ROBIN ROOT and C.H. BROWNER

PRACTICES OF THE PREGNANT SELF: COMPLIANCE WITH AND RESISTANCE TO PRENATAL NORMS

ABSTRACT. A major challenge of medical anthropology is to assess how biomedicine, as a vaguely-defined set of diverse texts, technologies, and practitioners, shapes the experience of self and body. Through narrative analyses of in-depth, semi-structured interviews with 158 pregnant women in southern California, this paper explores how the culture of biomedicine, encountered formally at prenatal care check-ups and informally through diverse media, influences pregnant women's perceptions of appropriate prenatal behavior. In the spirit of recent social scientific work that draws on and challenges Foucauldian insights to explore social relations in medicine, we posit a spectrum of compliance and resistance to biomedical norms upon which individual prenatal practices are assessed. We suggest that pregnancy is, above all, characterized by a split subjectivity in which women straddle the authoritative and the subjugated, the objective and the subjective, and the haptic as well as the optic, in telling and often strategic ways. In so doing, we identify the intersection between the disciplinary practices of biomedicine and the practices of pregnant women as a means of furnishing more fruitful insights into the oft-used term "power" and its roles in constituting social relations in medicine.

INTRODUCTION: THROUGH THE EYE OF THE BEHOLDER

[It] is always the body that is at issue – the body and its forces, their utility and their docility, their distribution and submission. (Foucault 1977: 25)

It was in studying the ideological origins of clinical medicine, in order to better understand "how the medical gaze was institutionalized [and] inscribed in social space," (Gordon 1980: 146) that Foucault discovered the diverse powers of Jeremy Bentham's "Panopticon" (in Ibid.: 146). In late 18th century France, the panopticon was much more than a principle of penal planning or a physical structure; in Foucault's hands, it was an institutional practice in which systems of "isolating visibility" endowed those at the center with the power to see without being seen. By the same token, it rendered those on the periphery subject to the power-knowledge exercised at the center. In "The Care of the Self," Foucault later refined his analysis of unidirectional power by exploring the distinction between ethics (self-relations) and moral codes (prescriptions and rules), deploying the term "moral acts" to "refer to specific practices [codes] of caring for the

Culture, Medicine and Psychiatry **25:** 195–223, 2001.

self" (Scott 1993: 123). The significance of these self-relations, explained Foucault, is their capacity to explain more about how individuals become subjects than do broad theories of power and self (Ibid: 115).

In this paper, we contend that contemporary prenatal care, given its plethora of technological and social monitoring mechanisms, can be viewed as a set of moral acts derived from implicit and explicit moral codes. "The Care of the Self" provides a theoretical rationale for our assumption that prenatal care is something more than mere guidelines for a healthy pregnancy. By listening to and reflecting on a group of U.S. pregnant women's "self-relations" on a range of issues relating to pregnancy and prenatal care, we avail ourselves of an opportunity to witness a pregnancy ethical subjectivity in the making. How pregnant women assess their own behaviors, we argue, takes us beyond the politics of dichotomized doctor–patient relations into the heart of Foucault's so-called "self-relations."

In the spirit of recent anthropological and other social scientific work (Finkelstein 1990; Osborne 1994; Porter 1996; Sangren 1995; Haine 1994) that explores social relations in medicine by drawing on and challenging Foucauldian insights, we illustrate ways in which pregnant women negotiate diverse subjugated and authoritative knowledges to suit their individual needs and desires. We suggest that pregnancy is, above all, characterized by a split subjectivity in which women straddle the authoritative and the subjugated, in telling and often strategic ways. We believe that an understanding of the construction of contemporary pregnant subjectivities benefits from an informed application of what might be called post-Foucauldian concepts, since many writers since Foucault have taken their cue and elaborated narratives of culture, power, and gender within the world of scientific medicine and medical practice. Most relevant for our purposes is the work of Barbara Duden, Brigitte Jordan, Lois McNay, Jana Sawicki, and Donna Haraway. Where we find Foucault's explanatory power to attenuate, we therefore invoke others' whose related insights help to carry us over problematic terrain.

Duden argues that the experience of pregnancy has, over the past century, been transformed by medical technology. Her analysis of how sensory indicators of pregnancy (notably quickening) have been replaced with technological "outputs" as the authoritative sign of pregnancy is a case in point (cf. Cartwright 1995; Georges 1996; Mitchell and Georges 1997). The apparent consequence of this shift in authoritative knowledge, explains Duden, is that contemporary pregnancies are given to women by physicians whose expertise, grounded in scientific medicine, is aggrandized through technology.

Consonant with Duden's observations, we find that women's compliance with a host of prenatal norms can be attributed in part to the fact that reproductive technologies and health providers are seen as powerful in that they "give" women a knowledge of their pregnancies. On the other hand, we investigate an equally important phenomenon – the paradoxical dependence of biomedical authority upon patient acknowledgment of its dictates. At the same time, the pregnancy narratives in this paper require that we challenge Duden's claim that the once authoritative haptic vocabulary has all but vanished in contemporary pregnancy. To the contrary, the words and images women invoked to describe their diverse encounters with biomedical personnel, texts, and other purportedly authoritative sources constitute an illuminating optic/haptic concordance. The process by which this occurs, in fact, provides a unique window on life, self, and social relations at a particular historical moment: late twentieth century, urban United States.

Similarly, we seek to extend Haraway's concept of situated knowledges, described as marked categories which structure how individuals come to know and experience the world, to include pregnancy; not because we wish to essentialize the procreative experience, but rather because, like race and sex, pregnancy is often physically manifest and subject to multiple interpretations. We therefore begin by asserting the highly situated nature of all knowledge. Given this condition, we construct 'authoritative' in this paper to refer to those pregnancy practices described by women that, first, appear to derive exclusively from scientific inquiry. By this, we mean that the credibility of the practice in the women's eyes is, directly or indirectly, a function of the western scientific gold standard, the clinical randomized trial or similarly valued litmus tests. Second, 'authoritative' refers to those practices that are conveyed to pregnant women through their health providers or other media, which produce and accrue their authority by virtue of their scientific medical origins.

Building on these concepts, we offer our own framework for observing how women's pregnancy accounts evince a broad spectrum between compliance and resistance to the many (often contradictory) biomedically-derived prenatal norms they encounter, whether through health care providers, prior pregnancies, other pregnant women, books or popular magazine articles. By attending to this spectrum, we are able to discern the fine gradations within resistance and compliance; and even more narrowly, beneath the rubric of pure resistance and pure compliance, those acts which appear constituent of both. For the analytical purposes of this paper, we schematize such a spectrum in the following manner:

Absolute Compliance ..... Absolute Resistance
over-compliance, minimal ..... understated, open

This unilinear and oversimplified representation of complex social phenomena takes account of, and incorporates into it, the highly contingent relations between pregnant women and the sources of their prenatal care knowledge. Haraway's verdict on the non-feminist history of binaries assists us in the decision to deploy such a schematic: "Binaries, rather suspect I know, can turn out to be nice little tools from time to time" (1991: 111).

The spectrum assumes *a priori* that the power relations between biomedicine and pregnant women are always in flux and that analytic distinctions between different forms of knowledge cannot be mapped onto specific social positions. Moreover, social positions are not immutable; a pregnant woman may well be a physician. The position of any particular person, technology, or practice along the spectrum is therefore only temporary, since new knowledge and changing conditions may reconstitute the means and meanings of any one idea, agent, or practice.

Understanding the manner in which authoritative and subjugated knowledges are produced is of paramount importance to, and part of the challenge of, this paper (cf. Abel and Browner 1998). Authoritative, it is important to note, does not necessarily mean repressive. Nor does authoritative imply a lack of contradictions or a steady-state condition in which the knowledge or norm is never changing (Jordan 1977). In fact, it is important to note that many pregnant women glean much satisfaction from the presence and role of these authoritative practices in their lives, some of which, such as the hazards of tobacco use, have yielded important advances in the maternal and infant well-being. The fact that many other practices, however, may be contradictory or vaguely stated, as is the case with certain nutritional and exercise guidelines, speaks further to the power of their authoritative status that they endure regardless of their flagrant incompleteness or inconsistencies. By a similar token, that which we label as subjugated is equally multi-layered in origins and effects. We define these as practices that do not depend for their credibility or authority on biomedical endorsements; their power to influence prenatal practices is a function primarily of the resonance they exhibit *vis-á-vis* pregnant women's needs and experiences, especially those which biomedicine cannot or does not directly address.

A key goal of this paper, then, is to go beneath the umbrella of biomedicine's apparent hegemony to explore and make more explicit the ways in which situated and subjugated knowledges simultaneously threaten and sustain the impermeability of that umbrella. It is in this manner that we see

how difficult it is, both in theory and in practice, to distinguish collusion from resistance, and domination from participation. And if, as we intend to show, the power of biomedicine is contingent on the sustained compliance of those who privilege scientific medicine and its attendant technologies, then one must question how powerful biomedicine truly is. At the very least, this proposition demands that we probe the nature of its operations as an authoritative discourse and privileged set of cultural practices in pregnant women's reported daily routines.

DESCRIPTION OF THE RESEARCH METHODOLOGY AND THE STUDY POPULATION

Our data were collected within the context of a larger study on the routinization of fetal diagnostic testing (Browner and Press 1995; Press and Browner 1997; Markens, Browner and Press 1999). Between 1989 and 1992, we conducted participant observation and interviewed patients, clinic directors, nursing staff, and health educators at five branches of a southern California health maintenance organization (HMO). Our focus on factors associated with pregnant women's attitudes toward fetal diagnostic testing allowed us also to explore women's self-care practices during pregnancy. This, in turn, created an opportunity to examine in what manner they incorporate biomedical prenatal advice into their own self-care routines.

Interview Format

Semistructured, open-ended tape recorded interviews of one and a half to four hours duration were conducted with 158 pregnant women of diverse ethnic, social class, and religious backgrounds, generally in study participants' own homes, but occasionally at the HMO. Tapes were transcribed and analyzed for content. Women's responses to the following questions provided the majority of data analyzed and presented in this paper:

- How have you been feeling these days?
- Are there ways that being pregnant has changed your daily life?
- How has your diet changed since you've been pregnant?
- How about physical activities? Have they changed?
- Have you changed your use of any substances since you became pregnant? (Probes: alcohol, caffeine, nicotine, any kinds of drugs, diet soda or chocolate)
- About each change ask: Why do you think you (should) do this?

- Do you think the things you're doing to take care of yourself during the pregnancy are different from what your mother or other women of her time did?
- Are there things you worry more about now that you're pregnant?
- Does worrying have an effect on the baby?
- Have you learned anything useful from your prenatal medical care?
- Why do you think it is important for a pregnant woman to receive prenatal medical care?
- Can prenatal medical care ever cause problems for pregnant women or their babies? [If yes] How?
- Who in addition to your physician or nurse do you look to for information or advice during your pregnancy? What kinds of things do you ask these other people that you wouldn't ask the nurse or doctor?

Study Participants' Prenatal Care

We also observed the prenatal intake appointments of 40 of the 158 women and twelve prenatal education classes at the five HMO branches. While class content and format varied little from one HMO branch to the next, health educators' instructional styles were quite diverse, ranging from openly paternalistic ("I let my pregnant diabetics . . .") to mildly cajoling ("I'll be pleased if you can get three servings . . ."). The women in our study also had access to multiple written sources of prenatal advice, including the HMO's own 96-page publication "Preparing for a Healthy Baby," which each woman was given at her first prenatal visit, along with a weighty packet of other materials, most of which were advertisements for products for pregnant and parturient women and their new babies. Even so, the most frequently mentioned written source of prenatal advice and information was Eisenberg, Murkoff and Hathaway's "What to Expect When You're Expecting" (Eisenberg, Murkoff and Hathaway 1991).

Demographics of the Study Population

We limited participation in the interview segment of the study to women from southern California's two largest groups, women of European or Mexican backgrounds, who had been raised Christian. This latter criterion was established to enable us to test hypotheses about the influence of religious background and religiosity on decisions about the use of fetal diagnosis. Sixty-three percent were European American, 25 percent were Mexican American (i.e., born in the U.S. to parents of Mexican ancestry or immigrated to the U.S. by the age of 10) and 12 percent were Mexican immigrants (i.e., immigrated to the U.S. after the age of ten). Median

household income was $30,000 to $35,000, although 22 percent had incomes below $15,000 and 22 percent had incomes over $50,000. Most had completed high school, although 25 percent had not; only 12 percent had earned a bachelor's degree or more. Because other research had amply documented the role of ethnicity and social class in shaping attitudes toward prenatal care and women's self-care practices during pregnancy (Kay 1980; Lazarus 1994; Martin 1987; Rapp 1993; Spicer 1977), we expected that this study would produce similar results. In fact, we could find no significant differences by ethnicity or social class in the women's attitudes toward prenatal care or their prenatal care practices[1] (Browner and Press 1996).

THE CONTEMPORARY HAPTIC

Emotions, fatigue and hunger were cited by the women we interviewed as the primary means by which they acquire and access knowledge of their bodies, especially during the early months in their pregnancies. Unfortunately, as Ehrenreich and English (1989) observed, these phenomena also constitute those aspects of pregnancy which biomedicine trivializes in its characteristically subjectless, mechanistic depictions of how pregnancy unfolds. Relegated to the margins of pregnancy "management," they accrue their subjugated status. We can better understand the nature of women's challenges to attribute value to these other ways of knowing by identifying those 'practices of the pregnant self' which derive from the haptic, unsystematic world of emotions, fatigue, and hunger, and which compellingly inform the beliefs and behaviors of the pregnant women with whom we spoke.

Answers to questions intended to foreground the most prominent features of being pregnant elicited a range of responses from women who invariably referenced the role that physical and emotional sensations play in daily life. The frequency with which we heard the following statements suggests that Duden's quickening, as the definitive sign of pregnancy, has been supplemented with a panoply of emotions and physical sensations, in particular hunger, irritability, and fatigue. When asked how her life had changed since her pregnancy, Sally Brocker, for example, explained: "At first, when you become pregnant, you eat everything, anything, a lot. You just get hungry and you want to sleep a lot. Your moods do change. . . . You're grumpy, you just want to be left alone most of the time."[2] Twenty-five year old Maria Iglesias responded similarly: "The number one thing for me is . . . how you go through a lot of changes because your body weight and your hormones mess with your mind and so forth. That's the

main thing that gets me. I'm a lot more moodier, not as energetic as I was before . . . But that's just your health." These sensations are, so to speak, the contemporary haptic means by which many women come to know and experience their pregnant selves while they have not replaced quickening entirely, they play a similar role in informing women of their pregnancy's progress.

We hear echoes of the dualism Duden describes in the narrative structure provided by Maria and Sally, above, who narrate their personal experiences in vacillating terms, from a distanced, objective "you" to an embodied "me." Maria, for example, elaborates a comprehensive etiology of her aches and pains that begins authoritatively enough in her own experience ("The number one thing for me . . .") but segues swiftly into pre-digested scientific objectivity ("You go through a lot of changes"). Her claims that weight gain and fluctuating hormonal levels "mess with your mind" and that "your health" is responsible for such negative side-effects, are partial evidence of the complex negotiation of subjugated and biomedical knowledges apparent in the majority of women's narratives.

Where Sally and Maria anchored their objective articulations in their own subjective experiences in order to invoke the biomedical, women such as Julia Carnero relied almost exclusively on the endorsement of health personnel to confirm their own insecure knowledge of their fatigue: "I told the nurse, 'You know, I'm always tired' . . . She goes, 'Well you do have three kids and they're kind of small.' I said, 'Yeah, well yeah, and then I cook, clean, wash. I do all that. Nobody helps me do all that. She goes, 'Well, that has a lot to do with it.' I was thinking maybe something's wrong with me." Distanced, though not necessarily disassociated from, a confident, subjective knowledge of her body's fatigue, Julia's request for information is, to a large extent, a request for an endorsement of knowledge she already has; namely, that she runs a very full household. Through Julia's request for legitimacy of her knowledge, a common feature of women's interviews, we witness how biomedical practitioners reproduce the power to confer meaning and significance on the information that pregnant women impart to them. The resultant dialectic between partial resistance (the voicing of one's subjugated knowledge as possibly equal to and a part of an authoritative knowledge) and partial compliance (the desire for authoritative affirmation of this knowledge), is characteristic of pregnant women's efforts to bridge the biomedicalized and subjugated in a manner that suits their particular needs.

Maria, Sally, and Julia, each in her own way, illustrate how many pregnant women strategically, if unwittingly, conjure and solicit a biomedical logic that endorses the haptic knowledge they derive from their own

bodies. As we will see below, however, this strategizing is an inherently more complex undertaking, as women seek out non-biomedical sources of experience and knowledge to both justify their resistance to biomedical norms and/or simply to help them make better sense of their pregnancies. We will also witness how the haptic resurfaces in subtle and profound ways to powerfully influence women's reported decision-making processes both in favor of and in resistance to biomedical norms of appropriate prenatal behavior.

THE MORAL LOGIC IN PREGNANT WOMEN'S BELIEFS AND REPORTED BEHAVIORS

When asked about their daily behaviors during pregnancy, and the rationale behind these behaviors, we discerned from women's narratives a broad array of knowledge and advice that, on one level, was distinctly conceptualized as moral codes. These codes carried both authoritative (based singularly on biomedical criteria) and subjugated (based solely on personal or others' sentient and experiential criteria) weight, and were conveyed as one or the other largely on the basis of context and self-cognition. In the process of synthesizing the diverse rules received externally and the messages their bodies sent them throughout their pregnancy, women were observed to rely upon their own ethics, or understanding of themselves, to determine how and when different rules were relevant to their needs. In so doing, they demonstrate the highly contextualized nature of power relations and the necessarily non-uniform, non-static manner in which biomedical hegemony operates.

To start, women's notions of the physiology of pregnancy often function as the logic by which they variably resist or comply with the prenatal norms of (and to) which they are subject. Katie Lazarus, for example, was motivated to increase her food intake during pregnancy because in her view: "The baby takes its nutrition first from whatever I eat. It's like the blood system knows you're pregnant. The body gives the best first to the fetus. So then I have to eat more if I want to keep up my strength." The blood system and the body appear as entities unto their own, exhibiting an agency, knowledge, and willfulness that are not only distinct from Katie herself, but which prioritize the fetus' nutritional needs above her own. In a sense, Katie has no control over the nutritional logic of her body during pregnancy. What, then, is the nature of her authority over her experience of pregnancy?

We can begin to answer this question by examining more deeply the language Katie uses to represent and convey her experience of heeding

nutritional guidelines targeted at pregnant women. Katie's nutritional narrative, like many biomedical models of the human body, fashions a distance between her subjective experience and the objective articulation of bodily changes during pregnancy. Her extrapolation from the biomedical knowledge she acquired in the course of her prenatal care about 'good' dietary habits demonstrates the ways in which biomedical explanations both shape and are shaped by women's personal experiences, that is to say, their ethics, of their pregnant selves. By parroting biomedical explanations, Katie renders biomedical know-how relevant to the transformation she, herself, experiences. Her body ("the body") allegedly 'knows' what to do during pregnancy without her even 'knowing' it; this she knows because biomedical media have represented her body to her in meaningful and comprehensible ways as endowed with these capacities. On the other hand, it is her knowledge of these bodily functions that ultimately constitutes her experience of pregnancy and determines her dietary habits. The multilayered embeddedness of her knowledge in her practices reveals, once again, the inherent difficulty in separating collusion from resistance and domination from participation.

A similar moral logic infuses pregnant women's views of miscarriage and, by their own accounts, lends the general public a prerogative to discipline its pregnant constituencies. Looking first at women's etiologies of miscarriage, we find a range of biomedically and morally-informed responses. The desire to identify a final cause was pervasive yet, as often, left unfulfilled. If this cause wasn't vaguely biomedical ("There's got to be some medical thing about it" or "the uterus isn't strong") or divinely indicated, for example as retribution for a prior abortion, then it was squarely because women did not heed a moral logic unique to pregnancy and based on biomedically-based prenatal precepts.

The most egregious breach of prenatal norms was committed, in the eyes of some women, by those who failed to follow doctors' orders or to attend prenatal care appointments. Such flagrant disregard, as it were, for biomedical authority incurred the highest risk for miscarriage. Sonia Lopez spoke for those women who felt that women have miscarriages "because they don't pay attention to their doctors. They don't communicate to the doctor or go to the clinic." When biomedical rituals, such as prenatal appointments, and norms were not specifically cited as causes of miscarriage, their moral and authoritative presence was nonetheless present. Lacking an empathetic tone, many women attributed miscarriage to being "overstressed" or "overdoing it." Janet Sivon, for example, indicted pregnant women who try to heed non-pregnant norms of beauty

for risking miscarriage: "They ... try to stay too thin, and exercise too much and overdo it."

The various rationales which women offer to explain miscarriage, biomedical and other, are but one example of how difficult it is to isolate the biomedical within pregnant women's practices and reasoning, and therefore to cast it as an object of either compliance or resistance. The effort itself, however, is of value, as it requires close scrutiny of the various ways that biomedical attributions of guilt and innocence embed themselves in what are often seemingly unrelated explanations for pregnancy events. Whereas in the above paragraph, women identified the causes of miscarriage as stemming from poor prenatal practices – i.e., not going to the doctor, not communicating with the doctor, trying to remain thin – others offered markedly more phenomenological explanations. These latter were voiced by women who felt that pregnant women's thoughts, rather than their behavior, determined whether miscarriage would occur. Bianca Morales, for example, was of the view that miscarriage is a direct function of the pregnant woman's desire, or lack thereof, to bear a child: "[Miscarriage is] from the mind. If [the fetus] thinks [the woman] doesn't want it, it [the fetus] opens up." Margie Haller concurred: If the fetus, with a mind of its own, is able to read the mother's mind, and "feels that way [unwanted], then it'll abort itself."

Opposing the biomedical and phenomenological views that hold pregnant women more or less wholly accountable in the event of a miscarriage were the etiologies offered by women who themselves had had miscarriages or knew intimately the pregnancies of friends who took "really good care of themselves," yet lost the baby, or who drank their way through pregnancy and still delivered "the most beautiful baby you ever saw." This disconnect between prenatal behavior and expected outcome could well have opened the door to skepticism of biomedical knowledge, since the outcomes were the exact opposite of conventional biomedical knowledge, yet most women concluded instead that miscarriage was likely due to a multifactorial combination of biomedical, moral, and environmental causes. Stephanie Ludrow, as a case in point, captures the essence of biomedicine's ultimate uncertainty, when she describes a pregnant woman's "body chemistry" as the cause of miscarriage, portrayed as something beyond the knowledge or control of the pregnant woman herself. The mystery inherent in this explanation, while still focused on the pregnant woman's behavior rather than, say, environmental exposures, contrasts with the purely behavioral etiologies described above.

When asked about the unsolicited advice they were given during pregnancy, women often railed against the public comment they daily

endured – even as the content of this advice often echoed women's own etiologies of miscarriage cited above. In fact, in describing this "advice," women expressed outrage at many of the explicit rules and regulations they are subject to by virtue of their pregnancy. Asked from whom she received unsolicited advice regarding her pregnancy, Marilyn Hapsburg responded pithily, "The whole world." It is perhaps less the substance than the intensity of public scrutiny that pregnant women recall best when they reflect on the unsolicited "counsel" they receive. Declared an over-advised Gloria Estes, "I don't think anybody should advise anybody about pregnancy, especially other women." So thoroughly inundated with unsolicited counsel was Catherine Slater that she could conjure only one explanation of this phenomenon of social scrutiny: A conspiracy of grandmothers. "Anybody that sees you and knows that you're pregnant will tell you something. I think there's a Grandma's Club or something. They hang around pregnant women and tell 'em things, give them advice . . . No matter where you are. Strangers in the mall seeing me in maternity clothes [criticize] 'Oh! You shouldn't be wearing tight-fitting pants.' "

The skepticism pregnant women express with the "whole world's" opinion of how they should conduct themselves during pregnancy is an appropriate segue for digging deeper into the decision-making processes by which they resist or adhere to biomedical prenatal norms. While these decisions are explored in this paper at the singular decision-by-decision level, it is important to keep in mind that they are a function, in most cases, of women's prior and on-going experiences with biomedical surveillance via their prenatal care, as well as their daily interface with other individuals and media that offer multiple opportunities for biomedical and other surveillance to be experienced.

THE SPECTRUM

Different streams of authoritative/subjugated knowledges, rules, and experiences yield a variety of pregnant practices that converge in the course of women's daily routines, rendering an "unconfounded" analysis of each stream impossible. To categorically label one practice authoritative and the other subjugated is not only disingenuous, it diverts attention from the more important point, that practices are functions of diverse relations, with oneself and others, as well as texts. In light of the moral logic outlined above, a logic that is a feature of both biomedical and other prenatal norms, we are prepared at this juncture to undertake a more nuanced analysis of women's self-reports. We begin by providing an example of how women synthesize different norms and articulate them in a moral framework.

We then profile examples of their reasoning processes and attempt to situate them along the spectrum described in the introduction, beginning on the left with absolute compliance and moving right through minimal compliance, center spectrum, understated resistance, and open resistance.

There is, most commonly, considerable competition among norms for pregnant women's attention. Cathy Delgado, for example, was encouraged by four different sources to change her dietary and other health-related habits. From her prenatal care courses, she learned to decrease the amount of red meat she ingested, from her mother to consume more fruit, from her five-year old daughter to quit smoking, and from her father to have an occasional glass of beer. Her resultant pregnancy practices reflect a tendency to syncretize these bits of knowledge, that is to say, to negotiate and make relevant diverse streams of knowledge, in a manner appropriate to her pregnancy needs: "I take a lot of my mother's advice [such as increasing her fruit consumption] because she had ten kids and went through ten pregnancies, so I believe her a lot of the times more than I do some of the nurses and some of the doctors. Because a lot of the times, things [the doctors] told me don't make sense, but what my mother has told me makes more sense. With ten pregnancies, she should know."

While complying with prenatal norms prohibiting smoking and caffeine consumption, ("That nutrition program had said that caffeine, something in caffeine causes . . . I don't know. They said something, something about it, so I just said, 'Oh, you're not supposed to have caffeine, so keep away'"), Cathy's enthusiastic endorsement of her mother's knowledge illustrates the manner in which many women draw from different streams of knowledge, biomedical and other, as they craft prenatal practices. However, where the basis of her mother's advice, and for Cathy's acceptance of it, is the elder's own haptic experience, Cathy's adherence to biomedical counsel appears to be a function almost entirely of the co-authoritative role that biomedicine plays alongside her mother's counsel, rather than how well she understands its scientific origins.

Syncretic attempts to coordinate diverse sources of information speak persuasively to women's diverse pregnancy needs. Manuela Larde explained that when she has a question, she seeks guidance from her doctor or nurse-practitioner. However, her "best information" came from books her sister gave her, "about how your body's grown and the changes you're experiencing . . . If I have something bothering me, I read it and it usually explains why I'm feeling this way and what to expect." Equally important were the conversations she had with other women about what they'd experienced: "It sets my mind at rest, instead of just asking the doctor." Shelley Summers likewise felt it unnecessary to have her doctor

answer every one of her questions: "I wouldn't panic and call the doctor, because I can talk to my sister when I'm upset." Again, the objective here is not to discount or react to the doctor's recommendations. Rather, to Manuela and Shelley, and the many women like them, the broad-based experiential and physiological explanations they needed were best met through diverse sources, biomedical and other.

Absolute compliance. Those examples of prenatal reasoning that reflect absolute compliance are labeled as such because they not only privilege biomedical know-how, they actively relegate the non-biomedical to the realm of non-credible and, at worst, dishonesty. The former, incredulity, results in many cases from the sheer variety of other women's experiences. Explained Mary Howard, when asked from whom she receives prenatal advice, "The doctor. For my diet." Asked whether her mom would be consulted, she answers, "No. Cause that's just the opinion of herself, of what she's been through." Leslie McGowan replied singularly, "My doctor." Pressed whether she drew from the doctor more than her mother, Leslie described not only the irrelevance of her mother's counsel, but its outright irresponsible inaccuracy: "There's just too many old wives's tales. I tell my mom, 'That's an old wives's tale ... Basically, you're a liar.' Everyone's got different opinions. If I want an honest opinion, closest to the truth as you can get, I ask the doctor." The sole reliable source of her prenatal care, her physician, is not only knowledgeable, s/he is also, in seeming contrast to others, more honest. It may be worth speculating, however, how the handicapped status of her first child informs Leslie's sentiments on this topic. Asked to formally pronounce her source of information, she may feel pressured to identify her physician as the sole source, since later in her interview she describes in considerable detail the very active role her mother plays in collecting any and all information about pregnancy: "I read lots of things, medical books ... I've always been interested in medicine and anatomy. I'm always reading something. Like magazine articles from my mom. Or she'll call me [and say] 'Quick! Put on Channel 11!' "

Pregnant women's descriptions of how they tailored social and biomedical guidelines to their own individual needs and beliefs revealed the authoritative weight that biomedical knowledge often wields to influence women's self-perceptions during pregnancy. Sylvia Canales's comment illustrates that portion of the resistance-compliance spectrum, for example, which women often perceive as compulsory: "I know the stages of development for a fetus, and how critically important it is to start with good materials, so to speak. That book ["What to Expect When You're

Expecting"] had what they call the Best Odds Diet, which is just to give yourself that much better a chance at having a healthy baby. And the best odds are to eat this way. So I was reading this and going, gosh, you know, they're really right. There's no arguing with the fact that most people want their children to be healthy and so the only way to start out that way is for me to really take it seriously, because that's the way they're getting all their nutrition. The onus is really on me." By accepting that the 'onus' is really on her to eat right, and the probabilistic argument (Best Odds) for good nutrition, Sylvia transforms nutritional guidelines into a powerful prenatal norm. The claim that "there's no arguing with the fact" illustrates the means by which biomedical norms secure their power to dominate many women's daily routines, despite their often conflicting recommendations.

Absolute compliance may take another form – that of indignation when pregnant women expect final, authoritative answers to their questions regarding appropriate prenatal practices and fail to get any. Melissa Dower expressed frustration when her doctor did not have answers to her questions, as that meant she would either have to actively seek them elsewhere or live with a certain tangible uncertainty: "It's like, you're a doctor, you should know." This expectation of total authority is an important engine for biomedicine's seeming hegemony. The question of when and how these expectations were generated is, of course, a critical one. While the primary and most general explanation for such a cultural phenomenon would be the medicalization of pregnancy in this century, what we observe currently is how biomedicine has cultivated a committed constituency which believes not only in its technological prowess, e.g., the ultrasound as an objective snapshot of a pregnancy, but in its moral claims as well, i.e., what is and is not appropriate prenatal behavior.

To some extent, biomedicine relies for its continued hegemony on women's faith in it tenets, both technological and moral. Marisa Hernandez's explanation of why she chooses her physician as a primary source of information speaks to the authoritative comprehensiveness with which biomedicine is often endowed and which it must work to maintain, especially in the face of "alternative" pregnancy care paths, such as midwifery, that draw from highly knowledgeable but non-technological traditions: "[Doctors] are more experienced and more trained into the chemistry of your body and the types of diseases, and types or problems you could have. They probably will have a solution for that problem or will try to prevent it." Physicians, in Marisa's view, have an awesome power to detect, diagnose, treat, and prevent prenatal problems. Such power is seen, below, to imbue physicians' counsel on diet, exercise, etc. with a medical as well as moral authority.

Minimal compliance. Interpreting, deciphering, and decoding the prenatal norms that biomedicine and attendant technologies underwrite are tasks in which pregnant women are constantly engaged. When Jackie Serra's doctor condoned the use of asthma medicine, for example, she was skeptical: "They did want to put me on a medicine that I would take internally, but I didn't because I just didn't feel comfortable with it . . . I didn't feel like my asthma was to the point where it was bad enough to risk something. I read the insert on the medicine and it tells you that really no tests have been proven for pregnant women. So I just didn't feel safe taking it." In fact, Jackie shifted strategically from one biomedical authority (her physician) to another (pharmaceutical insert), using the latter to resist the former on her own terms, yet with the end result being compliance to biomedical norms. In another instance, Maggie Packard noted that, "They tell me [Tylenol] don't have aspirin; it won't affect me or the baby . . . but I don't know why . . . I don't like to take any kind of medication."

Given the voluminous scientific evidence regarding different food, beverage and medicinal substances during pregnancy, Cathy Delgado demonstrated the personal selectivity pregnant women often practice in the course of developing their routines. She accepted the evidence against imbibing caffeine during pregnancy, yet, like Jackie, she had little confidence in studies that condoned the use of Tylenol: "They'd given me Tylenol to take because at the beginning of my pregnancy, I was stressed out . . . They said Tylenol was the only thing that wouldn't cause anything. But I thought I'd better be on the safe side, and I haven't taken any medication." On the one hand, in deciding not to take any medication whatsoever, Cathy, like Maggie, concedes to biomedicine its authoritative knowledge regarding the danger of medications to the fetus during pregnancy. On the other, by opting not to take even those items that biomedicine has condoned, Cathy puts a twist on the hegemonic operation of biomedicine; she resists its effects (authoritative permission to use Tylenol) at the same time as she complies with its dictates (avoid toxic substances).

We witness in such reasoning the circulation of resistance and compliance within one woman's pregnant practices: She defies her doctor's counsel yet heeds even larger, more overarching norms regarding purity and pollution of the body/fetus during pregnancy. It wasn't adequate, in her view, that Tylenol had been scientifically-established as safe. In the end, it was the generalized potential of medicinal substances to harm fetal and/or maternal health that both Jackie and Cathy privileged in their decision to pursue a particularly conservative set of personal pregnancy practices.

As snapshots of women's dynamic reasoning processes, these reports demonstrate the fragmentation of the self that results from simultaneous

acts of resistance and compliance. As the subject of diverse knowledges, Cathy attempts to forge an ethical pregnant self by reconciling her faith in the veracity of scientific studies condemning alcohol consumption during pregnancy (compliance in principle) and her own subsequent behavior (understated resistance in practice). The behavioral disconnect between the two points up the importance of assessing both knowledge and practice as separate but related processes of subjectification, i.e., of self formation. A disciplinary principle, such as the biomedical precept that alcohol causes harm to the fetus during pregnancy, may thus shape the thinking of pregnant women without altering behavior. Its hegemony is thus incomplete. But, to the extent that they remain uncertain and unacknowledged, so are acts of resistance. Both the ulterior reasoning, therefore, and the actual practice are best evaluated apart from and in relation to one another along the spectrum of compliance and resistance.

An important variable in the minimal compliance-to-understated resistance equation is the role of guilt. When women knowingly breach prenatal norms, an element of guilt often ensues which diminishes the degree of resistance that such an act might otherwise suggest. Note the confessional tone by which some women, such as Brenda Yates, divulged their transgressions: "I could be eating more fish, but I don't know how to cook it very well ... I've tried. I've really tried." The residual guilt experienced by Brenda suggests that while she resists in practice, she feels strongly that she should be complying, and experiences guilt when she fails. Sally Brocker's response to the question of whether or not she ceased smoking is similarly illustrative of the power of guilt to function as a surrogate form of compliance: "No. I wanted to, I swear I wanted to." Linda Rosario expressed a lesser guilt over her lapses in dietary discipline. Having proudly asserted her compliance with the majority of her provider's dietary recommendations, she admitted to difficulties curbing a strong soda-drinking habit: "[Soda] is something they tell you to avoid ... Well, soda, I have to admit, I do drink."

The confessional dimension in many women's narratives is, in many ways, a function of the moral codes which are part and parcel of biomedical precepts surrounding appropriate prenatal behavior. Even more so, it reflects the extent to which women have internalized these codes in relation to themselves. Yet, it is resistance by default, by a perceived inability to follow through, rather than by conscious intent to defy and undermine a set of principles and practices with which one differs. On the posited compliance-resistance spectrum, then, Linda's soda habit would tend towards the 'understated resistance' end of the resistance continuum. Were she to maintain that there was nothing unhealthy about drinking

soda during pregnancy, and to assert that biomedical studies were wrong, the practice of transgression would lean towards the outer edges of 'open resistance.'

The question arises, then, as we move along the spectrum from compliance in the direction of resistance, how to distinguish the gradations in women's reasoning and the experiences of their decision-making processes. The answer is predictably complex, in part because acts of resistance are not always identified as such. While women are generally enthusiastic in their itemizing of the rules they heed, the same cannot always be said for those they resist. On the potent and volatile issue of alcohol consumption and pregnancy, for example, Cathy waxed eloquent on fetal alcohol syndrome and the evils of drinking during pregnancy, implying through her words the importance of heeding this guideline: "A lot of people, they say, I could drink one or two beers and it might not do anything to me, but it can [harm] to the baby. I don't want to see my baby drunk. Because that's basically what it would come down to. I'm not drunk, but the baby is, because the baby can't take two beers. I wouldn't want something like that to happen to my kid, so that's why I stay away from that." On the other hand, Cathy conceded that she does occasionally consume small quantities of beer, at her father's suggestion. "My dad has said drinking a little beer before dinner, it's good for the milk?" She imparts this bit of information to the interviewer in an interrogatory manner, as if she herself isn't entirely convinced. Thus, while the practice itself is resistant of a prevailing prenatal norm against alcohol consumption, the logic behind consuming a bit of beer is virtually analogous: Because it is ultimately good for the fetus/baby.

Center of spectrum. In those domains where biomedicine has conceded its limited authority, women are often pressed to rely on their own reading of their pregnancies to determine what is "permissible." We witnessed this self-reliance from women who had either had previous pregnancies or who actively sought out diverse sources of information regarding their pregnancies. Ironically, Christine Lehman described her frustration with doctors who did not have answers to her questions. She reported "always" asking about her blood pressure at her appointments, speaking with her sister, reading magazines and pamphlets from doctors' offices as well as Baby Talk. Yet, at the end of the day, her "best information" was her own self and body: "I would have to listen to my own body, what it's telling me to do." Sophia Lakey likewise subscribed to numerous maternity and parenting magazines and had worked in an obstetrician's office earlier in her career. This exposure, and her past two pregnancies, combined to

form a consciously self-directed prenatal strategy: "I know what I've done before and what I plan to do that I don't do. I know myself. I know what I will do and won't do." While there is no active resistance in this assertion, it is replete with a self-assuredness that sets the terms for her prenatal practices and locates these women at the center of the spectrum.

Pregnant women's attitudes towards exercise, however, reveal how they perceive and experience their pregnant bodies in an arena in which biomedical knowledge is incomplete and evolving and, as a result, can claim no real authority. By extension, it also demonstrates how pregnant subjectivities are in constant flux. Biomedical guidelines surrounding exercise are vaguely stated and, as a result, leave much room for individual interpretation. The editors of the volume, *Exercise in Pregnancy*, concede that, "unfortunately, no standards for exercise in pregnancy are available" (Mittelmark, Wisell and Drinkwater 1986: iv). Indeed, the gray area of exercise points up the importance of avoiding the reification of behavioral labels as either resistance or compliant since, in reality, these categories are murky for biomedicine and subject to constantly changing conditions. Technical advisories on exercise vaguely state that 'moderate exercise' among women with 'low-risk' pregnancies is 'permissible.' As a result, women are obliged to gauge for themselves what constitutes moderation. Even this margin of seemingly independent judgment, however, is contingent on first having secured the biomedical evaluation of whether a woman is sufficiently 'low-risk' to assert her knowledge of what constitutes 'moderate.'

The extent to which women's practices of the self may be circumscribed, rather than extended, under conditions of incomplete biomedical knowledge is illustrated in the case of Janet Manchester, who ceased jogging, an activity she pursued with great commitment prior to pregnancy. Janet explained how she discontinued her exercise routine because she didn't "know much about taking her own pulse," as her nurse-provider counseled, when Janet prudently inquired whether she could continue jogging. In Maria Lopez's description of her personal exercise practices, the feedback between these different positions, of consulting biomedical authorities but using personal self-evaluations as the basis for decision-making, becomes apparent: "I know more or less what my body can take. Like I said, I don't exercise or anything so, when I walk, I get tired just walking." By making the claim that she knows what her body can take, Maria defiantly employed her own haptic knowledge of her body to escape the strictures against immoderate exercise. In so doing, she maintained the modicum of social accountability inscribed within prenatal discourse that prioritizes the hypothesized needs of the fetus. What appears on the

surface, then, as an arena of pregnancy wherein women might act at their own discretion is, in fact, fraught with tension. Unlike smoking, for example, where no amount of the habit is considered safe, there is neither a proscription nor an endorsement of a well-defined exercise with respect to pregnancy. Rather than learn more about taking her pulse, a practice which Janet seems implicitly to locate outside and apart from herself, she opts out of the behavior altogether.

In contrast, the lack of biomedical consensus left some women in our sample well-positioned to actively develop individuated exercise regimens, of which their own bodies were the primary knowledge source. They attained that "high point of . . . carnal knowledge" that Duden claims otherwise lies dormant when pregnancy is narrowly situated in a biomedical context (1993: 8). For example, self-esteem and active social networks of like-minded women were found to facilitate the assertion of seemingly haptic knowledges. Linda Rosario, a case in point, recalls how her sisters and her aunts spoke of 'bodyaches' during their pregnancies: "Exercising is very important ... I've noticed that, like, my sisters and my aunts, when they were pregnant, they talk about body-aching. Even myself, my body aches. It's just because your body needs exercise. Exercise helps your body, the changes in your body. Exercise ... I do recommend it to everybody that's pregnant. It helps a lot." Linda exhibited a rare haptic authority *vis a vis* exercise by pragmatically marrying the medical with the non-medical in a manner consonant with her individual needs, and which defies the conventional analytic tendency, reflected even in our language, to posit the "medical" against the other the "non-medical." Linda appeared sufficiently confident in the knowledges communicated to her through her bodyaches and the experiences of her female relatives, that she shifts easily into the advisory role normally played by biomedical personnel, a role few women assumed in the course of their interviews: "I do recommend it to everybody that's pregnant." Ironically, the haptic quality of her authority stems as much from her confident absorption of biomedical knowledge as from her female relatives, suggesting, once again, that the same decision (to exercise) may arise out of, as well as in opposition to, one another.

Accounts such as these point up some of the difficulties of distinguishing between practices that appear alternatively as capitulation and as resistance to the disciplinary techniques of biomedicine and their attendant norms. Maria's reasoning, "I know what my body can take" might imply a kind of understated resistance to the norms surrounding exercise, specifically because she frames her logic in terms of her own and not her physician's knowledge. Yet, her decision not to exercise can be portrayed simultaneously as a passive endorsement of counsel against strenuous

exercise, and thus as minimal compliance with conventional biomedical wisdom. It is imperative in the course of excavating pregnant women's reasoning processes that both the rationales and to the extent possible the reported practices are independently evaluated along the posited spectrum of resistance and compliance, as each may cast a different light on the relationship between disciplinary techniques and concomitant practices of the pregnant self.

Understated resistance. When the overarching objective of women's reasoning was not to resist biomedical rationale, but to highlight its inadequacies and to assert another kind of authority – generally haptic and experiential – the practice was identified as falling within the understated resistance portion of the spectrum. When pregnant women described their non-biomedical sources of counsel and information, they implicitly defined the limits of biomedicine to determine the terms of their prenatal routines. In so doing, they also described how they keep biomedical influences on their pregnancy experiences in check. It was often women's desire for supplementary advice on appropriate prenatal behavior that drove such resistance, as it led pregnant women to incorporate non-biomedical ingredients into their decisions about whether to adhere or resist to a particular prenatal norm. In these instances, women were as solicitous of their mothers' experiences and counsel as they were of their physicians'.

Calista Sores, for example, stated succinctly the manner in which she "checks" biomedical counsel for its accuracy and appropriateness: "I still always get that second opinion from my mom." It may well be that these lay sources are also informed by biomedical authorities. Therefore, we can see that the intent with such responses is not to resist biomedicine but rather to augment it with content from a wide variety of sources, especially those that are informed by a pregnant woman's own experience. Calista's practice of consulting her mother is a good example of this in that she subtly undermines biomedical authority without actively challenging it.

Such understated resistance might also be accomplished by challenging the doctor directly to confirm the validity and fit of the doctor's claim to the woman's own pregnancy experiences. Gloria Juarez, for example, described in the same breath that her best sources of information were her doctor and herself: "I follow my feeling. My instinct is good." She furthermore explained that she challenged her physician when she felt uncertain about his recommendations, expecting he be able to answer virtually any question she has about her pregnancy and at the same time deferring to her own "feelings and instincts" as a source of information and answers. The co-habitation of these two sources, herself and her doctor, and her

willingness to use the former to challenge or confirm the counsel of the latter, are key processes in understated resistance.

In foregrounding the pregnancy knowledge acquired from prior pregnancies or from other women's pregnancies, women unwittingly limited biomedical authority, not in conscious defiance of it, but in a manner that they felt best suited their needs. Soledad Jimenez articulated the distinction between these different sources, and their respective relevance to her prenatal routine: "If I feel a certain pain, then I would ask [the doctor or nurse practitioner] if this is normal [and] what type of medicine I can take for bad headaches." She also talks to other women about their experiences, who "tell me about little things and it reassures me . . . A lot of people go through [a certain pain]; it's just the baby growing. It sets my mind at rest, instead of just asking the doctor." In both instances, Soledad experiences a particular pain for which she desires an explanation. She appears to know which pain warrants which kind of reassurance, and seeks out that assurance, yet not at the expense of the other's credibility.

Understated resistance may also take the form of hiding certain pregnancy sequelae from biomedical evaluation. Under these conditions, the women themselves assert authority over what is and is not biomedicine's legitimate terrain. Christine Lehman, for example, explained that her best source of information was her mother, not only for the content of the information her mother imparts, but because with her Christine feels free to articulate the full range of her experience: "I wouldn't panic and call the doctor . . . because I can talk to [my Mom] when I'm upset."

Open resistance. Finally, where many women expressed guilt over 'bad' pregnancy habits, Maria Lopez's comments reflect the 'unrepentant' tone in which a few pregnant women described their eschewal of prenatal norms. "I'm just now into a lot of junk food," she explained, "I drink a lot of soda, that's one thing I have. I don't drink coffee, but I drink a lot of soda; that's caffeine. I think the doctors mentioned that that's not very good for you, but I have to have a soda everyday." When asked why she felt this way, Maria explains:

> That's just from what the – it's not that it's affecting me in any way. It's just from what the doctors say, "It's good or not good for you," what they feel. The doctors and different people have mentioned to me, "Oh, that's not too good for you" because of the weight, or the caffeine, or whatever reason . . . That's just from what people told me. It's not that it's affected me in any way though.

The referent of 'it' in Maria's refrain, "It's not that it's affecting me in any way," is unclear. Is it the doctors' admonitions? Or is it the proscribed

junk food? Do doctors not affect her habits since they seem only to say what they feel or do sodas and chocolate not affect her body? Is the me in "not affect me" inclusive of the fetus?

Where the majority of women either heeded their doctors' recommendations or expressed some concern or regret over having chosen not to comply with those recommendations, Maria was among those who separated and prioritized her needs above the fetus', "I have to have a soda every day," and in so doing openly resisted the prenatal norms she was subject to. The resultant confusion in subject (it, me, they) is palpable throughout and reflects Maria's efforts to consolidate a pregnant subjectivity that heeds its own self-determined rules. Maria's seeming disregard, however, could just as easily be an attempt to deflect the social stigmatization of women who defy, or for whatever reason are unable to comply with, prenatal norms. As such, a lack of repentance may function as a strategy to openly resist the guilt that society expects non-compliant expectant mothers to experience when they knowingly transgress its biomedically sanctioned dictates.

Pregnant subjectivities

One can detect in women's narratives telling slippages between authoritative knowledge that is derived from externally imposed constraints and subjugated knowledge based on bodily experience and haptic interpretation. This slippage parallels what we posit in this paper as a split in contemporary pregnant subjectivity. It is a split subjectivity that serves to highlight the almost necessary co-habitation of the one (authoritative) with the other (subjugated), as each derives its status only in relation to the other. Not only do different women interpret specific guidelines (moral codes) differently, any one woman might selectively adhere to, or internalize, one norm while consciously breaching another; hence, the ethically perforated notion of hegemony proposed herein.

By one biomedical explanation, pregnancy is a series of cell divisions and increasing cell specialization. Foucault similarly maintained that institutions normalize human beings "by a process of division either within himself or from others" (Rabinow 1984: 8). Elaborating the biomedical logos of cell division and Foucault's social formation of self, Iris Marion Young asserts that "[the] pregnant subject ... is de-centered, split, or doubled in several ways," and that "[pregnancy] entails, finally, a temporality of process and growth in which the woman can experience herself as split between past and future" (1984: 46). This splitting allows for the reproduction within the pregnant self of the social relations in biomedicine;

a structure often predicated on the physician's expert and the pregnant woman's subordinate status.

Viewed in this light, the practices of the pregnant self can be understood as an effort to manage the physical, social, and psychological changes incumbent upon pregnancy, not least of which are altered self-perceptions and an exposure to public scrutiny. Indeed, there is, in many women's accounts, a telling slippage in subjectivity from that of a pregnant woman acutely aware of her body's changes to that of a generic, omniscient physician explaining, and often downplaying, the magnitude or meaning of these changes. These vacillating grammatical choices are especially notable for the ways in which they suggest pregnant women's subjectivities to be transformed from unique and individuated experiences of their pregnant bodies ('I') to bodies that, through the disciplinary practices entailed in the biomedical care of pregnancy, are subject to social and medical scrutiny, and thus often generically articulated as a pregnant 'You.'

Despite the homogenizing potential of biomedicine to normalize women's pregnancy experiences along its own disciplinary lines, there endured through women's accounts an ever-present and potent individual agency. That the 'You' and 'I' subjects of women's narratives are unself-consciously intertwined are partial evidence that the complex subjectivity attendant upon pregnancy derives from women's selective compliance and resistance to a host of prenatal norms. We hear women repeatedly, though not uniformly, reconstitute their knowledge of their pregnancies from bodily-subjective to more detached, objective terms. This slippage, or in Foucault's terms, fragmentation, is carried out primarily via women's attempts in the interviews to forge hybrids among: 1) the bodily-knowledge intrinsic to pregnancy (fatigue, weight gain, and mood swings) which, though perceived through the prisms of a particular historical moment, are nonetheless sourced from the woman's body herself; 2) biomedical representations of such experiences as objective, mechanistic phenomena (e.g., mind as altered by hormonal fluctuations); and 3) the politicized representations of how expectant mothers should behave. In the course of exploring how modern subjects become fragmented by related social processes, Foucault provided insight into the different ways that external (social) roles intersect with (self) discipline.

We have described the myriad ways that compliant and resistant practices interact with one another to construct and serve pregnant women's needs. Resistance, we saw, was circumscribed by normalizing discourses of good and bad motherhood. These discourses, in turn, drew much of their authoritative weight from biomedical technologies that purportedly demonstrate how certain behaviors harm the health of the fetus and/or

mother. The power to secure compliance with prenatal norms was similarly constrained by women's occasional reliance upon, for example, knowledge furnished via their mother's or sister's experiences of pregnancy. The residual guilt women experienced, when their transgressions against biomedical prenatal dogma were acknowledged, was unpleasant, but insufficient to make women uniformly comply with biomedically-derived prenatal norms. It may also be that guilt functions as a kind of proxy for compliance, while the actual behavior, through its noncompliance, takes on the character of resistance. It is by virtue of these constraints that the homogenizing power of biomedicine, as an institution and discourse buttressed by strongly held beliefs surrounding truth, efficacy and personal responsibility, is dependent upon the individual's willingness and ability to evaluate the relevance of its norms for practice in daily life.

CONCLUSIONS

This paper takes up the task of discerning in women's self-reports the multiple strategies deployed during pregnancy to fuse knowledge garnered from the technologies of prenatal care (optic, authoritative) with the knowledge communicated to them by the profound changes attendant upon pregnancy (haptic, subjugated). These strategies, and the diverse medical and non-medical influences they comprise, are critical to understanding how the biomedical deployment of technology has produced a complementary and simultaneous culture of haptic resistance. This is especially important if one considers Haraway's observation that vision is "a much maligned sensory system in feminist discourse" (1991: 188). If vision is in some measure embodied in order to be made meaningful, then what we may be hearing in women's words are the haptic means by which they empower the biomedical knowledge lent them by optical means: their bodies make such knowledge relevant, rendering the optical dependent upon the haptic for its embodied import.

Above all, the reports of the women in this study demonstrate how the biomedical representation of pregnancy is inadequate for grasping women's experiences of their bodies and prenatal norms during pregnancy. It is for this reason that we have endeavored to show how prenatal norms produce a range of recombinant resistant and compliant practices, offering an ideal opportunity to explore situated knowledges in the making. The prenatal knowledges explored in this paper are inevitably in flux and derived from numerous sources, biomedical, bodily and the interactions among them. They are characterized by the context in which they are practiced and have meaning for pregnant women. They are multivocal,

including, not exhaustively, women's own knowledges, their mothers', sisters', and friends', as well as their health care providers'. They are dependent on each woman's way of seeing and being in the world, i.e., the particulars of their experiences and lifestyle. Finally, they illuminate how biomedicine's exercise of knowledge-as-power is ultimately mediated through women's compliance, or lack thereof, with prenatal norms.

Knowledge of women's prenatal practices is imperative for understanding the evolving relationships among physicians, biomedical discourse, lay practices and pregnant women; between social norms of 'good medicine' and 'good motherhood'; and among the different knowledges that are brought to bear upon, and which arise by virtue of, women's pregnant bodies. In so doing, one can thus furnish more illustrative "accounts of how certain institutional and cultural practices have produced individuals" (Sawicki 1991: 22). The interaction between these different practices, of institutions and individuals, is critical to understanding the processes by which the experience of pregnancy and the evolution of pregnant subjectivities change over time and across contexts. Exploring how the disciplinary practices of particular institutions and their legitimizing discourses intersect with the care of the (pregnant) self is a fruitful means to understanding the oft-used term 'power' and its role in constituting and being constituted through social relations in medicine.

ACKNOWLEDGEMENTS

The research for this paper was supported in part by grants from the National Institute of Child Health and Human Development (#HD11944), the UCLA Chicano Studies Research Center, and the UCLA Academic Senate. We wish to thank the administration and staff of the participatory HMO for graciously facilitating the project. The project from which these data derive could not have reached fruition without the participation of Nancy Press. Above all, we are most indebted to the women interviewed, whose generous disclosure of the intimate details of their pregnancies bring this paper to life.

NOTES

1. The absence of such a difference is a possible function of the relative homogeneity of our sample, as most of our Mexican-origin participants exhibited high levels of acculturation according to scores on a standardized instrument (Marin et al. 1987). In her research on Puerto Rican and European American obstetrical patients at an inner

city hospital in the United States, Lazarus similarly observed that "Puerto Rican and white women held similar beliefs about pregnancy and birth, managed these events in a similar fashion, and behaved similarly in their clinical interactions, despite the fact that the Puerto Rican women maintained a strong, separate cultural identity" (1988: 36). Lazarus concludes that factors associated with clinic organization such as the length of medical consultations and presence or absence of physician continuity, as well as the exigencies of medical resident training had a more powerful impact on women's prenatal care practices than cultural differences. In this paper, therefore, we will not differentiate by ethnicity or socioeconomic status in discussing women's pregnancy experiences.

2. This quote and all others throughout this paper have been chosen for their typicality or, when noted, the opposite.

REFERENCES

Abel, E.K. and C.H. Browner
1998 Selective Compliance with Biomedical Authority and the Uses of Experiential Knowledge. *In* Pragmatic Women and Body Politics. M. Lock and P. Kaufert, eds. Cambridge, MA: Cambridge University Press.

Breuer, S.
1989 Foucault and Beyond: Towards a Theory of the Disciplinary Society. International Social Sciences Journal 41: 235–245.

Browner, C.H. and N. Press
1995 The Normalization of Prenatal Diagnostic Screening. *In* Conceiving the New World Order: The Global Politics of Reproduction. F. Ginsburg and R. Rapp, eds. Pp. 307–322. Berkeley: University of California Press.
1996 The Production of Authoritative Knowledge in American Prenatal Care. Medical Anthropology Quarterly 10: 141–156.

Cartwright, L.
1995 Screening the Body: Tracing Medicine's Visual Culture. Minneapolis: University of Minnesota Press.

Code, L.
1991 What Can She Know? Feminist Theory and the Construction of Knowledge. Ithaca: Cornell University Press.

Deveaux, M.
1994 Feminism and Empowerment: A Critical Reading of Foucault. Feminist Studies 20: 223–246.

Dews, P.
1987 Logics of Disintegration: Post-structuralist Thought and the Claims of Critical Theory. London and New York: Verso.

Duden, B.
1993 Disembodying Women: Perspectives on Pregnancy and the Unborn. Cambridge, MA: Harvard University Press.

Ehrenreich, B. and D. English
1978 For Her Own Good: 150 Years of the Experts' Advice to Women. New York: Anchor Books.

Eisenberg, A., H.E. Murkoff and S.E. Hathaway
1984 What To Expect When You're Expecting. New York: Workman Publishers.

Finkelstein, J.L.
1990 Biomedicine and Technocratic Power. The Hastings Center Report 20: 13–17.
Foucault, M.
1977 Discipline and Punish: The Birth of the Prison. New York: Pantheon Books.
Georges, E.
1996 Fetal Ultrasound Imaging and the Production of Authoritative Knowledge in Greece. Medical Anthropology Quarterly 10: 157–75.
Gordon, C., ed.
1980 Power/Knowledge: Select Interviews and Other Writings, 1972–1977, by Michel Foucault. New York: The Harvester Press.
Haine, W.S.
1994 A Spectrum of Cultural Constructs: The Interrelationship Between Social, Legal, and Medical Constructs of Intemperate Behavior in Parisian Drinking, 1860–1914. Contemporary Drug Problems 21: 535–556.
Haraway, D.
1991 Simians, Cyborgs, and Women: The Reinvention of Nature. New York: Routledge.
Jones, C. and R. Porter, eds.
1994 Reassessing Foucault: Power, Medicine, and the Body. London: Routledge.
Jordan, B.
1977 The Self-Diagnosis of Early Pregnancy: An Investigation of Lay Competence. Medical Anthropology 1: 1–38.
1997 Authoritative Knowledge and its Construction. *In* Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives. R.E. Davis-Floyd and C.F. Sargent, eds., pp. 55–79. Berkeley: University of California Press.
Kay, M.A.
1980 Mexican, Mexican/American and Chicana Childbirth. *In* Twice a Minority: Mexican American Women. M.B. Melville, ed. Pp. 52–65. St. Louis: C.V. Mosby.
Lazarus, E.
1994 What Do Women Want? Issues of Choice, Control and Class in Pregnancy and Childbirth. Medical Anthropology Quarterly 8(1): 25–46.
Marín, G., F. Sabogal, B. Marín, R. Otero-Sabogal and E.J. Perez-Stable
1987 Development of a Short Acculturation Scale for Hispanics. Hispanic Journal of Behavioral Sciences 9: 183–205.
Markens, S., C.H. Browner and N. Press
1997 Feeding the Fetus: On Interrogating the Notion of Maternal-Fetal Conflict. Feminist Studies 23: 351–72.
Martin, E.
1987 The Woman in the Body: A Cultural Analysis of Reproduction. Boston: Beacon Press.
McHugh, P.
1989 Dialectics, Subjectivity and Foucault's Ethos of Modernity. Boundary 2(16): 91–108.
McNay, L.
1991 The Foucauldian Body and the Exclusion of Experience. Hypatia 6: 125–139.
1994 Foucault: A Critical Introduction. Cambridge, MA: Polity Press.
Metzger, M.J.
1990 Double Gestures: Feminist Critiques and the Search for a Useable Practice. Hypatia 5: 118–124.

Mitchell, L. and E. Georges
1997 Cross-Cultural Cyborgs: Greek and Canadian Women's Discourses on Fetal Ultrasound. Feminist Studies 23: 273–401.
Mittelmark, R.A., R.A. Wisell and B. Drinkwater, eds.
1986 Exercise in Pregnancy. Baltimore, MD: Williams & Wilkins.
Osborne, T.
1994 Epidemiology as an Investigative Paradigm: The College of General Practitioners in the 1950s. Social Science and Medicine 38: 317–327.
Pickett, B.
1996 Foucault and the Politics of Resistance. Polity 28: 445–466.
Porter, S.
1996 Contra-Foucault: Soldiers, Nurses and Power (Michel Foucault). Sociology 30: 59–79.
Press, N. and C.H. Browner
1997 Why Women Say Yes to Prenatal Testing. Social Science & Medicine 45(7): 979–985.
Rabinow, P.
1986 The Foucault Reader. London and New York: Penguin Press.
Rapp, R.
1993 Amniocentesis in Sociocultural Perspective. Journal of Genetic Counseling 2: 183–195.
Sandelowski, M.
1993 With Child in Mind: Studies of the Personal Encounter with Infertility. Philadelphia: University of Pennsylvania Press.
Sangren, P.S.
1995 "Power" Against Ideology: A Critique of Foucaultian Usage. Cultural Anthropology 10: 3–41.
Sawicki, J.
1993 Foucault and Feminism: Power, Gender, and the Self. Boston: Northeastern University Press.
Scott, C.
1993 Foucault, Ethics, and the Fragmented Subject. Research in Phenomenology 22: 104–137.
Smith, D.
1990 Texts, Facts, and Femininity: Exploring the Relations of Ruling. London and New York: Routledge.
Spicer, E., ed.
1977 Ethnic Medicine in the Southwest. Tucson: University of Arizona Press.
Stanworth, M., ed.
1987 Reproductive Technologies: Gender, Motherhood and Medicine. Oxford: Polity Press.
Young, I.M.
1984 Pregnant Embodiment: Subjectivity and Alienation. Journal of Medicine and Philosophy 9: 45–62.

University of California
Los Angeles