TIME AND TEMPORALIZATION IN PREGNANCY TEST COUNSELING

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PRELIMINARY DRAFT: Please do not quote, cite or reproduce without the author’s permission.
Late one summer afternoon at Midtown Women’s Clinic,1 a large, inner-city family planning clinic in western New York, a woman and her counselor began a pregnancy test counseling session with the following words:

1.1 Counselor You came in for a pregnancy test today.
1.2 Client Hm, hm.
1.3 Counselor Tell me a little bit about why you decided to come in.
1.4 Client Well I really already know I’m pregnant. I don’t really know what I want to do. It’s like I’m between two decisions -- I don’t know if I want to have an abortion or if I want to keep it.
1.5 Counselor Okay.
1.6 Client And it’s like, you know a couple of my friends, well my sister’s had an abortion before and a couple of my friends have had kids and they are like just go to [the Midtown Women’s Clinic] and then make up your own mind.
1.7 Counselor Yeah.
1.8 Client It’s like most of my friends, you know, they’re like “oh have it.” It’s like well you guys aren’t going to be there, you know, all the time to help me with everything and it’s not just an easy decision. (nervous chuckle)
1.9 Counselor Well today we are just going to talk through what you have been thinking about.
1.10 Client Hm, hm.
1.11 Counselor Okay. Kind of come to some conclusions.
1.12 Client Okay.

This paper is an analysis of processes of temporalization in such talk. It is based on four months of intensive participant observation in the counseling department of a large urban clinic operated by a not-for-profit family planning agency in upstate New York. To begin with I “shadowed” counselors,2 listening to telephone calls, observing counseling sessions, attending Counseling Department meetings, and collecting data from patient records. Toward the end of this round of research, when the counselors and I were comfortable with the project, we audio recorded and transcribed four counseling sessions, two of which I also observed.3

Here I focus on the counseling session from which I quote above, drawing on transcripts of other sessions for purposes of comparison. The client, who I call Brenda, was an 18 year old, unmarried white woman who attended community college and worked as a clerk at a local department store. She already had seen her private physician for a pregnancy test and knew that she was pregnant, but had been unable to decide what to do. Though Pro-Choice, she had seen her sister go through several abortions and felt that aborting would be wrong for her personally. On the other hand, she did not feel ready to be a parent and doubted that her boyfriend would be very supportive of a child. She had come for counseling at Midtown to help her make up her mind. The counselor also is white and quite young, only a few years older than her client, but she had worked full-time at Midtown for
over a year and before that worked at a Planned Parenthood affiliate in the southwestern United States. As far as I can tell, this session was notable only for the fact that Brenda was still “undecided” when it ended.4

On Pregnancy Test Counseling, Time and Temporalization

At Midtown Women’s Clinic, as at other family planning clinics in the United States, pregnancy test counseling is a form of psychotherapy.5 A manual written in 1981 by the then Director of the Counseling Department defines it as “a process that helps the client to: 1. Work through her feelings in order to-- 2. Clarify her thoughts, so she is better able to-- 3. Develop constructive courses of action.” In words that are frequently echoed by the women with whom I worked, Baker (1985:2) speaks of counseling as “crisis intervention.” Stressing “the communication of feelings and cognitive reorganization,” it is what Frank and Frank (1991:35) call an interview therapy. At Midtown and, I believe, elsewhere in the United States, it is based on the “client-centered” therapies and theories of “self-actualization” associated with Carl Rogers (see, for example, Rogers 1961). Within this broad class, it is what Beresford (1977) calls “short term relationship counseling.” Counselors rarely meet with clients more than once and sessions are relatively brief.

Counseling also is a form of gatekeeping. Clients must pass through the counseling encounter to get access to contraceptive, prenatal or abortion services at Midtown and other reproductive health care providers. As a gatekeeping encounter, counseling should take place prior to other services, though how this works out in practice can get a bit complicated. At Midtown, the clinical staff, especially, insist on this, sometimes denying services to clients who have not made finished counseling and made a decision. On one occasion, a counselor tried to get an immediate sizing6 for a patient who was uncertain of the date of her last period and whose choices -- to have an abortion or continue the pregnancy and, if the former, to have the procedure in locally or in another city, where abortions are available after 16 weeks -- depended, in part, on how far along she was in her pregnancy. However, the clinic staff refused, saying “she has to decide” whether or not to continue before they would offer her what they defined as an abortion related service. Conversely, counselors objected when, during the introduction of a new, two-day abortion protocol, clinicians began abortion work-ups before there had been any counseling. In one counselor’s view, some clinicians seemed to think women could “just decide.” Her own view, on the contrary, was that abortion was a difficult “emotional issue” and that many clients had a terrible time coming up with the money and other requirements.
Both the psychotherapeutic and the gatekeeping functions of pregnancy test counseling are accomplished through what Goffman called focused interaction: “the kind of interaction that occurs when persons gather close together and openly cooperate to sustain a single focus of attention, typically by taking turns at talk” (1963:24). Unlike casual talk among friends or colleagues, however, counseling talk is power laden. Pregnancy test counseling sessions are examples of what the conversation analysts Drew and Heritage call “talk at work” or moderately co-operative, informal institutional talk. “Talk-in-interaction is the principal means through which [clients] pursue various practical goals and the central medium through which the daily activities of [counselors] are conducted” (Drew and Heritage 1992:3). Though counseling is far more informal and co-operative than a police interrogation or a courtroom cross-examination it falls short, sometimes well short, of Grice’s (1975) preconditions for fully co-operative exchanges. The “issues” discussed in counseling are highly personal and may be stigmatizing and embarrassing. The goals of clients and counselors may overlap, but are unlikely to coincide perfectly. The power that pervades counseling derives from the fact that it is a variety of expert practice in which a “recognized authority,” the counselor, may invoke participation frameworks that are “distinct from (though obviously related to) those of everyday interaction among nonspecialists” and that “incorporate role possibilities marked by vast asymmetries in knowledge, responsibility, rights of inquiry, and the consequences of categorization” (Hanks 1996a:171).

Many women never participate in pregnancy test counseling sessions. As at other family planning clinics receiving Title X funding (Mosher 1994), the women served by Midtown Women’s Clinic are almost exclusively female, largely low income and disproportionately Black and Hispanic. In 1998 the clinic recorded 5255 client visits, all but one women. Of these, 77% had incomes less than or equal to 125% of the poverty level. Few had insurance. More than two-thirds were offered services at partial fees. 66% were white, 28% were black, 2% were Asians or Pacific islanders (since there are very few Pacific Islanders in the region this group must be almost entirely Asian); 5% were Hispanic.

Women that do receive pregnancy test counseling, do so at particular times in their life course. Somewhat more than 60% of the clients receiving services at Midtown in 1998 were 20-29 years of age. If these women resemble women in national studies, more than half have had no live births (Mosher 1994).
On a smaller temporal scale, women participate in pregnancy test counseling occurs at different points in the flows of conduct (see Giddens 1979) that occur between first intercourse and a pregnancy or between one pregnancy and another. Again, judging by national studies (Mosher and Horn 1988 and Finer and Zabin 1998), three quarters or more have already begun having intercourse. Most suspect or know they are pregnant. It follows that relatively few of Midtown’s clients are making what Ortiz (1973:269) calls planning decisions, i.e., decisions involving some attempt at maximization and active information gathering and made well in advance of the activity with which they are concerned. Far more often they are making decisions “in the course of action.” Ortiz (1973:247, 269) argues that satisfaction and security rather than maximization are the main concerns in decisions of this kind and that the effort devoted to the acquisition of information therefore may be safely reduced.

This paper is not concerned with the fact that pregnancy test counseling sessions are brief nor with the timing of counseling in the life course of the client and her flows of reproductive conduct. I am concerned, instead, with what Munn, following Fabian (1983:74), calls symbolic processes of “temporalization.” The notion of ‘temporalization’ É views time as a symbolic process continually being produced in everyday practices. People are ‘in’ a sociocultural time of multiple dimensions (sequencing, timing, past-present-future relations, etc.) that they are forming in their ‘projects.’ In any given instance, particular temporal dimensions may be foci of attention or only tacitly known. Either way, these dimensions are lived or apprehended concretely via the various meaningful connectivities among persons, objects, and space continually being made in and through the everyday world. (Munn 1992:116)

Pregnancy test counseling sessions are among the projects that make the time they are in. This paper focuses on the forms of that time and the activities through which they are made.

Hanks’ analysis of Maya shamanic practice (2000, see also 1984, 1996a) shows how this kind of approach to time may be used to analyze healing rituals. According to Hanks, shamanic performances involve the interaction of several distinct temporal frames or horizons. The participants in a shamanic performance are co-engaged and their “fleeting interactions É emerge from one moment to the next” within a “proximal” frame of “local, emerging time” (Hanks 2000:223-4, 234). The performance also produces and takes place within a frame of “midrange schematic time” that pertains to the contemporary, but not immediately present lives of the participants. This temporal field includes the client’s prior familiarity and patterns of shaman-patient interaction, [and] any prior treatment for a current condition, including diagnostic rituals whose purpose was to identify the condition and prescribe treatment. It also includes the history of encounters and memories binding a ritual specialist to his familiar spirits and to those humans from whom he has learned. É All this knowledge and prior experience is part of the actuality of performance, but it is present
as past. It is contemporary, but not current, and it defines a field of relative familiarity, not of immediate copresence. When projected into subsequent experiences, this frame pertains to anticipations less immediate than the nearly actual ones of the local frame. A blessing performed on one day is often part of a series in which it is prospectively oriented toward subsequent reenactments, and ultimately toward a cure. This prospect is inscribed in the performance itself. (Hanks 2000:225)

Finally, “factors such as the cosmological framework within which spirits have certain axiomatic characteristics inherent in their identity” pertain to a remote “memorial time” that is “neither copresent nor contemporary.” In this temporal frame, the shaman and his patient engage “only as human beings with different kinds of roles in the world, not as actual individuals with specific identities” (2000:225-6).

The Time of Co-engagement: The Proximal Temporal Frame in Counseling

As in the Maya shamanic performances studied by Hanks, the co-engagement of participants in a pregnancy text counseling session and the orderly succession of their improvised turns of talk from one moment to the next takes place within a “proximal” frame of “local, emerging time” (Hanks 2000:223-4, 234). This frame is continuously invoked, (re)produced and modified in part by conventional expressions that describe what the participants are doing and index their involvement in the ongoing interaction. Consistent with the character of counseling as expert practice, primary control over these frames is allocated to counselors.

Especially notable among the conventional expressions used by counselors to focus interaction within a frame of local, emerging time are verbs that refer to talking and listening. The counseling session transcript on which I focus here, opens with the request to “[t]ell me a little bit about why you decided to come in” (turn 3) and the statement that “Well today we are just going to talk through what you have been thinking about” (turn 9). It continues with numerous occurrences of “tell me about,” “tell my why,” etc. (turns 13, 21, 25, and 56), and “I want to talk about” or “let’s talk about” (turns 19, 40 [2 occurrences], 42, 52, 62 [3 occurrences], 72, 96, and 127). Conversely, the counselor routinely responds that the client has been “tell[ing]” her something (turn 88), that she is “hearing” the client say something (turns 40, 74), that “it sounds like” one thing or another is going on in the client’s life (turns 19, 29, 68), or that what the client tells her causes her to “think” one thing or another (82).

The counselor routinely uses single or multiple instances of the verbs “to talk,” “tell,” “to hear” and “to sound” to negotiate changes in topic as she explores the events that have brought the client to the clinic and the options she now faces (see Figure 1). First, in turn 13, how the client learned she was pregnant and, in turn 19, the results of the additional test the counselor routinely ran:
1.13 Counselor  **Tell me** a little bit about -- First of all how did you find out that you were pregnant?

1.19 Counselor  Okay. Well, hum Ê, **let’s talk about** the tests that I ran today was showing positive results just so you are aware of that. We do want todo a urine test that’s why we had you do a sample, hum,  **But it sounds like** you have known for about, probably about a couple of weeks.

Then, in turn 21, who the client has talked to about her pregnancy and what she has learned from those conversations.

1.21 Counselor  Okay. And **Tell me** where, who you have talked to and what the conversations have been like.

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Insert Figure 1 here

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Turning to future options, in turn 25, the counselor moves the conversation to the client’s feeling that an abortion is not for her.

1.25 Counselor  **Tell me** why, **tell me** about that part of you that really doesn’t want to have an abortion. What is it that, that makes you feel that way?

In turns 41 and 42, and 52 through 56 the counselor directs the conversation to the abortion option, how the client would avoid becoming like her sister, who has had several abortions, and what the abortion procedure would be like.

1.40 Counselor  Ê **I want to talk about** two different scenarios. First **let’s talk about** -- um, because everything that you have said so far with the exception of some emotions about this decision lead, you know like the logical side of you from what **I’m hearing** is saying “okay, abortion is definitely an option.”

1.41 Client  Hm, hm

1.42 Counselor  So, **let’s talk about** how you see yourself preventing, um, becoming your sister or a person like your sister if you have an abortion.

1.52 Counselor  Ê **Let’s talk about** the actual abortion. Okay? You said you’ve been with your sister through that?

1.53 Client  Yes.

1.54 Counselor  Were you in the procedure room with her?

1.55 Client  Hm, hm

1.56 Counselor  Okay. **Tell me** what you remember about that experience.

And finally, in turns 62 and 72, the counselor directs the conversation to the possibility of continuing the pregnancy and putting the child up for adoption.

1.62 Counselor  ÊUm, but, so with you thinking that this is something that’s wrong for you personally **let’s talk about** the ..., **let’s talk about** continuing the pregnancy. Okay? First of all how would that change your immediate relationship with your partner?

1.72 Counselor  So **let’s talk about** -- have you ever thought about adoption?
Having established that the client is well and truly undecided and offered her a framework with which to think further about her choices, the counselor again uses the verb “to talk,” in turn 96, to begin a discussion of the time limitations within which the client must make her choice.

1.96 Counselor É What **I do want to talk to you about** right now is limitations that you have. Okay? In terms of time and answer any other questions that you have -- about continuing your pregnancy -- where do you go? What kind of help do you need to get? Um, if terminating the pregnancy -- what to expect? Your last period was the 15th of May, you said you had some bleeding around the 1st right?

1.97 Client Hm, hm.

The client does not use the verbs “to talk,” “to tell,” “to hear” or “to sound.” Indeed, Brenda introduces only one topic shift of her own, asking the counselor, toward the end of the session, in turn 144, if many other 18-year-olds come to Midtown Women’s Center “with the same problem.” However, throughout, the counseling session, as in all of her utterances quoted above, she uses ‘hm,’ ‘okay’ and other speech particles to demonstrate continued engagement in the interaction and to return the floor to the counselor. And the counselor, for her part, does the same thing when the client has the floor.

All counseling sessions at the Midtown Women’s Clinic -- and, presumably, all focused interactions -- involve a proximal frame of local, emerging time, but the quality of this time varies from one session to another. At one extreme are those clients who see themselves as involved in a relatively straightforward, everyday task: completing the steps required to reach a desired outcome. Thus, following a brief exchange about Midtown’s consent forms, another counseling session got down to work with the following exchange

2.17 Counselor É Okay now we can get down to business. Um, Wendy, do you want to tell me why you thought you needed this appointment today for a pregnancy test?

2.18 Client Because I know I am pregnant.

2.19 Counselor You know I am pregnant. (Chuckle)

2.20 Client I’ve already set up the whole nine yard thing. (Chuckle)

2.21 Counselor Okay. You’ve had a pregnancy test somewhere else?

2.22 Client Yeah.

2.23 Counselor Alright. Anything other than the pregnancy test. The sizing or anything? Just the pregnancy test.

2.24 Client Yeah. Just the pregnancy test.

2.25 Counselor A home test?

2.26 Client No. Well it was then I went to PCAP

2.27 Counselor PCAP, where?

2.28 Client In Oswego.

2.29 Counselor Oh, okay. Oh you’re the one from Oswego.

2.30 Client Yeah. (Chuckle)

2.31 Counselor Alright. The test that I did of course came up positive too and that’s not a surprise for you evidently.

2.32 Client No. (Chuckling)
Counselor: Okay. And um, it sounds as if this isn’t a good time for you to be pregnant.

Client: No. (Chuckling)

Counselor: You say that very emphatically.

Client: Yeah.

Counselor: Alright. What I need to do Wendy is get some just go over this information sheet that you filled out already and then we will talk a little bit about your decision and then the next step will be the sizing. Okay? All righty, do you have any allergies to any kinds of drugs or medications?

For two women like Wendy, the local, emerging time of a pregnancy test counseling session is minimally different from the local, emerging time of the encounters involved in preparing for any other relatively noninvasive, outpatient surgical procedure: a laparoscopic tubal ligation, for example, or an IUD insertion.

At the other extreme are clients whose lives are on hold while they struggle to make a difficult decision. For these women, the counseling session is a transitional or liminal moment betwixt and between recognized states of the life course. As Brenda, the client in the first transcript put it, “Well I really already know I’m pregnant. I don’t really know what I want to do. It’s like I’m between two decisions -- I don’t know if I want to have an abortion or if I want to keep it” (Turn 4). Counselors appear to assume that this is the standard situation. In their view, they are dealing with “crisis” pregnancies and women who are “in crisis.” Thus, they routinely mention that “talking about” the client’s “decision” is the key function of a counseling session.

In counseling sessions that have a liminal character, the local, emerging time of focused interaction is “‘a moment in and out of time,’ É a state to which the structural view of time is not applicable” (Turner 1974:238). Counseling time, like the ritual time of Maya shamanic performances is “characterized by certain forms of reversal and transposition atypical of” other contexts (Hanks 2000:224).

At Midtown Women’s Clinic, counseling sessions that approach liminal moments do so in part through the use of what Varenne calls “secondary texts.” Primary texts, Varenne suggests, do the work of everyday life. Secondary texts are produced in settings where the work of everyday life is not being performed, where this work is suspended, so to speak -- interviews, therapy sessions, gossip sessions, scholarly papers. They are embodiments of the request “let’s talk about this” or “what do you make of this.” They are moments when people are “having a talk,” “really talking to each other,” “communicating,” “learning about the organization of the world.” (Varenne 1987:387).

Mainstream Americans, Varenne suggests, place peculiarempHASIS on the “meaningfulness” of secondary texts. And in America their “central stylistic feature É is É the extra emphasis that is placed on the singularity and separateness of the person of focus É, the ‘I’” (1987:390).
The Times of Women’s Lives : The Contemporary Temporal Frame of Counseling

Pregnancy test counseling session at Midtown Women’s Clinic are not confined within the proximal frame of local, emerging time. The “issues” with which counseling sessions are concerned are regarded as having historical origins and future consequences. As clients and counselors talk about past events and future possibilities, their focused interaction indexes or invokes and places itself within another frame of “midrange schematic time” (Hanks 2000:234).

The invocation of the midrange, contemporary temporal frame is accomplished in large part through the use of narrative. Looking backward, narratives recapitulate and evaluate “past experience by matching a verbal sequence of clauses to the sequence of events which (it is inferred) actually occurred” (Labov 1972:359-60). Looking forward, talk about the meaning of narratives sketches possible futures that might be brought about by actions taken now in response to past events.

For example, a third counseling session opens as follows:

3.3 Counselor Okay. Tell me a little bit about what uh, made you decide to come today. What’s been going on?
3.4 Client Well I missed my period two months in a row. So I just kind of figured that, because at first I, like I wanted to sort of, because me and my boyfriend we have been together for a long time, we plan on staying together, you know
3.5 Counselor Mm, mm,
3.6 Client and then we sat down and we talked and we decided that we just want to grow up some more, have fun and then start everything so, I don’t know, that’s, I don’t know kind of changed our mind and I think it was a little too late. I have been putting this off coming down here and I needed to come down here. I’m afraid it’s too late to, I wanted to get an abortion and everything. I hope it’s not too late for it.

Here the counselor’s question (turn 3) provides what Labov (1972:363) calls the abstract, i.e. an initial clause that “summarizes the whole story.” “Well I missed my period two months in a row” and the declaration that the client and her boyfriend “have been together for a long time” and “plan on staying together” are orientation clauses, “identifying the time, place, persons, and their activity or the situation” (Labov 1972:364). The key narrative clauses, “whose order is taken as the order of events” (Linde 1993:70), are marked by verbs (in bold) in the simple past tense: “I just kind of figured” and “we set down and we talked and we decided.” The client’s final words, “I have been putting this off ÉI hope it’s not too late for it,” provide an evaluation, stating the point of the story, its implications for human conduct (Labov 1972:366).
Counselors commonly respond by claiming the right to co-narrate their clients’ stories. A co-constructed narrative is one in which the components of the verbal sequence are shared among two or more speakers. As Ochs observes, this happens especially when a co-narrator feels that information vital to understanding the problem that motivates the actions and reactions of protagonists and others in the storytelling situation is missing. “Co-narrators [then] return, sometimes again and again, like Lieutenant Columbo, to pieces of the narrative problem in an effort to find ‘truth’ through cross-examination of the details, sometimes struggling for an illuminating shift in perspective” (Ochs et al. 1997:98).

This is precisely the role of counselors at Midtown Women’s Clinic. Counselors may analyze their clients’ narratives, drawing out distinct themes in terms of which they might be understood, for example, the part of oneself that feels or thinks one thing or another, or, more generally, the logical and emotional “sides” of one’s personality. Especially when they talk of what they are “hearing” or what the client’s talk “sounds like,” counselors also participate in the evaluation of their clients’ narratives, stating or restating the morals of the stories or sketching some of their implications for future eventualities.

One key “issue” is the date of the client’s last period and the duration of her pregnancy. In the session with Brenda, the undecided client, this is the second topic of conversation:

1.13 Counselor Tell me a little bit about -- First of all how did you find out that you were pregnant?
1.14 Client Well, okay in June I had like a slight period, but it wasn’t normal, usually my periods are very normal and they are very on time and this one came around the first of the month. I usually get mine in the middle and I was really late. I was like “well maybe.” I don’t know, stress. I wasn’t really thinking about it.
1.15 Counselor Hm, hm
1.16 Client So in July I was like “wow.” It was around the 15th, I was like I need to get tested. So I went to my primary care doctor and I got a pregnancy test.
1.17 Counselor Okay. Were you surprised when you found out the results?

The history of the client’s pregnancy diagnosis has an enormous impact on the time frame within which she must make a decision, some of the parameters of that decision, and the kinds of abortion services she may receive. At the time of my fieldwork, Midtown Women’s Clinic performed abortions only through the 12th week of gestation. They provided only two-day surgical abortions with laminaria12 insertion on the first day and they did not offer anesthesia. But they did accept Medicaid. Other abortion providers in the city offered slightly later surgical abortions. Some offered anesthesia and, for women less than 11 weeks pregnant, a one-day procedure without laminaria. One offered medical abortions.13 But, I believe, none were willing to accept Medicaid. Women who
were more than 16 weeks pregnant had to go to Buffalo for an abortion or, if they were more than 19.6 weeks pregnant, to New York City.\textsuperscript{14}

Brenda is very close to the 12-week threshold for an abortion procedure at Midtown. After establishing that she is undecided and recommending a way to think about her options, Brenda’s counselor outlines some of the ways in which future eventualities are time constrained.

1.96 Counselor É What I do want to talk to you about right now is limitations that you have. Okay? In terms of time and answer any other questions that you have-- about continuing your pregnancy -- where do you go? What kind of help do you need to get? Um, if terminating the pregnancy -- what to expect? Your last period was the 15th of May, you said you had some bleeding around the 1st right?

1.97 Client Hm, hm.
1.98 Counselor What I am going to do is go back to the 15th of May, um, Now obviously the only way that we could tell for sure was by doing an ultrasound but I want to do is give you the longest case scenario, okay?

1.99 Client Hm, hm
1.100 Counselor By that 
1.101 Client I did have an ultrasound because I had to be hospitalized because I was having pain. But they didn’t say how far along I was.
1.102 Counselor They didn’t? Do you know where that was?
1.103 Client At Teaching Hospital.
1.104 Counselor At Teaching Hospital. You may want to call them and what you need to do is find out the date the ultrasound was done and how far along it showed at that time and then we will have a better picture. By dates you are just over 11 weeks pregnant. Now by pregnancy we go back to the first day without a period. Um, what that means is that um, you are getting close to the end of the first trimester. Okay? The first 12 weeks are the first trimester. We do abortions here up to 12 weeks, here at [Midtown]. There are other providers in town that go over 12 weeks, some that go up to 19 weeks. Um, but depending upon your feelings and -- do you have any sense of the time that you have given yourself to make this decision?

1.105 Client Hm, how long have I been thinking about that?
1.106 Counselor Well have you given yourself like a date when you would want to have a decision made?
1.107 Client After today, that was my date. After today, I was going to hopefully get everything sorted out so I could reach some sort of decision that I could live with.
1.108 Counselor Okay. Okay. Um, let me propose this because I am going to give you a lot of information today. Why don’t you give yourself, let’s just say, today is Monday. If you wanted to give yourself, if you really wanted to stick to today and say like tonight at midnight I want to have this decision made. Obviously you are still going to be you, you are still going to have these same emotions, you’re gonna still be asking yourself the same questions. What you may want to do because of your time limit, um, you can go over the 12 week mark. Ideally, if you wanted to stay here the procedure, the procedures are easier if they are done before about 13 weeks. Okay? Um, so say if you wanted to give yourself till tomorrow afternoon.

1.109 Client Okay.
1.110 Counselor But be realistic with yourself on the decision. Okay? Um, what the procedure involves basically what you went through with your sister. If you came here we would see you one day and you would have an ultrasound done, another vaginal ultrasound done. Um, we would probably do that first because if you are over 12 weeks we would refer you off to another physician. You would have the blood work done, you would sign some consents and you would then be scheduled for the procedure, which would be the next day. You would also have something called a laminaria inserted into your cervix. Do you remember that at all?
Counselors also routinely invite their clients to talk about the history and likely future of their relationships with their partners and relatives. Brenda and her counselor open this topic with the following exchange:

1.21 Counselor Okay. And Tell me where, who you have talked to and what the conversations have been like.
1.22 Client Well, I talked to my boyfriend, of course. I have talked to a couple of my friends. Oh my boyfriend is like, you know he is like a very important part for the -- like he’s going to help me, I don’t know -- he’s not very “there.” He’s like it’s your decision, but then again I don’t want you to have it. You know what I mean -- he’s kind of like contradicting himself?

And when, playing the part of co-narrator, the counselor asks Brenda to tell about the part of her that doesn’t want to have an abortion, Brenda talks about accompanying her sister during abortion procedures.

1.25 Counselor Tell me why, Tell me about that part of you that really doesn’t want to have an abortion, what is it that, that makes you feel that way?
1.26 Client I’m Pro-choice but I always -- like I believe it’s the woman’s right to decide but for me I’ve always kind of been just for my personal, I guess, morals. I never wanted to have an abortion like my sister. (Inaudible) But she’s had, she has three kids and she’s had a lot of abortions, a lot. And I’ve been there a couple of times when she was having an abortion and I just never wanted to be like that. I mean I don’t want to go through that. And I don’t think it’s the child’s fault that I’m not responsible. You know what I mean? I mean it’s somebody’s right to decide but I just think it’s wrong, well for me personally.

Making a long story short, the counselor offers an evaluation of Brenda’s narrative when she images a possible future in which Brenda has had an abortion and asks what steps Brenda would take to avoid ending up like her sister.

1.38 Counselor So it sounds like you’ve seen a lot of this go on within your family, within friends and you know you have seen both sides. Uh -- what do you think because you say right now that you’re not really, you don’t know if you’re comfortable having an abortion or not and your main concern is that you don’t want to end up like your sister.
1.39 Client Hm, hm.
1.40 Counselor Um, I want to talk about two different scenarios. First let’s talk about -- um, because everything that you have said so far with the exception of some emotions about this decision lead, you know like the ethical side of you from what I’m hearing is saying “okay, abortion is definitely an option.”
1.41 Client Hm, hm
1.42 Counselor So, let’s talk about how you see yourself preventing, um, becoming your sister or a person like your sister if you have an abortion.
1.43 Client Hm, hm
1.44 Counselor How would you separate yourself and make this your own experience if you were to continue, if you were to have an abortion?

Giving Brenda a series of pamphlets on pregnancy, abortion, and parenting, the counselor asks her to think about how her life would be, financially, socially, and emotionally, 1 year and 5 years from now if she had the baby or terminated the pregnancy.
What I’m going to do, Brenda, is give you a bunch of information to read through, okay? And then I want you to take it home, look through it, think about the things that we’ve talked about today, especially where you see yourself in those three categories, financially, socially and emotionally. A year from now and five years from now. Whether you continue the pregnancy to parenting or whether you choose to terminate it. Um, and I also want you to think about resolution of feelings if you do choose to have an abortion.

And more concretely,

You’re in school right now. You’re at [Community College] and you are working. Think about how that would change, I mean right now without being pregnant where do you see yourself in five years. What do you see yourself doing?

Moving to North Carolina. Oh, I love North Carolina. Do you seeing that changing with a child?

Well, my mother’s side of the family is down there and they would probably say in five years if I want to move down there cause I’d probably go to school right up to the time I was going to have it but that the cost. I’m working but I’m not making $30,000 a year. I can barely support myself how am I going to support a child.

The schematic or conventional character of the contemporary temporal frame of counseling manifests itself in several ways. In talk about pregnancy diagnosis and resolution, the seven-day weeks of the Judeo-Christian calendar are the critical units. The succession of weeks qualifies a woman’s pregnancy. The work of the clinical staff who provide abortions is organized around the days of the week. Outline calendars and commercial pregnancy date calculators are placed prominently throughout the counselor department to help counselors locate clients in the temporal space of medicalized pregnancy and legalized abortion. The considerations that might enter into a “decision,” support from partners and relatives, plans for schooling and work, feelings of grief and their resolution, are imagined as working themselves out in terms of calendrical years.

The Times of Women’s Rights: The Mythic and Historical Frames in Counseling

Clients and counselors thus more or less continuously indicate that they are co-engaged in a focused interaction. While they are so engaged, one of the things they do is co-narrate past events in the clients’ lives and future eventualities to which they might lead. As trained professionals, family planning counselors also deploy specialist knowledge concerning what is taken to be enduring human nature and social organization: personality, gender, and relationships plus legal and medical standards governing reproductive health services.

Co-engagement in focused interaction is framed by local, emerging time. Talk about past events and future eventualities in the life of a client is framed by contemporary, schematic time. Specialist knowledge of human nature and social organization is framed by mythic and historical time.
One of the ways in which counselors move back and forth from the first two, relatively near temporal frames and the other, relatively remote temporal frames is by using different voices. Voice has to do with “the linguistic construction of social personae É Research on voicedirects attention to the diverse processes through which social identities are represented, performed, transformed, evaluated, and contested” (Keane 2000:271). In some settings, some persons are denied voice, but in most settings individuals routinely use a considerable array of voices (see, for example, Hill 1995).

In general, when they are speaking within the frames of local and contemporary time, counselors speak in a voice of empathy and understanding. In part, this is a matter of their tone of voice and body language. The voice of empathy and understanding also is a member of a dyad within which the client can “open up” and discuss her feelings. Counseling takes place privately, in a small room behind a closed door. The “we” in whose voice the counselor speaks in utterances such as the following is the counselor-client dyad, similarly closed to the surrounding world:

1.9 Counselor Well today we are just going to talk through what you have been thinking about.

1.62 Counselor Well what we’re concerned about is that it’s it’s great that you recognize that you’re Pro-Choice but that doesn’t mean that you would necessarily choose an abortion and that’s really important to recognize. And what we want to talk right here is just you. É

1.161 Counselor Then if you do decide to continue the pregnancy you can give me a call and we will talk about pre-natal care.

Within this private space, counselors use expressions such as “tell me about” and “let’s talk about” to voice the claim that their clients are to be the primary speakers while they are to be interested, attentive listeners. Conversely, expressions such as “I’m hearing” or “it sounds like” voice the claim that the counselor is an understanding, insightful listener who may now take a turn as speaker, “reflecting” on what her client has told her.¹⁶

When they draw on knowledge rooted in what I am calling the cosmological and historical temporal frames, counselors commonly speak in the didactic or preceptive voice of the teacher. In these phases of the session with Brenda, for example, the counselor steps outside of the counselor-client dyad. She uses an exclusive “we” that indexes her professional affiliation with Midtown Women’s Clinic and separates her from the client. In turn this exclusive “we” is matched with the third person personal pronoun, “they” and “women” to index Brenda’s membership in a class of persons for whom Midtown provides services.
1.52 Counselor So, you did mention birth control pills, um -- those are extremely effective and probably you would be, what we would call, a very affective user. Which means that you would be very conscientious about taking the pill. If that’s the method you decide you want to use. And we like to encourage women, whether they continue their pregnancy or whether they decide to terminate the pregnancy to really consider birth control especially if they are coming in and protecting themselves like you. 

Another feature of the didactic teacher’s voice in which counselors convey their professional knowledge is relatively formal spoken language, i.e. language with relatively little anaphora and relatively few deictic pronouns (see Cicourel 1985, 1986). For example, Brenda’s counselor describes laminaria and their use in the following terms:

1.112 Counselor This is the laminaria -- it’s a piece of seaweed, okay? It’s actually sterilized. This isn’t obviously. Um, and what happens is that this is inserted into the cervix. Okay? ????? inside your vagina, the vagina, your cervix. It’s inserted into this area right here. Okay? What happens is that it acts like a sponge and absorbs moisture and so it helps to open or dilate the cervix. This stays in overnight. It makes it more comfortable for you, its makes it easier on the doctor and also helps eliminate any um, undue risks. Otherwise, what we would be doing is we would dilating you all the day of the procedure. The quicker that we dilate the cervix, the more chance you have something happening. Okay? There are different physicians who will do that if they feel the risk is higher -- over 16 weeks or over 14 weeks. But here we feel that over 9 weeks that’s the point where we would like to dilate (interviewer just fades out here). So the next day you would come back in and have the actual procedure done. Now you have a good sense of how long the procedure lasts. It’s not a very long procedure.

At least two things place statements of this sort within the remote mythic and historical frames. On the one hand, the characteristics and use of laminaria and the protocols of different physicians enter into but have their origins outside the local, emerging time in which the counseling interaction takes place and the life course of the client. On the other hand, and especially in contrast to the statements in which clients and counselors describe what they think they know about the client’s circumstances, the relatively unqualified statements in which counselors convey their professional knowledge push the things that they know to the margins of the horizon within which facts and protocols are debated and contested toward the frames within which they may be treated as part of the settled conditions of our existence. I call this frame mythic if it pertains to scientific “truths” and historical if it pertains to the policies and protocols of one or another component of the reproductive health care system.

Though rooted in a remote temporal frame, professional knowledge, policies and protocols are, of course, subject to change. The effects of one particular change reverberate through counseling discourse at Midtown Women’s Clinic.
There have been two distinct periods in the history of Midtown’s counseling service. The first began with the creation of the Counseling Department early in the 1970s. According to a former member of the Department, a group of friends came together under the auspices of a local hospital administrator “to form a group that would help doctors address the needs and issues of patients with pregnancy concerns” following liberalization of New York’s abortion law. The group developed a training program and started the Family Planning and Pregnancy Information Group with offices in a building just outside the downtown area where volunteers “talked with women and couples to let them know what their available options were based on their particular situations.” When the group’s grant ran out they were invited to join the Midtown Women’s Clinic and formed the nucleus of the current Counseling Department. The second and current period began in 1995 when, in the absence of an abortion provider who would accept women on Medicaid, Midtown started its own abortion service.

Contemporary counseling has a prospective orientation. When I started working in the Counseling Department it was commonplace to hear a counselor responding to a telephone call say something like the following: “What most women do is set up an appointment for a pregnancy test and see a counselor to talk about your decision.” Following the exchange with Wendy that I quoted above, the counselor says:

2.37 Counselor All right. What I need to do Wendy is get some É just go over this information sheet that you filled out already and then we will talk a little bit about your decision and then the next step will be the sizing. Okay? All righty, do you have any allergies to any kinds of drugs or medications?

Similarly, Brenda starts off by stating that her aim is to come to a decision, “to make up [her] own mind.” Such counseling is concerned with what the client will do next in a situation that must be resolved within a few weeks. It wants to know whether or not the client will want to use the abortion services of Midtown or if the client should be referred to another abortion provider or to a prenatal service. It does look backward, but is primarily interested in past events as they enter into future decisions.

Prior to the introduction of the abortion service, counseling at Midtown Women’s Clinic appeared to have a retrospective orientation. I have no transcripts from the period prior to the introduction of the abortion service, but a counseling manual, written in 1981 by the then director of the Counseling Department, provides an indication of how counseling was conceived. On the first page the manual asks the reader, a counselor in training, to imagine the following scene:
Debby, 19, sits in your office, nervously waiting for the results of her pregnancy test. She’s been having sex with her boyfriend for over two years and she’s never used birth control. She looks familiar to you and you realize you’ve talked with her before; she was here six months ago, pregnant.

You get her previous form and the memory comes back. She was the first client you talked to when you got the job as a pregnancy counselor. You discussed the options with her, talked about birth control, and thought you’d done a pretty good job. But here she is again! So you ask yourself:

WHY DIDN’T SHE USE BIRTH CONTROL?

The manual explains that Debby’s counselor made a mistake the first time she met with her. She focused technical information about contraception and the future options Debby faced and failed to adequately address the tangle of feelings and thoughts that brought her to the clinic in the first place. When Debby is helped to “recognize, accept and work through” her feelings, she probably will “resolve her present situation effectively and be able to prevent similar occurrences. Clients who are counseled in this manner are likely to have little difficulty deciding deciding what to do about the situation that led them to ‘risk pregnancy.’” After Debby and her counselor have talked for an hour about her relationship with her boyfriend, she is imagined assaying

‘You know, this ISN’T all my problem. He thinks I should do all the work and he can just sit and watch TV. Well, I’m sick of it. We’re going to talk things over. Maybe my parents were right, maybe he isn’t any good for me. We’re going to talk about it and change some things.’ She smiles and says, ‘Thanks, I feel a lot better. Can I call you later to let you know what I’m going to do?’

The Uses of Anthropology

A counselor, like a therapist, “is a teacher who provides new information in an interpersonal context that enables the [client] to profit from it” (Frank and Frank 1991:45). Sodefined, counseling is widely regarded as a critical component of effective family planning and reproductive health services, but little is known about how it actually works. Remarkably, though it is understood that power differences (Schuler et al. 1985) and cultural expectations (Nathanson and Becker 1985) routinely deform the ideal counseling relationship, there are almost no observational studies of counseling. None of the research on client/provider interactions in family planning agencies reviewed by Simmons and Elias (1994) involves direct observation of client/provider conversations. Only recently have population scientists at the Johns Hopkins Center for Communications Programs carried out observational studies of family planning counseling in Kenya in which close attention is paid to the details of the participants’ talk (Kim et al. 1998). However, the value of this tantalizingly interesting work is undercut by its dependence on English translations.

The work on which I report here is thus among the first extended ethnographic studies of family planning and reproductive health counseling. The interpretation I have offered begins to suggest some of the ways in which
“crisis pregnancy” counseling in the United States might work. In the prescriptive literature on family planning services, the information-giving and interpersonal or affective dimensions of counseling are regarded as distinct (e.g. Bruce 1990:74ff). Against views of this kind, Hanks argues that to speak is never merely to convey information in an objective, value-neutral manner, but is always to “take up a position in a social field in which all positions are moving and defined relative to one another” (1996b:201). As they exchange information, counselor and client also move about in relation to each other and to the wider social world. In the Midtown counseling sessions described and analyzed here, clients and their counselors produce and embed themselves with a local, emerging time that frames their co-engagement in focused interaction. For many clients this is a liminal moment, a time outside of everyday time when the client is “in crisis” and her life is on hold. The discourse of counseling is also framed by the schematic, contemporary time in terms of which the participants discuss aspects of the client’s life course: the sequence of events that has led up to the present situation and the subsequent decisions that will produce an acceptable future. The professional knowledge of the counselor and the protocols of reproductive health care agencies are rooted in more remote mythic and historical temporal frames that are treated as if they were immune to change. These are among the rhetorics of counseling that, in this sociocultural setting, create an effective interpersonal context and construct the client as a competent agent with a manageable future.

The interpretation also begins to suggest some of the ways in which counseling might vary from one sociocultural setting to another. In the policy-related literature on family planning and reproductive health services, counseling commonly is treated as if it is or ought to be more or less the same throughout the world. Counseling may be offered by a variety of service providers, “doctors, nurses, midwives, community-based health workers, and trained retailers selling contraceptives” as well as counselors. However, the counseling role of all of these service providers consists of the “face-to-face communication” that helps clients make free and informed choices about family planning and to act on those choices (Gallen and Lettenmaier 1987:2). Service providers who use counseling skills appropriately are thought to be able to adopt the “user” or “client perspective,” “finding out about and respecting clients’ values, attitudes, needs, and preferences.” Clients as well as providers should participate actively, “exchanging information and discussing the client’s feelings and attitudes about family planning and about specific contraceptive methods” (Gallen and Lettenmaier 1987:3, 15; see also Bruce 1987, 1990). It is in this context that the “mystery client” studies of Huntington et al. (1990), Huntington and Schuler (1993), and Le—n et
al. (1994), situation analyses (Miller et al. 1997), and the Kenya Provider and Client Information, Education and Communication Project (Kim et al. 1998) all seek to measure the degree to which the prescriptive GATHER guidelines of Gallen and Lettenmaier (1987) are carried out in practice rather than describe and analyze particular counseling practices in their own situated terms.

Against approaches of this sort, anthropology routinely, and inconveniently, seeks to make the strange familiar and the familiar strange. Here I emphasize the latter. That is to say, I have been concerned to identify some of the cultural and social specificity of pregnancy test counseling at Midtown Women’s Clinic in the late 1990s. Symbolic processes of temporalization introduce another dimension of variation in counseling practices, one that cannot be eliminated by diffusing correct technical knowledge or prescribing American ideas of politeness. It seems likely that all counseling practices are framed by conceptions of local, emerging time; schematic, contemporary time, and mythic and historical time. Nevertheless, the specific forms taken by these temporal frames very likely will vary from one culture to another. The impact at Midtown Women’s Clinic of ideas about the purposes and techniques of therapy and the introduction of an abortion service suggests that local processes of temporalization also will be responsive to variations in healing practices and the design of reproductive health care services.
Footnotes

1 “Midtown Women’s Clinic” is a pseudonym.

2 “Shadowing” consists of following someone around as they go through their work routines. It appears to be a common form of training in social service agencies.

3 Readers will note that I am a male working in an almost exclusively female setting. Some might think that this research is vitiated by something like the Hawthorne effect in which the activities observed are modified by obtrusive observation. Against this, I would offer what Duneier (1999:338, 340) calls “the Becker Principle,” after the sociologist Howard Becker. The Becker Principle holds that “most social processes are so organized that the presence of a tape recorder (or white male) is not as influential as all the other pressures, obligations and possible sanctions in the setting.”

4 An undecided client is by no means unique, but it is something that counselors comment upon. The outcome of a pregnancy test counseling session involving a positive test result should be a decision: to abort or continue the pregnancy. A “decision” routinely is named as the topic of counseling and counselors may express some frustration if a decision is not forthcoming. Late in a long day, for example, one counselor told me “I shouldn’t be given any more counseling patients.” When I asked why, she said “I’m intolerant of indecisive people.” She had a 25 year-old client who could not make up her mind even though she had two children and had gone through this before. She was dealing with the problem of having just moved in with a man who did not want her to have a child and she was “right on the line and wouldn’t move off.”

5 Midtown also is required by Federal law to inform clients who receive positive pregnancy tests of the steps they can take to deal with the pregnancy. This is called options counseling. Options counseling sessions generally are brief. They usually are provided by counselors per se but maybe provided by nurses and other clinical personnel.

6 A sizing is a clinical examination, usually with ultrasound, to determine the size of a fetus and thus the date of a pregnancy.

7 See also Levinson (1992:69) on “activity types.”

8 This is not a novel proposal. As Turner (1974:23-24) notes, “the idea that human social life is the producer and product of time, which becomes its measure [is] an ancient idea that has had resonances in the very different work of Karl Marx, Emile Durkheim, and Henri Bergson.”

9 A frame is “a definition of what is going on in interaction, without which no utterance (or movement or gesture) could be reinterpreted” (Tannen and Wallat 1993:59-60).

10 On the use of speech particles to display interest in what is being said see Schegloff (1982). Levinson (1983:365) notes that in English ‘uh’ functions as a floor-holder while ‘hm’ functions as a floor-returner.

11 On liminality in rites of passage and other rituals see van Gennep (1960) and Turner (1967). Turner argues that rites of passage “are found in all societies but tend to reach their maximal expression in small-scale, relatively stable andycyclic societies” (1967:93). Large-scale, industrial societies lack elaborate rites of passage but have equivalent “liminoid” É forms of symbolic action É in which all previous standards and models are subjected to criticism, and fresh new ways of describing and interpreting sociocultural experience are formulated, [especially] the modern arts and sciences” (Turner 1974:1516). However, I speak of “crisis” pregnancy counseling sessions as liminal rather than liminoid because they appear to meet the criteria for liminal moments per se.

12 Laminaria are made of seaweed that has been sterilized, dried, and compressed. Inserted into the cervix, they absorb moisture and expand to roughly twice their original width. This dilates or opens the cervix so that subsequent steps in the abortion procedure can be carried out.
A medical abortion is brought about through the administration of two drugs--methotrexate and mifepristone--up to 49 days after the last menstrual period begins.

Counselors also were aware of personal idiosyncrasies: how various abortion providers dealt with patients who had drug habits, for example, or the pregnancy durations with which they were most comfortable.


A manual written by the then-Director of the Midtown Counseling Department instructs counselors to use interview techniques that “reflect back to [the client] what we understand about her feelings.” The aim of this process is to help the client to recognize her feelings. Reflection “allows [the client] to accept or reject our reflection or to elaborate on it, and as a result to move further into the exploration of her feelings. We act as a mirror, reflecting to her what we see and hear.”

On the forms of scientific statements and the movement of statements from one type to another see Latour and Woolgar (1986:151-186).

In my use of ‘mythic,’ I follow Frank and Frank (1991:43): “We have chose the term ‘myth’ to characterize theories of psychotherapy because such theories resemble myths in at least two ways: (1) they are imagination-catching formulations of recurrent and important human experiences; and (2) they cannot be proved empirically.”

For other non-observational studies of client/provider interactions see Phillips et al. (1993) and Arends-Kuenning (1997a and 1997b). See also Ball’s (1967) brief ethnography of an illegal abortion clinic in southern California, Candlin and Lucas’ (1986) study of family planning counseling sessions at a church-based clinic in Honolulu, Owen’s (1988) study of discursive practices at the Emma Goldman Clinic for Women in Iowa City, Iowa, Kinnell and Maynard (1996) work on HIV pretest counseling sessions in a clinic in a large midwestern American city, and Maternowksa’s (2000) brief report on her ethnography study of a Haitian family planning clinic. Joffe (1986) studied family planning workers in a major clinic in a large east coast city, but did not directly observe any aspect of counseling. Rapp (1999) observed genetic counseling sessions, but uses a different set of analytical tools to answer a different set of questions.

See also Carter (2000).

This perspective underlies the use of anthropology to explain why something from one culture is rejected or redefined by another or how it can be made more acceptable to another. A classic example in demographic anthropology is the meanings of contraceptives. The topic extends from the early work of Polgar (1969) and Polgar and Hatcher (1970) to the recent work of Bledsoe (Bledsoe et al., 1994, Bledsoe, Banja and Hill 1998).
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