

ing. I only started believing she was alive about two weeks into nursing. (Lorelei Kruger, 36, white homemaker)

Other women used the return of their menstruation as evidence that they were definitively done with childbearing: "When I finally got my period, I told Denny, I said, 'Let's have a garage sale.' And we did, we sold it all: The crib, the maternity clothes, the stroller, everything. We conceived it with our hearts, not our heads. And now, it's over" (Donna deAngelo, 38, white homemaker).

Becoming Un-Pregnant

Recovering from the late abortion of a fetus which was desired until a positive diagnosis transformed its status into undesirable entails the work of mourning with a double twist. Women poignantly described the difficulties of becoming an un-mother of a specific baby, a rather different process than simply becoming nonpregnant:

Friends kept telling me I was lucky to be free of such a difficult pregnancy. But you see, I had never planned to be free again in my life. I was planning to be a mother, not a free woman. It's a death. I had a little baby; it was alive, it was kicking, now it's gone. (Megan Johnson, 41, white writer)

I just didn't want her to disappear, she was my baby. It's dumb that knowing the sex of that baby really did me in, but it really did. I have a wonderful son, it isn't that, but somehow, I wanted a girl so badly. But I wanted a healthy child even more. (Marilyn de Soto, 34, Puerto Rican social worker)

Even though I have four healthy kids, and my youngest was there, delicious, playing superman, when I came home from the hospital, at that minute it didn't make a bit of difference. It was this one, *this* one I wanted. And I cried, and I mourned. (Leah Rubinstein, 39, white homemaker)

When I asked Doris Paul, eighteen months after her abortion following the diagnosis of Down syndrome, if she considered herself healed, she replied, "Never healed. No such thing."

Women also described a range of feelings concerning their responsibility for the death of a desired fetus. While some stressed an achieved understanding of responsibility described above in the discussion of abortions (like Green 1992), others felt guilt.

I can't help thinking I brought this on myself. First I made the damaged babies, then I killed them. (Diana Morel, 28, Puerto Rican secretary)

I keep asking, why did God do this to me, give me this terrible thing, allow me to kill it? I'm not a bad person, I know I'm not worse than the other ones having abortions. So why me? (Iris Lauria, 29, Puerto Rican hospital housekeeper)

Reactions like these were particularly likely to come from women from Catholic backgrounds, a finding I discuss below.

The problem of taking responsibility arose starkly for some women who—either voluntarily or without volition—immediately threw themselves back into work. I heard about this issue across the class spectrum, from professional lawyers and social workers, from freelance writers, secretaries, and hospital housekeepers. The return to work usually implied having a story of the pregnancy's end, a problematic issue in boundary maintenance. This problem of drawing a line between those who "deserved the truth," and those who "just needed to know I was hurting" was an issue that arose in all the interviews. It is deeply linked to attitudes about politics (most obviously, abortion politics) and religion. It is also linked to questions of social support and isolation. Both themes are discussed below. And it reflects the shift of "women's work" into the social service sector, where many jobs are highly public or visible. Many of the women I interviewed were teachers, social workers, secretaries, or hospital employees. They worked in busy offices and classrooms, where they encountered scores of colleagues and members of "the public" every day. In such circumstances, pregnancies are highly noticeable, and frequently discussed. So, then, are their unexpected endings. A story thus had to be constructed in which was condensed a statement about a dense range of issues: Individual attitudes toward disability, abortion, responsibility (or guilt?), and the relatively private or public nature of grief and mourning. Some women spoke openly about their diagnoses and abortions; others spoke only of a "loss." And most used a "mixed strategy" of elaborating the story for one circle of friends and relations, while giving less detail to a wider group:

So I took off two weeks, and they told my kids [in the classroom] that the baby came out too early and died. And that week, they showed a film about the Ethiopian famine, and one of the kids asked if they could buy a starving baby and give it to Mrs. Kansky. They had to be told something, you can see it really affected them. (Michelle Kansky, 38, white public school teacher)

I told my boss, and he told a few others, and they told the rest. Mostly, we just referred to my loss. I knew who knew. And I wanted them to know. But for months, the others who didn't know, they kept asking me, "What'd you have, what'd you have?" It was hard having to keep saying that I lost the baby. (Marilyn de Soto, 34, Puerto Rican social worker)

One other problem involving boundary-keeping narratives also arose in women's stories of mourning and recovery. Women who had other children took them into account throughout the decision-making process and the termination of their pregnancies. Indeed, one of the strongest differences among those I interviewed occurred between women expecting (and thus losing) their first child, and those with children at home. Childless women tended to fantasize perfect babies; their loss included the loss of an imaginary experience of new motherhood. They thus mourned the loss of a romantic motherhood, along with the specific pregnancy. Women who had children were less romantic in imagining life with the child who would have resulted from the diagnosed pregnancy; they already knew the burdens of caring for perfectly ordinary, healthy offspring. The mothers recovered more rapidly from their grief, in part because they had child-centered responsibilities which kept them moored to the earth; they could rarely find the time to focus on their own pain.

Another Voice?

Their attentiveness to the needs and reactions of other children should be underlined: Too often, the politicization of abortion is inscribed in a discourse of individual "selfishness" (a theme elaborated for white women in chapter 6). But in the interviews I collected, women usually positioned their abortion decisions in relation to the way they imagined their intimate others would be affected. The most salient of these were their other children. Many expressed fear that a sick baby would absorb an unfair share of the family

economy of love and time. Others were quite explicit about how having a disabled child would affect their families:

When the decision came through I told my husband, I just said, "We cannot take the time. We're working parents, that's what we are. We'll never see Antonia again if we have to take care of this sick baby. We've got to end it, and end it now." (Iris Lauria, 29, Puerto Rican hospital housekeeper)

Some people say that abortion is hate. I say my abortion was an act of love. I've got three kids. I was 43 when we accidentally got pregnant again. We decided there was enough love in our family to handle it, even though finances would be tight. But we also decided to have the test. A kid with a serious problem was more than we could handle. And when we got the bad news, I knew immediately what I had to do. At 43, you think about your own death. It would have been tough now, but think what would have happened to my other kids, especially my daughter. Oh, the boys, Stephan and Alex, would have done ok. But Livia would have been the one who got stuck. It's always the girls. It would have been me, and then, after I'm gone, it would have been the big sister who took care of that child. Saving Livia from that burden was an act of love. (Mary Fruticci, 44, white homemaker)

Such comments provide a healthy antidote to the discourse of "selfishness," substituting a more embedded sense of maternal responsibility and relationality in its place. But they also suggest that altruism toward other household members is the reason for the decision to end a diagnosed pregnancy. This important corrective then performs invisible work of its own, muffling cultural attitudes toward disability and the voluntary limits of maternity. But as we have seen throughout these chapters, standards for acceptable and unacceptable children, and the meaning of specific disabilities, are always culturally constructed. Though public support is strong for keeping abortion legal when "defective" or "damaged" fetuses are diagnosed, far less consensus exists on which disabilities are grounds for abortion (Drugan, Greb et al. 1990; Goldberg and Elder 1998). For some women and their supporters, the mental retardation accompanying chromosome trisomies is reason enough, while for others, physical stigmata are more upsetting, as indicated in chapter 5. In some times and places, infanticide or fostering is prescribed for babies born with socially inadmissible conditions;

in contemporary America, a medical procedure appears to offer a cutting edge in defining the limits of what women and their families are willing to accept. A discourse of "altruism" toward others thus masks an important discussion of whether, and under what conditions, women feel entitled to refuse specific pregnancies as a way to refuse specific disabilities in their children, and to refuse the surplus labors entailed in caring for them. At the same time, the possibility of positive effects—the acceptance of difference, the learning of compassion—which siblings of a disabled child might experience is never imagined. "Maternal altruism" thus papers over a terrain carved out by political demands for both reproductive rights and disability rights, even as it provides a more realistic portrait of the complexity with which many women approach an abortion decision.

In addition to including their other children in the constellation of decision-making factors, women also had to find appropriate ways to discuss the end of a pregnancy with them. Age-appropriate stories were constructed, with young children often being told some version of, "The baby was sick, and it died, and mommy went to the hospital to take it out." Older ones might be told more specifically what happened, such as, "We found out the baby was going to be retarded and might die from a heart problem. So the doctor helped us to end this pregnancy. Daddy and I are very sad, and we miss the baby. But its life would have been very difficult, and that would have made it hard for all of us."

In the small literature on the social impact of abortions after positive prenatal diagnoses, other researchers have commented on the "transient but real signs of distress" which the ending of the pregnancy—whether officially discussed or not—invoked in young children (Goldberg and Elder 1998; cf. from a child's perspective, Schrimshaw and March 1984). Conversations reported back to me included children's comments such as:

Mommy, what happened to your breasts? They're not so nice now. (3-year-old boy)

My son, now he takes his friends to his room, I hear him saying, "In this house, we are not happy, we are very sad. Because our baby was sick, and it died. And my mother had to get it taken out, and we all really, really wanted that baby. So we're sad." And he's 7. (Donna deAngelo, 38, white homemaker)

My little one only wants to know, "Will I catch that?" and I have to explain that it happens before you're even born, and no, she can't

catch that at all. The big one is more concerned with me: She sees me crying, she wants me to stop crying—and to have another baby. (Carolyn Williams, 36, African-American postal worker)

Some parents are obviously more comfortable explaining their abortion or their grief than others. But all who had children felt the impact of their situation on them. As "Rose Green," who published her "letter to a genetic counselor" after choosing to end a Down syndrome pregnancy put it,

I tell the children that the way I am acting now is normal, and that it *will* end (though sometimes I hardly believe it myself). When T says, "Mommy, I just hate it when you cry," I tell her I have ten thousand tears to cry about the baby, and I can cry them now, or I can cry them later, but they *have to be cried*. (Green 1992, 63)

Regimes of Truth

The work of mourning a voluntarily ended pregnancy may well include one other specific aspect: coping with the existential loss that accompanies entry into a "regime of scientific truth." Biomedicine offers "control" and "choice" at the individual level even as it normalizes outcomes, removing some unacceptable biological differences from the human community. Such normalization thus makes it both possible and plausible that some sectors of the population take partial responsibility for the genetic quality of their fetuses and children. This regime of scientific quality control is echoed throughout these interviews, as women regularly stumble over whether to call the ended pregnancy a "fetus" or a "baby." The first accords with a worldview in which genetic information leads to medical intervention to regularize the well-described and calibrated "products of conception." But in the second word, grief, desire, and human connection are more palpably present. Caught between the benefits of modern medicine and the emotions of pregnancy loss, many women cannot find a linguistic path, slipping back and forth between the two. When I queried this ambivalence of terms, one college professor answered, for example, "It just isn't clear." For her, the focus of loss was simultaneously a biomedical entity and a mourned child. Sometimes, women find themselves taken over and redescribed by the language of biomedicine under stress:

So I was in labor for twenty-four hours and absolutely nothing happened. I mean nothing. A dead fetus, but it wouldn't come out. So I

called Dr. X at 8 a.m., and I guess I must have sounded crazy. "Hello," I said, "I'm a demised fetus and a failed prostaglandin. "Oh no you're not, honey," the nurse said. "You're a lady that's losing a baby, and you'd better stop talking and start crying." (Sandra Larkin, 36, white direct-mail consultant)

"Living by the numbers," "becoming a statistic" are fantasized in responses to genetic counseling (chapters 3 and 4) and actualized here: For many with whom I spoke, confusion and anger accompany the necessary choices imposed by submission to the benefits of technology:

We're lucky to have this technology even though we're unlucky that we had to use it. How did we get caught? (Michelle Kansky, 38, white public school teacher)

I'm so sick of being a statistic. How do you get meaning off of a statistic? (Doris Paul, 43, African-American nonprofit education administrator)

This anger at statistical "unluckiness" seems particularly dramatic in those few cases where the amniocentesis itself, rather than a positive diagnosis, led to a pregnancy loss. I was able to locate only two people whose miscarriages seemed to be linked to testing, that is, which followed directly upon complications like leaking, cramping, bleeding, and fevers, right after having amniocentesis. And I was able to interview one woman whose amniocentesis led to what I can only label an iatrogenically induced abortion: Continuous leakage after the tap produced an extremely rare complication in which the fetus continued to grow in a "dry" environment that could no longer support its development. After weeks of attempting to save the pregnancy via bed rest and fluid replacement, sonograms revealed total, life-threatening lung degeneration. Pamela Meinhardt, a 35-year-old white librarian, frantically sought medical consultations throughout the city, and only reluctantly ended her pregnancy when a geneticist gently convinced her that the situation was already hopeless. Later she told me, "I'm so angry at this technology for having gotten me into this position when I was hoping I could be a beneficiary of it." Committed now to "living by the numbers," Pamela told me she surely intended to use amniocentesis in her next pregnancy, despite the grievous loss it had caused in this one. After all, the risk of this having happened in the first place was less than one in four hundred (this is a number calculated

from the rates of general amnio complications leading to miscarriages, and not based on any reported statistics for this particular rare event). Thus, she reasoned, the risk of having it happen twice was infinitesimal. And in all my interviewing, I never found a woman who had received a positive diagnosis who was willing to forgo testing in subsequent pregnancies. The "bottom line" for women from all social backgrounds who used the test was that it was better to know than not to know: "If the technology is there, it's better to use it. Better to live with the benefits of modern science, cry over your losses, but use every means science gives you to have a better life" (Michelle Kansky, 38, white public school teacher).

Learning to live inside of biomedicine may entail the loss not only of polysemic language possibilities, but of a concept of "fate," or the meaningfulness of being "chosen" to bear a particular problem for mysterious reasons. These strategies of explanation haunt memoirs of parenting ill and dying children, elevating familial suffering as a lens through which to view the entire human condition (Gunther 1949; Rogers 1956; Trautman 1984). The burden of "innocent suffering" can be reconfigured as a lesson in existential significance. This religious or philosophical quest for transcendental meanings is a subject on which biomedicine is, of course, silent.⁴⁴ As I indicated in chapters 5 and 6, religious discourse is richly connected to speculations concerning pregnancy in history, as well as in the present. Such connections are especially dense when discussing maternal/fetal pain, abortion, and death replacing birth. In looking at positive diagnosis, I was again struck by how quickly the women I interviewed turned to philosophy and religion in narrating their experiences with selective abortion and recovery. Often, they would describe convictions and confusions in explicitly religious or moral terminology long before the section of my interview schedule invited such considerations: The ethical standing of a disabled fetus was of enormous concern.

In one week of interviewing "positive diagnosis" cases, for example, the three women I encountered all began by framing their dilemmas in explicitly religious terms. Sylvia Lin opened our lunchtime conversation with a description of the Buddhist closure ceremony she had recently performed for her aborted fetus. A "returned" Buddhist from a thoroughly secular Japanese-American family, she had read about such ceremonies as a way to free mother and fetus from their linked cycle of rebirth: she therefore organized close friends to collectively enact one. Tamara Lefkowitz, daughter and sister of Orthodox rabbis, consulted three Jewish ethicists during and after the decision-making process which led to ending a pregnancy in which anencephaly had been diagnosed. "Without a brain, there is no question,

you must do what you must to do," two of them told her. The third knew of one anencephalic child who had survived for several months in an institution on Long Island. "If it's going to live less than thirty days," he said, "it needn't count as a life. But one that survives for several months, in principle, that changes everything." Nonetheless, he also offered the opinion that she was free to end the pregnancy. Mulling over the range of rabbinical consultations, Tamara's mother offered an explicitly religious statement which echoed one I had heard from virtually all the Jewish women that I interviewed: "When God sends bad news, he also sends us the medical progress to cope." And when I arrived at the publishing office where Nivia Hostos worked as an administrative secretary, the first story she told me concerned her participation in a Project Rachel support group. Founded in the late 1980s under the auspices of Milwaukee's liberal Archbishop Rembert Weakland, Project Rachel now has chapters in all fifty states. While the groups remain embattled in national and international Catholic politics, bucking official doctrine and attitudes toward abortion as sin, grass-roots chapters offer a range of counseling, confessional, and support group services (Rubin 1992). Raised a devout Catholic and the mother of a child in parochial school, Nivia was guilt-racked by having chosen abortion after the prenatal diagnosis of Turner's syndrome. Nonetheless, she believed that she had made the right decision, and was optimistic that the group would help her to resolve her bad feelings.

Nivia's responses underlined a powerful thread which runs through the stories of women who abort wanted pregnancies after positive diagnoses: Catholic women do not use abortion services less than non-Catholic women. Indeed, national and regional surveys suggest that Catholic women obtain about 32 percent of all abortions in the United States, a figure somewhat higher than their representation in the population at large (Goldberg and Elder 1998; Henshaw and Kost 1996; Rubin 1992, 41). While they thus regularly fall into the population aborting after positive diagnosis, my strong impression is that they suffer more guilt and frame their suffering more explicitly in terms of sin and the need for absolution. Of the thirteen women interviewed for this chapter who identified themselves as Catholics, eight considered themselves to be practicing, and all spoke explicitly of the problem posed by the confessional. Two described elaborate journeys to churches they had never attended before abortion, in order to secure absolution from a truly anonymous priest. One, angry as well as pained, said of her abortion decision: "Let the pope stand in my shoes. That's what I told the father that confessed me, 'Let the pope just stand in my shoes. Then we'd see what he'd decide'" (Marie Mancini, 38, white high school teacher).

The other, quite philosophical, made a distinction between ideal values and the actual conditions of her personal history:

I was raised to take what you get in life, any life you get. If I had stayed at home in Granville, if I hadn't gone to college, if I hadn't married Joe [who is Jewish], I'd still feel that way. I do feel that way. But even though I was brought up Catholic to believe abortion is murder, I also believe in a woman's right to choose. In people's right to choose. And that choice is a big part of me now, just as big as my religion. I'm not the same girl who went to Catholic school and thought that suffering would be redeemed. Now I'm suffering my own guilt. But it's in my own world, it's a bigger world, it includes more than just the sin of abortion. (Terry Hartz, 34, white homemaker and part-time book-keeper)

In such statements, and in the projections of the Catholic women who used prenatal diagnosis without receiving bad news (chapter 6), we see a larger ethical self emerging, one which includes but is not entirely bounded by Catholic ethics. There is a precipitate of liberal, individualist Catholicism separating out of official doctrine: These women uphold a general ethical worldview which is deeply Catholic, and personally accept its emotional consequences. Nonetheless, they reserve the right (and accord it to others) to choose abortion under certain circumstances. Navigating between the universalist claims of Catholic education, and a kind of secular ethical particularism, they worked very hard to philosophically justify their actions. Ten out of the thirteen also believed that their Catholic backgrounds had made it harder to recover from abortion than they imagined to be the case for non-Catholic women. And several genetic counselors and geneticists were explicit in their statements concerning Catholic women's guilt and the need to provide sympathetic clerical references. I should stress that every woman with whom I have spoken experienced enormous grief after choosing to abort a diagnosed fetus, and most expressed concerns about the moral standing of a disabled fetus in their families and their communities, and their responsibilities in deciding to end the pregnancies. But the Catholic women seemed to carry an additional burden of guilt.

Contextualizing Selective Abortion

Although the problem of guilt was construed in these interviews as an individual and philosophical burden, some abortion stories also alert us to the

larger realpolitik within which abortion decisions occur. Two women who live in small, upstate communities told me of their struggles to obtain abortions after diagnoses of fatal conditions in their fetuses. In both cases, Catholic and right-to-life influences on the local health care centers had made abortion unavailable. One spent a month unsuccessfully trying to get approval for the abortion of an anencephalic fetus through a specially convened hospital ethics committee, before transferring to a City Hospital. In another upstate case, members of the obstetrical and genetics staff tried to persuade a woman who had just received the diagnosis of Down syndrome to attend a local Down syndrome convention. "You'll accept this pregnancy, after you meet the other parents," they told her. No one mentioned abortion as an option, and several were extremely discouraging when she insisted on information and pursued her plans. When she made abortion arrangements at a hospital seventy miles from her home, her own health care providers refused to cooperate with the complex paperwork.

Such attitudes and behaviors among powerholders are, of course, punitive; under the guise of upholding "disability acceptance" they also attempt to coerce women into continuing pregnancies which they have already decided to end. There is, as the reproductive rights movement has continuously pointed out, a great difference between counseling that provides information on a range of options, and coercive directives. This problem is particularly clear when women are confronted with demonstrators attempting to dissuade them from receiving abortions. Two of the women I interviewed spoke of picket-line harassment at the abortion clinics they went to. "Go ahead," one of them screamed back at the right-to-life demonstrators. "You go raise this baby without a brain I'm taking out!" I was struck by the bravery and enforced activism of women who lived in places where abortion access was highly contested.

The links between legality, access, and the social and political climate within which abortion decisions are made was also brought back to me in a story told by a white health educator who had received a double and inherently ambiguous diagnosis which she researched intensely before coming to her abortion decision. While her story was more fully told on p. 231, it bears repeating here: Both her mother and mother-in-law expressed impatience and incomprehension when Jamie Steiner and her husband spent weeks weighing the meaning of the prenatal diagnosis they had received.

So finally I turned on my mother and asked her, "How can you be so insensitive? It's such a hard decision for us, you can't just dismiss this."

And as we talked, I realized how different their abortions were from mine. They were illegal. You've got to remember that, they were illegal. They were done when you worried about the stigma of getting caught, and maybe, getting sick. But you didn't think about the fetus. You thought about saving your own life. (Jamie Steiner, 33)

Illegal abortions were dangerous and expensive. They were performed under a different shadow of death—maternal, not fetal, death. The secularization of fetal personhood is a relatively new idea, condensing a variety of social forces which include the medical and technological objectification of fetuses, abortion reform, and right-to-life politics. Paradoxically, increased social consciousness of women's existence as a person apart from her maternity here coincides with a more independent focus on fetuses, too. In prior eras, mother and fetus were more culturally and materially fused; illegal abortion was a dangerous procedure, the major cause of death for women in their childbearing years (Garrow 1994; Gordon 1976; Petchesky 1984). Under these circumstances, religious hegemony was diffuse: It denounced the sin or crime of abortion, without a public focus on the fetus itself. The diverse movements which coalesced in support of abortion reform in the United States focused on maternal, or maternal/child health. It was the secular and medical authority of doctors which was posed against church doctrine in many of the successful court challenges which culminated in *Roe v. Wade* (Garrow 1994). In the wake of that historic decision, "Abortion related deaths . . . decreased by 73 percent" within a decade of decriminalization (Petchesky 1984, 157). By 1985, they had decreased fivefold (Council on Scientific Affairs 1992). Fear of criminal prosecution, and the morbidity and mortality of aborting women were thoroughly grounded in an older social matrix (Gorney 1998; Joffe 1995; Risen and Thomas 1998; Solinger 1993, 1998). On the heels of legalization, the right-to-life movement was quickly organized. We cannot analyze an emerging discourse of "fetal personhood" as it combines both religious and secular elements until we locate the meaning of abortion at the historic intersection of culture, politics, technology, and social change (Duden 1993; Ginsburg 1989a; Michaels and Morgan 1999; Petchesky 1984; Feminist Studies 1997). This intersection depends, in large measure, on struggles carried out among different power-holding sectors: The A.M.A., the right-to-life movement and its close ally, the Catholic Church, and various legal and governmental constituencies have all dominated national, state, and local struggles for and against abortion services. This power-laden struggle is reflected in the personal and quite philosophical

concerns of the women I interviewed, as well in more public and literate debates.

Yet however nuanced and clear their ethical, philosophical, or scientific convictions, virtually all women who ended their pregnancies after positive diagnoses described a profound sense of social isolation. Part of the isolation undoubtedly stemmed from the social ambiguity of "selective" abortion: Many find it morally permissible, but no one is prepared for the conundrum it entails. How can one grieve so deeply when you got the results you "wanted"? This chosen, personal grief is technologically, that is, socially, produced. Yet we have, as yet, no social acknowledgment or etiquette in which to contextualize it. I remember poring over the medical literature a month after my own abortion for Down syndrome, trying to find any indication of how women survived this trauma. After I got used to finding myself described in terms of "posttermination morbidity" and as experiencing "sequelae," I discovered that there were (then) only two articles describing the "psychosocial" impact of this experience. Both were quite frightening from a user's perspective. (Was I headed for a nervous breakdown? A divorce? Or both?) And both were based on very small, biased samples. In the biopolitical order within which prenatal diagnosis currently occurs, there is very little significance attributed to the personal and social consequences of positive diagnosis: It isn't a socially significant topic for research, hence, the comfort which such research might bring to relevant women (and their service providers) is nobody's high priority.⁴⁵ As I set about finding others who had survived this disorienting grief, it was almost a decade before I met anyone who had met anyone but me who had also sustained this particular experience. So the literal oddness of one's circumstances is considerable, as nobody else one knows is likely to have "been there."

I feel like I fell off the edge of this earth, like there's no one down here but me, like Alice down the rabbit hole, I've been falling through space so long I don't remember which end is up. Who could possibly understand this? (Pat Gordon, 37, white college professor)

Forgive me, but unless you've lost a parent, you can't tell me anything about what it was like. All the ones who helped me then, my cousin, my husband, my best friend, they can only go so far with me on this one. Meeting you, it's the first time I've talked to anyone who has anything to say about getting over this. (Leah Rubenstein, 39, white homemaker)

I never met anyone, anyone who's been through what I've been through. It's lonely, it's sad and lonely. That's why, when the genetic counselors called me, I was so curious to meet you. (Iris Lauria, 29, Puerto Rican hospital housekeeper)

Over the last decade, a small popular literature on the grief involved in ending desired pregnancies has emerged. It often includes direct quotations from letters, poems, and accounts written by parents going through this difficult experience (e.g., Fertel, Holowinsky et al. 1988; Ilse 1993; Minnick, Delp et al. 1990). Much (but not all) of it is self-published, and/or distributed through small counseling services. It is thus not widely available, although many genetic counselors do distribute copies to those who seek them out as part of their recovery. Though some of the women I interviewed had read this literature and found it very comforting, most had never heard of it. I know of one videotape produced by and about a support group for those receiving positive prenatal diagnoses distributed through a medical center in California, (Loma Linda School of Medicine, 1984), but I have never seen it in use in New York. There is thus no obvious cultural space which has, as yet, been created for healing this technologically produced form of chosen suffering. Only three of the women I interviewed had participated in support groups for those experiencing pregnancy loss; none had found a support group specifically designed for her kind of chosen loss, rather than general pregnancy loss. The difference between pregnancy loss due to miscarriage and stillbirth and *chosen* pregnancy loss is substantial: One woman found the groups set up by hospital social workers or community organizations helpful, while two others felt that they became targets for anger. After all, they'd *chosen* to end a pregnancy, while the women in the group had been the "victims" of miscarriage, stillbirth, or neonatal death. Thus, the focus on individual choice—a quintessentially American cultural value—here again disrupts the commonality of pregnancy loss.

Cultural notions of privacy may also erect barriers against seeking collective support: For the many years since my own abortion, I have made my name and telephone number available to all the genetic counselors with whom I have worked, in case someone wishes to speak with another woman "who's been there." While counselors call at least once a month to alert me to the fact that they have recently given someone my name, only a handful of their patients eventually call me. Among those with whom I have spoken, some women mentioned more extended sessions with professional psychotherapists or social workers as particularly helpful. While most of these

were professional middle-class women used to purchasing counseling services, some came from less privileged backgrounds. One hospital housekeeper dropped in to see her genetic counselor quite regularly, and two secretaries mentioned church-related loss groups that had been helpful.

Secrecy and Support

But most of the support women received came from close friends and family members. To my queries of "Who did you tell first?" and "Where did you feel support or criticism for your abortion decision?" the women I interviewed usually named mothers and sisters, with best (or close) friends following close behind. Sometimes, fine discriminations were made among family members: Marilyn de Soto found her mother-in-law's grief and distress paralleled her own, while Nivia Hostos was careful to describe her abortion as a "loss" or "miscarriage" to her own mother. Both these senior women were deeply pious Puerto Rican Catholics. Iris Lauria, also from a traditional Puerto Rican family, found the closeness and support offered by all her kin enormously helpful; no one questioned the abortion decision. When Tamara Levkovitz returned to her suburban home, shaken and in tears from the sonogram diagnosis of anencephaly, her parents were already in the living room, running interference with her children: Her brother, an Orthodox Jewish rabbi, had reached them by phone before she did. And writing this chapter, I recalled vividly that my own parents flew a thousand miles just hours after they received our call, determined to do anything they could to help us through a crisis. But other women had to hide their situations from families which were hotbeds of antiabortion sentiment. And friends sometimes made mistakes in their efforts to help: Margaret Thompson took a month to decide about ending her pregnancy after the biochemical diagnosis of an invisible spina bifida. During that time, she became enraged with anyone who articulated a clear opinion on what she should do. Megan Johnson had worked through an infertility crisis with a close friend some months earlier. After her own selective abortion, the friend failed to return phone calls for several weeks. When she finally reconnected, the friend told Megan, "At least you were lucky: You're able to get pregnant." Less dramatically, many women reported that friends, trying to be helpful, would say, "This is just helping nature along" or "It's all for the best." "They get me so angry when they say that stuff. This isn't 'all for the best.' It's rotten. It's just rotten" (Harriet Genzer, 41, white editor).

People make comments intended to help which actually hurt. Meeta Cabron's son's baby-sitter expressed great support for the affected pregnancy,

offering the services of her church's prayer circle: "We all believe your baby can be healed," she repeatedly proclaimed. But help and insight may also come from less obvious sources. For example,

The next week, this father of my friend, he's Catholic, he didn't know a thing about what I'd done, he just starts in on this conversation with me about how much he admires Geraldine Ferraro [one time Democratic senator from New York who ran for vice president in 1988], her stand on abortion, and everything. He says, "What does the pope know? He's an old man like me. Better to let the women decide on this for themselves." And I felt very comforted by that, like even Catholics might understand. (Michelle Kansky, 38, white public school teacher)

Pregnancy loss is culturally located in the realm of "the private" (Layne 1990, 1992, 1997). Likewise, abortions are not usually widely discussed and are socially fraught. Abortion after a diagnosis of a disabling condition is still a relatively rare occurrence and morally ambiguous: Some commentators denounce it as neoeugenics, while most Americans still consider it to be a justification for legal abortion (Goldberg and Elder 1998). Yet because the experience was "chosen," many people do not code it as a "loss." For all these reasons, women undergoing selective abortions after positive diagnoses usually feel isolated and find the support they receive, no matter how well-intentioned, insufficient.

The ambiguity of this experience resonates through women's social lives, affecting all intimate relations. This resonance was particularly present in the stories women told concerning their partners' reactions. If, as Jessie Bernard told us, there are "His" and "Hers" marriages (Bernard 1972), then there are surely "His" and "Hers" abortions, as well. The overwhelming majority of women I interviewed felt that their husbands or partners shared deeply in the pain of ending a wanted pregnancy. They told many moving stories about men's wishes for healthy children, and concern for their own misery and safety in undertaking a late abortion. Three said that their husbands felt angry that only women got sympathy for this traumatic event; they, too, wanted some social recognition of a grievous loss. And the overwhelming majority of women also reported that men recovered much faster and needed to put the experience behind them much sooner than they did. Much of this difference is, of course, an embodied one: As long as a woman still carries milk-filled breasts, extra pregnancy weight, hormonally modulated emotions, and awaits the hormonal changes reestablishing her menstrual

cycle, her memories of recent loss are inscribed in flesh. But many women from diverse social backgrounds also attributed gender differences in recovery to male psychology:

I think it's real for him, but there's just a real difference in how experience feels. I mean, he doesn't experience it in the same way, it wasn't as much of a personal loss, it was a different kind of loss for him. He's very closed off about his own emotions, and it's something that he doesn't articulate, and he doesn't want to articulate, he prefers to get away from it. He grieves differently. . . . I kept a journal the whole pregnancy, and I wanted to burn that journal, to finish it that way. . . . and he couldn't do it, he just couldn't do it. The most he could do was read it privately—he absolutely had to do it by himself—and then he had to put it away, he couldn't burn it. . . . We approach life differently; I just have to respect his way of doing things. (Margaret Thompson, 34, white psychologist)

It was like he was, well, it happened, and that's that. He put it away on a shelf. I didn't want him to do that. . . . He didn't ever want to talk about it, got kind of uncomfortable when I brought it up. Then a month later, it all came out. . . . I mean, he just . . . let it all out, and I was so surprised. . . . I wished he could have, we could have sat down together and just cried our hearts out. . . . But I guess being brought up in a Latin household, it's very hard for him. (Nivia Hostos, 26, Puerto Rican administrative secretary)

He got very upset about it. He didn't speak about it, but I know he did. He does have feelings, he's a human being. He kept to himself, but I know he felt it. (Iris Lauria, 29, Puerto Rican hospital housekeeper)

Their sympathy for their partners' seldom-expressed pain extended to interpretations of differences which they coded as similarities:

Even though he wasn't talking, I think he may have taken it a little bit harder than even I did, because he seemed to be more afraid to try again. . . . I was more optimistic, and I guess he was still grieving, and I was already on to, "Ok, let's try this again." But he wasn't ready, he was more afraid. Even when he's not talking, I know what he's feeling. (Marilyn de Soto, 34, Puerto Rican social worker)

In the hospital he was great, he was 100 percent there, and then a few days later . . . he just couldn't understand my pain, he denied that he had the same pain, and so this was, he said, you know, it was a fetus, and that was that, and it's over. . . . And I was seeing a psychiatrist, and I was hysterical, and I only wanted to talk about trying again, but I realized my reaction was hysterical. And then I realized his reaction was hysterical, too. Because he couldn't discuss this, he couldn't talk about trying again, he couldn't sit down with me and just talk it out. This was his hysteria, right, this big, giant denial. (Nancy Tucker, 36, white college professor)

Many women experienced marital stress in the forms of anger, arguments, or alienation. When I inquired about the reactions of her husband to her own longing for a replacement pregnancy, Tamara Levkovitz said, "To Martin, life is Atlantic City. We were ahead, we had three healthy children. Now we're losing. Ok, if you're smart, you walk out of the casino." One obstetrician told his patients who expressed anger at their husbands for being less grief-stricken than they were, "The Orthodox say, 'God forgives anything said by a woman in labor.' She's allowed to be very, very angry. So go ahead, curse God out. He'll understand. He knows better than your husband." A very few women told tales of gender reversal and gender pressure surrounding their abortion decisions:

My husband is very stalwart, I mean, he wouldn't do anything less than rational ever. He's an investment banker, that kind of says it all. But when we first found out, he was the one who considered keeping the baby, he really did. And I was the one who flipped around, I had to get it over with, I had to get it out immediately. (Nancy Tucker, 36, white college professor)

Carey Morgan, a white interior decorator, found abortion "morally repugnant" but acceded to the wishes of her lawyer husband and her obstetrician after a fetal diagnosis of toxoplasmosis. Sylvia Lin dreamed a conversation between herself, her husband, and her Klinefelter's fetus in which the baby told her he wasn't afraid of dying, if that would bring peace to the two of them.

But sometimes, gender conflicts are not reconcilable. Two women attributed the breakup of their marriages to the stress surrounding this experience. Additionally, one African-American and one Dominican professional, both

in nondomestic relationships where their pregnancies had been warmly welcomed, said that their partners had drifted away. "The partner? There's not always someone very involved," one said to me, as she described his lack of support around the time of the abortion of a pregnancy about which he had initially expressed great enthusiasm.

Thus the stresses and pains associated with choosing to end a wanted pregnancy after a positive diagnosis are more than individual and physical. They ripple through a woman's intimate network of partners, children, relatives, friends, and coworkers, spreading both disruption and reflection. I was continually reminded of the intense pain accompanying this experience, as my questions often provoked tears for which I was always apologizing. As the interpolator and mirror of that pain, I would often find myself returning home to pull the covers over my head after conducting "positive diagnosis" interviews. Although we feminist researchers who explore the terrain of miscarriage, childhood disability and death, and infertility often refer to ourselves ironically as mavens¹⁶ of reproductive grief, it was only in the course of rereading these transcripts that I considered the implications of my own first live born child's standing as a "replacement baby," conceived in the aftermath of this painful experience. And in analyzing the data for this chapter, personal history shadowed my analytic framework, complicating as well as enriching the issue of authorial voice throughout. The pain provoked by positive diagnosis, its aftermath, and its reanalysis on the part of both those receiving it and their anthropological interviewer is thus considerable. As I have tried to indicate throughout this chapter, this experience shares the hidden anniversaries, private losses, social separations and disruptions, and philosophical conundrums entailed by other forms of pregnancy loss, while also bearing its own unique and painful markings. But women and their supporters experiencing the pain of positive diagnosis also have much in common with those who give birth to children with disabling conditions, the subject of chapter 10 to which we now turn.

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*To the memory of XYLO and the futures of Mira and Teo,
all already and always children of a brave new world.*