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Affirmation and Resistance of Dominant Discourses: The Rhetorical Construction of Pregnancy

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This study investigates the origins of subversiveness and innovation with regard to existing master narratives on the topic of pregnancy. Two interviews of pregnant women who are defined as "at risk" are analyzed for how these two women positioned themselves discursively vis-à-vis others, particularly other pregnant women and the group of medical experts. Furthermore, the discourse was examined with regard to the moral positions and identity claims that were drawn upon in their claims of how their personal experience counters those that are considered "normal." *(Discursive Psychology, Identity Claims, Positioning)*

First-person accounts of personal experience and their claims regarding truth, knowledge, and values are typically framed in terms of preexisting master narratives (Boje, 1991; Mishler, 1995), culturally available narratives (Antaki, 1994), dominant discourses (Gee, 1992; Gergen, 1995), or cultural texts (Denzin, 1992). Hopper's (1993) detailed analyses of battle narratives of a World War II pilot, which were written down 40 years after the war, are an excellent example of how experiences can be framed in terms of a *John Wayne discourse,* a discourse that did not emerge as a culturally viable narrative format until 20 years after the fact. To those who share the worldview immanent in them, these master narratives seem to be reflections of the world as it "actually" is, rather than mediating interpretive frameworks. Master narratives derive from tradition, and they typically constrain narratives of personal experience, because they hold the narrator to culturally given standards, to taken-for-granted notions of what is good and what is wrong. At the

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same time, because the propositions implicit in master narratives or dominant discourses are widely accepted as self-evident, narrators who cast their own account in terms deriving from such a discourse are free to present the personal story as a description of events that is isomorphic to "reality." Therefore, there is no need to define or reason about the claims implicit in one's account, nor is one expected to legitimate these claims. Thus, master narratives and dominant discourses constrain and enable the personal construction of meaning in particular, predictable ways, without, however, restricting the individual's choice of what to narrate or how to word the account. "Telling a story allows us to create a 'story world' in which we can represent ourselves against a backdrop of cultural expectations about a typical course of action; our identities as social beings emerge as we construct our own individual experiences as a way to position ourselves in relation to social and cultural expectations" (Schiffrin, 1996, p. 170).

In recent years, considerable attention, particularly in feminist critique (Cohn, 1987; Nicolson, 1995) and critical race theory (Matsuda, Lawrence, Delgado, & Crenshaw, 1993), has been directed to the fact that narrative accounts can function as challenges and forms of resistance to master narratives (cf. Mishler, 1995). Our article reflects on this peculiar tension between the powers of dominant discourses and the potential in personal narrative for resisting these discourses. We attempt to delineate the nature of this tension by addressing the following questions: (a) What is the source of identity claims that resist dominant discourses, and how can such claims be recognized in personal accounts?[1] (b) How are these counter claims put to use? In considering this latter issue, we seek not only to describe how such counter claims are appropriated and employed in situated discourse, but also to examine what specific purpose they may serve for the narrator. Our study is a preliminary exploration of these questions; it is not intended to lead to definitive answers, but rather to stimulate further investigation of these and similar themes.[2]

The two personal narratives that we rely on in this article are drawn from interviews conducted with expectant mothers who had been diagnosed with medical conditions that placed them and their unborn children at risk during their pregnancies. Both women had given birth to healthy babies previously. Thus, we expected that in their narrative accounts of their own previous and current pregnancies, these women would redress the dominant discourses of pregnancy in light of their own personal experiences. More concretely, we expected a master narrative of the transition to motherhood, with its implicit claims and cultural expectations, to form

[1]Closely connected are the questions of whether or not these counternarratives have an existence or tradition on their own, and what their relation is to the dominant discourses, leading up to the critical question: What is their liberating and empowering force?

[2]Note that these questions are contiguous to key developmental and epistemological issues regarding the question of the appropriation of subjectivity (see Critchley & Dews, 1996; Valsiner, in press).

the backdrop against which personal claims were being formulated, claims that could endorse, reformulate, or resist the master claims.

Because the dominant discourse of pregnancy necessarily remains largely implicit in the interviews, we try to outline some of its most basic assumptions as they have been described previously in the works of others. According to Gardner's (1994) analysis of historical documents, pregnancy is a relatively recent topic in public discourse. It emerged with the more widespread recognition that "children are made by their parents, not sent, with all their imperfections on their head, from heaven" (Evans, 1875, p. 83; quoted in Gardner, 1994, p. 53). Central to this radical change in the conceptualization of pregnancy and birth giving is the appearance of the theme that reproductive processes are the responsibility of individual agents, who are capable of making key decisions that influence the well-being of the fetus and the mother-to-be. Historically, this general framework, which posits the individuation and manageability of bodies and lives, allowed for the emergence of a particular type of moral discourse. In this discourse, it is understood that the pregnant woman can endanger herself and the fetus she carries by engaging in wrong, risky behavior. On the other hand, by adopting an appropriate course of action, the woman can safeguard her own baby's health, and can even enhance her baby's physical and psychological well-being in later life. The availability of this theme opened the possibility for the emerging profession of medical experts to appropriate this type of discourse with the aim to legitimate the medicalization of pregnancy and birth, and subsume it to the domain of technical, scientific discourse. Perhaps for this reason, pregnancy narratives implicitly or explicitly address questions regarding the expectant mother's lifestyle, her competence as an agent, and her moral responsibility during pregnancy. They often thematize the role of others who have assisted in this process, particularly if medical experts were involved. Furthermore, personal narratives of pregnancies that have not concluded with successful births, or have otherwise been inconsistent with the normative claims of motherhood,[3] are constrained by the historical emergence of this type of dominant discourse, inasmuch as they have to give answers to questions (implicitly) asked: "Why did this happen?" "What did you do wrong?" "Who is to blame?"

Because the master narrative defines pregnancy talk as a moral domain in which agents must justify their conduct because they can influence and be held accountable for outcomes, women diagnosed with medical conditions endangering their pregnancies face a special problem, in that they are identified as being "at risk."

[3]See Modell (1992) for her insightful analysis of the moral discourse of "childless mothers"—mothers who gave their children up for adoption. Luker (1995) made a similar point showing how the popular conventional discourse on the topic of teenage pregnancy constitutes the roots of how and why teenage pregnancy is understood as a social *problem*.

Thus, within the moral universe of the master narrative, it becomes incumbent on them to explain the difficulties they experienced. In these explanations, narrators seek to refuse blame for these problems and vindicate themselves as moral agents. To accomplish this end, they might downplay their own agentive involvement, perhaps emphasizing their doctors' role as a responsible party. Alternatively, they may choose the approach we are most interested in: They can draw up a counternarrative consisting of claims as to what they did and who they are, that resist or even challenge components of the dominant discourse on pregnancy. Although reportedly the discourse setting of the interview is more likely to elicit a detached, reflexive stance that typically pulls narrators back toward acceptance of the master narrative,[4] we expected that some of the women interviewed in the study would make counterclaims, which would adumbrate alternative discourses facilitating the social reconstruction of the transition to motherhood.

Because we intend to explore the grounds that enable people (here, women) to draw up counterclaims and counternarratives, rather than to make general statements that are supposed to hold across populations, we present two detailed cases that give insight into the processes by which claims and counterclaims are formulated. Although it is possible (and necessary) to document how claims are interactionally facilitated by the participants of talk (see Schiffrin's, 1996, excellent study of claims to motherhood taking this approach), we do not follow this route in this article. Rather, we try to distill the cultural matrices and counterclaims from the interview discourse. To this end, we first explicate in a more systematic fashion the claims made by the interviewees. We then conduct a detailed analysis of the interviewees' positionings, giving particular consideration to the possible functions such positionings may serve for those who adopt them.

Note that in the context of this article, the term *narrative* is used in a broad sense. Although it is intended to include the ordered presentation of past occurrences, it is also meant to capture those aspects of people's talk in which they cite past events to explain, to reason, to give accounts, and to make claims regarding right and wrong. For our purposes, questions concerning issues of what happened, why it happened, who was involved, what was the narrator's role in it, who can be held responsible, what is morally right, and who the narrator is are all equally relevant. Thus, in the following, the terms *narrative* and *narrative analysis* do not refer to the traditional analysis of stories and storytelling, but rather designate this wider range of issues.[5]

[4]In a comparative study of women's accounts during their pregnancies with retrospective accounts, Smith (1994) was able to demonstrate that retrospective narratives are more likely to result in self-enhancing accounts, in which the interviewee can more successfully "draw on themes of identity available in social discourse and marshall them as part of constructing her own biography, to tell a particular story of her own" (p. 390). In the interview data of our study, because the interviewees had already successfully (though with complications) given birth, but were pregnant at the time of the interview, we expected their constructions to be "caught" within this process of self-reflection and self-reconstruction.

DATA AND ANALYSIS

The two interviews were part of a larger study whose purpose was to explore the extent to which pregnant women with and without gestational diabetes accept (or actively resist) the medical/clinical discourse of "self-care" and "risk avoidance." The participants for this larger study were recruited from hospitals and private obstetric/gynecological practices in the vicinity of a large city in New England. From the group of over 100 pregnant women who took part in the study, 5 participated in unstructured follow-up interviews concerning their personal experiences of pregnancy. The interviews were conducted by female interviewers. They were audiotaped and later transcribed. The main goal in interviewing was to elicit narratives about current pregnancies. However, certain aspects of the research context were evocative of accounts rich in other, nonnarrative forms of discourse as well. In our project, as in most narrative interview studies, the question put to the participants identified a given problem area (in this case, pregnancy) as a topic requiring discursively constructive work. As might be expected, therefore, the personal narrative accounts of our interviewees were shaped by and located within their understandings of pregnancy as a social "problem space." This being the case, the women placed emphasis on the kind of interpretive exploration and reasoning that has been termed *evaluative talk* by narrative analysts. The tendency to engage in evaluative elaboration was especially pronounced when the women attempted to make sense of their pregnancy-related health problems in light of their more general conceptions of pregnancy as a socially situated process. Interviewers actively encouraged participants' inclination to provide their interpretations of their experiences, often requesting that they add to and expand upon their reasoning.

Another feature of the interview context that influenced the nature of the accounts offered by participants was the fact that both women had given birth to children in the past. Thus, the interviewees' hopes and expectations regarding their current pregnancies, and indeed their personal constructions of motherhood, are presented against the backdrop of their previous histories of pregnancy and childbirth. This propensity to draw upon past experiences was interactively supported by the interviewers.

Because we wished to draw out the meaning of these tendencies in our participants' responses, we decided to deviate from traditional narrative analysis. It is

[5]This decision moves us closer to recent works in literature on account giving (Antaki, 1994; Buttny, 1993) and claims making (Ibarra & Kitsuse, 1993; Spector & Kitsuse, 1987). We see the confluence of this literature and our work on narrative as potentially enriching for both areas of study.

customary in narrative work to begin with the narrator's temporally ordered presentation of events, or *core narrative,* and work from there toward orienting and evaluating statements (Labov & Waletzky, 1967; Mishler, 1986), which establish the reasons why the narrator chose to arrange the events as he or she did and clarify what events "mean" to the narrator (Riessman, 1993). Thus, in customary narrative analyses, it is presupposed to start from the presentation of what happened and move from there to evaluative statements. Because the narrators in our interviews have chosen not to give elaborate narratives as examples for their claims, but rather engaged in elaborate claims making, interspersed occasionally with brief references to what happened in the past, we decided to follow their lead in the procedure of analysis. Accordingly, the focus of our analysis is on the organization of evaluative statements. Thus, for the purpose of this article, we extracted from the interview transcripts passages that were deemed most relevant in our participants' claims regarding the construction of pregnancy "as a social problem." Three types of passages were selected: (a) segments in which self and others were situated in terms of their mutual actions (which most often were statements of affirmation or objection), (b) passages in which participants' concrete action or activity descriptions were used as the basis for their claims regarding truth or the "real" state of the world, and (c) passages that entailed claims to knowledge and authority. These segments were chosen for inclusion in the analyses after the whole interview transcripts were read and discussed in a research group. After these decisions had been made, they were systematically expanded and explicated (for further elaboration, see Geertz's, 1973, method of "thick description," or Labov & Fanshels's, 1977, method of "expansion") with regard to their discursive implications. In a second step, these explications were used to perform an analysis with regard to the interviewee's "positionings." We examined (a) how the characters were positioned *within* the reported events (here we focused particularly on how the narrators positioned themselves vis-à-vis other pregnant women, and vis-à-vis their physicians), (b) how the interviewees positioned themselves vis-à-vis *the audience,* creating a particular discourse mode of advice giving within this process, and (c) how the interviewees positioned themselves vis-à-vis *themselves*—that is, making claims with regard to who they are and what in more general terms is morally right or wrong (for further details on the three levels of positioning, see Bamberg, 1996, 1997).

Although this method relies on the textual identification of "claims" with regard to the social construction of pregnancy as a social problem (Ibarra & Kitsuse, 1993; Spector & Kitsuse, 1987), it should be stressed that it nevertheless draws heavily upon the analyst's skills in cultural exegesis (Antaki, 1994 p. 113). However, because this form of exegesis is explicated in the text, and may therefore be replicated by those who choose to do so, we turn to a discussion of the excerpts. Regarding the potential argument that other passages of the interview could be pulled out to shift the focus to other claims that also could be considered relevant

for the participants' identity (e.g., claims with regard to family, marriage, upbringing, or gender), we admit that this is possible, although we tried to incorporate all claims that were of potential relevance to the topic of pregnancy by submitting our choice of segments to discussions in a group setting. Our analysis is meant primarily to provide first insights into the dynamics of individual claims that struggle with those of the dominant discourse on pregnancy.

Mary

At the time of her interview, Mary had two sons, 4 and 2 years old, and she had recently become pregnant again. She reported that her sons had been born healthy and that no complications had arisen in the current pregnancy. She also stated, however, that she had had problems with reduced fertility before conceiving her first child, and that she had developed gestational diabetes in the final stages of both previous pregnancies.

The principal rhetorical device used by Mary to elaborate her argument is a series of reported dialogues between herself and some other or others whose views on her pregnancy run counter to her own. These dialogues may be presented as reconstructions of actual interchanges in which Mary has taken part, or as hypothetical altercations. Mary typically casts some specific doctor, or doctors in general, as her opponents; she portrays them as spokespersons for a medical discourse of what is usual or desirable with regard to conception, pregnancy, and pregnant women's care of themselves and their unborn children.

In one such reconstructed dialogue that appears early in the interview, Mary discusses her use of a hormone therapy to enhance her fertility before her first pregnancy:

Excerpt A

And I—I was on a hormone, um, and the first month I was on it I was pregnant, which is unusual, too. My doctor told me that that's very unusual. Usually you have to be on it at least three months before you get pregnant. And he was surprised. I wasn't, though. I just knew I was goina be pregnant.

Here, Mary begins her anecdote by highlighting the rapidity with which she conceived a child (*"the first month"*). She identifies the speed of her response to the hormone as being a departure from some typical pattern (*"which is unusual"*), and she introduces her doctor's commentary, citing him as an authority who can provide information concerning the normal course of events following the commencement of the hormone therapy. She then notes that her response to treatment came as a surprise to her doctor (*"he was surprised"*), who presumably allowed his expectations with respect to Mary to be guided by his understanding of what constituted normality in this context. As if in answer to her doctor's reaction, Mary

immediately juxtaposes her contrasting evaluation of the situation as one that warranted no astonishment (*"I wasn't, though"*). She accounts for her relative coolness by stating that the news of her pregnancy merely confirmed a prior presentiment of hers: *"I just knew I was goina be pregnant."* This anecdote may be read, then, as pitting Mary's intuitions regarding her physical states against her doctor's medically informed conceptions of normality. The implied conclusion is that Mary's experiential self-knowledge has superior predictive power. Note that Mary does not question her doctor's ability to speak knowledgeably regarding typical treatment responses; indeed, Mary implicitly accepts the doctor's version of normality by endorsing his characterization of her experience as unusual. Thus, Mary does not call into question the validity of the medical model as a norm; rather, she seeks to dispute the applicability of this model to her own situation.

Shortly after relating this dialogue, Mary presents a reported conversation that resembles the hormone therapy anecdote both in terms of its structure and its apparent message. In this passage, Mary is commenting on her third and current pregnancy:

Excerpt B

And I found out yesterday I got pregnant four weeks after my period instead of two. Which is very unusual, it doesn't ever hardly happen, and my doctor's just shakin' his head like, "Are you sure?" And see, I always keep track of my dates. I know exactly because I've had a problem in the past, and I said, "My dates are right." I said, "I write 'em on the calendar every month cause I always wanna know, and I count the days in between because I always wanna make sure I'm ok. And I've been regular." So he's just like, "I can't believe this."

As in the previous excerpt discussed, Mary singles out a feature of her pregnancy as being remarkable (i.e., its timing in relation to her reproductive cycle), and she stresses that in this respect her pregnancy deviates from some standard. Once again, Mary depicts her doctor as manifesting amazement; in this instance, his response also includes skepticism, conveyed in a gesture (*"shakin' his head"*) that Mary interprets as a challenge to her conclusions regarding the date at which her pregnancy began (*"Are you sure?"*). In an aside to the interviewer, Mary vigorously maintains that her statements are accurate (*"I know exactly"*); she supports this assertion by explaining that she monitors herself assiduously (*"I always keep track of my dates"*), having a strong motivation to do so (*"because I've had a problem in the past"*). After giving the interviewer this evidence for the plausibility of her own account, thus appealing to her audience to regard her case favorably, Mary goes on to describe how she made the same argument to her doctor in an amplified form. In her reconstruction of her comments to the doctor, Mary begins and ends with unqualified declarations of her correctness (*"My dates are right"*; *"I've been regular"*). She justifies her certitude by twice underscoring the sustained character of her desire to maintain a thorough familiarity with the rhythms of her reproductive system (*"I always wanna know"*; *"I always wanna make sure ..."*). Mary repeats her earlier contention that her unflagging interest in her reproductive health provides a compelling reason for her to persevere in observing herself carefully, and she conveys a heightened impression of her own meticulousness by increasing the detail with which she describes her record-keeping practices (*"I said, 'I write 'em on the calendar every month'"*; *"and I count the days in between"*). Mary concludes her retelling of this episode by depicting her doctor as responding to her with continued doubt (*"He's just like, 'I can't believe this'"*). By ending the account of the reliability of her knowledge in such a way, Mary communicates to the listener that she does not require the doctor's concurrence, and can remain unshaken in her convictions, despite challenge from a representative of the medical viewpoint.

To recapitulate, in the dialogues just discussed, Mary suggests that her experiences of pregnancy do not conform to the usual course of events anticipated by the dominant medical discourse; moreover, she characterizes the insights gleaned from her inner promptings and careful self-observation as constituting an explanatory model of her pregnancy that is more reliable than standard medical descriptions of pregnancy-related phenomena. Mary's conviction that her understanding of herself surpasses her doctors' understanding of her is logically consistent with the conclusion that she can safely rely upon her own judgment in determining how best to care for herself and her unborn child during pregnancy. That Mary does indeed endorse such a view may be inferred from the manner in which she recounts instances in which her reasoning and behavior conflicted with the medical advice customarily given to pregnant women. Her justification of her methods, like her defense of her authority, is expounded in the course of remembered and imagined exchanges with doctors.

In the following passage, for example, Mary refers to an unorthodox measure of self-care that she has adopted, and she includes and responds to her doctor's tacit comment on her decision:

Excerpt C

[Interviewer: Have you been concerned about the gestational diabetes this time?] *Well, I'm actually more concerned this time because I'm more overweight than I was last time. Um, I usually, uh, before I had really thirty pounds I could kinda play with sort of, you know, like more than I do this time. Um, this time, I—I've lost seven and a half pounds, and I'm gonna try and lose three more, even though my doctor kinda looks at me like, "What?" But I'm not, I'm not dieting, I'm eating. I'm eating everything I need to eat.*

In her answer to the interviewer's question regarding gestational diabetes, Mary implicitly espouses the theory that in her particular case, weight gain in excess of

thirty pounds during pregnancy may precipitate the condition. In accordance with this principle, Mary apparently concludes that she can stave off diabetes by reducing her weight. She announces that she intends to persevere with her weight-loss plan (*"I'm gonna try and lose three more"*) despite indications that her doctor questions its advisability (*"even though my doctor kinda looks at me like, 'What?'"*).

Although most of the excerpt is addressed to the interviewer, it may also be read as a retort to the hinted criticism that Mary detects in her doctor's looks. By insisting (*"But, I'm not dieting ... I'm not that way"*), Mary seems to be answering what she takes to be her doctor's accusation that her eating behaviors constitute a diet. Her denial of this unspoken charge implies an acceptance of the notion that methods of weight-reduction falling under the rubric of "dieting" could be injurious to her own and her baby's health. Mary distinguishes her weight-loss efforts from such irresponsible dieting, stressing (*"I'm eating everything I need to eat"*). In sum, Mary demonstrates here that she can devise an approach to a pregnancy-related health problem that is in some sense logical and tailored to her individual needs. By summoning up her doctor's voice, she affords herself the opportunity to refute his objections to her unconventional practice, thus showing that her relative independence from medical guidance is reasoned rather than reckless.

Mary employs some of the same positioning strategies when discussing her consumption of vitamins prescribed to her by a chiropractor as an additional means of forestalling the development of gestational diabetes:

Excerpt D

I take not only prenatal vitamins, but I also take vitamins from a chiropractor, which not everybody believes in, but um, I do. So, I've taken them and last time I only had diabetes in my last three months that I was pregnant. And I ate pretty much whenever I wanted. Doctors don't like to hear that. Um, and they don't believe me. In fact, I ate worse with my second one than I did my first, and I did better because of the vitamins, I know that's why. And, um, so they don't believe me, but anyway, um, so I know it's true.

Mary states clearly that she takes *"not only prenatal vitamins,"* and reveals to the interviewer her awareness that within the context of the prevailing discourse on pregnancy, the use of such nutritional supplements is considered a basic and necessary self-care measure for pregnant women; just as she endorses the principle that dieting is harmful in the anecdote on weight-loss, she indicates here that she approves and abides by this culturally prescribed rule for expectant mothers. Next, Mary informs her listener that she has adopted an additional dietary practice, implying that she is thereby managing her health in a way that surpasses minimum expectations: *"Not only"* does she do what other pregnant women ordinarily do; she *"also"* takes vitamins from the chiropractor. At this point, Mary imagines how general opinion would evaluate her action, remarking that *"not everybody believes in"* her nonstandard approach to health maintenance. She then bluntly voices her defiance of this imagined disapprobation by the public (*"but ... I do"*), thus signaling that she is not unwilling to play the role of renegade. In justification of her divergence from orthodoxy, Mary maintains that her use of the chiropractor's vitamins during her second pregnancy secured a favorable outcome: She was diabetic for a period of time that she regards as brief (*"I only had diabetes for my last three months"*), despite the fact that she made no alterations in her diet to control her blood sugar.

At this point, Mary again allows dissenting voices to emerge into her discourse. Doctors as a group are identified as adversaries, who censure her actions and question her judgment as to the effectiveness of her chosen method of coping with diabetes. As if in reply, Mary reiterates her position more emphatically. Not only did she experience gestational diabetes for a shorter span of time in her second pregnancy than in her first; the decrease in the duration of the problem occurred in spite of the fact that her eating habits in the second period were *"worse"* from the point of view of medical professionals, who would regard adjustments in diet as essential for the management of her diabetes. Mary's experience of improvement in her condition from one pregnancy to the next is sufficient to convince her that the chiropractor's vitamins have brought about beneficial change (*"I did better because of the vitamins, I know that's why"*). Mary rests her case in favor of her alternative medicines by reminding the listener of her doctors' intransigent skepticism (*"they don't believe me"*), and countering with another declaration of faith in her own rightness (*"I know it's true"*). Thus, she finishes this story as she began it, displaying that she is resolved to rely upon her own intuitions and reasoning in preference to the strictures of others.

The central theme adumbrated in Mary's remarks about the management of her gestational diabetes appears as a general and explicit credo in the next excerpt, with which Mary concludes an extended explanation of her choice not to breast-feed her two sons:

Excerpt E

I figure whatever works for you, I—I always tell my friends "whatever works for you, do it, and enjoy your baby. Don't feel like you can't enjoy your baby," so that's my whole thing, "and do what's best for you."

In three slightly varying forms, Mary articulates the idea that pregnant women should feel empowered to make decisions regarding self-care that are grounded in their experientially based understanding of their own needs and circumstances (*"whatever works for you"*; *"whatever works for you, do it"*; *"do what's best for you"*); with the triple reiteration of *"for you,"* Mary seems to be giving particular emphasis to her belief in privileging the perspective of the individual. She identifies this notion as the unifying principle that informs her approach to coping with

pregnancy and infant care (*"that's my whole thing"*). As in the passages previously considered, Mary lets her listener know that she is formulating her views as she would if she were addressing some other audience outside of the interview situation. However, in contrast to those instances, where she portrays herself as defending her authority against challenges from doctors and their medical conceptions of normality in pregnancy, Mary imagines herself here as proselytizing in favor of her philosophy before friends who have borne children themselves. Perhaps because she regards women who know her and who have had similar experiences as likely allies, Mary does not depict them as raising objections for her to refute.

The following passage may be read as a distillate of the major themes that Mary has delineated in discussing her interpretation and management of the physical aspects of her pregnancy. The segment, which is preceded by an assertion that Mary and her father have both benefited greatly from their chiropractor's interventions, appears toward the close of the interview:

Excerpt F

Um, I'm not saying it's for everybody, but it works for us, so, you know, I—I'm very open-minded, I'm like, you know, if it works for you, do it, if it doesn't, fine. If you don't want to deal with it, fine, but it works for me, so, I'm doing it. So, um, my doctors don't believe in it, most of them.

In the excerpt, Mary returns to an idea suggested in the first two excerpts discussed: She and her father, as unique persons, are contrasted with the population at large (*"us"* vs. *"everybody"*). Generalizations that hold true for the majority may not be relevant for Mary and her family; thus, health remedies that others dismiss may be perfectly suited to their needs (*"I'm not saying it's for everybody, but it works for us"*). Mary goes on to characterize herself as *"open-minded."* As if to explain what she means by this term and how the quality of open-mindedness comes into play in her decisions regarding her pregnancy, she continues, *"I'm like, you know, if it works for you, do it."* In this context, this echo of Mary's earlier thematic statement places emphasis on Mary's willingness to embrace any self-care practice, however eccentric it may appear to others, provided that it has proved effective when she has resorted to it. Thus, for Mary, open-mindedness entails a readiness to experiment with unsanctioned practices, and to be influenced by the lessons of her own experience with such practices.

Subsequently, Mary reverts to her characteristic device of dramatizing her self-confidence by depicting herself as holding fast to her position in a hypothetical argument with stubborn opponents. With the phrase, *"I'm like ...,"* Mary signals that she is about to reproduce for the listener her usual manner of expressing herself on the subject at hand. Mary imagines herself taking part in a conversation in which the other speaker or speakers fail to meet her criteria for open-mindedness, in that they decline to give credence or respect to the self-care methods that she has tested

and judged appropriate for her: they *"don't want to deal"* with her ways of coping with pregnancy. Mary at once acknowledges and dismisses her conversational partners' lack of tolerance with a curt *"fine."* Having shown in this way that she is undisturbed by this lack of sympathy with her views, Mary reaffirms the overall messages implicit in Excerpts C and D, in which she gave specific examples of her behavior during pregnancy: *"It works for me, so I'm doing it."* In other words, no opposition will dissuade her from believing that she may safely regard her own experientially based judgments as well-founded.

In sum, Mary subscribes to an idiographic, individualistic understanding of pregnancy, contending that she herself is uniquely well qualified to understand her bodily experiences and to devise solutions to her pregnancy-related health problems. In the course of the interview, Mary interweaves her presentation of this argument with the delineation of two larger principles that appear indicative of her beliefs about life in general. Mary's attitudes regarding pregnancy are consonant with these more fundamental guiding rules, and may be seen as deriving from them.

Specifically, Mary identifies self-reliance as one quality of character to which she attributes especial importance. In the context of a discussion in which she is alluding to her efforts to help others by providing them with counseling, Mary makes the following comments:

Excerpt G

I always draw the line where people aren't gonna help themselves. And I always say if you're not gonna help yourself I can't help you, I'm sorry, you know. And I love them still, and I still care about 'em, and I'm still there for them, but if they're not gonna pick up the pieces and keep going there's nothing else I can do.

According to Mary, then, people who are struggling to cope with difficulties should take primary responsibility for their own well-being, for at least two reasons: First, she implies that unless people make use of assistance they receive by attempting to act in their own behalf, any such assistance will remain inefficacious (*"if you're not gonna help yourself I can't help you"*; *"if they're not gonna pick up the pieces and go on there's nothing else I can do"*). In addition, by maintaining that help should be withdrawn from those who fail to help themselves (*"I always draw the line ..."*), Mary appears to suggest that such people are undeserving, and more generally, that a lack of self-reliance is a characterological deficiency. In another passage relating to this theme, Mary refers to the period of time during her first pregnancy when she suffered from gestational diabetes, and comments on her reasons for choosing to give herself insulin injections rather than delegating this task to a health care professional:

Excerpt H

I'm very self-reliant, and I wouldn't rely on anyone else to give me the shots. I figured what, what if I needed it right away and I couldn't get to somebody, I, no I will do it myself, whether I like it or not.

In this instance, Mary conveys the idea that the ability to care for oneself is essential, because potential helpers may be unavailable at crucial moments. Thus, in Mary's view, it is incumbent on individuals, for both moral and practical reasons, to be as active and independent as possible in providing for their own needs.

Sue

We have argued that in her discussion of her pregnancies, Mary refers frequently to doctors' conceptions of normality in relation to the experience of pregnancy and the self-care practices of pregnant women; she repeatedly presents her own experience and practices to the listener by contrasting them with this posited norm, denying that it has usefulness as a representation of what she has undergone during her pregnancies. Ideas about normal pregnancy also figure prominently in Sue's discourse. She describes her pregnancies as diverging, in frightening ways, from the course that she and others expected them to take. However, Sue does not unequivocally conclude, as Mary might have done, that the surprising and disappointing aspects of her pregnancies were rare events, or that her reproductive functioning and behaviors during pregnancy were significantly different from those of most other pregnant women. Rather, Sue can be seen as moving toward the position that commonly held notions of normality in pregnancy misrepresent the experience of many women, and that her own pregnancy history appears unusual only when measured against this erroneous master discourse on pregnancy.

During her first pregnancy, Sue went into premature labor at 28 weeks. The labor was successfully arrested at that point. Sue then spent several weeks in the hospital on complete bed rest, and was able to carry her child to 36 weeks, when he was born healthy. She was in the 35th week of her second pregnancy at the time of the interview. The current pregnancy's course was similar to that of the first: Labor had begun and was halted at 24 weeks, and Sue spent the next 11 weeks on bed rest, this time in her own home. In her interview responses, Sue focuses on her apparent predisposition to pre-term labor. She describes her emotional reactions to this feature of her pregnancy and its attendant dangers and hardships, explaining in particular how the situation has engendered "frustrations" in her:

Excerpt I

It's just frustrating, because you feel like you do all the right things, and eat what you're supposed to eat, and no caffeine, no this, and ya know, and then, then it happens, and there's nothing I can do to stop it, and that's—that's upsetting.

Sue communicates to the interviewer that she adhered to the kinds of behaviors that are viewed within the dominant medical discourse as customary and appropriate for expectant mothers (*"all the right things," "what you're supposed to eat"*), listing some of them as if to emphasize the comprehensive character of her conscientiousness. By using the general *"you"* here, Sue seems to identify herself with a larger group of women who manage their pregnancies in these normative ways. Premature labor is the sequel of Sue's good and careful conduct: *"and then, then it happens, and there's nothing I can do to stop it."* By designating this conclusion and her powerlessness to forestall it as frustrating, Sue implicitly alludes to her disappointed expectation that she would be able to control the course of her pregnancy and prevent the appearance of any problems by doing *"all the right things."* At this point, Sue abandons the general *"you"* and adopts the pronoun *"I,"* perhaps as a means of conveying that her experience of unforeseen complications dissociates her from the body of women whose pregnancies conform to a standard pattern, in which proper self-care is followed by and seems to secure a successful outcome.

In the following excerpts, Sue notes another way in which her tendency to go into pre-term labor has thwarted her expectations regarding her pregnancy:

Excerpt J

I guess for me the worst thing of being pregnant is the high-risk part, and that there's no reason for it happening. There's no, no one can give me a reason why it happens, and it just happens to me for some reason.

Excerpt K

There's absolutely no medical reason for my going into pre-term labor. Um, in the first pregnancy, they thought, it was hypertension plus pre-term labor which I've been told are two separate things. I thought one bore on the other, um, but, it's just separate.

Excerpt L

I guess one, a couple a time during this pregnancy, I got a little angry, you know, Why does this have to happen? And it's frustrating, because there is no reason for it.

In Excerpts J and L, Sue states that her distress over the complications in her pregnancies has been exacerbated by the fact that *"no one"* has provided her with any explanation to account for these phenomena. Presumably, then, she had assumed or hoped previously that if her pregnancies did not proceed in an ideal

way, *"someone"* would at the very least be able to account for the deviations, thus divesting them of unpredictability; judging from her references to the absence of medical reasons (Excerpt K) and to a group of people who gave her their opinions regarding her physical condition (Excerpt K), it seems that she had looked to her health care providers to render these aspects of her pregnancy intelligible. In Excerpt J, there is perhaps a faint hint that Sue is dissatisfied with her doctors for failing to find the causes of her tendency toward premature labor: Her statement that *"it just happens to me for some reason"* suggests that her problems must after all have identifiable sources, and the formulation *"no one can give me a reason"* seems to cast doubt upon the capacities of those who might be expected to locate these sources. Elsewhere, however, she does not focus on her providers' inability to give her the explanations that she wants, but instead speaks of the absence of reasons as an absolute fact (Excerpt J, *"there's no reason ..."*; K, *"There's absolutely no medical reason ..."*; and Excerpt L); when she uses these terms, Sue seems to be accepting a version of the medical discourse that states that the complications arising during her pregnancies are mysterious by their nature.

In short, at those moments when Sue alludes to her disappointment over encountering serious difficulties in her pregnancies, she seems to adopt the dominant discourse's taken-for-granted perspective that a normal pregnancy is one whose course can be controlled and explained, and whose outcome is favorable. Elsewhere, however, as in Excerpt M (next), Sue challenges the status of these notions as matters of fact, identifying them as beliefs to which many people subscribe. Moreover, she characterizes these beliefs as misguided, denying that a pregnancy free from problems and unanticipated occurrences may properly be regarded as typical:

Excerpt M

Ya think you get pregnant, and nine months later you have a happy, healthy baby, and everything's fine, and the reality is, it's not always that way. So it is, it is something to think about. Where you see people who ya know, they become pregnant, and they go through their nine months, and it's fine. And then ya know, it hits me that it's really not that. Not that it's not easy, I I shouldn't say that, it's just that there are, there can be risks involved in having a baby, ya know, and I think most people take it for granted. You just get pregnant, and you have the baby, and it's fine ya know, at the end of nine months you have this baby, and um this time it was ear—I went into labor earlier.

In a manner somewhat reminiscent of Mary's rhetorical constructions, Sue presents her argument dialogically, in the sense that she alternates between speaking in the voice of her opponents and casting doubt upon her interlocutors' position. Three times Sue delineates what she takes to be the popular version of pregnancy, that is,

as a sequence of events in which a woman conceives, waits for 9 months to elapse, and gives birth to a healthy child; it is *"taken for granted"* that the process will conform to this predictable pattern, and that all aspects of it will be *"fine"* (at three points in the excerpts). By using this blandly positive yet vacuous word in representing *"most people's"* understanding of the pregnancy experience, Sue introduces an oblique suggestion that those who espouse such an overall view of pregnancy are thinking in simplistic terms and failing to consider the gravity of the situation for mother and child.

Each time that Sue presents what she regards as the standard discourse of normal pregnancy, she then negates or calls it into question in some way (*"it's not always that way"*; *"it's not really that"*; *"I went into labor earlier"*). Sue lends authority to her criticisms by presenting them as a generally valid statement of *"reality."* Her realization that the model lacks accuracy is portrayed, not as a belief generated from within herself, but as something that *"hits her,"* a hard fact impinging on her from the realm of the objective. In Sue's construction of the objective truth about pregnancy, she acknowledges that there are indeed cases in which women have relatively tranquil, *"easy"* pregnancies: *"you see people who ... become pregnant ... and it's fine"*; *"Not that it's not easy ..."*). But even though this ideal scenario sometimes becomes an actuality, it should nonetheless be appreciated that *"it's not always that way,"* and, more specifically, that *"there can be risks involved in having a baby"*; in other words, the process is marked by uncertainty, which even the most conscientious maternal behavior cannot eradicate. Viewed in light of this insight, the contrast that Sue draws between her own history of early labor and the master pregnancy story she rejects does not appear as evidence that her experience is anomalous. Instead, Sue's personal story stands within the context she establishes as an instance in which one can witness the actualization of the potential for unforeseen problems that is inherent in every pregnancy.

In a subsequent passage toward the end of the interview, Sue further sharpens her critique of prevalent notions about pregnancy:

Excerpt N

I don't know, um, I guess it's important that people real—it's hard for me that—for me because I've gone through the problems that I've gone through, it's—pregnancy isn't something that you can take for granted, that, you know, at the end of nine months, boom, you have this baby, there are many things that could go wrong. And being in the hospital all the times that I had, while being pregnant, I was in with people with a wide variety of problems, not only the same thing that I had, but other things, and I think that most people don't realize that something could go wrong.

At the outset, Sue designates her imagined interlocutors (*"people"*). At the same time, she expresses a wish that the hypothetical exchange presented here could

become an actual dialogue, in which the majority whom she addresses would acknowledge and accept the validity of the insight she has attained through her own difficulties (*"... it's important that people real*[ize]*...because I've gone through the problems that I've gone through ..."*). In elaborating this insight, she once again simultaneously states and contradicts the common view of pregnancy as a straightforward process (*"pregnancy isn't something that you can take for granted, that ... at the end of nine months, boom, you have this baby, there are many things that could go wrong"*), and stresses *"people's"* widespread obliviousness to the hazards pregnancy entails. Further, she situates herself within a larger group of women who had *"a wide variety of problems,"* thus suggesting that the appearance of complications during pregnancy does not in fact constitute a deviation from the norm, but is rather a frequent occurrence among expectant mothers, and should therefore be incorporated into a revised version of pregnancy talk.

In support of her contention that uncertainty and risk are intrinsic to pregnancy, Sue invokes the testimony of experts. Thus, in contrast to Mary, who identified doctors as adversaries who misguidedly try to assimilate her pregnancy to an idea of normality that fit it poorly, Sue portrays doctors as powerful, knowledgeable instructors who enlighten her as to the simplistic nature of the layperson's perspective on pregnancy, and who provide her with a more realistic alternative discourse.

Excerpt O

I was able to speak with the neonatologist ... cause I went into labor twice already, and ya know they stopped it both times, but ya know, speaking to him really lets you know that yes, it's serious if you have a baby pre-term, and that's what concerns me. I mean ya know, you think you get pregnant, and you're gonna have this baby, and then it could happen that something could happen, very serious.

In this excerpt, Sue recalls an exchange that took place between herself and a neonatologist after one of her episodes of premature labor. Before proceeding to the content of this conversation, Sue parenthetically pays tribute to the competence and efficacy of the physicians who attended by noting that they were able to avert an incipient crisis; in this way, she creates a halo effect, in light of which it appears reasonable to regard the medical specialist's communications as authoritative. In relating the conclusion that she drew from the information given her by the neonatologist, that is, that premature birth can have dangerous consequences, Sue emphasizes that the doctor's words carried conviction (*"speaking with him really lets you know ..."*); with the inclusion of the affirmative (*"yes, it's serious"*), she suggests that she may initially have questioned the gravity of the situation, and that the doctor gave her an answer that carried her doubts away. Shortly thereafter, in terms that recall those she used in Excerpt M, Sue presents once again her interpretation of most people's expectations regarding the predictability of pregnancy (*"... you think you get pregnant, and you're gonna have this baby ..."*). By her use of *"you,"* she seems for a moment to be associating herself with those who assume that pregnancy leads naturally and inevitably to birth; in the concluding line, however, Sue indicates with a marker of discontinuity (*"and then"*) that her allegiance to this point of view has been disrupted by her new understanding of pregnancy as entailing risks and threats of loss.

In Excerpt P, Sue again cites the opinions of medical personnel regarding the perils of premature labor and birth:

Excerpt P

At twenty-four weeks when I was in labor, I was told you know, that the mortality rate of the baby was in question. You know, you don't think of that. People don't think of that as happening, in that it very well, it could be a reality.

At the outset, when Sue is impressing upon the listener that her baby could have died if born at 24 weeks, she reaches for a suitable technical expression, and fixes upon *"mortality rate"*; in attempting to couch her communication in medical terminology, Sue's intent may be to evoke the presence and gravitas of the expert from whom the information originally proceeded. Commenting on this sobering news, Sue remarks first that *"you don't think of that,"* and then, that *"people don't think of that."* By using the general *"you,"* Sue suggests that she once shared the perspective of those who fail to consider the vulnerability of the unborn baby and the seriousness of the expectant mother's situation. Through her shift to the use of *"people,"* Sue appears to be stressing that others manifest this unreflective attitude, whereas she has dissociated herself from it.

Because Sue views doctors as experts who can provide well-founded testimony as to the true nature of pregnancy, she is well-situated to give full credence to those medical personnel who characterize her premature labor as a phenomenon without identifiable cause, and who thereby acquit her of responsibility for precipitating complications during her pregnancies. As Sue remarks, *"Nobody can tell me why I go into labor early ... I've only been reassured that it was nothing I had done to cause it"* (elsewhere in the interview). Doctors appear to stand in the background here, proffering this reassurance.

In the following passage, Sue may be heard as implicitly offering another kind of evidence in support of the position that her problems in pregnancy were not attributable to inadequate self-care.

Excerpt Q

[Interviewer: How's it been for you and your husband, having ano—a second time a—a difficult pregnancy?] *Um, my husband swore it wasn't gonna happen this time. He really felt, um, with my son I were, ya know when I was*

pregnant. And um, he thought it was probably because of the stress of working or whatever, and um, he was absolutely convinced that it was not gonna happen this time. So for him, he—he was I think, I, not that of course that I wanted it to happen, but I knew that it was a distinct possibility, and I just, um, it was, it's been difficult for him.

Sue outlines her husband's interpretation of her first episode of pre-term labor. His account appeared to be predicated on premises that are central to the master narrative of pregnancy rejected by Sue: The husband assumed first of all that the complications encountered by Sue during her first pregnancy were susceptible to explanation, and further, that they could be traced to an aspect of Sue's own behavior, namely, her persistence in exposing herself to *"the stress of working."* This reasoning led to the conclusion that the risk of premature labor could be eliminated: If excess stress had indeed brought on Sue's difficulties, it followed that Sue's decision not to work outside the home during her second pregnancy would prevent similar problems from occurring again.

Sue, however, observes that she remained unpersuaded by her husband's ideas about the causes of her pre-term labor. She portrays herself as recognizing all along that her second pregnancy could well be high risk, despite her extra precaution of refraining from work outside the home for its duration. Implicit in this judgment is Sue's previously articulated belief that pregnancy by its nature involves risk, and that some problems associated with pregnancy may simply be impossible to account for or to avert. Sue notes that the recurrence of premature labor in her second pregnancy was distressing for her and difficult for her husband. However, these further complications did in a sense vindicate her, in that their appearance suggested that her actions did not contribute to the problems in either the first or the second pregnancy. Thus, by juxtaposing her own and her husband's beliefs about the predictability and preventability of pre-term labor, and by demonstrating that hers were upheld by events, Sue underscores the plausibility of the alternative pregnancy discourse that she is proposing. In so doing, she takes steps toward reestablishing her own conscientiousness and blamelessness.

DISCUSSION

Mary's and Sue's interview responses were singled out and explicated in detail because both women explicitly position themselves vis-à-vis a discourse that posits conception, pregnancy and birth-giving as a moral domain with expectant mothers as the sole moral agents in it. In their own presentations, they redefine the discourse on the topic of pregnancy, and reposition themselves with their own experiential claims in relationship to master claims. They are at pains to demonstrate to the interviewer that their own pregnancies did not conform to the master discourse.

Both women nonetheless construe the contents of the master discourse in different ways, and identify different groups of people as its origins and representatives. Moreover, in their efforts to confirm the validity of their own experiential claims, they employ different strategies of alignment with already existent discourses. We elaborate on these points in the discussion that follows.

Beginning with the commonalities between the two interview transcripts, note that at no point does either of the two women characterize specific representatives of the master discourse as explicitly attributing blame to her for any personal wrongdoing that may have led to the physical problems she encountered during pregnancy. At the heart of both Mary's and Sue's talk is a concern about the moral imputations of the master discourse. The unspoken beliefs embedded in the master discourse, as we have outlined them in more historical and abstract terms, are attributed in the interviews to more concrete adversaries, so that they can be more easily rejected. Mary regards the normative discourse as being disseminated mainly by physicians whom she characterizes as narrow minded, whereas Sue ascribes norms relating to pregnancy to a naive and uninformed public, including mothers-to-be who have no idea of the potential risk inherent in their own pregnancies. By thus incarnating and, to a degree, personalizing the master discourse, Mary and Sue construct themselves in their accounts as protagonists who are facing antagonistic forces.

Making use of Davis and Harré's (1990) notion of *positioning* and our elaborations of this notion (see Bamberg, 1996), we can characterize the discursive move of positioning the characters in the narrative with respect to one another as a way of delineating the narrator's position for the benefit of the audience. In other words, by linguistically creating and drawing out the relationship between the story characters in a particular type of prot- and antagonist relationship, Mary and Sue construct their audience, while at the same time constructing a particular kind of discourse mode in which they want to "*come across*" to listeners. As some of the excerpts above illustrate, although the interviewer is the concrete addressee of the talk, rephrasings and repetitions clearly point to the fact that both interviewees "use" the interviewer to talk "through" her to a more generalized audience, and in doing so, they both construe the discourse mode of "advice giving." Mary can be heard as empowering other women to take charge and to trust themselves so that they, like she, can successfully challenge the dominant discourse as represented by doctors. For her part, Sue addresses exactly those whom she portrays as uninformed; these are not only pregnant women, or even exclusively women. She can be heard as alerting everyone to the unpredictabilities in life, and offering advice on how to face them. In sum, both interviewees position themselves vis-à-vis a much more generalized audience than just the interviewer, and each of them engages in a particular type of advice-giving discourse.

In positioning characters at the level of character and content organization (*Positioning 1*—in what is talked "about" in the "there-and-then"), and in the

positioning process between the narrator and the audience (*Positioning 2*—in the "here-and-now" of the communicative situation, where the discourse type is being organized), a third kind of positioning emerges, one in which the narrator positions herself vis-à-vis herself (*Positioning 3*). At this level of making claims to one's own identity, Mary describes herself as coming into conflict with doctors who attempted to interpret her pregnancy in terms of the medical discourse to which they ascribed. Mary does not deny that the doctors' perspective may adequately characterize the majority of pregnant women. The way she constructs her own identity is by asserting that she herself is unusual, and that ways of understanding pregnancy that may apply to others often are not useful to her in her efforts to cope with pregnancy. Her responses seem intended to convince the audience, and through the audience herself, that she is better equipped than anyone to devise a program of self-care that will meet her individual needs and ensure the health and safety of herself and her unborn baby. Her complaint regarding doctors is that they fail to respect the soundness of her judgment and the efficacy of her agency. Her identity claim as a self-reliant individual lends her authority as she advises others to claim self-reliance for themselves. Mary does not clarify whether she wants to be heard specifically as a woman; that is, her construction of herself as a self-reliant person is not a specifically gendered claim.

In contrast to Mary, Sue attributes the notion of pregnancy that she disputes, not to medical authorities, but to the majority of the general public, whom she portrays as uninformed. Her critique of this popular view of pregnancy is in a sense more radical than Mary's; Sue is asserting, not only that this widespread version bears no resemblance to her pregnancy, but rather that it fails to take into consideration the truth that complications are a common experience for many pregnant women. Bearing witness to this diversity of experience among expectant mothers, she concludes that the concept of normality embodied in the standard pregnancy story is in need of revision. Where doctors appear in her account, they are depicted not as opponents, but as benign and knowledgeable allies who help her to arrive at a more realistic appreciation of pregnancy as a potentially perilous undertaking. Thus, these experts have helped her to gain special insight. Her informed status permits her to adopt a didactic role with respect to others who have not as yet been exposed to this particular perspective. Far from constructing herself as asserting her power to control the outcome of events in her pregnancy, Sue instead insists that uncertainty is ineluctably a part of the process, and that no expectant mother can eliminate pregnancy's inherent risks or dispel its mysteries. Sue constructs herself as a realist, whose authority is grounded in openness to points of view beside her own and in her realistic acceptance of the limitations to her own control. In other words, she grounds her lack of power and self-control in a position of authoritative realism.

It should be stressed that we view the claims with regard to the identity of both interviewees as products that are locally and situationally achieved. We do not mean

to imply that there are any personality characteristics that stipulate the identity claims, nor do we hold that these claims are the product of "*experience.*" Rather, they are *linguistically* achieved by creating characters and positioning them with regard to one another *in the story* (Positioning 1), and by creating a particular discourse mode and positioning oneself as the speaker with regard to an audience *in the act of narrating* (Positioning 2). Thus, for the purpose of this article, identity claims at the level of Positioning 3 are, strictly speaking, the achievements of Positioning 1 and Positioning 2, and they hold only for the context within which and for the purpose for which they were constructed (see Schiffrin, 1996, for very similar claims).

In considering where these claims have their social origins[6] (where do Mary and Sue "find" these claims?) we can list a number of potential sources. The notion of self as an independent and individualistic moral voice, which Mary evokes in her discourse, is deeply ingrained in the American discourse of personal identity (see Taylor, 1989; and Elias, 1991, for the European historical roots of this discourse), where independence, self-control, and the individual monad as the source and goal of knowledge constitute the telos of (middle class) socialization. At points in Mary's accounts, however, she aligns herself with others, who have taught her how to become this (ideal) person: her father, her family, and God. At these moments, Mary does not seem to align herself with other women as the source of her knowledge and enlightenment. Thus, she does not identify her source of knowledge (and discourse for that matter) in a gender-specific way, although at times some of her claims to self-reliance have the potential for resembling a feminist orientation.

Although Sue explicitly grounds her claims in close relation to the medical expert discourse, two issues are noteworthy. First, her insights are not based on any privileged access to a realm of technical expertise. Rather, her claim entails that everyone who is open enough to examine life experiences from alternative viewpoints can gain the insight that lives are far more complex than they appear to be. A prerequisite for gaining this knowledge, however, is the acceptance of uncertainty, that is, relinquishing the reliance on some preestablished, taken-for-granted "truths." Thus, her claims can be heard as an appeal to be tolerant to alternative versions, such as hers, that come from nonexperts or from people whose life experiences are somewhat removed from what is normally expected. Second, Sue's attempt to align herself with medical experts does not reflect a positioning within the dominant medical discourse. By evoking a physician who admits that *"we don't know,"* she signals an attempt to question the widely accepted authority of medicine to control pregnancy and to claim high-risk pregnancies as falling within the realm

[6] As we have stated, although it is necessary to investigate in detail how these claims are *interactively* constructed, as Schiffrin (1996), for one, has demonstrated, we have intentionally confined ourselves to the question of the social and cultural origins of claims at some macro-level, as being located in a matrix of preexisting meanings, beliefs, and practices.

of curing and preventive medicine. By aligning herself with a physician who actually counters the dominant medical authoritative discourse, she can be seen as trying to borrow authority and believability for her own account as representing a "realistic appreciation of uncertainty." Interestingly, Sue's form of positioning herself pulls the plug to the legitimation of the medical master discourse, although representatives of this discourse were never the explicit target of Sue's claims. In sum, although Sue identifies a medical expert as an ally, she is able to construct an orientation that is not in agreement with the detached voice of authoritative certainty that characterizes the dominant discourse in medicine and research.[7]

In considering whether the claims of Mary and Sue actually represent counterclaims that challenge existing dominant discourses in a substantial way, or whether their discourses are overshadowed by "other" dominant discourses, and therefore derive from and feed back into existing prevalent discourses, we may not be able to come up with a definitive answer. It should be noted that neither Mary nor Sue dispute a central premise of the dominant discourse, namely, that the expectant mother bears moral responsibility for her pregnancy's course and outcome. However, a challenge of their two individual positions consists in their call to reconsider who has the right and the expertise to judge pregnant women as responsible or irresponsible, and what are appropriate criteria for making such judgments. Mary strips the public, but particularly the medical realm, of the right to make such calls for her, and claims the prerogative for herself, and by extension for each individual expectant mother. In contrast, Sue's argument regarding the diversity of pregnancy experiences constitutes a call for pluralism, and is thus a challenge to monistic discourses.

As we attempt to specify what constitutes subversiveness in the realm of claims and counterclaims about pregnancy and birth, we consider two possible definitions, both starting from different preconditions with regard to which aspects of a dominant discourse are considered as constraining individuals' actions. If the medical discourse is viewed as the dominant discourse mode that is to be held accountable for the medicalization of reproductive processes, Mary's counterclaims can be regarded as subversive, inasmuch as they seek to demedicalize pregnancy and birth and return them to the domain of the individual expectant mother's responsibility. And we can hypothetically assume that in cases like this, subversiveness may originate from seeking and finding particular culturally existent narratives that must be reassembled in an innovative way to gain the force of counterclaims. In Mary's case, the pool of master narratives of individualism can

[7]Mishler has characterized this discourse type in terms of "the voice of medicine" (Mishler, 1984; Mishler, Clark, Ingelfinger, & Simon, 1989) contrasting with the "voice of the lifeworld," whereas in our own descriptions of the medical discourse, we have preferred to couch this contrast in terms of the "voices of *curing* and *caring*" (Bamberg, 1991; Bamberg & Budwig, 1992).

be assumed to provide this backdrop. This definition of subversiveness would substantiate the assumption that master narratives themselves are selective representations, with holes and by no means fitting everybody's experience. Aspects of the constraining functions of a master narrative may be successfully resisted by counterclaims that can be collected and pulled together from already existent master narratives. Thus, within this definition, innovative counterconstructions are based on existing contradictions, and they also seem to be restricted in scope to the local constructions for which they are assembled. As in the discourse of Mary, who derives her claims from the traditions of individualism, subversiveness is restricted to the ways that individual rights and duties are culturally and socially defined and situated in her community.

Sue's approach to constructing her counterclaims might lead us to a different way of defining subversiveness and its origins. This second definition would start from the assumption that the confines of individual actions are ultimately to be sought and found in the master narrative of individualism, within which the medical discourse was given space to develop into one of the institutionally legitimate forms of discourse, paralleled by other historically emerging discourses as grand as the English novel, the Protestant ethic, or even capitalism. Within this alternative definition of the master narrative and what individual (subversive) narratives are up "against," Sue's counterclaims can be regarded as subversive, inasmuch as they constitute a challenge of *individualistic* narratives as closed in and monistic. Thus, within this definition of subversiveness, Sue's claims challenge the medical master narrative as one of the forms of discourse which grounds responsibility in the individual (only to claim parts and transfer them to the scientific curing community), but it challenges much more, insofar as it can be taken to subvert all claims to *individualistic truths*.

If we assume that this is the orientation of Sue's claims, then her appeal to pluralism cannot be taken to be grounded in the existent pool of master narratives of individualism. Rather, for an orientation like hers one might have to look outside of the master narratives with which one is surrounded. It seems as if this form of subversiveness requires the gaining of a superordinate position that may originate either from contiguity with other cultural forms of life that are not accessible in one's own, or from the study of narratives that once were alive in one's own cultural tradition, but have become buried or superseded historically by others.

The question as to whether these two different versions of subversiveness can ultimately be reconciled or integrated should not obscure the crucial psychological function performed by such counternarratives as Mary's and Sue's. In our opinion, these narratives bespeak an "ability to revise existing categories for the interpretation of social experience, coordinate new appreciations of self with new conceptualizations of the other, substantiate their beliefs, resolve interpretive contradictions, act on their insights, or comprehend their own action" (Rosenwald, 1992, p. 283). The narratives document the process by which each of the two women "seize[s] the

language and its power to turn cultural fictions into her very own story" (Smith, 1987, p. 175).

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