Expectant Fears and Racialized Reproduction: African American Women’s Lived Experiences of Pregnancy and Motherhood

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ABSTRACT
KAAREN M. HALDEMAN: Expectant Fears and Racialized Reproduction: African American Women’s Lived Experiences of Pregnancy and Motherhood
(Under the direction of Kaja Finkler)

This study explores the lived experiences of pregnancy, childbirth and motherhood among African American women living in central North Carolina. Although there are many anthropological studies of reproduction, there is very little in the way of explorations of the lived experiences of pregnancy. This work was conducted between April 2002 and July 2003 with a group of 62 African American women who received prenatal care at a local OB-GYN office founded by two African American physicians and located in central North Carolina. An in-depth analysis of life history interviews with six of these women grounds the final analysis. I have used an overarching theoretical framework that examines pregnancy as a life process and a unique physiological event in order to understand the full range of life experiences that can come to bear on a woman’s pregnancy. I have combined phenomenological understandings of perception and embodiment to explore the intersections of social, cultural and existential life in the contexts of pregnancy and motherhood. The women in this study have pointed to experiences of pregnancy that include experiencing pregnancy as fear of bearing a son and have developed a new way of understanding class experience in the context of a lived pregnancy. This study has pointed to experiences in African American women’s lives that are positively, negatively, or neutrally felt that inform how they live their pregnancies. Those negatively felt experiences and perceptions that are related to being a pregnant African American woman emerged out of lived experiences in a
racist U.S. culture whose histories, practices and ideologies of exclusion are still based on skin color.

This work is informed by a Black Feminist perspective in which the researcher is compelled to engage in a “critical radical praxis” to effect change in African American women’s lives. The goal of my research has been to provide information about those lived experiences of pregnancy in the lives of African American women that may help to address persistent and glaring inequalities in health.
To My Loves Gavin, Egan and Jameson

And

In Memory of
Ira Brooks Walsh
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Chapter One

Introduction

This study explores the *lived experiences of pregnancy, childbirth and motherhood* among African American women living in central North Carolina. Although there are many anthropological studies of reproduction (See Jenkins and Inhorn, 2003, for a recent review), there is very little in the way of explorations of the *lived experiences of pregnancy* (Longhurst, 1999, 2000; Young, 1984). While I initially began the work for other reasons, my journey through fieldwork and the relationships I formed with consultants over the course of the study and beyond led me to a much richer exploration of these *lived experiences*.

I began this study of pregnancy among African American women in order to more fully understand the social and cultural contributors to the two-and-a-half-fold higher infant mortality rate among African American women when compared with European American women (15.1 versus 6.6 per 1,000 live births in North Carolina, 1999-2001).¹ According to public health literature and published statistics (Krieger, 2000b), the greatest contributors to this discrepancy are preterm (less than 37 weeks gestation) and very preterm (less than 32 weeks gestation) deliveries of low birthweight infants (less than 5 lbs. 8 oz.).

Initially—and following Harvard social epidemiologist Nancy Krieger’s extensive work on racism and health (1993, 1999, 2000a,b)—I hypothesized that social inequality that is experienced as racism promotes preterm delivery and/or the birth of low birthweight babies. I

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drew from the larger public health literature on racism and health and the abundance of related literature on “social contributors” to preterm birth (Hogan, 2001; Jones, 2002; Krieger, 1993; Lumley, 1997; McGrady, 1992; Murrell, 1996; Mustillo, 2004; Rich-Edwards, 2001; Rosenberg, 2002; Rowley, 2001) in order to design a study that would explore social themes in women’s lives within the parameters of African American heritage, racism, female gender and class and how they might come to bear on preterm labor. In particular, I focused on those African American women of middle and upper class levels who still experience preterm labor and delivery of a low birthweight infant at more than two times the rate of European American women (Schoendorf, 1992). Using an anthropological approach, I tailored the study toward understanding the host of unexplained factors that contribute to these pregnancy experiences.

However, as the study progressed, I observed that few of these women experienced preterm labor (11%) and preterm or term delivery of a low birthweight infant (4.8%). The reasons why this may have been the case are no doubt many—the number of women who participated may have been too few or perhaps we need to rethink how preterm labor is presented in the public health literature and statistical science. However, conditions of life for this group of women may help to address experiences of racism in ways that prevent them from experiencing preterm labor. In the final chapter of this dissertation, I address the potential impact of attending an African American practice serving a predominantly African American clientele on pregnancy and birth for this group of women.

An anthropological exploration of lived experiences of pregnancy provides a window to understanding the intersections of micro processes of subjective experience and the broader macro forces of culture and history that impinge on the everyday lives of pregnant African
American women. In Chapter Two, I develop the theoretical underpinnings of this
dissertation and explore in more detail how experiences of pregnancy, like other experiences
of health, are embedded in larger social, cultural and historical relations. Below, I will briefly
introduce the theories that have informed this work.

A medical anthropological perspective eschews the Cartesian mind-body dualism espoused by positivist science and emphasizes the interconnections of human social and biological life. It is important to note that this is a perspective that partially rejects positivist etiologies of health and disease, for it recognizes (though not uncritically) the value of medical testing, physicians as healers and biomedicine as a culturally inscribed world that can effectively address particular health problems. However, it maintains a critical stance against a positivism that leaves little or no room for the interconnections of society, personal experience and physiological mechanisms.

I have used an overarching theoretical framework that examines pregnancy as a life process and a unique physiological event in order to understand the full range of life experiences that can come to bear on a woman’s pregnancy. I have combined phenomenological understandings of perception and embodiment to explore the intersections of social, cultural and existential life in the contexts of pregnancy and motherhood. In so doing, I engaged in conversations about felt experiences of pregnancy and motherhood within the contexts of being an African American woman and related experiences of class.

Conceptualizing pregnancy as a culturally informed social process and as a unique nine-month event rejects the biologization of this experience and constitutes one theoretical framework that guides this research. Although there is substantial anthropological literature on childbirth and pregnancy and the cultural and social processes that inform them, nearly all
maintain a conception of pregnancy as a discrete nine-month event (See Davis-Floyd, 1992; Ginsburg and Rapp, 1995; Jordan, 1993; Martin, 1987; Rapp, 1999. See Mullings and Wali, 2001 as an exception). Although this research explores the physical experiences of pregnancy, such experiences expand beyond the biomedically informed idea that it is limited to a nine-month period, bounded by physical bodies. In Young’s (1984) reflection on her own pregnancy, she affirms that boundaries of a pregnant woman are fluid: “The integrity of my body is undermined in pregnancy…by the fact that the boundaries of my body are themselves in flux. In pregnancy I literally do not have a firm sense of where my body ends and the world begins” (p.49). As this study shows, processes of history, memory and physiology are dynamically interconnected as women move through their current pregnancies. Experiences of Self and one’s body in times of pregnancy link cultural conceptions of pregnancy, birth and motherhood to imagined, past, current and future experiences of pregnancy.

Merleau-Ponty’s philosophy of perception allows for a theoretical field in which to explore sensory, bodily experiences and their connections with subjective lived experience in social worlds. Subjectivities are not formed solely by an individual but rather in dynamic connection with others—a concept Merleau-Ponty refers to as intersubjectivity. For instance, when an African American mother perceives the developing child who levels a kick against her abdominal wall as someone unwanted by society, phenomenological understandings of her own and his being-in-the-world are intensified and informed by perceptions of Self held by the wider society. Experiences of racism in a pregnant woman cast shadows on what she might otherwise perceive as her ability and power to bring forth new life.
Csordas reminds us that *embodiment* is not to be confused with the “body,” which he describes as “biological, material entity” (1994:12). Rather, the concept rests on “…perceptual experience and mode of presence and engagement in the world” (1994:12). Although intimately connected, *embodiment* expands on Merleau-Ponty’s *perception* by creating space for one’s engagement with history and culture. In order to avoid criticism that these concepts are oriented in favor of the individual, in their analysis of emotion phenomenologists Lyon and Barbalet emphasize the ability of one’s body to be understood on both individual and social levels: “…the concept of embodiment need not reinforce the idea that the individual is necessarily to be understood in terms of his or her ‘internal’ processes, but rather that [it] can lead to a deeper awareness of the sociality of being and emotion” (1994:62).

Finally, I approached these topics from a Black Feminist perspective of *intersectionality* in terms of addressing the “systems of oppression” identified by Black Feminist scholars as most relevant to black women’s lives—“interlocking systems of race, gender and class.” Patricia Hill Collins explains *intersectionality* as referencing “…two types of relationships: the interconnectedness of ideas and the social structures in which they occur, and the intersecting hierarchies of gender, race, economic class, sexuality and ethnicity (1999:263).” However, limits of this perspective include an assumption of imposed categories and their meanings that include constructions of “race, class and gender” that have not been critically examined.

Because this study is also a critical examination of an imposed social category of “race,” I must explain that although I recognize that *race* holds great meaning for some of these women, such as Helene, I do not accept *race* as a real category. Anthropologists have
historically contributed to ideologies of race but now reject its imposition on social and cultural life.² This work affirms a rejection of race and instead explores meanings and experiences of being African American and how these articulate with class and female gender in the contexts of pregnancy and motherhood. Those negatively felt experiences and perceptions that were articulated by women in this study and which were related to being a pregnant African American woman emerge out of lived experiences in a racist U.S. culture whose histories, practices and ideologies of exclusion are still based on skin color.

Throughout this work I have used both “African American” and “black” to refer to women who participated in this study because these are the terms used by them to explain how they see themselves in the world. Although interconnected, these are separate concepts that refer to different social experiences and reflect varied histories of people of African descent living in the U.S. Again, although I reject a color categorization of human difference, “black” holds deep meaning for some women and is a point of celebration for Helene and Zakiyyah, whom you will meet in Chapter Seven.

The women in this study have pointed to experiences of pregnancy that include experiencing pregnancy as fear of male gendered pregnancies and have developed a new way of understanding class experience in the context of a lived pregnancy. Women have emphasized those experiences during pregnancy that they believe may adversely affect their health as well as those experiences that may mitigate against such potentially harmful consequences. In addition, larger themes that I have addressed in interviews with this group of women and those themes that have emerged from observation over the course of this study have helped me come to a fuller appreciation for the ways in which these women live and

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² See Appendix 1 American Anthropological Association Statement on “Race.”
experience being African American, their female gender and their class in everyday life, especially during pregnancy.

This research adds to the paucity of studies on the lived experiences of pregnancy and to the larger literature on motherhood. As such, it is situated in anthropological studies of pregnancy, childbirth, reproduction and motherhood. This work also adds to understanding pregnancy as a racialized experience for some African American women as they confront the racist ideologies that impinge on the physiology and experiences of pregnancy.

Although my research focus has shifted to understanding more in-depth the phenomenological experiences of pregnancy, I conducted this research specifically with African American women in order to explore lived experiences of racialized pregnancy and motherhood with an eye toward practical action among public health, medical and other caregivers in order to address inequalities in health that are intimately tied to pregnancy. As I have adopted a Black Feminist theoretical framework that compels a researcher to engage in study in order to effect change, or engage in a “radical praxis,” this work can contribute to understanding those lived processes in African American women’s lives that may contribute to complications during pregnancy. In this way, although the majority of women in this study did not experience preterm labor and delivery, the processes and experiences that they have identified may potentially reflect Finkler’s (1994) concept of life’s lesions among other African American women.3

Finally, this study has pointed to experiences in African American women’s lives that are positively, negatively, or neutrally felt that inform how they live their pregnancies. I recognize that while some of these experiences are unique to African American women’s

3 See pp.30-31 for a description of this concept that links phenomenological understandings of the lived body to physiological outcomes.
lives, others could emerge from interviews with women of other cultural backgrounds. However, living a U.S. history of enslavement, violence and hatred based on the perceived color of “black” skin, African American women have endured particular historical insults that women of other backgrounds have not. Thus, the circumstances that give rise to these particular experiences are different for African American women. For example, given the historical denial of basic human rights to African American men and the subsequent economic and psychological toll such exclusion produced and maintained, tensions between African American men and women play out differently. Legacies of a racism perceived as predominantly directed at men have denied African American women the opportunity to examine and dissect male-female relations in their own communities for fear of “airing dirty laundry” or “contributing to literature that impinged and stereotyped African Americans” (Hill, 2005: 93). Thus, although many women experience difficulties with their partners—particularly during pregnancy—African American women experience such negatively felt perceptions as part of a larger, shared history with African American men.

This dissertation is organized into eight chapters. Chapter Two is a review of the theories and literature that inform this dissertation and is divided into five sections. First, I review the field of Medical Anthropology as I situate this work within the broad fabric of this discipline. I include studies of pregnancy and reproduction and include a review of the literature in pregnancy loss because those women who did experience preterm labor were faced with the possibility of losing the child they were carrying. Second, I address the theoretical perspectives in Medical Anthropology and emphasize those perspectives that I use in this project. Next, because I began this study as an exploration of preterm labor and there were seven women who experienced preterm labor, I discuss preterm labor and delivery, low
birthweight and infant mortality from a public health perspective in order to orient the reader toward one of the goals of this study. Last, I briefly review the literature on gender and health with an eye toward studies of reproduction and address the literature on African American experiences and “race.”

In order to understand the meanings embedded in African American women’s choices to visit a predominantly African American practice for their prenatal care and to underscore the historical ambivalence of the medical establishment to provide quality care for pregnant African American women and the attendant medical moralizing about “black motherhood,” Chapter Three examines the historical relationship between African Americans and the worlds of biomedicine and U.S. health care. I begin with a discussion of African American vernacular healing practices during enslavement and continue with a historical overview of the dubious relationship between race and medicine in the U.S.—including a history of local biomedical practice in North Carolina—leading up to current controversies. Last, I review the literature on reproductive health care in African American cultural contexts.

Chapter Four explains in detail the methodology that I followed over the course of this study and leads into Chapter Five, which describes the field setting in small southern North Carolina city and town. Included in this chapter is an ethnographic profile of the OB-GYN practice, its clinicians and staff, as well as oral history interviews with the African American physicians who co-founded the practice in 1983. Chapter Six provides a brief description of the larger group of women who participated in this study and presents some of the themes generated from my interviews and observations with this sample of women over the course of one-and-a-half years. Some findings from this group are also presented.
Chapter Seven examines in-depth the life histories of six women who chose to participate in a long-term relationship with me during the study. Some of them remain my close friends. Their life stories also include narratives of pregnancy that emerged from interviews prior to the life histories and come to bear directly on experiences of pregnancy and motherhood in the lived contexts of class, racism and being African American and female.

The concluding Chapter Eight synthesizes those themes that are emphasized in the life histories around experiences of pregnancy and motherhood, including those that came to bear in negative ways and those that mitigated against the adverse effects of such negative experiences. I analyze the meanings and experiences of incomplete fatherhood and incomplete motherhood that were large pieces of women’s narratives of pregnancy and motherhood. Both concepts point to experiences of loss, from the perspective of a pregnant woman, regarding her own childhood. The term incomplete arose out of discussions with Dr. Michele Berger around African American fatherhood and is a response to the U.S. cultural platitude of absentee fathers. I also analyze experiences of fear around having a son and experiences of class as they relate to pregnant African American women’s experiences of racism.

The final section of Chapter Eight is an admittedly brief analysis of larger questions of experiences of being African American combined with female gender, class and racism from African American women’s perspectives and that emerged out of the many discussions with women during the study period and beyond.

Again, it is important to emphasize that although my approach shifted to a more in-depth study of women who presented an array of pregnancy, birth and motherhood experiences, my

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4 In my experience with a NC state working group on Infant Mortality, African American women who were also part of the group called for a critical examination of this term.
goal remains the same: to provide information about those lived experiences of pregnancy in the lives of African American women that may help to address persistent and glaring inequalities in health.
Chapter Two

Review of the Literature

This thesis comes to bear on several related fields including medical anthropology of reproduction; studies of pregnancy and motherhood; African American life and studies of race and racism as they are shaped through experience; gender and health. This study also contributes to the literature on “black middle class” experience\(^5\) and more specifically to the limited literature on college-educated African American women and pregnancy\(^6\).

Below I present a review of the literature in the above-mentioned areas that informs the scope and practice of this research. First, I examine the field of medical anthropological discourse in historical perspective with specific attention to studies of reproduction including a review of studies that examine pregnancy and motherhood. Next, I present an overview of key theoretical perspectives that guide this research and follow with a review of literature addressing interconnections between gender and health with an emphasis on reproduction. I conclude this section with a brief analysis of “stress” from anthropological and medical perspectives. Next, I review the public health literatures with regard to the phenomena of preterm labor and delivery, low birthweight and infant mortality. Included in this discussion is an analysis of the history in public health of framing such health “outcomes” in terms of racialized “disparities” and the examination of “racism” as a “social stress” that may produce


\(^6\) See Jackson, 2001; McGrady, 1992; Mullings and Wali, 2001; Schoendorf, 1992.
such “outcomes.” Last, I provide a brief analysis of the U.S. social history of race as an introduction to Chapter Three.

Medical Anthropology in Historical Perspective and Anthropologies of Pregnancy and Reproduction

Medical Anthropology In Historical Perspective

The field of medical anthropology focuses on the understanding of the intersections of sociocultural and biological life. Its assumptions rest on the cultural nature of illness, health and healing and a partial rejection of positivist claims that biological etiologies “proven by science” are the only explanations of a person’s health or sickness. This subfield of cultural anthropology engages a wide variety of issues—broadly construed—concerning the etiologies of and responses to the health and illness of human beings. Early studies in medical anthropology, which often crosscut studies in medical folklore, investigated medical systems as cultural systems through the study of traditional or vernacular systems of healing (Baer, 1981; Finkler, 1985; Hufford, 1988; Hill and Mathews, 1981; Snow, 1974, 1978). Others leveled critiques at biomedical models of disease (Engel, 1977; Lock and Gordon, 1988; Martin, 1987 and 1989), and engaged in the study of biomedicine as a cultural system and ideological force (Baer, 1989; Finkler, 2000; Good and Good, 1989; Gordon, 1988; Hunt, 1985; Kleinman, 1978; Trostle, 1988). During this period, the field of bioethics became fertile ground for medical anthropologists as they began to problematize universal moral judgments in biomedicine in the name of cultural relativism (Dula, 1991; Finkler,

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7 For a more in-depth historical overview, see Baer (1997).
As the field developed, studies rooted in understanding the technoscience (Butter 1993; Jordan and Davis-Floyd, 1993; Pinckney and Pinckney, 1989) that has become the hallmark of biomedicine emerged in tandem with a move toward human-experience centered research with a more phenomenological perspective (Csordas, 1990 and 1994a; Farmer, 1992; Finkler, 1994a; Kleinman et. al., 1997). With an eye toward a “critical medical anthropology” (Baer, 1997) more recent Foucault-inspired work in the discipline centralizes the roles of power and social inequality and offers insight into how the processes that produce unequal relations of power also affect the health of human beings (Petersen & Bunton, 1997). Foucault’s (1980) conceptualizations of power (i.e., as capillary and constituting a shifting field of discourse that exists in connection with mobilizing points of resistance); his related idea of “bio-power” (1978) (i.e., “..techniques for achieving the subjugation of bodies and the control of populations,” p.140); and his scrutiny of “the body” as a shifting node in the discursive field of power relations inspired much of this work in medical anthropology.

Works that engage postmodern perspectives on the “body” as representation and site of production and reproduction of these power relations are exemplary of this tradition (Covino, 2004; Das, 1998; Haraway, 1991; Lupton, 2003; Lock and Kaufert, 1998; Petersen & Bunton, 1997; Scheper-Hughes and Lock, 1987; Sobo,1993). In concert with this postmodern move toward analyses of power, some authors have analyzed the political economic worlds

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8 I am not beholden to one idea of power, but rather refer to it as a constellation of what Marx would call “ruling ideas,” or those thoughts possessed by a ruling (e.g., class, racial) elite which translate into actions that ultimately do harm to those who are not members of the elite and which are perceived to be beyond the control of those who are harmed. In this work, analyses of power include social processes of racism and racialization; classicism; sexism; structural and symbolic violence of ingrained ideas about racial inferiority that harm, in multiple ways, African American people in the U.S.
that impinge on everyday life by interweaving human experience with those macro-social forces that are power-laden, thus problematizing the centralization of power in anthropological studies of health and illness (Finkler, 2000; Ginsburg and Rapp, 1995; Inhorn, 2003b; Lock and Kaufert, 1998). Other examples of recent work include ethnographies related to the role of genetic ideologies of inheritance in the (re)construction of kinship relations (Finkler, 2000); how processes of globalization shape the use and interpretation of new reproductive technologies and how these technologies shape pregnancy and birthing experiences cross-culturally (Franklin and Ragoné, 1998; Inhorn, 2003b; Rapp, 1999); how processes of late capitalism influence the most intimate of human bodily experiences (Layne, 1999); stress as a social process and its role in racializing health disparities (Mullings and Wali, 2001); and the influence of global forces on health policy and how individuals interpret such policies locally (Van Hollen, 2004).

Medical Anthropology and Studies of Reproduction

Ginsburg and Rapp (1991) discuss the discourse of reproduction that connotes a variety of ideas, practices and meanings. Following Ginsburg and Rapp, I am referring to reproduction here as the human and female experiences of conception, pregnancy, childbirth and motherhood. With the 1970’s “second-wave” of feminism came inspiration for more work in anthropology on the analysis of pregnancy as an experience of both power and subordination (Ginsburg and Rapp, 1991). With the surge of interest in gender studies—and the experience of pregnancy is profoundly gendered—pregnancy, childbirth and motherhood

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9 This term falls woefully short of how I am treating the topic in this analysis. I believe that reproduction distances the reader, researcher and participant from the lived experiences related to pregnancy. Although I will use the term reproduction throughout my work, I prefer that readers understand this research as an exploration of women’s lived experiences of pregnancy.
began to receive a great deal of attention from anthropologists. As Jenkins and Inhorn report, “After decades of scholarly neglect, the last 25 years have witnessed a veritable “explosion” of social science research on human reproduction…anthropologists Rayna Rapp and Faye Ginsburg note the “cresting wave” of scholarly and activist interest in reproduction in the past ten years” (Jenkins and Inhorn, 2003:1831).

Medical anthropology of reproduction has had its own historical trajectory. Traditionally, medical anthropologists have explored experiences of pregnancy by focusing on childbirth practices, settings and authoritative knowledge production in those settings (Davis-Floyd, 1992; Jordan and Davis-Floyd, 1993; Martin, 1987). Some challenged the way in which Western women (notably in the U.S.) give birth, relating the supine position and technological infusion of hospital births to the ideological hegemony of biomedicine in U.S. culture (Davis-Floyd, 1992; Davis-Floyd and Sargent, 1997; Jordan and Davis-Floyd, 1993). More recently others have focused on the (not so) new reproductive technologies such as amniocentesis and in vitro fertilization (Rapp, 1999; Ginsburg and Rapp, 1995; Inhorn, 2003a).

The most recent work on pregnancy in medical anthropology has engaged the historical and global political forces that affect the ways in which women conceive, bear and mother their children (Ragoné and Winddance Twine, 2000; Inhorn, 2003a). For example, Inhorn examines the ways in which the rapid “technology transfer” of new reproductive technologies to developing countries such as Egypt influences the consumption of such technologies to produce “test-tube” babies for the elite. In her analysis, Egyptian antinatalist policies and formal restrictions on adoption intersect and conflict with cultural conceptualizations of women’s bodies, vernacular understandings of conception and the
meanings of pregnancy and birth in Egyptian social life. According to Inhorn, the
intersections of the global and local limit the use of new reproductive technologies to the
Egyptian elite, allowing for selective reproduction of the advantaged and abandonment of the
problem of infertility among the poor.

*Anthropology of Pregnancy Loss*

Although part of this research addresses experiences of *pregnancy loss*, the focus remains
on those conditions of life that may contribute to or aid in the prevention of preterm labor
and delivery of an infant that is low birthweight and/or may not survive its first year of life.
Central to this study of a wide range of pregnancy experiences, particularly in relation to
preterm labor and delivery, is the understanding that not all pregnancies proceed according to
plan. Anthropological studies of pregnancy loss can provide insight into those moments
when women must deal with unanticipated and often unwelcome changes in an otherwise
healthy pregnancy. Further, those women who experienced preterm labor and/or delivery in
this study faced the possibility of their baby dying or being born with a disability.

“*Pregnancy loss*” is a medical term that includes all pregnancies that do not end in a live
birth, excluding abortions.10 The Durham OB-GYN practice in which this work is situated
records miscarriages (between 20 and 24 weeks gestation), preterm birth (greater than 20
weeks to 36 weeks), term birth (37 to 42 weeks) and intrauterine fetal death (IUFD). “Infant
mortality” refers to the death of a live born infant and is classified in terms of time: infant
(under 1 year of age); neonatal (under 28 days); early neonatal (under 7 days); and
postneonatal (28 days-11 months).

10 Communication from one of the founding physicians of the Durham practice in which this work was
conducted, October 31, 2005.
Although not experientially equivalent in any way, anthropologists have used the term *pregnancy loss* to refer to those experiences of infertility, miscarriage, abortion, stillbirth, perinatal death, and infant death.\(^{11}\) Although I also adopt this perspective, I note that each of these experiences needs further anthropological inquiry in order to understand the *conditions* and *experiences* of such loss rather than lumping such a wide variety of human experiences into one term.

Embedded in studies of reproduction, gender and health are narratives of pregnancy-, infant-, or child loss (Jordan and Davis-Floyd, 1993; Finkler, 1985a and 1994a; Layne, 1996, 1997, 2003a; Scheper-Hughes, 1992) and experiences of pregnancy that do not follow a prescribed path constructed by what Jenkins and Inhorn (2003) call a Western discourse of “happy endings.”\(^{12}\) Anthropological studies that explore experiences of pregnancy loss can provide a window to understanding the conditions and context of such loss and a woman’s response to it.\(^{13}\) However, few anthropologists have been able to ethnographically explore this subject silenced in U.S. culture. In contrast to work in the Yucatan (Jordan, 1993), rural Mexico (Finkler, 1994a), Northeast Brazil (Scheper-Hughes, 1992), and Nepal (March, 2001), U.S. women are nearly compelled to keep such “reproductive disasters”\(^{14}\) under wraps.

Layne (2003a) analyzes the ways in which the Women’s Health and Natural Childbirth movements uncharacteristically partner with a biomedical scientific discourse of pregnancies

\(^{11}\) See my discussion of Rapp (1999), p.19 for other interpretations.

\(^{12}\) Becker (1994) and Inhorn and Buss (1994) address infertility; Reinharz (1988) addresses miscarriage; Jordan (1993) and Finkler (1994a) discuss women’s responses to pregnancy or infant loss in the rural Yucatan and central Mexico respectively.

\(^{13}\) Layne (2000) also explored partners’ responses to pregnancy loss in her work with support groups in the U.S.

\(^{14}\) Layne, 2003b.
with “happy endings” to force narratives of loss into the shadows of American public expression and cultivate a sense of individual mother-blame for “unhappy endings.” Layne reports, “…we silence these stories and deceive ourselves with a ‘shared faith that chosen childrearing is always happy’” (2003b:1887). Scheper-Hughes accounts for this silence by contrasting mundane experiences of infant or child loss in Bom Jesus, Brazil with the constructed “randomness” of such events in industrialized nations: “…the dialectic between fertility and mortality has lost its edge and is buried in the back of our consciousness. For most Europeans and North Americans each birth signifies new life, not the threat of premature death” (1992:273). In the only ethnography of preterm labor and delivery and infant mortality, Mullings and Wali (2001) lamented they were unable to organize a discussion group for those women in Harlem who experienced loss of an infant.

Rapp (1999) and Layne (1996, 2000, 2003a) both engage experiences of pregnancy loss in their own personal narratives. Rapp examines pregnancy as it relates to a woman’s choice to end a pregnancy based on amniocentesis results. She also analyzes loss in terms of a “disabled fetal imaginary” where the possibility of a late abortion looms over an expectant mother: “Its presence is particularly palpable when interviewing women at home, where the presence of family life—other children, and plans for where the new baby will sleep and the conditions of its care—are embedded. Should the news be bad, the disruption of daily life within which the pregnancy lives is tangible” (p.129). In this way, Rapp explores the lived experiences of pregnancy as women engage the practices of prenatal testing and make decisions in the context of possibilities of loss. She links personal experiences to macro social forces that weigh on women’s decisions to carry a pregnancy to term or not. She invites us to rethink pregnant women as social actors who have become “At once conscripts
Layne (2003a) is one of the few anthropologists who has studied vernacular understandings of pregnancy and/or infant loss among white, middle-class American women. Layne (2000) emphasizes the importance of visual representations as they help grieving mothers cope with the loss of a baby, noting that many women choose to keep sonogram images or even photocopies of images if they did not have an ultrasound themselves. Layne describes such simulacra as substitutions for something that is unattainable—the living child—but which closely resembles what they are missing. She suggests that it is the tangibility, or real presence of such objects that is especially helpful for women who have suffered pregnancy loss because pregnancy itself is a creative, tangible process that is intensely physical. When such work, as Layne describes it, ends in loss there is a “painful physical void” that must be filled. Thus, the author points out, things not only help to produce the child (as in shower gifts before babies are born) but they also help suffering parents cope with the loss of a child.

Layne also calls into question the “realness” versus “falseness” of healthy, living children and children who die before or at birth. For mothers in Layne’s study, the pregnancy and the child were always, and continue to be real. Her analysis suggests it is society that denies the realness of motherhood for these women through its beliefs that dead babies are liminal beings and taboo subjects in the public discourse of pregnancy. Finally, Layne analyzes the Euro-American cultural work of memory through the lens of pregnancy loss. By collecting things that are stored, worn on one’s body or planted in the yard, these women are creating memory and combating the societal encouragement to keep their loss hidden. Layne conveys
the intensity of the experience for women and the tension that each grapples with when trying to legitimize their claim to motherhood.

*Medical Anthropology and Preterm Birth—Reproduction Gone-Awry?*

Before I turn to the two anthropological studies of infant mortality and preterm delivery—both addressing African American women’s experiences—I will first explain the relationship as presented in public health and medical literatures between infant mortality, preterm labor and delivery and low birthweight. The greatest contributors to infant mortality are the births of low (less than 2500 grams/5lbs 8oz) and very low birthweight babies (less than 1500 grams/3lbs 5oz) due most often to premature labor and delivery (less than 37 weeks gestation).

Until this research, there have been only two anthropological studies of the nearly two and a half fold higher risk that African American women have of delivering an infant prior to 37 weeks of pregnancy (Boone, 1989; Mullings and Wali, 2001). Boone’s statistically and epidemiologically-driven study of infant mortality among economically disadvantaged African Americans in Washington, D.C. examines the specific problems of preterm labor and delivery, low birthweight, very low birthweight and infant mortality among African Americans. She constructed her ethnography based on patient interviews and participant

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15 Jenkins and Inhorn, 2003 describe this concept, coined by Inhorn, to refer to the times when reproduction (i.e., conception, pregnancy, birth, mothering) does not go according to plan. Whether it manifests itself in difficulties with conception, an early miscarriage, the death of an unborn or newly born child, or the demands on mothering when a woman bears a child with special needs, it is a time when the discourse on pregnancies with “happy endings” that is so much a part of the Western imaginary conflicts with the traumatic experiences of women. I will return to this concept when I discuss how preterm labor and delivery of a premature infant fits the array of experiences of reproduction “gone awry.”

observation in the late 1970’s at a D.C. general hospital that served primarily African American poor. This questionably ethnographic and heavily quantitative study also includes data from vital records, coroner’s records, prenatal records, infant autopsy reports, qualitative material from medical records, census data and administrative files at the hospital. Boone conducted a follow up survey 3-4 years later.

The study serves as a critique of public policy that has historically ignored these problems and labels such policies as “social crimes.” Boone generalizes study findings to “American inner cities” based on four “ideal (maternal) types” she has generated from statistical and case history analyses. These four types of women include: teenage mothers (women under the age of 20 years); older mothers (25 years and older); women without a man (women who were not married to or living with a man); and advantaged women in a disadvantaged environment (women who were economically “advantaged” but who lived in inner-city and poor Washington, D.C.). Boone suggests that by generating these four “types,” she is able to “untangle the web of causation” of high infant mortality among African Americans in U.S. inner cities.

Unfortunately, there is little ethnographic material that fully addresses the life experiences of individual women, rather narratives are presented as belonging to an “amalgam” of women in order to protect the privacy of her consultants. Boone concludes with suggestions for policies that emphasize changing personal behaviors and lifestyles, attentive to the cultural importance of motherhood and pregnancy among African Americans in inner cities. This is ironic, given that there is little to no examination of the political-economic forces that shape the experiences of pregnancy for these women. For example, there is no analysis of how their conceptions of race and/or racism figure into these women’s lives and no
recognition that African American women may experience pregnancy and motherhood in specific ways due to the combination of being African American and female and related class experiences.

Mullings and Wali (2001) explore the macro-social contexts of African American women’s lives in their work on reproduction in Harlem. In conjunction with the Centers for Disease Control Division of Reproductive Health, Mullings and Wali (2001) report extensively on Harlem women’s structural barriers and interactions with the political-urban landscape of an historically African American city in order to understand their experiences of pregnancy and the reasons behind the high rates of preterm labor and delivery of low birth weight infants for these women. Overall, as the authors contend in the introduction, this book builds on Nancy Krieger’s prolific work as a social epidemiologist in areas of racism, race, class, gender and health in order to understand the creation and propagation of racial ideologies in the inner city and their production of social stress. The authors suggest that this is a publication meant to be quick information that all health workers can use to improve birth outcomes among African American women.

In the manner of what Marcus (1995) would call a multisited ethnography, Mullings and Wali conducted the research in geographically and experientially (i.e., work and home) diverse neighborhoods and engaged an interdisciplinary team of cultural anthropologists, epidemiologists, and students in various social sciences. Field work was conducted in three health district sites representing three class substratum as part of CDC’s Harlem Birth Right

17 See my review of stress literature, p.43 for further clarification.

18 Birth outcomes is part of medical and public health discourse used to describe the end result of a pregnancy. Jenkins and Inhorn (2003) might instead refer to these experiences as “happy” or “unhappy endings.” Although I do not care for the depersonalized term, I will use it here and in my review of public health literature.
The study population was defined as “women who live and work in Harlem” and included West Indian women, women of black Latino descent and African American women. Three Health District Sites were chosen for the fieldwork corresponding to areas populated by Harlem elite, those in an intermediate class stratum, and people living on low income. Some, though not all, were pregnant at the time of recruitment. None of the participants visited private health care providers.

Mullings and Wali’s analysis centered on the environmental context of reproduction with special attention to housing concerns that were often racially cast: instability of homes; home location in relation to work; women engaged in civic struggles to improve housing for them and their children and impacts on health; desire for additional space when pregnant and effects on health when desires were unmet. Further analysis on the economic conditions of life that influenced experiences of pregnancy revealed that women attempted to make decisions that would promote economic security and schedule flexibility and would allow them to care for their own children (e.g., working as a family child care provider). However, those women who worked in fast food sites or in a large hospital setting reported interactions between role hierarchies in the workplace and gender and race-based discrimination that added to their stress in pregnancy. The authors detail the structural constraints that these women experience as they live in an historically African American part of New York City and included limited funds for hospitals, lack of “good” grocers, and the restriction of job opportunities as part of the Giuliani administration agenda. Other pieces of the social process of stress that went largely unexplored in this book included depictions of pregnancy as a “crisis” for many of these women; experiences of pregnancy that included the expectation of

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19 For a full review of the Harlem Birth-Right Project, see Mullings, 2001.
“going it alone”; and the description of unintended pregnancy as a social fact in this particular environment.²⁰

Theoretical Perspectives in Medical Anthropology

There are several perspectives in medical anthropology, but what lies at the heart of much of the discipline is its devotion to two worlds of knowledge that are dialectically related in the experiences of human beings—those of biology and culture. The hallmark of medical anthropology is the recognition, exploration and analysis of the constellation of extrasomatic influences on physiological processes (Helman, 1992) that can include examination of human life through analyses of cultural practices, languages, socially constructed ideologies, geographic landscapes and existential experiences.

Some medical anthropologists employ a medical-ecological framework for understanding how human biology and natural environments are engaged with one another. McElroy and Townsend (1996) promote what they call a true biocultural perspective, foregrounding human interaction with ecological environments. The central thesis of this perspective is “…that the distribution of disease over time and across geographic space is directly related to a population’s role in its ecosystem” (McElroy and Townsend 1996, p.xviii) and emphasizes a combination of epidemiological, ethnographic and clinical science approaches to understanding the health of human groups.

By contrast, Sargent and Johnson (1996) depict a medical anthropology that begins by questioning the incontestable nature of scientific facts. It maintains that scientific knowledge

²⁰ The authors note that this text is part of a larger ethnographic piece that has not yet been published.
is also socially constructed and engages anthropologists in the deconstruction of the apparent monolith of biomedicine. As such allows for a critical medical anthropology whose
task at hand is not simply to demystify knowledge, but to critically examine the social conditions of knowledge production’ ” (Young, 1982:277). Although “science” and “biomedicine” receive much of the critique, the authors emphasize that theirs is a “more distant goal, an identification of the processes by which dominant voices and institutional forms come to exercise their control” (p.xi).21

Embedded in each of these broad perspectives are multiple theoretical frameworks that guide medical anthropologists in their work. These are not mutually exclusive, except perhaps in their most radical forms. Anthropological perspectives can begin to explain connections between lived experiences of racism, sexism, classism and preterm birth if we agree with Finkler that “…sickness is embedded not only in physiological impairments, but also…in conditions of life, social relations, unresolved contradictions…” and “culture guides people’s behavior, their comprehension of their bodies, and their interpersonal relationships; it structures people’s position in society and the reality they come to know and expect in their daily existence” (Finkler,1994a:6).

I have situated my work in the space between medical ecology and critical medical anthropology and have engaged two broad theoretical paradigms to more fully understand the experiences of pregnancy and motherhood for this group of African American women. First, a phenomenological/experiential perspective helps to illuminate those intensely felt experiences along the reproductive continuum that have been woefully underexamined. I combine this with a political economic perspective in which analyses of power and structured

race, gender and class inequalities are connected to personal experiences of these inequalities with particular attention to pregnancy, childbirth and motherhood.

Jordan and Davis-Floyd (1993) discuss the interplay of what they define as authoritative knowledge in women’s experiences of pregnancy and childbirth. They suggest that authoritative knowledge consists of systems of knowing that are not necessarily correct, but that are hierarchically arranged and carry more weight than others because “…they explain the state of the world better for the purposes at hand (“efficacy”) or because they are associated with a stronger power base (“structural superiority”) and usually both” (p.152). Most often in the birthing room and I would argue in the clinical obstetric setting, the authoritative way of knowing is entrenched in scientific “fact” and medicalized versions of bodies and selves. By adopting an anthropological perspective and phenomenological understandings of life processes as impinging on biological life, this work instead emphasizes the lived, subjective experiences of women as the dominant way of knowing about their pregnancy and motherhood experiences.

Phenomenology and the Anthropology of Experience

Phenomenology adds another dimension to studies of health and culture—the existential experiences of Self and conceptions of embodiment. Schuetz (1968) emphasizes intersubjective relationships in which meanings about one’s lifeworld (i.e., one’s world as it is experienced) are constructed in experiential dialogue with other human beings. The intersubjective character of lived worlds also draws attention to larger historical, cultural and social interactions that produce such lived experiences. When we construct ideas, for example, about pregnancy and birth, we construct them with and among others—in our
interactions with other women and men; relationships we construct with the medical establishment in the U.S.; and perhaps more elusively in relation to ideologies of gender, race, class and pregnancy.

In accord with Schuetz’ formulation of the lifeworld, Kleinman (1980b) elaborates on what medical anthropologists should identify as experience. Because medical anthropologists are ultimately concerned about connecting social and biological phenomena, Kleinman suggests that we must take into account the world of meanings, values, beliefs, actions and ways of thinking about being in the world when conducting ethnographies of health and healing. In his work on social suffering, he is able to make connections between the lived experiences of his consultants and the society at large. He examines the place that pain, as a lived human experience, occupies in personal constructions of powerlessness and lived contradiction between what is expected in life and what is actually lived.

Csordas (1990,1994b) develops Merleau-Ponty’s (1962) philosophy of embodied perception as it relates to sickness and healing. Merleau-Ponty’s conceptions of how we experience the world through our bodies (physical and existential) are particularly important for a critical medical anthropology. Csordas (1990) explains embodiment as one’s body as it is experienced, and in this way eschews any mind/body dualism that biomedical institutions and practices have attempted to cement. He asserts that “the body is not an object to be studied in relation to culture but is to be considered as the subject of culture or in other words as the existential ground of culture” (p.5). In other words, subjectivity as it is experienced bodily is the world of reality, and we stand as culturally constituted selves through the construction of subjective and intersubjective relations.
The anthropology of experience is central to a phenomenological approach of women’s lives. Experience is the crucial portal through and in which we construct subjectivities and intersubjectivities. As I explore experiences of gender, race and class in pregnancy I consider lived experience in Bruner’s (1986a) determination “…as thought and desire, as word and image…the primary reality. …it refers to an active self, to a human being who not only engages in but shapes action. …(and includes) not only actions and feelings but also reflections about those actions and feelings” (p.5). In this work, it includes any manifestation of how the world presents itself to consciousness as it is revealed to me through narrative: behaviors/actions toward the world that include thoughts, beliefs, felt emotions, physical feelings as they relate to pregnancy (e.g., pain, fatigue) and reflections about such feelings. It also includes expectations of the world around us and our actions/reactions when we come into conflict with those expectations. However, Bruner cautions us that because experience must be lived in order to understand, we can never fully know another’s subjective and thus primary reality.

There are few studies that examine the first-hand bodily experience of pregnancy as a central theme (Duden, 1993; Mann, 1999; Rich, 1986; Warren and Brewis, 2004; Young, 1984) and fewer that use phenomenological understandings of an experienced lifeworld in the study of pregnancy (Bailey, 2001; Longhurst, 1999, 2000). Feminist geographer Robyn Longhurst has engaged a phenomenological study of pregnant women in Western society and their relationship to public space as they begin to “show.” The “disorderliness” of their bodies—meaning that women experience a “fluidity” of the boundaries between their bodies and public space—constitutes a frame in which they begin to experience the world differently, sometimes in hostile ways (Davidson, 2001). Bailey (2001) underscores how
discourse around pregnancy can be used by women to renegotiate societal “body norms” as they take on a distinctly different bodily shape. Both Longhurst and Bailey frame their research as contributing to a feminist discourse around gendered experiences of the body and conducted research with only white, middle class women.

In Finkler’s (1994a) work, she approaches the lives of Mexican women from a phenomenological perspective in order to understand the larger interactions of sickness, gender and society and the ideological forces that support such relationships. Her concept of life’s lesions underscores her interest in a phenomenological anthropology that seeks to understand the world from the subjective experiences of her consultants. It is important to note that historically, this subjective experience has been largely ignored for African American women. Black Feminist understandings of how we should engage African American women in research point to methods that foreground women’s subjective voices.

Research findings that emerge from narratives of life experience promote new understandings of the powerful ideologies that promote contradiction in women’s lives and which may manifest themselves in physical disturbances of (e.g.) pain, disease and preterm delivery. Finkler describes the nature of what she means by life’s lesions as physical, embodied experiences that result from “…perceived adversities of existence, including inimical social relationships, and unresolved contradictions in which a human being is entrenched and which gnaw at a person’s being. Such lesions become inscribed on the body and manifest in anguish, in generalized pain experienced in the entire body, and in non-life threatening symptomatologies of unspecified etiology” (1994a:15-16). Finkler operationalizes life’s lesions as fluid, and subject to the changing conditions of people’s lives—in other words, are these women able to actively alleviate their suffering or will they
continue to live their lives through such lesions? Embedded in this construct are ideas and felt experiences of what should be and what actually is in the lives of human beings.

Following Finkler and Bruner in their assertion that human beings exist in relation to one another, and that there can be disconnects between the lived world and an expected lived world that is held hostage by the practices and ideas of others, it is important to recognize that although phenomenological theory compels us to “bracket our assumptions about the world,” experience is ultimately not a politically neutral category. Gordon’s (1997) collection of works in black existential philosophy is central to this understanding. Intersubjective experiences of race, gender, class, and I would add pregnancy, are layered with experiences of subordination. Existence in the lifeworld, then, is a situated existence. Henry (1997) suggests that “existence in black” involves “struggles against non-being” for in the felt experience of black men and women, they are born into a pre-existing “antiblack” world. In this way, argue several of the authors, lived experiences of race must be addressed within theories of racism. Gordon maintains that through the construction of a (white) superior Self and a (black) inferior Other, the Self for peoples of African decent is a black Self situated in a world that has historically denied his or her humanity.

**Narratives as Performance of Self and “Life as told”**

As mentioned earlier, I can only begin to know the experiences of others through their own presentation of Self in narrative. Bruner attests to the importance of narrative as an interpretation of experience, or “life as told.” Although there is a “slippage” between life as it is experienced and life as it is expressed in narrative, the power of this linguistic form lies in
its creativity in communicating, ordering, constructing and validating lived experience and thus constitutes culture.

In “The Illness Narratives,” Kleinman suggests that narratives integrate those immediately felt and remembered experiences that give voice to human suffering. McDonald and Ford-Ahmed (1999) claim that the phenomenological perspective is most important in understanding the meanings that constitute daily life for African American women, and Hamlet (1999) affirms the role of narratives in foregrounding experiences of the subaltern and their place in the production of history and social reality.

Narratives are part of larger social, psychological and cultural processes in that they are informed by a person’s life experiences and in this performance of Self, a woman will draw from those aspects of her life that she feels contributes to the life story she is telling. She is giving us a sense of her own history as she experiences it and is sharing pieces of it with the listener. Garro and Mattingly (2000a) remind us that this culturally informed memory is not perfect, but it is part of a larger search for meaning in a person’s life. “Consideration of remembering within the context of daily life leads to questions such as how remembering the past relates to what is done in the present or planning for the future…how an understanding of the past helps individuals give meaning to their lives and the world…or how hearing the remembered accounts of others augments the listener’s ‘fund of cultural knowledge with which to meet future illnesses’…” (p.71). Hunt (2000) recognizes narrators as social actors who, in the practice of constructing illness (and I would add other) narratives, “find the power to resist and restructure ideas of normalcy that do not fit with their experience, as they refigure their disrupted identity” (p.89). Garro and Mattingly (2000a) remind us that ultimately, narratives can be both rich and yet limiting in terms of the listener’s
understanding of the story told. There are many ways to tell a story and a person must select from a vast history of past experiences when constructing her own. The authors suggest that we as listeners understand that the narrative exists in relation to more than the immediate moment in which it is told for the person telling it is socially, culturally and politically positioned.

A phenomenological approach alone is but one side of the coin for my own project goals of understanding the complex relationships between history, race, racism, gender, class and health. As such, a limitation of this perspective lies in its relative inattention to macro social forces, with the possibility of making subjective experience too deterministic. Also, although we are compelled by this approach as ethnographers to “bracket” our assumptions about the world into which we are born and that already pre-exists for us, we can never truly accomplish this. We too are children of particular social, historical, cultural conditions that inhabit much of our own being in the world.

Political Economies of Health

Giddens (1991) reminds us that history bears on our interpretations of our existential selves. In the case of modernity with its attendant processes of industrialization, globalization, surveillance and capitalism, he asserts that experience is mediated by visual and other mass media through which ideologies of danger, risk and what constitutes “truth” are funneled into human consciousness. I would add that an in-depth examination of the histories of dominating ideologies that produce raced, classed and gendered positions in U.S. society, set within the specific historical experiences of race and gender in America, constitute the frame for interpreting contemporary experiences of African American women.
Political economy approaches such as Inhorn’s (1996) examine macro-social forces as they impinge on cultural life, namely those forces that are power-laden and socially legitimized over time (e.g., class-based stratification under capitalism; policies and law that govern social behaviors; hegemonic ideologies that medicalize human experience). Political economic studies in medical anthropology pay specific attention to larger economic, political, historical and other over-arching structures that constrain or otherwise inform human experience as they relate to health, illness and healing. Morsy (1990) simultaneously advocates for and critiques this perspective by noting that there is a tension between making capitalism (as a macro-social force and condition of “modernity”) or human agency too deterministic in political economies of medical anthropology. She encourages a perspective that acknowledges and explores the structural relations of power within which human beings act and the incorporation of human experience.

In accord with Morsy, scholars who write in this vein voice their concerns over approaches that are labeled “too individualistic” or ethnography that situates its subjects as if they exist in a social vacuum, untouched by the powers that structure and restructure their homes, workplaces, beliefs, values and everyday actions. Political economies of health, healing and illness are, as the name implies, political, and as such direct their inquiries in such a way as to contest, resist or otherwise critique those elements in human life that seemingly lie “beyond our control,” and often rest in the hands of a social elite. Political economic approaches pay particular attention to controlling ideologies of race, class, gender, and nationalism that penetrate the daily lives of human beings. In medical anthropology, ethnographers focus on how these ideological forces, often embedded in institutional and public policies inform experiences of health, illness and healing over time.
Lopez’ (1998) ethnography of the historical trajectory of Puerto Rican women’s acceptance of routine sterilization is a political economic analysis of the legacy of U.S. imperial domination, its attendant ideologies of “worthy” motherhood and what constitutes a “good” woman. She examines the racialized images of the “moral mother” and the political work that naturalizes these conceptualizations of Self. Lopez criticizes the internalization of such images by attending to the macro-structural forces that produced them and the work of the U.S. government in maintaining its homegrown version of a eugenic ideology. By controlling the reproduction of Puerto Rican women through reinforcement enacted by state policy, Lopez asserts that the U.S. was not only using Puerto Rican women as “test subjects” but it was maintaining that control over time as women internalized ideals of limited or no offspring.

Morsy (1990) explains that political economies of medicine and anthropology must be set within the larger sociohistorical contexts in which the subjects of our research live, work and breathe. In this way, she suggests that such work incorporates cultural understandings of power, hegemonic control (however it may be exerted) and cultural understandings of one’s situatedness in fields of power relations as developed over time. Again, she cautions us not to be too deterministic in our analyses, disempowering those we seek to liberate from such processes as racialization and medicalization. In other words, the danger of a radical political economy of health and healing is to reduce all human relations to relations of power. When we, as anthropologists, study human beings and the world in which they exist, we study them as social actors not passive recipients of what Marx refers to as dominant ideas. As a liberatory discourse, medical anthropology must not ignore the ability of its subjects to resist, contest or otherwise critique their own lives and conditions of existence.
Preterm Labor and Delivery, Low Birthweight and Infant Mortality in Public Health Perspective

I am reviewing the literature on preterm labor and delivery, low birthweight and infant mortality because I began this work in order to address these experiences. Again, although the focus of my work has shifted, this research bears on questions about inequalities in health that include these pregnancy experiences.

The phenomena of preterm labor and delivery, low birthweight and infant mortality among minority groups in the U.S. are cast in the public health discourse as part of larger “health disparities” that require immediate public attention. In fact, the script for much contemporary public health research—issued by the National Institutes of Health—*Healthy People 2010* states one of its two main objectives as “eliminating health disparities” by the year 2010. The document explains: “The second goal of Healthy People 2010 is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation” (*Healthy People 2010: Understanding and Improving Health*, p.11). 23

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22 For the full text and brief history of *Healthy People 2010*, see the official website for the directives, [http://www.healthypeople.gov](http://www.healthypeople.gov).

23 The language and approach embedded in the directives of *Healthy People 2010* have much larger social implications for how research is guided at the national level and how it is interpreted by individuals and healthcare providers, but I will not analyze this here. In addition, this language of “disparity,” produced and affirmed by statistical and epidemiological data, tends to present human experiences of structural and interpersonal violence that are raced, classed and gendered as quasi-neutral experiences of “difference.” Although I am critical of it, I believe the spirit of the document is admirable and it serves as a national acknowledgement of the social components of health that deserve our full attention.
“Health disparities” are shaped by a world of statistics that paint a grim picture of overall health in the U.S. First, it is useful to review a brief critique of statistical science. Woodward (1999) depicts the statistic as “the image fragment of postmodernism (that) contains meaning, albeit the banality and reductiveness of contemporary culture…Statistics are routinely used to make a certain sense of an event or moment in time, in the process often creating the contours of history” (p.178). She describes the use of statistics in public discourse as a means to create what she calls *statistical panic*: “fatally, we feel that a certain statistic, which is in fact based on an aggregate and is only a measure of probability, actually represents our very future” (p.185).

It is important to recognize that statistics are compiled in a variety of ways, and rely on other measures that may or may not be accurately collected. As such, Krieger (Krieger & Williams, 2001)—herself a social epidemiologist—cautions against hasty interpretations of statistical data that can have far-reaching adverse effects, and she has done much to portray the shortcomings as well as strengths of epidemiological application of statistical methods (1996, 1999a,b, 2000a; See also Jones, 2001). Hence, the statistical shaping of a world of risk in which we are all situated (to varying degrees) demands further scrutiny, but this is not the aim of my work. Instead, although I remain critical of statistics I also recognize their value in developing our understanding of the larger context of health and healing. They provide a gross profile of health that can help to generate new hypotheses and approaches to health problems—for behind every number lies an individual, in aggregate or not. Indeed,

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24 For a history of how statistical science established its authority, see Porter, 1986.

25 For reviews and critiques of the concept of risk, see Beck, 1992; Douglas, 1992 and Finkler, 2003.
public health and epidemiology in particular have assumed a majority of the work in understanding health inequalities.

Finally, although there may be concerns about how data is collected for health statistics (e.g., choosing which people to “sample”; types of questions respondents are given; contexts of the administration of questionnaires and surveys), such overwhelmingly disparate numbers in nearly all areas of health between African and European Americans point to much larger social conditions responsible for the observed differences. I will now review the latest statistical information regarding the health of U.S. groups.

The infant mortality rate (IMR)\(^{26}\) has been referred to as a critical indicator of the overall health of a society (Hargraves, 1993; Krieger, 2000a,b). It reveals more than the number of infant deaths, rather it exposes the conditions, experiences and social mores that do not support healthy mothers, fathers and families in a given society. Although IMRs have dropped over the last decades, the United States is infamously known for its consistently high IMR among industrialized nations (23\(^{rd}\) on a selected list of 29 industrialized countries and records a higher IMR than Cuba, Greece and Czech Republic)\(^{27}\). For the first time since 1958 the infant death rate has risen in the U.S. Most recent statistics suggest that much of that rise is due to an increase in the number of “smallest and earliest infants.” Further, “premature births increased 29 percent from 1981 to 2002 and prematurity now affects about 12 percent of all live births. In 2002, more than 480,000 babies were born prematurely…Premature birth\(^{28}\) is now the number one health risk for America's newborns. It is the leading cause of

\(^{26}\) The IMR is expressed yearly as the number of reported deaths before one year of life per 1,000 recorded live births.


\(^{28}\) Synonymous with preterm birth.
death in the first month of life. Babies who survive often suffer lifelong consequences, including cerebral palsy, mental retardation, chronic lung disease, blindness and hearing loss.”

Significantly, North Carolina has consistently recorded some of the highest infant mortality rates in the nation. The first state-wide analysis of infant mortality was conducted in 1994 by the NC Governor’s Commission on Reduction of Infant Mortality and found that the IMR for African Americans was the highest among all groups (17.1) and more than two times the rate for European Americans (8.1) (Bisgrove, 1995). In addition, nearly half of the infant deaths among African Americans occurred at less than 27 weeks of gestation, and the study states that “…even when all known risk factors were accounted for, black women still had an 86% higher chance of delivering prematurely than did white women” (Bisgrove, 1995:310). Although infant mortality rates in N.C. have declined in the last ten years, according to the latest statistics African American women are still more than twice as likely to experience infant mortality as their European American counterparts (IMR of 15.1 and 6.6 respectively). Preterm birth statistics also reveal significant lopsided differences (18.5 and 11.6 percent of all live births in N.C.), as do very preterm births (i.e., less than 32 weeks gestation) (4.7 and 1.8 percent of all live births in N.C.).

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30 Most recent statistics place NC as 40th in the country. From the official website of NC Healthy Start www.nchealthystart.org.

Epidemiological and other research indicate that factors such as higher parity, little maternal education, lower socioeconomic status and limited access to and/or inadequate prenatal care explain only a small fraction of the observed mortality (Krieger, 1993). In fact, differences in infant mortality rates between African Americans and European Americans persist even among highly educated women (Schoendorf, 1992; F.M. Jackson, 2001) and point to a host of unexplained factors that influence these experiences which this thesis will address.

Public Health Studies of Race, Racism and Health Including Infant Mortality

Nationally, mortality rates for nearly all causes of death remain higher among African Americans than European Americans. A recent study conducted by the steering committee for the Maya Angelou Center for Minority Health at the Wake Forest School of Medicine in Winston Salem, NC reported that “the health status of minority North Carolinians was similar to those of minorities around the nation. African-American death rates increased 150 percent for AIDS and 14 percent for diabetes mellitus between 1990 and 1996. Compared to whites, diabetes-related mortality rates were three times as high among African-Americans and twice as high for all other minority groups combined. Over the same period of time, minorities in Forsyth County were almost five times more likely to die from hypertensive disorders, three times more likely to die from diabetes-related illnesses, more than twice as likely to die from prostate cancer, and they experience a 50 percent higher death rate from breast cancer as well as a 30 percent higher death rate from heart disease compared to whites.”

32 The Maya Angelou Center was established in 2002 specifically to “bridge the gap in health care access and quality between minority and majority populations.”
Infant mortality, long considered an indicator of a nation’s overall health, has been the subject of much public health work over the past several decades. While it is well-documented and widely recognized in public health literature that race confers no biological risk to human health (Cooper, 1993; Krieger, 1993; Witzig, 1996), the differences in infant mortality between European and African Americans have persisted for over 70 years (Hogue, 1987; Rowley, 1994; Moore, 2003). High rates of preterm delivery, low birthweight and infant mortality in African American communities are particularly disturbing because they persist across all economic strata—indicating that financial constraints to quality care are not entirely responsible for the observed morbidity and mortality (McGrady, 1992; Schoendorf, 1992). This is not the case for other non-European American groups (James, 1993). Differences in infant mortality rates between African Americans and European Americans are even greater at upper class levels (Schoendorf, 1992; F.M. Jackson, 2001).

Increasingly, the African American infant mortality rate has become the “poster child for race relations” in much the same way as sickle cell disease in the 1960’s and 1970’s (Wailoo, 2001). The widening “gap” between death rates of African American and European American infants has reflected the failure of the U.S. government and society at large to address the injustices—structural and otherwise—that continue to produce this inequality. As such, there has been much work in the public health, medical and public discourse on characterizing/publicizing “the Gap” that exists between European- and African Americans (with some attention to other ethnic groups) in health, education, economics, employment and overall quality of life (Rowley, 2001). Health research has continued to focus on differences between African Americans and European Americans with regard to preterm

From the official website of Bowman Gray Medical College at Wake Forest University, http://www1.wfubmc.edu/articles/Maya+Angelou+Research+Center.

Interestingly, African- and Caribbean-born women living in the U.S. do not experience these high rates of preterm delivery and infant mortality (David 1997; Pallotto, 2000), suggesting that there is something about the particular socio-cultural-historical experiences of African American people, in relation to European counterparts, that contributes to the glaring differences.

Overwhelmingly, the work done to address infant mortality among African Americans has been completed by epidemiologists, physician-researchers, public health practitioners and demographers—not to mention biological scientists determined to uncover the molecular reasons behind preterm labor (Allen, 2001; Fricker, 1999; Wadhwa 1998, 2001). Epidemiology has conducted the bulk of research on race (albeit as a narrowly defined, fixed and therefore controllable statistical variable) and health with regard to preterm labor, low birthweight and infant mortality. However, studies have only recently begun to conceptualize race as a socially constructed category which confers no “biological risk” and much public health research still frames “African American” as a “risk factor” that contributes to a wide range of health inequalities (Krieger, 2000a; Witzig, 1996).

A small but growing number of researchers have begun to investigate the effects of experiences of racism, sexism and unequal social status on differences in mortality between people of African- and European- descent in the U.S. (Brandolo, 2003; Collins, 2000, 2004; F.M. Jackson, 2001; J.L. Jackson, Jr. 2001; James, 2003; Jones, 2002; Krieger, 2000b; Mustillo, 2004; Rich-Edwards, 2001; Rowley, 2001). Krieger (2003), Harrell (2003) and

33 Racial differences in other health indicators have also been emphasized public health research: hypertension and heart disease (Krieger, 1990); breast cancer (Krieger, 2002); sexually transmitted diseases (Thomas, 1999).
Cooper (1993) have addressed these connections directly. Cooper asserts that further research must incorporate a theoretical framework in which to understand somatic mechanisms that include social processes, however epidemiological research has continued to focus on individualized factors (e.g., work, single marital status, diet, income) without examining the processes that contribute to a person’s life experiences. These factors are often lumped into the broad and nebulous collection of human experiences labeled “environmental stress.”

In accord with Cooper’s analysis, there have been several studies investigating physiological responses to “stress” that have attempted to provide what James (2003) refers to as “sound, empirical knowledge” that social experiences of stressful events have measurable physiological effects (Hobel, 1999; Wadhwa, 1998; Wang, 2001).

**Stress in Medical and Medical Anthropological Perspective**

“Stress” is a word bandied about in medical and public health literatures as a catch-all phrase for the host of unexplained “environmental” factors that evidence-based medicine cannot name and that are believed to contribute to the ill-health of human beings. The medical model of stress suggests that adverse life events (e.g., death of a spouse, loss of a job) are internalized by the human body and act as catalysts in neuro-physiological sequences in order to produce medically diagnosable disease or ill-health. In the case of preterm labor, clinical scientists have pointed to neuro-immunological circuits that promote infection-related preterm contractions or to less specific pathways that produce hormones thought to be responsible for early labor (Hobel, 1999; Wadhwa, 2001).

Although ubiquitous in medical and public health literatures, there has been little critical attention to the concept of stress—which is nebulous at best—but medical anthropologists
have been working to illuminate exactly what “stress” has come to mean. McElroy and Townsend (1996) state that “Stress occurs when a person experiences and responds to excessive environmental demands…[the stress process] is a normal part of life and usually defends the body against threat and injury. But…either physical or symbolic danger can contribute to maladaptive physiological responses…” (p.238). The authors propose we think of stress as an “internal force” that can both damage and heal the human body. They propose a model of stress that incorporates evolutionary concepts of adaptation and neurophysiological responses to “environmental demands that threaten the well-being of the individual” (p.239). While acknowledging cultural and individual variation in “tolerance” of stress and promoting a broad understanding of what constitutes a person’s “environment,” I believe the authors fall short in a more comprehensive analysis of stress.

Finkler’s work among poor women in Mexico (1994a) illustrates the perspective on stress that I take in my work. Her analyses of women’s experiences of sickness and healing foregrounds women’s own perceptions of stress; what constitutes stressful life events for these women in their own words and how these are socially and culturally constructed; how those feelings are expressed physiologically; and how women cope with adverse physical effects of those conditions of life that make them sick. Critical of traditional models of stress, Finkler asserts, “Theories of life events, social supports, or even social relationships tend to model themselves after biomedical paradigms by reducing disease etiology to a single cause. By stripping the patient of his or her capacity to judge and evaluate his or her existence, the notion of stress has become just another sort of pathogen assaulting the human body” (p.15). Finkler encourages a deeper understanding of the broad and rich context of people’s lives.
within which stress operates, offering us a chance to understand the meanings of adverse life experiences and the resources people have, or do not have to cope with them.

Finally, this work is informed by Krieger’s (1993) analysis and subsequent work addressing racism, sexism and class inequalities as stressors that have fateful health consequences. Her position that long-standing health inequalities are “biological expressions of race relations and racialized expressions of biology,” has galvanized a flurry of public health work in the study of how racism adversely affects health. She is also one of the few researchers who has tackled the question of class as it relates to race in the U.S. (1993; 1994a; 2001c). Although her work leaves the fuller social contexts of women’s lives largely unexplored, she has approached the question of race with an understanding that it is a complex experience intimately related to gender for African American women (1990; 1994b; 1996).

**Gender and Health/Reproduction**

Inequalities in health are indicators of larger social relations that produce such lopsided differences. They are historically, politically, socially and culturally constructed. In the case of the U.S., they are also raced, classed and gendered depending upon the specific cultural histories of the people who experience those inequalities. The vast literature on gender and health suggests that gender structures our position in society and addresses the forces (ideologies, etc.) that produce these often unequal relations. Gender and health studies point to larger social relations that contribute to the health and sickness of women.

Theories of female gender offer competing perspectives on what it means to be a woman, or in phenomenological parlance how the lifeworld of a woman is constructed and presented
to her consciousness. Biomedical reduction of gender to a person’s biological sex has a particular history that compels human beings to be divided into two kinds, depending upon which genitalia one possesses. By contrast, gender is both a system and process of socially and culturally produced beliefs, practices, desires and meanings that exist in relation to those forces that impinge on, in this case, women’s daily lives.

Finkler’s (1997) examination of gender and domestic violence in Mexico attends to those relationships, specifically those between a woman and her male partner that shape the position of poor women in Mexican society. In the context of physical violence against women, Finkler suggests that the physical coercion of women by men has a particular historical moral character. Ideologies that support male superiority and female inferiority are transmitted inter-generationally as are ideas about possibilities for stability—financial and otherwise—outside of marriage. Finkler asserts that medical models of sex and gender perpetuate a male superiority as do idealized visions of romantic love. Through her examination of family life and residential relationships in the context of domestic violence, Finkler captures the particular gendered experiences of violence as part of a woman’s life’s lesions that can lead to a lifetime of ailment.

The recent burst of contemporary work on reproduction (See Jenkins and Inhorn, 2003 for a review) suggests that we are still far from understanding the unique positionalities of women in contemporary society, particularly as they relate to pregnancy, childbirth and motherhood. Ginsburg and Rapp (1995) go so far as to suggest that studies of reproduction should be “central to social theory.” The wide range of studies, subjects and perspectives speaks to the varied and rich lives of women and how we have come to understand the meanings of gender in an age of unprecedented global communication and technological
innovation. Similarly, social epidemiology has produced a small number of studies that have
directly addressed the gendered aspects of women’s lives, including analyses of racism as a
gendered construct (Krieger, 1993; F.M. Jackson, 2001).

For some women, gender alone does not explain their lived experiences in the world. In
counter to epidemiological and much anthropological literature, Black Feminist scholars
have acknowledged the complex interplay of female gender and being African American and
related experiences of class. These scholars explore experiences of race, class and gender for
African American women as “intersecting” (Crenshaw, 2000) or “multiplicative” (King,
1988) systems of oppression. This literature emphasizes the totalities of black women’s
lives—the relationships between class, race and gender-based identities that contribute to
black women’s lived experiences and the roles that these interrelationships play in producing
particular experiences. Since its development in the 1970’s, Black Feminist theory has
provided a voice to those experiences of African American women that were historically
ignored, suppressed, marginalized and made “theoretically invisible.” Since the 1970’s,
Black Feminist authors have developed numerous strategies with which to explore and
understand “the multilayered texture” of black women’s lives.

The central tenets of the theory: bringing to visibility and centrality the inherent value of
black women’s lives; praxis in resisting systems of oppression; and the interlocking and
inseparable nature of gender, race and class oppression for black women are not only
essential for understanding the responses of my consultants, but they are theorizations
generated by black women for black women. Black Feminism encourages the creative

34 It is not accurate to say that gender stands solitary in any female experience, but I am particularly concerned
here with those women whose African American heritage and class combine with female gender to produce
particular experiences as in the case of African American women in the U.S.
production of representations of self to combat ideological racism and the generation of new models of motherhood from black women’s lived perspectives.

**African Americana/Race**

Abu-Lughod (1991) warns that culture may be used to generate, maintain and reify conceptualizations of Self and Other. Although this may be true, and we should beware of cultural fundamentalism (Brumann, 1999), the making of Self and Other in the U.S. is crucial for understanding the raced, gendered and classed aspects of reproduction. Arguably *race*, racism and their socio-historical constructions are perhaps the most salient features of the making of a U.S. Self and Other. As many of the post-1960’s ethnographies of African American life attest (Gregory, 1998; Gwaltney, 1980; J.L. Jackson, Jr. 2001; Mullings and Wali, 2001; Patillo-McCoy, 1999; Stack 1974, 1996), peoples of African descent have experienced and endured particular histories in the U.S. that must be attended to in any analysis that includes African American women and their experiences of class and health.

The position that the term *race* itself occupies in the U.S. is one of engendering and maintaining social stratification and inequality (racial and other) based on skin color and other biological criteria. Its legacy has been violent, its stay has been extended and its effects far-reaching often into the world of the unknown (Mullings and Wali, 2001; Smedley, 1999). As a testament to its profound place in U.S. history and current culture and the historical legacy of U.S. conceptualizations of *race* in anthropological research, the American Anthropological Association issued its “Statement on ‘Race’” in 1998 to refute *race* as a biological category and affirm it as an ideology of social control exported by the U.S. and its
science worldwide. Smedley (1999) lays out for us the unique place that race holds in U.S. history as an ideological concept used as a means to produce, enforce and maintain social inequality and also describes its privileged place in the construction of U.S. human identities since the days of enslavement.

The above literature review emphasizes the scholarly work upon which this project is based and the theoretical approaches that have guided my research questions, practice, relationships and writing. In sum, this work examines those unexplained factors that may contribute to preterm labor and delivery of a low birthweight infant and subsequently to observed higher infant mortality rates among African American women. I am employing a phenomenological perspective within a critical medical anthropology context to address those questions in terms of experiences of racism, class and being an African American woman.

In the following chapter, I present an account of the historical relationship between people of African descent in the U.S. and the worlds of biomedicine and U.S. health care in order to more fully understand the contemporary experiences of pregnant African American women.

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35 See Appendix 1: American Anthropological Association Statement on “Race.”
Chapter Three

Relationships between African Americans and the Worlds of Biomedicine and U.S. Health Care in Historical Perspective


African American Vernacular Healing Practices in the Antebellum South

By way of background to present-day African American women’s experiences of pregnancy and motherhood, it is constructive to consider African Americans’ relationship to the biomedical establishment. In order to contextualize the relationship between African American peoples and the world of biomedicine, I will first briefly examine the ways in which health, illness and healing were conceptualized by the earliest Africans in the New World. Part of this exploration includes a discussion of vernacular healing practices that existed during enslavement and which persist in contemporary life.36

“…the ‘Priest or Medicine-Man’ was the chief surviving institution that African slave had brought with them: ‘He early appeared on the plantation and found his function as the healer of the sick, the interpreter of the Unknown, the comforter of the sorrowing, the supernatural avenger of wrong, and the one that rudely but picturesquely expressed the longing, disappointment, and resentment of a stolen and oppressed people’ ” (Levine 1977:58 [from DuBois Souls of Black Folk and The Negro Church]).

DuBois’ assertion that medicine-men/priests served a multiplicity of functions including healing of body, mind and spirit and as human metaphors for the suffering endured by

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enslaved Africans, provides us with some historical grounding for understanding the tension that still characterizes much of the relationship between African Americans and Western biomedicine (Baer, 1989; Byrd and Clayton, 2002; Gamble, 1997). Bankole (1998) and Gorn (1987) describe an African agency in the treatment of illnesses suffered by the enslaved, ranging from herbalism to methods of divining and conjure: “In addition to herbal pharmacopoeia, aspects of divining also included a catalogue of observations of spirits and ghosts in addition to magico-medical remedies. In every aspect of divining there was a lesson to be learned by the patient, including a deeper understanding of the nature of the origin of illness and disease” (Bankole, 1998:147). It is a matter of interpretation to suggest these practices existed in deliberate opposition to the dominant biomedical system. Further analysis of how health and illness were conceptualized by enslaved Africans offers some insight into whether the system of dominant medical practices of the time would have addressed the physical-spiritual needs of people who believed the two worlds were inextricably linked. For example, the removal and placing of curses, the protection of a gris-gris37 and the practice of Voodoo as an arena for medical ritual were all part of the active participation of enslaved Africans in their own health care. Biomedical care from European American doctors seemingly would have done little to address health concerns that were best approached by these means.

Gorn discusses the presence of “rootmen” in enslaved communities and the powerful beliefs in magic that formed part of a comprehensive health care system: “…the most powerful magic was practiced by specialists, sorcerers known variously as hoodoos, rootmen, voodoo priests, witch doctors, or…conjurers. Slaves sought out these individuals when they

37 Gris-gris is described as an African charm, something used to ward of bad luck or to place a curse on another person. “It is often a bag filled with hair, nail-clippings, etc.” (Bankole, 1998:153).
wanted to accomplish especially difficult ends through magical means” (Gorn, 1987: 300).
Laws such as the Black Codes prohibited worship that Protestant slaveowners claimed resembled African pagan ritual or worship of the devil. With the growing influence of Protestant Christianity and its condemnation of rootwork, preachers and root doctors competed for the privileges of healing and leadership in enslaved communities.

The rootwork system encompasses beliefs that illness or misfortune results from unearthly forces—often malevolent spirits or people—and remedies require mediation by a “conjure-man,” “conjure-doctor,” “root-doctor” or “hoodoo-man” (Coleman, 2000; Mathews, 1992). Coleman regards such persons as trained in the African tradition of priest or priestess, recognizing the confluence of religion, magic and healing. He notes, “…as a healer, the mediator kept the emotional and psychological health of individuals and the community in balance as much as possible” (Coleman, 2000:38). Such a person was trained to know how to ward off evil spirits, visit harm or good upon a person and right socially perceived wrongs.

Mathews notes that in contrast to voodoo in Haiti and New Orleans, in other parts of the southeast U.S. “…the religious role of the conjurer came to a rapid end with the conversion of slaves to Protestant forms of Christianity… …Magic was decried by Protestant denominations as the work of the Devil, and religious healing was undertaken exclusively by church-sanctioned personnel” (Mathews, 1992:70). Coleman complicates this picture by asserting that some preachers continued to practice rootwork. It is widely agreed, however, that the practices of rootwork and voodoo were driven underground, formally disassociated from Christian religious practice and continue to this day to be practiced in secret (Davis, 38

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38 The Catholic context is somewhat different and perhaps allowed for the survival of voodoo, hoodoo and rootwork practices in New Orleans to a greater extent than in primarily Protestant regions in the U.S. See Bankole, 1998 for a more in-depth look at the New Orleans, Catholic context.
In the frame of Protestant Christianity, rootwork was claimed immoral, blasphemous, illegal and was feared by slaveowners. The power held by root doctors was not only a power that the slaveowner could never possess, but it was a power that could be wielded against him (Levine, 1977). Gorn (1987) also suggests that beliefs about rootwork’s efficacy in protecting slaves and harming owners were important factors that contributed to driving rootwork underground.

Joyner (1994) contests the idea that the reason for the existence of the priest/medicine-man was to assist enslaved Africans when they received no help from slaveowners. Bankole proposes that the distrust and outright rejection of “white medicines” by African slaves as well as a preference for their own traditions in treating illness, accounted for the existence and persistence of the traditional healer. She argues that the persistence of such healing practices speaks to more than preference, rather a decisive choice and conscious effort to preserve and/or create healing systems grounded in the experiences of enslaved Africans. Bankole’s analysis supports the argument that perceived and formally sanctioned lack of control over one’s conditions of life combined with distrust and rejection of “white medicines,” although important contributing factors, are by themselves insufficient to account for thriving traditional healing practices and the creation of new ones.

Finally, Bankole suggests that conditions of geographic isolation from slaveowners (e.g., Sea Islands of South Carolina and Georgia) and legislation that reinforced the dominant society’s ambivalence toward health care of the enslaved and prohibited practices such as Voodoo (e.g., Black Codes of Louisiana), contributed to the retention of African healing practices. 

Accounts of rootwork mark some of the most famous slave rebellions and escapes such as those associated with Nat Turner, Frederick Douglass, Gabriel Prosser, Denmark Vesey and Gullah Jack (Coleman, 2000; Levine, 1977).
traditions. However, as mentioned earlier, the outright rejection of medical practices of European owners and reported preference for African-based solutions to socially defined health problems are testament to an active participation by the enslaved in the production of healing practices that would become marked by an African American cultural tradition.

The unique medical risks faced by Africans during enslavement are central to understanding not only their need for acute medical care of the body, but also the implications such brutality had for the construction of a strong spiritual consciousness and the invocation of spiritual forces to provide protection. Within the frame of political, social and physical oppression of enslavement, cultural beliefs and practices emerged that were shaped by myriad African experiences in America. DuBois’ assertion that priests and medicine men served the same function during enslavement and were often one in the same person, as well as more contemporary works that link more formalized religions and healing (Baer, 1981; Finkler, 1985; Jacobs, 1990), contribute to understanding the invocation of the divine to alleviate human suffering. In this work, Helene, Zakiyyah, Eva and Tisha explained how their faith in God brought them through the most difficult periods of their lives, including pregnancy and motherhood. Gorn describes the complex relationships between the prevailing Christian ideologies of the time and African American vernacular healing practices:

Preachers also acted as folk healers; conjure potions sometimes relied on Trinitarian symbolism; hoodoo doctors invoked the Lord’s name; and many slaves explained occult phenomena through Afro-Christian mythology. …God, Moses and Christ were living presences…but they sometimes failed to intervene in daily life. Magical powers formed part of a continuum of spiritual forces pervading the material world. …the supernatural was evidence of the unseen hierarchy mediating between human beings and the higher realms, a manifestation of a world far more spiritually animate than the modern one (Gorn, 1987:298-99).
Although Christianity was formally introduced to enslaved Africans in the period of the Great Awakening in the late 1740’s, the sacred world of the enslaved was not separate from the secular world of everyday life (Bankole, 1998; Coleman, 2000). It may be more appropriate then, to conceptualize religion in terms of African American religious life, in order to understand how healing was not readily separable from religious practice. According to Raboteau:

The reality of the early African American slave was one in which the spiritual and physical realms converged. Unlike certain aspects of Western dualism (for example, the separation of the sacred from the profane, or the spiritual from the physical), the perspective of the African American slave did not separate reality into clearly defined realms…reality was viewed as one interwoven fabric connecting human beings with spiritual ones. …Forces from beyond the physical realm were heeded as coming from messengers as guidance for living in this world. [From A.J. Raboteau (1978) Slave Religion: The “Invisible Institution” in the Antebellum South. New York: Oxford University Press]

Just as the syncopation of jazz was born of the rhythms of everyday life of the enslaved, so too was the constellation of healing practices that were incorporated into the survival of that life. Although there existed a myriad of vernacular healing practices among enslaved Africans devoted to the resolution of illness, dominant medical practices of the time did not readily offer to alleviate the pains suffered at the hands of slaveowners. Additionally, there were social forces at work that often compelled the participation of the enslaved and later, the freed in those medical practices.

A History of Race and Medicine: Experiences of Enslaved Africans with the World of Biomedicine—Medical Experimentation Part I

It is important to understand the relationship between African Americans and the medical system because it may, in part, explain the preference of women in this study for receiving care in an office that is owned and operated by African American physicians. Shared
histories of medical abuse at the hands of European American doctors combined with disillusionment with the historical segregation and discrimination in medical schools and hospitals, may have promoted a greater sense of comfort in visiting African American physicians for their gynecological and maternity care.

Medical care of enslaved Africans, if provided at all, was performed by European American physicians. However, Bankole suggests that such documented care may also have been part of a slaveowner’s imagined community of healthy and happy slaves and a means to reify the “good master” image: “…slaveowners perceived a slavocracy where enslaved Africans were continuously and consistently cared for” (Bankole, 1998:27). Additionally, Bankole recognizes that slaveowners needed healthy workers to sustain farms and thus, perhaps grudgingly, offered slaves medical attention. The nature of enslavement, including the voyage from Africa, the daily experience of forced labor when they arrived in America, and the brutality suffered at the hands of slave traders and slaveowners, affected the extent of care that enslaved peoples required but often did not receive from owners.

More frequent than accounts of caring for physical ailments of slaves are narratives of overt and covert medical experimentation, particularly in the South. Two narratives are most famous for exposing the dubious nature of medical experimentation and the preference for “black bodies” on which to experiment. Savitt (1982) and Gamble (1997) recount the story of Fed, an eventually freed slave who wrote of his harrowing experiences as an experimental subject in Georgia in the 1820s and 30s. Fed describes being forced to endure several experiments to determine how he could best resist heat exhaustion by sitting naked in a pit, covered up to the neck with dirt in the southern summer. Dr. Thomas Hamilton repeatedly performed this experiment, offering Fed various theoretical remedies as he sat in midday
heat. Each time, Fed would collapse from heat exhaustion. Once freed, Fed recounted a number of other experiments to which he was subjected, some in which he suffered blisters at the hands of Hamilton in order to determine the thickness of his black skin (Savitt, 1982).

The second narrative is that of the American “father of gynecology,” Dr. J. Marion Sims of South Carolina and Alabama who remains a controversial figure in the history of American medicine. Sims is known for his history of experimentation between 1845 and 1849 on three enslaved women in order to repair vesico-vaginal fistulas often suffered after difficult childbirth. Gamble (1997) points out that although Sims lauded the ability of those now-famous women—Lucy, Anarcha and Betsey—to withstand the pain of over thirty operations in just four years, he would not have operated on European American women before perfecting his technique on slaves: “Only after his experimentation with the slave women proved successful did the physician attempt the procedure on white women volunteers. He found, however, that they could not, or more accurately, would not, withstand the pain and discomfort that the procedure entailed. The black women had no choice but to endure. They…were forced to submit because the state considered them property and denied them the legal right to refuse to participate” (Gamble, 1993:36).

Apart from infamous narratives of experimentation such as those of Hamilton and Sims, folklorists also maintain the existence and power of local stories of “night doctors”—European American male physicians or medical students who robbed the graves of African Americans in search of bodies for experimentation (Gamble, 1993). There is also evidence to support that northern medical schools hired African Americans to rob the graves of their dead in order to provide them with bodies for experimentation.
Savitt reports that the body became an important part of medical education in the first half of the nineteenth century as a result of the influence of the Paris school of hospital medicine. Although this reliance on bodies (dead and alive) was not limited to the South, Savitt emphasizes that the unique social climate of the region contributed to a Southern preference for black bodies for experimentation. He writes, “It is to be expected in a slave society that the subjugated will be exploited. Such was the case in the American South where blacks acted not only as servants and laborers but also as medical specimens. Some medical scientists living in that society took advantage of the slaves’ helplessness to utilize them in demonstrations, autopsies, dissections, and experiments, situations distasteful to European Americans and rejected by them” (Savitt, 1982:347-8). Further, “Empirical trials of remedies on patients were not unusual in the practice of medicine anywhere in antebellum America, but outright experimentation on living humans may have occurred more openly and perhaps more often in the South owing to the nature of the slave society.” (Savitt, 1982:342). Indeed, southern medical schools proudly proclaimed their superiority to northern colleagues because of the abundance of black bodies they were able to procure for experimentation.

Medical historians also report post-Civil War abuses against African Americans in medicine. Apart from the use of freed slaves as “clinical material,” Savitt recounts the preference for black female patients in the South for experimenting with Cesarean section births—experiments that “occasionally met with success.” African American women outnumbered European American women in these experiments only in the South, when as of

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40 Savitt notes the complex irony of this situation: “Interestingly, people generally assumed that information gained from observation of Negro bodies was applicable to Caucasians…Negroes did not seem to differ enough from Caucasians to exclude them from extensive use in southern medical schools and in research activities” (p.332). Prevailing southern ideologies of segregated medicine and black inferiority appeared inconsequential when it came to experimentation on African Americans (See Haller, Jr, 1972).
1881 only twelve of the fifty-nine pregnant women to undergo these experiments were European American as compared with fifty-one of sixty women in the North (Savitt, 1982).

Finally, Gamble argues that the distrust engendered by years of abuse at the hands of medical doctors (and some untrained in medicine) was well in place before the infamous Tuskegee syphilis study conducted by the US Public Health Service—an experiment that began in 1932 that was to last four decades before being exposed for its unethical and brutal denial of human rights.

A History of Race and Medicine: The Relationship Between African Americans and US Health Care 1900-Present—Medical Experimentation Part II

Race and Medicine in the U.S.

Coincident with the rise of science and positivist thinking, the U.S. cultural context—replete with mechanisms with which to enforce such ideologies (including scientific experimentation, law and let’s not forget anthropology)—forged human identities based on skin color (Smedley, 1999). The specific economic, political and moral histories of the U.S., including the rise of capitalism, wage labor, the protestant work ethic and individualism, and the privatization of property all served to undermine the “other” ways of organizing human identity and thus human difference (e.g., kinship, language) (Smedley, 1999). Race became the signifier of human worth and was intimately tied to economic opportunity, or lack thereof, in a capitalist landscape that espoused individualism and discouraged kinship ties as forms of social identification.

Race in the U.S. context, in its service as a biological marker of human difference, has had violent, disastrous consequences for those peoples named and identified as racially
“inferior.” African American experiences of abuse in the name of medical “progress” speak to the larger ideological partnership between race and medicine. Science, and medicine in particular, provided the historical legitimacy and cultural currency for biological difference based on skin color. Processes of medicalization and racialization have operated simultaneously during enslavement through contemporary times to reify racial difference as biological difference (Gamble, 1997; Hargraves, 1993; Krieger, 2000a; Witzig, 1996). Finkler (2000) addresses the process of medicalization in her work on the implications of ideologies of genetic inheritance on family and kinship relations in contemporary U.S. culture. She explains, “Medicalization refers to the drawing in to the biomedical domain...physical aspects and behaviors...that could be understood alternatively as a sin, a crime, a moral fault, or a disease” (p. 175). The “cultural currency” of discourses of medicalization force this medical-moral vocabulary to gain wide and uncritical acceptance. As such, Finkler elaborates “Medicalization changes people’s perspectives on reality, on their being, and on how they experience the world” (p.176).

It is important to recognize that medicalization is a process that has been historically applied to race, whereby connections between socially constructed racial categorizations and biology are produced and legitimized in discourse and practice. Wailoo’s (2001) work on the historical relationship between race and medicine in the politics of sickle cell disease is an excellent analysis of this relationship. Witzig (1996) traces the beginnings of racial divisions to 18th century scientific racial “taxonomies” whereby biological distinction was overlayed with social-moral expectations and stereotypes. Each author points out that African Americans constituted the primary targets of classifications of biological and moral inferiority. Further, medicine’s role in perpetuating, historically legitimating and hence
reifying these divisions as “fact” has led to not only increased suffering and disproportionate care, but also in creating what public health terms “racial health disparities” where the health of historically subordinated groups is much compromised resulting in higher overall morbidity and mortality. Processes of medicalization then, legitimize class and race-based stratifications that often result in political and economic alienation of those labeled as “inferior,” and poor health that accompanies such experiences.

Wailoo maintains that health became a new way of talking about race, and conflating disease with race promoted the reification and acceptance of ideologies of biological, social and moral inferiority of African American people. The racialized stranglehold that medicine continues to maintain over the experiences of African American men and women is evident in internalized notions of race-based biological difference and current attempts to promote a genetic basis for differences in everything from intelligence to disease rates among ethnic groups.

Entwined processes of medicalization and racialization have contributed to an ideology of medicalized race whereby race (as a static and controllable variable) is viewed in terms of disease. As if in support of Wailoo’s analysis of sickle cell, diseases such as diabetes, hypertension, heart failure, and obesity are also often identified with African American people in public health and medical literatures.

The most recent example of the medicalization of race is the brewing controversy over the drug BiDil™ whereby “self-identified blacks” who participated in the African American Heart Failure Trial (Taylor, 2004) received treatment—BiDil™—for “advanced heart failure.” Because African American patients fared better in earlier trials than their non-African

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41 BiDil™ is the NitroMed name for Isosorbide Dinitrate and Hydralazine.
American counterparts, and because the drug performed so well that the clinical trial was terminated due to “significantly higher mortality rates” among patients receiving the placebo, BiDil™ has been reserved exclusively for the treatment of African American patients. Kahn refers to this kind of therapeutic as an “ethnic” drug (Kahn, 2004).

That the drug has had beneficial effects among African American patients is not the point in question, but the leap made between race and genetics of disease has strengthened due to its publicized success as a drug for “self-identified blacks.” In June, 2005, the FDA approved the pharmaceutical for specific use in “self-identified black patients” and, as Jones and Goodman (2005) write, “reinscribed ‘race’ as a surrogate for genetic variation” (p.26). That the Association of Black Cardiologists has approved its use for African Americans only speaks to the medical hegemony that is capable of producing the confusing and inaccurate ideologies of gene-based human variation that promote a biological basis for racial classification and a new regime of race-based medicine.

The African American Physician

Apart from the ideological partnership between race and medicine, the politics of exclusion in medical education prevented African American men from becoming physicians until the mid-19th century and even then there were few African American physicians, all graduates of northern, Midwestern or international medical schools. Byrd and Clayton (2002) describe the social climate of biological and scientific racism42 in the late 19th and early 20th centuries that invited the establishment of medical schools and hospitals exclusively for Negroes: “American government and public policy documents, biological treatises, and

medical journals were laced with pseudoscientific racist principles, derogatory racial character references, and pronouncements of impending Black racial extinction. …The American medical profession’s *de facto* policy of Black exclusion and racial segregation became its official national policy in the 1870’s as the profession wrote African Americans off as a debauched, “syphilis soaked, unfit race” (p.15).\(^{43}\) Regardless, as of 1860 at least nine northern medical schools admitted African Americans to their ranks. By contrast, it was not until 1948 that the first African American was admitted to a Southern, all-white medical school. The University of North Carolina admitted its first African American medical student in 1951 (Byrd and Clayton, 2002).

*Medical Education and Hospital Reform in the post Civil War South*

Between 1868 and 1904—in response to decades-long abuse, neglect and exclusion of African Americans in medical education and care— African American medical schools were established in several southern states including Louisiana, Tennessee, North Carolina and in the District of Columbia.\(^{44}\) This apparent era of remedy to three-hundred years of poor African American health was abruptly cut short in 1910 by the highly influential Flexner Report on Medical Education which ushered in what Byrd and Clayton (2002)\(^{45}\) refer to as the era of *Flexner reform*: “…the report painted a derogatory picture of them (Black medical

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\(^{43}\) The authors note that the official policy of racial segregation in organized medicine continued until court-ordered desegregation in the late 1960’s.

\(^{44}\) New Orleans University Medical College, 1887-1911; Meharry Medical College 1876-present; Chattanooga Medical College, 1902-1908; Knoxville College Medical Department, 1895-1900; University of West Tennessee College of Physicians and Surgeons, 1904-1923; Leonard Medical School (Shaw University), 1882-1914; Howard University Medical School, 1868-present. From the official Duke University Medical Center Library website [http://www.mclibrary.duke.edu/hmc/exhibits/blkhist](http://www.mclibrary.duke.edu/hmc/exhibits/blkhist).

\(^{45}\) Byrd and Clayton’s (2002) two volume series *An American Health Dilemma* is the most comprehensive historical analysis of African American experiences with the US health care system from the time of enslavement to the present.
and health professions schools). ...(and) categorized all these institutions as inferior and all Black physicians as limited, and assigned the products of these Black health professions schools to a caste designated as “sanitarian” and “public health” professionals rather than as participants in the biomedical scientific and surgical revolution. It codified a new institutional caste system in the health professions” (p. 94). The Carnegie-sponsored report also reinforced the cultural dominance of allopathic medicine and provided the “empirical evidence” it required to maintain its exclusive European American, middle and upper-class male ranks. By demanding professional standards that were unattainable by African American physicians due to extant policies of racial exclusion and relegation, the report sounded the death knell for all but three African American medical schools by 1915. By 1923, only Howard University Medical School and Meharry Medical College remained, and these are still in existence today. In yet an additional attempt at maintaining medicine’s European American, male professional character Flexner also recommended closing the three women’s medical colleges in existence at the time.

As African American physicians graduated in the early part of the 20th century, there were few institutions where they could practice their craft—hospitals would not only deny admission to African American patients, but also to African American practitioners. Fomented by a social climate that promoted race-based stratification, segregation and discrimination, hospitals dedicated to African American patients proliferated around the turn of the century, spearheaded in part by the National Medical Association.46 Byrd and Clayton

46 The National Medical Association is a professional medical society for black physicians founded in 1895 and advocates for the medical care of minorities and the poor. It was established to create a professional space of legitimacy for black practitioners who were discriminated against and excluded from white professional groups. The growth of black hospitals spanned 1865-1960’s with only three such hospitals remaining today. From the official website of Duke University Medical Center Library http://www.mclibrary.duke.edu/hmc/exhibits/blkhist.
point to the distinctly American profile of hospital infrastructure at this time: “Instead of hospital distribution based on rational numerical requirements and specialized function based on the needs of the entire population, as in Europe, in America they were specialized social and public works of ethnic, religious, and racial communities.”47 The authors describe Irish Catholic, Italian, and Jewish hospitals that served those generally excluded from white, mainstream medical care. In the case of the distinct origin of “Black hospitals,” the authors quote Gamble (1995): “Racial discrimination, white self-interest, black professional concerns, divergent strategies for black social advancement, and changes in hospital care and medical practice all played major roles in the development of these institutions…Regardless of motive, the goal behind the establishment of these hospitals was the same—to maintain and create a segregated hospital system” (p.53). Although a segregated hospital system may not seem palatable to the politics of today, it was a step up from the outright exclusion of African American patients by European American institutions.

Tuskegee

No single word conjures images of abuse, neglect, and medical racism more than Tuskegee. Although African American mistrust of the medical profession has a storied history that predates the 1932 study, the forty-year Tuskegee Syphilis Experiment confirmed already-held beliefs that African American health was not a priority and African American American life was not valued. Reverby suggests why this study has come to mean so much in the American cultural landscape:

It is not surprising that a historical experience, containing the elements of a sexually transmitted disease, African Americans, coercion and lying by government

47 See Byrd and Clayton (2002) for a review of the broader hospital movement in the U.S.
Exposed in 1972, the Tuskegee Syphilis Study of Macon County Alabama followed nearly 400 African American men who were in the late stages of the disease and approximately 200 healthy African American men who served as study “controls.” The goal of the study, endorsed by then prominent African American sociologist Charles S. Johnson, was to observe “untreated syphilis in the male Negro.” The men were led to believe they were patients in a joint federal and local effort to provide them with medical and nursing care for their “bad blood,” “a local idiom that encompassed syphilis as well as anemias” (Reverby, 2000:1), and as such never knew they were participating in a medical study.

During the forty years of the study, in an egregious abuse of human rights, the US Public Health Service (USPHS) knowingly kept secret the availability of remedies to alleviate and eventually cure syphilis, including penicillin in the late 1940s. The USPHS continued the experiment, “…never giving them a clear diagnosis, but providing them with the watchful eye of a nurse as well as exams…placebos, tonics, aspirins and free lunches. Burial insurance became an additional inducement for their participation. In exchange, the men or their families agreed to allow for autopsies without knowing that the researchers needed to confirm the ravages of syphilis on the men’s organs and tissues. Over the years, thirteen reports of the study were published in respectable medical journals…” (Reverby, 2000:2).

Reverby acknowledges that there have been other experiments that abused or denied the basic rights of individuals, but this study differs in that those conducting the study believed
what they were doing was right. 48 She explains that this difference was part of a larger American racialized belief system intertwined with medical research and which promoted the use of African Americans as experimental subjects. The experiment, then, became “‘normative’ for research in this country…the Tuskegee Study is America’s metaphor for racism in medical research. It is often paired with the Nazi doctor’s experiments on Holocaust victims…Both serve as reminders of what medicine aligned with state power can do to those defined as ‘other’ ” (Reverby, 2000:3).

The global disaster of Tuskegee, as we are all affected by the abuses it maintained, has been imagined and re-imagined in works like James H. Jones’ Bad Blood: The Tuskegee Syphilis Experiment and its 1997 screenplay adaptation Miss Evers’ Boys. It is invoked by African Americans who believe there is a government-sanctioned social and medical conspiracy to end their lives with HIV/AIDS or experimental pharmacopoeia.49 It is invoked in contemporary studies of racism and health and serves as a reminder of the necessity of full partnership between researchers and participants in any research effort. Reverby quotes sociologist Kai Erikson regarding this kind of “collective trauma”: “In writing about modern disasters, [Erikson] calls them ‘a new species of trouble’ because they are, in part, made through human hands and because whole communities find it difficult to heal. When this kind of ‘collective trauma’ happens…. ‘our memory repeats to us what we haven’t yet come to terms with, what still haunts us’ ” (Reverby, 2000:6). The legacy of Tuskegee is preserved in the remembered events of the study, institutional review boards for the protection of

48 She cites the use of military personnel to test LSD and exposure of civilians to radiation experiments during the Cold War as examples.

human subjects in research and other conscious efforts to protect the rights of the people of today.  

The relationship between African Americans and medicine has thus historically been one of mistrust, betrayal and violence (Gamble, 1997; Mullings and Wali, 2001). Gamble notes that late nineteenth and early twentieth century medical and public health journals contained numerous articles that linked moral valuations to African American health problems and as such did much to preserve and intensify the mistrust of science, medicine and public health: “…Many of the discussions focused on syphilis. White physicians maintained that intrinsic racial characteristics such as excessive sexual desire, immorality, and overindulgence caused black people to have high rates of syphilis.” (Gamble, 1993:36). These histories come to bear on experiences of women in this study, such as those of Helene and Sheri, who have chosen to visit an African American practice because of their beliefs that these doctors will not judge them nor mistreat them and, according to Helene, “will fight harder for me.”

Civil Rights Era in Health Care 1945-1965 and Beyond

After enduring the pains of the Great Depression and World War II—eras that witnessed an even more pronounced impoverishment and continued burden of poor health among African American people—African American medical professionals began to take an active part in formal legislative and informal efforts to end racial discrimination in health care.  

These efforts gained momentum in the postwar period and it can be argued continue today. Byrd and Clayton do not underestimate the influence this cadre of professionals had on

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50 After President Bill Clinton’s 1997 formal apology to the remaining men and families of the Tuskegee Syphilis Study, the Center for the Study of Bioethics at the University of Tuskegee was established.

transforming the overall health of African Americans: “Transmutation of their efforts in health care civil rights into the overall African American Civil Rights Movement helped set the stage for the most dramatic improvements in Black health since the Civil War” (p.249).

While these efforts are lauded for spurring on improvements in health, hospitals in the South remained segregated into the 1960’s and quality of care was poorest in hospitals that served African American patients. The Hill-Burton Act of 1946 sanctioned segregation and de facto racial discrimination in federally funded hospitals until 1964 when the U.S. Supreme Court upheld the decision in Simkins v. Moses H. Cone Memorial Hospital 52 that began to turn the wheels of hospital desegregation in the South. Although the efforts of African Americans, particularly in the South, coincided with Civil Rights Movement attempts at addressing and ending segregation and discrimination in all of America’s institutions, Byrd and Clayton note that these “…seemed to have a disturbingly sluggish effect on the health care system” (p.290).

What followed this era of promise and hope among the disenfranchised has been described as a period of “crisis” in health spanning the 1970s through the 1990s. Post-civil rights routine violations of responsibility to the poor and underserved by government and local programs and officials fomented the contentious relationship between African Americans who were fed up with promises of a better future and a health care system that continued to deny equal treatment for all. Cultural attitudes toward integration and an end to race-based discrimination flip-flopped from a liberal, post-civil rights consciousness in the 1970s to a more reactionary tone in the 1980’s. Byrd and Clayton cite various reasons for this shift:

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52 A group of 11 African Americans filed suit in 1962 against two Greensboro, N.C. hospitals for racial discrimination. The U.S. Court of Appeals in Richmond, VA ruled “racial discrimination for both patient and staff was illegal in federally aided hospitals and held the ‘separate but equal’ provision of the Hill-Burton Act unconstitutional” (Byrd and Clayton, 2002:267).
“Following a decade and a half of heightened possibilities, a perception of repeated domestic and economic policy failures, dramatic power and economic shifts, and variegated foreign policy failures—with the self-doubts and insecurities inherent in these events—most Americans entered the 1980s with a loss of confidence in liberal politics, cynical if not jaded attitudes toward social activism, and damaged faith in the Keynesian economics that had dominated since the Great Depression” (p.479). During the 1980s and into the mid 1990’s, the health care system became the dominant industry in the U.S., consuming 14 percent of the Gross Domestic Product. Byrd and Clayton note that African Americans enjoyed little of the health successes brought on by the expanding system. In addition, the “friendly racism” and “socially regressive health policies” of the Reagan and Bush administrations did little to engender confidence that the “color line” was being erased.

The Clinton administration inherited glaring inequalities in health among African Americans, the poor and other underserved and disenfranchised groups. In its ultimately failed attempts at health care reform, the administration sought to address what was known as a “Dual Health Crisis in Black and White.” There were indeed two crises in health care:

The first…was strongly rooted in dysfunctional health system financing, over-reliance on market mechanisms and refusal to acknowledge health system problems tied to America’s class system stratification and social arrangements. A second set of problems was dominated by America’s unique history-based, hierarchical, structural and institutional arrangements in the health system; its tradition of inadequate resource allocation to certain sectors of the population, often based on race and moral judgments …and a flawed medical-social culture regarding race and class. (Byrd and Clayton, 2002:570)

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54 See Byrd and Clayton (2002) for in-depth historical review of this period.
These authors note that this resilient cultural climate of race- and class-based discrimination, coupled with a national non-commitment to ameliorating moral-medical practices, attitudes and policies and a failure to “reign in” health care costs have set the stage for the establishment of a “permanent health and health care underclass” in the U.S. with a large percentage consisting of African Americans, the poor and other disenfranchised groups.

Reproductive Health Care

Although African American people as a whole were the target of historically-produced racial ideologies and attendant medical practices, African American women have suffered specific blows from the time of enslavement as the prime subjects of medical experimentation and victims of particular violences during pregnancy, including their gendered and raced devaluation as human beings (Gamble, 1993).

As mentioned in Section I above, the gynecological experiments of Dr. J. Marion Sims on enslaved women and the majority of experimental Cesarean sections conducted in the South on African American women speak to their marginalization and vulnerability to medical exploitation in a society organized and stratified unequally by race. Roberts (1999) grimly describes a slaveholder practice of digging a hole in the ground large enough to accommodate the pregnant belly of an enslaved woman while she was forced to lie face down to endure whippings. This, according to Roberts, was the first evidence of a “maternal-fetal conflict” whereby the pregnant woman was treated as a vessel that served only to bring forth new workers into the fields. The slaveholder was able to protect his economic investment, the unborn child, while punishing its mother. Roberts goes on to describe the practice of buying slave women as “breeders” and the economic impact a fertile woman
could have for an owner. “White masters…could increase their wealth by controlling their slaves’ reproductive capacity…An anonymous planter’s calculations made the point: ‘I own a woman who cost me $400, when a girl, in 1827. Admit, she made me nothing—only worth her victuals and clothing. She now has three children, worth over $3000’ ” (p.24). Graninger (1996) affirms this piqued interest in slave women’s reproduction by noting the abundance of detailed records regarding “every reported pregnancy, time of quickening, confinement, and pregnancy outcome on their plantation” (p.11). Roberts makes the case that the control of African American women’s reproduction has historically been a central piece in political-cultural-moral constructions of African American motherhood—themes I will return to later in this chapter.

Care for pregnant African American women from the time of enslavement through the mid-twentieth century, particularly in the South, was overwhelmingly provided by older African American women trained by their mothers and grandmothers to be “granny midwives.” Cultural preference for care by the midwife notwithstanding, conditions in the South such as segregation, de facto racism among health care professionals and geographic isolation in rural areas allowed for the persistence of the granny midwife.

During the mid-twentieth century, the U.S. government took steps to begin what would become the elimination of the “grannies.” Increased professionalization of medicine, combined with high maternal and infant mortality rates among southern African Americans that physicians attributed to the “unfit” granny midwife spurred the creation and enforcement of licensing regulations that many of the midwives were unable or unwilling to accede. According to Graninger, “Licensing also regulated many other aspects of a midwife’s persona, requiring that she be able to fill out the birth certificate, be free of communicable
diseases and hookworm, have healthy teeth, and be of ‘good moral character.’” (p.12)
Graninger eschews the idea that the elimination of the granny midwife was born of a “natural progression” toward medical advancement, but rather “...out of racist notions about the capabilities of black women and out of a need for a large patient pool for white teaching hospitals” (p. 13). Control over African American women’s reproduction had now entered the birthing room, and by the late 1970’s the number of practicing granny midwives had dropped dramatically.

African American Women and the Eugenics Movement of the 20th Century

Apart from experiencing an historically produced general disenfranchisement with the medical establishment, African Americans (men and women), along with poor European Americans and immigrants, were the targets of a national program predicated on Galton’s theories of heredity that resulted in the forced sterilization of thousands from the early part of the twentieth century into the 1970’s.55 Such sterilizations were carried out until 1974 in North Carolina and although Schoen (2001) points out that not all women were coerced and that the program offered some poor women the only form of birth control available to them at the time, the program’s overarching goals were to deny those women who were considered “unfit” an opportunity to have children. In addition, women who sought sterilization were often doing so in order to escape those life circumstances that made it nearly impossible to

55 Sir Francis Galton (1822-1911) is considered the founder of eugenics. Through various statistical analyses, he suggested that everything from intelligence to personality traits to disease resistance was determined by heredity. The corollary was that those persons deemed “unfit” by his standards should not be allowed to reproduce. Byrd and Clayton note that “Hereditarily predetermined, immutable, individual and racial hierarchies permeated virtually all of Galton’s work in eugenics” (2002:66).
raise healthy children including poverty, poor living conditions and lack of resources—all of which were intimately related to their race and class.

Roberts explains the inherent racial bias in the eugenics program: “White Americans had for over two centuries developed an understanding of the races as biologically distinct groups, marked by inherited attributes of inferiority and superiority. Scientific racism predisposed Americans to accept the theory that social characteristics were heritable and deviant behavior was biologically determined. The use of sterilization as a remedy for social problems was an extension of the brutality enforced against Black Americans” (p.61). In North Carolina alone, the state eugenics board authorized over eight thousand eugenic sterilizations, many of which have been later characterized as “forced.” 56 Controlling the fertility of poor and poor minority women was not without its economic as well as eugenic components. Schoen points to larger state efforts to limit the reproduction of mothers receiving welfare in order to curb state expenditures.

Lest we are lulled into believing eugenics is a thing of the past, accusations of genetic inferiority in intelligence and general hereditary “fitness” among African Americans are still with us in (best-selling book) _The Bell Curve_ and in moral-medical landscapes that deny equal access to quality care. As recently as March, 2005 victims of forced sterilization procedures in North Carolina—many of whom are African American women—petitioned Governor Mike Easley for reparations for a racist medical regime that undermined their right to bear children. Just as the eugenics programs of the past predicated medical procedures on moral judgments of “fit” and “unfit” human beings, configurations of African American

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56 See Schoen 2001 and 2005 for a complete analysis of North Carolina’s Eugenics Board. In 2001, NC was the only state to permit access to state sterilization records for an in-depth review of the Board.
motherhood continue to strike at the heart of African American women’s desires to achieve reproductive freedom.

The Rise of Science and Medical Morality—Defining (Un)Deserving Motherhood

In Ritchie’s (1999) analysis of the construction of the “immoral black mother,” cultural rhetoric of racial inferiority and superiority laid one foundation of health inequalities that U.S. public health workers, physicians, community activists and social scientists are still struggling to dismantle. In the era of the Civil Rights struggle, focus shifted toward African American women in reports about the “national character” of the U.S. which included the pathologization of “the black family” and more specifically “black motherhood” with attendant moral overtones as evidenced by the wildly popular Moynihan report of 1965 (Hill Collins, 1999a; Mullings, 1995). Discussions and actions around policy and the allocation of resources became discourses about “deserving” or “worthy” mothers, most of whom were European American and middle class (Brush, 1997; Hargraves, 1993; Ritchie, 1999). African American motherhood was publicly devalued, deemed socially insignificant and undeserving of support, both social and structural.

Hill Collins (1999a) maintains that mothering is itself a political act and as such is subject to policing and punishment for criminal transgressions. Roberts (1999) and Tsing (1990) echo this sentiment with Roberts citing a recent (1989) policy in Charleston, S.C. that required the arrest of women who tested positive for crack while pregnant. Of the forty-eight women arrested for such “prenatal crimes,” forty-seven were African American.

Roberts details the popular historical tropes of African American motherhood that perpetuate the idea that in America, “unregulated Black reproduction is dangerous” (p.8):
“Jezebel and the Immoral Black Mother”; “Mammy and the Negligent Black Mother”; “The Matriarch and the Black Unwed Mother”; and “The Welfare Queen and the Devious Black Mother.” All of these images, still with us today, continue to promote policies that are reminiscent of the eugenics of the past including the denial of benefits to children of welfare mothers and the mandatory implantation of the birth control agent Norplant in order to receive aid (Roberts, p.4). The staying power of these images is also evident as they have reverberated with many women in this study.

Schoen, Roberts and Hargraves document that, despite the state and national efforts to control their reproduction, African American women have had a storied history as activists in their own reproductive health care and decision-making. Such is the case for the consultants in my research who all attended a private health care practice located in Durham and Chapel Hill, North Carolina. The next chapter reviews the methodology that infuses this project and is followed by analyses—informed by observation and interviews —of the historical context of African American health care in the Durham-Chapel Hill area in which this practice is situated.
Chapter Four

Methodology

In order to explore the *lived experiences of pregnancy and motherhood* for African American women, I used anthropological methods of participant observation at a local OB-GYN practice, in-depth interviewing and the co-construction of narrative life histories. The study is prospective in design, in that I followed women as their pregnancies unfolded except for three women who participated soon (within one month) after the birth of their children.

Choice and Establishment of Field Sites

Central to this study is my desire to understand class differences among African American women in North Carolina and not to focus only on poorer women. The practice in which I conducted this research serves women of varying socioeconomic strata and is the only one in the area that serves a majority African American clientele with such a wide class range (e.g., women who receive Medicaid and women who are doctors themselves). The obstetrician who attended the birth of my son connected me with another physician who cared for Dr. V—an obstetrician at the Durham practice—while she was pregnant with her son now seven years ago. When I began work in April, 2002 I visited only the Durham OB-GYN office. My first visit with the staff was to explain the goals of my research in order to receive their permission to observe the daily life of the practice and recruit women who were receiving prenatal care there. Although I spent time at both Durham and Chapel Hill offices over the
course of the study from April 2002 to July 2003, I worked most often at the new office in Chapel Hill because I was able to gain considerable rapport with physicians and staff. As I neared the end of the study, I returned to the Durham office to assist, observe and recruit women into the study.

**Recruiting and Profile of Women who Participated**

Although this research was inspired by the well-publicized “health gap” between African Americans and European Americans, the goal of this study is to more fully understand the lives and experiences of *African American women*—particularly in relation to pregnancy, childbirth and motherhood. I was also exploring experiences of preterm labor and low birthweight as part of the study.

I chose only patients who attended this practice (except for one participant who was a staff member) and therefore it is important to note at the outset that this in an opportunistic sample of African American women who received prenatal care from this private practice between April, 2002 and July, 2003. As a result of their own decision to receive care and many patients’ ability to pay for such care, one would expect that these women would automatically have better chances for healthier, term pregnancies. Although the majority of women in this study experienced healthy, term pregnancies one physician explained about the practice, “We have one of the highest rates of second trimester losses in the area.”

As required by the AA-IRB, I identified study participant criteria as: African American, aged 18-35 and pregnant or up to one year postpartum. I began fieldwork in the spring of 2002, and after approximately four months at the practice I had established a routine with doctors and nurses where I could identify eligible participants on the list of patients for the
day and meet each woman in the exam room prior to the doctor’s visit. Medicaid recipients were identified by staff according to computerized insurance carrier information. Flyers with the title “Understanding Pregnancy and Social Stress Among African American Women” were posted on bathroom doors and in the waiting room to introduce women to the study, but I personally invited each woman to participate. Dr. A and one of the nurse managers also recommended that I speak to specific women.

I was able to recruit 62 women of varying economic and educational backgrounds, with a larger proportion of women from middle and upper classes, in different stages of pregnancy. It is important to note one of the research findings critically examines how one assesses class from an experiential perspective. Although I used education and income/occupation to roughly determine economic class position, I understand that these are limited in scope and contribute to misunderstandings of class experience. As women have shared with me, class position as defined by income is more relevant to those who belong to the dominant European American society and enjoy the benefits of such economic privilege.

This sample size allows for simple quantitative analyses and provides enough women from varying social class experiences to analyze intra-cultural variation regarding experiences of being an African American woman, related experiences of class, and racism, pregnancy and motherhood. 57

Quantitative and Descriptive Data Collection

During each initial interview, I collected quantitative data for each mother including age, parity (including the number of term, preterm and terminated pregnancies) other pregnancy

57 I discuss the women who participated in this study in more detail in Chapter Six.
losses, years of education, number of living children. If I was able to re-establish contact after the birth of their child, I recorded the birth weight and whether the baby was born preterm or term. I was also able to collect data on marital status, birthplace, occupation, co-morbidities (i.e., high blood pressure, gestational diabetes), type of delivery (vaginal or Cesarean-section), occurrence of premature rupture of membranes, preterm labor, preterm delivery, prescribed bed rest and health status of the child immediately after birth. During the study period, there were no infant deaths among the women I interviewed.

Finally, the practice statistician has provided me with statistics and demographic trends for the last two years. I analyzed these data with attention to whether this practice has made inroads in reducing rates of preterm labor and delivery and infant mortality among African American women.

**In-depth Interviewing**

While some indicators of racism are measurable (e.g., How many times have you been discriminated against?), many are not. I conducted multiple (2-3) in-depth (at least one hour) and open-ended interviews for twenty of the participants. The first interviews lasted between thirty minutes to two hours. I recorded shorter interviews for the remaining women. I interviewed women at the practice, in their homes, workplaces and restaurants and recorded all interviews (except for six women, three of whom requested they not be recorded). Each interview was assigned a number corresponding to the date of the first interview. Subsequent interviews were identified by -1, -2, etc. 58 Interviews tended to be emotional events and

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58 For example, one woman I recruited May 15, 2002 who completed three interviews would be identified by 051502-1, 051502-2, 051502-3. Interviews with multiple women who were recruited on the same day were assigned the original interview date with A, B, or C denoting separate women. For example, I recruited three women on February 15, 2003 who were identified as 021503A, 021503B, 021503C.
often very long, and I found that I could interview a maximum of three women per day. On average, I recruited one woman per day and spent an average of one hour in our first interview. I recorded brief notes immediately following each interview.

During the course of my research, I recognized the need to reformulate interview questions based on informal conversations and in-depth and life history interviews with women (See Appendix 2). Participants directed me toward those meaningful aspects of their lives which they foregrounded in interviews. In the first interviews, my consultants immediately broadened the line of questioning to include not just social inequality as experienced by pregnant African American women, but the feelings of social discrimination, threat, anger and fear surrounding the possibility of having a male child. For this reason, I adapted my interview questions to include “Do you know whether you’re having a boy or a girl? Do you have any concerns about having one or the other? If so, why?”

I found that questions about conceptions of a healthy baby or healthy pregnancy were frequently molded into a medical model of health and pregnancy as advocated by caregivers at the practice. Most women rejected grandmothers’ “superstitions” about pregnancy and articulated the need to “eat right” and “get plenty of rest.” Although I continued to ask these questions, I felt this line of questioning did not yield much information about the lived experiences of these pregnant women. As a result, I de-emphasized them in the later interviews. I will note however, that for those expectant mothers who live with a sick or disabled child (e.g., sickle cell, autism) the meaning of a “healthy baby” is influenced by experiences of sickness with their other children.

I included a question that aimed to understand class experiences of African American women that are sharply focused during pregnancy. I asked women, “Do people look at you
differently when you are pregnant?” This question emerged out of previous discussions with women about how society at large and African American communities view a woman’s pregnancy. Consultants have provided rich details about how they have experienced the instability of class that Mullings (1999) asserts is unique to African American women because of the complex articulation of being an African American woman and experiences of class.

In addition to conducting interviews with pregnant women, I interviewed physicians and staff at the practice in order to gain their perspective on the high rates of infant mortality and to understand more fully how they perform their medical roles in a predominantly African American office with a predominantly African American clientele. Example questions included: “What do you think contributes to the high rates of preterm delivery and infant mortality among African American women?” “Do you feel your practice has improved the chances for African American women to deliver term babies and if so, why?” “Do you feel it’s important for African American women to have African American health care providers and if so, why?”

Life History Interviews

A large part of my research consisted of recording life histories from a group of six women selected from the larger sample who reflect a range of class experiences (again, roughly defined by income and education) with whom I developed long-term social relationships and whose pregnancy narratives provided me with multidimensional perspectives on lived experiences. Interview questions were developed with attention to specific experiences of being African American and female, class, pregnancy, childbirth and motherhood. Several

59 For a full list of questions, see Appendix 3: Guide for Interviews with Physicians.
questions emerged out of conversations with women from the larger sample. Although I had developed questions before interviews, each woman inspired new formulations based upon where she directed our conversations and what she felt to be most relevant in her life story. As such, questions for life history interviews were tailored to each woman’s narrative.

These histories have helped me come to a much greater in-depth understanding of the meanings of pregnancy and motherhood for these women as they were expressed in their own narratives. In addition, as part of their narratives of pregnancy and motherhood, these life historians addressed questions of motherhood, fatherhood and male-female relationships that have helped me to more fully understand the totality of their life experiences as African American women. As a result, I have been able to explore connections between lived experiences of racism, being an African American woman and related experiences of class, and how they may influence a woman’s pregnancy and the overall health of mother and child.

**Participating and Observing**

In addition to recruiting and interviewing women, I spent several days per week at the OB-GYN office in order to observe the delivery of care to these women and to understand more about the perspectives of each practitioner regarding care before, during and after pregnancy. I began by visiting the waiting room with my son and recording observations and interactions with patients and personnel. After approximately one month of these visits, Dr. A suggested that I accompany her back to the exam rooms and station myself somewhere unobtrusive while she directed me to rooms where women were waiting for their physicians. I requested that I be able to sit at the nurses’ station, a central desk space that situated me closer to
patients as they came back to exam rooms. This place within the office setting provided me with greater contact with physicians and staff in order to establish good rapport and to engage in conversation about my research, its goals and their thoughts about the care of pregnant women.

I recorded field notes on a daily basis related to the beliefs and practices of physicians and nurses in caring for pregnant women. After a few months, I felt very comfortable at the practice and I was pleased to be invited to Thanksgiving and Christmas parties during which I participated in several “games” reserved for “new staff.” I was particularly honored to be invited to attend the 20th Anniversary Celebration of the practice and to provide some of the photos that were used in the slide presentation.

Apart from spending each week at one of the two offices, I attended two childbirth education classes in order to understand more about the flow and type of information that is given to the women of this practice and their partners. My husband and I also participated in an infant/child CPR class given by staff at the practice. Finally, I spent time with consultants in their homes, workplaces, churches and in other social settings outside of our scheduled interview times.

Ethnographic Data Analysis

Life history interviews were transcribed verbatim by a UNC-CH ethics-certified transcriptionist and myself. I uploaded all other interviews that were analyzed into Atlas.ti™ 5.0 in audio (.mp3) format for coding purposes. The primary advantage of this software is that it allowed me to code interviews while listening to conversations with each woman and to re-engage the material in its original form. In this way, rather than interacting with text, I
could once again hear voice inflections, note long pauses or relive emotional highs and lows present in conversations.

I conducted a content-analysis of all interviews with life historians (i.e., a total of 35 pregnancy and life history interviews). I reviewed my field notes and interview logs for the remaining 56 participants. Major themes that emerged from a subsample of 20 women who were chosen because they completed 1-3 pregnancy interviews helped to guide conversations and analyses of life histories. These themes are discussed in the conclusions portion of this thesis.

Reciprocity and Managing Relationships in the Field

I engaged a Black Feminist perspective in an effort to nurture open and honest partnerships. Leith Mullings invites us to approach relationships in the field with “mutual respect” and to foster what she calls “participatory research.” In this spirit, I began to share my preliminary findings with the physicians, staff, and those participants with whom I was still in regular contact in order to connect them with the emerging results of the research in which they participated. I arranged meetings with each physician to report on the preliminary findings and to ask for their comments/suggestions. In addition, I gave life historians and physicians a copy of the progress report I formulated for my exams in May, 2003. I continue to visit the office and share information with the physicians and staff. Finally, four life historians have read the written interpretation of our conversations and have provided me with input for the final versions you read here.

It was also important for me to offer women something in return for their time and devotion to this project. In addition to sending personal thank you notes to each participant, I
offered copies of our interview tapes as records and mementos of their narratives about pregnancy and motherhood. For those participants who did not have a partner, I offered to come to childbirth classes with them and to the birth itself if they felt comfortable with me. I provided one financially struggling participant with diapers and clothing for her older child. I brought flowers to several women after the birth of their children not only to congratulate those whose pregnancies were planned and socially sanctioned by marriage, but also to acknowledge and celebrate those women who received little positive attention for bearing children while unmarried.

My ongoing friendships with four life historians have moved beyond researcher-participant relationships. Although each woman was initially interested in the therapeutic nature of our conversations (i.e., each was pleased to have an impartial third-party who participated in discussions about her life), we have developed and maintained close friendships and have become more involved in each other’s lives. I socialize with one mother on a weekly basis and was honored to be part of the celebration honoring one woman’s daughter as the North Carolina Sickle Cell Syndrome poster child. My family recently attended a friend’s first sermon as she pursues her new life as a minister.

Experiencing the Field

Several feminist anthropologists have written about their own experiences of pregnancy and their effects on research methods, interpretations and understandings (Abu-Lughod, 1995; Rapp, 1999). Their work is testament to the power of experience to move, shape, engage and otherwise inform our lives as well as our research experiences. My simultaneous position as insider—according to my own experiences of pregnancy, marriage and
motherhood—and yet racial and cultural outsider have guided my conversations and interpretations over the course of this work.

My relationships in the field were informed by my own and consultants’ experiences as well as the social relationships we all encounter as children of U.S. culture. As I began the fieldwork, and well into the experience, I found myself trying to understand how I situated myself in relation to my consultants as well as how they situated me. As a member of European American society, poised in nearly every media as opposed to African American culture, I engaged in a making and remaking of Self and Other, insider and outsider throughout the research process.

I cannot escape my own lack of neutrality when it comes to examining race, culture, gender, reproduction and health in my work. I do wear cultural blinders that forced me to assume conditions between myself and an African American female consultant. During the early phase of the research, I was sensitized to my own racial outsiderness, perhaps giving it a greater valence than it deserved. As the work proceeded, however, I became more keenly aware of the layers of insiderness to which I belonged.

My experiences of pregnancy have placed me in my own existential position in relation not only to the world around me, but to the mothers who came before me, and the mothers whom I meet every day whether in the research context or not. I felt connected to my consultants in ways that I might not otherwise have felt and believe strongly that the intimacy of shared experiences of pregnancy, birth and motherhood have helped rather than hindered my work.

My own prolonged connection to the intersections of personal life and research has helped frame many of my research questions and my understandings of the complicated distances
that separate me from consultants. These shared experiences of pregnancy, birth and motherhood intersect in unpredictable ways to remind me that insider categories are never adequate to explain such connections. I am highly sensitized to women’s hectic schedules of work, parenting and the concerns that frame much of our shared experiences of motherhood. I know, first hand, how difficult it is for new mothers to have any schedule and how much work it takes for them to continue to participate in this research amidst a true restructuring of their lives with a newborn. I know, first hand, the experiences of troubled pregnancy and the daily worries that accompany the fears that rage in women’s minds.

These connections have also engaged me in framing research questions based on levels of intimacy that I am not insider to: Single motherhood, pregnancy as an experience of depression, raced pregnancy and motherhood, mothering sick children, pregnancy and infant loss. As Twine (2000) reminds us, insiders can distort the truth (assuming we can agree on what that is) as much as outsiders and as such I have made attempts in the design and practice of research to explore those avenues that I might otherwise not see. However, I can never travel all the paths in African American women’s lives that contribute to their own experiences of pregnancy and motherhood, particularly those to which the larger society often adversely responds.

A Methodology that “bleeds into daily life”

Behar (1996) operationalizes the ethnographer’s experience of her research in a visceral vein. She calls us “vulnerable observers” in that we can’t help but be personally affected by the lives we encounter everyday in the field. She foregrounds the felt experiences of

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ethnographers—experiences I believe contribute to understandings of Self as insider or outsider and which in turn elicit felt responses from consultants. When we privilege our own sentiment we position ourselves as vulnerable and invite sharing among the vulnerable, including our consultants. Behar compels those of us who are willing to write an “anthropology that breaks your heart” to infuse our ethnographies with those thoughts and feelings that are most deeply felt in the art and act of research—to lay it all out there for the world to see. I have spent sleepless nights worrying about consultants who are young single mothers with little support; women who mother sick children; women who have experienced a stillbirth; and the painful experiences of poverty and racism that women have entrusted me with.

I would suggest that there are other ways of being native or claiming insider status—categories that must be explored to include multiple layers of lived experience. Perhaps experiential native or Patricia Hill Collins’ outsider within theorizations aren’t bad vocabularies to begin with. The ways in which we as ethnographers experience our consultants and the stories they tell us are equally important in understanding our Selves as we exist in relation to the Other—and isn’t the Other, in many instances, a partial Self? The layers of intimacy that are simultaneously constructed and experienced as they unfold in interviews are complex and infinitely and unpredictably interconnected, yet difficult to articulate in text. Behar makes room for these layers and for the worlds of felt experience they open to us. Ethnography changes us, transforms our own experiences through intimate contact with our consultants and yes, there were days when it broke my heart.
…And that’s one of the things we talk about all the time in our practice and that is, if we can see you then perhaps we can impact your children indirectly. And we’re living breathing flesh, you can touch me you can talk to me you can pull on my coat and most of all you know that I’m real. (November 6, 2002 Excerpt from interview with Dr. J, co-founder of African American OB-GYN practice).

Local contexts: Two worlds of Durham and Chapel Hill

…my son and I packed up and headed out for the day into the rush hour traffic. Roxboro Road was moving pretty steadily (as opposed to the ride up) and the flow carried me quickly to the I-85 intersection, past the giant Lowe’s Garden Center, a Wal-Mart, and Durham Regional Hospital where all of the pregnant women in my study will deliver. Further down the road, I drive through what strikes me as a solid middle class neighborhood, with small brick homes and modest front porches decorated with plants and children’s bright plastic toys. A mini downtown unfolds beyond that, with Mexican tiendas, pawn shops, a “sports bar” that looks more like someone’s old garage, and a McDonald’s. …I hop on I-85 after dodging the potholes and construction cones and head to Chapel Hill.

On my way home, I pull into the Oaks, an affluent neighborhood of wrought iron gates and meticulously manicured lawns along a Chapel Hill country club golf course, and I think about class. I think about geography. I think about the 18 miles that I have driven that connect these two places, and never the two shall meet. ‘Two different worlds,’” one doctor’s words ring in my ears, as do those of a young first grader I tutored in reading a couple of years ago. I knew she lived in apartment housing behind a thick grove of trees off the highway that runs along the perimeter of Chapel Hill. I had volunteered in her neighborhood in 1992, probably before she was born. The residents were predominantly African American, there was a Head Start on the premises and frequent patrolling by police. The neighborhood was rough and I had noticed one child there with cigarette burns in his skin. It is Chapel Hill’s best-kept secret. My little student asked me where I lived. I told her in Chapel Hill. ‘I live in Chapel Hill too. Where do you live?’ she asked. I replied, ‘Well, it’s near a big green lawn, a golf course.’ ‘Oh,’ she said softly, ‘you live in a different Chapel Hill.’” (Field notes, May 22, 2002)
Snapshot of North Carolina—A Brief History and Local Contexts of Fieldwork

When I first moved to North Carolina, I knew I wasn’t in Kansas anymore. First of all, it was sweltering. A July move-in date and my northern car with no air conditioning hinted quickly that I was no longer home. Upstate New York—the region of my birth and upbringing—although rather similar (when not covered in snow) in its expansive farmlands and winding country roads, seemed awfully far from the southern accents I heard, the confederate flags I saw emblazoned on beach towels, and the pork barbecue I tasted in my first months here. Although struck by the intense beauty of Chapel Hill, I vowed I would be here for six years at the most (the presumed length of my then-graduate program) and would immediately high tail it back to the North. Fourteen years later, here I am and I have grown to love the Old North State.

Contrary to popular belief (articulated to me primarily by recent northern transplants), North Carolina is very much a part of the South. It lies well beneath the Mason-Dixon line, a northern Virginia marker delineating who can claim belonging to “the North” or “the South” which ignites ideas about what divides us as a nation. Indeed, after North Carolina seceded at long last from the Union in 1861 it supplied the largest numbers of men and supplies to Confederate troops and, as such, suffered the greatest casualties of any Confederate state during the Civil War. Its history is also a history of enslavement of African peoples dating back to the early 1700’s and immortalized in still-standing structures like Moore Square in Raleigh where African men, women and children were sold to European American buyers. It is now converted into art spaces, restaurants, bars and boutiques.

North Carolina is a state thick with southern dialects, cuisine, religion and social mores whose people have an intense devotion to preserving and protecting their southern and North
Carolina heritage. It is a state historically peopled by three cultural groups: seven state-
recognized tribes of Native American Indians,\(^\text{61}\) African Americans and European
Americans—many of whom claim English, Scotch-Irish or German lineage.

In recent years, however, North Carolina has changed considerably. Local booms in
construction and low-wage service industry jobs, as well as a desire for cheap farm labor in
rural parts of the state have attracted migrants predominantly (approximately 90%) from
Mexico who have begun to settle more permanently. It is a state in transition—culturally,
linguistically, socially, economically. Overall, the number of residents who are of Hispanic
origin has risen by more than 950% in the decade spanning 1990-2000, creating the fastest-
growing Latino population in the country.\(^\text{62}\) Currently, people of Hispanic descent make up
nearly 6% of the state’s total population.

Part-rural, part-urban Durham and Orange counties, located in the heart of North Carolina,
have experienced much of this growth. Although Durham is traditionally known for its rich
African American heritage, as noted earlier it has experienced substantial growth in its local
Latino population (up 730% from 1990-2000). Orange County, which includes Chapel Hill,
has also seen similar though not as dramatic trends (up 312% from 1990-2000).\(^\text{63}\) Chapel Hill
itself is home to approximately 1,500 and the city of Durham has 16,000 residents of
Hispanic descent. Although both locales are working to meet the needs of this growing
segment of the population through nonprofit groups, and I have witnessed some real effort on
the part of North Carolinians to understand their new neighbors, the changing demographics

\(^{61}\) Only one of the seven, the Eastern Band of Cherokee, is recognized by the federal government.

\(^{62}\) Migration Information Source website, \text{http://www.migrationinformation.org/}, accessed June 1, 2005.

\(^{63}\) From the North Carolina state demographics official website \text{http://demog.state.nc.us}, accessed May 20,
2005.
have produced some tension between new immigrants and locals where the refiguring of race, home, language, economics and culture can become a fulcrum for contention and distrust.64

The eleventh most populated state with nearly eight and a half million people and ninth in the country in its rate of growth, North Carolina stretches across more than 56,000 square miles. It is divided into three geographical regions that are home to its 100 counties: the mid-Atlantic coastal region to the east, the looming Appalachian Mountains to the west and the Piedmont Plateau in-between.65 The varied topography lends itself to a number of local economies, including fishing, farming, tourism and manufacturing. Historically, the Coastal Plain and southeastern Piedmont—known as the Sandhills—regions have produced much of the tobacco that North Carolina is still famous for. Although soybeans, cotton, peaches and hogs are among the major “crops” grown to Carolina farmers, “tobacco road” is the moniker that most associate with the state. The temperate year-round climate not only sustains the family farm but also the luxurious golf courses that pepper the state and entice large numbers of retirees to settle here.66

North Carolina continues to promote education, manufacturing and agricultural technology across the state, although transitions in global economies have particularly affected local textile and other industries. Additionally, the recent controversies/lawsuits against the

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64 While exploring field sites for this work, it became increasingly clear that African American men and women were abandoning long-visited public health care clinics while Latino men and women were filling the vacancies. After speaking to several health care workers and physicians, I began to understand that no one seemed to know where the African American clients were going for care. Several hinted that relations between African Americans and Latinos were strained due to competition for similar jobs and cultural misunderstandings and that these experiences may have led to African Americans leaving these clinics as Latinos began to access them.

65 From the official state website of North Carolina State [http://demog.state.nc.us/](http://demog.state.nc.us/). Numbers are according to 2002 U.S. Census figures.

66 From the official website of the North Carolina State Library [http://statelibrary.dcr.state.nc.us/](http://statelibrary.dcr.state.nc.us/).
American tobacco industry have permanently disabled many smaller farms across the state. North Carolina’s commitment to higher education, however, has been longstanding and local universities continue to rank at the top of national “best” lists. Its commitment to higher education has earned it recognition as the “progressive conscience” of the South.  

Despite Emancipation in 1865, a rather insidious turning point in North Carolina history came with the infamous post-Reconstruction Wilmington Race Riot of 1898. It is reported that a European American mob terrorized the port town, reportedly murdered an as-yet-undetermined number of African Americans and destroyed the African American-owned *Daily Record* newspaper office. These acts ushered in an era of Jim Crow legislation and social practice beginning with the outright denial of voting rights for newly-freed African American people. Jim Crow laws legalized *race*-based segregation in this state until the 1960’s. In 1998, marking the 100th anniversary of the Wilmington Riot, North Carolina established a commission to investigate this event more in-depth and to report on the economic and social impact the riot had on people of African descent across the state and over time.

North Carolina is home to a total of eleven historically black colleges and universities (HBCUs) that reach from the western Piedmont eastward to the coast. Established in 1865, Shaw University in Raleigh is the oldest HBCU in the country, and was home to one of the

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67 The University of North Carolina statewide system consists of sixteen institutions and includes five historically black universities. The University of North Carolina at Chapel Hill was the first state university in the country, founded in 1789 and opened to students in 1795. Thirty-seven private colleges and universities, including Duke University in Durham, confer over half of the state’s law and medical degrees and North Carolina’s community college system consists of 59 institutions, ranking third largest in the country. From the official website of the North Carolina State Library [http://statelibrary.dcr.state.nc.us/](http://statelibrary.dcr.state.nc.us/).

68 From the official website of the North Carolina Office of Archives and History, Department of Cultural Resources [http://www.ah.dcr.state.nc.us/1898-wrrc/](http://www.ah.dcr.state.nc.us/1898-wrrc/).

69 See previous chapter for a brief history of segregated hospitals and medical schools in North Carolina.
first medical schools for African Americans, the Baptist Mission Society for Negroes-supported Leonard Medical School (1882-1914).\textsuperscript{70} Overall, one-fifth of North Carolina’s eight and a half million people are of African descent—a number boosted by the return-migration of many African Americans from northern cities to family homes beginning in the 1970’s (Stack, 1996). This demographic move to the South is complex in its origins and, knowing the history of race-based violence in the region, one may wonder why people of African descent would ever return. As Stack explains in her ethnography of African American return-migration to North Carolina,

> The South, scene of grief and suffering for black Americans, never ceased to represent home to many city dwellers. The people returning there are not fools; they are not seeking a promised land. They know that home is a vexed place, and they often consider it a virtually unchanged place. The years have not changed conditions at home so much as they have changed the people who once left home so urgently; …they are…changed in particular and profound historical ways, their consciousness shaped by their experience of America at a certain time, in certain American places. They have come home, turned their backs on the city with its ready made streets, and set about appropriating local time and memory and blood and symbols for intimate community purposes of their own (Stack, 1996:xv).

\textit{Durham and Chapel Hill—Corners of the Research Triangle}

The OB-GYN practice that granted me the opportunity to conduct this research was founded by two African American physicians from North Carolina whose intentions were—and continue to be—to serve “the African American community.” It is one of only two private obstetric and gynecology practices that are staffed by predominantly African American physicians serving a majority African American clientele.\textsuperscript{71} The practice operates two offices in which they receive patients—one in Durham and one in Chapel Hill. Because

\textsuperscript{70} From the official website of the Duke University Medical Center Library \url{http://www.mclibrary.duke.edu/hmc/exhibits/blkhist/}.

\textsuperscript{71} Personal communication with Dr. V, June 2005. The other practice is in Greensboro, N.C.
this area is unique across the state, I will briefly take the reader through the city of Durham and the town of Chapel Hill in order to understand those places that have produced the practice and its clients.

The city of Durham (pop. 196,000) and the much smaller town of Chapel Hill (pop. 52,440)\(^2\) are two corners of what is known internationally as the Research Triangle (Raleigh is the third corner). Research Triangle Park (RTP) was designed in 1959 as a joint effort among the three local universities—the University of North Carolina at Chapel Hill, Duke University, and North Carolina State University—to draw national and international minds to the area and to promote technological advancement in an array of industries. As a result of university and RTP efforts, higher education is perhaps the hallmark of triangle residents earning it the distinction of having the highest number of PhD’s in the nation per capita.\(^3\)

Both Durham and Chapel Hill boast economies centered on research and education, with Durham adopting the nickname “City of Medicine” in 1981 due to the large number of city residents working in the medical industry, including three large hospitals and numerous medical research centers located in and near the city (Darkis, 1991). University of North Carolina Hospitals and its rapidly-expanding medical research complex are located in nearby Chapel Hill. With its proximity to beach and mountains and its well-publicized “small town charm with big city amenities” combined with state of the art health care, the triangle has swelled in population and continues to be rated one of the best places in the country to live, work and retire.


\(^3\) I have often seen this quoted in local newspapers and publications. Carolina Living Magazine boasts this statistic as a selling point for those considering a move to the area, [http://www.carolinaliving.com/heartlands/raleigh.asp](http://www.carolinaliving.com/heartlands/raleigh.asp).
Although geographically cozy (8 miles from one downtown to the other), Chapel Hill and Durham differ in dramatic ways. Chapel Hill is a quintessential college town whose local economy and culture revolves around the university that abuts the main downtown thoroughfare, Franklin Street. Its liberal politics are (in)famous across the state and region and it boasts vibrant arts and music scenes. Despite the university’s rich cultural diversity, the majority of Chapel Hillians tend to be European American (78%), educated (73.7% have bachelor’s degree or higher) and wealthy (median family income of $73,483).74

On the west side of town, however, one finds majority African American homes, churches and businesses—testament to the active participation that people of African descent have had in the town. The historically African American Northside neighborhood, for example, was settled by freed slaves and the stone wall tracing parts of the perimeter of the university was fashioned by slave labor. Despite its liberal politics, the university and town suffered the pains of segregation in the Jim Crow era. Franklin Street was the site of protests and sit-ins during the 1960’s to urge the town to desegregate its social spaces. In “A Walking Tour of Black UNC,” Timothy McMillan, anthropologist and Professor of African and African American studies at UNC, notes that the university cemetery in which African slaves are buried in mostly unmarked graves “remains segregated to this day.” He notes that the first African American graduate students in law and medicine were admitted in the 1950’s, and the first African American undergraduates were admitted to the university “with limited privileges” in 1955.

74 From the official website of the Town of Chapel Hill http://www.ci.chapel-hill.nc.us/.
Currently, and after much controversy in the early 1990’s, the university houses the Sonja Hanes Stone Center for Black Culture and History. UNC has also just recently (May, 2005) installed a monument to the university’s “unsung heroes”—African slave laborers—who participated in the building and overall culture of the university. In a curious juxtaposition of histories that are at once diametrically opposed and intimately entwined particularly in the South, the monument lies within a stone’s throw of Silent Sam, the statue of a Confederate soldier commemorating the Civil War and linked to an era of rising of white supremacy in the South.75

Although Durham is also home to university culture, it is more sprawling in area and encompasses more than a single downtown. Duke University, begun as Trinity College by tobacco magnate Washington Duke, sits as the crown jewel of Durham’s educated elite. It has its own single-street downtown, walkable from campus and thick with boutiques, bookstores and restaurants. Washington Duke was also the benefactor of Lincoln Hospital, the first hospital for African Americans in the state located in the historic Hayti community near North Carolina Central University—the youngest HBCU in the state (1910) and the first public liberal arts college founded for African Americans.76

In his analysis of Durham as the “capital of the black middle class” E. Franklin Frazier offered these backhanded compliments to the people of Durham in the 1920’s: “Durham offers none of the color and creative life we find among Negroes in New York City. It is a city of fine homes, exquisite churches, and middle class respectability. It is not the place where men write and dream; but a place where men calculate and work. No longer can men

75 From “A Walking Tour of Black UNC”, Timothy McMillan, PhD.
76 See previous chapter for more information about Lincoln Hospital and Lincoln Community Health Center.
say that the Negro is lazy and shiftless and a consumer. He is a producer. He is respectable. He has a middle class” (Frazier, 1968 [1925]:333).

Frazier was referring to the establishment and success of African American-owned institutions in Durham: the North Carolina Mutual Life Insurance Company, the Mechanics and Farmers Bank and the National Negro Finance Corporation—all of which were begun and supported by the same group of investors. As a result of these local business enterprises, Durham’s historically African American Hayti neighborhood, still in existence today albeit fractured by the building of the Durham Freeway in 1958, earned the nickname “Black Wall Street.” Today, the NC Mutual Life Insurance Company is the largest African American owned company nationwide and the Hayti neighborhood, although suffering economically, continues to promote an arts and cultural center to celebrate the lives of African American people in Durham and the United States at large.

Lest this description sound like an advertisement from the Durham Chamber of Commerce, Durham also lays claim to some of the highest crime statistics in the country so, like Chapel Hill, there are (at least) “two” Durhams. “…Sperling’s Best Places shows Durham's violent crime rate in 2001 was nearly double the national average. Catalytix, the statistics firm of Rise of the Creative Class author Richard Florida, rates Durham no. 1 among 274 U.S. counties as a creative center, but ranks the city 227th for ‘freedom from violent crime’” (F. Morgan, The Independent Weekly, Durham, North Carolina, October 13, 2004 Is the City Ready for Prime Time?). Crime data for 2004 indicates that Durham scores higher than the national average in every violent and property crime category except arson.77

77 National arson data was not available. From Area Connect website, Durham NC crime statistics and data resources, http://durham.areaconnect.com/crime1.html.
Although Durham is home to some of the wealthiest residents of the area, it is also home to many of the poorest. The 1999 poverty rate for Durham county was 13.4% versus the state’s rate of 12.3%. Durham’s notorious housing projects like the one in which doctors from this practice volunteered, speak to the still-limited economic opportunities for a majority poor and African American subculture. One doctor commented that he always “packs” [a gun] when he visits women in this development and comments on the life of violence young children and mothers face there: “I know that a patient [there] puts her children in the bathtub at night because she thinks a bullet won’t penetrate that.” North and east ends of town, though peppered with middle-class bungalows, are also lined with homes with run-down porches, broken windows and stoop-sitting residents who wear the blight around them in the worn lines of their faces.

Field Settings

Diplomas, awards, reviews and accreditations fill the wall of the entranceway to the exam rooms, lending that all-important air of authority and expertise to the words and practices within. A couple of UNC and Wake Forest diplomas boast a local familiarity with patients and life in Durham. (Field Notes, November 21, 2002)

Although I met women participants in a variety of places (e.g., cafes, restaurants, homes), the OB-GYN offices were the sites of most of my first interviews with women. The Chapel Hill and Durham offices belong to the same practice but there are differences between the two, reflecting the local settings that tend to produce such differences. Both offices, however, are freestanding buildings, far from the hospital setting in which women in this study would deliver.

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All of my memories of the drive to the Durham office are filled with images of construction, and my first trip was no different. The orange cones marked the red clay of North Carolina like exclamation points heralding the dawn of a new infrastructure with promises of burgeoning local economies. It was a gorgeous sunny day—in the upper 60’s with a strong breeze. After finally exiting the highway, I exhaled and launched my car onto the four-lane road that would take me to my destination. North Durham unfolded along Roxboro Road’s straight corridor of shops, tiendas and bargain superstores.

I found myself driving through seemingly quiet, modest neighborhoods of one-level brick homes with carefully flowered front yards. Each day I looked inquiringly at the New Lamb coffee shop—curious whether it was a church, a café or both. I don’t know what I expected the office to look like—although I was pretty sure it would be constructed from ubiquitous North Carolina red brick.

As I approached Durham Regional Hospital, I imagined I was getting closer to my destination and looked carefully for the sign marking my turn. When I finally made it, thirty minutes on a good day from my home in Chapel Hill, I was in awe of the medical complex that lay before me. Nestled among a host of other medical facilities that specialized in conditions such as diabetes and arthritis and far from the sirens and whizzing traffic of the road I took to get there, the large practice stood at the entrance to the cluster of buildings—all an elegant gray stone accented with salmon pink. A thirty-foot fountain surrounded by a glassy pond bubbled about 50 yards behind the office and gave the entire place an air of austerity. It could be seen that this was not a public clinic.

Once inside its doors, the waiting room filled with light from the large front windows. The green and mauve flowered wallpaper and glossy wood furniture was reminiscent of hotel
décor from the 1990’s. A long doubled row of back-to-back chairs lined the center of the large waiting room and single chairs covered three sides of the perimeter of the room. Large plants and a china cabinet filled with polished peach-colored dishes suggested a hotel lobby rather than a doctor’s office.

I was first struck by the music—not a typical doctor’s office beat—Martha and the Vandellas’ “Dancing in the Street.” Music was often a part of the audio experience of both offices. I would come to understand that I would be able to know which doctors were in the office by the music piped in overhead. Most often I would enter the front doors of the office to the sounds of jazz or a local R&B radio station. Some days it was uncanny how the melodic flows of the music mimicked or otherwise streamed with activity in the office. Music of the renowned saxophonist and North Carolina’s own John Coltrane appeared to bring out the worst in the staff as they grimaced in response to the up-tempo and sometimes-cacophonous sounds. On many occasions, beats from the fetal heart monitor mixed with the up-tempo music and conversation within the office walls, reminded me of the omnipresence of pregnancy and birth and all of the thoughts and experiences that come with them.

There is a long table to the left with medical and other literature displayed on its top, including pictures and short bios of the newest physician in the practice and a pediatrician recommended by the office—both African American practitioners. Pictures of the staff including the two founding African American male doctors, four other associates (three of whom are African American including one male, and one woman of Japanese and Korean descent) and three female physician’s assistants (two European American and one Mexican American) greet you in the waiting room. I remember asking one of the founders about non-African American clients who visit the practice and he noted that if they didn’t like what they
saw in front of them, they could go back out the door. A basket of magazines lay to the right of the reception desk next to a large comfortable chair and included copies of Business Weekly, Parents, Parenting, Carolina Parent, Carolina Woman and a Duke Health care system publication “Health and Healing.” It also contained a copy of “The Black Pages,” a directory of African American owned and operated businesses in the triangle. Women’s and Men’s restrooms are located to the right, just before you approach the large reception desk.

Women who Visit this Practice

According to Dr. A and my own observations, the Durham office serves a 70-80% African American clientele. On many occasions, I was the only woman of European descent in the waiting room. For those who are not teenagers, most are married, have graduated from high school and have had some post-secondary education. The Durham office serves the majority of Latina women who visit this practice, perhaps due to the native Spanish-speaking receptionist and physician assistant in the office. The Chapel Hill office tends to serve a half and half split of African American—European American/Asian women. These clients also tend to be married, college-educated and employed. Overall, the practice serves approximately 12-14% Medicaid recipients who are generally single, young, high school-educated African American women.79

The reputation of this practice in African American communities, local and extended, is both impeccable and powerful. Many of the women who grew up in the area come to this practice because their mothers, sisters, aunts, friends and even grandmothers have been

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79 See p.78: Recruiting and Profile of Women who Participated for the description of women in this study.
coming here for their own care. There are also a number of young women referred by a local historically black college, North Carolina Central University.

Profile of Physicians, Staff and Clinic Setting

Dr. J

There are six physicians who travel between the two practices and all but Dr. H are African American. Dr. J and Dr. X are the co-founders and have been close friends since they began the practice in 1983. Dr. J hails from Durham and according to other staff, knows most of the “old Durham” African American families. He completed his undergraduate education at North Carolina Central University and his medical degree at Wake Forest University Bowman Gray Medical School. After completing his residency in Tennessee, he returned to Durham to partner with Dr. X in this now-thriving medical practice. He is married and is the father of two sons and a daughter.

Dr. J is a “no bones about it” kind of guy who speaks his mind clearly, loudly and generally with a sharp sense of humor. He smiles often beneath a get-down-to-business and don’t-mess-with-me veneer. I remember being more than a little intimidated by his presence at first and later realized that Dr. J took great delight in such responses.

We all eat, and Dr. J jokes with all of us. He goes on call tonight, so he attempts to fill up on healthy food before heading to the hospital. Dr. H later says he has been known to “terrorize” young residents in the hospital. She says that if they can survive him, they all grow to love him. His sense of humor is omnipresent in the office and everyone teases him in return. (Field Notes, November 20, 2002)

Always impeccably dressed, Dr. J’s round face is accented with a gray-black moustache and short patch of beard beneath his lips. His tinted glasses shade deep brown eyes that become devilish when poking fun at his long-time friend and colleague, Dr. X. Although not
particularly tall, Dr. J is a commanding presence. His deep voice echoes in the walls of the practice, and yet turns soft and reassuring when addressing his patients. Born and raised in Durham, he is known among patients and staff for having a sharp sense of humor and commented one day while I was sitting in his midst, “You’ve got to have tough skin to work in this place!” Throughout my time here, I have had numerous conversations with Dr. J about politics, African American life, women’s health, economics and American social life. Like Dr. X, it has been clear to me that Dr. J loves his work and communicates incredibly well with his patients and his staff. And he never minces words.

Dr. X

Dr. X was born and raised in the coastal town of Elizabeth City, N.C.—a predominantly African American part of the state—and completed his undergraduate and medical degrees at the University of North Carolina at Chapel Hill. He believes he was shunned by his alma mater because of being African American, and as such he attended Duke University for medical residency. Regardless, Dr. X remains a staunch UNC Tarheel fan. He is the father of two sons, now in their late teens and early-twenties, and is married to their mother who is also a physician.

When I first met Dr. X, I was impressed by his stature. He stands about 6 feet 3 or 4 inches tall and is not a slender man. Rectangular spectacles rest beyond the bridge of his moustached nose, giving him a professorial air. His physical presence was intimidating at first, but soon after I met him I began to understand why staff referred to him as a “big teddy bear.” He has a soft southern accent and polite demeanor that I associate with southerners I know. He also appreciates the art of quick-wit and humor that he and Dr. J engage in each
time they see one another at the nurses’ station. The friendly goading reveals an enduring more-than-professional relationship. Dr. X and I also had many conversations, often revolving around Carolina basketball, but also about “American values,” African American culture and politics of health care. His patients adore him and he has cared for generations of women from the same families.

Dr. V

Dr. V is closer to me in age than Drs. X and J and she was my initial contact with this practice. Dr. V also attended the University of North Carolina at Chapel Hill where she earned her undergraduate and medical degrees and public health masters. After completing her residency at the Medical College of Georgia, she joined this practice as the second African American female physician in 1996. Tall with impeccably-styled hair and bright lipstick, Dr. V has a business-like demeanor juxtaposed by her easy and soft laugh.

Dr. V’s patients love her. Of all of the physicians, I observed that she connected with her patients in more openly friendly ways, calling them “girlfriend” and expressing herself in African American linguistic patterns—what one of my consultants called “a second language”—as they would exit exam rooms together, often laughing. Dr. V had her share of pregnancy difficulties and agreed to an interview about her own pregnancy spent on bed rest and the very premature delivery of her son (24 weeks) after six miscarriages. When we met, she explained that her son was “four years old and I’ll never go back to zero!” To this day, she believes that her son’s survival was a miracle and that he is exceptionally blessed as a result of his ordeal. Dr. V remained my contact over the course of this study and was incredibly supportive of the research.
**Dr. T**

Dr. T was the most difficult physician for me to get to know initially. She was the first female physician to join the practice now fourteen years ago. She completed her undergraduate degree at North Carolina Central University and her medical degree at Duke University. After completing her residency at West Virginia University Medical School, Dr. T returned to Durham in 1989.

In our first several meetings, I could only see Dr. T’s salt and pepper hair and top edges of her spectacles as she barely looked up from her charts. She initially seemed disinterested in my presence and the research, but we grew to appreciate one another through our discussions around African American films and music. Of all of the physicians, Dr. T was most explicit in talking about her understandings of race. During one of our interviews, she explained that she felt there were genetic differences between African Americans and whites that promoted preterm labor.

Dr. T’s hardened exterior did not go unnoticed by her co-workers. Despite her seeming gruffness, Dr. T’s patients appreciated her “all-business” approach and her devotion to “the facts.” To quote one consultant, women who weren’t “looking for a friend” found her to be perfect as their physician.

**Dr. H**

Dr. H is the most recent female physician to become part of the practice, joining in 2000, and is the only non-African American M.D. She is of Korean and Japanese descent, grew up in Chapel Hill and is the mother of two children. She received her medical degree from Duke University and completed her residency at the University of Texas, San Antonio.
Dr. H talked with me often about her perspectives on racialized inequalities in preterm labor. She wondered why so many young, African American women would refuse childbirth education classes, as was her professional impression. Of all the physicians, Dr. H believed in and promoted childbirth education among her patients. If women refused to sign up, she would spend extra time during appointments “counseling” them so they would prepare themselves for labor and delivery. She also believes that there are anatomical differences in pelvic shape between African Americans and people of European descent that may promote preterm labor.

Despite her petite frame, Dr. H is a commanding presence when she speaks about her work. Women who choose to see her appreciate her attention to detail and command of scientific knowledge. Despite being a “cultural outsider,” she feels completely at ease in this practice and believes it is the best environment in which she has practiced. She attributes her perceptions to Dr. J’s and Dr. X’s struggles to gain acceptance in their field as African American physicians and is pleased she is not working with doctors who practice medicine “as a sense of entitlement.”

Dr. R

Dr. R started at the practice the same month I did—April, 2002. He attended North Carolina Central University and earned his medical degree at East Carolina University in Greenville, N.C. before completing his residency at Sinai Hospital in Baltimore. Dr. R was an associate professor at Emory University’s Department of Obstetrics and Gynecology and moved back to Durham to be closer to his child from a previous marriage. During his first
months at the practice, he married his second wife and moved into a home they built in Durham.

Tall and handsome, Dr. R is well-known for his warm personality and friendly approach. Those women who choose him as their primary GYN love him. As a new member of the practice just beginning to build a client base in gynecology, Dr. R seemed to have little trouble acquiring new patients. He smiled and joked often, putting many women at ease within minutes of meeting him.

Dr. R’s thoughts on preterm labor revolved around his belief that more African American women are single mothers who have to work and who most often don’t live near their extended families. He feels that because they must work, they are unable to care for themselves should problems arise. Contrary to his generally personable and warm demeanor, I observed his disdain for Medicaid recipients on more than one occasion. In several conversations about class, Dr. R maintained that he didn’t like to treat Medicaid patients and that the practice suffered as a result of treating too many women on public assistance.

Other Clinicians

Women may visit one of three physician assistants (PAs) during their obstetric care, although none of the PAs are present at deliveries. All three clinicians are female—two European Americans and one Mexican American—two of whom are fluent in Spanish. During my tenure at the office, only one PA had full-time status while the others would work one day per week or less.

Originally from West Virginia, Ms. C is four years my junior and is the mother of three young children. She continues to work full time at the practice and, at the time of the study,
worked most frequently in Chapel Hill where she lived. Ms. C continues to take great interest in this study and commented frequently on her own observations as a clinician in the practice. Also relatively new to the practice, she and I spoke often about African American women’s perceptions of her as a white woman within the OB-GYN setting. She wondered whether some women would prefer an African American clinician and were perhaps disappointed when they met her.

Despite these insecurities, Ms. C is well-liked by her patients. She is approachable, friendly and beams a smile at everyone who comes through the office. She is also the only clinician who openly expressed distress when she had difficult days with her patients. During one particular week in the office, Ms. C saw several women who were planning abortions and another who had a late miscarriage. She was overwhelmed by the weight of their experiences and expressed how difficult OB-GYN can be, hinting at the life and death nature of birth.

Staff

There are approximately fifty staff members who help to operate both offices. Each office has a nurse manager who is in charge of maintaining the flow of patients through the office during the day, stocking shelves, and performing nursing duties. Ms. S at the Durham office is an older African American woman who runs the office much like a military sergeant. She has a gruff personality but is well respected and has been working with the group for over ten years. Ms. L, of European descent, manages the Chapel Hill office and was an energetic advocate for this study. A childbirth educator since the 1970’s, she would mention this work to women in her childbirth education classes and was sure to point me toward women who
came through the office who were candidates for the study. Despite having terminal cancer, Ms. L never seemed to run out of energy. In her now second year with a terminal diagnosis, she still teaches childbirth education and works at the office once per week. Ms. L and Ms. S did not get along well and during my stay tension between the two offices was omnipresent.

The majority of the receptionists and nurses at both offices are African American. There is one Latina receptionist and two others of European descent most often seated behind the desks in Durham. When I commented that most patients are greeted by African American women at the desk, Dr. X reminds me that this is just “how it happens to be right now,” because they strive to present a multicultural atmosphere to appeal to all women in the area. In my discussion with both Dr. X and Dr. J regarding the practice’s logo, they had discussed how important it was to have a picture of a woman who could be “any woman.”

Clinic Setting

One word best describes this Durham office—busy. The flow of patients to and from the desk, in and out of the door leading to exam rooms, back and forth from the restrooms, mothers walking with children or entertaining them as best they can while waiting created, day in and day out, a quick tempo and feeling of comfort and assuredness. In other words, with this many clients, these guys must be good. Overall, this practice serves approximately six hundred pregnant women per year and, in my observation, anywhere from seventy-five to one hundred women per day between the two offices.

The three or four headset-crowned receptionists manning phones and attending to patients entering and exiting the practice spoke to the commitment to professionalism that the

80 The logo consists of a curved-line silhouette of a woman who, to my eyes, appears African American.
physicians here often spoke about with me. Behind the desk are shelves upon shelves of folders with multicolored tabs, each containing the medical history of a particular woman. Apart from the few spouses, partners and male relatives of women who come here, the only males I saw in the waiting room were behind the desk—two young African American men, diligently moving back and forth from the shelves and disappearing into the stacks. I would come to know them as the records keepers, in charge of maintaining the massive collection of files at this office. Although I spent the first month observing the waiting room, Dr. V suggested I move back to the exam rooms in order to recruit women into the study. I stationed myself at the nurses’ station where I was able to observe the comings and goings of patients and doctors and invite women to participate.

The Chapel Hill office—in operation in this particular location since April, 2002—worked hard to keep up with the busy atmosphere of its Durham partner. Although there had been an office previously in the town, sandwiched between a Pizza Hut and the Chapel Hill Chamber of Commerce in a building with scarce office space, the physicians looked forward to the opening of the new location that would afford them more space and a more modern appeal. The office itself is in a seemingly odd place—near the edge of a recently built planned community approximately three miles east of downtown toward Durham. The development is filled with high-end homes ranging from apartments, lofts and bungalows to Georgetown-esque row houses and 4,000 square foot single family homes. A large senior complex with single-level cottages that are walking distance to a large, state of the art “wellness center” speak to the number of retirees moving to the area. A miniature downtown with red brick walkways encircles a large central fountain. Café tables are clustered just

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81 The practice had just moved into this space when I began the study.
beyond the roundabout that one passes through to visit the practice. Most of the problems encountered by this office in the first year involved people getting lost on their way, or lost once they entered the development. I was asked several times to give directions over the phone—as Chapel Hill was my then-home base—and I fielded many complaints from women about its location.

This office is also not connected to any hospital but rather is housed in a two-story red brick building on the same floor as an insurance company and a cardiac care center. Upon entering the office door, a patient is greeted by a beeping sound, alerting the staff that someone has arrived. The waiting room is much cozier than the Durham office, with an aesthetic that belongs to the new millennium—the low lighting, dark cream walls and warm earth tones of deep red, bronze and sage green furnishings lend a womb-like atmosphere to the small space. Just to the right of the cushioned high-back waiting chairs is the reception desk. The regular staff at this office during my stay consisted of two African American receptionists, an African American lab manager and two European American nurses.

Women follow a cheery yellow corridor past an ultrasound room, then a small private room with a phone and two deep rose colored chairs seated near a round table, to the lab area where their weight will be taken. Before entering the hallway to exam rooms, women walk past a large photo collage of babies delivered through this practice. Below it hang several flyers announcing labor and delivery tours, childbirth education and breastfeeding classes, my research and other studies recruiting pregnant women. I began my time at the Chapel Hill office in one of the exam rooms in the back but would soon move to the nurses’ station to become more involved in the daily lives of the people in the practice. My first observations
of exam rooms in both offices will seem familiar to many women who have visited a
gynecologist for care:

It’s a standard gynecological exam room. One chair, one rolling stool, a papered
exam table and long-necked lamp, a biohazard waste bucket and trash can and a
sink/counter with boxes of latex gloves, KY jelly and Kleenex. There’s health
information about vaginal yeast infections and a magazine entitled “Managing
Menopause.” Faces on the literature are of white women. The bright overhead lights
undermine the warmth of the earth tones that cover the walls, cabinets and chair. It
seems as though so much effort is made to create a warm inviting atmosphere, but
the cold glare of an exam room is still the cold glare of an exam room. (Field Notes,
May 24, 2002)

The nursing station itself is a magnet for stories of all stripes. It is where the lives
of patients, families, practitioners and myself all meet. We talk about medical
histories, whisper medical information and publicize our own experiences, thoughts
and feelings about the worlds of which we are a part. It’s an open space where the
flow of patients is easy and smooth and where all staff converge when they want to
“chat.” Nurses often come back to chat about work, kids, thoughts on movies, etc.
The more relaxed velocity as opposed to the Durham office—promoted an easy-
going atmosphere and genuine comfort. (Field Notes October 31, 2002)

As in the Durham office, music fills the air amidst the beeping of the front door and hum
of the air conditioning. The playful notes promote an informal and easy-going atmosphere
where physicians can joke with a woman client or ask about her family or why they didn’t
see her at church on Sunday. Notably, Dr. J and Dr. X have this kind of rapport with women
whom they refer to as “clients” “patients” and “friends,” revealing both a devotion to
professionalism and intimate knowledge of these women’s lives. It was Dizzy Gillespie’s
trumpet on this day…

On Wednesday mornings, there is an all-physician meeting in Durham, so the
office doesn’t get busy until 10:30 or so. …I emerge from the library after talking
with a woman for about an hour. The receptionist comes in during the interview to
collect two more chairs. The waiting room is overflowing. The jazz overhead is
contributing to a frenzied feeling today. I can hear the busy waiting room and the
nurses station is bustling. I hear a little girl talking happily and loudly to herself
behind one of the exam doors. One by one, exam room doors open and shut as if in
concert with one another. Almost all of the red lights on the wall above the desk
(indicating exam rooms are occupied) are flashing. Dr. V still has time to smile and
laugh with a young African American nurse intern. Another nurse rushes back to the desk, smiles and says “breath!” Nurse Linda greets everyone with “Hello Ladybug” “What can I do for you Sugarpie?” in her slow southern drawl. Dr. V emerges from an exam room, looks my way and says, “She’s white” and laughingly adds, “I’m getting the hang of this!” (Field Notes, July 3, 2002).

Oral Histories of Local Practice

As is always the case when Dr. J is at the practice, jazz plays (somewhat loudly) in the background. I sit down in the leather chair opposite his desk. The office has a warmth made cozier by the many knickknacks, books, and pictures that crowd his small space. I explain how many women we have recruited into the study and he offers suggestions to speed up the recruiting. (Field Notes November 6, 2002)

This practice, situated in both a southern university town and larger urban center is affiliated with a large regional hospital that forms part of a university-wide health care system. Despite its affiliations with such bureaucratic organizations, I observed that the OB-GYN group operates as a private practice with all of the southern charm one might expect. I noted that this was due in great part to its co-founders, Dr. J and Dr. X.

In July of 2003, Dr. J and Dr. X celebrated at a gala affair their twentieth anniversary of practicing together. In 1983, Dr. X called Dr. J while he was still living in Tennessee and proposed they go into business together. Dr. X had difficulties finding a practice that would hire him which, he felt, was because he was African American. For this reason, combined with a desire to serve his “own community” who had suffered for quality health care for generations, he decided he would open his own practice.

They had never met, but Dr. X’s father knew Dr. J’s brother and decided the two should meet. When I asked why he decided to partner with Dr. X, he replied that there wasn’t a private practice that would hire him. When he met with Dr. J and realized how similar their philosophies of care were, he decided to move back to Durham. He is noticeably proud when he talks of what he and Dr. J overcame to build this practice.
Even in the face of all the things people told us. And that is, you can’t make a living here. You guys need to go somewhere else.... because at the time there was only one black OB-GYN in the city of Durham. This is nineteen eighty-three.

...There was one black OB-GYN the rest were all white doing all the deliveries in Durham County. That is in Duke Hospital, Durham Regional Hospital all those hospitals. Nineteen eighty-three.

Dr. X explained that he was explicitly not hired because he was African American.

Well, even though I had gone to the best schools the state has, access as far as job opportunity was very limited. I mean let’s face it, there weren’t many groups who were willing to hire a minority physician. Still aren’t. And with UNC and Duke training.

Dr. J explained that they encountered a great deal of resistance from other practices in the area, and even other “black physicians” told them they would “starve” for lack of a client base. But this just fueled their desire to succeed.

…Our intent when we started the practice and I’m gonna use this word, dominate OB-GYN. And that’s been our driving philosophy to not lose our personality is part of it. We still have that fire burning and every move is a good move and we’ve always been in front of every other practice around.

Dr. J feels this attitude is still present among other physicians but the tremendous success of his practice gives him not only an overwhelming sense of pride, but satisfaction that he has proved his detractors wrong.

It does, it makes us feel really good when everybody including the well-established groups that have been here for 35, 40 plus years wondered how we ever made a living. They said that to us openly. We had one guy and I’ll quote him directly said…“now, I don’t know how you boys eat.” …So now we’re just kicking their ass all over the place. And you see it’s just stuff like that that fuels, drives me every day. To come in here and do the work. It’s just that I know and he (Dr. X) knows, and our young partners don’t know but we’re trying to educate them that there are still people who don’t want us here even in 2002.

Once Dr. J and Dr. X decided to go into practice together, they encountered further resistance from banks. Dr. X explained they were rejected by thirteen banks and that the only
reason they were offered a loan was because of a chance conversation between his former professor and his neighbor, a vice president of a local bank.

Both Dr. J and Dr. X believe that they have an obligation to serve African American communities “because we will serve our community better than anybody else” (Dr. J). Dr. J believes that as an African American physician, he has a more intimate knowledge of African American life and this aids in patient rapport and generates feelings of comfort for women that her provider knows the “negative things” and doesn’t need to probe. He feels this comfort is especially felt among his economic class peers.

We know how you think. We know what you feel when you look in the mirror. We know all the negative things. No matter how much money you have, no matter where you train there are just certain things I innately know that make you and I exactly alike, no matter what. And we don’t even have to explore those. Unless you just feel a little need to. I don’t have to get to know you because I already know you. …and I enjoy seeing all patients—but especially upper crust black movers and shakers because I feel they’ve come through a lot and worked hard the same way they’re sort of moving all of us along so we have that common bond, common motivation, common drive, common sense of accomplishment all of that.

He also sees his practice as an opportunity and obligation for educating young African Americans in the economic and professional possibilities that can exist for them.

… so what we’re trying to do is get people a dose of reality and this is reality every day. So it could help you as a child growing up if you knew there were people like you who did these things that you had contact with for years and years. A black dentist, a black doctor, a black pharmacist, a black psychologist, a black minister, all that you see. But you have to be able to get inside of the heads of kids early on so that they don’t even think that they can’t do anything. Because the truth is they can. So when these other naysayers out there say you can’t do you know it’s not real and those are not the people who can limit you. You are the only limiting factor.

Dr. X acknowledges that he wants to do “best” in the African American community, but he also views the practice as a business, as does Dr. J. As such, they have taken care to promote themselves as a practice that serves all women and have hired three staff members (two clinicians) who are fluent in Spanish. Dr. X explains that they “took a lot of heat from
the black community” when they decided not to put their Durham office in an almost exclusively African American neighborhood.

Absolutely, but not totally. We wanted to do well in the African American community, and I think that if the last thing…that we do well is that, I’ll be very happy. On the other hand, I think economically you have to see, we like to do well in the African American community because that’s who we are and what we do but on the other hand, to survive the economics of medicine we have to take care of a broad cut of whoever’s out there. And that’s what we’ve decided to do, which was a tough thing. We got a lot of heat from the black community when we decided to put an office near Durham Regional Hospital rather than over near Fayetteville Street. You know, if I had an office on Fayetteville Street I wouldn’t have anything other than black patients. Patients are consumers.

Like Dr. J, he felt that be being African American, he could have conversations with women clients that they might not otherwise have with another physician. He explained that although he is a doctor, he can walk across class lines in African American communities and still feel as though he is part of their communities in a powerful way.

… you have to understand, I know that a patient from Few Gardens puts her children in the bathtub at night because she thinks a bullet won’t penetrate that. And so…a white doctor who doesn’t understand what the projects are may not really understand how to relate to what that patient’s problems are. For example, we all have schedules, but if a patient comes late they want to know are you going to see them. Well, you gotta understand why they’re late. If this lady rides the bus, the bus runs on schedule and she may not get to the office on time, and she may not be on time if she has to walk from the bus stop. So I think there are things that people just inherently feel more comfortable with. … I mean still I do think the care that sometimes people get is different. So I think it’s a matter of comfort but it’s also a matter of understanding some of the nuances…it’s like me, I can go to country club and I can go to the ghetto.

His understanding of the plights of poor women has informed Dr. X’s desire to serve them in his practice. As he recalls the history of segregated hospitals and the legacy of poor care given to African Americans, he believes it is his duty to provide excellent care to poorer women.

We’re here to take care of patients. This is a business, but we have from day one…we try to make even our patients who are poor feel comfortable. So you know

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it’s an educational process. After a few visits to your office, people who usually, say if they’re used to going to the clinic used to taking the whole family and the dog. They get re-educated to the fact that hey, I can’t take 15 family members with me to the doctor and take up the whole waiting room. You don’t have to say anything. They just do that but at the same time you have to make them not feel uncomfortable. And I think that’s part of what limits access to health care sometimes is people feeling uncomfortable. And on the other side, the millionaire folks have to put up with patients that they feel are less desirable but that’s a issue with them and not us. We treat everybody the same.

Finally, Dr. X elaborates on specific perils of working as a male gynecologist in “the black community.”

…In gynecology, I think sometime…you more or less isolate yourself socially so those lines never blur because one of the worst you could do God knows as a gynecologist in the black community would be to have an affair or something like that. It would be devastating. It’s not necessarily the women, it’s their spouses who are a little bit unsure as to what gynecologists do. That’s why we welcome them to come…bring ‘em come and see what we do. So I think there’s a fine line to walk in the black community because I think a lot of black patients have come to expect something less than absolute professionalism and we’ve worked very hard on the other hand to maintain…and sometimes like I said socially it might…makes it a little harder, but that’s what we’ve chosen to do. …I just think that I wouldn’t feel I’d done a good job if we hadn’t done the best job we could do in the African American community cause that’s who we are.

With this historical backdrop in mind, I will now move to presenting the voices of women who participated in the study. The material that follows includes an overview of the women who participated in this study and a review of the major themes in their lives. Following this brief synopsis is a chapter that includes the narratives from extensive life history interviews with six women. It is important to note that these women do not speak for all African American female experiences. Further, it is not my aim to generalize their experiences but rather to present the themes they have generated and discussed as being important in their lives to broadly reflect a range of African American experiences as they relate to pregnancy, childbirth and motherhood.
Chapter Six

Women Who Participated in this Study

Overall, the clinicians in the practice were very supportive of this study. They allowed me to interview women in exam rooms and conference rooms in the office, aiding me in recruiting women into the study providing a space for quiet conversation during prenatal visits. As such, I had a tremendous response to the flyers in the first months of the research as many women approached me about the study. I was able to recruit sixty-two women into the study whom I will describe below. I will also describe some of the major themes in these women’s lives that later informed conversations with life historians and other findings related to experiences if pregnancy, childbirth and motherhood.

All but two of the sixty-two women who participated in this study visited one of the two OB-GYN offices described in Chapter Five for their prenatal, delivery and postpartum care. This was an opportunistic sample of African American women who received care at this local practice between April 2002 and July 2003 and consented to be interviewed. The overwhelming majority of women worked and resided in Durham and approximately 70% are native to the area. At the time of our first interview, five women had already delivered their babies while all others were at varying stages of pregnancy.

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82 See Table 6.1, p.121 for selected sociodemographic variables of each sample of women. See Table 6.2, p.123 for selected birth characteristics of each sample of women. See Table 6.3, p.125 for a comparison of pregnancy outcomes from this group of women; overall statistics from the OB-GYN practice and for African American and European American women at the North Carolina state and U.S. national levels.

83 One woman was a staff member at this practice but delivered her baby with another medical group in Durham. One woman transferred to another practice just weeks prior to her delivery.
Table 6.1 below shows some selected sociodemographic characteristics of the larger group of women and smaller subsamples used in this analysis. The age range of participants spanned 19 to 43 years with a total of six women over the age of thirty-five. Several of the youngest women were specifically referred to this practice by the historically black university they attended. The mean age of women in the group was 28.9 years and women had an average of 2.89 years of college education. Of the total, forty women were married (64.5%) and but three worked outside the home. They were employed in a wide range of occupations, some of which included: nurse, doctor, department store manager, bus driver, home caregiver, teacher, data analyst, student, lawyer and engineer. Approximately 13% received Medicaid assistance. Women had an average parity of 1.8, reflecting the common experience of having one child already in the home while pregnant with a second baby.

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (N=62)</th>
<th>Subsample (N=20)</th>
<th>Life Historians (N=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age (Age Range)</td>
<td>28.9 (19-43)</td>
<td>28.62 (21-39)</td>
<td>30.83 (28-35)</td>
</tr>
<tr>
<td>Mean College Education (years)</td>
<td>2.89</td>
<td>3.25</td>
<td>2.8</td>
</tr>
<tr>
<td>% Married (number)</td>
<td>64.5 (40)</td>
<td>70 (14)</td>
<td>83 (5)</td>
</tr>
<tr>
<td>% Medicaid Recipients (number)</td>
<td>12.9 (8)</td>
<td>15 (3)</td>
<td>16.6 (1)</td>
</tr>
<tr>
<td>Parity (number of children including current pregnancy)</td>
<td>1.8</td>
<td>2.05</td>
<td>2</td>
</tr>
</tbody>
</table>

I selected a subsample of twenty women from the larger group of sixty-two who completed one to three interviews over the course of their pregnancies. None of these women participated in the life histories, but I came to know several of these women quite well over
the duration of the study and hours of conversation with this group informed the larger
discussions I had with life historians. This smaller sample does not differ greatly from the
total group of women in terms of sociodemographic profile. The age range of this group was
21-39 years with a mean age of 28.6. On average, these women had more years of college
education (3.25) and slightly more (70%) were married. Three women received Medicaid
assistance (15%). These women also had an average of two children including the baby they
were carrying at the time of our interviews.

Life historians will be described in more detail in Chapter Seven. They tended to be
women who were slightly older than those in the larger samples (mean age of 30.83) and all
but one were married (83%). They were women who had achieved nearly three years of
college education on average, similar to the larger samples, and also had two children. One
woman received Medicaid assistance.

As mentioned earlier, this study began as an exploration of the factors that may contribute
to preterm labor and delivery, low birthweight and infant mortality. Although in terms of
outcomes I did not interview a large number of women who experienced these phenomena,
this study can contribute to understanding experiences in African American women’s lives
that can adversely affect pregnancy including those pregnancy experiences mentioned above.
As such, I collected information on each of these experiences over the course of the study.
Table 6.2 shows some selected birth characteristics of women who participated in the study.
Table 6.2
Selected Birth Characteristics of Women in the Study*

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (N=62)</th>
<th>Subsample (N=20)</th>
<th>Life Historians (N=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Birthweight</strong></td>
<td>7lbs. 1oz.</td>
<td>7lbs. 0oz.</td>
<td>6.7lbs. 7oz.</td>
</tr>
<tr>
<td><strong>% Known Preterm Labor (number)</strong></td>
<td>11.3 (7)</td>
<td>15 (3)</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td><strong>% Known Preterm Delivery (number)</strong></td>
<td>4.8 (3)</td>
<td>5 (1)</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(33 weeks, earliest)</td>
</tr>
<tr>
<td><strong>% Known Low Birthweight Baby (number)</strong></td>
<td>8.1 (5)</td>
<td>0</td>
<td>33.3 (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(5lbs. 4oz., lowest)</td>
</tr>
<tr>
<td>Known Infant Loss</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Approximate values based on known birth weights and deliveries only. Values for life historians are exact.

Of the deliveries I was able to document through interviews, phone conversations and personal observations, there were no infant deaths in the entire group of women and all but five delivered healthy birthweight babies (mean birth weight 7lbs. 1oz.). Seven women experienced preterm labor and three also delivered their babies preterm, with the earliest delivery at thirty-three weeks. Average birthweight for the subsample of twenty women did not differ greatly from the larger sample (7lbs. 0oz.) and three of the seven women who experienced preterm labor are included in this group. One of the three preterm deliveries is also in this group, occurring at thirty-four weeks gestation.

Life historians had a slightly lower average birthweight (6.7lbs. 7oz.) and include one woman who experienced preterm labor, one woman who experienced preterm delivery\(^{84}\) and

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\(^{84}\) This woman underwent a Cesarean-section birth due to complications. She did not experience preterm labor.
two women who delivered low birthweight babies—one delivered at thirty-three weeks and one delivered at thirty-seven weeks.

Table 6.3 compares pregnancy outcomes of the sixty-two women who participated in this study in terms of preterm labor and delivery, low birthweight and infant mortality with outcomes among African American and European American women in North Carolina and the U.S. I have also included overall statistics from the OB-GYN practice in which this work is conducted, but it is important to note that information on race of mother is not collected in this practice in association with birth outcomes.
Table 6.3
Comparison of Pregnancy Outcomes for African Americans (AFAM) and European Americans (EUAM)

<table>
<thead>
<tr>
<th></th>
<th>THIS STUDY AFAM</th>
<th>NC* AFAM</th>
<th>NC* EUAM</th>
<th>U.S.* AFAM</th>
<th>U.S.* EUAM</th>
<th>OB-GYN Practice**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm Labor**</td>
<td>11%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Preterm Delivery</td>
<td>4.8%</td>
<td>18.5%</td>
<td>11.6%</td>
<td>17.4%</td>
<td>10.9%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Low Birthweight</td>
<td>8%</td>
<td>13.8%</td>
<td>7.5%</td>
<td>13.1%</td>
<td>6.7%</td>
<td>&gt;1.9%</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>0</td>
<td>15.1</td>
<td>6.6</td>
<td>13.6</td>
<td>5.7</td>
<td>0.003 (1 recorded in 2003)</td>
</tr>
</tbody>
</table>

+ Approximate values based on known birth weights and deliveries only. Rate based on small number of women (N=62).
++ Statistics for the local practice in which this work was done. Information on race of mother is not collected in relation to statistics. Numbers based on 583 deliveries in 2003.
+++ Birthweight is recorded as less than 5lbs; 5-6lbs. The latter category includes some low birthweight babies.
** No statistics are compiled for preterm labor.

Major Themes

Although my analysis is rooted in conversations with six life historians, themes that emerged from many discussions with other consultants guided my conversations with them and contributed greatly to understanding a wide range of experiences of pregnancy and motherhood within the parameters of racism, class experience and being an African American woman. The subsample of twenty women consists of those whom I got to know better over the course of the study either through multiple interviews, personal emails or phone conversations.
Themes that continued to emerge from this subsample, upon which I will elaborate more in Chapters Seven and Eight, included an overwhelming number of women who expressed fear of having a male child.\textsuperscript{85} Discussions around this issue led me to ask life historians whether they knew the sex of their unborn child and how they felt about having a boy or a girl. Many women who expressed fear of having a boy explained that it was difficult for them to imagine raising a “responsible” son and spoke about fears for a black male’s safety in a society that sees him as threatening. Discussions of “responsibility” almost always revolved around teaching a son how to treat women with “respect.” They also included discussions of building self-esteem in young African American men and their concern over how they were to accomplish this as women. Some married women explained that it would be their husband’s “job” to raise a “good black man”—an expression that emerged in many interviews over the course of this study.\textsuperscript{86} I noted that once women had their babies, these concerns faded but did not disappear.

As a result of these discussions around African American males, I engaged in lengthy conversations with life historians, and some women in this subsample of twenty, regarding male female relationships in African American cultural contexts. First, there were many women who explained that they were “blessed” to have a supportive husband in their lives. Many pointed to this as being essential to a healthy and safe pregnancy and an experience that afforded a pregnant African American mother some comfort when preparing to raise a son. Other themes that emerged from these discussions included unhappiness in marital

\textsuperscript{85} This is particularly interesting from a cross-cultural perspective where many Western societies prefer a boy. See Marleau, 2002.

\textsuperscript{86} Intrigued by the repetition of this phrase, I visited a website called “agoodblackman.com,” also mentioned in Cole and Guy-Sheftall’s \textit{Gender Talk}. The site, begun by an African American woman, is described as “an online magazine dedicated to honoring, uplifting and celebrating Black males.” From \url{www.agoodblackman.com}.
relationships, conflicts with husbands who were engaged in African American church life, conflicts with the fathers of their babies who were not living with the mothers and feelings of *incomplete* fatherhood concerning their own childhood and upbringing.

This concept of *incomplete fatherhood* (and also *incomplete motherhood* in some cases), as I explain in the introduction, refers to the physical or emotional absence from or only *partial presence* of a father (or mother) in a woman’s life that the woman experiences as a loss or sense of *incompleteness* as a person. Narratives that addressed these experiences often revolved around a woman’s unmet expectations of her own father (and/or mother) and the hurt she experienced as part of his *incomplete fathering*. Fathers who were physically absent were often still very present in the experiences of some women, particularly in conversations dealing with expectations of the baby’s father as a parent and spouse/partner.

I observed over the course of the study that there were almost predictable answers to questions of having a boy depending on a mother’s level of education or financial situation. The less educated and less financially stable a woman was, the more likely she was to *prefer* a boy and was usually expressed in terms of “not wanting a girl.” Reasons for this response remain unclear to me, but several consultants have explained why they feel there is this difference in gender preference. First, for educated, financially stable women there is a sense that they have done all they could to avoid a difficult and violent life for their children. Experiencing a violent everyday life is foreign to these mothers and as such they are more fearful of their child being influenced by others who might pull him into that world. Their unfamiliarity combined with their hard work to attain their own position in life breeds a fear that they will come into intimate contact with such a world through their sons. Second, there is a feeling among upper-class African American women in this study that poorer women
simply do not worry about these issues in favor of concentrating on their survival of a
difficult life.

I observed that those poorer women who desired a boy tended to do so in order to engage
the father of the baby in an active fathering according to their own specifications. These
women tended to be unmarried and young and were most concerned about the father
abandoning them during the pregnancy (which some were experiencing already), labor and
delivery of the child, and after. But I also observed among this same group that as much as
they wanted a boy, they were just as wishful they would not have a girl. Reasons almost
always involved not wanting a girl “like me” and reflected a low self-esteem embedded in
the mother’s understandings of being female. Tied to these feelings of low self worth were
discussions around their inability or lack of desire to “do hair” for a daughter. There has been
much work on the cultural significance of hair in African American culture (Banks, 2000;
Byrd and Tharps, 2001; Ebong, 2001). I noted that women who expressed an inability or lack
of desire to braid, plait or otherwise style their daughters’ hair, including a hairstylist, felt
that they would be unable to help their daughters present themselves to the world in such a
way as to promote a positive self-image and acceptance by their own cultural communities as
well as society at large.

Finally, women who had children out of wedlock were concerned that their daughters
would repeat “the same mistakes I did.” I observed a tremendous amount of shame in
mothers who were now in their late twenties and early thirties but who had borne children
out-of-wedlock in their teens and early twenties. These women tended to be concerned that a
daughter would have the same experience. There was a sense of a lack of control over such
events or a deeply held feeling that mothers would be unable to prevent such a “mistake” in their daughters’ lives.

The second major theme that emerged from conversations in the larger sample of women and that I will develop further in the next chapter was one that addressed their class experiences regardless of their ascribed class position. Mothers of all economic strata expressed feelings of disapproval of their pregnancies by both the larger society and members of African American communities. Pregnant African American women in this study tended to perceive and experience looks of disdain particularly in public space. Several women observed that people, namely women of African American or European American descent, looked for their wedding bands. When women outgrew their wedding rings over the course of a pregnancy, they became more intensely focused on these gazes.

That this experience occurred across all economic strata in this study sample of women was a finding that encouraged me to ask more in-depth questions around experiences of class and how it was felt during pregnancy. For many women who were economically successful and who had achieved some college education or a college degree, their pregnant bodies intensified a disruption of their own class histories and magnified their perceptions as women of lower class status. Several women invoked the powerful U.S. cultural image of a “black welfare queen” and explained that they had worked so hard to be successful and yet were reduced to this class status by virtue of their pregnancies.

I observed that many of my consultants experienced the world around them more intensely when they were pregnant—particularly as the pregnancy progressed. Some felt that those seemingly inconsequential issues and events in their lives that they would normally be equipped to deal with (e.g., aggravation in the workplace, racist comments, spouse’s lack of
help in the home) were instead magnified and more intensely felt experiences. This intensification was most often blamed on “raging hormones” during pregnancy.

**Other Themes**

I expand on the above themes in the life history narratives but I also noted a number of other themes that emerged from discussions with this subset of women and that deserve further exploration in future studies. Overall, women expressed “stress” in both medicalized and social terms. Some spoke of elevated blood pressure or increased levels of circulating hormones while others mentioned stress as the manifestation of feelings of loss of control.

In response to my question about differences between African American and European American women in terms of birth “outcomes” such as preterm delivery, women expressed a wide range of feelings and answers. Some believed in an added burden of history for African American women—a sense of owing to ancestors who endured tremendous violence and suffering in U.S. society. Others were most wounded by interpersonal relationships with fathers of their babies and their own fathers and mothers. Regarding the fathers of their babies, some women believed that “too much” was expected of African American men in a society that would not let them achieve those successes because of the color of his skin and male gender. Others contradicted this by saying there was “too little” expected of African American men so that if they “know their child’s name, I should be happy.”

There was often a perceived difference between European American women and African American women in terms of class experience in the context of work. Several women in this study presumed an upper class lifestyle for European American women and an idealized vision of the European American woman as stay-at-home mother who does not “have to
work.” It was further presumed that European American men make enough money so that their wives could stay home, whereas for African American women it was expected that one works in order to sustain the household financially. Reasons for this ranged from “being looked down on” by other African American women if one chose to stay at home to a sense of indebtedness to history. As one women put it: “…we have to prove ourselves, we have to do better than our forefathers. We have the tradition of all the sacrifices made by our families immediate and extended and those who were slaves to succeed. We owe it to them.” This woman, a genetic counselor with a Masters degree, saw it as her duty to “represent” her race in the act of working successfully outside the home.

Misperceptions of the range of class experiences of European American women and men were not limited to work. Some women commented on the experience of mothering as being related to one’s cultural background and class position. Mainstream (read, European American) middle class visions of pregnancy, childbirth and mothering dominate the streams of information in magazines, television and the worldwide web. Although it is questionable whether European American women experience pregnancy according to these expectations, I can say that many of my consultants have found little in common with these utopian experiences of pregnancy and motherhood.

Many consultants didn’t “feel happy” about their pregnancies, even though they are wanted babies. One woman remarked, “I don’t know why, but when I see black women who are pregnant they always look unhappy.” The performance of motherhood, especially in public spaces, in ways that are promoted in mainstream discourse is subject to criticisms from other African American mothers. When one consultant reprimanded her child at the shopping mall for being “grumpy,” she felt other African American mothers looked upon her
with scorn: “They think I’m mothering like a white woman.” For this woman, African American cultural norms suggested that physically disciplining children is the “correct” way to mother. She was being told, through disapproving looks of other mothers, that she was not conforming to those expectations.

The above experience brings into relief the intracultural politics of performing motherhood and points to additional strains on African American women to straddle the world of acceptance in African American communities and their own visions of what it means to be a “good mother.” In addition, the social pressures of performing pregnancy in “acceptable” ways forced some women to also bear the burden of becoming a “white middle class woman” and subsequent alienation from some members of the African American community. These pressures of performing pregnancy and motherhood according to widely accepted social norms placed additional strains on some African American women’s pregnancies. Tensions between local cultural norms and “white” motherhood weighed on women’s own experiences of motherhood and informed expectations of themselves as they mother.

Overall, pregnancy for this group of women affirmed the overarching framework of pregnancy as life process as women explained the experience of pregnancy as part of a continuum of mothering and fathering. Their own remembered experiences of childhood and adult life in relation to their own parents permeated their thoughts on motherhood and fatherhood as their pregnancies progressed. In addition, the large number of women in this study offered a range of experiences of racism and class and being an African American woman as they are lived and experienced and provides a more in-depth analysis of these
experiences rather than assuming a uniform *race consciousness* that Brush (2002) proposes we guard against.

Finally, and in the same manner as they provided insight into the array of experiences of *class* and *being an African American woman*, this group of women offered new ways of thinking about experiences of *racism*. Nearly all women expressed racism in terms of white and black relationships in the U.S., but complicated the way we in the U.S. may think about racism. For pregnant African American women who normally accept racist acts as “a fact of life,” concerns over the treatment, schooling and opportunities for success for their children brought into relief the lived realities of being African American in a racist society. For example, a large number of women commented that they were trying to choose names for their children that would not be read as “black” on an employment application. This applied to both male and female children. These mothers believed that a name that appeared “too black” alienated potential employers and would deny the child those economic and social opportunities that would help them to live a comfortable life.

Although there is not a European American comparison group for this study, I cannot help but draw from my own experiences as a mother to understand the limits of a “universal motherhood.” Experiences of pregnancy and motherhood, although not the same for any two women, are further informed by a mother’s experiences of *being an African American woman* and related experiences of *class* and *racism*. These themes guided my discussions with women who participated in the life history portion of this study and it is to their lives that I now turn.
A central thesis of this work is that the \textit{totality} of burdensome life experiences, due wholly or in part to one’s remembered experiences of being an African American woman and related experiences of class and racism, can impact the physiology of pregnancy in adverse ways. In addition, there are \textit{specific} felt experiences during the nine-month biological event that constitute, produce and otherwise inform understandings of ones lived worlds of being African American and female and related experiences of class and racism that come to bear on a woman’s pregnancy.

Understanding how these African American women have experienced and defined \textit{race}, class and gender over the course of their lives is crucial to understanding their own experiences of pregnancy and motherhood and can point to those aspects of African American women’s lives that may contribute to glaring inequalities in preterm births and low birthweight babies that contribute to higher infant mortalities. Although much has been published on the health consequences of what researchers have defined as \textit{racism} (Brandolo, 2003; Harrell, 2003; Jones, 2002; Krieger, 1993, 2000b; Mullings and Wali, 2001; Rich-Edwards, 2001), these narratives explore how \textit{race} and \textit{racism} are experienced and defined for this group of women and how these experiences articulate with female gender- and class
experiences in ways that may affect their pregnancies, including preterm delivery, delivery of a low birthweight baby or other complications.

Experiences of pregnancy and motherhood have brought into relief themes in individual women’s lives that they feel most impact them on a daily basis such as work-related negatively felt experiences and difficulties in maintaining a healthy marriage within a larger sociocultural context of being African American women. Within this sociocultural context, I will explore often negative conceptions of African American men, “burdens and blessings” of being African American and female, class experiences, and the demands and existential questions of motherhood. Having said this, I also argue that there are experiences in the everyday lives of African American women that can mitigate against adverse health effects and that these histories can provide information on what may be “going right” in their lives to promote healthy pregnancies and healthy birth weight babies.

The six women who agreed to participate in the life history portion of this research are between the ages of 28 and 35 and all but one are married. Three women have bachelor’s degrees or higher and two are currently working on undergraduate degrees. Their occupations vary widely and include an attorney, a cosmetologist, a medical supply buyer, a quality control specialist/Navy reservist, a medical technician-turned-divinity student and a clinical trials project manager. At the time of our first interviews, all of the women worked outside the home. Two women are native North Carolinians from Clinton/Durham and Raeford and one woman was raised in Fayetteville. Three are from urban centers including New Orleans, Baltimore, and Irvington, New Jersey by way of Washington, D.C. All six women currently live and work in Durham.
The dialogues included in this section are taken from much longer narratives that engaged in larger discussions about the meanings and experiences of being an African American woman and related experiences of class, and pregnancy, motherhood and male-female relations. I have included the following sections to specifically address how these conditions of life may have informed experiences of pregnancy and motherhood for these women.
Helene—A World in Black and White and Fears of Bearing a Boy

I always knew I was black. And my mother, being the person that she is, always told me that they were what the lucky people were (laugh). (Helene, July 2002)

Being in contact with injustice everyday has an effect. I think it changes who I am. So I wonder often, this baby that’s inside of me…I wonder about increased stressors, hormone levels with the baby… The truth tends to come out [in medical tests]…I am particularly concerned if this is a male child how to protect it and how to protect itself… (Helene, May, 2002)

The major themes in Helene’s narratives revolve around her intense consciousness of the spectrum of skin color and her ideas about men. She is also a woman with strong opinions of the opposite sex that are rarely flattering. Of the six life historians, Helene stands out most for her understandings of how she feels as a “black woman” in a race-conscious U.S. society. Our conversations centered on her own understandings of the “burdens and blessings” of being “black” and female and often emphasized how she sees herself in relation to African American men. Further, Helene articulated the most concern over bearing a male child. Helene delivered a low birthweight daughter at thirty-seven weeks after a very difficult pregnancy experience.

Helene began our first conversation by describing herself in these words, “You either love me or you wish I got hit by a big truck!” Originally from New Orleans Louisiana, Helene exudes personality, warmth and intellect. She curses freely throughout our interviews (much to the dismay of my transcriptionist), but informed me that she never takes the Lord’s name in vain. At five feet, 225 pounds, Helene told me, “I was always a big girl.” I would not have known she was eight months pregnant at our first meeting if not for her telling me this over the phone.

Helene is the mother of two young girls, now aged seven and three whom she absolutely adores: “They’re my heart with arms and legs.” Her husband of now ten years is from nearby
Fayetteville and is also her law partner. Helene is a defense attorney and former Durham District Attorney who established her own practice in the heart of what is known as “Black Wall Street” in downtown Durham. Her primary clients are young, African American male criminal offenders who have been charged with everything from theft to murder. We agreed to meet at her office even though she informed me when I got there that she was “technically on bed rest.”

“My parenting issues with both of my parents are real huge holes in me.”

Helene’s narratives about her parents come to bear specifically on her pregnancies as she (re-) imagines herself as a mother and considers the importance of a father in a young child’s life. Her life story begins with growing up poor in an all-African American neighborhood in New Orleans with an older sister with whom she is very close and her mother whom she describes as a tough woman who knows how to cuss. Her mother raised Helene and her sister as a single parent with the help of her own grandmother and yet persevered for ten years to finish a college degree at the University of New Orleans.

Helene comes from a long line of strong-willed women, including her great grandmother—her mother’s grandmother whom her mother calls, “Mama”—with whom she spent much of her youth. When we talk about her passing when Helene was sixteen, tears well in her eyes and it was clear to me that this woman meant a great deal to her. Helene describes how her great grandmother shaped her own ideas about being a woman:

Oh my God! Honey when I tell you that was a woman…That was a Wo-MAN! Whoo Jesus! Oh my God if I ever just get to that level of just uhm, at peace, whatever, bring it. If you got it, bring it! Fuck it - I’m gon’ deal with it! That was just her. And just, poor, black and couldn’t read and didn’t give a shit. Never saw her bow and scrape, never saw her scuffle. She…owned her own home, owned her own business, just was, you know, she found a way to get something out of nothing.
And just, you know, I’m so…I’m so proud to…to be from that that it just…Oh it just fills me with joy…Yeah she is so, honey, I’m talking about a woman. And I named my first-born daughter after her.

Helene, often painfully, recounts memories of her father, whom she is still in contact with and who lives in New Orleans not far from her mother who lives with her female partner of nearly sixteen years. Helene describes her father as a well-liked man who leads a meager existence in part due to his rather pathetic addiction to gambling. Helene’s stories of her relationship with her father are filled with disappointment in him and a profound sadness for the loss of a “devoted father” in her life.

Although her relationship with him is admittedly complex and despite the fact that he has yet to come to North Carolina to visit her daughters, she feels she doesn’t want to exclude him entirely from her life. However he has done little, in her memory, that she feels a father should have done for his children. She stops short of blaming him, but I sensed that she has tried to make sense of her father's behaviors because she still loves him and she knows he loves her even though he has let her down.

I tell people I have a whole momma and a half a daddy (laugh)! [My husband] he’s kind and he’s very gentle with them [their daughters], and he looks at them, and touches them and holds them like they are special and unique and to be treasured. And I just think, you know, I never had that with my father. And I can remember going to…[a] birthday party and [the girl’s] father had spent the day making her birthday cake from scratch. And…I could just, you know, to have a memory like that with my father and my father baking, baking my birthday cake…I mean I would have paid…I would pay cash money to be able to just go back into my memory and come up with something like that. You know, it’s just not there. You know, I just did not have that level of attention from him.

This caused her to lament the lack of such memories in her own childhood and to expand on the meanings embedded in such actions. She affirmed that she is working to save her marriage because of the devotion her husband has to their daughters. Helene revealed that if she had the kind of father her daughters have, she would be a different person: “I don’t even
want to think of the woman I would be if I had access to that kind of a dad.” When I asked her whether she thinks often of her relationship with her father, she responded, “It is something I think about. It’s a relationship I’m missing.”

Although she attempts to understand why her father has treated her with such indifference, Helene feels she has been scarred by his behavior in powerful ways. Further, although she has tremendous respect for her mother, Helene explained that her father is not the only parent who has left her wishing for a better childhood and more “complete” adulthood and how her parents’ incomplete parenting has shaped her own sense of who a mother should be.

There’s a real distance there, you know, that I’m not trying to bridge. And it’s the same with my mother. I sort of feel like…and it’s interesting but you know, if they’re not going to expend the energy then I shouldn’t be able to expend the energy. …I do feel like the same sex parent is the biggest influence on a child and I’m always very conscious of that with my children that, you know, that I’m teaching them a lot about their blackness, I’m teaching them a lot about their woman-ness, and I’m teaching them a lot about…you know, honor and character and what those things mean.

*Experiencing Pregnancy: “Pregnancy is hard for me between the ears.”*

Both of Helene’s pregnancies have occurred during what she considered stressful times in her life. Her first daughter was born during her tenure as District Attorney, a job Helene described as very stressful, and which she left during a difficult period to begin her own practice. Her second pregnancy began while she was experiencing marital strife, harassment at her office and intensive self-reflection. Although Helene talked about how much she loved being pregnant and how she equated those feelings with her love of motherhood, her pregnancies have been particularly difficult for her “between the ears” and she had been seeing a therapist for several months before we met.

I loved being pregnant. I physically loved being pregnant. I loved being a mother. Loved being a mother. And I’ve always been very excited about it.
...Pregnancy is hard on me between the ears. Physically it’s no problem. And... I had relatively healthy pregnancies. My blood pressure tends to go up from 37 weeks on. So I spent, with both of them, I spent the last two or three weeks in the bed.

In her third trimester of pregnancy, Helene still wasn’t “showing” and had a difficult time convincing co-workers that she was pregnant and wished they would have recognized this before she worked herself into being sick.

I don’t think that judges, clients expect any less out of me and the truth is I really am nine months pregnant and I need to be not working from 7am to 6 and so, I just really didn’t want to do some things this week and I think the stress of having to do those things anyway, I think I just made myself sick.

Although much less bothered by it, Helene also commented on how she felt others looked at her in public as a pregnant woman of African descent and the assumptions they made about her as a person.

...I’m sure when people look at me, when I was pregnant, they thought the same thing. Lord, another hoochie mamma… another hoochie mamma comin’ into the world! I mean what does she…what…what…Lord, have mercy! You know what I mean? Anoth…you know, she gonna be a grandmama at 31! You know? Who knows?

Helene suggested that it’s “the hormones” that she was overwhelmed by and she believed that events in her life are responsible for contributing to her hormonal responses. She recounted her mounting expenses in owning a home, maintaining a law practice and the weight of people’s futures that lay in her hands. Helene’s blood pressure began to rise during her thirty-sixth week of pregnancy and she understood that these stressful experiences in her life would adversely affect her pregnancy if she did not find some help. She described herself as “unraveling, at the ends…actually from the middle, outward!” when she finally visited a therapist.

And I took and take the obligation of pregnancy and nursing really really seriously, so I wanted to not only insist that my doctors give me good care but do everything I could to give her a chance and I just didn’t think it would be a healthy
pregnancy. And I was concerned about a person living inside of me that’s experiencing that much stress without a good outlook. I didn’t want her to be born nervous or not have a serene outlook, so I just really needed a little bit of help.

Higher blood pressure readings revealed to Helene that she had been under more stress than usual, since she felt she does not usually “internalize a lot of stress.” Helene described how she felt during her pregnancies and how she becomes a different person. She felt it affected how she thinks and she wonders what implications these experiences may have on her later reproductive life.

…Everything is more intense when I’m pregnant, but my reactions are slower. I think I react more emotionally when I’m pregnant. If someone let me down while I was pregnant, I would suffer and basically do my version of hand wringing… If I wasn’t pregnant I would either tell you to kiss my tail or confront you about it or do something. I just see myself as being a little bit less powerful somehow when I’m pregnant. I’m really not myself. And I don’t realize it when I’m pregnant. It’s only when I’m not pregnant and I look back and say, “Why didn’t I tell her to kiss my ass?”

_Fears about having a boy child: Expectations of Men and Wishful Thinking_

Helene’s relationships with her own parents have shaped the way she parents her own children and the expectations she has for her husband as a father. Throughout our conversations, Helene talked extensively about the impact a father can have on his children, particularly his daughters. She felt she would be a more “complete” person if she had a father who showed how much he loved her. Her feelings about her father bleed into her own expectations of fatherhood and, in a more general sense, her meager expectations of men.

But I certainly think just as far as happiness and completeness, I just think that women learn intrinsically, you know sort of what…what it means to be a woman, how men treat women, I think through interactions with their fathers a lot of times. And if your father looks at you like you’re a thing of value then you tend to expect other people to do that. I think mothers help that, you know …but I think one of them just carries a greater weight so I think when a man loves either a girl child or, you know, an almost a woman child, and teaches her that, you know, women are things of value to be respected, not just by other women because I always
understood that, that women needed to be bonded together, and that, you know, women united could do a whole lot of things. But the part about the interaction between men and...men and women, I didn’t have...I didn’t have that...and I think that if I had that, it would make me, a more complete person and that I think that I have very low expectations of men in general.

Helene explains that her own mother and grandmother did not possess positive examples of men when they were growing up. She feels that this has contributed substantially to her own attitudes toward men. She also explains that she is happy for her daughters because they do have an example of “positive maleness” in their father and simultaneously wonders how different she might be if she were to have had such experiences growing up.

It was interesting to me that during our many conversations, Helene would rarely speak about men in her life except when I explicitly asked. She explains that her relationship with her father is just one reason why she has come to expect little from men. Her ideas about marriage were also shaped by the lack of “good examples” of men—“It wasn’t just that my father wasn’t a particular good example, there weren’t any good examples”—and her mother who “leaned heavily toward the female spirit.”

These poor expectations of men have done more than color Helene’s ideas about fatherhood and marriage. Young African American boys cause her particular concern. During our first conversation, I asked whether Helene thought about the future of her children while she was pregnant. Immediately she explained her concern around having a boy.

Uh, I think about the future a lot for my children. I think about what kind of world they’ll grow up into. I think if it’s the...I think if I have a male child, what it...what it’ll be like to raise a black man and to do it well. I think about how the world will perceive him before he opens his mouth and what that means and I think about, you know, what if some yahoo sheriff when he’s driving up I-40 will, you know, stop him and blow his head off because he looked...or what...I mean...I think about a lot of things.
Helene felt that there were unique challenges to raising an African American son.

Oh Jesus yes! (laugh) I mean growing up in a country that doesn’t care for you very much is difficult. You know I mean they’re cute ‘til they’re about eight, and all of a sudden they become enemy number one. So yeah, yeah, I’m very concerned about that. And I don’t…I don’t see any point in diluting that reality. …I think that children, and people in general, live up to the expectation of what society places on them and I think the greatest injustice is really that you’re expected to be something just above…an animal and often that’s what you get.

I asked Helene whether she felt that being in contact with injustice each day in the courtroom and in her practice impacted her pregnancy in any way. Again, she responded with concern over raising a son who, she feels, will suffer dehumanization by society.

Oh, my God. …I think it changes who I am and so I wonder often, you know, this baby that’s inside of me, I’m thinking you know, I guess as a lawyer trained not to react externally but you react internally to things all the time and so I wonder about increased stressors. Hormone levels, with baby and…because I…I mean I could be very upset right now and you wouldn’t know it… But I have real concerns about injustice issues. I’m particularly…particularly concerned if this is a male child…on how I am going to protect it, and teach it to protect itself. But at the same time maintaining humanity. Very, very, very challenging because really what you are trying to teach someone, even in a little, small person, is to not treat people the way they treat you. And at the same time not let how it is they treat you change you. And that’s not really con…I don’t see that as being consistent with human nature. Especially not in little ones.

Helene felt that these concerns would manifest themselves in physiological responses of high blood pressure, increased heart rate or higher stress hormone levels. When I asked whether she would “breathe a sigh of relief” if her child is a girl, Helene answered by analyzing why it was she just couldn’t “wish for a boy.” Apart from being perplexed by male behavior in a general sense and her lack of a good example of a man in her childhood, Helene felt that being a criminal defense attorney and her experiences in juvenile court influenced her attitudes about having a boy and her perception of boys in general. She began to describe what she felt were her own capabilities in raising a son.
Hmmmm. It's very difficult for me because I don’t...I just wasn’t really reared in house where men were of much value and so that is...I don’t know how much of that is what’s going on but my husband is actually the last male in his family named Williams so if this...and this is the last...he will need a new wife to get a new shot... all things being equal I still can’t really wish for boy, but I think that in a lot of ways I feel as if...if I can’t raise “a good black man”, who the hell is supposed to do it? I mean you know what I mean? What’s...what...you know, why not me, you know? So I really can’t...I just sort of don’t think about it. ...And then I realized...but you know it’s women raise sons. Especially in my culture, you know what I mean? And all of these complaints that we have about black men...the statistics say that it’s the women who are raising them. And that concerns me (laugh). You know what I mean? ...We should have it together a little better by now. We should sort of know what you need and you know - fix it! But yeah, I can’t...the best I can do is just sort of be silently hopeful.

When I repeated her words from our previous conversation on this subject, Helene elaborated on what she felt would be her challenges in raising a son. She makes a distinction between raising a male and raising a black male. Helene discusses the added burdens on African American women to raise sons and that burden her as she thinks about the sex of her unborn child.

Oh Jesus! It’s scary. *(What do you mean by raising a black man well?)* I would answer that in two ways. I would consider it to raise a man well to be someone who was attached enough to their emotions that they didn’t have to physically act out on them. I think that’s the real conflict for men. …But specifically raising a black male I think it’s just how to maintain your own sense of humanity your own sense of dignity your own sense of right and wrong to people who don’t treat you the way they should, and you recognize it. Treating others as they should be treated without regard to how they treat you is pretty much what you have to do if you’re a black male and to a large extent if you’re a black female. I think that’s challenging cause I think that’s asking an awful lot of people, I really do. And recognizing that makes you a better person. Dignity essentially and humanity and in a society that pretty much tries to dehumanize and undignify you at every opportunity. Raising a person who has enough whatever to do those things is what you have to do to raise a black male. … And then worrying for the rest of your life that some yahoo won’t stop him because he’s speeding and shoot him or lock him up or beat him half to death.

Helene answers my question about differences in mothering between women of European descent and women of African descent by describing how she perceives their experiences of

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87 My words are italicized.
pregnancy and motherhood. She explains, as several other women in this study have, that once African American boys turn (about) eight they become transformed by others from cute child to societal threat.

I would have to say if I were white and giving birth to a child, I think I would worry less about it. Because people presume a goodness in them when they see them and I don’t have that luxury to pass on to my children. A lot of people think babies are cute and little black boys are cute –up until they’re about eight. And then they’re not cute anymore. I just think there’s a hope for the future. They say that every generation wants to do better than the last. You give birth to children with the expectation that things are going to get better for them that they’ll have a better life. I don’t know that black women necessarily feel that way. And I think that just adds a level of stress it takes away some of your confidence in the proceedings.

Helene feels that although all mothers fear for the safety and well being of their children, there is an added layer of fear that mothers of African descent must deal with that others do not.

…Never have peace of mind…all of our children are vulnerable because it’s just hard times to grow up. There definitely is a compound on it that is just palpable fear. She (a mother of an African American son) is worried sick that some cop, flipping around just waiting to get arrested. And it’s funny I’ll pass a group of kids like that I’ll say “probable cause! You are subject to warrant-less searches and seizures!”

Finally, when I approached Helene much later in our relationship about the same issue, and after she had given birth to a baby girl, she restated her concern over bearing a child who may harm someone else. In a sense, her work has aided in internalizing and affirming societal expectations of African American men. “…But I wasn’t concerned about it from like an embarrassment perspective or anything like that. I think I was more concerned from a humanitarian perspective. I wouldn’t want to give birth to someone [like that].”
“I’ve never wanted to be homogenized. I never wanted to assimilate. That’s not where it is for me. I love being a black woman. Love it. Love it, love it, love it!”

In contrast to Helene’s admitted confusion over the “Y chromosome,” she has clear ideas of what it means to be a woman and a woman of African descent. She continued our conversation regarding her concerns about having a boy by describing her own beliefs about African American cultural expectations of African American women.

I also do think it’s a burden to have the stereotype whether it’s true or not that the woman is the stronger portion of the gender. I think that that is a burden in a lot of ways. Not only is it unfortunately true in many instances, but if you’re trying to raise a son it really emasculates them almost from birth and that really isn’t true in any other culture. …It’s a hard thing to raise a male when you’re a female first of all and it’s another hard thing to raise a male in a country who just doesn’t care, care for black men. They’re cute until they’re about five or six then they become real problems. In a lot of people’s perceptions.

Helene feels that the expectation placed on African American women to be the “stronger” of the genders is unique to African American culture. She repeated this observation throughout our interviews. She also pointed out that this expected strength has not benefited interpersonal relationships between African American men and women.

I think that, you know, there’s actually an article on the cover of Newsweek - I didn’t read it but I saw it - about the fact that black women are out-earning, being more successful, than black men and the effects on interpersonal relationships of that kind of stress…stress and strife, and you know, I’ve told you before that I really feel like if you divided couples into races, I think that black women are the only race where the women are expected to be stronger. …They’re supposed to work two jobs. They’re supposed to work three jobs, if that’s what’s supposed to happen. They’re supposed to, you know, be able to raise children with their feet and drive the car with their arms…you know what I mean? They’re…that’s just what you do. If you’re a sister, you do whatever you have to do to make it, period, you know what I mean? And it’s…it’s like…failure just is not an option, you know, you don’t have any choice but to keep up.
I asked Helene where she thought these ideas about a “stronger” sex came from. She responded by talking about black men.

…I think it’s just mostly the percentage of black men who are in prison, the percentage of black men who are unemployed, the percentage of black men who are substance abusers. …those numbers are…are accurate. I mean and they’re not false. The why is very interesting but generally the foundations of most homes are...are black women. The leaders of the homes are black women so there’s not much to dispute about that. I think the, you know, the devil’s in the details. The why is really of interest to me but, you know, what is is so…there’s not much you can do about that! (laugh)

Through Helene’s eyes, this strength is culturally perceived to be greater than that mustered by African American men and Helene feels this is a specific burden that weighs heavily on mothers of African American sons. She feels that in her culture women sacrifice some sense of their femininity because they have had to shoulder so much during their lives. Helene sees "that part" of herself as valueless and describes herself as male or androgynous "between the ears." Despite this, she takes great joy in being an African American woman.

Helene invokes experiences of enslavement as points of liberation for women who have come after. They have, in a sense, offered her an opportunity to be completely “fearless” in the face of society’s attempts to harm her.

I think…it’s a special privilege to be a black woman. I mean I’ve…I’ve…I feel as if you know in a lot of ways, I mean, biologically I think we’re the beginnings and the ends of society and I think that…if I can teach her that the worst things that you can imagine have already happened to us as a people and we’ve survived it, and to grow up fearless, that, you know, the world’s hers. And that’s…I… I really view it that way. I really view it that way because I think fear paralyzes a lot of people but when they’ve already came and taken your kids and sold them and you don’t know, uhm, anything about your history past four or five generations I mean it doesn’t get any worse than that. And if you survive that and you’re up and willing and on your feet and able to fight the next fight, then fuck ‘em!…is pretty much my attitude about it.

Helene discusses her own conversations with her mother about the “blessing” of being a black woman and how these have shaped her own views about herself.
I never… I always knew I was black. I never thought I was anything other than a black girl but I thought that was a fan-fucking-tastic thing to BE! I mean it just was, both my woman-ness and my blackness was always celebrated from the first. It was never anything to be concerned about and my mother would have been ashamed if I wanted to be anything different. And I never wanted to be anything different. …from when I knew I knew I was black and I knew I was a girl and I knew that those were very, very special things to be and that the lucky people were female and the really, really fortunate were black females.

Helene discussed ideologies of race and female gender that promote an idea of oppression as the "cause" of black women’s "grit and determination" and "sisterhood." She took issue with a European American friend’s assessment that this sense of collectivity is due to common experiences of oppression. She responded, "The day I wake up feeling oppressed, I’ll probably kill myself." Instead, she believes these shared qualities are testaments to the strength of African American women in "taking the best shot someone had at you and still be standing…maybe not flourishing, but standing."

Helene sees these aspects of herself—a black-ness and a female-ness—to be parts of her core identity to be celebrated. She uses the metaphor of stereoscopic vision to describe how these parts of herself operate in the way she sees the world.

I think it’s my left eye and my right eye. I’m not interested in giving up my woman-ness or my femininity any more than I’m interested in giving up my blackness. I would not want to be male. And I would not want to be white. It’s like choosing between your left eye or your right eye. …one works just as well as the other…

Helene experiences herself as an African American woman as she mothers her own daughters. She feels her daughters have “unlimited potential” if they can see their African heritage and female-ness as sources of strength, but remembers a difficult conversation she had with her mother about how to raise African American children.

… I think black people raise their children to be tough because the world’s going to be so hard on them, you need to tough ‘em up. Don’t hug ‘em, don’t love ‘em, don’t kiss ‘em, don’t…. And my mother will say that to you. …she’s like, “don’t
love ‘em too much. Don’t do it.” You know…I never asked her why she said that. It was always so offensive to me whenever she says it to me and I … But I think that at least part of that rationale is…you’ll make ‘em weak. The world’ll eat ‘em up.

In mothering her own children, Helene has seized opportunities to be the parent she wishes her mother would have been to her. She sees her children as extensions of herself and explains how important it is for her to educate her daughters about “who they are.” She is committed to instilling a sense of pride rather than oppression in her daughters, but wonders how she will do this.

I haven’t dealt with this subject directly and, you know, and I’m pondering, I think…I don’t know the best way to do it, like how to teach her about slavery, how to teach her about the legacy of that, how to explain to her the discrepancies that still exist in a way that empowers her as opposed to oppresses her. …I don’t want her to think that woman-ness or blackness is a limitation. …I never, ever viewed either of them as a weakness and so I just don’t internalize that. And I …I want her to have that same perspective…

Despite her feelings that being an African American woman is empowering for her and her belief that her own daughters will be brought up in a way to value being females of African descent, Helene recognizes that not everyone feels this way. She acknowledges that there are many women who feel instead that it is an unmanageable burden.

…you have to overcome so much to see the power and it also can be, I mean, a burden like you cannot imagine because, so many black women that I meet, you know, are stressed out and won’t get the help, won’t find a therapist, won’t do anything and they just suffer, but I think there’s almost something in the DNA like a survival instinct where they just keep on plugging on. …but its daunting to say the least, I mean, it is overwhelming sometimes….

Analysis

Late in each pregnancy, Helene experienced an abrupt rise in blood pressure and was put on bed rest for the last week of her pregnancies—something she felt only her African American doctors would have recognized and sympathized with enough to write a medical
recommendation for bed rest. At exactly thirty-seven weeks, her second daughter was born at five pounds, four ounces. It is an interesting and powerful point that, from a medical outcome perspective, Helene’s class position as an attorney did not fully mitigate against the burdensome life experiences she articulated in her narrative as being related to being an African American woman.

Helene lives with many contradictions in her own life. On one hand, she eschews the "oppression" that some feel is part of the experience of being a black woman but not because she is not aware of her position in the wider society. She feels it is a personal quality she has that allows her to rise above victimhood. Helene’s constructions of self are generated by a sense of shared history of struggle among African American women that, in her mind, dates back to experiences of slavery and her own feelings that there are gendered differences in the survival of enslavement. In other words, African American men became the “weaker” of the two sexes while African American women were expected to be the “stronger.” This was articulated repeatedly by Helene and weighed heavily on her during her pregnancy and beyond. On the other hand, she feels that African American cultural expectations of African American women are misguided and harmful to women and men.

When speaking about her pride in being black, Helene adds how proud she is to be a black woman. For her, experiences of race operate together, always, with experiences of gender. Being black means being a black woman. Her upbringing in a household filled with women and in a climate that devalued men contributed to her own understandings of men as confusing, worthless and often violent human beings. Conversely, she is aware of the specific obstacles that African American men face even as young boys. If she were to bear a son, she revealed that she would worry constantly for his safety and that she would be powerless to
protect him. She was conflicted about whether or not she would ever wish for a boy because although she feels confident in herself as a mother and is secure in her “blackness” and “female-ness,” she simply does not understand why she feels she couldn’t raise a son well.

This sense of worry over a male child manifested itself in experiences of fear for Helene. She described it as “terrifying” and “scary” to think about having a male child. The experiences of being afraid for herself as the mother of an African American male and also for her imagined son as he grows up were especially felt by Helene during her pregnancy. Based on my observations, I began to understand that these experiences of fear contributed, unwittingly or not, to her delivery of her second low birth weight baby.

As I listened to how Helene describes the world around her, I note that she experiences the world in colors—she is always quick to describe someone as black or white. Helene’s “color consciousness” both adds to her appreciation of every human being as special and different and heightens her concern over the disadvantages suffered disproportionately by African American people. Her everyday work in juvenile court and the criminal justice system seem to put an exclamation point on these disadvantages as she defends predominantly young African American men. Helene’s self-described burden of having to be the “stronger” sex along with this chronic color consciousness associated with unfairness and disadvantage among African American people, and a gendered color consciousness associated with violence and weakness among African American men worked to produce those life’s lesions that may have influenced adverse aspects of her pregnancies.

Helene’s discussions of incomplete fatherhood and incomplete motherhood in terms of her experiences with her own parents have produced what she describes as “real huge holes” inside her. Incomplete refers to a partial absence or presence of, in her case, both her father
and her mother, that she experienced existentially as an *incomplete* person. Although her father was physically absent of much of Helene’s life, his *presence* as a disengaged father whom she loved anyway was what created great emotional upheaval in her life. The emotional detachment from her mother also created a sense of *incomplete motherhood* despite her presence in most of Helene’s life. Although Helene received much mothering and guidance from her great grandmother, she most desired this from her mother.

*This* emotional terrain of *wishful thinking*—wishing for a childhood she was denied and for parents who would make her feel more “complete”—resurfaced in Helene’s life during pregnancy and as she struggled with leaving her husband. Helene admitted to thinking frequently about the relationships she was missing in her life, and her own thoughts about who a mother and father should be and what their responsibilities are to their children were heavily informed by experiences of her own *wishful thinking*.

In sum, Helene’s narrative points to her sense of history associated with enslavement that contributes to an ongoing experience of racial “difference”; female gendered experiences of being African American as often burdensome; a color- and gendered-color consciousness that heightened her concern over glaring inequalities in American society; and an upbringing and work atmosphere that both contributed to fears around having a male child. Her powerful discussions around motherhood are woven with narratives of *African American female experiences* in the practice of motherhood. During pregnancy, when Helene becomes particularly sensitized by the conditions of her lifeworld, such *life’s lesions*—more complex than what health literature calls “stressors”—may have contributed to the low birth weights of her daughters. Helene’s narrative speaks loudly about the experiences of “being a black woman” in today’s world and how those experiences may impact a pregnancy. She often
returned to the theme of raising her children as being part of her pregnancy and in this way nuances one of the overarching theoretical frameworks of this study—pregnancy as a life process. Her experiences explored the continuum of pregnancy from days of girlhood through biological pregnancy and beyond into the realm of motherhood. In her eyes, for African American mothers, even seemingly inconsequential decisions become mountains to climb. 88

I cannot describe the stress that went into just making that decision public or private school because I don’t want to raise a person who’s not aware that they are black, that that is a burden and a blessing and it’s an obligation to be pursued. I would consider that a sense of failure on my part. Four generations of my family up here I would think they would be rolling in their graves if I raised a woman who didn’t think that way and that is part of the stress of being pregnant. Raising people who can contribute…positively to the world and that is very very stressful.

88 This analysis would not be complete without mentioning the work experiences of sexual harassment that Helene endured through her pregnancy. Due to the sensitive and idiosyncratic nature of this situation, and Helene’s request, I am not including nor did I record any of our conversations on this subject. However, Helene is proud of herself for using this experience as an opportunity for growth in her own life.
Zakiyyah—Emerging from the Flames of Her Own History and Mothering Sick Children

The fact that I have two children with a chronic illness that can cause problems to resurface at any time. It scares me to know that I don't have control over this disease. I also realize that it's never easy trying to deal with problems that my girls may have that are associated with the disease. (Zakiyyah, June 2002)

Major themes in Zakiyyah’s life often centered on her own violent past and her current experiences of mothering daughters with sickle cell disease. If I were to predict who in this study would have experienced preterm labor and delivery or other complications during pregnancy based on stressful experiences of everyday life from birth to adulthood, I would have immediately thought of Zakiyyah. Of all of my consultants, she had the most distressing and violent history. Further, she was experiencing both intense difficulties at work and marital troubles over the course of a pregnancy that was unplanned and difficult to bear knowing she was carrying a second daughter with sickle cell disease.

Zakiyyah suffered bleeding during her second trimester of this pregnancy, an experience she blamed on her difficult work situation, but was able to deliver a healthy birthweight girl (7lbs.) at term. Zakiyyah’s turbulent life story provides a window into those aspects of women’s lives that may adversely affect their overall health and narratives of sickle cell and memories of incomplete motherhood bring into relief those experiences that come to bear specifically on her pregnancy. Of all of the life historians, Zakiyyah spoke most often about how her relationship with God has helped her cope with difficulties throughout her life.

At thirty-five, Zakiyyah was working on her bachelor’s degree and was also employed as a quality analyst for Medicaid. Trained as a licensed practical nurse in the Navy, and still a

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89 Zakiyyah has asked me to use this name for her because “this is the attribute my parents gave to me almost thirty years ago.” She tells me the name means “growing in purity, intelligent and intellectual.” Her mother still calls her by this name.
Navy reservist, Zakiyyah’s job at the company entailed dealing with customer complaints and had been a very stressful experience for her over the last few years. When we met, she was having a particularly difficult time with her supervisor, another African American woman, who expected more of Zakiyyah than she felt was warranted. In addition to her stressful workplace, Zakiyyah explained that she was having marital problems with her husband of then ten years.

Zakiyyah was born to teenage parents in Washington, D.C., and does not know her biological father well. She refers to her stepfather as her dad throughout her life history. When she was three, Zakiyyah moved to New Jersey with her mother after living with her grandmother in D.C. for three years prior. Her father had a history of violence and began to abuse alcohol when Zakiyyah was young. Her relationship with her mother continues to be a source of much grief and distress for Zakiyyah. A devoutly spiritual and self-described “Christian” woman, Zakiyyah feels it is her greatest responsibility to be a strong person and good mother to her daughters.

I would not have guessed that this woman who sat across from me at a local restaurant in June of 2002 had endured such a torrent of violence in her life. Despite such a difficult upbringing, Zakiyyah has an easy and radiant smile that she unveils often in our conversations. She is a very attractive and intensely intelligent woman who wore long braids the day we met and dressed in a flowing skirt that accented her lean figure. Zakiyyah adeptly maneuvered her stroller that nestled her newborn daughter through the aisles of tables and

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90 Several months after the U.S. declared war on Iraq, Zakiyyah was called to active duty and served one month in Maryland training health staff in preparation for deployment. Our conversations were by phone and email during this time.
chairs and offered me a gentle smile that suggested she was weary in that new-mother kind of way.

“I don’t remember any violence at that age.”—The Burdens of a Violent Past and an Invisible Childhood

I asked Zakiyyah what she knew of her own birth and early life. She began by explaining that she herself was a “preemie” and was told that she used to sleep in a drawer in her grandmother’s home, but she laments that she does not know much more about her own birth. She does recall a memory of sleeping on her mother’s back—a memory that became more profound for her as she spoke about her childhood and her current relationship with her mother. I came to understand it as a reminder of what Zakiyyah wished for in their relationship and what she felt she had been missing in her older years.

…I remember sleeping on my mother’s back and I have the nickname of “monkey.” And I don’t know if that name was derived because I slept on my mom’s back, or if because I loved to eat bananas once upon a time. But I remember, I literally can still see me getting on climbing on my mom’s back and I used to sleep like that every night.

Zakiyyah’s childhood was not filled with happy memories. In fact, there were few memories she could recall that she felt were joyful. Memories of her earliest days are memories of loss, or what was not done to chronicle her time as a baby. She relates this sadness to mothering her own children and not being able to show her daughters a picture of herself as a baby to see if they look like her.

During our casual meals together, I was often shocked when Zakiyyah would recall incidents in her life, with not even a lilt in her voice, that were unbelievably violent. She remembers her early childhood, before her father started drinking, in terms of the absence of violence, “I don’t remember any violence at that age.” When I asked her why she moved
from D.C., she explained that her mother wanted to be with her stepfather, whom she’d met in New Jersey. Without hesitation, she replied:

So, I don’t know, my stepfather lived with his mother when my mother met him. He had just come out of jail. He had shot his first wife. That should have been a red flag to my mother right off the bat. And also he had about eight kids, no about six. My brother and sister make his seventh and eighth children.

Zakiyyah went on to explain a history of violent and tragic events in the lives of her parents that, she feels, contributed to their alcohol and drug abuse.

They lived in the inner city also, in the projects. …my dad, his mom was killed. She was killed by some guy she was dating, he shot her to death. And then my mother’s mom committed suicide. So, I never really got to know my grandmothers too well because they both died tragic deaths. And I think it affected my parents. In that they, really indulged themselves in different substances like marijuana, the drinking and stuff like that.

Zakiyyah tried to make sense of why her father behaved the way he did toward her. Although she was sensitive to the tragedies in his life, she also felt he didn’t live like the “typical” only son in an African American family. In other words, he wasn’t expected to support his family.

I think my father….he’s very insecure about himself and that was one of the reasons why he was so verbally abusive. Because he wanted to tear you down so that you would never think that you were any better than him. Because he had issues. I don’t think he graduated from high school. He was a teen father. His mom was killed. His dad abandoned them. He was the only boy, so a lot of weight was weighed on him. However, I heard that his mother spoiled him. So he didn’t even live the typical male lifestyle of the sole male lifestyle in the Black family. It wasn’t like he was forced to go out and do anything.

I was surprised Zakiyyah’s tenderness when she spoke about her father who was emotionally and physically abusive to her, her siblings and her mother. Zakiyyah vividly remembers the night her dad pulled a gun on her mother, accusing her of infidelity with his own son. Zakiyyah recalled this event with startling stoicism. I wondered whether this was such a normal part of her growing up that the violence didn’t faze her in its retelling and how
her seemingly cool response to such a violent past may influence her health, especially during pregnancy.

This was one of several experiences Zakiyyah had as a young girl in which she cared for and protected her mother when she felt her mother should have been protecting her. Each experience distanced her from a mother-daughter relationship that she still wishes for. Even as a very young child, Zakiyyah did not approach her mother for help when she needed her most, as in the case of a sexual assault when she was five or six. When Zakiyyah finally did speak to her mother about the assault, she discovered she was part of a family history of sexual violence.

Then in talking to my mom, I found out she was raped at 18 or 17 years of age. I found out my sister was raped, gang raped by three guys. I mean but I knew that about her. She was like 13 years old because they even gave her a v.d. And so, you know my mother and her girls all of us were sexually abused. That hurts. So I know that hurts her because she feels like she was not there to protect us.

She continued to explain how, as she grew older, her stepfather emotionally abused her and how she suffered sexual humiliation under his gaze. These experiences have taken a large toll on Zakiyyah’s sense of self worth and esteem which in turn has affected her relationship with her own husband. Zakiyyah cites her own relationship with her father, and his incomplete fatherhood that led to her legacy of poor choices in men. She would enter several relationships that were abusive—physically and emotionally. She bears the scars of these relationships in her marriage and in her own ideas about self-worth, beauty and honor.

I think because my father didn’t show me a lot of love and affection. I think getting it from these guys even at the cost of being cheated on, I was gonna take it. Because I had a man. And I literally fought to keep the man. And I didn’t know then that it was doing me more harm than good. Out of the three boyfriends and my father… all together three men have hit me in the face to the point where I think that’s why I had a detached retina in my left eye. And that’s not love. That’s not
love. …Well I had love but not the kind of love a daughter should get from her dad where he makes her feel like she’s important that she’s beautiful. Not ridiculing her. Not feeling jealous of her.

Zakiyyah joined the Navy reserves in an attempt to escape her controlling father. When Zakiyyah returned from the Navy in a newly muscled body, she felt she was finally able to defend herself against her father. However, she felt that her experiences in dealing with her father in such a way led to her physical approach to solving problems with other men in her life.

“…that’s why I’ve got so many problems with my mom because I just think of the things that I did for her.”—Experiences of Incomplete Motherhood

She started calling after the baby came. She pretty much keeps it up. Maybe once a month she’ll call me. And I can just hear that it means so much to her to know that I love her still. Or it means so much to her to know that I’m listening to her say that she loves me.

Zakiyyah’s relationship with her mother, still strained but improving, has been a source of great sadness for her and the loss of a mother-daughter relationship as a young person is something she feels acutely today. Memories of incomplete motherhood penetrated her thoughts during her pregnancy as she continued to formulate how she was becoming a mother. Zakiyyah believes that she protected her mother in ways that a mother should protect her daughter and this reversal of daughter into mother left her wanting that maternal presence she never experienced. She did not recall one example of a time when her mother acted like Zakiyyah felt a mother should have.

But I um you know I didn’t want to every time me and my mom got to a “you’re up in my face,” “well, you almost got shot,” or “when you were all shy, I was your eyes.” Or you know, “whenever you needed help with this or that, I was the person for you.” Because you know through the years, after that situation [her dad pointing a gun at her mother], there would be times when I would hear him cussing her out.
Or trying to hit her or whatever, and I would come to her defense. I don’t know if she realizes that. I know she feels incredibly guilty these days.

Zakiyyah returned to D.C. when she was 21 to live with her mother because she felt “too much solitude” in New Jersey. However, her mother had adopted a way of life that Zakiyyah found distasteful and that left her to care for her younger brother and sister. She experienced motherhood prematurely, unexpectedly and grudgingly. This further burdened their already fragile mother-daughter relationship. Today, she continues to understand a good mother in terms of who her mother was not.

Despite a sorrowful history and painful memories of a relationship lost, Zakiyyah is still working hard to have a nurturing relationship with her mother. As she began to understand alcoholism as a disease she became closer to forgiving her mother, and her mother’s more genuine spiritual journey in recent years has given Zakiyyah hope that the worst will not return.

And I just pray, it really scared me so bad when I was talking with her last week that I just actually started crying when I was on the phone with her. Because she was just really realizing how important it is that she has this connection with God and how she just really feels like she will never go back to that lifestyle again. I don’t think she heard me crying or anything because I didn’t make it a point to tell her but I just remember just crying because I miss having a mother in my life you know. I really really do.

…I still love my mother, she’s my mom, you know, and I just pray that, when she comes out of her rehab that she stays clean and sober and that the Lord don’t take her away too soon. You know. That we have a chance to really enjoy each other.
Sickle cell disease is most commonly found in the U.S. among African Americans (8% have the trait, 0.8% have the disease). Thus, for African American women in particular, having the sickle cell trait creates a unique set of negatively felt experiences for pregnant moms. In Zakiyyah’s discussions around her relationship with her mother, she began to interweave narratives about sickle cell. This trait that she possesses (she was tested in the Navy as a young recruit) and its subsequent disease in her daughters color her experiences of motherhood on a daily basis. In her fifth month of pregnancy, when she discovered she was carrying a second daughter with the disease, Zakiyyah remembered how her worries mounted over how she would mother another sick child.

Zakiyyah recalled how angry she felt when she had her first daughter with sickle cell disease. Since it is a heterozygous trait, Zakiyyah had a 25% chance of delivering a child with the disease. She desperately wanted to believe that God wouldn’t let this happen to her again. Although she feels she looks at the disease in her children more positively now, there are still experiences related to it that she is very concerned about.

I thought it was gloom and doom. But after having children with it and getting more educated, I think about it more positively. I went into a depression after [my first daughter] was born. Spiritual help and a supportive husband helped me through. I just thought it was going to be a lot of pain, pain, pain. I thought my child would die from this, how would we deal with this? I found out I had the trait in the Navy. With [my second daughter], we had an amniocentesis and a corticocentesis. I remember when we found out, I was so mad at God. I felt like “Why are you doing this twice?” Our first child had a splenectomy and that was stressful. I didn’t want to deal with this stress twice.

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91 The 2004 Sickle Cell Disease U.S. postage stamp was released to raise awareness about the disease and to encourage early testing. The stamp depicts an African American mother and infant. See Appendix 4.

92 A splenectomy is a complete removal of the spleen. Zakiyyah’s daughters had the procedure around the age of one and a half.
The lived realities of this disease weigh daily on Zakiyyah. Both of her daughters had their spleens removed before their second birthdays and any fever over 101 degrees immediately sends them to the emergency room for treatment. Other consultants have spoken about sickle cell trait in their pregnancy narratives, and most of the women knew whether they and/or their partner were carriers.\(^93\)

Zakiyyah’s first experiences of sickle cell disease through her aunt and the memories of her pain caused her great distress when she found out her first daughter had the condition. It has taken her several years to understand the course of the disease and to take comfort in those victories she feels her daughters have achieved, such as living lives that are not filled with pain crises. As is often part of Zakiyyah’s narratives, she believes that God has directed her on this path and that God continues to show her how she can come to some peace as the mother of two chronically ill children.

And again, in hindsight, I’m like, I know why God did that now. Out of all her siblings that I really lived with for an extended period of time, she was the only one that I ever did and I saw her struggle with sickle cell disease. However, I think that my perception of the sickle cell disease was, when I found out that [my first daughter] had it, was solely based on what I saw my aunt go through, who had chronic problems. So that’s why when [she] was born I was totally depressed about it. And then since that time, I’ve learned that the disease is very individualized and it doesn’t necessarily mean that the person is going to be in pain all the time. Thank God for that.

When I asked Zakiyyah whether she knew the sex of her child, she said she found out for both of her pregnancies. She then expressed concern over having a son for two sets of reasons—one related to how African American men are viewed by the larger society and one related to sickle cell.

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\(^93\) Although other cultural groups have sickle cell disease, African Americans have the highest rate in the U.S. See the Sickle Cell Information Center homepage, [www.scinfo.org](http://www.scinfo.org) or the Congressional Black Caucus Foundation health homepage, [www.cbcfhealth.org](http://www.cbcfhealth.org) for further information about sickle cell disease.
We knew we had the sickle cell (trait). It’s a disease that is internal, you can’t tell someone has it by looking at them. Boys may be viewed as lazy or stigmatized. It’s more acceptable for a girl (to have it). I don’t want a boy to go through it. As a mother of a black male, I would also teach him to be respectful. But I wanted a girl. With my godson I saw the difficulties with raising a boy.

Aside from sickle cell, just knowing that black males have to be a certain way in order to get accepted in society. There are very successful black men, but they may wear dread locks or braids, or wears baggy clothes. But people may think they’re dirty. I think it’s hard for a black male to express himself because of the way he’d be viewed.

…I feel like it’s gonna be tough in society. My brother likes to wear braids and jeans. When someone sees them, they see a thugness about them. [I worried about] having to make sure they have a positive role model, letting him know it’s okay to be a little emotional sometimes. Express yourself. For a black male, the most important thing is instilling a positive image in themselves.

Zakiyyah’s case is different from Helene’s for example because she is concerned about raising a son who has sickle cell. She feels that society brands black men already, but a sick black man would be seen as weak, lazy and “drug dependent.” She feels sickle cell is an “invisible disease” where one would not know someone was suffering from it just by looking at him. She feels that society views disease differently based on gender, and sickle cell would only work to make a man feel weak and for society to label him as such. Zakiyyah feels this is especially difficult for African American men. She feels it is imperative that a black man has a positive image of himself. She sees an example of a “good man” in her husband who is “respectful” “intelligent” and loves her “in spite of” herself.

“Nobody knew. It was like, ‘It’s your baby. You deal with it.’ ”—Negatively Felt Experiences in the Workplace

When I first met Zakiyyah, she was experiencing a tremendous amount of distress related to her workplace, even though she was away from the office on maternity leave. She explained: “My position really stressed me out. I worked until the third of May and was
scheduled to work part-time for the coming week—thirty hours a week.” Zakiyyah’s
daughter was born two days after her last day of work. These same issues of personal choice
and feelings of alienation and abandonment by co-workers streamed through several other
women’s interviews. When Zakiyyah started experiencing complications during her
pregnancy, she knew the stress had reached a critical point and attributed her feelings to a
new position and because she is an African American woman.

Zakiyyah felt her pregnancy was seen as an added burden in the workplace. She struggled,
even during complications, to assure her coworkers that the pregnancy wouldn't interfere
with her performance. She suffered not only abandonment during this time in terms of
support, but negative reinforcement by co-workers.

I felt like I knew that going into the position I would be responsible for more than
I thought I would. My supervisor can’t expect me to be able to know all of this, and
lead a team too. And being pregnant. But I didn’t want my pregnancy to be a
hindrance. When I started having trouble with my pregnancy, I thought they should
be mindful. I don’t want them to say “Oh another whiney pregnant woman.” I
worked hard to get the position. I didn’t want it to be an excuse. The VP went to
[my supervisor] three times. I felt he looked at me differently as a black woman, and
the pregnancy probably compounded negative feelings. I have seen him treat other
women differently.

I feel like at my job I am one of three pregnant women there. I feel I was treated
very differently. The woman who is in a higher position than I am (who is white)
was treated very differently by the VP. It wasn’t so much the pregnancy, but being
African American. The VP was more receptive to other pregnant women where with
me he was more critical and judgmental.

Some of her poor treatment also lay at the hands of her supervisor, an older African
American woman who is also a minister. She recalled her interactions with her with almost
disbelief that another African American woman would treat her this way.

I didn’t have great support from my supervisor who is also African American.
“She has an MBA, and that’s a beautiful thing, but…” She was not supportive or
sympathetic. She’d lost three babies, she’s a Christian woman too. I’m taking three
months of maternity leave. She didn’t understand what I was going through. Mainly
it was stress with my position. It was crushing. I felt I was giving my all, but I got no recognition.

Not only was she surprised by this treatment because she and her supervisor shared the same cultural community, but Zakiyyah also felt her behavior was hypocritical as a Christian woman of God. Zakiyyah wondered aloud why her supervisor would treat her entire team of African American women with such disrespect.

But I know that that doesn’t mean that my love for the Lord is any weaker or any stronger than those who profess to live by the Word twenty-four seven. And so with her, the way she has, it’s just another hypocrite. Another one who’s preaching the Word and sitting up there being vindictive and spiteful. Now, because she’s in a position of authority as a director, she feels she can just treat you any kind of way. But, you know, it’s like, “You need this team in order to flourish, you know. And if you’re going to sit there and try to talk to us any kind of way and get upset because we’re voicing our opinions when yet you’ve done the same thing to us and we’re supposed to take it and swallow it and not say anything?” I mean, that’s contradictory in itself, for you to be a Christian woman and not take what’s been given to you and digest it and try to see what it is she can do to make it better.

Finally, although Zakiyyah affirmed that she enjoyed “working,” she felt that African American women, in contrast to “Caucasian” women, have limited opportunities to care for themselves during pregnancy because most African American women must work in order to help support their households.

I don’t know what the statistics are but there may be significant disparity between the number of African-American women and the number of Caucasian women that have to work during their pregnancy. If a woman is able to relax and not worry about the stress of bringing additional income into the household, she can take better care of herself. She can stay in bed if she's too tired or when she isn't feeling well—unless there are other children in the home, of course—and not worry about the repercussions of not showing up at work. Caucasian men have traditionally held the highest positions in Corporate America. This may prove my theory that their wives are less likely to work during their pregnancy than African-American women based on the income that's brought into the home.
“I have to be mindful.”—Experiencing Race and Gender

When I asked Zakiyyah whether she felt anyone looked at her differently when she was visibly pregnant, she replied with two very different experiences.

I can say that I don't feel like I was looked at differently, not in a negative way. I received compliments from many of my peers and family about how well I looked and on my maternity attire. This was during my second pregnancy. I felt like a queen while I was pregnant because people really extended themselves to me—holding doors open, offering me a seat at a crowded restaurant, front of the line privileges in the restrooms etcetera. During my first pregnancy, I remember being self-conscious about not being able to fit my wedding ring. I didn't want to people to think I was another single African-American pregnant woman. In our society, there's a lot of negativity associated with this.

I guess people think you'll turn out to be another welfare recipient living off the government which means their tax dollars would be used to help take care of me and my child. I did notice a few people looking down at my hand to see if I had a ring on...at least that's what I assumed they were looking for. After awhile I didn't care because I knew I didn't need to live for anyone's approval other than my own.

Like many of the consultants in this study, Zakiyyah’s first pregnancy speaks loudly to how some African American women experience lower class status while pregnant. She felt the gaze of a society that looked with disdain on her as the child within her became more visible. She believes her own strength from within helped her to overcome the negative assumptions she felt others had about her. This step seemed to carry her past these feelings when she was pregnant with her second child.

When I asked Zakiyyah about specific experiences of racism, she replied that she has not been the recipient of many explicit racist comments, she has had to deal with racism in mothering her children.

…I can still remember [my daughter] coming home from kindergarten telling me that one of her Caucasian classmates telling [my daughter] that her parents told her not to play with the brown children. To say I was disgusted is an understatement. I did my best to explain that there are people that are ignorant and that they make comments that aren't nice and to know that she is a wonderful person and that it's too bad not everyone is smart enough to realize this.
Zakiyyah is pained by the hurtful experiences her young daughter has had to endure. Mothering African American children, as in Helene’s narrative, means dealing with questions of race whether you want to or not. Early in our discussions, Zakiyyah had mentioned that she hoped she would never have to bring race into conversations with her children. But experiences at school and with society at large have forced her to do otherwise.

“I know my Christian walk with God.”—The Power of a Divine Relationship

Zakiyyah continues to take great comfort in her own relationship with God. Before every meal we ate together, Zakiyyah prayed over her food and nearly every time we speak she praises God for the health of her daughters. She recalled knowing her “Christian walk with God” at an early age and understands her relationship with God as complex and that although she may be angry that God gave her two daughters with sickle cell, she knows there are important reasons why her life is the way it is. She felt God especially helped her through two difficult pregnancies.

I can remember God being in my life at an early age maybe four or five. This is the age when my parents decided to join the Islamic faith. There have been times when I've questioned God, I'm sure we're all guilty of this. Overall, I know that God is trying to teach me a lesson in every aspect of my life, I always try to remind myself of this especially when times are hard. My faith in God allowed me to deal with each pregnancy in a positive manner in spite of the negative situations I had to face. When I was told that I might have to abort [my first daughter] due to the possibility of her having complete organ situs inversus, it was then that God gave me such a peace unlike any other that my child would be fine. I believed it and God came through for us. With [my second daughter] I found out during my fifth month of pregnancy that she had sickle cell disease. I had a choice to abort or keep her...Abortion was never an option. I knew that God would bless her regardless of what the doctor's told us. So far so good...
**Analysis**

Zakiyyah bears the scars of her painful and often violent history. It has taken its toll on her self-image and feelings of self-worth and may have manifested in complications she had with her pregnancy. In the fifth month of Zakiyyah’s second pregnancy, she knew she was carrying a child with sickle cell disease.

The demands of her supervisor, and the disappointment that Zakiyyah felt as a result of being treated poorly by another African American woman, created an incredibly stressful work environment. Feelings of abandonment by people in her workplace and of implied and racialized irresponsibility for being pregnant may have contributed to the complications she suffered.

Zakiyyah’s experiences of *incomplete motherhood* are a constant source of pain for her. During pregnancy, when her own motherhood was slowly being fashioned, these reminders of a hurtful past may have impacted her daily experiences of pregnancy. For Zakiyyah, experiences of *incomplete mothering* and the mourning of a lost mother-daughter relationship cause her to reconnect with a hurtful past on a daily basis and influence her own mothering ideas and practices.

As an African American woman, Zakiyyah was burdened by the thought of having a male child and expressed concerns similar to those of Helene, but these were compounded by the thought of having a boy with sickle cell. Whereas a healthy boy might have been perceived as a “thug,” a boy with sickle cell might have been perceived as “lazy” and “drug dependent.” Although Zakiyyah did not express fear over having a male child, she possessed a heightened concern that weighed on her until she discovered she was having a girl. But raising African American girls is also hard for Zakiyyah. Part of mothering her children
involves addressing hurtful experiences of racism and tackling questions of race that her young daughters ask. This contradiction between how Zakiyyah would like to mother and how she must mother is part of her overall mothering experience.

Zakiyyah’s life is organized around sickle cell. Her daughters take antibiotics every day of their lives—a reminder of their condition—and the possibility of visits to the emergency room is sometimes overwhelming. When she asked me to attend the luncheon celebrating the choice of her daughter as the poster child for sickle cell disease in North Carolina, I witnessed the love and deep relationships they have formed with her daughters’ doctor and the program at UNC. These relationships, the experience of a “mild” sickle cell disease in her children, and her faith in God have all helped Zakiyyah deal with the disease in the best way possible. Still, Zakiyyah’s life as mother is filled with worry each day that one of her girls will have a pain crisis or will succumb to the most benign childhood sickness.

Zakiyyah delivered two healthy birth weight girls around their due dates. In terms of these health outcomes, she has managed to overcome the pain of impaired relationships and abuse at the hands of people she loved, the obstacles of maintaining a healthy marriage, a damaged self-image and the difficulties in mothering sick children. Her choice to join the military, and her continued service, may mitigate against the memories of violence and neglect that she suffered as a young woman. Zakiyyah joined the military in an effort to carve for herself a more independent life filled with dignity and respect. Although Zakiyyah found this sense of freedom in her military life, she has not completely escaped feelings of low self-worth.

I think perhaps the greatest influence in Zakiyyah’s life has been her deepening relationship with God and God’s presence in her daily life. She sees her path in life as part of God’s larger plan for her. Despite her initial anger at God for giving her a second child with
sickle cell disease, she believes God is granting her a good life and that there are reasons for events in her life happening the way they do. In nearly every communication we have, she affirms, “The girls are doing really well. PRAISE GOD.” Her faith has transformed potentially poisonous experiences into positive forces in her life as mother. For example, Zakiyyah’s memories of abuse at the hands of men play into her own mothering practices in her determination to instill positive self-images in her daughters. In her own practice of mothering, memory operates as a creative force in how she attempts to direct the lives of her daughters and as a reminder to herself that she must try and protect her girls from experiencing the abuse and neglect she endured.

In sum, there are experiences in Zakiyyah’s life that may have mitigated against the effects of violence and abuse in her history. But she continues to experience contradictions between how she feels her life should be and how it has played out thus far. She has suffered the loss of a childhood that she feels should have been remembered in some documented way and she wishes for a mother who should have protected her rather than one whom she had to mother. She continues to be watchful of how she conducts herself at her job and in the military so as not to offer anyone the opportunity to disparage her work performance on the basis of race. She is burdened by the chronic disease of her children and the uncertain futures they face. Perhaps somewhere, in the slippage between what is and what should be, there are felt physiological consequences that led to her complications during pregnancy.
Sheri—“I’m a different kind of mommy.”—A Story of Motherhood Lost

Pregnancy, sickness and loss of control were constant themes for Sheri throughout our relationship. Sheri’s narratives also often centered around themes related to the stillbirth of her daughter one year prior. I met Sheri when she was three months into her pregnancy. She had delivered her first child at term, a stillborn girl, just one and a half years prior. When I asked her whether she felt she was already a mother, she immediately replied, “Yes” and with a gentle smile, “But I guess I’m a different kind of mommy.” During this pregnancy, Sheri intensely felt the memories of bearing a dead child and the pain that it caused her and her family and her remembrances triggered new fears in her most recent pregnancy.

Sheri’s difficulties in conceiving and her burdensome and extremely complicated pregnancy created an ever-present vigilance and nervousness for Sheri until her son was born via Cesarean section at thirty-three weeks gestation. Although born four weeks early, her son was 5lbs. 10oz. due to Sheri’s gestational diabetes. Sheri did not experience preterm labor, but she delivered her son the earliest of any of the women I interviewed due to a “lack of movement” during her last fetal non-stress test (NST⁹⁴). When he was delivered, the obstetrician noted that there was a “true knot” in the umbilical cord which caused a disruption in the flow of oxygen to her baby.

Sheri is a tall woman with broad hips and shoulders, was thirty-two when we met and she was always impeccably dressed, looking as though she belonged on the cover of a magazine touting the glamour of pregnancy. Her almost perpetual smile would fool an observer into thinking her life was filled only with happiness whereas her large brown eyes spoke more

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⁹⁴ A non-stress test (NST) involves connecting electrodes from the mother’s abdomen to a fetal heart monitor and recording fetal heart accelerations and decelerations. Health care providers look for patterns indicating fetal movement and overall health or distress. Sheri would sometimes be connected to the monitor for long periods of time.
about her hidden sadness and experiences of grief and loss. When we met, Sheri was still grieving the loss of her daughter but perhaps not in socially recognizable ways. As I began asking her about this pregnancy, she rather stoically explained this was her third pregnancy and that she had given birth to a dead child—a daughter—just over a year ago. When she was seven months pregnant with her daughter, Sheri married a man from Trinidad whom she met at the dining hall of one of the local campuses. Although there were cultural differences Sheri was working to understand, her husband remained intensely supportive of her during her last two pregnancies.

Sheri was born in the country town of Clinton in Sampson County, North Carolina and described growing up in Durham in a “middle class black neighborhood.” She attended “mostly white” elementary and high schools but graduated from a local historically black college. She began her postgraduate career as a teacher, but after experiencing racist remarks from students and, she felt, being abandoned by her African American principal in the face of such remarks, Sheri left the public school system. At the beginning of this study, she was working as a medical research supply buyer for a local university. Her job, and her supervisor in particular, created a great deal of anger and frustration for Sheri during this pregnancy.

Sheri’s experiences of this pregnancy were intimately entwined with experiences of her last pregnancy. From my observations, memory and physiology almost seemed “hardwired.” Because of the death of her daughter, she became so fearful of this pregnancy and for the health of her baby that nearly every physical event in her daily life became a matter of the life or death of her unborn son. Sheri’s pregnancy quickly became an experience of sickness when she was diagnosed with gestational diabetes and hypertension. During the course of
this pregnancy, she had nine NSTs and several more ultrasounds than would someone with a “low-risk” pregnancy. As a result of her “co-morbidities” of gestational diabetes\textsuperscript{95} and hypertension, she endured several trips to the hospital for various conditions—nausea, vomiting, anemia—and was transported once via ambulance from her workplace.

Finally, Sheri’s experiences of being African American in the workplace, including a past history of dealing with interpersonal racism in the public school system, caused her particular stress and frustration. In her current job, she felt she was being treated differently because she was African American, she was pregnant and because she was enduring a complicated pregnancy. Ultimately, Sheri spent much of her life trying to “fit in” with European American society and proving herself to her supervisors at work—both efforts to mitigate what she felt were the effects of poor treatment of African Americans by the larger society. Sheri articulated fears around having a male child because of racialized stereotypes, but her overwhelming concern was whether she was carrying a child who “still had a heartbeat.”

\textit{“Because with African Americans you can either fit or not fit.”— Memories of Race, Class and Color: The Power of Stereotypes and Having a Boy}

Sheri’s earliest recollections of differences in skin color coincided with the birth of her younger sister, born five years after Sheri. Although she was aware of such differences at an early age, Sheri had yet to associate any differences in life experiences with skin color. As she grew up among other African American girls, she began to associate economic experiences with skin tone and hair texture.

\textsuperscript{95} Gestational diabetes develops in the second trimester of pregnancy and occurs more frequently in African American and Native American Indian women. After the birth of the child, the condition usually resolves although it places the woman at risk for developing diabetes later in life.
All my girlfriends in…all those same girls that, you know, we grew up together…they were light-skinned, they had the naturally curly hair, they were doctors’ daughters, they could get, you know, they had designer clothes. I mean I…and I had to have the same clothes. So mom went through this thing with me about designer clothes. You know, especially in junior high school, I wanted Calvin Klein jeans… I wanted this, and I’m still like that to a certain point now.

Sheri feels as though her "own culture" looks down on people who have "average" jobs. Her upbringing in a household that stressed education and with a father that enforced good grades contributed to Sheri’s own understandings about race and class. Her ideas about pursuing a relationship with a man in “food service” initially distanced her from the man who would become her husband.

He’s standing there making pizzas! You know that’s just totally out of my norm. You tended to date guys who had college educations… Right! Exactly. Which is another stereo…it’s a stereotype with him being African-American. …stereotype within our own culture…mediocre, average…You think they’re just kinda not with it…

Sheri saw in her now-husband all the qualities she felt were not “compatible” with her own upbringing. Although she often felt it incumbent on her to work against the stereotypes that the larger society placed on her, she internalized those stereotypes that she felt were produced by her “own culture.” Interestingly, she regards her Trinidadian husband as both participating in a larger African American collective experience and as a cultural outsider.

Sheri feels the weight of a larger African American cultural community who is suffering and believes we, in the U.S., are heading toward other forms of enslavement. Although she does not have any personal experiences of knowing about specific ancestors who were enslaved, she experiences enslavement as “hurtful.”

Those things meaning …during enslavement? Yeah. That…that just hurts and you know we’re not too far from it again. What makes you say that? The way things are going, the economy, everything, I mean you know, blacks are no longer the minority but we’re still the ones that have all the problems. You know, we’re no
longer in the minority in America but we’re still the ones who take on the biggest…hardships.

Although Sheri does not have any personal experiences of economic difficulties, she perceives herself as part of a larger cultural community that bears this burden more substantially. She continued to explain that it is her father’s goal to give her and her sister what “white families” are able to give their children. She understands that it is her duty to do the same for her son.

No. Not…no, not any personal things. No, because my…my family does a very good job of…of making sure we don’t have those hardships. And Dad makes sure he, you know, he tells us okay, “you have children now and I want you to make sure that you do the same things for your children that I’ve done for you. I actually want you to do…work harder at doing this than I did.”

Sheri discovered she was having a boy midway through her pregnancy. She felt her husband was rejoicing while she expressed very mixed feelings. Again, Sheri explains how stereotypes operate in generating the fears she had around having a boy.

Uhm, I think it’ll be hard to raise a black…a black male. …Be very hard. Because there’s so many stereotypes and stigmatisms and it’s just so hard for a black male today that it’s just…I think it would be very hard. Appearance. I have no idea what my child will look like. I mean, you know, and you don’t want to say “No, you can’t wear your hair like that.” …It’s what they look like. Oh, they look nasty or you know, they’re gonna be a robber or…I mean, some of them…there are people out here who are geniuses that have dreadlocks. (laugh) So I mean, that has nothing to do with the person. So I mean, you know, that’s one of the things that I, you know, really hate sometimes about being African American because you know people look at you and they see a black face, and it’s not even a black face, it’s a brown face, you know…

Sheri laments that African American people are judged by their appearance as “black” and is burdened by racialized stereotypes. In terms of having a son, she is particularly concerned that he will be treated poorly if he does not conform or “fit in” with European American society. She feels that African American men have more stereotypes to work against than do
African American women, especially an educated woman, and this worries her when she thinks about raising a boy.

Had the ultrasound and found out it was a boy. My husband was jumping for joy. Why I don’t know, it was like he had done something great. …I think what I said last I was like it’s scary, to be a…to bring a black man into this…into society because it’s just…I don’t know, it’s a cross between, punishment and…what’s the other word… enjoyment for my family because there was no other boys, you know? But I mean, people say boys are very easy to raise. And then you have people that say that with girls you’re always worried about what’s happening to them and you know, them getting hurt and…you have to do the same thing with boys…Like who are they getting…I mean who are they out messing around getting pregnant and…just being a black man…I watched the history of the Ku Klux Klan the other night …I mean the Klan targets African-Americans but mostly they target black men. …We are just like scum to them. And I just don’t…you know, now…and they talk about how now, these days you can look at a person and never tell, you know. You don’t know who you’re looking at and how they’re thinking of you. That’s scary. You know you never know who’s looking at you to plot something against you because you’re black. So, but and I mean that’s what I think of when, you know, a son. You know, how do you…how do you teach that to your child? And at the same time, teach to not be prejudice? That’s hard.

Sheri believes she will have higher standards for a boy.

I mean, it’s so much.. people expect so much of men. I mean I expect so much of [my husband], and I know how I get upset when he doesn’t meet those expectations. So if I can expect it from him, then I would expect more from my…my child. I mean, it’s so much…people expect so much of men. Even growing up, learning A, B, C’s and all that, I want him to become like, a genius, you know? I don’t want him to be perfect but I do want him to be, you know, decent. Better than me, better than Mom.

Ultimately, she is most concerned about her son not fitting in to the larger society—a feat she recognizes as nearly futile. She sees this experience of social alienation based on non-conformity as producing a son who is a “vagrant.”

Because with African-Americans, you can either fit or not fit. And then most of the time you’re still not gonna fit. And you’re always having to…especially in corporate world, you’re always having to prove that you are competent first of all. And secondly that you know, I’m just the same as Billy over here, who has the same potential that I do. That’s my whole…that I’m not gonna have a vagrant. (laugh)
After the birth of her son, Sheri was still concerned about the same issues and believes, like Helene, that life will be okay for him as a baby but that society’s attitude toward him will change as he grows into a young boy: “It’s gonna be rough, it really is. Yeah. Really. I mean…It’s okay now because he, you know, that cute infant stage. But as he gets older, I’d say around ten or eleven [life will change for him].”

Work and Stress—Racialized Pregnancy in Relief: Proving herself and “The domino effect.”

Sheri experienced a tremendous amount of distress at her job during this pregnancy. She felt that her pregnancy, particularly because she was African American and because she was enduring myriad complications, suffered unwarranted and close scrutiny by her supervisors. Her pregnancy became a site of intensification of problems she was experiencing at work and she perceived that other white colleagues would not have received the same ill treatment. Further, she feels that as an educated African American woman, she is constantly trying to “prove herself” to her supervisors. She feels this is especially true in her relationship with her superior who is an African American male.

Oh yeah. I have to prove myself a lot. Oh yeah. Oh yeah. Definitely. That’s the one I have to prove myself the most to. Because he’s proving…it’s like a domino effect. …His immediate supervisor is a late 40’s, early 50’s white woman. …he’s the only black in our department at that level. He has to prove to her that he’s competent. Okay? Although he has a degree. Some of the others who are white do not. On his same level, do not. So once he’s proven he’s competent, he now has to prove that his people are competent, okay? Which now trickles down to my immediate supervisor, who’s not so necessarily competent. (laugh) So what she has to…what he has to do to her, is continually push her and pressure her and stress her so she’s working all the time. She takes work home every day. She’s always pushing us, pushing dominos down to us. Who has to prove to her I don’t need you standing over my back all the time. I’m competent enough to know what I’m doing. And they…at the same time try to move up and prove to myself to him that okay, yes I have a degree, but now I gotta prove that I earned my degree.

Sheri believes that her male supervisor must endure difficulties because he too is
trying to “prove” himself to his white co-workers. She feels the weight of his burden as well as hers to work harder than white co-workers. Sheri described other work experiences that brought into relief her own perceived differences in pregnancy between African American and “Caucasian” women. Sheri sees her white co-worker’s complaints as trivial, inconsequential in comparison with hers. She believes that African American women see pregnancy as more of a burden and suggests that white women experience it through rose-colored glasses. The power of a perceived white media contributes to this idea in the public space through magazines, advertisements and other print and video media that are specifically marketed toward pregnant women.96

Most Caucasian women I know that’s how they explain pregnancy. But most African-American women that I talk to, they don’t explain pregnancy like that. (laugh) And I don’t know what it is! What the difference is? Uhm, because I do have a Caucasian friend at work who’s also pregnant. She is, oh, Judy is thirty-two weeks pregnant. Now she’s the only Caucasian woman that I know that has complained about pregnancy. But everybody… “Oh, it’s so glorious!” No, it’s not. (laugh) “Oh, you’re so beautiful!” and…no you’re not. (laugh)

In our discussions around work, Sheri spoke about what she feels to be the “norm” for European American women’s experiences of pregnancy. Sheri generalized European American women's experiences to include analogies with upper-class lifestyle and mythical views of pregnancy. I observed that she experienced wishful thinking that her husband would be able to support her on his own.

I don’t know if it’s because Caucasian women…the average…they can stop work, be at home, the husband makes sometimes 6 figures. They can take care of them and, they can sit at home and their moms can come and take care of them. I can’t do that! I have to work! And my husband doesn’t make six figures. I make more than my husband does so I’m the one who has to…my household depends on me to go to work. So I’m the one who’s, you know, still doing the budget and doing the shopping and all of that stuff. So I can’t stay at home. So that’s stress on me

96 Interestingly, of all print media in the OB-GYN office that I examined over the course of 1.5 years, I counted less than five magazines that had African American women and/or babies on the cover.
and my girlfriend, oh, and she…her husband…well, she’s the average marriage
where the man takes care of…makes…takes care of the woman. She can stay at
home if she wants to. She’s a salesperson so she can work from home if she wanted
to.

Finally, and perhaps most distressingly, Sheri experienced a heightened and intensely felt
gaze from her supervisors during her pregnancy. She felt she was endlessly queried regarding
her doctor’s appointments and her general whereabouts when it came to managing a
pregnancy that was not “normal.” Sheri was asked several times to meet with the FMLA\textsuperscript{97}
coordinator at work in order to assure her supervisors that she was not abusing her leave
time. The mistrust she felt at the hands of her supervisors was worsened by their comments
about Sheri’s insulin needles at her desk.

…by me being a diabetic, I have insulin needles…at my desk, in my area. Well
she asked to…sometimes I leave them on my desk because if I leave them on my
desk I can see them and I know I have to take my insulin. Or I have to stick my
finger to get my reading. If I leave them in my purse, I’ll forget. Well she asked me
to move my needles because she was afraid a drug addict was gonna come in off the
street and take the needles and try to use them.

Sheri was particularly upset that her supervisor associated her needles with drug use instead
of her diabetic experience. Sheri felt that her intensely personal experiences of sickness and
pregnancy were subject to unnecessary and invasive scrutiny by her supervisors and that this
contributed greatly to her overall “bad” pregnancy experience.

\textit{Experiencing Pregnancy as Sickness}

Sheri’s difficulties in the workplace made her pregnancy-as-sickness more palpably felt. I
asked Sheri early on how this pregnancy differed from her last.

\textsuperscript{97} The Family Medical Leave Act was established in 1993 by the Clinton Administration in order to provide
“eligible employees” with twelve weeks of unpaid leave for birth of a child or the placement of a child with an
employee through adoption or foster care; employee’s “serious” illness; or when tending to a “seriously ill”
immediate family member. See \url{http://www.dol.gov/esa/regs/compliance/whd/whdfs28.htm}
This one? Nauseous is my first name. I don’t feel well. Yes! Still. I don’t feel well. You know, I sleep all the time. I don’t eat. I’m diabetic. I wasn’t diabetic with the last one. Uhm, I don’t eat because I have to shoot insulin. And you know, with going to the last nutritionist visit, ‘Oh, you’ve got to eat more food!’ I mean, that means I have to stick myself. You know, I stick myself in my thighs and in my abdomen. So, it’s very different. They say all pregnancy’s different. There’s no doubt about that.

…I don’t have a…I won’t say “normal” but one of those people who go to the OB/GYN once a month. It’s just not me so…Uhm, I still go to OB/GYNs every two weeks. I go to the uhm, the endocrinologist. She has me going once a month. I haven’t been to the nutritionist and dietitian since last month so I’m pretty…you know, pretty stable. Pretty stable. [I’m on a two week schedule at the OB] because of my diabetes…and blood pressure. Yeah.

As the weeks and months advanced, Sheri’s pregnancy became diabetes, high blood pressure, and nausea, leaving little else to be physically experienced as the pregnancy itself. For Sheri, this last pregnancy has influenced her desire to undergo sterilization after the birth of her son.

In addition to experiencing pregnancy as illness, Sheri also felt that “older” white people looked at her differently when she became visibly pregnant. Although no one ever said anything to Sheri, she felt these “looks” were based on racialized class assumptions about welfare mothers.

Yes. I do. Oh here’s another one…welfare wo…child or, uhm, you know, is she gonna be able to take care of her child, or, you know, look at her…I mean especially like me working at [a local private university]. I see those looks. Uhm, I can’t say that, you know, if they’re students or researchers or doctors or whatever. It’s just…they’re not my ethnic people so…Yeah [they’re mostly white folks]. Older, like older, say 40’s and up. And then sometimes you can see a…you can tell a yuppie, they’ll be like “Oh there she is!” (laugh) So…It’s like they’re…like looking through you sometimes, you know. …I mean you can tell when somebody looks at you like, out of disgust or that they don’t like you. And that’s what it is. Like you’re in their space and you’re, you know, they just look at you like, why is she here? And I can’t describe it. It’s just, you know, when you have a, I won’t say an enemy but somebody that you’ve had animosity for, they just look at you like ”Oh my God, look who’s coming!”
Sheri was especially interested in associations with stress, pregnancy and birth because she was offered no explanation for why her daughter had died the night she was born. The autopsy report suggested absolutely nothing wrong with her baby except for a shoulder dislocation. This report continued to worry Sheri during this pregnancy. The document continued to prompt an active remembering of that night for Sheri and produced thoughts and concerns about her current pregnancy.

For Sheri, pregnancy became an experience of life or death for her unborn child. Sheri’s last pregnancy and the stillbirth of her daughter are living memories that impinged on this pregnancy. Over the course of our relationship, Sheri vividly recalled the stillbirth experience and the still vivid and violent delivery of her daughter. Her water had already broken and contractions were coming hard. Sheri had to endure a twenty-two hour labor to deliver her daughter, already knowing the child was not alive.

Um-hmm. She was actually, uhm, Dr. V was the one who told me that she couldn’t find a heart beat and Dr. V…actually Dr. A was there up until I…I dilated up to nine centimeters. So then Dr. V came in and delivered me and it was a very hard delivery. Twenty-two hours of labor. Uhm, it was very hard, …and because she was so large, Dr. V really had to work and try to get her, you know, she didn’t want to use forceps because…because she said, you know, when a …there’s a baby that has died inside, the skin rips. So she can’t use the…she couldn’t use the forceps. So she really had to be kind of careful and twist her out and, you know, she had to give me a full fourth degree episiotomy. So now I’m split wide open…

Several conversations later, I asked Sheri how she made the transition from her daughter’s death to trying to get pregnant again. She stopped, looked at the ceiling, and repeated the question, “How did I transition…I guess I really didn’t transition.”
With this pregnancy, she was on Clomid—a fertility-enhancing drug. I asked her why she was on Clomid since she had not had trouble conceiving before. She explained, “After the birth of [my daughter], I just stopped ovulating.” She was diagnosed with endometriosis and the treatment put her in a state similar to menopause. After awhile on Clomid, she was ready to say “forget it,” but her husband just wanted “to be somebody’s daddy.” In order to make him happy, Sheri continued on the drug until they conceived.

But this pregnancy has been anything but happy for Sheri. She guarded herself against being too happy, or really happy at all. She was duped by those feelings last pregnancy and she doesn't want to go through that again. Her daughter’s birth and death are very much a part of her current pregnancy. Sheri never suggests that she herself has had a hard time dealing with her daughter’s death. She claims it has always been her family that has had the difficult time. She is afraid she will be caught off guard again and although she bought a fetal monitor to try and maintain some control over this pregnancy, she is still scared she will one day find that the baby has died. She and her husband were in a kind of “limbo,” existing in-between excitement and fear. Sheri and her husband vowed before they even became pregnant again that they would do “nothing” for the baby until he was brought home. She recalls that “last time” her family packed up all of the reminders of her baby before Sheri arrived home.

Because of the complications Sheri was having with this pregnancy and the living memory of the unexplained death of her daughter, she felt that she began having trouble distinguishing between what she was “really” feeling and what she considered to be “psychological.” Despite repeated explanations by her physicians, She began to feel embarrassed when calling the practice with her concerns.
Although Sheri was pleased with the care and attention her son was receiving after his
birth, she still grieved when she left the hospital without her newborn.

…everything was charted so I felt pretty good about that because they were
taking extra care of him. And the only thing is when I got ready to go home, again I
was going home without a baby so that kind of…that was a bad feeling. I really
didn’t realize how much it was gonna be on me coming back that next week and I
think the first time I went…that next…let’s see, I left that Sunday. That Monday
when I came back I was like okay…I hope this doesn’t last long because…it’s a lot,
you know, to get up, get dressed, especially when you’re sore,…

Sheri’s family, and especially her father, is still upset about the way Sheri’s last pregnancy
was handled. According to him, Sheri should have had a C-section delivery that he feels
would have saved her daughter’s life. He is haunted by those images of childbirth and death.
Her father’s constant interest in the care Sheri receives for this pregnancy, and his painful
and often angry memories of witnessing the delivery of Sheri’s daughter have connected him
to Sheri’s life in a way that she had not experienced before. If there were a silver lining on
her last pregnancy experience, it was that her relationship with her father began to grow.

Sheri’s husband also remembers her last childbirth experience, but in a way that began to
bother Sheri as the pregnancy progressed. His focus shifted from her to their unborn son,
leaving Sheri to feel like she was being neglected.

…you know, she’ll make the call to my dad and then eventually, I’ll call him,
because he just gets so…you say, “I’m in the hospital.” And…and that’s all he
hears. He doesn’t listen to which hospital and what’s wrong…you know. He
automatically think that…thinks there’s something wrong with the baby. So, you
know, he comes in with that on his mind. Yeah, like I don’t feel well, you know,
and his first question is “Well is the baby moving?” “Yeah, he is. But I just don’t
feel well. There’s something wrong.” And uhm, he’s like “O.K., I’ll be there.” But
you know, when he gets there, he asks you like, thirty thousand questions and I hate
that.

The memory of her daughter’s death and the subsequent problems she faced with this
pregnancy influenced Sheri’s decision to undergo a tubal ligation immediately following the
birth of her son. She decided to be sterilized out of fear that something else might go wrong
with a future pregnancy and also because she felt she already had the two children she
wanted to bear.

Despite all of the complications and tragic memories Sheri has experienced during this
pregnancy, she found that she was looking forward to motherhood in a specific way.

I mean, uhm, like I can see my sister when she gets home, how she lights up
when she sees [her daughter] and she says “Mommy!” you know? Even though
she’s sitting there with me…and I’ll probably get teary…even though she’s sitting
there with me, she’ll jump up and go “Mommy!” you know. I just think that’s just
like the best thing. So uhm, you know, regardless of how your day has been…I’m
looking forward to that.

Analysis

Sheri’s story is rare because of culturally constructed U.S. social taboos around discussing
infant death. She agreed that there were few avenues she felt were open to her to discuss the
stillbirth of her daughter. When we worked on Sheri’s life history, often our conversations
would return to her pregnancy with her daughter or to difficult work experiences with this
pregnancy. An ongoing battle with her supervisor regarding sick time and with the human
resources department at her workplace over the particulars of FMLA caused Sheri much
heartache and stress—factors she felt contributed to her hypertension and complicated
pregnancy.

Sheri was particularly sensitized to images of poor African Americans and worked hard
against those stereotypes she had internalized. She was reluctant to even talk with her now-
husband while he was working in a food service occupation and remained concerned that her
son might become a “vagrant.” These stereotyped images gained an intimacy in Sheri’s
pregnancy experience as she grew more and more concerned about the boy she was carrying.
As her son grew within her, so too did her concern around bearing a male child and whether she could raise him to defy societal stereotypes. Rather than encouraging him to embrace his heritage as Helene and Zakiyyah taught their daughters, Sheri felt that the best approach for her son would be to “try to fit in” as she had done throughout her life.

In addition to feeling the burdens of prejudiced attitudes toward African American men, and the weight this placed on her as a mother, Sheri felt that while pregnant she was fulfilling stereotypes of the *welfare queen.*

For her, this was a personal affront to all she had strived to accomplish—a college degree, a steady and well-paying job, a married life. Her visibility as a pregnant woman heightened her awareness of herself in public spaces and coincided with felt experiences of being African American and female and related experiences of class. Sheri experienced her pregnancy as a lower class status—an unwelcome gaze in an already difficult pregnancy. According to Sheri, there was no room at her workplace for a pregnancy that was not “normal.” This manifested in daily confrontations with her supervisor over the validity of medical appointments, her requests that Sheri hide her insulin kit from public view, and in numerous conversations with the human resources department over FMLA regulations.

Sheri elected to use the leave time “intermittently” in order to go to her myriad doctors’ appointments but felt she was asked to provide documentation over and above what was outlined in the regulations. Thus, the intersecting worlds of *race,* work and pregnancy produced much anxiety for Sheri. She felt that as an African American woman she was invisible to her supervisors when it came to recognition for her hard work but became *over-visible* when she requested leave for medical appointments. Sheri perceived that her

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98 Mullings (1992) and Roberts (1999) have described this popularized image in US culture.
pregnancy heightened her *racialized visibility* in the workplace. Her pregnancy, combined with other health complications, created opportunities for her supervisors to play out office politics that she felt were informed by their ideas around *race*.

Sheri’s pregnancy made her feel vulnerable to “the domino effect” that was produced by her African American male supervisor. An intensification of feelings of betrayal by an African American male were the unfortunate byproduct of what *should have been* a happy event—her pregnancy. As Sheri endured all of the complications of her pregnancy, she also had to divulge often private information to her co-workers. This was an added insult to an already difficult work experience.

Sheri believed that “most” African American women did not view pregnancy itself as something to be celebrated. She also believed that “most Caucasian” women felt that pregnancy was a positive physical event. From my observations, Sheri was burdened and somewhat angered by knowing that others experienced pregnancies with little or no difficulty, as she described in her account of her European American co-worker’s pregnancy. She was also distressed at the burden of having to work to support her family.

As Zakiyyah articulated, Sheri’s cultural frame of reference for European Americans was upper-class elite women whose husbands “make six figures” and could therefore remain at home during pregnancy. She felt she did not have this luxury, as her husband worked contract jobs with little stability. I noted that Sheri wanted very badly to be put on bed rest by her doctors in order to escape her work situation, but each office visit was a disappointment in that regard. Her complications were so many that she began to question whether they were real or imagined, placing her on a fault line of uncertainty that remained with her throughout the latter half of her pregnancy.
Sheri’s pregnancy with her son and the loss of her daughter operated as streams of lived experience that were not separate. She felt she had not made any “transition” into this pregnancy, but rather experienced it as a continuum of her last. Her motherhood had, in a sense, been placed “on hold”—a kind of still motherhood. Memories of her loss were also lived by other members of her family and began to concern Sheri as her delivery drew near. Sheri’s deep and meaningful memories of her daughter’s birth and death may have streamed together with her physiological experience of pregnancy to contribute to the myriad of complications she suffered, including the premature birth of her son.
Tisha—“There’s nothing to me like prayer.”

Major themes in Tisha’s life revolved around her tremendous faith in God and her distressful experiences in the workplace that, she believes, caused her to experience preterm labor. She was the only one of the life historians to experience preterm labor during the course of this study and we met several times during her six weeks on bed rest. Tisha attributes her preterm experience to a very stressful workplace and ill treatment by co-workers that she felt was informed by their ideas about African Americans. Fortunately, she delivered her first baby—a healthy girl at 8 pounds, 11 ounces. She feels it is her tremendous faith in God that helped her deliver a healthy baby and recover from a traumatic birth.

I first met Tisha at an ice cream shop in the north end of Durham. We both squinted in the glaring June sun as the wind whipped around us at a small outdoor table. The first thing I noticed about Tisha was her bright smile. As she would later tell me, she and her husband had tried to conceive for two years and until this pregnancy had been unsuccessful in their attempts. She was bursting with happiness about this pregnancy and her face radiated her joy. Tisha’s smooth skin and soft, rounded face added a gentleness to her rather determined demeanor. Her short-cropped hair was impeccably styled and the small round spectacles perched on her nose added to her professional appearance. She had just interviewed several pediatricians and was on her way to question day care providers for her child due mid-September.

At twenty-eight, Tisha and her husband had been married ten years. They are both from Baltimore, Maryland where they attended high school together. Tisha explained that they moved to Durham to “leave the cycle” in Baltimore for better job and living opportunities, although they often travel to Baltimore to visit their families with whom they are very close.
At the time of our first interview, she and her husband both had well-paying, stable jobs. He managed a shift at a local car dealership and she was a medical technician at a private dermatology practice. They owned a newly built but modest house nestled in a unique Durham north side neighborhood that was home to a mixture of residents of both European and African descent. Small brick ranches built in the 1950’s topped the neighborhood hills and gave way to a cluster of new two-bedroom prefab homes where Tisha and her family lived.

When we first met, Tisha was both exhausted and exasperated by her work situation. As a medical technician, she spent most of the day on her feet and had no support from colleagues regarding her pregnancy. She also endured negative or “ignorant” comments from patients about her race and Tisha was quick to point out that she was the “only black person” in the office. At thirty-three weeks pregnant, Tisha began to experience labor pains and visited her doctor. After a hospital stay, she was sent home on required bed rest for the duration of the pregnancy. At thirty-nine weeks, she delivered a healthy baby girl who weighed seven pounds, twelve ounces.

The granddaughter of a minister, Tisha explained that religion had always been a large part of her life. Now, as she embarks on a career change in divinity school and ministering, she feels she is answering God’s call to serve. Her devotion to reading the Bible and her relationship with God as part of her self-defined “spiritual growth” helped Tisha through the darkest hours of her pregnancy experience.
“I was always concerned about the baby’s health but it’s now more prominent. It’s more up in my face, you know.”—Shifts in Living Pregnancy: Experiencing Preterm Labor

Despite Tisha’s meticulous attention to her health before and throughout her pregnancy, she was not surprised when her doctor explained that she was having preterm labor contractions.

Yes, I’m one centimeter dilated. Actually I wasn’t surprised because I knew that I was having contractions, but I kinda wanted to work through ‘em because they would stop, come, and go, so I figured, oh you know, they must be false labor so it really wasn’t …too surprising that I was having contractions. It did surprise me that I was dilated though.

Although Tisha experienced some difficult moments while on bed rest, she tried to keep her situation “in perspective.” Daily phone calls to her mother—everyday at 12:30—and constant reading of her Bible helped Tisha to engage in more positive thoughts regarding her pregnancy.

Oh, I read my Bible continuously. And surprisingly a lot of the evangelists, ministries that’s on TV come on during the day. And that helps keep me grounded somewhat and put things in perspective. But I think the biggest thing is just being put in…just putting your situation in perspective…you know, and seeing it truly for what it is, whether it’s an uncomfortable situation or it’s a good situation. Just seeing it for what it is. ‘Cause I remember many a times I would try to fool myself into thinking it was one thing but it really wasn’t.

Tisha knew that going to church would have helped her maintain the “grounding” and positive “perspective” she desired while on bed rest, but she was pained to know that she was physically unable to attend services.

It helps me to put things in perspective. Gives me a sense of peace. Uhm, it’s…it’s a comfort. It’s really a comfort to me. But, like I said before and I’m not sure if you remember but my grandmother is a minister, my mom and them is really into church so when I do slack, it’s…they’re there to pull that up, you know. “Tisha, have you prayed lately? Tisha…” you know and the mere fact that I can’t get out and go to church right now it’s a little frustrating.

During our conversations while Tisha was on bed rest, she commented on how
painful the pregnancy had been and continued to be. She explained her pregnancy in
terms of the pain she felt and eschewed popularized ideas that she would feel “sexy.”
Tisha also experienced uterine fibroids\textsuperscript{99} that became particularly painful as her womb
swelled to accommodate her growing baby, and she grew concerned about the pain
medication she was taking and its potential effects on the child. Tisha’s very supportive
husband and her close relationship with her mother aided her in moving through the
slowed time she experienced on bed rest.

I am still in a lot of pain but my pregnancy was complicated because I had
fibroids. And the fibroids were very much so painful. Uhm, and they’re still very
much so painful. But I’ve been dealing with that for six months so…I’m learning to
adjust to it and I do… I thank my husband a lot because there are times where I’ve
just been ill. I mean emotionally, physically…attitude-wise! (laugh) And he’s been
really good about that. But, like I told my mom yesterday I said for the first time
I’m tired of just feeling bad, you know, and I try to put that in perspective. The
reason why I feel bad is because of the baby. The baby is something I really wanted
so therefore you try to suck it up and just hold on…

Tisha constantly reminded herself that she and her husband had tried for years to conceive
and that they “really wanted” this baby. As a result, she felt she was not entitled to talk about
“feeling bad.” Further, she felt that talking about her complications was a form of
complaining and that she did not want to burden others who already had difficult issues in
their lives.

\textsuperscript{99} Fibroid cysts are benign growths that grow quickly and can become very painful over the course of a
pregnancy. They occur more frequently in African American women.
“...it's not this job's responsibility that you're pregnant and you're making everybody affected and it was just a whole bunch of foolishness.”—Experiencing Pregnancy as “Fault” in the Workplace

Tisha spent six weeks resting at home before she delivered. She was unable to be on her feet for more than a couple of minutes without having more contractions, so she was only able to go to the bathroom and then return to the couch. Although the bed rest was difficult for her as a very active woman, she welcomed it as a respite from what she described as a very stressful job situation.

Actually I think the bed rest was the best thing for me because I was in a lot of pain and work was becoming very stressful, very stressful and I think that contributed to what was going on with the early labor. Just because the type of job I had. One, because I was on my feet a lot…and then two, the type of environment that it was in. It was a very demanding environment so therefore I couldn’t keep up with the pace, and I wasn’t going to keep up with the pace. You know, so it made a difference. So me going out on bed rest was good…it was very beneficial. Even though it’s driving me up the wall, it’s still beneficial, you know.

Tisha was convinced that her difficulties at work impacted the physiology of her pregnancy enough to produce preterm labor contractions.

It was…it really was stress-related. I know it was. ...And then just the situation…I was always…just so uptight about it and just had so many anxieties about it. And it wasn’t necessarily that I had anxieties about getting fired ‘cause I…I mean I knew that legally they couldn’t do it. And I also knew that it wasn’t gonna be very difficult for me to find another job. It was just the…tension of the co-workers and it being uncomfortable there for everybody and just the gossip and the hearsay, it was just so much. And just how it wasn’t fair that I was being treated this way and you know I didn’t ask to get pregnant or you know just stuff…foolishness like that. You know, or it’s not this job’s responsibility that you’re pregnant and you’re making everybody affected and it was just a whole bunch of foolishness and I felt really bad because I well yeah, you didn’t tell me to get pregnant but this is the situation. “I’m pregnant, it’s temporary, and you can deal with it.”

Tisha would get very exercised when she spoke about her work—a topic I decided to broach gingerly while she was still on bed rest. But it was clear that her concerns about work were many-fold. She explained that she and her employer, a female physician with children, were
having difficulties over Tisha’s maternity leave request. Tisha was angered when she
discovered that FMLA did not apply to companies with fewer than fifty employees, which
included her workplace. She was hoping to take eight weeks of leave and found considerable
resistance from her employer and co-workers. Additionally, her co-workers became
embittered about her pregnancy and were not only unsupportive but, as in Sheri’s case, were
increasingly negative in their comments to Tisha. Tisha was thrilled about this pregnancy
only to be torn down at work and made to feel “irresponsible” for being pregnant. When
Tisha began to have difficulties with her pregnancy, she garnered no support from people in
her workplace.

…I was pregnant and it’s another young lady that works with me that is pregnant
and her lab…her pregnancy’s been pretty much, you know, happy-go-lucky and I
wish her [the] best that it continues to be that way but you can’t understand because
the first thing people say is well I didn’t do that, or I didn’t have that problem. And
I’ve learned that you’re right, you might not have had that problem but I have it, so I
have to deal with it. And you can’t compare each pregnancy to …to each other
because they’re very so much different, you know. And I learned that dealing with
the work situation, that has become a very frustrating issue…and it is an issue
unfortunately because you’re dealing with women who say, well I didn’t go through
that. I didn’t deal with that. Well, that’s you.

As in Sheri’s case, when Tisha began experiencing problems she became isolated from
women who did not have similar problems with their pregnancies. In the work context, Tisha
felt that this lack of understanding translated into blame and negativity. Her required bed rest
became an incendiary issue for Tisha and her employer.
“I think I can prove that I’m just capable. I think people just always underestimate black women or just black people in general, as just inept, just can’t do or just ignorant.” —
Racialized labor and proving herself in the workplace

Tisha elaborated on why she felt her experience of work was different as an African American woman. She felt, as several other women did, that she needed to prove herself capable of performing her job well even while experiencing a painful pregnancy.

... I really think that the demands are different in a sense or...I felt obligated to work there, so kind of help... stay with them and felt like I had something to prove...you know, regardless. Because I remember the day that I went into labor early, I was in a surgery with my doctor, and I kept cramping really bad and I told her I said I don’t feel well. She said “Yeah I see you bent over. You want to sit down?” And instead of me saying yes I said “No, I’ll finish this up,” because I didn’t want you to sit back and say “Well, you couldn’t do your job.” So I stayed and I think...it got progressively worse. Instead of me leaving, I stayed the next...I stayed that whole entire day. And now I think back and I’m like man! My priorities wasn’t right because if it was I would have said you know, “I think I’m having contractions and I’m going home” but I stayed out of obligation just...I was trying to prove a point that regardless of whether I’m pregnant, I can still do my job. Uhm, and then everything else that had transpired before made it even more like regardless of whether I’m having contractions, I’m not the only woman that had had a baby at work and I just keep on going! You know! (laugh) Uhm, and like I said it’s different for me of the simple fact that money was an issue but it wasn’t that big of an issue because I knew I could find another job. I knew [my husband] was working...I knew that [he] was there so I wasn’t going to [be] totally out. But I can understand too if you don’t have a spouse you have to...and you’re your only income, I can imagine you pushing yourself to go...you know, regardless, so...
And you feel that there are more African-American women who are in that situation? I do. Yeah, I really do, you know...

Tisha stayed longer at work and on her feet to prove to her boss that her pregnancy would not hamper her work performance. She felt that if she stayed and continued to work that no one would have anything bad to say about her. I noted that she felt a deep responsibility to represent African Americans in a positive way, through her work performance.

I think I can prove that I’m just capable. I think people just always underestimate black women or just black people in general, as just inept, just can’t do or just ignorant and I’ve been in situations where I’ve worked that I’ve had to prove that I am very much so capable of doing my job and so that’s a stressor...
there…you know. And I know there’s many a times too that I’ve gotten paid less than my counterparts, you know…but it’s a…it’s what it is, you know. And that’s how you deal…I don’t know, maybe I…I just have dealt with it for so long I’m just kind of like, hey, it’s what it…but then I’ve always worked in a office where I’m the only black person there.

Tisha’s experience with her employer and maternity leave requests led her to retain legal counsel to resolve the issue. She felt alone in her experience as a pregnant worker (despite the presence of another pregnant co-worker) and remembers the concerns she had when she felt she might lose her job as a result of the deteriorating relationship with her boss.

…and therefore you have to either stand your ground…and that can be really hard if you standing it by yourself, you know. And then you thinking about “Man, can I still pay my mortgage? Can I pay my car and still maintain my lifestyle and not falter on who I am?” That’s a stressor all by itself on your body and even though you’re not really thinking about or, you know, ‘cause I remember that.

Further, Tisha explained that her experiences as a pregnant woman at work brought her private concerns into public space. As an intensely private person, Tisha felt that her medical problems and heated discussions regarding maternity leave brought the whole office “up in her business.” She felt the weight of that undesired intimacy when she commented, “…doctor’s room offices are very small and when your belly starts to get big (pause).” As someone who also professed a desire to have “control” over her life, Tisha felt that she had lost that sense at work and this upset her greatly.

Honestly. I mean I think a lot of it has it has to do with the type of job that I have. I’m constantly on my feet eight hours, nine hours a day. And you just always want to have in the back of your mind that you’re carrying your weight, your own load, you know. You don’t want to inconvenience anybody because you’re pregnant. I think that’s a really big issue for a lot of people because you’re already in a situation where you’re looked at different anyway… And, it’s not anybody else’s fault that you decided to get pregnant so, you take it for what it is. I waited three and half months before I told…I told my supervisor immediately because I was tired and sick a lot…but I had asked her not to tell anybody else in the office until that three and a half month…and I did it for two reasons. One because the risk of miscarriage is…you know, it decreases, and if I…I didn’t want everyone…up in my business and I preferred to [deal...
with it] by myself. And then two, it was just a thing…it was a private thing and I …when I was ready I would let everybody know. (laugh)

“In growing up, my grandmother and my mom always taught me that God is a loving God. He is someone who’s always been with me, always protected me, guided me.” —Experiencing Pregnancy as Spiritual Journey and Self-Transformation

Tisha explained that her pregnancy brought on a period of personal "spiritual growth"
during which she read her Bible and posed questions about her relationship with God and the church. She felt that the pregnancy had transformed her in deep and meaningful ways.

I think ‘cause I spiritually went through a lot. And I’m just not the same person. I think what’s important to me is different. I just view life different now. So what used to trouble me doesn’t trouble me. …I don’t care about some things I used to care about. I think I kinda re-evaluated life. So and my priorities are different. Definitely [it was because of the pregnancy]. It was because [my daughter], because of the birthing situation. Just her and the ordeal of labor and delivery. It was time I spent on bed rest. I think it was a lot of factors that changed me. And my priorities changed.

Tisha recalled how her relationship with God developed and how it operated in her life. She took comfort in these beliefs when she began having early contractions.

In growing up, my grandmother and my mom always taught me that God is a loving God, He is someone who’s always been with me, always protected me, guided me. Things that happened in my life was a plan that He has always made for me. And, growing up I’ve always believed that. And even to this day I believe that. ...He’s always provided for me, even in the midst of a lot of chaos, even when I didn’t think things happened, things that did happen it kind of worked out, even though I didn’t like it, later on…I just..I can’t really explain it, it’s hard. ...And so that’s what my grandmother always taught me, God kinda molds you, puts you in paths and…and in situations that make you learn and prepare you for different things in your life later on and even sometimes at that situation or that instance, you know, it...He’s just always been there with me. And I never not questioned that or believe it…well I’ve questioned it, I can’t say that…that’s not true, because I’ve had hard times where I’ve felt like God has forsaken me, you know, but then that’s when you do have to get down and pray more, you know.

Tisha explained her preterm labor in terms of God’s greater plan for her, but admitted that there are moments when she has a difficult time coping with her experience.
My mom and I’ve always had a spiritual background and I believe that God only puts so much on you. And there’s some reason that I’m going through this. I don’t know if I go through it to help other people, to learn a lesson or whatever the case may be but I’m going through it for what reason and I need to make the best out of that situation. But there are times where I just don’t have it together. I know that, you know, and I get mentally or physically tired. But I just believe firmly that God only puts so much on you and, whatever you learn, you might be able to help somebody else, and it’s an experience.

After speaking with her grandmother during her early period of bed rest, Tisha found herself wondering whether she was defying God's will by allowing the doctors to suspend her labor contractions. Tisha saw this as a conflict that was part of her larger spiritual growth.

My grandmother talked to me yesterday and it was very ironic ‘cause she said “You know, a doctor’s a man, and God knows what’s going on. And sometimes…”-‘cause I was very concerned about them stopping the contractions for the next six weeks, and how that would affect the baby. She said “Sometimes Tisha, things happen that you don’t understand, you know? And maybe it was an error on how far along you are… you don’t know really what the case may be. But to continue to hold up the contractions for six weeks may be a thing where you need to just let nature take it’s course, you know.” And I really sat down and I thought about that and she… you know she’s never steered me wrong before. That’s one thing but a lot of it just made sense, you know. You can’t keep holding up nature. Sometimes things just have to take its course…And they are very much so conflicting spiritually to me, as much as, like I said, mentally ‘cause I know one thing but my spiritual aspect is saying something different, you know, so…but yeah.

However, she also spent much time feeling “conflicted” about her relationship with African American churches. She felt “betrayed” by what she perceived to be a greater emphasis on money rather than spiritual substance, and I noted that this was a source of much distress for her. Her “walk” with her new church—a very different and predominantly white congregation—testified to the meaningful changes that were taking place in her life.

Now that’s why I said the church has become so superficial and they’ve become so wrapped up in the outside world and not what they need to be to be doing, you know. And for me it’s personally, it’s taken me a long time to find a church that I’m happy at, you know, and not become so…fixated on the outside. And the surprising thing is that the church that I found that I was so happy at is a church that is… predominantly white. You know, I’m not in church for three or four hours, you
know, it’s no whooping and it’s no hollering…it’s something so different from what I would normally go to…and that surprised me. But I’ve learned a lot since I’ve been there. And I’ve continuously grown since I’ve been there, so, it is quite an interesting walk for me.

Tisha saw it as futile for her to try and "fight" injustice in her life. She believes that this life is just one "phase" of her human existence and that her sense of “spirituality” helps her through difficult life experiences.

…there is so much more out of life that now that…I want. And for me just to expel that much energy into trying to fight this injustice or…whatever you want to call it, it’s just not worth the hassle anymore because you fought it for so long and you just get, well OK, it’s what it is and I just have to expend my energy and time into other things, you know, and I think spiritually that plays a role because you learn that just hey, you know, this…this life for me is just…just what it is. It’s just another… a phase in another life. You know you pass on and you begin to experience another life, whether it be heaven, hell, or however you want to put it, but you experiencing another phase in the life cycle.

Tisha experienced a prolonged and difficult labor and delivery that resulted in the emergency C-section birth of her daughter. She and her husband found themselves praying especially hard during those hours. She began labor on Friday and her daughter was born on Sunday afternoon. She felt her “spiritual time” on bed rest helped to prepare her for this experience.

I also had a lot of time to just read my Bible, do a lot of spiritual time. And that helped prepare me for a lot of things especially during my labor and delivery when we was having a lot of problems because we did lose her heartbeat so that was a concern in time and that was a time we had to do a lot of praying so that was important and it helped me prepare.

“Then the week that [my husband] went to church with me, the whole atmosphere was so different.”—Class experiences and racialized mothering

Tisha believed that white women were not as likely to feel disapproving looks when pregnant or when they are alone with children in public. She remembers going to church with her newborn daughter without her husband and how differently people responded when he
came with her one Sunday morning. She believes this was due to misperceptions of her as a single African American mother.

… I went to church and [my husband] didn’t go to church with me a couple of times because [he’s] going through his spiritual growth and the women there was so…they were like…they were very…very nice, very nice, but they were nice in the aspect of…because I still don’t wear my wedding band as well…there was in the more of the mode of oh they feel sorry for me because I was a…mom…a single mom with a child. Then the week that [my husband] went to church with me, the whole atmosphere was so different. People came up and hugged me and…I was like wait a minute! I been in this church for two months and not one person hugged me. Not one person. …but I was really surprised at the…how people just came and rallied to us and was talking to us and I was like wait a minute—y’all never did this to me when I was by myself! You know you would say “Hi how you doing, is there anything I can do, you need any help?” But the entire time I was there with [my husband] no one ever asked that. And I was really surprised. I mean I was really taken back. But I looked at the situation…I’m the only African-American in this church.

Tisha bristled when she described how others thought she was a welfare recipient. This experience was brought into relief as she engaged the health care system. She explained to me that she moved from Baltimore to escape that “cycle” and that she has worked hard to combat stereotypical expectations of African American people.

I was often aggravated when people said, well are you on Medicare? No I ain’t on Medicare! Why, do I look like it? You know, why do you think that, you know? It’s just the perception of white people have this certain class, black people have this certain class, Hispanics have this certain class, we all have this certain type of education and, the ways of life are different, you know. But you can’t apply every situation to one…it doesn’t work that way, you know, because we all are different.

Tisha found it difficult to deal with people who thought she was “in the system” and on welfare. She explained that, much like Sheri, she has worked hard to disrupt the racialized stereotypes of African American people. While Tisha was surprised that some of the assumptions about her were made by African Americans, she confessed that she held similar assumptions about others.
A lot of it is really just thinking that I’m on welfare, I’m in the system. And that really does peeve me. And like I said before, the reason why is because I work really hard not to fall into that statistic. And surprisingly enough I think a lot of misconceptions come from that black people tend to all stay in that…that lot. And that isn’t true because I fought really hard not to be that…you know, and did my education, going back to school…or whatever the case may be. But I also had to…I mean I have to catch myself because there are times when I make that assumption myself. You know, and you have to kind of put yourself in somebody else’s shoes because I know how that feels, you know, [because] I spent a many a night studying, trying to make sure that I had something to fall back on…and I’m really…I’m not, me and my husband aren’t, you know, we make decent money so therefore, I just don’t like just because you look…you look at me…think “Oh well, she must be on WIC.”¹⁰⁰ or “She must be on…” you know…some service or…living in this type of house or vice versa. Because no one gave me that. I worked really hard to get it…you know?

She was angered that some African American women feel that they’ve been wronged—by men and society—and, she felt, they possess a sense of entitlement that leads them to depend on welfare rather than look for a job. She felt this reflected poorly on her and made her work against stereotypes even harder.

…and just appearance and that if I’m doing it everybody else is doing it. Yeah. It’s just such a common thing. It’s so readily accepted amongst all cultures and it shouldn’t be, to be quite honest. So when you see it, it’s like, okay it’s another person…or another black woman on welfare or something like that. And that’s not…to me, that’s not acceptable…you know, but then that’s because I have real strong personal goals and I have goals. You know for me to sit there and expect somebody to give me something, that’s the wrong idea. You’re not entitled to anything…you know. And a lot of African-American women feel like I’ve been through a lot so I’m entitled too! But no, not really, you’ve had some bad luck, some bad breaks but you’re not entitled to anything. You still have to work just as hard as you would….

Tisha used to get angry when people would ask her whether she was “in the system” or when she fielded racist comments, but now she feels she can laugh instead of getting upset. I noted, however, that these experiences did still anger her as she retold them in her narrative.

¹⁰⁰ WIC is a federally funded supplementary food assistance program for Women Infants and Children.
I usually laugh. I do. Because that’s... I used to get upset by it. Really, I mean, I used to get angry by it, but then I learned that you can’t change everybody’s thoughts... and some people are ignorant because they don’t know. And then some people are ignorant because they just choose to be. And it makes a big difference. But if I sat there and I confronted everybody that had a certain thought, I would be tired, and I would have missed out on half my life.

Ultimately, Tisha was very clear about what she felt were responsible for her experience of preterm labor, and she suggested that for each woman there will be something different in her life that may lead her to experience a similar event. She feels there is a diversity of complex life experiences that contribute to this physiological event.

Why did I go into labor early? It wasn’t financial, it wasn’t the fear or threat of having a boy because I didn’t know. Mine was stress but it wasn’t stress of losing a job it was just stress of the maternity leave and the stress of having people constantly on my back about being pregnant. That was my thing. Whereas another person it might be the stress of I’m not gonna get paid for going out on maternity or I already have other kids and this is more added onto it. It’s hard to just label it.

**Analysis**

Tisha felt that she experienced the world around her more intensely while she was pregnant. She described losing her “tolerance” as the pregnancy progressed and as the situation at work became more volatile. Tisha was clear about why she felt she experienced labor at thirty-three weeks and attributed it to her distressful work experiences.

Early on in the pregnancy, Tisha felt that the demands of her job—a busy practice where a nurse or technician could "make or break" the practice—weighed on her. Later, it became conflicts with her boss over FMLA and lack of support and negativity directed at Tisha and her pregnancy. She experienced pregnancy as a sense of “fault” in her workplace, invoking feelings of irresponsibility, burden and choice by her co-workers who in turn influenced Tisha’s daily experiences of stress, frustration and anger. I observed over the course of our
conversations that Tisha felt that her pregnancy was viewed by co-workers, health care providers and church members as a racialized pregnancy. Discussions around welfare, Medicaid, single motherhood and public disapproval often returned to her experiences as an African American woman.

I noted in our conversations that society’s expectations of who she should be—a welfare recipient, single mother, inept worker—grated against her very being. She had worked hard to prove to others that she did not embody or otherwise affirm those stereotypes, physically overworking herself in the process. In this way, much like Sheri, she found herself agitated and frustrated by the negative ways people looked at her or acted toward her while simultaneously trying to manage a painful pregnancy. Tisha experienced a kind of racialized labor—experiences in the workplace as a pregnant woman that were produced by a silent but felt discourse on who she was expected to be as mother and worker and that revolved around prevailing ideas of African American productive and reproductive labor. As such, she was doubly burdened as the weight of performing productive and reproductive labor against racialized images and perceptions of both, became too much to bear. These experiences of racialized labor denied Tisha the freedom to experience the pregnancy as she so desperately desired.

Tisha was unable to truly be happy about the pregnancy as she had initially been. This disappointment at not being able to fully rejoice in her impending motherhood, after a prolonged period of trying to conceive, was difficult for Tisha to reconcile as she endured several complications. I observed the difference in Tisha when we met for the second time

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101 I do not separate productive and reproductive labor except to indicate that Tisha’s difficult work experiences were heavily informed by her pregnancy. For a review of productive and reproductive labor, see Ginsburg and Rapp, 1991.
during her first week of bed rest. Her optimism was replaced by a heaviness that became part of what she felt was a time of spiritual growth.

Tisha’s relationship with God, nurtured and affirmed by her mother and grandmother, mitigated against the deleterious effects of her job situation. As she rested each day at home, she engaged in a spiritual dialogue with God and family that would eventually lead her to choose a life apart from medicine and intimately connected with her Christian faith. Although the journey would prove beneficial for Tisha, it was not without its stumbling blocks and intense periods of self-reflection. However, after the traumatic birth of her daughter, Tisha felt that her own rebirth and self-transformation accompanied by a new appreciation for her life in God, helped to re-orient her energies away from the negative experiences in her life and toward expectations for a better future for herself and her family.
Almost all of Tania’s distress that she experienced during this pregnancy was generated by her very strained relationship with the father of her second baby and whom she refused to call “my baby’s daddy.” Perhaps more than any other participant in this study, race did not seem to be a useful or important concept for Tania as she told her life story. Tania’s experiences of pregnancy and motherhood are informed by the birth of her first son when she was seventeen, and the experience instilled a sense of fear in her regarding how she would manage raising another child “by herself.” Of all life historians, Tania had the lowest paying job and relied on her gainfully employed boyfriend and father of her baby for financial support.

When I first met Tania at the practice, I was immediately struck by her articulate and energetic presence. As I walked into the meeting room, she sat in a powder blue velour jogging suit—nearly forty weeks pregnant—exhausted and quietly slumped in the cushioned pink chairs of the office. But as we began talking, she spoke passionately and intellectually about her pregnancy experiences. A twenty-nine year old cosmetologist who described herself as “divalicious,” Tania always had well-manicured, painted nails and adorned herself with simple gold hoop earrings, necklace and rings. Perhaps speaking to my own assumptions, I was surprised when I heard her speak to the receptionist at the office in terms of her Medicaid coverage.

The second of three girls, Tania was born to a military family in Augusta, Georgia but left for Fort Bragg in Fayetteville when she was very young. She spent “seven or eight” years in Germany until she returned to Fayetteville for her seventh grade year. Tania never attended college but has a degree in cosmetology and is proud to have graduated from high school.
after the birth of her first child when Tania was seventeen. Since his birth, her then-twelve-year-old son lived with her parents in Fayetteville. Tania lived with them until she moved to Durham in 1995 to be with her sister. She leaves work at a Durham beauty shop at the end of each week to drive the now-familiar route to spend her weekends with her eldest son. Tania’s childhood, spent alternatively in North Carolina and Germany, gave her a larger view of the world than most of my consultants. Her ideas about *race* were shaped during childhood encounters with people from Africa, Germany and military families from the United States.

Tania’s perceptions of her upbringing as the unfavored middle daughter weighed on her, as did her past “mistakes,” when she was carrying her second child. Further, she explained that the birth and care of her oldest son was much easier due to her parents’ assumption of his everyday (and night) care while she attended high school. When we met, she was living with the father of her second child in what I observed as a heated, adversarial and tense relationship. She was concerned throughout her pregnancy that he would not be a good father to their son, and she was deeply hurt when he did not ask her to marry him. Being unmarried and pregnant, for Tania, was further cause for the disapproval she experienced from her mother and society at large.

*The perils of being “Divalicious”—Fear of “having a girl like me.”*

Contrary to Helene, Zakiyyah and Sheri, Tania was thrilled to know she was having a boy and *not* having a girl: “I wanted a boy. I was so scared I was going to have a girl. I didn’t know what to do, and my thing was if I have a girl, oh my God what am I going to do? What if she’s like me?”

(Heaving a sigh of relief) I’m glad it’s a boy because at this stage of the game I didn’t want to switch up. I want to stick to what I do know. I do have some
experience with boys. It’s already going to be another experience, I’m just glad it’s something I kind of know about. With a girl, it woulda been a whole nother thing. I look at my sister and my niece and “wooh” (shudders). She is just, I don’t know what it is about little girls. I’m not saying my little girl would be like that, but she’s off the hook. She’s off the hook. She’s just so prissy and I’m just afraid she’d be like ME. She’s VERY prissy. She has to have her lipstick and her nail polish and she wants her dresses and her frilly umbrellas and she’s three! …I guess all of us, me and my sisters are all kinda dramatic in our own little ways. …The older I get, the business I’m in I’m very they say “diva, divalicious” you know. Hair and makeup and clothes and shoes and traveling to hair shows…I just felt like I needed to have a boy. I just felt I needed to have a boy.

Tania felt that her baby’s father wanted a boy and she's hopeful that they can have a close father-son relationship—something her boyfriend never had as a child. As soon as he found out he would have a son, Tania believed he took more of an interest in her pregnancy.

And then I felt better because if it was a girl then I knew that [he] would really have it on me. I don’t know (why). I just felt like if it was a boy he would be more open to do things. “Well, I’m gonna take my son, you know everything is “my son” now. “My son” this and “my son” that. So I’m like okay, maybe they’ll have some time to do football. He’s very excited about that. “I’m gonna teach my son how to play football. I’m gonna teach my son to play this. Because [my older son] and sports…he’d much rather be on the computer. …[He will say] “he’s gonna go to NC State!” That’s why I’m glad it’s a boy, when he took interest like that…it still made me feel like if it was a girl he wouldn’t have done that. He woudn’t have cared what color clothes I bought or what type of sports she played. It woulda just been like, “Well, you take her.”

“Oh, that kills me, I hate it, I absolutely hate it.”—My baby’s daddy/mama and the (non) prospect of marriage.

Although several participants found the phrase “my baby’s daddy” rather humorous (some would sing and move to the once-popular song), Tania was incensed during conversations with her boyfriend that left her feeling like the phrase characterized their relationship. His refusal to discuss marriage, or his tendency to become confrontational when Tania raised the question, further angered her.

…he looks at everything as an ultimatum, “So what? If I don’t marry you tomorrow, you going to leave me?” “That’s not what I’m saying, I’m saying I don’t
like for you to have to introduce me as your girl, ‘This is my girl friend, this is my baby’s mama.’” Oh, that kills me, I hate it, I absolutely hate it...so...Oogh, I hate it, I hate it. Yes, and I hate it. Why do they say that? And I just try so hard not to describe, I mean even when I’m talking about [the father of my first son], we’re not together anymore, I refuse to say “my baby’s daddy.” What does that imply as far as the relationship goes? That you don’t have a relationship with him, that’s all he is, he just fathered my child, he’s the sperm donor, you know, that’s how that sounds to me. It’s just really hard chop-cut, no softness to it at all, I just don’t like it. I don’t know, someone told me before, “You like everything sugar-coated,” and maybe I do, maybe I do, I just don’t like anything so rough and hard...and that’s rough and hard to me. I mean, I don’t even like [my oldest son’s] dad, but I still don’t refer to him, I don’t even consider his dad “my baby’s daddy.” Never. He’s not. He is the sperm donor, but I still wouldn’t say that either...because it’s so hard.

As much as Tania despises the phrase as it pertains to herself, she also believes it is a hurtful way to describe the relationship of a father to his child. Ultimately, for Tania the question becomes directed toward the world of the child. If there is an implied non-existent paternal relationship with the baby, then to whom will the child feel he belongs?

It’s so mean. Yes, it does [demean certain things] and sometimes they need to be demeaned, but I don’t know, I guess it’s just, you can do it some other way...more privately, just don’t say it like that. It’s like scratch on a chalkboard, I don’t like it, I don’t like it. ...And that’s where the song came in, it came in like a joke, and it just makes everyone look so bad, anybody who’s not married to their child’s father, it just made it like an awful joke, and it’s not funny most of the time, it’s not funny, even if, “You’re not married to the child’s father” is not a joke. I mean, that’s your child’s father. What is the child supposed to think, you’re just talking about that’s just my baby’s daddy? So what is the baby?

During Tania’s pregnancy, questions of marriage became particularly salient, as she was already disappointed that she was “doing things backward...again.” She had truly hoped to be married with her second child and she felt that her boyfriend did everything in his power to show her he was unwilling to make that commitment. Tania was extremely angry when she spoke about an experience at a friend’s recent wedding.

When they got ready to throw the garter, you know his brother didn’t even throw it, she walked up to him and tossed it to Tyler. I mean he act like he threw him a rattlesnake. And you know, that pissed me off. ...I was hot, I was real mad because you don’t do that in front of everybody, anybody that jumped off like he’s thrown
you like some type of disease or something, because you’re afraid that you might have to get married. I was like, “What you’re telling me is that you don’t love me, you don’t want to be with me.” “Tania, you know I love you, you know I want to be with you, you know I’ll do anything for you, I’ll give you my heart out of my body.” “But you don’t want to marry me.” “Just like I just want to do what I need to do first.” “Are you doing it?”

“…you can get a divorce over a dollar.” —An economic discourse of marriage

The difficult and tension-filled conversations she had with her boyfriend around the issue of marriage often led to heated discussions over money and long-term finances. Tania’s boyfriend maintained that he was unable to marry Tania because he had to save more money and had other activities in his life he was unwilling to give up. She feels he is scared of committing to her in marriage.

By Tania’s own admission, she can be careless with money, spending it on items that make her happy rather than paying bills. This has become a tremendous source of friction in her relationship with her boyfriend and, he claims, is the reason why he has not married her. Tania’s discussions about marriage with her boyfriend were almost entirely grounded in financial controversies. Tania referred to her parents’ financial arrangements and their long-lasting marriage when she explained that she planned to maintain her own bank account after she is married. Finally, she commented that she has other married friends who face the same financial difficulties.

…I don’t know what that is about that money thing, I’m just feeling like if you have some money, then I have some too, but he’s like “If you have your own account and your account is empty, you don’t have any money, Tania.” Okay, then that’s fine, I don’t have any money then. You got some money, then I’m safe, I’m still safe…Right, you gotta eat, you have to have a roof to live up under, so I’ll just stay with you, and he’s like “No, I need you to be able to pull your weight like I pull my weight,” so one of his good friends from school came to visit and I was like, you know they had just gotten married, I was like “How’s married life, Darrell, you enjoying, you loving it?” He said, “Let me tell you something, Tania, we will get a divorce over one dollar.” He was like you can get a divorce over a dollar.
The reality for Tania is that she simply does not make a lot of money working at a hair salon while her boyfriend earns quite a bit more. Late in her pregnancy, when she began to need diapers and formula and other necessities, her boyfriend unrealistically suggested she pay for them in order to show him she could “pull her own weight.” Although her boyfriend claims she is irresponsible with money, Tania launched into a very heated discussion of his purchase of a large-screen high-definition television while arguing with her over a couple-hundred-dollar crib. She was intensely upset that his friend persuaded him to buy a used, cheaper crib instead and considered it a personal insult to her, their son and their relationship.

…At first he went out and bought a big screen tv and even though we don’t even have a crib yet. I mean it’s huge and we live in an apartment! I’m like why would you go out and buy a large screen tv when we don’t even have a crib yet? You didn’t ask me about the tv. “I paid for it. I shouldn’t have to ask you.”…So when we got ready to buy the crib, I’m thinking he’s gone out and bought this beautiful top of the line huge tv, I’m going all out with the crib. I want a very nice crib. I want it to be what I want it to be. And he let one of his friends…We went and looked and picked out cribs and it took us a couple of hours to pick one out and we put it on layaway. The day he was supposed to pick the crib up, he’s talking to one of his stupid friends and the friend suggests to him, “Why are you buying a new crib? …You can get a crib for about fifty dollars at a pawn shop or whatever.” So I’m like no. No. It never even occurred to him that this is the bed that his child, his brand new baby is going to be laying in…and that didn’t bother him at all. All he could see was fifty dollars, three-hundred fifty dollars. …We scrapped the crib we had picked out. And that was an argument I know for at least a straight month. I didn’t even talk to him for two weeks. Because I was so angry that he let somebody else who had absolutely nothing to do with us come in and…give you this advice and you just take his advice like that. This is your child! How could? [He told me] “You pay the difference… I’m givin’ you fifty dollars.” And that just made me so angry I could have cut him. I was furious. …Now we’re arguing about a Pack-N-Play.

Tania’s boyfriend joked that she and the baby would be sleeping in another room when they came home from the hospital. She believes he “makes everything out like a joke” but she “knows he’s serious.” He continues to go out with friends after work rather than coming home to her. Conversations about money bled into other areas of control that Tania’s
boyfriend attempted to maintain, including Tania’s decision about whether or not to breastfeed. Ultimately, however, Tania controlled the outcome of the discussion.

…then we got into it about the breastfeeding and…I don’t know if I’m gonna be able to maintain my composure and breastfeed and deal with you…so he said “No. You’re breastfeeding. That’s final.” …It kinda made me mad…the fact that he just tried to put his foot down and say actually you don’t have a choice you’re breastfeeding my son and that’s the bottom line.” I said, “Okay, then you’re getting married next week.” He hasn’t said a word about breastfeeding ever since.

Tania explained that she felt events in her life more intensely when she was pregnant. One of those experiences included her mother’s pressure to marry the father of her baby. Although Tania desperately wanted to be married, she disconnected her pregnancy from the act of marriage.

I don’t know…maybe I just didn’t notice it as much before I was pregnant. I feel like everything stresses me out. What am I gonna do about daycare? What am I gonna do about going back to work? How long am I gonna stay out. And the father we are together we live together. My mom is pressuring me probably every day why don’t you get married? That is just…and she never really said anything about that before she found out I was pregnant. I’m already dealing with being pregnant and having the baby and keeping the baby and then you turn around and break out with “When are you gonna get married?”

Tania felt hurt that some people thought of her as a woman “out here havin’ babies.” She comments that it is primarily women who look at her with disapproval or desire for her to be married. She felt particular pressure to express positive feelings about marriage to young girls in her shop and worried that mothers would treat her with distrust or disdain because she was pregnant and not married. She imagined the life that others may believe she is living and felt hurt because she does “have goals.”

I don’t know what it is that makes me want to be married so bad. I think just because I’m not. …Is it really good? So then why do you feel so ashamed and embarrassed when you walk around with no ring on? I almost got to the point where I would just take off all my jewelry. And then nobody will know…I’ll just tell people my fingers are swollen and my rings are at home. …I feel like people are saying “She’s not married. She having another baby. She’s pregnant again.” Even
though it’s been twelve years. …If I have a teenage client and her mother comes in with her, I feel like I have to overextend myself to let her know that I’m not gonna put bad things in your child’s head about marriage…I feel like they’ll look at my hand and see that I’m not married…when you get your hair done, people like to tell you things and ask for advice. …I am for marriage. Please don’t think I’m gonna tell your child to have children out of wedlock…I want to give them the impression that I do have goals. That I don’t wanna be this person out here havin’ babies. I don’t view myself as that so I don’t want anybody else to either. But I feel like I should tell you that…it still makes me feel…I just don’t want you to think that, please don’t think that. …I don’t think men pay that much attention to it. When I’m around males…they won’t even ask you, “So you gonna get married?” Women, especially my female friends when they know I’m not married, they’re “So are you getting married?” Why would you jump all the way to that?

“Do you know what I mean when I say responsible? You’re responsible for half of everything that I’m responsible for. We have to do it together.”—Becoming Father

Tania spent the early parts of her pregnancy feeling very sad. It was underscored by her boyfriend’s lack of understanding and concern for her overall health.

It’s hard for me to make him come halfway with me and really understand what it is I’m going through. What it is that I’m doing. I break down crying and he’s immediately defensive, “What are you crying for?” And I really don’t have an answer. …And he clearly had no, and this was in the beginning, just had no compassion.

Tania had very clear ideas about whom a good father should be and what he should do in order to show her he was committed to her and their child. This included his support—from start to finish—in the delivery room. Unfortunately, her boyfriend refused to be convinced which led to her feelings of uncertainty and potential abandonment during and after the delivery. Tania spoke often of how she hoped the relationship would change after the birth of their child, but the uncertainty of her boyfriend’s devotion was a great source of distress for her over the course of her pregnancy and beyond.

We have argued about some of the major things…like going into the delivery room…he’s like you know I don’t want to see that…you have to go in the delivery room with me and that’s just the bottom line…and that was like pulling teeth…I was like you can’t leave me in there by myself! He’s like “you’ve got the doctors
and nurses.” No. Absolutely not. …I can just see him now when I go into labor if I
get a little angry and might say a few things I can see him walking out the door.
Cause he’s looking for anything to get out the room. That makes me feel very
nervous that he might just try to…retaliate with me, knowing I’m laying here about
to die and he’s not feeling anything...and I can’t get up and jerk him back in here.
…He refused to take Lamaze. Refused.

When I met Tania, she was due to have her baby at any moment. She explained how afraid
she was becoming as the birth drew near. Memories of her first son’s birth emerged as
powerful reminders of the pain, suffering and the lack of support she received from her
mother during his birth. Combined with her boyfriend’s initial refusals (he did stay with her
in the delivery room), the memory of a difficult first experience caused her to worry
constantly about the impending birth of her son.

…and the whole time I’m just, “Mom, this is not going to work, it’s not going to
fit, it’s not working, I can’t do this.” And she’s standing beside me, whispering in
my ear, “Now...you should have thought about that before you laid down.” I was,
“Oh, god. OK, I’m not saying anything else to you.” So, we get in the delivery
room, pushing, pushing, pushing. And I’m just, “OK, what’s not...?” I wasn’t
screaming, it wasn’t horrible. But it was just definitely experience that I could have
waited several years for. …My mom was, “No, don’t give her an epidural. I want
her to be able to know exactly what’s going on. I want her to feel this, as much as
she can take.” So they gave me the twilight sleep, they were, “This will just kind of
take the edge off. ...She thought that was going to be some sort of birth control. Just
to have that thought in my head. “Maybe she can feel this, she can see that this is
not something that you want to continue doing. This is not something that you’re
going to go out and do again next year. And you just let her get a grip.”

Despite her boyfriend’s seeming lack of interest in the birth of his child, Tania maintained
that he was determined to have a relationship with his son because he did not have a
relationship with his own father until he was older and became a successful football player.

I know we discussed it before I had the baby, he was like “You know I didn’t
meet my dad until I was like twelve, thirteen, something like that.” You know, his
mom never said anything, his mom and he never said anything, his mom didn’t say
anything. He said one day he asked, he came home from school and said “Where is
my dad, who is it?” So…he went to church one Sunday, that Sunday, came home
from church, he said there was a man sitting at the kitchen table and his mom said,
”That’s your dad.” …you know he didn’t have this great bonding relationship, you know, he has a relationship with him now.

Although her boyfriend believed he was performing fatherly duties when buying essentials, Tania felt that he had expressed little interest in the baby otherwise. The way she felt he could show this was for him to buy clothes or other more meaningful items for him.

We had this discussion a couple of weeks ago, and it like “You’re always out buying something, and I was like “There are things that the baby needs that I need to get.” Now he will go out and buy cases of Pampers, he will go out and buy a case of wipes, he does everything big, everything big. Go out and buy a case, he’s just content with that, and I’m like “Have you bought him anything to wear? …Have you even looked at baby clothes? Do you even go down the aisles?” He’ll buy milk, baby formula, but outside of that stuff, like “Hunh-uh, I’m not doing it.” I don’t know [why]... and that’s what I was saying, “You don’t have to go to the mall to buy a baby’s outfit. You could go to Wal-Mart, you can go to K-Mart, you can stop wherever you are, when you stop at some store and buy your stuff, I know it’s something in that little shopping center, in that little area that sells baby clothes. Look at it.” I said, “If you don’t know the size, call me, buy the wrong size, I’ll exchange it, but you have not even went out and shopped at all for him.” Not even tennis shoes, his first N. C. State paraphernalia came from his friends… I was like, “You didn’t even go to the school store and buy him his first Wolfpack stuff.” “Ahh…you are just, spend money, you just want to spend money, that’s all you can see, spend.” And that’s all he hears is “spend money.” You know, “He’s got clothes in there; his closet’s full of clothes in there, what’s wrong with those.” “Not like they came from you.”

Finally, during our last visit when her son was three months old, Tania explained that her boyfriend was beginning to take more care with him. However, she still found herself having to explain what his duties were as father.

I expect him to do everything with me, in everything that I can. I expect him to be there. I insist on him being there. And he does not fight me on that. He’s pretty good with that. He’s pretty good with that. And I notice the bigger [the baby] gets, and the older he gets, the more he wants to do. I don’t even have to ask. Like at first it’s like, you know, “Can you hold him for me while I do this?” Now it’s like, “Bring him here.” You know. “Let me hold him, let me get him.” …You’re responsible for helping me raise him, and that means you have to bathe him sometimes, that means you have to make bottles or wash them out if you see them dirty, that’s your responsibility.”…I just almost left him the other day (laughter), gosh, yes, it’s a-h-h, and then of course, he always comes to ‘Okay, okay, okay, gonna be more responsible,’” and that’s when I was “Do you know what I mean when I say
responsible? You’re responsible for half of everything that I’m responsible for. We have to do it together.”

Analysis

Despite Tania’s accomplishments and happiness in her occupation as cosmetologist, she saw her own “divalicious”-ness as “too prissy” for her daughter and hence too difficult for her to manage as a mother. Her biggest concern was not just about how her daughter would present herself to the world, but that she would be just like Tania. This, combined with a strong desire to “not do hair,” was a common response from women who did not want to have a girl. These comments reflected Tania’s self-image that, although boosted by her successful career, was not altogether positive. She envisioned how difficult it would be to mother a girl who gave her as much “trouble” as she gave her own mother. During her pregnancy, Tania revisited the strained relationship she had with her mother and led her to imagine a mother-daughter relationship with her own child as unhealthy.

Tania’s boyfriend maintained that it was her lack of financial responsibility that kept him from marrying her. This contradicts his own behavior when he bought an expensive television when they had yet to buy his son a crib. His disparaging remarks about marriage grated on Tania particularly during her pregnancy. For Tania, the experience of pregnancy drew too many other people—whose advice or opinions were negatively felt by Tania—into her personal life with her boyfriend. She would feel this especially when her girlfriends, who were normally very supportive, would ask her about marriage. Her own mother’s intervention in her life particularly affected Tania, as these conversations revolved around when she would marry the child’s father. Tania’s difficult relationship with her mother, brought into relief during her pregnancy, caused Tania much pain, anger and resentment. Perhaps in concert with one another, all of these relationships that should have been
supportive—her boyfriend, mother and girlfriends—became more negatively felt and invasive for Tania during pregnancy. Her anger and pain over the insulting terms “my baby’s daddy” and “my baby’s mama” revealed her disappointment in herself as an unmarried mother and her distress over her relationship with the baby’s father.

Tania’s boyfriend viewed the marital relationship as economic and restrictive, whereas Tania felt deeply that he should view it as loving and supportive. His own ability to care for himself financially was something he often lorded over Tania as a reminder of her financial dependence on him. Discussions about money foregrounded Tania's dissatisfaction with the father's priorities and economics became the language of their relationship. The longer she endured questions from friends and family about marriage, the more resentful she became of others, like her sister, who entered into marriage. Regarding marriage, Tania felt in limbo during her pregnancy and compelled her to become both father and mother, however unwillingly. She wished her boyfriend would suddenly become who she wanted him to be and she felt it incumbent on her to teach him how to be a father. Controversies over his presence in the delivery room caused her to worry about him "slipping away" at the beginning. She was preparing herself for this by already becoming father.

Tania saw herself in terms of what she wasn’t. She imagined her future as a negative image of what her life is like now (e.g., “I want to be married because I am not.”). I observed that she would communicate all that she had not done, or done wrong, or done "backwards" and this language filled our conversations. Tania used the word “denial” to describe her pregnancy experience as if she were creating another world for herself where she wouldn’t have to think about her future as a new mother—experiences related to breastfeeding, daycare and childbirth experiences of pain and desertion.
It is interesting that Tania, despite those experiences in her life that weighed on her during pregnancy, delivered a healthy eight-pound, fourteen ounce baby boy at term. Tania’s views about race were very different from other life historians’ perhaps because of her partial upbringing in Germany and in the integrated atmosphere of military community life. Experiences of race were not a part of her history that she articulated unless I specifically asked. Even then, she assumed a very neutral point of view regarding being African American, creating a space for a consciousness that was quite different from what mainstream ideologies of race presuppose. Although she felt that by participating in this study, she would contribute to information that “was directly related to me,” she also felt that the experience of being pregnant had a universal quality that comforted her.

Although Tania reported few other sources of real comfort and support in her life, she felt that for her, supportive and positive ideas of self emerged with age. Her work and her upper-class clientele contributed to newfound self-images of intelligence, authority and accomplishment. Perhaps those experiences combined with the world of denial that Tania created for herself as a means of coping over the course of her pregnancy and her neutrally felt experiences of race to ameliorate the unhealthy effects of potentially harmful social relationships.

Further, although Tania’s experiences of race were neutrally felt, I observed that her everyday world is one in which she did not engage with non-African Americans on a regular, social basis. She works in a beauty shop with African American clients and co-workers, her close friends are African American, and she attends a predominantly African American health practice. Although she did not mention this specifically as a supportive environment,
and by her own admission it could also be stressful, Tania may have received unspoken and invisible reinforcement from a community of people with whom she felt closely connected.
Eva—“I just wish someone would have told me the whole story.”

Eva often lamented during our early conversations that no one had ever revealed to her “the whole story” regarding pregnancy, motherhood and marriage. Eva never experienced preterm labor or any other diagnosable complications during her second pregnancy, but she was perhaps the most visibly distraught consultant when we spoke about difficulties in her life. Her marriage continues to cause her a considerable amount of distress and impinges on her mental health in a variety of ways. Like Tania, race was not a salient feature of our conversations and I observed that Eva only thought about being African American when it came to understanding how she would educate her children.

It was a dark, hurricane-like July day when I first met Eva at her workplace in Research Triangle Park during her tenure as a clinical trials manager. A very tall woman with a deep and easy laugh, Eva exuded a quiet confidence seated in her office. Her loose-fitting deep purple silk suit and her youthful face hinted at a professionalism combined with an easy-going manner. At twenty-eight she was expecting her second child, an unplanned pregnancy, due in January. With an eighteen-month-old boy at home, she was having great difficulty managing work, husband and motherhood while experiencing the early pains of another pregnancy.

Born and raised in Raeford, Hoke County North Carolina, Eva moved to Chapel Hill for undergraduate study and earned her bachelor’s degree in chemistry. She grew up with four siblings under the care of her mother and grandmother after her father left the family when she was just three months old. She describes her neighborhood as “middle class” but commented that she “didn’t have much” growing up. Eva still attends family reunions where
she reconnects with extended family members, and her mother currently lives with her and her family in Durham.

Intensely self-reflective, Eva now sees herself as an attractive and healthy woman, although this was not the case when we were engaged in this study. Just after her daughter was born, she cut her hair in a style that her friends viewed as “old lady” and that reflected Eva’s suffering self-esteem. Her soft eyes were laid bare by the constant plucking of her own eyelashes—a medicalized condition known as Trichotillomania\textsuperscript{102} due to the pain she was experiencing in her life. Fortunately, Eva has since stopped pulling out her lashes, but she still speaks of wanting to lose weight and gain a more positive and affirming self-image even though she has lost several pounds over the past two years. Negative visions of herself emerged during conversations about her being “notorious for not wanting a girl.”

Perhaps the greatest difficulties Eva experienced during her pregnancy were those related to a strained relationship with her husband. They met during college while he was in the Army and they married in 1997, one year after she graduated. When we met, Eva also described feeling under a great deal of stress due to a situation that was developing with her mother-in-law, a heroin abuser. Her husband was planning to invite his mother—who was potentially still using—to live with them in their modest home.

Eva described her marriage as “existing in extremes” and spent much of her time reflecting on the roles of wife and mother as prescribed by her church pastor and her husband and that often conflicted with her own feelings about marriage, motherhood and fatherhood. Related to the strains in her marriage were financial concerns that played a major role in her decision

\textsuperscript{102} The National Mental Health Association views trichotillomania as a medical illness related to obsessive compulsive disorder and low self-esteem. See the official website of the NMHA, http://www.nmha.org/infoctr/factsheets/92.cfm for further details. Eva was aware of this term after watching a 20/20 news special on the behavior.
to return to work within months of the birth of her daughter. Her decision—whether to stay home or to continue working—has taken several turns over the last few years. She is currently back to work but hoping to create a home business that would offer her the flexibility to stay home with her children.

Eva lamented that she abandoned her female friends in favor of her husband’s company in their early courting days. As a result, she could not name one person with whom she felt close enough to confide about marital or other difficult issues. Over the course of their relationship her husband has completed two associate degrees at a local community college, but often changed his mind regarding his career. His imagined and unrealistic goals that often centered on earning as much money as possible weighed heavily on Eva. At one point, he told her he was going to train to become a professional football player and then an FBI agent, before becoming involved in a money pyramid scheme over the internet. His simultaneous obsession with earning and irresponsibility with the money they did have was a constant source of distress for Eva.

Eva excused some of his behavior due to his own upbringing in New York City where he left his mother at the age of eleven due to her inability to care for him. He lived with several relatives over the course of his young life and did not feel he had a father figure to whom he could look for advice, support or love. Although Eva did not grow up with her father either, she experienced her childhood as stable and supportive and reflected on it as a happy time in her life.
In our first interview, Eva was noticeably worn out and explained that she felt her work was never done. She was irritated that no one, namely her mother, told her what her life would be like after she was married with children. She felt that her marriage contradicted the idyllic images of married life that she witnessed on television and commented that one day she would write a book entitled, “The Whole Story.” Divulging this story was part of her motivation for joining the study.

…it’s so funny cause you watch things on tv and you have a dog you have a car…you have a house you have your husband you have your babies and dinner just appears on the stove. I called my mom and asked her why don’t you just tell me the whole story? …I feel like I’m just doing everything.

Eva often felt like she had “too much going on.” In addition to her work inside and outside the home, she was an organist at her church for four separate choirs. Whereas some women received great support from their church experience, Eva felt it as a source of stress in her life. She felt unable to step down as choir director as there was no one else to replace her, and attending church after resigning would not be an option. When she was home with her newborn, she re-evaluated how she approached each day and began examining the conditions of her life that produced feelings of being overwhelmed and overworked. She wondered whether overextension of herself contributed to a lower birth weight baby.

If it doesn’t happen that day, then it doesn’t happen. That’s kinda what I’m trying to do with Eva in general these days. Because I had way too many things going on. And I wonder if that affected her weight because she was so much smaller than [my son].

Eva’s second pregnancy was not planned and she was dismayed at the prospect of having more children. She wanted to have a tubal ligation soon after the birth of her daughter, but her husband believed that reproductive decisions were in God’s hands. Nonetheless, Eva
decided to discuss sterilization surgery with her doctor—a conversation she kept from her husband. Her doctor suggested that her husband’s feelings were common for African American fathers involved in the church.

My husband felt that if it wasn’t for us to have any more children that God would prevent us from having more children. [My doctor] said, “believe it or not, I’ve heard that one too. I don’t know where men get this from…especially African American men who are in the church.” That God doesn’t hold them responsible for anything, that they’re just pieces of a…puzzle. He said they just don’t want to be responsible for contraception. …My husband even said we could just abstain. [My doctor] said, “I wouldn’t recommend that either. That’s part of a normal marriage relationship.”

Eva continued to have conversations about long-term contraception with her doctor and eventually decided to implant a five-year intrauterine device (IUD) to prevent another pregnancy. Again, she did not share this information with her husband.

Apart from feeling overwhelmed by working motherhood, Eva felt that she was devalued as a mother in both public and private life. Although Eva commented that she found herself trying to “shove” her wedding ring on to discourage disapproving looks in public, she did not attribute most of her negative treatment to the experience of being African American, but rather to societal, structural problems that made it difficult for mothers to navigate public space, as in a department store. She viewed her public life as a very different experience after she had her baby than when she was pregnant.

…people appreciate you more when you’re pregnant than after you have the baby…you’re regarded differently while you’re pregnant. People hold doors for you. …I just noticed how impossible it is, how our society’s not set up for women with children. …I was trying to get into the store…I opened the door and these people come walking out and I’m standing here, holding the door with the baby in the stroller…I go to turn around to back the stroller in and the people behind me commence to go around me! I thought wow, this is really something…maybe we should go to Europe. Here…in the US of A where you can barely push your baby out before they kick you out of the hospital and don’t try and stay home for too long cause you’ll get fired. And even during that time they don’t even give you all of your pay…I didn’t need all my pay before? I need it even more so now!
Eva felt there were no differences between black and white women as they experience stress during pregnancy. I noted that she believed more in a universal experience of the burdens of motherhood. However, she felt as Helene did that African American mothers begin to worry early on whether to educate their children in ethnically diverse environments.

[My friends] think there is a great difference between their child going to an all one culture daycare like all black children versus a mixed-diversity…one said there was a study done…that proves that black children learn better with black children. That when you put them in a mixed culture they don’t necessarily get the same benefits…So that concerned me as an African American mother. Where I put him in these important early years, am I scarring him?

Further, she felt her decision or ability to stay at home to care for her children was not the “typical” choice for African American mothers. She relates the experience of a stay-at-home mother to the disappearance of extended families for support and the desire of many African American women to work in order to buy expensive material items.

I think in general any mother has the same common problems…but in the African American community and unfortunately because our society is getting so advanced you just don’t have that immediate family like you used to have…you don’t have that family there so that your child doesn’t have to go to daycare…and then you get blasted [for] whether you have to stay at home. And I have to say for African American women typically that is not the choice, to stay at home. And even when I say that to other women, be it black or white or Indonesian or whatever, their response is, “You can stay home…with your child?” And I don’t wanna say that it’s because they’re looking at me saying that black people can’t do that, but I really do think for us, it is to work. And it is to buy a Lexus and to live in an apartment. Because I guess for so long, some of us as children didn’t have those things. And then when we grow up to get money to get those things and we just go way overboard which does not prepare us for when we do have a family. My husband and I didn’t even think about …what we were doing now would affect when we had children. We could have been saving…so that when we did have children and you were adamant about me staying home, it wouldn’t have been such a big financial burden. …it’s a lot about appearing you have a certain lifestyle. …I think things are turning for us…

Although Eva infrequently suggested that motherhood and/or pregnancy were different for African American women, she mentioned the process of naming as weighing more heavily
on African American parents. When Eva explains the reaction from African American friends to her daughter’s name, she reiterates a common sentiment among the women in this study. 103

It’s so weird because whenever I tell people her name, they go “that’s not a typical black person’s name.” (laugh) You know we’re kinda used to the Takeishas and Lakeishas or some ten-letter name that you can’t fit on an application. But a friend of mine said she wanted to give her child a name that if you saw it on a resume you wouldn’t know whether they were black or white. Cause a lot of times we give our children these names and they can be the nicest people but because of their names people just don’t want to talk to them. I hope that wouldn’t be the case, but sometimes people are in those positions that are prejudiced or biased that way and they’ll put that application at the bottom because of their name.

“I almost have to be nothing in order for him to be something.”—Ideologies of Marriage and Submersion of Self.

Eva’s “decision” to stay at home was a source of constant inner conflict as well as daily struggle with her husband. He was “adamant” that she stay at home with their children and, although Eva stated she really wanted to be home, I observed that she was not completely happy with the decision. Eva would cry during several of our conversations, distraught about her home life and finances that were suffering because she gave up her job. The decisions her husband was making for her and their family were generally poor ones that were not well thought out. Eva worked hard not only to ameliorate the effects of his decisions, but also to save their marriage from dissolution. She softened her criticism of his behaviors by discussing the legacy of her husband’s upbringing and how she felt her own childhood shaped who she is.

103 The concept of naming African American children “white” names in order to gain employment was the subject of a news article and University of Chicago/Massachusetts Institute of Technology study in 2003. (Raleigh News and Observer Jan. 22, 2003) The study reported exactly what these women suspected. Those people with African or African American-sounding names were less likely to be interviewed for a job.
Unfortunately I think it’s one of those cyclic things…I really think [my family] caused me to be the compassionate, emotional person that I am. My mom really made sure that we always had what we needed. …I was around my immediate family, grandmother, grandfather, cousins. …And my mother worked a whole lot. My mom is a very loving person…I often see myself in her. But I think with my husband he only had his mom, but it was very different. …He didn’t have any brothers or sisters. …his mom was a substance abuser. He lived in an inner-city…it was a whole other dynamic for him. …I think his [unresolved issues] seem to be much more tragic, or harder than mine. Even though I didn’t have my father, it’s okay because my mom raised me the way she did. You always treat everybody right. …I was raised in the church, my husband was not. …I think because of that, that’s a lot of where our stress comes from. …[his mom] I don’t know whether she’s dead or alive. The ties with his mother are non-existent.

Regardless of his loose ties with his mother, Eva’s husband felt compelled to care for her when she became very sick. Eva tried to convince her husband that his mother moving in meant many difficult things for their family. Her husband felt she was “against him” and that she was trying to further distance him from his mother. At this time during her pregnancy, Eva began crying herself to sleep at night. She later discussed that she was beginning to prepare herself to leave her husband.

I was deeply deeply deeply afraid. …I was in my car, crying, frantic…and [my husband] was adamant about her moving here. …I’m thinking she could have AIDS. I would not dare to invite my friends into this house. …I mean what do you do, she’s sick, it’s your mother…I knew my husband was in a very bad place with this decision which was not good for our family. Do you leave your mom where she is or do you move her here and put your family in jeopardy? My husband took my response that I was working against him…anything I would say he would take it I was trying to divide him and his mother even more.

I noted that greatly contributing to the stress of their relationship was the gap in education that distanced Eva from her husband. He believed she felt superior to him and Eva thought this encouraged him to attempt to maintain financial and authoritative power over her. She still feels he is not treating her in this way “on purpose.”

…and I think he’s always focused on the fact that I have a four-year degree from a really good university and a pretty rough major. And he’s compared that with his…and I think that’s why a lot of times he gives me the comments, “Miss
Psychotherapist, you think you know everything.” …I was commenting to a friend of mine that I almost have to be nothing for him to be something. Like with my job, I have to not be working for him to feel like he’s a responsible…he can take care of his family. Or if I go into a store and I see something I like…he has to be the man and I have to really appear to be the weaker person for him to feel…I don’t think he does that on purpose, it’s just the way it’s working out to be right now.

Eva was frustrated that she didn’t know who she was anymore. She had a "programmed response" that she used to interact with her husband. She began living contradictions daily by being someone with whom she was unfamiliar in order to maintain a peaceful home. She ties in notions of responsibility with her husband’s failure to keep his word about menial tasks around the house or playing with his children.

I see the trend…it’s a programmed response. I am less familiar with who I am. I’m not that person anymore. And his aunt was here and…said whatever you do, don’t lose yourself. And she was crying.

Eva struggled to come up with examples of "good marriages." She felt this was why she and her husband had so many difficulties in their own relationship.

Marriage…it’s really hard work when you don’t have any examples. It’s like going to a job and no one shows you what to do…I think those frustrations in every day life in trying to figure out, what do I do with these feelings when I don’t like my husband or I don’t like my wife? And when our relationship seems to exist only in extremes. We’re really happy or really sad. There’s never an area where you’re just okay. …I can’t even think of examples of marriages that I’ve seen. …there’s not really a reference for me…

Eva believed that growing up in the church did little to reinforce her own ideas about marriage. She felt her pastor instead strengthened ideas of male superiority and power in the household, but failed in explaining how men should go about “being responsible” for their families. Eva suggested that her pastor’s comments were rarely directed toward women.

At church…it seems like even those relationships are really unbalanced. In my church growing up, my pastor was very strong about teaching men that they’re the head…responsible for your family. ….Kinda like you’re the master and everybody else follows your lead. But not really telling you or teaching you how to be responsible for a family…those marriages [that I see in church]…the man is very
dominant and the woman is following along. I never thought that’s what marriage was supposed to be about. So I never really considered those as a reference point for marriages.

Although Eva believed that her position in her marriage was to “help” her husband care for her family, as it says in the Bible, she viewed this very differently from her husband. She felt she did all of the work to maintain the family. Later in our relationship, Eva revisited a book that a friend gave her called “The Power of a Praying Wife.” After reading it, she felt she needed to stop trying to change her husband and instead needed to change herself. The book suggested she pray for him, rather than engage in arguments, when they would begin to have difficulties.

When I did that, I learned how to be a wife. Not a wife and a husband and a father. …I don’t know how it worked, but it worked. I tried to stop being responsible for everything and when I let that go…he was only reacting to what I was doing. …It wasn’t like I read the book and I did it…it took some time. I had developed some bad habits. …I am going to be Eva, the wife and mother and you are going to be husband and father. …my mother taught me to be everything because she had to be a mother and a father and a friend.

“I was notorious for not wanting a girl.”—Birth Imagined as Repetition of Mother’s Life and Experiencing Victimhood

Like Tania, Eva had hoped for a boy. She spent one conversation trying to unravel why she was uneasy about having a girl. As Eva talked about her fears, she began to talk about her own shortcomings as she saw them. She felt she would “connect” more with a girl child and she became afraid that her daughter would be like her. Eva remembered and was saddened by the things she endured as a woman—sexual assault when she was a teenager and her current disappointing and abusive marriage—and didn’t want to see her daughter endure the same experiences. Eva felt that she was working through so many difficulties in her own life that she didn’t feel capable of raising a girl who would be strong enough to tackle such
experiences. On the other hand, she felt like she had more control over her son and could prepare him for experiences in the world such as being denied a job because he is black or dealing with interpersonal racism.

I can prepare my son...why can’t I do that for her? That hasn’t clicked in for me yet. … I don’t know why I feel I have so much control over him coming out to be a responsible man, and feel like I don’t have any control over her being a responsible woman. …there’s so many issues that I’m trying to work through. And I don’t want her to go through that. …I feel like me being a woman I can tell him how to treat a woman. …and him being a black man...I can teach him what to do and make him aware that this is the kind of thing that’s gonna happen when you’re out and people may clutch their purses...go to the other side of the elevator. I can prepare him for that. And I don’t know if I can prepare her for being, not that I’m hoping she’ll be a victim, of like rape or an abusive relationship. Maybe that’s what it is…Maybe as a woman I feel more susceptible to being a victim.

Contrary to her earlier statements about growing up without her father, Eva believed that his early exit from her life and incomplete fatherhood account for her fears about being female and perhaps contributed to her perceptions of self as victim.

…My other thoughts are evaluating my own self as a female and some of the fears and thoughts I have about being female, …I really don’t want to pass these emotions on to her. I’m sure it revolves around my family and …not having my father there.

Eva began a discussion of all of her attributes she wished she could change. In much the same vein as those women who wished against a boy, Eva was hoping against a girl rather than for a boy. Much of her shortcomings (as she saw them) seemed to stem from her marriage and her desire to tell people how she feels rather than keeping it inside. Her husband, although perhaps trying to be supportive, confirmed Eva’s “bad qualities” and suggested she “just change.”

When I found out it was a girl, I was kind of bummed about it. My husband said, “Just because you’re having a girl and you have bad qualities it doesn’t mean you’re a bad person. …Just change em.” [Like] not being able to really say how I feel. …and that causes a lot of conflict for me. I found myself doing a lot of things I really did not want to do. Some social things. A lot of things in my marriage. He
would do something and I wouldn’t necessarily like it and I wouldn’t feel
comfortable necessarily saying I didn’t like it. …I was holding back a lot of things I
wanted to say. …I felt like maybe if I said it, he would be angry or he would get
mad and that would create other problems. …I wanted him to be happy or satisfied.
…but it was making me feel like I wasn’t important.

As the pregnancy progressed, Eva became more saddened by the prospect of having a girl.
She spoke of how she often felt she was giving completely of herself and yet received
nothing in return. She worked hard at the end of her pregnancy to speak more positively
about her experience. In this way, she hoped she would become more positive about having a
girl. Knowing she was carrying a girl, Eva spent much time reflecting on her own approach
to life and who she was.

In my reflective moments…in a way I feel like, not that I don’t want her to be
like me. Cause I don’t think I’m a bad person. I guess…my flaws. Nobody wants to
pass their flaws. But I guess I kinda took that to heart. “If I have another girl, she’s
gonna be like me! Oh why can’t I just have a boy?” As if I had a boy he wouldn’t be
like me. …I often try to think about who I am because I like to be true to myself,
which I haven’t been for a long time.

*Analysis*

Although Eva delivered a healthy birth weight (7 lbs., 6 oz.) baby girl at term, she was
concerned that all of the intensely difficult issues she was dealing with had some effect on
the one-pound difference between the weights of her daughter and son. For Eva, her
experience of marriage wore on her existential Self and led her to question her own value as
a wife and mother. Her beliefs about marriage as an equal partnership conflicted with those
of the church and her husband—a situation that compelled Eva to create an entirely different
Self whom she presented to the world. Living inside this person whom she did not know
caused Eva to despair over her place in the world and to question who she really was.
Eva’s educational attainment cannot be overlooked as a great source of *negatively felt experience* in her life. Although she is very proud of her achievements, her husband did not allow her to celebrate, or even articulate them. It is important to note that several women in this study remarked that among African American couples, women are more likely than their spouses to have earned a bachelor’s degree or higher. This situation, several noted, caused a great rift between couples where questions surfaced around what it means to be a man. The financial fallout from these marriages involved a woman earning more than her husband, something several participants felt was anathema to a healthy marriage.

Eva’s husband attempted to equalize his perceived lower status by maintaining control over her in the home and being “adamant” Eva leave her well-paying job. His power extended to reproductive realms when he asserted that God would decide whether Eva would have more children and would not agree to a sterilization procedure for her. With the support of the church, he became engaged in the *making* of a wife, a wife Eva felt incapable of being.

Although Eva never spoke of her relationship as abusive, her growing feelings of low self-worth at the hands of her husband spoke otherwise. Existential questions of what it meant to *be wife* troubled Eva and landed her in moments of deep-seated conflict within herself. In practice, however, she found herself ultimately unsuited for a submissive position in her relationship. She often spoke lovingly of him, but expressed sadness over a married life that did not gibe with the happiness she expected from it.

Her relationship with the church, although grounded in her strong Christian beliefs, caused her much grief and frustration. She was saddened that her joy, music, had metamorphosed into a joyless pursuit in a church that failed to offer her the support she required. The ideologies of patriarchal marriage perpetuated by her husband and the church steadily eroded
Eva’s sense of personal self-worth. Her eyelash plucking and “old lady” haircut spoke to disappointment with herself and feelings of inadequacy. Her four-year degree did little to ameliorate these feelings, rather it contributed to her husband’s belittling behaviors. When she explained that she didn’t know who she was, she revealed a submersion of Self at the hands of a failing and unhealthy marriage.

Eva often cited her husband’s own experiences of incomplete parenthood when explaining his behaviors. She believed that he was only repeating the “cycle” of poor parenting that he was exposed to as a young boy. As a result, Eva felt she and her children were suffering his incomplete fatherhood. In turn, Eva felt she had to become mother and father.

Finally, Eva was burdened by the thought of reproducing her own “flaws” in a daughter. Her feelings that she would experience a re-birth of Self—and only those attributes she felt were negative—in a female child caused her much distress, particularly after an ultrasound confirmed the sex of her child. Knowing she was carrying a girl caused Eva to look reflectively at herself and examine what she liked and didn’t like. As with women who feared bearing sons, this experience of gendered pregnancy and the imagined victimhood she saw for her daughter contributed to conditions of life that produced an existential kind of suffering.

Eva still appears to be able to cope with her continued suffering, for better or worse. For Eva, marriage and motherhood became landscapes of personal change that compelled her to engage in periods of intensive self-reflection and prayer. She maintained a perception of universal pregnancy whereby African American woman experienced the stresses of pregnancy no differently than other women. Eva’s felt experiences of being African American emerged only as part of her narratives that addressed the parenting of her children.
and included discussions around financial planning for their future, her husband’s incomplete fatherhood and her concerns over raising her children in a race-prejudiced world.

Although Eva mentioned several experiences of interpersonal racism while in college (her first such experiences), her life narratives—much like those of Tania—suggested that race as defined by African heritage and skin tone informed little of her ways of being in the world. The power of her intense moments of reflection and her faith in God, combined with neutrally felt experiences of race and perceived near-universal experiences of motherhood may have woven the web of support Eva required in order to deliver a healthy child.
Chapter Eight

Synthesis and Conclusions

... I’m a black woman. I mean I’m black, and then I’m a woman and that’s the way it is. And I wouldn’t want to give up one or the other ... I see the world through that set of eyes. I mean that’s my identity and that imposes upon me obligations different and special and that’s a burden and a blessing and I don’t see any sense in pussyfooting around with that. (Helene, 2002)

American culture is replete with derogatory icons of Black women—Jezebel, Mammy, Tragic Mulatto, Aunt Jemima, Sapphire, Matriarch, and Welfare Queen. Over the centuries, these myths have made Black women seem like “nothing more than the bearers of ‘incurable immorality.’” (From Dorothy Roberts 1999, Killing the Black Body: Race, Reproduction and the Meaning of Liberty)

The psychic bouts with self-confidence, the existential agony over genuine desirability, and the social burden of bearing and usually nurturing black children under these circumstances breeds a spiritual strength of black women unbeknownst to most black men and nearly all other Americans. (Cornel West 1993, Race Matters)

The goal of my research has been to more fully understand those experiences in African American women’s lives that come to bear, in both positive and negative ways, on experiences of pregnancy. Although this became an exploratory study of themes in African American women’s lives that speak more of the lived experiences of pregnancy, I have paid particular attention to those experiences related to the interacting systems of being African American, female gender and class in the context of pregnancy and motherhood in order to address the longstanding and glaring inequalities in preterm labor, preterm delivery and infant mortality between African American and European American women.
The narratives presented in the previous chapter speak to those experiences in African American women’s lives that come to bear on the courses of their pregnancies. Although some of the findings could apply to other women who are not African American—e.g., low self-esteem and desire to not bear a daughter; male-female relations that are *negatively felt*; experiences of *incomplete fatherhood*; experiences of class that articulate with pregnancy—I propose that *lived histories* of African Americans in the U.S. and the legacies of enslavement have produced specific conditions of life that are culturally informed and give rise to such *felt experiences*. For example, the position of African American men in a racist society that has limited their economic and, according to Hill (2005), “psychological” achievement endangers intimate male-female relations, particularly when a woman has achieved greater educational and economic success than her male partner. Also, the character of some experiences—e.g., experiencing pregnancy as social class and articulations with imagery of a black welfare queen—are culturally informed by experiencing a racist society as an African American woman.

Some findings, however, are entirely unique to African American female experiences. One example (as in Helene and Sheri’s narratives) is experiencing pregnancy as fear generated around bearing a son in a society that sees him as threatening and whose mother fears for his safety as a young boy and man. The powers of racist stereotypes on *negatively felt* perceptions are intensified during pregnancy as per Sheri and Tisha’s experiences.

Although I collected pregnancy narratives from 62 women and extensive life histories from six—only a small part of which I am able to present here due to the constraints of space—it is not my aim for this research to speak for all African American women nor to present this analysis as generalizable to all African American experiences.
By intensely exploring lived experiences in individual women’s lives, this work eschews bi-
molecular theories of race-based difference and examines how these women understand and
experience being African American, racism, female gender, and class as lived rather than
socially imposed (or uncritically examined) categories. Last—and most importantly—I
situate this work in a broader landscape of antiracist scholarship, discourse and activism.

As mentioned in the introduction, a key theoretical framework for this study is one that
conceptualizes pregnancy as a culturally informed life process and a unique physiological
event. This is in keeping with Rudolph Virchow’s perspective on medicine as a “social
science” and in support of the connections between a lived, culturally informed social life
and biological responses (also see Kleinman, 1978). Although there are some researchers
who study circulating hormone levels and molecular cascades in response to “social stress”
in order to explain these connections, this is not my aim. Instead, I have explored the
meanings of pregnancy, childbirth and motherhood using an anthropological approach that
allowed me to understand women’s lives in full and meaningful ways. Intense interviewing
and observation combined with engagement in the lives of my consultants has allowed for a
deeper understanding of the lived experiences of these African American women and the
existential dilemmas they face in a society stratified by skin color.

I originally proposed that social inequality that is experienced as racism is associated with
preterm delivery of a low birthweight infant. However, the group of women whom I
interviewed described various experiences of race-based social inequality but had
remarkably low numbers of preterm and/or low birthweight deliveries.104 As such, I cannot
say that experiences of racism predicted such outcomes in this sample of women. But I

104 See Table 6.3 Comparison of Pregnancy Outcomes, p. 125.
propose that African American women experience and help to define gendered and classed racism in different ways when they are pregnant and that those experiences can weigh on them in adverse ways. These burdens may have myriad manifestations including complications during pregnancy and/or delivery, high blood pressure, depression, preterm labor and/or delivery of a low birthweight infant. In addition, I propose that there are elements in women’s lives that mitigate against the adverse health effects of felt experiences of race-, class- and gender-based inequalities including visiting health care providers who are also African American.

In “The Absent Body,” Leder maintains that when human beings are healthy, we tend to take our bodies for granted. When we feel pain or are sick, we experience our bodies in heightened and more fully conscious ways. He applies this concept of dys-appearance also to pregnancy: “Our self-interpretation, importantly tied to the appearance and integrity of the body, is thrown into question at times of puberty, pregnancy, and aging … These are moments of impending birth or death, devastation or renewal, calling forth deep-seated responses” (Leder, 1990: 92). My consultants remind us that our bodies are not all viewed or experienced in the same, neutral ways. Helene suggests, as did many of my consultants, that being a black woman carries its own unique burdens and blessings that are heavily informed by their experiences of class and being African American and female.

Finkler’s concept of life’s lesions is useful in understanding the social and cultural lives of these African American women and physiological responses during pregnancy and postpartum. The concept “rests on the assumption that to be human is to simultaneously perceive, evaluate, and embody the physical and social environments and to impose order on

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105 Leder uses the prefix dys not in the Greek sense of “bad” or “ill,” but rather the Latin “doubled, away, asunder from itself” (p.89).
them. When the perceived order vanishes or recedes in the background, we experience disorder in our bodies; we become sick and cease to take our bodies for granted” (Finkler, 1994a: 15). I would add to this concept that perceived order is culturally constructed and felt experiences of *race*, gender and class reflect society’s construction of what is “normal” or “fact.”

To explain further, *negatively felt* experiences of being an African American female in particular were often expressed simply as “facts of life,” implying that such experiences are part of the social “order.” The perceived order is a racist order. In other words, “disorder” may come to mean an absence or reversal of negative experiences of *race* and gender. *Negatively* felt experiences of class and being an African American woman may actually be experienced as “order,” yet are *negatively felt*. Further, *positively felt* experiences of being an **African American woman** and related experiences of class can impose a welcome “disorder” and help to mitigate against the effects of living in a racially stratified society. Helene, for example, experiences “being black” as a “blessing” and elaborates extensively on her joy and pride in being “one of the lucky ones” as an African American female. This disrupts the perceived racist order that exists in U.S. culture and celebrates those experiences that are expected to produce feelings of inferiority in a racist society.106 I suggest the use of the concept of *balance*—a powerful and meaningful concept in many of my conversations with mothers—rather than “order” to both highlight the cultural construction of order and to elevate experiences of perceived *balance* and *imbalance* as co-producers of health and illness. I will return to this concept of *balance* later in this chapter.

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106 My conversations with Helene around this subject are reminiscent of the “Black is Beautiful” movement of the 1970’s.
This research affirmed that, during pregnancy, women experience their bodies in distinctly different ways than when they are not pregnant. As their bodies grow, their pregnancies become visible to a larger society as well as themselves, making room for a combined public-private intersubjective space that is not always experienced as benevolent by a pregnant woman. As pregnancy progresses and women grow into that space, the burdens of living in a society stratified by skin color can become intensified. The combined experiences of being pregnant and being an African American woman have brought into relief those aspects of women’s lives that may complicate or contribute to a healthy pregnancy and birth.

The narratives of African American women in the previous chapter suggest that there are issues, events and concerns that they articulated as “stress”—a negatively felt experience of embodied tension—that can impact the life of a pregnant woman and her unborn child. I will refer to “stress” instead as a complex array of negatively felt perceptions and/or experiences. Each woman also suggests that there are ways in which they are able to cope with these experiences, thus ameliorating potentially detrimental effects.

In this final chapter, I will first address those experiences that women perceived and felt negatively with specific attention to African American experiences of female gender and class. I will incorporate felt experiences that are generated from within and that are most difficult to address for these pregnant women. Next, I will address those factors women discussed that may have helped them cope with negatively felt perceptions during their pregnancies and contributed to the delivery of a full-term, healthy birthweight baby. Finally, I will explore the meanings and experiences of racism, class and being an African American woman as they relate to these women’s experiences of pregnancy.
Negatively Felt Experiences of being African American and Female: Gendered Pregnancies and Fear of Bearing a Black Boy

Perhaps the most striking and disturbing narratives in this study have been those of the large number of women who said they were afraid of bearing a male child. All parents harbor some fears for their children, ranging from fear that they may become sick to the existential angst that they might not grow up the way we had hoped. We fear that we aren’t being “a good parent” or that we’ve let our kids down in those small ways that only parents can know and feel. However, the fears that have been expressed to me by these African American women are like none I have experienced, nor are they fears to which many others can relate. Being afraid for your child’s life before he is even born because of the perceived color of his skin and his male sex is an experience that was retold to me several times over the course of this study. These experiences are perhaps the gravest consequences of racism in contemporary U.S. culture.

As I explored the reasons behind these feelings, women began to describe the lives of their would-be black sons in terms of the violence—symbolic, structural and otherwise—they would suffer at the hands of a society that has made no secret of devaluing them. Imagined gendered fetuses generated a negatively felt experience from within that resisted traditional coping methods women used for other kinds of negatively felt experience. African American male physicians at the practice found themselves engaging in discussion with women about their fears around having male babies. They would advocate for a child in its earliest stages of development, telling the mothers “Black male children are gems. Do you realize what you’re carrying?” Regardless of support from some physicians regarding culturally-informed
existential questions of mothering sons, women in this study felt burdened by the prospect of bearing a male child. In the cases of Sheri and Helene, fears around this possibility heightened as their pregnancies progressed.

Negatively felt experiences of race and gender—traditionally addressed in public health and medical literature as belonging to experiences of the mother based on African American heritage and female gender—are turned on their heads in this study finding. Some African American women experienced the violence of a society directed at their imagined (or known) sons based on his African American heritage and male gender. In other words, during pregnancy they began to intimately experience what it would be like to be African American and male.

Sheri and Helene illustrate this concept, for they suffered this violence themselves in the everyday imaginings and concerns that they would bear a child that society worked to dehumanize. The complex interplay between a chronic consciousness of fear and/or harm and the physiological progression of pregnancy may contribute greatly to the preterm delivery of a child and complications of sickness (as in Sheri’s case), and also to the low birthweight of a term child and depressive conditions suffered during pregnancy (as related in Helene’s narratives).

Narratives of fear unfolded into narratives of burden as many women asked themselves “How much work will I have to do to make him a responsible black man?” “Will I be able to do it?” and “If I can’t do it, then who will?” Women articulated specific concerns around bearing a child who could potentially become violent—mirroring the expectations of a racist U.S. society—or who would reject social responsibilities in his home and working life. In this way, women found themselves internalizing pervasive stereotypes of African American
men or, in Helene’s case, being so bombarded with real experiences of young, African American male criminal offenders that they began to imagine bearing violence in a son. Helene saw this as an unforgivable act and felt great pressure to not produce a son who would become another statistic. She and others said they were “silently hopeful” or “wishful” that they were not carrying boy babies.

Sheri worked hard to imagine a name for her son that would not mark him as black so that he would have a chance at landing a good job and would be able to provide for his family. Throughout our conversations, she would speed through her child’s life wondering where he would go to school, whom he would marry and whether he’d be able to provide for his children as her father had directed her to provide for hers. These imaginings were experienced as fear and contributed to existential questions around her own capabilities as a mother and ideas of failure as they related to raising “a good black man.”

Many women besides Sheri spoke about raising “a good black man” and voiced concerns over whether they were equipped to manage that challenge. They invoked ideas of “responsibility” and “respect for women” when they spoke of their unborn child and the distress over feeling incapable of shaping such a person. In his book Countering the Conspiracy to Destroy Black Boys, Kunjufu writes, “Mothers raise their daughters and love their sons,” implying a hands-off approach to maternal rearing of African American boys. Among these women this was not the case, but many approached raising a son with trepidation even when they were in a stable relationship in which the father had an active part in childrearing. Although some believed that a boy would identify more closely with his father, nearly all women acknowledged that they would also work to raise a “responsible” son.
For Helene, Zakiyyah and Sheri, fears were generated around past negative experiences with men—particularly fathers and boyfriends—and those images of black men that are projected into mainstream culture by television, movies and news media. For these women, pregnancy itself became a state of suspension where imagined gendered fetuses produced a terror that they would bear sons who were not “responsible” or who would suffer the violence of a society that does not want them. Ideas of “responsibility” were intimately tied to ideas of masculinity that included fatherhood.

There is very little literature on the relationships between African American fathers and daughters (Cochran, 1997) and the consequences of relationships that are marred by full or quasi-absence of fathers or disengagement of present fathers. Although this is not a phenomenon unique to African American women, the conditions that produce such incompleteness may be the result of historical and cultural conditions of life that are unique to African American cultural communities, and warrants further investigation. Several women explained that poor relationships with their fathers contributed to poor constructions of men and gendered ideas of “responsibility” that they felt their sons would have difficulty achieving. I suggest that experiences of incomplete fatherhood contribute to such ideas and inform ideas about African American men that are felt by pregnant women who may be carrying a son. I return to this idea of incomplete fatherhood below in my discussion of male-female relations.

As I noted previously, there were apparent class-based preferences in this study regarding the gender of a child. Because I did not have a large number of low-income women, this merits further investigation. I observed that those women who were upper-class as defined by income and education generally preferred a girl, which was often verbalized as “not wishing
for a boy” whereas women who received Medicaid assistance tended to prefer a boy, which was often expressed as “not wishing for a girl.” This was not always the case as in Eva’s narratives, but Tania felt that in order to maintain a long-standing relationship with her boyfriend she needed to have a boy. She felt her boyfriend would connect more with a son and that this would also translate into a renewed commitment to their relationship and eventually to marriage.

As noted in both Eva and Tania’s life stories, feelings of female inferiority permeated their narratives and carried over into their own misgivings about having a female child. Again, I recognize this is not an experience limited to African American women, but it was a salient part of both women’s life histories. Other women described feeling inadequate in the management of everyday activities for their daughters, especially in braiding, plaiting or styling their hair. Although this may seem like a minor concern to some readers, the cultural importance of women’s hair in African American communities has been the focus of recent scholarship (Ebong, 2001; Banks, 2000). In speaking about their inability to care for daughters’ hair, mothers such as Eva and Tania who suffered the pains of poor self-image felt unable to nurture a healthy, positive Self in their daughters. Further, and not different from mothers who feared for their sons, Eva felt that she would be unable to protect her daughter from being victimized like she had been and worried for her safety. However, she did not link the experience of being a victim to her African American heritage but rather to her female gender alone.

We don’t often think of pregnancies as being gendered. Women and men seek out ultrasound services to reveal the sex of their unborn baby, but little has been discussed about how the pregnant woman might experience those results. For those women who knew the sex
of their child before birth, the knowledge was experienced both as fear as in Sheri’s case and comfort in Tania’s and Zakiyyah’s life stories. Eva experienced the knowledge she was carrying a girl as depression, which ultimately led to intensive self-reflection as a way of approaching this knowledge and the implications it would have in her life as the mother of a daughter. Helene, along with others who did not want to know the sex of their children, found herself preoccupied with whether or not she was carrying a boy. As described above, she found herself in a state of suspension, between knowing and not knowing how her life would unfold after the birth of her baby. She experienced her pregnancy as male gendered while being “silently hopeful” she was not carrying a boy.

In sum, African American women may experience a gendered pregnancy as fear. Fear was experienced as a penetrating feeling—a “terror” able to reach across layers of muscle and decidua and travel through placental barriers thought to protect and nurture an unborn child. For these women, chronic fears led to existential dilemmas around mothering black male children and both challenged and affirmed longstanding negative images of African American men. These negatively felt perceptions around mothering sons are the end-results of these women living in a racist U.S. culture that perpetuates ideologies of black men as threatening.

As women attempted to understand their fears around having a male child, the intimate presence of memories of incomplete fatherhood and destructive stereotypes of African American men became entwined with their experiences of pregnancy. In addition, fears generated around a black male experience of violence engaged mothers like Helene in the process of becoming black boy, black man. This is not to suggest a masculinization of African American female experience but rather to propose that there may be an added burden
experienced by a pregnant African American woman. Narratives that included imagined sons’ lives as they unfolded at various ages—eight to 10 years old being consistently pivotal—spoke to an intimate involvement in a process of becoming that was not only unfamiliar but sometimes hostile—an intimate experience of what it might be like to be black and male during a quintessentially female experience of pregnancy.

Male-Female Relations: Expectations, Realities and Perceived Loss as Negatively Felt Perceptions

In an effort to understand current expectations of men as fathers and perceptions of men in women’s adult lives, I recorded extensive histories from women that depicted layers of fathering experiences. This is in part to deconstruct theories of African American families as “matriarchal” or “pathological” and to more fully comprehend experiences of fatherhood from the earliest recollections of these women.

Much has been written about “absentee fathers” particularly as they relate to delinquent child support payments and non-residence with mothers of their children. This is especially true in writings concerning African American fathers (See Hamer, 2001 for a review). Few scholars, however, have attempted to understand how fatherhood operates in contemporary African American families nor how experiences of fatherhood by daughters may shape women’s understandings of men in their adult lives (Cochran, 1997). I have come to appreciate the enormous value of research that would address African American men’s experiences of fathering—a suggestion repeated to me by consultants in this study.

The concept of incomplete fatherhood arose out of discussions with consultants, academic committee and community members who cautioned against reducing fatherhood in African American families to whether or not he married or resided with the mother(s) of his children.
The construct is an effort to avoid the notion of absenteeism, or the idea that African American men father children and exit with little or no further contact with them, and to combat criticism of African American families that dates back to Moynihan. However, the stories of incomplete fatherhood are among the most painful for these women to tell. Some women experienced this sense of incompleteness as daughters while others experienced it as girlfriends or wives. Eva experienced it as both.

This work suggests that there is an array of fathering experiences among African American women, some of which may contribute to ideologies of absenteeism. For some, like Helene, a father’s participatory absence was a strongly felt, and often negative presence. In turn, her lack of positive experiences promoted a devaluation of men that invaded her thoughts while pregnant and fomented fears of having a boy. Tisha affirmed fathering experiences that were positive and healthy which may have contributed to her difficulty in understanding why anyone would be afraid to have a boy child.

Incomplete fatherhood also relates an existential sense of loss when daughters grow up without a father participating in her life or with a father whose actions lead her to devalue men and internalize race-based stereotypes which can then haunt a pregnant woman or mother of a son. I expand this concept to include incomplete motherhood in order to acknowledge that mothers’ relationships with their daughters are subject to fractures that are also felt by a woman as she prepares herself to become a mother.

Tania’s history suggested that her experience of her boyfriend’s incomplete fatherhood revealed a failure of their intimacy as a couple. In her discussion of the phrase “my baby’s daddy,” she echoed the sentiments of at least two other participants in the study. The negative connotations of this phrase were intensely felt by Tania—particularly as her
pregnancy progressed. This phrase, popularized by several songs and a movie,\(^{107}\) has
singlehandedly placed African American male-female relationships under public scrutiny.

Idealized visions of masculinity that included an equal partnership in raising their son and
a respectful and deepened relationship with her melted away as Tania’s due date drew near.
In her case, her own experiences of growing up with a father who participated in her life did
not gibe with the difficulties she was experiencing with her boyfriend. The experience of
pregnancy for her was one of unmet expectations and heightened concern that she would
raise a second son without his father’s help. It is important to note that this can also occur
within the context of a marriage, as in Eva’s narratives.

Finally, I propose that an added dimension of *negatively felt experiences* in the context of
male-female relationships is one that engages ideas about paternal financial responsibility as
an indication of manhood and the reality of a more highly educated female partner/spouse.
Several women in this study believed that this economic inequality between spouses was
responsible for much of the domestic trouble faced by middle and upper class African
American women. In Eva’s life her husband in effect held her education against her. She was
made to feel inferior even though she had worked hard to achieve academic and professional
success. Among the six life historians, three held positions that were equal in economic
productivity to those of their husbands.

Inequalities in income generated inequalities in experiences of economic and educational
class for the men in the lives of these women. In turn, as in Eva’s case, a spouse may turn on
his more educated partner and demand power in other areas of home and social life. This in

written and performed by Wyclef Jean; “Yo Baby’s Daddy” (2000) written by Dave Hollister, Dreamworks
“My Baby’s Daddy” (2004), Buena Vista Home Video.
combination with the added pressures of providing the major income for the survival of their families weighed on both Eva and Sheri throughout their pregnancies. Further research and analysis is necessary as graduation rates for African American women continue to rise in comparison with male counterparts and in recognition of the central relevance of these experiences to the understandings of a pregnant woman as mother, wife and woman—particularly in the lives of middle and upper-class African American couples.

Hill (2005) discusses that black male-female relations are under particular stress due to longstanding effects of a racist culture that has limited African American male economic and psychological success and simultaneously created financially independent African American women. Further, dominant culture ideologies of gender and marriage grate against the opportunities and experiences of many African American couples who work to maintain relationships and economies outside the “traditional” marriage relationship. African American male-female relations have been considered “race secrets” (Cole, 2004) and constructed as culturally taboo subjects.

Speaking about these relationships is often viewed as airing dirty laundry and as an act of division within African American communities. Hill, along with Cole and Guy-Sheftell (2004) also remind us that public scrutiny of these relations is anathema to African American cultural communities’ senses of race-based solidarity and that the history of purposeful exclusion of narratives of what she calls “black intimacy” have masked gender-based inequality in these relationships and silenced experiences of domestic and other abuse. I remind the reader that this research contributes to the array of African American cultural and gender experiences and acts as a voice speaking to gender-based discrimination within those communities.
As I point to in the life history narratives, further in-depth exploration of male-female relations in African American cultural communities from the perspectives of men and women is crucial to understanding not only the interpersonal experiences of men and women but also their impacts on pregnancy and parenthood.

The Racialization of Pregnancy and Experiencing Class as Feeling

Within the broad stream of experiences of pregnancy in this study, several women expressed feelings of lower-class status while visibly pregnant. Such pregnancies have been racialized by the larger society and members of African American communities to the extent that a black pregnant woman invokes perceived assumptions about her marital status, her (ir)responsibility as a mother, and the economic burden she and her children are imposing on “taxpayers.” Not only do these women experience a lower class status because of interactions between their race and female gender but they experience lowest class status when they are pregnant. In other words, these women experience pregnancy as social class.

The pregnant black woman becomes a symbol of welfare itself with attendant, and permeating moral overtones about how she should be living. Finkler’s (1994) concept of life’s lesions addresses these contradictions in women’s lives and how they become inscribed on their bodies. Life histories have given me glimpses into those experiences over a woman’s lifetime that may contribute to the development of ideas on what life should be in contrast to what life is. Fear, anger and other felt experiences of class subordination point to those contradictions and are embodied and experienced as tension, pain and I would say sometimes diagnosable complications during pregnancy such as high blood pressure (in Sheri’s and Helene’s cases) and early onset of labor (as described in Tisha’s narrative).
Embedded ideas of being viewed as “in the system” brought into relief societal stereotypes and low expectations of pregnant African American women for Tisha. She had worked exhaustively to avoid being “in the system” and yet faced this scrutiny when she sought prenatal care. For Sheri, becoming pregnant was experienced as the fulfillment of negative images of African American women. Not only did she experience this as anger but also as a denial of all she had accomplished as college graduate and working mother. Further, her aim was to “fit in” to the mold of a dominant Euro-centric culture but her pregnancy placed her firmly outside the possibility of doing so.

The somatization of class is a concept that arose out of numerous conversations with women about how they were “looked at” by wider society as they grew into that combined public-private space. As Cataldi (1993) and Gordon (1997) remind us, that space is not neutral for people who have been systematically oppressed because of the color of their skin. As I proposed above, skin color precedes these women as being-in-the-world. Skin color becomes more intensely felt for these women when they are also visibly pregnant.

The articulation of pregnancy and experiences of class affirm concepts of perception, perceptibility and embodiment as related in the narratives of Tisha and Sheri. Although disparaging words may never have been uttered, each felt as if they were viewed as lower class. The perceived and felt disapproving gazes of others, including both Euro-Americans and elder and/or female African Americans, speaks to the life of skin color and a pregnant body that lies beyond the individual. Perceived as low-class while pregnant—regardless of income, education and marital status—these women capture the process of embodiment whereby their pregnant black bodies become symbolic of social inequality and mark “the material process of social interaction” (Csordas, 1994). Their pregnancies, then, are
experienced as entwined processes of physiology and felt experiences of class. Chronic battling of negative and wrongly-held assumptions in the daily life of a pregnant woman can burden her physiology in much the same way as they burden her socially and culturally.

Further, as married women lamented being unable to wear a wedding band as their pregnancies progressed and unmarried women wished for a ring of any kind to appear married, the felt experiences of unwed motherhood combined with perceived moral and racist overtones of a disapproving society came to bear on daily interactions in public spaces. This visible symbol of marriage became a proxy for life experience as both married and unmarried women perceived social censure for being pregnant. These perceived ill feelings from society contributed to degrading feelings in a pregnant woman regardless of her marital status.

Work, Race, Gender and Sickness

Almost all women in this study worked outside the home. In many discussions about women, work and pregnancy, several themes emerged as important in understanding experiences of pregnancy in the workplace for African American women. As several consultants pointed out, African American women “have always worked.” Affirming the disconnect with a broader “white” feminist movement that sought to increase the numbers of women in the workplace, and recalling the preferential employment of African American women over men in the early days of Reconstruction, many explained that they were not torn between staying at home with children and working. They enjoyed work, their mothers “had always worked” and it had become a “fact of life” for them. However, experiences in the workplace took on a different tone when they became pregnant.
Many women “hid” their pregnancies until they had grown too large or until they needed to request maternity leave from their employers. Some, like Tisha and Sheri, experienced a devaluation of pregnancy in the workplace that they felt was exacerbated by their African American heritage. Tisha felt she was singled out because of her race in an all-white work environment. After two years of trying to conceive, Tisha was bursting to tell the world about her pregnancy. When she finally did reveal it to her co-workers she wasn’t met with congratulations but rather with disappointment, disapproval and ultimately rejection. She is convinced that the weight of these negatively felt perceptions produced premature labor contractions that hospitalized her.

For Zakiyyah, daily run-ins with her African American female supervisor proved physiologically harmful when she began bleeding midway through her pregnancy. Her disappointment in the failure of a perceived cultural and gendered support network registered a sense of imbalance in her life that bled into daily experiences in the workplace. In combination with her deep disappointment in her supervisor as a minister and given the valence of spirituality and faith in Zakiyyah’s life, her treatment at the hands of this woman was almost too much to bear.

Sheri’s experiences of pregnancy as sickness streamed together with negatively felt work experiences. Her description of “the domino effect” spoke to complex experiences of class and being an African American female in her work environment. She too felt a sense of betrayal by an African American male supervisor whom, she felt, was under scrutiny of a predominantly white group of colleagues. Sheri often cited ageist and racist reasons behind her own white, female supervisor’s actions toward her. As she began to experience pregnancy as sickness in the early part of her pregnancy, Sheri’s workplace became an even
more hostile environment. Inquiries into her personal health, scheduled appointments and disagreements about maternity leave were experienced as an unwelcome and penetrating surveillance of her private life. Boundaries between personal and public information were not only blurred but dissolved, as Sheri had to account not only for time lost on the job but for her personal health reasons for leaving work.

Workplaces can be great sources of negatively felt perceptions for pregnant women, but for African American women there may be added dilemmas that preserve raced and gendered hierarchies. Intracultural tensions produce feelings of betrayal and disappointment as perceived advocates metamorphose into adversaries. Chronic experiences of negatively felt perceptions in the workplace intimately connect with perceived sensations of high blood pressure, nausea, dizziness and headaches. In Sheri’s case, sensations translated into medicalized conditions that would begin to complicate her late pregnancy.

Experiences of negatively felt perceptions due to fears around bearing a male child; damaged male-female relationships; feeling of lower class status imposed by a societal gaze; experiencing pregnancy as sickness in the workplace; and chronic conflicts with co-workers that are not only felt as raced and gendered but are more intensely felt during pregnancy all work to impose a perceived imbalance in the lives of these women. It was my observation that those women who experienced race as more salient in their lives (Helene, Sheri, Tisha, Zakiyyah)—in both positive and negative ways—had heightened senses of imbalance between expectations and reality. Felt experiences of being African American contributed to a heightened consciousness of the ways in which race and racism operate in American society. All of these women suffered some complications during pregnancy, delivery and/or postpartum.
Conversely, Tania and Eva’s experiences of being African American were noticeably articulated as neutrally felt. This is not to say these two women were unaware of race-based injustices, but their narratives gave experiences of being African American (positively or negatively felt) a weaker valence in how they remembered their lives and, interestingly, these are the women who had healthy birth weight babies at term with no detectable physiological complications. However, this is not a signal for those of us who wish to address health inequalities to propose that African American women disengage from a cultural community to which they feel they belong. As mentioned in Tania’s narrative analysis, although she articulated that her understandings of race were not germane to the telling of her life story—nor were they experienced as negatively felt perceptions during her pregnancy—she surrounded herself with African American people in her work, home and social life.

Maintaining Balance: Positively and Neutrally Felt Experiences of Class and Being an African American Woman, and Means of Coping

When confronted with racialized ideologies that promote skin-color-based discrimination (perceived or otherwise) and that impinge on one’s day to day life, African American women may find themselves living lives replete with contradiction and dissatisfaction that manifest in physical experiences of pregnancy complications, including preterm labor or delivery of a low birth weight infant. In much the same way as culture becomes a social agent in phenomenological analyses, culture guides the experiences of African American women in ways that combat the contradictions in which they live and also works to promote healthy births across life experiences.

The influence of an obstetric practice that is predominantly African American cannot be overestimated. It is important to note that the existence of such a practice is rare in North
Carolina and perhaps nationwide. Physicians at the practice could only name one other in
existence across the state, located one hour from Durham. Women came to this practice for
many different reasons. Although many women suggested that they came because of
excellent care, many also felt it was “an added bonus” that they were being cared for by
African American physicians. Some women felt strongly about receiving care from African
American physicians—part of a larger fabric of decisions to specifically patronize other
“black-owned businesses.” One consultant believed that, in a life or death situation, black
doctors would fight harder for her life, while others explained a negatively felt gaze from
white physicians.

Some women found great solace in their care experiences. The existential dilemmas
around pregnancy and motherhood that plagued them were often addressed by caregivers and
staff in the office. As one physician noted, it wasn’t the visible presence of African American
doctors that they felt was important but rather the invisible and understood experiences of
racism, class and being an African American woman.

Experiences of this kind of cultural empathy manifested in the myriad ways physicians
managed individual cases. African American male doctors spoke to women about bearing
sons and relationship difficulties from their own perspectives. African American female
doctors understood the demands of work and home life, combined with the difficulties of
dealing with gendered racism. In these ways, visiting a practice with physicians who shared
their cultural background invited these women into a world where race was not a factor, and
where experiences of being African American became positively or neutrally felt and
contributed to a felt sense of balance in at least one arena of life. Brush (2001) encourages
such an exploration of what she calls a presumed “race consciousness of women of color.”
Physicians felt responsible to their patients as representatives of the economic, educational, professional and personal possibilities for African American men and women and generated positively felt experiences of being African American in a pregnant woman that worked to counteract negatively felt experiences generated from society at large. The chronic conflict between imposed objective and often negative perceptions of race and subjective, lived experiences of racism, class and being African American and female was, as any chronic condition might be, addressed by physicians with a culturally constructed remedy. Cultural empathy does not imply, however, a universal experience of being African American but rather the possibility of understanding one’s life experiences on a deeper level where skin color may be perceived by others as positive and, in turn, positively felt by a pregnant woman. I propose that simply acknowledging the “blessing” of being a black woman and understanding positive experiences of being African American both help to tip the sense of balance in favor of subjective understandings of African American women’s lived worlds.

Current research in North Carolina addressing attitudes and experiences with African Americans and the health care system revealed a prevailing distrust and antagonism between African American women and non-African American, generally white, doctors. The rare nature of African American-centered private practices compels further study of the patient practitioner relationships that play out along intra- and inter-cultural and class lines and how these relationships inform health and healing. Although this was not the focus of this study, I propose that the nurturing cultural environment of an African American practice helped to ameliorate the negatively felt experiences previously described.

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Finally, intensely personal journeys in conventional therapy, religion and private self-reflection played central roles in how some women coped with negatively felt perceptions in their lives. I propose that coping comes to mean restoring or generating a sense of balance in women’s lives during the course of their pregnancies and beyond. Several women spoke of being “resilient” and “strong” in the face of adverse social and personal circumstances, while others like Helene recognized the need for professional help with a pregnancy that was “hard between the ears.”

I propose that locating experiences of racism, class, and being African American and female in subjective space helped to combat experiences that were negatively felt. This is not to say that external support did not help pregnant moms bring their babies to term. Mothers, pastors, physicians, spouses, therapists and myself were integral layers of subjective space that pregnant women navigated over the course of their pregnancies.

**Mapping the Geography of Racialized Pregnancy: Some Thoughts on “Race,” Racism, Gender and Class**

As mentioned in the Introduction, it is difficult to explain lived worlds of race when the concept has been shown to be a socially constructed category with an objective reality that is not recognized by anthropologists, among others. In historical perspective, however, it is essential to use the term in order to understand its trajectory in U.S. culture and in scholarly work and it is a term that my consultants in this study have used to describe their own experiences. However, this work rejects such an objective reality and as such I explain experiences of race as phenomenologically informed experiences of being African American.

While we engaged in lengthy and multiple conversations around pregnancy and motherhood, women invited me into larger discussions addressing experiences of racism,
being an African American woman and class. An important contribution of this work is to more fully understand imposed constructs of “race, class and gender” from an experiential perspective in order to support and/or challenge assumptions we make in U.S. society about these experiences for African American women and in an effort to contribute to understanding global ideologies of these constructs. In a medical anthropological context, these understandings may reveal ways in which such experiences impinge on our health and well-being.

The strengths of a Black Feminist perspective lie in the attention to multiple and interlocking hierarchical systems that impinge on daily lives of African American women, but the frame does little to invite personal, lived experiences of these systems. Objective assumptions about class as intimately tied to income and education for example, limit our understandings of class as feeling. Assuming that female gender and an uncritical examination of race operate only as oppressive systems denies the positively felt experiences of being African American and female. In addition, as outlined above, experiences of gender must expand to include felt male gender oppression in a woman who fears she will bear a son. In sum, although intersectionality maintains that African American women’s lives must be understood in terms of “interlocking systems of oppression,” these “systems” are replete with meanings that are not necessarily coincident with oppression, but rather reveal a complex landscape of lived worlds.

The U.S. history of making and remaking Self and Other with attention to race as the primary identifier of human identity was an essential component of a legitimization of exclusion and campaign of violence that enforced such a racist ideology. Ideologies of

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109 See Chapter One, Introduction for further explanation.
human worth were generated that continue to be racialized, classed and gendered. Cataldi expands on phenomenological understandings of race that include perceptions of others that contribute to ideologies of skin-color-based inferiority, or racism.

The significations of our skin and our skin colors matter to us, and matter deeply—in the ways we are perceived by others...They make a difference in terms of the groups with which we identify...They influence our self-esteem and our status in society’s eyes. To a larger extent, they govern the degree of our visibility and invisibility... determining whether we will be simply overlooked or stared at as “exotic,” whether we will be oppressively harassed or mercilessly beaten up. ...To a person of color, the world is already given, felt to be a racist world. (Cataldi, 1993:140)

I propose that while pregnant, African American woman locate themselves in yet another social space that intensifies negatively felt experiences of being African American due to lived worlds of racism. Racism as a construct is woefully underdeveloped in the literature. We cast our own assumptions about what racism or racist means based on historical experiences, practices and media representations of racist acts, racist policy, racist mentalities. However, understanding racism as it operates in contemporary life often rests in structural analyses of “unequal power relations” and institutional practices that promote race-based inequality based on skin color. Although there is great value in these analyses, they tend to overlook the complex experiences of racism as they are intensely felt.

Pregnant African American women in this study tended to believe that racism as it operated in their personal lives was a “fact of life” and felt very equipped to deal with interpersonal experiences that they classified as racist. However, women who feared having a male child experienced racism as they imagined it in the life of their sons. Lines between imagined and real became almost non-existent for those who were chronically concerned about bearing a son and led to state of wishful thinking for these women—wishful they would not have a boy. Several women also spoke to the burdens of raising African American
children (particularly boys) in a world that not only devalued them, but also perceived them as threatening. Helene suggested that white women were able to feel that society “liked to see” their children and thus were able to impart hope to them whereas African American mothers “do not have this luxury.”

Experiences of *racism*, then, were articulated as either *neutrally felt* or *negatively felt experiences* of being African American when women spoke about their sons, a burdensome work environment or being perceived as low class when pregnant. Although women believed they were well-equipped to combat racisms directed at them, this confidence dissolved when imagining raising African American sons and daughters in what Gordon (1997) calls an “antiblack world.” It is important to add to the layered concept of *racism* a dimension of intensely felt experience that reaches beyond the interpersonal and structural into areas of existential life that are symbolic and lie deep beneath the epidermis. The intimacy of a mother’s felt experience of *racism* imagined for her son or daughter then emerges in the public space as she chooses a name for her child that is not identified with African American heritage or chooses a school in which he will learn best and escape the damages of a society grounded in *race*-based inequality.

*Lived Experiences of Being African American Woman*

Social life in the United States has been historically racialized. Dominant perceptions of inferiority and superiority are ideologically and socially constructed around skin tone.\(^{110}\) Our skin *color* radiates from us, infuses others with ideas about who we are, and is culturally weighted material that others reach out to perceive. Those perceptions then return to us—

\(^{110}\) For a contemporary history of race-based ideologies in the U.S., see Omi and Winant (1994).
invited or not—in gazes, words and feelings about how we are experienced by others. In other words, others’ ideas about race and attendant racism precede us as being in the world. It is also a more complicated human experience (See Mead, 1913).

It is important to note that the nature of being an African American woman is fluid and ever-shifting and that each experience (ie., being African American and being female) carries a different valence for each woman. Helene, for example, would consistently articulate being black in terms of being a black woman. As indicated in her quote in the beginning of this chapter, she “sees the world through that set of eyes.” Experiences of being African American woman do much to eschew an assumed collective cultural consciousness and create a more complex understanding of how being African American operates in the daily lives of men and women.

I noted that experiences of female gender rarely stood as unconnected to cultural experiences of being African American among women whose sense of Self included more salient narratives of being African American. In a related vein, these women also experienced being African American male as they vividly imagined bearing sons who faced particular and different obstacles in a racially stratified society. Experiencing African American descent and female gender in this way denies a collective African American experience often perpetuated by Afrocentrist models of social activism (hooks, 1999) and highlights unique experiences of African American women.

Challenging ideas of a collective gendered African American consciousness, women who experienced being African American as neutrally felt expressed that female gender operated independently of being African American and was most often negatively felt in the context of male-female relations with a boyfriend or spouse. These women experienced their female
gender as oppressive in the demands of work and home life and gave these experiences a greater valence that African American heritage. Again, this is not to say that such women were not conscious of a racially stratified society or of race-based social inequalities, but their lived experiences of being African American women spoke to more complex meanings that informed negatively felt perceptions during pregnancy and postpartum.

It is important to note that intersubjectivities as webs of meaning that are constructed in process through personal lived experience, experiences of other human beings and society at large are non-neutral. Intersubjective space, as Cataldi reminds us, is not uncharged by ideologies of race:

Some of us are more closely identified with our bodies than others. …Some of us, more than others, perceive ourselves in a sort of double vision—through the duress of externally imposed stereotypes, as we struggle to distance ourselves from the imposition of their roles and meanings. …“Flesh” cannot speak for all of us, although it appears to occupy a universal position—“the” human condition of embodiment. For the expression flesh is not a neutral term: when it is translated into the visual…it refers to the color of a white person’s skin. …As a surface of human sensibility, there is no “flesh” that is not of a particular color, size, or shape; and there is no body that has not incorporated the results of its own enculturation.” (Cataldi, 1993:140)

Experiences of being African American and female are emotionally, intellectually, spiritually, experientially felt as charged. Partially charged lived experiences of being African American (and we can expand this concept to include experiences of class and gender) include negatively and positively felt experiences that contribute to fuller understandings of how being African American operates in the daily lives of these women. Theorizing race in this way goes beyond an assumed collective color consciousness that is experienced as oppressive and makes room for understandings of racism that are more complex and contribute to existential experiences of balance and imbalance in African American women’s lives.
As some biological molecules have a greater positive or negative valence, so too do human experiences of being African American. Processes that inform felt experiences of being African American vary in their contributions to what women perceive as positive or negative. Understanding the processes that promote positively felt experiences of being African American may guide future efforts to ameliorate or counterbalance those that are negatively felt. In addition, felt experiences of being African American and being African American woman can be situational, informed by immediate circumstances such as a pregnancy, at which time they may be intensified. Many of the women in this study experienced class, racism and being African American and female through their physiological experience of pregnancy and existential experiences of motherhood.

Finally, the phenomenological perspective has provided insight into the diversity of experiences for African American women. Initially, I theorized that there may be an existential collective burden of the violence of enslavement that permeates African American women’s bodies in ways that promote early onset of labor but, as outlined above, a collective cultural burden is complicated. Although several women in this study invoked enslavement in their narratives of pregnancy and motherhood, this was not a universally shared concept. Because a woman does not share this in an interview also does not mean that it is not part of her lived experience, but this is not for me to say.

A Word About Class and Its Relation to Being African American and Female

This brings us to the mysterious relationship between race and class in the U.S. Although there is an abundance of literature on class in the U.S., it is often related to economic class position as measured by income and education (See Krieger, 1993 and 1994a for studies of
Thus, there is still work to be done in deconstructing class as a purely economic category and as a function of educational attainment and income level. This work examines *felt class experiences* within African American cultural communities and recognizes intracultural differences in such experiences. Even much of the Black Feminist literature assumes class as an economic category rather than a relational one. This is not to say there are no good examples of inquiry into the cultural constructions of class. I propose understanding *class experience* as a constellation of relations that are not solely economic but rather are *felt*.

In their pregnancy narratives, many of these women perceived that others viewed them as “in the system,” “another statistic” or “on welfare” when they became visibly pregnant. Moral overtones were cast in the gazes they felt as women would instinctively reveal a wedding band. Regardless of a woman’s income, education or marital status, *felt assumptions of lower class* permeated her consciousness. In turn, she felt irritated, distressed, disappointed, concerned that others including members of her own cultural community viewed her in this way.

Black feminists have written about the “instability” of class for African American women, but this is an alternative formulation of class that exists only when a woman is visibly pregnant and speaks to a *hyperinstability* of class. In his ethnography Harlemworld, John Jackson (2001) compels us to examine class as more than an economic “reality” but rather to understand lived experiences as “complicated connections that link any invocation of class to other forms of social differentiation” (p.60). Understanding *class as feeling* may help us to better understand the processes that produce such feelings and to more critically examine the
construct of “stress.” I propose further study of the concept of *class as feeling* across cultural, economic and gender boundaries.

Finally, and intimately woven with experiences of class, *race*, racism and mothering are *negatively felt experiences* in the form of misperceptions about the “realities” of a white existence when compared with African American life. In conversations around maternity leave and work, Sheri, Zakiyyah and Tisha believed that white women traditionally stayed home with children, rarely worked and lived with a husband who earned, in Sheri’s words, “six figures.” The assumption of an “easy” life for white women combined with *felt perceptions* of lower class status while pregnant created an abrasive social and existential space that grated on the everyday life of Sheri in particular.

This experiencing of wider social relations intimately bound up in class and *race* inequalities denied the diversity of class and *race* experiences of women of European descent and contributed to feelings of *perceived oppression* for women who felt they “had to work.” These misperceptions of Euro-American women’s experiences spoke to a lived disconnect from those worlds. Interestingly, when I asked Sheri, Zakiyyah and Tisha whether they would like to stay home with their children they answered “no.” Through narratives of *perceived lower class status* during pregnancy, women revealed the possibility of misperceptions of their own lives by wider society. These dual misperceptions worked to universalize a human experience stratified by *race*.

*In Sum*

Medicalized views of birth rarely mesh with ideas about personal experiences as perpetrators of preterm birth or other pregnancy complications. Ways of *human being-in-the-
world that too often rest on assumptions the larger society possesses about us affect our physiology in ways that are still poorly understood. The existence of health inequalities today, including differences in preterm delivery and infant mortality, is evidence of the long-standing moral dilemmas that American society and policy have not adequately addressed. Phenomenological concepts of *embodiment* and *perception* aid in a more complete understanding of the global social, economic and political forces that shape ideologies of racism and that encourage and maintain female gender and class subordination—all of which impinge on our very being in *felt experiences* that are often revealed in *life’s lesions*.

Merleau-Ponty compels us to understand our bodies as *perceptive Flesh*, and although he is speaking of an ontological *Flesh*, our bodies are the quintessential sites of inscribed life experience. This work has incorporated such understandings of *being in the world* in order to map a geography of racialized pregnancy that includes *positively, negatively and neutrally felt* human experiences.

Just as the cytoplasmic activity of human cells reflects its larger bodily milieu, African American women’s pregnancies are reflective of the larger social and cultural milieu in which they are experienced. Just as cellular membranes stretch or contract to repel or absorb substances that may harm or help cellular and bodily health, pregnant African American women *perceive, absorb and feel* the “burdens and blessings” of being black and female. In response to contact with a sociopolitical, historically charged cultural milieu, a pregnant woman’s body may encourage physiological pathways to intensify or quell. Experiences of *being African American woman*, racism and other forms of social inequality reach across the stretched membranes of pregnancy, crossing the inner layers of uterine decidua to transform
and potentially harm a developing fetus. The resulting *balance* or *imbalance*, in combination with experiences of coping, translates into healthy or complicated pregnancies.

Although medical science may not agree, felt perceptions of social inequality—including but not limited to racism—that are experienced by African American women during pregnancy can just as easily travel the physiological superhighways of blood and sinew as any other biological insult. The medical mystery of what actually triggers labor partially unfolds in narratives of lived experience. And just as our physical bodies are comprised of countless living, intricate webs of communication and translation, so too are our experiences of *being in the world*.

The intimacy of mother and child in the physical experience of pregnancy reflects the closeness of biological and social life. This is not to say, however, that mothers pass on social “traits” to children, nor should they be blamed for unhealthy pregnancies. Rather, I would suggest that understanding the adverse social forces that impinge on the daily lives of pregnant African American women provides insight into such complications. I propose that only then can we begin to address social inequalities in health that affect pregnant African American women disproportionately and that can help them to begin to mother beyond what Helene calls a “culture of survival” and into a world of living spiritually, intellectually and free.
Epilogue

I undertook this work in an effort to bring to light issues in African American women’s lives that weigh on them during pregnancy and in order to inform the decisions of policy makers, health care providers, loved ones and society at large that are directed at reducing the numbers of preterm deliveries, low birthweight babies and infant mortalities in African American communities.

This work has contributed to focus group research across the state of North Carolina and has informed the construction of interview guides and focus group composition. One of the strengths of this work has been to highlight the need for improved communication between African American men and women. A direct contribution has been the inclusion of all-male focus groups across the state in order to include their voices in matters of male-female relations, fatherhood, motherhood and pregnancy. If there is anything these women have highlighted for me, it has been the need to understand the men in their lives in order to fully understand who they are as women. It is my hope that the work will guide our own individual and collective praxis in approaching social inequalities in health as they exist in local and global worlds.
APPENDIX 1

American Anthropological Association Statement on "Race"\textsuperscript{111}

(May 17, 1998)

In the United States both scholars and the general public have been conditioned to viewing human races as natural and separate divisions within the human species based on visible physical differences. With the vast expansion of scientific knowledge in this century, however, it has become clear that human populations are not unambiguous, clearly demarcated, biologically distinct groups. Evidence from the analysis of genetics (e.g., DNA) indicates that most physical variation, about 94\%, lies within so-called racial groups. Conventional geographic "racial" groupings differ from one another only in about 6\% of their genes. This means that there is greater variation within "racial" groups than between them. In neighboring populations there is much overlapping of genes and their phenotypic (physical) expressions. Throughout history whenever different groups have come into contact, they have interbred. The continued sharing of genetic materials has maintained all of humankind as a single species.

Physical variations in any given trait tend to occur gradually rather than abruptly over geographic areas. And because physical traits are inherited independently of one another, knowing the range of one trait does not predict the presence of others. For example, skin color varies largely from light in the temperate areas in the north to dark in the tropical areas in the south; its intensity is not related to nose shape or hair texture. Dark skin may be associated with frizzy or kinky hair or curly or wavy or straight hair, all of which are found among different indigenous peoples in tropical regions. These facts render any attempt to establish lines of division among biological populations both arbitrary and subjective.

Historical research has shown that the idea of "race" has always carried more meanings than mere physical differences; indeed, physical variations in the human species have no meaning except the social ones that humans put on them. Today scholars in many fields argue that "race" as it is understood in the United States of America was a social mechanism invented during the 18th century to refer to those populations brought together in colonial America: the English and other European settlers, the conquered Indian peoples, and those peoples of Africa brought in to provide slave labor.

From its inception, this modern concept of "race" was modeled after an ancient theorem of the Great Chain of Being, which posited natural categories on a hierarchy established by God or nature. Thus "race" was a mode of classification linked specifically to peoples in the colonial situation. It subsumed a growing ideology of inequality devised to rationalize European attitudes and treatment of the conquered and enslaved peoples. Proponents of slavery in particular during the 19th century used "race" to justify the retention of slavery. The ideology magnified the differences among Europeans, Africans, and Indians, established a rigid hierarchy of socially exclusive categories underscored and bolstered unequal rank and

\textsuperscript{111}American Anthropologist, 100(3), 712-713.
status differences, and provided the rationalization that the inequality was natural or God-
given. The different physical traits of African-Americans and Indians became markers or
symbols of their status differences.

As they were constructing US society, leaders among European-Americans fabricated the
cultural/behavioral characteristics associated with each "race," linking superior traits with
Europeans and negative and inferior ones to blacks and Indians. Numerous arbitrary and
fictitious beliefs about the different peoples were institutionalized and deeply embedded in
American thought.

Early in the 19th century the growing fields of science began to reflect the public
consciousness about human differences. Differences among the "racial" categories were
projected to their greatest extreme when the argument was posed that Africans, Indians, and
Europeans were separate species, with Africans the least human and closer taxonomically to
apes.

Ultimately "race" as an ideology about human differences was subsequently spread to other
areas of the world. It became a strategy for dividing, ranking, and controlling colonized
people used by colonial powers everywhere. But it was not limited to the colonial situation.
In the latter part of the 19th century it was employed by Europeans to rank one another and to
justify social, economic, and political inequalities among their peoples. During World War II,
the Nazis under Adolf Hitler enjoined the expanded ideology of "race" and "racial"
differences and took them to a logical end: the extermination of 11 million people of "inferior
races" (e.g., Jews, Gypsies, Africans, homosexuals, and so forth) and other unspeakable
brutalities of the Holocaust.

"Race" thus evolved as a worldview, a body of prejudgments that distorts our ideas about
human differences and group behavior. Racial beliefs constitute myths about the diversity in
the human species and about the abilities and behavior of people homogenized into "racial"
categories. The myths fused behavior and physical features together in the public mind,
impeding our comprehension of both biological variations and cultural behavior, implying
that both are genetically determined. Racial myths bear no relationship to the reality of
human capabilities or behavior. Scientists today find that reliance on such folk beliefs about
human differences in research has led to countless errors.

At the end of the 20th century, we now understand that human cultural behavior is learned,
conditioned into infants beginning at birth, and always subject to modification. No human is
born with a built-in culture or language. Our temperaments, dispositions, and personalities,
regardless of genetic propensities, are developed within sets of meanings and values that we
call "culture." Studies of infant and early childhood learning and behavior attest to the reality
of our cultures in forming who we are.

It is a basic tenet of anthropological knowledge that all normal human beings have the
capacity to learn any cultural behavior. The American experience with immigrants from
hundreds of different language and cultural backgrounds who have acquired some version of
American culture traits and behavior is the clearest evidence of this fact. Moreover, people of
all physical variations have learned different cultural behaviors and continue to do so as modern transportation moves millions of immigrants around the world.

How people have been accepted and treated within the context of a given society or culture has a direct impact on how they perform in that society. The "racial" worldview was invented to assign some groups to perpetual low status, while others were permitted access to privilege, power, and wealth. The tragedy in the United States has been that the policies and practices stemming from this worldview succeeded all too well in constructing unequal populations among Europeans, Native Americans, and peoples of African descent. Given what we know about the capacity of normal humans to achieve and function within any culture, we conclude that present-day inequalities between so-called "racial" groups are not consequences of their biological inheritance but products of historical and contemporary social, economic, educational, and political circumstances.
APPENDIX 2

Schedule of Guideline Questions for Open-Ended, In-Depth Interviews With Women

Can you tell me why you have decided to participate in this study?

Can you tell me how this pregnancy has been going so far? Have you experienced any difficulties? If so, can you tell me how you felt when you were having these problems?

Can you tell me about your past pregnancies, if any? Can you tell me about the birth(s) of your other child(ren)?

Are there things in your life that you consider stressful for you? If so, could you describe them? How do these experiences make you feel? Do you feel they impact your pregnancy in any way? If so, how? How do you deal with these experiences in your life?

Do you notice that people look at you differently when you are pregnant? If so, how do their looks/reactions make you feel?

How have people at work responded to your pregnancy? Is work something you enjoy? Have people been giving you lots of advice? If so, who gives you the advice and what kinds of things are they telling you? How do you feel about what they are telling you?

Do you know whether you are having a boy or a girl? How do you feel about having one or the other?

What does “being a mother” mean to you? Where do you think your ideas about motherhood come from? What does “being a father” mean to you? Where do you think your ideas about fatherhood come from?

In your opinion and experience how would you describe a healthy pregnancy?

In your opinion and experience, how would you describe a healthy baby?

Why do you come to this practice for your care? How do you feel about having African American physicians care for you during your pregnancy?

What do you hope for your child? What do you hope for yourself after the child is born?

112 These questions have guided the in-depth interviews, but the conversations are open-ended and ultimately guided by the participant.
APPENDIX 3

Guide for Interviews with Physicians

Do you believe this practice is unique among other local OB-GYN practices? Why?

What attracts so many African American women to this practice?

What impacts do you see this practice having on the care of women and specifically the care of African American women?

Is it important to you to serve African American women? Why?

Would you define what is clinically meant by “preterm labor?” How is it diagnosed?

What do you believe causes preterm labor?

Do you feel there are any connections between what women identify as “stress” and preterm labor? Why?

Would you explain to me why you believe there are higher rates of preterm delivery and infant mortality among African American women when compared with European American women?

Would you explain why you believe this difference is even greater among college-educated women who have access to good prenatal care?

How do you, as a caregiver, manage preterm labor for your patients?

What are your thoughts on how we could address this problem of preterm labor more effectively?

Do you have any questions or comments about the research I’ve presented thus far?
APPENDIX 4

U.S. Postal Service Stamp to Raise Sickle Cell Awareness
BIBLIOGRAPHY


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