



## In the Salon Doing Engaged Feminist Scholarship

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Discomforted Research and Teaching: Using Physical  
and Digital Archives in Gendered Health Communication

Bethany Johnson

University of North Carolina at Charlotte

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*All human beings are practicing historians.* (Lerner, 1997, p. 199)

In late 2012, what began as a foray into the field of health communication to discuss a birth method called Twilight Sleep (TS), led to a year and a half of intense research and learning, culminating in the on-going transformation of my teaching and scholarship. This spring, I will complete two articles on TS as well as a qualitative study on doctor-patient communication—all three of these projects examine women's agency in healthcare from the early 20th century to the present. Moreover, each of these projects utilizes archival records from the first half of the 20th century.

My initial analysis of the TS debates in New York City (Manhattan, specifically) from 1914-1918, as well as the female activists and lay writers using technical language in the public sphere, highlighted the value of communication theory in my work. TS is a drug cocktail used to induce a semi-conscious state in the parturient patient. A successful TS birth is one in which the mother holds her child for the first time with no memory of the process. I found that in the early 20th century, women referring to themselves as “feminist”<sup>1</sup> led the fight for a semi-conscious birth (Johnson & Quinlan, 2014). Ultimately, the definition of an “empowered” birth shifted across generations, even among those who self-identify as women's rights activists. However, many of the historical sources I collected remained unused—namely, hundreds of journal articles written by doctors during this debate—and I felt the doctors' story must be told. Nonetheless, over the course of many months, the documents I pored over pointed me to the influence of *The Brooklyn Eagle*, the most popular newspaper in that city in the early 20th century.

This prompted my next project in which I discovered that *The Brooklyn Eagle*, with the support and assistance of local doctors, played a vital role in framing the TS debate in Brooklyn. The newspaper discussed TS using what I call a “high-society frame.” From an agenda setting perspective (see McCombs & Ghanem, 2001; McCombs & Shaw, 1972), my research suggests that the media framing of TS in Brooklyn acted

as powerful motivator, increasing both the potential clientele for the procedure and expectations for access to it among the wealthiest families in Brooklyn.

While investigating some of the most lauded doctors in the pages of *The Brooklyn Eagle*, I read about Dr. R. L. Dickinson, who not only used TS, but also treated women for infertility and practiced artificial insemination long before other doctors considered it (Marsh & Ronner, 1996). While working with Dr. R. L. Dickinson's papers at the Frances A. Countway Library of Medicine at Harvard University, I found material that supported and also complicated themes emerging in my qualitative research. This qualitative project, still in progress, studies doctor-patient communication in Reproductive Endocrinology (infertility) practices.<sup>2</sup> This development was the most exciting for me and completely unexpected. Before this experience, I never considered using materials from this (or any) archive to inform qualitative research.

Historians often praise "the archive," which has many definitions in our field. Each physical archive is unique, because the founders begin by choosing the organization and structure of the records (Howard, 2014). In fact, women's history began as an effort to find what seemed to be "missing" in archival collections—the voices of women (Lerner, 1997). Each archive contains documents and records that prompt further inquiry.<sup>3</sup> If these primary sources<sup>4</sup> are thoughtfully and properly contextualized, Freire's (1993) conception of knowledge, one resulting from "the . . . continuing, hopeful inquiry human beings pursue in the world, with the world, and with each other" arises in the individual and in the classroom (p. 53). If communication theory provides a framework within which to analyze the mechanics of dialogue, then a physical or digital archive sheds light on how that conversation began. As Clair (1997) suggests, no story stands alone and there are numerous narrative "genres" involved in shaping each story. New York University's Tamiment Library, which hosts the Robert F. Wagner Labor Archives, provides scholars a wealth of documents in which many thousands of stories emerge from the surviving ephemera from the American labor movement. To work at a physical archive or to examine materials in a digital one is to enter into a story as it continues to unfold, in which a host of narrative voices remain inchoate and ready for analysis.

As a professor, my use of primary and secondary historical documents provides a "safe space" for student engagement with controversial issues. In classes and even at conferences, when examining a debate or conflict, historical newspaper articles, the surviving papers of various individuals, pamphlets, diaries, and other materials found in archival collections provoke meaningful discussions. At the 2014 OSCLG Annual Conference in San Francisco, I answered audience queries after a panel presentation by referring directly to a collection of papers (Dennett, 1874-1945) and a pamphlet I studied, which survives in the Beinecke Rare Book and Manuscript Library at Yale (Twilight Sleep Association, 1914). Without these materials, my arguments about the early 20th century and the role of TS in American women's history would remain general, that is, properly contextualized, but lacking specificity and thus, weight.

I use this same technique of “leaning on” documents in the classroom and class time is much more productive as a result. Studying materials from both physical and digital archives creates space for deeper, more informed dialogue, yet it can also challenge much of what the student and professor assume they already know. It is not always a comfortable process, but it is a worthwhile one. For example, I used the materials in the Dennett Papers at the Schlesinger Library and historical articles from *The New York Times*<sup>5</sup> for a lecture on TS I regularly give in a class called “Gendered Health Communication.” I often begin the post-lecture discussion by asking students if they would consider TS or other options popular at the turn of the 20th century, such as cocaine, heroin, chloroform, etc. When the students say “no,” I question the notion of birth “choices” and how they are “given” through medicines and technologies available in a particular historical moment. It is easier for students to examine the experience of a person long dead—suddenly it is safer to ask difficult, probing questions. I challenge students to think about communication around birth (for patients, practitioners, and supportive communities) since the process is often labeled “good” or “bad,” depending on individual perceptions of what is important in the birth process.

Once students begin to understand the challenges women faced in healthcare a hundred years ago, they conceptualize the decisions women make in the present in a broader way. The discussion often turns to C-sections, “natural birth,” “home birth,” “push-prizes” and how these and other terms become barbs or judgments used by birthing mothers and medical practitioners against others mothers and practitioners; a small battle in the larger “mommy wars.” Finally, I ask students to consider whether individuals define an empowered birth differently because of gender expression, race, class, sexual orientation, and/or other social constructs. After returning to TS for a second time, we consider our role in the “mommy wars,” without pointing fingers, using communication theory as our guide, including narrative theory (Burke, 1954; Fisher, 1987) and dialogic theories (Bakhtin, 1981; Buber, 1970). Alongside communication theory, the historically shifting notion of “empowerment” acts as an over-arching theme and the TS debates serve as our historical anchor. At the end of class, I suggest to the students that respecting an individual’s birth experience, despite our own views, is a feminist act. Without TS as our context, the class quickly becomes polarized and students struggle to openly examine birth practices that are foreign, unfamiliar, or discomforting.

As a scholar, the sources framing the TS debates in New York City from 1914-1918 are rich with material useful in more than one context. This is certainly true with TS records in personal papers (Dennett, 1874-1945; Twilight Sleep Association, 1914), which include newspapers and magazine clippings as well as copies of medical journal articles with personal notes in the margins. As previously mentioned, in *The Brooklyn Eagle* between 1914 and 1916, there are hundreds of examples of the depiction of TS as a “high-society” obstetric procedure (Johnson & Quinlan). The ways in which the *Eagle* framed TS reflected a resistance to the changing demographics and economy of Brooklyn—the fear that the “right” women must bear more children to offset the high

birth rates of immigrant populations was common among White elites in the early 20th century (Bederman, 1995).

Moreover, the late 19th and early 20th centuries mark an explosion of medical coverage in print media, a phenomenon referred to by Tomes (2002) as “proto-science journalism” (p. 630). In all forms of print media, proto-science journalism shaped the contours of debate around TS. Investigating the framing of TS in media sources in Brooklyn allows for an alternative analysis of the TS phenomenon without narrowing the focus to my previous research on technical and public spheres in Manhattan. Furthermore, these materials allow comparison between media framing and proto-science journalism in the early 20th century and today. Media framing continues to play a powerful role with the public, shaping reactions to and knowledge about both common and esoteric medical practices. Proto-science journalism now exists on “health and wellness” pages and the public can easily access information on new cancer drugs, diets to control blood sugar, or the benefits of cord-blood banking. Indeed, the public expects media sources to provide this kind of information.

While the archival materials I use in classes enrich dialogue and reflection, they also provide an additional lens through which to examine my own research. Formulating research questions using a feminist analysis, while simultaneously investigating primary sources illustrating infertility treatment throughout American history, transformed my perspective on qualitative research. In a feminist inquiry informed by health communication, scholars might ask questions such as: (1) How (if at all) does gender further complicate the power imbalance in doctor-patient relationships? (2) In what ways (if at all) do those who identify as female contend with or work around this power imbalance in healthcare settings? In my current qualitative project studying doctor-patient communication in infertility practices, I uncovered empowering and disempowering potentialities. Namely, while intrauterine insemination (IUI)<sup>6</sup> is much more effective than it was in the 1890s (Marsh & Ronner, 1997), infertility treatment is still, by and large, structured around a stereotypical, binary conception of sex and gender.

As is my practice, I immediately looked into the history of infertility treatment in America when I began conducting interviews with females diagnosed as infertile. I read the comprehensive study by Marsh and Ronner (1996), *The Empty Cradle: Infertility in America from Colonial Times to the Present*; the only one of its kind I found. While the conclusions are now quite dated (technologically speaking), the text and the references remain immensely useful. Before studying the history of infertility treatment in America, I did not understand the startlingly long tradition of doctors and wives shielding men from their infertile status as a way to guard socially constructed masculinity, or the ways in which gender-biased thinking, disguised as health norms, remain largely (if not completely) unexamined in infertility practices and among infertility patients today.

While conducting interviews during the summer and fall of 2014 for a qualitative study on doctor-patient communication, silence around male infertility to protect traditional masculinity emerged as a theme even before I understood the historical context of this silence. Vivian,<sup>7</sup> an interviewee, reflected on her experiences with disclosure and partner communication: “. . . we also had my husband’s semen analysis which . . . [the doctor] basically just glanced at and said was fine. Which, later turned out it wasn’t . . . fine. Um . . . (laughs).” Vivian and I then discussed the lack of resources for treatment of male fertility, and I noted that according to current research, male infertility rates are equal to that of women in the United States. She responded:

But they say women are . . . I—I wanted it to be me, my problem. Because I could handle it . . . you tell a man that something’s wrong it takes away their manhood and, um, I—it’s not that he’s infertile, um, with his semen analysis and I reviewed it and I Googled everything on it (sigh).

During this interaction, the interviewee had a hard time even categorizing her partner’s condition as infertility, because she assumed the label meant his inevitable emasculation. Interestingly, she expressed far less concern over her own ability to weather her infertility treatments throughout our interview together. The emotional strain and stress associated with balancing a full-time job and an expensive, intrusive, complicated infertility treatment remained preferable to the risk of any emotional discomfort for her partner.<sup>8</sup> The suffering female as martyr, shielding others from physical or emotional pain is a well-worn trope—yet this image appeared in stark relief in interviews as well as in my research on infertility diagnosis and treatment throughout the past one hundred and fifty years. Before these interviews and my parallel historical research, I naively assumed we had made more progress divorcing binary gender stereotypes from infertility treatment.

According to the initial findings of my study, this “protective” attitude is reflected in the treatment practices at some infertility clinics and has been for more than a century. For example, if a cis-gendered female does not appear to have an obvious condition or marker for infertility and her male partner refuses to be tested, doctors will still perform IVF, or in-vitro fertilization, sometimes in tandem with ICSI, or intracytoplasmic sperm injection.<sup>9</sup> IVF chemically circumvents the female reproductive system, and ICSI utilizes a sample provided by the male partner to inject the highest quality sperm directly into the follicle retrieved through IVF. The ultimate goal of IVF with ICSI is the production of a healthy embryo to put back into the woman’s uterus three to six days hence. However, as previously mentioned, some of the women receiving this treatment have male partners who would not consent to testing, unwilling to believe they were contributing to the couple’s inability to conceive, or because they felt that the testing is invasive and embarrassing.<sup>10</sup> While some cis-males are willing to be tested and are deeply involved in the process of infertility treatment either through pursuing treatment options or by supporting their female partner, other men resist engagement with the process. In some cases this resistance results in fertile women receiving infertility treatment to become pregnant.



Women remain at a disadvantage in a medical system that automatically assumes females are the source of infertility in a heterosexual relationship, when current research suggests the rate of infertility among men and women is similar (ASRM, 2015). This assumption is part of a long historical arc as well: physicians defined infertility as a “disease of women,” in the 19th century despite infertility rates among men and women remaining more or less constant since the 1890s (Marsh & Ronner, 1996, p. 42). In the late 19th century, many doctors feared that a college education would render a woman infertile, while some doctors feared that unprotected premarital sex would render a man’s future wife infertile via untreated gonorrheal infection (Marsh & Ronner, 1996). Despite these and other suspected causes of infertility, doctors worked diligently to “protect” young men from having to bear the indignity of the label “infertile”; doctors expressed less concern over labeling female patients as “infertile.” Thus, the practice of shielding men from their lack of virility began more than a century and a half ago.

Despite attempts in the 1850s by Dr. Marion Sims and others, the first wave of successful artificial inseminations did not occur until the 1930s (Marsh & Ronner, 1996). Dr. Sims was so committed to using the husband’s semen that he would collect it from the vaginal canal—in the couple’s home, directly after intercourse (Marsh & Ronner, 1996). By the 1930s, physicians such as Dr. Frances Seymour were willing to use donor sperm, but both female patients and doctors were unsure about whether or not to reveal the use of donor sperm to infertile male partners (Marsh & Ronner, 1996). In the Dickinson papers, there is an article dated 1943, penned by Alan F. Guttmacher, who said the following regarding donor sperm:

Keep donor, recipient (and her husband) completely unknown to each other . . . never urge the procedure. . . . In the ideal case, by the time the patient reaches term, the woman, the husband and the doctor have to think twice to remember the pregnancy is physically not the husband’s for psychically it has become his . . . falsify the hospital record and the birth certificate. Here a white lie is a kindly humane act. (Dickinson Papers, n.p.)

Guttmacher preferred the use of deception on hospital records and birth certificates to the psychological discomfort of a male client. Hence, for some physicians practicing in the late 19th and early 20th centuries, only subterfuge offered enough protection for the male psyche (Dickinson Papers; Marsh & Ronner, 1996). Today, few (if any) doctors encourage this kind of deception, yet communication and even procedural choices can achieve the same goals of psychic protection and avoidance of “emasculat[i]on.”

Ultimately, by examining statistics and communication trends in archival collections (both physical and digital), as well as historical medical journals and turn of the 20th century newspapers, I am far better prepared to discuss the historical context for the constructs I see in doctor-patient communication of infertility practices in the present. This context reveals how much has been accomplished in some areas and how little has been achieved in others. For example, while available treatments for infertility have become far more successful, easier, and less painful (comparatively speaking),

the success rate of artificial insemination has increased only marginally since the 1940s and 1950s (Marsh & Ronner, 1996; Dickinson Papers). Treatments for men were nearly non-existent until the introduction of endocrinology-based treatments in the 1920s, but the hormone therapy popularized in that decade proved to be ineffective (Marsh & Ronner, 1996). Today, men can receive a detailed analysis of their semen from an andrologist, but, doctors still have very little to offer men for treatment of a low or nonexistent (azoospermic) sperm count. Some men are prescribed a drug called Clomid, originally developed and marketed to prompt ovulation in women (Marsh & Ronner, 1996). Infertility practices do not have in-house male infertility specialists—they outsource male patients to urologists (Fretz & Sandlow, 2002).

In effect, the lack of treatment and support for men mentioned by many of my study's interviewees reflects entrenched beliefs rooted in a binary, sexist conception of gender. The assumptions that women are more likely to be infertile or biologically unfit (in contradistinction to the virile male) appear throughout women's experience from the late 18th century to the present (Marsh & Ronner, 1996; Weiner and Hough, 2012). Further, the notion that all women (and historical sources often define "women" as White, heterosexual, and middle-class) are more willing to bear the emotional, economic, and physical discomfort of infertility treatment because of assumptions of a universal biological predisposition towards motherhood among females (Bederman, 1995; Breslaw, 2012; Eig, 2014; Marsh & Ronner, 1996; Weiner & Hough, 2012). Again, these assumptions, largely unexamined in infertility practices, frame the communication between females seeking treatment and their reproductive endocrinology practitioners.<sup>11</sup>

Similar to Lerner (1997), the goal of my research and teaching is to show students that studying the past requires considerable effort and engagement, but if one "enter(s) past worlds with curiosity and respect . . . the rewards are considerable" (p. 201). The study of primary sources, gleaned from physical or digital archives, allows students to analyze contentious present-day issues and provides a unique lens for my own interpretive and critical work. Without studying Dickinson's papers and mining secondary texts (such as Marsh and Ronner's monograph) for unfamiliar primary sources, I would not assess accurately the ways infertility treatment has progressed over time, and the surprising ways in which it remains the same. Furthermore, I could not examine how the progression of infertility technology and treatment—or lack thereof—affects patients today. Without studying the Dennett papers, and spending time in the archives at SUNY Downstate Medical Center, the Brooklyn Historical Society, and the digitized *New York Times* archive, I would not understand the changing notions of empowerment for women over time, or the role the media plays (and played) in framing medical procedures and practices.

Though these projects may seem loosely related, to me the connections are clear; the pairing of communication theory and my training in American history has proved to be the most exciting of my career. When writing with health communication scholars, a focus on historical events in the period of my expertise (the "long 19th century")



continues to anchor my research, providing insight for richer work. But beware: as Howard (2014) said, “There is a tradeoff between what we want from the archive and what we are given” (n.p.), so any search will take time; some investigating will not produce immediately useful resources (n.p.). Nevertheless, when the effort pays off, it pays off magnificently. Thus, I will continue to look to primary sources in both physical and digital archives to enrich my work—to rediscover the voices of women in these records, to enrich collaboration with health communication scholars, to deepen the classroom experience and to grow as a scholar.

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## Notes

<sup>1</sup> For more on the early twentieth century feminist movement in New York City, see Sandra Adickes’ (1997), *To Be Young Was Very Heaven: Women in New York Before the First World War*; Nancy Cott’s (1987) *The Grounding of Modern Feminism*; Elaine Showalter’s (1989) collection, *These Modern Women: Autobiographical Essays from the Twenties*; and Christine Stansell’s (2000) *American Moderns: Bohemian New York and the Creation of a New Century*.

<sup>2</sup> For a list of available materials in this collection, please refer to the online guide to the collection here: <http://oasis.lib.harvard.edu/oasis/deliver/~med00073>

<sup>3</sup> As Walter Isaacson argues in *The Washington Post*, something is lost when archival collections are digitized—namely, that experience of visiting the “cozy house on the edge of Caltech campus,” where eager scholars working on the Einstein Papers Project were eager to meet with visitors and “ply them with guidance, insights, and tea” (2014, n.p.). I have had a similar experience in the rare book room at the New York Academy of Medicine—the archivist brought me the books I requested, and then after we discussed my project further, she left and returned with more sources. Some of her choices became vital to that research, and none of these texts and papers came up in my own extensive searching. The knowledge of archivists and librarians who work in specific collections is invaluable to any scholar. Still, to Isaacson’s point, the fact that the Einstein papers site will eventually include 14,000 annotated documents is revolutionary. As he suggests, the digitization of these kinds of primary sources is likely the greatest innovation in historical research in our time. Unfortunately, without an expert’s guidance, finding the most useful sources can take longer. Searching any kind of archive takes time and one doesn’t always have that “eureka!” moment at the beginning, which discourages some scholars from continuing to dig. I spent over a year working with TS materials from Brooklyn and it really took that long for all the pieces to come together. Still, it is well worth the effort.

<sup>4</sup> For those who may be unfamiliar with the use of this term in the field of history, “primary sources” are written or created during the period of study, and may include

formal or “creative” documents as well as artifacts, while “secondary sources” analyze primary sources. For more, see: <http://www.princeton.edu/~refdesk/primary2.html>

<sup>5</sup> *The New York Times* has one of the most extensive digital archives of past publications, stretching all the way back to 1851, which can be found here: <http://www.nytimes.com/ref/membercenter/nytarchive.html>. However, there are difficulties when using this digitized archive in place of a physical one—unless you want to pay to view a newspaper page as a whole, the article is viewed by itself, such as here: <http://query.nytimes.com/mem/archive-free/pdf?res=9E02E2D71638E633A25753C2A9669D946596D6CF>. The problem with these articles is that they often lack author’s names and other important details, which an archivist could help you with at a physical location.

<sup>6</sup> Beginning in the 1890s, this process was referred to as “artificial insemination,” though the accepted term today is “intrauterine insemination.”

<sup>7</sup> Names are changed to protect the identity of interviewees.

<sup>8</sup> For more information on disclosure see: Bute, 2009, 2013; Bute & Vic, 2010; Petronio, 2002. For a study on the stress of infertility treatment and its effects on intimate partnerships, see Beutel et al., 1999. For more information on support sought and received during infertility treatment see: High, 2014. Also see Altman & Taylor’s (1973) work on social penetration theory. All of these authors, both inside and outside of communication studies, have influenced my interpretations of the data.

<sup>9</sup> For more on these procedures, descriptions and suggestions for further reading please see: <http://www.resolve.org/family-building-options/ivf-art/>.

<sup>10</sup> Cis-gendered males are required to provide a sperm sample and place it in a sterile receptacle, as well as getting blood drawn. In my research, I found that agencies provided a private room in the facility for specimen collection and others allowed individuals to drop off samples collected at home. The testing for women is more invasive, and could include having dye injected into the fallopian tubes, saline injected into the uterus (causing contractions), multiple (sometimes bi-weekly) blood draws, vaginal ultrasounds (sometimes weekly), cervical swabs, and more.

<sup>11</sup> I am at the beginning of this research now—my research partner and I have yet to focus on the experiences of individuals in the LBGTQQIA community, and hope to do so in a future qualitative study. It will certainly be a difficult experience to isolate in the archives given the social climate over the last one hundred years.

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