TIME AND TEMPORALIZATION IN PREGNANCY TEST COUNSELING

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Paper prepared for discussion at the XXIV IUSSP General Conference,Salvador, Brazil, 18-24 August 2001.

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Late one summer afternoon at Midtown Women's Clinic,[1] a large, inner-city family planning clinic in western New York, a womanand her counselor began a pregnancy test counseling session with thefollowing 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 tocome in.
1.4	Client	Well Ireally already know I'm pregnant. I don't really know what Iwant to do. It's like I'm between two decisions -- Idon't know if I want to have an abortion or if I want to keep it.
1.5	Counselor	Okay.
1.6	Client	Andit's like, you know a couple of my friends, well my sister'shad an abortion before and a couple of my friends have had kids and theyare like just go to [the Midtown Women's Clinic] and then make up your own mind.
1.7	Counselor	Yeah.
1.8	Client	It'slike most of my friends, you know, they're like "oh haveit." It's like well you guys aren't going to be there, you know, all the time to help me with everything andit's not just an easy decision. (nervous chuckle)
1.9	Counselor	Welltoday we are just going to talk through what you have been thinkingabout.
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 oftemporalization in such talk. It is based on four months of intensive participant observation in thecounseling department of a large urban clinic operated by a not-for-profitfamily planning agency in upstate New York. To begin with I "shadowed" counselors,[2] listening to telephone calls, observing counseling sessions, attendingCounseling Department meetings, and collecting data from patient records.Toward the end of this round of research, when the counselors and I werecomfortable with the project, we audio recorded and transcribed four counseling sessions, two of which I alsoobserved.[3]

Here I focus on the counseling session from which I quote above, drawing ontranscripts of other sessions for purposes of comparison. The client, whoI call Brenda, was an 18 year old, unmarried white woman who attendedcommunity college and worked as a clerk at a local department store. She already had seen her privatephysician for a pregnancy test and knew that she was pregnant, but had beenunable to decide what to do. Though Pro-Choice, she had seen her sister go through several abortions and felt thatabortion would be wrong for her personally. On the other hand, she did notfeel ready to be a parent and doubted that her boyfriend would be verysupportive of a child. She had come for counseling at Midtown to help her make up her mind. The counselor alsois white and quite young, only a few years older than her client, but shehad worked full-time at Midtown for

over a year and before that worked at aPlanned Parenthood affiliate in the southwestern United States. As far as I can tell, this session wasnotable 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 familyplanning clinics in the United States, pregnancy test counseling is a formof psychotherapy.[5] A manual writtenin 1981 by the then Director of the Counseling Department defines it as"a process that helps the client to: 1. Work through herfeelings in order to-- 2. Clarify her thoughts, so she is better able to-- 3. Developconstructive courses of action." In words that are frequentlyechoed by the women with whom I worked, Baker (1985:2) speaks of counselingas "crisis intervention." Stressing "the communication of feelings andcognitive reorganization," it is what Frank and Frank (1991:35)call an interview therapy. At Midtown and, I believe, elsewhere in theUnited States, it is based on the"client-centered" therapies and theories of "self-actualization" associated with Carl Rogers (see, forexample, Rogers 1961). Within this broad class, it is what Beresford(1977) calls "short term relationship counseling." Counselors rarely meet withclients more than once and sessions are relatively brief.

Counseling also is a form of gatekeeping. Clients must pass through thecounseling encounter to get access to contraceptive, prenatal or abortionservices at Midtown and other reproductive health care providers. As agatekeeping encounter, counseling should take place prior to other services, though how this works out in practice canget a bit complicated. At Midtown, the clinical staff, especially, insiston this, sometimes denying services to clients who have not made finishedcounseling and made a decision. On one occasion, a counselor tried to get an immediate sizing[6] for a patient who was uncertain of thedate 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, inpart, on how far along she was in her pregnancy. However, the clinic staffrefused, 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, cliniciansbegan abortion work-ups before there had been any counseling. In onecounselor's view, some clinicians seemed to think women could "justdecide." Her own view, on the contrary, was that abortion was adifficult "emotional issue" and that many clients had a terrible time coming up with the money andother requirements.

Both the psychotherapeutic and the gatekeeping functions of pregnancy testcounseling are accomplished through what Goffman called focusedinteraction: "the kind of interaction that occurs when persons gather close together andopenly cooperate to sustain a single focus of attention, typically bytaking turns at talk" (1963:24). Unlike casual talk among friends or colleagues, however,counseling talk is power laden. Pregnancy test counseling sessions areexamples 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] pursuevarious practical goals and the central medium through which the dailyactivities of [counselors] are conducted" (Drew and Heritage1992:3).[7] Though counseling is far more informal and co-operative than a policeinterrogation or a courtroom cross-examination it falls short, sometimeswell short, of Grice's (1975) preconditions for fully co-operativeexchanges. The "issues" discussed in counseling are highly personal and may be stigmatizing and embarrassing. Thegoals of clients and counselors may overlap, but are unlikely to co-incideperfectly. The power that pervades counseling derives from the fact thatit 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 amongnonspecialists" and that"incorporate role possibilities marked by vast asymmetries inknowledge, responsibility, rights of inquiry, and the consequences ofcategorization" (Hanks 1996a:171).

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

Women that do receive pregnancy test counseling, do so at particular timesin their life course. Somewhat more than 60% of the clients receivingservices at Midtown in 1998 were 20-29 years of age. If these womenresemble women in national studies, morethan half have had no live births (Mosher 1994).

On a smaller temporal scale, women participate inpregnancy test counseling occurs at different points in the flows ofconduct (see Giddens 1979) that occur between first intercourse and a pregnancy or between one pregnancy andanother. Again, judging by national studies (Mosher and Horn 1988 andFiner and Zabin 1998), three quarters or more have already begun havingintercourse. 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 informationgathering 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 thanmaximization are the main concerns in decisions of this kind and that theeffort devoted to the acquisition of information therefore may be safelyreduced.

This paper is not concerned with the fact that pregnancytest counseling sessions are brief nor with the timing of counseling in thelife 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 asymbolic process continually being produced in everyday practices. Peopleare '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 ofattention or only tacitly known. Either way, these dimensions are lived or apprehended concretely via thevarious meaningful connectivities among persons, objects, and spacecontinually being made in and through the everyday world. (Munn1992:116)[8]

Pregnancy test counseling sessions are among the projects thatmake the time they are in. This paper focuses on the forms of that timeand 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, shamanicperformances involve the interaction of several distinct temporal frames orhorizons.[9] The participants in a shamanic performance are co-engaged and their"fleeting interactions É emerge from one moment to thenext" within a "proximal" frame of "local, emerging time" (Hanks 2000:223-4, 234). The performance also produces and takes placewithin a frame of "midrange schematic time" thatpertains to the contemporary, but not immediately present lives of the participants. This temporal field includes theclient's

> prior familiarity and patterns of shaman-patient interaction, [and] anyprior treatment for a current condition, including diagnostic rituals whosepurpose was to identify the condition and prescribe treatment. It alsoincludes the history of encounters and memories binding a ritual specialist to his familiar spirits and tothose humans from whom he has learned. É All this knowledge and priorexperience ispart of the actuality of performance, but it is present

aspast. É 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 actualones of the local frame. A blessing performed on one day is often part ofa series in which it is prospectively oriented toward subsequent reenactments, and ultimately toward acure. This prospect is inscribed in the performance itself. (Hanks2000:225)

Finally, "factors such as the cosmological frameworkwithin which spirits have certain axiomatic characteristics inherent intheir identity" pertain to a remote "memorialtime" that is "neither copresent nor contemporary." In this temporal frame, theshaman and his patient engage "only as human beings withdifferent kinds of roles in the world, not as actual individuals withspecific identities" (2000:225-6).

The Time of Co-engagement: The Proximal Temporal Frame inCounseling

As in the Maya shamanic performances studied by Hanks, the co-engagement ofparticipants in a pregnancy text counseling session and the orderlysuccession of their improvised turns of talk from one moment to the nexttakes place within a "proximal" frame of "local, emerging time" (Hanks 2000:223-4, 234). This frame is continuously invoked, (re)producedand modified in part by conventional expressions that describe what theparticipants are doing and index their involvement in the ongoinginteraction. Consistent with the character of counseling as expert practice, primary controlover these frames is allocated to counselors.

Especially notable among the conventional expressions used by counselors tofocus interaction within a frame of local, emerging time are verbs thatrefer to talking and listening. The counseling session transcript on whichI focus here, opens with the request to "[t]ell me a little bit about why you decided to comein" (turn 3) and the statement that "Well today we arejust going to talk through what you have been thinking about" (turn 9). It continues with numerous occurrences of "tell meabout," "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, and127). Conversely the counselor routinely responds that the client hasbeen "tell[ing]" her something (turn 88), that she is"hearing" the client say something (turns 40, 74), that "it soundslike" one thing or another is going on in the client'slife (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 multipleinstances of the verbs "to talk," "totell," "to hear" and "tosound" to negotiate changes in topic as she explores the events that have broughtthe 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, inturn 19, the results of the additional test the counselor routinelyran:

1.13	Counselor	**Tell me** a little bit about -- First of all how did you find out thatyou were pregnant?
1.19	Counselor	Okay.Well, hum É., **let's talk about** the tests that I ran todaywas 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 knownfor about, probably about a couple of weeks.

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

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

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Insert Figure 1 here

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Turning to future options, in turn 25, the counselormoves the conversation to the client's feeling that an abortion isnot for her.

1.25	Counselor	**Tell me** why, **tell me** about that part of you that reallydoesn't want to have an abortion. What is it that, that makes youfeel that way?

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

1.40	Counselor	Um, **I want to talk about** two different scenarios. First **let's talkabout** -- um, because everything that you have said so far with the exception ofsome emotions about this decision lead, you know like the logical side ofyou from what **I'm hearing** is saying "okay, abortionis definitely an option."
1.41	Client	Hm, hm
1.42	Counselor	So, **let's talk about** how you see yourself preventing, um, becoming yoursister or a person like your sister if you have an abortion.
1.52	Counselor	É **Let's talk about** the actual abortion. Okay? You saidyou'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 aboutthat experience.

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

1.62	Counselor	ÉUm, but, so with you thinking that this is something that's wrongfor you personally **let's talk about** the ..., **let'stalk about** continuing the pregnancy. Okay? First of all how would that change yourimmediate relationship with your partner?
1.72	Counselor	So **let's talk about** -- have youever thought about adoption?

Having established that the client is well and truelyundecided and offered her a framework with which to think further about herchoices, the counselor agains uses the verb “to talk,” in turn 96, to begin a discussion of the time limitations within which theclient 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 andanswer any other questions that you have -- about continuing your pregnancy-- where do you go? What kind of help do you need to get? Um, ifterminating the pregnancy -- what to expect? Your last period was the 15th of May, you saidyou had some bleeding around the 1st right?
1.97	Client	Hm, hm.

The client does not use the verbs “totalk,” “to tell,” “tohear” or “to sound.” Indeed, Brenda introduces only one topic shift of her own, asking thecounselor, toward the end of the session, in turn 144, if many other 18year olds come to Midtown Women’s Center “with the sameproblem.” However, throughout, the counseling session, as in all of her utterancesquoted above, she uses ‘hm,’ ‘okay’ and other speech particles to demonstrate continued engagement in theinteraction and to return the floor to the counselor.[10] And the counselor, for her part, does the same thing when the client hasthe floor.

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

2.17	Counselor	É Okay now we can get down to business. Um, Wendy, do you want to tellme why you thought you needed this appointment today for a pregnancytest?
2.18	Client	Because Iknow I am pregnant.
2.19	Counselor	You know you are? (Chuckle)
2.20	Client	I’ve already set up the whole nine yardsthing. (Chuckle)
2.21	Counselor	Okay. You’ve had a pregnancy testsomewhere else?
2.22	Client	Yeah.
2.23	Counselor	Allright. 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 fromOswego.
2.30	Client	Yeah. (Chuckle)
2.31	Counselor	Allright. 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)

2.33	Counselor	Okay. And um, it sounds as if this isn't a good time for you to be pregnant.
2.34	Client	No. (Chuckling)
2.35	Counselor	You say that very emphatically.
2.36	Client	Yeah.
2.37	Counselor	Allright. What I need to do Wendy is get someÉ just go over thisinformation sheet that you filled out already and then wewill talk a little bit about your decision and then the next step will bethe sizing. Okay? All righty, do youhave any allergies to any kinds of drugs or medications?

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

At the other extreme are clients whose lives are on holdwhile they struggle to make a difficult decision. For these women, thecounseling session is a transitional or liminal momentbetwixt and between recognized states of the life course.[11] As Brenda,the client in the first transcript put it, "Well I really alreadyknow I'm pregnant. I don't really know what I want to do. It'slike I'm between two decisions -- I don't know if I want tohave an abortion or if I want to keep it" (Turn 4). Counselorsappear to assume that this is the standard situation. In their view, they aredealing with "crisis" pregnancies and women who are"in crisis." Thus, they routinely mention that"talking about" the client's "decision" is the key function ofa counseling session.

In counseling sessions that have a liminal character,the local, emerging time of focused interaction is "'amoment in and out of time,' É a state to which the structuralview of time is not applicable" (Turner 1974:238). Counseling time, like the ritual time ofMaya shamanic performances is "characterized by certain forms ofreversal and transposition atypical of" other contexts (Hanks2000:224).

At Midtown Women's Clinic, counseling sessionsthat approach liminal moments do so in part through the use of what Varennecalls "secondary texts." Primary texts, Varenne suggests, do the work of everyday life. Secondarytexts

> are produced in settings where the work of everyday life isnot being performed, where this work is suspended, so to speak --interviews, therapy sessions, gossip sessions, scholarly papers. They areembodiments of the request "let's talk about this" or "what do you make ofthis." They are moments when people are "having atalk," "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 theextra 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 ContemporaryTemporal Frame of Counseling

Pregnancy test counseling session at MidtownWomen's Clinic are not confined within the proximal frame of local,emerging time. The "issues" with which counseling sessions are concerned are regarded as havinghistorical origins and future consequences. As clients and counselors talkabout 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 temporalframe is accomplished in large part through the use of narrative. Lookingbackward, narratives recapitulate and evaluate "past experience by matching a verbal sequence of clauses to the sequence ofevents which (it is inferred) actually occurred" (Labov1972:359-60). Looking forward, talk about the meaning of narrativessketches possible futures that might be brought about by actions taken now in response to pastevents.

For example, a third counseling session opens asfollows:

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 Imissed 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 boyfriendwe have been together for a long time, we plan on staying together, youknow
3.5	Counselor	Mm, mm,
3.6	Client	and t**hen we sat down and we talked and we decided** that we just want to grow upsome 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. Ihave 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 andeverything. I hope it's not too late for it.

Here the counselor's question (turn 3) provides whatLabov (1972:363) calls the abstract, i.e. an initial clause that "summariz[es] the whole story." "Well I missed myperiod 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, "identify[ing] É the time, place, persons, and their activity or the situation"(Labov 1972:364). The key narrative clauses, "whose orderis taken as the order of events" (Linde 1993:70), are marked byverbs (**in bold**) in the simple past tense: "I just kind of figured"and "we set down and we talked and we decided." Theclient's final words, "I have been putting this off ÉI hope it's not too late for it," provide an evaluation, stating the pointof the story, its implications for human conduct (Labov 1972:366).

Counselors commonly respond by claimingthe right to co-narrate their clients' stories. A co-constructed narrative is one in which the components of theverbal sequence are shared among two or more speakers. As Ochs observes,this happens especially when a co-narrator feels that information vital tounderstanding the problem that motivates the actions and reactions ofprotagonists and others in the storytelling situation is missing."Co-narrators [then] return, sometimes again and again, like LieutenantColumbo, to pieces of the narrative problem in an effort to find 'truth' through cross-examination of the details, sometimes struggling for anilluminating shift in perspective" (Ochs et al.1997:98).

This is precisely the role of counselors at MidtownWomen's Clinic. Counselors may analyze their clients' narratives, drawing out distinct themes in terms of which they might beunderstood, for example, the part of oneself that feels or thinks one thingor 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 "soundslike," counselors also participate in the evaluation of theirclients' narratives, stating or restating the morals of the stories or sketchingsome of their implications for future eventualities.

One key "issue" is thedate of the client's last period and the duration of her pregnancy.In the session with Brenda, the undecided client, this is the second topicof conversation:

1.13	Counselor	Tell me a little bit about -- First of all how did you find out that youwere pregnant?
1.14	Client	Well, okayin June I had like a slight period, but it wasn't normal, usually myperiods are very normal and they are very on time and this one came around the first of the month. I usually get mine in themiddle 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 JulyI was like "wow." It was around the 15th, I was like I need toget tested. So I went to my primary care doctor and I got a pregnancytest.
1.17	Counselor	Okay.Were you surprised when you found out the results?

The history of the client's pregnancy diagnosishas an enormous impact on the time frame within which she must make adecision, some of the parameters of that decision, and the kinds ofabortion services she may receive. At the time of my fieldwork, Midtown Women's Clinic performedabortions only through the 12th week of gestation. Theyprovided only two-day surgical abortions with laminaria[12] insertion on the first day and they did not offer anesthesia. Butthey did accept Medicaid. Other abortion providers in the city offeredslightly later surgigal abortions. Some offered anesthesia and, for women less than 11 weeks pregnant, aone-day procedure without laminaria. One offered medicalabortions.[13] But, I believe, none were willing to accept Medicaid. Women who

were more than 16 weeks pregnant had to go to Buffalo for anabortion or, if they were more than 19.6 weeks pregnant, to New YorkCity.[14]

Brenda is very close to the 12-week threshold for anabortion procedure at Midtown. After establishing that she is undecidedand recommending a way to think about her options, Brenda's counselor outlines some of the ways in which future eventualities aretime constrained.

1.96	Counselor	É What I do want to talk to you about right now is limitations that youhave. 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 doyou need to get? Um, if terminating the pregnancy -- what to expect? Your last periodwas the 15th of May, you said you had some bleeding around the 1stright?
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 theonly way that we could tell for sure was by doing an ultrasound but I wantto do is give you the longest case scenario, okay?
1.99	Client	Hm, hm
1.100	Counselor	By that
1.101	Client	I didhave an ultrasound because I had to be hospitalized because I was havingpain. But they didn't say how far along I was.
1.102	Counselor	Theydidn'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 isfind out the date the ultrasound was done and how far along it showed atthat time and then we will have a better picture. By dates you are justover 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 firsttrimester. Okay? The first 12 weeks are the first trimester. We doabortions 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 thisdecision?
1.105	Client	Hm, howlong have I been thinking about that?
1.106	Counselor	Wellhave you given yourself like a date when you would want to have a decisionmade?
1.107	Client	Aftertoday, that was my date. After today, I was going to hopefully geteverything sorted out so I could reach some sort of decision that I couldlive with.
1.108	Counselor	Okay.Okay. Um, let me propose this because I am going to give you a lot ofinformation today. Why don't you give yourself, let's just say, today is Monday. If you wanted to give yourself, if you reallywanted to stick to today and saylike tonight at midnight I want to have this decision made. Obviously youare 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, youcan go over the 12 week mark. Ideally, if you wanted to stay here theprocedure, the procedures are easier if they are done before about 13weeks. Okay? Um, so say if you wanted to give yourself till tomorrow afternoon.
1.109	Client	Okay.
1.110	Counselor	But berealistic with yourself on the decision. Okay? Um, what the procedureinvolves basically what you went through with your sister. If you camehere we would see you one day and you would have an ultrasound done, another vaginal ultrasounddone. Um, we would probably do that first because if you are over 12 weekswe would refer you off to another physician. You would have the blood workdone, you would sign some consents and you would then be scheduled for the procedure, which would be the nextday. You would also have something called a laminaria inserted into yourcervix. Do you remember that at all?

Counselors also routinely invite their clients to talkabout the history and likely future of their relationships with theirpartners and relatives. Brenda and her counselor open this topic with thefollowing exchange:

1.21	Counselor	Okay. And Tell me where, who you have talked to and what the conversationshave been like.
1.22	Client	Well, Italked to my boyfriend, of course. I have talked to a couple of myfriends. Oh my boyfriend is like, you know he is like a very importantpart 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 thenagain 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 asksBrenda to tell about the part of her that doesn't want to have anabortion, Brenda talks about accompanying her sister during abortionprocedures.

1.25	Counselor	Tell me why, Tell me about that part of you that really doesn't wantto 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'sthe woman's right to decide but for me I've always kind of been just for my personal, I guess, morals. I neverwanted to have an abortion like my sister. (Inaudible) But she'shad, 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 justnever wanted to be like that. I mean I don't want to go throughthat. And I don't think it's the child's fault thatI'm not responsible. You know what I mean? I mean it's somebody's right todecide but I just think it's wrong, well for me personally.

Making a long story short, the counseloroffers an evaluation of Brenda's narrative when she images a possible future in which Brenda has had anabortion and asks what steps Brenda would take to avoid ending up like hersister.

1.38	Counselor	So it sounds like you've seen a lot of this go onwithin your family, within friends and you know you have seen both sides.Uh -- what do you thinkbecause you say right now that you're not really, you don'tknow if you're comfortable having an abortion or not and your mainconcern is that you don't want to end up like your sister.
1.39	Client	Hm, hm.
1.40	Counselor	Um, Iwant to talk about two different scenarios. First let's talk about -- um, because everything that you have said so far with theexception of some emotions about this decision lead, you know like thelogical 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 yoursister or a person like your sister if you have an abortion.
1.43	Client	Hm, hm
1.44	Counselor	Howwould you separate yourself and makethis your own experience if you were tocontinue, 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 thepregnancy.

1.137	Counselor	É 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 aboutthe things that we've talked about today, especially where you seeyourself in those three categories, financially, socially and emotionally. A year fromnow and five years from now. Whether you continue the pregnancy toparenting or whether you choose to terminate it. Um, and I also want you to think about resolution offeelings if you do choose to have an abortion.

And more concretely,

1.151	Counselor	You're in school right now. You're at [Community College] and you are working. Think about how that wouldchange, I mean right now without being pregnant where do you see yourselfin five years. What do you see yourself doing?
1.152	Client	Moving toNorth Carolina.
1.153	Counselor	Movingto North Carolina. Oh, I love North Carolina. Do you seeing that changingwith a child?
1.154	Client	Well, mymother's side of the family is down there and they would probablysay 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 butthen the cost. I'm working but I'm not making $30,000 ayear. I can barely support myself how am I going to support a child.

The schematic or conventional character of thecontemporary temporal frame of counseling manifests itself in several ways.In talk about pregnancy diagnosis and resolution, the seven-day weeks of theJudeo-Christian calendar are the critical units.[15] The succession of weeks qualifies a woman's pregnancy. The workof the clinical staff who provide abortions is organized around the days ofthe week. Outline calendars and commercial pregnancy date calculators are placedprominently throughout the counselor department to help counselors locateclients in the temporal space of medicalized pregnancy and legalizedabortion. The considerations that might enter into a "decision," support frompartners and relatives, plans for schooling and work, feelings of grief andtheir resolution, are imagined as working themselves out in terms ofcalendrical years.

The Times of Women's Rights: The Mythic andHistorical Frames in Counseling

Clients and counselors thus more or lesscontinuously indicate that they are co-engaged in a focused interaction.While they are so engaged, one of the things they do is co-narrate pastevents in the clients' lives andfuture eventualities to which they might lead. As trained professionals,family planning counselors also deploy specialist knowledge concerning whatis 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 bylocal, emerging time. Talk about past events and future eventualities inthe life of a client is framed by contemporary, schematic time. Specialist knowledge of human nature and social organization isframed by mythic and historical time.

One of the ways in which counselors move backand forth from the first two, relatively near temporal frames and theother, 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 identitiesare represented, performed, transformed, evaluated, and contested" (Keane 2000:271). In some settings, some persons are denied voice, but inmost 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 andcontemporary time, counselors speak in a voice of empathy andunderstanding. In part, this is a matter of their tone of voice and bodylanguage. The voice of empathy and understanding also is a member of a dyad within which the client can "openup" 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 isthe counselor-client dyad, similarly closed to the surrounding world:

1.9	Counselor	Well today we are just going to talk through what you havebeen thinking about.
1.62	Counselor	Wellwhat we're concerned about is that it's it's greatthat you recognize that you're Pro-Choice but that doesn'tmean that you would necessarily chose an abortion and that's really important to recognize. Andwhat we want to talk right here is just you. É
1.161	Counselor	Thenif you do decide to continue the pregnancy you can give me a call and wewill talk about pre-natal care.

Within this private space, counselors useexpressions such as "tell me about" and "let's talk about" to voice the claim that their clients are to be the primary speakers whilethey are to be interested, attentive listeners. Conversely, expressionssuch as "I'm hearing" or "it soundslike" voice the claim that the counselor is an understanding, insightfullistener 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 cosmologicaland historical temporal frames, counselors commonly speak in the didacticor preceptive voice of the teacher. In these phases of the session withBrenda, for example, the counselor steps outside of the counselor-client dyad. She uses an exclusive"we" that indexes her professional affiliation withMidtown Women's Clinic and separates her from the client. In turn52 this exclusive "we" is matched with the third person personal pronoun,"they" and women" to index Brenda's membership ina class of personsfor whom Midtown provides services.

1.52 Counselor So, you did mention birth control pills, um -- those areextremely effective and probably you would be, what **we** would call, a very affective user. Which means that you would be veryconscientious about taking the pill. If that's the method youdecide you want to use. And **we** like to encourage **women**,whether **they** continue their pregnancy or whether **they** decide to terminate thepregnancy to really consider birth control especially if **they** arecoming in and protecting themselves like you. É

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

1.112 Counselor This is the laminaria -- it's a piece of seaweed, okay? It'sactually sterilized. This isn't obviously. Um, and what happens is that this is inserted into thecervix. Okay? ?????? inside your vagina, the vagina, your cervix.It's inserted into this area right here. Okay? What happens is that it acts likea sponge and absorbs moisture and so it helps to open or dilate the cervix. This stays in overnight. It makes it more comfortable foryou, 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 dayyou would come back in and have the actual procedure done. Now you have agood sense of how long the procedure lasts. It's not a very longprocedure.

At least two things place statements of this sort within the remote mythicand historical frames. On the one hand, the characteristics and use oflaminaria and the protocols of different physicians enter into but havetheir origins outside the local, emerging time in which the counseling interaction takes place and the lifecourse of the client. On the other hand, and especially in contrast to thestatements in which clients and counselors describe what they think theyknow about the client's circumstances, the relatively unqualified statements in which counselors convey their professional knowledgepush the things that they know to the margins of the horizon within whichfacts and protocols are debated and contested toward the frames withinwhich they may be treated as part of the settled conditions of our existence.[17] I call this frame mythic if it pertains to scientific"truths" and historical if it pertains to the policies and protocols of one oranother component of the reproductive health care system.[18]

Though rooted in a remote temporal frame,professional knowledge, policies and protocols are, of course, subject tochange. The effects of one particular change reverberate throughcounseling discourse at Midtown Women's Clinic.

There have been two distinct periods in the history ofMidtown's counseling service. The first began with the creation of the CounselingDepartment early in the 1970s. According to a former member of theDepartment, a group of friends came together under the auspices of a localhospital administrator "to form a group that would help doctors address the needs and issues ofpatients with pregnancy concerns" following liberalization of NewYork's abortion law. The group developed a training program and started theFamily Planning and Pregnancy Information Group with offices in a buildingjust outside the downtown area where volunteers "talked with women and couples to let them know what their available optionswere based on their particular situations." When thegroup's grant ran out they were invited to join the MidtownWomen's Clinic and formed the nucleus of the current Counseling Department. Thesecond and current period began in 1995 when, in the absence of an abortionprovider who would accept women on Medicaid, Midtown started its ownabortion service.

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

2.37	Counselor	All right. What I need to do Wendy is get someÉ just go over thisinformationsheet that you filled out already and then we will talk a little bit aboutyour decision and then the next step will be the sizing. Okay? All righty, do youhave any allergies to any kinds of drugs or medications?

Similarly, Brenda starts off by stating that her aim is tocome to a decision, "to make up [her] own mind." Such counseling is concerned with what the client will do next in asituation that must be resolved within a few weeks. It wants to knowwhether or not the client will want to use theabortion services of Midtown or if the client should be referred to anotherabortion provider or to a prenatal service. It does look backward, but isprimarily interested in past events as they enter into futuredecisions.

Prior to the introduction of the abortion service,counseling at Midtown Women's Clinic appeared to have a retrospective orientation. I have notranscripts from the period prior to the introduction of the abortionservice, but a counseling manual, written in 1981 by the then director of the Counseling Department, provides an indication of how counseling wasconceived. On the first page the manual asks the reader, a counselorin-training, to imagine the following scene:

Debby, 19, sits in your office, nervously waiting for theresults of her pregnancy test. She's been having sex with herboyfriend for over two years and she's never used birth control. She looks familiar to you and you realizeyou've talked with her before; she was here six months ago,pregnant.
You get her previous form and the memory comes back. She was thefirst client you talked to when you got the job as a pregnancy counselor.You discussed the options with her, talked about birth control, and thoughtyou'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 amistake the first time she met with her. She focused technical informationabout contraception and the future options Debby faced and failed toadequately address the tangle of feelings and thoughts that brought her to the clinic inthe first place. When Debby is helped to "recognize, accept andwork through" her feelings, she probably will "resolve her present situation effectively and be able to prevent similaroccurrences. Clients who are counseled in this manner are likely to havelittle difficulty deciding deciding what to do about the situation that ledthem to "risk pregnancy." After Debby and her counselor have talked foran hour about her relationship with her boyfriend, she is imagined assaying

'You know, this ISN'T all my problem. He thinksI 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 parentswere right, maybe he isn't any good for me. We're going to talk about it and changesome things.' She smiles and says, 'Thanks, I feel a lotbetter. Can I call you later to let you know what I'm going todo?'

The Uses of Anthropology

A counselor, like a therapist, "is a teacherwho 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 andreproductive health services, but little is known about how it actuallyworks. Remarkably, though it is understood that power differences (Schuleret al. 1985) and cultural expectations (Nathanson and Becker 1985) routinelydeform the ideal counseling relationship, there are almost no observationalstudies of counseling. None of the research on client/providerinteractions in family planning agencies reviewed by Simmons and Elias (1994) involves direct observation ofclient/provider conversations.Only recently have population scientists at the Johns Hopkins Center forCommunications Programs carried out observational studies of familyplanning counseling Kenya in which close attention is paid to the detailsof the participants' talk (Kim et al. 1998). However, the value of this tantalizinglyinteresting work is undercut by its dependence on Englishtranslations.[19]

The work on which I report here is thus among the firstextended ethnographic studies of family planning and reproductive healthcounseling.[20] The interpretation I have offered begins tosuggest some of the ways in which

"crisis pregnacy"counseling in the United States might work.In the prescriptive literature on family planning services, theinformation-giving and interpersonal or affective dimensions of counseling are regarded asdistinct (e.g. Bruce 1990:74ff). Against views of this kind, Hanks arguesthat to speak is never merely to convey information in an objective, valueneutral manner, but is always to"take up a position in a social field in which all positions aremoving and defined relative to one another" (1996b:201). As they exchange information, counselor and client also moveabout in relation to each other and to the wider social world. In theMidtown counseling sessions dsecribed and analyzed hereclients and their counselors produce and embed themselves with a local,emerging time that frames their co-engagement in focused interaction. Formany clients this is a liminal moment, a time outside of everyday time whenthe client is "in crisis" and her life is on hold. The discourse of counselingalso is framed by the schematic, contemporary time in terms of which theparticipants discuss aspects of the client's life course: the sequence of events that has led up to the present situation and thesubsequent decisions that will produce an acceptable future Theprofessional knowledge of the counselor and the protocolsof reproductive health care agencies are rooted in more remote mythic andhistorical temporal frames that are treated as if they were immune tochange. These are among the rhetorics of counseling that, in thissociocultural setting, create an effective interpersonal context and construct the client as acompetent agent with a manageable future.

The interpretation also begins to suggest some of theways in which counseling might vary from one sociocultural setting toanother. In the policy-related literature on family planning andreproductive health services, counseling commonly is treated as if it is or ought to be more or lessthe same throughout the world. Counseling may be offered by a variety ofservice providers, "doctors, nurses, midwives, community-based health workers, and trainedretailers selling contraceptives" as well as counselors.However, the counseling role of all of these service providers consists ofthe "face-to-face communication É that helps clients make free and informedchoices about family planning and to act on those choices" (Gallen and Lettenmaier 1987:2). Service providers who use counselingskills 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 aswell as providers should participate actively, "exchang[ing]information and discuss[ing] the client's feelings and attitudes about family planning and about specific contraceptivemethods" (Gallen and Lettenmaier 1987:3, 15; see also Bruce1987, 1990). It is in this context that the "mysteryclient" studies of Huntington et al. (1990), Huntington and Schuler (1993), and Le—n et

al.(1994), situation analyses (Miller et al. 1997), and the theKenya Provider and Client Information, Education and Communication Project(Kim et al. 1998) all seek to measure the degree to which the prescriptive GATHER guidelines ofGallen and Lettenmaier (1987) are carried out in practice rather thandescribe and analyze particular counseling practices in their own situatedterms.

Against approaches of this sort, anthropologyroutinely, and inconveniently, seeks to make the strange familiar and thefamiliar strange.[21] Here I emphasize the latter. Thatis to say, I have been concerned to identify some of the cultural andsocial specificity of pregnancy test counseling at Midtown Women'sClinic in the late 1990s.Symbolic processes of temporalization introduce another dimension ofvariation in counseling practices, one that cannot be eliminated bydiffusing correct technical knowledge or prescribing American ideas ofpoliteness. It seems likely that all counseling practices are framed by conceptions oflocal, emerging time; schematic, contemporary time, and mythic andhistorical time. Nevertheless, the specific forms taken by these temporalframes very likely will vary from one culture to another. The impact at Midtown Women'sClinic of ideas about the purposes and techniques of therapy and theintroduction of an abortion service suggests that local processes oftemporalization also willbe responsive to variations in healing practices and the design ofreproductive health care services.

Footnotes

[1] "Midtown Women'sClinic" is a pseudonym.

[2] "Shadowing" consists of following someone around as they go through their workroutines. It appears to be a common form of training in social serviceagencies.

[3] Readers will note that I am a male working in an almost exclusively femalesetting. Some might think that this research is vitiated by something likethe 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 thesociologist 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 somethingthat counselors comment upon. The outcome of a pregnancy test counselingsession involving a positive test result should be a decision: to abort orcontinue the pregnancy. A"decision" routinely is named as the topic ofcounseling and counselors may express some frustration if a decision is notforthcoming. Late in a long day, for example, one counselor told me"I shouldn't be given any more counseling patients." When I asked why, shesaid "I'm intolerant of indecisive people." Shehad 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 dealingwith the problem of having just moved in with a man who did not want her tohave a child and she was "right on the line and wouldn'tmove off."

[5]Midtown also is required by Federallaw to inform clients who receive positive pregnancy tests of the stepsthey can take to deal with the pregnancy. This is called optionscounseling. Options counseling sessions generally are brief. They usuallyare 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 alsoLevinson (1992:69) on "activity types."
[8] This is not a novel proposal. AsTurner (1974:23-24) notes, "the idea that human social life is the producer and product of time, which becomes itsmeasure [is] an ancient idea that has had resonances in the very differentwork of Karl Marx, Emile Durkhein, 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 beinterpreted" (Tannen and Wallat 1993:59-60).

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

[11]On liminality in rites of passage and other rituals see van Gennep (1960)and Turner (1967). Turnerargues that rites of passage "are found in all societies but tendto reach their maximal expression in small-scale, relatively stable andcyclical societies" (1967:93).Large-scale, industrial societies lack elaborate rites of passage but haveequivalent "'liminoid' É forms of symbolicaction É in which all previous standards and models are subjected tocriticism, and fresh new ways of describing and interpreting sociocultural experience areformulated, [especially] the modern arts and sciences" (Turner1974:1516). However, I speak of "crisis" pregnancycounseling sessionsas liminal rather than liminoid because they appears to meet the criteriafor liminal moments per se.

[12] Laminaria are made of seaweedthat 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 carriedout.

[13] A medical abortion is brought about through the administration of two drugs-- methotrexate and mifepristone -- up to 49 days after the last menstrualperiod begins.

[14] Counselors also were aware of personal idiosyncrasies: how various abortion providers dealt withpatients who had drug habits, for example, or the pregnancy durations withwhich they were most comfortable.

[15] SeeZerubavel (1985).

[16] A manual written by the then-Director of the MidtownCounseling Department instructs counselors to use interview techniques that"reflect back to [the client] what we understand about herfeelings." 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 onit, 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."

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

[18]In my use of 'mythic,' I follow Frank and Frank (1991:43): "We have chose theterm 'myth' to characterize theories of psychotherapy because such theories resemblemyths in at least two ways: (1) they are imagination-catching formulationsof recurrent and important human experiences; and (2) they cannot be provedempirically."

[19] For other non-observational studies of client/provider interactions seePhillips et al. (1993) and Arends-Kuenning (1997a and 1997b).See also Ball's (1967) brief ethnography of an illegal abortion clinic in southernCalifornia, Candlin and Lucas' (1986) study of family planningcounseling sessions at a church-based clinic in Honolulu, Owen's (1988) study of discursive practices at the Emma Goldman Clinic for Womenin Iowa City, Iowa, Kinnell and Maynard (1996) work on HIV pretestcounseling sessions in a clinic in a large midwestern American city, andMaternowksa's (2000) brief report on her ethnography study of a Haitian family planning clinic. Joffe (1986) studiedfamily planning workers in a major clinic in a large east coast city, butdid not directly observe any aspect of counseling. Rapp (1999) observedgenetic counseling sessions, but uses a different set of analytical tools to answer a different set ofquestions.

[20] See also Carter (2000).

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

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Figure 1: Topic Shifts in a Pregnancy Test CounselingSession

1 Introduction [Turns 1-12]

2 How Was the Pregnancy Diagnosed [Turns 13-21]

3 Discussing the Pregnancy with Others [Turns 21-24]

4 The Abortion Option [Turns 25-61]

- 4.1 Avoiding another Pregnancy/Abortion[Turns 40-52]
- 4.2 What Would an Abortion Be Like [Turns 52-61]

5 Continuing the Pregnancy [Turns 62-73]

- 5.1 Adoption [Turns 72-73]

6 Advice on How to Decide [Turns 74-96]

7 Time Frame for Decision [Turns 96-110]

8 Describing the Abortion Procedure [Turns 110-126]

- 8.1 A Week after the Abortion [Turns127-136]

9 Toward Closure [Turns 137-143]

- 9.1 “Do You Have aLot of 18 Year Olds Coming in with the Same Problem?” [Turns144-154]
- 9.2 Toward Closure [Turns 155-162]
- 9.3 Re Questions on the Pregnancy Test Visit Form [Turns 163-177]
- 9.4 Closure [Turns 177-181]