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Maternal Healthcare Experiences of African American Women in Milwaukee : A Relational Dialectics Perspective

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MATERNAL HEALTHCARE EXPERIENCES OF AFRICAN AMERICAN WOMEN IN MILWAUKEE:

A RELATIONAL DIALECTICS PERSPECTIVE

by

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ABSTRACT

MATERNAL HEALTHCARE EXPERIENCES OF AFRICAN AMERICAN WOMEN IN MILWAUKEE:
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Black women are experiencing pregnancy-related complications at a significantly higher rate than women of other races in the U.S., as Black women are three to four times likely to die from pregnancy-related complications compared to non-Hispanic White women (CDC, 2019a). I applied relational dialectics theory (Baxter, 2011), a critical communication theory, to examine dominant and marginalized discourses that are present in women's talk about maternal care. I conducted interviews with 31 African American women living in Milwaukee county, Wisconsin. Women narrated their pregnancy stories, noting how they constructed meaning through the interactions they had with healthcare providers. Through a contrapuntal analysis of the transcripts, I identified the discourses of healthcare providers' dominance (DHPD) and maternal healthcare as holistic (DMHH). The DHPD views pregnancy as primarily a medical condition that needs expert management from a healthcare professional. The DMHH constructs pregnancy as holistic life event needing the "expertise" of both healthcare professionals and women. In their construction of meaning, African American women resisted the hegemonic view of pregnancy as a medical condition, thus disclaiming the DHPD. Their narratives gave credence to the DMHH by incorporating their racial identity and background into maternal care. The findings exemplify how communication occupies a central position in healthcare delivery where individuals, especially those on the margins of the society, interpret their experience. The findings, in

particular, identify hegemonic healthcare discourses that position African American women as subject to providers' control. Importantly, the hegemonic discourses reflect racial discrimination as seen through the theme of "Unfair Treatment Because We are Black." Additional findings include the discourses of intensive mothering, pregnancy (motherhood) as distressing, and the theme of African American women are baby mamas.

Keywords: pregnancy, African American women, maternal healthcare, relational dialectics theory, contrapuntal analysis, motherhood

DEDICATION

To

Immortal, Invisible, God Only Wise…

My Husband, Ifemi

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I. Introduction

A maternal health crisis is confronting the United States. According to the Centers for Disease Control and Prevention (CDC; 2019a), pregnancy-related deaths have increased "from 7.2 deaths per 100,000 live births in 1987 to 17.2 deaths per 100,000 live births in 2016" (para. 7) which translates to about 700 women dying each year from pregnancy-related complications. African American women are disproportionally affected with 42.8 deaths per 100,000 live births, which is three to four times higher than for non-Hispanic White women (CDC, 2019a; Creanga et al., 2015; Creanga et al., 2017).

Racial disparities in healthcare delivery is well established in the literature (CDC, 2019a; Creanga et al., 2015; Mkandawire-Valhmu et al., 2018). Numerous studies report that African Americans receive low-quality and differential treatment when accessing healthcare services, which is a situation linked to being Black[1] (Cuevas et al., 2016; Dovidio & Fiske, 2012; Keith et al., 2010; Krieger et al., 2011; Mays et al., 2007; Ryan et al., 2006). Disparities exist for African Americans, for example, in limited information disclosure by healthcare providers (Martin et al., 2013), verbal dominance by healthcare providers (Ha & Longnecker, 2010), dismissive attitude of healthcare providers toward patients' concerns (National Public Radio, NPR; 2017), and provision of low-quality care (Ward et al., 2013).

Historical events of racism and racial discrimination are factors that have been linked to

[1] In this study, I do not use the terms "Black" and "African American" interchangeably. Whenever the term "Black" is used, I am referencing all people of African descent, including African Americans, while the use of African Americans specifically speaks to African Americans in the United States (See American Psychological Association, 2019, p. 143).

the delivery and experience of race-based care[2] in the U.S. healthcare system. From the historical events of slavery to the infamous Tuskegee Syphilis study[3] of 1932 (Scharff et al., 2010) and the ongoing socio-political discourses that reinforce racial discrimination in the U.S. (Williams & Wyatt, 2015), African Americans have continued to report racial disparities as reinforced through some preconceived notions about the identity of African American women. For example, "the strong Black woman" (Davis, 2015; Stewart, 2017; Watson & Hunter, 2015; Watson-Singleton, 2017), "the angry Black woman" (Ashley, 2014), "less-educated Blacks", and "medically non-compliant patients" (Dovidio & Fiske, 2012) are some of the cultural stereotypes about African American women that potentially affect their care. These preconceived notions manifest as implicit and explicit biases that impact healthcare delivery (Ashley, 2014; Cooper et al., 2012; Dovidio & Fiske, 2012; Hall et al., 2015; Williams & Wyatt, 2015).

Aside from the cultural stereotypes that impact the experiences of African Americans when accessing healthcare services, social determinants of health also impact the quality of healthcare services accessible to this population (Noonan et al., 2016). For example, education level, housing, type of neighborhood, environmental exposures (e.g., lead), and poverty level are factors found to impact how healthcare providers treat African Africans. However, studies have shown that regardless of the social determinants of health for African Americans, their racial identity as Blacks always stands in the way of the quality of care provided to them by healthcare

[2] This is a type of healthcare delivery that displays healthcare disparities based on racial differences, especially between Black and White patients (Goodman, Gilbert, Hudson, Milam, & Colditz, 2016).

[3] The Tuskegee study was an unethical famous study that was conducted on African American males from 1932 to 1973 to experiment the natural progression of untreated Syphilis in men. About 600 men were enrolled in the study, deceived to believe that they were receiving treatment for Syphilis while they were only been watched to see how worse their cases got over a period of 40 years (Brandt, 1978).

providers. “Race is a factor in health disparities that is not moderated by age, sex, and level of education” (Noonan et al., 2016, p. 4). Historical and systemic racism have stood at the core of their experiences across different sectors. While slavery has been physically eradicated, the aftermath effects continue to socially permeate the everyday experiences of African Americans (Bonilla-Silva, 2006; Noonan et al., 2016). Even for the most affluent of African Americans, their racial identity still stands in the way of their healthcare experiences (Harris, 2019; NPR, 2017). The focus of previous studies on the healthcare experiences of African Americans attends to issues of inequity, one that transcends age, socioeconomic status, class, and education level.

In reporting the experience of racial discrimination when accessing healthcare services or low-quality care, patients (regardless of racial identity) have identified communication factors as pointers to racial discrimination or the quality of care received during healthcare encounters (Cuevas et al., 2016; Ha & Longnecker, 2010; Raine et al., 2010; Wang & Luo, 2005). For instance, in assessing barriers to healthcare services by African Americans, Cuevas et al. (2016) found that racism and differential treatment of African Americans were reported through factors such as poor communication and lack of expressed respect. These factors are core communication markers. These findings are similar to many others that have examined the healthcare barriers of African Americans. As evidenced in previous studies (e.g., Cuevas et al., 2016; Raine et al., 2010), patients often assess the quality of care received through the lens of communication; how the provider related to them, the clarity of the message, the depth of the message; the content of the message, and the display of interpersonal connection with the patient. Specifically, the quality of interpersonal communication between physicians and patients impacts health outcomes by influencing patient satisfaction, physician-patient trust, and rapport, willingness to disclose important health information (Arnold & Boggs, 2019). Communication

functions as a significant tool in shaping the quality of healthcare services in any context (Abioye Kuteyi et al., 2010; Ha & Longnecker, 2010). Quality communication or its lack influences both physicians' and patients' perceptions of the healthcare system and the services delivered during patients' visits. More specifically, implicit and explicit racial biases thrive through (verbal and non-verbal) communication. Studies show that "Black patients feel less respected by the physician, like the physician less, and have less confidence in the physician regarding their medical encounters when the physician exhibits greater implicit racial bias" (Dovidio & Fiske, 2012, p. 948).

Systemic racism and issues of racial discrimination have been identified as primary influences of racial disparities and inequities in the healthcare experiences of African Americans within the U.S. healthcare system (Noonan et al., 2016). These different forms of racism manifest through stereotypes that circulate about African Americans as well as other people of color. Specifically, these stereotypes are situated in, and advanced through discourses, which are systems "of meaning-a set of propositions that cohere around a given object of meaning." (Baxter, 2011, p. 2). Moreover, discourses are enacted through communication. "All of communication is rife with the tension-filled struggle of competing discourses" (Baxter & Braithwaite, 2008, p. 4). The interactions healthcare providers have with their patients are charged with discursive tensions through competing discourses, even when they are not aware of it. Healthcare providers are actors and gatekeepers within the healthcare system, serving to either reinforce or resist stereotypes and racial discrimination toward African Americans through the delivery of care, through the discourses that manifest in their interpersonal interactions. Discourses inform and are evoked (as well as resisted) in human interactions. However, in a high-stake system like healthcare, discourses voiced through communication significantly impact

the way healthcare users make sense of their identities and experiences within this context. For instance, in the United States, pain normalcy is a dominant cultural discourse about women's (especially African American women's) reproductive health. In African American women's maternal healthcare, women have reported the manifestation of this discourse through communicative acts of healthcare providers, ones that undermine or even dismiss African American women's' health symptoms, especially during prenatal visits, (Mkandawire-Valhmu et al., 2018; NPR, 2017; Ward et al., 2013). Thus, these women come to understand (the perception) of their identity through their healthcare encounters.

Given the role of communication in healthcare delivery, communication scholarship is a vital tool in unveiling how cultural discourses, advanced through interpersonal communication, impact the meaning-making process of patients in healthcare access and delivery. Communication scholars must help shed light on these women's experiences and also identify how these women are making sense of, participating in, and/or resisting the cultural discourses that are present in their healthcare experiences. Cultural discourses, voiced by individuals in interpersonal relationships, dictate our view of the world and environment. As individuals give voice to different discourses in different interpersonal contexts, those discourses function as the lenses through which individuals make sense of their experiences and identities (Norwood, 2010). Within the context of this study, identifying the discourses that are present in African American women's maternal healthcare experiences will further reveal how these women are making sense of those discourses, whether they are affirmed, resisted, and/or transformed. As Baxter (2011) rightly argued,

> Rarely is language use an equal playing field; some utterances pack more authority than others, based on cultural norms or social stratifications along lines of gender, race, and

class, among others. And utterances mean different things based on the relationship that the parties bring to the interaction moment. (p. 29)

Thus, I apply relational dialectics theory (RDT; Baxter, 2011), a critical communication theory "of relational meaning making— that is, how the meanings surrounding individual and relationship identities are constructed through language use…[and] are wrought from the struggle of competing, often contradictory, discourses" (p. 2). RDT has been useful in giving voices to marginalized cultural discourses and identities. In this study, it is a valuable theoretical tool in identifying and understanding cultural discourses that punctuate the identities of African American mothers, while also helping to understand how these women make sense of and potentially resist or change them. RDT scholars have applied the theory to identify which discourses are privileged or marginalized in the meaning-making process and how they relate to one another. Scholars have applied the theory to study different (marginalized) discourses in the U.S., such as discourses of motherhood (Cronin-Fisher & Sahlstein Parcell, 2019), gay fatherhood (Baker, 2019), adoption (Baxter et al., 2014), and racial identity (Simmons et al., 2013). It is a particularly useful theoretical tool for identifying the experiences of populations on the margins of the society, those whose identity, as well as experiences, have been marginalized, challenged, and, in some cases, de-legitimated, or what Galvin (2006) labels as discourse-dependent. Using RDT will allow for a scholarly (1) identification of discourses, and (2) an expanded understanding of how these women make sense of their maternal healthcare encounters.

Historically, African American women have experienced discursive tensions as it pertains to their identities of race (Nuru-Jeter et al., 2009), gender (Ashley, 2014; Thomas et al., 2008), and motherhood (Jackson et al., 2001). For instance, African American women's

identities are historically associated with the pathology of abuse, independence, hard work, and stress (Stewart, 2017, p. 32). Dating back to the colonial era of slavery and exploitation, Black women were subjected to different forms of mistreatment by men, especially rape, forced labor, abortion, and economic nonconsensual health procedures, including genital mutilation (Prather et al., 2018). These historical events of abuse and discrimination of Black women, still, in the modern-day, influence Black women's experiences in different spheres of the society (Prather et al., 2018). For instance, several decades after the abolishment of slavery, African Americans are still "the least healthy ethnic group in the United States," topping the ladder for different kinds of chronic illnesses even when controlled for socio-economic determinants of health (Noonan et al., 2016, p. 1). Particularly, African American women experience more reproductive health are chronic illnesses as compared to Whites (Prather et al., 2018). While there are biomedical explanations for the experiences of Black women, race remains a central discourse in their healthcare experiences (Noonan et al., 2016).

Particularly, during pre and post-natal periods, African American women are marginalized at a material level as they continue to experience a disproportionately high rate of maternal crisis (CDC, 2019a). The maternal crisis, as it pertains to African American women, is a site of a discursive struggle, as the cultural discourses surrounding the experiences of African Americans suggest that of a second-class citizen. Navigating the dynamics of their race and gender place these women on the margins in the society. As such, there is a site of struggle for African American mothers as they try to navigate the permeating cultural discourses of race and gender that intersect with their healthcare experiences during maternal care. RDT was used to identify discourses that animate the healthcare experiences of African American women. Health communication scholars, in studying African American women's healthcare experiences, have

often approached it from an interpretive lens (e.g., Best et al., 2016; Kenerson et al., 2017; Muturi & An, 2010). Given the focus and value of interpretive qualitative research, these studies have provided a manifest understanding of the experiences of these groups. However, to enact change in a discursive site of power inequality, a critical qualitative approach is an appropriate tool for conducting research. The marginalized identities of African American women coupled with historical issues of disenfranchisement and injustices, call for a critical qualitative approach, one that attends to latent issues of power inequality. Moreover, the limited visibility of healthcare communication scholarship on African American women's maternal health necessitates a study like this. RDT, as a critical communication theory, provides both the theoretical and methodological paths to attending to issues of marginalization, as resident in the healthcare experiences of these women. More specifically, this study has the potential for understanding the role and power of discourses in influencing the experiences of African American women when receiving pre and post-natal care services. Identifying discourses that inform their meaning-making around healthcare experiences will help offer a perspective on the maternal crisis among the population that is not currently available. This step has the potential of giving insights into how Black women resist and/or participate in the discourses that define them within the healthcare setting. Specifically, in this study, I examined (1) how 31 African American women made sense of the U.S. maternal healthcare crisis, (2) what discourses they evoked when talking about their healthcare experiences, and (3) how these discourses interplayed with one another.

II. Literature Review and Theoretical Framework

Maternal health experiences of African American women occur at the intersection of race, pregnancy, gender, and motherhood. This chapter reviews relevant literature on these topics. This includes a review of the U.S. healthcare system and the experiences of African American women when accessing it. Next, I identify and describe discourses relevant to this study: pregnancy, motherhood, African American womanhood. Lastly, I provide an overview of relational dialectics theory and its application in related research.

Healthcare in the United States

Healthcare is one of the most studied areas of scientific research in the U.S. (Hitlin, 2016). Ranging from healthcare policy, chronic diseases, and mortality focus on healthcare constitutes an important area of concern and scientific research in the United States. However, according to a Pew Research Centre report, despite the millions of scientific studies, including those related to healthcare, published annually (Hitlin, 2016), the United States healthcare still falls short in many regards. For instance, according to Schneider et al. (2017) in their Commonwealth Fund report, "Among the 11 countries we studied, the U.S. was ranked last in overall health system performance, while spending the most per capita on health care." This ranking in health performance includes issues such as high infant mortality rate, low life expectancy, inequities in the healthcare system, different forms of health disparities, and higher cost of healthcare spending compared to other Western countries such as Sweden, Australia, Switzerland, the United Kingdom, and Germany. Consequently, despite having one of the highest levels of healthcare spending among the Western countries, the United States healthcare overall performance still rates poorly.

Factors that affect the low-performance ranking of the U.S. healthcare system include,

higher healthcare cost, low administrative efficiency, and class and racial inequities, (Adebayo et al., 2019; Hashim, 2017; Lopez & Gadsden, 2016; Schneider et al., 2017). For instance, studies show that healthcare costs in the U.S. rate highest among wealthy Western countries (Kumar et al., 2011; Papanicolas et al., 2018; WHO, 2014) with physician service fees (Schroeder et al., 2013) and pharmaceutical fees (Dieleman et al., 2017) as the major contributors to the high costs of healthcare. However, with the high costs of healthcare services in the country, preventable healthcare problems persist (Papanicolas et al., 2018). According to a survey conducted by Pew Research Center, "majority of Americans (83%), regardless of their income, say a big problem is that the high cost of medical treatments makes quality care unaffordable" (Milanez & Strauss, 2018). Iuga and McGuire (2014) explained a cyclic relationship between healthcare costs and adherence to medications. They found that medication non-adherence leads to higher healthcare costs due to health complications that may arise for nonadherence and vice versa. Inversely, it is argued that nonadherence to medications and other recommendations of healthcare providers may not always begin with the patient's defaulting in compliance or adherence. Other underlying factors influence this decision to not comply or adhere to healthcare providers' recommendations (See Ferrera et al., 2015), one of which is high costs of healthcare services (Eaddy et al., 2012). These high costs of healthcare as it results in patients' nonadherence, may, in turn, lead to poorer health outcomes, including pregnancy and delivery. For many low-income African Americans, accessing healthcare may indeed be a challenge (Noonan et al., 2016).

Despite the high-cost healthcare services in the U.S., administrative inefficiency is still a major issue within the healthcare system. Administrative inefficiency is a major contributor to the poor ranking of the U.S. healthcare system among other Western countries (Schneider et al., 2017). For instance, a complex billing system associated with complex insurance coverage and

different forms of deductibles were found to waste both providers' and patients' time during healthcare access. Kumar et al. (2011, p. 366) argued that improving efficiency in the U.S. healthcare will include streamlining the complexities in the system to reduce different forms of "waste" present in the administrative structure of the system. The authors also found overutilization of technology as a major driver in U.S. healthcare administrative cost, noting that "there is substantial evidence that overutilization and misuse of technology lead to spending that exceeds its value for patients" (p. 376). This, again, creates more barriers for healthcare patrons, especially low-income individuals, given the evidence that overutilization of technology leads to high costs of healthcare services. Additionally, it may also take away the simplicity and accessibility that individuals should have in the healthcare system due to complex and complicated processes, which may further impact individuals' willingness to utilize healthcare services as needed. Using a central technology system that will reduce time wasted on billing and other administrative processes is a major recommendation for healthcare providers.

Class inequities, as it often intersects with racial inequities within the U.S. healthcare system, accounts for one of the major problems when accessing healthcare services (Lopez & Gadsden, 2016). Although data on class disparities are not commonly reported in the U.S. healthcare research (Kawachi et al., 2005), it is almost impossible to isolate racial disparities from class disparities in U.S. healthcare research, as there is usually an intersection between race and class in any given context. Access to healthcare and its quality is often influenced by socioeconomic status, especially for African Americans. Moreso, intersectionality in scholarly inquiry has offered researchers analytical tools in understanding various factors that contribute to complex human problems in different contexts (Collins & Bilge, 2016). Due to the high costs of healthcare services in the United States, lower-income individuals have been challenged by

accessing healthcare services due to financial constraints as well as adherence to healthcare providers' recommendations. For instance, in a study focused on barriers to accessing prenatal care among low-income African American women (Mazul et al., 2017), findings show that structural barriers such as lack of health insurance and perceived low quality of care constitute a primary position in their willingness to even access prenatal care. Unsurprisingly, lower-income individuals are also those on the racial margins of the society, which in turn complicates their experience as their race and class, among other social determinants, intersect in a way that influences their quality of care (See Lopez & Gadsden, 2016). Specifically, African Americans have been reported to experience poor quality of care and health outcomes associated with their race alongside other structural factors (Adebayo et al., 2019; Hashim, 2017).

Healthcare Experiences of African Americans

In researching the healthcare experiences of African Americans, many studies have documented the report of discrimination perceived by African Americans from their healthcare providers (Abramson et al., 2015; Krieger et al., 2011; Shin et al., 2016; Williams & Wyatt, 2015). Racial discrimination appears to be a major reported experience of African Americans, as well as other people of color in the U.S. (Abramson et al., 2015). To be clear, the experience of racial discrimination and differential treatment of the people of color, Blacks, in the U.S. is a historical event (Hansen et al., 2016). Stemming from the infamous Tuskegee study of 1932, African Americans have continued to report the experience distrust in the U.S. healthcare system, a system that treats them differently (as guinea pigs) because of their race (Gamble, 1997; Lang et al., 2013). Put together, African Americans experience the worst healthcare conditions compared to any other minority groups in the U.S. [Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care,

2003].

Discrimination involves “a process in which a member or members of a socially defined group are treated differently due to their membership in the group” (Mouton et al., 2010, p. 288). Race-based discrimination involves an unfair treatment of some people because they belong to a particular race. The healthcare experiences of African Americans are charged with racial discrimination on every font (Williams & Wyat, (2015). “From the simplest to the most technologically advanced diagnostic and therapeutic interventions, African American (or Black) individuals and those in other minority groups receive fewer procedures and poorer-quality medical care than white individuals” (Williams & Wyat, 2015, p. 555). The experience of racial discrimination by African Americans when receiving healthcare services is multidimensional and multilayered. In fact, it cuts across both males and females, just as African American women experience racism, African American men also do, when receiving healthcare services. It is important to underscore that the experience of racial discrimination as reported by African Americans in many instances reflects a structural dimension to racial discrimination. Bailey et al. (2017) defined structural racism as:

> the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices, in turn, reinforce discriminatory beliefs, values, and distribution of resources. (p. 1453)

Succinctly, racial discrimination in the healthcare system, as reported by African Americans, manifests in different ways. However, communication stands at the core of the perception of racism by African Americans when accessing healthcare services.

Studies that have examined African Americans’ experience of racial discrimination in the

healthcare context have often reported it (directly or indirectly) through a communication lens (Care et al., 2003; Clark & McMillan-Persaud, 2014; Cuevas et al., 2016; Williams & Wyatt, 2015). Some of the reported manifestations of racism by African Americans in the healthcare setting include lack of empathic communication (Raine et al., 2010), lack of communication immediacy (Ellis et al., 2016), verbal dominance of physicians during interactions (Ha & Longnecker, 2010), limited information disclosure (Cuevas et al., 2016), and disrespect. Discourses thrive through communication. Racial discrimination, as a discursive position for African Americans, can only be recognized through communicative acts that are sent or received by interlocutors. Consequently, communication stands at the core of understanding what is perceived as racial discrimination by those who experience it.

Racial discrimination has grave health outcomes (Assari et al., 2017). In a recent survey conducted by NPR (2017) "33 percent of black women said that they personally had been discriminated against because of their, race when going to a doctor or health clinic, and 21% said they have avoided going to a doctor or seeking health care out of concern they would be racially discriminated against" (para. 23). Undermining African Americans' health challenges (NPR, 2017), rushed interactions and lack of effective interpersonal communication by providers (Hansen et al., 2016), unconscious or subconscious providers bias (Williams & Wyatt, 2015), and lower quality of care (Shin et al., 2016) are different dimensions of this discrimination in the healthcare system. To be clear, this is not an attack against healthcare providers, it is a critique of a system, and that includes all the stakeholders in the system; patients and providers. While we recognize the existence of provider bias and their central role in delivering healthcare services, the problem of racial discrimination within the U.S. healthcare system is only a reflection of the overall state of U.S. society toward racial minorities in every sector (Bonilla-Silva, 2006).

Maternal Mortality in the United States.

Maternal mortality is a major problem in different parts of the world, particularly in less developed countries. According to World Health Organization (WHO; 2014), "94% of all maternal deaths occur in low and lower middle-income countries," with Sub-Sahara Africa and Southeast Asia accounting for over 86% of maternal mortality cases across the globe**.** The Centers for Disease Control and Prevention (2019) defined maternal mortality as

> as the death of a woman while pregnant or within 1 year of the end of a pregnancy – regardless of the outcome, duration or site of the pregnancy–from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Maternal health has been a major concern in the public discourse over the last few years as the U.S. still rates very poorly in this regard. According to Agrawal (2015) in a report of the World Health Organization

> maternal mortality and morbidity remain a challenge in the United States of America (USA). Between 1990 and 2013, the maternal mortality ratio for the USA more than doubled from an estimated 12 to 28 maternal deaths per 100 000 births and the country has now a higher ratio than those reported for most high-income countries and the Islamic Republic of Iran, Libya and Turkey. (p. 135)

While the rates of maternal mortality have decreased in less developed and developing countries over the last few years (WHO, 2019), maternal mortality remains at a high rate in the U.S. (Creanga et al., 2017). The U.S. has one of the highest maternal mortality rates among Western countries (Kassebaum et al., 2016), with about 700 women dying each year from pregnancy-related complications. Although efforts are currently being made to address the problem, the rate

has consistently increased over the last several years. According to the CDC (2019a), pregnancy-related deaths have consistently increased from "7.2 deaths per 100,000 live births in 1987 to 17.2 deaths per 100,000 live births in 2015." Pregnancy surveillance data provided by the CDC is focused primarily on clinical causes of maternal mortality (CDC, 2019a; Creanga et al., 2014). This includes an increasing number of chronic illnesses in pregnant women, such as hemorrhage, cardiovascular diseases, hypertension, preeclampsia, mental illness among others (CDC, 2019a; Creanga et al., 2014; Creanga et al., 2017). However recent research has also underscored the influence of race in the health menace. Similar to other health issues, racial disparities have been identified as a key influence in the maternal mortality problem in the United States. Specifically, African American women are at higher risks for maternal death compared to women on other races.

Maternal Mortality Among African American Women

Despite efforts made to unravel the clinical causes of maternal mortality in the U.S., statistics still show that there is a racial dimension to this health problem. Specifically, non-Hispanic African American women have been at the top of the ladder when it comes to death resulting from pregnancy (CDC, 2019a). To put this into perspective, non-Hispanic African American women are three to four times more likely to die from pregnancy-related complications as compared to non-Hispanic White women (CDC, 2019a; NPR, 2017). In addition to this, Tucker et al. (2007) also found that having the same chronic illness during pregnancy as a Black woman compared to a White woman also increases the likelihood of maternal mortality at the rate of two to three times higher.

Arguably, while some evidence exists for the clinical and pathological causes of maternal mortality in the U.S. (CDC, 2019a; Creanga et al., 2014), the prevalence of this health problem

among African American women remains a puzzle. Previous studies have documented the existence of racial and health disparities in the quality of care received by African Americans when accessing healthcare services (Krieger et al., 2005; Krieger et al., 2011). Additionally, social determinants of health outcomes play a major role in the healthcare experiences of African Americans (Lopez & Gadsden, 2016). This influence explains the need for an intersectionality approach (e.g., race, class, gender, and education) in understanding the healthcare experiences of populations on the margins of the society (e.g., African Americans). Consequently, to argue that the maternal health crisis is a genetic problem peculiar to African American women is a misleading approach. More specifically, it is important to note that when it comes to maternal mortality or crisis among African American women, race is a central driving force, regardless of socio-economic status as compared to White women (Harris, 2019). This is further supported by the reported experiences of prominent African American women like Shalon Irvings, an Epidemiologist at the Centers for Disease Control and Prevention, who passed away weeks after delivery in 2017 (NPR, 2017). Irving's case was not one linked to poverty or low education, she had two doctoral degrees; rather it was linked to racial disparity in the healthcare as reports show that her health symptoms were repeatedly dismissed days before her demise (NPR, 2017).

Undermined health symptoms is a common report across maternal health literature on African American Women. Stemming from historical events of slavery, African American women are often perceived to be "strong" and able to go through hardships beyond the normal (Davis, 2015; Watson & Hunter, 2015; Watson-Singleton, 2017), and able to withstand pain "abnormally." This racial discourse of (perceived) strength has often worked to the disadvantage of African American women in the health context. The perception of being strong has been reported to "force" African American women to internalize their pains and hardship even as

healthcare providers often reinforce this discourse (Collins, 2000; Schiller et al., 2012; Watson-Singleton, 2017).

Discourses of Pregnancy

Pregnancy is a highly revered life event in different cultures of the world. For instance, in many African and eastern cultures, it is considered a sacred, cultural, and religious life event, one that demands the collective responsibility of the extended family (Carolan & Cassar, 2010; Hill et al., 2012). Members of these cultures approach pregnancy from a multifaceted perspective, not just from a medical standpoint. In the United States, pregnancy has been mostly viewed and studied from a pathological perspective. One would think the multicultural demographic of the United States would have been a strong influence in approaching pregnancy from multiple perspectives; however, this is not the case. Pregnancy in the U.S. is understood from a Western-centric, medical perspective.

Pregnancy is often considered an initiation process in earning the title of a mother. Traditionally, earning the title of a mother is reserved for those who have passed the pregnancy test. This is a dominant view of motherhood in the U.S. and across different parts of the world (Park, 2013), as "authentic motherhood is viewed as stemming from a particular set of biological processes (e.g., pregnancy, birthing, lactation), which are believed to induce an irreplaceable, biologically based mother-child bond" (Suter et al., 2015, p. 459). Consequently, women are seen as natural mothers who "naturally" know the intricacies of pregnancy. In the U.S. culture, pregnancy is seen as a natural event (intensive mothering) as well as a medical condition that needs to be cautiously managed. As a medical condition, pregnancy is mainly approached from a biomedical perspective, that is, it is considered a health condition that needs the expertise of healthcare professionals. Feminist theorists have critiqued this approach given the control it takes

from women regarding their body and their birthing experiences (Collins, 1994; Willard, 2005). The following section reviews how pregnancy has been approached from the biomedical perspective, including the critiques against it.

Biomedical Discourse of Pregnancy

Traditionally, the biomedical discourse has been criticized for disempowering women, since women are the primary consumers of healthcare services in the United States and even other parts of the world (Willard, 2005). Particularly, concerning women's reproductive health, the medical profession has been critiqued for its medicalization of women's experiences, including pregnancy. In this way, the woman's body is treated as a machine, programmed to perform certain operations, and can be managed, when "faulty" to ensure its appropriate functioning. The dominance of the biomedical discourse in healthcare has been found to result in "the medicalization of normal life events (e.g., giving birth, menopause) and an over-reliance on technological solutions" (Willard, 2005, p. 135).

In the U.S., pregnancy is primarily considered a medical condition, which needs medical intervention for its management and treatment, which reflects a biomedical approach. Consequently, the practices that come with pregnancy are often highly pathological. This means the woman's body is viewed as an independent entity that naturally performs what it was manufactured to do. As Andipatin et al. (2019) stated that in the biomedical discourse of pregnancy

> the woman is the laborer, the body the machine, the baby the product and the doctor or medical staff the supervisors of the labour process…the body is alienated from the woman giving birth, it functions almost independently of her will or desires, and the uterus is (re)presented as an involuntary muscle that automatically performs the task. (p.

e553)

Consequently, women have traditionally treated pregnancy as a medical condition, given the prevalence of the biomedical discourse in healthcare. In this way, they see themselves as vulnerable as they are expected to comply with their provider's recommendations regardless of how they feel about it since the providers are considered the experts of the body, that is, the "machine" (Willard 2005, p. 133). This approach implicitly labels some pregnancies as "ideal" while others as "bad", depending on how smoothly the "machine" runs during pregnancy. The biomedical discourse of pregnancy inherently ignores other important determinants of maternal health during pregnancy (e.g., mental health). Postpartum depression has been found as a major experience for many women in the United States, with higher rates among racial and ethnic minorities (e.g., African American women; Ceballos et al., 2017). For instance, in some Asian cultures, it is traditionally believed that the mental health of a mother during pregnancy impacts the temperament of the child after birth. In investigating this cultural belief and its validity, Chong et al. (2016) established a positive correlation between "maternal antenatal anxiety and negative infant temperamental trait" (p. 585). This example shows how problematic it is for healthcare practitioners to ignore the cultural and psychological aspects of women's health during pregnancy. This approach is in contrast with pregnancy practices in some other cultures of the world that view pregnancy as a holistic (not just medical) life event.

Other Pregnancy Discourses

While the biomedical discourse has constituted the dominant approach for women during pregnancy, other discourses are present. This includes the spiritual discourse, one that sees pregnancy as a miraculous event (Moloney, 2007), which is spiritually experienced and managed. As Moloney argued, "to be pregnant is to be touched by the creative power of

something infinitely greater than self and such proximity with the divine is transformational" (p. 122). Internationally, this discourse is more dominant in African and Asian cultures, as pregnant women closely situate their health issues within their faith and spirituality (Aziato et al., 2016). Pregnancy and childbirth are considered a "sacred" event (Callister & Khalaf, 2010, p. 19). Moreso, during pregnancy, a highly revered health condition, women closely practice their faith alongside the recommendations of healthcare providers. In this context, women associate their condition with a lot of religious practices, including baptism among other rituals; since pregnancy is considered a manifestation of God's will (Cheadle et al., 2015, p. 2). In the United States, African American women have been found to view pregnancy and postpartum experiences through the lens of spirituality. Studies show that African American women engage more in spiritual activities as it concerns different aspects of their health (Cheadle et al., 2015; Jesse et al., 2016).

Historically, religious institutions have functioned as gatekeepers for reaching the African American community of different social and health issues (Cheadle et al., 2015). Even during pregnancy, African American women have been found to place a high priority on their faith. Consequently, the discourse of pregnancy as spiritual is a strong belief among this population. Given the paucity of data on pregnancy and spirituality in the United States, little is known about how African American women negotiate the dialectics that may occur in their pregnancy journey, as they navigate different competing discourses of pregnancy (e.g., biomedical vs. spiritual discourses).

Furthermore, the responsibility discourse of pregnancy is another circulating discourse about women and pregnancy. In this discourse, also known as "intensive pregnancy," women are considered to be "solely accountable for producing a healthy child ...to adopt an intentional,

reflexive, research-driven orientation…sifting through the available medical and health information to make the best choices for their fetuses" (Tiidenberg & Baym, 2017, p. 2). This ideology implies that the female body is inherently aware of pregnancy functions and can successfully do so at its intuition. Here, the body is seen as capable and aware of what it is supposed to do without being interrupted by medicine. This discourse further places women as being naturally aware of how to manage their pregnancy, given the fact that, pregnancy is natural to them (Tiidenberg & Baym, 2017).

Additionally, pregnancy, as well as other similar life events are a cumulative experience of social, cultural, and medical influences, (for health-related ones) which shape the meaning-making process of people during this time of their lives. Thus, it is important for healthcare providers to become aware of the reality that "pregnancy and its associated biological processes are complex and expressed in an assortment of ways, they are lived out in equally complicated sets of social and power relations" (Andipatin et al., 2019, p. e553). African American women have unique social and cultural milieu, as Blacks and pregnant women, one that has positioned them on the margins of the society. As such, considering the power dynamics that also manifests between healthcare providers and their patients (Ha & Longnecker, 2010), it is important to understand how different sites of meaning for African American women influence their maternal healthcare experience and how they make sense of it.

Discourses of Motherhood

While different discourses define motherhood in different cultures, the intensive mothering discourse has traditionally functioned as the idealized way of assessing motherhood and the expectations that accompany it in many parts of the world. The intensive mothering discourse draws upon both biological and socially constructed ideologies of motherhood. This

includes the notion that women are biologically made for mothering, given their physiological makeup, as such motherhood is naturally desired by every "normal woman." This discourse also includes being able to (naturally) conceive, birth, and also breastfeed (Suter et al., 2015). In addition to the biological determinism of motherhood discourse, motherhood has also been socially and culturally constructed, as the society has idealized some expectations that come with bearing the title of a (good) mother (e.g., being able to breastfeed; Cronin-Fisher, 2018)

In the United States, intensive mothering, a dominant motherhood discourse posits that women are primarily responsible for child-making, rearing, and discipline (Hays, 1996). It advances the notion that a woman's primary and most important responsibility should be to selflessly take care of the children by always putting their needs first, even against theirs. It further argues for a concentrated focus on children through the devotion of the mother's time, money, and energy. Through this, mothers are "expected to balance the harsh world of work while simultaneously providing a haven for her family at home" (Taylor, 2011, p. 898) It is important to note that the intensive mothering discourse and its critique, in the U.S., is predominantly from the White married, middle-class woman's perspective, leaving out other identities as African American (single) mothers (Hays, 1996; Seurer, 2015). Even for feminist scholars within the motherhood scholarship, the critique of the intensive mothering discourse is strongly situated within the hegemonic Western, patriarchal culture (Collins, 1994), as such failing to account for several other nontraditional identities (e.g., single Black woman). It is misleading to assume that the hegemonic conceptualization of motherhood and its resistance is universal across different racial groups and even social class. Given the lived realities of different minority groups in the United States, it is necessary to understand, from their perspective, their conceptualization of motherhood.

In challenging dominant ideologies of motherhood, feminist theorists like De Beauvoir, Patricia Collins, and Elizabeth Suter have been at the forefront of scholarship. Their critiques have addressed issues of power inequality between males and females in the society and other traditional conceptualizations of motherhood and family. These theorists have also focused on giving voice to marginalized motherhood discourses (e.g., female-female co-motherhood; Suter et al., 2015). For instance, De Beauvoir seminal work of 1953, *The Second Sex*, focused on the rejection of the dominant discourse of motherhood as a vital step to reject patriarchal dominance in the society. She argued that childbearing served as a rite of passage for women's oppression and subjugation by men. As such, rejecting childbearing would reclaim women's agency and their rights in the society. Radical at the time, De Beauvoir's feminist discourse of motherhood was quite unpopular, thus, marginal.

While feminist theorists challenge dominant motherhood ideologies (e.g., intensive mothering), their critique does not account for the motherhood realities of (racial) minority women, in this context, African American women, who many times solely care for their children (Collins, 1994). According to the findings of Pew Research Center, 47% of Black children in the United States live with single mothers, as against 13% of White Children (Livingston, 2018). As such, many African American women are confronted with the reality of being a "good mom" and at the same time the breadwinner, who can economically sustain their families. This leaves many African American women in a heightened discursive struggle as they try to fulfill the traditional expectations of motherhood, at the same time filling other parenting roles in the family. For instance, in exploring the lived experiences of African American mothers uncovered the discourse of motherwork, an alternate discourse to intensive mothering. This motherwork discourse shifts the *sole focus* of mothering from the children to a communal focus on both the

children and the mother as well as the community. Collins (1994) argued that within this motherhood discourse, “themes of survival, power, and identity form the bedrock and reveal how racial ethnic women in the United States encounter and fashion” (p. 49). Particularly the motherwork discourse is central to the experiences of African American mothers, as it reflects their ongoing fight for survival in a society that ignores and marginalizes their experiences.

Thus, it is important to examine the discourse of motherhood within different racial and cultural contexts, as this may provide different perceptions of motherhood, dissimilar to the hegemonic ideologies. As Collins (1994) opined, it is impossible to isolate the discourse of motherhood from the attending context of race and other social determinants of health (e.g., education, class, gender)

> Motherhood occurs in specific historical situations framed by interlocking structures of race, class, and gender, where the sons and daughters of White mothers have every opportunity and protection, and the colored daughters and sons of racial-ethnic mothers know not their fate. Racial domination and economic exploitation profoundly shape the mothering context, not only for racial ethnic mothers in the United States, but for all women. (p. 45)

In addition to the contested notions of who is a ‘real’ mother, African American women, as racial minorities further contend with their motherhood identity as they are continually “assessed” not just by the dominant ideology of who a is a ‘real mother’, but also impacted by their race, which is systemically marginalized in the United States. For instance, premature birth, infant mortality and pregnancy loss are material realities, which often are made sense of as “bad mothering” for (African American) mothers and not bad medical care by health professionals or the outcomes of historical systemic racism. Unfortunately, infant mortality is disproportionately

high for African American babies, especially in Wisconsin, the 17th highest state for infant mortality in the country (CDC, 2019b). Additionally, in Wisconsin, the latest report shows that "the death rate for infants born to black mothers is the highest in the nation and is getting worse"; at a rate that is three times higher than that of Whites (Wisconsin Department of Health, 2019). With Milwaukee having the highest number of Blacks in the state, in 2017 alone, there were 18.1 deaths per 1,000 live births for non-Hispanic Blacks as compared to 3.6 deaths for non-Hispanic Whites (City of Milwaukee Health Departments, 2018). These health disparities are capable of shaping the sensemaking process of African American women's perception of motherhood. Consequently, African American mothers may have to overly contend their motherhood identities given the maternal health disparities prevalent among them, thereby making their identity discourse-dependent.

Investigating the discourses at play in the sensemaking of African American women does not only contribute to the voices of African American women to the literature of motherhood. Indeed, it is not a simplistic attempt to merely contribute diverse racial groups' voices to the discourse of intensive mothering. Rather, it provides a heuristic, extended perspective on how these women are making sense of motherhood, given their experiences of racial discrimination and systemic racism in different contexts. This research trajectory helps to understand their conceptualization of motherhood, and their sense-making process of mothering, which includes how they resist, affirm, or even create new discourses that represent their perception of motherhood. It further provides an extended understanding of motherhood by African American women as situated in their maternal healthcare experiences.

Discourses of African American Womanhood

All stemming from historical events of slavery, the American culture circulates certain

discourses peculiar to African American women, as well as other Black women. Examples of these discourses include “the strong Black woman” (Abrams et al., 2014; Davis, 2015; Watson & Hunter, 2015; Watson-Singleton, 2017) and “the angry Black woman” (Ashley, 2014). The strong Black woman discourse is a very popular discourse associated with African American women, as well as other women of African descent in American society. Stewart (2017, p. 31) stated that this discourse has been used by the American culture

> to applaud the Black woman for how well she keeps her dynamic emotions and complex issues from being expressed and affecting the lives of other people while simultaneously knocking her down, exploiting her labour, working overtime to destroy her worth and consistently broadcasting on a global level that she has no value. The SBW stereotype is a trap that disables and dehumanizes Black women. It is a colonial chain that derives from the mammy caricature that feeds on the myth of the infinitely independent Black woman who does not need no one and their help. (p. 31)

The perpetuation of this discourse can be traced to the era of slavery as a way to “justify their enslavement” (Watson-Singleton, 2017, p. 779). However, the socialization and advancement of this discourse has also been reported to be welcomed and reinforced by African American another Black women themselves (Abrams et al., 2014). In fact, being strong for a Black woman is part of the Black culture, as African American women have been socialized into “super women” ideology, as women who have an innate strength, able to assume multiple roles and withstand difficult situations. Marcia Ann Gillespie describes her as follows:

> She’s the fearless foremother…stealing back into the pit of slavery boldly leading us to freedom…She’s that Mama men love to brag about who sacrificed all for them… the tough mother ready to…raise hell with anybody who dares wronging one of her

> chicks…The do-it-all mother, always on call, raising children, sustaining households, working both outside and inside the home…the community mother…the determined sister who against all odds got that college degree…the multidimensional woman…in the midst of all the stereotypes that swirl around her. We've named her the "Strong Black Woman" (Parks, 2010, p. viii).

Additionally, while this discourse of strength was developed from the unfortunate era of slavery, it has become a welcomed racial identity marker, even for African American women, albeit to their disadvantage in the health context (Abrams et al., 2014). African American women have criticized providers' advancement of this notion that "she is strong," or "she got this" (Stewart, 2017, p. 31) whenever their illness symptoms are undermined and normalized even in the face of serious health implications and threats. For instance, Watson-Singleton (2017) found that while African American women validated the discourse of "the strong Black woman," it results in negative impacts on their levels of social support and mental health. The implication of this is that the more African American women alluded to the notion of being strong, the more they received less social support while also experiencing a higher level of psychological distress. This study implies that while women, on the one hand, entertain "the strong Black woman" discourse, they, on the other hand, experience negative outcomes in an effort to suppress any perceived display of laziness, weakness, and dependence. Consequently, it is expected to find African American women consistently reporting how healthcare providers undermine their pains during pregnancy.

In contrast, Ashely (2014) argued that though cultural discourses are influencing the experiences of African American women in the healthcare contexts, such discourses should not be suppressed or ignored by healthcare providers and African American women themselves. In a

case study on mental health and psychotherapy experiences of African American women, Ashley found that the perceptions and responses of African American women to psychotherapy sessions were strongly influenced by the historical myth of "the angry Black woman." The woman in her study tried to suppress this myth by denying the label of "an angry Black woman" because of the negative cultural interpretations that come with that label (e.g. aggressive, hostile, irrational). Instead of this, she emphasized her present challenges (relationship issues) to appear as a "normal" female and not the "angry Black woman." She struggled between how she was perceived (avowed identity) versus how she saw herself (ascribed identity). The woman was thereby affecting the quality and effectiveness of the care she received during her sessions. However, the moment she began confronting the historical and cultural depictions of the angry Black woman, by normalizing that myth with her healthcare providers, she began to experience significant healing and improvement in her mental health. This way, she acknowledged the anger she had regarding the historical mistreatment of African Americans, and how that impacts her lived experiences. Recognizing this, her healthcare provider was able to contextualize her socially constructed identity and its impact on her mental health. This turning point paved the way for effective care as it also helped her provider situate her care within the historical and cultural realities of African American women. Given this, Ashley maintained that healthcare providers need to be culturally aware of myths (discourses) that are present in African American women's healthcare experiences. She argued that only when healthcare providers begin to acknowledge the impact of cultural and historical experiences of Black women can the "archaic illusion of color-blind therapy be ameliorated and the psychological stress of being Black in America can be integrated into the biopsychosocial spiritual narrative of Black female clients" (p. 33).

African American women's healthcare experiences are often associated with their race as well as the cultural discourses connected with their identity. Understanding (and potentially changing) African American women's experience of disparities must include attention to cultural assumptions that have defined them. Thus, identifying how African American mothers make sense of their maternal care experience can provide insights into what discourses propagate racial and health disparities, how they make sense of these discourses, and how they make sense of the high rate of maternal crisis among African American women. Discourses present in the experiences of people have the power to shape the understanding of their situations and identities, and in this context-maternal care. The scholarly understanding of the aforementioned issues necessitates a theoretical approach that helps to identify discourses, while critiquing them for power imbalance. Given the centrality of communication in voicing discourses, applying a discourse-centered critical communication theory is expedient. The following section discusses relational dialectics theory and its value in the present study.

Theoretical Framework: Relational Dialectics Theory (RDT)

RDT is a theory, like all theories, that has evolved over time. In its first iteration, RDT was developed as a communication theory that identifies contradictions that are inherently part of interpersonal relationships (Baxter, 1988; Baxter & Montgomery, 1996). Under this tradition, the theory underscores the argument that relating is a process of negotiating between opposing and unifying forces; this is referred to as contradictions. The theory, in its interpretive focus, has been useful in identifying different forms of contradictions present in interpersonal relationships as mostly studied through autonomy/connection, openness/closedness, and predictability/novelty, and certainty/uncertainty (Baxter & Montgomery, 1996). "Relationships are organized around the dynamic interplay of opposing tendencies as they are enacted in interactions" (Baxter &

Montgomery, 1996, p. 6). Consequently, individuals in interpersonal relationships are always faced with different forms of contradictions, which in turn shape meaning-making processes in their relationships. RDT, under this tradition, further focuses on how individuals, through communication, negotiate those contradictions that they experience in their relationships. Clearly, Baxter and Montgomery (1996) positioned contradictions as normal in interpersonal relationships, thus, debunking the belief that healthy relationships are free of contradictions (e.g., uncertainty/certainty).

The latest iteration of the theory, however, moves beyond the initial focus of identifying tensions to identifying competing discourses present in relational talk. It uncovers "how the meanings surrounding individual and relationship identities are constructed through language use (Baxter, 2011, p. 2). As a critical theory, it emphasizes the role of power in discourses as seen in dominant and marginalized discourses. In this tradition, Baxter positions the theory to uncover centripetal (taken-for-granted) and marginalized discourses that shape meaning-making in relational talk. She posits that interpersonal relationships and talks are filled with competing discourses of unequal power, often reflecting cultural ideologies of the society. Thus, in its critical capacity, it tends to unveil dominant discourse while giving voice to the marginalized ones.

Given the focus of the present study, I apply the latest iteration of this theory to understand the discourses African American women use to make sense of their maternal care encounters. I provide an overview of RDT (latest iteration), discussing the conceptual and methodological underpinnings of the theory. I also provide examples of studies that have applied the theory in the contexts of family and motherhood communication research.

Overview

Relational dialectics theory (RDT), a critical theory focused on relational meaning-making, was introduced by Baxter and Montgomery (1996) and re-articulated by Baxter (2011). RDT is grounded in the work of the Russian philosopher, Mikhail Bakhtin. Bakhtin's works were focused on the concept of dialogism and its presence in the construction of self and everyday conversation. Bakhtin (1990) posits that self is socially constructed and that meaning is holistic only in relation to the "other." By inference, we make sense of self through the lens of others. This focus was initially prevalent in literary works and writing, especially with a focus on authors and how it was impossible to isolate their literary works from their everyday life and realities (Baxter, 2011). By 1924, Bakhtin's dialogic work began to focus more on linguistic features in everyday conversation. Particularly, he attended to the inseparable influence of the social in shaping meaning in everyday conversation. His work critiqued the abstract form of language use by advancing the study of language in relation to social and cultural influences which we are always in conversation within our everyday conversation. Whether we are in conversation with other (physically present) people or by ourselves, utterances are shaped by a dialogic performance with the other as we

> create meaning not only based on the structural features of language or the motivations and predispositions of individuals, but additionally, we grasp language as something a particular other says to us in a specific temporal, spatial, and social situation… utterances mean different things based on the relationship that the parties bring to the interaction moment. In short, meaning is not just about linguistic structure and individual psychology; it is a decidedly social process, a joint undertaking of meaning making between interactants. (Baxter, 2011, pp. 29-30)

RDT is situated within this theoretical background of dialogism as it positions interpersonal

communication as a site of meaning making between interlocutors who construct meaning beyond the abstract, linguistic use of words to the sociocultural implications of language use. Succinctly, RDT studies how utterances (which will be discussed in greater detail in the next section) in interpersonal relationships are shaped by broader (and context-specific) cultural ideologies that dictate the norm in the society. In interpersonal communication, Bakhtin's principle of dialogism manifests in a way that utterances are only considered meaningful in relation to the "other" existing cultural discourses that punctuate meanings in human interactions. For instance, while studying abroad, away from her husband, Betsy said, "I really want to spend time focusing more on my research during my time abroad, but it doesn't speak well of our relationship if we only communicate once a week." Implicitly, Betsy is speaking to a larger cultural discourse of connection in interpersonal relationships (Baxter, 2011), where partners are expected to be connected through frequent interactions such as talking on the phone. At the same time, she struggles with wanting some autonomy despite the cultural expectation. In this example, Betsy dialogically makes meaning with unstated, yet present cultural discourse of connection in a romantic relationship, such that the meaning making process in this utterance is sociocultural constructed. Bakhtin (1986) argued,

> Each utterance is filled with echoes and reverberations of other utterances to which it is related by the communality of the sphere of speech communication. Every utterance must be regarded as a response to preceding utterances of the given sphere (we understand the word "response" here in the broadest sense. Each utterance refutes, affirms, supplements, and relies on the others, presupposes them to be known, and somehow takes them into account. (p. 91)

Furthermore, this meaning making process is understood through the interplay of discourses and

how they impact interpersonal relationships and individual identities (Baxter, 2011; Suter, 2018; Suter & Norwood, 2017). RDT is firmly rooted in the assumption that meanings in relational experiences are "ideologically saturated" (Bakhtin, 1981, p. 271). They do not exist in a vacuum. In summary, RDT posits that meanings in relational talks take place and are constructed through competing and contradictory discourses that are inevitably present in utterances- this constitutes the primary focus of RDT (Baxter, 2011).

Meaning making, as discussed in this theory, is influenced by, and is in a struggle with social, cultural, and political ideologies of the society. In its critical component, RDT goes beyond identifying competing discourses to and their interplay, to recognizing positions of power inequality in the discourses. As Baxter argues, discourses are not usually equal in power; some are dominant (centripetal) while others are marginalized (centrifugal). Within an utterance, no two discourses are equal in power. Thus, Baxter encourages scholars to move beyond the identification of discourses to issues of power inequality in those discourses. This focus on power inequality is a major hallmark of RDT as a critical theory (Braithwaite et al., 2017).

Since its development, the theory has received much attention from qualitative communication scholars, especially family communication scholars (e.g., Baker, 2019; Cronin-Fisher & Sahlstein Parcell, 2019; Suter et al., 2015). Recent application of RDT in communication scholarship (e.g. Baker, 2019; Baxter et al., 2014; Norwood, 2010; Suter et al., 2014) has embraced Baxter's suggestion by engaging in a kind of scholarship that identifies and critiques power inequalities present in competing discourses and their impact on "individual and relational identities" (Baxter, 2011, p. 2; Suter & Norwood, 2017). Given this focus, scholars have identified and challenged dominant cultural discourses that marginalize or suppress minority voices in the society (e.g., racial minorities, adopted children, and non-traditional

families and gender, and women). In a study like this, RDT serves as a powerful theoretical tool in unveiling discourses that are present at the intersection of the marginalized identities of race, gender, and pregnancy. More importantly, it helps to identify power inequalities resident in how African American women make sense of these discourses.

Conceptual and Methodological Underpinnings of RDT

For a successful understanding and application of this theory, discourses and utterance chain stand at the core. Baxter argued that discourses as resident in the utterance chain form the theoretical bedrock of RDT. In the following sections, I focus on the conceptual and methodological underpinnings of the theory, that is, discourse, utterance chain, and contrapuntal analysis respectively.

Discourse

Baxter (2011) argued that the process of meaning-making in interpersonal relationships is grounded in the infinite competing discourses present in human interactions. The meaning of discourse in RDT extends beyond the layman's definition of discourse, as seen in a discussion. As Baxter (2011) stated, discourse under RDT "is a system of meaning—a set of propositions that cohere around a given object of meaning" (p. 2). By inference, discourses accentuate meanings in human interactions. Discourses that circulate in a society or a particular culture are not singularly defined; they are multivocal and culturally driven. They are closely informed by what is known as the "norms" and "ideals" of that society.

For example, in reference to cultural discourses about African Americans, historical events of slavery, colonialism, and racism cumulatively contribute to dominant and circulating discourses about this population. For a long time in the U.S., African Americans have contested the notion of "second-class" citizens as voiced through reported systemic injustices and

discrimination. Various forms of discrimination are experienced by this population at different levels of social institutions in the U.S. (Bonilla-Silva, 2006). However, these different forms of discrimination are discourse driven. There are existing, dominant discourses about African Americans in the U.S. that consistently impact their experiences as individuals (e.g., "the angry Black woman," Ashley, 2014), making them discourse-dependent as they discursively engage in meaning making process to "defend" their identities (Galvin, 2006, p. 8).

Importantly, RDT identifies the interplay of these discourses as they complete for centrality in utterances. This is identified through lexical markers used in voicing discourses in a way that shows negation. Rooted in the dialogic work of Bakhtin, the identification of competing discourses in a given utterance is only achievable through close attention to the lexical markers use by the interlocutors, in a way that presents contrast or negation. As we know, RDT does not really focus on individuals voicing the discourses, rather the central focus is on the discourses and how they compete for power. However, the words, lexical markers that these individuals use in voicing the discourses set a foundation for understanding how the discourses compete and interplay.

In the struggle for power, discourses can either take centripetal or centrifugal positions in utterances. Discourses in centripetal positions are those that are dominant and popular, considered as the norm within a given culture. For instance, the discourse of biological children is a dominant discourse in the United States, as biological children are considered as "the legitimate" children, and other types of children (e.g., foster children and adopted children) are often considered "less real" (Baker, 2019; Baxter et al., 2014). Inversely discourses in centrifugal positions are those that defy the traditional archetype of the society. For example, the discourse of female-female co-mothering is marginalized in the United States as it defies the traditional

ideology of a family as represented in a father, a mother, and their children. Female-female parenting and family types are considered less than "ideal" and often delegitimized (Baxter et al., 2015; Suter et al., 2015).

Discourses are identified within utterances, and any given utterance consists of a minimum of two competing discourses, they could be more. As discourses compete, meaning is constructed (i.e., praxis) through diachronic separation or synchronic interplay. Diachronic separation occurs when discourses switch positions of power (centripetal versus centrifugal) over time within a relational context, such that at one point in time a discourse may be centered, and at some other pint it may be marginalized. Diachronic separation manifests in two different forms; spiraling and segmentation. On one hand, Spiraling manifests when two or more discourses shift power positions, when they are punctuated by time, such that at one given time a discourse is dominant and at another time, it is marginalized. For example, a first-time mother may privilege more information from her healthcare provider during her prenatal appointments while she may consider "more information" unnecessary during her subsequent pregnancies over time. On the other hand, segmentation occurs when activities change, such that in one context within a relationship, a discourse is dominant, and, in another context, it is marginalized. For example, a couple may decide that connection is a priority for them when they are together but may privilege autonomy when they are with their families. Synchronic interplay as a form of praxis, manifest in three ways; negating, countering, and entertaining. Negating occurs when, in a given utterance, there is a direct rejection of a discourse. In this way, a discursive position recognizes a discourse with the ultimate goal of rejecting it as valid. Countering, though similar to negating, supplants a discourse by replacing it with another. Lastly, entertaining as a synchronic interplay occurs when a discursive position is acknowledged as one possibility of

multiple discourses around a given subject or context.

In this study, RDT serves as a valuable tool in underlining discourses that are prevalent with discourse-dependent identities. For example, an African American woman without a sign of being married is more likely to construct meaning differently even when she has the same healthcare encounters as a White unmarried woman. The identity of an African American woman in the U.S. culture has been subject to different forms of delegitimization, as such, discourse-dependent.

Utterance Chain

An utterance, as conceptualized in this theory, is a combination of previous utterances coming together to make meaning with the present and future utterances. In other words, utterances are neither autonomous nor abstract. They are speaking from the knowledge of previously spoken utterances and also speaking to future ones. Bakhtin (1986) stated that an utterance "is filled with echoes and reverberations of other utterances to which it is related" (p. 91). This is, perhaps, one of the most profound aspects of Bakhtin's principle of dialogism that is applied to RDT. Voloshinov (1986) further argued that:

> The organizing center of any utterance, of any experience, is not within but outside- in the social milieu surrounding the individual being…even the most primitive human utterance produced by the individual organism is, from the point of view of its content, import, meaning, organized outside the organism, in the extraorganismic conditions of the social milieu. Utterance as such is wholly a product of social interaction, both of the immediate sort as determined by the circumstances of the discourse, and of the more general kind, as determined by the whole aggregate of conditions under which any given community of speakers operates. (p. 93)

More importantly, the focus of RDT is not just attending to utterances made within the confines of individual, interpersonal relationships (it surely does not ignore this), but it attends, even more, to how utterances in interpersonal relationships are socially constructed and socially driven (Baxter & Norwood, 2015). While individuals in their unique interpersonal relationships have utterances that may be driving that relationship (proximal already-spoken and proximal not-yet-spoken), RDT focus is not mainly focused on these unique or subjective relational talks. Rather it is focused on the notion that utterances are embedded into larger utterances in the past or in the future; utterance chain.

In discussing the chain of utterances that cumulatively influence utterances in interpersonal relationships, Baxter and Montgomery (1996) proposed four forms of utterance links that influence utterances: distal already-spokens, proximal already-spokens, proximal not-yet-spokens, and distal not-yet-spokens. Distal already-spokens include utterances that are broadly circulated in a given culture. These utterances are embedded in larger discourses about a given domain or context and they are known to members of the culture while they serve as a reference for meaning making (Baxter, 2011; Baxter & Norwood, 2015). In interpersonal relationships, individuals construct meaning in their relationship through utterances that are centrally influenced by the culture in which they are (psychologically) located. Examples of some cultural discourses in the U.S. include discourses of heterosexuality (Baker, 2019; Suter, 2015, intensive mothering (Hays, 1996), and biological children (Baxter et al., 2014). In characterizing the discourse of marriage as a prerequisite for starting a family, Liz told her mom, “I am happy about my pregnancy, Jeff and I are going to get married anyways.” The foregoing example speaks to the larger U.S. cultural discourse of marriage as a necessity for starting a family. Liz, though linguistically unstated, draws upon that discourse to validate her pregnancy.

She spoke to an already spoken discourse in the larger U.S. culture.

Proximal already-spoken, however, attend to utterances that are specific to individual, interpersonal relationships. These utterances are specific to an interpersonal relationship as they guide their meaning making process of their relational experiences. In this context, relational partners construct meaning based on a mutually intelligible history of the relationship, as meaning is thus constructed in response to the "relational meaning system of the pasts" (Baxter, 2011, p. 52). Distal not-yet-spokens include anticipated discourses that will be spoken at the cultural level of meaning based on existing utterances already spoken at the cultural level. For instance, in this hypothetical scenario, Gizelle was asked if she was treated differently by her healthcare provider, she responds to her interviewer by saying, "well I don't want to see it as racism, but I felt discriminated against." In this example, Gizelle spoke to a distal not -yet - spoken but anticipated, given the historical experiences of racism by African Americans. She anticipated that the interviewer would respond that she experienced racism. Lastly, Proximal not-yet-spoken include utterances that are anticipated to be spoken at the relational level, based on previous experiences and utterances in operation in that specific relationship.

In this study, I will focus on distal already-spokens and distal not-yet spokens in the utterance chain. Since this study seeks to identify racial and gendered discourses about African American mothers, it is justifiable to concentrate on these utterance links. Moreover, Baxter and Norwood (2015) suggested that researchers should focus on one type of utterance at a time to allow for a careful, uncomplicated, and in-depth analysis of meaning-making.

Contrapuntal Analysis. A major evaluative criterion of any critical theory is its ability to go beyond the goal of just interpreting findings and identifying meanings, to finding contradictions and differences between them. Braithwaite et al. (2017) argued

> the interpretive scholar seeks to identify patterns or consensus, the critical scholar rejects that goal and focuses on contradictions, dissension, or inequities, finding meaning in differences… the critical researcher would be interested in determining whose norms were legitimated and whose norms for communicating were silenced or de-legitimated. The researcher's goal would be the recovery of perspectives and norms that were silenced in the power-filled dynamics of family life. A good critical theory is evaluated by its capacity to uncover marginalized voices and foster social justice, thereby emancipating disempowered groups from oppressive social structures or ideologies. (p. 7)

As a critical methodological approach contrapuntal analysis, as defined by Baxter (2011), focuses on the interplay of contrasting discourses (i.e., systems of meaning, points of view, world views) in spoken or written texts. The general analytic question that guides contrapuntal analysis is, "What are the competing discourses in the text and how is meaning constructed through their interplay?" (p. 152)

Contrapuntal analysis builds on thematic analysis. Thematic analysis, which focuses on "systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set" (Braun & Clarke, 2012, p. 57), is the basis for contrapuntal analysis, which goes beyond the identification of recurring patterns in the data to identifying underlying cultural discourses that inform the language and sense-making process of participants in the study. It is a deeper, iterative level of data analysis that focuses on the interplay of discourses in texts. While thematic analysis may stop at just identifying patterns, contrapuntal analysis seeks to further identify power as situated in discourses; dominant (centripetal), and marginalized (centrifugal). Furthermore, it unveils how individuals voicing these discourses are making sense of alternate discourses by negating, countering, or entertaining them.

Negating, as a type of power interplay between discourses, involves a rejection of an alternate discourse, in a way that renders it irrelevant or unacceptable. It does not deny the existence of other discourses, but only to disclaim their validity (Baxter, 2011, p. 167). For instance, a Black woman might negate the "the strong Black woman" discourse by saying, "Black women need help." In this example, there is a direct rejection of the cultural discourse "the strong Black woman" by claiming they need help from others. Countering discourses occur when one discourse disclaims or displaces another. Discourses in this category are usually predicated on the use of countering conjunctions that indicate the opposition of two discourses. For instance, "The doctor treated me well even though I am an unmarried pregnant Black woman," contains two countering discourses, as being Black is seen as a default experience of a lesser time from the doctor. Here, the speaker identifies the expected behavior of healthcare providers alongside the discourse of the unmarried Black woman, where African American women are socially constructed as women who have babies with multiple partners outside of marriage (Dixon, 2017). The acknowledgment of quality treatment by her doctor counters the discursive position that unmarried pregnant Black women do not get quality treatment from their healthcare providers. Entertaining discourses is evident when a speaker acknowledges a discourse as just one of the many alternatives of a discursive position. For instance, a Black woman saying "On the one hand, Black women are strong. On the other hand, they also have weaknesses." In this example, the speaker acknowledges the discourse of the "strong Black woman" as an acceptable characteristic of a Black woman but admits that not being "strong" is also an acceptable component. With the help of contrapuntal analysis, scholars have used RDT to study power imbalances advanced through discourses in different interpersonal contexts.

Applications of RDT in Communication Research

Given the epistemological focus of RDT as a meaning making theory in interpersonal contexts, most of its application has been within family communication and other interpersonal communication contexts (e.g., Baker, 2019; Baxter et al., 2014; Suter et al., 2014; Suter et al, 2015). In fact, it is safe to argue that RDT takes a stronger root in family communication scholarship. However, within the family communication research, RDT has been particularly applied to different topics or identities that are associated with the family. This includes topics on motherhood (Cronin-Fisher & Sahlstein Parcell, 2019), adoption (Baxter et al., 2014; Thomas & Scharp, 2017), sibling relationship (Halliwell, 2016), fatherhood (Baker, 2017), divorce (Long, 2018). Additionally, gender communication research has also benefited from the use of the theory in uncovering different forms of power dynamics in gender identities, especially non-traditional gender identities (Baker, 2017; Norwood, 2010; Suter, 2015; Suter et al., 2015).

In family communication research, RDT has been widely used to study marginalized identities within the family discourse in the U.S. culture. Broadly speaking, the U.S. culture privileges the traditional construction of family as seen in a father, mother, and biological children. In the U.S. society (as with many other societies), the biological and genetic concept of family (also known as the structural) has remained a dominant cultural discourse about family identity (Baxter et al., 2009). New constructions of family, though marginalized, have emerged over the years, that is, the functional and transactional definitions of the family (See Segrin & Flora, 2011). Other forms of family relationships, such as fostering and adoption, are still considered "second- best," given the non-blood relationship between the children and the parents. Critical family communication scholars (e.g., Baxter et al., 2009, 2014, 2015; Norwood & Baxter, 2011; Sahlstein Parcell, 2014; Scharp & Thomas, 2016) over the last decade have been focused on exploring other types of family, outside the archetypal traditional definitions of a

family (Floyd & Morman, 2006). Through its critical lens, RDT has served as a useful theory in giving voice to alternate family structures or identities that have been considered discourse-dependent (Galvin, 2006). For example, Suter et al. (2014) examined the construction of "family" through online narratives of foster adoptive parents in the U.S. culture. In this study, RDT was useful in identifying the competing discourses of biological normativity (DBN) and constitutive kinning (DCK). The DBN is the dominant discourse of family relationships in the U.S. culture, as members of a family are considered as those who are connected by blood (Baxter et al., 2009). The alternate DCK of the family is "established and maintained through communicative and performative acts for members, thus linking family to enacted behaviors and expressions of love rather than genetic ties" (Suter et al., 2014). Here, RDT helps us to see the meaning-making process of parents as they make sense of what constitutes family for them. Remarkably, even in an attempt to counter or negate the DBN, parents still acknowledged its value in the construction of a family. For instance, one of the women reported having lied to everyone that the adopted child is her biological daughter in an effort to assert the biological connection that defines a family. The feeling that biological children are the "real" children is a discourse some of the women still struggled with despite having adopted children. Aside identifying the DCK as another legitimate family discourses, an important contribution of the study through RDT is the understanding of the interpenetration of different constructions of the family in the U.S. culture and how meanings in each site of construction intertwine with other discourses. In this way, meanings are not isolated, neither do they exist in a vacuum. The meaning of the family is constructed only in relation to or even interdependence with other family discourses (see Baxter, 2011). Consequently, the discourses present in parent's narratives of family are not only identified, but the study also helps us to see how these parents construct

meaning as they engage with other competing family discourses in the U.S. culture.

Similar to the DBN, the discourse of marriage in the U.S. culture is centrally established through heteronormativity, which is the assumption that a marital union is only between a man and a woman. RDT has been applied to study other, often marginalized, marital discourses in U.S. culture. In a recent study, Baker (2017) examined the discourses of marriage, family, and fatherhood in married gay relationships. Notably, in his study, he detailed the discursive struggle that married gays experience as they try to create meanings in their new relationship, which is traditionally decentered against the archetypical discourses of different-gendered marriage, biological family, and traditional fatherhood in the U.S. society. Through contrapuntal analysis, he focused on how the participants constructed meaning by negating, countering, and entertaining competing discourses emergent in the study. For instance, some participants *entertained* competing discourses by acknowledging that both the traditional and marginalized notions of marriage, family, and fatherhood are legitimate, albeit privileging one at a time. This way, one discourse is centralized while the other is marginalized, though they are both considered as legitimate but one is taking a more powerful position per time. Some participants negated the traditional discourses of marriage, family, and fatherhood by privileging their created meaning as seen in married gay relationships. Again, as seen in Suter et al.'s (2014) study, the dominant discourses of marriage, family, and fatherhood were still valued even when alternate discourses were entertained. Dominant discourses, even when they are negated or countered are still influences in the meaning-making process of participants about marriage, family, and motherhood. Marginalized meanings are sensical only in relation to the (dominant) other (Baxter, 2011). More importantly, RDT research like Baker's helps to make visible how meanings are never finalizable. They are constantly being construed and (re)negotiated. Despite the gay

fathers' attempts to "normalize" their relationships, they still negotiated meanings the legitimacy of their family relationships through the dominant discourses of heterosexual/cis-gender marriage, biological family, and traditional fatherhood.

In motherhood research, RDT has been successfully applied to understanding the tensions and contradictions that mothers face in the traditional American society. For example, in their study, Cronin-Fisher and Sahlstein Parcell (2019) examined the dissatisfaction that women experience as they navigate their experience with the dominant and marginalized discourses of motherhood in the U.S. society. Through a contrapuntal analysis, the authors identified the dominant discourse of motherhood as one that is naturally desired by women, including the desire to want to be a mother and to be seen as a good one. These discourses have permeated the society as what should be the natural desire of every woman. On the contrary, the women in the study expressed clear dissatisfaction as not meeting up to these traditional expectations of how they should feel as mothers. This dissatisfaction is further reinforced through other unpopular discourses of motherhood, such motherhood is a job, unnatural, and should be learned. These alternate discourses challenge the legitimacy of mothers as good ones, as motherhood has been repeatedly presented as a natural, desired, and satisfying experience for every woman (Hays, 1996). Experiencing contrary feelings is considered deviant and unacceptable. Many narratives in this study rejected or countered the dominant discourse of motherhood as innately desired (DMID) while centralizing the discourse of motherhood as learned (DML). Through their motherhood experiences, they constructed a new meaning of motherhood for themselves, affirming the DML. Others entertained the discourse, defining their identity through it, despite the dissatisfaction they experienced as mothers. This study unveils the power dynamics involved in motherhood discourses in the U.S. society. More importantly, the study in its application of

the theory advanced this discourse further by offering useful recommendations for change in our traditional perception of motherhood, and how that could serve as a tool of "oppression" for mothers in our culture (Miller, 2007).

In examining how dominant discourses of motherhood can be injurious or oppressive to women's health, Scharp and Thomas (2017) examined how women construct the meaning of motherhood when confronted with prenatal and postpartum depression. The study attended to the interplay of discourses for mothers experiencing prenatal and postnatal depression, as they struggle between the hegemonic discourse of intensive mothering and the attending health challenges of maternal depression that impedes their ability to live up to the cultural standards of motherhood. While some women acknowledged the importance of self-care during prenatal and postanal stages of motherhood, they also, on the side, acknowledged the need to be happy as a mom, because having a child is "bliss" (Scharp & Thomas, 2017, p. 405). Despite the health challenges confronting the women in this study and the exigency to redefine motherhood, the traditional notions of motherhood (intensive mothering) were still present in their new meanings of motherhood, thereby creating a discursive struggle. Dominant discourses have the power to maintain a line of oppression for marginalized groups. As Briscoe and Khalifa (2015) argued,

> For over 500 years racialized groups have been enslaved and/or oppressed in the United States. Over these years, complexes of ideologies, discourses, practices, and policies were developed, to justify and maintain their oppression. When viewed alone, individual components seem innocuous, but together in complexes of policies, practices, and discourses, they act to detrimentally affect racialized groups. (p. 741)

Thus, in different contexts including healthcare, dominant discourses that delegitimize the identity of African American women can have serious negative impacts on their identity as

mothers as well as their health (e.g., prenatal and postpartum depression)

RDT, in its application to motherhood research, helps us to see alternate ways of constructing motherhood alongside the dominant discourses of motherhood as seen in intensive mothering (Hays, 1996) or DMID (Cronin-Fisher & Parcell, 2019). Within this body of research, it is clear how women, in their narratives, did not outrightly refute the hegemonic discourses of motherhood (self-sacrifice, positive emotions, joy, and immediate love), rather they created a space for their new realities to create new meanings that accommodated their (health) challenges and experiences (Scharp & Thomas, 2017. In this way, the dominant discourse of motherhood is not decentered but modified to accommodate the health challenges of these women. It is expedient to note that the issue of power inequality even in this "new meaning" remains in a polemic interplay of power (Baxter, 2011; Scharp & Thomas, 2017). This way, hegemonic ideologies or dominant discourses are not always negated, instead, they are sometimes *accommodated* in a way that creates new meaning.

Applying RDT to gender communication research, scholars have examined alternate discourses to heterosexuality as seen in exploring how individuals with gender identities that upend the dominant construction of gender make sense of their identity in different forms of interpersonal relationships (e.g., Baker, 2017; Breshears & Braithwaite, 2014). In transgender identity research, Norwood (2010) examined the construction of meaning and identity for family members of transgender individuals. She identified how the dominant cultural discourse of gender is used to construct meanings with family members' (new) gender identity. This includes the discourse of a sovereign self versus the discourse of a social self. Norwood found that the construction of personal identity of transgender individuals is lurked in an interpenetration of social, dominant discourses of sex and gender as represented through the discourse of biological

essentialism and the sociocultural discourse of gender. Similar to the findings of other RDT research, transgender identity is constituted only in relation to the dominant discourses of sex and gender, albeit, decentralized to privilege the discourse of the sovereign self, which is the notion that "identity is an internal, inborn possession belonging solely to the individual… independent of the body" (Norwood, 2010, p. 89). Within this body of research, communication is strongly emphasized as a tool of meaning-making in trans-identity and functions as the way individuals resist their old selves while constructing their new selves. "Meanings surrounding individual and relationship identities are constructed through language use" (Baxter, 2011, p. 2).

In health communication scholarship, RDT in its critical iteration has not received as much attention. In one of the studies applying RDT to the diagnosis of Endometriosis in women's reproductive health, Krebs and Schoenbauer (2019) identified dominant and marginalized discourses about the meanings associated with being diagnosed with endometriosis. Through online narratives, they analyzed data to understand how women are making sense of their diagnosis. They identified the dominant discourses of psycho-abnormality[4] and biological normality[5]. In this study, women report struggling with competing discourses that challenge these dominant discourses. For instance, one of the women narrated how her physicians tokenized her symptoms and classified her as being weak because she was complaining a lot about her symptoms. In other cases, women were told, having endometriosis was a "normal" part of a "blossoming" woman's life and should be accepted as such (Krebs & Schoenbauer, 2019, p. 6). However, they identified an alternative discourse in these narratives, as women began to

[4]Pscyho-abnormality is when a diagnosis is figment of their imaginations and not necessarily real (Krebs & Schoenbauer, 2019).
[5] This discourse assumes that the experience of endometriosis is a "normal" part of "womanhood" and should be embraced as a natural phenomenon (Krebs & Schoenbauer, 2019).

personally make sense of endometriosis as abnormal, and not a woman's default lot to "suffer." This alternate discourse negated the dominant discourses earlier mentioned. In this way, women reclaimed their agency by personally making sense of endometriosis as abnormal to a blossoming" womanhood. This study is an example of how dominant cultural and gender discourses about women's reproductive health impacts their sense-making process of "abnormal" when experienced.

These different bodies of research point to some fundamental understandings about RDT. First, RDT, as a critical communication theory, is useful in identifying dominant and marginalized discourses in different forms of interpersonal relationships (beyond the present applications of the theory). Second, RDT, through its methodological tool of contrapuntal analysis, helps us to understand how (marginalized) identities and meanings are constructed in relation to one another through diachronic and synchronic interplays of negating, countering or entertaining. Also, even in the event of the construction of new meanings, such meanings are developed in relation to other discourses, that is, they are constructed in response to a particular discourse. Third, RDT is useful in understanding that discourses thrive through communication and the use of language, not necessarily individuals. Consequently, communication is positioned as a vital tool in understanding identity construction in different interpersonal contexts. Lastly, the construction and (re)negotiation of meanings through RDT research gives further insight into the impact of dominant discourses on individuals' experiences such as their health (Krebs & Schoenbauer, 2019; Scharp & Thomas, 2017, p. 405).

Despite the growing scholarship in the application of RDT to different communication studies including health and motherhood, there has been a dearth of research on racial issues. Nonetheless, "racial minority families face the communicative and psychological burdens of

everyday discrimination" (Suter & Norwood, 2017, p. 291, citing Daniel & Daniel, 1999) where they engage in "labeling, explaining, legitimizing, and defending" their identities (Galvin, 2006, p. 6). Minority racial identities are discourse-dependent in the U.S. society, as members of minority racial groups face forms of marginalization in different contexts (Briscoe & Khalifa, 2015), especially African American women (Collins, 2000). The marginalization and oppression of minority racial groups occur through discourses, as "social actions and the power relations…are largely (re)produced and organized through discourse" (Briscoe, 2006, p. 2) that is, through hegemonic ideologies that are set up to only advance the agenda of the "powerful" while "supporting particular power relations and their related knowledge paradigms, while delegitimizing others" (Briscoe & Khalifa, 2015, p. 740).

In (inter)racial communication scholarship, RDT is a valuable theoretical tool in underscoring discourses that permeate the maternal healthcare experiences of African Americans, as it attends to dominant and marginalized discourses about their identities in different interpersonal contexts. RDT's application in the present study will be useful in unveiling dominant constructions of pregnancy, African American womanhood, and motherhood. Additionally, RDT as a critical theory will be useful in identifying discursive sites of power and its inequality in marginalized identities like the women in this study, especially in physician-patient interactions. African American women broadly embody discourse-dependent identities, as they work to defend and legitimize their identities and experiences in a racially marginalized society. The theory will help to understand how these women construct meaning through different competing discourses that tend to accentuate their identities, even in their vulnerable state. Furthermore, critical theories that have studied motherhood have often decontextualized race, especially minority race (Collins, 1994). Focusing on African American

women will not only add the voices of these women to the ongoing conversations circulating about motherhood and pregnancy, but it also will record their construction of motherhood as contextualized within the social realities of the Black race in the U.S. culture. It will further the understanding of how discourses impact maternal health, which may include its effects on issues such as traumatic birth (Cronin-Fisher, 2018) or even postpartum depression (Scharp & Thomas, 2017). The application of the theory in a context like this will be among the first of its kind in interracial communication scholarship. Thus, I posed the following research questions:

RQ1: What discourses animate the meaning-making of maternal healthcare experiences from the perspectives of African American mothers?

RQ2: How do these discourses interplay?

III. Method

In this chapter, I discuss the methodological choices. First, I present my rationale for the critical qualitative research methodology. Next, I describe the study site and my data collection procedures. I then discuss how I analyzed the data through contrapuntal analysis. In the end, I establish the credibility of the study and explain how the findings are presented.

Rationale for Methodology

My main research goal was to identify discourses that are evoked in African American women's sense-making of their prenatal and postnatal healthcare encounters. I further sought to identify how discourses interplay in the narratives of African American women in Milwaukee county, Wisconsin. Identifying these discourses and understanding how women make sense of them provides a critical lens to underscore dominant discourses that are present and /or interfere in African American women's maternal healthcare experiences. Broadly speaking, qualitative research methodology helps to identify issues that may not be richly addressed through surveys or other structured methodological approaches. As Tracy (2012, p. 6) argued, qualitative research helps to

> uncover salient issues…that encourage a level of disclosure unparallel in self-reports or snapshot examinations of a scene. Such work has the potential to provide insight about marginalized, stereotyped, or unknown populations…to tell a story that few know about.

Qualitative research is capable of giving scholarly insights into relationships, groups (including ethnic and racial groups), and cultures, especially through stories that unveil issues of power inequality in different contexts, that might otherwise be missed through structured forms of data collection. The depth that comes with qualitative research methods during data collection (e.g., interviews) provides insight into espoused cultural values, beliefs and actions that "that few

know about," which can further "provide knowledge that targets societal issues, questions, or problems" such as maternal health crisis among African American women (Tracy, 2012, p. 5). Specifically, critical qualitative research methodology provides an avenue to address real-life problems among marginalized groups (e.g., African American women), in a way that seeks to empower them to resist oppression and social injustices (Denzin, 2015). Furthermore, "critical qualitative inquiry often functions as a form of political resistance influenced by various complex power relations and discourses of injustice of various kinds," while identifying power and health inequities that punctuate the maternal healthcare realities of African American women (Denzin et al., 2017, p. 494). To identify the discourses evoked in African American women's talk about their maternal healthcare encounters, one needs a methodological approach that allows participants to share their experiences and tell their stories in a way that provides deep reflection for the participants, contextualizing their stories, while giving room for clarifications as needed.

For this study, I employed the critical qualitative research method of semi-structured interviews. Interviews readily provide a researcher, conducting contrapuntal analysis, rich data that helps one to understand distal-already spoken discourses imminent in a relational site (Baxter, 2011). Specifically, I combined narrative and respondent interview formats (Lindlof & Taylor, 2019). Narrative interviews are less-structured interviews that allow participants to tell their stories in a "natural" and uninterrupted way (Tracy, 2012). Given pregnancy is a major life event for a woman, allowing women to tell their pregnancy stories provided an opportunity to understand the meanings women associate with happenings during this time of their life. Interviews also helped to contextualize their stories while naturally identifying what events were significant to them in their pregnancy experiences. Additionally, Baxter (2011) recommended narrative stories as a qualitative research method for conducting contrapuntal analysis. In her

argument, narrative stories "are, on theoretical grounds, potentially fruitful discursive sites in which to identify contrapuntal intertextuality" (p. 153). While listening to the women's stories, I followed up with questions to clarify important information provided during the narration in a way that advanced the goal of the study, which includes understanding how women made sense of their maternal healthcare experiences. Given the benefits of narrative stories for the kind of data analysis employed in this study, I used respondent interview format to situate their stories within the goal of this study. The respondent interview format is useful in helping researchers to "clarify the meanings of common concepts and opinions…to determine what influenced a person to form an opinion or to act in a certain way…to understand the interpretations that people attribute to their motivations to act" (Lindlof & Taylor, 2011, p. 179). This way, I asked questions that provided additional details on how women made sense of maternal healthcare delivery toward African American women (e.g., "Why do you think those experiences were unique?"). Additionally, to conduct contrapuntal analysis, semi-structured interviews served as one of the bests paths to access cultural discourses. These discourses include those already circulating within the context of this study, that is, the distal already-spokens. Baxter (2011) argued that interviews readily provide the researcher with data to identify and understand the cultural discourses of distal already-spokens and proximal already-spokens. In this context, individuals talk about their relationship to third parties while referencing cultural codes (discourses) in ways that make their talk "intelligible to cultural outsiders, most immediately the interviewer" (p. 155) and

> when parties talk about their relationship to third parties, when others talk about relationships in their midst through gossip and similar communicative enactments—these are occasions when cultural codes are implicated in order to render the relationship

> intelligible to fellow members of the culture. Border work—communicative enactments in which relationships go public in a variety of ways—is thus fruitful in understanding cultural discourses of relating. (p. 155)

Employing a critical qualitative approach and theory further nuanced this study by helping to identify and critique areas of disparities and inequalities in African American women's maternal healthcare encounters. "Critical approaches are oriented toward investigating exploitation, unfairness, and false communication – and how cultural participants reaffirm, challenge, self-subordinate to, or accommodate existing asymmetrical power relations" (Tracy, 2012, p. 44). Critical qualitative research comes with the ultimate goal of transformation and change (Lindlof & Taylor, 2019), one that will empower African American women and other marginalized populations in the U.S. healthcare system to resist different forms of power inequities, as it "brings power relations to conscious awareness and, by doing so, provides space for questioning and transformation" (Tracy, 2012, p. 42). The maternal health crisis for African American women is an indication of racial injustices in the U.S. culture, indicative of a broader issue of racial discrimination in the U.S. society. RDT, as a critical qualitative communication theory, helped me to situate discourses that are present in African American women's maternal healthcare experiences within the context of their racial identity. This is a new application of the theory, that is, in a race-focused critical communication research. Doctor-patient interaction in the context of this study is a discursive site for understanding the "communicative conduct of their relationships" (Baxter, 2011, p. 154) with their healthcare providers who, historically, might have been found to undermine and marginalize the identities and experiences of African American women as they relate to maternal healthcare (Mkandawire-Valhmu et al., 2018).

Study Site

Data collection for this study took place in the county of Milwaukee, Wisconsin between March 2019 to February 2020. Milwaukee presently rates as the most racially segregated metropolitan city in the U.S. (Frey, 2018). Milwaukee also has had an increasing rate of infant mortality (City of Milwaukee Health Department, 2018; Ward et al., 2013). According to the Wisconsin Department of Health Services (2019) in their latest statistics on maternal mortality rate among African Americans in Milwaukee, maternal mortality rates five times higher among African American women compared to non-Hispanic White women in the city. Considering the disparities in Milwaukee, it was justifiable to limit the scope of this study to African American women living in this city.

Participants

Thirty-one African American women participated in this study, which includes four women who participated in the pilot study for this present research. Participants were African American women who were currently living in Milwaukee county and had maternal care experiences with healthcare providers in the city or surrounding area. Participants ranged from 20-44 years old and were either pregnant (n = 6) or have been pregnant within the last one year (n = 21). Participants also included women who were part of the pilot study and had been pregnant within the last 10 years[6] (n = 4). The majority of the women were either pregnant with their first child or have had only one child (n = 16). In reporting their marital relationship status, eight women reported being married while 23 reported being single or engaged. For participants who reported their annual income, ten did not report their income or are currently unemployed, 13 has a household income of less than $35,000 per year, five reported an income between

[6] The four women who participated in the pilot study for this research had their children within the last 10 years (See Table1).

$36,000 and $70,000 per year, while three reported an annual household income between $71,000 and $120,000 (See Table) for a comprehensive summary of participants' demographic information).

Procedures

In this section I provide a report of my data collection and analysis activities.

Recruitment

Upon the approval of the study by the University of Wisconsin-Milwaukee IRB (UWM IRB # 19.A.238; Appendix A), I recruited participants through purposive and snowball sampling. I made announcements on social media sites such as Facebook and WhatsApp (See Appendix B for recruitment flyer), including Facebook groups and pages dedicated to moms (e.g., Milwaukee Moms, KidsCycle: NS Milwaukee area, and African American Breastfeeding network Milwaukee) and one I created (Black Moms Maternal Health) for African American women living in the Milwaukee area. I also designed and distributed handbills to Black women in public places like museums, a doctor's office, and in Black-majority childcare centers around the Milwaukee area. Lastly, I encouraged participants to share the study information with their eligible friends and family members.

Semi-Structured In-depth Interviews

Prior to scheduling interviews with participants, I conducted an eligibility check based on the criterion listed above. I asked them when last they were pregnant and if they identified as African American by race. Upon confirmation of their eligibility (that is, must identify as African American and must have been pregnant within the last one year), participants enrolled in the study participated in either a face-to-face interview (n = 6) or a phone interview (n = 25). Before the commencement of the interview, I read the consent form (See Appendix C) to the participants, and consent was established through verbal affirmation for both face-to-face and

virtual participants. Interviews lasted between 50 to 75 minutes.

I divided the interview into two major parts; demographic information questions (See Appendix E) and content questions. Demographic questions solicited age, number of children, level of education, and household income (See Appendix E). The first content question asked participants to narrate or tell their most recent pregnancy stories starting from the day they learned of their pregnancy until delivery or present (for those who are still currently pregnant; narrative interview format). I asked follow-up questions to clarify meanings and solicit other relevant information based on their stories and the focus of the study (respondent interview format). This included descriptive, experience, typology, and example questions (Spradley, 1979; Tracy, 2012). Examples of these questions included, "What were your expectations about prenatal care with your healthcare providers (doctors, nurses, insurance companies, receptionists)?" and "What did you experience in comparison to your expectations?" In the latter part of the interview, I asked questions that solicited information about their perception of the maternal crisis among African American women. These include questions on their racial and pregnancy identity and how they think healthcare providers perceive them. Examples of these questions include, "Do you think there is a difference between how doctors treat pregnant African American women patients versus other women?", "What do you think about African American women's maternal crises in Wisconsin?", and "How do you think healthcare providers perceive pregnant African American women?" (See Appendix F). At the end of the interview, I asked participants member-reflection questions (Tracy, 2012), to solicit their suggestions on how healthcare providers can better serve pregnant African American (e.g., "Reflecting on our conversation, in what ways do you think the healthcare providers can better serve African American women during pregnancy?"). Upon the completion of the interview, each participant

received a $20 gift card, which was either an amazon or a Walmart gift card. The incentive was funded by a John Paul Jones scholarship through the University of Wisconsin-Milwaukee Department of Communication.

Data Recording, Transcribing, and Cleaning

I recorded the interviews on a digitally handheld device (face to face interviews) or recorded through a phone recording app (Cube) for phone interviews. After each interview, I transferred the recording to a central folder on my password-protected computer. I used the Temi.com™ transcription service for transcribing the majority (n = 27) of the interviews. Undergraduate research assistants transcribed the remaining interviews. Upon the completion of transcription, I cleaned the data by camouflaging the transcripts (e.g., I assigned participants pseudonyms) and organized each participant's interview to a new section within a master document. I also cleaned the data to edit words incorrectly transcribed by the Temi™ software or the research assistant. Transcription produced 554 single-spaced pages of data.

Data Saturation

Data saturation is defined as a moment in qualitative research data collection where there is little or no new information emerging from additional data (Miles et al., 2013; Tracy, 2012). Depending on the focus of the study, the process of achieving saturation in qualitative research may be different. Saturation can be achieved through data saturation (when there are no new information emerging from the data), code saturation (when no new codes or themes are generated from the existing data) or theoretical saturation, which involves a point in data collection and analysis "in which new data add little, if any, new value to the emergent analysis" (Tracy, 2012, p. 202). In this case, the data adequately reflects the core constructs of the theory (Saunders et al., 2018; Starks & Brown Trinidad, 2007). Given the theoretical framework

employed in this study, RDT, it was important to reach data saturation as well as theoretical saturation (i.e., have data that richly exemplify cultural codes needed for contrapuntal analysis) (Tracy, 2012). Consequently, after conducting 23 interviews, I reached data saturation. However, I continued to conduct interviews because eight additional participants had enrolled in the study. Upon the completion of interviews with the remaining participants, I stopped recruiting participants. The data at this point provided enough information to engage the theory.

Data Analysis

Data analysis commenced during data collection as I engaged in an iterative process of interviewing and reflection. Reflecting on interviews and reading notes during the process of data collection are useful practices in making sense of the data at the preliminary level (Saunders et al., 2018; Starks & Brown Trinidad, 2007). These practices helped identify interview questions that needed to be revised due to ambiguity or any other technical issues. For instance, in the first set of interviews that I conducted during the pilot study in March 2019, I identified questions such as, "How many years did you go to school" and "What is your religion?" as unclear to the participants. Consequently, I revised them in subsequent interviews based on the feedback I got from the first set of participants (i.e., "What is your highest education level" and "What is your religion, if you have one?"). During the interview, I also noted questions that participants responded to more than others. As such, I prioritized such questions in the follow-up inquiries. I also took jottings as I completed interviews, to document my observations and preliminary interpretation of the data. Jottings can "strengthen coding by pointing to deeper or underlying issues that deserve analytic attention" (Miles et al., 2013, p. 94). Reflecting on my interview transcripts, written fieldnotes, and personal jottings helped me to (1) reflect on my perceptions of the interviews, (2) identify possible problematic procedures in the data collection

process, and (3) provide an initial interaction with the data, in a way that helped me prepare for further analysis.

Upon the completion of data collection and transcription, I conducted a contrapuntal analysis on the data. Contrapuntal analysis is the methodological component of RDT. Baxter (2011) identifies this type of analysis as another kind of discourse analysis, albeit focused on dominant (centripetal) cultural discourses and marginalized (centrifugal) discourses. Contrapuntal analysis also allows for identifying the interplay of discourses in texts or spoken words, revealing how they compete for power while constructing meanings (Sahlstein Parcell & Baker, 2018; Suter, 2018; Suter & Norwood, 2017). This meaning-making process could manifest through negating, countering, or entertaining those discourses that were evoked their talk (Baxter, 2011). Given the scope of this study, I analyzed my interview transcripts for discourses that permeate African American women's talk about their maternal healthcare, and how these women made sense of maternal healthcare as discourses compete for power. Ultimately, the critical dimension of RDT positions this methodological approach to uncover (to be critiqued) issues of power and inequality in individuals' talk about their relationship, experiences, as well as identities (Suter, 2018).

While many types of qualitative data analyses focus on recurring patterns in the data, contrapuntal analysis identifies how these patterns, in this case discourses, are "speaking" to one another. Contrapuntal analysis focuses on the narratives of the participants while analyzing the utterance chain resident in the narratives. This focus includes attending to the cultural context of the narratives in the text, such as distal-already-spoken or proximal-already spoken. Baxter (2011) echoes this methodological choice stating that "researchers might choose to emphasize one or another of the sites of the utterance chain over others, depending on the particular focus of

the research question" (p. 156). In this study, I focused on distal-already-spokens given the goal of identifying what cultural discourses are at play in African American women's talk about their maternal healthcare experiences.

Conducting Contrapuntal Analysis

Baxter (2011) posited that to successfully conduct a contrapuntal analysis the researcher must be familiar with the communication and cultural codes of the site being studied. She argued that this can be achieved either through extensive knowledge of the research literature on the field and/or through ethnographic immersion. Lack of knowledge about the existing cultural and communication codes might impede a researcher's identification, interpretation, and understanding of the discourses at play in the data. While I racially identify as a Black woman who also went through maternal care in Milwaukee before and during data collection, it was important to situate the interpretation of the findings within the perspectives of the women in this study, as evidenced in previous studies (e.g., Mkandawire-Valhmu et al., 2018). As such, to aid in my identification and interpretation of the discourses, at the beginning this study I immersed myself in previous literature on African Americans' healthcare experiences. Throughout the period of analysis and writing, I continued to read relevant literature on African American women (e.g., Mazul et al., 2017). This immersion also included conducting empirical and systematic reviews of research on this subject area (e.g., Adebayo et al., 2019) and resulted in a robust knowledge of African American culture. Once a researcher is ready to begin a study using RDT, they engage in three basic procedures: identify appropriate texts, identify competing discourses, and identify the interplay of competing discourses (Baxter, 2011).

Identifying the Text

The locus of analysis in any qualitative study is the text. My transcribed interviews constituted the texts for analysis in this study. For contrapuntal analysis, the researcher's immersion into the text provides a rich understanding of discourses at play, as situated in the natives' culture, while revealing how participants make sense of those discourses (i.e., their interplay and the resulting meanings). Baxter (2011) argued that successful identification of text for contrapuntal analysis begins with a researcher's identification of sites that "are commonly purported to be problematic or are sites of rupture, challenge, or change because the animation of competing discourses is likely to be particularly salient" (p. 153). Discourses surrounding the identities and experiences of racial minorities, especially African Americans have always been laced with contradictions and different forms of power inequities. For instance, in the health communication literature studies have shown that African Americans are more likely to experience different forms of discrimination when accessing healthcare services. This, as earlier discussed, was evidenced in the Tuskegee syphilis study and continues to manifest today (Scharff et al., 2010; Watson-Singleton, 2017; Williams & Wyatt, 2015). As such, the context of this study already provides a platform for identifying dominant and marginalized discourses as seen in the identities of African Americans versus Whites or other groups. Additionally, successful text identification for contrapuntal analysis also involves locating "texts in which competing discourses are likely to be etched in bold relief" (Baxter, 2011, p. 153). In achieving this, I focused on the part of the data (the text) that presented discourses already reflected in the literature or those known to be dominant in the U.S. culture e.g., intensive mothering; Hays, 1996). Given the volume of the text, it was expedient to concentrate more on the aspects of the

text that closely informed the objectives and the goals of the study at this time. Consequently, I engaged in data reduction.

Data reduction is defined as a qualitative data analysis method that allows a researcher to focus on certain parts of the data that copiously speak to the research goals or questions of the study (Lindlof & Taylor, 2019). While qualitative data gives rich data, not all the aspects of data collected are often used or can be used either as exemplars or an interpretive lens for the study. Data reduction might occur due to "unuseful" material in the data or due to the volume of the data, one that would limit the researcher to intensively present the findings of the study. Given the volume of the data and the different issues it could address in African American women's maternal healthcare literature, I decided to focus on the aspects of the data that attended to dominant and marginalized discourses within the context of this study. This way, I initially focused on the first set of interview questions that solely focused on women's pregnancy experiences. With these first set of questions, women's talk about their pregnancy experiences, naturally evoked discourses surrounding healthcare providers' dominance when delivering care to them. To get into more depth about the intersection of race in maternal healthcare delivery, I further concentrated on aspects of the data that evoked discourses surrounding the women's racial identity, particularly in the second section of the interview questions (e.g., "How do you think healthcare providers perceive pregnant African American women?"), giving room for more focused data analysis without ignoring any aspect of the data as it concerns the present study.

Identifying Competing Discourses

Thematic analysis serves as the first step in identifying discourses for contrapuntal analysis. Thematic analysis helps the researcher locate themes present at the surface and underlying level, also known as manifest and latent themes respectively (Baxter, 2011). At the

manifest level, themes can be easily located through the words of the narrator, as the content of the narratives can provide information on emergent themes and discourses. However, at the latent level, discourses are identified through the unspoken, yet present discourses. This is why understanding cultural codes in the context of a study is necessary for the researcher (Baxter, 2011).

I engaged in thematic analysis as a first step in identifying discourses present in the women's talk. As recommended by Baxter (2011), in conducting this type of analysis, I began by getting familiar with the data. This involved repeatedly reading the data. I also listened to the audio recordings to further develop my familiarity with the data, which gave an additional level of meaning to the words by helping me to connect emotionally to the data. Next, I generated initial codes. These codes represented patterns emergent in the data (e.g., the unmarried pregnant Black woman). The process was iterative, as I engaged in close and repeated readings of the data to clarify patterns in the data. For instance, the initial codes of "the abnormality in experiencing pain", "because you are women, pregnancy pain is normal," and "the abnormality of expressing pain" were evident throughout the data as women talked about their experiences in the labor and delivery room. However, I understood that this code may be reflective of a cultural issue bordering the racial and gender identities of the women in this study as well as the paternalistic culture of the U.S. healthcare system. Consequently, I further examined the data reflecting them in the next step of the analysis. In the next stage, I revisited the initial codes and looked for how I could cluster them together into broad categories, known as themes. At this point, I merged the initial codes (i.e., "the abnormality in experiencing pain", "because you are women, pregnancy pain is normal," and "the abnormality of expressing pain") generated about women's pregnancy pains to form a single theme of "dismissed concerns," while analyzing its position in the U.S.

culture. At this point, I located the theme in the broader cultural discourse of healthcare providers' domineering attitudes with female pains, such as normalizing their pains and symptoms. These codes were eventually renamed and represented under the discourse of the healthcare providers' dominance (DHPD). Locating themes in broader cultural discourses allowed for a more focused analysis of discourses at play in the women's talk. I continued this cycle of analysis for subsequent topics, emergent in the study. This analysis includes locating discourses at the sociocultural level with the ultimate goal of identifying distal already-spoken discourses that are present in African American women's talk about maternal crisis and their maternal healthcare experiences, while also identifying other discourses within this context.

After identifying discourses in the data, I assigned names to them (e.g., the discourse of healthcare providers' dominance). Next, I culled exemplars that evocatively represented the discourses. For instance, during the data analysis an emergent theme is that of "Dismissed Concerns Because Pregnancy Pains are Normal." Women repeatedly talked about how their illness or pregnancy complication symptoms were undermined or dismissed by their healthcare providers. However, to identify the discourse at play here, it drew upon the findings of previous literature as it establishes that African Americans are often treated as second class citizens in every institution in the U.S., even in the healthcare system. I understood, based on my immersion into the African American culture through the literature, that being dismissed during maternal healthcare visits, at the implicit level, was reinforcing the dominant perception of African Americans as second-class citizens, who should be controlled by "the superior group." Moreso, as participants used the phrases "not surprising" "as usual" and "like always" to describe their experiences, these became clear indications that their narration was beyond their individual experiences but speaking about a larger, unstated cultural "norm" or perception about African

Americans. For instance, when I asked Rachel what she thinks of the maternal crisis among African American women, she said, “Right now, we always get the bottom of the barrel with anything. So, I’m not surprised honestly ‘cause we get to the bottom of the bill with anything.” Also, when I asked Grace if she thinks there is racial discrimination against African Americans when accessing healthcare services, she said

> I know racism does exist in a lot of different things that we do every day. I wouldn’t be surprised to find out that there is excessive racism in healthcare. I wouldn’t be surprised. You know what I’m saying? Because I haven’t experienced it. I don’t have a reference. So, it’s not anything that I would be surprised. I mean… I wouldn’t be like, “Oh my God, I can’t believe that’s going on.” I would be like, “Okay, there you go.”

These examples show how the women drew upon discourses about African Americans to make sense of their own experiences. They made a reference to the everyday mistreatment and discrimination of the Black race. This reference is identified through phrases like, “I’m not surprised” or “there you go.” An understanding of the historical mistreatment of African Americans (a cultural code) helped me to situate their narratives into the discourse of African Americans as second-class citizens.

Identifying the Interplay of Competing Discourses

Identifying competing discourses in the process of contrapuntal analysis involves locating “ways in which the speaker’s position is aligned or disaligned with respect to various value positions (discourses) at play” (Baxter, 2011, p. 165). The interplay of discourses involves focusing on how participants’ talk sides with and/or opposes broader cultural discourses. As Baxter (2011) further argued, the focus at this point is not on the participants’ positions, rather how the discourses evident in their stories agree with or contradict one another. It is important to

note that even in the case where discourses agree with one another, no two discourses are equal in power. There is always a privileged one that takes a centripetal position. For example, in the data of the present study, as the pathological discourse of pregnancy and the integrative discourse of pregnancy were evoked in women's talk, while women affirmed both discourses, somehow, the pathological discourse of pregnancy was still privileged over the alternate discourse of pregnancy as an integrative experience, especially when talking about labor and delivery expectations. Focusing on their prenatal visits, they sometimes privileged the integrative discourse over the pathological discourse of pregnancy. When asked how healthcare providers can better serve pregnant African American women, they mostly talked about clinical changes that their healthcare providers can adopt. Thus, the context of care (prenatal visits versus labor and delivery) punctuated which discourse held more power even as both discourses were dominant in their talk.

After identifying the discourses present in the text, I looked for how the discourses in my data interplayed via negating, countering, and/or entertaining (Baxter, 2011). As previously discussed, negating involves the voicing of a discourse for the purpose of rejection. I specifically looked for utterances that show the rejection or disapproval of a theme (discourse). For instance, when I asked Kevris how healthcare providers perceive pregnant African American women she said,

> I think they see another black woman who is pregnant. That's what I think. I don't think they see us as the person that needs help, and you're pregnant, I think immediately they see another black woman pregnant. You know, it hurts and it's not there…I think that's ignorance. And I think that it doesn't matter what race that you are, that everybody should get treated fairly.

In the foregoing excerpt, Kevris resisted the discourse of racism, which she identified in the way healthcare providers perceive and treat pregnant African American women. Countering, another kind of discourse rejection involves repositioning a discourse so as to replace it with an alternative discourse in order to position the alternative discourse as dominant. I specifically paid attention to lexical markers that may indicate an ongoing competition, with conjunctions like "although," "but," and "however" (Baxter, 2011, p. 168). When I asked Sadiat how healthcare providers can better serve pregnant African American women, she said, "Everyone thinks women are so strong, we are a strong group, don't get me wrong, but at least we still experienced depression and we still go through these things and I feel like it needs to be noted and acknowledged." On the one hand, she acknowledges the discourse of the strong black woman, on the other hand, she supplants it with the discourse of mothers as whole people (DMWP; Scharp & Thomas, 2017). Lastly, in identifying how discourses might entertain one another, I looked for when one discursive position was framed as "one possibility among alternative discursive positions" (Baxter, 2011, p. 168). It is often marked with phrases like "it's a possibility," "looks like," and "might." For instance, when I asked Tammy if she thought her sister was mistreated based on her race, she said

> Um, it could have been, um, it could have been. It could have possibly been…it could have been a chance given where it was, I wasn't there to see it myself. And so, it was very, um, I wasn't there…if there was racial or not. Um, it could have been a possible chance.

Tammy identified racial discrimination as a possible reason for the mistreatment of her sister, through words like "possibly," "it could have been." However, she thinks there may be other reasons for this mistreatment. She entertained the discourse of racism as one reason, but not the

only reason, for the mistreatment of pregnant African American women in the healthcare system.

Establishing Credibility and Presenting the Findings

One of the responsibilities of a qualitative researcher is to present the findings of their study in a way that establishes credibility and trustworthiness of the study. Given the subjective nature of qualitative research, researchers working within this paradigm are laced with the burden of convincing their audience that their work is not merely based on personal preferences and biased selection of the data to soothe personal beliefs and values. Rather, a good qualitative study is transferrable, in terms of the findings, while also spurring ideas for future areas of research (i.e., "heuristic significance"; Tracy, 2012, p. 241).

To establish trustworthiness, I provided a thick description of the data. Tracy (2012) defined this as "the ability of qualitative research to tap into tacit knowledge, which is considered to be the body of implicit meanings floating" (pp. 235-236). It involves expounding on the contextual interpretation of the data. In cultural studies, groups have languages, actions, expressions, and discourses that are peculiar to them and may be difficult to decode by an outsider. Given the fact that I spoke to African American women, a racial group of which I am not a member, I focused on identifying cultural attributes that have meanings in the context of African American women's culture and maternal care experiences. Prior the data collection process, I immersed myself into the literature of African American women, identifying patterns and cultural codes used by women during talking about maternal or reproductive health. This helped me to be better positioned in meaningfully accessing these codes when they came up during the interviews. For instance, "another pregnant African American woman" was a phrase that came up a lot when women talked about how healthcare providers perceive them. Given my understanding of the contextual and cultural meaning of this phrase in my own previous research

and through other studies, I further attended to it as women brought it up. I asked follow-up questions such as "what does this mean to an African American woman?" Importantly, during the data analysis, I contextualized the narratives of the women in a grander context of the historical and cultural experiences of African American women, not just what their narratives mean within the physician-patient interaction. Baxter (2011) called for this process in conducting contrapuntal analysis, that is, the researcher should have an in-depth understanding of the cultural codes within the context of the study.

Additionally, I engaged in data conferencing (Braithwaite et al., 2017). Data conferencing is a qualitative data analysis method for establishing credibility. It involves engaging knowledgeable scholarly peers in the process of data analysis to help in verifying, critiquing, and assessing the findings of the researcher. Braithwaite et al. (2017) defined this as a "collaborative verification strategy that brings together scholars with specialized knowledge of the context, topic, theory, research method, and/or paradigmatic orientation to discuss, question, and assess the research process, analysis, and findings" (p. 2). For this study, I engaged faculty as well as peers who have scholarly and publication experience in the use of contrapuntal analysis in qualitative research. They assessed the research process by focusing on the recruitment process, data collection, and data analysis. As recommended by Braithwaite et al., (2017), upon the completion of data analysis, I invited these scholars to a discussion where I explained the research in its entirety to them. In the first stage, they focused on the transparency of the process involved and the choices made. In the next stage, the scholars focused on the findings of the research as represented by the exemplars chosen to support themes, arguments, and interpretation of the data. They assessed the study for "theoretical application, support for claims, sufficiency of exemplars for the research report, and clarity" (Braithwaite et al., 2017, p.

2). In the end, I took into careful consideration the recommendations of the scholars as I revised the manuscript for presentation. In presenting the findings of this study, I consciously wrote the manuscript in the language of the target audience-communication and healthcare scholars. Lindlof and Taylor (2019) argued, “it is extremely important for qualitative researchers to consider who our audiences are (or might be) and to adapt our writing to their needs and expectations” (p. 383). This includes the use of genres and terminologies that are common to scholars in these fields. In this way, the research is accessible to them, such that it is clear “attractive, credible, and likely to be taken seriously” (Tracy, 2012, p. 228).

IV. Findings

Discourse of Healthcare Providers' Dominance

The discourse of healthcare providers' dominance (DHPD) in Black women's maternal healthcare was evoked as a dominant discourse in this study. This discourse draws upon the larger cultural discourse of the pathological approach to pregnancy. The DHPD reveals how providers advance a domineering position in their maternal healthcare delivery. This way, providers advance the position of authority, while placing their patients as receivers and subjects of their decisions. Healthcare providers' dominance in this study manifest in doctors' and nurses' attitudes, but also other healthcare providers, such as clinical social workers. The DHPD is also present in the way women talked about their experiences and was reflected in four themes: The Biomedical Approach to Pregnancy, Dismissed Concerns Because Pregnancy Pains Are Normal, Questioning Natural Birth Choices, and "Unfair Treatment Because You Are Black."

The Biomedical Approach to Pregnancy

In the United States, pregnancy is highly medicalized. This way, healthcare providers treat pregnancy as a medical condition that needs to be primarily managed from a medical standpoint and by medical experts (Andipatin et al. 2019; Willard, 2005). There is an overt focus on the physiological changes and experiences of mothers during pregnancy while ignoring or placing less importance on other aspects of their pregnancy (e.g., mental health). This approach has left pregnant women with little input about their bodies and their babies. One of the major critiques against the biomedical approach to pregnancy is its failure to acknowledge other components of pregnancy that may not be strictly physiological. This includes the psychology, spiritual and emotional health of the mother. Willard (2005) furthers this argument by stating:

> Critics of the biomedical model characterize it as overly mechanistic and maintain that biomedical practitioners view the body as an object to be repaired…. This view, critics claim, results in a mind/body dualism and physical reductionism that overlooks psychological and social causes of illness. (p. 118)

Narratives of women in this study reveal how they, alongside their healthcare providers, hegemonize the biomedical approach during their maternal healthcare visits. When I asked women how they would describe a perfect doctor's visit during pregnancy, women discussed their expectations from a biomedical perspective. Zee, a 23- year old pregnant woman said, "Me being able to trust them (healthcare providers) and they're coming in basically telling me what was wrong and making sure they're constantly checking up on me and checking up on my baby." In the foregoing excerpt, Zee embodied pregnancy as a medical condition that exposes what is wrong versus what is right, but more so, one that needs a medical intervention to manage the process. She privileged the focus on pregnancy as a medical condition. As such her priority was finding a doctor who has medical expertise to treat her medical condition. Similarly, Sadiat, a 23-year-old mother of one, said: "I would say a perfect doctor's visit is, if you're due for an ultrasound there should be an ultrasound, they explain whatever it is on the ultrasound so you could see everything clearly." Similarly, Tee, a 26-year-old mother of two, said when she started attending her OB visits, "I was expecting the resources. I was expecting the doctor to show me how to take care of my body." Tee voiced the biomedical approach during pregnancy as she reasoned that doctors are better positioned to guide her pregnant body. She, in fact, affirmed the "machine" metaphor of the biomedical approach, as she positioned her body as one that needs the expertise of medical professionals to be managed. Other women referred to healthcare providers as the experts, as she stated that she expected the doctor to "show me how to take care

of my body." As such, they positioned doctors in the place of authority, who should instruct them on their health issues, including pregnancy. Pregnancy was framed from the standpoint of medicine where finding a medical expert who can "treat" the condition well was a priority.

In another dimension, women's maternal healthcare talk evoked the DHPD, albeit critiquing it. In their stories of healthcare provider's overbearing biomedical approach in their pregnancy experience, Beth, a 21-year-old mother of one, who had both a midwife and a doctor during her pregnancy said her plan to have home delivery was upended by her healthcare providers because of their financial interest in hospital birth:

> So, from the first time that I found out I was pregnant, I knew right away that I wanted to have my child at home or at a birthing center. I know that I wanted it to be as natural as possible and I knew that I did not really want to go the regular route of going to like the doctor checkups and stuff…."I want to have this baby at home, I want to do a natural, I don't plan a birth in the hospital"….So, I talked to my doctor about it and he became inconsistent. He said that I'm high risk and blah blah. And I feel like he started to say that because I told him about me wanting to birth at home. I feel like as soon as I told him about that, everything just changed. So, then they started telling me that I would have to come in every two weeks and monitor my baby's growth because I had IUGR, which is injuring growth restriction. So, they claimed, they told me I was really high risk.…I had told the doctor like, "Well, I'm still gonna have my baby at home." And the doctor walked out on me He never came back in the room...I'm like, "Y'all are treating me wrong. You're not listening to me. You're not respecting me. This is my body, my baby."

Beth suggested manipulation by her healthcare providers because of their financial gains in having her deliver at the hospital. She felt the diagnosis of IUGR was untrue. She noted that the

doctor's characterization of her pregnancy as high risk was a manipulative attempt to keep her as his patient because of his financial interest against her interest. This experience led to mistrust as she reported a traumatic birth having lost the confidence in her healthcare providers:

> They were trying to force me to induce my baby, which I don't believe in cause I'm a very agitated person. I know about natural childbirth. I feel like children, they need someone there ready to come and force the baby to come in and they're not coming in. It's just not time yet.…It was really a negative traumatic experience for me as a mother. I feel like in a vulnerable, in such a vulnerable state. During like the labor process things started to get kind of bad. I got into the room. I feel like they were doing unnecessary cervical checks. They never asked me if they could check my cervix, they just decided to put their hand there, my space…they're all white people, I'm in a white space. So, I'm already feeling very uncomfortable cause there's no one that looks like me and I'm being treated like this.

Subsequently, Beth's experience of mistrust further deepened as she believed that her healthcare providers tried to control her because of her racial identity, and their racial dominance as Whites. The experience of mistrust due to healthcare providers' domineering attitude toward pregnant African American women was also evident in Rachel's story. Rachel, a 23-year-old first-time mother, narrated how she felt mishandled by her healthcare providers due to their push for medicine even when there was no reason to do so. She said she switched providers midway through her pregnancy when she no longer trusted the recommendations of her doctor:

> I was diagnosed with gestational diabetes…they also diagnosed me to take baby aspirin. Like no reason. They said that as Black people, it's more common to have that preeclampsia…I honestly don't see why I need to take this. Like I don't have a history of

> it. This is my first pregnancy. So, I'm like, "I'm not taking the baby aspirin," but me being me, when they asked me like, "Oh, are you taking your medicine?" "Yes," because I don't want to say no, and they'd try to diagnose me with something, like, "Well she's not taking her medicine, so she probably has this thing."

Rachel considered this medical push as a hegemonic and homogenous view about Black women's health, such that they are often perceived as having poor health. She said healthcare providers usually lump African American women together, without paying attention to each individual. She said, "Like I don't have a history of it. You can't like, um, basically stereotype me because I'm African American." This way, they believe an instance of illness or behavior in one African American is present with others. Telither, a 30-year-old mother of two, had a similar experience and shared how her healthcare providers tried to limit her decision-making about her movement and body shortly after delivery.

> Whether it was African American women or women in general, I just think they kind of have their, everybody's pretty much the same and nobody's treated as an individual. Different nurses had different opinions. I wanted to deliver naturally. I wanted to be allowed to use the birthing ball. I wanted to be allowed to use the birthing tub. All these things that were there and available to me weren't allowed to be used. It was like, "Stay in the bed." …I don't think there's anything wrong with me moving around after being in labor. I was told it's a good thing to do to move around and not sit down or just sit in the bed. But they were judgey and rude.…They said, "Do not do that." "Yes, I am. I carried a child for nine months out of my body…push him out of my body and gave him to his dad. Yes, the hell I am." "I'm going to go for a walk, and I'll come back to my baby because I'm going to take care of my child, don't judge me."

Dismissed Concerns Because Pregnancy Pains are Normal

The DHPD further suggests that pains experienced during pregnancy are normal and part of being a "woman." In this context, women talked about their experience of pain and how healthcare providers normalized their pain as part of the pregnancy experience, thus dismissing their concerns even when things seemed abnormal to the women themselves. For example, Sadiat, a 23-year-old first-time mother, narrated her experience pain during her pregnancy:

> At about one in the morning…I was just like, I like, this is not feeling right. I am not comfortable.…We went to the ER and I don't know if it was because it was late that they just like were not taking their job seriously, but like the tone of voice, like I said, super nonchalant…disregarding my pain, and I remember one nurse is just like, "Well yeah, you're pregnant."…as a doctor, if I'm explaining my pain to you and the symptoms that I'm having, like I expect you to take me seriously. I don't expect you to tell me, "Well yeah you're pregnant." "I know I'm pregnant. That's why I'm here explaining my pain to you so I can make sure that my child is okay."

In another instance, Rihanna, a 22-year-old first-time mother, narrated her ordeal with swollen feet and backaches, both of which her healthcare providers characterized as normal pains of pregnancy, even when she perceived them as abnormal. However, she said she had to accept her doctor's assessment "because she is the doctor," that is, the expert. As such, she disregarded her own perception of the abnormality of the pains.

> Like one time I mentioned like my feet, are swollen and she took a look and say, "Oh that's normal," but like the pictures, it was like severe swelling. But every time I told her about it, she would say, "Oh just put your feet up, this swelling is normal." I'm like, "Okay." You know, her being the doctor, I thought, "You know, I'm just listening to

her." I was also having like really bad heartaches, like my chest will be hurting. I couldn't breathe, and I told her about it once. It was actually my last appointment before I had my baby. So, I told her about it, and she was like, "It's probably because of the back pain." So, she never really like, you know, took it really serious. She just, like I said, dismissed everything.

Rihanna's example shows the authority of healthcare providers overriding that of the patient. Here, the doctor dismissed her pain, even when Rihanna felt what she was feeling was not normal. Given the power dynamics in the provider-patient relationship, Rihanna submitted to her provider's perception of her pains, thus, she did not talk to her about it again.

Normalizing women's pains as a manifestation of the DHPD was even more prominent in women's labor and delivery stories. Women recalled how their experience of pains was trivialized or totally dismissed. Kevris, a 30-year old mother of four, considered her delivery experience a traumatic one because of how the nurses belittled her pains, one that eventually resulted in complications after delivery.

During the contraction and the painful contractions and I kept telling them, "Hey, you know, I'm working so much pain. This hurts. This hurts. It hurts." And by me telling them how painful it was, they would brush off the pain I was in and kept telling me to keep drinking the Apple juice, that's what they did. I mean, I wasn't given anything to help with the contractions. I mean, I don't think, I don't know if they would have given me something, but I didn't get anything. I just I dealt with it.

Despite the expression of pain Kevris's providers did not offer her any pain medication, given their perception of the pain as normal or even unreal. Ebony, a 43-year old mother of five, who had previously lost a pregnancy, painfully shared her story of her son, who passed away two

weeks after his birth. When asked to narrate her pregnancy story, she particularly attended to her labor and delivery experience, which she considered traumatic. In her recalling, she said:

> Forty-eight hours after delivery…I'm shaking, I'm having pains. They were like, "Oh, you are just reactive to the pain medication." I've never had this issue before, and they're like, "You're fine." They just totally dismissed everything I was saying here. I was complaining about like, not feeling well. Something didn't feel right. They realize, well, "What we'll do is we'll treat you as if you had an infection. So, we'll just give you a medication and you just take it." And I was like, Wait, is it safe to take this medication while breastfeeding?" They said, "Well, you're only going to take it for a couple of days, so you should be fine. [The baby] should be fine." But that's not what I asked. [I asked,] "Is it safe to take while breastfeeding?" And then they got me on narcotics for the pain.

Ebony's story reflects the dismissal of pains and concerns, and it also shows suppression of her influence and agency in her own healthcare experience. Even when she raised concerns about the safety of the drug while breastfeeding, her question was never answered nor was it addressed. Unlike women who adopted silence as a response to their healthcare provider's dominance, Ebony kept telling her healthcare providers her symptoms were far from normal:

> She was like, "No, you're just being paranoid." And I was like, "I still don't feel well." She was like, "Oh, you're fine, you're fine." And I was like, "Something isn't right." And then I was telling her like, "I'm passing these, these chunks of blood clot." They were like…"You're fine…." I'm still having problems and, in a strain, even after taking the narcotics, I'm still like damn pain, cramping bad. And she was like, "You're fine. You know, you're older. That's why you know, you're feeling like this." And I was like, "That's not what this is." And all I kept telling her, "Something is wrong with [the baby].

> Something is wrong with me." She's like, "You're okay." So, two weeks after he was born, I decided to go to the ER, and they told me that I needed a D & C because I still had some of my placenta in me.

Despite her repeated pleas for help, their dismissal of Ebony's pains both for her health and that of her baby resulted in a traumatic end. She had to have surgery to remove the remains of her placenta that had been causing her pains, while she also lost the baby after her concerns about his health were repeatedly dismissed. Through her story, healthcare providers are dismissed her knowledge about her body and privileged their expertise and experience. Ebony believed that she would not have had further complications or lost her baby if her healthcare providers had not dismissed her pains and concerns. Her story showed how undermined concerns may be fatal for both mother and baby. Similar to Ebony's experience, Abigail's case was also traumatic mainly because she felt her story would have been different if only her healthcare providers listened to her a day before she lost her baby at 37 weeks. In her report she recalled that:

> At 35 weeks. [My doctor] had told me that the cyst had grew a little bit and I asked them, "Was there any concern or anything about that?" He was basically saying he didn't think it would be a concern, but they'll keep an eye on it, and instead of like checking on it like every week or, so they didn't. He didn't check on it for a while. Literally, the same week I was supposed to go in to deliver. And I expressed concern to the provider that I had at that time, which she was basically was like, she has to speak with [my specialist] and that they'd see what was really going on. But by the time they got to speak about it, the baby basically had passed…I had expressed to them multiple times even before that day that I didn't feel him moving a lot 'cause he was like a very active baby. So, he always was moving around…I had told the ladies there that I wasn't feeling him move like that. She

> was like, "Oh, maybe it's because you didn't eat breakfast this morning."…I'm trying to really think about that because I don't really want to say race at the moment because I don't kind of feel like it was my race…but, I'm not sure.

Abigail, while reflecting on her traumatic experience, tried to find answers to why her concerns were dismissed. She admitted that she was not sure if it had to do with her Black identity and didn't want to place it on her race, but she admitted it was a possibility that she could not dismiss. The case of Abigail presents a clearer perception of how the dismissal of pregnant patients' concerns could significantly impact health outcomes not just for the mother but also for the unborn child.

In another instance of undermined pains, Tafi, a 35-year old mother of one, narrated her ordeal with her physician when she repeatedly discussed her experience of depression after multiple miscarriages. When she discussed her depression symptoms with her healthcare provider, she recalled that:

> [My physician] was like, "I think you should go see a psychiatrist." And I was like, "I don't need to see a psychiatrist. I don't want to be on more medication or get to the point of seeing a psychiatrist to prescribe medication. I'm trying to explain to you my symptoms [of postpartum depression]"…but she wasn't listening and…I forgot about this. I actually ended up seeing a hormone specialist myself like that my friend recommended.

Tafi expressed her concern for repeatedly being placed on medication to "treat" her mental health, one that she objected to, but again, her preference did not prevail as her healthcare provider assessed her experience as dysfunctional, thus demands a psychiatric intervention. In another woman's experience, Tabithe, a 20-year old mother of one, thought healthcare providers

perceive African American women as deceitful about the level of their pains. When asked about how healthcare providers perceive pregnant African American women, she said:

> African American woman are seen as lying about what type of pain we're in and how bad it hurts. "Don't tell me how bad I'm hurting. You are not inside of me." And that's how they always come at you…like you're lying or exaggerating…they treat you like you're lying or like it's not that serious.

Tabithe's story revealed healthcare providers' lack of trust in African American women's reports of their pains. The DHPD as evidenced through the dismissal of women's concerns and pains shows the paternalistic structure in the healthcare system, one that advances an elitist attitude by healthcare providers toward African American women, more specifically during prenatal and postnatal care.

Questioning Natural Birth Choices

Another theme of the DHPD is seen in healthcare providers' response to women's decisions about their birth plan. Women reported their disappointment in how healthcare providers encourage C-sections at every slight instance of what healthcare providers call "abnormal" cases. Women in this study repeatedly referred to the natural instincts that come with birthing as though "women are built' for it. They reported their desire to have a natural delivery experience. In their narration, they referenced how they wanted to go through pregnancy "naturally" without any medical interventions, such as medicine and medical procedures. Specifically, women expressed their desire to have natural, vaginal delivery instead of a C-section. Their natural birth plan includes labor and delivery, as they considered any medical interjection and interruption to the natural process of birthing, which is natural to women.

However, their healthcare providers' decisions overruled theirs in most instances. Lisa, a 21-year old mother of one, in her labor and delivery narrative said:

> I heard one of the doctors [say] "She might need a C section,"…I started crying, like bawling, crying. Like I did not want to have a C-section. I wanted to deliver naturally, provided my sister did a few years before. I mean I wanted to, I just want him to deliver naturally. I did not want a C-section, but I have to get one. So, I remember being in a doggy kind of position [still trying to have a natural delivery] and being like pushed through the hallway. They were taking me to where I was going to have my C-section.

Lisa in her narrative suggested that she wasn't really given time to try to have her baby naturally. She wanted to try a different posture to aid a natural delivery, for example. However, she said she was not given that opportunity as she was wheeled to the operating room in a rush. Similarly, Beth, a 21-year-old mother of one, also wanted to have her child naturally, emphasizing the process of listening to her body to take the lead to deliver her child, instead of the interruptions the healthcare providers had with her delivery:

> I wanted to birth my child and bring my child to the world. It didn't happen. I wasn't at home. I wasn't in my comfort space...they were telling me that they had to keep monitoring the baby instead of just allowing me to do what I felt was natural. Instead of me listening to my body. They just wanted me to listen to them, and they're not even the ones like in labor, which is crazy…so they feel like they have to follow these rules when really birthing is not about following any rules or regulations. I feel like birthing, it's the most natural thing ever. Like it's just instinctual. A mother knows what to do.

Beth and Lisa expressed their desire to be agents and not bystanders in their birthing experiences, because, for Beth, her body understood the process of birthing ("it's instinctual"). As such, she

didn't want any interruption of medicine or a C-section to disrupt what her body could do naturally. She evoked the discourse of women as natural mothers whose bodies understand the birthing process, albeit to delegitimize the dominance of healthcare providers in women's maternal healthcare. Ashley, a 21-year-old pregnant woman, expressed the option of having C-section as a forced one. When I asked her what procedures would be used during her birth, she said:

> I mean originally before I found out that I was high risk, I wanted to stay off of the epidural and all that stuff. But since I have to go with C-section now, I think that I'm kind of forced to do it. So, I guess I'm open to the medications at this point.

Ashely indicated in her narrative that she was being forced to have a C-section. Here, we see another instance of the loss of agency in a decision that should have been jointly made with her healthcare providers. Her providers positioned themselves as both experts and managers of her health, while Ashley assumed the position of passive patient, one that lacks power or any input in decisions that concern her health. Telither, in a similar experience, also encountered the imposition of medicalized birth by her healthcare providers. She recalled the reaction of her nurses in the delivery room when she told them she wanted a natural birth:

> I think the staff pushed more for different directions for my choices. So, like if I said I want to do a natural birth, they were like, "Why? Why would you want to go natural? We got drug for that and you won't do this"…I think they have the assumption that we don't know what our bodies are capable of.

Although Telitehr's healthcare providers did not succeed in overruling her decision to have a natural delivery, they still indirectly invalidated her choice by questioning why she would decide to have her baby naturally. Telither further noted that she perceived she was treated differently

because of her race. As for Ebony, she insisted on following through on her natural birth choices even when her nurse tried to force her to get epidural:

> My goal was to have a natural birth. I was trying not to have an epidural. She knew that my birth plan was to try to be natural, to go through it naturally and try to do it without pain medication…they were pushing me for an epidural and I was like, "I don't want that."…I really couldn't breathe very well…And she was like, "I'll give you some more of the intravenous fluid." I said, "I don't want any more of that." She's like, "You should have an epidural." And I was like, "…I don't want to do an epidural." And she was like, "Well, that'll be the better thing for you. That's what you should do." "I don't want to…never mind, I'll figure it out, I'll breathe my way through it."

Ebony's preference for a natural birth was not only in the form of vaginal delivery, but she also wanted to have a medicine-free delivery, that is, without epidural and other birth-related medicine. However, her healthcare providers repeatedly pushed for a medicalized intervention. She ended up delivering her baby naturally even after her healthcare providers suggested a C-section.

Unfair Treatment Because We are Black

Historically, African Americans have been treated as second-class citizens in the United States. The aftermath effects of slavery (and colonialism, for Black immigrant families) continue to persist for African Americans in almost every social institution in the country (Bonilla-Silva, 2006). It was unsurprising to identify how African American women in this study clearly drew upon this history of disenfranchisement toward their racial group for their maternal healthcare experiences. The DHPD manifests in how women perceive the quality of care provided to them. Not just in who has the control but also in what type of care is provided to them. They attributed

the prevalence of maternal healthcare crisis to racism as advanced in healthcare providers' differential treatment of African American women compared to Caucasian women. They expressed their displeasure in how healthcare providers try to control and belittle their input in their own maternal care and attributed this experience to issues of systemic racism in U.S. society. When I asked the women how they think they are perceived by healthcare providers during pregnancy, Shirval said:

> I think a lot of times ultimately your socioeconomic status plays a lot into that. I think originally, they see someone of low class before they even have a conversation with you before you even give them any information. I feel like ultimately that's the first thing they see is your being preserved, um, before those conversations are even made, I believe… "Oh, they have a lot of kids" you know. So, they think we could deal with the pain a little bit longer and hold out a little over. I think ultimately you are again seen as low class, even before conversations I had, and I just think that you're just looked negatively

Shirval's story emphasized the perceived socioeconomic status of African American women, one that positions them as poor and low class. Additionally, it also positioned them as having high pain tolerance, one that makes healthcare providers ignore or undermine their pains. Kevris furthered this perception in her story:

> I think some health care providers see African American women as a minority, I think they perceive African American women at the bottom of the barrel. I do. And I feel a lot of African American women that have, you know, state insurance don't get quality treatment. They don't because of their race and their insurance. I think [healthcare providers] say, "Oh, if you get state insurance and you're this race [Black], I'm not going

> to do my utmost treatment because of that alone." And I think that that's not right. It's not right at all.

Kevris believes African American women are treated as second class citizens in the healthcare system because of their race and enrollment in state insurance. Since being on state insurance often indicates some level of poverty, Kevris attributed this as the reason for African American women being pushed to "the bottom of the barrel" when accessing prenatal and postnatal care. She clearly stated that the kind of treatment provided is often based on their racial category, where Blacks do not get "quality treatment." Unique corroborated this story by further arguing that even when majority racial group(s) provide any kind of assistance to them, the motive is still to establish a majority-minority status as they are often seen as "a charity case."

> I think there's racism everywhere, but I think there's racism in the healthcare system…we're just looked at differently…I think African American women are more looked at as a charity case in a way. They looked at us like, "It looks better if I help this lady lift weights because I'm Caucasian and I'm helping somebody different than me, so it'll look better on my end if I help her."

Unique reasoned that the care delivered to African American women during pregnancy is not aimed at their best interest, rather as a way that doctors, whom she framed as Caucasians, foster a positive image for themselves, so as "to look better." The DHPD is seen to manifest through racism and different forms of discrimination during maternal healthcare encounters. Healthcare providers' dominance in making decisions about African American women's maternal health is critiqued as another form of racism, which is, unfortunately, dominant in every U.S. system as Unique stated. In another instance, Zee furthered the ideology of racism in African American women's maternal care as she claimed that:

> I just feel like people more care about other races than our, than our own race. Uh, you know, they're just like, "Well, we don't care about the Blacks. Let's just make sure that other races are okay." Like, the Caucasian just make sure they're okay before we make sure the African Americans are okay. So, they basically like put us on the backburner.

Specifically, Zee believes that Caucasians get better treatment at the expense of African Americans, as African Americans are treated as inferior, thus, uncared for. Megan, framed doctors as representatives of the "oppressors," who do not want to see Black women thrive through increasing population:

> You know, I don't want to say it like that, but there are doctors who don't want to see Black women thrive or even multiply and break even because they feel like they are more dominant than you, so you shouldn't even be able to have a kid, you know? And that's how some doctors probably look at us like we know nothing…they look at us as like …we shouldn't be able to do nothing without their permission.

When I further asked Megan why she had this perception about doctors, she said:

> It's just, I don't know, like I never had that problem with a doctor, but it's just a thought that crosses my mind too as well. Like, you know, "You [Whites] sit and help us, but you feel like we just beneath y'all, like we don't deserve it." Like they think, some not all, but some doctors could possibly think, "We shouldn't have to help because this money [for your healthcare] expenses is coming out of our pockets, we got to help y'all. We really don't want to.

Megan perceived the prevalence of the maternal health crisis as an attempt of the (White) majority to control the Black population, which includes limiting their ability to reproduce. Given this, she reasoned that healthcare providers want to control the decisions African

American women make about their health, their bodies, and their babies, thus dominating their maternal health decisions. She further perceived doctors as controlling because of their perception of paying for Black women's healthcare costs through taxes that go into Medicaid. Sadiat and Kevris further talked about the influence of race in healthcare providers' care delivery to pregnant African American women:

> I don't think we're taken seriously. Me personally, I don't think that black women are taken seriously. I feel like no one says that we can do it. No one acknowledges our questions or concern, things like that. So that's why I feel like it's that way. It's like, "Oh, you know, she's just, she's another [pregnant Black woman]." That's how I feel. -Sadiat
>
> I feel like it's because of our race and the things that we've gone through. In America, there's always been a difference in, you know, race, in the color of your skin. You know, it's always been that way. Like if you're white, you have more of a privilege and you are given more opportunities, you know, but if you're black and if your skin color is black, no matter if you're, you know, Black from Africa, like, have African roots, I feel like you're still seen as lesser. -Kevris

The ideology that Blacks are inferior and second-class citizens manifest in the way African American women made sense of their care. They attributed the dominance of healthcare providers in decisions that concern their maternal health to racism, which they argued is resident in every social institution in the U.S.

Discourse of Maternal Healthcare as Holistic (DMHH)

The DHPD advances the notion that healthcare providers are the experts in pregnancy care, as such, they should be the ones to make decisions about pregnant women's health. However, the DMHH constitutes pregnant African American women's experiences as co-owned

with healthcare providers. The DMHH was reflected when women characterized their pregnancy as a holistic experience, one that requires the incorporation of different aspects of their life into their healthcare delivery. They advanced the notion that maternal healthcare decisions should be jointly made by their healthcare providers and them, not to be controlled by healthcare providers. This way, the DMHH acknowledges the DHPD as one of the possibilities of care during pregnancy but not the only path to having a satisfying pregnancy. I identified three themes under this discourse: (1) Healthcare Providers Should Listen, (2) "Cultural Sensitivity is a Big Thing," and (3) "Pregnancy is Spiritual."

Healthcare Providers Should Listen

Present in the idea is that healthcare providers do not pay attention to African American women's concerns during maternal healthcare visits. Women attributed this attitude to their racial identity. They believed they are not taken seriously because they are Black. This way, women are asking to also be part of the decisions made about them, their bodies, and their babies. When I asked women how healthcare provides can better serve pregnant African American women, Kylie in her narrative said healthcare providers should listen more to women's concerns and not dismiss their concerns: "You know somebody's telling you especially they know their body. There's something that's going on with them listen to them figure out what's going on and how you can help them." Kylie stated that to successfully serve pregnant African American women, the first step is listening to them regarding their perceptions about their health and their bodies. Ebony, whose son passed away a few weeks after delivery said:

> I think they did not listen to anything that I see about my physical health or organ…I feel like she was wholly dismissive and like, "You're just being dramatic." Basically, she just was not listening. Like there is no other way to put it. She just was not listening. She just

> was very dismissive everything that I said and by very dismissive, that's the best way I can describe it. I'm like, "Something is wrong. I know something is wrong. My son is not okay." I've had four other children and never did I experience the things that I had experienced with him, and I wasn't a brand-new mom. I knew what it was like. I knew the thing that he should have been doing and he wasn't doing. I knew, I knew, that he had not been suctioned out. I knew he needed to be suctioned out. He died from pneumonia. That was the official statement.

Ebony had repeatedly complained about the abnormalities she noticed with her son's health, but she said the nurses did not listen to her. Unfortunately, when her son passed away, her fears were confirmed, albeit too late. She specifically noted that she was not listened to because her healthcare providers belittled her knowledge about her body and her baby's health, an experience she found frustrating. Ashley echoed this theme by sharing her own experience with her providers, whom she said did not listen to her when she complained about incessant pains during her current pregnancy. They later found out that she had some complications with forming enough amniotic fluid, leading to low weight for her baby. She said:

> Maybe if they actually listen when patients communicate, because women know their bodies, that they're coming to you saying, "Hey, something's not right." Maybe they should look into it rather than just thinking like, "Oh, well." I don't feel like we're been taken seriously.

When I further asked Ashely why she felt her healthcare providers did not listen to her, she said her racial identity could be a possibility, given her perception that African American women are often not taken seriously. This perception was further echoed by Zee. When responding to how healthcare providers can better serve pregnant African American women, she said, "[Doctors

should] listen, pay attention. Paying attention to us, making sure that things are straight, and being as concerned for us as they are to the other races." She reasoned that healthcare providers treat African American women lesser and differently from other races, a form of racial discrimination.

Beth attributed the problem of maternal health crisis among African American to healthcare providers inattention to African American women's concerns during healthcare encounters:

> I feel like this happened to literally every single black woman that I've talked to. I had the same experience cause they're not listening. Honestly. I just feel like they're not listening to us. I don't know if they don't believe it. I don't know if they think they're smarter, duh. You know, I just don't understand what would make you think that, you know what's better for a woman when it's her own body? Like, "You're not the one pregnant, you know, like you're not going to baby growing inside of your body." Don't get me wrong, everybody has their own unique experience, but, Oh mom, it's sad though. It's sad. It's frustrating. It is. It is really sad. This is why we're dying. We're not being listened to.

Andrea, a 22-year-old mother of one, said healthcare providers' inattention could significantly impact health outcomes. In her case, she said she wouldn't have experienced perineal lacerations if her healthcare provider had listened to her during her labor:

> I will say take the time and actually listen to what we said. Cause I know when I was in my labor, like I said, my baby wasn't ready, but the nurse told me to push. I wouldn't have ripped, but she was pulling my baby out of me and I ended up ripping

Andrea positioned paying attention to pregnant African American women not just as a respect for the patient but also as an effective practice to ensure good health outcomes. In the same way, Sadiat in her expectation for an ideal doctor's visit during pregnancy said:

> I would say a perfect doctor's visit…should also include you're in complete understanding of what's happening with your baby, check on you to make sure you're okay mentally and physically as well, acknowledging you, acknowledging your concerns and questions. I would say that's like the perfect appointment right there, not shutting you down and tell me like, "Oh no, that's wrong." And being clear, I would say being extremely clear. That's like a perfect appointment right there.

Through Sadiat's narrative as well as other women's, we see a desire for a holistic maternal healthcare experience, one that allows women to assume a partnership role with their healthcare providers in decisions that concern their health and that of their baby's. This way, both the providers and the women collaboratively work together to co-make decisions that concern women, in the interest of the women, not the providers or the system. Consequently, their racial background, which women considered as an integral part of their maternal health, is also incorporated into the type of care provided to them.

"Cultural Sensitivity is a Big Thing"

Another manifestation of the DMHH was present in how African American women characterized their pregnancy as cultural alongside its medical dimensions. As women recalled their interactions with the healthcare providers, they talked about the lack of awareness of the "Black culture" in the U.S. healthcare system, one that limited the effectiveness of the services they received during prenatal and postnatal care. In this regard, they acknowledged that the cultural values of a pregnant patient are at least as important as the medical interventions offered

by healthcare providers. Specifically, referring to their racial identity and background as Blacks in the U.S. culture, women in this study advanced the incorporation of culture into their maternal healthcare. For example, when I asked Shirval, a 32-year-old mother of two, what doctors can do to become more effective in their maternal care delivery to pregnant African American women, she said:

> I think cultural sensitivity is a big thing…like they should have like annual training or whatever that looks like as far as, you know, how they can be sensitive in a certain culture and try to educate themselves on learning what that looks like…that's the first step…they have these clear prejudices…when you're in the field…you should be compassionate to people because they're so vulnerable.

Shirval presents culture as an integral part of the pregnancy experience. She, in fact, argues that understanding African American culture should both be formally taught and practiced during medical encounters. She further emphasized this need for cultural sensitivity because pregnant African American women are vulnerable, given the realities of their race, gender, and medical condition (pregnancy). In Rihanna's response to how healthcare providers can better serve pregnant African American women, she said:

> I feel like biases and stereotypes really have an impact on how you treat and view people. So, stepping out of your comfort zone and just trying to be able to understand the perspective of other minority groups…I feel like that's the best way, honestly.

Rihanna specifically drew upon the sociocultural history of minority groups (in this context, African American women as a site of consideration for healthcare delivery). This way, Rihanna reasoned that healthcare providers need to consider the "minority status" when relating with African Americans. This includes not ignoring their positionality in the U.S. society. Issues such

as biases, stereotypes, and racial minority status are factors she believes should be incorporated into healthcare providers' delivery of care during maternal healthcare encounters. Furthermore, Ebony emphasized that providers should focus on the overall health of the woman.

> I feel like I want a doctor that has capacity to understand my [racial] experience…I feel like a good doctor is a doctor that not just treats a physical ailment but the overall patient. So, I just feel like a good overall treatment of a person not just as an experiment.

Ebony is carefully constructing pregnancy as a holistic experience, one that includes the acknowledgement of her racial background as well as her whole person.

Race was a recurring concept when participants talked about the need for a cultural approach in prenatal and postnatal care for African American women. They situated their concept of culture within the category of their racial identity as they indicated that the African American racial group presents "different" cultural beliefs, values, and experiences. Consequently, they expressed how it was impossible to separate their healthcare experiences from historical events of slavery and ongoing resistance toward the African American race and culture. They justified how these events have necessitated the need for healthcare providers to incorporate their historical and ongoing experiences into their care-given their vulnerability. Unique, a 24-year-old pregnant woman, in responding to how healthcare providers can better serve pregnant African American women said:

> [Doctors should] be more accepting and open to understanding as to why [African American women] do the things they do. Because you can have a patient that is of a different race and they will come in and be like, "Oh, well I'm six months pregnant and this is my first doctor's appointment" and it could just be because they didn't have the option to come see a doctor due to insurance or whatever it is. Whatever their reason is,

> [doctors] just need to be more open and understanding that it's more common to see [African Americans] like that.

Flaky, a 29-year-old first-time mom, also argued that healthcare providers who attended to African American women need to be aware of African American culture and experiences as much as they do on the medical practice and knowledge. She said, "You know statistics and [medical knowledge] is different…They need to do more studies for African American women so that they're more sensitive to me." These women argued that healthcare providers should acknowledge and incorporate racial realities into their care given their vulnerabilities as pregnant African American women. Flaky's narrative supports Ashley's (2014) recommendation to healthcare providers, one that rejects the color-blind healthcare delivery.

Additionally, in advancing the DMHH through the thematic focus of maternal care as cultural, women expressed the idea that maternal health crisis and differential treatment of African American women can be addressed only with an increased number of African American healthcare providers. They argued that African American healthcare providers will both apply their medical expertise as well as their cultural awareness of African Americans' values during pregnancy to care for them appropriately. For example, after multiple miscarriages Tafi decided to find an African American doctor for her next pregnancy. When I asked her why she wanted an African American healthcare provider, she said, "I just feel more heard. Like I feel if I told another African American woman [doctor], I feel like she understands me more and she's willing to listen." Tafi justified her choice by relaying how she felt an understanding of her race and culture would positively impact her maternal healthcare encounters if she had a provider that shares in her cultural experiences. Abigail also said she would only recommend Black doctors to African American women for maternal healthcare services.

> I would say I definitely look for a Black nurse or a Black doctor ‘cause I feel like they can relate to us more, as well. As long as I’m there, they can take me serious. And like when I have concerns, they’re able to break down what’s going on step by step. What we’re going to do to basically find a solution to it…I feel like they can relate to us more because they go through the same thing that we go through. Their body is, I mean, every woman’s body is the same, but it’s like, I don’t know, I just feel like it’s something different about us and that they can relate to us more as far as what we need to do with our body.

Women’s talk under this theme indicates the desire of women to experience pregnancy culturally. Their stories reveal an understanding of how pregnancy spans through different aspects of a woman’s life, that is, it is a holistic experience not just a medical one.

Pregnancy is Spiritual

The third theme of the DMHH was that pregnancy is a spiritual experience. Women in my study established the importance of spirituality in their pregnancy and healthcare experiences. Mainly speaking from the Christian religion perspective, they saw pregnancy as a gift from God, which implied that God is ultimately the one who helps women go through it successfully. Rachel, in her narrative about her C-section experience said:

> I don’t trust doctors at all. I don’t trust, honestly, like I said, I’m a Christian so I based all my faith in the Lord in that surgery room. I say, “Lord be with me because I don’t trust these people.” They could leave something up in me. They could leave a tool, and it’s happened before, so I said, “Lord, be with me in this whole situation,” which is why I feel like he guided me to the right doctor because he got to me out of the other hospital ‘cause he knew like they wasn’t doing me right.

Despite utilizing the expertise of medical doctors during her pregnancy, Rachel gives power to her spirituality. She used it to guide her to the "right" doctor as well as a source of comfort during her labor and delivery. Similarly, Beth said her decision to go to a birthing center was partly because she considers pregnancy as a spiritual experience, and the birthing center staff are trained to respect patients' wishes, especially that of vulnerable populations:

> I know what to expect if I were to birth in a hospital. I already knew what to expect from a doctor's point of view. I just knew because all medical stuff, like it's all medical and it's really all about the person that is following through the way it's going to [turn out]. That's why I chose to go the route that I did…because I know that I will be respected and I will be treated as I like and then my wishes would be respected because [midwives at birthing centers] are trained. They understand the vulnerable, the vulnerability of a pregnant woman. Like I feel like everything is a very spiritual thing. I feel like birthing is an initiation.

Sandy furthered this theme when sharing her story about pregnancy and prenatal depression. She said it was her spiritual connection that took her through the depression period, which could have ended her life:

> No one really knew my story like there was a specific doctor that I gave her like bits and pieces of certain things that I was going through, mentally I was worn out. And it did most definitely took prayer, but I mean like what if a person wasn't spiritually connected. So, then they're either…deeply depressed to the point that they're…gonna take matters into their own hand to get rid of the depression.

Here, Sandy, a 29-year old mother of one, saw prayer as a backup for the gaps healthcare providers do not fill during maternal healthcare delivery. In her experience, while she was

pregnant and homeless, she noted that given the lack of attention of her providers to her mental health, it was her spiritual connection that kept her going and kept her from engaging in a dangerous action during her depressing moments. She believed healthcare providers need to approach pregnancy holistically by incorporating other aspects of a woman's life into their maternal healthcare delivery.

The Interplay of DHPD and DMHH

As Baxter (2011) argued, meanings reside in discourses and not in individuals. Given this, I identified a discursive interplay between the two discourses of DHPD and DMHH as manifested in what Baxter calls a "double-voiced dialogue," where two "equally-valued" discourses interplay, but one is centered at a time while the other is given secondary priority (Baxter, 2011, p. 126). Three forms of synchronic interplay were present in women's talk about their maternal healthcare encounters: negating, countering, and entertaining.

Negating

The narratives, in some cases, put the one discourse in a centripetal position by rejecting the other discourse. Andrea's narrative revealed an outright rejection of the DHPD as evident in doctors lack of awareness of pregnant African American women's needs:

> Oh, do they [healthcare providers] understand our needs? they don't, they don't get the feeling. They don't feel as we do. They don't understand basically our body and our needs. I do think they don't know [about our needs]. I mean, reading about it [from medical textbooks], hearing about it is different from actually knowing about it.

In the above excerpt, Andrea resisted the DHPD by critiquing the limitations of the textbook knowledge as represented in the biomedical approach to pregnancy. She voiced her critique of

that approach by positioning it as unrepresentative of the healthcare needs of African American women, even as it may involve the unique experiences of each individual in their maternal care. Similarly, Beth, through her narrative rejected the DHPD, privileging the DMHH by stating that pregnancy and birthing are natural experiences for women, as such, women should be given the liberty to be in control of their birthing experience:

> Instead of me listening to my body, they just wanted me to listen to them and they're not even the ones like in labor…It was really a negative, really negative experience. it wasn't a happy experience. I absolutely think my experience would have been different if there were more people that looked like me [Black healthcare providers] in the room because statistically like we know that the doctors underestimate the pain of a black woman or black people in general. So, they feel like they have to follow these rules when really birthing is not about following any rules or regulations. I feel like birthing, it's the most natural thing ever. Like it's just instinctual. A mother knows what to do.

The rejection of the DHPD in Beth's narrative was a rejection of the biomedical approach as well as the unfair treatment of African American women in the healthcare setting. This way she acknowledged the intersection of healthcare providers' elitist attitudes combined with unfair treatment, as factors cumulatively taking agency from pregnant African American women in their maternal healthcare experience. Her narrative critiqued the DHPD for its paternalism and advancement of racial discrimination toward pregnant African American women.

As discussed under the theme of "Unfair treatment because you are Black," the women in this study, communicatively resisted the DHPD as it was positioned as a manifestation of racism, which has so long dominated the lived experiences of African American in the U.S. society:

> I think they see another black woman was pregnant. That's what I think. I don't think they see us as the person that needs help, and you're pregnant, I think immediately they see another black woman pregnant. You know, it hurts and it's not there. Um, I feel that the fact that maybe they do see that, I think that's ignorance. And I think that it doesn't matter what race that you are, that everybody should get treated fairly.

Similar to the Kevris's example above, Ebony's narrative also participated in this negating interplay as her story also clearly rejected the DHPD, privileging the DMHH, as she empathized the priority of having a doctor that understands her racial identity and experience, one that would listen to her:

> I have an African American doctor and an African American pediatrician because I just don't feel comfortable with Caucasian doctors. I want to be with a doctor that looks like me. I want to be with a doctor that has the capacity to understand my experience…So I wanted to have a doctor that I go to, he's going to listen to my concerns …So I wanted to make sure that I had an extremely different experience for what I had with my son.

The racial identity of healthcare providers is seen to also be at the intersection of their practice as medical professionals. As a result of this, women constructed the meaning of their maternal healthcare experience from the interwoven identities of Whites as a dominant racial group and healthcare providers as a dominant professional group. This is why Ebony's narrative positioned the DMHH as one with a healthcare provider that has the racial experience, not just knowledge, of African American women. Rachel's narrative furthered this discursive interplay as it disclaimed the DHPD as manifested in doctors' lack of knowledge on the holistic approach to pregnancy:

> I know what to expect if I were to birth in a hospital. I already knew what to expect from a doctor's point of view. I just knew because all medical stuff, like it's all medical and it's really all about the person that is following through the way it's going to [turn out]. That's why I chose to go the route that I did…because I know that I will be respected, and I will be treated as I like and then my wishes would be respected because [midwives at birthing centers] are trained. They understand the vulnerable, the vulnerability of a pregnant woman.

Contrary to the negating of DHPD, Rose's narrative privileged the DHPD. In her response to how she perceives the maternal health crisis among African American women, she said, "If I go to the doctor, I think that my doctor knows everything because obviously, "You're a doctor." So I'm believing, yeah, whatever they're telling me is true." Thus, she positioned healthcare providers as experts because "they are the doctor" and should know "everything."

Countering

In this discursive interplay, the DHPD was voiced only to be disclaimed by the DMHH. Here is an example in Rihanna's story:

> You know, I don't really rely on the information that a doctor's given me, you know, I just rely on how my body is feeling. If something isn't feeling right then I'm relying on that instead of relying on the information that's given to me. I really don't trust [doctors] that much honestly. I mean, because you know, a lot of the times I feel like the nurses and doctors, they seem to rely on textbooks like a textbook as far as like working with specific demographics specific races. 'Cause I remember one time one of the nurses or doctors or the residents on duty at the hospital. I was, we were talking about like my high blood pressure and I don't know, I just felt like everything that she was saying, she

> probably got up out of a textbook because she was like, but like you cannot always rely on it, you know, like the stereotype. Like so yeah, I just, I mean I do value the things that they say, but I always am always double checking and this ain't going to help my body.

In the foregoing excerpt, Rihanna's narrative acknowledged the DHPD as manifested in healthcare providers' centralization of the medical textbook knowledge in their practice. However, she countered it through the DMHH, as she considered the DHPD in this regard as counterproductive in delivering maternal healthcare services to certain races and demographics, specifically referring to the African American population. She believed that her own knowledge about her body (natural birth) should guide her decisions and not the medical knowledge. Thus, her narrative counters the DHPD while centralizing the DMHH. Race was a primary discourse in African American women's interpretation of their healthcare experiences.

In another instance, the DMHH was supplanted to centralize the dominant DHPD. Leslie's narrative privileged the dominant DHPD while countering the DMHH, she affirmed the DHPD, acknowledging the dominance of healthcare providers in African American women's care due to women's inability to make the best choices during pregnancy:

> I think a lot of African American [women]…[are] not making the best choices…I understand that we're pregnant or we want to have fun sometimes, but sometimes it's okay to just sit at home and not go have fun with the family or you know, those little bar or party.

In the foregoing excerpt, Leslie's narrative centralized the DHPD. In doing so, her narrative first critiqued African American women's ability to make the best decision when it comes to their maternal health, supplanting the DMHH. She further affirmed the DHPD by explaining why women need to adhere to and prioritize healthcare providers' advice even if they want to "go

have fun." Through this exemplar, the meaning-making process of African American women about maternal healthcare discourses is revealed, as it does not always constitute an outright rejection of DHPD. Here, the DMHH is disclaimed to centralize the DHPD.

Entertaining

On the one hand, African American women emphasized the value of the medical approach to "treating" pregnant women as manifested in medical competence. On the other hand, they underscored the place of intercultural and interracial competence given the vulnerability of African American women because of their race, medical condition, and gender. This interplay was exemplified when participants were asked what better ways doctors can serve African American women during pregnancy. In Kiyante's response, she said: "I'm not sure, maybe requiring some sort of education process on different ethnicities, different races." She further said that in an ideal provider-patient interaction, she would expect an interaction that is collaborative and two-sided, where both the doctor and the patient make decisions about the woman's health and the pregnancy:

> [a perfect doctor's visit would be] one that allows transparency, both ends, on the doctors and the patients. Going in and then having a conversation that is educational, pretty much every time that you go in, you learn something new or you learn about an experience that you didn't think of. Just making sure that they are walking you through what they're doing.

Kiyante's narrative entertains both the DHPD and DMHH, as it positions each of the discourses as important ways of approaching pregnancy. Although each of those discourses is centralized per time, depending on the context of the talk (e.g., prenatal visit versus labor and delivery room) they were both privileged in women's talk about ideal pregnancy experiences. Similarly, Beth

also stated that an ideal healthcare provider would be "somebody who's respectful a lot, someone that listens to me. That doesn't brush off my belief. Somebody that really listens. Somebody that understands pregnancy." She went on:

> I feel like during pregnancy, the whole knowledge and information they're giving on pregnancy, like instead of it just being like medical based, it needs to actually be like from a pregnant woman's perspective for one to really understand. In addition to what's being taught in school, like that we'll need to tell her change- like maybe they do need to have classes on dealing with black people, which is sad and unfortunate cause we're just people.

Beth's narrative evoked the DMHH as the dominant discourse while the DHPD is entertained alongside. She expects her provider to respect her "beliefs", that is, her cultural values (DMMH), and should also "understand pregnancy" (DHPD) This way, she is positioning both approaches as integral to a woman's overall experience, albeit centralizing one discourse at a time. Flaky's narrative also exemplifies this interplay:

> I think healthcare providers are aware of African American women's needs, but I think, they need to do more studies because African American women, you know, hard statistics and how everything is different. So, that I would say I think they do need to do more studies.

Flaky, in the above example, acknowledged the awareness and expertise of African American women's healthcare needs in healthcare providers' practice, but she further argued that, beyond medical knowledge, healthcare providers also need a cultural awareness of the healthcare needs of these women, underscoring their "difference." Her narrative is constructively positioning

DHPD as a dominant discourse while entertaining DMHH, acknowledging the essentiality of both discourses in the maternal healthcare experiences of African American women.

In another example, Kevris' narrative identified the DHPD as seen through unfair treatment of African American women due to their racial identity. When I asked her if she perceives any form of racial discrimination in the way pregnant African American women are treated by healthcare providers, she said:

> I think that it could be because I'd say the color and the insurance is based on the treatment that you get. I don't, I'm not, I'm not there…I feel that we're not getting the best of treatment. I feel that we deserve better and I feel that if we got better [treatment], we could probably be able to make better choices, as far as health-wise.

The lexical markers in Kevris story signify that she entertains both the DHPD and the DMHH. Words like, "it could be," "I'm not there" (trying to distance herself), and "we could probably be able to make better choices" suggest that DMMH is just one of the possible ways of experiencing effective maternal healthcare, the DHPD is subtly recognized as another possible way, as Kevris even tried to distance herself from the notion that healthcare providers treat women unfairly during pregnancy.

In summation, the narratives of African American women in this study underscore the importance of cultural awareness, cultural sensitivity, and its incorporation into maternal healthcare delivery. The narratives of women generally acknowledged the need for a good medical approach (DHPD) in treating them during pregnancy, however, they alongside this, privileged the DMHH in its different manifestations, given, the positionality of these women in their lived experiences as African Americans.

Other Findings

Given the intersectional identities evident in the context of this study, other findings which did not directly address the issue of maternal healthcare among African American women emerged in the data. I identified discourses of mothering, that is, the discourse of intensive mothering and the discourse of pregnancy (motherhood) as distressing. Lastly, I discuss the theme of "African American Women are Baby Mamas."

Discourse of Intensive Mothering (DIM)

Motherhood is a highly revered and traditional identity marker oftentimes used to define a "real woman" (Carolan & Cassar, 2010; Hill et al., 2012). Central to this ideology is the notion of "good mothering," conceptually referred to as "intensive mothering" - a primary marker for assessing who a good mother is (Hays, 1996). Similarly, U.S. culture also centrally privileges this ideology and its attending attributes (Cronin-Fisher & Sahlstein Parcell, 2019; Scharp & Thomas, 2017). Biologically and culturally, intensive mothering has been identified as a natural trail for women. This includes the notion that women have inherent mothering abilities, that selflessly privilege child making (pregnancy and birth) and rearing over their personal needs. As argued by Cronin-Fisher and Sahlstein Parcell (2019), "American culture naturalizes the skills and challenging work mothering involves while undervaluing its worth" (p. 1). Given this ideology, women have been socially and culturally constructed to have natural instincts for pregnancy, mothering, and child-rearing. In this study, the DIM manifests through the theme of "motherhood is exciting."

First published in the late seventies, *The Joys of Motherhood* became a popular literature text for college entrance examination in Nigeria (JAMB, an equivalent of SAT in the U.S.) in the early 2000s. Emecheta (1979) ironically presents the joys of becoming a mother as presented by the story of a woman in patriarchal African culture. In the modern-day, dominant discourses of

motherhood are still prevalent, as becoming a mother is expected to be something joyful and desired by every woman. Similarly, in this study, "the joys of motherhood" as a cultural discourse presents itself in the stories of African American women. While women, on the one hand, narrated the discomfort that came with pregnancy, on the other hand, they eulogized the beauty of being pregnant and ultimately becoming a mother. Situated in the cultural discourse of women as natural mothers (Cronin-Fisher & Sahlstein Parcell, 2019), the women in this study reinforced the discourse of the beauty and excitement that comes with being pregnant and becoming a mother by expressing how the conception and birth of their children supersede whatever discomfort they felt during pregnancy. This theme reinforces the discourse of intensive mothering as posited by Hays (1996). In this study, women expressed their excitement about motherhood, starting from the moment they found out they were pregnant. When I asked Kevris to narrate her pregnancy story. She said:

> First, I was like slaphappy and I didn't know what to do at the same time because it was like a rush of emotions, you know? And I'm going to be a first-time mom and like everything that I did have, I could have done up to that point would change. You know, my priority is, you know, my child now, right…Like that's my life. That's my heart and joy.

The excitement of having a child was also presented in the gender of the child. For Nancy, becoming a mother was not the only excitement but knowing that she was going to have a girl like herself, something she had always desired, "It was a funny experience, but I cried to joy because I was so happy that I was having a girl." Furthermore, the women in this study also expressed their excitement about having a child even when they had challenges that could impede a smooth motherhood experience. For example, Keffi a 22-year old woman, who had an

unplanned pregnancy, expressed her excitement about the news of becoming a mother, even though it was not expected:

> I was shocked. Like I wasn't really sad and anything like I was happy and like excited and it was, I don't know, it was like weird for me because I never thought I could, like I never was expected to be pregnant. I'll take my birth control at the time. I really thought I was sick.

Regardless of other life stressors that they had, including the absence of the child's father in the pregnancy journey, their stories animated the DIM, which positions pregnancy and motherhood as an exciting desire for women. As echoed in Telither's story when she found out that she was pregnant, she said she was happy despite the anger she felt because of the expensive bill she received for the pregnancy test:

> I had just come back from a vacation and wasn't feeling good I will never forget when I got the bill for that… I just went ahead and made an appointment to urgent care stating I didn't feel good and when I got to urgent care, they actually asked me if there were any chance I could be pregnant. and I told them, "yes." Then, they billed me for everything …they didn't do anything. They just gave me a pregnancy test. Like I could've did that at home…I was irritated. But then, you know, like just moving on and being happy about my being pregnant.

Telither further narrated how the father of the child was not in the child's life throughout the pregnancy period, but that didn't stop her excitement about becoming a mother. The above examples show how the "initiation into motherhood," as Beth puts it, is an exciting experience regardless of the stressors and pains that may be experienced. Despite the demands of being a [single] mother Tee stated that it was an exciting experience as well:

> When I went to the doctor, I just expected it. I was happy. So, I was excited. It's a fulltime job. I love it though. I love having a baby 'cause it give me something to take care of, especially with me being alone. I love every moment of it 'cause it keeps me focused.

The joys of motherhood as a manifestation of the DIM was further uncovered in the narratives of women about pregnancy and labor pains disappeared upon the birth of their children. This was evident in Hannah's and Lisa's stories:

> I'm on a yoga ball, I'm walking around…I'm getting irritated...they say, "You ready to push?" I kept pushing and pushing and then she came out. She cried…and I looked at her, I was like, "Wow, this is all, baby. Like all this pain is the reason why." I was really happy.

Lisa shared, "I remember coming into the room and seeing my baby, and I just lost it. I was just like so happy, you know, that I actually have a kid like me, like I have a kid. I couldn't believe it." Hannah and Lisa's stories did not only present pregnancy and motherhood as exciting experiences, they acknowledged the existence of pains during the process, but they privileged the excitement and joy that comes when the child arrives, as Hannah said, "Like all this pain is the reason why." They belittled the pain in comparison to the joy of becoming a mother.

Discourse of Pregnancy (Motherhood) as Distressing (DPD)

The DPD is an alternate, marginalized discourse that emerged. It positions motherhood as not always exciting or desired by every woman. Pregnancy and the entire motherhood experience is positioned to be an all-encompassing experience, not always desired, not always exciting, and, in fact, sees pregnancy and motherhood as sometimes traumatic and distressing. In telling their pregnancy stories, the women's narratives showed that, against cultural notions of the excitement

that [should] always come with pregnancy and motherhood, women sometimes experience some form of distress both in their pregnancy and motherhood journeys. The data reveals the discourse of pregnancy and motherhood as distressing both directly and indirectly. For example, Rihanna, when narrating her story said her pregnancy put her in a sad place:

> [My pregnancy] was unexpected. It's with someone that I've been with for a while, my boyfriend. But like during my pregnancy, the first time I found out about it, I was very sick. Like really, I was like in sad place, because you know, just dealing with a lot of emotions, you know, like just finding out and then those thoughts. So, I was doing it, and then on top of the sickness. I was just not in a really in a really good place…There's just a lot of stress…my third trimester was tougher cause you know, I started to get bigger and then I was really swollen…I would say it was very traumatic. The delivery part was very traumatic…so I was feeling very, very weak. I was having hot flashes. Like heat flashes. I just felt like terrible.

Rihanna's story reveals that motherhood, though culturally positioned as an exciting life event does not always happen that way for every woman. Without being prompted about whether she was excited about her pregnancy or not, she naturally narrated the stress and unhappiness that she experienced about her pregnancy. This experience directly negates the domain ideology of how women feel about pregnancy and motherhood. Unplanned pregnancy is seen as a cause of distress and unhappiness, contributing to the emotions experienced during this time. Rose, a 27-year old mother of one further corroborated this claim, as her unplanned pregnancy also caused her prenatal depression:

> I was in my last semester of my bachelor's degree, so I was trying to finish that up…and then so that was just an added stress factor. So, for a long time I didn't mention it. I didn't

> say anything because I just didn't want it to be real. It was kind of hard. I think I was probably really sad and depressed for a while until I started showing, which was roughly, six, seven months for the pregnancy to become real.

Particularly, the physiological changes that women experienced in their bodies during pregnancy also contributed to the experience of distress, and in some cases caused prenatal and postpartum depression. This was representative in Hannah's story:

> It was hard. And I think I got really depressed even in the midst of me being pregnant...I quit my job because I had to go on bed rest and about before a month, my body just couldn't take work anymore. I was too tired.

Following the delivery of her baby, Hannah said she continued to feel mental and emotional stress:

> Being a parent now, you know, after having her, I experienced post-partum depression for a very long time. I didn't feel like a mom at first. I just looked alive. For a very long time. You know, I tried. I breastfed her for about three weeks, and I just couldn't do it no more. I wasn't eating so I had to, you know, bottle feed her. I was pumping. That wasn't working so she got enough of breast milk but not more as much as I want.

Though acknowledging the DIM, Hannah's story presents it as incongruent to her lived pregnancy experience. When she describes "not feeling like a mom," the talk reflects an existing, dominant expectation of what a mom should feel like, or even look like. The acts that have been culturally extolled as desired by women during motherhood (e.g., breastfeeding) did not turn out to be exciting for her, rather difficult. Similarly, Tammy, a 24-year-old mother of two narrated the physiological impact of pregnancy on her body. She said, "You know, having a baby is a lot of work and then also going through the process and also having to deal with the different

emotion changes, the body changes. It just takes a toll." Tammy acknowledged that pregnancy brings emotional changes that result into negative feelings, not the excitement that is dominantly presented in pregnancy stories.

Furthermore, subsequent demands of caring for their children after delivery were also reported as hard, painful, and for some, frustrating. Tee, a 26-year old mother of two, had this experience:

> It is hard…my son, he cried. I couldn't get no sleep. And he was my first, so I was on my own going through this…I tried breastfeeding. when I first tried, I didn't like that at all. So, I tried for like at least three months after he was born but I kept saying I didn't want to do it. [The healthcare providers were] like, "But it's healthy. It gives the baby skin to skin contact." I told them a few times I didn't want to do it but then they pressured me.

Tee, against the dominant DIM did not find breastfeeding comfortable. However, noted that she was pressured into doing it; not enjoying breastfeeding was seen by her providers as deviant to the expected behavior of a new mother toward their child.

The Interplay of DIM and DPD

The discourses of the joys of motherhood and the pains of motherhood interplayed as women narrated their stories. This interplay manifested through countering interplay of the DIM and DPD. The DIM is often used to supplant the DPD, and vice versa.

Countering. As for Hannah, she expressed her experience of joy as well as fear about the journey into motherhood. She, at the beginning of the interview, expressed how happy she was when she found out that she was pregnant, given the fact that she had just lost her brother to a case of homicide, so becoming pregnant was exciting news for her family. However, she also expressed fear that comes with birthing a child as an African American woman. Specifically, her fear stems from the statistics about the maternal crisis among African American women

> One is thinking about, okay, this the day I got to give birth to the child and what if I don't make it home tomorrow, it is scary. And I think it makes our labor so intense and traumatic for a lot of people. Like I had a cousin, she went through preeclampsia, she was Swollen like crazy. And it scared me cause I'm like, 'Oh my God, I couldn't imagine going through that with her'. I'm happy that her baby came… but it's scary. Even if I wanted another child, I'm scared …' am I going to make it? So, it scares us as women in general, not even our culture or race alone. It scares everyone because it's hard to say, "Okay I'm pregnant, but when that day comes, all I have to do for the baby to come is scary."

The foregoing example shows a struggle between the pain of motherhood and the joy of having a baby. This struggle results into fear, as Hannah, on one hand, relishes the joy that comes with babies (DIM), but on the on the hand, expresses fear, one that is rooted in the pains and discomfort that comes with pregnancy-DPD. Her narrative acknowledges both discourses, acknowledging their existence and legitimacy, albeit supplanting the DIM through the DPD. In contrast, Rachel's narrative supplants the DPD while privileging the DIM:

> Pregnancy is very draining and then you have to recover physically of course. But yeah, absolutely it is traumatic because the first time around they had to see that I couldn't have

> vaginal birth…which I feel negative, traumatized, cause I felt tortured. Like I just felt so uncomfortable. Like I have stuff hanging out of me and then I was bent down for a certain part. That experience made me want to be like, "I don't want no more kids." But, you know, look at my blessings because it could have went a lot of different ways. That's why the good definitely outweighs the bad.

Rachel clearly acknowledged the DPD in her own experience, as she classified pregnancy as "draining". However, she voiced the dominant DIM in an attempt to downplay the DPD, classifying the distressing moments of pregnancy as insignificant compared the "the blessing" that comes with it, that is, the child. Nancy's narrative does the same by supplanting the DPD to privilege the DIM:

> I do want another kid. I just don't want to hold the child again for nine months. I'm scared to get sick again. I hated throwing up. I hated throwing up with a passion. It was horrible. I hated not being able to eat 'cause I love to eat. So that was the only downfall of my pregnancy, but it was so exciting. Like it was the best time of my life cause I got to experience something that I never experienced before.

Despite Nancy's acknowledgment of the physiological stress she experienced with pregnancy, she still unequivocally privileged the DIM. The DIM still functioned as a dominant discourse in the way Nancy viewed pregnancy and motherhood. As such, the stress that comes with being pregnant was belittled because pregnancy is "exciting." Inversely, though Sadiat's narrative demonstrates a synchronic interlay of negating between the DIM and DPD, in her case, her narrative privileged the DPD to counter the DIM:

> So, my pregnancy was not what I thought, like I wanted it to be flowers and sunshine and smiles every day and just running through green pastures. But that was not it at all. It was

more like “Give me that towel cause I’m about to throw up and run into the bathroom,” and barely making it sometimes. Like it was all of that.

Overall, the interlay of DIM and DPD were centrally evident in a countering interplay, as women supplanted the DIM or the DPD to privilege the alternate discourse of DPD and DIM respectively. The DPD is positioned in the data of this study as an all-inclusive pregnancy experience, one that particularly includes negative emotions, stress, and distress. Some women even reported experiencing depression during and after their pregnancies. However, they still privileged the dominant discourse of pregnancy as exciting as resident in the DIM. Thus, the women in this study participated in both DIM and DPD, albeit privileging one and supplanting the other depending on their experience.

African American Women are Baby Mamas

This theme emerged in women’s talk regarding how they are perceived by healthcare providers. The theme, as interpreted in women’s narratives, positions African American women as promiscuous, women with multiple partners, having many babies with different fathers. This characterization of African American women as baby mamas was either personally experienced or perceived in their interactions during pregnancy. The theme is situated within the discourse of marriage as a prerequisite for pregnancy, that is, only those who are in legal, committed marital or romantic relationship have (legitimate) children. The theme also draws upon the traditional discourse of family, that is, one that consists of a father, a mother, and children (Baker, 2019; Baxter, 2014). Women in this study evoked this theme as they talked about healthcare providers’ perception of their identity as pregnant African American women. For example, promiscuity as a manifestation of this theme emerged in Nancy’s talk about perceptions of healthcare providers about pregnant African American:

> I think I'm perceived as, "Here's another Black pregnant woman" and especially if she walked in there by herself, "Here's another Black pregnant woman who [is] single, who doesn't know who her baby father is." You know, anything like that. Just racial.

Nancy's talk reveals that there is a circulating perception of African American women, regarding being promiscuous and not knowing the father of their children. This theme supports a historical perception of African American women and their romantic relationships, such as having multiple romantic partners, multiple children with different fathers (Dixon, 2017).

Furthermore, when I asked Sadiat to narrate her pregnancy story, she said, "so, I have been with my boyfriend since I was 16. So, like me being pregnant wasn't like a bad thing or a bad feeling. We were happy." She spoke to the unstated discourse of marriage and its necessity in child-making and rearing by noting that "being pregnant wasn't bad thing," as though she was in conversation with the discourse of marriage being a prerequisite for pregnancy. When I further asked her how healthcare providers perceive pregnant African American women, she said:

> Like, okay, like, "Oh no, we have another black pregnant girl, not married." Like, I'm sure they look at these things like, "Okay, is she married? No, how old is she?" You know, teens to mid-twenties, things like that. Like, I'm sure all of that counts with them and I'm sure they do a lot of that with a lot of minorities coming in pregnant, maybe on a first, second or third child for some of us. I'm sure they pay attention to that and consider like, I feel like they just look, step back and say, "Oh, it's another one, another statistic, another one come in through the door or another one with, you know, who may not have a dad for their child. Another one who may be alone. Another one who, you know, again, not married or in a stable relationship or stable home, no job, things like that."

Sadiat did not only reference the theme of marriage as seen as a prerequisite for pregnancy, she particularly evoked the theme of African American women being baby mamas, that is women with many kids with multiple partners ("a lot of minorities coming in pregnant maybe on a first, second or third child for some of us"). In further demonstrating the theme of African American as women with many kids (i.e., baby mamas), Mary reported her friend's experience when asked about the perception of healthcare providers toward pregnant African American women, "Oh, I think of when my friend and her doctor urging her to have to get birth control… I think…a lot of black women have kids and aren't married, you know, for the most part." Additionally, Tafi said this perception of African American women as baby mamas does not only manifest in the healthcare context. She said it circulates on the U.S. society as a whole. When I asked about how pregnant African American women are perceived by healthcare providers, she said, "You come in there, you pregnant. They feel like, 'Oh she's just another statistic, she got another baby daddy. This her fifth child.' They already have the stereotype." Women reported that this perception of being "baby mamas" may influence how healthcare providers treat them when accessing maternal healthcare services.

The primary findings (the DHPD and the DMHH) of this study helped do not only help identify discourses that are present in African American women's healthcare experiences. It further revealed how these women responded to these discourses as they manifested in their healthcare encounters, that is the meaning making process involved in the discourses evoked in this context. This is a unique contribution of RDT to the literature of African American women's maternal healthcare experiences. The other findings, while they do not primarily speak to the research questions of the present study, reveal the inseparability of motherhood and gender discourses and identities in the meaning making process of maternal care. In the following

chapter, I provide further discussions on the latent implications of these findings to health and interracial communication scholarship.

V. Discussion

Scholarly work on pregnancy and motherhood have over the years garnered the attention of critical scholars (Collins, 1994, 2000; Willard, 2005). Dominant hegemonic discourses of pregnancy and motherhood have been critiqued for delegitimizing other discourses that animate women's pregnancy and motherhood experiences (Scharp & Thomas, 2017; Suter et al., 2015. However, the experiences of African American women are still not widely represented in this line of research (Collins, 1994). Examining the maternal healthcare experiences of African women in this study does not merely include the voice of a different population to the ongoing discourse of maternity and healthcare. It critically uncovers hegemonic racial, maternal, and healthcare discourses that animate the maternal healthcare experiences of African American women, and their influence on the sense-making process of these women when accessing care. Guided by RDT, I conducted contrapuntal analysis to identify discourses present in African American women's talk about prenatal and postnatal care, while focusing on how women make sense of their experiences with the presence of these discourses. Similar to the findings of other RDT studies on women's reproductive health (e.g., Krebs & Schoenbauer, 2019), my analysis identified the centralized discourse of healthcare providers' dominance as a centripetal force in women's healthcare experiences, one that undermines their agency and control when it comes to their health (Willard, 2005). Competing with the discourse of healthcare providers' dominance is the alternate, often marginalized discourse of maternal healthcare as a holistic experience, one that incorporates different aspects of a woman's life into her care. The sociocultural location of African American women further positioned them on a farther margin as pregnant women and mothers, given their racial identity as Blacks (Collins, 1994). The Black racial identity has historically suffered different forms of marginalization in the U.S. society (Bonilla-Silva, 2006),

thus, discourse-dependent. Consequently, the primary findings of this study uncover how African American women, at the intersection of race, gender, and patienthood make sense of their maternal healthcare as different cultural discourses intertwine to punctuate their maternal healthcare experiences. The discussion of these findings is organized under categories of healthcare discourses (DHPD and DMHH), the primary focus of this study. Other findings, such as motherhood discourses (DIM and DPD) and African American womanhood are then discussed. I further attend to the implications of this study for health communication scholars while focusing on practical steps that healthcare providers can take in better serving African American women. In the end, I provide suggestions for important sites of inquiry for future health and interracial communication scholarship.

African American Maternal Healthcare Discourses

Two primary discourses circulated in the narratives of these women: the DHPD and the DMHH. One discourse privileges the healthcare providers' authority and dominance in the delivery of maternal healthcare services, while the other values African American women's struggle for partnership and collaboration with their healthcare providers on decisions that concern them. In answering my RQ1, the dominant discourse of DHPD was evident and prevalent in the women's healthcare narratives, while the alternate discourse of DMHH struggled for centering with the DHPD. The DHPD manifested under the themes of the Biomedical Approach to Pregnancy, Dismissed Concerns Because Pregnancy Pains are Normal, Questioning Natural Birth Choices, and "Unfair Treatment Because You Are Black." In its manifestation, the DHPD advances a hegemonic view of healthcare providers as supreme and complete authorities in African American women's maternal care. In this manner, healthcare providers primarily make decisions that concern women's health and that of the baby based on what they feel is the

best for the women, strictly from a medical standpoint. Without consultation with women, healthcare providers man ownership of the decisions that concern prenatal care, labor, and delivery, leaving the women as subjects of their decisions. In this study, African American women resisted the imposition that the DHPD brings into their maternal care, criticizing it for its limitation in ignoring other salient aspects of women's life that impact their pregnancy experiences.

Under the theme of the biomedical approach of pregnancy, pregnancy is centrally treated as a medical condition that needs to be managed primarily through medical knowledge and methods (Andipatin et al., 2019). With this approach, women's bodies are considered and treated as machines that are programmed to perform certain functions, including childbearing, and should, therefore, be managed in certain ways by medical experts. Machine has been commonly used as a metaphor that accurately captures the medicalization of pregnancy and the woman's body, especially in Western countries (Kukla & Wayne, 2018; Shaw, 2012; Willard, 2005). This school of thought presents pregnancy as "a disruption to health that necessarily requires expert medical intervention and thinking of pregnancy as primarily about health and illness" (Mullin, 2005, p. 54). As such, healthcare professionals have positioned pregnancy as a critical condition, and pregnant women as critical patients. While this approach to pregnancy has been helpful in investing more medical interventions into the health of pregnant women and women's reproductive health in general, feminist scholars have continued to critique its imbalance, as it rips women of their power and control over their body. In this way, women have little control over what happens to them and their babies during pregnancy as healthcare providers are positioned as experts who have the knowledge to "manage' and "treat" the pregnancy. As Kukla and Wayne (2016) argued, "when medical professionals become the primary managers of

reproduction, pregnant women's epistemic privilege is undermined, and they are arguably reduced to playing passive roles in their own pregnancies and births" (para. 3).

In the present study, while women acknowledged the necessity of medical interventions during pregnancy, they refuted the notion that it should solely dominate their maternal care. As their narratives disclaimed the DHPD, women criticized the control it took from them regarding their ability to make informed decisions about them and their babies. Through synchronic interplays of negating and countering, women's talk criticized the DHPD for reducing pregnancy to a "structured" medical condition that requires some predefined rules for its management the biomedical approach positions pregnancy as an illness (Willard, 2005), as such:

> It leaves no room within its framework for the social, psychological and behavioral dimension of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. (p. 13)

A critical perspective to the medicalization of pregnancy and birthing advances the argument that women's bodies are subjected to a patriarchal healthcare structure (Parry, 2008; Shaw, 2013; Willard, 2005), restricting them from having the freedom they want, including that of natural birth choices. The way the U.S. healthcare system is structured, like other Western countries, women's autonomy in birth choices are highly constrained, given the reality that the system hegemonically frames pregnancy as an illness that can only be effectively managed by a healthcare professional. In addition to the autonomy that the biomedical approach takes away from women, African American women in this study also resisted it for its shallow approach to pregnancy, one that ignores other salient aspects of pregnancy, like mental health. As the DHPD

was resisted in women's stories, it was criticized for its inattention to women's mental health symptoms, thus undermining it or totally ignoring as healthcare providers focus centrally on the "pregnancy." Healthcare providers as actors of the DHPD were criticized for rendering women's mental health unimportant.

Postpartum depression is a serious illness problem for women in the United States. According to the CDC (2020), in the United States, one out of nine women experience postpartum depression, and the rate could be higher, depending on the state. For African American women, the rate of postpartum depression is higher, given other factors such as intimate partner violence, childhood trauma, socioeconomic stress, and lack of social support (Karras, n. d). The biomedical approach while valued for its investment in medical knowledge about women's health, it ultimately devalues women in their ability to partake in maternal healthcare choices. In previous RDT studies, Scharp and Thomas (2017) unpacked women's narratives with prenatal and postnatal depression. As they supplanted the dominant discourse of intensive mothering (i.e., motherhood is a bliss), through their narratives, they drew upon an alternative discourse of mothering, one that acknowledges the holistic view of women as mothers. As such, they argued for a motherhood experience that accounts for a comprehensive view of women, one that includes their mental health. Despite the traditionally stigmatized notions of mental health illness (Seurer, 2015), particularly for African American women (Ceballos et al., 2017), women voiced it as an important aspect of their pregnancy, which the biomedical approach often ignored. As Scharp and Thomas (2017) argued, legitimizing the marginalized discourse of depression in mothers' experiences my yield valuable help healthcare providers provided the needed support for women who are struggling with mental health and its attending cultural perceptions toward mothers.

While African American women's narratives resisted the DHPDS, some women's narratives entertained it. Through their talk, they positioned healthcare providers as experts and authorities, who drive their pregnancy experiences while they position themselves as subjects. Despite the privileging of the DHPD in their talk, women in this study did not see the biomedical approach to pregnancy as the ***only*** way to provide maternal healthcare. Through entertaining they acknowledged the possibilities of other approaches in the way women are cared for during pregnancy.

As the United States continues to invest in different forms of medical technology for maternal care, maternal mortality is still prevalent (Creanga et al., 2017; Kassebaum et al., 2016), especially among African American women (CDC, 2019a; NPR, 2017). This reality challenges the notion that medical interventions ultimately help in decreasing maternal mortality. As African American women resisted the DHPD in this regard, they drew upon the discourse of midwifery as an alternate, holistic, and effective plan to experiencing their autonomy during pregnancy. They emphasized the benefits that come with having a woman, who also shares in their racial experience, manage their pregnancy in a way that does not take away the agency of their health. Ultimately, as women constructed meanings in their maternal healthcare experience, they affirmed the holistic approach to pregnancy, advancing the notion that women's bodies are not distinct from their pregnancies. As such, the DHPD through the biomedical approach is challenged for isolating women's bodies from their pregnancies.

Under the theme of "dismissed concerns because pregnancy pains are normal," the DHPD is further refuted for its failure to give voice to women's concern in their maternal healthcare plan. As women narrated how healthcare providers consistently dismissed their concerns during pregnancy, the DHPD is identified as one that advances the hegemonic,

patriarchal view of pains as normal to woman's experiences. As Krebs and Schoenbauer (2019) argued, undermining women's pains is a reflection of a patriarchal culture that punctuate the experiences of women in different contexts, including reproductive health. In this study, The DHPD under this theme, framed women as been hysterical, "paranoid," or even mentally disturbed when they expressed their pains to their healthcare providers. In Ebony's narrative, her healthcare provider invalidated her labor pains, telling her she was just being dramatic and overly emotional. As healthcare providers reproduced the broader discourse of the normalization of women's pains, women firmly resisted this discourse as they considered it insensitive to their health. Not only that, DMHH negated this discourse for the danger it may further pose to women's health and that of their baby. In some instances, in this study, dismissing women's concerns and normalizing their pains led to fatal outcomes, like the death of the baby or other serious complications as in the case of Ebony. Historically, women's health pains have often been normalized, and ultimately dismissed (Hoffmann & Tanzian, 2001), rendering them powerless. The advancement of the DHDP under this theme furthers the larger cultural discourse of intensive mothering, one that positions women as natural mothers, bodies were made for child-making and rearing. Consistent with the findings of Cronin-Fisher (2018), the broader discourse of intensive mothering positions women as "natural endurers" of pains, rendering women's experience of pains as biologically normal (Krebs & Schoenbauer, 2019). As the women in Cronin-Fisher's (2018) study voiced, pregnancy and birth were considered "bad" when it involves some level of pain, given the cultural ideology that good pregnancies are free of complications. In the same manner, healthcare providers, in (un)consciously advancing the DHPD placed women in a position where the legitimacy of their experience was questioned.

As African American women narrated their expression of pains to their healthcare providers, they reported that their experience of pains was rendered unreal and normal, affirming the broader discourse of normalization of women's pains and intensive pregnancy (Tiidenberg & Baym, 2017). Words such as "you don't really look like you're in pain" were reported as ways healthcare providers responded to African American women's pains during labor and delivery. Specifically, African American women whose discourse-dependent identity has culturally placed them as strong" and "supernatural" (Davis, 2015; Stewart, 2017; Watson & Hunter, 2015; Watson-Singleton, 2017), thus, resistant to pains. Previous research argued that the normalization of pains for African American women has grave consequences, especially for their mental health. As these women, constrained by the cultural depictions of the "strong Black woman", internalize their struggles, thus, not getting the support they need (Collins, 2000; Schiller et al., 2012; Watson-Singleton, 2017).

When women's desire to pursue a natural birth was upended, they, again, resisted the DHPD for its overt push for medicalizing pregnancy. Under the theme of "questioning natural birth choices," women reported the pressure they got from healthcare providers for medical interventions, such as epidural, even when they had made their preferences known to their healthcare providers. Shaw (2013) stated, "For millions of years normal or "natural" birth for women generally consisted of an unmedicated, vaginal delivery, over the past few decades in North America birth has become more medicalized and less reliant on women's innate birthing abilities" (p. 527). As healthcare providers pushed for medical interventions, narratives of women revealed the position of powerlessness, as they were often pressured into having some form of medical intervention. Aligning with the biomedical discourse of pregnancy, as healthcare providers question women's natural birth choices, The DHPD is negated through the DMHH.

Their narratives showed how healthcare providers try to medicalize their pregnancy and delivery process as they questioned their choices of natural birth. Healthcare providers continued to centralize the biomedical approach through controlling attitudes that rendered African American women powerless in their decisions about natural birth. Unfortunately, as women's choices were questioned or ultimately dismissed by healthcare providers, women lost trust in their healthcare providers. Specifically, African American women in this study constructed the meaning of the DHPD in this regard as an attempt to oppress them as a manifestation of systemic racism in U.S. society. This oppression is interpreted to be an attempt to control the Black population from increasing through childbirth. Alternatively, women's narratives privileged the broader cultural discourse of intensive mothering as they constructed the meaning of pregnancy as one that is natural to women, thus disclaiming the DHPD. The discourse of natural mothering, as manifesting in pregnancy positions women as possessing innate abilities to experience motherhood including, pregnancy and childbirth (Bobel, 2002). Consistent with the arguments of feminist theorists, women's choices during pregnancy should not be overturned by hegemonic views of pregnancy, one that situates pregnancy as an illness (Willard, 2005). As long as women continued to experience oppression through the DHPD, they lose trust and confidence in the ability of their providers to seek their best interest, even as they turn to midwives who share in their cultural birthing experiences as African American women.

The paternalistic culture is not a new operation in the U.S. healthcare system. However, given the historical treatment of African American women, when healthcare providers dominate women's experiences, it does not only position them as subjects based on their patient identity, it further triggers historical issues of medical mistreatment as in the Tuskegee Syphilis study of 1932, thus, positioning them as second-class citizens based on their racial identity. Goldberg

(2009) argued that the paternalistic approach to obstetrics embodies, "a historical imbalance of power in gender relations [that constrains] individual choice by complex medical technology, and the intersection of gender bias with race and class bias in the attitudes and actions of individuals and institutions" (p. 34). Under the theme of "Unfair Treatment Because We are Black," the DHPD places women as ones who are not capable of making their own decisions, ones who should always be told what to do, and ones who should be controlled because they are Blacks. Cultural discourses that animate the Black identity in the U.S. society includes that of inferiority, oppression, poverty, and low education.

While other women (e.g., Caucasian) *may* experience the same dominance, African Americans interpret their experiences beyond their patienthood to their racial identity even as it intersects with their gender identity. Consistent with the argument of Collins (1994), while other critical feminist studies have been productive in addressing issues that concern mothers across different races, investigating the maternal experiences of African American women yield "markedly different themes" (p. 48). The marginalized race of African American women, coupled with their identity as women in a patriarchal society, naturally renders them powerless. As women made sense of their maternal care under the theme of "Unfair Treatment Because We are Black," their talk and the interpretation of their maternal healthcare reveal the interwovenness of patienthood and race. Just as Ashley (2014) argued, in providing effective care for African American women, there needs to be an incorporation of their racial realities into *how* healthcare is delivered to them. Although healthcare paternalism has been argued to have faded from healthcare practice in the United States (Epstein & Street, 2011), African American women still experience it in their maternal healthcare. The practice of dominating paternalistic

care is damaging to patients' health (Thompson & Whiffen, 2018), taking away women's agency, control, and participation in decisions about their health.

As factors such as racial identity (Mazul et al., 2017) and gender identity (Jackson et al., 2001) intersect with African American women's maternal healthcare experience, it is apparent that the DHPD may (un)consciously ignore other salient aspects of African American women's health, such as the sociocultural background of African American women, thus, fostering the historical discourse of African Americana as second-class citizens (L. Williams, 2016), whose concerns should not be taken seriously. Healthcare providers' failure, as actors of the DHPD as they solely focus on the pregnancy (from a medical perspective) while ignoring or undermining other aspects of the woman's health, may result into larger problems for both the child and the mother.

Ultimately, the rejection of the DHPD in women's maternal care further drew upon the cultural discourse of individualism. The discourse of individualism in the U.S. culture promotes the idea of independence, self-reliance, and self-worth (Myers, 2000). This way, individuals have control over what they want for themselves without any imposition from other people. In motherhood research, RDT has been used to uncover the discourse of individualism in mothers' talk about their pregnancy as well as motherhood experiences, one that calls for a form of independence about their bodies and the experiences they have as mothers (Cronin-Fisher, 2018). African American women in this study also drew on this discourse as they resisted the idea of being controlled or told what to do regarding their own bodies, as they put it.

As an alternate discourse to the DHPD, the DMHH positioned maternal healthcare as a holistic approach to pregnancy, one that incorporates different important aspects of African American women's health to their care. As women's talk evoked this discourse, it is considered

as a collaborative effort between healthcare providers and African women as against the one-directional approach posed by the DHPD. Situated within this discourse, are the themes of Healthcare Providers Should Listen, "Cultural Sensitivity is a Big Thing," and "Pregnancy is Spiritual." Consistently in women's talk about pregnancy and birth, they affirmed the DMHH, using it to negate or counter the DHPD in its different manifestations in their care. Despite the fact that women's narratives negated, countered, or entertained the DHPD, the DMHH is consistently provided in women's talk about maternal healthcare. None of the narratives also resisted it in any of its manifestations. African American women espoused the DMHH as a healthcare approach that is comprehensive in its usage. When describing it, women often referenced midwives and how they advance this discourse in their delivery of maternal care. Women's advocacy and preference for midwifery as an alternative to medicalized birth is consistent with the findings of Shaw (2013), who also found that midwifery care is constructed as an alternative healthcare care services as it helps women to "resist many aspects of medicalization by providing more holistic care that focuses on creating positive and empowering birthing experiences" (p. 532).

As women affirmed the DMHH, calling on providers to upend their dominance and listen to women's concerns, they challenged the centripetal discourse of the medicalization of pregnancy as evident in the DHPD. In this manner, African American women voice their ownership in their maternal healthcare. As the DHPD silences women, allowing healthcare providers to make decisions for women without adequately consulting with them, DMHH challenges it, asking healthcare providers to work as collaborators with women, not supreme authorities. This way, the DMHH (through the theme of "Healthcare Providers Should Listen") rejected the DHPD (through the theme of dismissed concerns because pregnancy pains are

normal). By calling on healthcare providers to listen to them, African American women sought to reclaim their lost agency in their maternal care, thus positioning their authority as owners of their body alongside healthcare providers' expertise.

As the DMHH further uncovered the theme of "Cultural Sensitivity is a big Thing," African American women advocated for awareness of their culture, especially their racial background in maternal healthcare delivery. Women discoursed pregnancy as encompassing different aspects of their lives, especially their culture, albeit culture is often referenced as their racial identity and experiences. Unmistakably, women talked about the importance of good medical care. The data presents the DMHH as a necessary approach to maternal healthcare, alongside the DHPD. Race has long functioned as a core determinant of healthcare delivery for African Americans in the United States (Cooper et al., 2012). Color-blind healthcare delivery still serves as an alternative to ensuring fair treatment with all patients when accessing healthcare services. It has been argued to promote a type of healthcare that treats everyone "fairly" regardless of their race. Despite this, the promotion of this ideology, African Americans, as well as other racial minorities continue to experience differential healthcare delivery and outcomes (Ludwig et al, 2019). Research has shown that the practice of color-blind healthcare delivery does more harm than good, especially for people of color as it subtly suggests a "rejection of the concept of racism" within the healthcare system, thus, fostering White privilege (Ludwig et al., 2019, p.15). In healthcare delivery, race matters. It influences healthcare providers' delivery of care (even when they are not aware of it; implicit bias) as well as patients' assessment of care. Consequently, the expectations of the women in this were unmet as through the color-blind healthcare delivery that did not take into consideration, their racial identity as well as their experiences. These experiences are contextualized at political and sociocultural sites. They

voiced their preference for an integrative approach that contextualizes their racial experiences as seen in stereotypes (cultural), discrimination, and systemic racism. They reasoned that positioning their racial background in their maternal care influences their healthcare experiences and outcomes. Similar to the argument of Collins (1994), "motherhood occurs in specific historical situations framed by interlocking structures of race, class, and gender" (p. 45). Contextualizing the sociocultural and political experiences of African American women's maternal care provides a patient-centered approach, one challenges dominance by healthcare providers.

The DMHH further positioned pregnancy as a spiritual experience, a narrative that African American women used as a remedy for the DHPD. This way, they harnessed their spiritual resources and network as a form of support as they experienced a loss of agency in their maternal healthcare. As medical understanding advance as the dominant frame through which women's maternal care is constructed (DHPD), they utilize their spiritual support to "trust God" for a successful delivery. Spirituality is highly revered among African Americans, especially regarding health (Cheadle et al., 2015). For women in this study, while they did not expect the integration of their religion or spirituality into the medical care, they consistently referenced it as the resource they used whenever they experienced challenges with the pregnancy.

A holistic approach to pregnancy as advanced through the DMHH, helps healthcare providers to incorporate into their practice, other determinants of health that may impact pregnancy outcomes for these women. African Americans relate at a discursive site, given their discourse-dependent identities. Consequently, there may be more difficulty legitimizing their healthcare experiences, including their symptoms when interacting with healthcare providers. This reality should, in fact, prompt healthcare providers to reject the color-blind healthcare, as it

clearly deprives African American women of quality care and imbibes maternal care that acknowledges and integrates their lived realities into their maternal care. In a healthcare system that has already lost its trust with this racial group due to historical and ongoing issues of racism and racial discrimination (Adebayo et al., 2019; Durant et al., 2011; Kennedy et al., 2007; Scharff et al., 2010), women struggled with accepting maternal care that did not incorporate to their racial experience into their care. While the biomedical approach was criticized for its overbearing method to women's health, it was still privileged as a central discourse in women's stories. Particularly, when women were asked about their recommendations for a good maternal care practice, their narratives entertained the DHPD as well as the DMHH. Although at different points in the narratives, each of the discourses took a central position, while the other is positioned as an alternative.

Additionally, findings from this study show how relationships in themselves continually constitute meaning, a major reworking of the recent iteration of RDT (Baxter, 2011). The "illusion of relationship as a container" is challenged the relationship between healthcare providers and African American women in the context of this study shows how communication is constructed based on the meanings associated (Baxter, 2011). Given the existing power dynamics in the provider-patient relationship (Nimmon & Stenfors-Hayes, 2016), women made sense of their interactions given the way this type of relationship has been culturally (and structurally) defined. The discourses evoked as these women interact with their providers during their maternal visits continuously constructed their relationship and meaning making processes. The implication of this for healthcare providers is that communicative acts that advance dominant discourses are capable of shaping the relationship their patients have with them, which

may include adherence to their recommendations, trust, and willingness to disclose salient health information.

True to the focus of RDT, data from this study shows the focus of power in the DHPD as while the DMHH was marginalized, a case of power inequality in the discourses not necessarily the people (Baxter, 2011). A critique of the DHPD is not in any way an attack on healthcare providers or the use of different medical interventions to better the lives of people. Healthcare providers' communicative acts just functioned as "bridges" for the advancement of the DHPD. However, maternal healthcare becomes problematic when women's experiences are overly framed from a medical perspective, overturning their agency, and ignoring other salient aspects of their health.

Motherhood Discourses

Discourses of maternal healthcare are inherently interwoven with discourses of motherhood. Pregnancy with its care is a discourse within the broader motherhood discourse (Collins, 1994; Tiidenberg & Baym, 2017). Consequently, motherhood discourses were naturally evoked in women's talk about their pregnancy and maternal healthcare experiences. I identified the dominant discourse of intensive mothering (DIM) and the marginalized discourse of pregnancy (motherhood) as distressing (DPD). The DIM in this study primarily focuses on the excitement that is expected to come with motherhood.

Interwoven with the discourse of pregnancy, DPT was evoked centrally in this study as women reflected on their pregnancy, labor, and delivery, as well as phase of becoming a new mother.

Dominant discourses of motherhood have been prominent in women's narratives in the United States (Scharp & Thomas, 2017). These include discourses of intensive mothering (Hays, 1996), intensive pregnancy (Tiidenberg & Baym, 2017), ideal mothers (Collins, 1994), good

mothers (Cronin-Fisher & Parcell, 2019), and all forms of ideologies that position women as natural mothers, thus, experts in child-making and rearing. Historically, motherhood has been positioned as an extolled, excited, and innately desired experience for women- an iteration of intensive mothering (Cronin-Fisher & Sahlstein Parcell, 2019; Hays 1996). In this study, the DIM manifested as women eulogized their experiences upon learning about their pregnancy and subsequently after delivery. They unequivocally relayed their excitement about their pregnancy even when situations surrounding the conception were not perfect. For instance, Telithe recalled her excitement about becoming a mother even though the father of the child was not present during the pregnancy and subsequently in the child's life. The women also evoked this discourse as they narrated their labor and delivery experience, talking about the excitement and joy they felt despite the pains of labor.

However, this discourse interplayed with the marginalized DPD, as women simultaneously evoked both discourses, albeit positioning DIM as a central discourse. More importantly, the DPD was centralized in utterances that sought to delegitimize the inadequacy of healthcare professionals in the women's pregnancy and motherhood experience. The DPD was situated in women's stories of traumatic birth perpetrated by their healthcare professionals. Thus, healthcare professionals were positioned as agents in determining women's pregnancy and motherhood outcomes. Specifically, communication was centralized in how women evoked DPD, as advanced through the interactions with their providers. Communication functioned as the measure through which women assessed their maternal care. For instance, for women who specifically named their pregnancy experiences as traumatic, they discoursed it from the kind of interactions they had with their providers. Rihanna said the nonverbal expressions on the faces of her healthcare providers made her delivery a traumatic one.

In a countering interplay, women affirmed the DIM as positioned in both their pregnancy and motherhood experiences, while they supplanted the marginalized DPD, albeit informed by their experiences with their providers. In their interplay, DIM continues to be centralized as the expected reality of every real woman (Carolan & Cassar, 2010; Hill et al., 2012), while DPD is positioned as an experience alien to natural motherhood but often evoked by healthcare providers. In this way, the burden of traumatic birth is placed on healthcare providers as women position themselves as naturally excited about motherhood and when that does not happen, the burden is on healthcare providers.

Additionally, unplanned pregnancy served as a trigger for how women made sense of their experiences. Some of the narratives that entertained the alternate DPD were situated in stories of unplanned pregnancies. Unplanned pregnancy, as evidenced in this study is capable of influencing a woman's emotional response to pregnancy and motherhood, such as distress and trauma. Pregnancy or motherhood-triggered depression challenges the ideology of intensive mothering, one that posits that women naturally desire children, thus, happy with the experience (Hays, 1996). More specifically, the experience of prenatal and postpartum depression became evident in the DPD as well. As women narrated their stories and the experience of maternal depression, their talk, again, pointed to a broader U.S. cultural discourse of individualism. Here, women sought to maternal healthcare that focused on their personhood, not just as a baby-making machine (Willard, 2005). In this way, motherhood departs from the dominant DIM, one that positions women's identity in connection with their children's identity (e.g., happy babies have happy mothers and vice versa).

Black motherhood, as evidenced in this data, acknowledges both the DIM and DPD. Specifically, the DPD is centralized when there is a perception of unfair treatment by healthcare

providers. This finding confirms the argument of previous studies on how the relationship between healthcare providers and patients can impact health, especially birth outcomes among African American women (Ward et al., 2013). Within the experiences of African American women, we see how race impacts their healthcare experiences, thus, impacting their motherhood experiences. This, again, reiterates the argument of Collins (1994) on the inseparability of race and sociocultural realities of African American women from motherhood research. While feminist theorists have been leading the way in deconstructing the biomedical discourse of pregnancy and women's reproductive health, they fail to account for the unique sociocultural background of African American women. While lack of economic resources ay be stressors for traumatic motherhood for White mothers, racial discrimination within the U.S. healthcare system. Thus, meanings associated with motherhood is arguably race-dependent. Africa American women make sense of pregnancy-related trauma from the experience of racial discrimination while accessing maternal healthcare services.

African American Womanhood

Historically, the racial and gender of African American women have often placed them at a discursive site, where they have to consciously engage in processes to affirm and maintain the legitimacy of their identity. Socially, economically, culturally, and medically, African American women have been reported to experience racial and gendered marginalization (Davis, 2018; Woods-Giscombé, 2010). African American womanhood is an identity in the United States that is highly discourse-dependent. By this, I mean women in this category constantly engage in "discursive processes to manage and maintain [their] identity" (Galvin, 2006, p. 2).

Culturally, the discourse of African American womanhood has been placed at the intersection of strength, independence, and immorality. The biblical jezebel character has often

functioned as a metaphor used to describe African American women. This referent historical referent to presents African American women with "unbridled sexuality," including having many children with different men (R. K Williams, 2016, p. 100). Consistently, this discourse was present in women's talk about healthcare providers' perceptions of pregnant African American women through the theme of "African American women as Baby Mamas.' In a marginalized struggle with the broader cultural discourse of sexual morality (Baxter, 2011), the theme of "African American women as Baby Mamas" was evident in the meaning making site of African American womanhood. In this way, the women in this study made sense of their healthcare experiences from the cultural ideology of being baby mammas (Parks, 2010). African American women have been discursively positioned at the site of promiscuity, where they are perceived to "make" babies, have children with different men, while not settling in a "legalized" marital relationship (Dixon, 2017). Similarly, in this study, this theme emerged women's maternal healthcare encounters, albeit limiting, in their assessment, the quality of care provided to them by their healthcare professionals. For instance, Mary's report on a doctor asking her friend to get on birth control inadvertently positions her within the Jezebel discourse, as she made sense of this as a reference to the alleged promiscuous life of African American women.

Theoretical Implications

A major hallmark of RDT is that meanings are constructed through competing discourses that animate individuals' talk in interpersonal relationships (Baxter 2011). As discourses struggle, meaning is constructed through an ongoing, unfinalizable process. Consequently, utterances uttered within the context of a relationship are in conversation with other utterances already spoken or yet-to-be-spoken, one that is mutually intelligible to the relational partners. As such, constructing meaning without identifying discourses at play in individuals' talk may be

misleading for understanding interpersonal relationships. As this study examined the discourses that animate African American women's talk about their maternal care experiences, it uncovered how women construct meaning of their maternal care based on the discourses evoked in their relationship with healthcare providers.

Consequently, the application of RDT in the context of this study helps to identify circulating cultural discourses that animate the identity as well as maternal healthcare experiences of African American women. Discourses are systems of meaning, a "set of propositions that cohere around a given object of meaning" (Baxter, 2011, p. 2). Meanings in interpersonal relationships are a product of the interplay of competing discourses. The discourses that animate the identity and healthcare experience of African American women, were brought to the fore through the application of RDT to develop interview questions and analyze women's narratives on how they made sense of their maternal healthcare experiences. Identifying discourses in interpersonal relationships uncovers ideologies. For instance, discourses embedded in African American women's utterance might have been unidentified without a theory that unpacks cultural ideologies that animate individuals' talk in interpersonal relationships. As utterances do not occur out of context, RDT, in this study provided insights into systems of meanings that are embedded in the utterances of African American women as well as how they made sense of their healthcare providers' talk. Given the marginalized identity of African Americans in the U.S. culture, RDT provided a theoretical lens to identify cultural systems of meanings that shape their maternal healthcare experiences, one that may not be easily identified through an interpretive approach. Sahlstein Parcell and Baker (2018) further argued that

By identifying and analyzing the interplay of discourses circulating around a particular phenomenon, researchers guided by this version of RDT are able to understand the ways

relational partners create, sustain, or reshape identities and make sense of the world around them. (p. 674).

On the one hand, through the application of RDT, this study identified different ways as well as attitudes that healthcare providers engage in to reproduce cultural discourses that construct meaning for these women. On the other hand, RDT also provided deeper insights into how discourses that were evoked in African American women's maternal care created, sustained, or reshaped their perceptions about African American womanhood and pregnancy. For instance, as the DHPD was centralized in healthcare providers' attitude and delivery of care to African American women, the dominant discourse of African American women as second-class citizens was evoked. As such these women constructed meaning based on how their identity was perceived. This is why, for instance, women made sense of healthcare providers' dismissive attitude toward their concerns as one that renders them as inferior, subjects, and "charity cases" as Unique describes it.

In collapsing the false binary of public and private lives, RDT provided a critical lens to identify how women made sense of their maternal healthcare experiences such that discourses evoked in provider-patient interactions reflect the influence of cultural ideologies that punctuate the identities and the relationship of African American women and healthcare providers in the U.S. society. As Baxter (2011) stated:

> Just as sociocultural life is deeply relational, so relating is a deeply sociocultural process. Traces of sociocultural discourses lurk in every utterance voiced by relationship parties—whether in joint conversations with their relational partner, in conversations with third parties (including fellow social network members or even strangers, including

> interviewers), or in the inner dialogues of intrapersonal communication in a speaker's mind. (p. 9)

Consequently, in relating with healthcare providers, the cultural ideologies that surround the identity of Blacks, specifically, African American women in the U.S. culture were lurked in what utterances were made as well as how meanings were constructed. Beyond the provider-patient relationship that characterizes the talk, public discourses that surrounding their identities in the U.S. culture copiously punctuated how meanings were constructed within that private context. For instance, in identifying the DHPD, utterances such as, "You're not in pain," could have been taken for granted if the meanings surrounding African American women's racial and gender identity were not further explored (that is, the discourse of pain normality in women; Krebs & Schoenbauer, 2019). As such, there was a collapse between what is rendered a public sphere versus private space.

In its critical capacity, RDT in this study provided an avenue through contrapuntal analysis, to identify power inequality (Suter, 2018), not in healthcare providers and African American women as such, but in the discourses evoked by these relational partners during maternal healthcare encounters (Baxter, 2011). As Baxter reasoned that no two discourses have equal power in utterances, that is, one is dominant while the other is marginalized, discourses evoked in women's talk further revealed discursive struggle of power. Centripetal and centrifugal discourses that animate the maternal healthcare experiences of African American women were identified at the intersections of race, gender, and patienthood. This way, women identified dominant discourses (e.g., the DHPD). As the DHPD advanced the dominant biomedical approach, African American women lost their agency in their maternal healthcare decisions. As such, their view of maternal healthcare as seen in the DMHH was marginalized.

Not only that, as women's narratives revealed power inequities in the discourses evoked in their maternal care, the inadequacies and limitations of the DHPD were revealed through the DMHH. Through the synchronic interplay of entertaining, African American women (re)constructed both discourses as important in their maternal care.

Engaging in a critical examination of Black women's maternal healthcare experiences does not merely add more vices to motherhood research (Collins, 2000). It indeed provides insights into the unique, often marginalized experiences of African American women. For instance, the discourse of intensive mothering (Hays, 1996) has been studied and critiqued for the burden it places on women in a way that is detrimental to their identity whenever they fall short of the "standard" (Green, 2010). However, this discourse even in its critique by feminist scholars does not account for the intersections of race and motherhood. As such, both the discourse and its critique may not represent the dialogic construction of motherhood for African American women. Collins (2000) argued, "a Black women's collective standpoint does exist" (p. 28). As such, the application of a critical theory helped to contextualize the interlockings of race and gender, as they punctuate the maternal healthcare experiences of women in this study. The unfair treatment of African American women as a theme under the DHPD might have been unnoticed if this study did not contextualize the historically marginalized racial identity of African American women. This critical approach helped to see ways in which African American women are making sense of maternal healthcare experiences in a way that is unique to them.

RDT, before now, has not been applied to study critical family and health communication from a racial standpoint. This novel step is capable of furthering research on racial minorities in different contexts, especially family and health. While this study may not literally solve the problem of maternal health crisis among African American women, it is a giant step in

identifying problematic structures, communication practices, and dominant discourses that may impede effective maternal healthcare outcomes.

The application of RDT in this study helped to develop interview questions that consciously guided women to evoke discourses that are present in their maternal healthcare experiences. During the interviews, these questions were valuable to the women as well, as it helped them to consciously construct meaning around their experiences as African American women. The majority of the women, at the end of their interviews, expressed their satisfaction with the interview process and how it allowed them to communicatively reflect on their racial experiences and how that has (re)defined their identities or constructed new meanings for them. The core of critical research is to bring about change in a site of power inequality (Braithwaite & Schrodt, 2015), seeing how this study helped women in (re)negotiating their identities is a valued achievement.

Practical Implications of the Study

Communication Scholars

In communication scholarship, the findings of the study help us to understand the influence of communication in healthcare delivery, as women in this study identified discourses, and also made sense of them through communication. In reporting how healthcare providers perceive them, African American women consistently reported communicative acts, both verbal and nonverbal, as indicators of how they are perceived. Communication functions at the heart of healthcare delivery. Specifically, with the end goal of addressing maternal mortality crisis among African American women, communication scholars are better positioned to identify communication markers, discourses that may significantly affect healthcare processes, including the interpretation of healthcare providers' attitudes toward patients.

Medical school curriculums should closely incorporate communication courses, ones that train medical students to pay attention to the role of both verbal and nonverbal communication attributes in their delivery of care. As discourses can also be identified through the unsaid, medical doctors should be thoroughly equipped in their training with the nonverbal communication dynamics. This training, beyond teaching the attributes of effective communication, should also attend to communicative acts that promote a racially-safe healthcare environment for racial minorities.

Exploring communicative processes involved in healthcare delivery further helps to identify how sources of communication (healthcare providers) are capable of shaping meaning. Most of the women in this study talked about the identity of their healthcare providers when making sense of their healthcare interactions. They factored in the gender and racial identity of their providers as important influences in the way they made sense of their interactions.

Healthcare Providers

Healthcare professionals have a lot to imbibe from the findings of this study. Healthcare providers need to note that communication functions at the heart of their service to patients. They "cannot not communicate" (Watzlawick et al., 2011, p. 32). Even in their silence, healthcare providers are constantly sending messages to their patients. Importantly, for identities that are overly discourse-dependent, every message is interpreted within a larger cultural context that sends a message about their identity (Galvin, 2006). In this study, women consistently made sense of their experiences through messages they perceived were being sent by their healthcare providers even when those providers are unaware of their communicative actions. While the healthcare system is considered a joint venture for both patients and providers, the burden of fostering a respectable atmosphere for patients heavily rests on the healthcare providers. No

matter how much we advocate for an equal level of power, the paternalistic structure of the healthcare system makes it difficult for healthcare patrons to decide how they will like to be treated. However, healthcare providers who interact frequently with patients, especially nurses, should help to promote a culturally and racially safe environment for African American women as well as other patients, particularly those on the margins of the society.

Additionally, as seen through the DHPD, dominant biomedical discourse about women's health are inadequate and problematic in their representation. They do not comprehensively capture the expectations of women about maternal healthcare. While medical interventions are valued as part of their pregnancy care, women advocated for maternal care that acknowledges their agency in decisions that concern their health. This way, they do not want to be controlled, rather consulted about issues that contain their health. Even though the DHPD is a dominant discourse in the U.S. healthcare system (Shaw, 2013), this study can help providers to begin to acknowledge and incorporate other salient aspects of women's health (e.g., mental health), as they desire into their care.

Healthcare providers in their capacity as gatekeepers in the healthcare system must continue to engage in critical reflections in way that help them to recognize implicit bias that may permeate the way they deliver care to African American women. As the California state government has led the way in providing implicit bias training to healthcare providers (The State of California. 2019), healthcare administrators in other U.S. states should also organize training that will consistently help healthcare providers recognize and address the biases they may have toward racial minorities.

Limitations

While the findings of this study pose a valuable understanding of the construction of meaning in African American women's maternal care experiences, it needs to be cautiously interpreted. One of the limitations of this study is the limited diversity in the sample with regard to the socioeconomic status. The socioeconomic status of participants in this study mainly represents that of low-income individuals. As such the transferability of the findings of this study may be limited only to African American women of similar socioeconomic status. Although research has shown that the socioeconomic status of African American women has little to do with the kind of racialized healthcare services offered to them in the U.S. society (Harris, 2019), it is still important to pursue a socioeconomically diverse sample to see how different social classes experience maternal healthcare, and what discourses are evoked as they make sense of their maternal healthcare.

Data from this study was based on reported speech of healthcare providers by African American women. This might have posed some challenges regarding the context of the speeches. In some instances, some women could not recall specific information about their experiences. For instance, women easily remembered labor and delivery experiences more than prenatal and postnatal visits. As such, the findings in this study rely more on women's experiences during labor and delivery. Reported speech in qualitative research may lead to the omission of salient information that might have further nuanced the findings of this study. As Baxter (2011) stated, "reliance on self-reports overemphasizes meaning making to third parties (researchers) and provides us with limited insights into the meaning making that unfolds in the moment between relationship parties" (p. 61).

Additionally, using snowball sampling presented some limitations. In this case, some participants were mostly from the same closely knitted social network as well as the same neighborhood. As a result of this, participants had pre-informed information about the study which could have led to preconceived responses, fostering social desirability (Bergen & Labonte, 2020). Also, because many of the participants referenced a particular hospital in the Milwaukee area, their experiences might have been closely informed by the structure in that hospital. While this does not in any way invalidate the stories of these women, it might have narrowed the findings to the experiences of women in that particular healthcare facility.

Future Areas of Scholarship

Given the information provided from the current scholarship, there are many areas of research that communication scholars can begin to explore in more depth. First, for RDT scholars, real-time observation of African American women's interactions, in naturally occurring conversations with healthcare providers, may provide first-hand information for examining the maternal care experiences of African American women. Baxter (2011) argued that researchers who understand "relationships as deeply cultured communication processes" can benefit from ethnographic observation, one that produces data that reveals natural conversations that may uncover "borders of private and public life" (p. 155).

Second, within the body of family communication scholarship, the application of RDT can be steered toward studying racial minorities and how they construct meanings as compared to dominant racial groups (e.g., Whites). As seen in this study, the racial background of African American women influenced how they made sense of the DHPD, given a history of marginalization in the U.S. society (Davis, 2018). In the same manner, discourses surrounding family identity, pregnancy, and motherhood may yield new meanings when they are studied

among different racial groups. Discourse dependency in family communication and RDT research should move beyond discourses surrounding biological versus essentialist constructions of family and motherhood (Suter et al., 2015) to also examine racial minority groups, as discourse-dependent identities, construct meaning. (e.g., of motherhood). As Collins (2000) argued, examining dominant motherhood discourses among racial minorities, particularly African Americans, reveals sociocultural influences of their race in the way they construct meaning as discourses struggle for power. Specifically, "for women of color, the subjective experience of mothering/motherhood is inextricably linked to the sociocultural concern of racial-ethnic communities- one does not exist without the other" (Collins, 2000, p. 47). This way, family communication research, in advancing the tenets of RDT, is representative of both dominant and marginalized racial groups.

Third, in other communication contexts, only one study has applied RDT (under its first iteration) to examine the experiences of African Americans (Simmons et al., 2013). Given the ongoing issues of racial tensions and discourses in the U.S. culture, RDT, as critical theory, can be used to empirically examine how discourses influence the experiences of marginalized identities, like African American women across different contexts. In its capacity as a critical theory, RDT can be applied to examine hegemonic discourses surrounding the construction of racial identity, especially for African Americans. Specifically, in the U.S. healthcare system, where discourses surrounding the reproductive health of African American women are naturally evoked, RDT can serve as a theoretical tool to unveil dominant discourses that may stand in the way of effective healthcare delivery. RDT can also further give voice to marginalized discourses about women's reproductive health, especially regarding issues relating to the normalization of pain.

Additionally, as women drew upon the DMHH, they identified midwives as an alternate, more effective healthcare providers in experiencing the DMHH during pregnancy. It will be important to examine the maternal healthcare experiences of African American women specifically with midwives, to see any similarity in the way they evoke discourses and construct the meanings surrounding their care. The use of midwives for maternal care has been argued to be a form of resistance to the medicalization of pregnancy and its care (Shaw, 2013).

Fourth, the healthcare system consists of healthcare workers as well as patrons who utilize the services. Research on healthcare-related issues should focus on collecting and analyzing data from both patients as well as healthcare providers. This way, through the identification of discourses ta play, RDT can further help unpack how healthcare providers make sense of their interactions with African American women. This effort is capable of even providing more insights int the experiences of healthcare providers with marginalized identities. More importantly, the problem of the maternal mortality crisis among African American women may be better understood and addressed through a collaborative effort between African American women and healthcare providers. Continuous focus on either of the parties may be limited in addressing the crisis.

As Baxter calls on communication researchers to adopt different forms of communication enactments to advance data that is dialogically expansive. To this end, future research can focus on using multiple data collection methods. For instance, focus group discussions are valuable in examining experiences that are unique to a group of people (Lindlof & Taylor, 2019). This may include racial groups, religious groups, and organizational groups. Lindlof and Taylor (2019) argued that focus group interviews are exceptionally useful for understanding group experiences through group effects,

> unleashing a kind of 'chaining' or cascading effect in which each person's turn of the conversation links to, or tumbles out of, the turns that came before it….In this mode…group members work towards attaining a shared understanding, if not consensus, about the topics under discussion. (p. 234)

When combined with other data collection methods, findings of studies can yield dialogically expansive texts that mitigate the limitations of each method, thus producing rich data, while enhancing the stud's credibility and validity.

Conclusion

This study, in its attempt to understand African American women's construction of meanings at the site of maternal healthcare, identified the discourses that permeate African American women's experiences. In their construction of meaning, African American women resisted the hegemonic view of pregnancy as a medical condition, thus disclaiming the DHPD. Rather, through their narrative's women gave credence to the DMHH, affirming it for its holistic approach, including its incorporation of their racial identity and background into maternal care. The understanding of pregnancy, motherhood, and African American womanhood, and the meanings associated with them are underscored from African American women's perspective. These constructions and renegotiation of meanings advance the understanding of African American women's identity within the context of the U.S. healthcare system. This study serves as a pacesetter in the exploration of RDT in interracial communication scholarship.

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Table

Demographic Information

S/N	Name	Age	Length of Stay in Milwaukee/ Years	Marital Relationship Status	Religion	Education[7]	Household Income (in thousand dollars)	Health Insurance?	Type of Care	Type of Delivery	Pregnant?	No. of Kids	Ages of Kids Y/M
1	Tafi	35	13	Married	Christianity	MSc	120	Yes/Employer	OB	C-Section		1	10M
2	Rihanna	22	22	Single	Christianity	BSc	22	Yes/State	OB	Vaginal		1	3M
3	Kevris	30	30	Married	Christianity	BSc	34	Yes	OB	Vaginal		4	9Y; 5Y; 2Y; 5M
4	Unique	24	24	Single	None	HS	---	Yes/State	OB	N/A	Yes	0	N/A
5	Mary	26	23	Married	Christianity	HS	80	Yes/Employer	OB	Vaginal		2	5Y: 4M
6	Sadiat	23	18	Single	Christianity	HS	---	Yes/Employer	OB/MW	Vaginal		1	5M
7	Zee	23	23	Engaged	Christianity	HS	15	Yes/Employer	N/A[8]		Yes	0	N/A
8	Hannah	24	24	Married	Islam	LHE	20	Yes/State	OB	Vaginal			10M
9	Tammy	24	24	--	Christianity	HS	40	Yes/State	OB	--		2	4Y: 1Y
10	Keffi	22	22	Single	Christianity	HS	1.5	Yes/State	OB	---	Yes	0	N/A
11	Sara	26	10	Single	N/A	HS	---	Yes/State	OB	---	Yes	3	9Y: 7Y: 6Y
12	Megan	24	24	Single	Christianity	HS	30	Yes/Employer	OB	Vaginal		1	1Y
13	Rachel	23	23	Married		HS	15	Yes/State	MW/OB	Vaginal		1	3M
14	Ebony	43	43	Single	Islam	HS	22	Yes/State	OB/Doula	Vaginal		5[9]	22Y; 9Y; 9Y; 8Y; 2M
15	Nancy	22	22	Single	---	HS	50	Yes/State	OB	Vaginal		1	9M
16	Ashley	21	21	Single	Christianity	BSc	40	Yes/State/Employer	MW/OB			0	
17	Beth	21	21	Single	---	HS	25	Yes/State	OB				1Y
18	Lisa	21	17	Single	Christianity	HS	25	Yes/State	OB	C-section		1	1Y
19	Andrea	22	22	Single	--		---	Yes/State	OB/MW	Vaginal		1	1Y
20	Abigail	25	20	Married	--	HS	50	Yes/Employer	OB	Vaginal		1	1Y
21	Shirval	32	20	Married	Christianity	Masters	82	Yes/Employer	OB	Vaginal		2	3Y; 3M
22	Tabithe	20	20	Single	---	LHE	---	No	---[10]	C-Section		1	1Y
23	Rose	27	27		---	BSc	50	Yes/State	OB	Vaginal		1	3M
24	Kiyante	30	10	Married	Christianity	AS	70	Yes/State	OB	C-Section		3	10Y; 4Y; 1Y
25	Telither	30	20	Single	--	--	--	Yes/Employer	OB/Doula	Vaginal		2	7Y; 6M
26	Flaky	29	29	Single	Christianity	HS	---	Yes/State			Yes	1	8Y
27	Leslie	26	26	Single	Christianity	HS	23	Yes/State	OB		Yes	2	6Y; 3Y
28	Kylie	25		Single	---	BSc	27	Yes/State		C-Section		1	2Y
29	Tee	26		Single		HS	19						4Y; 3Y
30	Sandy			Single									10
31	Grace	45		Single	Christianity	HS	35	Yes/Employer		Vaginal			4

[7] LHE= Les than High school education; HS= High School Diploma; BSc= Bachelor's; MSc= Master's

[8] Haven't found an OB yet as she is only 6 weeks pregnant. She has been seeing her primary care provider and the emergency room healthcare providers.

[9] Has had 6 children but lost one of the children after 2 weeks of delivery

[10] Only saw doctors at the emergency room throughout her pregnancy because she did not have health insurance

Appendix A: UWM IRB Study Approval Letter

UNIVERSITY of WISCONSIN
UWMILWAUKEE

Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3182 *phone*
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uwm.edu/irb
harries@uwm.edu

New Study - Notice of IRB Exempt Status

Date: March 11, 2019

To: Erin Parcell
Dept: Communication

CC: Comfort Adebayo

IRB#: 19.A.238
Title: Black Women Pregnancy Experiences Within US Healthcare System: A Comparative Study between African American Women and African Immigrant Women

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has been granted Exempt Status under Category 2 as governed by 45 CFR 46.104(d).

This protocol has been approved as exempt for three years and IRB approval will expire on March 10, 2022. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, please respond to the IRB's status request that will be sent by email approximately two weeks before the expiration date. If the study is closed or completed before the IRB expiration date, you may notify the IRB by sending an email to irbinfo@uwm.edu with the study number and the status, so we can keep our study records accurate.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation, and best wishes for a successful project.

Respectfully,

Melody Harries
IRB Administrator

Appendix B: Social Media Recruitment Flyer[11]

Black Women's Pregnancy Experiences Within the US Healthcare System

Individual Interview /Focus Group Discussion

- *Purpose: To understand the healthcare experiences of Black women during pregnancy*
- *Eligibility: African American or African immigrant women, 18 years and above, currently pregnant or pregnant within the last one year*
- *Living in Milwaukee county*
- **Time Commitment:** About 60 minutes
- **Who to Contact:** cadebayo@uwm.edu/309-318-1495

You will receive a $20 gift card for your participation

[11] In this study, only interviews were conducted.

Appendix C: Informed Consent Form

Study title	Black Women's Pregnancy Experiences Within the US Healthcare System: A Comparative Study between African American Women and African Immigrant Women
Researchers	Student Principal Investigator: Comfort Tosin Adebayo/Ph.D. Student/ Department of Communication, UWM Principal Investigator: Erin Parcell/Faculty member/Department of Communication, UWM

I am inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

What is the purpose of this study?

I seek to understand the pregnancy experiences of Black women when accessing healthcare services in the US

What will I do?

You will participate in one focus group discussion or an individual (face to face or phone) interview. The focus group discussion will involve 4-5 other participants who are either African American or African immigrant women. To be able to participate in either of the methods, you must be at least 18 years old, able to communicate in English, have been pregnant, and have received prenatal care in the US. During the focus group discussion or an individual (face to face or phone interview), you will share your experience receiving care from your healthcare providers during your previous pregnancy(ies). Topics will include your perception of the US healthcare system towards pregnant Black women. You will be asked to recall specific experiences that challenged or reinforced your identity as a Black woman in the US. You will also discuss how your healthcare experiences impacted your pregnancy journey as a whole.

If you choose to participate in an individual (face to face or phone interview), the interview will take place at your preferred location where I will come to interview you. Individual interviews will take between 45-60 minutes. The interview will be audio-recorded for transcription and data analysis. Recordings will be discarded after transcription and no identifying information will be reported with the study after analysis.

If you choose to participate in a focus group discussion, it will take place on the UWM campus in a classroom inside Merrill Hall. Focus group discussions will take between 60-90 minutes. The focus group discussion will be audio-recorded for transcription and data analysis. Recordings will be discarded after transcription and no identifying information will be reported with the study after analysis.

Risks

Possible risks	**How we're minimizing these risks**
Some questions may be personal or upsetting	You can skip any questions you don't want to answer.
For focus group participants, others in the focus group could share your responses	We ask everyone to keep everything said during the focus group confidential. However, we can't control what others say, so it is best not to share anything you don't want

	others to know.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• We'll remove all identifiers after transcription • We'll store all electronic data on a password-protected, encrypted computer and a password-protected Microsoft software (TEAMS) • We'll store all paper data in a locked filing cabinet in a locked office. • We'll keep your identifying information separate from your research data, but we'll be able to link it to you by using a study ID. We will destroy this link after we finish collecting and analyzing the data.

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	• This study will help healthcare providers understand group differences within the Black population and help them become more culturally aware of (and respond to) different healthcare needs of African immigrants and African American women.
Estimated number of participants	200
How long will it take?	45-60 minutes (Individual interviews) or 60-90minutes (Focus group discussions)
Costs	For Focus group participants, you'll pay for your own transportation or parking
Compensation	For Focus group participants, babysitting will be provided for your young kid(s) if needed during the focus group discussion. You will also receive a $20 gift card for your participation.
Future research	De-identified (all identifying information removed) data may be shared with other researchers. You won't be told specific details about these future research studies.
Recordings	We will audio-record you. The recordings will be transcribed by a third party transcription service or a research assistant. Only the transcribed data will be used for data analysis. The recording is necessary for this research. If you do not want to be recorded, you should not be in this study.

Confidentiality and Data Security

Where will data be stored?	• We'll store all electronic data on a password-protected, encrypted computer and on a shared Microsoft software (TEAMS), which is only accessible to the researchers and the research assistant.
How long will it be kept?	3 years. Data from this study may be used for future studies.

Who can see my data?	Why?	Type of data
The researcher, the Principal investigator, and the Research assistant, who will transcribe the data.	Principal investigator: To provide feedback on the research procedures Research Assistant: To Transcribe the data **Online Transcription Service**	Coded (names removed and labeled with a study ID)
The IRB (Institutional Review Board) at UWM The Office for Human Research Protections (OHRP) or other federal agencies	To ensure we're following laws and ethical guidelines	Coded (names removed and labeled with a study ID)
Anyone (public)	If I share my findings in publications or presentations	• De-identified (no names, birthdate, address, etc.) • If I quote you, I'll use a pseudonym (fake name)

Contact information:

For questions about the research	Comfort Tosin Adebayo	309-3181495 cadebayo@uwm.edu
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	414-229-3173 / irbinfo@uwm.edu
For complaints or problems	Comfort Tosin Adebayo	309-3181495 cadebayo@uwm.edu
	IRB	414-229-3173 / irbinfo@uwm.edu

Research Subject's Consent to Participate in Research:

By participating in this interview, you are indicating that the investigator has read the consent form to you, you are 18 or older, an African American or an African immigrant woman, you are currently pregnant or was pregnant within the last one year, have received or currently receiving prenatal care in the Milwaukee county , and that you voluntarily agree to participate in this research study.

Appendix D: Demographic Information Questions

1. How long have you been living in Milwaukee? _____
2. How old are you?_____
3. What is your highest education level?_____
4. What is your religion?_____
5. How much is your household income per year?_____
6. When last were you pregnant?_____
7. Are you married?_____
8. Do you have health insurance?
9. What prenatal care did you have? Postnatal? Use a doula? Birthing coach?
10. Did you have a c-section? What procedures were used during your births?
11. What would you estimate the age of your doctor to be?
12. What is their gender?
13. What is their race?
14. How many children do you have?_____
15. How old are your children?
    a. _____
    b. _____
    c. _____
    d. _____

Appendix E: Interview Protocol

[After greetings, I will read the consent form to the participants and verbally secure their consent. Once this is completed, participants will be informed about the start of audio-recording, then the interview will begin with the demographic questions which will be verbally answered.]

Interview Questions

All right. Now I will get to my main questions which are about your experiences as a pregnant woman in the U.S. using the healthcare system.

1. Describe as much as you're willing to disclose your last pregnancy and the visits you had with your doctor.
    a. How were you treated? How did you respond?
    b. What were some unique experiences you had in the way you were treated?
    c. Why do you think those experiences were unique?
    d. Were your other pregnancies similar to the most recent one?
2. What were your expectations about prenatal care with your healthcare providers (doctors, nurses, insurance companies, receptionists)?
    a. What did you experience in comparison to your expectations?
3. How much did/do you trust your doctors or nurses or other healthcare providers?
4. What was your labor and delivery like during your last pregnancy?
5. Would you consider your birth as traumatic? If yes, why?
6. If you were to describe a perfect doctor visit, what would it be like? what would your doctor say to you? what would you say to your doctor?
7. Do you think there is a difference between how doctors treat pregnant African American women patients versus other women…non-pregnant African American women patients?

a. Can you recall any specific experience that gives you this feeling?

8. What do you think about African American women's maternal crises in Wisconsin?

[Thank you for sharing your experiences. Now I will like to get to some more personal questions that focus on your experiences as an African American woman]

9. How do you perceive U.S. healthcare services as an African American woman?
10. How do you think healthcare providers (doctors, nurses, insurance companies, receptionists) perceive African American women?
    a. Can you recall things they have said to you that have given you this feeling?
11. How do you think healthcare providers (doctors, nurses, insurance companies, receptionists) perceive pregnant African American women?
    a. Can you recall things they have said to you that have given you this feeling?
12. How aware do you think your healthcare providers (doctors, nurses, insurance companies, receptionists) are/were of your needs as an African American woman?
13. Reflecting on our conversation, in what ways do you think the healthcare providers (doctors, nurses, insurance companies, receptionists, etc.) can better serve African American women during pregnancy?
14. Is there anything else you'd like to share about your pregnancy experience(s) in the U.S.?

Thank you! I'll turn off the recorder now. [Once off, appreciate the participant for their time and participation].

Curriculum Vitae

COMFORT TOSIN ADEBAYO

CONTACT INFORMATION

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EDUCATION

Ph.D. University of Wisconsin-Milwaukee (UWM)
Department of Communication
Concentration: Intercultural, Health, and Instructional Communication
Dissertation Title: Maternal Healthcare Experiences of African American Women in Milwaukee: A Relational Dialectics Perspective
Advisor: Dr. Erin Sahlstein Parcell
G.P.A: 4.0/4.0
Expected Date of Graduation: May 2020

M.A. Western Illinois University (WIU)
Department of Communication
Concentration: Organizational and Intercultural Communication
Advisor: Dr. Peter Jorgensen
G.P.A: 4.0/4.0

B.A. University of Ibadan, Nigeria
Department of English
Concentration: Language and Lexical Structures
G.P.A: 4.8/7.0

ACADEMIC APPOINTMENTS

2016-2019 Graduate Teaching Assistant, Department of Communication, University of Wisconsin-Milwaukee
Courses Taught: Public Speaking, Business & Professional Communication, Intercultural Communication, and Qualitative Research Methods in Communication

Winter 2018 Associate Lecturer, Department of Communication, UWM
Courses Taught: Public Speaking

2014-2015 Graduate Teaching Assistant, Department of Communication, WIU
Courses Taught: Public Speaking

SCHOLARSHIP

Peer-Reviewed Publications

Allen, M., Bourhis, J., Burrell, N., Benedict, B., **Adebayo, C. T.,** Cherney, M.,…Richards, R. (2018). Evaluation of communication master's program on the basis of google citations. *Journal of Association for Communication Administration 36*(2), 20-28. Retrieved from https://static1.squarespace.com/static/58dbe18c03596e2e942115e9/t/5be0878e4d7a9c6daef85f14/1541441426779/JACA+36-2.pdf.

Adebayo, C.T. (2019). Teaching perspective taking in intercultural contexts: Encounters with international teaching assistants with foreign accent. *Communication Teacher,34*(1), 47-52. doi.org/10.1080/17404622.2019.1593473.

Adebayo, C. T., & Allen, M. (2019). The experiences of international teaching assistants in the U.S. classroom: A qualitative study. *(*Published online first). *Journal of International Students.* Retrieved from https://www.ojed.org/index.php/jis/article/view/1086.

Adebayo, C. T., Walker, K., Hawkins, M., Olukotun, O., Shaw, L., Sahlstein Parcell, E…& Mkandawire-Valhmu, L. (2019). Race and Blackness: A thematic review of communication challenges confronting the Black community within the United States healthcare system. *(*Published online first). *Journal of Transcultural. Nursing.* https://doi.org/10.1177%2F1043659619889111

Manuscripts Under Review

Adebayo, C. T. (Revise & Resubmit). Physician-patient interactions in Nigerian hospitals: Applying the theory of motivated information management. *Journal of Intercultural Communication Research.*

Adebayo, C. T. (Under Review). Intercultural communication apprehension in the public speaking classroom: A focus on international students. *Journal of International Students.*

Adebayo, C. T., Mkandawire-Valhmu, L., Olukotun, O., & Sahlstein Parcell, E. (Manuscript in Progress-Accepted for Further Review). Maternal crisis among African American women: A critical race theory perspective. *Health Communication* (Special Issue).

Work in Progress

Adebayo, C. T., & Sahlstein Parcell, E. (In preparation for Journal Submission). Embodied pregnancy experiences of African immigrant women in the U.S. *Journal of Intercultural Communication Research.*

Sahlstein Parcell, E., Kim, S., & **Adebayo, C. T**. (In preparation for Journal Submission). Race talk at play in interpersonal conversations.

Suter, E. A., Sahlstein Parcell, E., **Adebayo, C. T**., Weadock, C., & Romo, D. (Manuscript in progress). A meta-analysis of the application of Relational dialectics theory in communication studies.

Hawkins, M., **Adebayo, C. T**., Olukotun O., & Mkandawire-Valhmu, L. (Manuscript in progress). Healthcare Providers' knowledge of Refugee women's healthcare needs.

Conference Presentations

Adebayo, C. T. (2020, April). *Accessing healthcare beyond the borders: Challenges of African immigrants in the U.S.* Panel accepted for presentation at the annual meeting of the Central States Communication Association. Chicago, IL.

Adebayo, C. T. & Richards, R. (2020, April). *Pedagogy beyond the borders: Best practices for training international teaching assistants in the communication discipline*. (Top Paper Panel). Competitively selected paper accepted for presentation at the annual meeting of the Central States Communication Association. Chicago, IL.

Adebayo, C. T. (2020, April). Relational dialectics theory 1.0 versus 2.0: A critical review. Competitively selected paper accepted for presentation at the annual meeting of the Central States Communication Association. Chicago, IL.

Adebayo, C. T. (2019, November). *Re-centering the healthcare experiences of African immigrants in Black studies scholarship: A thematic literature review.* Competitively selected paper presented at the annual meeting of the National Communication Association Conference. Baltimore, MD.

Adebayo, C. T. (2019, November). *Stop asking about my due date! that's personal information: Pregnancy experiences of African immigrant women.* Competitively selected paper presented at the annual meeting of the National Communication Association Conference. Baltimore, MD.

Adebayo, C. T. (2019, November). *The maternal health crisis in the U.S.: Communicating for survival*. Panel presented at the annual meeting of the National Communication Association Conference. Baltimore, MD.

Adebayo, C. T. (2019, April). *Advancing the dialogue: International students in the public speaking classroom*. Competitively selected paper presented at the annual meeting of the Central States Communication Association. Omaha, NE.

Adebayo, C. T. (2019, April). *Diversity and integration: Obstacles confronting international students in the diverse US college.* Competitively selected paper presented at the annual meeting of the Central States Communication Association. Omaha, NE.

Adebayo, C. T. (2019, April). *In dialogue with African Communication and culture*. Panel presented at the annual meeting of the Central States Communication Association. Omaha, NE.

Adebayo, C. T. (2018, November). *Physician-patient interactions in Nigerian hospitals: Applying the theory of motivated information management*. Competitively selected paper accepted for presentation at the annual meeting of the National Communication Association. Salt Lake City, UT.

Adebayo, C. T. (2018, November). *Still the dark continent: African communication scholarship.* Panel accepted for presentation at the annual meeting of the National Communication Association. Salt Lake City, UT.

Adebayo, C. T. (2018, November). *Intercultural pedagogy: Bridging the gap for international students in the public speaking classroom*. Panel presented at the annual meeting of the National Communication Association. Salt Lake City, UT.

Sahlstein Parcell, E., Kim, S., & **Adebayo, C. T**. (2018, November). *Race talk at play in interpersonal conversations.* Competitively selected paper presented at the annual meeting of the National Communication Association. Salt Lake City, UT.

Adebayo, C. T. (2018). Resilience at play: Communicative approaches to understanding, researching, and extending resilience research. Panel presented at the annual meeting of the National Communication Association Conference. Salt Lake City, UT.

Adebayo, C. T. (2018, April). *Exploring the difference: International teaching assistants in the US classroom.* Paper presented at the annual meeting of the Central States Communication Association. Milwaukee, WI.

Adebayo, C. T. (2018, April). *Teaching perspective taking in intercultural contexts: Encounters with international teaching assistants with foreign accent*. GIFTS Paper presented at the annual meeting of the Central States Communication Association. Milwaukee, WI.

Adebayo, C. T. (2018, April). *Why is your teaching style so different? International teaching assistants and pop culture references*. Panel presented at the annual meeting of the Central States Communication Association. Milwaukee, WI.

Adebayo, C. T. (2018, January). *Intentionality and impact: Engaging international students in the classroom*. Abstract presented at the University of Wisconsin-Milwaukee annual teaching symposium. Milwaukee, WI.

Adebayo, C. T. (2017, April). *Female international teaching assistants in the US classroom*. Paper presented at 2017 4W Summit on Women, Gender, and Well-Being. Madison, WI.

Adebayo, C. T. (2017, January). *International students/teaching assistants and the U.S. college classroom.* Abstract presented at the University of Wisconsin-Milwaukee annual teaching symposium. Milwaukee, WI.

Adebayo, C. T. & Jorgensen, P. J. (2016, November). *Empathic communication in superior–subordinate interpersonal relationships*. Competitively selected paper presented at the annual meeting of the National Communication Association. Philadelphia, PA.

Adebayo, C. T. & Jorgensen, P. J. (2016, November). *A study of empathic communication: collectivist versus individualist societies*. Competitively selected paper presented at the annual meeting of the National Communication Association. Philadelphia, PA.

Adebayo, C. T. (2015, March*). Empathic communication in organizational context: Superior–subordinate interpersonal relationships.* Paper presented at the Organizational Communication Mini-Conference. East Lansing, MI.

Akinwehinmi, C. T. (2015, March*). Outside-classroom interpersonal communication and learning.* Paper presented at the annual Sooner Conference of the University of Oklahoma. Norman, OK.

Akinwehinmi, C. T & Presnell, M. S. (2015). *Imagined interactions and messages in celebrity political endorsements.* Paper presented at the annual Sooner Conference of the University of Oklahoma. Norman, OK.

INVITED GUEST LECTURES AND PRESENTATIONS

Adebayo, C. T. (2018, August). *Intentionality and impact as the "Other" in the US classroom.* University of Wisconsin Milwaukee International Teaching Assistants' Orientation. Milwaukee, WI.

Adebayo, C. T. (2017, August). *Effective teaching in an intercultural context*. University of Wisconsin Milwaukee International Teaching Assistants' Orientation. Milwaukee, WI.

GRANTS & AWARDS

2019	NCA Doctoral Honors Seminar Participant
2019	UWM Distinguished Graduate Student Fellowship ($15,000)
2019	John Paul Jones Memorial Trust, Department of Communication, UWM ($1000)
2018	Renee A. Meyers Award Memorial Scholarship, Department of Communication, UWM ($2,000)
2017	Amelia Lucas Trust Fund, Department of Communication, UWM ($300)
2017	Wayne State University Summer Doctoral Fellowship, Department of Communication, Wayne State University, Detroit, MI
2016 & 2017	John Paul Jones Memorial Trust, Department of Communication, UWM ($400)
2016 & 2017	NCA Student Travel Award ($400)
2016	UWM Chancellor's Fellowship Award ($3000)

2015	Wayne Thompson Scholar Award-WIU, Macomb, IL
2014	Western Europeans and Others Group (WEOG) International Students' Scholarship, WIU, Macomb, IL

PROFESSIONAL SERVICE

Academic Journals

2020-Present	Reviewer, *Journal of Intercultural Communication Research*
2019-Present	Reviewer, *Transcultural Nursing Journal*
2017-Present	Reviewer, *Journal of International Students*

Organizational Service

2018- Present	Paper Reader, Intercultural Communication Division, CSCA
2018-Present	Paper Reader, GIFTS Division, NCA
2017-Present	Paper Reader, Interpersonal Communication Division WSCA
2016-Present	Paper Reader, Student Section Division, NCA
2016- Present	Paper Reader, Student Section Division, CSCA
2016	Paper Reader, Intercultural Communication Division, ICA

University Service

University of Wisconsin-Milwaukee

2018-Present	Graduate Student Member, UWM Institutional Review Board for Human Subjects
2017-Present	Communication Liaison Officer, UWM Center for International Education
2017-Present	Founder and President, International Teaching Assistants' Community (Registered Student Organization)
2017	Writer, UWM Center for International Education spotlight stories

2017	Mentor to incoming international students, UWM Center for international Students
2017	Member, UWM Graduate Students' Advisory Committee
2016-2018	Co-chair, Public speaking showcase, UWM Communication Department

Western Illinois University

2015	Nigerian Students' Representative, WIU International Students' Board Council

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

National Communication Association

Central States Communication