Childbirth is an intimate and complex transaction whose topic is physiological and whose language is cultural. Topic and language or, to put it another way, content and organization are never available one without the other. They must be considered together for a holistic view.

(Jordan 1992 [1978]: 1)

In *Birth in Four Cultures*, a founding work in the anthropology of reproduction, Brigitte Jordan (1992 [1978]) employed “language” as a metaphor for the cultural variations of practice that surround and support the physiology of childbirth. Yet, her statement went not far enough. Childbirth and reproduction more generally are not only “like” language, but also constructed and constituted by, through, and of language. Human reproduction is a linguistic as well as a biological, social, and cultural experience.

This chapter considers the significance of language both in and as practices of reproduction. Whether written, spoken, or signed, language both provides humans with a means of communication and vehicles for expression, thus mediating our experiences, and also itself constitutes social action affecting and effecting consequences for the people involved and invoked in the exchange of text or talk. Through language, we enact, perform, embody, and reproduce relationships and persons, as this chapter discusses. What we say about reproduction and to whom, when, where, and how we say it inflect our expectations and experiences of bearing, birthing, and bringing up children.

As other authors in this volume also argue, human reproduction is a topic that particularly demands a holistic approach. Yet, the “holism” of reproduction is described most frequently in terms of biology, society, and culture, and the integration of biological and sociocultural anthropology. There has been growing interest in the material culture of reproduction, with archaeology providing important methodological and theoretical frameworks (see Nowell, Mitchell, and Kurki in this volume); indeed, there is also increased recognition of reproduction in the past and the contributions of bioarchaeology as relevant to our understanding in the present (see Scott and Betsinger, and Halcrow et al. in this volume). Language and linguistic anthropology,
Language and anthropology of reproduction

however, remain missing from the anthropology of reproduction. An aim of this chapter is to fill this gap.

In studies of language, “reproduction” has referred to the transmission or learning and teaching of language from one generation, with a particular focus on the interactions of caregivers and children (Ochs and Schieffelin 1984; Garrett and Baquedano-Lopez 2002; Kulick and Schieffelin 2004), and to the related larger questions about continuity and change in language. While linguistic anthropologists have made significant contributions to studies on children and childhood, they have given scarce attention to the ideas, practices, and experiences of pregnancy and parturition. This oversight is mirrored in the neglect of language in the anthropology of reproduction. At its founding in the late 1970s, this area of study had as its aim to counter the assumption that human reproduction is natural and biological by bringing into focus the social and cultural dimensions of human reproduction. Even though so much of human sociality and culture is comprised of language and talk, sociocultural anthropologists have not taken the opportunity to more specifically examine them. This lack is as evident in the anthropology of reproduction as in other areas.

In other work (Han 2018), I have outlined a linguistic anthropology of reproduction, approaching human reproduction as experiences that are “talked about” in public discourses; comprised of “talk between” and “talk to” persons; and mediated also through the reading and writing of texts. I continue this effort here, but focusing on pregnancy, text, and talk between and to persons. The discussion here is comprised mostly of reading between the lines in the literatures of the sociocultural anthropology of reproduction and of linguistic anthropology, which have engaged each other only glancingly. It draws from studies in literacy and in sociolinguistics, particularly from research on medical communication. The language and linguistic practices of biomedicine figure significantly in the expectations and experiences of the pregnancy experiences that Tsipy Ivry (2010) called “normal” and that I called “ordinary” (Han 2013); see also Teman and Ivry in this volume. Much of the work referenced here is based on research in societies where childbearing and childbirth have come to be regarded and treated, to varying degrees, in biomedicalized terms. This includes my own ethnographic study in the United States. This chapter, however, does not cover the text and talk of infertility and assisted conception, which deserve their own analysis (see Inhorn and Gerrits in this volume).

Important to note here are the deliberate uses of the terms “pregnant people” and “women” (see also Mishtal and DeZordo in this volume). The adoption of “pregnant people” is part of the larger social, political, and legal movements of the present moment to change the assumed ideas and practices surrounding gender and to build a more expansive understanding of gender and the inclusion of more people. However, my past research and most other work that I cite here did not necessarily ask and address questions about gender and people, but about gender and women (as well as men). Thus, when I discuss my previous study, I continue to use “pregnant women” as well as “expectant mothers” (or “fathers”). Similarly, I use terms such as “fetus” and “baby” intentionally, not interchangeably.

Textual reproduction

Planning for a pregnancy is an ideal or illusion toward which a number of would-be pregnant people in the US invest their efforts, resources, and time, and it is a moment in which texts figure significantly. Or put in the terms of linguistic anthropology, modern American conception and pregnancy are literacy events, which linguistic anthropologist Shirley Brice Heath (2001 [1982]) defined as “occasions in which written language is integral to the nature of participants’ interactions and their interpretive processes and strategies” (319). Heath’s work considered the
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bedtime stories that American middle-class parents read aloud to their children. This chapter discusses the efforts of American middle-class women to become mothers. For both occasions, the texts provide structure and significance; in each event, individuals interact not only with the texts, but also through them.

In linguistic anthropology and other disciplines concerned with language, literacy has come to be understood more expansively than the ability to read and write, as linguistic anthropologist Patricia Baquedano-Lopez (2004) has noted. It is now recognized as “part of one’s orientation to a lived reality made meaningful through the interpretation of text . . . Literacy is less a set of acquired skills and more an activity that affords the acquisition and negotiation of new ways of thinking and active in the world” (Baquedano-Lopez 2004: 246). Text, too, includes a broader range of forms and materials. Modern American reproduction features the reading and writing of traditional and newer forms of print and media ranging from books to blogs. It also includes other materials and units of meaning, like basal body thermometers, mobile phone apps, pregnancy tests, and the bodily conditions and substances that they, in turn, make interpretable and intelligible. Interactions with these various forms of text shape and form the core experiences of conception and pregnancy.

By the book

Even before as well as during pregnancy, reading figures significantly for expectant parents in the US. Most of these texts are addressed to pregnant women in particular, with limited consideration of men as male partners and expectant fathers. The texts that pregnant women read include the books they buy, borrow, and receive offering guidance on pre-conception planning, pregnancy, birth, breastfeeding, and baby care. (This does not include the number of memoirs about pregnancy, birth, and parenting, which lie outside the scope of this chapter.) Each time expectant parents visit the doctor’s or midwife’s office, they are given information sheets and pamphlets advising them on nutrition and diet, fitness and exercise, and emotional health and wellness. In addition, there are websites to browse, newsletters received by email, and mobile apps sending daily informational text messages.

One way of understanding the significance of literacy in reproduction is to view the reading of these texts instrumentally as an acquisition of knowledge. Drawing from fieldwork she had conducted during the 1980s, Robbie Davis-Floyd (1992) noted: “One of the very first sensations experienced by first-time mothers in my study was panic at the realization of their near-total lack of knowledge about birthing and babies” (31). Thus, the women in Davis-Floyd’s study turned to texts whose authors are considered experts and whose contents are their written expertise.

Whether flipping through the pages of a pregnancy book, browsing a website, or scrolling a text message from a mobile app, readers are presented with the descriptions and explanations of the physiology of gestation and the development and growth of the fetus as the “facts” of reproduction. Notably, then, these facts have to do specifically with fetal bodies. Often, the words are accompanied by images such as anatomical drawings and other illustrations, which reinforce that the facts of reproduction are bodily. It is within the context of this factual information that pregnancy books and other texts include consideration and discussion of the pregnant people’s experiences with a focus on their unfamiliar physical and emotional sensations. The language and tone used in the texts are intended to be empathetic and reassuring as well as clear and accessible. The Girlfriends’ Guide to Pregnancy, which was popular with the women in my study (in the 2000s), employed a humorous voice and frank take that were modeled on what a close female friend might say. The texts of reproduction not only provide “facts,” but also actively invite readers to engage with them emotionally.

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Thus, another way of understanding literacy as reproduction is to consider how and why expectant parents look to texts in the first place, not only as authoritative forms of knowledge, but as resources of meaning and interpretation. The continuing proliferation of texts in terms of both content and form—from books to blogs to daily notifications from a mobile app—suggests more than a want or need for instrumental knowledge about reproduction. Our interactions with these texts themselves also shape and form what we know and feel and how we think and act so that they come to constitute reproductive experiences themselves.

**Bodies of text**

In the early 2000s, based on the recommendations they read in a book titled, *Taking Charge of Your Fertility*, a number of the women in my study closely observed and “charted” or documented a number of bodily signs, such as menstrual periods, basal (or resting) body temperature, and cervical fluids, which pointed to the time of ovulation and “peak” fertility. More than a decade later, there are a number of apps, with names like Fertility Friend and Clue, which can be used to “track” fertility cycles and schedule to have intercourse on the days that seem optimal for conception to occur; linguistic action begets social action. By reading a book or the screens of information on an app, ovulation, which is otherwise largely undetectable, becomes discernible. By charting or tracking one’s cycles, the bodily conditions and substances of female reproductive bodies become not only inscribed in and as written records, but also ascribed with importance and meaning. In effect, body temperature and cervical fluids become texts that are interpretable and intelligible only in interaction with still other texts and materials and units of meaning, specifically books and mobile apps.

As literacy scholar Uta Papen (2008) observes: “Pregnancy starts with a literacy event—the pregnancy test” (377). Indeed, as medical historian Sarah Leavitt (2006) suggests: “For millions of women who came of age in the 1980s and 1990s, there is no such thing as pregnancy without the home pregnancy test” (321). Since their approval for use in the US in 1976, the tests have become simpler to use as well as more sensitive. Then, tests required a sample of the first urine of the day and a waiting time of about two hours to produce a result; now, “early” pregnancy tests are advertised for use as soon as the first day of a missed period. Although the makers and marketers of home pregnancy tests today claim results that are easier to read and more accurate—and provide detailed written instructions for users to follow—Linda Layne (2009) notes women themselves “sometimes doubt their own perceptions and question their ability to accurately read the home test results” (65). For most of the home pregnancy tests sold in the US, the results appear in the form of one line (negative) or two lines (positive) indicating the absence or presence of detectable quantities of human chorionic gonadotropin (hCG), one of the hormones associated with the early stages of pregnancy. Interestingly, the women in my study took notice not only of the number of lines, but also their faint or clear presentation and the rapidity with which they emerged. When the results appeared almost immediately as two clear lines, it seemed to indicate the “strength” or certainty of their pregnant status, yet they might still feel disbelief. When the results appeared more gradually and faintly, they seemed more ambiguous. In both cases, many women, like those in S. Leavitt’s and Layne’s studies, took more than one test.

Both S. Leavitt’s and Layne’s work apply (and illustrate) the critical frameworks and insights of feminism, medicalization, and science and technology in the sociocultural anthropology of reproduction. S. Leavitt (2006) described the home pregnancy test as a “private little revolution” that promoted the interests of women and reversed the medicalization of pregnancy “by illuminating an area in which women assumed control of knowledge that had previously had been in the hands of their doctors” (319). Layne (2009), however, questions whether the home
pregnancy test can be called a feminist technology. She raises concern not so much about the test itself, but the context and conditions in which it is used. While women may gain the knowledge they are pregnant even at the earliest stages, they do not necessarily gain the power to act on it. The availability of home pregnancy tests has had no appreciable impacts on prenatal care and birth outcomes over the last 40 years, and even in the US, where abortion on demand is recognized as a right, access to safe abortion care has become increasingly restricted.

Re-reading the home pregnancy test in terms of literacy brings additional insight into the making and meaning of human reproductive experiences. This includes the construction of the new reproductive experience of the “chemical pregnancy” (Han 2015). The presence of hCG has been detected in an early pregnancy test, but there is no further development. Without the test, the chemical pregnancy might have been experienced as a “late” period. With it, however, a woman may understand herself to have been pregnant and then experienced its loss. So it was for Nicole, a woman in my study who first introduced the term and concept to me. She not only kept detailed notes on her current pregnancy (with a daughter who was later born at home with the help of a midwife), but also carefully preserved the results from her previous chemical pregnancy. This was a pregnancy that existed only on paper—literally, the test strip contained in the plastic handle of a home pregnancy test. There had been no bodily signs, but what had been observed and still remained was a chemical signature. Shaped and formed by test and text, the chemical pregnancy is a technological artifact and a literacy event.

Writing a pregnancy

Pregnancies are not only the makings of babies (and parents), but also of the makings of documents ranging from the bodily texts considered above to the more conventional texts of medical records and personal journals and diaries discussed below.

Medical records are not merely representations of an individual’s medical history and what has taken place over the course of the interactions that occur in the giving and receiving of clinical attention. Instead, sociologist Marc Berg (1996) described them as

a constitutive element of current medical work. It enters into the “thinking” processes of medical personnel and into their relations with patients and with each other. It helps to shape the form the patient’s trajectory takes, and it is actively involved in the transformation of the patient’s body into an “extension” of the hospital’s routines.

The records typically contain standard, economical phrasings that are written and later read quickly, providing nurses, doctors, and midwives a point from the previous visit against which they compare the present one. Thus, the records also serve as a script to guide the current interaction as questions are asked in order to update the file.

These documents had been kept primarily on paper, but since the 2000s in the US, UK, and elsewhere, they are maintained as electronic health records, which also has ushered the presence of desktop computers into medical examination rooms and their involvement in the interactions between clinicians and patients. In a study of visits with general practitioners, Deborah Swinglehurst (2014) suggests there are important consistencies and contrasts between the making of paper and electronic records, noting the electronic records are “not only a source of patient information but also a means of highlighting what information ought to be sought, constituting new external lines of accountability” (24). As with the paper records, the electronic records serve as a script and guide, but the institutions that maintain them also require the col-
lection of more and other information, which clinicians themselves experience as distracting their attention from the immediately relevant issues of their patients, and place on patients “a burden of additional interactional work to maintain or retrieve the attention of the clinician when faced with ‘outside’ competition” (Swinglehurst 2014: 24).

The keeping of records, then, keeps medical personnel and patients “in place” in multiple ways, including the enactment of authority. Davis-Floyd (1992) observed that prenatal medical care requires pregnant women in the US to subject their bodies to being routinely examined, evaluated, and written about. Yet, they do not necessarily have free access to “their” files, which in fact were held in the possession of the medical practice where they received prenatal care. Papen (2008) describes the expectation for pregnant women in England to literally keep their own notes in a Personal Maternity Record, which they then presented at their visits with the doctor or midwife. Tasking pregnant women to keep their own records had been intended to “engage” them in their medical care in such a way as to improve their outcomes and experiences. However, written in a booklet with a green cover, the “Green Notes” were issued by the National Health Service and prescribed what the notes ought to contain, providing spaces for the dates of their antenatal care appointments, the topics and recommendations that were discussed, and the doctor’s or midwife’s own notations. In addition, the medical personnel wrote and kept their own records apart from the Green Notes. Papen, reflecting on her own experience with keeping her own Green Notes, comments: “for me the Notes were associated more with professionals—my carers—than with me. As a literacy practice, they were shaped by the needs of the healthcare providers and the culture of the NHS” (2008: 388).

Ivry (2010), in her ethnographic account of pregnancy in Japan, describes an interesting contrast to the experiences of medical record keeping in the US and UK. In Japan, too, pregnant women are tasked with keeping their own notes in a mother–child handbook or boshitecho that is issued to them as part of their prenatal care. However, the women whom Ivry encounters in her study describe their pleasure in the writing of their notes, describing their displays of “talent” at keeping a diary and expressing their satisfaction with producing a document to have in hand and later to share with a child. Ivry suggests that the boshitecho, as an artifact of “a literary cultural tradition of meticulous, snapshot-style documentations” that dates even to the personal diaries of medieval courtesans (2010: 145–46), is not a record of surveillance, but “a written manifestation and symbol of the shared responsibility of the mother and medical practitioners: it is designed for both the mothers and the practitioners to complete” (2010: 142, emphasis in original).

For women in the US and UK, the keeping of medical records gives institutionally prescribed shape and form to pregnancies as biomedicalized events. It is within this context that the keeping of personal journals and diaries during pregnancy becomes important and meaningful. For a number of the US women in my study, journaling enabled the writing of what seemed a more complete document than medical records, which in any case were not theirs to keep. Although I do not recall any of them describing their keeping their own notes as acts of “resistance,” it seems an apt word, particularly since many of these women were aware and critical of the medicalization of childbirth and actively sought their own education in and support for more “natural” approaches. Early in the pregnancy, writing in their journals or diaries provided a means of making sense and order of what felt like disruptions to the physical, emotional, and social dimensions of their ordinary lives. Later, as their pregnancies furthered, the US women whom I came to know in my research, like the Japanese women in Ivry’s study, were interested also in creating a tangible record of their thoughts and feelings, which they kept both for themselves and for an imagined and expected child with whom they hoped to share their memories.

Men’s reproductive experiences remain an area to be explored and examined more thoroughly (see Powis and Gray, Straftis, and Anderson in this volume). This includes their par-
ticipation in the literacy events of reproduction. At the start of this discussion of “Textual reproduction,” it was noted that most of the texts of reproduction in the US are intended for a readership of pregnant women and expectant mothers. The books, websites, and mobile apps addressing men employ language and tone that are rather different from those used in the texts for women. For example, beginning in the 2010s in the US, mobile apps with names like Daddy Up and Who's Your Daddy have become recommended as resources that combine comic relief with information and advice for expectant fathers. Interestingly, mobile apps like Contraction Timer frequently become recommended as tools of support for expectant fathers and male partners, when in fact they might be helpful for pregnant people as well as partners, regardless of their gender.

In addition, men’s participation in the making of the documents of reproduction also requires attention, from the medical records of men as patients seeking treatment for infertility to the other texts of normal and ordinary pregnancy that they may produce. Historian Judith Walzer Leavitt (2003) has provided an especially meaningful historical example in her discussion of the “Fathers’ Books” that were kept in US hospitals during the mid-twentieth century, when cultural ideas, social practices, and hospital policies barred men’s presence during childbirth. Sent to the so-called “stork club” or men’s waiting room, expectant fathers of the 1950s and early 1960s passed their time by recording their feelings and thoughts in the Father’s Book or blank journal that was placed in the room for this purpose. J. Leavitt (2010) notes that while some of the men’s written entries were humorous or sarcastic, most of them were reflective and even vulnerable. Interviewed 50 years after he wrote in the Father’s Book, one of them men remarked: “I was very serious when I wrote that, and I think probably in most if not all cases all of the men who wrote in that book were writing some of the most honest statements they have ever or ever will make” (68–69).

Pregnancy as formed of talk

For ethnographers, the aim is to capture the minutiae of human experience, but unless the goal is to produce an account of language and the linguistic practices of everyday life, much talk remains under-explored. In my own research on pregnancy in the US, talk had not initially been a primary interest, but it emerged as one. By listening to the women in my study, I came to understand that the ordinary experiences of pregnancy are formed of diverse talk (as well as silences, which I also briefly discuss in this section).

During the interviews I recorded with them, I began to ask about the conversations they had with partners, mothers, friends, and neighbors. Unfortunately, however, I collected less information about this kind of informal talk than I did about talk in more structured settings. For example, I was able to take advantage of events like a “gender reveal” party (held in 2003 before these celebrations became widely popular, and the first I ever attended) and baby showers and birthing classes, where I could participate in and observe the talk about pregnancy. In the discussion that follows, the focus is on the conversations with medical personnel at prenatal care visits and sonograms; the interactional sensitivity and silence that surround reproduction; and talk about and to an imagined and expected child.

Medicalizing pregnancy through talk

Even while we live in so much talk in our own lives, gaining access to the ordinary talk in other people’s lives is quite challenging. So, this is a practical reason why pregnant people’s interactions with medical personnel figure prominently in a scholarly consideration of the linguistic
experience of reproduction. In addition, medical communications significantly shape pregnancy for US women. In the US, 75% of women receive what CDC defines as “adequate” prenatal care provided by a physician or other healthcare professional (Osterman and Martin 2018). Ideally, this includes a series of regularly scheduled consultations and examinations that begins with the confirmation of pregnancy and continues through the birth. At various points, various tests or screenings are recommended to evaluate the condition of the developing fetus as well as the health of the pregnant person. The prenatal care visits become more frequent approaching the estimated date of delivery. Almost 99% of US births occur in hospitals. Globally, meeting healthcare needs and improving pregnancy and birth outcomes, particularly for Black, brown, and poor people, have been raised as priorities. While biomedicine is only one approach to health and reproduction, it is also the dominant one. Thus, the interactions that occur during prenatal care visits and in hospital delivery rooms and other medicalized settings are important and meaningful sites for study.

Communication is regarded as an essential practice of medical work/labor and care (Briggs 2020). The globalization of biomedical ideas and practices has raised the stakes further, as the shortcomings and failures of communication become counted among the causes and effects of health disparities and inequalities. Medical interviewing has long been an area of interest and concern. In fact, much of the research in this area is intended to inform clinicians and thus improve their communicative practice. Even while “talking with patients” comprises much of a doctor’s work, Elliott G. Mishler (1984) noted medical students received little formal training in it, raising questions about clinicians’ preparedness to do their work and the possible effects on patients. In particular, the hierarchical structuring of doctor–patient communications and the discursive practices that contribute to the construction of authority have faced increasing scrutiny as a number of studies describe the impacts on individuals’ decisions about their medical treatment (Ong et al. 1995).

The talk between medical personnel and patients ostensibly becomes represented in medical records (discussed earlier), so that a not uncommon complaint of both clinicians and patients is that the point of these conversations seems to be the production of these documents. The shift from paper to electronic records has prompted the insertion of desktop computers into the interactions between clinicians and patients, which in turn creates additional tensions atop already existing ones, as Swinglehurst (2014) finds in her linguistic ethnography of visits with general practitioners in the UK. When clinicians face their computer screens, for example, patients may interpret their action as the giving of attention, priority, and authority to the screens rather than to themselves. Although this may not be the clinician’s intention, Swinglehurst, following the insights of Erving Goffman, observes that “actual intentions are inaccessible and may be of little significance when it is only the display or outward expression that interactants (and analysts) have to go on in their ongoing evaluation of a social situation” (2014: 25).

Gender has received particular attention in research examining the hierarchical structuring of communications between doctors and patients. The history of childbirth had entailed the privileging of men’s expert knowledge and male attendance and the displacing of women’s experiential know-how and female attendants. Yet, analyses of gender and medical communication cannot assume the equation of doctor-as-male and patient-as-female, particularly now that many physicians, both in training and in practice, are women; in fact, the majority of US obstetricians are female. The presence of more women in obstetrics and gynecology does not necessarily translate into differences in communication—or care, for that matter. A 2018 study of births at a large US hospital found no statistically significant differences between the patients of male and female obstetricians in the rates of cesarean delivery or episiotomy (Yee and Miller 2018). In a study on the uses of humor in the interactions of both male and female obstetrician-
gynecologists and female patients in Milan, Italy, Franca Pizzini (1991) observed that male doctors employed humorous remarks “in order to stop patients from talking” (486). Female doctors also used humor to regulate the behavior of patients, and in fact they made “more use of humorous remarks at the expense of their patients” (486). The female patient, as “the person with the least authority” also “makes least use of humorous remarks” (486).

In the sociocultural anthropology of reproduction, Jordan (1992 [1978]) was among the first scholars to call attention to the discursive practices constructing (male) physicians as the figures of authoritative knowledge in biomedicalized childbirth. However, she also noted the active and critical roles that (female) nurses played in the construction and communication of biomedicine as authority. In US hospital delivery rooms in the 1980s, Jordan observed that physicians did not necessarily speak directly with laboring women. Instead, nurses and medical students would “explain, highlight, and interpret his actions to the woman with whom he does not communicate directly” (1992 [1978]: 163). Their verbal “shadowing” of the physician established and enacted hierarchies in relation both to the other staff and to the laboring woman. Moreover, nurses were involved “in a number of different participation frameworks, shifts in which are indicated by changes in body posture (e.g., straightening up, turning away from the woman and toward the door) and, maybe most significantly, by voice quality” (Jordan 1992 [1978]: 165).

The range of practices and actors whose talk contributes to the makings of biomedicalized pregnancies—and the stakes of these communications—are nowhere more evident than in the conversations surrounding prenatal diagnosis, as Rayna Rapp (1999) detailed in her account of amniocentesis, genetic counseling, and decision making in the US. The performance of predictive and genetic tests and screenings such as amniocentesis and fetal sonogram have become regular features of even normal and ordinary pregnancies (Ivry 2010; Han 2013). In the US, these tests and screenings typically become recommended by doctors, who in turn refer patients to genetic counselors. Positioned as “gatekeeper between science and social work, between epidemiology and empathy” (Rapp 1988: 143), genetic counselors are not doctors, but receive training in medical genetics and counseling. Since the formation of genetic counseling as a profession in the US in the 1970s, Rapp notes, all but a small percentage of genetic counselors are women, who “seemed especially suited to a field that was designed to counsel pregnant women. And ‘counseling’ was a field in which ‘female qualities’ seemed particularly appropriate” (1988: 144).

In many, but not all biomedicalized settings, undergirding the conversations about prenatal screening and testing are the ethics of non-directiveness and consent. Tine Gammeltoft (2014), drawing from her ethnographic research on reproductive decision making in Vietnam, reminds us that these imperatives are themselves bound to a historically and socioculturally specific notion of “choice” that is “in many respects, empirically misleading; it tempts us to overemphasize people’s freedom to shape their world as they want to” (15). Alison Pilnick (2004) contends that in fact, “achieving informed choice is not necessarily an interactionally easy or straightforward procedure” (464). Based on her study in the UK, she argues even the “facts about” prenatal diagnosis as well as the decisions themselves are themselves produced through conversational interactions, specifically in the turn-taking in which a midwife describes the screening and the pregnant woman asks questions and then affirms her understanding of the midwife’s explanations.

Whether midwives, genetic counselors, or doctors, medical personnel are tasked with not only providing information and advice about testing and screening to the patients, but also offering an interpretation of their results and guidance on their next steps. They conversationally navigate what Per Linell and Margareta Bredmar (2007 [1996]) call delicate or interactionally sensitive topics “that cannot be addressed directly or explicitly by the speaker without endanger-
ing the interactional harmony of the encounter by threatening the listener’s face (and therefore also the speaker’s own face)” (418). In the genetic counseling of pregnancy, abortion and disability are the most interactionally sensitive of topics. Linell and Bredmar, in their own study of midwives and pregnant women in Sweden, observe “the clinical frame may be seen as involving efforts to remove some of the moral concerns from the delicate topics, and yet the participants’ actual handling of the topics as ‘sensitive’ reinvokes the moral dimension all over again” (2007 [1996]: 419).

The significance of not talking about pregnancy

Approaching the topics of reproduction with an understanding of their interactional sensitivity brings additional insight not only to what is spoken, but also unspoken. More specifically, not talking about pregnancy is a linguistic practice and experience of reproduction. Ethnographers in diverse settings remind us that the uncertainties surrounding reproduction are a reason why silences may be practiced around childbearing and childbirth. Other reasons include avoiding unwanted attention, especially envy and more malevolent feelings. In the US, silence about pregnancy has frequently been interpreted in terms of its “tentative” status (Rothman 1986) and women’s acceptance of it. While these concerns seemed to hold in my own research, equally significant are the interactional sensitivities that surround talking about pregnancy.

For the US women in my study, sharing the news of a pregnancy “too early”—in other words, when the risk of a loss is relatively high—also presented the risk of having to “take back” these tidings and the “awkward situations” this itself might create. Thus, talking about pregnancy is indeed fraught with interactional sensitivities. A few women initially discussed their pregnancies only with their partners and their care providers. Some avoided telling even their closest friends and confidantes, including mothers and sisters, because they worried about “disappointments.” Looking back at my field notes now, I realize that I did not necessarily ask these women to explain precisely what they meant. On the one hand, I assumed they were referring to the chance that there might be a miscarriage, which is an understanding confirmed by the women who candidly told me so. So, I did not feel the need to ask. On the other hand, I think now that I, too, wished to avoid causing not only these women (the speakers) to say what they did not want to say, but also me (the ethnographer and listener) to hear it.

There were other reasons to avoid talking about pregnancy. Women expressed concerns about attention that was unwanted from particular people and in specific settings. For example, co-workers were not typically the first people with whom pregnant women shared their news. Not talking about one’s pregnancy was importantly a way of managing impressions at work—at least while it was not visible to others. Pregnant women described their wish to keep the news “close,” telling only trusted friends and family members (as well as an ethnographer who promised them confidentiality). One woman described relishing a feeling of heightened emotional closeness with her partner because the two of them had decided to keep the pregnancy “private” initially, planning to announce it later at a gathering of their family members.

Talking about and to the “baby” in the body

Pregnancy as a linguistic experience includes talking about and to the fetus and the imagined and expected child or “baby” in the pregnant body. No discussion of contemporary pregnancy can be complete without consideration of fetal ultrasound imaging and the talk that occurs at the sonogram. The fetal scans are routinely recommended and prescribed by physicians as part
of the medical supervision of pregnancy. However, as occasions for looking at an imagined or expected child and taking “baby’s first picture” (Mitchell 2001)—as well as learning the child’s imagined and expected “gender”—they also have become meaningful rituals of family and kinship.

Colossal stone sculptures of fetuses were found at a 3,000-year-old Olmec site in Mexico (Tate 2009) and written descriptions of fetal development appear in Buddhist and medical texts of third-century India (Kritzer 2009), indicating both that ancient (non-Western) peoples had knowledge of fetuses and that an understanding of fetal development is not the achievement of Western science only. However, the ascription of their importance and meaning as “icons of life” (Morgan 2009) is certainly one that is specific to the historical and sociohistorical conditions of Western sciences and technologies. The development and uses of the fetal sonogram have played a significant part in the recent social and cultural history of pregnancy (Dubow 2011). Earlier critiques had been focused on the “visual power” of fetal imaging (Petchesky 1987). However, ethnographic accounts and other recent observational studies call attention to the role of talk, particularly the narration of scans like “tours” of the womb by which the bodies of fetuses become constituted through the naming of their parts (Mitchell 2001; Taylor 2008).

Aug Nishizaka (2014) suggests the construction of a fetus as a person does not result inevitably from the power of either vision or talk. Instead, based on an analysis of the videotaped conversational exchanges between midwives and pregnant women during sonograms in Japan, Nishizaka contends that fetal bodies and persons emerge from interactions, which include not only speech, but also gestures and other embodied communications. For example, a midwife points with her finger at two locations on the fetal image and names them as two ears. When the pregnant woman responds with silence, the midwife then turns her own head and grasps her ear, telling the woman “it is this part of the ear” (Nishizaka 2014: 228). In Nishizaka’s analysis, this interaction is especially rich as it involves the differentiation of points on the screen as the ears of the fetus and, indeed, specific parts of the ears. The midwife, with her gestures, positions her own body as an analogy for the body of the fetus.

In my own observations at sonograms in the US, I witnessed instances not only of the medical personnel’s (sonographer’s) talk about the fetus, but also talk to the fetus from pregnant women and others who accompanied her, typically partners and occasionally their own parents, or the expectant grandparents. I have referred to these and other interactions directed to the imagined and expected child as “belly talk” (Han 2013). Belly talk includes pregnant people and others talking, reading aloud, and singing to the belly as well as playing musical recordings and touching, patting, or massaging it. These activities have come to be prescribed as prenatal stimulation or learning, non-specifically referencing “research” and “studies” on the abilities of newborns and fetuses to apparently recognize voices (cf. Voegtline et al. 2013). The expectant parents whom I came to know, however, seemed to regard them as enactments of their ties of family and kinship and embodiments of the roles and responsibilities of parenting, which were especially compelling for men as expectant fathers (Han 2009). Belly talk is noteworthy as part of the linguistic experience of reproduction because the use of human language to address fetuses (or even infants and young children) has not been universally regarded as relevant or appropriate (Ochs and Schieffelin 1984). However, whether this might be changing is a question to ask, given the adoption of the practices of biomedicalized pregnancy, like fetal ultrasound imaging, and the promotion of the ideas of middle-class parenting from WEIRD (Western, educated, industrialized, rich, democratic) societies, like talking to infants and young children to close a so-called “word gap” between poor and rich families (Avineri and Johnson 2015; Han 2020).
Conclusion

If the aims of the anthropology of reproduction are to explore and examine the human experience of reproduction, then the approaches and perspectives must be drawn from the four fields of the study of humanity. Through this holistic understanding, which anthropology is singularly situated to provide, reproduction can come to be known as a biological, social and cultural, material, and linguistic experience of the present and the past.

Notes

1 Although “text” is used in everyday references to text messages received and sent by mobile phone, in this chapter, its use is grounded in studies of language and literacy to refer to forms and materials ranging from traditional writing/reading to visual images and displays (both still and moving) to voice and audio. Multimodal texts incorporate more than one of these forms and materials.

2 Most of the women whose pregnancies I had documented were White and middle class, and all of them had attended college for at least one year and been raised with English as their first language.

3 A shift in language about pregnant “women” to “people” is discussed in legal scholarship. David Fontana and Naomi Schoenbaum (2019) argue for the “unsexing” of US laws governing pregnancy alongside parenting and caregiving in order to further undo sex discrimination in the legal system: “Sticky behaviors marking women as caregivers and men as providers emerge during the pregnancy and are difficult to reverse after birth. We will never fully unsex parenting as long as pregnancy is sexed” (313). Jessica Clarke (2019) applies their argument toward the legal protection of transgender people’s reproductive experience.

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