The Phenomenology of Pregnancy and the Alienation of Subjectivity

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Abstract:

This study focuses on a phenomenological analysis of embodied knowledge during pregnancy. Historically this alienation has occurred during pregnancy due to the objectifying language surrounding pregnancy and birth, a lack of informed decisions regarding childbirth practices, the altering of legal and political rights, the way in which societal expectations exclude pregnant women, and the constant fluctuation of personal identity. This alienation has begun to decrease as pregnant women have started to gain more agency. Phenomenology elevates the analytical status of experience and the embodied experience of the pregnant woman in particular. Although there has been significant progress in women becoming active agents in their pregnancies, structures that contribute to alienation remain. This research can be used to better understand the embodied experience of pregnant women, and to provide insight into the cultural phenomenon of pregnancy in the United States.

Keywords: pregnant embodiment, phenomenology, objectivity, alienation, medicalization
Introduction:

During the 1950’s doctors generally encouraged pregnant women to rest as much as possible— ideally with their feet up (Brynie 2013:1). They were considered to be delicate and frail, and were treated as though they were critically ill. Any sort of movement was seen as potentially hazardous to the unborn child. Recently, not only have doctors begun to encourage women to be active during their pregnancies, but supporting scientific evidence has emerged as well. Studies have shown that a sedentary pregnancy can actually be detrimental to the health of the baby. The brains of babies whose mothers had maintained an active lifestyle while pregnant, developed more quickly and efficiently than those who had remained sedentary (Brynie 2013). It has also recently become accepted in the scientific community that activity during pregnancy produces a more robust cardiovascular system in the baby (Reynolds 2013).

A 35-year-old woman named Lea-Ann Ellison posted a picture on Facebook of herself lifting weights with the caption: “8 months pregnant with baby number 3 and CrossFit has been my sanity. I have been CrossFitting for 2-and-a-half years and strongly believe that pregnancy is not an illness, but a time to relish in your body’s capabilities (O’Connor 2013:1). The photo received many positive comments, but many people were visibly upset. Many felt that Ellison’s dedication to maintaining an active lifestyle was a narcissistic effort to stay in shape without regard to the health or safety of her baby (O’Connor 2013:2). Ellison’s publicized response explained how she continued to exercise for her own health as well as the health of the baby, although she had decided to lift less weight than usual to lessen the pressure on her belly. She expanded on this stating that her active lifestyle helped her to avoid the more negative aspects of pregnancy experienced by many others including backaches, sickness, sciatic nerve pain
and cravings. She also emphasized that by keeping up an active exercise routine she continued to release endorphins, and “happy mom equals happy baby” (Ellison 2013 as quoted by O’Connor 2013: 2).

Ellison’s experience exemplifies a way that women are beginning to have the opportunity to be active agents, for whom pregnancy means activities such as heavy lifting, running marathons and overall fitness. The very fact that articles now exist about pregnant weight training shows the shift from seeing the pregnant woman as an object to a subject. However, it also exemplifies how societal misperceptions of pregnancy are not necessarily changed by scientific discoveries or new publications of phenomenological evidence. Although there is emerging information about the positive impact of activity during pregnancy, the concept has not become completely accepted by the public, and there continues to be skepticism.

I was first introduced to the concept of embodied knowledge during pregnancy while enrolled in Professor Deborah Heath’s class “Anthropology of the Body” at Lewis and Clark College. Iris Young’s paper “Pregnant Embodiment” had been assigned as part of the week’s reading, but the subject meant little to me. As I started reading, I was surprised at how personally impacted I was by her words. Although I have never been pregnant, nor have I been very close to anyone during her pregnancy, I was impacted by my existence as a woman. I was struck by the impact of the societal gaze as pregnancy changed a woman from a person with rights to a container protecting another being’s rights. I had never looked at pregnancy in such a critical light. Suddenly, pregnancy
didn’t seem so foreign. Instead of being a situation that didn’t affect me, pregnancy had become a potential future point where I could lose the rights to both my body and my freedom. In my thesis, I explore embodied knowledge through pregnancy in the United States, focusing on the pregnant subject. The pregnant woman as a subject is often excluded during debates over her objective pregnant body. In this essay, I give a voice to her subjectivity by exploring the ways in which her embodied knowledge, and its social context, changes and grows throughout the nine months she is pregnant. Additionally, I intend to echo Young’s effort to document positive change in her “Throwing Like a Girl Revisited” essay through the phenomenological lens of pregnancy. I revisit Young’s work as it relates to current cultural conceptualizations and practices with a modern critique by examining contemporary positive changes in the embodied experience of pregnancy.

Using a theoretical framework based on conceptions of identity and embodied knowledge, my research explores the evolution of cultural understandings of the phenomenology of pregnancy. I draw close attention to the change in the medicalization of pregnancy including technological innovations such as the cesarean section and fetal monitoring. I exemplify cultural changes using publicized photography of the pregnant body. In order to fully understand the pattern of alienation of subjectivity, I rely on literary analysis, quantitative and qualitative data, and scholarly research.

Phenomenology is a practice that focuses on personal description of existence and experience rather than analysis (Merleau-Ponty 1962). This investigation has shown that historically there was a lack of phenomenological exploration regarding the pregnant experience. After influential theorists such as Iris Young began to address the
importance of the phenomenology of pregnancy, many organizations and institutions have begun to create more empowering approaches to understanding the pregnant experience. My work is indebted to Young for her focus on Merleau-Ponty’s phenomenology and in bringing Beauvoir’s feminist takes on women’s limitations as transcendent subjects. I aim to give a voice to pregnant women by describing a small portion of their phenomenological knowledge and analyzing the way those experiences are received by the public. In order to extend the limits of the objective world, I promote the importance of subjectivity and learning about pregnancy through a phenomenological lens.

Identity is a complex concept central to the exploration of pregnant embodiment. It situates pregnancy simultaneously in the social collective and in the individual lived body. During pregnancy, personal identity is constantly changing due to drastic physical changes, an altered societal gaze, and the sudden existence of a second being within a single body. I expand on this by exploring spatiality and temporality. A changing sense of spatiality and temporality are central to the phenomenology of pregnancy. The physical changes that occur during pregnancy substantially alter a woman’s habitus and require new perceptions of bodily existence regarding both time and space. Her change in habitus can be found in altered legal rights of pregnant women, and a change in cultural perceptions regarding clothing, sexuality and social status.

I address the ways in which language and availability of information affect the embodied experience of pregnancy. Objectifying language regarding the experience of pregnancy expands the societal gap between the notions of mothering and pregnancy. This has begun to be countered by individuals and organizations consciously
utilizing an empowering and active vocabulary rather than an objectifying and passive one. There is a lack of informed decisions regarding pregnancy and the birthing process, which furthers this sense of disempowerment. This fuels the existence of biased legal rights and ignorance regarding the way pregnant bodies often exist in professional environments.

**Theoretical Framework:**

Iris Young theorizes that in the United States pregnancy does not belong to the pregnant woman. She argues that social and cultural constructions have conceptualized the woman as a container to grow a baby and consequently remove her subjectivity. This objectification is promoted by the medical world by labeling pregnancy as “a condition which deviates from normal health” (Young 1984:46). There is an alienation of the pregnant woman from both her pregnancy and birth by the very fact that she requires medical treatment. The process is no longer something she can experience in a positive sense, but rather is pathologized and requires a cure. Pregnancy symptoms are not socially acceptable as part of the pregnant process, but instead are generally portrayed as symptoms in need of treatment.

This objectification is enhanced through the use of medical instruments during examination as the woman loses her power to control her experience. Her innate embodied knowledge becomes superfluous compared to a physician's academic knowledge and legitimacy. Young expands on this by stating that hospital rituals negate aspects of the natural birthing process in order to provide organization and cleanliness. She exemplifies this stating that
Most hospitals do not allow the woman to walk around even during early stages of labor, despite the fact that there is evidence that moving around can lessen pain and speed the birthing process. Routine breaking of the amniotic sack enforces this bed confinement. Woman usually labor and deliver in a horizontal or near horizontal position, reducing the influence of gravity and reducing the woman’s ability to push (Young 1984: 57).

I illuminate Young’s arguments about the alienation and objectification of women’s subjectivity during pregnancy by researching first-hand accounts of pregnant women as well as media and biomedical representations of pregnant bodies. At the same time, I contrast this with contexts in which women’s agency, their active subjectivity, are allowed to prevail. While looking back at her pregnant experience, Adrienne Rich states “I realized that I was effectively alienated from my real body and my real spirit by the institution—not the fact—of motherhood” (Rich 1974:38-9). I explore this type of alienation focusing closely on historical shifts in texts written about pregnancy in order to establish a timeline portraying the way in which pregnancy has been conceptualized in medicine and in the media.

Identity is a complicated subject that is central to the idea of pregnant embodiment. I call upon several theorists in order to form a complete theory of identity. I combine Kannen’s and Earle’s theories of identity as a form of social understanding in order to locate identity in social interaction (Kannen 2013, Earle 2000). I expand on this with Merleau-Ponty’s and Moi’s theories of the lived body in order to form a well rounded understanding of bodily identity (Olkowski 2006, Young 2002). I use Hopper and Aubrey’s and Neiterman’s theories of pregnant identity as a social objectification in order to explore the ways in which a developing identity can diminish subjectivity (Hopper and Aubrey 2013, Neiterman 2012). By situating identity as simultaneously
social, bodily and objectifiable, I aim to show the fluidity and complexity of the concept of identity, specifically as it exists during pregnancy.

Victoria Kannen describes identity as the way we understand ourselves and the social collective. She theorizes that identity is “a relational organizing principle through which aspects of ourselves are inconsistently categorized, yet placed within thinkable terms” (Kannen 2013:180). She expands on this by arguing that bodily identity is the way in which identities become readable. Kannen’s theory of identity situates it as a fluid principle, visually representing intrinsic social truths. Bodies are a medium through which societal norms are embodied, and subjectivity is rationalized (Kannen 2013). I apply Kannen’s theory of identity to pregnant embodiment as a way in which a woman’s pregnant body changes both her personal and social identity. I illuminate this theory with Sarah Earl’s argument that self-identity is constituted in terms of similarity to others, and a desire to feel simultaneously normal and unique. She exemplifies this by researching the ways in which midwifery satisfies this need during pregnancy. The practice of midwifery situates each woman as an individual with a unique experience, while also maintaining an informed dialogue about the range of expected pregnant conditions (Earle 2000). The practice of midwifery as described by Kannen exemplifies changing practices that foreground agency and minimize alienation. I use her theory as a way to both understand how identity is situated in a social context, and to explore the ways in which the embodied experience of pregnancy is gaining societal importance.

I use Maurice Merleau-Ponty’s theory of transcendence of the lived body for its phenomenological approach to identity. He argues that the lived body contains bodily knowledge of the world with “a structured capacity for actions and intentions” (Olkowski
His theory of the lived body argues that the physical experience of the material body is able to transcend cognitive thought by understanding bodily movements and situation without verbal representations. He situates the lived body as transcendence of the material body in order to intertwine the person with the world (Olkowski 2006). I combine Merleau-Ponty’s perspective with Toril Moi’s theory of the lived body as “a unified idea of a physical body acting and experiencing in a specific sociocultural context” (Young 2002:16). She argues for the fluidity of bodily identity stating that a body’s identity is specific to its particular situation in time and space. The situation is a form of embodied knowledge that is constantly changing (Young 2002).

I illuminate a combination of Moi’s and Merleau-Ponty’s approaches by applying them to the pregnant body. The pregnant body is constantly changing and developing, and I argue that the bodily knowledge through the lived body is constantly evolving. This is important when considering the way in which a woman’s bodily freedom changes as her pregnant body develops. Moi states, “to claim that the body is a situation is to acknowledge that the meaning of a woman’s body is bound up with the way she uses her freedom” (Moi 2001, as quoted by Young 2002:16). Moi argues the lived body as always situated between sex/gender and nature/culture, as essential to its given situation (Young 2002). The combination of Moi’s and Merleau-Ponty’s perspectives on the lived body is important when considering the ways in which every pregnant body is distinct, and should be considered as having a unique and specific situation.

Elena Neiterman theorizes that the embodiment of pregnancy is a performance (Neiterman 2012). She argues that it involves learning how to be pregnant in terms of
literature and social experience, as well as the daily process of “mastering the daily
routines of self-care” (Neiterman 2013:373). This approach understands pregnancy to be
a socially cultured experience requiring specific actions in order to be deemed socially
(and legally) acceptable. K. Megan Hopper and Jennifer Stevens Aubrey exemplify this
phenomenologically by applying pregnant expectations to Fredrickson and Roberts’
theory of objectification. They argue that pregnant women “surpass the culturally
accepted and normalized boundaries for women’s bodies” (Hopper and Aubrey 2011:
768) confusing their conceptualization of their personal identity. They expand on this by
arguing that societal expectations force women to try to conform to unrealistic
expectations in order to assume an acceptable pregnancy identity. I use this form of
objectification of the pregnant body in order to complete my analysis of identity.

**Historical Perspective - Medicalization and Photography:**

In order to understand the importance of pregnant embodiment, it is important to
understand the historical significance of this concept. I begin by outlining Lock and
Scheper-Hughes’ notion of the mindful body in order to establish the necessary
theoretical framework. I compare the contemporary conceptualizations of pregnancy and
childbirth practices with those outlined by Iris Young (Young 1984) and William Ray
Arney and Jane Neill (Arney and Neill 1982). Looking at the rise of the Women’s Health
Movement in the 1980’s due to feminist critiques of biomedicine and technological
advances, I look at the way methods have both improved and declined (Lazarus 1994). I
will also use the existence of pregnancy in publicized photography to show the way in
which the media has socially situated the pregnant body (Hopper 2013).
Margaret M. Lock and Nancy Scheper-Hughes argue that there are three different cultural perspectives to understand the body. The first is through phenomenology, the second is as a social body that interacts with structuralism and symbolism, and the third is as the regulated and controlled body politic (Lock and Scheper-Hughes 1987). Biomedicine tends to view the body as fragmented parts that can be individually healed rather than a whole connected entity with subjective properties. Because of this, symptoms are approached as individual solvable problems. This lack of an individualized self can cause alienation, which has historically been especially prevalent regarding the pregnant body. Lock and Scheper-Hughes expand on this by arguing that the institutionalization of medical care promotes illness by a focus on abnormalities (Lock and Scheper-Hughes 1987). This is represented in the pregnant body, as symptoms become a negative side effect rather than a transformative experience.

In the essay entitled “The Location of Pain in Childbirth: Natural Childbirth and the Transformation of Obstetrics”, William Ray Arney and Jane Neill explore how the experience of pain has changed over history (Arney and Neill 1982). Arney and Neill argue that pain signifies a woman’s active participation in her birthing process. Although I do not completely agree with this statement as applied to modern pregnancy standards, I do think it serves as an accurate representation for one of the ways in which pain was embodied during the 1980’s.

Before technological advances made it possible for pain to be obliterated from the birthing process, the experience of pain was simultaneously accepted as a natural aspect of birth, and a manner of Godly punishment (Arney and Niell 1982). Midwives and other birthing attendants were present mainly to comfort the birthing woman and ease her level
of fear. Pain was commonly understood as “the Curse of Eve”, as a punishment for woman’s original sin (Arney and Niell 1982:3). Then in the 1930’s, technological advances enabled medical professionals to perform procedures that served to nullify the pain of childbirth. However, these advancements primarily served to objectify the birthing woman by pacifying her and diminishing her control so that doctors could easily remove the baby. According to Arney and Niell, “pain interfered with the obstetrician’s duty to supervise and conduct childbirth according to the procedures established by early pioneers of the field” (Arney and Niell 1982: 4). Pain was no longer seen as natural part of childbirth, but almost as a burden on the medical professional. Anesthesia, ether and chloroform were all presented as ways to ease the pain for patients, but were more commonly used so the performing doctor would have more control over the birth (Arney and Niell 1982). This lack of pain alienated the subject by forcing her reliance on a higher-up. When pain was eliminated, so was her subjectivity.

In a birth report collected by Emily Martin, a woman explained her delivery process: “I asked for an epidural, not knowing that I was actually in transition and nearly fully dilated. At six o’clock I was ready to push, but with the epidural I wouldn’t feel the urge; we had to watch the monitor to know when to push” (Martins 1987:74). Another woman explained the process as feeling like she was on a TV show: “Your legs are up and you’re draped and all of them are going like this [gestures in the air with a poking motion]. You wonder what they have down there, a portable T.V., or are they really working on me? What is going on? Half of you is numb so you can’t feel what they’re doing” (Martin 1986:74). Women lost most of their control during the birthing process the moment pain was eliminated. Although I do not believe that a lack of pain necessarily
negates subjectivity, the way in which it was initially used without providing simultaneous knowledge or choices is certainly an objectifying process. Rich argues that often the pain that existed in childbirth was due to alienation and fear rather than physical pain (Rich 1976:158). Because of this, a solution to eliminate pain through drugs was not addressing the problem.

In her essay “Pregnant Embodiment”, Iris Young explores how a pregnant woman can experience her body. She argues that there is a bodily disconnect during pregnancy that can be both positive and negative. She expands on this by arguing that society can alienate women from their bodies during pregnancy (Young 1984). The medicalization of pregnancy is one of the most prominent ways in which this alienation can occur. Young argues that the medicalization of pregnancy excludes the experience of the woman, in exchange for medical processes that fit nicely into societal expectations. She exemplifies this with her research of hospital procedures during the 1980’s:

Most hospitals...do not allow the woman to walk around even during early stages of labor, despite the fact that there is evidence that moving around can lessen pain and speed the birthing process. Routine breaking of the amniotic sack enforces this bed confinement. Women usually labor and deliver in a horizontal or near horizontal position, reducing the influence of gravity and reducing the woman’s ability to push. The use of intravenous equipment, monitors, and pain relieving drugs all inhibit a woman’s capacity to move during labor” (Young 1984: 57).

These medical conditions all serve to alienate the pregnant woman from her body by removing her subjectivity. By objectifying the pregnancy through the use of tools, medical institutions take control over a woman’s pregnancy. Due to Young’s extensive research and position as an experienced scholar, I hold her research as an accurate representation for the medicalization of pregnancy during the years surrounding 1984.

In 1994, Ellen S. Lazarus revisited childbirth conditions in medical institutions in her essay “What Do Women Want?: Issues of Choice, Control, and Class in Pregnancy
and Childbirth”. Lazarus states that due to the Women’s Health Movement and other feminist critiques of biomedicine, many changes took place in medical institutions in order to make women feel more in control of their pregnancies and childbirth practices. However, she argues that “in actuality, they have a limited influence over the medical procedures applied” (Lazarus 1994: 25). Technological advances aimed at improving the conditions of women in labor have both opened and closed doors for personal advocacy. Lazarus exemplifies this with the technological development of fetal monitoring. Fetal monitoring allows women to follow the health of their fetus, and enables them to determine whether or not something has become problematic, in which case they may opt for a Cesarean section (Lazarus 1994). Initially, this seems like an empowering development since women are given a way to monitor their own pregnancies. Interestingly, research also shows that fetal monitoring has little to no correlation with success in low-risk pregnancies. So excluding cases of high-risk pregnancies, fetal monitoring only gives the illusion that women have been given more control over their bodies during pregnancy.

Cesarean section is another example of the ways in which technological advances have increased this illusion of control. Between 1965 and 1991, the amount of deliveries by cesarean sections increased from 4.5% to 23.5% (Lazarus 1994). Rather than being understood as a last resort, cesarean sections became used as a precautionary measure to legally protect doctors. Rather than being a technological advance that increased women’s control, this procedure became another illusion of freedom designed to protect medical institutions (Lazarus 1994).
Resistance to the medicalization of pregnancy is exemplified through the self-help book *Our Bodies Ourselves*, which provides a phenomenological approach to experiencing pregnancy. By approaching the body phenomenologically, this book promotes Lock and Scheper-Hughes’ concept of bodily integrity by connecting the body and mind (Lock and Scheper-Hughes 1987). It provides the political history of women’s sexuality and reproductive health, and first hand accounts of pregnancies over the years. It also provides the names of resources and empowering organizations that women can look to for positive guidance (Boston Women’s Health Book Collective 2011). This book has been an important intervention to the medical health of pregnant women, and has inspired women all over the world to take action to ensure that women have support for their pregnancy choices.

The historical significance of pregnant embodiment can also be understood through the photographing of the pregnant body. Before Demi Moore famously appeared nude showing off her pregnant body on the cover of Vanity Fair in August 1994, there was a public cultural anxiety regarding the pregnant body (Hopper and Aubrey 2013). The pregnant body existed outside of the idealistic expectation that treated “thin” as the ideal state. However, after Demi Moore’s appearance, pregnancy rapidly became a sexualized concept by the media. It is important to note that only pregnant celebrities who maintained a “glamorous and toned” pregnant body shape appeared in magazines (Hopper and Aubrey 2013). A fixation on the sexualization of the pregnant body emerged, which can be understood as both empowering and limiting. On the one hand,
by sexualizing pregnancy, the pregnant body has become more socially acceptable and inspirational. But on the other hand, the specificity of body shape depicted creates a self-conscious underlying atmosphere (Hopper and Aubrey 2013). Hopper and Aubrey argue that the general pattern to show only a certain pregnant body type in the media holds pregnant women to impossible standards. They expand on this by arguing that by focusing mainly on the body, this fixation negates the internal experiences of pregnancy. In fact, their research shows that in gossip magazines there was more focus on the physical bodies of pregnant women than of non-pregnant women. (Hopper and Aubrey 2013: 770). By only showing one pregnant body type, and by negating internal experiences, the sexual objectification can be understood as something which has exceeded its empowering expectations and entered into the realm of alienation.

This extreme focus on the pregnant body is exemplified by several US Weekly magazine covers. Kim Kardashian’s pregnant body is featured on the front of the May 2013 edition of US Weekly’s magazine next to the headline, “Kim Dares to be Bare, You Call This Fat?” (US Weekly 2013). The attached article views her pregnancy in a positive light, but only focuses on her bravery for actually showing her pregnant body in public (US Weekly 2013). Not only does this objectify the pregnant body, it also encourages the idea that the sexualized pregnant body should generally be covered up, unless you are as sexy and courageous as this celebrity. The contradictory messages imbedded in this one image show Kardashian
as a positive example of a pregnant body, while promoting the idea that there are good pregnant bodies, and that there are bad ones.

Although there is an over sexualization of the pregnant body in the media, there are several media sources that provide empowering images of the sexualized pregnant body. The magazine *Fit Pregnancy* provides phenomenological stories of women during their pregnancies. The cover of their March 2014 magazine featured Daphne Oz sporting her baby bump. To her left in bold it read “Your New Body! Sexier Than Ever, See Why it’s Extra Amazing” (*Fit Pregnancy* 2014). This cover exemplifies one way that media photography has started to be used to empower pregnant women’s sexuality.

This move away from separating the pregnant body from the pregnant subject is additionally exemplified by Katsoulis Photography in their 2011 tribute to the Demi Moore Magazine (*Katsoulis Photography* 2011). Throughout August, they posted nine different takes of Demi Moore’s famous cover photo. By incorporating different races and body types, Katsoulis Photograph was able to promote an all-inclusive portrayal of the sexualized pregnant body.
Methodology:

My research lies heavily on literary analysis and scholarly research. I combine this with prestigious social theorists in order to analyze previous research from a sociological and anthropological perspective. I combine feminist, sociological and anthropological research in order to form a well-rounded understanding of the embodied experience of pregnancy. Using theories from scholars such as Maurice Merleau-Ponty, Simone de Beauvoir and Iris Young, I combine social theory with external research on the embodied experience of pregnancy.

Additionally, I use quantitative research to understand legality regarding pregnant women. I conduct a state-by-state analysis to examine the legal rights both inside and outside of the work place. This quantitative research allows me to present my findings in a more objective manner, and helps to support my claims supported by individual phenomenologies. I extend my research to media sources focusing on the photographic display of the pregnant body. By studying visual representations and their historical evolution I am able to understand an additional medium through which pregnancy is conceptualized.

The data that I obtained is not meant to be an all-encompassing representation of pregnant women, but a case study on how certain women experience their
pregnancies. I predict that certain themes that I discovered such as my theory that women are culturally alienated from their pregnancies will be true for many other pregnant women, but that certain aspects will remain particular to these individuals.

Alienation of Subjectivity:

I argue that during pregnancy there is an alienation of subjectivity that extends beyond the physical experience of pregnancy to the conceptualization of femininity. During pregnancy this alienation occurs due to the objectifying language surrounding pregnancy and birth, a lack of informed decisions regarding childbirth practices, the altering of legal and political rights, the way in which societal expectations exclude pregnant women, and the constant fluctuation of personal identity. I expand on this by arguing that phenomenology elevates the analytical status of experience and embodied experience in particular.

The loss of subjectivity during pregnancy extends far beyond the physical experience. I argue that patriarchal social constructions influence the way the female body is understood elementally. Iris Young’s theory of feminine spatiality in her essay “Throwing like a Girl: A Phenomenology of the Feminine Body Comportment Motility and Spatiality” argues that the societal construction of femininity has structured the way that women are able to use their bodies (Young 1980). She argues that the objectification of women’s bodies has become so normative that women learn to innately see themselves as people who are looked at by others. This makes bodily fluidity much harder, and changes the way women conceptualize and experience bodily space. Young argues that
feminine bodily existence is an “ambiguous transcendence” making it hard to conceptualize moving in a way that extends beyond their socially constrained lived bodily experience (Young 1980).

Young’s theory rests heavily on Merleau-Ponty’s theory of transcendence of the lived body as explored earlier in my theoretical framework, and on her definition of femininity. She defines femininity “a set of structures and conditions which delimit the typical situattion of being a woman in a particular society as well as the typical way in which this situation is lived by the women themselves” (Young 1980:140). By applying Young’s theory of feminine spatiality to pregnancy, along with the varied ways in which it has been approached and represented, simultaneously has the potential to reinforce these spatial constrictions and to transcend them.

This argument in Young’s work is deeply indebted to Simone de Beauvoir’s work *The Second Sex* that describes the gendering of the philosophical polarity *immanence* (female) and *transcendence* (male). De Beauvoir argues that woman is only defined as relative to man which promotes the idea of women as principally sexual beings (de Beauvoir 1949). She expands on this by describing *The Other* as the essential differentiating category in most primitive societies (de Beauvoir 1949). This separation of *The Self* from *The Other* can be seen in the way a pregnant woman may interact with the fetus growing inside her. She has spent her entire life coming to understand her lived body as her *Self*. Yet this self becomes compromised with the addition of another life existing inside her own body. The fetus can simultaneously be understood as an extension of the self, and of an invasive other (Bergoffen 1997). Interestingly, in the case of the law, this polarity can actually be switched so that
the fetus becomes the self protected by the law, while the woman becomes the other body who serves the sole purpose of protecting the fetus.

Although women lose some of the rights to their bodies during pregnancy, they are also given power through responsibility. This responsibility is conveyed to women through the promotion of self-help literature, vocal advice and social media (Carter 2010). Blogs such as Birth Without Fear and The Pregnancy Coach empower women through education, body positivity and a focus on gaining personal confidence. The Pregnancy Coach promotes “The Empowered Birth method” which is

a process that enables [pregnant women] to transform [their] birth experience by consciously choosing and creating based on [their] values & priorities, exploring [their] options, preparing [their] mind and body and ultimately stepping into [their] true power as [women] (The Birthing Coach 2014).

By conveying responsibility as empowering, women are able to reclaim their subjectivity as a key component in their pregnancies.

However, due to this sense of individual responsibility, women are blamed and blame themselves for any negative outcomes after birth (Carter 2010). This is exemplified by Rich when she states, “Two days before my first son was born, I broke out in a rash which was tentatively diagnosed as measles, and was admitted to a hospital for contagious diseases to await the onset of labor. I felt for the first time a great deal of conscious fear, and guilt toward my unborn child, for having ‘failed’ him with my body in this way” (Rich 1976:26).

Objectifying Language
Pregnancy is one of the only natural life experiences that is treated as an illness that requires treatment. There is an alienation of subjectivity due to the objectifying language surrounding the experience of pregnancy and birth. This problematic use of language can be traced to the language regarding conception. When simplifying the process of conception, people often attach heteronormative gender stereotypes to the sperm and ovum (Wagner 1995). They way in which conception is objectified detaches the sperm and ovum from the body and turns it into a social action. This objectifying language is continued in the vocabulary used to convey the birthing process. There is a societal gap between the notion of mothering and of birth giving for many different reasons (Ruddick 1994).

This medicalized notion prefers for pregnancy to be taken care of by educated medical professionals rather than the phenomenological embodied experience of women. In the medical world, the body has come to be understood as a machine that can be repaired using formulaic equations (Martin 1987:54). This mechanical metaphor has been applied to pregnancy in a way that has been phenomenologically alienating. Emily Martin states that this began in the 17th century in France when hospitals began to refer to the uterus and the womb “as though they formed a mechanical pump that in particular instances was more or less adequate to expel the fetus” (Martin 1987).

Faye Ginsburg argues that state-power has historically maintained its position by defining normative family values. The language that surrounds reproduction promotes particular values. For example, technologies are introduced to “cure infertility” automatically labeling the inability to reproduce as a negative cultural aspect. This Western value has interesting political value since it contradicts population control
problems that exist in other parts of the world. Ginsburg argues that cultural values regarding reproduction often differ depending on what forms of reproduction the state-power is oppressing. This is where values begin to get political. Ginsburg exemplifies this by contrasting anti-abortion protests, with protests against one-child policies (Ginsburg 1991).

Birthing a child does not necessarily entail mothering, and a lack of birthing does not necessarily negate the experience of mothering. However, this separation has contributed to the language categorizing pregnancy as a “condition”, and birth as a single momentous event (Ruddick 1994:35-6). When explaining the experience of waiting for a baby to be born during pregnancy Ruddick states, “To call that waiting a ‘physical condition,’ as I just did, obscures the activity of waiting” (Ruddick 1994:39). During the nine months of pregnancy, there is constant development as a woman’s fetus begins to grow a human being.

The language surrounding birth objectifies the pregnant and birthing experience, which can alienate the woman from her subjective experience. Ruddick argues that “birth givers can be deprived of infants by a contract that has turned them—by means of turning their uterus with which they are identified—into an object of property” (Ruddick 1994:37). This statement shows one way in which the use of objectifying medical/curing language to describe pregnancy can alienate a woman from her pregnant body, and therefore her baby. Using the words such as “condition” implies abnormality, which in the medical field (in which pregnancy has come to exist) is generally understood as something problematic that needs curing.
There have been many ways in which women have begun to reclaim their subjectivity during pregnancy. One way in which this is taking place is through the media. Websites have begun to spring up encouraging fitness during pregnancy. *Fit Pregnancy* fights objectification by promoting ways in which women can embrace and own their pregnancies (Fit Pregnancy 2014). In order to fight against objectifying pregnancy vocabulary, *Fit Pregnancy* uses empowering words in all of their work. They consistently refer to the “activity” of pregnancy, which encourages women to see themselves as actively participating in their pregnancies, as opposed to passively waiting as outlined earlier by Ruddick (Ruddick 1994). *Fit Pregnancy* also encourages women to embrace the experiences associated with pregnancy which society as deemed “side-effects”. In an article published on the website entitled “Morning Sickness: The Upside”, *Fit Pregnancy* outlines the benefits to morning sickness. The main point that they focus on, is that morning sickness can be a way for women to figure out which foods are healthiest for them during their pregnancies (Fit Pregnancy 2014). Although this article has the potential to be negative and condescending, the authors present it as a learning opportunity that includes women’s subjectivity. By using vocabulary that implies a woman’s active participation in their pregnancy, websites like *Fit Pregnancy* are able to promote the reclamation of subjectivity in a positive and constructive manner.

*Lack of Informed Decisions*

There is an alienation of subjectivity during pregnancy due to a lack of informed decisions regarding childbirth practices. Women have consistently been expected to experience pregnancies passively, which is both alienating and disempowering. Adrienne
Rich outlines the way in which the natural process of pregnancy has historically excluded the pregnant woman’s ability to intelligently process her pregnancy:

In Judeo-Christian theology, woman’s pain in childbirth is punishment from God...it was assumed until the last three decades that she must suffer passively...In the nineteenth century, chloroform was finally allowed to blot the laboring woman from consciousness, rendering her so totally passive that she awoke unaware that she had delivered. Others would *do* to her what had to be done. ‘Nature’ is often referred to in manuals of early midwifery as wiser than the ‘art’ of the surgeon with his hooks and forceps; but that a woman might learn to understand the process herself, and bring to it her own character and intelligence, her own instinctive and physical equipment, is never hinted (Rich 1974: 128-9).

I argue that this misconception of a woman’s ability to understand and make informed decisions regarding her own birthing process alienates women from their pregnancies. There has come to be a social undertone that places the knowledge of pregnancy completely within the medical field. This removes phenomenological knowledge from the pregnant experience, and assumes a lack of knowledge. I expand on this by arguing that “social differences in power, authority, prestige and access to resources shape birthing practices” (Ellison 2003: 323).

Biomedical hierarchies require professional expertise, which persuades pregnant women to make birthing decisions based on external sources of knowledge rather than thinking critically for themselves. The social expectation for planned pregnancies enforces this type of thinking by promoting the idea that pregnancy will easily fit into current living habits (Ellison 2003). Birthing practices that exist outside medical institutions tend to minimize social hierarchies and rely more on maternal aspects of the birthing process such as touch, cultural practices and instinct (Ellison 2003).

In a study conducted by Marcia A. Ellison, she found that single pregnant women generally felt a great amount of isolation and fear. Ellison partially attributes this to social
stigmas surrounding pregnancy, and the heteronormative social understanding that it takes two to achieve success (Ellison 2003). Adrienne Rich argues that her pregnant experience (which she combines with the experiences of other women) was completely controlled by others:

None of us, I think, had much sense of being in any real command of the experience. Ignorant of our bodies we were essentially nineteenth-century women as far as childbirth (and much else) was concerned… We were, above all, in the hands of male medical technology. The hierarchal atmosphere of the hospital, the definition of childbirth as a medical emergency, the fragmentation of the body from mind, were the environment in which we gave birth...The experience of lying half-awake in a barred crib in a labor room with other women moaning in a drugged conditions, where ‘no one comes’ except to do a pelvic examination or give an injection, is a classic experience of alienated childbirth. The loneliness, the sense of abandonment, of being imprisoned, powerless, and depersonalized is the chief collective memory of women who have given birth in American hospitals (Rich 1974: 176).

Rich’s experience exemplifies the powerlessness and alienation that has often been the result of a lack of information. Rich complied with the societal expectation of the right way to experience childbirth, and was subsequently alienated from her subjective experience.

Currently there are many different ways to both conceptualize and experience birth in the United States. I argue that each body is a subjective entity operating slightly differently. Given this definition, I suggest that different approaches to pregnancy benefit every individual slightly differently. There are many cases of irregular pregnancies that require medical technologies often unavailable to midwives. I argue that the problem does not lie in the particular birthing practice, but the uninformed way in which many women often chose to give birth. Interestingly, in a study researched by Amy Richards, it was discovered that the majority of women are satisfied with their birthing experience,
but aren’t satisfied with their level of control (Richards 2008). Richards describes her reasoning behind choosing her particular birthing experience:

I chose a doctor over a midwife because I’m generally wimpy about medical things: I always fear that the worst will happen, and I wanted to be overly prepared...Personally I think that a person can have a feminist pregnancy that doesn’t hinge on giving birth unassisted in the woods. An epidural isn’t evil; doctors aren’t anti-patient rights, midwives aren’t necessarily kind and benevolent souls; water births could be both calming and weird” (Richards 2008:92-3).

Richards’ experience echoes my belief that every pregnancy is situational and subjective. In order to avoid alienation due to a lack of informed decision-making, pregnant women need to be in genuine consensus with the way they have chosen to experience their own pregnancy and subsequent birth (Campbell 1997).

Informed decisions also require social and professional acceptance. Non-medical approaches such as doulas and midwives are not often recognized by the health care system as viable or responsible decisions (Campbell 1997). Doulas (a non-medical pregnancy assistant) average around $500, are generally not covered by insurance, and often are not a viable option for many women (Richards 2008). Professional and social judgment influences childbirth decisions, and bases them on external sources of knowledge (Ellison 2003).

Cesarean sections have become so normalized, that they are often understood as an accommodation to the pregnant woman’s busy lifestyle (Richards 2008). By creating the ability to decide exactly when a birth will take place, they promote an idea of continuous care and predictability (Lazarus 1994). They also completely remove the woman’s ability to control her birth reducing her to a level of passivity and fragmentation (Martin 1987).
Midwifery is centered around caring for the pregnant woman, rather than just for the process inside her. Campbell states that the three most descriptive words for the practice of midwifery are “choice, continuity and autonomy” (Campbell 1997:349). These characteristics echo the way in which midwifery focuses on maintaining health rather than identifying abnormalities (Campbell 1997). Midwifery can be understood to simultaneously appropriate and resist professionalizing tendencies (Ginsberg 1991: 322).

Gortmaker argues that infant fatalities are generally most affected by social conditions rather than biological issues. He claims that medical technologies have permanently impacted the way in which pregnancy and infant illness is prioritized, but that infant mortality is much more of a social problem than anything else (Gortmaker 1997). He argues that the way in which infant mortality is dealt with is ineffective, because it focuses on improving the after-care rather than fixing the system producing the problems. He argues this by analyzing childhood diseases stating that improving the dietary conditions of children is much more beneficial than improving medical care (Gortmaker 1997).

In a study conducted by Ellen S. Lazarus, she found that middle-class women are concerned with choices that would allow them to have an illusion of control over their pregnancy/childbirth, while poor women are more concerned with continuous care than control. The medicalization of childbirth has removed the possibility of tragedy during childbirth by creating an atmosphere where there is always someone to blame (Lazarus 1994). Once a woman submits herself to a medical institution, she is expecting guaranteed satisfaction. She no longer needs to be informed about her pregnancy or
birthing process, because her pregnancy has become the hospital’s responsibility. Blame has become such a prominent fear, that medical professionals will perform unnecessary procedures at the slightest hint of any abnormal condition, and pregnant women will be blamed for any potential problems the minute they stray from societal expectations (a sip of wine, a drag of a cigarette). This constant responsibility requires one person to dominate and the other to remain relatively anonymous. This relationship ignores natural loss, and always requires someone to be at fault (Lazarus 1994). The expectation for complete responsibility over pregnancy requires the medicalization of pregnancy. Subsequently, this increases a loss of local and cultural control over normative definitions of the pregnant experience (Ginsburg 1991) and justifies cultural gender norms (Almeling and Waggoner 2013).

This lack of knowledge on the part of pregnant women has begun to be addressed by several multimedia sources aimed at making information regarding pregnancy more accessible. Websites such as The Birth Coach, Fit Pregnancy and Birth Without Fear provide phenomenological stories of pregnant woman, and encourage women to ask questions and to take it upon themselves to become informed. In an article entitled “4 New Approaches to the C-Section”, Jeannie Faulkner provides guidelines regarding the current conditions that necessitate the operation, and other possible options (Faulkner 2014). Faulkner argues that C-Sections are overused, and outlines many of the reasons C-Sections are given. She points out the reasons that doctors choose to give C-Sections, and explains the situations clearly and informatively. She additionally provides the current medical guidelines for what necessitates a C-Section, so that women will be able to make informed decisions about their birthing process. For example, Faulkner
encourages women to request a “fetal scalp stimulation” (involving rubbing the baby’s head to raise heart-rate) if an abnormal heart rate is found before undergoing a C-Section (Faulkner 2014: 1).

Perceptions of Health: The Drinking Debate

During pregnancy, health generally becomes a higher priority to both the pregnant woman and to her greater community. Historically this has been one way in which pregnancy has been pathologized. Historically fitness has been a form of disempowerment for pregnant women who have been categorized as delicate “baby-vessels” in need of protection. But recently it has begun to transition to a source of empowerment through the promotion of pregnant weight lifting, yoga and other physical activities. Articles that encourage women to take advantage of their pregnancies exemplify this transition from object to subject, as women become active agents for whom pregnancy means activity.

Alcohol consumption is an issue that repeatedly comes up regarding health during pregnancy. It has been proven that excessive alcohol consumption can be extremely harmful to a growing fetus and increases the risk of reduced milk intake, reduced motor development, impaired sleep patterns, and an increased risk of hypoglycemia (Davies and Deery 2013: 47-8). Scientists and credited scholars have varying opinions on the risk of alcohol consumption, and range from arguing that even a sip of alcohol is detrimental to the fetus, to arguing that it is safe to consume as much as one drink per week (Hobbins 2013). With varying scientific opinions on the safety of
alcohol consumption during pregnancy, society tends to assume the worst about pregnant women who choose to consume any amount of alcohol.

In a study conducted by John Hopper in 2013, 5,628 pregnant women were monitored regarding their alcohol consumption during the first 15 weeks of their pregnancies. He grouped participants in four different categories depending on whether they consumed no alcohol prior to conception, no alcohol during the first 15 weeks, no alcohol within 15 weeks before conception, or drank continuously during the first 15 weeks. After birth, Hopper found that there were no differences relating to the amount or timing of alcohol consumption regarding the infants birth weight, birth in regard to projected date, and the existence of preeclampsia (Hopper 2013). When discussing his study Hopper stated “since thus far there are no conclusive data to link modest intake with fetal effect, it is very unlikely that an occasional drink would have an adverse effect” (Hopper 2013: 2). However, he also stated that since alcohol consumption can potentially affect the fetus, abstaining from consumption is the safest practice (Hopper 2013). This last statement exemplifies the way in which many people view alcohol consumption during pregnancy; No matter what studied have shown, it is better to be safe than sorry. Medical studies such as this one exclude the phenomenology of pregnancy by focusing exclusively on scientific data rather than the individual situations. This suggests that regardless of scientific evidence, social concerns take priority over medical concerns.

Change in Legal Rights
I argue that a woman’s legal rights change during pregnancy resulting in an alienation of her subjectivity. On November 26, 2014 Erick Muñoz found his wife, Marlise Muñoz dead on their kitchen floor. Although the Fort Worth hospital pronounced her brain-dead with no chance of recovery, they were legally obligated to keep her on life support due to her 14-week pregnancy. Erick and Marlise Muñoz were both paramedics, and had spoken on numerous occasions about what their final wishes would be if an accident ever occurred. Her family protested the hospital’s decision, saying that Muñoz had never wanted her body to be kept alive by machines if she had already died. However, the Texas “state law required them to maintain life-sustaining treatment for a pregnant patient” (Shoichet 2014). Eight weeks later, the hospital stated that the fetus was not viable. Three days after that, the hospital was ordered to remove Muñoz from life support, an order that they complied with two more days later (Hellerman 2014). Although there was no doubt about Muñoz’s final wish, she and her family lost all legal rights over her body due to her pregnancy.

On the one hand, if a fetus is considered to be a separate being from the mother’s body that it is growing inside, then it seems logical that it should have its own legal rights. But if the fetus is considered a part of the pregnant woman’s body, then it seems unethical that the woman should lose rights to her own body. Through this ethical debate, Marlise Muñoz lost her subjectivity and had essentially become nothing more than a baby-growing container.

Muñoz’s family’s concern with the way she was treated exemplifies the way in which people have begun to acknowledge the necessity of a phenomenological analysis of the embodied experience during pregnancy. While the legal rights to Muñoz’s body were the main concern in this story, her family simultaneously fought to reclaim Muñoz’s
subjectivity as a woman who had wishes and desires. Through familial and communal support, an understanding of the phenomenology of pregnancy has started to become apparent in the United States.

This begs the question, at what moment does the right to a woman’s body shift from her own to the state? Legally, the answer to this question changes based on the given state’s laws, and the quality of the specific situation. In the case of Muñoz, her death was allowed based on the poor viability of her fetus. There are many other ways in which the state claims legal control of different aspects of a woman’s pregnancy.

After extensively researching legal policy for the employment of pregnant women, I found that each state has varying levels of acceptance and accommodation. Only 40 states in the US have laws that prevent employer discrimination against pregnant women, and only 12 states provide work accommodations for pregnant women (Legal Momentum 2013). These accommodations may include more bathroom breaks, less time standing, or less physical demand. However, these laws vary state by state and often aren’t specified. By allowing employers to discriminate against pregnant women, the pregnant body becomes objectified as a debilitating condition and alienates women from their pregnancies. Several States including Alaska have instituted laws to appropriately accommodate a woman’s working condition during her pregnancy. Alaska states that,

A pregnant employee may request a transfer to a suitable position. All state employers that employ at least 21 employees are subject to this accommodation, and may not fill the position with a person other than the requesting employee until the employer has offered the position to the employee. An employer shall compensate the employee as closely to the rate at which the employee was compensated before the transfer or the position into which the employee transfers is compensated (Legal Momentum 2013).

However, other states such as Alabama do not even have laws preventing employment discrimination against pregnant women (Legal Momentum 2013).
In order to see how new mothers are treated and legally accepted after they have given birth, I researched breastfeeding laws. I found that only 17 states required women to be allowed to either breastfeed or breast pump in their place of employment. Although most states allow women to breastfeed in public, most do not include the workplace. I was surprised to find that five states --Alaska, Idaho, Michigan, South Dakota and West Virginia-- still prohibit women from breastfeeding in public places (Legal Momentum 2013). Although I expected that states that did not prohibit pregnancy discrimination would also not require breastfeeding accommodations, this was not always the case. This is exemplified in Indiana where it is legal to discriminate based on pregnancy, but also requires employers to provide new mothers a private room and a location to store cold milk (Legal Momentum 2013). Several other states have similar policies including Arkansas who requires that employers “must provide unpaid break time and a reasonable location that is not a bathroom stall for women to pump breast milk” (Legal Momentum 2013).

States who prohibit pregnancy discrimination include: Alaska, Arkansas, California, Colorado Connecticut, Delaware, Hawaii, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Iowa, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Wisconsin and Wyoming.
States who require employers to accommodate pregnant women (such as allowing more bathroom breaks, less standing time, and less labor intensive assignments) include: Alaska, California, Connecticut, Illinois, Louisiana, Minnesota, New Jersey, New Mexico, New York, Iowa, Texas and West Virginia.

States who allow employers to provide accommodations for breastfeeding include: Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Maine, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, New York, Rhode Island, Tennessee and Vermont. Seventeen other states allow women to breastfeed in public, but don’t have clear laws regarding the legality of breastfeeding or pumping in a place of employment.

Another way that pregnancy is controlled legally is through medical regulation. Although it is legal to give birth outside of a hospital, there are strict laws regarding who must be present during the birthing process. Within the practice of midwifery, most states require the midwife to be under the authority of a practicing doctor (Richards 2008).
Individual responsibility for fetal outcomes is medicalized and institutionalized (Carter 2010). Women are held responsible for every action that could potentially harm their fetus, such as drinking, using drugs, and smoking. There have been numerous cases where mothers have been severely criminalized after using drugs or drinking during pregnancy. There have even been cases where women have been court ordered to have a Cesarean section against their will in order to protect the unborn fetus (Carter 2010: 995). The existence of these situations although extreme, promotes the idea of alienation. Essentially, if the state views a woman’s behavior during pregnancy as reckless, they have the right to isolate or punish her body.

In 2011 Caroline Gatrell conducted a study aimed to understand how women manage their pregnant bodies at their workplaces (Gatrell 2010). By looking at online activity (including interactive websites and chat rooms) she was able to uncover the oppression that pregnant women continue to feel from their employers. Although discrimination based on pregnancy has technically been illegal since the 1960/70’s, there are many ways in which women still feel the pressure. Gatrell gives numerous examples of the ways in which employers conveyed to their pregnant employees that although they were allowed to continue working, their presence was not welcome. Some employers commented on social expectations and hinted that the right choice would be for the woman to be a mother at her home. Others looked for every opportunity to make their pregnant employee fail and appear incompetent in other ways.

Gatrell’s research found that although legal policies had incorporated pregnant women into the workplace, nothing had been done to physically incorporate their bodies (Gatrell 2010:162). This is problematic because of the extreme physical changes that
exist during the pregnancy experience. Gatrell states, “the notion that employers should, as a matter of policy, change everyday working routines in order to accommodate pregnancy is largely absent and any qualitative acknowledgement of the bodily changes women undergo when pregnant is lacking” (Gatrell 2010:162). Further, it was found that employers only tolerated the pregnant body if the employee was able to hide physical effects.

Through medical regulation and control of a woman’s pregnant body, she becomes physically alienated from her pregnancy. Individual responsibility for fetal outcome alienates a woman’s subjectivity by legally judging the way a woman cares for her body. Continued discrimination within the workplace reinforces this alienation by expecting pregnancy not to affect the physical abilities of the body.

*Change in Identity*

Merleau-Ponty states that subjectivity is equated with an individual body saying, “It is essential for me not only to have a body, but to have this body” (Olkowski 2006: 216). This bodily connection to subjectivity becomes problematic during pregnancy when the body is constantly and dramatically changing. Pregnancy shifts the focus to “these bodies” both the mother and the fetus, altering the pregnant woman’s social status. Women are excused from certain aspects of their identity during pregnancy but are still expected to maintain their same subjectivity. Women are simultaneously expected to give up aspects of their personalities that may not be as beneficial to their child, while also expected to act in the same way as they were able to prior to their pregnancies (Bailey 1999).
In the public realm, there are numerous articles regarding the loss of friends due to pregnancy. This is exemplified by *Cosmopolitan* magazine in an article entitled, “How to Handle the Baby Betrayal” (Shelasky 2014). In this article supporting the friends of pregnant women, Shelasky argues that a friend's pregnancy can be a burden on friendship:

I felt as though she were abandoning our girl code and way of life — hanging out late, drinking dirty martinis, and living a little dangerously — without my vote. She went from being up for anything to wanting to stay home and rest. The few times I did drag her away from the baby-naming books (Aiden! Liam! Hudson!), she'd want to talk only about her overtaxed bladder, which I was happy to sympathize with…to a point. And I obviously had to drink alone. Ugh (Shelasky 2014:1).

This quote exemplifies the dichotomy between expectations for pregnant women to simultaneously maintain their social identities while altering aspects that are not seen as healthy for a pregnant woman to do.

In a study conducted by Lucy Bailey, women stated that there were many activities that women engaged in and withdrew from during their pregnancy experience including “National Health Service ante-natal classes, National Childbirth Trust ante-natal classes, a range of ante-natal yoga and exercise classes and various support group, for example around home births” (Bailey 1999: 343). This temporary change in activities surrounding identity can result in a feeling of loss of subjectivity. Women felt like they were practicing how to identify with their new selves by integrating new activities and practices into their daily lives. Bailey also found that pregnant women began to identify more strongly with their identification as women (Bailey 1999). In this way, their subjectivity can be understood as becoming more rooted in their physical identity.

The physical changes that a body undergoes during pregnancy have a strong effect on the subjectivity and identity of pregnant women. There is often an assumption
that the pregnant body is uncontrollable and uncontained, which pregnant women often feel compelled to fight against (Carter 2010). There are certain so-called “body techniques” that pregnant women often use to maintain a socially desirable body in an attempt to represent a sort of “inner self” (Carter 2010: 994). This can be represented through diet, exercise, and other physical maintenance such as clothing choices (Carter 2010).

Changes in dress (to maternity clothes) can “suspend identity” or promote a new identity (Ogle, Tyner and Schofield-Tomschin 2013). Clothing can be understood as an extension of bodily identity and of the self. Since physical change requires constant changes in clothing, this can be understood as another reshaping of the self. In a study conducted by Jennifer Paff Ogle, Keila E. Tyner and Sherry Schofield-Tomschin, they found that choosing maternity clothing can help women feel more in control of their changing identities and physical bodies. They argue that women used clothing consumption to “manage role uncertainty...achieve an ideal self… cope with liminality...and… to bridge identities (Ogle, Tyner and Schofield-Tomschin 2013:121). Although maternity wear can be understood as a way in which women are able to “practice” their pregnancy, findings show a general dissatisfaction with the identity associated with maternity clothes suggesting its temporality as identity (Bailey 1999: 343).

One way in which organizations have started empowering women through maternity wear is by encouraging women to own their pregnancy with clothing. This is exemplified by the business “Pretty Pushers” that sells stylish and attractive delivery gowns for women to wear during labor (pictured below). They argue that choosing your
own clothing is an empowering decision that can help women feel more confident while giving birth.

During pregnancy, there is a change in sexuality and relationship quality that can contribute either to a sense of alienation or to a sense of empowerment through changed identity (Sagiv-Reiss, Birnbaum and Safir 2012). In a study conducted by Dafna M. Sagiv-Reiss, Gurit E. Birnbaum and Marilyn P. Safir, they found that relational concerns motivated sexuality during pregnancy. In their study they found that there was a loss of sexual desire among some pregnant women. However they argue that sexual arousal is often provoked by a desire for intimacy and closeness with their partner, a feeling that was generally fulfilled among pregnant women by their closeness to their unborn child who as a result felt a lessened sexual desire. They also attributed this to the amount of fatigue and weakness experienced during pregnancy (Sagiv-Reiss, Birnbaum and Safir 2012).

Many women feel that during pregnancy, their bodies display their sexuality and fertility. There can be an increased relationship between a woman and her body and a more pronounced gendered identity (Bailey 1999). This fulfilled celibate pregnancy argument can be understood as the product of cultural taboos regarding pregnant sexuality. It can be refuted when looking at the pregnant women who fully embrace their sexuality and surmount those taboos.

Recently there has been a reclamation of pregnant sexuality that has been promoted through the media. Websites such as Fit Pregnancy promote sexuality in pregnant women as a form of empowerment (Fit Pregnancy 2014). As opposed to magazines that serve to objectify the pregnant body, there have been many sources that
serve to promote healthy sexuality in an empowering manner. In an article entitled “The
Best Sex Positions for Pregnant Women”, *Fit Pregnancy* outlines the most comfortable
sex positions, and addresses the normality of physical changes during sex (Mehmet and
Roizen 2014). Several positions are outlined including “Spooning”, “You On Top”, “Side
of the Bed” and “Living Room Love” (Mehmet and Roizen 2014: 2). This article
empowers pregnant women by arguing that they do not need to give up sex during their
pregnancy, and additionally acknowledges that their bodily changes may require
adjustment. This focus on accommodation is important because it focuses on treating
pregnant women equitably rather than equally.

Reclaiming subjectivity during pregnancy does not entail treating women as if
they are not pregnant by not acknowledging that certain physical accommodations are
necessary. This is exemplified in the middle of Mehmet and Roizen’s article when they
argue that because of the physical changes of the pregnant body, “Missionary Style”
often becomes uncomfortable (Mehmet and Roizen 2014: 2).

Bourdieu’s concepts of power and habitus are reflected in the embodied
experience of pregnancy. Bourdieu defines habitus as the “disposition...of individuals in
collective action” (Lemert 2010: 378). By not focusing on subjects or objects, Bourdieu
uses habitus to explore the ways in which societal ideologies are expressed through
everyday interactions (Lemert 2010). He argues that there are social conditions and
structures that develop habitus so that it becomes collectively orchestrated without being
socially organized. The practical world is in constant interaction with habitus, and its
influence is constantly in motion (Bourdieu 1974). It is simultaneously a product of
history, and produces both social and individual actions (Bourdieu 1974: 446).
Prior to their pregnancies, women become accustomed to a particular habitus that has become part of their embodied knowledge. Once a woman becomes pregnant, her habitus must change since her physical body has also changed. This new habitus is socially acquired based on the way in which other people interact with a pregnant woman’s body. This lived-body is built upon the way that a woman feels physically, and her center of balance. This new body along with new social norms based on that body, can be understood in both positive and negative lights. “Pregnancy ‘effectively disrupts the ordinarily stable, and largely taken-for-granted, boundary between inside and outside, person and place (Davidson 2001:283, as quoted by Kannen 2001:184).

There is a loss of subjectivity due to societal expectations that exclude pregnant women. Often, the way in which a woman had been treated her entire life, and had come to expect, vastly changed upon her physical development during pregnancy. Authority changes as expectations of social responsibility are pushed upon pregnant women. There is a great amount of judgment that surrounds pregnancy, regarding everything from acceptable social activities, to correct medical procedures (Ruddick 1994). It is not uncommon for a stranger to approach a pregnant woman to let her know if they think she is doing a good job being pregnant (Neiterman 2012). Similarly, it becomes socially acceptable to stare at a woman’s body. There is a large amount of public scrutiny regarding how a woman carries herself as a pregnant woman, and staring is often the way in which that judgment is conveyed (Kannen 2013). All of a sudden it becomes socially acceptable to comment on a pregnant woman’s body as right or wrong.

While conducting interviews, Victoria Kannen noticed that her interviewees felt empowered to comment on her body, and simultaneously began to interact with her on a
more personal level (Kannen 2012). In this situation, unexpected comments on a woman’s physical body can be understood in a positive light, since as a result her interviews become more personal and honest. However, they still exemplify the way in which Kannen’s pregnant status encouraged less professional behavior. This change also alters the way a woman has come to expect to be socially treated, and can feel alienating. During pregnancy, it becomes socially acceptable to ask personal questions in formal environments. Bosses may begin to give breast-feeding advice to their pregnant employees (Gatrell 2010:169), or comment that a woman should prioritize being a mother over her employment (Bailey 1999). It is also often understood as acceptable to asked questions about romantic partners, or a woman’s ability to balance parenting and work, when previously those topics had been considered disrespectful (Kannen 2012).

This is reinforced by the social expectation that is okay to touch pregnant women. Although the example of touching a pregnant woman’s stomach often comes to mind, there are other ways in which this physical barrier is dissolved. Kannen exemplifies this when she states that while pregnant, almost every one of her interviewees (except one male) hugged her at the conclusion of their interviews. She initially didn’t think much of it, but once she had given birth, she noticed that nobody tried to hug her in that professional environment (Kannen 2012). This change in societal expectations can make women feel like their bodies have become public property (Bailey 1999). These changes in societal expectations can alienate women resulting a sense of lost subjectivity.

*Temporality and Spatiality*
Time and space are two key elements of phenomenological analysis that are represented in pregnant embodiment. During the experience of pregnancy, phenomenology elevates the analytical status of experience and embodied experience in particular. Societal constructions of femininity structure the way in which women understand and are able to use their physical bodies (Young 1980). The very way in which space and time are understood is embodied differently during pregnancy. Abigail Lewis states that during pregnancy time can no longer be wasted since it is being used resourcefully by the fetus to grow (Lewis 1951). Often times pregnant women feel like they need to start planning farther into the future and committing themselves to certain spaces (Bailey 1999). Often women make reproductive choices under social constraints to which they are powerless such as time (Earle 2007). The ability to have control over time can be understood as a form of power. Since the experience of pregnancy is relatively temporal over the nine months of the average pregnancy, a pregnant woman’s experience of embodied time changes (Earle 2007). Prior to pregnancy, women often expect to be able to time their pregnancies. Because of this, whenever a lack of control over time is perceived, the analytical experience of the pregnancy becomes more uncertain (Ellison 2003).

In the United States, there is a general cultural expectation that women take up less physical space than men. However, during pregnancy this is challenged both physically and socially. In a study conducted by Lucy Bailey, women reported that strangers gave them extra space than was actually necessary when they were visibly pregnant (Bailey 1999: 340). Rather than feeling isolated, Bailey found that the women
felt empowered by this gesture as it gave them the feeling of having additional cultural value (Bailey 1999).

Spatiality changes as the body and perceptions of the body evolve during pregnancy. Barbara Duden states,

> With her own eyes, she could not pretend to see reality in the cloudy image derived from her insides. And in this luminescence, her exposed innards throw a shadow over the future. She takes a further step—a giant leap—toward becoming a participant in her own skinning, in the dissolution of the historical frontier between inside and outside (Rapp 2007).

The societal assumption that women lack control over their bodies is especially prominent during pregnancy (Carter 2010). I propose that this perception of a lack of control may be explained by Iris Young’s theory of feminine spatiality.

Young argues that there is a different way that each gender uses their body when approaching different tasks. Regardless of actual physical ability, Young argues that women generally don’t perceive themselves as able to do stereotypically masculine tasks such as lifting, pushing, shoving, and using significant force (Young 1980). During pregnancy this feeling still exists, and there are countless measures taken to ensure that pregnant women treat their bodies in a healthy manner (Carter 2010). Not only does this reinforce the ideology that women can’t control their bodies, but that they shouldn’t even try. This is conveyed to pregnant women by the numerous ways in which pregnancy is represented in the media from self-help texts to Hollywood movies (Carter 2010). This is exemplified by Victoria’s account of her pregnancy as quoted by Carter:

> I went [to see the doctor] and you know when you start going every few weeks, like at the end? My blood pressure was going up. … And they were like, ‘you really have to watch this now.’ And me being worried the way I was, I went in my car after I left and I was just sobbing. ...And so they said ‘you can’t work, you can’t do anything.’ So I go to work, right after my appointment, pack all my crap up, and then go lay in bed. And I
had to *lay in bed*. I could get up to pee, I think they said I could be up for one hour total for the day (Victoria, quoted by Cannon 2010:1000).

This quote shows how society can reinforce the idea that women cannot control their bodies. This lack of control is problematic to a woman’s ability to fully live her life. Unity of physicality and a sense of bodily control are essential to an intelligent embodied experience of both femininity and humanity (Rich 1974:39). The seemingly unpredictable nature of the pregnant body comprises a woman’s ability to manage her body. This perception of a loss of bodily control is combined with a loss of control regarding her ability to influence the way she is socially perceived (Gatrell 2011).

Ruddick theorizes that the bodily ego is social from birth until death. The way the body is touched dramatically affects the transformation and development of the bodily ego (Ruddick 1994). This bodily ego is apparent in pregnancy during the embodied experience of birth. She states, “conceptions of pain are not given with its experience but are carried out of past and future social meaning” (Ruddick 1994:42). This embodied experience has been given an incredible amount of social meaning that is physically internalized through the bodily ego. This phenomenological bodily space can also be viewed in a positive light. Bailey argues that women are often given even more space than they actually require which can add cultural value to her experience of pregnancy (Bailey 1999). During pregnancy, bodily space can be enhanced by an increased social awareness of a pregnant woman’s body, and the space that she needs.

*Iris Young Embodied Pregnancy Revisited Today*
Iris Young’s germinal article “Pregnant Embodiment: Subjectivity and Alienation” greatly influenced the phenomenological study of pregnancy in the United States. However, since 1984 there have been large changes regarding the objectification of women during pregnancy. Although Young’s essay is still applicable in many ways, it is important to address the evolution of this subject during the past three decades. As the years progress, it seems there are an increasing amount of opportunities for women to reclaim their subjectivity through both media sources and the medical field.

Although I still believe that pregnancy does not automatically belong to the woman herself, there are ways for women to reclaim their pregnancies by reclaiming their subjectivity. If we understand the embodiment of pregnancy as a performance learned from literature and social experience (Neiterman 2012), then it seems logical that as societal understandings of pregnancy progress, women will become better able to embrace their pregnancies. Although the dichotomy of object and subject still exists, there are more ways to address this feeling of alienation. Young states that the “dominant culture projects pregnancy as a time of quiet waiting” (Young 1984: 53). Although this cultural perception still exists, websites such as Fit Pregnancy, Baby Center and Birth Without Fear actively work to promote active and informed pregnancies (Fit Pregnancy 2013, Baby Center 2014, Birth Without Fear 2014).

The medicalization of pregnancy is an interesting subject because although other birth methods have gained popularity, medicalization remains the primary discourse in the United States. Since Young’s essay, the severity of the medicalization of pregnancy has decreased, but still remains in the mainstream.
I argue that Young’s essay is still applicable to the phenomenology of pregnancy today, but should be treated more as the extreme than as the general rule. Her work represents an easy road for pregnant women to follow if they do not take the extra effort to reclaim their own subjectivity. However, if pregnant women actively choose to own their pregnancies, there are an increasing number of ways for them to achieve this.

**Conclusion:**

Pregnant women are objectified while remaining active subjects. Although modernity and the medicalization of pregnancy have created a pathology that didn’t previously exist, support systems have begun to arise in even the most oppressive institutions. Understanding pregnancy as a transformative experience rather than as a bodily condition with side effects allows for the body to be understood as a communicative entity (Lock and Scheper-Hughes 1987). My investigations of subjectivity during pregnancy have not only shown me the many ways in which women have historically been alienated from their pregnancies, but has also illuminated the different ways that individuals and communities are currently addressing this issue. This includes resistance to oppressive practices such as the medicalization of pregnancy, sexist vocabulary and disempowering constraints on legal rights. It is essential to support and reinforce these emerging ideologies in order to ensure this positive progression.
The experience of pregnancy is one of the only natural life stages that is approached as an illness. This approach alienates the woman from her pregnancy and ignores her embodied knowledge. Pregnancy needs to publicly be acknowledged as a natural and subjective life experience unique to every woman. I propose that in order to elevate the embodied experience of pregnancy, it is essential to fully reinstate women’s agency. One way in which this can be accomplished is through the de-medicalization of pregnancy. Although the women’s health movement has been striving for this since the 1970’s, there has only been moderate success within the medical community. Pregnancy needs to be acknowledged in the medical field as a lived experience specific to every woman.

Additionally, there needs to be an increase in informed decisions made by pregnant women regarding their pregnancies and birthing processes. Women need to take the initiative to understand their different birthing options, and to decide what way works best for their body and mind. By being an active agent in their birthing decisions, women will be able to have a more subjective and empowered pregnant experience. Informative and empowering books such as the worldwide phenomenon *Our Bodies Ourselves* (2011), provide engaging resources aimed at supporting active and subjective pregnancies. Rather than only having the choice of who can assist with pregnancies (doctors, midwives, doulas, etc.), there needs to be more open discussions about the different ways to approach pregnancy and birthing methods. This array of choice needs to not only be acknowledged within the medical field, but openly promoted through the media and financially supported by insurance companies.
Iris Young’s germinal work on both pregnant embodiment and feminine spatiality has been essential to the transformation of the way pregnancy is approached in the United States today. By calling attention to the objectifying and disempowering ways that pregnant woman have been treated, she was able to start a transformative process to reclaim women’s subjectivity. Her work emphasizes the importance of considering the woman with the pregnant body during pregnancy debates, rather than just focusing on the pregnant body or the birth.

Although this essay has purposefully not focused on the effects on anti-abortion rhetoric, it is a topic that has greatly affected and continues to affect the empowerment of pregnant women. Arguments that dissuade women from having the choice to not be pregnant impact the potential to reclaim women’s agency on larger scale. Regardless of the moral debate that surrounds abortion, a woman’s lack of power over her body alienates her from her pregnancy. The existence of anti-abortion rhetoric supports many disempowering ideologies including the idea that women aren’t capable of making intelligent decisions about their pregnancies. This idea is encouraged by suggesting that women shouldn’t be able to choose how they treat their own bodies, and that they don’t know enough about their pregnancies in order to be able to make informed decisions. It excludes subjectivity and differing situations by assuming that abortion is a black and white decision. This is problematic for the progression of empowering pregnant women, and limits the amount of transformation that is possible. In order for this to be addressed, there needs to be a more centralized focus on the issue of choice rather than morality.

As Bergoffen states,

To speak of the pregnant body as the passive instrument of species demands is, according to Irigaray to be taken in by patriarchal myths…
The pregnant body… is engaged in an active-passive, immanent-transcendent dynamic... The biology of pregnancy reveals a complexity that is at odds with the cultural imaginary of the pregnant woman (1997: 207)

This quote describes the subjective-objective struggle that exists internally within the phenomenology of pregnancy. It also serves to describe the external relationship that society has with the pregnant body. The conclusion of my research provides the platform for further research to be conducted regarding issues such as socioeconomic factors that I was only able to touch on.

My investigation attempts to provoke extensive thought on the way in which pregnancy is conceptualized, in order to both critique oppressive institutions and call attention to the empowering structures that strive to support women in their active pregnancies. The phenomenology of pregnancy underscores a critical and transformative human experience that deserves attention and appreciation.
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