sampling) were not key concerns of this study.

Participants were a self-selected group. When I initially contacted the East Suffolk and North Essex NHS Trust to post my recruitment flyer, I was warned that I was unlikely to recruit many participants through a flyer. Unfortunately, they had evidence to back this up: of the qualitative studies conducted at this trust the year before my project, half received no interest from potential participants through the NHS trust. Prepared for the worst but hoping for the best, I also posted flyers in nearby cafés which ran parenting classes and playgroups. Although a call for participants was the intended recruitment source, most were recruited via a snowballing strategy. They were friends of friends who had heard about the study from a mutual acquaintance. Only two participants contacted me after seeing a flyer, while the other nine participants (myself excluded) contacted me after hearing about the study from a friend. Handcock and Gile (2011) wrote that there is some confusion over what snowball sampling is, as there are two methods for it. Thompson (2012, p. 164) explained,

> The term 'snowball sampling' has been applied to two types of procedures related to network sampling. In one type …, a few identified members of a rare population are asked to identify other members of the population, those so identified are asked to identify others, and so, for the purpose of obtaining a nonprobability sample or for constructing a frame from which to sample. In the other type, individuals in the sample are asked to identify other individuals, for a fixed number of stages, for the purpose of estimating the number of 'mutual relationships' or 'social circles' in the population.

While a snowball sampling strategy itself does not tend to pose significant ethical issues, the snowballing, in this case, relied heavily upon my social circle, so some of my participants were known to me prior to the study. Brewis (2014) outlined some perceived benefits of using friendship as a recruitment method for research, including the ability to quickly and effectively establish rapport and trust, an increased willingness to share honest and highly personal experiences with a person already known to them, and a deeper level of understanding between the researchers and participants. Brewis (2014, p. 850), however, also cautioned that using friendship as a tool for recruitment may also spark a feeling of 'betrayal' when personal stories are published and may carry the "possibility of reducing friends to little more than paper

stereotypes, objectifying them in our writing so that their individuality is stripped away". The reliance on snowball sampling relieved the pressures of finding participants, as there was an ample supply through friendship circles. Nevertheless, it made the consent procedures, described later under ethical considerations, all the more important.

4.3.2. Interviews

The BNIM interview starts with a single question, formatted in a very particular way. This question aims to reveal the individual's inner and outer worlds – the cultural dimensions they find themselves in and their own biographical and emotional responses to them. My single question-inducing narrative (referred to as a SQUIN by Wengraf (2004)) was:

> As you know, I'm researching women's experiences of pregnancy. So, can you please tell me the story of your pregnancy, from the moment you found out you were pregnant until now, and all the experiences and events that have been important for you personally? Tell me when you've finished. I'll listen first, and I won't interrupt. I'll just take some notes in case I have any questions for you when you've finished telling me about it all. Start whenever you like and take the time you need.

Initial stories responding to this question varied in length from about 7 minutes to about 45 minutes. The transcripts show just the participant talking, with an occasional "mmm" from me. Initially, I found staying quiet to be very difficult. Often, interview training teaches extensive preparation, with interview schedules, pilot trials, and perhaps background fact-checking to support the interview. However, any disruption or preconceived ideas is discouraged, as Wengraf (2004) warned it could provide affirmation for the direction of the story told; instead, the interview should give space for the participant to tell their story in their own words and their own way. The BNIM method reduces the interference of the interviewer by eliminating interviewer cues and allowing the participant to talk freely.

From that initial question, there are then one or two further subsessions. These can happen on different days or when the participant is done telling their story. The questions in these subsessions are also structured in a very particular way. It is essential to use the exact words of the participant to elicit further detail about particular incident narratives (PINs), and it is imperative to maintain the integrity of quotations and not to rephrase the participant's words. So, follow-up questions would be structured as follows:

> "You said [quotation of speech] … Can you remember any more detail about how it all happened?"

There are a few different options based on whether further examples of emotion are elicited or if asking for more detail about an event. Like the initial question, there is a strong emphasis on phrasing the questions to limit bias. Sometimes, these probes fail, and the participant may say, "No, I don't remember anything else about that." If so, questioning moves to the next quotation of speech, keeping the narrative in the same exact order initially conveyed by the participant.

My main concern in employing this method was a fear of the participant's non-response: what if they did not have a story to start with? In psychoanalytical interviewing, even a short life story could be a rich telling, but as a new interviewer, I worried about how I would handle a particularly short narrative. Of course, this happened, merely three participants into data collection, when a pregnant woman, named Susan, said she was having a lot of trouble remembering anything, explaining to me brain fog was a common symptom of pregnancy. Her initial narrative lasted only 7 minutes, most of which were nonverbal words ("um") and pauses. She started her story with, "The first baby was a surprise… and we made a decision to have two under two, so this one was a bit more planned… Everything has been a blur [since we found out I was pregnant], and that's when my memory stopped working." And indeed – her story stopped there. She then waited for questions, but there was minimal narrative to probe at this point, and I had to start making up questions to try and get her to share a little more story.

This was very much against the BNIM interview, as it introduced bias, direction and shaped the participant's story. However, I had not encountered anyone who could not remember their story. I had practised probes, which focused on the participant's words, but she had very few words to form these probes. In an absolute panic, I reverted to some questions I had prepared before deciding on BNIM interviewing and began asking directly about her experiences.

While the experience helped me think through strategies for interviewing, it also exemplified the difference between BNIM and other forms of more structured interviewing. A key feature of narrative research into people's lived experiences is in the attention paid to a variety of past and present experiences, dominant and less dominant perspectives they hold on those stories, as well as perspectives they held during those experiences (Wengraf, 2004). Conversely, a more structured interview guide may ask about attitudes or elucidate mostly explicit, present-time perspectives, giving less space for the possibility of counternarratives, implicit or even suppressed perspectives, or reflections on the past. This random, semi-structured interview with Susan yielded far less material to draw from when compared with other narrative interviews and often gave answers which were not as personal. It was as if she was answering according to a commonly understood experience instead of her lived experience. For example, I found the idea of where stories started to be particularly interesting. Before starting interviews, I had thought this would usually start with a pregnancy test or some sort of confirmation of pregnancy. Most participants, however, began their stories of pregnancy much earlier, reflecting on a decision to have children or the decisions that led to conception. Their stories, in short, had a clear start and direction and gave glimpses into particular narrative incidences. Susan, however, was prompted with a more direct question about when she first discovered she was pregnant, which was, indeed, through a pregnancy test. I tried a broader question, "Tell me about those initial days – what was it like?", trying to avoid using too many words to lead her answer. While her answer still reminisced of themes drawn from other

narrative interviews, she did not expand on details, giving only vague feelings of a story rather than specific incidences (e.g. “the baby was a surprise” compared to another participant, Eva, who explained the day she found out she was pregnant, from the moment she woke up). Susan returned for two more subsessions, in which she began to build a narrative of her pregnancy. My initial failed attempt to elicit a narrative from her may have been based on a number of different issues: first, her initial reluctance may have been my own inexperience in effectively building rapport with participants; second, she was an educated woman who may have had pre-existing ideas how an interview is structured, and felt off-guard by the open-mindedness of the interview (thus her remark that I would ask more questions); or third, she her experience of “brain fog” that day was her story, but this changed in subsequent interviews. Nevertheless, there remained a clear difference between the coding for a BNIM interview and Susan’s semi-structured interview, demonstrating a clear value to the rich narratives drawn from BNIM interviews.

Within the details supplied in these interviews, the goal is to find a particular incident narrative (PIN). BNIM differentiates between two kinds of PINs – in-PINs and about-PINs. In-PINs, where the participant almost experiences the incident as they are telling it, help to reveal something more about an individual’s subjectivity. Tell-tale signs of an in-PIN include getting emotional, making hand gestures to imitate the story, or gazing off as if watching something play out in their minds. In-PINs allow a glimpse of the lived experience or what it was like at the time of the event. While in-PINS are desirable, they are also rare and difficult to elicit. However, less intense about-PINs are also useful, in which the person stays firmly in the present but looks back on the event in detail, like recounting a childhood memory, without permitting access to the *lived* experience. The difference between these tellings is significant: about-PINs mean that the participant stays within the subjective experience of the interview itself, while the in-PINs allow access to the subconscious, situated subjectivity of the experience (Wengraf,

2004). The BNIM method of narrative interviewing, therefore, provides a coherent ‘whole story’, Gestalt or ‘long narration’, with a relatively large number of recalled PINs inserted within that long narration, thereby providing rich material for any method of narrative interpretation.

4.3.3. Field Notes

Recent decades have seen social scientists grow increasingly suspicious of the claims of objectivity and neutrality in research, with growing recognition that researchers do not shed personal identities or biographies to become neutral observers. In his landmark book, Rabinow (1977) highlighted a reflexive turn in anthropology that challenged the objectivity of research and field notes, and he proposed a more nuanced understanding of the inherent power dynamics of fieldwork. Haraway (1988) has famously argued that claims to observe from a distance and see everything from nowhere is an illusion, a “god trick”; there are no neutral observers, and no research is entirely unbiased. Furthermore, if researchers are subjective and carry unique, individual biographies, the knowledge they produce is necessarily affected and situated within the researcher's specific historical and social context (Haraway, 1988).

Documenting reflexivity, or the researcher's awareness of and active engagement with their role, biases, and subjectivity throughout the research process, is one way of responding to these debates. As part of the research process, free association writing was recorded for one hour after each interview, as Wengraf's (2004) method recommended. This additional layer of reflection included a range of thoughts, observations, and experiences. I started by writing down what I could remember from the interview setting and what stood out most to me about what was said during the interview. I also noted what I thought and felt during the interview. I

also made analytic notes (or memos) of initial interpretations in later interviews. A model developed by Schatzman and Strauss (1973) considered four different types of field notes:

- Observational notes (ON) – an accurate, objective note about what happened during the data collection,
- Theoretical notes (TN) – "attempts to derive meaning" as a researcher reflects on experiences,
- Methodological notes (MN) – reminders, instructions, or critique of the process,
- Analytical memos (AM) – progress reviews or end-of-day summaries.

Morgan (1997, pp. 57–58) stated that field notes are "part of the analysis rather than the data collection" as they already involve some interpretation. In this case, the field notes added a layer of transparency that helped to explore the research process (Rajendran, 2001). Flynn and Wengraf (2021, p. 2) outlined a process that can be used in narrative interviews (and that was explicitly used in Flynn's BNIM interviews), which maps the "defended researcher". They built upon Hollway and Jefferson's (2008) notion of the "defended subject" and argued that the participant is not the only one defended within the research context: the researcher also performs a particular presentation of the self. Flynn, completing this work as part of her PhD, reviewed her free-associative field notes, which were taken throughout the research process and compared to the research outputs. Further, upon a peer audit, she made her field notes available for further scrutiny, which noted some discrepancies between the interview and the field notes, pushing her to re-evaluate the narrative of one of her participants. They argued that the field notes of free association writing allowed a glimpse into the researcher's situated subjectivity and an exploration of how this impacts interpretations. Flynn and Wengraf (2021, p. 14) are careful to note that the point of this exercise is not to paint analyses as wrong but rather to aid a deeper examination of the interview situation and resulting biographies. In this case, the field notes served as a critical strategy for reflexive research practice.

4.3.4. Diaries

Like the diary: diary-interview method, participants were given the option to keep a diary alongside their interviews. However, unlike Zimmerman and Wieder's (1977) method, diary entries were not read or analysed before the interview. Both Zimmerman and Wieder (1977) and Corti (1993) viewed the diary as a very straightforward record, carefully guided by the researcher, to capture precise information and are not “intimate journals” (Zimmerman and Wieder, 1977, p. 481). Corti (1993) went as far as to warn that diaries are susceptible to errors such as respondent biases, incomplete recording and under-reporting, lack of recall, insufficient cooperation, and sample selection bias, which further indicates the role of the diary as a record of activities. However, the diaries in this project are meant to be reflective self-explorations of the diarists' reality. While participants have the opportunity, if they choose, to verbally process their entries during interviews, the point of the diaries is not simply to fill in missing information before interviewing. Instead, the idea is to engage participants in an activity of self-discovery and further exploration of their subjectivity. The diary within this study does not necessarily serve the same purpose as the diary in Zimmerman and Weider’s method. Instead, the diary within this study is meant to serve one of the other purposes described by Alaszewski (2006): that of a memoir. After transcription, the diaries were returned to participants as a memento of their pregnancy. One participant explained that she had written it with the intention of giving it to her child when he was older, whereas another kept the diary solely for the purpose of the research project and did not want it back.

The justification for keeping the processes separate was two-fold. First and foremost, this was meant to relieve any pressure that the narrative written in the diary would be “checked” and further interrogated by the researcher. Kenten (2010, p. 22) discussed the value of exploring the inconsistencies between interview answers and diaries. However, there are significant differences between Kenton’s diary-interview method and this project. Kenten (2010) asked

participants who were "coming out" (with their sexuality) to record a diary over the course of two weeks and take part in an interview before and after the diary writing period. This project, however, asked participants to keep a diary for a much longer time (up to 6 months), with a series of up to four interviews taking place throughout the time of diary writing (note, not simply before or after diary writing has taken place). Given the overlapping procedure of interviews and diary-writing, it was deemed important not to give participants the impression that interviews would be a time to check diaries but that instead, they should tell their story the way they wanted it to be told in the moment. The diary was a much more personal space for participants to open up; thus, there was a need to ensure that diary writing remained uninterrupted. Therefore, this diary is meant to tell another narrative of participants' everyday lives rather than serving as a log of facts.

Second, as interviews were only conducted every eight weeks, the thoughts and emotions recorded in the diaries may have been quickly outdated or long forgotten, particularly given the rapid and unrequited change in the pregnant body and identity. Asking participants to continually reflect in interviews on something written about several weeks ago, as their pregnancy, bodies, and presumably psyche had significantly changed, or their narrative interviews may encompass things which did not elicit the same emotional response as the story they wanted to tell in the moment. Of course, while this was a key consideration for the research, the reality proved slightly different. One participant, who was writing in her diary quite regularly about the stress of an ongoing court case she was involved in, would reference her diary within her narrative (e.g. "I had to be in court yesterday, which was really difficult…I wrote about it."), at times, seemingly forgetting that I had not seen her diary. In the interview, she would refer to details she wrote in her diary without elaborating on what was written, even at times looking for a response from me (e.g. "You remember – it's in my diary."). Sometimes, the pregnancy progressed in a way that interrupted the plans for research participation. For

example, one participant only kept a diary, as she miscarried before the first interview could take place. Another had intended to keep a diary but gave birth prematurely (extraordinarily, at 29 weeks, just a couple of weeks after her first interview). Generally, take-up on the diary proved difficult, as only three participants opted to submit a diary. Still, the collected diaries added dimension and covered topics not brought up in the interviews.

As Bennet (2014, pp. 539–540) wrote, "A writer does not always know what he or she knows, and writing is a way of finding out." The diary, thus, serves as a practice which makes possible one's knowledge of their self. Foucault, in his text "Self Writing", explained that the practice of writing is not simply writing about a person and their everyday experiences but renders the subject itself so that the subject on the page is constituted, not merely reflected or constructed (Foucault, 1997). The difference between "constituted" and "constructed" is one of agency; that is, saying a subject is "constructed" puts more emphasis on the writer who is writing (an actor doing the constructing), while "constituted" emphasises the processes of subjection. Writing is the habitual practice that shapes the self and makes possible knowledge of subjectivity. Conducting interviews alongside the diaries allows diarists to further explore their subjectivity more personally and intimately. The aim of keeping interviews and diaries as entirely separate processes is to encourage participants in their process of self-writing. The diary, then, aimed serve both participants and the researcher. While participants may have used it as an exploration tool to lead and reflect on their thoughts throughout the study, the researcher can then go back through the diary to analyse the changes throughout the time period.

4.3.5. Unexpected Ethnographic Materials

Page (2017) wrote there is a risk of losing sight of the broader picture and being seduced by the story and by the self-representation of the interviewee. Recognising this, however, is

difficult unless something happens that necessitates this recognition. In addition to the data collected on my participants, I also had the happenchance opportunity to collect ethnographic material. About halfway through my fieldwork, I became pregnant. I never intended to turn my project into an autoethnography, but the timing of life seemed to move in that direction. After announcing my pregnancy, mere weeks before my body began to "out" me, my supervisors suggested that I keep a pregnancy diary, like the one I asked participants to keep, as well as arrange to be interviewed.

I did not, however, know how to reconcile my data with the data of my participants: surely my data needed to be kept separate? Or do I add it to the dataset and try to "objectively" analyse the data as if it were just like the others? While collecting data on myself, I returned to how I used that data in my analysis. I found insight in Abu-Lughod (1993), who also wrote about how she found herself pregnant while doing her fieldwork with pregnant Bedouin women in Egypt. In her writing, she explained

> one's own constructions of personal experience would be shaped by knowledge of these women's lives and even by particular women one had come to know. In being pregnant, I was finding that the cultural resources I had at my disposal to think about what I was experiencing and to fill in gaps in my knowledge of an uncertain terrain included both those from "home" and those from the "the field", often juxtaposed (Abu-Lughod, 1993, p. 347).

It led me to question the extent to which my fieldwork shaped my experience and how my analysis of interviews was rooted in my experience. Reading back through my diary reflections, I replied directly to this question. On 9 April 2019, then seven months pregnant, I wrote, "I've been absorbing myself in the narratives of participants, and I think it's starting to impact how I feel and interpret my own pregnancy…" I went on to reflect on the idea of "using pregnancy" to ensure the outcome favoured what I wanted. I reflected on this power of pregnancy and concluded that "there's opportunity here to re-shape so many other aspects of my life using pregnancy as my way of becoming visible in a way I wasn't before. The combined

mother+baby is more powerful than just woman alone." At that moment, I had mapped my own way through the borderland of two-and-one ("mother+baby") by using the words of my participants who talked through the experience of shifting, contesting and accommodating identities to navigate through 9 months of pregnancy. "Using pregnancy" was a term used by several of my participants in an interview months before this one. That view, internalised before circling back out as a way of understanding how pregnancy and being seen as "two" held much more social value than me on my own. In subscribing to the position of "pregnant", it exemplified the obtuse ways that my research reflections crept into my experience of pregnancy.

4.4. Ethical Considerations

Initially, I assumed this project's ethical considerations would largely follow a "standard", interview-based qualitative study focusing on the four principles of ethics: autonomy, non-maleficence, beneficence, and justice (Kitchener, 1984; Flick, 2020). This section overviews the process of gaining ethical approval from the HRA and outlines the three key issues debated by the REC. While this is not exhaustive of all ethical and legal considerations, it hopefully addresses the key points raised by the REC during the process of obtaining ethical approval and expands on how I responded to these before beginning data collection.

4.4.1 The HRA Ethical Approval Process

Posting a "call for recruitment" poster in a hospital maternity ward waiting room and GP offices' notice boards required ethical approval from the HRA, which I have often heard informally regarded as the gold standard of research review committees in the UK. While the ethical approval process for the NHS has been criticised for its lack of coordination and consistency in the past (for example, see Tod, Nicolson and Allmark (2002), it has undergone

several restructures to address this. At the point of seeking ethical approval, the average wait time for ethical approval was six months, involving an array of paperwork and multiple panels. After months of preparation for the process, including information workshops, speaking with researchers who had been through the process before, and talking to NHS research managers at my local trust, I was ready to submit my proposal. This was, by no means, an easy task: I had to complete an online ethics form of 64 largely open-ended questions and prepare twelve further documents, totalling approximately 40,000 words of text. At that point, however, the HRA restructured the ethical review process to streamline the paperwork and make the approval process quicker. While this did not materially change my proposal, this restructure offered the opportunity of a new route of research approval: proportionate review.

Proportionate review is an accelerated ethics approval process where paperwork is submitted to a panel that decides if the project is "low risk", and a decision is returned in approximately two weeks. "Low risk" was broadly defined as small-scale studies, done for educational purposes, and not proposing methods of significant intrusion on the participants. My project – asking a limited number of individuals for their stories of pregnancy, done to fulfil the requirements of a PhD – seemed to qualify. I submitted my paperwork for proportionate review and hoped I would be eligible. That same day, I got a call back: I did not qualify for a proportionate review. It was decided that my sample group – pregnant people – was a vulnerable group, and I had to go through the full Research Ethics Committee (REC). Even thinking back now, I still wonder how that was decided so quickly. I wondered if there was a list of vulnerable populations, or was it decided based on the wider context of my study? Before submitting my paperwork, I thought they might label the research topic "sensitive", given the possibility of divulging personal health information. The decision, however, was based on the participants, not the topic: pregnant people were vulnerable, even if they were not considered vulnerable before pregnancy. The decision sparked a debate within me about what

vulnerability in research means. Informal conversations with women about pregnancy did not seem to invoke a particularly strong sense of vulnerability. “Ask them what they called their babies!” said one. Another, who had been pregnant many times but never carried to term, told me, with a smile, about “Bean”, which she carried the longest. These ad-hoc stories were full of happiness and excitement, grief and despair. But vulnerability? Do these emotions and life stories depict a vulnerable individual?

Even within medicine, however, there seems to be no clear definition of vulnerable (Boldt, 2019). Some of these definitions seem to make sense. In Racine and Bracken-Roche's (2017) analysis of vulnerability within research ethics frameworks, for example, definitions vary from “incapacity to make decisions” to “historically…have been treated unfairly…or excluded from research opportunities”. There is no doubt that pregnancy and the historical stories which are told of medical inventions in pregnancy often involve experimental, traumatic treatments in which those who are pregnant are given very little power and often tokenistic, if any, ability to consent. Kapsalis's (1997) book explores this very topic in detail, outlining the development of gynaecology and noting its reliance on experimentation of un-consenting women. Sometimes, however, the only other option to such traumatic intervention and experimentation was certain death. For example, Skippen *et al.* (2004) traced the history of the modern chainsaw and found it was designed for use in obstructed labour (at a time before anaesthesia was discovered) as one of the only alternatives to a messy, inaccurate, and painful surgery which usually resulted in the death of the mother, baby, or both. In this historical sense, pregnancy surely put women in a vulnerable position.

The HRA assessment ruled that people receiving medical care for pregnancy expressed a level of dependency on others and, therefore, fit the definition of a vulnerable population for the duration of their pregnancy. My ethics application was forwarded to a “full” Research Ethics Committee (REC), and I received a date for which I, alongside one of my supervisors, Mike

Roper, would need to appear before the panel of 15 professionals who would ultimately decide under what conditions I could proceed, if at all. The chair of the committee, herself a medical doctor, was concerned about the potential for safeguarding issues, leading with questions about potential disclosure of illegal activities or child neglect. Once safeguarding procedures were clarified, she moved on to concerns about midwives and doctors having knowledge of the study. At this point, another panel member, a social worker, pointed out that the study was not about medical care itself but about women's broader experiences of pregnancy. At one point in the meeting, the chair called the participants "patients" before immediately correcting herself. Immediately, I questioned: "Habit? A Freudian slip? Or a bit of both?" Despite the disagreement amongst the panel, the committee made an information letter for the participant's midwife or doctor as a condition of my approval. This was a manageable condition to meet, even if I did not, in principle, agree with it. (It might also be noted that, in the end, no participant asked for a letter to give to their medical team).

The debate about participants' vulnerability left me with unanswered questions: in what ways are participants vulnerable, and how should this narrative research address this? Hollway and Jefferson (2008) coined the term "defended subject" as a way of describing the role anxiety played in "protecting" an individual from knowing too much about themselves. They argued individuals invest in particular subject positions to protect vulnerable aspects of the self (the "defended subject"), advising, "if memories of events are too anxiety-provoking, they will be either forgotten or recalled in a modified, more acceptable fashion. Defences will affect the meanings available in a particular context and how they are conveyed to the listener" (Hollway and Jefferson, 2008, p. 3). Frosh, Phoenix and Pattman (2002, p. 41) explained that this particular perspective joins together cultural forces and agency of the individual by exploring how people "produc[e] their individualised cocktail of beliefs, behaviours and accounting practices abstracted from those available in the cultural pool." Through the introduction of the

concept of the defended subject Hollway and Jefferson (2012) claimed that interviewees are necessarily psychically defended. That is, everyone has an unconscious that contains motivations, instincts and impulses constrained by the social world in which they live. A defended subject may not (consciously or unconsciously) tell a complete and transparent story. Becoming aware of these defences and their underlying causes can result in an enriched understanding of the interviewees' deep-rooted feelings and enable the interviewer to recognise the undercurrent of emotions which underpin the socially acceptable front, which is performed on a much more conscious level. Using this perspective, everyone is a defended subject. The recognition, however, of the ethics committee in framing pregnant people as vulnerable revealed something important about the kinds of subject positions pregnant people are expected to take and the ones which are "untellable" (Wigginton and Lafrance, 2015, p. 33).

4.4.2. Sensitivity

Reflecting on the perceived vulnerability of my participants, I considered the topic's sensitivity a top priority. Lee (1993) argued that any topic asked at a difficult time or to a vulnerable person can be considered "sensitive". Within this project, it was anticipated that pregnant people would be talking about their changing bodies and changing selves, a topic which may, at times, be challenging, confusing or even difficult to discuss. However, the HRA pointed out that topics are only sensitive if the participants define them as sensitive. To give evidence to this effect, I conducted a "consultation" with pregnant people (or perhaps better described as a practice interview with pregnant acquaintances) on 5 April 2016. People were eager to talk about their experiences of pregnancy and did not view the research topic as sensitive. Rather, it was simply an "ordinary", albeit unique, part of their lives. Many even expressed an eagerness at the opportunity of sharing, remarking that "no one ever listens" to their experiences of pregnancy.

However, the sensitivity of topics may also be aggravated if there is a problem with the pregnancy, including a miscarriage or a decision to terminate. Inconsistencies in practice for foetuses born at the limits of viability, 24 weeks, make statistics difficult to calculate (Smith and Field, 2016). However, the (National Health Service, 2022a) reports that one in five pregnancies end in miscarriage before the 24th week, and miscarriages are most common in the first twelve weeks of pregnancy. Given that it takes time (and often an initial visit to the midwife) to confirm pregnancy, it was unlikely that most participants would join before their second or third trimester. Nonetheless, interviews followed the protocol for a right to withdraw, as outlined in the participant information sheet and consent form (Flick, 2020). Any participant who wished to withdraw at any point would have been able to do so easily and quickly without any questions. Participants were reminded of this just before each interview, and it was printed in the directive on the front cover of their diaries. While no participant requested to withdraw, two participants withdrew because their pregnancy ended early – one gave birth prematurely at the very end of her second trimester, while the other miscarried. The participant who miscarried wrote in her diary:

> I said this was the end of my pregnancy story already but I suppose it wasn't. I was told to take a pregnancy test 2 weeks following the miscarriage to ensure the test came back negative. You know – just in case hormones didn't drop off? At what point did we stop trusting our bodies to do their thing… and what would they do if it came back positive? Force my glands to stop producing hormones? I decided not to take the test. I've had enough. I'm letting my body just get on with it.

She ended her entry explaining to whom she had told the news, remarking that "misery loves company". Despite the turn of events to pregnancy loss, her diary continued to make short entries throughout the weeks following her miscarriage, with a much longer reflective account of the day she miscarried all retained products of conception. Bornat (2010, p. 48) argued that when sensitive subjects came up in interviewing, research may sometimes play a therapeutic role in helping participants realise and understand their emotions. Since this participant was

never actually interviewed (she miscarried before the first interview), it did seem that perhaps the diary played a role in helping her process and share her story of reproductive loss, which is why she returned to the diary in the weeks following her miscarriage. A similar circumstance happened with Florence, who became emotional during her initial narrative when telling of a difficult scan where she found out the baby was measuring smaller than expected. Florence had since progressed in the pregnancy and had no current concerns. However, this reflection elicited an in-PIN, or situated subjectivity of the memory, causing a vivid emotional response (Wengraf, 2004). I broke my silence momentarily to quietly ask if she wanted to take a moment or if she preferred to keep going. She quickly said she wanted to keep going and remarked how "you can see it still affects me". These moments of sensitivity did not stop participants from taking part; on the contrary, participants seemed to want to be heard even when presented with the option to stop.

4.4.3. Consent

Since May 2018 and the passage of the Data Protection Act, informed consent has not only formed an ethical consideration but also a legal requirement (Corti *et al.*, 2014). As such, the informed consent sought to ensure participants knew:

- The purpose and procedures of the research
- The risks and benefits of the research
- Their right to withdraw from the study
- The processes by which identities will be protected
- The arrangement for safe storage of all personal, identifying information.

Consent was an ongoing process, obtained through formal means (such as the initial visit, where an informed consent sheet was signed), as well as informal means (such as questions to the participant to ensure they know what will happen to her data and if they wish to continue with her participation in the study). Participants were given an information sheet explaining the purpose and nature of the study, the benefits and risks of participation, and their rights to

withdraw from the study at any time without repercussion. Most were sent this information electronically before the initial meeting, but a printed information sheet was given to participants and verbally explained at the initial meeting. The participant was then able to ask questions about the study at any time. Importantly, guidance from the General Medical Council (GMC) on assessing capacity was used to determine that participants could give informed consent (General Medical Council, 2020). Specifically, this included the participant being able to retain information presented, indicating they understood what is involved in participation, and indicating that they can make a free choice without deferring to anyone else.

At the start of the interview, after gathering written consent to participate, verbal consent to audio-record the interview was taken before the interview began. Since it is impossible to know what might come up within the interview, the participant was asked after the interview was complete if they were still happy for it to be used in the study or if they wished for any part of the interview to be edited out. In addition to these formal points of collecting informed consent, participants could also text, call, or email the student if they wish to withdraw or change their consent at any point in the study until the point of analysis. A further explanation of this point is outlined on the participant information sheet, and it explained that it would not be possible to extract their information from the results once the analysis is complete and results are written up. Participants could also edit transcripts or withdraw their data from the final dataset until 31 December 2020, after which point I would need to begin finalising my analysis. However, as my data collection was delayed and further participants joined the study after this point, they were given a new date of 31 December 2021.

The consent form also stipulates who has a claim of ownership of the data. The consent form is derived from the UK Data Service's template, which covers a comprehensive range of wishes, from participation to use of the data to future use (UK Data Service, no date). For example, participants were asked on the consent form if they agreed to assign both copyright

and permission to reuse the data for research purposes to the researcher. This addition to the consent form was a direct response to the HRA ethics panel, for whom the layperson, a copyright lawyer, wanted to ensure participants could retain ownership of their words in the event they wished to publish or use their diaries or interviews for another use. This amendment ended up having a much larger impact, as it was then re-incorporated into the model consent form used by the UK Data Service and amended the training provided by the UK Data Service on the legal and ethical responsibilities of researchers.

4.4.4. Researcher Safety

A prevailing concern in preparation for HRA ethical approval was dealing with the fact that I was a lone researcher, potentially visiting participants in their homes (if that was most convenient, and it often was). To appease the ethical review board, I noted that I would follow the Lone Working Guidance set out by the University of Essex policy and the Health and Safety Executive (University of Essex, 2020). This included:

- Ensuring my mobile phone was on when conducting interviews and that StaySafe, a personal attack alarm for lone workers, was fully functional. Although the alarm works in low signal areas, I ensured there was appropriate signal for the app to work as I arrived at the place of interview.
- Communicating with supervisors if any concerns or issues arise during an interview.
- Reporting all incidents or dangerous occurrences to the University of Essex's Health and Safety Advisory Service as soon as possible after the occurrence, as per the university's incident reporting policy. As there were no incidences, I made no reports.
- Acting reasonably within the law and care for my health and safety and those of others affected. In an emergency with immediate danger, I could use the StaySafe lone worker's app to call for help and remove myself from the situation until authorities arrive.
- Making sure someone knew the dates and times of appointments during data collection and when I would be expected to finish.
- Complying with health and safety rules and regulations by the University of Essex, including "Fire Safety Essentials" and "Health and Safety Essentials" training.

Throughout the research project, no issues or concerns arose regarding my safety. Taken in perspective, this project, completed with friends of friends in my local area in the UK, held relatively little risk compared to other research situations where researcher safety may be compromised. This was an interesting contrast to the ethical approval board, who sought reassurance from my supervisor, Mike Roper, during the face-to-face panel, and details were included in amendments that addressed my safety. Despite being a preoccupation for the HRA REC, it seems this preparation adequately addressed my safety throughout this research.

4.5. Analysis

A tension arises in qualitative research on how it treads neutrality: it strives to be systematic, analytical, and valid, uninfluenced by the biases and assumptions of the researchers themselves. Yet the reality of qualitative research is that a relationship is needed with participants, if not also localised, tacit knowledge. Hammersley (2010, para. 3.4) makes this point well when he wrote: "In the process of data collection researchers generate not only what is written down as data but also implicit understandings and memories of what [has been] seen, heard and felt, during the data collection process". In other words, context matters. Data does not exist independently of the context in which they were produced or (co)constructed or generated. However, Hammersley (2010, para. 3.4) went on to stress that conclusions should be informed by a systematic analysis and argued,

> After all, surely we do not and should not *make up* our data?... [T]he data must in some ways constrain what inferences we make and the conclusions we reach, rather than being freely constructed in and through our inferences. And this implies that they must, in some sense, exist prior to and independently of the research process…

Nagel (1986, p. 3) also reflected on this, noting,

> [The] problem [is] how to combine the perspective of a particular person inside the world with an objective view of that same world, that person and his [sic] viewpoint

> included. It is a problem that faces every creature with the impulse and capacity to transcend its particular point of view and to conceive the world as a whole".

When beginning the process of analysis, I was encouraged by my supervisor to first write freely before starting any processes of coding, constant comparison, and thematic analysis. Initially, I resisted this, aiming instead to follow the strategic qualitative data analysis described in texts like LeCompte (2000) or Silverman (2006). However, after some encouragement, I produced my first analytical writing, "'Feeling' Pregnancy" (see Appendix H). This piece was written after only having conducted five interviews and beginning the transcription process.

4.5.1. Process of Transcription

I used denaturalised, verbatim transcription for readability. To maintain a consistent approach, transcription guidelines were drawn up prior to this process of transcription (see Appendix F) and anonymised at the time of transcription (see Appendix G), as recommended by Corti *et al.* (2019). However, this form of transcript focuses on what was said, not how it was said, and there is something in listening to a voice which is different from reading a transcript. Listening to the audio while transcribing, I was very aware of my own voice - the nervous laughter and awkward pauses. Listening back evoked those feelings of imposter syndrome I felt at the time, which I recorded in my free association writing, especially in early interviews. Hearing the voices of the interview made me focus in on the interaction between participants and me in a way that just looking at transcripts did not. The transcripts are clearly missing annotations, which would point to the relative inexperience of the researcher. This, however, was not reflected in my initial analytical writing – it was very much focused on the words of participants. Listening to the audio during transcription was a difficult exercise, which I felt was increasingly important the more I realised how awkward it felt and wondered how I might acknowledge this in my analysis. Bornat (2010), an oral historian, described a similar feeling

when re-analysing an interview from her PhD research thirty years after it was collected. She remarked how she could identify a "narrative epiphany" where she might have probed the interviewee more and realised that she was unprepared and unable to cope with the emotions from such probing. For Bornat, thirty years changed her positionality enough to see better how her social context affected the interview outcome. These realisations point to the messiness of research, particularly within qualitative research. Clift *et al.* (2019) pulled together a range of scholars who all shared their stories about messiness in their research, with one PhD student, Thomas Lister, remarking that "qualitative analysis is presented in methods books oversimplifies complex and non-linear analytical processes". Instead, he advocated for an "honest approach", which showed the range of methods and approaches used to analyse data.

4.5.2. Coding

After transcription, I went back to the process of coding, starting with line-by-line coding, as recommended by Glaser (1978) and Strauss (1990), and organising my coding through NVivo CAQDAS software. Using NVivo allowed me to easily code and retrieve text and revisit previously coding material, recoding text, and recategorising codes (Silverman, 2020). The analysis also combined some elements of hermeneutical cannons of interpretation in that it was a circular process of visiting and revisiting the texts. However, I became lost in the coding, losing a sense of what was important while generating hundreds of codes. Feeling I needed more context, I returned to my interviews' audio recordings, engaging in live coding or coding without transcription (Parameswaran, Ozawa-Kirk and Latendresse, 2020). Given the importance of in-PINs to the narrative, hearing the voice of the participant helped me identify what was significant through intonation, pacing, and non-word cues, such as laughing, crying, or sighing. Additionally, the earlier pieces of analytical writing I had been encouraged to write helped to format the larger picture of my thesis analytical chapters.

4.6. Concluding Thoughts on the Research Story

This chapter aimed to methodically outline the methodological and ethical decisions made throughout the research process, told in a way that reflects the reality of doing the research. Some of these discussions include the general approach and mindset going into the data collection stage, outlining the reasons for using BNIM as a method, detailing all the data sources, discussing the ethical considerations of the REC panel, and reflecting on the analysis and coding process. Describing these methodological decisions has highlighted the difficulties in doing qualitative research and doing it well. As Clift *et al.* (2019) noted, qualitative research is rarely a linear, straightforward process. Titling this chapter "The Research Story" was a deliberate choice to reflect that there were details that had to be left out (if only for brevity) and details that could be featured here. As in all tellings of a story, this chapter reflected one of the many journeys taken through the process of designing research, gaining ethical approval, and working with data.

Chapter 5: The Socially Constituted Self

This chapter is the first of three data analysis chapters. Each chapter aims to provide a different level of analysis of the pregnant self, including engagement with dominant discourses, making sense of the materiality of their bodies, and counter-narratives to dominant discourses. These three aspects are framed within different ways the self is shaped and reacts to culture: the constituted self, or how discourse is practised (or "performed") through the materiality of the body; the constructed self, or how one uses their bodies to draw boundaries between the self and others; and the agentic self, where individuals use their bodies as a site of agency to react to dominant discourses. Discussions include explorations of how pregnant participants have folded into existing social structures to regulate, control and understand their bodies, how they interpret and use their bodies to shape their own vision of themselves, and how they use their pregnant bodies to express their own desires and regain some level of power and control. These three analytical chapters provide a multi-faceted way of understanding the self, body, and identity during pregnancy.

This first analysis chapter focuses on the constituted self, or how one is constituted through dominant discourses. Being constituted through discourse means identities, knowledge, and understanding of the world are shaped and constructed through language and communication. Discourse goes beyond mere linguistic expressions; it encompasses the broader systems of meaning-making, including how language produces and reproduces social realities, norms, and power structures. This chapter delves into how the pregnant body is constituted through medical and natural discourses, exploring the implications of language, knowledge production, and power dynamics on the pregnant individual's experience. This chapter explores these discourses in more detail, explaining what medicalisation means to pregnant people and how this is compared with ideas of naturalness.

5.1. The Medicalised Body

Women in this study tended to discuss medical interactions primarily as unproblematic or even, at times, completely absent. After the first few interviews, I was surprised: I had assumed many women would start stories with the first antenatal visit to the midwife or perhaps reporting symptoms to their doctor. However, direct medical interactions did not often feature in these early interviews, although this is something which changed as I collected more interviews. Where there were direct medical interactions, most women positioned themselves as knowledgeable, thus "allowing", if not directly contributing to, any medical treatment. When medical care was deemed to be problematic, however, this was often rooted in midwives or doctors attempting to assert a truth claim about the pregnancy, which the women deemed to be inaccurate or dismissive of the women's own knowledge about their bodies. In these instances, women would offer ample detail, describing not only the interaction with the doctor but also how it made them feel, including expressions of incredulity at the situation, suggesting these experiences were important to women.

One woman, Eva, wanted a home birth but initially was not permitted this within her birth plan because of a previously diagnosed heart murmur and a family history of high blood pressure. Her heart murmur resulted in a stricter threshold for her blood pressure to qualify for a home birth. However, as a physical trainer, she was extremely fit, and even while heavily pregnant, she continued to run back-to-back spin classes. She wrote in her diary, "I've said I want my heart rate to be increased or monitored in the same way as everyone else given my fitness... I'm not backing down on this and although nobody tell you this I know they can't force us into hospital on that alone. It's our choice." After some persistence and a change in midwife, she was finally signed off to have a home birth plan. She excitedly wrote in her diary:

> Good news about our home birth care plan – they're not going to set a lower limit for my heart rate! Yay – big relief. Now I know I can concentrate on birth, my body, my baby and hypnobirthing. She only asked that I tell the midwife if I feel my heart is racing or if I'm short of breath which I think a midwife would be able to see anyway. The only caveat was they asked to check my pulse every 15 minutes when normally they would do it every hour but I can refuse this if I want to. If I feel everything is going well.

In the final weeks of pregnancy, she also had a change of midwife, who she declared "is very kind, she takes the time to explain and she's very experienced. She made an appointment for us at the birth choices clinic to discuss our home birth." The critique of medical intervention went beyond those who wanted non-medicalised care versus those who accepted medicalised care. Susan, who was pregnant at the same time and attended the same hospital as Eva, wanted a hospital birth. Since Susan was deemed "low risk", her midwife tried to get her to agree to a home birth; Susan was told it looked like the month she was due was going to be a very busy month on the maternity ward, possibly without enough beds available for everyone due to give birth. Again, Susan had to continue to insist on a hospital birth plan, which the midwife agreed to in the end. In both scenarios, the critical issue was not about whether to accept medical care or even a specific kind of medical, but the extent to which the women were able to influence decisions about their care and the extent to which medical practitioners used their knowledge of the body to override the women's own beliefs about their bodies. Eva, trying to make a decision based on her own embodied, experiential knowledge of her body and her advanced knowledge of the body as a fitness instructor, felt angry and resistant to those whose "knowledge" about her heart and the standardised care plan which accompanied that knowledge, conflicted with her everyday experience of how strong her heart was. Conversely, Susan, who was very accepting of medical intervention and relied heavily on medical practitioners to advise on the right choice, wanted medical oversight but was also initially denied. The interactions between these women and their midwives demonstrate how knowledge about the body influences power dynamics in medical interactions and the capacity

for medical professionals to privilege their knowledge over that of these women. The use of medical truth claims based on expert interpretation of risk out-powered the risk felt by the women themselves. In both these situations, the decisions were not made based on an existing risk but on the *potential* for risk. Steyn (2000) and Loretzen (2008), both researching women's anxieties about reproductive care, similarly concluded that such anxieties are not based on a perceived notion of risk but on fears of actually losing control. In short, the loss of influence in medical decisions, even where the final decision was not made in favour of what the woman originally wanted, resulted in resistance to becoming a medicalised subject. The contrast between a medical practitioner's fears for what could happen versus the pregnant person's fears for what is happening created conflict and resistance to becoming a medicalised subject.

In both cases, however, midwives relented in their decisions, deciding in favour of the wishes of both women, even when this challenged their standardised care plans or resourcing. In Eva's case, her midwife changed, shifting the field of play, which seemingly improved the chances of Eva being heard. Eva's affinity for the new midwife and the new midwife's openness to hearing Eva resulted in Eva concluding how "knowledgeable" the new midwife was. Susan's case was slightly different, where the scales were already tipped in favour. If Susan wanted a hospital birth, the hospital could not deny this. This suggests that the power relations in medicalised settings also enable resistance. However, medicalisation is a changing phenomenon, whose scripts are routinely re-written as the institution of medicine is modified. Participants were often empowered to self-regulate according to medical values and received "patient-centred care". Medicalisation, therefore, did not always express the same kind of alienation documented by Rich (1976) and Young (1984); participants actively resisted following "doctor's orders" with their own counter-claims, and women often critiqued or even refused to comply with medical advice. Whereas in the past, women may have been expected

to submit to labour with no option to induce, delay, or change labour, now women have come to expect some level of control over the process.

Within these changes to the medicalisation of pregnancy, doctors and midwives gained a higher status as someone to defer when there was a concern or something "felt wrong" rather than day-to-day monitoring. This was particularly illustrated through Alison's case. Alison had given birth twice, with both ending before the third trimester was underway. Premature birth, or birth before 37 weeks, is unusual: within the UK in 2021, only 7.6% of live births end preterm (Office for National Statistics, 2023). Alison was even more uncommon in the sense that her premature births happened on the cusp of viability, ending barely a couple of weeks from her third trimester. With her first pregnancy, she did not realise, initially, that she had gone into labour. After feeling persistent contractions ("Braxton-Hicks", she thought), she called her midwife for advice, who advised getting examined at the hospital. Unbeknownst to her at the time, Alison had lost her mucous plug that morning and was in active labour. Once examined, she was quickly referred to a consultant on-call, who decided, within minutes of entering the room, that she would need a C-section. Alison explained, "She just came into the room, all in a whirlwind, and abruptly said I needed a [C-]section. And I didn't really want a [C-]section. Already my labour hadn't gone the way I wanted it to, and now it was ending in a [C-]section, so I was a bit miffed with her…she was quite abrupt." A few days after the birth, they had a follow-up with the consultant, who explained that their baby was lying transverse, which she knew from the difficulty they had in finding the baby's heartbeat. When Alison was first examined, her waters had not yet broken. However, once her waters broke, the baby would be quickly pushed down into the vaginal canal. Given the size of the baby (who was just over 3 lbs) and the transverse position, a vaginal delivery would have fatally crushed the baby. After hearing this, Alison felt surprised, expressing, "I was like, wow. She saved our lives from something potentially fatal, certainly for [CHILD 1]". Despite her initial reservations about the

consultant, the new knowledge about the decision-making process during the birth had effectively built trust between herself and the consultant. When Alison found out she was expecting again with her second child, she requested the same consultant to oversee the pregnancy and birth because "we would feel safer in her hands.". Unfortunately, however, the consultant had changed job roles and was leading a diabetic clinic on the maternity ward. As Alison did not have diabetes, her request for this consultant was initially refused. After some perseverance on Alison's part, they eventually transferred her to the diabetic clinic so the same consultant could see her through this pregnancy. She then expressed relief, stating, "I think as soon as I saw that consultant at 14 weeks, I thought "Good". I feel more, I guess, optimistic because I'm seeing her… just knowing I'm under her care, psychologically, makes me feel a bit more at ease and more hopeful that we can get further along with this pregnancy. If I can get to 32 weeks, I'll be thrilled." Alison gave birth just weeks after our interview, having only made it to 29 weeks, even after attempts to delay the onset of labour. Nevertheless, on a follow-up meeting, she expressed gratitude for the consultant being available, "helping" in a time of need, and doing everything possible within the circumstances. On the face of it, Alison seemed to become a medicalised subject, even seeking out the same consultant. However, Alison's changing attitude toward the consultant suggests that the production of her medicalised reality is not wholly uncontested. Despite being a very medicalised experience, which she acknowledged when she said she was required to check in with her doctor every two weeks, the pregnancy was very much "on the forefront of [her] mind, even more so than with the first pregnancy". However, the negotiations and resistance between healthcare providers and these pregnant women suggest that medicalised subjectivity cannot be the only possible outcome of doctor-patient interactions. In these examples, both medical practitioners and patients were able to advance their own truth claims and resist the truth claims of others, whether that was based on expert medical opinion, embodied knowledge, or any other type of knowledge.

Consequently, such medical power relations, based wholly on who has the "right" or "expert" knowledge, are more nuanced than simply producing a passive, compliant patient. The use of knowledge both empowers and overpowers pregnant individuals in making decisions related to their care.

5.2. The Case of Florence

As explored in chapter two, a large body of feminist literature has already critically examined the role of knowledge, specifically gendered knowledge, in how it contributes to processes of medicalisation. Knowledge, however, is not the only aspect of interactions that produces a medicalised subject. As Birke (1999, p. 8) observed, "What counts as scientific knowledge, as the "facts", depends on who counts it as such and in what context." This is an important point, which suggests it is not knowledge alone which produces medicalised subjects, but also other key actors within these circumstances. The following case of Florence, explored in detail, examines the peculiar circumstances which arose for pregnant people following the first lockdown of the COVID-19 pandemic. As mentioned in chapter four, toward the end of data collection, I received a call from a colleague who insisted I must hear her friend's story of pregnancy. At this point, I felt data collection was done, but I was nonetheless intrigued by the promise of a story so powerful that I *must* hear it. Dutifully, I contacted the friend and scheduled a time to interview her. What follows is the story of Florence, whose isolation during medicalised care of her pregnancy brought to light further aspects of medicalisation.

Florence was a professional working for an international charity that provided for women and families in need worldwide and advocated for women's rights. She was articulate, acutely aware of the political and social issues facing mothers, and found herself pregnant in her mid-30s, much later in life than the average woman. She confessed at the start what, as she put it,

was probably one thing a pregnant person should not ever admit: she was not 100% certain she wanted to have a child. Her story's first reflection and emotion begins with uncertainty, which continues throughout her story. Throughout, she even questioned herself, “What have I done? But this is amazing! What’s next?”

While many parts of her story seemed to reflect other stories – for example, she talks about feeling sick and fatigued throughout the first trimester but having to get on with life as usual, or feeling as though she was keeping a “quiet secret” from everyone – she also posed a level of uncertainty not in other stories. “Pregnancy is very hard not to talk in cliches”, Florence said. “There’s so much you realise you heard before, but yet it is very unique. Things being very relatable but also very personal. It’s a hormonal mess, so much to process. It’s definitely an experience, it’s definitely a learning experience: mentally, physically, what you learn about yourself as well.” Florence’s story, however, *was* a bit different from others; while all other stories took place before February 2020, this story took place at the height of the COVID pandemic during the first lockdown.

During this time, the guidance on healthcare for pregnant people changed. NHS guidelines were amended to recognise the inherent risk of too many people gathered in a small space, so it is recommended that maternity services restrict the number of visitors during antenatal and postnatal care. Florence found out she was pregnant in March 2020, just days after the entire United Kingdom went into lockdown. During this lockdown, socialising outside of a household was prohibited, and individuals were only allowed outside the house for up to one hour a day for exercise. New guidelines were released to ensure people kept a distance of three meters from each other, and new parameters were set for maximum occupancies of indoor spaces (Cabinet Office, 2020). Alongside this, hospitals took a very restrictive line, partly out of the uncertainty of how the virus would impact high-risk groups (like pregnant people) and partly in anticipation of the unknown impact on staffing numbers. For pregnant people, this meant all

care, including standard prenatal checks, ultrasounds, and emergency care, must be done alone. Some services were suspended entirely in some NHS Trusts, including homebirths, water births, elective Caesareans, and midwifery-led birth centres. Partners of pregnant people, including expectant fathers, were not allowed to attend any medical appointments (Royal College of Obstetricians and Gynaecologists, 2020). Sanders and Blaylock (2021) found that although pregnant people were generally happy to adopt this precautionary approach, it led to considerable distress and emotional trauma. Pregnant people discussed being responsible for further relaying (sometimes distressing) messages about the pregnancy to partners, going through the entirety of labour alone, and being unable to see their partners during post-natal hospital stays. One woman in their study described, "Having my 20-week scan alone, being told there was a problem with the baby was awful…I was extremely distressed…Then, having to relay the information to my partner whilst sobbing on the phone. Every appointment since has been awfully distressing" (Sanders and Blaylock, 2021, p. 3). The guidelines also had a detrimental impact on fathers; Andrews, Ayers and Williams (2022) found restrictions produced feelings of isolation and a sense of loss, along with a disconnect from the pregnancy. Just weeks after these restrictions on maternity services were put in place, national maternity support groups began responding to the stress that accompanied these restrictions and advocating against the implementation of blanket visiting restrictions (Birthrights, 2020; National Childbirth Trust, 2022).

The isolation had a profound impact on Florence's experience of pregnancy. Her first experience, just days after a national lockdown was declared, was to attend her 20-week scan appointment, often the first glimpse parents get of the growing foetus. Going into the hospital, she was told that her husband was not allowed in. While setting up in the room, she asked the sonographer if she could call her husband on a video call while in the appointment; however, this wasn't allowed:

> I said to the sonographer – can I at least call him on the phone? You know, dial him in. He's just waiting out in the car park.
>
> And she said no.
>
> And I said but why?
>
> And she said it's because it's a medical appointment.
>
> But it's my medical appointment. It's my information. I'm the patient. If I consent to someone else being part of this conversation, surely that's my right?
>
> But apparently not. And we had a bit of an argument. And there was nothing I could do about it except crack on with the appointment. And, um… (cries) It was especially frustrating. On the one hand, I feel bad in retrospect…(crying). You can tell a lot of this is quite raw. The sonographer was very sweet and put down the gender on a piece of paper and folded it up so I could take it home and we could open it at home together. Which was nice. But the downside was that they had discovered that they were a bit concerned about some of the measurements of our baby girl. That she was a bit small. And we immediately had a referral to another hospital…
>
> I remember going to that first referral appointment alone, again. So I went to Addenbrookes Cambridge, which [HUSBAND] still wasn't allowed in. And I remember lying down while the sonographer took my pulse. And the sonographer said, "Oh, you're nervous!" And I said, of course, I'm nervous – what do you think? I've been sent here because there are concerns. I don't know what's going on. I haven't got any support here. What do you expect?

Up until the point of talking about the moment in her first referral appointment at Addenbrookes, Florence has referred to all aspects of the pregnancy as "we": "We had the 20-week scan", "we immediately had a referral to another hospital", and "we had to have regular growth scans every three weeks." Initially, I had thought Florence was referring to herself and the baby as a way of recognising her child and building her identity as a parent. However, once the story got to the point of taking her pulse at the first growth scan appointment, she switched to "I": "I remember lying down…", "I've been sent here…" and, finally, "I haven't got any support here." After this point, she never returned to referring to "we" to describe her actions during pregnancy.

The lack of connection of an audience in which to perform her pregnancy and in which to occupy the subject position of a pregnant person expanded beyond these moments at the

hospital: She and her husband had decided to tell people about her pregnancy after the first ultrasound scan. Since this followed the national declaration of lockdown, nearly everyone had to be told over WhatsApp or in a phone call, which she remarked was a "weird" conversation to have. She also talked about how she finally began to feel better and had more energy in the second trimester, but lockdown meant they couldn't go anywhere or do anything. Although they had planned a "babymoon" vacation to Italy, this was cancelled. She also had hoped to meet with friends and family to show her growing bump but was not allowed this either.

Trying to get at the root of why the baby was measuring small, she explained that medical professionals "throw all these possibilities at you". However, she said she was left thinking, "How do we know? How do we test?". She explained there was limited testing, and the available testing (amniocentesis) carried a risk of miscarriage. She explained that the question "Is everything ok?" never left her. She was shocked that healthcare "basically rely on scans and sticking in some needles", but there was "very little they can control". When she said this to a consultant, they replied, "You are absolutely right - a lot of this is guesswork". "Is it the nature of pregnancy?" she wondered, "Or that it is women's health?" She remarked that the "one thing I learned from that experience was that I – I just find it amazing that in 2020, with all the advances in medical science, there so little that they know antenatally. I was actually quite shocked by that." The worry she felt for the growth of her child and the progression of pregnancy never went away for the rest of the pregnancy. She said she constantly questioned herself, thinking, "I'm fine, but is the baby ok? That was a strange feeling."

Interestingly, despite this questioning and worry, initially spurred by her medical appointment, she continued to note that she did not blame the sonographer or the medical care she received and even went as far as to say how reassuring it was to be able to have a referral, so the baby's measurements were thoroughly checked. Here, she may have been referencing the dominant narrative of a medicalised pregnancy and how this is an accepted course of action for a pregnant

person. But she explained that the lack of support for her choice of people around her was "dislocating". The uncertainty she felt may not have been wholly about concern for her or her baby's health, as much as it was around the reassurance received by being seen and recognised as pregnant. Without a stage in which to perform her pregnancy, she felt uncertain about what to think or do about its progression.

She went on to say that eventually, she got used to the routine of being pregnant, and by the time she reached the third trimester, the uncertainty she felt shifted from the progression of pregnancy to the progression to motherhood and the moment of childbirth. She described, "You just get so fed up [laughs] Once you've got sausage fingers and toes and ankles and everything... And then it got really hot because, of course, it was June/July, and I was just sweating and struggling and thinking, "Ah, can this just get to the end?" She remarked how it was "very weird – stuck thinking I want to stay where I am, but equally you want it [the pregnancy] to end." Her doctor advised early delivery because the baby had measured so small, so she was scheduled for Cesarean at 37 weeks. The end of her pregnancy had an equally "weird sudden end – [I] needed further tests, COVID tests, injections, and so on to prepare for operation." She felt the whole experience was "mind-blowing. No clean break between before me and then the childbirth and then the afterward." She remarked how she was just "muddling through" the whole pregnancy.

Her story of pregnancy bore a striking parallel to the national story of COVID. She described it as this thing that is far away, not real, until it was. She became pregnant in January 2020 when murmurs of a virus began. Her first ultrasound was at 20 weeks, just one week after the United Kingdom went into lockdown. She, herself, reflected on the parallels between the national story of the pandemic and her own personal pregnancy, observing that those first three months, from January to March, both realities (having a baby and living through a pandemic and subsequent lockdown), seemed like distant "potentials", something that might come to pass

or might disappear before its reality is truly known. For both those finding out they were pregnant and for those testing for COVID, worlds changed instantly once a test stick showed a positive result.

Florence also remarked on her profound vulnerability by being pregnant and living through the pandemic and the sense of responsibility that came with both experiences. On a national level, there was a sense of personal responsibility to tackling COVID; the national responses to lockdown followed a very neo-liberal approach: individuals were expected to wash their hands, keep their distance, limit contact, and test regularly (Crouch, 2022). Beyond public health information updates and the national vaccine drive, very few other inventions considered a healthier public body: schools were not retrofitted with air filters, there was no investment in better cleaning and sanitation systems that could target viruses, and borders were closed for an extended time rather than taking a more equitable global approach to vaccination. On a more personal level, she described feeling incredibly vulnerable and fragile, knowing "you were carrying this thing you are carrying inside that you are responsible for, but don't really know "it"." Consequently, she questioned everything, from what she could eat to the position she could sleep in or how much exercise she could do. In some ways, she drew from many existing social narratives which set social expectations for pregnant people. Underlying this story is the subset of COVID, which she often references as the driver of her experience and as the key parallel to her own personal story.

The critical space throughout Florence's experience of pregnancy was in the way her experience of medicalisation was positioned within a frame of isolation, even where there were technically people present (e.g. the sonographer or consultant or contact with wider family via WhatsApp). The processes which medicalise pregnancy have (famously) been described as a process of alienation (Young, 1984; Akrich and Pasveer, 2004; Shaw, 2012). Young (1984, p. 55) explained that,

> A subject's experience or action is alienated when it is defined or controlled by a subject who does not share one's assumptions or goals... a woman's experience in pregnancy and birthing is often alienated because her condition tends to be defined as disorder, because medical instruments objectify internal process in such a way that they devalue a woman's experience of those processes, and because the social relations and instrumentation of the medical setting reduce her control over her experience from her.

Florence, however, noted how understanding the sonographer and consultant were in her interactions, noting they shared a moment together, acknowledging "there's so much we don't know" and praising their diligence in monitoring her baby's growth. Since the 1980s, medical practice has strived to adopt more patient-centred care (Greene, Tuzzio and Cherkin, 2012), and it's clear here Florence did not feel aggrieved by the treatment by medical practitioners. Institutional policies restricting the "audience" of her pregnancy milestones, however, reinforced the isolation felt as a consequence of COVID, keeping her from being able to fully engage with dominant pregnancy narratives. It seems that connection to key people who have been constant in her identity before pregnancy was most important to Florence, and medicalisation is a process which can help (or hinder) the location of a pregnant person within their social groups and communities. This is referenced in other ways by other participants as well, including one woman at high risk of premature birth who pushed early on to get the same consultant that delivered her first child, even though the consultant had changed medical specialities, and that meant her appointments were held in a diabetic clinic. Others talked about the "amazing people" they met throughout their pregnancy with whom they continue to maintain relationships.

The story offered a glimpse into ongoing processes typically concealed in "normal" times. Florence often struggled to articulate her sense of isolation and disconnection from others, clearly aware of the importance of the issues she raised but unable to find the right language. She described a sense of isolation and loneliness but continued to explain how difficult it was to put into words, even breaking down to cry intermittently, completely at a loss for words.

Within this case, there are three inter-linked issues: one, the loss of access to friends and family who help to underwrite and give meaning to the experience of pregnancy; two, the impact of being reliant on medical people to frame meanings; and three, how medical milestones may also become moments for friends and family to help frame meanings.

This is also the only story that explicitly sought to be told, written down, and discussed. In the end, Florence explained she wanted to tell her story so others did not experience pregnancy in the way she did and hoped this story would find its way to being told to midwives or other medical professionals working with pregnant people. Throughout 2021, NHS Trusts began slowly lifting visitor restrictions in maternity services. By January 2022, all NHS Trusts welcomed back partners during antenatal appointments, and almost half (70 out of 149) of NHS Trusts allowed eight or more hours of visitation during labour and postnatal care, including 17 who offered 24-hour access (Birthrights, 2022). Nevertheless, at the time of writing, six NHS trusts continue to restrict visitation on maternity wards, allowing only one visitor a day for less than four hours. While research continues to consistently show that pregnant and birthing people are unhappy with restrictions (Thomson *et al.*, 2022), it remains important to stress that this access to family and friends provides not only mental support but also introduces a new way of making sense of pregnancy, changing the context from that of a simply medical situation to one for which pregnant people can draw from a range of knowledge and support to make sense of their bodies. The cultural frames and meanings brought in by social circles help move beyond medical frames and, as was the case with Florence, allow for a clearer sense of self and intention.

5.2 The Natural Body

While medicalisation is undoubtedly a dominant discourse of pregnancy, it is not the only discourse from which pregnant people draw to make meaning of their experiences. Within my interviews with women, there was also a strong reference to the "natural", often posed as a de-medicalised, and therefore alternative, approach to treatment and care which prioritised the pregnant person's voice. Defining what is "natural", however, is complicated. The dichotomy between natural and medical bodies sometimes reflected an opposition between nature and culture. The obviously fleshy and sensational aspect of pregnancy is deeply associated with pain and pleasure, invoking claims to a natural or biological force, which stands in contrast to rational, scientific, and cultural views of medicine. There is also a gendered element to this opposition: the historical shift, outlined in chapter two, from supporting pregnancy and birth through female companions in the confines of the private sphere to monitoring and treating pregnancy by medical men in a public hospital reflects another layer on the dichotomy between a "natural" pregnancy and a medicalised pregnancy. Embedded within these discourses are also moral connotations. As Woodward and Woodward (2019, p. 88) explained, "If it's natural, it must be right… Those who wish to defend their own decision might refer to these natural forces, and nature is construed as having capacities that are in opposition to medicalisation". Medicalisation seems to have a much more straightforward definition, which is "definable, visible, and unquestioned" (Brubaker and Dillaway, 2009, p. 38), with clear processes, hierarchies, and settings. On the other hand, the natural discourse is far less clearly articulated and seemingly defined as anything that is not medical.

A natural pregnancy, nonetheless, was often cited as desirable by the women in my study. Most women desired a "natural pregnancy" or "natural birth". Initially, I took this to mean a pregnancy with minimal medical appointments, overseen by a midwife, ending in spontaneous labour and vaginal birth. This interpretation of the "natural" movement in pregnancy and birth

care, led by Sheila Kitzinger, has been critiqued for essentialising women's "natural" capacities (Brubaker and Dillaway, 2009), as well as for its classed and racialised inequalities (Woodward and Woodward, 2019). However, several other versions of this natural discourse also prevail, including the hypnobirthing methods (Mongan, 2015). Indeed, some of my participants took part in hypnobirthing classes, and almost all took part in antenatal classes aimed at exploring all the options for birth. Two participants also planned for a home birth, with both being advocates for a natural birth. When talking about these envisaged "natural" pregnancies, part of that discussion certainly reflected a key point of what these movements challenge, which was the continued dominance of medicine over the meanings and experience of pregnancy. However, this never extended as far as an outright rejection of medical care. Even Eva, who pushed fervently for a home birth and advocated a more "natural" approach to pregnancy, declared when she reached 24 weeks, the point of viability, "Baby is now at a stage where it can be born and have a good fighting chance of survival. I would prefer to stay longer because it's much safer to be born a bit later in pregnancy, and I would love to have a natural delivery, but it still brings me some comfort." I was also surprised when Alison, who experienced a highly medicalised pregnancy and birth due to her history of preterm labour, expressed as a desire for a "natural" birth, alluding to her ideal of an unproblematic pregnancy where her child could go home with her immediately after birth. "Natural", in this sense, was not resistance to receiving medical care, but resistance to cultural categories that confine pregnant experiences into something relatable only through medicine. In other words, pregnant individuals can resist medical control in favour of a more natural experience, but this does not necessarily mean that they do so outside of the bounds of medicine. As such, natural and medical discourses of pregnancy are in dialogue with one another and co-constitute each other.

While most participants seemed to yearn for "naturalness" to be part of their pregnant, embodied experience, they also recognised the limits of this. As one participant explained, "There's so much pressure on women to have these perfect births, without painkillers and using hypnobirthing..." The decision on the limits of these ideas and how far to take them was also highly contingent on a woman's local context. Often, what was "natural" enough was decided and reinforced through family, friends, and partners, in addition to themselves. Annandale and Clark (1996, pp. 30–31, emphasis in original) made a similar point:

> [w]e would argue that 'alternatives' such as 'natural birth' are *relational* concepts constituted through dialogue with biomedicine… The frameworks of women, their partners and friends, midwives, nurses and obstetricians are unlikely to be opposed in an ontological sense but instead may elide and collide in response to local contexts.

Other references to the "natural body" from my participants highlight this highly contextual idea of naturalness, such as a participant who talked about the pressure of being "natural" with babies:

> I was on the [CPR] course with the males, and none of them treated me any differently or even asked about the pregnancy – it was actually a relief! If there had been women present, I might have worried more when I did CPR on the baby. I always feel like there is pressure from other women to be 'a natural' when holding babies (even fake ones!), so being around men was a relief yesterday on the course.

In this case, naturalness speaks not to medicalisation but to a social identity related to an ideal of what a "good mother" looks like. In these moments, "naturalised" forms of embodiment held the same struggles as "medicalised" forms of embodiment. As Cosslett (1994, p. 3) has also argued,

> [T]he consciousness of a birthing woman, whether constituted in an autobiographical account, or as a 'character' in a fiction, involves a process of negotiation with prevailing ideologies, whose aim it is, I would argue, power: in terms of writing, the power to take over the story, in terms of childbirth the power to control the experience; or, in both cases, the power to protest or celebrate lack of control.

The performance of "naturalness", whether that is bearing through the pain and discomfort of pregnancy without medicine or acting to a good and moral standard as a doting parent, still restricts the pregnant, embodied experience within the confines of this discourse and limits the agency of the pregnant individual.

As an alternative discourse to medicine, natural pregnancy also brings its own contradictions. Browne (2022, p. 3) pointed out that a child is often viewed as the "'natural' and 'normal' endpoint" of pregnancy, which problematically creates a discourse around pregnancy which does not acknowledge the processes of a gestating body for what it is, but rather for what is expected of it. In explaining this, she draws a distinction between "normal" and "natural". Normality is about aligning with social conventions and is a way to get to naturalness. Browne (2022, p. 46, emphasis in original) went on to argue that, paradoxically, "the so-called 'natural/normal' body always remains to be realised precisely because it is a normative ideal – an *achievement* that requires constant maintenance and modification…" Browne's (2022) work on miscarriage explains how such ideologies give rise to a "double bind". The conflation between natural and normal within the natural discourse frames the pregnant body as a passive, "natural" biological body while, at the same time, the pregnant subject is expected to make choices to ensure the "natural" progression of their pregnancies. Women undergo numerous medical exams, for example, not because they are passive recipients of medicalisation, but because there is a strong desire to know that everything is progressing "normally" and "naturally". In this way, both natural and medicalised discourses are, once again, shown to be intertwined with each other. When pregnancy does not progress as expected, there is a reliance on the natural to explain bodily experiences outside of the control of the pregnant subject, such as in the experience of Jane, who, after a miscarriage, explained:

> I've been really worried this miscarriage means I won't be able to have children at all. My mother says, "Nature doesn't care if it's your first, second, or third – if it's not right, it won't be." It's a nice way of thinking about the sporadic nature of pregnancy. It

> certainly helped calm my anxieties – for a time. I'm waiting for my next period before we try again. Could be another 4-6 weeks, if we even conceive on the first try. I imagine I'll be much more reserved next time. Either not excited about anything at all until the second trimester. Or anxiously checking for blood. Probably the latter."

After signing off that it would be her last entry, she later wrote:

> I said this was the end of my pregnancy story already but I suppose it wasn't. I was told to take pregnancy test 2 weeks following the miscarriage to ensure the test came back negative. You know – just in case hormones didn't drop off? At what point did we stop trusting our bodies to do their thing… and what would they do if it came back positive? Force my glands to stop producing hormones? I decided not to take the test. I've had enough. I'm letting my body just get on with it.

Jane uses the "natural" to explain why her pregnancy ended unexpectedly, contrasting it to the medicalised frame, which requires further confirmation of a change in hormone levels. However, these discourses rely on one other to construct ideas of what is expected and how to (appropriately) respond to this.

However, this desire was often cited in many ways, including in Caitlin's narrative. Caitlin was undergoing IVF treatment to aid becoming pregnant. The first round of IVF was unsuccessful, so another round was scheduled after her next cycle. As the day drew near, she began to feel unwell, and her period had not come. She explained she was "desperately afraid" this would affect her IVF treatment, so she managed to quickly book to speak with a doctor and reassure herself. The doctor asked if she had taken a pregnancy test, to which she replied, "No – what was the point? We've been trying for so long…" The doctor used a dipstick test to confirm there was a faint line: she was pregnant. After a moment of elation, the doctor cautioned further investigation was needed to check that her IVF results were not a false negative, meaning the pregnancy may be ectopic or growing outside the uterus. After another run to the hospital, the scans confirmed that the pregnancy was in the right place, thus meaning the pregnancy occurred spontaneously after the IVF treatment. A follow-up two weeks later confirmed the pregnancy was progressing, and she was six weeks pregnant. She reflected, "It was quite nice the

pregnancy happened the natural way, not the IVF way. I quite liked that." However, there was still a conflict within Caitlin. While she was pleased to have conceived "naturally", she also remarked, "I almost feel like I betrayed the infertile women of the world." Somewhat ironically, her guilt of becoming pregnant "naturally" challenged the beliefs she had about what was "normal" for her body. Before becoming pregnant herself, she also admitted feeling jealous and odium toward pregnant people, commenting, "It was weird because I spent ages hating pregnant women. Because I couldn't get pregnant... I had a friend who was pregnant with her second child while we were trying to get pregnant… and I was like, 'You already have one; why do you need another one? And I have none.'" Her conflicted emotions in trying to make sense of what her body could/could not do are not uncommon. Many people trying to conceive through assisted reproduction report feelings of guilt and shame (Quatraro and Grussu, 2020). Tied up in these complex emotions and identities are the preconceived ideas of what is "natural" and the extent to which individuals should have control over their reproduction.

5.4. Concluding Thoughts on the Constituted Self

This chapter has examined how pregnancy exists not just in biological reality but also in the social reality of discourse. Exploring these discourses and the relationship between them helps to shed light on the complex ways in which the pregnant embodiment falls into familiar frameworks and helps to make sense of the experiences and feelings of the body. Viewing the self through discursive action examines the outer world's influence on the internal self. This understanding of the self examines how individuals are engaged with and shaped by their social environment. In short, they are constituted through the interactions of those who understand and reinforce discourses. In this way, the self relies upon a discursive script to help it perform; it both creates and affirms the social norms of the outer world, which in turn shapes the boundaries of the inner world. Butler (2011) has been particularly influential in articulating the

role of discourse in shaping the self. However, this view of the subject has been criticised for leaving little room for understanding the role of materiality, framing the self exclusively in cultural terms, and producing an individualistic account of subject formation (Boucher, 2006). In an interview for *Radical Philosophy*, Butler brushes around the problem of the body, explaining:

> I do not deny certain kinds of biological differences. But I always ask under what conditions, under what discursive and institutional conditions, do certain biological differences – and they're not necessary ones, given the anomalous state of bodies in the world - become the salient characteristics of sex (Butler, Segal and Osborne, 1994)…

In this interview, she is explicitly asked about the critique that a discursive understanding of the self does not adequately account for the materiality of the body, nor does it explore the connection the body has with identities. In using pregnancy as an example (of some bodies which reproduce and others which do not), she responds by talking about the feelings of failure that are well-documented in women who struggle to reproduce and how these feelings originate from discourses which align gender with reproduction. Similarly, participants from this study co-constructed and reflected dominant discourses in reproduction, including a medicalised pregnant self, an object of medical oversight, and a natural pregnant self, an object of natural, biological functioning. Understandings of the natural and the medical shift and rely upon both language and context. At times, participants participated in their own discursive constitution, by being encouraged to "monitor their bodies" and "make the right decision for their bodies", drawing on others to help situate them within these discourses or to resist these discourses.

Chapter 6: The Socially Constructed Body

The previous chapter explored the medicalised and natural discourses of pregnancy, observing how pregnant subjectivity is constituted through both knowledge and context of these discourses, with the context being heavily contingent on relations. Although often understood as aiming to support pregnancy or the pregnant subject, both medicalised, and natural discourses also objectify the pregnant person, relegating the pregnant body as passive and biological, whether that is by treating the pregnant body as an object of study or relegating the pregnant body to its biological processes. These processes of medicalising and naturalising the body further impact how the foetus is conceptualised. This chapter further recognises the processes involved in the interpellation of foetal subjectivity and the ways the body is drawn on to construct, de-construct, and re-construct a foetal body and personhood. Inspired by Haraway (1991, p. 150), this chapter "is an argument for pleasure in the confusion of boundaries and for responsibility in their construction". This chapter extends upon these observations, and explicitly brings into the discussion the bodily sensations of touch, sight, and proprioception, I explore how these experiences constantly redraw bodily boundaries of the pregnant subject.

In some ways, medicalisation and natural discourses share a strong drive to support and advance outcomes for pregnant people, although both undermine pregnant subjectivity in doing so. Instead, both discourses effectively shift the focus from the pregnant subject to the foetus, visualising it as independent, bolstered with the rhetoric of "foetal personhood". Pushing against this personification of the foetus, feminists have long argued for the rights of pregnant people, proposing relational models of the self to secure consideration for pregnant subjectivity (e.g. Young (1984), Hird (2007), and Baraitser (2009a)). Implicit within these conceptualisations is that a foetus is not independent, as its existence relies upon the *relation* to the pregnant subject. Nevertheless, as Takeshita (2017) argued, there remains a concern of

reminiscent notions of Western “corporeal autonomy”. In other words, while many of these arguments have made it clear the foetus requires the pregnant subject to ensure or construct its health, psyche, and social position in the world, and vice versa; however, they do not explicitly address the ways the foetus may sometimes feel (or even be) corporeally distinct from the pregnant subject. Using Browne's (2016) concept of “protopersonal”, this chapter engages with these distinctions and, in examining the corporeal distinctiveness of the foetus, also examines how this “distinctiveness” is still driven by and constructed by the pregnant subject.

The materiality of the pregnant body is not unrecognised in feminist work in this field. The expanding, changing physical boundaries of the pregnant body are often mentioned, for example, in Young's (1984, p. 49) work where she wrote, “I move as if I could squeeze around chairs and through crowds as I could seven months before, only to find my way blocked by my own body sticking out in front of me… As I lean over in my chair to tie my shoe, I am surprised by the graze of this hard belly on my thigh…. My habits retain the old sense of my boundaries”. She went on to explain that she did not feel her body for the sake of it or because of its weighty resistance, but rather she became aware of her “projects” or aims. The body, then “call me to my limits, not as an obstacle to action, but only as a fleshy relation to the earth” (Young, 1984, p. 52). As pregnancy progresses and the body continues to change, she explained that “ordinary efforts of human existence, like sitting, bending and walking which I formerly took for granted, become apparent as the projects they themselves are” (Young, 1984, p. 52). Focusing on the raised awareness of her body allowed her to see how all her bodily movements are aims that contribute to her own sense of self. In this way, there is an intentional subject behind movements, and pregnancy brings to the fore the role of the body in accomplishing her intentions. The body, with its limitations, boundaries, and capabilities, is not a discursive feature but a materiality which either facilitates or resists the intentions of the subject. In this way, the body must be understood, seen, and visualised to either facilitate or accomplish such

intentions. Young's (1984) work went on to overlay techno-medical discourse on this experience, transforming her corporeal experience and leading her to feel alienated from her own body. While understood through discourse, the materiality of the body also exists outside of discourse, providing the means to shape the subject. The alienation described by Young highlights this gulf between the constituted self, which reflects outer worlds and fits into discourses, and a constructed self, which constructs a self from the materiality available. Young's pregnant body raised awareness of how materiality factors into her intentions, adding another layer to the self and highlighting the importance of mapping the corporeal experience in understanding her pregnant self. This chapter seeks to build on these observations, explicitly bringing into conversation how the pregnant subject uses her materiality to create new boundaries and, in doing so, recognising that sometimes these boundaries draw a corporeal understanding of a distinct other.

6.1. Feeling an Other

Participants were prompted to tell their stories of pregnancy from the moment they found out they were pregnant. The tellings of these stories have unique starts, and ideas of "knowing" are varied. While some used a pregnancy test, others "just knew". Many, either with or without a positive pregnancy test, noted changes in their body, coming to recognise these as signs of pregnancy. Sometimes, these changes were ignored when they did not fit their current narrative of what was happening in their lives. This section re-tells some of these stories, examining what role the body played in helping them determine their pregnancy.

Women often described they just "knew" they were pregnant – sometimes despite negative pregnancy tests, delayed tests, or other medical doubts. While all told about a point where a pregnancy test was taken, most stories of pregnancy did not start with a test but rather a

"strange" feeling or feeling of sickness, sometimes reflected on in retrospect. Even when the pregnancy was taken as a surprise, women still told a story of knowing something about their body had changed, as Eva described:

> Baby was a little bit of a surprise, but a happy one... I think initially it was a shock because I hadn't been doing anything you're supposed to do when you're…you know. [laughs] You know you're supposed to start taking the prenatals right away, but um… obviously I had been pregnant for a couple of weeks before you do the test, and I had still been drinking and carrying on life as normal. Although I suppose… Well. I don't know…. I kept feeling really sick, like I hadn't eaten for like 4 hours at a time… That might have been an early sign.

It was not always a feeling illness, however, as Jane explained in her first diary entry:

> So this is my first pregnancy! A couple weeks ago I suspected something was different. I just felt different. I was so excited to show my husband. Nothing fancy. Just held the pregnancy test and told him I was pregnant! I don't know why I needed to show him the pregnancy test – it's pee on a stick, so it's a bit gross. But he was happy nonetheless. So here we go!

Knott (2019, p. 23) reflected on how often it is assumed pregnancy is uncertain until a medical test confirms it and cited a seventeenth-century midwifery book which wrote, "Young women especially of their first Child, are so ignorant commonly, that they cannot tell whether they have conceived or not. If only they knew better, they would properly anticipate the time of birth and not so suddenly be surprised as many of them are." Within this early midwifery text, there is also, helpfully, a list of signs to watch for, which Knott (2019, pp. 24–25) cited in full, including: "growing breasts with swollen veins; pains in the abdomen; cravings for things not typically fit to eat or drink, and what we would name mood swings… an unusually flat belly, reddened nipples, sour belchings, a discoloured face, and more prominent veins around the eyes." Missed menstruation, of course, appears on the list but is buried in the middle. The National Health Service's (2023) contemporary list of pregnancy signs placed missed menstruation at the top, along with a range of bodily signs of pregnancy, including: "a metallic taste in your mouth, sore breasts, nausea, tiredness, new food likes and dislikes, a heightened

sense of smell… thicker and shinier hair, and bloating". Missed menstruation seems like it would be listed first as the most obvious sign, however many of my participants ignored or did not immediately recognise a late period, as this was often understood as an unreliable framework of timing. Moreover, lists like these of signs and "symptoms" position the body as purely biological, a vessel for pathological processes, without considering the range of emotions that come alongside the challenges of trying to get pregnant.

The search for symptoms is sometimes "disorientating", as Cadwallader (2011) phrased it. Caitlin, after having waited to become pregnant for some months, vociferously tracked her period for her IVF treatments but ignored her late (and altogether missing) period as a sign of her pregnancy. Instead, her consultant confirmed her pregnancy with a pregnancy test, which led Caitlin to reflect on other bodily changes, including feeling ill and tired. Her story of pregnancy started instead at the previous, unsuccessful cycle of IVF, noting when she began feeling ill some weeks after the negative test from the IVF cycle. Susan, mentioned in chapter four for having such a short initial narrative, began her story at the point when she and her husband decided to have another child, moving swiftly through her story to when she started experiencing neurological changes, including memory loss. These stories do not necessarily start with a clear physiological symptom, like a missed period, but instead begin with a feeling, idea, or sense. Browne (2016, p. 393) discussed this temporal location of "beforeness", which she calls "protopersonal", noting how this is a significant starting point of relationality. This takes the form of a corporeal feeling, like the participants who had feelings of illness, or it could be psychosocial, such as when a decision is made to conceive or steps taken to conceive. Sometimes, this feeling is described as unusual, "not myself", or, more positively, as in the words of Jane, who wrote, "I feel like a whole new person". The tacit feelings exist not only at the point of a physiological pregnancy but signal a creative, generative form of embodiment experienced by those who are both pregnant and not pregnant. As Browne (2022, pp. 57–58)

wrote, “Women are expected to produce the baby, but pregnancy itself is not regarded a properly ‘productive’ or ‘creative’”. “Knowing pregnancy” experiences, moulds, and directs the body.

The wait for these physiological, tacit feelings seemed to especially impact a sense of knowing. In these cases, the pregnancy test was still a powerful signifier for those who had spent a significant amount of time waiting to become pregnant, as relayed by Cerise:

> I found out I was pregnant in middle of December. So excited … we had been trying for about six months, so we got to the point where we thought there might be a problem. Then found we were pregnant. Over the moon. Told everyone at Christmas… Got to New Year’s Eve, and started bleeding. So we had a miscarriage on New Year’s Eve. So that was a bit of a tough week that week… Luckily, the army let him off work, so we actually had a really lovely week. Sounds weird because the circumstances were horrible, but we actually had a really lovely week spent with just us two. Anyway, carried on as normal. Both went back to work. He- He was convinced I was pregnant. And I was like, I just had a miscarriage, my hormones are all over the place; of course, I’m not already pregnant, you idiot. And he kept on, he kept on. And my period was late. And I spoke to my boss. because I got no help at all with my miscarriage. It was very much, um, “That’s a shame; take a test in 2 weeks and find out”. And I couldn’t bring myself to take another test. Because I was like… I can’t see that this is not pregnant. Like, I just don’t want to see that. I went to my midwife appointment, and they were like, “Oh, thanks for letting us know.” I got no information, no support, nothing. So I was talking to my friends and family about what do I expect, what should be happening? Is this right? Everyone I spoke to was like, “I was a good two weeks late with my period afterwards.” I was like, hopefully normal. And he kept on and on and on… And I was like, “You’re gonna upset yourself. You’re gonna get yourself stressed because you think I am and I’m not.” Anyway, well, one day I woke up and I was travelling for work, so I had to get up really early at six. And I thought I’m just gonna take a test to show him. Pregnant. I was like, “Oh, ok.”

Cerise, convinced because of her recent miscarriage that she could not be physiologically pregnant again so soon, but also aware of a change and felt worry over her what her bodily sensations meant. Jane, who wrote of her miscarriage in a diary, also described the shift in knowing she was *not* pregnant, describing feelings of distress:

> I’ve had moments over the past two weeks where I just cry. I think it’s to grieve the loss of all the plans we had started more than anything else. I didn’t know/feel the baby,

> but I think we build up an idea in our heads of what it will be like... And overnight, all that energy is put into something that will never be. I'm more than gutted, though – this wasn't a cancelled holiday. It was a different way of living… I was certainly attached to something, but I'm not sure it was the baby.

Her observation of feeling "attached" to something highlights the relationality of pregnancy and the tacit feelings associated with pregnancy.

Browne (2016, p. 393) also observed that "others can share in feeling the movement". Pregnancy seemed to bring a self-consciousness and was not necessarily about "telling" others or about feeling the presence of a foetus. Eva, Alison, and Georgia all talked about how nice it was to not tell others about her pregnancy for the first three months and just keep it secret between them and their partners. Eva explained, "Not a lot changed for quite a long time in terms of work… we didn't tell anyone for ages because… I guess we didn't want to… Even keeping it to ourselves was quite nice in a way. Because people are very judgmental about things. And I guess I didn't want that judgement." Control over who was able to "know", and therefore who was able to be in relation to the foetus, was extremely important, regardless of whether women shared the news of pregnancy early or later in pregnancy. Laila, for example, had waited until later in life to have a child and, after reproductive loss, became pregnant through IVF. She confessed she was very particular about sharing the news of her pregnancy and explained,

> We got to our 12-week scan, and that's when we started announcing to people. And we organised it so that he told his sister as I was calling my siblings... I just remember there was one of my siblings which we couldn't get a hold of right away and by the time we did, [my husband's] mother had already told all of her closest friends. And I just remember thinking my whole family don't even know yet, and you have already told people who are complete strangers to me about my pregnancy…

The three-month mark seemed a universally accepted point at which women began sharing their news of pregnancy more openly, and it was sometimes a difficult wait. The debate over who should know and when caused distress, as Caitlin complained after getting confirmation

of her pregnancy, “Then after that, it was a matter of getting past three months… it was absolutely terrifying. It was like constantly being on tenterhooks. They tell you not to tell anyone for the first three months, but if I don’t tell anyone and something goes wrong, then surely I want to people to know because I want people to know I am actually upset.” Bodily changes, included missed periods, nausea, or fatigue, along with a more abstract feeling of “knowing” prompted along with the growing group of relations around the foetus helped to interpellate foetal subjectivity.

Beyond telling of others, however, participants also described sharing baby kicks and other movements. However, access to the foetal body had to be negotiated for everyone else. Women sometimes described disappointment when the baby moved but then stopped once a partner tried to feel movement through their bellies. Alison made a point of trying to remember every day when she felt movement, saying, “Because with [my first son], I don’t really remember that – I have an anterior placenta, so you don’t necessarily feel as much movement. But certainly, I’m conscious every day… and looking to the point where [my husband] will be able to feel it more…” Caitlin explained that rather than rely on a picture of the baby’s face, she described “knowing him” through his increasing movements. She said he followed his father's sleeping pattern: "So it’s like he has his own personality already – it’s like he’s [her husband’s] son already. It’s nice to see that.” Georgia, even after having ultrasounds, explained said how she “couldn’t see [the baby’s] face in scans because of the way that he was laying” but was “quite glad not to see his face though”. Instead, she wanted “get to know” the baby through his movements but did not want a picture image of what he would look like. Simiarly, Laila, still remembering her reproductive loss, explained, “this time around, we needed to know as much about him as possible,” but didn’t want to “meet him until birth”. Some tried to involve the foetus in daily activities, such as Georgia who said “if I feel a movement, I might to talk to it.” Eva, stressed from having to testify in court while pregnant, remarked that she was ”gutted my

baby has to endure it with me." The presence of the foetus, known through both the internal feelings of movements as well as sharing these movements with others, became a meaningful way to bring in other relations to get "to know" the foetus, pulling the foetus into everyday life.

Participants did not often describe a feeling of de-centring or alienation, but instead of ambiguity. There was a discussion which hinted at a "twoness", but it was more nuanced -- the foetal body was described as being on the cusp of the outside world, with both Eva and Susan using almost the exact phrase, that there is only "1 inch of skin" between the baby and the external world. Another commented that the mounting baby gear in their flat was "like he's moving in" – but just not there yet. There was always an imagining of "another"; the foetal body seemed to straddle an ambiguous line that borders upon the world. It was not as simple as two-in-one, but more like two "imagined". Another woman described this as "there's days where you not certain if you feel the baby move or not, then you're not sure if it was just your stomach rumbling…" There was assurance in women's bodies, but ambiguity around what was the foetal body. Halfway through her pregnancy, Caitlin described, "As they start to move – they are a human. They are part of me. They are attached to me." Alison felt she could move in certain ways to get the baby to move, too. It was a ritual at night to have her husband feel the baby kick before dropping off to sleep, so she was able to do things which would wake, shift, and move the foetus until it kicked. The prediction of movement became more of an intuition to her, adding further to the blurred boundaries of the pregnant subject and foetal subject.

For some, however, their bodies began to "tell" others even when the women had not shared with others the news of their pregnancy. As Ophelia explained, "People started to guess…I didn't want to say no because it was like I was denying it. But I didn't want to say yes either…" As the pregnancy progressed, the bump became a clear indicator of pregnancy and a growing sense of another: the foetus. It is probably worth noting that all women in this study had a

discernable bump, unlike some women who experience “stealth pregnancies”, where there is no visible bump. The attention that the bump received garnered frustration more than anything else – women often felt judged, different, and othered based on their size and shape. Nearly all women remarked on how others described their pregnant bellies to them, including being told they were big or compact and small. The reaction, however, changed when the comments focused on the size of their bellies. Eva, a personal trainer who paid close attention to her body size and weight, remarked, “A lot of people keep saying, ‘Oh, you’re not very big’. But I’ve been checking my weight regularly, and I’m in line with what is expected!” Cerise was particularly affected by this and said, “People find it perfectly acceptable to tell that I have a fat ass…they think they are giving you a compliment, but no…” Throughout history, the language of size in pregnancy has had some importance. Begiato (2016) examined women’s descriptions of pregnancy in the eighteenth century, and noted the particular importance of the term ‘increase’ or ‘encrease’. This term was used in two ways: one, figuratively to refer to the increasing size of the family and, two, to discuss the changing profile of the pregnant body. Fox (2022) noted that these terms were not necessarily used positively. For example, she wrote of Jane Scrimshire, who, in 1756, described her pregnancy as a “complaint … of the Encreasing kind” in a letter to her friend, Elizabeth Parker. Similarly, in 1778, Sophia Curzon referred to “us fatning Ladies” in a letter to her aunt, complaining about her friend’s frightening, pregnant appearance. Even if they were not unhappy with the way their bodies “told” their stories of pregnancy, most participants complained about how their body’s size impacted their daily activities. Georgia, for example, complained how “getting fat” hampered her ability to go about her day-to-day life, while Alison lamented not being able to go running with her friend. These noticeable changes to the body again began expanding those who could perceive and contribute to foetal subjectivitivation.

6.2. Seeing an Other

Beyond a tacit sense of knowing, participants also relied upon sight to construct and interpellate foetal subjectivity. As noted in chapter two, ultrasound scans became a regular practice in the 1980s and are now even accompanied by the sound of a heartbeat and three-dimensional movement. A technician oversees this process and "reads" the images produced by medical technology. These ultrasounds are a powerful way of confirming, knowing, and visualising the pregnancy. Caitlin, whose pregnancy test may have been affected by her IVF treatments, explained that the doctor told her, "Don't want to piss on your chips, basically, but you need to go to hospital for a scan to see if it's not the IVF and you got a false… negative - from the IVF…" In this scan, they checked both sizes of the foetus to estimate a gestational age but also placement to ensure the pregnancy was not ectopic. Women also decided to use early scans as a way to add further detail and nuance to their foetus narratives. Cerise, whose miscarriage happened just a couple weeks before her pregnancy, explained that they wanted a scan to confirm the suspected miscarriage had actually occurred and this was, in fact, a new pregnancy:

> So I think this is like the 6th of February. I literally went upstairs and woke him up, and I was like, "I'm pregnant… OK, I need to go to work now. Bye!" and just sort of walked out and started driving to work. And he rang me and was like, "I couldn't go back to sleep 'cause I feel like if I went back to sleep, I'm gonna feel like this is a dream. [laughs] And he was like, I just need to confirm what you told me. But obviously, at this point, we were worried that maybe I hadn't had a miscarriage? Maybe it was just a really heavy bleed? Stranger things have happened, and so we didn't actually know if we were six weeks or three months. So we were a little bit worried. Um… so if it was three months, I was like, I need to have an appointment now. So we booked a private scan. Went along. Luckily, everything was fine. They thought I was six weeks and three days at that point.

By this point, she knew she was already pregnant, but the ultrasound added further nuance to the protopersonal story of the foetus. In addition to adding nuance, ultrasound images also became important as personal mementoes of their pregnancies. Some opted for additional scans on top of the typical twelve- and twenty-week scans, including Cerise, Eva, Georgia, and Laila.

Sometimes, participants shared this image with others, which in turn was then memorialised by others, like Laila's sister-in-law, who framed the ultrasound image. In anticipation of her upcoming scan, Alison commented that she was "really excited about seeing him and seeing how he developed." Even with this excitement, however, there was a tension between interpretations of what medical equipment "saw" (as interpreted by medical professionals) versus how women internally processed events. The images sometimes had the impact of causing distress and anxiety. Eva, who was going through a particularly difficult month after her court appearances, described getting a 4D scan "as a treat". This, however, took a turn when the ultrasound revealed an underlying issue:

> The 4D scan revealed a liquid mass that the sonographer said we needed to get checked ASAP. She didn't say what it was, only that it was in the stomach area and that she wasn't qualified to say more. She rang the hospital who made an appointment for us today (Monday) because the consultants don't work weekends. I was panicking a lot Saturday and asked her if my baby was going to die or have a disability. She said no, but we might need medical attention. She even had the cheek to say on the phone that she had tried to reassure us – that was a complete lie, and to say she was like a robot would be offensive to the robot… [It turned out that the b]aby has a cyst that may go away on its own and just needs monitoring. However, the consultant was a bit concerned as he said baby was measuring small, apart from the head circumference. I didn't say exactly what we'd been going through, but I said we'd had a lot of stress, and I hadn't been eating as much. Although he said that wouldn't caused anything I believe he underestimated the amount of stress. We will be monitored and have to go back for more scans.

Her mistrust of the doctor's understanding of her pregnancy grew further when future scans showed the foetus's growth to be back within average sizes. Life's stresses had begun to ease, and she was feeling better, which coincided with a more positive ultrasound reading. She and other women trusted their own internal corporeal work, even when it was not the medical average. In this way, ultrasounds were a way of confirming what pregnant women already knew. Eva finished off her reflection on her ultrasound, writing, "Everyone keeps telling me how well I look – if only they could see inside my head, they would see how fake a brave face can be. I am trying to be positive, though, so I guess that is what they are seeing." "Seeing" the

internal through ultrasounds did not always provide a clear, distinct image of the foetus. Sometimes, the image was literally blurry. Jane wrote in her diary about looking for a "baby bump" at seven weeks pregnant. A few weeks later, she began to bleed, so she went to the doctor:

> The GP did a physical exam of my pelvic area – pressing and prodding, until she found a really tender spot on the right side of my abdomen. She was worried it was an ectopic pregnancy, so called up the EPU and booked me in the same day. The EPU is based in the hospital, so I went in not knowing what to expect. They started with an ultrasound, which was inconclusive. I didn't even know you could have an "inconclusive" ultrasound. I was told there were "echos" of something, but they couldn't confirm it was a foetus, and they couldn't find a heartbeat. They assured me it was probably because it was still too early in the pregnancy to find a heartbeat/see anything, and the sonographer even said that she knows of women who bled throughout their pregnancy but still carried to term. I left, not really knowing what was going on – was I still pregnant? Was it ectopic? Was I miscarrying?
>
> I broke down and called my mother... We hadn't even told her about the pregnancy, and I called her in floods of tears, asking her what was going on with my body. She listened at first and flatly said, "It sounds like you have symptoms of a miscarriage." She was the first person to tell me… I was experiencing a miscarriage.

Birth was, of course, the ultimate way to "know" the foetal body. Georgia talked about her impending birth, saying she felt "braver now - I'm growing a human being, and I'm going to push it out…" so she needed to "woman up, basically." Others talked about the excitement to "meet" their baby for the first time at birth – particularly in the final weeks before the due date. Prior to this, however, "knowing" the "two" bodies always seemed to be borderline – perhaps, maybe, not quite, maybe two, but definitely one to the women themselves.

Further contemplating this brings about reflections on the position of others within their narratives. We create "others" within society through cultural images, often built upon social inequalities, contrasting identities, and clearly defined spaces. Behar (1996, p. 165) critiques this, arguing that "Our classical dichotomies of Self and Other, Subject and Object, the West and the Rest have become hopelessly inadequate in the face of feminist and minority cultural critiques…" Perhaps this two-and-one was never about being two. In describing the baby,

women described those that were most important to them. Even in my own pregnancy narrative, I spent one-fifth of the interview talking about my husband's experience of "being pregnant" by proxy. Another said it in a way that allowed her to transform her understanding of herself: "You are no longer you – you are you and your child. You are a mother." Pregnancy seemed to allow recognition of others in the self and of themselves in others and a new way to think about such connections. One participant took this further, reflecting how a headline news story of a boys' football team stuck in a flooded Thai cave upset her: "That's someone's son…you can feel what that mother must be feeling like."

6.3. The Case of Maureen

I found writing about bodily sensations from the perspective of participants to be difficult. First, it was not my bodily experience, so finding the words to articulate this accurately and meaningfully was challenging. Second, participants did not always reference their bodily sensations. They would often talk in terms of emotion or a physical response but did not directly reflect on their quotidian movements. As mentioned in chapter four, I gathered ethnographic data when I became pregnant partway through data collection. I asked a friend to interview me using a BNIM structure and kept a diary. Unsure of how to incorporate this material into my analysis, I essentially treated it like all other data in that the material supported the themes arising from the dataset as a whole. However, in the spirit of some of the phenomenological work done in pregnancy, I have written this case study to examine this data in more detail, exploring proprioception and my corporeal boundaries and incorporating data from my diary and interview.

I remember the first time I saw the foetus move. Standing in the shower, I looked down to see my stomach moving in waves before "this little mountain rose out (could've been a heel?).

Haven't seen anything so distinct about the baby [before]." Strangely, I felt strongly I could predict the movements. This was not a prediction of a pattern as such; instead, I would get a sensation when my foetus was about to move, or perhaps I could feel the beginning of a movement, before the baby more clearly kicked. I could also make her move. I could move myself, causing her to move, or prod in just the right spot to encourage her to move. As Young (1984, p. 48) described "I have a privileged relation to this other life, not unlike that I have my dreams and thoughts, which I can tell someone but which cannot be an object for both of us in some way." Sensing one another, moving together.

My pregnancy was probably "typical", if there is such a thing, except for one key feature. My foetus had what doctors called macrosomia, literally meaning "large body". At 28 weeks, my fundal height, or stomach girth, showed that I had grown to be about 20% larger than the upper limits of average. I felt fine; I knew nothing was wrong. Nevertheless, I dutifully completed a gestational diabetes test, and I attended regular scans in the final months to check on the foetus's growth and to rule out any of the typical health problems that cause macrosomia. The scan at 34 weeks showed the baby was already seven pounds, with a predicted final weight of over ten pounds. At the time, I wrote:

> …Now my stomach hits corners, hits the dining table, shoves anything in my lap out of the way (e.g. laptops), and hits my desk while I'm working. It's a bit painful too – it's not nice having a table or desk digging into your stomach. I long for the small baby bump – much easier to manage! Now it just gets in the way.

My pregnant belly made me very aware of not only my boundaries but also the boundaries of everything and everyone else around me. I described another scene at a play where I was sat in the middle of the row. The chair uncomfortably pressed against my lower back, and people continually tried to move in and out of the row. I wrote, "You literally couldn't squeeze me and another person together in the space. So my bump kept getting….bumped. It's happened in other places – I think I'll fit through somewhere and accidentally brush up against someone

with just my stomach." My proprioception was off-kilter, unable to precisely decide exactly which spaces I could fit in, and thus surprised when I could feel the pressure of something against my stomach. I reflected on the "constant adaptation to a bigger and bigger bump" and looked forward to when I did not have to "trail my dinner over the bump before it goes into my mouth…".

The size of my foetus probably also contributed to pregnancy-related pelvic girdle pain (PGP). The stretching of the ligaments during pregnancy sometimes causes joints to become loose and bones to misalign. The pelvic bone is separated into two parts connected with cartilage. As these separate to accommodate the size of my foetus, they rubbed together, creating strange sensations. Sometimes, it was a sharp pain, stopping me and making me aware immediately of my body's position and quickly forcing me to correct it to stop the pain. Other times, it was a dull, lasting pain, requiring ice packs to help reduce the inflammation, thereby immobilising me. Tasks that, previously, I could do quite easily became hard. By the end of my pregnancy, I struggled to even walk. But then, most things made me aware of my enormous belly pressing against my bones. Sitting for extended periods of time or in an uncomfortable chair became painful. At one antenatal class, we sat on plastic chairs for four hours, with only two breaks. Afterwards, I slowly hobbled to the car, with my stiff body unable to stand upright.

Diprose's (2002) concept of 'corporeal generosity" presents a model for thinking about the interrelatedness of bodies. Diprose (2002, p. 4) explained, "It is an openness to others that not only precedes and establishes communal relations but constitutes the self as open to otherness." Trying to shed an economic-driven idea of "gifting", she draws up an ethical and political argument that explains how subjectivity is reliant on relations. Hird (2007) then applies this to pregnancy, exploring the way genetic material, blood and the placenta all become "gifts" which constitute the foetal other. Diprose (2002, p. 9) observed, 'Accounting for the corporeal dimension of generosity allows the possibility of better locating the operation of social injustice

as well as the openness to others that would enhance its overcoming". It's important to note here, however, that Diprose assumes a *concept* of the corporeal, adhering to the idea that the body is discursively constituted, as she makes clear in her opening pages. However, Hird (2007, p. 12) interestingly applies these ideas to the physical body, focusing on the material of the pregnant body, noting, "The pregnant body represents a particularly potent site of corporeal generosity – an open process of bacterial, viral and micro-organism transfers." To this list, I would also add the pregnant subject's sense of proprioception, as well as her ligaments and bones. While not consumed, these are nonetheless used.

6.4. Concluding Thoughts on the Social Constructed Body

By scrutinising the processes whereby the materiality of the pregnant body shapes the imagination and potential aims of the pregnant self, it becomes clear how, in turn, the aims of the pregnant self shape engagement with the pregnant body. This chapter referenced relational models of subjectivity, specifically Browne's (2016) concept of a protopersonal sphere to help conceptualise "relational corporeality". Specifically, I have mapped out three key senses of knowing of another body within: feeling an other, telling others about an other, and seeing an other. In using the body to explain the other within, participants actively constructed another, which in turn created the role of child and mother. From these processes of knowing, telling, and seeing, participants also created parental scripts to follow, continuing an engagement with the body that reinforced being two. These processes of knowing, telling and seeing are often weaponised against pregnant people as a way of attributing foetal personhood, and thereby awarding rights, to another within the pregnant body. There is an underlying caution in defining assemblages, which leads to ontological assumptions of who is recognised and by whom. It should be noted that all participants wanted to be pregnant and decided to continue with the pregnancy at the time of the interview. This aim, therefore, will have shaped their experience

of their bodies and subsequent scripts and roles created to reflect this. This is not a testimony as to whether there are two, but rather how intentional and unintentional sensations, movements, and fleshy encounters impact subjectivity, reinforcing underlying projects. While the previous chapter on the constituted self examined how pregnant selves are shaped by discourse, this chapter explored a more internal construction of self/selves, which engages with materiality available to the body. It is a different aspect of the self, which reflects on both inner and outer processes to construct and affirm the self. In constructing another in their foetus, they inevitably constructed themselves as a pregnant subject.

These points are particularly important as conceptions of the boundaries of self and others continue to be pushed further. On 4 May 2022, the University of Cambridge hosted a forum titled *Ectogenesis: Ethics, Rights and Regulation*, featuring legal experts, including Chloe Romanis and Amel Algharani, and medical researcher Alan Flake to discuss the implications of the development of artificial wombs (Flake *et al.*, 2022). The critical point of discussion for the day was the legal implications of EXTEND, an artificial womb and placenta technology which acts as a fluid-filled incubator for premature babies or babies who may require foetal surgery. As the project moved into human trials, the most pressing ethical question for the forum was whether a foetus, transferred from the pregnant individual into the extrauterine environment, would have the same legal rights as any other neonate. When posed this question, Alan Flake was somewhat incredulous at the thought that this transfer would *not* be considered the birth of the child and replied that this was, of course, the same as any other birth via C-section and the obvious point to mark the child's birth. Algharani agreed to some extent that, although it is often confused that a foetus has no legal personhood, there was a well-established legal precedent which affords the foetus protection, especially where it can be demonstrated that the foetus was *capable* of being born alive, as this technology would demonstrate. Romanis, however, contended that Paton v British Pregnancy Advisory Service [1979] QB 276

established that birth affords legal personality, where it was ruled that “The foetus cannot […] have any rights of its own at least until it is born and has separate existence from the mother”. Furthermore, policies like the Births and Deaths Registration Act (1953) also stipulate that “complete birth” and “born alive” are thresholds of this legal status. At present, the “born alive” test considers whether a breath of air has been drawn (Romanis, 2020), which would not happen until a child was removed from the EXTEND incubator. However, this was not a simple argument, as Romanis (2020) conversely contended that the foetus is also not dead, as this is often measured by brain activity or heart rate, both of which could be measured. With a foetus being not dead nor born alive, EXTEND technology raises significant legal issues in the UK by redrawing the boundaries of what being “capable of being born alive” means, which, in turn, could have a significant impact on the rights and responsibilities of pregnant people. While medical and legal discourses continue to debate the status of the child, feminist literature also has an imperative to address the corporeal distinctiveness of the foetus if there is any hope to fundamentally impact the ontological arguments about the pregnant subject versus foetal subject and the complex ways in which pregnant subjects feel both distinctive and related.

Chapter 7: The Agentic Person

The previous chapter explored how participants observed and felt their bodies, which led to a protopersonal understanding of their foetus as distinctive to their pregnant body. Interestingly, sometimes women ignored "obvious" bodily sensations, only to later reflect that these were, in fact, signs of a change in self. Ignoring their bodies was often spurred by discursive understandings of what the body *should* be doing or feeling, and they tried to frame their own sensations within these boundaries. Medicalised and natural discourses treat pregnant bodies as passive, beholden to their biological processes which will revert to the "normal" self once the pregnancy ends. But what is a "normal" body for those who become pregnant? Chapter three examined the theoretical musings of the pregnant subject, noting the intertwined ideas of maternity and femininity. Historically, essentialist arguments supported the assumption that femininity required a body which was "naturally" able to conceive and carry a child, thereby imbuing pregnant subjectivity with gendered knowledge about what a "female body" is and does. This point has been critiqued by feminists offering a relational model for thinking about the body and subjectivity (e.g. Irigaray (1993), Diprose (2002), and Baraitser (2009a), and whose work has opened the conversation about what pregnancy can feel like and what that means for the pregnant subject. Pregnancy also expands boundaries, bringing to the fore some of the problematic nature of discourses and presenting materiality in which to practice new forms of embodiment. As chapter five showed, this corporeal understanding of themselves also elicited resistance to discourse. One of the critical functions of those dominant discourses is to build an identity around normative experiences. In this way, those discourses serve as a blueprint for stories, which allows others to understand the subject position but also around which to build an identity of self. This chapter re-tells counter-narratives or stories people tell and live that resist dominant cultural narratives, either implicitly or explicitly. Examples of resistance to medicalised and naturalised discourses have been touched on already, so this

chapter will build on this theme and examine how women built counter-narratives to dominant gendered discourses, specifically looking at the way the pregnant body can be used as a site of power to re-write ideas about what it means to be feminine.

Counter-narratives hold power to disrupt hegemony by "exposing the lies which hold together the ideological armour of the privilege, domination and oppression"(Fine and Harris, 2001, p. 14), thus allowing individuals the agency to examine, adopt, or reject narratives for themselves. Discursive resistance and counter-narratives can then expand boundaries and shift focus, creating space for alternative versions of the self that acknowledge and validate the complexities of people's lives. On a similar note, Freud (1900, p. 160) observed that "Everyone has wishes that he would prefer not to disclose to other people, and wishes that he [sic] will not even admit to himself". In the stories they tell, speakers reveal the power of counter stories to "expose the construction of the dominant story by suggesting how else it could be told" (Fine and Harris, 2001, p. 13). This resistance, sometimes viewed as deviance, poses a new challenge to making sense of the self and finding meaning outside what is normally available. New possibilities arise regarding how stories can be told and how the self can be understood. It also speaks to the possibility of both seeking and resisting subjection (and the space between this, if there is one) and opens up the conversation about the ability to have agency to not only choose this but influence others to take part in this counter-narrative.

Guilfoyle (2015) writes that these counter-narratives, or alternate stories, are often "relatively un-storied" or "easily co-opted" into dominant discourses. He goes on to explain that "people often disregard or disqualify aspects of their lives which do not fit with more dominant narratives…[and] the person may unwittingly close off openings onto alternative pathways and block their transition from constituted to agentive subjectivity" (Guilfoyle, 2015, p. 38). He then identifies two occurrences for these counter-narratives: "unique outcomes", or outcomes that do not fit with the dominant story and its cultural script, and "absent but implicit" stories

which are not explicitly told, but their hidden meanings are evident. These two narrative occurrences are interlinked: when something does not fit (unique outcome), it may imply or suggest something meaningful instead. This chapter examines three key counter-narratives: First, it investigates women's challenges to the shape and profile of the female body. A pregnant body convolutes the female body, presenting a new shape and prompting new ways for the women in this study to challenge and practice a different kind of body shape. Second, it details a case study of Caitlin, who challenged the narrative of a "sexual violence survivor" by resisting the medicalised procedures imposed upon her during pregnancy. Third, the chapter looks at presumed capabilities, further scrutinising the claims of "feeling fine" during pregnancy and how these claims resist the presumed capabilities of the women in this study.

Furthermore, McKenzie-Mohr and Lafrance (2014) noted that counter-narratives "not only change individuals' meanings of themselves and their lives but also alter our collective understandings". In other words, counter-narratives demonstrate agency in two ways: while they allow individuals to make choices about the meaning of their experience, counter-narratives can also persuade others of new meanings and understandings. In this way, counter-narratives attend to two aspects of agency: free will and the ability to influence others. These stories and the new positions that come with them demonstrate how the agency is practised, particularly by a group with clear cultural expectations, scripts, and sanctions for following dominant narratives. The consequences of not "doing right" in pregnancy carry significant consequences, and these counter-narratives provide a glimpse into the agency held by individuals to circumvent these dominant narratives and the processes used to garner support and collaboration in this effort.

7.1. (Re)Shaping

Beyond locating a person within their social groups, medicalisation has also historically defined the shape of a "normal" body. Recent decades have seen a significant rise in concern around fatness, even framed as the "war on obesity", where fat is equated to poor health and a failure of self-management. A 'maternal turn' in obesity research has placed pregnancy at the epicentre of this "war", both as a consequence and cause (Parker and Pausé, 2018). Fatness in pregnancy is regarded as one of the key factors in predicting childhood obesity, along with a risk factor for a range of pregnancy complications, including infertility, miscarriage, and stillbirth to the growing rates of cesarean section, postpartum haemorrhage and infection, neonatal unit admission, and failure to initiate breastfeeding. Even a recent public health announcement on battling childhood obesity focuses on pregnancy weight, reminding people that "there's no need to eat for two" (National Health Service, 2020a). Self-care and managing the body through "good" choices have become a key feature of foetal protectionism, denoting responsible citizens and, most importantly, capable parents (Lupton, 2012). Some notable research has also focused on the effect of weight expectations (e.g. Nash (2012b) and Pausé and Parker (2021)) or at least mentioned the impact of size on pregnant selves (e.g. Longhurst (2000b)).

At times, these concerns about pregnancy weight reflected some of the feminine ideals of slender bodies and striving to ensure the weight gain is minimal and reflects only the weight of the foetus and pregnancy tissue. As Ophelia wrote in her diary:

> At this point [approximately five months pregnant], I've gained about 25 lbs – that is not holiday weight! But to be honest, I'm not sure where it has gone. Many of my clothes still fit unless it's something that nips in at the waist (collared shirts, mid-rise trousers…)… I did have a friend though that commented 25 lbs sounded like a lot since that all she gained in her entire pregnancy (and I'm only halfway!). That comment affected me a lot more than I thought it would. I'm really not worried about weight – I eat when I'm hungry, I've gone off eating cakes and sweets (they taste awful to me for some reason), so it's all fruit and veg; I don't even own a scale, but I'm still about the

> same size everywhere but the stomach. I haven't even really put on any fat around my hips/thighs, which is what I expected. I'm an odd shape –everything is as it was than just randomly the stomach juts out just above the hip bones. I'm having a hard time with maternity trousers because they keep falling down – not because the bump band is too big but because I have too much room in the hip area. Despite knowing that everything looks and feels fine to me, the focus on the number was really disconcerting. It didn't help that [my husband] tried to "help" by making a joke about me not being able to eat something (I don't even remember what it was) – I just exploded at him. He totally didn't get why I feel sensitive about my weight because – obviously – I'm pregnant so of course my weight has gone up. But I do feel sensitive… and it's not even about the shape of my body; it's the number. This is why I don't own a scale. I'd obsess about it. I only know my weight because they weigh me every time I go to the doctor.

In this entry, Ophelia breaks down her weight, hunger, health, and clothing to question how much weight was "too much" in pregnancy. Conversely, there was also a concern over being "too" small and not allowing for "enough" growth within pregnancy. For example, Eva said, "Everyone – it seems – keeps calling me 'small'. I have been checking weekly, and I'm within normal weight gain for my height and previous weight. I don't know why we have the impression that pregnant women should look huge or fat almost instantly." In both of these examples, one where there was concern expressed over being "too big" and the other over being "too small", highlight normalised ideas about size. The focus on weight is hardly new for many pregnant people, especially as weight often defines the feminine contours of the body (Bordo 1995, Orbach 2009). Although weight was invoked, with the implicit notion that this was reflective of much broader ideas about idealised images of the body, which both women rejected, pulling in both corporeal feelings and wider experiences of body shape and size.

Beyond critiquing the expectations of shape and size, pregnancy also offered an opportunity to question eating habits, even at times recruiting others to defy expectations of food. Alison, whose preferred consultant was leading a diabetic clinic, recalled, "I sit in the waiting room with all these other ladies who obviously assume I am diabetic as well and I feel a bit guilty because sometimes they talk to me about the foods they can't eat and - I won't tell you that

actually I am eating all of that [laughs] every night [laughs].” Alison’s history of preterm labour gave rise to concerns over a weakened, cervix, so she stopped exercise and admitted that she “feel[s] a bit conscious of my shape and body, which is probably quite normal for lots of pregnant women”. She later reflected there is “lots of time after pregnancy to do these sorts of things” and admitted that she does “moan about getting big”. However, she also claimed to remind herself that she may not be pregnant again, so she’s “just trying to enjoy it”. Later, she invoked the idea of “enjoying it” again in relation to food, saying,

> “[I] felt a bit bad about eating so much, but then I can’t stop myself. It’s become a bit of an excuse. Certainly at work – so before I got pregnant, me and the girl I sit opposite were, you know, always be eating our rice cakes every morning and trying to be really healthy. Or we’d tell each other off if we were trying to have a biscuit. And now I feel sorry for her because I’m the one who’s like should we – I’ve brought some biscuits, should we have these? Should we have a McDonald’s breakfast? And she’s still trying to be good, whereas I’m just…enjoying it.”

Here, she overlaid the idea of morality, or what is “good”, with these expectations of food. However, when defying expectations, she also sought to include others, such as when she remembered passing a McDonald’s going from her antenatal appointments to work and decided that she “really fancied a McDonald’s”. When she got to work, she then asked everyone, “How about as a treat on Thursday, I get us all a McDonald’s breakfast?” She explained how she “used it as an excuse to everyone else so I could have what I fancied.” On the one hand, she acknowledged how much work she put in before her pregnancy to “eat healthy”, exercise, and how comfortable she felt at that size. However, her constant reminders to herself to “enjoy” the pregnancy and the freedoms that came with it were juxtaposed against the typical body maintenance norms. In this way, her pregnant body allowed her to question the typical, gendered expectations to moderate her fast food intake and exercise regularly and instead used her pregnant body, even inviting others to join her, as she used her pregnant body “as an excuse” also to rebel. Godrej (2011, p. 116) wrote about the ways in which counter-narratives are used as a linguistic reclamation to reconstruct identities, and explained that dialogical and narrative

reclamations will "[occur] within the context of communal support, in a space of public discourse. Engaging in the narration about oneself is a public endeavour in that it requires a group of others who give credence to and confirm the meanings and narratives that the self puts forth". Similarly, Alison leaned on her workmates to help her reaffirm the new expectations of shape and size. It also exemplified the extent to which a pregnant woman can resist dominant discourses surrounding weight and influence others to either accept this resistance or join in. Eva similarly explained,

> "[Husband] asked me today how I was feeling about the pregnancy. I know that he was fishing for an answer about something more specific, so I asked what he meant. He said because the belly is getting bigger, how do I feel. I think he was worried I might be upset with getting bigger because I think he's worried I might not like it or see it as bad. He had an ex who was bulimic, so I wonder if he's worried I might be going down a negative path. I am not. I'm quite happy with my size, and I was a little offended. I told him so, and he said his intention was to see if I felt invaded. I'm not feeling invaded, either. I'm (so far) feeling fine, normal and quite happy. I think baby is too. I guess he felt he needed to ask, and I'm happy he cares, but I hope he doesn't worry too much.

Importantly, these women do not use the language of nutrition, "obesity", or "overweight" to describe their pregnant bodies, instead relying on more relative words like "big", "small", or "normal". In writing her new narrative, she even sought to include her baby, noting her foetus was also "fine, normal, and quite happy" with the pregnant body. There is a broader acceptance now that biology is no longer destiny; the body can be shaped, perfected, and worked on to meet expectations, and body image (specifically size) can be worked on and changed (Bordo, 2004). Undoubtedly, many pregnant people closely monitor their weight, hoping to minimise risk to their babies, reinforcing their emergent maternal identities, as Lupton (2012) has argued. However, many participants centred resistance to these expectations on the body and, specifically, creating their own corporeal expectations of size and shape.

Looking the part of "pregnant" was sometimes equally important to women. Georgia, for example, tried to capitalise on her pregnant body when travelling. While waiting for public

transportation, she noted that those who were pregnant could skip the queue. Her husband encouraged her to "push out her stomach", exaggerating her pregnant state. She followed the plan, delighting that they did not have to wait in the long line. Even when not pregnant, the image of a large, pregnant belly has cultural capital and portrays a certain power of the woman's body. For example, upon learning she was pregnant, Queen Mary I sat at Whitehall Palace, "richly apparelled, and her belly laid out, that all men might see that she was with child" (Hayward, 2007, p. 168). It later turned out that Queen Mary I suffered from a phantom pregnancy, or false pregnancy, where she experienced classic symptoms of pregnancy (including a distended stomach) and believed herself to be pregnant, but she was not, in fact, pregnant. Those who could afford the luxury of showcasing their pregnancies in such opulent fashion did so through pregnancy portraits, which left the viewer "in absolutely no doubt that the sitter is heavily with child, and where this message is signalled in almost exaggerated fashion" (Hearn, 2020, p. 10). While the popularity of pregnancy portraits waned through the 19th century, that practice has been revived, with celebrities like Demi Moore, Serena Williams, and Beyoncé releasing spectacularly pregnant images of themselves. The display of pregnant bodies was not limited to onlookers either; personal writings of 19th-century women show their role in monitoring their weight and tracking their body's growth. Decades before doctors directed pregnant women to follow guidelines for "healthy" weight, they determined that women would measure their weight regularly while pregnant, even if it meant breaking social taboos like appearing in public while visibly pregnant (Withycombe, 2015). Monitoring weight allowed women to continue to access a unique insight into the patterns and growth of the foetus and became an important way for her to wield the power that came with pregnancy. Although weight is also hugely influential in medicalising the body, it continues to be a source of empowerment for women. Those who tracked their weight were able to use their weight gain and relative size to resist ideas about the "correct" size and shape. Likewise, "looking"

pregnant or alluding to their pregnancy allowed them to interrogate dominant discourses, thereby capitalising on the size and shape of the pregnant body to shun the gendered expectations of weight and food.

7.2. The Case of Caitlin

Increasingly, recognition of gendered discourses focus on the ways that women are physically harmed, as is the case in sexual violence. Within these narratives, language of "victim" and "consent" are especially important, as it helps to secure the rights of those affects (Alcoff, 2009). Sometimes, however, these discourses of sexual violence do not effectively consider the individual's desires and wishes, as was the case with Caitlin, who explained her situation as a survivor of sexual violence:

> I have to see a specialist midwife because I was raped when I was younger, and it's really difficult to talk about this stuff in front of her. And… she's a really nice woman, but it's really difficult…they keep on wanting to refer me to counsellors and stuff, and I'm actually like "I'm ok". And I know I'm ok! I've been in the situation before…where I know if I'm going downhill and I'm getting flashbacks… then I know when I need to seek help. But they're just overly paranoid about the fact that I'm pregnant, and they're almost trying to force it on me. And that's not been the best or the easiest. It's just that I'm trying to enjoy this, and I don't want to think about that time in my life.

For those who have experienced sexual violence or trauma, it is a standard protocol within the NHS to refer them to a specialist midwife. McKenzie-Mohr (2014) shed light on the underpinning discourses surrounding this policy, and identified two dominant discourses of sexual violence: the "negate or blame" (where victims either need to rapidly "move on" from the experience, or are victimized again by being held responsible for the experience) or the "rape as traumatic" discourse, which has been advocated by feminists and health care professionals in response to the "negate or blame" discourse. As part of the care provided during these specialist sessions, the midwife and counselor may revisit the trauma through therapeutic interventions or try to talk through how previous trauma might be affecting their

experiences of pregnancy. When Caitlin said she did not want these sessions, the specialist responded, “Well you kind of have to have them”. Ironically, these sessions are framed as “support” for survivors, although Caitlin was left with no ability to consent to this support. Nevertheless, Caitlin dutifully folded to this structure – for a time.

Because of Caitline’s work schedule, however, she was only able to attend the specialist’s clinic on a day where it was held in the local hospital in a mental health unit. Caitlin recounted the experience of going to one of the specialist’s sessions:

> You go into the building and you have to be led everywhere, because the doors are locked because they – obviously - have patients in there who by law can’t leave or escape. So you have to be walked everywhere by someone. This is just too scary, I’m pregnant and when you’re pregnant you just get more worried about your body and falling over and hurting yourself. So I just started becoming paranoid about going in there. And because I have been raped, I don’t like being trapped. I don’t like being in situation I can’t get out of. I wouldn’t be able to get out of there without someone, if that makes sense. And there were alarms constantly going off because people were… I don’t know. Doing whatever…

Caitlin attended a couple sessions, but then told the midwife on the second visit, “I can’t come to this anymore. It’s actually more traumatizing to me.” Caitlin further explained, “I have had therapy. I have had flashbacks. I’ve had issues like that… If I needed this, I would refer myself to it. I really would. They’re just forcing it on me.” After speaking with her husband, who encouraged her that if she did not have to go, she told the midwife she would not come back. The midwife instead referred her to a specialist nurse who would come to her house to speak to her at home. Caitlin reflected, “They constantly need to force it on me, because it makes me feel I am unwell when I’m not. That’s upsetting. I feel like I’m not in control, and this time in my life I need to feel like I am in control.” Within any narrative, subjects are positioned in particular ways; either allowing them a great sense of worth and agency or framing them with lesser worth and agency. Caitlin’s identification as being deprived of control indicates some level of what Nelson (2001) called “injured identities”. A person's identity is injured when a

powerful social group, like the NHS, unjustly prevents members of less powerful group, such as pregnant survivors like Caitlin, from occupying social roles or entering into relationships they members themselves consider identity constituting. Caitlin's resistance to being a "trauma survivor" sparked further need to for the specialist midwife to find another route of compliance. Eventually, Caitlin rejected the home visits as well, and called on her husband to ensure that she would not have to continue specialist sessions. This final end to the counter-story engaged in "narrative repair" (Nelson, 2001), enabled by her husband and justified by her visceral response to attending the clinic sessions. She concluded by observing that before becoming pregnant, she was not confident in confrontations, but pregnancy "Gave me more confidence…to say no."

7.3. (Re)Power

Feminist scholars have detailed ways that hegemonic discourses are oppressive to women, with earlier frames of body shape and sexual violence already explored. Such discourses also position women as "less able", with gender bias in neuroscientific studies reinforcing such truth claims (Fine, 2011). The pregnant body poses an interesting conundrum where the physical symptoms typically impact day-to-day living, rendering the pregnant body as passive. Medicalisation has certainly impacted this view, normalising what should or should not be done during pregnancy. However, the women in this study often brushed these expectations off, claiming they were "feeling fine". After a time, it seemed almost a strange phenomenon in which participants would list off a long, descriptive list of ailments, limitations, and generally unpleasant conditions but then finish saying that they were "just getting". For example, Ophelia described her pregnant life as follows:

> [M]ostly business as usual – although I do have some strange symptoms that I've never had in my life pre-pregnancy. Like daily nosebleeds, which are annoying

> because sometimes I accidently get blood on clothing, bedding, etc. And fainting spells! The most recent one landed me in hospital for observation. It happened during a pre-natal appointment, and the midwife gathered that I'd fainted at work only days before… so she called up the hospital to get me monitored. There was no underlying reason found – just low blood pressure I guess. I had low pressure pre-pregnancy, and I was surprised to find pregnancy lowers blood pressure further. I would've thought the opposite, with the extra 40-60% of blood going through my body. But the foetus takes it all! So it actually lowers the mother's blood pressure. In any case, I've now had to just tell people not to worry if I pass out – I'll come around in a minute or two. I've also had pelvic girdle pain, which is basically where the ligaments become too loose too soon, so my hips are out of alignment. I've scheduled to see the NHS physiotherapist, but the soonest appointment was a month away. So I'm just waddling around ignoring the pain for now. At least I can still walk! Although that is relative – I do have a lot of trouble standing up, flipping over in bed, and sitting down on certain types of chairs... Probably sounds awful, but I've found ways to cope.

Upon arrival to an interview in mid-summer, Susan explained how she was completely swollen and only capable of waddling in any trousers or shorts, so she decided to "go with it" and dress as a "goddess" in a flowing, pleated dress. Another Caitlin, also in her third trimester in mid-summer, lamented how her feet were so swollen she had had to buy new "boring but functional" shoes to combat her feet being painfully pinched in her shoes. Despite all these challenges, women continued to just keep going. As Georgia observed, "I've never been one to let pregnancy take over." Women often talked about "going about everyday life" as though "nothing had changed" despite those feelings of sickness and burgeoning changes in their bodies. In many ways, their lives had not changed. Their personal and professional lives continued, sometimes aware of and sometimes not aware of her pregnancy. Despite the physical challenges, these women's counter-narratives came through their insistence to carry on, despite it all. For example, Georgia was advised by her Pilates teacher to not to do specific exercises, and she exclaimed, "I was just like, 'No! I want to do it!' I remember thinking 'I want to be like everyone else. I want to carry on just as I have.'" While she made some adaptations, she continued to practice yoga until the end of her pregnancy. Eva had a similar experience, but in a yoga class she was teaching. Someone in her class warned her of an acquaintance whose baby

"dropped out early and died" as a result of yoga exercises, and she advised to Eva not to carry on with the class as a precaution. Eva, indignant at this, carried on as before, ignoring this advice in favour of her own corporeal knowledge of her body and her training for maternity-specific yoga poses.

When pregnancy became more apparent, however, it could signal to others that power could be easily exerted over the pregnant individual. For instance, Ophelia was denied a soft serve ice cream (presumably, because it contained raw egg, although she was not entirely sure), so she left the shop empty-handed. Both Eva and myself had experiences where we were told not to climb on ladders while pregnant, despite both of us feeling capable of doing so. Sometimes women alluded to this themselves, such as one participant who described a feeling of waiting, saying, "It's like being in the most boring airport lounge. It's like watching really crap daytime TV… I'm physically and mentally exhausted, even though I've done nothing. Just waiting." While sometimes participants fell into a more passive life, other times they resisted, continuing to draw a counter-narrative against this passivity.

At times, this counter-narrative became apparent, even to women themselves. Ophelia, an educated woman who took part in a range of prenatal class, described her experience of a hypnobirthing class.

> They did show two videos of births, which was difficult. I just stared at the floor. I don't mind something from a woman's point of view – if she held the camera or spoke into a microphone – but a video taken from an external position renders the woman as something to watch. It doesn't help me understand how I'll feel during and after the process. I imagine it would help my husband, who does see from that point of view. There is a strange internal/external tension. While hypnobirthing is meant to be woman-centred (re-labelling language, placing her concerns at the centre of care, etc.), this film stood in stark contrast for me personally. Some of the language used in the video as well – "I breathed out my baby" – seemed to take all the work that woman do physically during pregnancy and birth completely out of the equation. There's so much focus on relaxation, they forget that there is a real woman behind the pushing, suppressing stress and anxiety and carrying the baby to term.

While pregnant people are not confined to private sphere, as they have been in the past, there is still debate over what roles and capabilities those bodies can have. Perhaps this is not surprising since pregnancy is not experienced regularly by those in power. In 2018, Jacinda Ardern, Prime Minister of New Zealand, became the first world leader to be pregnant and give birth while holding office and the only second world leader to confirm being pregnant while in office. Benazir Bhutto, Pakistan's late Prime Minister, was also pregnant while in office but, unlike Ardern, kept her pregnancy shrouded in secrecy and purposefully led a campaign of misinformation to keep her due date confidential and prevent political manoeuvres from eliminating her as a candidate for Prime Minister in a snap election. Perhaps unsurprisingly, in an almost ultimate counter-narrative to the idea of a passive, resting, or even incapable body, women chose to keep their pregnancies secret for as long as possible, coping with any physical discomforts in effort to stop others from treating them differently. The "quiet secret" of pregnancy is less about not sharing and more about not recognising or attending to the social expectations of those who are pregnancy. Choosing to "not share" pregnancy was highly influential to the individual, as it allowed them to be able to continue to act in ways that suited them. And this is how many women started their stories: pregnancy was a "little secret", and they just got on with life as usual. One explained it was "more in the forefront of your mind" after some kind of confirmation of pregnancy but that she "didn't want to tell anybody" and "didn't want to dig into it too deeply". Another said, "I found out and started doing the things you are supposed to do. But then not a lot changed." Still, another proclaimed, "You've got to be the person you always were – get up and do the work and do the things you were always doing. But you're starting to go through this monumental life change. It's bizarre." Pregnancy was often used as a frame for interpreting individual's decisions and abilities, regardless of whether they related to the pregnancy or not. In an effort to avoid being read through these frames, women thus kept the pregnancy a secret.

7.4. Concluding Thoughts on the Agentic Person

Feminist critique has highlighted how these medical and legal discourses have silenced women's voices in issues related to pregnancy and refocused the public eye away from the woman to the foetus. While these conceptualisations have certainly positioned the pregnant body within a very limited space of movement, it is important to remember these conceptualisations of the foetus and its place within the pregnant body are situated within a particular historical and cultural location. Discourses provide individuals with identity and a structure in which the world can be understood and organised. A counter-narrative, however, gives the person a place, delineates their role, and what the expectations of that role are, which will make the narrative make sense. Counter-narratives give space to challenge dominant discourses which alienate the subject from themselves. This chapter explored three such counter-narratives, including where participants were able to challenge ideas about the "normal" size and shape of the body, reflecting on how their pregnant bodies allowed them to contravene bodily maintenance that would typically be expected of the feminine bodies. At times, they even called on others to help counter such expectations. It also discussed the case of Caitlin, who provided a counter-story to being a survivor of sexual violence. While her pregnant body framed her as someone who required specialist support, she resisted, eventually ending specialist support in favour of adopting an identity of someone who is "just" pregnant, not a pregnant survivor. Finally, the chapter also explored counter-narratives to the passive, powerless pregnant body, critiquing expectations to "do nothing" while also combating the multitude of bodily changes requiring physical labour. Freeman (2002, p. 298) stated that counter-narratives are those "culturally-rooted aspects of one's history that have not yet become part of one's story". While these counter-stories appeared in pregnancy, it may be likely that some of these disappear as pregnancy ends. For instance, I expect gendered expectations of

body shape will return once their bodies are no longer pregnant. However, it also demonstrates how the pregnant body serves as an important material site for the practice of agency. On thinking about this during my pregnancy, I summarised in my diary:

> I've been really toying with the idea of "using it [pregnancy]" to my advantage… However, there's opportunity here to re-shape so many other aspects of my life using pregnancy as my way of becoming visible in a way I wasn't before. I almost feel as though there might be a bit of fear – but not over me. Over the pregnancy – what if the baby is hurt? The combined mother+baby is more powerful than just woman alone. So I get the idea of women "using" their pregnancy as an "excuse" – it's not. It's a source of corporeal power.

Chapter 8: Conclusion

When I first started my research into stories of pregnancy, I was not, nor had ever been, pregnant. I was not particularly interested in reproduction *per se*; instead, I was interested in how the self is negotiated through experiences of the physical body. The liminality of pregnant and foetal bodies – "with all their attributed conceptual liabilities and somatic messiness" (Gottlieb, 2000, p. 58) – was explicitly a biological process in which the self was made and remade and perhaps offered an opportunity for theorising of all bodies as unfinished projects. At the start of this thesis, I argued that pregnancy provided a "critical case study" in which the lived experiences encompass both rapid bodily and identity changes, offering an opportunity to explore the links between body, embodiment, and identity. The ability of the pregnant body to act, grow, and move without the conscious direction of its subject is certainly unique; even internal organs are rearranged, impacting involuntary functions like breathing, digestion, or heart rate. The changes in social interactions, including what a pregnant person is/is not allowed to do, and the ability of others to perceive this bodily change present another dimension of dramatic transformation. Pregnancy brings the body overtly to the fore and poses a challenge for sociology, given how physiological the experience of pregnancy is. In exploring pregnant embodiment, I wanted to better examine the links between the body and identity and better understand how sociology can be used to investigate the materiality of the body.

Furthermore, however, I was influenced by my own background. Raised within an Irish Catholic family in the United States, where reproductive rights continue to be compromised within a febrile atmosphere, the research question I wrote on my proposal forms at the start of this PhD specifically aimed to explore bodies – that of a foetal body and a pregnant body – and the boundaries between them. Problematically, this research question assumed, at least to some extent, that pregnancy would result in a child. The research process, however, has given me a slight paradigm shift, allowing me to think about how my pregnant participants dealt with

change in their lived experiences and how this helps us examine our own borders and boundaries of the self. This research project has sought to identify the embodied processes, discourses, and narratives that help configure the pregnant subject in their own right.

8.1. Reflections on the Research Question

In the chapters where I summarised my findings, I explored how personhood is constructed through bodily experiences, how the body is shaped, moulded, and seen through discourse, and how the body can serve as a corporeal site for agency. These chapters – "The Constituted Self", "The Socially Constructed Body", and "The Agentic Person" – represent my effort to highlight the central importance of the body in shaping different aspects of the self. In other words, individuals cannot express identity and agency or situate themselves within discourse without a body to locate them. Within "The Constituted Self", I examined the role of discourse within pregnant people's lives, specifically focusing on medicalisation and naturalisation of the pregnant body. Both discourses are well-recognised within the field, and both have been shown to position the pregnant body as either an object of study, in the case of medicalisation, or as a passive recipient of the biological body, as is the case in natural discourse. These discourses, however, are part of an ongoing process which adapts and transforms to society. The shift to patient-centred care gave participants some space to resist becoming medicalised, but also invited them to take an active role in medicalisation. The case study of Florence reinforced that discourse relies not only on language, but also on context, and specifically the relations to significant others, to maintain some level of autonomy and resistance, calling into question the policies that restrict who can be present during medical appointments and birth. "The Socially Constructed Body" began by questioning the extent to which current, relational models of subjectivity allow for corporeal distinctiveness. Given many of the debates surrounding reproductive rights revolve around this very, ontological assumption of "how many" are

present, feminists have skirted this issue by placing arguably heavier emphasis on being one body (as in "my body, my choice"). However, this chapter validates the corporeal distinctiveness felt by participants, and used Browne's concept of protopersonal to explore the bodily sensations of "knowing" and "seeing" pregnancy. Importantly, this chapter again reinforces the central importance of others, noting how the foetal body was first constructed corporeally, but shared with others, noting a particular issue over controlling who could also "know" and "feel" and when. The final analytic chapter, "The Agentic Person", explores the counter-narratives that arise during pregnancy. These challenged dominant discourses not only of medicalisation or the "natural body", but also of gendered discourses. Examining issues of weight, sexual violence, and assumed capabilities, this chapter explored how participants used their pregnant bodies as a material site of agency to question, evaluate, and choose a different story to their experience, which did not always follow discursive expectations. All three chapters address different aspects to the self, with a particular focus on the role of the body in allowing participants to write and tell their story of pregnancy.

8.2. Reflections on the Field

A number of important trends have emerged in the discussions of this research project in the way pregnant subjects are conceptualised, portrayed and treated. First, pregnant people actively construct the personhood of their foetus through embodied processes, acting as gatekeepers to "knowing" the unborn. Previous literature has often argued that medicalisation has weakened the ability of a pregnant subject to "know" their bodies and effectively works to erase the pregnant subject in favour of the foetal subject. The participant narratives in this study, however, show the specific, embodied ways in which pregnant people continue to share knowledge and, specifically, actively construct the personhood of their foetus. This, in turn, also shapes identities through the relationship formed with this newly constructed person.

Second, pregnancy choices are defined by dominant discourses of medicalised and natural pregnancy. These discourses can be set in contrast to the other, where "natural" pregnancy is often seen as the opposite of "medicalised" pregnancy. These discursive positioning further communicate the morality and beliefs of their pregnant embodiment, with a "natural" pregnancy often viewed as the purest or most moral choice. Third, pregnancy provided space and configuration to challenge the bodily norms from pre-pregnancy forms and highlighted (often feminine) bodily norms that individuals sought to expose or defy. At least historically, the pregnant body has been viewed as representative of pinnacle femininity. While this is a changing norm, the tendency to measure a woman's worth by reproductive and mothering capacity is so deeply embedded in the social fabric that it continues to impact women today. The juxtaposition of the pregnant body (a potential demonstration of "peak femininity") with decidedly unfeminine behaviour or appearance gave space for individuals to explore how such counter-narratives feel, leaving the potential for future modes of being.

The field of body studies, predominantly influenced by feminist research, has grown significantly in the last thirty years. Young's (1984) phenomenological account of her pregnancy was foundational to work done on pregnant embodiment and subjectivity. In her work, she examined how the increased medicalisation of pregnancy has progressively alienated the pregnant subject from their own reproductive and bodily processes. The impact of technology and medicine effectively worked to silence and erase the pregnant subject in favour of examining the foetal subject. This research spurred a myriad of further research into the alienating impact of medicalisation on the pregnant body (including, for example, (Petchesky (1987), Duden (1993), and Lupton (2013). However, the cultural practice of medicine and technological advances have changed significantly since Young's work. For example, the technologies of foetal imaging and diagnostics are now so routine and embedded in pregnancy norms (Young's pregnancy would have been in the first years of introducing ultrasound

imaging) that pregnant people use such images to support and construct their own narratives about their pregnancies. There has also been a rise in "natural" choices, led in the UK by Sheila Kitzinger in the 1990s (just a few years after Young's work on her own pregnancy). While it is clear there remains a medicalised discourse which is often set against a natural discourse, this research shows how pregnant individuals both embrace and reject medicalised selves. As one participant acknowledged in a conversation with her doctor, there is still so much medical science "does not know" about pregnancy (to which the doctor agreed). While medicine undoubtedly maintains a hierarchical control over lived experiences, its "expert role" is now also outsourced to pregnant people themselves through self-monitoring and making the "right", or simply moral, decision about how to experience pregnancy. Narratives in this historical and social situation have changed away from alienation and toward "informed" medical "choices", which include "naturalised" options (at least in rhetoric). This research further interrogated what is meant by medicalised and natural pregnancies and how power is negotiated within these discourses.

Young's work was superseded by a significant movement within sociology to "bring back the body" and acknowledge its, as Leder (1992) put it, "absent presence" within sociology more broadly. Turner's (2008) seminal work explored the paradoxes of how the body can be both a set of cultural practices and a physiological and material assemblage. He explained, "The body is the most proximate and immediate feature of my social self, a necessary feature of my social location and of my personal enselfment and at the same time an aspect of personal alienation in the natural environment," noting that the body is both material and physiological *and* an elusive marker of the subject's place in the social world (Turner, 2008, p. 43). How bodies are experienced is invariably social, and this research project has aimed to explore the social stories told by those with this experience. Feminist literature has long focused on the status of a foetal body, trying to explain how something can exist in a material form and yet be defined as a

cultural entity at the time. This research explored some of those meanings for pregnant people, examining how their own corporeal experiences help to build personhood and even the personality of their foetus. These processes examine the body's central role in constructing otherness, which in turn can reinforce changes and adaptations in identities. In some instances, words seemed to fail to describe these processes adequately, and participants made up new configurations, such as one participant who wrote in her diary of the power associated with being “mother+baby”. Shilling (2012, p. 5) conceptualised this as a body project, or something which “should be worked at and accomplished as part of an individual’s self-identity”. The development of participants sometimes instinctively “knowing” another, to being able to “instinctively” feel, or move, their foetus, to eventually “seeing” their child also represented something about the identity being formed around the identity of themselves as parents.

Bringing the focus back onto gestating subjects, there are calls for a clearer concept of gestation, which does not rely upon a foetus to be in competition with pregnant subjectivity. One branch of feminist scholars used the pregnant body to present a relational account of pregnant identities and embodiment (for example, Maher (2002), Hird (2007), Martin (2010)). Maher (2002) argued for the need to look at pregnancy for its possibility of creation, whether that is parental scripts or the creation of others, upon a corporeal site, namely the placenta. Hird (2007) described this sharing as corporeal generosity. A relational account, however, requires the view that pregnancy would result in a child. Browne's (2022) work on miscarriage, explicitly looking at pregnancy which does not result in a child, critiques the future-oriented approaches in pregnancy, defaulting to “milestones”, such as check-ups and growth scans, instead of focusing on the present and whatever that may mean to the person who is present. One participant, who had given birth at the end of her second trimester twice, noted that she just wanted to “enjoy the pregnancy”, a sentiment repeated by several participants as they recognised the temporality of their pregnant state. This research describes these moments of

just “getting on” and eluding the dominant, medicalised notions of pregnancy and feminine ideals by calling on their present bodies to express their desires and feelings. This pregnant subjectivity fell into discourses that framed pregnant individuals as parents-to-be but circumvented these to test new ways of living and enjoying their unique shapes and boundaries.

8.3. Reflections on Methodology

While this project aimed to contribute further discussion for the body of research on reproduction, it also spurred some reflection on good methodology practices. As part of the process of learning within the PhD, I attended specialist training with Tom Wengraf to learn how to use the biographical narrative interviewing method. The 5-day intensive course explored the theoretical underpinning of the method, gave ample opportunities to practice interviewing with a single, narrative-inducing question (SQUIN), and went through examples of analysis. Even with training, I was very aware throughout data collection how experience can help aid or hinder an interview. At times, I felt awkward and unprepared, having only a single question to ask, with a clear imperative not to interrupt the participant’s narrative. I became acutely aware of my own embodied processes as part of this: how to hold myself to show active listening, how to respond without words, and how to build a rapport without a conversation. While some of these reflections are covered in chapter 4, further experience collecting data may yield further insight into embodied processes of research.

Embodiment of the research process is not simply about the data collection; a similar point of embodiment can be made about the analysis. BNIM is well supported and complimented by other well-known methods, like Rosenthal’s Quatext “mix of methods” and Jefferson and Holloway’s free association narrative interview method, all of which aim to capture data from the life history *and* the data collection moment itself. After each interview, the BNIM procedure

specified that the interviewer should do free association writing for a time (up to an hour) to record observations, any recall or specific parts of the interview that particularly struck the interviewer, and anything else that came to mind. These reflections served as an important element of analysis and documentation of the interview's context. Flynn and Wengraf (2021) argued this free association writing and other similar documentation can serve as a reminder that it is not simply participants who tell stories as "defended subjects", as Hollway and Jefferson (2012) have argued, but it is also the interviewer who has a defended subjectivity. Within her work, Flynn found notes from the free association writing, which were used as a kind of "audit trail" of her assumptions and biases and later served as an important point of triangulation. Revisiting the interview context gives an opportunity to see where analysis has been "seduced by the story", as in Flynn's case, or simply wrapped up within the cultural moment of the interview, changing the understanding of the participant's story. Within this research, this free association writing lay in the background until I revisited it in the writing process. By this point, I had already begun the process of analysis and writing. There is also an evident growth in confidence, where earlier field notes speak to the discomfort felt during the interview (for example, figuring out how to pose me, as discussed above). In contrast, later field notes focus much more on the participant and how they held themself during the interview. My focus throughout the research process shifted, and I expect my interview conduct to reflect this as well. Specifically, my third participant gave the shortest narrative to work with – approximately seven minutes before she stopped and said she could not remember much else. In the free association writing, I mentioned how I had no idea what to do at that point and started talking to myself to fill the silence. In later interviews, however, I was much more comfortable with silence, giving participants time to stop, think, and carry on. Whether this was a development of interviewing skills or a different state of mind, the narratives of later interviews seemed much more detailed, including the longest narrative of about 46 minutes.

Consideration of free association writing (or field notes or research journals) seems to be at least a good practice, but also a useful insight into reconstructing the historical situation of the interview itself. It also points to the ways in which researchers may be influenced, not just by a participant's told story but also by the story they tell themselves of how the research was conducted.

The free association writing also reminded me of particular incident narratives (PINs), which stuck in my head immediately after each interview. When reviewing transcripts, however, it was not as apparent what I felt at the time of the interview was so obviously a PIN. As I read these within my written reflections, I decided to return to the audio files rather than work with the transcripts. I used an edited transcription approach for this project, which involved editing for readability. The transcription approach is detailed in Appendix C and includes a range of sounds, including non-verbal words (e.g. "mmmm") or emotional sounds (e.g. notations on crying and laughing). It made me wonder what the audio files might offer that the transcripts, using this edited transcription approach, did not. There is a whole body of research within psychology dedicated to the way text is read and, specifically, how the brain aims to efficiently read by skipping over what is deemed "predictable" or too short to matter (e.g. Rayner *et al.* (2016). Reading transcripts, then, becomes a task of close reading, but even still, the flat text still seemed to leave something out. Roller and Lavrakas (2015) pointed out transcripts are simply a device which can distance the researcher from the reality of the data collection moment. My transcriptions, for example, did not consider pauses, fluctuations in the voice, or the speed at which stories were told. Analysing with audio alongside transcripts helps to recall peripheral but valuable content and examples and reinforces meaning by providing a broader context. There are some tools to help create better transcripts. One project, the Speech Data and Technology project funded by CLARIN EU, brought together social scientists, data archivists, and software developers to conceptualise a "transcription chain", or a workflow of

tools that could be used to enhance interview transcripts (Scagliola *et al.*, 2020). The transcription chain starts with an audio file, transcribed using automatic speech recognition software before adding in a range of further annotations, including speaker allocation, emotion markers, speech velocity, and analytical notes. Much like how free association writing can help to contextualise the interview, the audio can also help to contextualise stories as they are told and add further dimension to understanding that transcripts may leave out.

Finally, analysis is not only nuanced in how data is read or heard but also in the level at which analysis is done. Exploring situated subjectivity – that is, the way their sense of self is formed from the social processes going on around them, as well as the internal feelings and reactions to those processes – allows analysis at multiple levels. While most of this analysis followed a thematic analysis, focusing on the micro-, individual experience, there was also scope to do 'whole case' comparisons, as seen in chapter six with an exploration of Florence's experience of pregnancy during COVID-19. In exploring the interviews at different levels, dominant and less dominant perspectives and emotional and contradictory lines of thought emerge. Trying to articulate the contradictions and, sometimes, opposing views was a challenge throughout, as it often felt like for every conclusion, there was at least one example of contradiction. Some of these I addressed directly, like in chapter six, where I structured the chapter around the medical versus natural discourses. Participants often expressed a desire for a "natural" pregnancy while fully embracing a "medicalised" pregnancy. Similarly, the counter-narratives in chapter seven often describe moments of subjugating the pregnant body (to medical rules or general social norms) to, paradoxically, break the norms that restrain feminine bodies. Writing, consequently, became a prolonged, arduous process, with several re-writes or false starts before finally settling on something. While I aimed to construct a multi-dimensional explanation, as the method allows, I would benefit from secondary analysis or further analytical strategies to maximise the value of the data.

8.4. Future Research

While there is still much to explore within this dataset, there are also related areas deserving of research attention. Research on reproduction seems to be having its moment following the plethora of political, medical, and ethical moments related to reproductive rights. Just within the last five years, the world has seen abortion rights challenged, in the overturn of Roe v Wade in the USA and the 2020 Constitutional Tribunal in Poland, as well as greatly expanded, as in the repeal of the 8th amendment in Ireland. Within the UK, the limits of abortion rights have been tested in the very public trials of three British women who allegedly terminated their pregnancies outside the 28-week limit of the Abortion Act 1967. There are also significant medical advances, including the first human trials of the EXTEND ectogenesis project (De Bie *et al.*, 2023) and further clinical trials of a new male contraceptive pill (Balbach *et al.*, 2023). Alongside these advances are arguments over advancing medical research, including renewed calls to raise the gestational age of embryonic stem cells used in medical research from 18 days to 28 days (Appleby and Bredenoord, 2018), which could greatly expand existing knowledge of embryonic life, but also challenge notions of personhood. While these events themselves call for further research into reproduction and its effects on reproductive bodies, there remains a real debate over how the voices of those who are reproducing are represented within these narratives and research. Moreover, political changes in reproductive rights continue to highlight how difficult pregnancy can be on the body and the lasting impact it has on identity. High-profile pregnancies, such as those of Serena Williams and Kim Kardashian, both of whom nearly died through complications within their pregnancies, have revealed how those who are pregnant are still ignored or silenced, sometimes resulting in early and unnecessary death or life-changing disability of pregnant individuals. As Browne (2022) has pointed out, political, legal and medical discourses need to shed assumptions that pregnancy and all the embodied

processes and identity changes happen regardless of whether a child is born. This further research needs to find a way to balance notions of personhood, reproductive rights, and treatment of pregnancy so that it acknowledges the pregnant subject as a being rather than a state of becoming.

In addition to continuing the exploration of gestational stories, this research has also raised the importance of exploring the stories of companions during pregnancy. During COVID-19, research found that the role of companions throughout pregnancy was vitally important to avoiding emotional trauma during pregnancy. Surveys like Sanders and Blaylock (2021) and Andrews, Ayers and Williams (2022) showed that COVID restrictions in maternity care, including not allowing companions into routine antenatal appoints or excluding them from maternity wards during/after birth, had negative impacts on pregnant people and their families. Other research, like Kendall-Tackett and Beck (2022), explored the effect of COVID-19 restrictions on medical professionals, including obstetricians, nurses, and midwives. They found that medical professionals experienced "moral injury" caused by witnessing people labouring alone and parent/baby separation. This moral injury was found to correlate with more medicalised decisions, such as opting for Caesarean sections, to avoid the possibility of traumatic births. Examining the stories of those surrounding pregnancy and birth may help to ensure those supporting pregnant people are fully able to do so.

This research project, however, has highlighted how pregnancy and birth companions play a larger role than simply treating or helping pregnant individuals. They become part of embodied processes, serving to reinforce the discovery of "knowing", "feeling", and "seeing" the foetus, as described in chapter 4, and can help to play a role in counter-narratives, as discussed in chapter 7. Research on secondary trauma faced by companions who witness their partners going through traumatic pregnancies and births could serve to expand the support and resources available for pregnancy more generally. A recent survey of new mothers found up to 45% of

those who give birth experience traumatic births (Beck, Watson and Gable, 2018). Daniels, Arden-Close and Mayers (2020) have noted that, although there is a recognition that birth partners can experience post-traumatic stress disorder, research on birth partners remains limited. There is a historical precedence for the relatively small focus on birth partners, not least being that, within the UK, partners were not allowed to attend births until the 1970s, relegating pregnancy and birth to "female concerns" (King, 2017). This attitude toward birth partners continues to be reflected in UK policy, where male partners are only listed on the birth certificate or given parental responsibility when married to the mother or as dictated by the court system. Despite this, there is a rising trend of birth partners attending the birth, with up to 90% of birth partners accompanying their partners into the delivery rooms (Redshaw and Henderson, 2013). Further research is devoted to the voices of those who provide companionship to pregnant individuals and who, as noted in the discussion around medicalised pregnancies and natural pregnancies, serve a more significant role in pregnancy than simply witnesses.

8.4. Concluding Thoughts

What is perhaps the most illuminating point to reflect on within this project was how pregnant people navigated a world defined and made by those (often) without tacit knowledge of pregnancy. In this way, it seems pregnancy, as a form of embodiment, may pose an example of ways of thinking about other types of bodies, equally existing and performing in a world often made without the tacit knowledge of the challenges faced by that particular form of embodiment. As Mullin (2002, pp. 40–41) explained, "It is only when we stop thinking of pregnancies solely in terms of whether or not they end in the birth of children that we can start appreciating their full significance… It is only when we start paying attention to women's [*sic*] experiences of change during pregnancy that we can begin to appreciate what these

experiences may have to tell us about the borders of the self, the boundaries between persons, and the relationships between our bodies and our plans."

How others relate to the pregnant body plays a significant role in shaping pregnant subjectivity, which often uses frames of medical, legal, or political discourses. Many of these conceptions of pregnancy leave little room for the consideration of the pregnant individual's subjectivity, either by erasing their voice entirely (as many medical and technological advances have done), speaking in their place (as many policymakers have done), or by emphasising the distant, perhaps never-to-materialise role as parents for another (specifically, a child, whose subjectivity is posed in competition to those who are pregnant). The project has not, nor did it ever aspire to, identify and relay a specific pregnancy narrative to help explore a definitive, fixed pregnant body. Instead, this project has countered the dominant discourses by bringing the voices of the pregnant subject(s) to the fore. My analysis has - hopefully - demonstrated the complex and multifaceted nature of the pregnant subject and their bodies, which confirm, inspire and perform the self. Indeed, pregnant selves both embrace and reject the medicalised versions, natural forms, and feminine values which become attached to their bodies during pregnancy. The pregnant self also actively takes part in constructing and owning personhood of both themselves and their foetus during pregnancy. In giving a voice to these diverse narratives, it is possible to discern what lived experiences are most impactful during pregnancy. Ultimately, these experiences should be central to critical, ongoing politico-medical debates about reproductive rights, especially in relation to changing technology and policy, but can also inform a model for thinking about the *all* bodies as relational but distinct, discursive and material. As one of my participants said, "I have a whole new appreciation for when someone says when they're pregnant… and what that means."

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Appendix A: Call for Participants

Appendix B: Participant Information Sheet

Conceiving subjectivity: an exploration of women's subjectivity during pregnancy you are invited to take part in this research project, which I am conducting as part of the requirements of my doctoral degree. Joining the study is entirely up to you; before you decide, I would like you to understand why the research is being done and what it would involve for you. If you would like to take part in this project, I will go through this information sheet with you verbally and answer any questions you may have to help you decide whether you would like to take part. Please feel free to talk to others about the study if you wish.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen if you choose to take part. Then it gives you more detailed information about the conduct of the study. Please ask if anything is unclear.

What's involved?

This research seeks to explore the everyday lives of pregnant women. I am particularly interested in how pregnant women adapt and manage their daily routines. Anyone who is currently pregnant and over the age of 18 can take part in this project. To find out more about your how pregnancy impacts your everyday life, the project will involve two different ways of communication: personal diaries and face-to-face interviews. If you would like to participate in both the diary and interviews, you can, or you can choose to do one.

- Diaries: You'll be asked to keep a diary throughout your pregnancy. The diaries are designed to be a personal account of your pregnancy, so the number and length of entries is entirely up to you. You can also include pictures, drawings, or anything that speaks to you about your pregnancy. I'll provide you with a diary, but you can also keep a diary in whatever form is best for you – whether it is a written journal, an audio recording, or a typed Word document. You can also choose if you'd like me to send you a reminder to make an entry in your diary via text message or email. If you do ask for a reminder, I'll send this in your preferred way once a week. As your due date approaches, I'll arrange a time to collect the completed diary from you. I'll then photocopy the diary and return the original to you to keep.

- Interviews: I will also ask if you would like to take part in face-to-face interviews about your pregnancy. In these interviews, I'll ask you a few questions about your pregnancy – such as how you found out you were pregnant, what sorts of things have changed the most for you and what has changed the least. Interviews will be scheduled will take place every 4-6 weeks during your pregnancy, and will be scheduled to fit around your availability. You can expect interviews to last about 40 minutes to an hour each, and will take at place convenient to you (for example, these can take place at a private room at University of Suffolk in the Waterfront Building or if preferred, this can be at your home). Before and after each interview, I'll also ask for permission to audio record and transcribe the interview. If you prefer not for the interview to be recorded, you'll be able to let me know so I don't record the interview.

Depending on at what point you join the study during your pregnancy, the length of your participation could be anywhere from 1-6 months. The research project is scheduled to

continue until 31 December 2020, so the project may continue even after your participation is over.

How will the data be used?

I'm asking for permission to use anonymised quotations and narrative themes, along with any photographs and video you provide in the interviews or diaries for research purposes. All diaries and interviews from all participants will be analysed together for common themes about what everyday life is like when pregnant. As I work through my analysis, I will transcribe any audio recordings or handwritten diary entries. As I transcribe, I'll anonymise any identifying details, such as your name and address. All digital files will be saved on a password-protected computer at University of Essex and all paper documents will be stored in a locked drawer at my office at the University of Essex, to which only I have access.

Throughout the project, I will be the only one with access to un-anonymised data, and my supervisors will have access to anonymised data. Since this project has gone through ethical approval from the Health Research Authority, NHS Trust staff may also be audit this project to ensure I am protecting your information appropriately, and may ask to see relevant sections of data.

I may need to break this confidentiality if you disclose illegal or criminal activity to me or I become aware of an issue that puts you or a child's safety at risk. In this instance, I will aim to first discuss the issue with you, but I may be legally obliged to share this information with the appropriate authorities.

What will happen with the results of this study?

The goal of the project is to produce a doctoral thesis, which may include examples and anonymised quotations that you've shared with me. In addition to the doctoral thesis, I may also produce other academic publications which may include stories and anecdotes or anonymised quotations you've told me. Every effort will be made to appropriately anonymise quotations used, however complete anonymity cannot be guaranteed. After every interview, I'll ask if there were specific sections of the diaries or interviews you wanted removed or edited. Please let me know if so, and I will ensure these are edited according to your wishes. When I collect the diary at the end of your participation, I'll ask again if there was anything in the diaries that you would like to keep confidential. If so, let me know and I'll ensure these sections are not included in final transcripts or any research outputs, such as publications or reports. If you change your mind after you are done participating and decide you want something removed from the final interview transcript or diary, you'll be able to let me know until 31 December 2020, after which point I will need to finish and submit my thesis.

What will happen when I'm done participating?

I will return your original diary to keep as a memoir of your pregnancy within 2 weeks of collecting the diary from you. You can decide if you would like any further contact from me after participation in the study. If you would like, I can send you a summary of my findings after the study is completed, which will be 31 December 2020.

With your permission, I would also like to deposit the anonymised diaries and interviews with the UK Data Service. The UK Data Service is a data archive which allows other

researchers to re-use this information for further research. Other researchers interested in experiences of pregnancy can apply to see the data and use it for their own projects. Anyone using the data would be required to sign a legal agreement to ensure anonymity and confidentiality. On the informed consent sheet, you can indicate whether you would like the anonymised interview transcripts, anonymised diaries, and/or audio recordings deposited at the UK Data Service. Please note, I will only archive your anonymised interviews, anonymised diaries, and audio recordings if you give me permission to do so.

Benefits

After I've photocopied your diary entries, I'll return the diary so it will be yours to keep as memoir of your experience. For participants directly, I hope that this serves as a way to reflect and discuss your pregnancy with someone, and hopefully provide a unique and creative way to remember this time in your life. Finally, I hope some of this research will inform discussions on issues that affect pregnant women.

What are the possible disadvantages and risks of taking part?

Although unlikely, the level of detail provided in diaries and interviews sometimes means that, even with anonymization, there is a chance someone you know could still identify you. After each interview and when I collect the completed diary from you, I will ask if there are any specific details or even full entries/interviews that you would like me to exclude from any publications that result from this study. If you change your mind at any point in time about what information you'd like me to use, you just need to let me know so I can edit the final transcripts. Even if you decide to allow me to use all of the information you've shared (without any editing), I will still anonymise interview transcripts and diaries.

How to withdraw if I want to do so?

Participation in this project is voluntary. You are free to withdraw and there will be no penalty for doing so. Any data you have given would be retained and used in the study. No further data will be collected. To withdraw, you just need to contact me via email, text, or phone. As soon as you have withdrawn, I will not contact you any further.

If you have any questions or concerns about the study, you can contact the researcher, Maureen Haaker via email: [EMAIL ADDRESS].

If you continue to have concerns, you can contact Prof Mike Roper who is one of the supervisors for this project (University of Essex, Wivenhoe Park, Colchester, CO4 3SQ; [EMAIL ADDRESS]). If you remain unhappy and wish to complain formally, you can do this by contacting [NAME], the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester, CO4 3SQ, by emailing: [EMAIL ADDRESS].

Appendix C: Consent Form

Consent Form for
'Conceiving Subjectivity: An Exploration Women's Subjectivity during Pregnancy'

Please read each statement carefully and, if you agree, place your initials after the statement.

Taking Part

I have read and understood the project information sheet dated DD/MM/YYYY.	
I have been given the opportunity to ask questions about the project.	
I agree to take part in this project by writing a diary.	
I agree to take part in this project by being interviewed.	
I would like to receive a weekly reminder to make a diary entry. Please circle: Text reminder Email reminder	
I understand that my taking part is voluntary; I can withdraw from the study and all information collected prior to my withdrawal can be used, but no additional data will be collected.	

Use of the information for this project only

I understand my personal details, such as phone number and address, will not be revealed to people outside the project unless there is a requirement for disclosure, such as disclosure of illegal activity or a safeguarding issue that puts the participant or a child at risk.	
I understand that the researcher's supervisors will have access to fully anonymised interview and diary transcripts.	
I understand that my fully anonymised words, images, video, and narrative themes will be used for research purposes and may be quoted in publications, reports, web pages, and other research outputs.	
I understand that relevant sections of data collected during the study may be looked at by individuals from the University of Essex, regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	

Use of the information beyond this project

I agree for fully anonymised, typed transcriptions of diary entries I provide to be archived at the UK Data Service.	
I agree for fully anonymised, typed transcriptions of interview I participate in to be archived at the UK Data Service.	

I agree for audio recording of interviews I participate in to be archived at the UK Data Service.	
I understand that other researchers, as defined in the participant information sheet, will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that other researchers, as defined in the participants information sheet, may use my words in publications, reports, web pages, and other research outputs, only is they agree to preserve the confidentiality of the information as requested in this form.	

So I can use the information you provide legally

For any materials in this project which I hold copyright in, I agree to assign both joint copyright and permission to reuse for research purposes to Maureen Haaker.	

_____ _____ _____

Name of participant [printed] Signature Date

_____ _____ _____

Researcher [printed] Signature Date

Appendix D: Diary Instructions

Diary instructions for
'Conceiving Subjectivity: An Exploration Women's Subjectivity during Pregnancy'

Thank you for taking part in this study on women's experiences of pregnancy. This diary is for you to share anything about your pregnancy whenever you can. If you are not able to fill in your diary for a period of time, please do not give up - just try to fill it in again as you are able. Here are some points to consider when you are filling in your diary:

- I am interested in your day-to-day experiences of life during pregnancy; this involves all of your experiences, not just visits to the doctor or experiences specific to pregnancy.
- Remember, this is YOUR diary. You should fill it in with everything that is important to you and that you would like to remember in future years. Feel free to write, draw, or include photographs – anything that you think reflects your experience of pregnancy.
- I know that time is precious, and you will be preparing for the birth of your child, so please feel free to write as much or as little as you like.
- Please don't worry about spelling, grammar or 'best' handwriting, but try to write as clearly as you can. Alternatively, if you prefer to use a computer or audio/video recording, you can.
- Please fill in the date and week of pregnancy in the space provided on each new diary page.
- When your diary is complete, I will come and collect it and make a photocopy for my project. If there is anything in your diary you would like to edit or remove from the copy I am using in my project, just let me know. I'll finish making a copy and return it to you within 2 weeks.
- You can withdraw from this study at any point, with no questions asked. To do so, please call, text or e-mail the researcher, Maureen Haaker.

If you have any questions about the diary or wish to withdraw from the study, please use the following contact details:

Maureen Haaker
[EMAIL ADDRESS]
[PHONE NUMBER]

Appendix E: Doctor's Letter

University of Essex
Wivenhoe Park
Colchester
CO4 3SQ

[DATE]

To Whom This May Concern,

[Participant's name] has agreed to participate in a study on experiences of pregnancy, titled "Conceiving subjectivity: an exploration of women's subjectivity during pregnancy". This study is being conducted as part of the requirements of a PhD qualification at the University of Essex. This letter explains a bit more detail about the conduct of the study. If you have any questions or concerns, please feel free to contact either the PhD student, Maureen Haaker, or one of the supervisors at the contact details found at the end of this letter.

What's involved?

This research seeks to explore the everyday lives of pregnant women. I am particularly interested in how pregnant women adapt and manage their daily routines. The project will involve two different ways of communication: personal diaries and face-to-face interviews. Participants can choose to if they wish to do both diaries and interviews, or just one.

The diaries are designed to be a personal account of pregnancy and may include pictures, drawings, or anything the participant would like to share about her pregnancy. Participants can also opt to receive reminders to diary about her pregnancy, and she can request to stop these reminders at any time.

I am also conducting face-to-face interviews, in which participants can also choose to take part. In these interviews, I'll ask a few questions about the experience of pregnancy – such as how the participant found out she was pregnant, what sorts of things have changed the most and what has changed the least. Interviews will be scheduled will take place every 4-6 weeks during pregnancy or whenever is most convenient.

Participants will never be asked specifically about care they are receiving, although health may be a general topic area that could come up when talking about everyday life while pregnant. Throughout the study, I will never offer any sort of medical advice and, should the participant raise any questions about health, I will always refer them back to their doctor or midwife for health advice.

Depending on at what point in the pregnancy the participants joins the study, participation may last anywhere from 1-6 months. The research project is scheduled to continue until 31 December 2020, so the project may continue even after the participant has finished her participation in the study.

How will the data be used?

I've asked for permission to use anonymised quotations and narrative themes, along with any photographs and video provided in the interviews or diaries for research purposes. All diaries and interviews from all participants will be analysed together for common themes about what everyday life is like when pregnant.

What will happen with the results of this study?

The goal of the project is to produce a doctoral thesis, which may include examples and anonymised quotations shared with me. In addition to the doctoral thesis, I may also produce other academic publications which may include stories and anecdotes or anonymised quotations told to me.

How does someone withdraw from the study?

Participation in this project is voluntary. Participants are free to withdraw and there will be no penalty for doing so. Any data given to me before the point of withdrawal would be retained and used in the study. No further data will be collected. To withdraw, participants just need to contact me via email, text, or phone. As soon as someone has withdrawn, I will cease all contact.

If you have any questions or concerns about the study, you can contact the researcher, Maureen Haaker via email: [EMAIL ADDRESS].

If you continue to have concerns, you can contact either of the supervisors of this project via email: [SUPERVISOR NAME] ([EMAIL ADDRESS]) or SUPERVISOR NAME ([EMAIL ADDRESS]). If you remain unhappy and wish to complain formally, you can do this by contacting [NAME], the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester, CO4 3SQ, by emailing: [EMAIL ADDRESS].

Thank you for taking the time to read this letter.

Yours faithfully,

Maureen Haaker
PhD candidate
[EMAIL ADDRESS]
[PHONE NUMBER]

Appendix F: Transcription Guidelines

Transcription instructions for
'Conceiving Subjectivity"

Background to the research

In 1984, Iris Marion Young (1984, p. 45) noted that not much work had been done on the pregnant woman "*as a subject*" (emphasis in original) or on "the mother as a site for its proceedings". Although more research has been done on and with pregnant women since this time, much of it tends to focus on reproductive politics, the social experiences of motherhood and new reproductive technologies which engage the pregnant body. Pregnant and foetal bodies "with all their attributed conceptual liabilities and somatic messiness" stand to contribute a critical test case to social theory (Gottlieb 2004, p. 58). The liminality of pregnancy – whereby the form of the body is discursive and negotiated, not fixed – offers a unique foundation for social theory's thinking of *all* bodies as unfinished. Given that they are encased within another body, foetal bodies provide uncertainty about personhood and individuated embodiment. Their rapid and constant physical changes and inextricable link to another body calls into question the very core ideas surrounding subjectivity within Western society. The very physical-ness of pregnancy which challenges the underlying ideas behind Western bodies and subjectivity offers social theory the opportunity expand its ideas to a case which has been firmly planted within biomedical realm of explanation.

This project on experiences of pregnancy picks up on this shortcoming and explores subjectivity in much more detail. Rather than focusing on the "social outcomes" of pregnancy, this thread has noted the way pregnancy surreptitiously brought the body to the fore in conversations about power, kinship networks, and the roles of individuals.

Transcription approach: Intelligent transcription

Decisions about how transcription should be carried out are intimately connected with the type of analysis that is intended. Transcription of speech is always a compromise: greater detail gives more material for interpretation, yet too much detail can slow up the reading of the text in an artificial manner. This project is focused on the content of speech, rather than the way the speech is portrayed. While there are some places where it may be appropriate to include non-words, the primary focus of transcription will be to ensure a readable, word-for-word transcription of the audio or image file. This will balance the amount of time needed for transcription while ensuring preservation of intention of the words said.

General notes

- Document should include a header on every page with the project title and interview ID.
- Insert page numbers at the bottom of each page, in the centre
- Use Times New Roman, font size 12, speaker tags should be bolded and speech text indented
- Interviewee tags should be specific to the person (e.g. I = Maureen Haaker, I2 = Vanessa Rawlings, initials of pseudonyms for participants)

- Filler words or ‘back channel utterances’, i.e. where the interviewer can be heard in the background saying words such as “right”, “yeah”, “I see” or utterances such as “mmhhmm” whilst the interviewee is speaking should also be transcribed. These function to encourage the respondent to continue speaking and reassure them that they are being listened to, and may be important for some types of analysis.
- For diaries: use punctuation as for normal written prose. Grammar should not be altered or “tidied up”. For interviews: do not use ‘eye spellings’ (e.g. “enuff” for ‘enough’) – these should be written to be as readable as possible.

Things to include in full

- Unfinished questions or statements that trail off – indicate these with ellipses (…), for example: “I never did understand her approach, the way she saw it, or…”
- False sentence starts
- Repeated phrases, words, statements or questions
- Discussion that continues after the interview appears to be ‘formally’ finished
- Non-lexical utterances or ‘fillers’ such as ‘umms’ and ‘errs’ and ‘uhs’
- Hesitations and Pauses – indicated with ellipsis (…), for example: “well…recovery to me…sort of means…err…”
- To indicate an exclamation of surprise, shock or dismay, use the standard exclamation mark
- Emphases – indicate any emphasis on a word or phrase by putting it in italics

Things to include in brackets

- Noises in background - for example (loud banging) or (door slams) or (muffled voices)
- Non-words - for example: (laughter) or (mumbling) or (sigh)
- Unclear words or phrases must be marked where they occur within the text by placing the word “inaudible” in brackets and in bold e.g. (inaudible)

After Transcription

Files should be saved on a protected server as an RTF. Audio recordings and images of diaries are to be retained alongside word documents unless participant has specified not to archive these.

Appendix G: Anonymisation Plan

Anonymisation plan for
'Conceiving Subjectivity"

Background to the project

This qualitative study is a detailed examinations of the experiences of pregnant women. In total, there are 20 interview transcripts, 3 diary transcripts, and 19 interviewer notes. Ethical approval (from the HRA) requires the anonymization of all data. This document contains a guideline to inform a standardised anonymisation procedure so replacement procedures are consistent throughout the anonymisation process. This data will be deposited as a safeguarded collection at the UK Data Service (where permission to share data has been granted), so the overall approach is a "light touch" to anonymise any details which pose a major ethical issue. The level of anonymisation required by each of the interviews will vary subject to the degree of detail contained in each interview.

File management

- A copy of the original file (audio or jpeg) is to be made; all changes will be made to a new, transcribed version and anonymised at the time of transcription. The original file is to be kept until all anonymization of the whole project is complete. Once anonymization is complete, the original files will be stored under \noissue.
- Each interview is to be read in full at least twice for anonymisation. Any details which pose possible ethical issues are to be described in a separate document, along with the page number of the interview transcript, for review with PhD supervisors.
- After review, if changes are deemed to be necessary, changes will be indicated by square brackets around the anonymised word or phrase.
- No anonymisation log will be created for this small-scale project. This document and the use of [ ], and the retention of unanonymised versions is deemed to be sufficient.

Mandatory anonymization

Direct identifiers

- All names will be changed. Each interviewee will be given a full pseudonym (first and last name) and all other names will be given a pseudonym (first name only).
- Phone numbers, addresses, and other identifying contact details will be removed and replaced with [phone number], [street address], etc.

Places

- Town names will only be changed where necessary. Where a town name potential unveils easier re-identification (e.g. a rural town with very low population), then it will be replaced with [(region) town].
- Names of workplaces and schools will only be changed where necessary. Where a town name has been changed, workplaces should also be changed. Where a workplace refers to a very small organisation (e.g. public-facing staff page with >20 employees), then the name will be replaced with [workplace].

Ages and dates

- Dates, where they pertain to pregnancy dating, will not be changed. Specific dates of birthdates, anniversaries, etc. will be aggregated to month and year. Ages for data lists and public-facing (open) documentation will be aggregated to NS-SEC standardized groupings (e.g. 0-18, 19-24, 25-34, 35-44, etc.).

Possible anonymization

Changes to the following details will be made on a case-by-case basis. There will be careful consideration of the context of where these details arise and whether or not anonymisation is absolutely necessary.

Medical

- Pregnancy is not, in itself, considered legally to be a "health condition". However, health conditions may arise in discussions which should be flagged for consideration of redaction or anonymisation. Anything flagged will be discussed with supervisors for a final decision on appropriate anonymization.
- Where health information about other people (not participants) is discussed, this should also be flagged to ensure it is not disclosive of those people. Where health information is disclosed without appropriate consent in place, transcripts will be edited to remove this content.

Sensitive Material

- Any material deemed to be particularly sensitive (included details of legal cases or unfavourable opinions of others) will be removed from transcripts. Transcripts will be edited to minimal amount needed to remove any sensitive content.

Appendix H: Early Analytical Writing

Initial thoughts: "Feeling" pregnant

This is an initial impression of the interviews taken as a collective – the things that have struck me while conducting and transcribing interviews. As a point of order, it should be said how vastly different every woman's story is. No two pregnancies are the same, and at first it seemed daunting to try and find a way through the complexities of the data. Sometimes women's stories (if they were able to do more than one interview) evolved as their pregnancy progressed, resulting in a change of view between the start and end of pregnancy. Understanding, articulating, and "settling" these changes is not easily expressed, so this write-up serves to only reflect on the multi-faceted account of what pregnancy "feels" like – do pregnant women see themselves as "pregnant", and what that means to them? We can easily measure pregnancy in objective way – through ultrasounds, pregnancy tests, blood tests, and physical examinations – but what does it feel like to be "pregnant"? Do women themselves actually feel different?

It seems obvious, but worth saying, that women developed an identity of "pregnant" early on – even when it didn't seem obvious from their bodies that they were pregnant. This identity became central to their lives, despite how early narratives talk about how "nothing has changed" and "everything feels the same". One woman wrote in her diary about looking for a "baby bump" at 7 weeks pregnant. A few weeks later, she began to bleed, and had an "inconclusive ultrasound". Confused at what it meant, she asked herself, "Was I still pregnant? Was it ectopic? Was I miscarrying?" Practitioners refused to confirm the miscarriage until after blood tests were taken and hormone levels began to drop off. When she later passed all pregnancy tissue, she wrote,

> "I've had moments over the past 2 weeks where I just cry. I think it's to grieve the loss of all the plans we had started more than anything else. I didn't know/feel the baby, but I think we build up an idea in our heads of what it will be like. You start thinking about names, looking at things to buy, planning parental leave… And overnight all that energy is put into something that will never be. I'm more than gutted though – this wasn't a cancelled holiday. It was different way of living.
>
> It does make me wonder what attachment is though. I know some women talk about not "feeling" attached to their baby at first – pregnancy is uncomfortable, birth is traumatic, and it can take a while... I was certainly attached to something, but I'm not convinced it was the baby. It was the life (for me) it brought with it, the one I would force upon the baby as soon as it was born. I didn't even know I wanted it until I was pregnant!"

Pregnancy seemed to bring a self-consciousness and was not necessarily about "telling" others or about feeling the presence of a foetus (although feeling movements brought in another dimension to pregnancy). Another woman talked about how nice it was to not tell others about her pregnancy for the first three months and just keep it secret between her and her partner. Even with those early feelings, however, pregnancy is still tied up in the body, and as the pregnancy progressed, women's feelings changed. Another woman who gave birth at 29 weeks in a previous pregnancy remarked that she had "felt robbed of the last trimester"

and had hoped this pregnancy would go on to full term (it didn't – she gave birth again at 29 weeks again). It seems all women wanted "enjoy" pregnancy, despite any physical or emotional difficulties. Medical staff and interventions were sometimes seen as obstacles to this enjoyment. One interviewee had been raped years before her pregnancy, but was required by medical practitioners to see specialists to talk through that time in her life. She resisted this, remarking "I'm trying to enjoy this, and I don't want to think about that time in my life." Pregnancy was demarcated as a significant physical and emotional shift which changed the trajectory of life, whether it lasted 9 weeks or was carried to term, and created a new meanings and ways of thinking for women. There was a clear sense that pregnancy should be treasured, with many women describing trying to "enjoy" pregnancy. On her second pregnancy, one interviewee said she was "trying to appreciate it a bit more, and enjoy more of it rather than feel uncomfortable and moan about it all the time."

Tension between internal/external views

Ultrasound scans became a regular practice in the 1980s, and are now even accompanied by the sound of a heartbeat and three-dimensional movement. A technician can overseas this process, and "reads" the images produced by medical technology. Previous literature argues that this is a way for experts to bifurcate the body, visually establishing both a mother and foetus as two, separate entities. The images themselves often "erase" the mother – the focus is on the foetus alone, with little to no depiction of the womb or amniotic sac. Duden (1999) points out that what is more significant than the images themselves is how these images are collectively deciphered. Stabile (1992) argued that these images continued to switch the focus from the gestating body to "foetal personhood". She went on further to say that this erasure of the female subject has given rise to the disputes over abortion and even child support and custody. Karen Newman (1996), however, questioned this, suggesting such illustration do not represent a significant shift in conceptualization of the foetus – simply put, foetuses have always been depicted as separate entities and an ultrasound has not changed this. While this academic debate rages on, it also reflects a tension within women between wanting to see the inside versus "knowing" their internal workings.

There is no debate – it would seem – nearly 40 years after ultrasounds were introduced, that women have claimed those images as important, personal mementos of their pregnancies. Some opted for additional scans on top of the typical 12- and 20-week scans. One woman, who was going through particularly difficult month after making having make several court appearances to testify against someone, described getting a 4D scan "as a treat". Others, like one participant's sister-in-law, framed the ultrasound image. Another commented about being "really excited about seeing him and seeing how he developed."

Even with this excitement, however, there was a tension between interpretations of what medical equipment "saw" (as interpreted by medical professionals) versus how women internally processed events. The images were not formative to their experiences – they were an added bonus as long as the image confirmed what the women felt to be true. The woman who described a 4D scan as a "treat" then went on to describe a traumatic experience:

> The 4D scan revealed a liquid mass that the sonographer said we needed to get checked ASAP. She didn't say what it was, only that it was in the stomach area and that she wasn't qualified to say more. She rang the hospital who made an appointment for us today (Monday) because the consultants don't work weekends. I was panicking

> a lot Saturday and asked her if my baby was going to die or have a disability. She said no but we might need medical attention. She even had the cheek to say on the phone that she had tried to reassure us – that was a complete lie and to say she was like a robot would be offensive to the robot… [It turned out that the b]aby has a cyst that may go away on it's own and just needs monitoring. However, the consultant was a bit concerned as he said baby was measuring small, apart from the head circumference. I didn't say exactly what we'd been going through but I said we'd had a lot of stress and I hadn't been eating as much. Although he said that wouldn't caused anything I believe he underestimated the amount of stress. We will be monitored and have to go back for more scans."

Her mistrust of the doctor's understanding of her pregnancy grew further when future scans showed the foetus's growth to be back within average sizes. Life's stresses had begun to ease, and she was feeling better, which coincided with a more positive ultrasound reading. She and other women trusted their own internal corporeal work – even when it wasn't the medical average - and "seeing" the internal through ultrasounds was often described as an exciting event rather than dictating how they felt about the pregnancy. In this way, ultrasounds were a way of confirming what pregnant women already knew. This woman finishes off a reflection on this time, writing, "Everyone keeps telling me how well I look – if only they could see inside my head they would see how fake a brave face can be. I am trying to be positive though so I guess that is what they are seeing." Others don't really "see" what's going on with the pregnancy. The women who miscarried and had an "inconclusive ultrasound" (mentioned earlier) equally described "knowing" something was wrong, but no one else would confirm it with the images - the images were in tension with how things felt internally.

Ultrasounds were also seen as only one way of knowing the pregnancy. One woman said how she "couldn't see [the baby's] face in scans because of the way that he was laying" but was "quite glad not to see his face though". She wanted "get to know" the baby through the images but did not want a picture image of what he would look like. The pregnancy was preceeded by IVF treatments, so "this time around, we needed to know as much about him as possible," but didn't want to "meet" him until birth. Rather than rely on a picture of his face, however, she described "knowing him" through his increasing movements. She said he followed a sleeping pattern of his father, "so it's like he has his own personality already – it's like he's [her husband's] son already. It's nice to see that." Feeling movement was also an important way to share and exemplify their feelings to partners so others on the outside could "know" the baby as well.

On the cusp of "twoness"

Literature describes the pregnant body as a unique "two-in-one" body. Kristeva (1981) noted "pregnancy seems to be experienced as the radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and another". Meanwhile, pregnant women have been compared to "containers" for the developing foetus, "de-centred, split, and doubled", and women with a "condition for which she must take care of herself". Longhurst (2005), Schmied and Lupton (2001), and Young (1984) have documented the difficulty pregnant women have conceptualising the ontology of their pregnant embodiment. For many women, the first sensations of movement, or "quickening", signals the splitting into two parts (Nash 2013, Root and Browner 2013). Many women describe these sensations as

strange or “weird” because they are so different from the sensations of their non-pregnant embodiment (Nash 2013). Schmied and Lupton (2001) found women struggled to articulate their experiences, often remarking “I don’t know how to put it into words” or “I can’t explain it”. Even when speaking of the foetal body within, women from Nash’s (2013) interviews found there to be a divide between those who viewed their foetuses as “part of me” and those who thought of them as separate bodies. Still others, as Warren and Brewis (2004: 223) found, described their pregnancy like a “foreign invasion”, stating that their body “no longer belongs to them”.

Surprisingly (to me anyway), foetal movements were not a central feature in women’s narratives. There was discussion which hinted at a “twoness”, but it was more nuanced -- the foetal body was described as being on the cusp of the outside world, with two women using almost the exact same phrasing that there is only “1 inch of skin” between the baby and the external world. Another commented that the mounting baby gear in their flat was “like he’s moving in” – but just not there yet. There was always an imagining of “anOther”, but not necessarily one that could always be known or felt – the foetal body seemed to straddle an ambiguous line that borders upon the (real?) world. It was not as simple as two-in-one, but more like “two imagined”-with-“one physical body”. Another woman described this as “there’s days where you not certain if you feel the baby move or not, then you’re not sure if it was just your stomach rumbling…” There was assurance in women’s bodies, but ambiguity around what was the foetal body. As another said, “as they start to move – they are a human. They are part of me. They are attached to me.” Another felt she could move in certain ways to get the baby to move too – it was a ritual at night to have her husband feel the baby kick before dropping off to sleep, so she was able to do things which would wake, shift, and move the foetus until it kicked. The prediction of movement became more of an intuition to her.

Access to the foetal body for everyone - except the pregnant woman - always involved some sort of “presence” – presence of hormones (as on a pregnancy test or blood test) or feeling a foot kick. Pregnant women, however, sometimes tried to see the world from the foetal perspective. The participant who had several court appearances remarked that she was ”gutted my baby has to endure it with me,” while the woman who gave birth at 29 weeks also commented that she felt “[m]y body that let the baby down.” Some tried to involve the foetus in daily activities, such as one who said “if I feel a movement, I might to talk to it.” Access to this body, however, had to be negotiated for everyone else: women described disappointment when the baby moved, but then stopped once a partner tried to feel movement through their bellies. One made a point of trying to remember every day when she felt movement, saying “Because with [my first son] I don’t really remember that – I have an anterior placenta so you don’t necessarily feel as much movement. But certainly I’m conscious everyday… and looking to the point where [my husband] will be able to feel it more…” Even the woman who miscarried at 9 weeks wrote a couple weeks after the miscarriage,

> “I said this was the end of my pregnancy story already but I suppose it wasn’t. I was told to take pregnancy test 2 weeks following the miscarriage to ensure the test came back negative. You know – just in case hormones didn’t drop off? … I decided not to take the test. I’ve had enough. I’m letting my body just get on with it.”

The idea of “two-in-one” certainly captures an element of this feeling of anOther, which seems to peak in the lead up to birth. Birth was, of course, the ultimate way to “know” the

foetal body. One woman talked about her impending birth saying she felt "braver now - I'm growing a human being, and I'm going to push it out…" so she needed to "woman up, basically." Other talked about the excitement to "meet" their baby for the first time at birth – particularly in the final weeks before the due date. Prior to this, however, "knowing" the "two" bodies always seemed to be borderline – perhaps, maybe, not quite, sometimes two, but definitely one.

Describing the bump

This writing would be amiss without discussing the way pregnant women's bodies were talked about. This is a major theme from previous research, but focused largely on how pregnant women's bulging, leaking bodies are disturbingly non-stable. Tyler (2000) wrote that it was the August 1991 *Vanity Fair* front cover featuring a heavily-pregnant Demi Moore, with the caption "More Demi Moore", that spurred a proliferation of similar images, putting celebrity pregnancies under scrutiny within media and reframing fertility as a "fashionable spectacle". Just two and a half decades later, weekly "soft news" is decorated regularly with gestating celebrities, while tabloids keep a close "bump watch" on high profile personalities (Chambers 2009). These images have, in turn, have also acted as a catalyst for the visibility of pregnancy in general and its reassessment of its previously taboo status within Western culture. The change in visibility has not only represented a change in attitudes toward pregnant women, but, as Chambers (2009) clarifies, a further tightening of codes associated with the ideal of the "body beautiful" at a time when women are feel they lose personal control of their bodies. In British research, women talked about the changes to their bodies' sizes, and expressed eagerness to returning to their usual size and shape (Earle 2003). Nash (2013) found the same to be true in Australia, where women reported disliked feeling "fat" or being described as "fat" while pregnant. The descriptions and scrutiny of bumps certainly features within this data as well.

The bump was the clear indicator of pregnancy, and, within this study, seemed to one of the few things that "crossed" the border between the internal and external world. It served to show everyone that there was anOther. It's probably worth noting that all women in this study had a discernable bump, unlike some women who experience "stealth pregnancies" (where there is no visible bump). The attention that the bump received garnered frustration more than anything else – women felt judged, different, and othered. Nearly all women remarked on how others described their pregnant bellies to them – being told they were compact, big, or small. One was particularly affected by this, saying "people find it perfectly acceptable to tell that I have a fat ass…they think they are giving you a compliment, but no…" Another woman admitted, "I do moan that I'm eating too much and that I am getting big…and I then I think 'you know what? I may not do this again.' So just try to enjoy it." My own recent experience was similar – always being told I had a "neat" bump until the third trimester. I'm now told that I am big and "ready to pop at any moment", despite having another month of pregnancy left. One person absolutely insisted I wouldn't make it to term given the size of my bump. The bump has become some sort of indicator of "readiness", underlined with ideas about an ideal pregnant body. It seems that comments about the shape or size of the bump were not well received by pregnant women.

The weight and size of the bump clearly affected women in more physical ways too. One said "at 30 weeks, noticed started to increase in size. Quite frustrating that you can't move things

and will need help soon to tie shoes." Around 34 weeks another woman, who had just gone glamping, said "I'm still feeling tired so have to come to terms with the fact that I can't do everything!" She felt bad because she wasn't able to help unpack/pack up the car. Similar experiences across the board, nearly all after 30 weeks, commented on not being able to do as much – sometimes because it wasn't recommended or simply because the bump itself got in the way. One complained, "I can't lift this and I can't do that, and now with the heat wave on, I can't leave the house." Another woman said even walking down the street became difficult, especially in the heat. While physical restrictions seem to dominate experiences at the end of pregnancy, there was still some internal fascination. With the larger bump came new experiences, like one woman who said, "You can actually see my stomach move likes waves" – a signal perhaps of the increasing strength of the growing bump.

Understanding "natural births"

One woman, reflecting back on the care during her first pregnancy, said "I don't know when I fell pregnant. I [knew I was] pregnant because I took a pregnancy test. I wasn't expecting to become pregnant type thing… I was just being pushed through a service." While some emphatically embraced midwife appointments, ultrasounds, and intensely followed the development of their babies, there was a limit to how much women wanted to engage – and would engage – with the advice, recommendations and directions from medical practitioners. For example, one interviewee said, "I go to midwives' appointments and they ask "how far along are you?" And I go "Oh – I thought that was your job…I don't know! I am due on the 15th July and then I'll have a baby!" Others tracked down to the day how far along they were or, conversely, how many weeks until their due date.

The level of care was also negotiated along the way. One woman really wanted a home birth, but initially wasn't allowed because of a family history of high blood pressure. After some persistence she got her midwife to agree to higher thresholds for her heart rate, she excitedly wrote in her diary that the consultant signed off on her home birth plan. Another woman, however, really wanted a hospital birth, but since she was low risk the midwife tried to get her to agree to a home birth since it looked like the month she was due was going to be a very busy month on the maternity ward, possibly without enough beds available. Again, after some insistence, the midwife agreed she would come into the hospital. The woman who had was referred to a specialist midwife in a mental health unit as additional care (following a rape that happened years before the pregnancy) engaged a couple of times with the specialist but on the second time had to say she couldn't come anymore – the experience of seeing a specialist midwife in a mental health unit was traumatic. On arrival, she had to be escorted through the building as the unit was locked down, and alarms would constantly go off in the background. When she told her midwife she didn't want those sessions, the midwife insisted that she had to have them. To compromise, she arranged for a specialist nurse to come to her house. She felt as though she was being made to feel unwell when she was not – the additional care was more re-traumatizing than the experience of pregnancy. Despite having vastly different care plans, there was a clear pattern where there had to be compromise and agreement – women usually had a clear idea of what role they wanted healthcare to play in their pregnancies.

A large part of stories of pregnancy – and the energy of women - seem to be planning for birth. Most women desired a "natural birth" (spontaneous labour followed by a vaginal birth,

usually overseen by a midwife) – sometimes regardless of circumstances. Part of this seemed to be embracing their own gut feelings and the mental preparation they put in throughout the pregnancy leading up to birth. Many women attended antenatal classes, hynobirthing classes, or invested in other ways to plan for birth. The woman who gave birth at 29 weeks talks about the challenge of accepting the level of medical intervention needed in her first pregnancy. She recalls waking up, passing her mucus plug (which at the time, she didn't realise was her mucus plug) and going out for the day with her family to walk along the waterfront. As they were walking, she started having contractions (again, not realizing they were contractions). Eventually her husband became concerned enough to call the midwife, who wanted them to come into the hospital for additional monitoring. Between her husband's concern and the unusualness of the physical pains, she began to worry. Once in the car, however, she felt immediate relief and said she knew they were "going to the right place". Once they got to the hospital, the staff realized how far gone she was into labour and reacted immediately with an emergency C-section. It wasn't until then that she fully realized that her pains were actually labour pains, and that she was going to be having her child that day. She said,

> "I really didn't want a section – my labour already hadn't really gone the way I wanted it to, and now it was ending in a section. So I was a bit miffed, and she [the doctor] was quite abrupt. It wasn't until the day after or a couple days after and she actually explained what she had done, and we were like 'Wow. So she saved our lives potentially, or at least [her son's] life.'"

The baby was so small at 29 weeks and positioned sideways, so it would not have survived a vaginal delivery. Following the C-section, the baby had to stay in the hospital for another 3 months. She and her husband stayed in the hospital with him every day. She lamented watching other women going home straight after birth – the story she had envisioned for herself but couldn't have. Now, however, she says appreciates that is part of her son's story. Nevertheless, with this pregnancy she hoped to go to full term and that she would have that story for this son.

Motherhood

Motherhood was not a clear focus for many women, at least within their initial narratives of pregnancy. Narratives tended to focus much more on how they related to others (whether old friends or complete strangers) and the intense scrutiny of their bodies. Nonetheless, some women gave thought to how they would mother their babies postpartum. There were two aspects to becoming a mother – one hinted at the environmental changes happening around them while the other described the change in emotions. The environmental shift was simply house preparations for a newborn – one said that it "felt like someone was moving in", and later said "this was our first flat together as a couple, and now it's like our house as a family. It's a big shift…it's physically happening. It's not like a mental shift – you can see it." On the emotional side of change, however, women talked about feeling more deeply. One woman talked about the seeing the news of the boys football team stuck in the Thai cave, and how it really affected her. She remarked, "That's someone's son…you can feel what that mother must be feeling like." This emotional change sparked feeling of protection for the foetus, with several women commenting about how protective they feel of their bumps and/or babies. One explained, "I can feel the love for him already and…he's not even here."

This was delicately balanced, however, with ensuring their own “pre-pregnancy identity” was never completely lost. One complained, “All they talk to you about is babies. I still am actually a human being with likes and dislikes, not just a mother.” Others talked about ensuring their bodies went back to the way they were before pregnancy, usually through a strict exercise regime. The exception to this was when it was a second pregnancy, in which case the women talked extensively about their first child. Women who had a child already really focused their initial stories on navigating pregnancy as a mother to a child already. One explained, “You are no longer you – you are you and your child. You are a mother.”