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The Power of the Pregnant Body: Perspectives of Agency and Autonomy in Pregnancy

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Abstract: This paper reviews the literature on pregnancy, examining two dominant discourses: "the pregnant body as foetal containment" and "the pregnant body as illness". A third discourse, which looks at the complex ways in which the pregnant body is used as a site of agency and autonomy, is also presented. Rather than viewing the pregnant body as solely a condition which compromises women's subjectivity and places them within strict boundaries of societal structures, this overview argues for seeing the more complex and nuanced ways in which women negotiate power through their bodies and considers how the pregnant body is a site of agency for women.

Keywords: pregnancy; agency; reproduction; the body

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1. Introduction

> I've really started toying with the idea of "using it" to my advantage ... There's opportunity here to re-shape so many other aspects of my life using pregnancy as my way of becoming visible in a way I wasn't before. I almost feel as though there might be a bit of fear—but not over me. Over the pregnancy—what if the baby is hurt?! The combined mother+baby is more powerful than just woman alone.
>
> Diary entry, participant 6, 9 April 2019

When I started my PhD research on women's experiences of pregnancy, I wanted to know how women's experiences changed as they progressed through their pregnancies. I was not interested in pregnancy itself, per se; rather, I was interested in how embodied experiences fundamentally shape the way people think of themselves. What better focus for research into embodied subjectivity than a moment when the biological body is constantly changing, forcing the individual to adapt along with it?

I was not the first to question the embodied experience of pregnancy. In 1984, Iris Marion Young published her seminal work delving into a phenomenology of her pregnancy. At the time, she noted that not much work had been done on the pregnant woman "*as a subject*" (emphasis in original) or on "the mother as a site for its proceedings" (Young 1984, p. 45). Her work aimed to explore maternal subjectivity, which included a rejection of the alienating, medical gaze and an embrace of the desires of pregnant women and the promotion of "self-love". She used her bodily experience while pregnant as a platform for understanding female experience: the way her body took up more space, the changing capacity of her body to move the way she wanted it to, and the relationships she built with others, including the foetus.

While research since Young's work has continued to explore pregnancy and how society frames and treats the pregnant body, I still wanted to hear more from women's voices in these stories. For my research, I used an in-depth, unstructured interview–diary method, based on Wengraf's (2004) biographical narrative interview method (BNIM). Each interview started with a single statement: "Tell me the story of your pregnancy. Start

your story wherever you like. I'll listen and won't interrupt. Please tell me about the events and experiences that have been important to you up until now." The word choice of the question and format of the interview is very specific and aims to ensure that resulting narratives are strictly the voices of the participants, told in a way that makes sense to the participants themselves. In this way, I hoped to capture the female voice that has long been excluded, or even silenced, and what it teaches about embodied subjectivity.

The majority of studies on pregnancy focus on social aspects of pregnancy (for example, Brubaker 2007; Katz Rothman 1993; and Oakley 2007), while less attention is paid to the physiological changes and impact this has on identity and subjectivity. Withycombe (2015) writes that there are two "neat" models used to describe pregnancy discourse over the past two hundred years: "pregnancy as foetal containment" and "pregnancy as illness". Much of the social research feeding into my initial literature review mirrored this. Consequently, when collecting narratives from women, I expected to hear about the myriad of medical appointments, the constant managing choice and risk, and an ongoing debate over the ontological status and ownership of the foetus. To a certain extent, the narratives in my interviews covered these issues, especially where women felt the oppressive nature of these discourses. However, I have continued to come back to a very different theme within these narratives: stories of powerful bodies and women "using" pregnancy to their advantage. The above quotation from participant 6 is a prime example of this theme. In this diary entry, participant 6 explains that she had to make a health and safety complaint regarding additional work she was asked to do for her job, which she argues violated her risk assessment. She notes that it was not that she was unable to do the work, even in her pregnant state, but that she felt the request was an unfair, additional expectation laid onto her by her employer. What makes this quotation so interesting is the way she recognised and used her pregnant body as a way of asserting a newfound voice. The last line, explaining that the perceived "mother + baby" duo wielded more power than a singular woman, hints at a complexity surrounding the embodied experience of pregnancy that stretches beyond just a basic idea of choice. While I tried to fit these particular incident narratives into a theme around making choices, I found that it did not quite fit this description. This was not simply about an ability to make different choices as a consequence of their pregnant state. Instead, my participants spoke about a fundamental shift in how they perceived and experienced the world. The pregnant body itself became a source of power which affected the way these women felt about their bodies, how they talked about themselves, and even the very physical way they positioned their bodies. It is in these moments that the pregnant body opened possibilities and new ways of being.

At the moment of writing, I have only just completed the data collection phase and have begun the initial steps of analysis. To explore the theme within this dataset better, I have since gone back to the literature to try and see how these narratives may fit with research already done on pregnancy. The literature review process started with an open search for any social research which mentioned pregnancy. For the purposes of this piece of writing, I set inclusion criteria for empirical research which specifically included women as participants or their writing as the focus of study. The section 1 and section 2 lay out the social research which fit into the more common, traditional discourses of pregnancy: "pregnancy as foetal containment" and "pregnancy as illness". The section 3 explores a third discourse which views the pregnant body as a powerful tool and corporeal site of agency for women. By further exploring the perspectives used to describe pregnancy in the literature, it can help to make new connections and to better understand the experience of pregnancy.

2. The Pregnant Body as Foetal Containment

For many women, the first sensations of movement, or "quickening", signals the splitting into two parts (Nash 2013; Root and Browner 2013). Women have described these sensations as strange or "weird" because they are so different from the sensations of their nonpregnant state (Nash 2013). Schmied and Lupton (2001) found that women struggled

to articulate their experiences, often remarking "I don't know how to put it into words" or "I can't explain it". Young (1990, p. 163) similarly wrote, "in pregnancy I literally do not have a firm sense of where my body ends and the world begins. My automatic body habits become dislodged; the continuity between my customary body and my body at this moment in broken". She argued that, as the foetus grows within a woman, these changed contours affect not only how pregnant women think of themselves but also their relationship with the material world. This splitting of the pregnant body spanned beyond the emergence of a "foetal body" and has also been argued to shape women's experience of their own pregnancy. Even when speaking of the foetal body within, women from Nash's (2013) interviews found there to be a divide between those who viewed their foetuses as "part of me" and those who thought of them as separate bodies. Still others, as Warren and Brewis (2004, p. 223) found, described their pregnancy like a "foreign invasion", stating that their body "no longer belongs to them". As Kristeva (1981, p. 31) eloquently put it, "pregnancy seems to be experienced as the radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and another". Kristeva went on to argue that, in pregnancy, a woman is lost and cannot be placed. This decentring, splitting, and doubling of women is the key ontological supposition made within medical, legal, and popular discourse where women are treated as "containers" for the developing foetus; they are seen first and foremost as two rather than one.

2.1. Conceptualising a Child

Prior to the seventeenth century, a woman would have stagnation or a "fruit" that could eventually emerge as a child but no such thing as a secondary being or "foetus" (Martin 2010, p. 24). Even in the 18th century, Duden (1993, p. 65) noted that European physicians recorded foetuses as "wrong growths", "bubbly lots", "singed blood", "flesh morsels", and "false conceptions". Foetuses had no status as a person or even person-to-be. The 18th century became an important turning point, as medical science began its dissection and isolation of the foetal body.

According to Gelis's (1991) analysis of early modern medicine, the developmental model arose in a concerted effort to construct the "chain of life". He wrote, "surgeons seized every opportunity to perform autopsies on the corpses of aborted babies…the aim was clear: to reconstruct the chain from the first days and weeks of life to full term" (Gelis 1991, p. 219). In one particularly stark example of this, Withycombe (2018a) recounted the story of Dr J. Stolz, a physician who, in 1866, attended the miscarriage of a 16-year-old woman. The pregnant woman delivered a five-month-old foetus, which the doctor wrapped in flannel before giving remedies to the mother. When he turned back to the foetus, he was surprised to see it "gasping for breath, making regular inspiratory movements". He took the living foetus back to his office where he was joined by two friends, Drs Jenner and Booths, where they watched the foetus breathe for one hour and forty minutes before expiring. Withycombe (2018a) acknowledged how cruel this seems within the current context but points out that physicians were only able to remove foetal remains with the permission of the family. In a time when women were trying to limit family size and had little access to effective birth control, miscarriage would sometimes be seen as a comfort. Consequently, foetal remains were not conceptualised as infants but were much more akin to specimens, leading women to allow physicians to take foetuses with them for preservation and study. In the early 1900s, Franklin P. Mall began building a collection of these human embryological specimens and put out a call to physicians to hand over any specimens they had collected and preserved over the course of their careers. In a few short years, he was able to amass 500 jars and to piece together the full range of stages of foetal development (Withycombe 2018b). Paradoxically, it was this research that led to discoveries, such as when the heart could beat or when hair grew, which would ultimately lead to personifying the foetus. The emergence of the foetus, complete with its own life history, had an adverse effect on the pregnant body: as Clark (1995, p. 147) put it, "pregnant bodies [were] erased to make way for the one true person—the fetus". The history of

this knowledge, which changed the cultural context and the status of foetuses is paradoxically rooted in women's permission to preserve and study foetal remains.

2.2. Visualising a Child

Once a separate foetal body was imagined, the next step was to see the foetal body. Foetal images have been around since the thirteenth century, although unlike today's images, they were usually depicted as a more mature child scaled to fit inside of a pregnant woman (Duden 1993). Oakley's analysis (Oakley 1984, p. 155) of ultrasound devices found them to be "revolutionary because, for the first time, they enable obstetricians to dispense with mothers as intermediaries, as necessary informants of foetal status and lifestyle". A perhaps latent, but nonetheless evident, consequence of this exercise encouraged the study of a pregnant body without interference from the woman. Oakley went on to argue that women's bodily experiences were marginalized and devalued and that foetal-centric technology became the equivalent to uncovering the natural and true "facts" of the pregnant body.

Some feminist critiques, however, make the argument that the foetal images today are different from those of the past in very important ways. In 1990, Swedish photographer Lennart Nilsson, using a high-tech scanning electron microscope, introduced the public to a 7-week-old foetus for the first time ever (Chambers 2009). In the image, all traces of the female body, including the amniotic sac and placenta, disappeared. Stabile (1994) argued that these images alongside now common ultrasound images of the foetus have continued to switch the focus from the gestating body to "foetal personhood". She went on further to say that this erasure of the female subject has given rise to disputes over abortion and even child support and custody. Valerie Hartouni (1997) brought up more extreme examples where the female subject had fallen into the background of decision-making, citing examples where braindead or comatose women have been kept alive long enough to given birth. In these cases, the body literally becomes an incubator, of which the only purpose is to gestate long enough to give birth to a child.

Given this centuries-old history of the autonomous foetus, Newman (1996) questioned the feminist strategy, calling for a revisualization of reproduction, suggesting that such illustrations do not represent a significant shift in conceptualization of the foetus. Duden (1993), however, contested this conclusion, pointing out that such images must always be interpreted, and what is more significant than the images themselves is how these images are collectively deciphered. Moreover, images and the way images are used have massively changed since the thirteenth century. While drawings of the thirteenth century depicted a miniature adult, the first "photographic" appearance of the unborn came about in the 1950s, revealing a child with a large head, tiny body, and translucent skin (Shrage 2002). By the 1980s, ultrasound scans became regular practice, now even accompanied by the sound of a heartbeat and three-dimensional movement. Although Newman's (1996) study was taken out of historical context, she recognized that the often fuzzy or unrealistic ultrasound images require an "expert" technician to assist in an "accurate" reading of the blurry images, ultimately applying appropriate cultural meaning for the pregnant woman and, importantly, humanizing the image. The pregnant woman was thus "read" by medical technology and experts as bifurcated, which established both mother and foetus as two separate entities, unconnected as illustrated by their visual individuality.

Petchesky (1984) called attention to the significant shift in conceptualization in her study of antiabortion groups and legal discourse. She argued that this representation defined abortion as a mortal struggle between a foetal individual and a woman. In support of women's autonomy and rights, Petchesky (1984, p. 187) argued, "We have to restore women to a central place in the pregnancy scene. To do this, we must create new images that re-contextualize the foetus, that place it back into the uterus, and the uterus back into the woman's body, and her body back into its social space." Eighteen years later, Laurie Shrage's (2002) study of visual representations of pregnancy found that the medico-legal

rhetoric of pregnancy still depicts the foetus as an autonomous self, often floating independent of the womb that carries it, with only a placenta to signify its relationship to the world. Unlike Petchesky, however, Shrage (2002, p. 70) wondered if replacing current foetal images with even more "realistic", albeit woman-centred, images reflects "a naïve realism about images" and feeds a public desire to reflect the world only as one is able to see it. In other words, she questioned if images are really the best way to represent the pregnant body. In line with this inquiry, Hartouni (1997) suggested that the autonomous foetal patient is a product not only of the image itself (after all, any interpretation can be made of an image) but also as a consequence of individualistic, liberal political discourses underlining the reading of images. She argued that this practice of visualizing and describing the foetus as a separate entity within a liberal ideology is what has made it possible to ask questions about the obligations women "owe" to the foetuses they carry. Ruhl (2002, p. 38) writes, "The liberal paradigm of the individual is inherently unable to accommodate pregnancy, either on a philosophical level or on the level of lived reality. It is not possible to speak of the pregnant woman as a liberal subject". Since the pregnant subject has been proven, by virtue of an ultrasound image, to be not one but two bodies, the view of the woman as a foetal incubator has flourished. This becomes problematic when the law, which relies upon liberal principles, is called up to defend or prosecute pregnant bodies. The harsh consequences of this rhetoric are outlined in Bordo's (1993, p. 81–2) exhaustive list of United States' cases in which pregnant women were legally prosecuted for harm to the other "individual" (that is to say, the unborn) within them:

"In 1989, a Florida judge sentenced twenty-three-year-old Jennifer Johnson to fifteen years' probation on her conviction of delivering illegal drugs via the umbilical cord to her two babies. A Massachusetts woman who miscarried after an automobile accident in which she was intoxicated was prosecuted for vehicular homicide of her fetus. A Connecticut woman was charged with endangering her fetus by swallowing cocaine as police moved to arrest her. A Washington judge sent Brenda Vaughan to jail for nearly four months to protect her fetus, because a drug test, taken after she was arrested for forging a check, revealed cocaine use. In 1990, a Wyoming woman was charged by police with the crime of drinking while pregnant and was prosecuted for felony child abuse."

Bordo (1993, p. 87) contended that this ideology of "woman as foetal incubator" renders foetuses as "super-subjects", allotting them rights that have never been granted to anyone else in society. It is as though all the subjectivity of a pregnant body was drained away and deposited into the foetus alone. It is important to note here that the point is not to argue that foetuses are simply an extension or even an appendage of the pregnant subject but rather to emphasize the ontological conceptualisation of the foetus as a separate, independent entity which has arguably rendered the woman as a container of the foetus, which has been constructed by advances in modern medicine.

3. The Pregnant Body as Illness

While constructing the pregnant body as a container for the foetus, medicalisation of pregnancy also quietly constructed the pregnant body as a condition for which women need to take care of themselves. Over the past century, advances in medical technologies, including reproductive technologies like in vitro fertilization and birth control, and monitoring technologies, like amniocentesis and ultrasounds, have framed the pregnant body as a passive object of the medical gaze. Shaw (2012) noted that society is so well-conditioned to seeing pregnancy as a condition to manage that certain events, such as the absence of menses, bleeding, or even movements of the foetus, are carefully documented and taken back to the doctor for further examination. Johnson (2014) noted that the smartphone revolution has brought a whole new aspect to monitoring pregnant body: it has allowed women themselves to track their health and become "expert patients" by consuming a huge range of health information. From this internalisation of medicalising pregnancy, "choice rhetoric" arose seemingly as a compromise to satisfy the inherent idea that the individual is a "free agent" who exercises her rational capacity to make an

autonomous decision—as long as that decision is one which manages the risks of pregnancy and safeguards the health of the foetus.

Petchesky (1984, p. 685) wrote, "The 'right to choose' means very little when women are powerless … women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions which they themselves create but under social conditions and constraints which they, as mere individuals, are powerless to change." The "choices" that Petchesky identified not only are made under particular social conditions but also are often only acknowledged within *favourable* social conditions. To put it another way, social exclusion remains a determining factor of women's access to healthcare and therefore the reproductive "choices" that are available to them. For example, Earle and Letherby (2003, p. 5) noted that, in the United Kingdom, almost twice as many of the poorest women will give birth to a stillborn or premature baby when compared with women in other social classes, a trend that is repeated throughout the world. Even the choice to terminate a pregnancy or to request sterilization is not routinely available "on demand"; other times, such options can be forced. In both cases, such a treatment must be approved by (at least) two medical professionals, supported by family members, and performed within certain timeframes in certain settings, "favourable social conditions" which may not reflect a woman's actual social environment.

"Choice" also refers to a set of social expectations for pregnant women. Bennett (cited by Earle and Letherby 2003, p. 2) sardonically offered a short list off all of these rules for pregnant women: "Want to have a child? Well don't do it too early. Don't leave it too late. Don't do it before you're nicely settled. Don't have an abortion. Don't have an unwanted child. Don't be a single parent. Don't miss out on the joy of childbirth. Don't think you can do it alone. Don't let your children be reared by strangers. Don't sponge off the State. Don't have a child for selfish reasons. Don't be childless for selfish reasons. Don't end up in barren solitude. Don't expect fertility treatment to work." Longhurst's (2005) critical account documented the ways in which others, including strangers, supervise the behaviour of pregnant women to chastise them for breaking the "rules". She noted that these rules are what were deemed as "proper and natural behaviour" for pregnant women, which included an assessment of how antagonistic a woman was to the foetus. Recent years have seen a plethora of newspaper and magazine articles, books, and television programmes devoted to telling women their choices and which of those choices are the best ones to make. The ramifications for women who do not follow these suggestions, however, can be extraordinary: Bordo (1993, p. 83) quoted a full-term, pregnant woman who decided to have a drink with dinner, explaining that the rest of her dinner party "tried to make [her] feel like a child abuser". Bordo (1993) went on to explain that pregnant women are expected to create a kind of environment for the foetus that is not expected of the father, the state, private industry, or anyone else that is a part of the foetus's "environment"—whether it is those that affect the mother's well-being or those that impact the foetus directly through, for example, physical abuse, second-hand smoke, or inadequate healthcare coverage. The social discourse that targets the habits of pregnant women as the sole causes of foetal abnormalities places a duty of care squarely on the shoulders of women rather than implicating the entire network that aids foetal development. Pollitt (1990, p. 172) pointed out that no government or healthcare service offers the support needed to make it possible for women to abide by this extensive (unwritten) list of societal expectations, citing examples such as landlords evicting pregnant women; obstetricians refusing to care for uninsured women; or drug treatment programmes rejecting drug-addicted, pregnant women. As Nettleton (1997, p. 212, emphasis in original) said, "individuals are recruited to take care of themselves, but the techniques that are deployed by the 'experts' of human conduct must in turn invariably shape how individuals come to think about them*selves*".

The pregnant body is not simply constructed as a passive object of the medical gaze but can also be an active participant in the production of optimal foetal health. The weight of expert knowledge about the impact of the pregnant woman's lifestyle upon the future

health and well-being of her children will often prompt women to self-regulate their conduct during pregnancy (Bertin 1995). Through the wide dissemination of health promotion information, pregnant women are continually encouraged to act responsibly in order to promote "normal" foetal development. As Raphael-Leff (1991, p. 137) put it, the pregnant woman herself typically "wants to be treated as an adult person on a creative mission, an active, cognisant participants in a strange exciting experience not merely a dumb container come to the 'workshop' for a service checkup". Raphael-Leff (1991) discussed the anxiety dreams which pregnant women often have, for example, giving birth to monstrous babies or suffering a miscarriage.

Women can use the technological powers of medicine to configure their bodies in a particular way through the power of medically naming their bodies (albeit such configurations are highly influenced by larger social structures). Women seeking medical care under biomedicine's promise to normalize their bodies signifies that women's reproductive organs are a complex interplay between what is going on in the body, the instruments used to measure the pregnant body, and the materiality of their bodies. It is also gendered knowledge that is employed to produce compliance in medical power relations. For example, women who chose not to reproduce were found to be measured against the idealized visions of motherhood and labelled as "flawed" or "incomplete" (Wager 2000). Morell (2000, p. 318) explained that "self-respecting other-than-mothers inherit the psychological task of re-definition". Although they certainly were able to make the choice to be voluntarily childless, they still must deal with the stigma as a "failed" woman. The choices that personally confront each pregnant woman outside the doctor's offices and in the privacy of her own home encourage her to conform to very specific reproductive processes, even when no one is looking. Given that the attention remains on the uterus and the foetus, it is no wonder that women, framed as essentially reproductive beings, are often denied the choices to suit their own desires. Pollitt (1998, p. 280), for example, attacked depictions of pregnant women as self-indulgent, undisciplined, and animalistic, suggesting that the model of "'innocent' foetuses would be fine if only presumably 'guilty' women refrained from indulging their 'whims'" was both unhelpful and inaccurate to what is actually going on within a pregnant body.

4. The Power of the Pregnant Body

Feminist critiques have highlighted how these medical and legal discourses have silenced women's voices in issues related to pregnancy and have refocused the public eye away from the woman to the foetus. While these conceptualisations have certainly positioned the pregnant body within a very limited space of movement, it is important to remember that these conceptualisations of the foetus and its place within the pregnant body are situated within a particular historical and cultural location. Before the advancement of medicine that would eventually autopsy and dissect pregnant corpses, test for pregnancy hormones, visualise the foetal body, and hear its heartbeat, the foetus, particularly in their earlier stages of development, was enigmatic and hidden. Pregnancy tests were not introduced until the 1970s, so "quickening", or the internal sensation felt when a foetus first moves, was how a woman confirmed that she was pregnant (Laqueur 1992). Usually, only the pregnant woman can feel these early movements, and thus, it was the woman's word which was first relied upon for a judgement of pregnancy. Historically, this was a powerful tool to navigate society when women had relatively very little influence and power. For example, in medieval and early modern Europe, women were able to report abuse if they were pregnant. "Abortion by assault", although relatively rarely tried, was a crime of felonious proportions and would lead to someone being tried for homicide (Butler 2005, p. 15). While men were able to legally beat their wives with impunity, they could not beat their pregnant wives. Rublack (1996, p. 103) noted that pregnant women enjoyed a privileged position and "if husbands did not realise the cost of their violence, women forced them to". In one story, Rublack (1996, p. 84) tells of a Cologne wine-merchant who was awoken by his wife with the news she has miscarried in the

night. In the dim light, she showed him wadded up, wet paper stuffed into her chamber pot. The wine merchant was not even aware his wife could conceive, so he was shocked and assumed the (violent) quarrel they had two days earlier disrupted the pregnancy. He immediately felt he should have protected his pregnant wife from overexcitement. Only later that day when he was able to get a better view of the chamber pot did he realise he had been tricked. The pretended miscarriage served as a subtle message from his wife relaying her anger at his violence and demand for more respect. The behaviour of the woman here was typical, and using the pregnant body was one of the only ways that women could gather support and exert influence within marriage.

Within court systems, pregnant women were given special consideration. Where women found themselves as the defendant, they were able to use pregnancy as a way to find clemency. Ghosh (2010) recounted the case of Peggy in colonial India, who was tried for the murder of a slave woman. After being found guilty, Peggy claimed to be 2 months pregnant, building a case for herself against capital punishment. Ghosh (2010, p. 155) wrote that Peggy's "voice" was "performed through [her pregnant body] and not through spoken or written testimony." In a similar vein, women have used their pregnant bodies as a way of pleading mercy on behalf of others. Rublack (1996, p. 105) noted that "at executions women could thus gain a rare public voice in matters of justice". In 1509, for example, friends of a man about to be executed arrived at the execution with a group of pregnant women who cut him down from the hangman's rope. Over a hundred years later, in 1620, fifty-two pregnant women gathered to beg for an offender's life. These examples point to an inherent reverence reserved for pregnant bodies, and, sometimes, even just the appearance of pregnant bodies.

Perhaps one of the most fascinating examples of using the pregnant body comes from Verberkmos and Jansen's (2000) exploration of the phenomenon of rāqid or sleeping child. This is a folklore from the Maghreb which claims that a foetus can fall asleep, sometimes for years, before the mother gives birth. Interestingly, Jansen's work interviewed migrants and children of migrants based in the Netherlands who continued to use these cultural understandings of the pregnant body. Some participants had never even lived in the Maghreb but were brought up by families with identities still rooted in the Maghreb. While considered an old tradition, Jansen noted that women today still seek out traditional midwives to confirm rāqid. Rāqid—and the appearance of a pregnant body—protects vulnerable women, including those who need to cope with reproductive losses, menopause, long-term absence or desertion by the husband, or other traumatic experiences. For example, in one case, a husband became impatient when his wife did not have a child within the year following their marriage and threatened to leave her for another woman who would have children. She finally fell pregnant but miscarried at four months. Worried her husband would leave her, she saw a traditional midwife who said she had a rāqid. On the word of the midwife, her husband believed her. Two years later, she finally gave birth to the child, who was said to have finally woken up (Jansen 2000 p. 223). The phenomenon is felt corporeally—temporarily infertile women may experience amenorrhea, finding support for the case of a sleeping child in her physical symptoms. While rāqid typically lasts two years, it can span longer. In another case, a woman declared herself pregnant when her husband died. Ten years after his death, she gave birth to a son, who was recognised as the rightful descendent of her late husband, thus inheriting all his land (Jansen 2000, p. 230). Some countries, like Egypt, Algeria, and Morocco, have now codified into law that pregnancies can last a maximum of 1 year. Jansen argues that the biomedical model has enough influence where many no longer believe women who claim rāqid, particularly in cases of paternity or inheritance; however, it continues to provide women with routes to preserving support in a way that biomedical explanations cannot. This reflects the attitudes of the participants of his research, who still acknowledge and trust in these folklores, even when situated within a society which largely relies upon the medical model as the primary source of knowledge about pregnancy. As Jansen (2000 p. 234) writes, "It should not simply be seen as ignorance, nor as a survival of premodern medical

perceptions, but as an idiom by which sexual and bodily experiences are expressed and power is negotiated between the sexes".

Looking "pregnant", even when not, has cultural capital and portrays a certain power of the woman's body. For example, Queen Mary I, upon learning she was pregnant, sat at Whitehall Palace, "richly apparelled, and her belly laid out, that all men might see that she was with child" (Hayward 2007, p. 168). It later turned out that Queen Mary I suffered from a phantom pregnancy, or false pregnancy, where she experienced classic symptoms of pregnancy (including a distended stomach) and believed herself to be pregnant, but she was not, in fact, pregnant. Those that could afford the luxury of showcasing their pregnancies in such an opulent fashion did so through pregnancy portraits, which left the viewer "in absolutely no doubt that the sitter is heavily with child, and where this message is signalled in almost exaggerated fashion" (Hearn 2020, p. 10). While the popularity of pregnancy portraits waned through the 19th century, it is a practice that has revived, with celebrities like Demi Moore, Serena Williams, and Beyoncé releasing spectacularly pregnant images of themselves. The display of pregnant bodies was not limited for onlookers either; personal writings of 19th century women show their role in monitoring their weight and tracking their body's growth. Decades before doctors were directing pregnant women to follow guidelines for "healthy" weight, determined women would measure their weight regularly while pregnant, even if it meant breaking social taboos like appearing in public while visibly pregnant (Withycombe 2015). Monitoring allowed women to continue to access a unique insight into the patterns and growth of the foetus and became an important way for her to wield the power that came with pregnancy. Although this eventually would lead to medicalisation of the body, it—at least momentarily—was a source of empowerment for women.

5. Conclusions

Despite being a liminal stage for women, the experience of pregnancy continues to influence the life trajectories of women. The current research into pregnancy has certainly empowered women and validated their experiences by calling for more women-centred care, better visibility of the pregnant body in everyday life, and more positive representation of pregnancy in popular culture. As I continue my own analysis of the interviews and diaries of pregnant women, I will continue to look for the complex ways in which they align and subvert these dominant discourses to suit their particular situation and how these discourses shape the cultural context which informs women on how to read, perform, and experience their pregnancy.

Looking back at the corporeal experiences of women, however, reveals another theme within the experiences of women which offers a more nuanced and complex understanding of how women navigated through society. Taking into consideration the displays of agency and empowerment practised through the pregnant body, the true value and power of the pregnant body show many of the strategies used by women to ensure their safety, support, and welfare fit well into the unique social, political, and historical contexts in which they lived. However, the pregnant body equally became an important mechanism for women to defend themselves against the demands of such systems. From abortion by assault laws to rāqid, relinquishing pregnancy tissue to monitoring pregnancy weight, women were able to use their pregnant bodies as a site of agency and autonomy. Considering the evidence of how pregnancy was turned into a tool of empowerment, further research should explore the ways in which women continue to use pregnant bodies to negotiate more power.

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