# “At least you have a healthy baby”: Birth trauma, manufactured crises, and the denial of women’s experience in childbirth.

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## ABSTRACT

The increased medicalization of childbirth is a reality. Technological 'management' is playing a larger part in the 'normal' birth experience, despite the fact that organizations that oversee health and well-being have mandates that warn against the movement toward viewing birth as an illness that requires routine intervention. In the wake of this progression toward medicalization of a process once viewed as 'natural,' women are reporting dissatisfaction with their birth experiences and a desire to speak openly about the feelings of trauma and disempowerment that often follow unexpected childbirth outcomes. Many women, when attempting to find words to express these feelings, are silenced with remarks such as "At least you have a healthy baby," words that often successfully undermine issues such as lack of consent, a common domino effect of physical interventions, and perceived helplessness. I will address how this issue has widespread sociological implications in the Western world, where medicalized childbirth is normalized, perhaps at the emotional and physical expense of women.

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## Chapter 1. Introduction

For most of human history, women's ability to give birth has not been questioned. Women moved about freely in labour, were attended by female friends, family members and/or midwives who, for the most part, allowed nature to take its course; aiding delivery by way of gravity and social support. While there is no question that infant and maternal mortality rates have decreased considerably with the advent of certain technological advances, this is a very limited basis by which to measure the quality of the childbirth experience. While surgical birth was once anomalous, occurring in only the most emergent situations, by the late 1980's, the rate of surgical birth stood at a shocking 23%, and twenty years later, in 2009, encompasses almost a full third of all births in the United States (Macdorman, Declercq, Mathews and Stotland 2012). This implies that there has either been a drastic change in the natural functioning of women's bodies in the space of one generation, or that there has been a drastic shift in social perception, channelled through diagnostic criteria. This is reflected in statistics that reflect very high rates of interventionist birth, low rates of 'natural' birth in otherwise healthy women, and narratives of trauma that are being voiced when women are given a venue to speak about their birth experiences.

Though the physiological act of 'birthing' is legitimated and recognized for its importance, other aspects are often overshadowed by an increased normalization of medically managed childbirth. Given this, it is important to recognize the role of social sciences, especially sociology, in the exploration of this phenomenon. Childbirth is much more than a biological process; it exists in a social realm (Oakley 1980; Davis-Floyd 1993). According to Kitzinger (2012), birth was historically a social act that was performed in communities, in spaces of women. It was an aspect of ordinary life to be celebrated and recognized as a bonding process

that held women close together; something that was integral to the survival and social cohesion of communities. This is still the case in Indigenous models where birth remains very much a social act. Often there is not one 'expert' who is considered the midwife, but all women, especially those who have raised children, are respected as having knowledge of the birthing process (Kitzinger 2012). In our medicocentric society, there is an almost unchallenged assumption that the evolution toward medicalized childbirth is not only superior to the social model, but that it has improved women's birth experiences (ibid).

In contemporary biomedical discourse, pregnancy is treated as pathological, something that needs to be managed, like a disease. This leads to the vast majority of babies being born in hospital settings, and contributes to the pervasiveness of the technocratic experience of birth (Crossley 2007). According to Lowis and McCaffery (2004), while birth in less developed countries is understood as a complex process infused with physical, emotional, and spiritual meaning, "Childbirth in Western Society tends to be viewed as a clinical phenomenon, governed by biological laws, and virtually unaffected by social processes and events" (6). Obstetricians, who are ultimately most often in charge of most births in North America, focus on the biological and physiological functions underlying the birth process. In contrast sociologists working from a social constructionist perspective focus on how the process is embodied and interpreted by those involved, including the birthing woman, the attendants, family members, and the larger society (Lowis and McCaffery 2004). These authors explain that "prior to hospitalization it is the birthing woman who defines what is happening and what it means, whereas upon hospitalization it is the hospital that structures the birthing experience inasmuch as it defines for the women what is happening and what it means" (ibid:8). In other words, the institutional locale of birth

(i.e., the hospital) creates and defines the process of birth; often in a manner that is extraneous to the experience itself (Lowis and McCaffery 2004).

Put simply, women "personify the union of nature (biological reproducer) and culture (social person) directly" (Oakley 1980:8). This distinction is flimsy, exacerbated by the fact that women are fixed to their role as those who birth. The act of reproduction is unavoidable, and, as Lowis and McCaffery (2004) point out, "all childbirth behaviour is culturally patterned" (11). Cultural conditioning begins early. For example, media are saturated with images of what is expected when a pregnant woman goes into labour. In most cases, her water breaks unexpectedly, a bag full of necessary items is hurriedly packed, and she is rushed off to the hospital, breathing rapidly while those around her panic. In the next scene, the birthing woman is typically in a hospital bed, screaming while people shout at her to push – harder! She is not doing it right; her baby's life is clearly in danger. Once her infant is born, he is expected to cry immediately. In the absence of this cry, he is swept away from his mother and father, something unknown happens, perhaps in the peripheral vision of his anxious mother, and after a while he is handed back, clean and swaddled; a gift from medicine presented to his parents. How much of this 'scene' is a story that has been told so many times that as a culture, it is believed to be real or unavoidable? This question is one that seems integral to the study of conditioning, and, ultimately, of humanity itself.

However, issues of reproduction and childbirth have historically been relegated to the fringes of most academic disciplines, with sociology being among the more negligent in addressing the specific concerns of women (Oakley 1980; Annandale and Clark 1996). Because childbirth is both a biological and a cultural event, it must be understood beyond the confines of the 'hard' sciences; it is the challenge of the social scientist to expand upon existing knowledge

of women's experiences (Oakley 1980; Davis-Floyd 1993; Kitzinger 2006, 2012). While sociology has added significant and meaningful discussion in the areas of family and mothering, sociological analysis of birth has neglected the very important aspect of the collective narratives of birthing women (Oakley 1980; Davis-Floyd 1993). The groundwork for such an analysis has only recently been laid, mainly in the seminal works of Oakley, Davis-Floyd, and Kitzinger. Cahill's (2001) narrative of the usurpation of the birthing movement over the past few decades provides further context for need for more considered analysis of the disappearance of midwives and normalization of medicalized childbirth (Wright 2009).

Davis-Floyd (1993) and Kitzinger (2012) further critique the modern era of childbirth, arguing that within a hyper-masculine, technology-centered society, women's bodies have been constructed as weak and defective; as a result they must be managed carefully and skillfully. Davis-Floyd (1993), Crossley (2007) and Kitzinger (2012) question the very meaning of the word 'skill,' pointing out that midwives, and even regular women, were once considered experts, trained in the physical, emotional, and spiritual realms of childbirth. Only in the recent past has the significance of the midwife's holistic approach been eclipsed by a professionalized, obstetrical paradigm of childbirth; one where every birth is seen as abnormal or pathological (Oakley 1980; Davis-Floyd 1993; Crossley 2007; Kitzinger 2012).

Where would we be if the historic narrative of childbirth had never 'progressed' to where it is now? Is there such a thing as 'natural' childbirth, and what does it mean? There are, according to Mansfield (2008), academic paradigms that see the push toward natural birth as a romanticization of what used to be, of some connection with nature that no longer exists, while others see the perpetuation of the notion of a divide between nature and society, one being more civilized than the other. Thus, women are the victims of gender essentialism, relegated to one

side because of their inherent connection with nature by virtue of the ability to bring forth life (2008). This is, obviously, an issue for many feminists. Mansfield found that, in her study of non-fiction books targeted toward women who were interested in natural birth, on one hand, the books urged women to 'follow their own paths' and 'do what feels instinctive,' while on the other hand the books created a template that offered an unrealistic and improbable variety of 'choices' to be made (2008). According to the author, "The books contend that having the right people present, who are able to do the right things, can facilitate birth; conversely, having the wrong people present, doing the wrong things, can directly inhibit birth and lead to problems" (1093). This is a paradox – creating the perfect 'alternative' birth, is not as simple as it may seem; it is, in fact, 'against all odds' (Mansfield, 2008). Women are, instead, often reporting a felt loss of control, unexpected interventions, and other incidents of birth trauma (Beck 2004a; Beck 2004b; Kitzinger 2006; Zimmerman 2013).

The consequence is that where these births are treated as unsafe, potential disasters, they are much more likely to manifest as dangerous, life-threatening experiences (Kitzinger 2012). These 'life threatening experiences' are thought to be forgotten upon exiting the delivery room, but evidence shows that they are not (Beck 2004a). 'At least you have a healthy baby' is a phrase that many women hear over and over again after experiencing trauma in childbirth; it often seems that as soon as negative words are spoken, this is the mantra used to pacify dissent to the medical model of birth. "At least" are words meant to minimize what came before, namely the experience itself. The 'healthy baby' is the prize at the end of the medicalized journey that was somehow, along the way, destroyed by her own physical shortcomings. In the end, her body didn't work as it was meant to, but she was lucky that there were so many health-care professionals willing to step up and save her and her baby from herself. What is possible,

however, is that many of the crises that appear along the way are, in fact, not crises at all, and if there had not been such vigilant monitoring, or such an intense distrust of the birth process itself, the mother may have been the victor in the end, not the obstetrician. 'At least' may not be good enough after all. Oakley (1980) sums up the need for a more complex understanding of the lived experience of childbirth: "Women evaluate the success of their childbirths in a more holistic way than the medical frame of reference allows" (27). In other words, the end goal of obstetrics is a healthy baby; for women the end goal is more complex; the experience matters.

The purpose of this thesis paper is to deconstruct these experiences by examining closely the embedded notion of childbirth as a pathological event in need of 'management,' to investigate how much technology used in the typical birth experience is 'necessary,' and, finally, to illustrate a possible link between the medicalization of childbirth and resulting trauma. First, in Chapter 2, I will review existing literature concerning interventionist childbirth, and present the two theoretical perspectives that together inform this analysis. In Chapter 3, I will provide a methodological framework for a critical deconstruction/discourse analysis of the medicalization of birth, which is informed by social constructionism and Foucauldian social theory. Chapter 4 presents an examination of risks and rewards as they present themselves in the biomedical paradigm of childbirth, and addresses the question of why the 'Manufactured Crises' of technocratic birth explored in Chapter 5 are so prevalent. Chapter 6 demonstrates that the shift from the social to the medical model of birth has not been without consequence; birth trauma is not an individual phenomenon, but the result of the social construction of childbirth as a risky endeavour that often ends in failure.

## Chapter 2. Literature Review

There has been a modest amount of research employed in the area of women's experience of childbirth, in the form of both historic narratives and reports of satisfaction and outcome of modern maternity care. For example, Oakley (1980) focused much of her writing on the intersection of childbirth as both a biological and a cultural act, situating maternity care as a microcosmic reflection of power and control in society. According to Lowis and McCaffery (2004), in order to understand the current paradigm, we "must see our own culture of childbirth in historical and cross cultural terms, and this can occur only if we have sufficient knowledge of a different birthing system, namely the traditional system" (5). The authors employ a comparative method that attempts to illustrate the evolution of childbirth from the social model, which was "family and community centered" to the technocratic model, which is very different (5). The traditional system allowed women to have control over the process of their birth, while, at the same time, benefitting from the supportive presence of a midwife and women in the community (Lowis and McCaffery 2004, Davis-Floyd 1993). While traditionally childbirth was primarily a social act, a celebratory rite of passage attended by women, in the modern era it has been enveloped by a medical model, or what Davis-Floyd (1993) refers to as a 'technocratic' model of birth. The Western, technocratic/medical model of birth is radically different, and, as stated by Lowis and McCaffery (2004), "tends to be viewed as a clinical phenomenon, governed by biological laws, and virtually unaffected by social processes and events" (6). Mansfield (2008) adds that "The medical model stems from a dualistic and technocratic worldview in which progress is defined as the triumph of civilized society over primitive, feminine nature" (1085). This gendered description of the dichotomy between natural and technocratic birth is important; it is not argued that childbirth has moved into the domain of the masculine. Cahill

(2001) traces medicalization of childbirth to the 17th century introduction of privileged medical professionals who used their social capital to gain power and label 'laypeople' as dangerous and uninformed sources of care. This shift, including the exclusion of women from professional roles, was instrumental in institutionalizing gender roles.

Based on a collection of over seventy women's narratives, Akrich and Pasveer (2004) found that women's experiences of labour were often offered up and mediated by other people, and the perception of the physiological process of birth actively constructed an antagonistic relationship between the woman and her uterus. The researchers, in the interest of learning about "the constitution of women's relationships with their bodies during childbirth" (66), use the example of a woman who experienced what she appeared to intuitively know as labour contractions. During the time that she experienced cramping, there were several external processes that mediated her perception of her (non)labouring self, including her sister, other women, her husband, and ultimately, her midwife. All had different perceptions of her experience, and only when cervical dilation was verified by her midwife, did the woman mark her birth process as having officially begun (Akrich and Pasveer 2004). The authors reveal a pattern of necessary 'qualification' of bodily sensations, "which become the subject of a collective conversation" (66). This 'conversation,' undermines women's experience of labour, contextualizing the process as one that happens only under the legitimation of others.

Several researchers have pointed out that women's contractions are measured with straps and monitors, and when they do not 'perform' as expected, they are often subject to synthetic labour augmentation, an intervention that often comes at a high cost (Oakley 1980; Davis-Floyd 1993; Akrich and Pasveer 2004; Crossley 2007; Kitzinger 2012). According to Oakley (1980), patriarchal social discourse on childbirth has done women an incredible disservice; she states,

"through its ideological construction of the uterus as the controlling organ of womanhood, it effectively demoted reproduction as woman's unique achievement to the status of a pitiable handicap" (12). This situates women as baby-making machines, not human beings, separate and at a disservice by virtue of their reproductive capacity.

Berger and Luckmann (1966) lay the foundation for a sociological analysis of childbirth as a social construction that has been subject to profound transformation over several centuries. The question of how women give birth at this particular point in history cannot be answered with reference to notions of objective reality. That is, all discourse surrounding childbirth, including its inherent risk, has evolved over time and led us to the current paradigm of birth. According to Berger and Luckmann (1966:70), "Social order is a human product… is not biologically given or derived from any biological data in its empirical manifestations." Following Berger and Luckmann (1966), we come to understand that the social reality of how childbirth is performed in a particular culture is a by-product of conventions and habitualization; built on a foundation of compromise to, and acceptance of, social norms. The institution of childbirth; the hospital, represents an objective reality that is structured and maintained by its own existence. Emerson (1970) takes this social constructionist conception and applies it to the precarious situation of the gynecological exam; an event that is commonplace in modern birthing practice. The woman who attends as visitor to routinized medical care is initiated into this act by medical personnel, who normalize not only the act of the gynecological exam, but also normalize it against contradictory realities that it finds itself up against. Under any other circumstances, the physical act of inserting one's fingers into a woman's vagina would be in the context of either consensual or non-consensual intimacy (Emerson, 1970). The gynecological exam is what it is because it

has been constructed as such; it is not sexual because it is not *reported* to be. The experience is socially constructed as a medical necessity.

Foucault's (1977) concepts of power and knowledge lend themselves well to the examination of power relations embedded in the social construction of childbirth. Women, who are in possession of legal power, often submit to the disciplinary power of the institution (hospital) because there are serious repercussions for refusing to comply with expectations of doctors. Women who are noncompliant are infused with fear that they are putting their lives and the lives of their infants in danger (Fahy 2002). Thomson and Downe (2008) cite Agudelo's (1992) discourse surrounding power structures in health-care settings: "Agudelo [31] postulates that a pre-condition for violence and abuse is an imbalance between heterogeneous entities – the greater the inequality, the greater the potential for violence. An imbalance in power between women and their caregivers was evident during a traumatic birth" (271). In keeping with Foucault's conception of disciplinary power, the participants in Agudelo's (1992) research reported a sense of authoritative ownership of their bodies by those 'in charge.' Women described feeling the need to 'go with the flow' in order to avoid being blamed for making decisions that they did not have the knowledge or jurisdiction to make (Agudelo 1992).

Foucault's (1977) view of panopticism is also a relevant concept in the discursive construction of childbirth, adding the concept of surveillance to the discussion of control and governance in maternity care (Fahy 2002). The internalization of gender roles eluded to in Foucault's (1977) work is explored further by Martin (2003), who questions the socially constructed image of the labouring woman commonly seen on television; the woman who is 'acting up,' in her full power, non-compliant with gender roles, offering an alternative. Women

are not only subject to internalized concepts of gender, but also of pressure from outside sources, disseminated through childbirth classes, books and other social discourse (Martin, 2003).

In addition, Parson's (1951) classic formulation of the sick role and how pregnancy and birth fit in with societal expectations of normal, healthy bodies reminds that pregnancy and childbirth are both biological and cultural experiences. One is forced to question, how does the 'sick role' apply to the antepartum period when pregnancy is actually a variation of a normal physical state? Martin (2003) argues that her experiences of women in childbirth clash with both Parson's (1951) classic conception of the sick role, and with the feminist argument that because birthing women are not 'ill,' they are exempt from it. According to the author, "During birth, normal gendered social obligations were the very things that these women felt compelled to fulfill and that disciplined women and their bodies during childbirth" (2003:58). Women in Martin's (2003) research did not fit the classic conception of the birthing mother as demanding and irrational; instead most mothers were timid and submissive. Martin (2003) argues:

> internalized technologies of gender serve to make birth more difficult for women and often cause them not to ask for what they need while giving birth and/or not to put themselves at the center of the birth experience, something many feminists argue is essential for control over the experience and empowerment from it (59).

The current biomedical framework that most women are giving birth inside of renders women powerless in their birth experiences; the embedded nature of gender roles create a dichotomy between what women want for themselves in their experiences, and what is within the realm of possibility for most women (Martin 2003).

Furthermore, Goffman's (1961) four elements of his formulation of the 'total institution,' though originally designed to describe life inside of a mental institution, are relevant to the social construction of birth in hospital. The following excerpt illustrates certain parallels:

> First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a pre-arranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution (6).

These elements are reflected in many elements of the 'introduction' to medicalized birth. Women are 'tagged' with bracelets upon entering the hospital, stripped of their belongings, denied food and water, and expected to comply with 'authority.' (Oakley 1980, Davis-Floyd 1993). The bracelets are meant to match baby with mother; both of whom are 'numbers.' There is no 'special treatment;' hospitals have protocol established to ensure seamless entry and exit, provided there is proper compliance (ibid). The 'stripping of self' is part of what Goffman (1961) described as a process of mortification that is standard in many institutions; anything that once separated one woman from another is removed, and a stigmatized status is conferred (1961). According to Goffman (1961), this process involves a broad spectrum of rituals that allow for institutions to broaden their scope of control over patients. This often includes the obvious removal of any roles or identities held previous to entering the institution by way of reducing individuals to compilations of data kept in files, allowing little privacy even in situations that may require modesty for personal comfort, and placing restrictions on activities that would normally be considered benign in the outside world, such as pouring oneself a glass of juice, or wearing 'outside' slippers (1961). While comparing hospital birth with Goffman's (1961) conception of the 'total institution' may seem radical, Goodman (2013) reminds the reader that "although the total institution was manifest (often literally) in concrete form, its social processes are not" (81). Therefore, although Goffman's (1961) concept brings to mind the looming asylum, or prison walls, social processes of institutionalization are much more complex than material

reality. Goodman (2013) reiterates: "demolishing the concrete does not necessarily demolish the social; the totalising process may simply transfer to new concrete settings" (81). Goffman's (1961) conceptions allow the reader a critical view of medical institutions that aim for total control of individuals once they are initiated into the medicalized birthing process.

In line with Goffman's (1961) description of the unrestricted power of institutions, it is not hard to imagine that once authority over women in birth had been established, there was no turning back. There was, with the decline of midwifery and the advent and pervasive implementation of sophisticated interventions such as electronic fetal monitoring, routine episiotomy, caesarean section, and increased use of painkillers in childbirth, a perception of loss of agency and control on the part of mothers. Kitzinger (2006), for example, describes this as a type of institutionalized violence. According to recent research, the shift toward routine intervention and obstetric management of childbirth may represent a movement away from what women are desiring, and ultimately benefiting from, in their birth experiences (Oakley 1980; Davis-Floyd 1993; Akrich and Pasveer 2004; Crossley 2007; Kitzinger 2012). The issue of risk and 'blame culture' is explored at length by Scamella and Aleszewski (2012), who examine and verify the limited control that women have over their birth experiences. According to these authors, rigorous management of birth even by midwives, creates an atmosphere of blame toward mothers, while high-intervention birth shifts blame onto both medical personnel and the birthing woman (Scamella and Aleszewski 2012).

One possible explanation for hyper-vigilance in maternity care is the pervasive discourse of risk that has infiltrated medical journals. Skolbekken (1995) attributes this phenomenon to "a set of paradoxes" (291), or, more simply, the difference between perceptions of risk and reality that become matters of professional discourse disseminated through medical journals. An

example of one such paradox is that of medical technology, which is more sophisticated and accessible than ever before, and the concurrent focus on medical malpractice. According to Skolbekken, despite "increased use of monitoring devices, introduction of risk management, systematic surveillance of perioperative complications and development of medical device simulators" (291), there is little evidence to back up the efficacy of these measures (1995). In other words, there is no statistical evidence to support the claim that there is a cost-benefit relationship between panoptic medical surveillance of medical patients and decreased risk of harm (Skolbekken 1995). However, one glaring illustration of the power of medical discourse is in the realm of maternity care and obstetrics. According to Skolbekken, "With regard to what is seen as a safe practice in perinatal care, U.S.A has adopted a 'worst case-strategy' (all patients treated as high risk) whist the Netherlands are at the opposite end of the risk pendulum, with midwife-assisted home-births as the rule" (1995:291-292). Interestingly, the Netherlands, despite having much lower rates of intervention in childbirth, also have lower infant mortality rates, with 4 infant deaths per 1000, compared to the U.S.A's rate of 7 per 1000 (van Teijlingen, Wrede, Benoit, Sandall and Devries (2009).

Førde (1998) critiques the culture of epidemiology, stating that the quest for risk reduction has failed to incorporate "political and cultural consequences" (1998:1155). Instead, Scamella and Alaszewski's (2012) 'risk society' has been constructed, leading to fear of things that were once considered harmless. According to Førde, although data utilized by epidemiologists often increase an inflated sense of dis-ease and risk, the relentless pursuit of risk-reduction has created a public discourse of risk that differs greatly from reality (1998). The author states: "Increased risk awareness not only changes the way people think about health, disease and death. More profoundly, and more seriously, it ultimately changes human values,

self-identity and our perspective on life" (1998:1157). The social construction of risk culture, not surprisingly, has had profound implications for birthing women.

Malacrida and Boulton (2013) discuss concepts of risk in childbirth, examining expectations and realities of birth experiences in order to understand if childbirth 'decisions' really are decisions, and how they may be constructed by domination of medical and consumer interests. According to these researchers, women's expectations of childbirth differ greatly from their actual experiences; both plans for natural or interventive birth ultimately had little effect on outcomes. In reality, the birthing woman had little control over any aspect of her birth; in other words, she is far from being 'in the driver's seat' (Malacrida and Boulton 2013). Several authors refer to the concept of the 'birth plan' with most finding that it is frequently ineffective in creating positive birth outcomes (England 1998; Kitzinger 2006; Crossley 2007 and Lundgren et al. 2012). Though they offer what appears to be a wider range of choices in childbirth, their lack of efficacy is not well understood. Maher (2008) explores the timelines that women are subjected to in hospital settings, finding that everything is structured on the clock. Adhering too strictly to notions of time in the childbirth process is anxiety-producing and often leads to what I will describe as 'manufactured crises.' Freestanding birth clinics appear to offer women an option that leads to more positive psychosocial experiences of birth than do obstetric units (Overgaard, Fenger-Grøn and Sandall (2012), but as Jackson, Dahlen and Schmied (2011) point out, many times options are limited. This lack of choice and agency can exacerbate anxiety when women are forced to birth in high-interventionist settings.

Nilsson and Lundgren (2007), found that women's fear of childbirth, though often diagnosed as post-traumatic stress disorder, cannot be unexpected - it is a normal reaction to the treatment of labour and childbirth as a pathological event. This fear, however, has been found to

be exacerbated in women who have a predisposition to depression, who have experienced previous trauma (especially in childbirth), and who experience births with high levels of intervention (Beck 2004a, 2004b, 2006, Zimmerman 2013). Kitzinger (2006), Zimmerman (2010) and Beck (2004a) emphasize the subjectivity of trauma in childbirth, noting that the woman's experience seems to fade into the background once the infant is born, and she is left alone, furthering her experience of vulnerability. She is often left, quite literally, open, and exposed. The same author found, in her studies of women who had experienced difficult births, that there were five concurrent themes of post-birth PTSD, perhaps the most highly emphasized being a lack of acknowledgment and even overt denial of their experience. Not surprisingly, when experiences were left unshared, women's emotional health declined, often to the point of almost complete social isolation and profound depression (Beck 2004a; Beck 2004b; Beck 2006; Zimmerman 2013). The concept of 'birth rape' has been explored in an informal manner, but has yet to make its way into academic sociological discourse. The similarities between sexual assault and birth rape are, explored in this paper, as is discussion regarding the necessity of routine vaginal exams in labour (World Health Organization 2013, Zimmerman, 2010). There is a very modest amount of literature devoted to the experience of trauma in childbirth as it relates to increased technology.

There are however, even fewer studies concerning what constitutes a positive birthing experience. This resonates with the pathogen-focused mindset of most research surrounding health; Antonovsky's (1979) salutogenic orientation is what he described early on in his research as "the conceptual neologism of salutogenesis – the origins of health" (13). Antonovsky (1996) offers an alternative to the pathogenic orientation, which views the body and its systems as intrinsically deficient or flawed. When birth is contextualized under a pathogenic model, there is

little thought given to the default state of health of most pregnant women. Melender (2006) described five types of experience in the maternity system that women described, in hindsight, as having been affirming or positive. They were described as: an "unhurried atmosphere" (333), lack of complications, a short labour, a feeling of safety, and a sense of control, especially over pain. In short, women who had support and agency in labour reported more positive birth outcomes. Perception of control in childbirth is defined and explored by Namey and Lyerly (2010), who expand on the findings of Melender (2006). Half of the participants in their study stated that there is no such thing as 'control in childbirth', while others identified similar adjectives to Melender's (2006), including "self-determination, respect, personal security, attachment, and knowledge." Patient-centered care in birth has become a recent focus of the health-care system in an attempt to integrate women's needs with an ever-evolving increase of medicalization of childbirth (Overgaard et al. 2012). According to Dahlen, Jackson and Stevens (2010), restrictive maternity care options push women turn to alternatives, such as freebirth, homebirth, and the use of doulas, who serve as emotional support persons and labour advocates.

The World Health Organization's Reproductive Health Library (2013) provides information that supports the understanding of increased prevalence of interventionist birth, but disrupts the notion that technocratic birth is either necessary or progressive. While it is understood that interventions are sometimes necessary, information provided by the World Health Organization presents an empirical opportunity to explore who is benefiting from interventions, and at what cost. While infant and maternal mortality rates have significantly decreased since the advent of certain technological advances, women's lived experience of childbirth seems to have suffered significantly (Scamella and Aleszewski 2012). The Reproductive Health Library (World Health Organization 2013) provides a plethora of materials

that can be utilized to critically examine empirical data, keeping in mind that many medical journals claim knowledge of the birth experience strictly from a medical/biological understanding of wellness.

## Chapter 3. Methods

Methods employed in this thesis involve a critical deconstruction/discourse analysis of the medicalization of childbirth, influenced by social constructionism and Foucauldian social theory. While both Foucauldian and social constructionist discourse analysis (DA) are informed by social constructionist theory to some degree, the work of Foucault focuses specifically on power relations (Stevenson 2004). Social constructionism has a wider scope of application, representing notions of embodiment and materialism in addition to addressing issues of power (Stevenson 2004). This thesis is informed mainly by social constructionist DA, utilizing Foucault as a theoretical rather than methodological framework. Willig (1999) provides the reader with a definition: "Discourse analysis is concerned with the ways in which language constructs objects, subjects and experiences, including subjectivity and a sense of self. Discourse analysts conceptualise language as constitutive of experience rather than representational or reflective" (as cited by Stevenson 2004:18). Stevenson (2004) stresses the relationship between discourse and power in the field of medicine. According to the author, "the discursive practices around being a health professional include the conduct of assessments that position the professional as 'expert inquirer'. In contrast, the discursive practices of the patient include reporting symptoms and seeking help from the expert" (Stevenson 2004:21). This directly relates to the event of childbirth, keeping in mind that notions of embodiment and materialism inherent in social constructionist discourse analysis cannot be discarded in favour of Foucauldian DA. Instead, it makes sense to utilize an 'embodied discourse analysis' that allows for positioning the body as "capable of communication outwit and independent of language. The body literally displays ways of being in the world and as such is the embodiment of lived experience" (ibid: 21-22). Because, according to Foucault, the body is socially constructed and only knowable through its "cultural significations" (40), social constructionist discourse analysis that embraces

phenomenology (the study of consciousness or being in the world) is more appropriate when dealing with the lived experience of the body (Stevenson 2004; Nilsson and Lundgren 2007).

Berger and Luckmann (1966) explain well the implications of the socialization process, which is not separate from the body itself; the authors state: "Habitualization and institutionalization in themselves limit the flexibility of human actions" (134), creating and perpetuating reified institutions, such as marriage, as well as specific roles that individuals are expected to play (Berger and Luckmann, 1966). "The paradigmatic formula for this kind of reification is the statement 'I have no choice in the matter, I have to act this way because of my position'" (108). Because reification is the default state of humanity, de-reification of the current paradigm of childbirth is a complex analytical process of deconstructing social reality in order to allow room for critical analysis of the institution of childbirth, as well as the emotional consequences of childbirth rituals of the type that Emerson (1970) described in her description of the gynecological exam (Berger and Luckmann 1996).

Sociological concepts of human reproduction have long been dominated by male hegemony; particularly with reference to concepts of health, the male body is exalted, seen as ordinary, natural, traditional (Annandale and Clark 1996). Women's bodies, on the other hand, are problematized as irrational – "deficient, associated with illness, with lack of control, and with intuitive rather than reasoned action" (19). The female body has been constructed by pathological discourses of abnormality and dysfunction; individual truths that are seen to be fixed in nature are "discursive categories created through the use of binary logic" (Annandale and Clark 1996:21). This technocratic model of reality infiltrates everything; it gives birth to a patriarchal, technological, scientific paradigm that, ultimately, constructs women's bodies as inferior to men's in every way (Davis-Floyd 1993). According to the same author, "Insofar as it

deviated from the male standard, the female body was regarded as abnormal, inherently defective, and dangerously under the influence of nature… due to its unpredictability and its occasional monstrosities" (Davis-Floyd 1993:300). Foucauldian DA illuminates this concept, explaining that"women's bodies are only knowable through the discourses that constitute them" (Annandale and Clark 1996:20). This is a central methodological warrant for the application of discourse analysis to the critical deconstruction of the technocratic birth model.

Deconstructing these discourses requires a process of destabilizing and subverting 'knowledge' of gender, which is also socially constructed, and unconcerned with facts or biology (Annandale and Clark 1996). According to Reynolds, "The deconstructive strategy is to unmask these too-sedimented ways of thinking, and it operates on them especially through two steps—reversing dichotomies and attempting to corrupt the dichotomies themselves" (The Internet Encyclopedia of Philosophy n.d. para 3). Part of the deconstructionist analysis presented here includes a deliberate focus on qualitative research. The quantification of risk statistically, and, in general, the scientification of the female body obscures or actively negates other forms of knowledge of the process of childbirth. However, some statistical information provides balance and additional support to the qualitative analysis, primarily to demonstrate the phenomena of 'manufactured crises.'

To understand that "Social order exists only as a human activity" (Berger and Luckmann 1966:70) is to understand that many of the rituals that take place in technocratic birth are constructed and reconstructed as normal and natural because there is a vested interest in maintaining particular realities, especially in relation to power and governance. Again, this objective reality is a consequence of institutions that create patterns of experiences (Berger and Luckmann, 1966). The authors clarify the usefulness of this process of habitualization: "In terms

of the meanings bestowed by man upon his activity, habitualization makes it unnecessary for each situation to be defined anew, step by step. A large variety of situations may be subsumed under its predefinitions" (sic, ibid: 71). Interventions in childbirth are not often questioned; women defer to the authority of the institution of medicine and to their own subjugation.

In regards to an analysis of birth trauma, it is paramount to include qualitative data in the investigation of the perception of harm. Harris and Ayers (2012) found that research regarding post-partum post-traumatic stress disorder generally fit into one of two separate categories. The first area of research typically implemented quantitative methodologies such as questionnaires that examined specific factors associated with the development of symptoms connected with PTSD. The authors state, "This research broadly finds that postpartum PTSD is related to prepartum factors such as a history of psychiatric problems, previous trauma and antenatal anxiety/fear of childbirth, primiparity and intrapartum factors such as intrapartum dissociation and assisted or emergency caesarean deliveries" (Harris and Ayers 2012:1167). While quantitative studies associate specific intrapartum interventions with trauma, qualitative studies show that there are inconsistencies in exactly what interventions women report as traumatic. Harris and Ayers (2012) explain that the reason for this may be found in studies that take into consideration variables such as "level of support or interpersonal difficulties" (1167) that are often present in qualitative research. In short, "the obstetric severity of birth events alone does not determine whether women develop PTSD" (Harris and Ayers 2012:1167). In other words, statistics tell one story, a story that becomes more nuanced with the introduction of qualitative methods such as phenomenological studies, in-depth interviews, narrative storytelling, and discourse analysis.

Fox (1997) states that, according to Foucault, discursive practices are "embedded in technical processes, in institutions, in patterns for general behaviour, in forms for transmission and diffusion, and in pedagogical forms which, at once, impose and maintain them" (1977: 200:36). Women suffering from birth trauma, especially those who felt that giving birth was "to lose oneself as a woman into loneliness" (Nilsson and Lundgren 2007:4), find themselves in a position where they are expected to put the trauma behind them – especially if, in the end, they have a healthy baby. Silence is not only expected, but enforced through a series of appeasements. Because the 'ordinary bad birth' is normalized both through everyday language and medical discourse, suffering has become part of the institution of early motherhood. I wish to challenge the 'ordinary' presence of suffering and silence by establishing, through social constructionist discourse analysis, that women's experiences are manufactured through a systematic process of conditioning.

## Chapter 4. Risk and Reward

For the past fifty or so years, obstetric medicine has been instrumental in constructing both public and institutional discourse surrounding pregnancy and childbirth (Cahill 2001). Pylypa 1998) states that, according to Foucault, "the medical profession historically gained considerable power to define reality through the control of privileged and respected scientific knowledge" (30). This authoritative 'knowledge,' plays an important part in the construction of power in the childbirth arena. Midwives, once the chosen caregiver for the vast majority of women in the prenatal period, have declined considerably both in numbers and in social power, a by-product of the fact that resources were centralized into centralized technologies "dedicated to the pathology of childbirth" (334). The social model of birth has been successfully replaced by a medical model, as witnessed by the fact that at the turn of the new millennium, 97-99% of infants were born in hospital (Wright 2009). This shift has culminated in an almost complete envelopment of childbirth by experts trained in physiologically anomalous birth experiences, some say to the loss of recognition of childbirth as an endeavour that was once successfully navigated by women themselves, in spaces of other women whose knowledge may have been identified more as wisdom. According to Cahill (2001), "medical frames of reference and knowledge have been legitimated within a system that has brought about not only a surge in engineering obstetrics but a steady erosion of maternal choice, control and satisfaction in relation to many aspects of pregnancy and labour" (335). This movement towards medicalization of childbirth is occurring despite little empirical evidence to support its superiority over the social model (Oakley 1980), as witnessed by rates of intervention that are much higher than are recommended by the World Health Organization. The World Health Organization is a governing body that describes some of its crucial mechanisms as "shaping the research agenda and stimulating the generation,

translation and dissemination of valuable knowledge" and "articulating ethical and evidence-based policy options" (World Health Organization 2013). The World Health Organization, which is as powerful a voice for the institution of biomedicine as any, is not only critical of the amount of intervention used in medicalized childbirth, but clearly states that unnecessarily high intervention rates have serious negative medical implications. The failure to implement recommendations made by the World Health Organization is concerning and may be linked closely to a firmly-established social construction of risk and the technological imperative to manage even low-risk births.

Cahill (2001) argues that despite growing recognition of the necessity of placing midwives back in control of uncomplicated births, the obstetrician continues to be cast in the leading role of saviour for the large percentage of women whose pregnancies or births fit into an ever-expanding list of high-risk categories. While the midwife seems to be a viable option for women who are wanting to birth at home, discourse surrounding childbirth has officially stripped her of her competence as a primary health-care professional. This leaves many women who are considered 'low risk' without the option of giving birth without an obstetrician or general practitioner (Cahill 2001). Midwifery, particularly in the United States and Canada, has lost its occupational prestige; for the most part, midwives (especially those who do not operate under the medical model, or who are not officially regulated), are no longer seen as capable of 'handling' even the least complicated births (Lowis and McCaffery 2004). What if something unforeseen happens that falls outside of her medical capability? The perpetuation of this risk, consciously and effectively, helps to establish every birth as a potential catastrophe, despite overwhelming evidence that suggests otherwise. Cahill explains "Whilst the definition of 'complicated' or 'high-risk' remains hugely subjective, importantly the decision to label individuals as such

remains solely in the hands of this influential professional group" (2001:335). In other words, because public and medical discourse constructs the view of birth as risky and dangerous, women are often left without the option of choosing a midwife or primary caregiver who has not been trained in the pathology of the perinatal period. It is no surprise that sociology, as a discipline, has been complacent in its (largely absent) discourse regarding reproduction and childbirth (Oakley 1980).

However, when examined from a social constructionist framework, it is clear that from birth, human beings are assigned roles that are imposed by many different forces, embodied in culture and environment. Berger and Luckmann, (1966) describe the inevitable momentum of these forces that shape us from the time we are born:

> the developing human being not only interrelates with a particular natural environment, but with a specific cultural and social order, which is mediated to him by the significant others who have charge of him. Not only is the survival of the human infant dependent upon certain social arrangements, the direction of his organismic development is socially determined (sic, 66).

According to Berger and Luckmann (1966), this is the first of the two-step process of socialization. Interestingly, childbirth holds a unique place in that it encompasses both the primary and secondary processes; at the time that the introduction to primary socialization begins for the infant, the secondary process is amplified for the birthing woman. She is socialized into motherhood beginning with the experience of her birth, which, for many women, involves mandatory compliance with the technocratic model. The institution replaces intuition. This is witnessed in Fahy's (2002) conception of power relations during childbirth; women who are 'noncompliant' are often punished, shamed, and manipulated into believing that they are putting themselves and their infants in harm's way if they do not do as they are told, even if it feels wrong; this is well illustrated in Emerson's demonstration of the paradox of the gynecological

exam (1970), explored on a theoretical level here, and later in this paper, as it relates to birth trauma and sexual abuse.

Cahill (2001) questions the inherent belief in the need for 'maintenance' of the female body, stating: "the development of a specific medical speciality for dealing with women's reproductive functions (i.e. gynaecology) and its association with obstetrics serves to further reinforce the pathological nature of pregnancy and illustrates the controlling influence of medicine over women's lives" (335). She adds that there is no relevant counterpart for managing male productivity. The gynecological exam is an example of a precarious situation that, according to Emerson (1970), requires a more complex analysis of secondary socialization, defined by Berger and Luckmann (1966) as "any subsequent process that inducts an already socialized individual into new sectors of the objective world of his society (150). Most medical care, according to Emerson (1970) requires some sort of "reality maintenance" (76), but the gynecological exam, common in most births, requires greater maintenance than others for a variety of reasons. There is an exaggerated urgency to the construction of this particular act because it involves the touching of a woman's genitals, an act that under any other circumstance would denote either a sense of sexual intimacy or possible abuse (Emerson 1970). Because the patient represents only a small fraction of the many hours spent enacting the same ritual day after day, medical professionals have been very successful in creating the very specific reality of the gynecological exam (ibid). The physician guides the patient through the procedure, controlling the narrative as it happens, "keeping the patient in line, defining the situation by his reaction" (77-78). The role that the obstetrician plays in the complex induction of the individual into a particular process of secondary socialization is very important for the preservation of power and control (Emerson 1970).

Emerson's (1970) social constructionist analysis of the gynecological exam is useful in the illustration of power relations in the social construction of childbirth arenas a medical event. Why do women succumb so easily to something that feels so counterintuitive? According to Foucault (1977), knowledge plays a large part; obstetricians are powerful by virtue of their ability to provide women with information that comes from somewhere other than their own felt experience. Foucault (1977) maintains that there is no way to separate this power from embodiment of knowledge; power and knowledge are interwoven in such a way that they cannot be divorced from one another. There are, however, distinct types of power. The two that Foucault focused on primarily were legal power and disciplinary power (Fahy, 2002). According to Fahy (2002), because it is women, not medical professionals, who possess most legal power in the birthing arena, there is an attempt at leveling that occurs in the struggle for control over the experience. Legal power, with its openness, does not seek the invisibility of Foucault's concept of disciplinary power. Foucault's insistence that disciplinary power was largely invisible until made visible by this struggle is re-enacted in many birthing narratives. These concepts can usefully be applied to power operations in childbirth (Fahy, 2002). The goal of the hospital is to gain complete and utter submission in the neonatal experience. Fahy (2002) explains that, "When disciplinary medical power is used the purpose is to coerce patients to do what the doctor wants" (5). This is usually in response to push-back from women who are resistant to relinquishing power in their birth experience. As Fahy explains the Foucauldian perspective, "disciplinary power requires the co-operation of the subject" (2002:6). Disciplinary power, when freely given, provides an illusion of control that is important to maintain in institutions with a vested interest in protecting their interests. Its fragility, however, is often only witnessed once challenged (Fahy 2002).

Foucault's (1977) conception of panopticism is also applicable in the case of medicalized childbirth. The 'gaze' of the panopticon, where there is constant surveillance, is so effective that the end goal of self-regulation, of no longer even having to appoint a 'watcher,' is nearly always realized. Docility is reinforced because individuals are fearful of reprisal, and "subjects generally behave in ways that their observers desire" (Fahy 2002:7). During the childbirth experience, women are rewarded for being submissive and compliant, and emotional consequences are high. According to Fahy (2002), "the promises that medicine offers are 'life', 'health' and 'pain relief', while the punishments are fears of 'pain,' 'death' or ' 'disability'" (8). Compliance with the medical system of childbirth is meant to guarantee both a pain-free experience and a healthy baby. These in exchange for complete resignation of agency and control (ibid). Often, a doctor's felt response to loss of power is to "counter with an escalation of disciplinary power" (12) by manipulating the birthing woman into believing that her own or her baby's health is in danger. According to Thomson and Downe (2008), the women who participated in their study demonstrated that trauma occurred "in the imbalance of power between the victim and the abusing authoritative others; and in the inducement of passivity, helplessness and dependency through rituals and procedures" (270). When there is no legal power for doctors to exercise over women, they will often resort to disciplinary power in order to control the woman and her birth (Fahy 2002). When women choose noncompliance, "punishments can include being treated rudely, being neglected, and/or being threatened with death or bodily damage of self or baby" (Fahy 2002:12).

Parsons (1951) conceptualized the 'sick role,' as a role that excused individuals from social contracts and obligations because of their inability to perform certain tasks. Martin (2003) points out that though pregnant women are not ill and therefore should not be included in

Parsons' (1951) formulation of the sick role, they are placed in this role by virtue of medical management and hospitalization - pregnancy and birth are viewed as illnesses. Martin (2003) argues that there may be differences between the way that men and women perform the sick role and that "femininity looks more like the sick role than the (masculine) social role that Parsons used to conceptualize it" (59). Again, we witness how masculine hegemony dominates in the social construction of what is and is not considered 'normal.' The experience of childbirth is often seen as objective – schedules, timelines and clocks ticking in a perfectly framed understanding of what ought to be, or, on the flip-side, what was not and should have been. And yet, childbirth takes many different forms and the technology involved varies widely in women's experience (Akrich and Pasveer 2004). According to Martin (2003), "Internalized technologies of gender are those aspects of the gender system that are in us, that become us" (56). No matter how arbitrary categories of gender seem, they are a large aspect of our socially constructed selves, and those categories are carried into the birth experience, for better or worse (Martin 2003). Martin states, "In particular, these identities are important to any understanding of birth, as it is a gendered event through which the self is often altered or transformed" (2003:57). If gender is something that is 'performed,' in order to enable placement of individuals into categories of sex, it makes sense that there is something else compelling women to perform gender through an obviously gendered experience such as childbirth (Martin 2003). Under a Foucauldian (1979) theoretical framework, technologies of power not only shape understanding of reality, context, and identity in the world, but we carry those meanings with us in our everyday experiences, with women carrying these gendered conceptions of "self" into the arena of maternity care (Martin, 2003).

Martin (2003) states that though writers such as Fishman (1978) and Gilligan (1982, 1992) situate women as constructed producers of gentility and sacrifice, willing to work hard to make others happy at the expense of their own well-being, these are arguments that perpetuate gender essentialism. Instead, Martin (2003) contends that these conceptions are "internalized technologies of gender that discipline us from the inside out" (57). That is, technologies that manufacture the self, continuously through all types of experiences. According to Martin (2003), "Foucault's (1979) notion of technologies of the self allows us a sharper understanding of these gendered ways of being by showing us how they discipline and control from the inside, how they compel us to act in gendered ways from within" (57). The author maintains the importance of examining gender as an internalized process, especially in relation to 'performing' birth, but adds that there are external influences that are also at play. Women are almost never seen as being 'in charge' of the birthing process. These roles are almost exclusively played by men, and the more powerful the part, the more likely the actor is male (Martin 2003). Interestingly, one of the ways that the concept of 'respect' was categorized by women in Maher's (2010) study as a type of stringent self-control exhibited in labour. She describes how women who did not yell and scream felt that they had maintained their self-respect and dignity in the presence of those around them. These roles are both internally and externally imposed. There was also a sense that women were proud of their ability to maintain mental control; playing the role of the subordinate female of which Martin (2003) speaks. According to Berger and Luckmann (1966), "The institution posits that actions of type X will be performed by actors of type X" (72). This ensures the patterned execution of dominance inside of controlled spaces. In Foucault's terms, some are afforded the privilege of knowledge and subsequent commentary, while others are dehumanized and made subordinate (1973).

Following this Foucauldian perspective, Martin (2003) and Akrich and Pasveer (2004) discuss the importance of the 'gaze' of the other in women's experience and memory of childbirth. Martin (2003) explores the sensation of disembodiment in labour that exists in many birth narratives. According to the author, many women rely on others who were present at their births, especially partners, to piece together their birth stories (2003). According to Martin (2003), "Nearly all said talking with their husbands helped them to remember what the birth was like, and in recounting their birth stories, many women told the interviewer what their husbands or partners said happened" (64). Many women report feelings of having 'missed' their birth, because birth is constructed as a physiological process that they are not physically able to witness by virtue of birthing position (Martin 2003; Akrich and Pasveer 2004). Akrich and Pasveer (2004) describe the process of embodiment in labour as being one that is often mediated by enabling the birthing woman to witness her birth in a mirror, as they sometimes do when women give birth vaginally in hospital maternity wards; before this time, women often feel completely separate from their birth experiences. The authors state, "A new form of duality is thus defined: the woman is in and out of her body, both actor and spectator" (Akrich and Pasveer 2004: 76). Though this duality is an unwelcome feeling for some women, according to Martin (2003), when denied the use of a mirror, many women felt as though they had to construct the events of their birth to compensate for a lack of "authoritative knowledge" (64), a type of insight enjoyed by partners who are present at the birth of their babies. Martin (2003) explains the irony that, "Culturally, birth has become more real for those with this outsider gaze than those with the lived bodily experience of it" (64). In response to this sensation of estrangement, Martin (2003) found that that women craved experiences and possessions that would help them to construct first-hand accounts of their reality such as photographs and video, which served this purpose

well, but are often forbidden in medical settings for legal reasons. However, those women who were afforded the experience to witness their births, no matter how difficult, seemed to benefit from the ability to construct their own narrative (ibid). According to Akrich and Pasveer (2004), there is danger in the reality that many women do not directly 'witness' their births. They argue, "this body is constituted through extremely varied mediations, among which obstetrical expertise plays a significant role" (66). Unfortunately, when childbirth narratives are constructed by medical personnel, they tend to situate the female body as deficient and responsible for unwanted or unnecessary interference.

The discursive construction of labour and childbirth as a risky, precarious endeavour validates the necessity of intervention by health care professionals in what used to be considered a natural event. Oakley's (1980) Transition to Motherhood study provides strong evidence toward public discourse of the precarious nature of pregnancy and the impending danger of childbirth. In a study of 55 women, "100 per cent took drugs of some sort in pregnancy, 100 per cent had blood and urine tests, 68 per cent were given

**Figure 1. Medical vs. Social/Midwifery Model of Care**

| Medical model | Social / midwifery model |
|---|---|
| ❖ Doctor centred | ❖ Woman/patient centred |
| ❖ Objective | ❖ Subjective |
| ❖ Male | ❖ Female |
| ❖ Body-mind dualism | ❖ Holistic |
| ❖ Pregnancy: only normal in retrospect | ❖ Birth: normal physiological process |
| ❖ Risk selection is not possible | ❖ Risk selection is possible |
| ❖ Statistical/biological approach | ❖ Individual/psycho-social approach |
| ❖ Biomedical focus | ❖ Psycho-social focus |
| ❖ Medical knowledge is exclusionary | ❖ Knowledge is not exclusionary |
| ❖ Intervention | ❖ Observation |
| ❖ Public | ❖ Private |
| ❖ Outcome: aims at live, healthy mother and baby. | ❖ Outcome: aims at live, healthy mother, baby and satisfaction of individual needs of mother/couple. |

Medical vs. Social Model of Childbirth. van Teijlingen, Edwin. 2005. Sociological Research Online, Volume 10(2).

ultrasound, 19 per cent X-rays and 30 per cent other tests; the average number of visits was thirteen" (20). According to van Teijlingen (2005), this rampant medicalization of childbirth is not surprising, as we witness the shift from a social model to a medical model. As reported by van Teijlingen (2005), the reasons for public perception for the necessity of medical management of childbirth is entangled both with fear for the safety of mother and child, as well as "the link between parenthood and social identity" (para 6). As illustrated in Figure 1, although both paradigms share the aim of a healthy baby and a healthy mother, there is one important difference; under the social model, the concept of health encompasses more than just mortality and physical wellness. The outcome includes a more holistic interpretation of health. This encompasses the subjective term 'satisfaction,' which leaves room for a multi-layered interpretation of the birth experience (van Teijlingen, 2005). The author cites Comaroff (1977), who states:

> Pregnancy in western society, in fact, straddles the boundary between illness and health: the status 'pregnant' is unclear in this regard and women perceive that others are not sure whether to treat them as ill or well. Most medical specialities dealing with the physical aspect of the human body do not give rise to the same fundamental controversy, since the 'pure' illness character of their field is more straight forward, hence more generally recognised, which in turn legitimates medical intervention and control (van Teijlingen 2005, para 6).

Therefore, van Teijlingen (2005) posits that what is under examination is actually risk. Looking at Figure 1, it is clear that the medical model is concerned primarily with potential risk, while the social model views childbirth as a natural event that does not signify illness or the need to be 'managed' (van Teijlingen 2005). The natural model operates on the principle that the vast majority of women have the ability to give birth safely and naturally. Statistics gathered and disseminated under this school of thought indicate that around 97% of women require no interventions in their birth experiences, and if these interventions were not available, would give

birth without incident to healthy infants requiring no medical attention (Oakley, 1980). Mansfield (2008) argues "medicine replaces risky natural processes with technological practices that are better because they introduce human control into the birth process" (1085). The medical model of birth sees every birth as a risky venture; requiring vigorous attention to signs of possible pathology (van Teijlingen 2005). This attention attempts to ensure that, at the end of the 'event' of childbirth, there is a healthy baby – the badge of the obstetrician (Davis-Floyd 1993: 301). For many obstetricians, pregnancy is a case of 'sick until proven well'; the proof, of course, knowable only after birth. According to van Teijlingen (2005), "schools of thought are more than just abstract and academic; they are associated with concrete and practical ways of doing things" (4.2). In other words, the 'ordinary' act of birth has been transformed into an 'extraordinary' act of interference.

Interference in childbirth has often been linked to its inherent risk. 'Risk' is a concept that is often used to analyze childbirth discourse, and for good reason. There is no argument that, historically speaking, birth posed a much larger risk to mother and child before the advent of sanitation and other basics of health care. While there is an idealistic push toward natural childbirth, the reality of contemporary childbirth is anything but natural and herein lies a paradox (Scamella and Alaszewski 2012). Although childbirth has proven over time that it is safe, the construction of childbirth as dangerous and impossible without the help of technological intervention is very real and this reality informs everyday maternity care – it has created "an apparent relentless expansion of 'the birth machine'" (Scamella and Alaszewski 2012: 207). However, the discourse that surrounds and perpetuates this 'birth machine' assumes that we can measure quality of the childbirth experience solely in terms of physical risk. However, what happened at the same time that birth was becoming 'safer,' was that something was lost in

exchange; mainly agency and choice (Scamella and Alaszewski 2012). Risks can be quantified, measured; numbers can be assigned to every woman's experience. It makes no sense to quantify birth narratives. The concept of birth-risk is explored further by van Teijlingen (2005) who explains, 'Birthing women are thus objects upon whom certain procedures must be done". (Rothman 1982:84); "This practice is based on a science-oriented perspective, whereby risk is defined as statistical risk, and whereby solutions and improvements are based on measurements of outcome through mortality and morbidity statistics. Pregnant women are labelled as high risk on the basis of statistical, rather than individual considerations" (van Teijlingen 2005, 7.1). The concept of 'high risk until proven otherwise' has not been substantiated as 'worth it' in either economic terms, or emotional and physical outcomes (Skolbekken 1995). In other words, the experience of childbirth cannot be measured solely in quantitative terms (Oakley 1980, Kitzinger 1993).

According to Scamella and Alaszewski, we live in a culture of blame - for every negative experience, blame lies with someone or something (2012). As a result, "Birthing is no longer a purely 'natural' process in which the outcomes are the product of chance and adverse outcomes are unpreventable 'accidents'. It is increasingly viewed as 'man-made', and therefore adverse outcomes cannot be accidental… but must be the fault of those who made the decisions" (Scamella and Alaszewski 2012:209). Even when childbirth happens within the social/midwifery model outlined by van Teijlingen (2005), women are consistently monitored for possible risks. For example, blood pressure is checked routinely, fetal heart tones are auscultated, urine is checked for protein, and the uterus is palpated to ensure that the fetus is presenting as he/she should be in preparation for labour (Scamella and Alaszewski 2012). Prenatal checkups are a process of searching for the absence of 'normal.' Vigilance and focus on physical well-being are

hallmarks of both the medical and social models of childbirth. No matter how many times women are reassured that their births will likely be uneventful, cautious surveillance speaks otherwise (ibid). According to Scamella and Alaszewski (2012), the pervasiveness of the medical model is not difficult to measure: "the categorisation of birth as high risk should be rare and exceptional. However, as we noted above, in practice the majority of births in England take place within a high risk birthing facility regardless of the risk status attributed to the pregnancy" (209). If women are birthing in hospitals under the hyper-vigilant gaze of medical personnel, the message conveyed is that their bodies are defective, and ultimately to blame if something goes wrong. There is strong evidence, however, that suggests that many childbirth interventions are not the fault of birthing women; they are manufactured crises.

## Chapter 4. Manufactured Crises

According to Davis-Floyd (1993), birth is a rite of passage that, when replaced by the obstetric paradigm, was reconstructed by the replacement of rituals by others, namely technology. The author argues that "Despite its pretenses to scientific rigor, the Western medical system is less grounded in science than in its wider cultural context; like all health care systems, it embodies the biases and beliefs of the society that created it" (2001). Davis-Floyd (1993) describes how "Such a template can only mold reality to fit its conceptual contours when these contours are specifically and consistently delineated and enacted through ritual" (297). Medically managed births are in themselves socially constructed rituals that have deeper implications than we seem to understand. Because birth rituals that are normalized (such as caesarean section, fetal monitoring, and episiotomy) are used so widely and without reflection, they have established themselves within the ordinary woman's birth consciousness through repetition. Berger and Luckmann's (1966) description of the process of institutionalization helps to understand this phenomenon: "Institutionalization occurs whenever there is a reciprocal typification of habitualized actions by types of actors. Put differently, any such typification is an institution" (72). Individuals form and reinforce the institution by honouring rules and norms created by the society; rules are reinforced by actors in authoritative positions. According to Berger and Luckmann's (1966) conception, the institution of childbirth is not challenged because it is what people know. Often, only when one sees the institution from the outside is it questioned, otherwise it is embedded as objective reality (Berger and Luckmann, 1966). According to the authors, "Men together produce a human environment, with the totality of its sociocultural and psychological formations" (sic, ibid: 69). Berger and Luckmann (1966) stress that this is not a

process that occurs over a short period of time and, as such, we understand that the current paradigm of birth has become institutionalized by process of habituation. According to Davis-Floyd (1993), the path away from woman-centered birth was an alarming descent into medicalization: "our exaggerated dependence on technology and our accompanying fear of natural processes has led to the 're-ritualization' of birth under the technocratic model in a manner more elaborate than anything heretofore known in the cultural world" (298). It has to be this way; it is integral to the process of ongoing habituation that Berger and Luckmann (1966) describe.

It is believed by some critics of the technocratic model of birth that midwifery is subjugated under the obstetric paradigm because of subjugation of women themselves (Oakley 1980). As stated by Lowis and McCaffery (2003), "Eighteenth century medical men – who themselves had nothing medically sound to offer women in labour – were quick to contemptuously dismiss the herbal remedies, potions and charms employed by midwives" (27), despite the fact that Western medicine often did more harm than good. Furthermore, according to Oakley (1980), "In Britain in the eighteenth and early nineteenth centuries many of the male midwives' innovations were often fatal for both mother and child" (11). A good example is the introduction of forceps, which, when introduced, were used infrequently and when they were used, actually increased the likelihood of infant death. Forceps are still used relatively frequently in childbirth despite the fact that they continue to carry physical risk for both infant and mother, as well as emotional trauma for the birthing woman (Irion and Boulvain 1998; Zimmerman 2013).

Midwifery was officially usurped by obstetrics in the 1920's when women began to gain some social freedom. It was not an accident that the two realities coincided with one another.

Before this there was a narrative being written about who women were – their inherent defectiveness; their helplessness (Oakley 1980). There is a discrepancy between discourse around childbirth (placation), on one hand telling women that pregnancy is normal and natural and on the other hand encapsulating that 'normal' only within a medical context (ibid 1980). Their bodies can only be contextualized in terms that the layperson, or birthing woman would not understand; education provides a further separation from information – this renders women powerless (ibid 1980). Procedures that objectify the body, to ensure that someone is there to convince the women that she is, indeed, in labour, and that she can, indeed, give birth to the baby. Foucault states that the knowledge afforded to the medical professional, knowledge that is kept from the woman herself, is inseparable from notions of power (1973). It is the women herself who offers herself up to the medical profession; who surrenders her body, her baby, to the professional. There are rituals enacted upon the body; enemas inserted, monitors snapped into place. She is doing what they want her to do (Akrich and Pasveer 2004). Foucault (1973) asks the question, "How can the free gaze that medicine, and, through it, the government, must turn upon the citizens be equipped and competent without being embroiled in the esotericism of knowledge and the rigidity of social privilege?" (45). The answer is partially embedded in the notion of the clinical or medical 'gaze.' With Enlightenment came the belief that the physician held almost magical powers; he was able to see beyond what others could, by virtue of time spent observing the actions of those who were ill, or confined to the medical bed (Foucault, 1973). Assumed to be high risk, everyday births are handled as such; subjected to interventions once reserved for high risk births. The consequence is that where these births are treated as unsafe, potential disasters, they are much more likely to manifest as dangerous, life-threatening experiences (Kitzinger 2012).

If there is a body-as-machine (299) metaphor for the body that is operationalized in medical settings, that machine is male (Davis-Floyd 1993). In several studies, there is an analogy implemented by participants that situate the body as something that is completely out of the realm of their control from the moment they enter the hospital (Davis-Floyd 1993; Wolf 2001; Malacrida and Boulton 2014). Davis-Floyd (1993) calls this process 'assembly-line birth.' The hospital is a factory, the baby is the final product, and if there is a woman involved, she exists somewhere in the background, in the abstract. She is secondary, passive; barely a participant in the manufacturing of her own child. According to Davis-Floyd (1993), "a woman's reproductive tract is treated like a birthing machine by skilled technicians working under semi-flexible timetables to meet production and quality control demands" (300). This reduction of women to birthing technologies in the background is encapsulated by Beck's (2004a) account of women's experience of the moments directly after birth. Beck describes how women felt "If the baby was born alive with good Apgar scores, that was what mattered to the labor and delivery staff and even to the mother's family and friends" (34). A healthy baby meant that the hospital and thus configured medical technologies had functioned properly. There is a personal investment of the outcome for those involved; it marked "the achievement of clinical efficiency and of professional and fiscal goals" (34). Wolf (2001), as cited by Crossley (2007), uses the metaphor of conveyor belt to describe her own experience with hospital maternity care. Women are placed on this conveyor belt upon admission to the hospital, and subjected to a host of routine, often unnecessary interventions that are active obstacles in the progress of labour (Wolf 2001). Not only must women produce a healthy baby, but the process often takes far too long for most health care professionals. In Malacrida and Boulton's (2014) research, women described

their experience in much the same way as Davis-Floyd (1993) and Wolf (2001), instead using the metaphor of a passenger train that, once moving, was impossible to exit.

Whatever the description, most women felt out of control, or invisible in the birthing process (Davis Floyd 1993; Wolf 2001; Crossley 2007; Malacrida and Boulton 2014). Accordingly, Davis-Floyd (1993) describes maternity care as an example of Goffman's (1961) total institution. Oakley also points out that Goffman's (1961) concept of the total institution fits well the experience of many women birthing in hospital in that there is a process of infantilization embedded in many procedures that are routine in maternity wards. Women are frequently subjected to domination by staff, universal rules and routines, and pressured into unnecessary and sometimes harmful interventions (Oakley, 1980). Until very recently, women were subjected to routine shaving of the vulva, as well as enema administration in order to clean out the rectal canal, symbols of enforcement of a further separation between mother and infant, who may become 'contaminated' by the body that he is, literally, attached to (Davis-Floyd 1993). She is immobilized by the belts of electronic fetal monitoring, and routinely checked for anything that would verify the seemingly relentless suspicion that something may go terribly wrong at any moment. She is hooked up to an IV, just in case. Davis-Floyd (1993) states, "Symbolically speaking, the IV constitutes her umbilical cord to the hospital, signifying her now-total dependence on the institution for her life, telling her not that she gives life, but rather that the institution does" (302). This is further illustrated by the routine act of whisking away the infant from the mother either immediately after birth, or after a short introduction; he is often placed out of eyesight of his mother, in a plastic basinet (ibid). The baby does not ultimately belong to his parents, but to the medical professionals who intercepted before inevitable catastrophe. Davis-Floyd (1993) describes this succinctly: "in this way, society demonstrates

conceptual ownership of its product. The mother's womb is replaced not by her arms, but by the plastic womb of culture" (301).

Medical discourse is that childbirth is risky and there is a need for intense medical management of birth; it saves lives. The more control the medical profession has over birth, the better the outcomes (Malacrida and Boulton 2014). However, according to Malacrida and Boulton, there are hazards associated with interventions, particularly with caesarean section:

> Risks to the mother include pulmonary and circulatory problems, post-partum infections, evisceration and long-term risks associated with uterine scarring and weakening; risks to the child include surgical injuries and prematurity and poor lung development if fetal age calculations are inaccurate (2014: 43).

It is important to understand that these are physiological risks, far from encompassing the entirety of a woman's experience. It has been widely recognized that the amount of intervention used in childbirth does present physical risks to both mother and infant. For instance, Table 2 indicates that the total caesarean rate for the United States increased considerably from 1989-2011, while VBAC (Vaginal birth after caesarean section rates) declined even more considerably. This is telling of the normalization of surgical delivery. The World Health Organization (2012) recommends that the caesarean rate not rise above 10-15%, but in 2011, according to the U.S National Center for Health Statistics (2012), the caesarean rate was around 33% nationwide. Malacrida and Boulton (2014) explain:

> In 1970, in Canada, the United States and Australia, the CSR was approximately 6 per cent (Cherniak and Fisher, 2008). In the intervening years, this rate has increased over fourfold: in Canada, in 2005, the CSR was 26.3 per cent (Canadian Institute for Health Information (CIHI), 2009); in the United States, in 2004, it was 29.1 per cent (Martin et al., 2006) and in 2007, in Australia, it was 28.5 per cent (Cherniak and Fisher, 2008).

Obviously, these statistics show a marked increase in surgical delivery in all three countries that were studied. How can this be when the risks of caesarean are becoming well-known? Some

authors trace the movement toward surgical birth as being closely connected to time-management and what is often referred to as 'drive-thru' delivery (Oakley 1980; Davis-Floyd 1993). Because childbirth is subject to the tables of 'normal' phases of labour, there is room at every stage for intervention due to deviance from appropriate timing. Almost every health promotion poster or online source follows the same guidelines for what constitutes a 'normal' course of labour.

The first stage of labour is the stage when women are encouraged to rest; contractions are usually mild, and the cervix dilates to 3 centimeters (American Pregnancy Association 2014). According to the APA, the first stage of labour should last between 8 and 12 hours. The second, or active stage of labour is expected to last no more than 5 hours (APA 2014); this is the stage when women are strongly encouraged to attend the hospital, because they are assumed to be in need of medical management. According to England, an experienced midwife, author, activist and academic, pain relief is often encouraged while fetal monitoring is often insisted upon (1998). It is during this stage that labour is most likely to 'stall out,' a term usually meant to describe CPD, or Cephalo-Pelvic Disproportion (England, 1998), meaning that the baby's head is too large to fit through the pelvis. England (1998) points out that "CPD is the common explanation given to many mothers whose labours fail to progress and end in birth by Cesarean" (p. 135). The diagnosis is often made prematurely, according to England (1998). The author explains, "CPD is often incorrectly diagnosed, when other causes actually arrest labour progress (such as contractions that weren't strong enough, inactivity, lying down during labor, or not having allowed enough time for the mother's cervix to dilate before making the diagnosis)" (135). The World Health Organization (2013) addresses the issue of induction of labour due to suspected fetal macrosomia, or a fetus that is 'large for dates,' stating that though large babies,

defined as those who weigh more than 9 lbs. 9 oz. at birth, can be difficult to birth, induction of labour for suspected macrosomia carries its own risks (Boulvain 1998). According to the authors, unnecessary induction of labour can lead to premature delivery, difficult birth, or, ultimately, caesarean (1998). Artificial induction of labour is not as exact a science as it is purported to be. However, if labour is judged to be 'stalled' or 'slow,' synthetic augmentation is likely. The third stage of labour, often called 'transition,' is the stage that marks cervical dilation from 8-10 centimeters (APA 2014). This represents, in most hospital settings, the 'panic' juncture. In most hospital births, there is strong outside pressure, especially by health-care professionals and support people, to push hard and well in order to get the baby out as quickly as possible (Oakley, 1980). If this stage takes longer than it is believed it should, often an episiotomy is often cut in order to prevent tearing (England, 1998). Figure 2 depicts data collected by a teaching hospital in Nigeria (Ojiyi et al. 2012).

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**Figure 2. Frequency of Episiotomy**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| EPISIOTOMY | 89 | 71.2% |
| PERINEAL TEAR | 5 | 4.0% |
| INTACT PERINEUM | 31 | 24.8% |
| **TOTAL** | **125** | **100** |

Ojiyi et al. 2012. The Internet Journal of Gynecology and Obstetrics. Volume 16(1).

out,' a term usually meant to describe CPD, or Cephalo-Pelvic Disproportion (England, 1998), meaning that the baby's head is too large to fit through the pelvis. England (1998) points out that "CPD is the common explanation given to many mothers whose labours fail to progress and end in birth by Cesarean" (p. 135). The diagnosis is often made prematurely, according to England (1998). The author explains, "CPD is often incorrectly diagnosed, when other causes actually arrest labour progress (such as contractions that weren't strong enough, inactivity, lying down during labor, or not having allowed enough time for the mother's cervix to dilate before making the diagnosis)" (135). The World Health Organization (2013) addresses the issue of induction of labour due to suspected fetal macrosomia, or a fetus that is 'large for dates,' stating that though large babies, defined as those who weigh more than 9 lbs. 9 oz. at birth, can be difficult to birth, induction of labour for suspected macrosomia carries its own risks. Though it may make sense to induce labour to intercept weight gain in a fetus who is already expected to be at risk for cephalo-pelvic disproportion, the World Health Organization is quick to point out that ultrasound is far from an exact science; not every fetus who is judged 'large for dates' actually is (Irion and Boulvain 1998). According to the authors, unnecessary induction of labour can lead to premature delivery, difficult birth, or, ultimately, caesarean (1998). Artificial induction of labour is not as exact a science as it is purported to be. For example, Kitzinger (2006) states, "The US Listening to Mothers survey of 2002 revealed that 44 per cent of women experienced attempts at induction, but these were successful only one third of the time" (38). However, if labour is judged to be 'stalled' or 'slow,' synthetic augmentation is likely. The third stage of labour, often called 'transition,' is the stage that marks cervical dilation from 8-10 centimeters (APA 2014). This represents, in most hospital settings, the 'panic' juncture. In most hospital births, there is strong outside pressure, especially by health-care professionals and support people, to push hard

and well in order to get the baby out as quickly as possible (Oakley, 1980). If this stage takes longer than it is believed it should, often an episiotomy is often cut in order to prevent tearing (England, 1998). Figure 2 depicts data collected by a teaching hospital in Nigeria (Ojiyi et al. 2012).

The World Health Organization (2013) discourages the use of episiotomy, stating: "Limiting the use of episiotomy to strict indications has a number of benefits: less posterior perineal trauma, less need for suturing and fewer complications. Episiotomy does not lead to reduction in most pain measures and severe vaginal or perineal trauma" (Liljestrand 2013: para 1). However, in North America, episiotomy rates remain high. According to the National Partnership for Women & Families, episiotomy rates vary largely according to place of birth; midwives had lower rates, obstetricians had the highest of all primary caregivers, averaging out to be around 35% in the United States, well above the recommended parameters (2002). According to Davis-Floyd (1993), "Estimates of episiotomy rates in first-time mothers (primagravidas) range from 50-90 percent; large teaching hospitals often have primagravida rates above 90 percent. Multi-gravida rates are estimated at 25-30 percent. In contrast, in the Netherlands episiotomies are performed in only 8 percent of births" (303). Some researchers speculate than high rates of episiotomy are primarily due to impatience on the part of the medical attendant, as well as fear of substantial tearing (Oakley 1980, Davis-Floyd 1993, Akrich and Pasveer 2004, Kitzinger 2006, Kitzinger 2012).

Everyday discourse around labour and birth reflect the biomedical preoccupation with timing; one of the first questions asked by family and friends in the post-partum period is how long labour lasted. Time is placed in a medical context that can be potentially harmful to women (Maher 2008). Contractions can last too long, or can be too short; time between them can also be

too long or too short. Linear phases of labour correlate to specific templates of how time in labour is to be spent. According to the medical model, differing from specific time parameters in any significant way can lead to serious consequences (Maher 2008).

Because of this, England (1998) warns against using "labor math" (242), and stresses the importance of viewing every labour as a separate physical, emotional, and spiritual event that cannot be assessed only in terms of cervical dilation. There are, for when it is important, other ways of assessing 'labour progress,' including, most importantly, observation of the women giving birth. At various stages of labour there are signs of progression of labour, especially at the point between transition and the time when the cervix is fully dilated (England, 1998). In other words, it is important for those who attend to women in childbirth to know that paying attention to subtle cues in behaviour plays an important part in avoiding unnecessary interventions.

Alternatively, some categorize the stages of labour differently; the first stage being at the onset of cervical dilation to full 10 centimeters, the second stage characterized by a fully dilated cervix, urge to push and birth of the infant. During the third stage, the placenta is delivered, and in hospital births, this is when the infant is usually hurried away while any damage done by the doctor is repaired; episiotomy or caesarean incisions are stitched, and the panic recedes (Maher 2008). Regardless of how the different ways the stages of labour are fashioned, the expectations of the body are the same throughout; labour is expected to proceed as a linear process that fits neatly into a timeline (Maher 2008). Unfortunately, there are many iatrogenic issues with labour 'progression' in contemporary maternity care, one of the largest being the prevalent use of the lithotomy position. Figure 3 illustrates the effect of contemporary birthing discourse on women's knowledge of birthing positions. Even in the developing country under study, women

had an almost complete absence of knowledge of what would normally be seen as 'instinctive' birthing positions (Okonta 2012). The lithotomy, or supine position, being the dominant position in medicalized childbirth, was known by 99.2% of participants in the study, while only 22.4% of women in the study demonstrated knowledge of any alternative birthing positions (Okonta 2012).

Accordingly, the World Health Organization (2013) expresses concern over the use of the lithotomy position as the dominant birthing position for women whose mobility is not encumbered by epidural anesthesia. The lithotomy position is defined by Oxford Dictionary as "A supine position of the body with the legs separated, flexed, and supported in raised stirrups, originally used for lithotomy and later also for childbirth" (2014). The World Health Organization strongly recommends that alternative birthing positions be available to use if a woman chooses, stating that "giving birth in upright or lateral position was associated with reduced duration of second stage of labour, small reduction in assisted deliveries, reduction in episiotomies… reduced reporting of severe pain during the second stage of labour and fewer abnormal fetal heart rate patterns" (Lavender and Mlay: para 2). England (1998) provides a possible reason for the difficulty that women encounter when attempting to give birth in this position; squatting actually

**Figure 3. Knowledge of Birthing Positions**

| | Birthing position | Number of women aware of the position for birthing (n=392) |
|---|---|---|
| 1 | Supine (lying on her back) | 389 (99.2%) |
| 2. | Squatting | 42 (10.7%) |
| 3. | Sitting | 28 (7.1%) |
| 4. | Kneeling on hands and knees | 18 (4.6%) |

Okonta, P. Birthing Positions. 2012. Awareness and Preferences of Pregnant Women in a Developing Country. The Internet Journal of Gynecology and Obstetrics: 16(1).

opens the dimensions of the pelvic outlet an astounding 28 degrees in comparison with the lithotomy position. According to Pam England (1998), upright positions allow the baby's head to apply even pressure to the cervix, allowing it to open more easily. "Most mothers find this position more painful and feel they are pushing their baby uphill!" (England 1998:140). Figure 3 demonstrates the reality of the birthing process for most women under the care of a doctor or other health-care professional with a vested interest in maintaining control over the 'delivery.' For example, in many hospitals, women are tethered to electronic fetal monitors in the first stage of labour, which limits their movement considerably. Every small deviation from back-lying and stillness can potentially 'upset' or displace the monitor and cause panic. In the second stage of labour, women are usually placed in the lithotomy position with little choice; while some hospitals have a birthing bar available for use, doctors tend to prefer women to birth on their backs because the position naturally makes the process easier to control. Davis-Floyd (1993) states:

> In childbirth, one of the most graphic demonstrations of the power of "doctor's choice" is the lithotomy position so popular with doctors not because it is physiologically sound, but because it enables them to attend births standing up, with a clear field for maneuvering. We know very well that this position complicates childbirth, but the many good physiological reasons to allow women to give birth in upright positions (which include increased blood and oxygen supply to the baby, more effective pushing, and wider pelvic outlets) are far less important to most physicians than their own comfort, convenience, and status. In the West, "up" is good and "down is bad": the person who is "on top" has the status and the power, and rarely gives it up for the good of the laboring woman and child (4).

England (1998) underscores this point, arguing that it was only until the late 18th century that women were no longer encouraged to give birth according to how they saw fit. There are several historical accounts of why this particular birthing position became the norm. Whether it was introduced by Mauriceau, the queen's childbirth attendant, who found it necessary to have full

access to the vagina in case there was need of the aid of forceps, or France's King Louis XIV, who is said to have persuaded the local physician to have women lie on their backs to give birth while he stood behind a curtain, using the display for his own sexual enjoyment, the lithotomy position quickly became the norm (England, 1998). The position was later aided by the invention of stirrups that hold the birthing woman's feet in place, allowing for full view of the vagina and perianal area (ibid). For many academics, the story stops here, but for women who experience the powerlessness of birthing under the technocratic model, there is damage that is not often spoken about. Behind all of the statistics, recommendations, and constructions of risk, there are mothers leaving hospitals every day, suffering in silence.

## Chapter 4. Birth Trauma

Trauma has been socially constructed as normal in the biotechnical ritualization of childbirth; women have babies, they become traumatized. Their bodies betray them, are full of mysteries that have not yet been solved; they have 'ordinary bad births.' These experiences are not understood as "human reactions to human events," (113), but as issues that are situated inside of an inevitable, gendered tragedy that silently holds its place in the lives of women (Oakley 1980). Berger and Luckmann (1966) term such processes as the "reification of human reality" (106). Reification is a term used to illustrate the ways in which humans are divorced from their own participation in the creation of social realities. In this case, to look at birth as anything other than a socially constructed entity "implies that man is capable of forgetting his authorship of the human world" (*sic*,106). It is this movement toward objectivity that creates a sense of hopelessness that what has been done can be undone; "the objectivated world loses its comprehensibility as a human enterprise and becomes fixated as a non-human, non-humanizable, inert facticity" (Berger and Luckmann 1966: 106). Berger and Luckmann's theoretical framework (1966) helps us understand that the evolution of childbirth as a risky process is positioned as a natural and inevitable process.. Though Berger and Luckmann (1966) do not refer directly to childbirth, this is a theory that is productively applied to the positioning of birth as a social reality, one that is produced over and over again, because "man is capable paradoxically of producing a reality that denies him" (sic, 107). The reification of roles in the biotechnical birthing apparatus restricts the subjectivity of all involved, through the process of habitualization.

In contemporary social discourse there is a great disservice done to women when depression and trauma are gendered and divorced from the bodies that are experiencing them.

Understanding emotional phenomena as part of the human condition rather than part of the female condition is an important step in the movement toward equality (Oakley 1980). Trauma resulting from contemporary medicalized childbirth is not surprising in its frequency, as traumatic suffering is often exacerbated by feelings of powerlessness and vulnerability. This vulnerability is ever-present due to the life-changing, formative nature of giving birth (Oakley 1980). Not surprisingly, in Oakley's (1980) study of self-reported 'birth outcome,' the two results most strongly correlated with results of 'medium' or 'poor' feelings for the baby were the gender and temperament of the infant herself, and the amount of technology used in the birthing process. These findings were especially evident when women provided descriptions of their childbirth experiences. Other factors, such as job loss and the overwhelming duties of motherhood were also significant influences in the development of mother-infant bonding (Oakley 1980). While the 'baby blues' is a well-known phenomenon, many women do not link negative childbirth experiences with symptoms of trauma in the post-partum (Kitzinger 2006).

Accordingly, postpartum post-traumatic stress disorder (PTSD) is frequently misdiagnosed as depression, because the emotional pain often presents in a similar fashion. However, Zimmerman (2013) makes it clear that feelings of low mood, or depressive symptoms, only scratch the surface of what is often going on in cases of childbirth-related PTSD. The researcher found that, similar to women suffering from postpartum depression, traumatized women experienced high levels of self-reported suicidality, physical pain, and difficulty bonding with mother-child bonding (Zimmerman 2013). However, these issues were intensified by experiences of a myriad of other trauma-related symptoms, including extreme fatigue, inertia, and pain specific to the childbirth experience, such as at the site of a caesarean incision. In the case of vaginal birth it is not uncommon for women to experience painful sex or numbness at her

episiotomy site (ibid). In addition, women who reported trauma in childbirth were much more likely to disclose feelings of anger directed both toward the self and toward her partner, possibly for not protecting her, as well as fear of getting pregnant again, sometimes leading to hyper-vigilant sexual behaviour and concern about birth control (ibid).

In 1980, the DSM III introduced post-traumatic stress disorder as a psychological affliction mainly affecting veterans who, upon returning from war, suffered panic, feelings of terror, flashbacks, and invasive thoughts (Beck 2004b). Later, the DSM IV identified PTSD as an experience that was not confined to soldiers, but anyone who experienced something that involved "actual or threatened death or serious injury, or a threat to the physical integrity of self and others" (Beck 2004b: 216; Oakley 1980). It is important to understand that previous trauma and depression can create a predisposition to the experience of PTSD after childbirth. For instance, Zimmerman (2013) found that women with a history of trauma and/or depression had a 16.3 % chance of developing post-birth post-traumatic stress disorder. Traumatic birth incidents, such as those outlined in Beck's (2004a) figure, are strong enough stressors to fit this criteria.

Many of these interventions are extremely common, while others, such as infant death, are less common. In a Swedish study it was found that 55% of women who had experienced an emergency caesarean section "reported experiencing intense fear of death or injury to themselves or to their baby during the delivery process, which fulfilled the stressor criterion of DSM IV" (Beck 2004a: 29). Common emotions were terror of losing their baby, and anger toward healthcare professionals who they perceived had harmed them during their childbirth experience. Harris and Ayers (2012) identify peritraumatic 'hot spots,' or "moments of extreme distress during traumatising events that are implicated in symptoms of PTSD" (1166), in this case occurring in the perinatal period. Hotspots are defined as "specific parts of the trauma memory

that cause highest levels of emotional distress" (1166), and it is these hotspots that often cause symptoms such as flashbacks and intrusive recollection of the traumatic event. The hotspots identified in Harris and Ayers (2012) research were sorted into three separate categories, including those described as 'interpersonal,' 'events concerning the baby,' and 'obstetric events and pain.' (1170). Reported trauma associations were fairly evenly distributed throughout the three groups, with the highest number of respondents from the sample (n = 453) reporting hotspots that fell under the 'interpersonal' category, followed very closely by experiences of obstetric events and pain (Harris and Ayers 2012). Hotspots defined within the interpersonal section, by level of reported frequency, included feelings of being ignored, a lack of support, poor communication, being abandoned, and being put under pressure (Harris and Ayers 2012:1170). According to the authors, "In this sample, interpersonal difficulties during birth were the strongest predictor of PTSD, with over four times increased risk, as well as being associated with anger and conflict" (ibid: 1173). Additionally, 98 women who reported hotspots in the 'obstetrics and pain' category (n = 163), associated the hotspot with obstetric events, not physical pain (Harris and Ayers 2012). This disrupts the common media portrayal and subsequent public perception that pain in labour is the most traumatic part of childbirth. Instead, labour is a complex event that involves a wide range of emotions and other processes that can cause significant and long-lasting psychological implications (ibid).

Although thought to be highly underreported, Beck states that the frequency of diagnosed PTSD after childbirth ranges from an estimated 1.5% to 6% (2004a:216; Creedy et al. 2000; Harris and Ayers 2012; Thomson and Downe 2008). However, even in cases where there was no formal diagnosis of PTSD, the author found that a large percentage – between 34% and 55% of women characterized their births as traumatic (Beck, 2006). Harris and Ayers (2012) place this

number at between 20-48%. Many of these women go misdiagnosed or undiagnosed because they are afraid to get help, or because they experience a common feeling of relief that their birth has already happened; it is in the past and does not need to be revisited (Kitzinger, 2006). According to Kitzinger (2006), "They may even be euphoric and thank the obstetrician who, they are told, rescued the baby from disaster. But after a few weeks or months this is followed by inner turmoil, with flashbacks, nightmares and panic attacks" (2). This is a symptom of internalized misogyny; most women enter their prenatal period having been socialized to believe that their bodies are incapable of performing the act of birth. The things that could go wrong are endless; one only has to consult the back of popular pregnancy books to learn about the fallibility of the female body. Going back to Wolf's (2001) description of the 'ordinary bad birth' that comes up over and over again in conversation with women when they describe their birth experiences, there follows an understanding that though extremely common, birth interventions are far from innocuous. This, according to Foucault, is paradoxical. Pylypa (1998) describes the double edged sword of resistance, beginning with the understanding that the concept that 'controlling' one's body serves to objectify it, divorcing it further from the self:

> Arguments for women's rights to 'control' and 'ownership' of their bodies therefore encourage the idea of the female body and its 'products' (children) as property or commodities- separate objects subject to the laws of ownership. But property is alienable and ownership can be regulated by the state. Thus, resistance to obstetrical practices which calls for a recognition of a woman's right to control over her body reinforces the objectification of the body that makes possible external regulation and control. In Foucault's terms, resistance is power disguised (33).

According to studies conducted by Beck (2006), traumatic childbirth is not easily forgotten, with some of her interviewees suffering symptoms well into their child's teenage years. Elmir, Schmied, Wilkes and Jackson (2010) cite Creedy et al. (2000), who report concerning results from an Australian study that demonstrated that "one in three women continue to experience

trauma symptoms 4-6 weeks after a traumatic birth" (2143). Kitzinger (2006) citing research conducted by Simkin (1992), concurs, stating that there does not appear to be significant memory loss, even when memory of the event is measured years after birth. Often on the anniversaries of traumatic events, individuals with post-traumatic stress disorder experience a high level of anxiety and despair. This, Beck (2006) reminds us, is also true in the case of birth trauma.

In fact, when comparing narratives regarding intrapartum trauma to a wider review of literature regarding trauma, women's stories were found to be similar to those of individuals who were victims of abuse or violent crime (Thomson and Downe 2008:270) Accordingly, any women have described their birth experiences as being "comparable to rape" (Kitzinger 2012:304). Beck (2006: 381) explains that, "In the words of one mother, "Every birthday is no longer the celebration of the child but is really an anniversary for the rape. Rape day. My son was conceived from love and born out of rape". Thomson and Downe (2008) employed an interpretive, phenomenological approach to study women who had sought help for trouble coping with traumatic birth. The researchers state, "Women used powerful and highly evocative words such as 'barbaric', 'intrusive', 'horrific' and 'degrading' to describe their traumatic birth" (Thomson and Downe 2008:271). There appear to be predictive factors for women susceptible to experiencing birth in the context of sexual violation, the biggest one being a history of previous sexual victimization. Sheila Kitzinger (2006) states that the rate of sexual abuse of girl children has been estimated to be as high as 55%, and sexual abuse can have profound implications for birthing women. According to Zimmerman (2013), "For some women who have been victims of sexual abuse, vaginal exams, nakedness in the presence of others, a perceived or actual lack of control in the situation, and pelvic pain are all potentially traumatic events" (p. 62). There is nothing to be gained by pathologizing women who have been sexually

**Figure 4. Commonalities between Sexual Assault and Birth Rape**

| SEXUAL ASSAULT | BIRTH RAPE |
|---|---|
| Power and control are all or nearly entirely in the hands of perpetrator/s | Power and control are all or nearly entirely in the hands of perpetrator/s |
| Victim, at times, immobilized by drug | Victim at times immobilized by epidural |
| Victim takes on blame, shame, disgust with self | Victim takes on blame, shame, disgust with self |
| Social stigma against discussing | Social stigma against discussing |
| Fear provides leverage for perpetrator | Fear provides leverage for perpetrator |
| Penetration of victim is by body part of perpetrator (penis, finger, etc.) and/or object. Sharp weapons are often involved. | Penetration of birth woman is by body part of perpetrator (finger/s, hand) and/or object. Sharp instruments are often involved. |
| Target zone on victim's body are generally considered to be "private" areas | Target zone on victim's body are generally considered to be "private" areas |
| Social myths about who usually perpetrates are typically unfounded or mistaken. The fact is that most victims know their perpetrator/s and feel tremendous shock and betrayal at the assault | Social myths about who usually perpetrates are typically unfounded or mistaken. The fact is that most victims know their perpetrator/s and feel tremendous shock and betrayal at the assault |
| Perpetrators can be either gender, however, are most often men | Perpetrators can be either gender, however, are most often supported by patriarchal system |

Storton, Sharon. http://www.birthactivist.com/2010/11/what-feminists-should-know-about-birth-rape

abused; everyone has memories of helplessness and feelings of being powerless as children. To put it simply, "Women who have been abused as children are not 'special cases' to be treated differently from other women" (Kitzinger 2006:54). Instead of singling women out with special classes for survivors, education for caregivers about the possible triggers of sexual trauma in the childbirth process is important, as full disclosure is of childhood or adult sexual abuse is rare (ibid).

Affording women agency in childbirth is a way of alleviating potential suffering, assuming that a large fraction of those who are giving birth have experienced some sort of sexual trauma (Kitzinger, 2006). Kitzinger (2006) attempts to contextualize the behaviour of survivors during the process of birth, stating that "compliance and confrontation are both strategies in which we try to control what is done to us when we feel attacked" (56). Many women have experienced non-consensual sexual contact in their lives; it is estimated that 1 in 3 girls under 18 will experience some form of sexual abuse before they turn 18 (The Women's Center, Inc. 2014). These are significant numbers. Not surprisingly, one common potential trigger for women who have suffered sexual abuse is the incidence of routine vaginal exams in labour; an example of one way in which the childbirth process is one that does not adhere to normal social

and physical boundaries (Kitzinger 2006). Sexual boundaries in the context of the birth experience are much looser; women are often subjected to painful vaginal exams that are frequently conducted unexpectedly and without question or choice (Kitzinger, 2006). Modesty is not an often an option in hospital birth, where there is little privacy and women have little control over who is in the room, even during vaginal exams or other procedures that involve genital contact, such as artificial rupture of membranes or application of prostaglandin to ripen the cervix in early labour (ibid). Figure 4 shows some of the commonalities between sexual assault and birth rape. Sharon Storton (2010), a psychotherapist, birth activist and founder of the group 'Solace for Mothers,' illustrates well the similarity of experience in terms of power imbalance, control over mobility, shame, stigma, and the areas of body targeted, namely the genitals. These are all potential triggers for survivors of sexual abuse. Kitzinger (2006) comments:

> The more intrusive the style of management the more these boundaries are attacked. A woman's genitals are exposed, she lies in the 'victim' position, while other people who are fully clothed stand around and stare at her body. She may be attached to tubes, monitors, blood pressure cuffs and other restraints (57).

Additionally, the World Health Organization actually stresses that routine vaginal examinations in childbirth are not only unnecessary, but can also be damaging. Research indicates that vaginal exams are used primarily to check for shoulder dystocia, which, once diagnosed, can lead to risky interventions such as caesarean section or mechanical vaginal delivery (Downe, Gyte, Dahlen and Singata 2013). The authors state, "It is surprising that there is such a widespread use of this intervention without good evidence of effectiveness, particularly considering the sensitivity of the procedure for the women receiving it, and the potential for adverse consequences in some settings" (2013, para 12). However, almost no woman is surprised when her labour is interrupted for an invasive vaginal exam, to check the 'status' of her cervix; this

ritual is so culturally embedded in the way we birth in the Western world that it happens without question (Davis-Floyd, 1993).

To understand that trauma is truly in the eye of the beholder (Beck 2004a), is an integral aspect to the study of women's birth narratives. Not all women will interpret their birth experiences in the same way. Beck (2004a) reminds the reader that "What a mother perceives as birth trauma may be seen quite differently through the eyes of obstetric care providers, who may view it as a routine delivery and just another day at the hospital" (28). Beck's (2004a) study revealed several common themes in women's narratives of birth trauma, the first being an unfulfilled expectation of being cared for and protected. Mothers' feelings of violation and sexual trauma following their birth experiences were exacerbated by feelings of being discarded or unimportant; they reported being subjected to invasive questioning and physical exams with little eye contact, as if the experience was meaningless (Beck 2004a). Mothers also reported feelings of invisibility, remembering conversations going on in the room as if she was not there. The author describes a situation where a mother listened to health care professionals talking about the possibility that her baby may not make it through the delivery alive, disregarding her presence in the room and invoking terror that was left unspoken (Beck 2004a). The third theme that Beck's (ibid) study indicated was difficulty trusting their caregivers, while at the same time experiencing a lack of agency and a perceived lack of choice. Finally, mothers felt vulnerable, open, exposed, while their baby was thrust into the spotlight of the delivery room while she faded into the background. It's a time for celebration! How could the mother be so selfish as to demand attention in this moment? Foucault's (1977) conception of the 'docile body' leads the mother to this moment; she has been institutionalized, trained to forget her pain. She is not powerful in this moment; it is those who have given her infant life who hold the power of

scientific knowledge. Foucault reminds us that not only is the power in the maternity room embedded in the ritualistic performance of birth, but it is also embedded in the construction of the body.

Beck stresses that diagnosed cases of post-birth PTSD are grossly underreported, and in a subsequent phenomenological study, identified five themes common to women's lived experience of birth trauma (Beck 2004b). Theme 1 was characterized by the experience of flashbacks typical of those who have experienced trauma. These flashbacks often prevented mothers from living in the moment, triggered nightmares, and interfered in their relationships with their infants and significant others. This often results in an avoidance of situations that may trigger memories of the trauma (Beck 2004b). The second theme was described as a feeling of numbness. Beck (2004b) states, "Traumatized by their birth experience, mothers experiencing PTSD considered themselves only a shadow of their former selves" (220). Long after their birth, women who had experienced trauma such as hemorrhages, emergency caesarean, and unwanted interventions such as forced or coerced epidural, had difficulty shaking their feelings of dullness and apathy (ibid). Theme 3 expressed a strong desire for these women to gather information about their birth; the author states: "This obsession took on many different forms. For some women, it entailed making repeated appointments with the physicians or midwives who had delivered their infants to have their questions answered and to go over their medical records" (221). Some were drawn back to the places where their births took place while others read textbooks in order to attempt to make sense of what happened to them. The fourth theme outlines what the author describes as "The Dangerous Trio of Anger, Anxiety, and Depression" (221). These three emotions were common amongst victims of birth trauma, often to the point where they have difficulty functioning, venting their anger toward others but also toward the self,

and asking questions like “How could I have let this happen? Why did I trust the doctors? How could I have been so stupid?” (221). The fifth theme was characterized by feelings of extreme isolation, breaking the “three lifelines to the world of motherhood: the woman’s infant, the supporting circle of other mother, and hopes for any additional children” (222). The post-partum period is one of extreme vulnerability; women have always turned to other women who have had children for emotional support and advice in the early stages of motherhood (and beyond) (Kitzinger 2006). Feelings of shame at having ‘failed’ at childbirth often prevents women from feeling able to convey the full magnitude of their experiences.

Most of all, according to Beck (2004b), women wanted someone to talk to, who shared their experience, who witnessed them at their most vulnerable, and could fill in the blanks of their narrative where they existed. When they were not afforded someone to talk to who took their experience seriously, this is where the most sinister disintegration of self took place. This reality lends itself well to the importance of follow-up care after birth (Beck 2004b; Kitzinger, 2006; Zimmerman 2013). Women reported intense sensations of loneliness, an emphasis on newborn health, and subsequent denial of their own emotional pain.

Post Structuralist feminist analysis allows for the examination of blaming women for their childbirth experiences, recognizing that it is not actually women who have control over their own births; there is a well-constructed illusion of control on both the medical and the alternative models of care (Malacrida and Boulton (2014). In their exploration of the childbirth narratives of 22 women, these researchers found that choice and expectations in pregnancy had surprisingly little impact on childbirth outcomes. According to Malacrida and Boulton (2014), “The women’s narratives revealed a disjuncture between their expectations of choosing, planning and achieving as natural a birth as possible, and their lived experiences of births that did not

typically go to plan" (41). Crossley (2007) agrees, stating that though there is a strong push toward avoiding interventionist labour, that "natural discourse' towards childbirth may create idealistic expectations that are totally at odds with the reality of the actual birthing encounter" (543). For example, there is an assumption made that women have their choice of caregiver, that they can choose an obstetrician or a midwife, but the reality is that even when there are midwives available, women are often 'risked out of care' for reasons that range from potentially serious (preeclampsia, gestational diabetes), to potentially unimportant (one high blood pressure reading, a higher-than average BMI) (Kitzinger, 2006; Crossley, 2007). Additionally, if intervention-free, natural birth is assumed to be superior to birthing in hospital, there is an inherent value-judgment placed on the birthing woman, who is, despite most evidence pointing otherwise, subject to the assumption that she is in full control of her birth, and that she is ultimately in charge of her experience (Crossley 2007).

Furthermore, while the concept of the birth plan, described by England (1998) as a "ritual of modern pregnancy" (96) perpetuates the illusion that women are in control of their birth process, there are varied opinions regarding their efficacy as a means of empowerment. According to Lundgren, Berg and Lindmark (2003), "To help women have an improved experience of childbirth, birth plans were introduced in the 1980s" (322), in order to afford women more choice in birthing options, and to open communication between women and their caregivers. The same authors explain that "Birth plans take a variety of formats: they may be a formatted list of events that might occur during labor, which the woman checks as acceptable, or a list with yes or no options, or a more open format with headings as prompts" (Lundgren et al. 2003: 322). Crossley (2007) is critical of the efficacy of this particular measure: "These efforts in the natural/alternative discourse are seen as tools with which women can reduce the

impositions of the medical model on the ideal, intervention-free birth, again reflecting an assumption that women have the capacity to plan and implement birth 'choices'" (44). Though information-seeking is important for new parents, England (1998) likens birth plans to "a hidden reef on which your efforts towards deeper birth preparation may run aground" (96). Birth is, obviously, a natural event that cannot be conceptualized before it happens, but more importantly, hospitals are sovereign institutions capable of overriding decisions made by expectant parents (England, 1998).

Mothers in Malacrida and Boulton's (2014) study saw a birth plan as a possible means of having some control over their experience under the medical model of care, often linking the place of birth and the hospital or birth center's promises of low intervention care to positive birth outcomes. For example, women birthing at home or in birth centers expected low intervention births, while women birthing in hospital typically had the same expectation of control over what interventions they did and did not experience (Malacrida and Boulton 2014). Birth narratives, however, indicated that birth plans had almost no effect on women's experiences in labour, though place of birth did (Overgaard et al. 2012). Kitzinger (2006) cites the work of Jones, Barik, Mangune, Jones and Gregory (1998):

> In a midwives' study of birth plans in one hospital the authors of the study complain that 'birth plans may put pressure on midwives to comply with patients'. They reveal that birth plans irritated the midwives and 'provoked some degree of annoyance' because they were 'unreasonable'. As a result women who made birth plans had more forceps and ventouse deliveries, Caesareans and interventions of every kind (20).

The aforementioned study was conducted in the United Kingdom, where midwives often attend births in hospital, and appear to adhere more to the medical than the social model of care. Although negative institutional response to birth plans is not universal, a large proportion of women who create birth plans for births in amenable hospitals reported that a profound power

imbalance between themselves and staff prevented their needs from being met, regardless of how clearly they were outlined (Kitzinger 2006). According to Lundgren et al., "Women of higher socio-economic status placed more importance on birth plans, placing emphasis during pregnancy on a birth that was characterized by "control and self-empowerment" (322), in contrast to women of lower socio-economic status, who emphasized a wish for a healthy infant and as little pain as possible in childbirth (2003). Ultimately, speaking directly and firmly with doctors and other medical professionals seems to be the most effective way of preventing unwanted interventions and subsequent trauma in the birth experience. Doulas, or women who serve as advocates for birthing women, can also serve as effective mediums for dissemination of expectations (England 1998).

Not surprisingly, according to a recent study, the birthing venue plays a fairly significant role in birth outcome. Overgaard, Fenger-Grøn and Sandall (2012) found in their comparison of women's experiences in free-standing midwifery units and obstetrical units, women who birthed in FSMUs reported much greater satisfaction with their overall experience, despite the fact that both institutions were working toward the same goal of providing "an ideal of high-quality, humanistic and patient-centred care" (973). Free-standing Midwifery Units subvert Foucauldian notions of control and governance. According to Pylypa (1998), "Women who believe that a technologically controlled birth may not be the best or safest approach are 'individualized' as deviant, in Foucault's terminology, and are subject to criticism from doctors, family, and friends" (32). Expectation of obedience, though important, is not centralized. Foucault sees power as something that is "embedded in a network of practices, institutions, and technologies--operating on all of the 'microlevels' of everyday life" (21). In other words, women may not be forced into

conformity but the construction of social norms is often enough for women to want to seek acceptance through adherence to moral codes (Pylypa 1998).

Of women who participated in Overgaard, Fenger-Grøn and Sandall's (2012) study, those who were attended by midwives reported a greater sense of freedom, fewer restrictions, and an overall stronger sense of agency and control. Allowing women opportunity to choose their place of birth is an important step in alleviating suffering of women in the post-partum. Even language surrounding what 'caregivers' are available for attending births of women discursively constructs birth as an event in need of active management. Freebirth is the act of giving birth without an attendant (other than the birthing woman herself, or her partner), a practice that is, for obvious reasons, frowned upon in the medical community (Shanley 2012). A small fraction of women who do not have access to midwives, or who are unhappy with the current evolution of midwifery toward the medical model, choose to give birth at home without assistance of any sort. According to Shanley (2012), someday women will give birth without fear, and no longer view their labours in terms of pathology: "Instead, like their animal sisters, women will someday deliver their own babies peacefully and painlessly at home. Women will understand that birth is only dangerous and painful for those who believe it is" (xi). These women subvert Foucault's (1977) conception of the docile body; while they *are* socially regulated and subject to all that comes with disruption of power distribution, they choose resistance. Many of these women contend that even if freebirth was found to be much riskier than birth under the care of a physician or other licensed professional, they would choose it anyway; there is, overall, less fear of death or infirmity (Shanley 2012). *How* these women manage to trust, despite the socially constructed, deeply pervasive doubt surrounding their body's ability to function is unknown. It does, accordingly, raise questions about the quality of the birthing experience when one feels

fully in control which is in stark contrast to the women spoken of earlier, who reported leaving their births feeling angry and traumatized.

## Chapter 5. Conclusion

This analysis has shown how the experience of childbirth has changed drastically over time. While childbirth was once an event celebrated by women in the company of women, it is no longer; obstetric management of birth has officially become the norm, with an estimated 97-99% of births now happening in hospital. It used to be that 'managed' childbirth was reserved for women who were considered high risk for various reasons. Currently, the very act of birthing has been constructed as a risk-fraught undertaking, full of potential hazards and possible human casualty if not guided by the hands of 'experts.' While infant and maternal mortality rates have decreased significantly, women have lost a sense of agency in their birth experiences that is anything but benign; women are paying a very high price in terms of embodied subjectivity. Though estimates of diagnosis of post-partum post-traumatic stress disorder rest at approximately 1-6%, the majority of women are now describing their births as traumatic. This is not a surprise, given that upon entrance into the medicalized birthing arena, women are faced with little choice in what was once considered instinctive. In Berger and Luckmann's (1966) terms, these instincts have given way to institutions. Mothers' movements and position are controlled virtually at all times; they no longer have the most basic physiological mechanisms of birth on their side; they are strapped down for the ease of fetal monitoring, then often forced into the lithotomy position for the ease of obstetric management of the perineal area. They are, indeed, rendered 'docile bodies.'

In spite of the overwhelmingly pervasive belief that medicalized childbirth equals progress, The World Health Organization, perhaps the most influential of biomedical institutions,

warns strongly against the over-use of specific interventions. Despite this, many of these same interventions are rising in popularity, in light of demonstrated and sometimes extensive emotional harm. An average of one-third of infants born in the United States are born by caesarean section, despite the fact that the World Health Organization recommends a rate of 10-15%. Via the medium of medical journals, health-care professionals are subject to the discursive construction of childbirth as risky and potentially treacherous; it is no surprise that it is treated as such. If it is 'risk,' ultimately, that determines the physical and emotional experience of birthing women, choice falls by the wayside. Do women really have agency in the ways that they are birthing? Studies focusing on alternative birthing environments such as free-standing birth units, which have lower rates of intervention and a more relaxed environment, can help to validate existing research that suggests that place of birth determines women's perception of their birth experience.

'Manufactured crises', also described as unnecessary and/or unwanted interventions, are important to quantify, but equally important are the sociological implications of collateral damage caused by a system that is severely flawed. Because most people do not think about women's experience in childbirth, in this thesis I have attempted to bring those experiences to the fore. We have seen that not only are many women suffering from trauma after birth, but that trauma may be experienced as the direct result of gratuitous interference in the birth process. If the majority of women are experiencing psychological distress following childbirth because of unwanted interventions, and those interventions are routinized due to the pervasive belief that the female body is incapable of birthing, this is meaningful and worthy of further investigation. Foucault states that defiance does not go unpunished; the goal of the medical model is absolute submission. Fear of punishment itself is often enough for women to choose to comply with

medical authority; this creates an environment where women defer to the absolute power/knowledge of the expert. It is difficult to gauge how many 'emergency' caesareans are actually emergencies, how many episiotomies are really necessary, or how much the process of immobilizing women in labour with the use of drugs or routine electronic fetal monitoring encumbers the birthing process, but exact numbers do not need to be known in order to indicate patterns. The data presented in this thesis suggest that birthing women are often treated as baby-makers; the whole of the woman is pushed aside and she is split, for her time in labour, into two parts - body and mind. Her uterus is the vessel that holds the trophy at the end of the journey. Her body is manipulated and placed where it ought to be, sometimes cut, often drugged, all in the pursuit of a healthy baby. Because she is merely a vessel, she is powerless; a casualty.

Sociology, as a discipline, has failed to address the human suffering caused by the technocratic paradigm of birth, choosing instead to problematize mothers who are single, poor or otherwise disadvantaged (Oakley 1980). This approach has left the felt experience of childbirth to be dealt with individually, under a psychological framework that fails to acknowledge the cultural and socially pervasive patterns underlying the issue of birth trauma and subjugation of women. The experience of childbirth is so powerful that many women can remember years, even decades later, the joy or pain surrounding the event. This is significant; birth trauma does not always fade with time. Clearly, a healthy baby is not enough; a healthy mother must somehow factor into the equation. How much of this suffering is necessary, and how much is created by habitualization and the reification of the institution of childbirth? Berger and Luckmann (1966) provide a powerful foundation for the deconstruction of the childbirth process as it is performed today.

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