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Preparing for Motherhood: Authoritative Knowledge and the Undercurrents of Shared Experience in Two Childbirth Education Courses in Cagliari, Italy

This article compares the social settings and teaching organization of two differently structured childbirth education courses in Cagliari, Italy, in order to understand how social processes and contexts work to negotiate authoritative knowledge. Although the explicit goal of both courses was to transmit biomedical knowledge, knowledge based in women's experience nonetheless dominated some course sessions. Thus, I examine the social processes and interactions that enabled women's experiential knowledge to dominate discussions and subsequently share in the authority of biomedical knowledge in some situations. Because few existing studies do so, this article also addresses a gap in our current understanding by exploring not only how experiential knowledge comes to share authority with biomedical knowledge, but also, why it is important that it does. Focusing on the efficacy of differently structured courses, this article informs the planning of future childbirth education courses in similar settings. [childbirth education, authoritative knowledge, reproduction, prenatal care, Italy]

Since the early 1980s, institution-based childbirth education courses taught by medical professionals have become increasingly common throughout Italy. The rise of the childbirth education course as a necessary precursor to motherhood has followed the medicalization of maternity in Italy, as well as in the United States (Orrù 1993; Pizzini 1986; Sargent and Stark 1989). A corollary finding—true in many cases—is that childbirth education courses serve as agents of further medicalization (Nelson 1982:342–349; Sargent and Stark 1989:49).

However, in Italy, biomedical professionals are not the only—or even the loudest—proponents of prenatal training. Women themselves vocally express the need to attend these courses and learn what is taught there. But what is taught there, and further, how is it being taught? Most important, how do childbirth education courses affect women as they proceed through the sometimes difficult maternity

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transition? In this article, I explore how childbirth education courses can serve as forums within which women develop multifaceted friendships through which they share their experiences and subsequently revalue both their own and each others' experiential knowledge.[1] I demonstrate that, through these friendships and the shared experiential knowledge that is a part of them, women and course instructors partially *demedicalize* maternity and unexpectedly redefine that which constitutes authoritative knowledge within the course setting.

Brigitte Jordan explains the concept of authoritative knowledge:

> for any particular domain, several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand, or because they are associated with a stronger power base. [1993(1978):152]

Authoritative knowledge is that system which comes to carry the most weight. Jordan states that, as social processes legitimize one way of knowing as authoritative and more valid, other ways of knowing are devalued or dismissed altogether (1993[1978]:152). Although Jordan provides an outstanding account of how the use of technology structures authoritative knowledge (1993[1978]:156–166), and many authors have more recently built upon her work (see Davis-Floyd and Sargent 1996), little is known about the specific social processes that legitimize some types of knowledge while dismissing others. Based on my examination of the social interactions in two typical childbirth education course sessions, this article illuminates some of those processes.

In my observations, when childbirth education course instructors and participants placed experiential knowledge at the center of their discussions, they did not necessarily do so to the exclusion of the ever present categories of biomedical knowledge. Rather, women's experiential knowledge gently nudged the usually dominant biomedical knowledge aside such that both were accorded equally legitimate status during course sessions. This article investigates the social contexts and processes that made this mutual accommodation possible, and it explores reasons why this heterogeneous mixture of knowledge was so important to women as they became mothers.

Methods and Background

Methods

This article is based upon field research I conducted in Cagliari, the largest city and capital of the Italian autonomous region of Sardinia, from September 1993 to July 1994. I draw primarily upon observations I made during six months of attending two sessions per week at each of two childbirth education courses. During each course session, which lasted between one and two hours, I took written notes on the information exchanges and conversations among women and between women and course instructors. After course sessions, I asked follow-up questions to course participants and instructors. For this article, I randomly selected the notes from one session in each course setting, which, upon. systematic comparison, proved to be generally representative of sessions at each location.

In addition, I rely upon the life history narrative interviews I conducted with 60 women and ten nurse-midwives *(ostetriche)* from in and around Cagliari. These women were between 19 and 75 years old.[2] I met younger women, still in their childbearing years, in hospitals, clinics, and childbirth education courses. The older women were, in most cases, the younger women's mothers, grandmothers, aunts, and mothers-in-law. These relationships provided continuity to the narratives. All but five of the younger women were first-time mothers, while all of the older women had more than one child. All of the women had lived in the province of Cagliari for at least ten years, and all were natives of Sardinia.

The interviews can best be characterized as unstructured and in-depth (Cramer and McDonald 1996:161) and focused on women's reproductive lives. I conducted all interviews in Italian and taped and transcribed all of them. Interviews varied in length, but most were done in two or three sessions that lasted about two or three hours each. They explored women's family, work, and educational histories; their decisions (or lack thereof) to have children; their experiences of pregnancy, care during pregnancy, learning about perinatal processes, infant care, and birth; and changes in relationships, work schedules, self, and emotions during the postpartum period. If a woman had more than one child, I asked her to talk about her experiences individually and in comparison. In concluding the interviews, I asked more abstract questions about maternity, requesting that women delineate characteristics of mothers they felt were definitive, discuss maternity in terms of the larger changes in their lives and society, and compare their perceptions of maternity in the past with contemporary maternity. In this article, I focus upon the interview sections that deal with women's opinions about and experiences in childbirth education courses in order to understand the role that the courses played in women's reproductive experiences.

The Setting

Although many writers have characterized Sardinia as a peripheral area that outsiders have historically exploited (Braga 1989; Clark 1989; Counihan 1981, 1984; Lelli 1975), living standards have risen dramatically in recent decades. Scholars describe this post-war economic change as "modernization without development" (Schneider et al. 1972), in which government funds, limited and often misguided development programs, emigrant salaries, and tourism revenues have provided cash to improve living standards and fuel consumerism. These economic changes have in turn resulted in new models of self, family, and society (Bandinu 1989; Counihan 1981, 1984; Edelsward 1992; Mathias 1979; Salzman 1992; Schweizer 1988; Weingrod 1979). Of particular interest here are the changing conceptualizations of adult personhood that have accompanied economic transformation. Previous research on social relationships in Sardinia has demonstrated that prior models of adult personhood included caring for, being connected with, and being dependent upon a wide variety of others within an extensive system of reciprocity (Ayora-Diaz 1994; Counihan 1981, 1984). Contemporary adult personhood, on the other hand, requires that individuals be autonomous, independent, and self-realized. These changes in what it means to be, and indeed what is required of, an adult person have clear implications for women as they become mothers.

A demographic transition has paralleled economic and cultural change. The birthrate in 1992 was less than half that of 1952, while the infant mortality rate dropped from 45 to 7.9 per 1,000 live births during the same period (Istituto Nazionale di Statistica [ISTAT] 1961–94).[3] The biomedical and social institutions that provide the context for contemporary maternity have expanded and been restructured. Until the early 1970s, most Sardinian women gave birth at home, assisted by lay or local midwives *(levatrici, ostetriche condotte).* By 1989, 99 percent of births were taking place in medical facilities (Orrù 1993), attended by nurse-midwives (ostetriche)[4] and physicians, relying heavily on technologies and practices such as ultrasounds,[5] fetal monitors, and cesarean sections.[6] Pregnancy has increasingly become a focus of social attention and cultural elaboration, as the growing number of women who attend childbirth education courses clearly demonstrates. Indeed, many women described what they perceive as an almost instinctive desire to learn during pregnancy.

In addition to recent economic, cultural, and demographic transformations, the Italian government instituted a number of family policy changes during the 1970s that altered the way in which women experience maternity. These included policies that guaranteed the rights to divorce, abortion, contraception, and maternity leave (Donati 1990; Saraceno 1984, 1991, 1992). Of greatest importance here, however, is the 1975 law that set forth the parameters for the *consultori familiari,* or family counseling centers.[7] The autonomous region of Sardinia established its first *consultorio* in 1981 in Cagliari (Pigliaru 1983).

Since 1988, Sardinia's consultori familiari have offered childbirth education courses. In 1988, there were six courses accommodating 64 participants in all of Sardinia—that is, 0.35 percent of all women giving birth during that year. By 1993, these numbers had increased to 130 courses with 1,914 participants—12 percent of all women giving birth during that year (The Autonomous Region of Sardinia's Council of Hygiene, Health, and Social Assistance,[8] personal communication, August 23, 1994). This 34-fold increase in the percentage of pregnant women participating in these state-sponsored childbirth education courses paralleled an expanding number of private childbirth education courses and signaled the increasingly important role that such courses play in shaping women's experiences of contemporary maternity.[9]

Authoritative Knowledge, Experience, and Power

The stated intent of the two childbirth education courses compared here was to prepare women for maternity by transmitting a basic biomedical understanding of pregnancy, birth, and hospital procedures to them. Nevertheless, during course participation, I noticed that women shared a substantial amount of experiential knowledge within the long-lasting friendships that they often developed. To be sure, most women underplayed the importance of the experiential knowledge that they received from other women outside of the childbirth education course. Interestingly, however, the same women frequently stated that, to their surprise, sharing feelings and experiences with other course participants eclipsed the transmission of biomedical knowledge as the most important element of the childbirth education course (Ketler 1997:301). I discovered, though, that course structure and

the organization of teaching were critical in determining whether the exchanges of experiential knowledge that women deemed so important could easily occur.

In Cagliari, women increasingly view the childbirth education course as a necessary prelude to maternity. As Elena A.,[10] a midwife and course instructor, put it, "Women have a great need to talk with us—with the people who teach the course, because they have a thousand doubts and a thousand problems. They ask so many questions and are so curious." In Cagliari and other settings, as the perceived need for information during pregnancy has grown, childbirth education courses have become primary sites at which dominant biomedical knowledge is transmitted and women are transformed into "modern pregnant subjects" (Duden 1993:107; Georges 1996).

In spite of the increasing numbers of women attending childbirth education courses and a growing anthropological interest in prenatal care, surveillance, and information transmission (e.g., Browner and Press 1996; Georges 1996; Kaplan 1994; Markens et al. 1995; Rapp 1991, 1993, 1994), few anthropological studies analyze the childbirth education course as a site where information transmission takes place. Most existing literature focuses on the relationship between course attendance, perceived control, and attitudes toward birth from a psychological perspective (e.g., Berwin and Bradley 1982; Lumley and Brown 1993). The few existing anthropological studies look at how course attendance differentially affects working- and middle-class women's attitudes about biomedical control of birth (Nelson 1982; Sargent and Stark 1989). Little is known about the social contexts in which, and the social interactions through which, authoritative knowledge is constituted and transmitted in childbirth education courses. This article casts light upon these processes.

To understand how the transmission of knowledge is shaped by the social situations in which it occurs, I employ Jordan's concept of authoritative knowledge presented above. There has been a recent surge of interest in how social processes in diverse cultural settings work to constitute authoritative knowledge about various aspects of the maternity transition (Browner and Press 1996; Davis-Floyd and Sargent 1996; Fiedler 1996; Georges 1996; Jambai and MacCormack 1996; Sargent and Bascope 1996; Sesia 1996). Despite its growing popularity, none of these recent inquiries explores the childbirth education course as a domain in which authoritative knowledge about maternity is constituted through the interactions of participating women and course instructors. Thus, I contribute to this ongoing discussion about authoritative knowledge with a detailed analysis of how it is negotiated in two childbirth education course sessions.

Furthermore, many feminist and anthropological analyses suggest that a revaluation of women's experiential knowledge about maternity is an important objective. However, few of these studies indicate why this should be so, especially given that several of them demonstrate that many women feel most comfortable when biomedical knowledge and practices guide them through the maternity transition (Davis-Floyd 1992; Lazarus 1988; Michaelson 1988; Sargent and Bascope 1996:215). In short, although some medical anthropologists agree that a validation of experiential knowledge is important, many women appear to disagree. Many women, both in my research setting and in others (see Davis-Floyd 1992), consciously neither want nor expect their experiential knowledge to be accorded equally legitimate status with biomedical knowledge. Thus, we need to reflect

upon why an incorporation of women's experiential knowledge into authoritative knowledge about maternity, "such that one single authoritative knowledge structure emerges," (Jordan 1992) is helpful—and indeed, empowering—for women as they become mothers. None of the recent research on authoritative knowledge contemplates this question. Another purpose of this article, then, is to address a gap in our current understanding by considering why the revaluation of experiential knowledge should be a goal for medical anthropologists, as well as for women and their care providers.

In Cagliari, the recent medicalization of maternity has replaced the authority of women's experiential knowledge located and shared within the family with that of formal biomedical knowledge located in institutions (Ketler 1997). Many researchers have convincingly shown how maternity care in high-technology settings such as Italy and the United States are dominated by technologically mediated biomedical knowledge (Colombo et al. 1984; Davis-Floyd 1987, 1992; Jordan 1993[1978]; Martin 1987; Michaelson 1988; Pizzini 1986; Romalis 1981; Rothman 1986; Sbisa 1986). In contrast, that which women know through their own and each others' lived experiences usually has little recognized value in the biomedical settings within which women become mothers.

Following the biomedical dismissal of experiential knowledge, women themselves often discount it as irrelevant or even harmful. Medicalized maternity devalues knowing through one's own experiences and obscures the possibility of learning through the experiences of others, thereby contributing to what I have termed an ideology of exclusive motherhood (Ketler 1995, 1997). There are several defining characteristics of exclusive motherhood. First, it is based upon intangible and indescribable changes that are thought to happen within a woman as she undergoes the physiological processes of maternity. In this respect, exclusive motherhood is clearly linked to the increasing sociocultural elaboration of those physiological processes. Because it is based on one's own experiences of the physiological processes of maternity, exclusive motherhood, according to the women who espouse it, cannot be understood by those who have not undergone such processes. During interviews, younger women voiced this aspect of exclusive motherhood when they told me that "you can't really understand it unless you've gone through it." In analogous fashion, the ideology of exclusive motherhood defines a mother and her relationship with her infant as completely unique and different from anyone and anything else. Viewing it as something special and indescribable, younger women often characterized exclusive motherhood in religious or spiritual terms. Furthermore, because it is based on unique individual experiences, exclusive motherhood particularizes maternity. That is, it denies the validity of knowledge gained through other experiences, whether these are one's own prior infant care experiences or other women's prior maternity experiences. Many younger women participating in this study expressed the particularizing tendencies of exclusive motherhood, making statements such as, "It's always different with your own child."

Unlike younger women, who experienced exclusive motherhood in an institutional context, older women became mothers within a familial context, surrounded by related women and guided by the knowledge gleaned through their past experiences. In this context, older women conceptualized motherhood as an identity built primarily through the social activities of mothering rather than as an individual state of being achieved by experiencing the physiological processes of maternity.

Their life history narratives indicate that the transition to a motherhood thus conceptualized and organized was guided by their own and other women's experiential knowledge. This experiential knowledge was produced and utilized within the context of multifaceted, multipurpose relationships between women in their local, familial environments. This contrasts with the experiences of younger women who, within the ideological confines of exclusive motherhood, conceptualized each maternity experience as inherently different from every other one. As such, other women's experiences are devalued and viewed as little more than easily ignored examples rather than as the useful guides that they once were thought to be. As Giulia C., a 37-year-old new mother put it, "I know women who've had three children, and they've had each experience totally different from the others. Therefore, even if another woman tells you something, it's nothing but an example—that's it."

Within the ideology of exclusive motherhood, individual women can responsibly rely only on the universalizing and uniform professional knowledge that they receive in biomedical institutions. The unfortunate and unintended result is the loss of the shared experiences, special relationships, and social solidarity between mothering women that were once so important. Although not their expressed purpose, childbirth education courses sometimes helped women to partially recover these losses. It is clear, however, that certain ways of structuring courses and organizing teaching were more effective than others.

Through comparison of the two courses described below, I demonstrate how the social settings established in differently structured courses differentially promoted the kinds of relationships within which exchanges of experiential knowledge could occur. In such situations, these exchanges of experience both contested and shared in the authoritativeness of biomedical knowledge. Jordan explains that "transformations in modes of teaching and learning are instrumental in redefining what constitutes authoritative knowledge" (1993[1978]:170). Mindful of this possible redefinition, I compare the settings, structures, teaching methods, and information content of these two childbirth education courses to see how and to what extent these factors enabled women's experiential knowledge to usurp the centrality of biomedical knowledge and thereby establish a new authority.

Such a redefinition of authoritative knowledge, Jordan continues, redistributes not only expertise, but also the power associated with it (1993[1978]:170). Consequently, my investigation here shows how courses can be structured so that they partially redistribute both expertise and power back to the women who are, in fact, the agents of maternity. In doing so, courses can promote the development of multifaceted friendships and empathetic solidarity between mothering women that, in turn, helps to smooth their entry into motherhood. I now turn to a description of a typical session of a childbirth education course held at a public consultorio familiare.

The Structure and Organization of the Courses

The Consultorio

The consultorio course meets twice weekly for eight weeks in a large room at a family counseling center in a working-class neighborhood on the outskirts of

town.[11] The course is team-taught by two midwives, a gynecologist, a pediatrician, a psychologist, and a social worker.[12] Of these personnel, all except the pediatrician are female. The Tuesday morning sessions usually last between one and two hours. The 15–20 participating women come from the neighborhoods and towns in and around Cagliari, and they represent a diversity of occupational, social, and economic backgrounds.[13] First, they meet with Luisa, one of the midwives. She guides them through about 40 minutes of stretching exercises. The women, sitting on mats placed in a large circle that hugs the perimeter of the room, are mostly silent during the exercises. Occasional questions, usually employing the formal address *(Lei),*[14] are directed at Luisa.

Afterwards, Luisa conducts a brief "lesson" *(lezione).* Today, she focuses on bathing the newborn. Although she initiates her lesson with a question intended to draw the women into a discussion, even those in their second pregnancy remain quiet. After several moments of uneasy silence, Luisa continues with her lesson in lecture form. Her explanation focuses on the measured specifics of bathing an infant—what to have on hand, how to choose the right tub, which kinds of soaps to use, and how to rinse the baby. She provides the women with the preferred water temperature and suggests that they buy a thermometer that looks like a toy. When one woman points out, "Our mothers used their elbows!" the others respond with a little restrained laughter. Luisa then gives step-by-step instructions on how to wash the umbilical area, demonstrating on a model doll. She makes no mention of the anxiety, so prominent in their narratives, that most younger women feel about the newborn's first bath *(il bagnetto).* After Luisa's short presentation, she asks if there are any questions. Two women ask questions about when the baby should be bathed.

Next there is a short break during which the women put away their exercise mats and line the surrounding desks into rows so that the room resembles a classroom. The group reconvenes for a 40–50 minute lesson with Dottoressa Carta, the gynecologist. First, she tells them about fertilization and fetal development, accompanying her lecture with slides that depict the size of the fetus and the growth of the pregnant uterus. She continues with an explanation of birth that focuses on hospital procedures—the use of the fetal monitor, severing the umbilical cord, stitching the episiotomy, the possibility of cesarean section, and the use of anesthesia. Like the midwives, Dottoressa Carta also gives the women specific measurements, such as the normal fetal heart rate and the average length of labor. Using a pelvic model, she shows them the various fetal positions. In conclusion, she asks if there are any questions. When the women remain silent, she dismisses them.

Lessons with the other instructors of the consultorio course parallel this one. The women always sit at desks in rows, listening while the instructor provides information pertaining to his or her field of expertise; the social worker presents information about maternity leave, the pediatrician lectures about childhood illnesses and vaccines, and so forth.

Only the sessions with Elisabetta, the psychologist, diverge from this structure. These sessions, intended to elicit group interaction, are held Thursday afternoons in a smaller room on the second floor of the same family counseling center. The women sit in a large circle while Elisabetta encourages them to participate in exercises that explore the psychological dimensions of maternity. One such exercise involves drawing oneself before, during, and after pregnancy. After several

minutes of drawing, Elisabetta asks each woman to discuss why she drew herself at each stage as she did. The women answer her questions directly, usually in one or two sentences, and they provide no extra information. For instance, when Elisabetta asks one woman why she drew her pregnant self so small, she responds, "I thought I'd need space on the paper to draw more."

Centro Sant'Elena

The second course meets twice weekly at Centro Sant'Elena, a private gynecological practice in the center of town.[15] Between five and ten women, usually in the last trimester of their first pregnancy, assemble in a small room with space enough for them, plus the instructor and me, to sit on exercise mats in two face-to-face rows. Like those participating in the consultorio course, these women also come from the neighborhoods and towns in and around Cagliari, and they represent a variety of occupational, social, and economic backgrounds. The course has a rolling attendance in which women arrive in their seventh or eighth month of pregnancy and attend until birth. There is no division of labor between the two midwives who teach the course; they teach on alternating days, and both of them cover any and all issues as they arise.

During the particular meeting described here,[16] as during most others, Angela, one of the midwives, asks the women what they want to do first—exercises, relaxation, or discussion. As usual, the women choose the series of yoga-based stretching exercises. As they exercise, lively discussions ensue among them. These friendly, informal conversations focus, as they often do, on women's fears and worries—of fetal malformations, pain during labor, and complications during birth. While they talk about their concerns, they also make recommendations to one another about how to resolve them. Angela joins in on their conversations and provides her own recommendations.

After the exercises, the group begins a ten-minute relaxation period during which Angela encourages the women to visualize their labor and birth. Afterwards, they discuss what they envisioned. One woman tells how she saw a healthy baby. Another says that she imagined a natural birth. As they talk about the relaxation exercise, the conversation oscillates informally between small groups of two or three women and the whole group. Some women share their own thoughts while others relate the past experiences of women they know. Someone asks a question—what happens when you go to the hospital? Anna Paola, a course participant pregnant for the second time, answers this question. Everyone's attention turns to her as she tells of an unexpected cesarean section that left her feeling angry and deluded.

Angela asks the women what else they would like to talk about. Their interests center upon breast-feeding, postpartum psychological problems, and infant care. Soon the conversation turns to changes that the women are experiencing in themselves as their pregnancies progress. One woman tells how she is organizing herself better, and another explains how her pregnancy has limited her.

Next they talk about birth. Angela briefly outlines the physiological aspects of birth, explaining to the women what they will feel during each stage of labor. They ask her questions about her own birth experience, and she tells them what she felt, feared, and thought throughout the birth process. In a similar manner, the women offer insights to each other from both their own experiences and those of

family members and friends. As the session concludes, Daniela, a former course participant who gave birth several weeks earlier, unexpectedly arrives with her newborn son. Although not all prior course participants return to tell about their birth and postpartum experiences, because they have maintained friendships with other course participants and instructors, many of them do. The women shower her with questions. How did it feel when labor began? What was the pain like? Were you scared? How did it feel when you first saw your baby? What happened when you returned home? Daniela is happy to spend a half-hour answering their questions.

Comparison and Analysis

One notices a significant difference in the frequency and quality of interactions among the participating women from one course setting to the other. At the consultorio, interactions between women were limited to brief exchanges either before or after the session. Valentina A., a 40-year-old consultorio course participant, expressed a common disappointment about the absence of communication between participating women during course meetings:

> There weren't really relationships between the women at the course. That is, we all participated in the same course, we did everything together, but there wasn't a relationship, a way in which we could communicate our experiences . . . there wasn't much interpersonal communication between the women at all.

Conversely, the sessions at Sant'Elena were dominated by interactions among participating women. They talked together throughout the sessions, often laughing and obviously having fun. Daniela explained why these informal interactions with other women were the most important part of course participation for her:

> Because my labor was induced, I had to lie down and I couldn't do the exercises we learned in the course. In the delivery room, the course isn't at all useful. You're in such a unique situation; you don't remember the positions and the pushing you learned at the course. I was agitated and scared, and I didn't remember anything. I just did what the doctor and midwife who assisted me suggested. You just follow their advice. At the moment of birth, you don't have your wits about you to think about what they told you during the course . . . but the course did allow me to meet new, different people with whom I got along very well. With some, I have continued to have friendships.

For women like Daniela, the specifics about birth that they learned during course sessions were rendered useless by both biomedical interventions and the excitement of the moment. However, the ongoing friendships formed during course participation remained crucial, especially during the postpartum period when many new mothers are insecure about their ability to care for their newborn babies. I observed strong friendships develop among Daniela and five other women who attended the Sant'Elena course. After they gave birth, these women continued to call and meet with each other, sharing their experiences of infant care and breast-feeding. They often invited me to join them, and when I did, I noticed that while their conversations frequently focused on concerns common to new mothers, their long-lasting friendships also came to encompass other aspects of their lives.

Interactions between participating women and instructors at the two courses also differed dramatically. At the consultorio, interactions were elicited by the instructors, and information flowed unidirectionally from instructors to course participants. There was little spontaneous exchange of information between the instructors and the women, whose participation consisted of answering specific questions put forth by the instructors or asking their own questions during a designated question-and-answer period. This limited participation was centralized, in that the communication it brought about was directed at the instructors rather than at the other women. Even during the relatively interactive sessions with the psychologist, women's participation remained structured by, elicited by, and directed at the instructor.

The interactions between women and course instructors at Sant'Elena were quite different. Women's participation was spontaneous, as they freely discussed whatever concerns came to mind whenever they wanted, both with each other and with the midwives. This spontaneous interaction was decentralized, in that women frequently interacted directly with each other as well as with the course instructors.

Because the social structure of the consultorio course limited the active participation of the women attending it, their experiences and feelings rarely entered into the session's discourse, and they certainly never guided it or became central to it. Most of the information presented during lessons was derived from and organized according to biomedical and professional categories; concerns and categories derived from women's experiences were rarely mentioned. Not surprisingly, lessons focused on biomedically described physiological processes, such as that undergone by the egg after fertilization or that occurring in the uterus during dilation. Aside from the psychologist's structured elicitation, women's feelings, fears, and experiences were not mentioned during consultorio lessons. Centralized participation and instructor-defined sessions left little room for women's experiences and concerns, which remained at the margins, unstated and unshared.

On the other hand, the decentralized, spontaneous interactions among women and instructors at Sant'Elena placed women's feelings, experiences, concerns, and expectations centrally, so that they usually dominated the discussion. Rather than relying solely on their biomedical knowledge like the instructors of the consultorio course, the midwives at Sant'Elena frequently used their own maternity experiences as tools for teaching. For instance, on one occasion when course participants asked about cesarean sections, Rita, one of the midwives, used the experiences that led up to her own c-section as an illustration. Decentralized, spontaneous interactions allowed participants to define what was discussed—invariably, their own experiences and feelings. In this setting, women's experiential knowledge subtly challenged the unique authoritativeness of biomedical knowledge and subsequently came to share in its authority.

Although it is difficult to say exactly why the social dynamics in each course differentially allowed for the central placement of experiential knowledge, the differences almost certainly derive from several factors. Undoubtedly, the small course size and close physical setting at Sant'Elena contributed to the development of friendships and subsequent legitimization of experiential knowledge that occurred there. The larger number of women attending the consultorio course and the cavernous room in which they met simply inhibited the easy development of intimate friendships and the exchanges of experiential knowledge that are a part of

such relationships. However, because patterns of interaction did not alter significantly when the women attending the consultorio course met with the staff psychologist in a smaller room, there must be a more compelling explanation for the distinct differences in social interaction at the two courses. This explanation lies in the way teaching is structured in each course.

The sharp division of teaching labor among consultorio instructors limited the extent to which close, friendly relationships could develop between instructors and women. As Lazarus points out, a division of labor in which the care and education of pregnant women is accomplished by a number of professionals "hinders developing a relationship between a supportive caregiver and a pregnant woman" (1994:32). The absence of supportive friendships between women and instructors, in turn, helped to maintain the existing hierarchy between the professionals instructing the course and the women attending it. The maintenance of this hierarchy continued to sideline women's already marginalized experiences and feelings. Given the structure of this course and the social interactions that resulted from it, it is not surprising that biomedical categories and issues defined consultorio course sessions, and the singular authoritativeness of formal, biomedical knowledge was maintained.

In stark contrast, the absence of a division of teaching labor at Sant'Elena allowed closer, more intimate friendships to develop between course instructors and participating women. These close relationships minimized the hierarchy between professional instructors and participating women. Browner and Press explain the role of hierarchy in structuring authoritative knowledge:

> In non-hierarchical settings, individuals choose from among several equally legitimate sets of rules or forms of knowledge. In situations of structural inequality, however, one set of rules or form of knowledge often gains authority, devaluing and delegitimating others in doing so. [1996:142]

My examination of the two courses described above reveals some of the social processes that create the situations of structural equality enabling women to choose from several equally legitimate forms of knowledge, including that based in their own experience, and to subsequently redefine that which is considered authoritative. The egalitarianism promoted by the close relationships women were able to form with course instructors at Sant'Elena made it possible for them to participate more fully in defining what was discussed and accomplished during each session. Women's active participation brought their experiential knowledge, as well as that of the course instructors, to the fore. In this way, centrally placed experiential knowledge was able to contest the dominance of biomedical knowledge and usurp its authority.

As biomedical knowledge and categories were pushed aside to make room for experiential ones, the childbirth education course became a central location at which biomedical hegemony (Lazarus 1994) was challenged. As the passages cited above indicate, courses that placed experiential knowledge centrally were more useful to women than those organized solely according to biomedical and professional categories. If, as Lave and Wenger (1991:29) suggest, learning is a situated activity in which learners participate in communities of practice, then courses structured similarly to the one at Sant'Elena will inevitably provide the

best opportunity for women to learn, through their own participation, about becoming and being mothers.

I propose here that these course-facilitated friendships and the exchanges of experiential knowledge that are a part of them represent continuity with the past, in which older women became mothers in a salient familial context, surrounded by related women and guided by the knowledge gleaned through their past experiences. I suggest that the friendships that developed between younger women in properly structured childbirth education courses in small measure served to replace the familial relationships that have lost their salience as maternity has recently and simultaneously become individualized and institutionalized.

Because of the recent transformations in the organization of mothering and the ideology of motherhood, however, women rarely perceived experiential knowledge as valid. Even older women, in retrospective light of the ascendancy of biomedical knowledge, often discounted the experiential knowledge that successfully guided them through the maternity transition. Despite the sometimes extensive instruction that they had received from familiar women and local midwives, older women described themselves as unaware, unconscious *(incosciente),* and "knowing nothing" compared to today's new mothers. Likewise, when directly asked about the usefulness of other women's experiential knowledge, most younger women's responses mirrored that of Elena, cited previously. When asked if she listened to the experiential advice of other women, Elena responded:

> No, I didn't listen to the advice of others, because everyone has their own formula for feeling good during pregnancy and assuring that all goes well. Everyone becomes an "expert." But really, in fact, there is no need to listen to anyone . . . you know, all of these little superstitions—don't do this, because that can happen to you, don't tire yourself, don't move too much, don't move like this, everyone has advice to give you, and if I let them, they managed to influence even me.

Like Elena, most younger women did not consider what they learned through conversations with other, especially older, women to be valuable information, if, indeed, they viewed it as information at all. Yet, such knowledge and the relationships within which it is embedded remained indispensable to younger women as they became mothers. In more subtle ways, younger women's narratives revealed this need. Elena continued:

> My mother was always reassuring. She always told me not to worry, that in pregnancy, she had done everything, she had moved about and continued working, never considering herself "sick." Also, she always reassured me about birth. Yeah, she told me that in birth you suffer, but it is a suffering that you can tolerate.

Reflecting the feelings of many younger women who participated in this study, Elena's comments begin to suggest why the equal valuation of experiential knowledge and biomedical knowledge regarding maternity is important for women's well-being.

Discussion

On the surface, childbirth education courses, as key points for the transmission of biomedical knowledge, appear to be a primary means by which maternity is further medicalized. However, a closer look indicates that the social processes that

occur in some courses actually allow participating women to challenge the authoritativeness of biomedical knowledge as they revalue their own and each others' experiential knowledge. I argue that in this way, depending upon how they are structured, childbirth education courses may actually serve to demedicalize maternity. When courses are structured in such a way that they enable women to share their experiences and feelings and to develop long-lasting, multipurpose friendships with one another, their experiential knowledge becomes as legitimate as the biomedical knowledge that is usually singularly authoritative. When so legitimated, women's experiential knowledge can provide an alternative to the biomedical knowledge that sometimes compromises their subjective agency and personhood as they become mothers.

Although reassuring, to depend upon experiential knowledge alone would signal not only adherence to a recently outmoded way of doing things, but it would also mean a dangerous and irresponsible disregard for biomedical "facts" that can save lives. It is biomedical knowledge that younger women were expected to have and biomedical and professional advice that others expected them to follow. Biomedical knowledge would prepare them for the institutions and procedures that play a large part in their maternity experiences. Learning biomedical knowledge would also legitimize younger women as responsible mothers in the eyes of those around them, who expected that the women would do everything possible to minimize risk (Browner and Press 1995, 1996; Duden 1993). In this sense, the formal, biomedical aspects of childbirth education courses filled an external need for pregnant women, demonstrating that they were responsible enough to be appropriate mothers.

Yet, it was the comforting advice based on the experiences of known others that women themselves needed to guide them through the lived and embodied maternity transition. The experiential knowledge of other women served as a familiar yardstick against which to measure their own feelings and daily experiences. Consequently, courses that were structured so that they promoted exchanges of experiential knowledge also fulfilled an equally important, *internal* need for women as they became mothers. That is, the exchange of experiential knowledge reassured women by creating and reinforcing important relationships and letting them know how others had lived through the maternity transition.

This dual purpose of the childbirth education course brings me back to one of the central questions posed at the beginning of this article, that is, why is it so important that experiential knowledge be accorded equally legitimate status with biomedical knowledge during the maternity transition? As younger women's narratives indicate, listening to experiential knowledge clearly reassured them during pregnancy and addressed their psychological needs. But why does experiential knowledge based in close relationships with well-known others smooth insecurities and resolve worries so much better than powerful and usually dominant biomedical knowledge? Giddens provides a response to this question in his analysis of trust in modern expert systems:

> Trust in persons, as Erikson emphasizes, is built upon mutuality of response and involvement: faith in the integrity of another is a prime source of a feeling of integrity and authenticity of the self. Trust in abstract systems provides for the

> security of day-to-day reliability, but by its very nature cannot supply either the mutuality or intimacy which personal trust relations offer. [1990:114]

Trust in the experiences of well-known persons similar to oneself reinforces the self. More important, such trust resides within the relationships through which those experiences are communicated. Trust in knowledge, the exchange of which is but one component of an ongoing, multifaceted relationship, provides an ontological security that, according to Giddens (1990:92, 114), cannot be replicated by trust in expert systems. Put differently, experiential knowledge gives women a sense of security that comes from both the knowledge itself and from the intimacy with the persons who are its source. While biomedical knowledge speaks with the "voice of medicine" (Mishler 1984), which is divorced from the context of women's daily lives and social experiences, experiential knowledge speaks with the "voice of the lifeworld" (Mishler 1984), which is more reassuring due to its continuity with the context of women's daily lives and social experiences. Experiential knowledge, embedded in a social matrix composed of well-known others, provides women with a sense of security that distant, decontextualized, and statistical biomedical knowledge, for all its powerful efficacy, cannot afford.

In this contradictory situation, the childbirth education course that promotes decentralized, spontaneous participation by attending women provides an externally legitimate biomedical setting in which women can obtain necessary biomedical knowledge while they simultaneously share their experiences and feelings, thereby fulfilling their internal needs. Personal accounts that are dismissed in daily conversation gain legitimacy when told in the context of the childbirth education course and affirmed by the course instructor. If women's experiences and the knowledge that arises from them are able to take center stage, they take on a momentum of their own, guiding conversations and course sessions. Experiences are subtly revalued, and as they gain ascendancy, the knowledge that derives from them helps women to calm their worries and to resist usually authoritative biomedical knowledge when it demeans them or deprives them of the active personhood that is the essence of mothering. The alternative that revalued experiential knowledge provides can, in some instances, help to ease the anxieties and problems that contemporary new mothers often face.

If the goal of childbirth education courses is to afford women a measure of security as they become mothers, then the results of my analysis point to several ways in which this goal can be achieved. First, courses that are small in size and involve only a limited number of participants and instructors appear to promote primary relationships that provide trust. Second, a division of teaching labor among a host of professionals maintains a hierarchy between experts and lay persons. This hierarchy inhibits development of the trusting, multipurpose relationships through which women obtain, alongside the biomedical facts that they perceive to be so necessary, a "trust in persons" that affords real security. Thus, in this setting and similar ones, continuity in instruction appears to be an important factor in improving the efficacy of childbirth education courses. As demonstrated by the childbirth education course at Centro Sant'Elena, courses that are small in size and have little division of teaching labor are likely to promote the development of friendships that provide trust. These friendships subsequently give women psychological and

social benefits that in turn ease the sometimes difficult process of becoming a mother.

NOTES

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1. In this article, *experiential knowledge* refers to knowledge that is either embodied, based in one's own daily practices, or based in the daily practices of other local, familiar persons.

2. I have divided research participants into three generational cohorts based on the year in which they became mothers. Women to whom I refer here as "younger" had their first child between 1988 and 1994. Those to whom I refer as "middle-aged" had their first child between 1964 and 1975, while those to whom I refer as "older" had their first child before 1964. These generational divisions correspond to important social and political markers in post-war Italy. The oldest group became mothers before the Italian "economic miracle" of the early 1960s and before the demographic transition. The middle group became mothers after the "economic miracle" and during the demographic transition, but before the implementation of major family policy changes. The youngest group became mothers well after the demographic transition and the implementation of new family policy. For more on these generational markers and how they have influenced women's lives, see Saraceno 1984, 1991, 1992.

3. Demographic transformation has been both a cause and an effect of changes in the Italian family. In Italy as a whole, the 1901 birth rate was 32.7 live births per 1,000 inhabitants; by 1991 it had fallen to 9.9 per 1,000. During those years, the infant mortality rate declined from 159.7 deaths during the first year of life per 1,000 live births to 8.4 per 1,000. In the province of Cagliari, the 1952 birthrate was 27 per 1000, and by 1991 it had dwindled to 9.9 per 1,000.

4. For an interesting account of this change in terminology, see Triolo 1994.

5. All of the younger women participating in my study had at least one sonogram during pregnancy, and most had several. They expressed nervousness at the idea of giving birth without having had a final sonogram. For many of them, seeing the ultrasound image of the fetus was the defining moment at which pregnancy became a reality.

6. The national cesarean section rate in Italy in 1990 was 21.2 percent (ISTAT 1994). At the hospital in which I based my research, the rate was 20–24 percent, while at the clinic in which I worked, the rate was much lower—about 12 percent (personal communication with nurse-midwives at Clinica Villa Elena, Cagliari, March 1994).

7. The plans for the consultori familiari were outlined in a national law, but each center was implemented at the regional level. The consultori grew out of two opposing historical

trends: (1) the Opera Nazionale di Maternità e Infanzia (National Agency for Motherhood and Infancy), established in 1925 by the fascist regime to promote an increase in population and to indoctrinate women into their life mission as wives and mothers, and (2) the feminist movement of the late 1960s, whose goals were to promote a "conscious motherhood" and to conquer the silence that surrounded sexuality, bringing problems to light in a pedagogical exchange of experiences (Saba 1983).

8. Regione Autonoma della Sardegna Assessorato dell'Igiene e Sanità e dell'Assistenza Sociale.

9. In this article I do not intend to compare the merits of state-sponsored courses and private courses. Rather, I intend to compare the structure, teaching methods, and participant interactions of these two particular courses, which happened, by coincidence, to differ in that one was state sponsored and the other was private. The differences discussed here are not necessarily related to that fact. Indeed, I have attended private courses that more closely resemble the state-sponsored one discussed here and vice versa. A comparison of state-sponsored and private courses would require looking at several courses of each type, at minimum, and such a comparison is beyond the scope of this article.

10. All names have been changed to protect the privacy of the individuals who were kind enough to take part in this research and open enough to share their experiences with me.

11. Although these observations were made in 1993 and 1994, I have used the present tense here so that these sections flow better and are easier to read.

12. All of the midwives discussed in this article are nurse-midwives *(ostetriche)* who have obtained nursing degrees with specializations in midwifery. Prior to the 1970s, however, lay midwives *(empiriche)* and licensed town midwives *(ostetriche condotte)* attended most births in Sardinia (Lai et al. 1992; Martinetti and Roascio 1992). For more on the professionalization of midwifery in Italy, see Triolo 1994.

13. Women attending both courses come from the various neighborhoods in Cagliari and the provincial towns surrounding the city. Middle- and working-class women attend both courses, although a slightly higher percentage of middle-class women attend the private course. Women at both courses also represent a range of occupational diversity, including librarians, secretaries, clerks, teachers, and housewives.

14. *Lei* is a third-person singular pronoun that translates as "she." In most of Italy, including Sardinia, it is also employed as a second-person formal pronoun, regardless of whether the subject is male or female.

15. I have changed the name of the center to protect the privacy of those who work there.

16. It is instructive to note that both instructors and women participating in the consultorio course routinely referred to course sessions as "lessons" *(lezioni)*, while those participating in the Sant'Elena course never did so.

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