Negotiating normalization: The perils of producing pregnancy symptoms in prenatal care

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ABSTRACT

In this paper, I argue that pregnant women confront a “double-bind” in complying with medical directives to report pregnancy symptoms: the combination of the routinization of prenatal care, understandings of fetal subjectivity, and the cultural discourse of maternal sacrifice create a situation in which women are at risk of failing as either as good patients, good mothers, or both. Longitudinal, in-depth interviews were conducted with 64 pregnant women in the New York metropolitan area. I found that health care providers make women’s embodied experiences a priority of surveillance, connecting symptoms to fetal well-being and emphasizing timely reporting of these symptoms to medical authorities. I found that women generally accepted this connection between symptoms and fetus, but were often perplexed as to which symptoms they needed to communicate to their providers when time constraints on routine prenatal appointments limited women’s ability to comply fully. Women also reported cultural pressures to “suffer nobly” the symptoms of pregnancy, no matter how uncomfortable. As a result, women found themselves with considerable responsibility for identifying problems in their pregnancies, with no clear way to adhere to the multiple and sometimes opposing mandates for managing symptoms they encountered.

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Introduction

Whether or not a patient complies with medical advice is a moral question (Conrad, 1985; Hunt, Jordan, Irwin, & Browner, 1989; Trostle, 1988). Although patients do frequently depart from “doctor’s orders” because they find the prescriptions (or resulting “side effects”) too onerous or disagreeable, to do so is to run the risk of being defined as ignorant, lazy, or undisciplined— all characteristics associated with low moral worth. Patients who do not comply (or, to use the more current terminology, adhere) to medical directives are frequently seen as “bad patients” (Kelly & May, 1982; Murcott, 1981).

When the patient is pregnant, the moral weight attached to compliance is much greater because of the cultural perception of a maternal-fetal conflict placing responsibility for pregnancy outcomes on women’s behaviors (Chavkin, 1992; Pollock, 1999). From social stigmatization of women who commit minor infractions with regard to the “rules” of ideal mothering to the criminal prosecution of women for the use of drugs, tobacco, and alcohol during pregnancy, scholars have demonstrated the high stakes of non-compliance for pregnant women (Flavin, 2008; Oaks, 2001).

In the U.S., participation in formal prenatal care is commonly understood to be one such moral obligation of pregnant women, and participation in minimal prenatal care is near universal (Martin, et al., 2009). Although the effectiveness of prenatal care remains a matter of debate (Alexander & Kotelchuck, 2001), medical authorities see prenatal care as an opportunity to educate and reassure anxious expecting parents and an occasion to assess fetal development and maternal well-being through interviews and population-based screening tests. The standard regimen for women with “low-risk” pregnancies consists of first monthly, then biweekly, and finally weekly appointments. Only a few of the 10–12 prenatal appointments were what my informants commonly referred to as “big appointments”, those that included a full physical exam, hearing the fetal heartbeat, viewing the ultrasound, or undergoing major tests. The remaining appointments screen for “risk factors” and typically consist of some combination of blood pressure surveillance, weight monitoring, blood tests, urinalysis, and exchange of information between provider and patient. The relative importance that women placed on these “big appointments” was apparent in their efforts to include family members, whereas many women discouraged such guests at the appointments in which, as
Trish put it, “nothing really happens”. Pregnancy, after all, is one of the few conditions that require sustained interaction with medical experts even when it develops normally.

Contemporary prenatal care occurs at the junction of two important historical trends: the increasingly significant cultural notion of the “fetal subject”, which attributes qualities of personhood — sentience, intentionality, rights — to the fetus in utero (Petchesky, 1987; Taylor, 2008; Terry, 1989) and the rise of “surveillance medicine”, which emphasizes control and individual responsibility for health outcomes for maternal behaviors (Copelton, 2007; Longhurst, 2001; Markens, 2006). A large body of scholarship identifies the complementariness of these trends in establishing the moral imperative for the extension of medical authority to all aspects of maternal behaviors, focusing on how attributing subjectivity to fetuses narrows the acceptable boundaries for maternal behaviors (Copelton, 2007; Longhurst, 2001; Markens, 2006). This work is extremely valuable in establishing how women decide if and when they will depart from medical directives, demonstrating the deeply gendered forces at play in evaluations of pregnant patients and the consequences of their compliance.

The literature on typification of patients demonstrates that individuals who complain or make “excessive” demands are often seen as “problem patients” (Rosenthal, Marshall, Macpherson, & French, 1980), and the rationalization of medicine, which itself results from historically specific legal, regulatory, and financial imperatives (Starr, 1982), has, in important ways, narrowed boundaries of acceptable patient behaviors in provider—patient interactions. This paper, part of a larger study on contemporary pregnancy in the U.S., develops the finding that pregnant women confront a “double-bind” in complying with some medical directives, as the combination of institutional needs of prenatal care, understandings of fetal subjectivity, and the cultural discourse of maternal sacrifice that emerges from “intensive mothering” (Hays, 1998) create a situation in which women are at risk of failing as good patients, good mothers, or both.

I centre my analysis on pregnancy symptoms because health care providers make women’s embodied experiences a priority of surveillance, connecting symptoms to fetal well-being. This requires that women not only observe their embodied experiences routinely in their daily lives, but also that they report significant phenomena to their health care providers in a timely way. The mandate to “report back” regularly distinguishes pregnancy symptom surveillance from other maternal behaviors, such as drinking or drug use, that are understood to be simply “off limits” during pregnancy; as such, pregnancy symptoms provide a unique opportunity to explore any constraints that contemporary prenatal care practice exerts on women’s ability to comply with the requirements of medical surveillance.

Research design and methods

I base this analysis on data from 178 longitudinal, in-depth interviews with 64 pregnant women in the greater New York metropolitan area. All participants were enrolled in prenatal care at the time of interviews: 23 women sought care from public, hospital-based clinics and the rest from private practices. Just over half of the women were expecting their first birth. The women represented a range of socioeconomic and racial/ethnic backgrounds and received prenatal care in diverse settings; despite these differences, I found the patterns with regard to pregnancy symptoms to be remarkably similar. Quotes used in this paper reflect these broader patterns; social class status reflects educational background, most recent employment type, and household income, while race/ethnicity was self-reported.

The study design was approved by the New York University Committee on Activities Involving Human Subjects and the hospital review board associated with a research site. The names of women and the hospitals are pseudonyms. The semi-structured interviews ranged between one and 4 h, and were carried out from 2003 to 2006. All informants participated in a minimum of two interviews, one before and one after the birth; most (50) participated in three. I sought to develop an in-depth understanding of women’s experiences of medicalized pregnancy, and asked women to report on their interactions with providers, their pregnancy behaviors (such as changes in eating or exercise), their information sources, their embodied experiences, their feelings about the pregnancy, their work and family situations, and the pleasures and concerns of the pregnancy thus far. I analyzed the data with ATLAS.ti, drawing on the theoretical concerns that drove the study as well as identifying emergent codes, with an aim of developing a conceptual understanding of normality in pregnancy.

The data on which I report here are women’s accounts of their experiences, not observed behaviors in women’s private prenatal appointments with their providers. Given my interest in understanding women’s perceptions of the problems in prenatal care and the strategies they employ to resolve them, the emphasis on women’s accounts is appropriate. Further, my informal conversations with providers suggest that many identify structural concerns, such as limited time for appointments and barriers to access, similar to those of their patients.

Consistent with the diverse embodied changes women are expected to track, I define a symptom not primarily as a “discomfort” as it is common among scholars of illness behavior (Brown, 1995), but more broadly as a phenomenon accompanying a particular condition and interpreted as an indication of that condition. All of the women in my sample reported multiple phenomena that met this definition of pregnancy symptom, although they sometimes expressed confusion or uncertainty about the etiology of the symptoms. The majority of my informants reported they were surprised by the number of changes in their bodies and by the amount of discomfort they experienced during pregnancy. Articulation of pain did not vary systematically with informants’ backgrounds; most women expressed moderate pregnancy discomfort.

Making symptoms matter: self-surveillance as medical mandate

Though they relied heavily on a wide array of prenatal tests to diagnose problems, health professionals also instructed women to mark changes in their bodies in order to report them more accurately during office visits and consultations. They taught women to take pregnancy symptoms seriously and report them so that their providers could know of any indications of danger. Across my sample, women reported that each prenatal examination typically began with the question, “How are you feeling?” While physicians did not perform physical examinations at every appointment, they consistently solicited self-reports throughout the pregnancy. Echoing most descriptions, Erica (34, Latina, upper-middle class, pregnant with her second child) explained what usually transpired in her interactions with her obstetrician:

Well, they tell you to bring your list of questions, and then they ask you a bunch of questions, too. “How are you feeling?” “Any swelling in your legs?” That kind of thing. And mostly it’s just: “fine, fine, that’s fine”. And all the time they’re looking at the chart, too, so they sometimes ask about something there. And then I get my turn to
As Erica’s description makes clear, health professionals made symptoms matter by socializing their patients to providers’ “own interpretations of the signs and symptoms the women will experience as the pregnancy proceeds and the significance that should be attached to them” (Browner & Press, 1997: 116). By telling women what they could expect, providers normalized some pregnancy symptoms; by emphasizing what they should be concerned about, they conveyed to women that at least some symptoms could legitimately reveal problems in a pregnancy.

This socialization to medically-significant symptoms was pervasive. Posters reminding women to do “kick counts,” timing the movements of their fetus, were prominent on the walls of the Bronx clinics, and handouts from a Manhattan practice urged women to contact the office immediately in the event of heavy bleeding. Women were instructed to watch out for clamping or lack of fetal movement and were told that, in some instances, waiting for their regular appointments to share their symptoms could result in losing a pregnancy or endangering themselves. They were instructed that maternal vigilance could help to identify problems, and possibly aid physicians in averting negative or even life-threatening consequences.

Browner and Press (1997) and Oaks (2001), among others, show how health professionals use explanations of symptoms’ significance to encourage compliance with specific directives about pregnancy behaviors (such as to cease drinking, smoking, or drugs and to change diet or exercise habits). Providers described symptoms as “reactions” of the fetus to maternal behaviors that are viewed negatively by the medical establishment, lending credibility to the idea of fetal subjectivity. I documented many cases of providers using symptoms in this way through my interviews. But providers’ efforts to socialize their patients were much more fundamental than that: by encouraging a woman to engage in self-surveillance, health professionals made an awareness of symptoms and the production of a report on her embodied experience an integral part of an individual patient’s pregnancy responsibilities. Such self-reports could, and did, bolster the legitimacy of a specific directive or diagnosis. More importantly, however, women’s reports of self-surveillance allowed providers both to enact their authority through the interactions of the examination and to extend the medical gaze beyond that interaction.

After all, the intended effects of all of these efforts were to prompt patients to seek professional evaluation of their symptoms; no providers encouraged patients to substitute their own judgment for that of their providers when it came to unfamiliar or unanticipated symptoms, according to women’s accounts. While they instructed women that symptoms could signal a problem or a potential problem for their fetus, self-surveillance was not enough; their symptoms needed interpretation. Providers controlled access to medical technology and medical solutions and could determine what the meaning of reported symptoms would be within context of the medical examination. The report of women’s self-surveillance thus reinforced the provider’s authority to interpret her embodied experiences as a medically-significant connection to the fetus, or not. Ultimately, providers made symptoms matter within their framework of knowledge/power.

The contradictions of the prenatal appointment

All of the women in this study got the message that they were supposed to be aware of what was going on in their bodies and to read new or unfamiliar embodied experiences as pregnancy symptoms. But the imperative that women produce a report of their embodied experience caused similar tensions across women’s experiences with care providers, much of it rooted in the rationalization of medicine. One such tension was the result of limited time. Prenatal appointments are typically scheduled for 15 min, and the heavy schedule of providers was impressed upon all patients, even when providers disclaimed its importance. As a result, women were quite conscious not to take up “too much time” and reported that the time allotted to the examination often influenced how much they shared or asked of their providers. Women noted these time constraints were also evident in the length of time it took for providers to return their telephone calls or the number of interruptions that characterized those calls. Patients at the public clinics were also undermined by the systemic barriers to access care. Long telephone waits and connections to wrong extensions by the hospital switchboard when women lost the direct number to the prenatal clinic frustrated many women’s attempts to call with questions. Such difficulties made it far more likely that these women would have to choose between waiting for their next appointment or seeking urgent care at Emergency Department. As a result, women I interviewed articulated a clear sense of the burden their providers carried and their own efforts to minimize adding to it or being a “bother”.

Another tension arose from the repetition and routinization of the prenatal encounter, which necessarily resulted in some providers hearing reports of the same symptoms time and again. As a result, all but five of the women in my sample said that, at one point or another in their pregnancy, a provider had encouraged them to report symptoms, while simultaneously implying they would be inconsequential: “It will probably be nothing” or “You should call even if you think it is foolish”. In some cases, providers simply dismissed the report with a tired or paternalistic wave of the hand, while others constructed the exchange simply as an exercise of reassurance for the patient’s benefit. It is important to note, of course, that medicine, while responsible for identifying potential problems in pregnancy, can offer few interventions to improve women’s embodied experiences in pregnancy. As such, there are often cases in which providers cannot treat or resolve pregnancy symptoms.

In exchanges such as these, women detected a contradictory quality to their care. Providers typically instructed women as to the potential dangers of pregnancy, but they also subtly conveyed the sense that women’s worries about potential problems were likely to come to nothing and that a good portion of what women reported would be irrelevant from the provider’s point of view. For example, two women told me their physicians commented on how they never heard from them, simultaneously chiding and praising their ability to contain their worry. These women recognized a mixed message in this exchange: on the one hand, they were encouraged to take the moral responsibility for self-surveillance and the accurate reporting of symptoms, but on the other hand, quieted by the providers’ need for “good patients” who “make no trouble at all, who do not interrupt the smoothness of medical routines” (Lorber, 1975: 223); As a result, women tried to produce a report of their embodied experience with the understanding that it held clues to the well-being of their fetus/baby, but at the same time, they were often unsure about which symptoms mattered, which they should include in their reporting, how much they should say about them, and so on. While women were charged to report everything to their providers in theory, institutional obstacles, provider ambivalence, or the sheer volume of symptoms meant that women had to learn to share their symptoms selectively with their providers.

Productive symptoms and the discourse of maternal sacrifice

Women’s reporting of symptoms was further complicated by their acknowledgement of the dominant cultural discourse of
“maternal sacrifice”, which suggests that good mothering is based on sacrifice for, and identification with, fetal interests (Casper, 1998; Hays, 1998). I found no significant differences by class or racial/ethnic background with regard to endorsement of the discourse of maternal sacrifice. The rationale on which this sacrifice rested was the idea of the productive symptom. Just as some symptoms could reveal danger to the fetus, other symptoms reflected the needs of the fetus. Familiar, “normal” pregnancy symptoms comprised part of the generally productive process of pregnancy and could even be understood to make specific contributions to the well-being of the fetus. Shelly’s (26, working-class, white, pregnant with her second daughter) determination to “get through” her unpleasant symptoms of nausea that fell within the range of “normal” pregnancy morning sickness was typical of this reasoning:

I just had the nausea at the beginning, you know, and that’s normal. I can get through that… they say that’s what your body does to protect the baby, to keep any risky foods from affecting the baby.

It wasn’t just that morning sickness is well-established in what I refer to as the “cultural mythologies of pregnancy”, a repetition of popular images and narratives which distill the most crucial elements of deeply rooted idealizations of pregnancy. Shelly understood symptoms of nausea to have a purpose in protecting fetal development. Putting the baby first meant that women not only had to participate in self-surveillance, but also to accept and possibly even appreciate the changes wreaking havoc on their bodies and their self-identities.

The discourse of maternal sacrifice was omnipresent in women’s discussions of pregnancy symptoms. My informants censored women who, by complaining about their symptoms, did not conform to this discourse. A few women who discussed their struggles with pregnancy symptoms indicated that they felt judged by others, but also internally conflicted. Anita (28, Black Latina, poor, pregnant with her first child) explained, “It’s not too easy to do some things, but I don’t want to be a crybaby or nothing. I want everybody to know I’m going to be a great mommy”. Complaining about “normal” pregnancy symptoms did not fit the discourse of maternal sacrifice.

On the other hand, women who were “suffering nobly” despite the “real” difficulties and pain involved in maternal sacrifice often earned praise and sympathy. While they did not report every symptom they experienced (an impossible task), they tried to delegate the responsibility for screening all but the most mundane symptoms to professionals. Lynn (36, white, upper-class, pregnant with her third child) was particularly emphatic on this point:

She hates needles. Has always had this total fear. So this is pretty much the worst thing that we’ve come up against… I want to be the best dad I can be, but Lauren is already a mom, you know? She’s already stepped up to the plate, and I see her already putting the baby first, and I think, wow. I knew this was in her, but to see her doing it.

Darryl constructed himself outside the pregnancy here; his work as father still in the future, presumably not beginning until the birth. Lauren, who had never alluded to her fear of needles with me, took up the maternal role in pregnancy by adopting the discourse of maternal sacrifice integral to mothering. While providers made self-surveillance synonymous with maternal vigilance, self-sacrifice and silent suffering co-existed as core themes in the construction of pregnant mothering. In the context of actual exchanges with providers, these two discourses often worked synergistically to encourage compliance, but they could also combine with the institutional constraints on provider—patient interactions to create conflict for women.

Consequences of the contradictions: strategies for navigating the reporting mandate

Once a woman experienced what she classified as a pregnancy symptom, she sought to insure that it did not indicate a problem. Women’s tendency to read embodied experiences as potential problems stems from the equation of pregnancy symptoms with fetal subjectivity and the moral responsibility this placed on women to engage in self-surveillance and understand what was going on with their bodies. To distinguish between “problematic” and “productive” symptoms, women drew on conversations with doctors, their previous experiences of pregnancy or the experiences of friends, the Internet and pregnancy guides, as well as their general familiarity with the cultural mythologies of pregnancy.

Generally, well-known symptoms of pregnancy—such as nausea and moderate weight gain—were easily dismissed, if not easily endured. Some pregnancy symptoms, such as the sensation of fetal kicking, were often productive of reassurance; vaginal bleeding, on the other hand, resembled the “problem symptoms” women had been warned about and was almost always defined as a potential problem requiring medical attention. In these and other cases, women were able to identify symptoms as medically significant or insignificant. But given how many symptoms were not known to pregnant women in advance of their pregnancies and how embodied experiences were symbolically invested with danger, most symptoms required a more involved reading to determine if they were a problem or not. Even women who had previously carried a pregnancy to term found that their current pregnancy symptoms could depart dramatically from their previous experiences. Women were then faced with a decision: to contact a provider (whether by telephone, at their next appointment, or via the Emergency Department) or not. Certainly, the stakes of each choice were different, depending on women’s situations, their insurance types, and the configurations of their prenatal services. Women who had access to a nurse by phone sometimes felt better about calling because she could relegate the burden of her call to a provider whom she saw as less busy than her physician, while women who had more limited telephone access could see a trip to the emergency room as a better choice, especially if she paid little or nothing for that visit. Despite these variations, either choice carried a risk of being a problem patient or bad mother or, as was often the case, both.

Reporting symptoms and risking the problem patient label

A small group of eight women reacted to the sense of danger invested in their bodies by consulting their health professionals with nearly every unfamiliar embodied difference, taking their charge to “confess” all of their symptoms literally. While they did not report every symptom they experienced (an impossible task), they tried to delegate the responsibility for screening all but the most mundane symptoms to professionals. Lynn (36, white, upper-class, pregnant with her third child) was particularly emphatic on this point:

I call a lot. If something feels different, I think it is very important to be on the safe side. I’ve always called, with all of them [her pregnancies]. It’s not a big deal. They are the professionals; this is what they do; this is why I found Dr.____, I wouldn’t feel comfortable making that decision [if a symptom indicated a problem], I’m not a doctor.

Women who embraced this strategy tended to be the most economically privileged of those I interviewed, those who could take for granted a greater ease of access to a physician’s or nurse’s opinion. Women who had been diagnosed with conditions which
posed some risk to their own lives or that of their fetus, such as gestational diabetes or preeclampsia, were also more likely to report calling between appointments. After being diagnosed, these women typically gave up any authority to judge whether or not their symptoms might signal a problem or not. Their diagnosis replaced pregnancy as their master status through which symptoms were read, and although women could come to normalize condition-specific symptoms over time, they typically expressed far less confidence in assessing their embodied experiences and felt entitled to “extra attention” from care providers owing to their condition.

Expectant mothers who utilized the “problem patient” strategy often embraced that label as a badge of good mothering; for example, Sandra (37, white, upper-middle-class, pregnant with her fourth child) described herself as “the classic neurotic mother”. Acknowledging that she could be seen as overly-anxious by providers, Sandra attempted to leverage the discourse of maternal sacrifice by demonstrating that she was willing to make herself appear ridiculous to medical professionals in her efforts to be vigilant about her children’s well-being.

However, there were two important downsides to this strategy. The first was that women who called frequently often felt that being seen as a “neurotic mom” invalidated the legitimacy of their concerns and potentially minimized their importance in the view of the provider. Despite Lynn’s endorsement of calling “a lot”, she also occasionally worried that she might wear out her providers’ patience and be unable to receive timely help if she needed it, “like the boy who cried wolf”. In this way, the boundaries between “proudly proactive” and “problem” patient were often unclear.

The second downside was that, instead of harnessing the moral value of maternal vigilance, the sense of being seen as too overbearing as a patient could transfer to being too overbearing as a mother, threatening both a woman’s claim to being a good mother. Martha reported that one of the nurses at her private practice had referred to her as “high maintenance, as a joke, but not really, more like I’m trying to tell you something”; similarly, Britanny commented that her doctor had told her: “more than anything, the baby needs me to relax and not be so stressed”. In these comments, women felt their concerns in pregnancy were seen as indicative of a dysfunctional or overanxious style of mothering.

Even among the larger number of women who restrained themselves from contacting providers as frequently as they experienced unfamiliar symptoms, the risks of reporting persisted. Women who infrequently contacted their providers between appointments still often described themselves as “stupid” or apologetic about the emergency that wasn’t. Just under half of the women I interviewed described themselves as having “overreacted” (or used a close synonym like “freaked out”) to a symptom that was diagnostically meaningless although she had made efforts to consult pregnancy books or more experienced mothers before “bothering” her providers.

Providers sometimes appeared to reinforce this concern by invoking the discourse of maternal sacrifice themselves and threatening women’s status as “good mothers”. Implicitly or explicitly, physicians reminded women how much worse their symptoms could be with stories of “real” suffering on the parts of other patients, as Heather (28, white, middle-class, pregnant with her first child) described:

There was this insinuation, you know, “well, at least you’re not really sick”. I know they see women who are much worse off than me, and I know they have a million women asking the same silly questions, but I’m just me. I don’t know what it is. And the cramping scared me.

Heather’s claim that her provider had encountered the “same silly questions” illustrates that the routineness of the prenatal encounter shaped her interpretation of the response she was provided. This type of dismissal could occur even when the symptoms were experienced by women as quite debilitating, if women appeared to cross the line between reporting symptoms and “complaining” or “whining”. Marie (34, white, middle-class, pregnant with her first child) felt indignant at her obstetrician’s response when she reported her back and pelvic pain:

I was disappointed by her response, frankly. She just said, “That’s just being pregnant, you have to expect some amount of discomfort”, no, “anticipate some amount of discomfort”. And I thought, well, I did anticipate some discomfort, but now I’m having a lot of discomfort. It wasn’t that I wanted her to do anything in particular — what can you do, really? — but it felt bad, she treated me like, like she thought I was whining.

Marie felt she had been incorrectly perceived as not upholding the discourse of maternal sacrifice; this was a violation of Marie’s identity as a good mother as much as it was a failure to acknowledge her efforts to conform to the needs of the busy obstetrician.

It is important to note that, when a woman did contact her provider with concerns about pregnancy symptoms, it was not uncommon for the interaction to bring neither reassurance, nor relief. For some embodied experiences, there were no easy answers and little help in interpreting symptoms from obstetricians and other professionals. It is worth noting, too, that many pregnancy symptoms are chronic, and any reassurance offered by a provider was often provisional: as such, women often found themselves having to decide once again whether or not to seek medical attention for their symptoms. I asked Leisha (21, Black, poor, pregnant with her first child) if she saw a contradiction between her fears that her backaches could indicate a problem and her willingness to “put up with them”:

What can I do? If it’s a problem, it’s a problem. Nothing I can do about it ‘til it’s over.

I: But you said before that you worried it was a problem, to watch it to make sure it didn’t become a problem, but you still have to get through it everyday. How do you do both of those things?

Ah, yes, I would tell the midwife if it gets worse. But, right now, she says it’s okay. But I would ask her to check it out.

I: And now?

But now, she says it is growing and that is why my back hurts. But it is better it grows now, for the baby.

Leisha’s account of wary watchfulness combined with resignation was common among women with chronic pregnancy symptoms. By eight months’ gestation, Leisha had made a temporary peace with her symptoms after a long lecture from her midwife about the ill effects of stress on her baby and reassurance that this symptom was both “normal” and productive. At the same time, she was on guard should her backaches become worse in the future. I read her frequent use of the word “but” as she bounced between her worries and discomforts and her understanding of her baby’s needs as revealing just how uncomfortable it was for her to stay with either reading of her symptoms, whether as problem or as productive, for very long.

While providers could show greater or lesser sympathy for women’s experiences, the emphasis on the accurate reporting of pregnancy symptoms transferred a great deal of responsibility to women for the timely diagnosis of any potential problems with the pregnancy or the fetus. Yet, when women did report their symptoms, it did not necessarily provide women with much greater control over the prenatal appointment nor legitimize embodied experiences deemed insignificant by their health care providers. Although the emphasis on the exchange of information in the prenatal encounter did allow women to give voice to some
important concerns, symptoms that were not seen as clinically significant were often dismissed by providers as “normal”.

**Normalizing suffering**

When asked, expectant mothers would frequently answer my direct questions about their specific symptoms, but then follow up with comments that undercut the severity of the pain they had just described: “It’s not really that bad”, and “Of course, I manage”. In this way, they minimized their embodied experience of pregnancy symptoms and denied the legitimacy of their own pain and suffering, as well as that of others. Lydia (38, white, working class, pregnant with her first child) explained how she saw the normalization of these symptoms as continuous with her new role as a mother at thirty-three weeks gestation:

> Oh, what can I say? Complaining about it [her back pain] isn’t going to make it any better! I hate to be one of those miserable complained [sic] women. They drive me nuts! Just get over yourself already! You’re having a baby! I just keep thinking “I have another two months to go”, and then I’ll have her.

Most of the women I interviewed shared this sentiment, indicating that they could and should “suck it up for nine months”, “grin and ignore it”, and “bite the bullet”. In this way, they sought to conform to the discourse of maternal sacrifice by focusing on the “prize” at the end of the painful journey. This normalization often extended into the prenatal encounter, where women reported choosing perhaps just one or two symptoms to share with a provider during their regular appointment.

The commitment to noble suffering often translated into a refusal to employ the few interventions that are endorsed by providers for relief from pregnancy symptoms. Adherence to medical authority was an important component of the discourse of maternal sacrifice, but some women felt that their providers were too permissive. Just over a quarter of the women I interviewed reported refusing their physician’s advice, as when Hannah (32, white, upper-middle-class, pregnant with her second child) skipped an advised dose of Tylenol on the grounds that she “wouldn’t want to risk it… it’s okay, it’s just a headache”, a small but powerful immanent critique of the medical establishment. Hannah linked this choice to maternal sacrifice in her post-birth interview:

> The time that you are pregnant is such a small, uh, piece of your life, but it’s time you can never get back. And it’s hard, but… well, I guess I have a hard time understanding why more women – I hate to say this – why women who put, just put anything into their bodies while they are pregnant. I guess I get why drug addicts, women who are addicted, do it, but, for normal women, what can’t you give up for nine or ten months? You have to care for that child; you’re going to be a mom.

Hannah and others invoked sacrifice as a part of their long-term maternal duty which had already begun – though somewhat paradoxically, the idea of pregnancy as a temporary experience and something that would soon be over (as women count down months and weeks to go) was integral to this interpretation as well. The willingness of some women to sacrifice more than was required from them, so different from most accounts of symptom accommodation in chronic illness, was powerfully linked to and performative of the maternal role; the contrast to women who complained about pregnancy symptoms could not be more clear. But the temporary nature and definite end-point of the pregnancy condition, however far it sometimes seemed, meant that many women were able to strive for better-than-good-mothering. Taken together, the productivity of pregnancy symptoms, the understanding that pregnancy symptoms connected mothers to their fetuses, the limited time frame of pregnancy, and the cultural imperative of maternal sacrifice created a situation in which most women normalized and minimized their pregnancy symptoms.

Yet this better-than-good-mothering also had its risks. Occasionally, women “failed” to construct their symptoms as problems or seek help for their symptoms, as Lauren’s case (introduced earlier) demonstrates. She told me that she would “never forgive herself” if the delayed diagnosis for gestational diabetes caused a problem for her first son. Until she took the routine sugar test in her sixth month of pregnancy, Lauren thought her “yucky” tiredness was a symptom of pregnancy and nothing to worry about:

> I feel, well, yucky sometimes. I thought I was going to feel better in the second trimester, but then again, I thought it was just being tired from being pregnant. And then I took the sugar test, with the drink, and I flunked it. So I had to take the three hour one and they told me I had gestational diabetes. I didn’t get it right away, but now I can tell, I can connect the yuckiness with high sugar.

Lauren had to revise her understanding of a “normal” pregnancy symptom to see her “yuckiness” as a signal that she needed to monitor and adjust her blood sugar. Once diagnosed with gestational diabetes, she read this diagnosis back onto experiences she once thought were reflective of “normal” pregnancy tiredness, but now revealed a problem. Lauren was heartened by the fact that she might have been tested earlier if she had mentioned her tiredness to a physician (which itself is questionable, as Lauren had no family history of diabetes). The fine line between “normal” tiredness and “diabetic” tiredness proved a crucial distinction for Lauren’s treatment and interpretation of her symptoms in the last months of her pregnancy. By mistaking problematic low sugar levels for productive “normal” pregnancy exhaustion, Lauren felt she had “failed” her first test as a mother, despite the validation she would later receive from Darryl for her willingness to embrace her new diabetes regimen. Despite the complexity of the situation Lauren faced, the responsibility for her “late” diagnosis fell on her alone, even by her own account. While Lauren’s case was somewhat unusual, the perceived risk to her son and the individualization of responsibility for that risk served as the cautionary tale of normalizing symptoms that most women feared.

**Conclusion**

My research documents how women’s embodied experiences during pregnancy are usually interpreted as pregnancy-related, so much so that, as the possibility for other causes of embodied experience became circumscribed, women came quite literally to “embody” their pregnancies. Rather than teaching women to disregard their embodied experiences, as has been suggested by some scholars (Gregg, 1995; Jordan, 1997; Rothman, 1987), medical authorities encouraged a self-surveillance more consistent with Foucault’s idea of the medical examination, in which the inducement to speak, of “having to tell about everything”, reinscribed “the procedure of confession in a field of scientifically acceptable observations” (Foucault, 1978: 65). While Young is correct to note that the experience of pregnancy “is reduced in value” by the proliferation of obstetric technology, it has not been “replaced by more objective means of observation” (2005: 58). Instead, as my research shows, women’s embodied experience is incorporated into the contemporary prenatal regime: guided initially by provider request, women routinely objectify their embodied experiences over the course of their pregnancy. In this way, medical surveillance of women’s embodied experience extended far beyond the medical encounter itself.

The key finding of this research is that contradictory understandings of the “good patient” underlie the women’s reporting of symptoms. That is, the mandate to report symptoms could be at
odds with not only the time constraints on provider—patient interactions and their routinization, but also with deeply-held notions of good mothering based on sacrifice and the normalization of suffering. This finding has three important implications for the literature on pregnancy and reproduction.

First, previous research on women’s embodied experiences of pregnancy has documented how women’s management of pregnancy symptoms is discounted as intuitive adaptation to the maternal role rather than mental, physical, and emotional labor (Miller, 2005; Warren & Brewis, 2004). As Gatrell notes, “medical and social expectations about self-regulation, and compliance with screening regimes, are wrapped up in the role of ‘good’ and ‘selfless’ mother… but are socially discounted as ‘natural’” (2008:63). In my research, the labor of constant self-surveillance was indeed discounted, my data also show that women recognized that the expectations they faced in pregnancy were often tacit in conflict with each other and, furthermore, described themselves as making strategic choices about reporting symptoms. Pregnant women were sensitive to the ways in which they could be labeled a “bad” or “problem” patient by offering too much information in their interactions with health care providers; at the same time, their internalization of broader cultural understandings of maternal responsibility and sacrifice left them open to criticism as a “bad” or “problem” patient as well. As a result, compliance, in the strictest sense of the word, proved elusive. Pregnant patients were always subject to critique, and, to a great extent, they knew it.

Second, despite recognizing the “double-bind”, including (sometimes) its institutional and cultural dimensions, the women I interviewed saw themselves as responsible for reconciling these contradictory imperatives. This finding is consistent with much of the literature demonstrating that surveillance medicine reduces “social problems” to individual behaviors (see, for example, Armstrong, 2003; Flavin, 2008). In holding themselves (and other pregnant women) responsible for violating standards of “good mothering”, women rendered invisible the complexity of “compliance” with which they struggled. Importantly, this reductionist tendency was present in both strategies women used to navigate the double-bind. Reporting symptoms could be read as indicative of personality flaws: being overly anxious, entitled, or aggressive; “whiney”; or without the judgment required of good mothers. Normalizing suffering was unlikely to be seen as a problem until a “mistake” in reading a symptom as “normal” and failing to report it to providers was detected through other means of diagnosis; the penalties that attach to women’s reproductive “negligence” are severe, especially when they are understood to affect fetal well-being. This individualization of responsibility for reporting symptoms obscures the mixed messages, interactional contradictions, communication barriers women faced, as well as the fact that the diagnostic usefulness of women’s embodied experiences is limited to a small number of situations, that interventions to correct problem or “save” a pregnancy are few, and that detection of a problematic pregnancy symptom may often in fact reveal that a problem has already occurred.

Third, at the outset of this paper, I argued that compliance was a moral question and that numerous studies have demonstrated that health care providers judge their patients on their ability to conform not only to medical prescriptions, but also to institutional regimes. Previous research has documented the varied tools that providers use in order to influence patients’ behaviors; in reproductive medicine, invocations of “good mothering” and approval of women’s self-sacrifice are dominant (Armstrong, 2000; Casper, 1998; Pollock, 1999). The practice of medicine, then, is not acultural, but instead reflects contemporary ideology about motherhood. Like these researchers, I found that providers often invoked the discourse of maternal sacrifice in their attempts to change women’s behaviors, gendering compliance by linking it to cultural scripts about good mothering, but also creating contradictions of which providers often appeared to be unaware. This research also extends their accounts by demonstrating the ways in which institutional routines of prenatal care were also frequently in tension with other stated needs of providers (such as a “full report” of symptoms). At the intersection of pregnant women’s experiences and the current organization of prenatal care is a double-bind that, left unresolved, can only hinder the best goals we have for each.

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