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PARADOXICAL SUBJECTS

WOMEN TELLING BIRTH STORIES

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ABSTRACT

This study focuses on the construction of subjectivity in and through the telling of birth stories. Drawing on 50 interviews with middle-class women, most of who 'chose' to birth either at home or via elective caesarean section, the thesis explores how women make birth 'choices' and 'experience' home-birth and caesarean-birth within a South African setting. Furthermore, by employing a range of theoretical resources, including the work of Julia Kristeva, Simone de Beauvoir, Iris Young and materialist feminists such as Nancy Hartsock and Maria Mies, this study explores the forms of embodied subjectivity that emerge in birth narratives. Engaging in both an ideological analysis and a narrative analysis, the thesis shows how women's 'choices' and 'experiences' are always situated within or in relation to cultural story lines, dominant ideologies and material contexts. However, at the same time, through the use of a Kristevan theory of bodies-language-subjectivity, the thesis also demonstrates how 'the body' itself often becomes transfused into women's talk about birth, resulting in paradoxical and contradictory forms of subjectivity.

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The language of the brag

Sharon Olds (2004:8)

I have wanted some epic use for my excellent body,
some heroism, some American achievement
beyond the ordinary for my extraordinary self,
magnetic and tensile, I have stood by the sandlot
and watched the boys play.

I have wanted courage, I have thought about fire
and the crossing of waterfalls, I have dragged
around
my belly big with cowardice and safety,
my stools black with iron pills,
my huge breasts oozing mucus,
my legs swelling, my hands swelling,
my face swelling and darkening, my hair
falling out, my inner sex stabbed again and again
with terrible pain
like a knife.
I have lain down.

I have lain down and sweated and shaken
and passed blood and feces and water and
slowly alone in the center of a circle I have
passed the new person out
and they have lifted the new person free of the
act
and wiped the new person free of that
language of blood like praise all over the body.

I have done what you wanted to do, Walt
Whitman,
Allen Ginsberg, I have done this thing,
I and the other women this exceptional
act with the exceptional heroic body,
this giving birth, this glistening verb,
and I am putting my proud American boast
right here with the others.

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CHAPTER 1

Frames, contexts and background

> Unlike death, its only competitor as an essential human experience, birth has an involved witness who lives to tell the story, a birthing woman. Her experience is of universal importance, because it is she who is caught up in that elemental activity, childbirth, with hurricane intensity. And it is her story that is rarely, if ever, told.
> (Carol Poston, 1978:20).

> Birth stories are everywhere and nowhere.
> (Della Pollock, 1999:1).

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Embarking on a thesis about childbirth is a daunting task. After all, what more could there be to say? The subject has been pursued relentlessly from every conceivable angle. In the last three decades, a veritable avalanche of cross-disciplinary academic research has been published, appearing in history, anthropology, sociology, medicine, nursing, geography, religious studies, literary studies, psychology, cultural studies and evolutionary theory. Popular childbirth preparation books have been pouring out (with no end in sight) for a great deal longer. The Internet is awash with websites dedicated to women's birth stories. Even mothers themselves are now getting in on the publishing frenzy – e.g. the recent spate of "momoir" (Baraitser, 2005) literature, in which women are 'coming out' and telling their personal stories of becoming mothers (e.g. Johnson, 1999; Cusk, 2001; Belkin, 2003; Buchanan, 2003; Cowen, 2005). Whether in the form of expert advice, personal 'momoirs', polemical stories (e.g. Wolf, 2001), television documentaries, talk shows (e.g. Oprah), antenatal classes, everyday gossip, family folklore, snippets in the newspaper, feature spreads in the likes of *Time* (James, 2004; Song, 2004) or sound bites on the evening news bulletin (e.g. Entertainment Television, South Africa, 21 August 2005), stories about birth are everywhere.

However, despite the growing amount of writing and talk about childbirth, this thesis will argue that some aspects of birth nonetheless still remain largely silenced. Thus, despite the

proliferation of research and scholarly attention focussed upon birth, a key argument of this dissertation will be that the complex embodied subjectivity of the birthing woman is still largely missing from cultural narratives, academic studies and women's own stories about childbirth. Although almost thirty years have passed since Carol Poston (1978:25) wrote that, "It is a rare thing to see birth from the birthing mother's point of view", this thesis will argue that three decades and a torrent of research later, childbirth is still rarely articulated *from* the embodied perspective of the birthing woman. Thus, although all around us, it will be shown that birth stories are often told via formulaic cultural recipes in which the subjective experience of birth-giving disappears. This is perhaps why, in her engaging 'momoir', Rachel Cusk (2001:18) can still speak of a "vow of silence" about birth despite all the 'how-to' books, expert advice, childbirth preparation classes, friendly chat and frank images.

In this introductory chapter, I present the key points of departure for the thesis, narrate (some of) the theoretical shifts and turns that underpin this particular research project, outline the study's theoretical framework and briefly consider some pockets of research which serve as important contextual background for the study.

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Points of departure…shifts and turns

The central purpose of this thesis is to explore subjectivities in and through women's birth stories. This was not, however, always the primary goal of this research study. In fact, this project was originally designed as an exploration of *agency* in relation to childbirth. Having read the enormous and cross-disciplinary body of literature on birth fairly well *and* having conducted a preliminary study[1] in which a total of 77 women were interviewed about their birth experiences, I noticed that the 'outlier' choices of home-birth and elective caesarean section were both analytically interesting and relatively under-researched. The dominant trend within studies of childbirth has been to study so-called 'women-in-between' (Davis-Floyd, 1992/2003), that is: middle-class women who choose to give birth in the hospital but who hope to have a 'natural birth'. Many of these studies have shown that such expectations or 'hopes' are generally not met and that 'women-in-between' often end up disappointed by the medicalised 'reality' of their childbirth experiences (e.g. Oakley, 1980; Humphreys, 1998; Miller, 2005). Few studies have looked explicitly at the birth experiences of women who lie on the 'extreme' end of such an imaginary birthing continuum (i.e. home-birthers and elective caesarean birthers), although Davis-Floyd's (2003) study did serve to highlight the potentially interesting paradigmatic differences between these two 'groups' of birthers. As far as I know, there has been no published research

[1] See Appendix A and B for basic demographic details of this preliminary study.

that has conducted a *comparative* study of these two 'outlier' groups. As a means of addressing this gap in the literature, this research study was originally designed as a comparative study of home-birthers and elective caesarean birthers, with the primary aim of exploring birthing agency. Centrally I was interested in 'who' these 'active-birthers' were, 'why' they made these particular birthing choices and 'what' kinds of births they went on to experience. As a result, this thesis is predominantly[2] based upon pre- and post-birth interviews[3] with fifteen home-birthers and nine elective[4] caesarean birthers.

However, along the way, this research project has shifted and turned. Starting out as an exploration of birthing agency, this study evolved to become a 'troubling' of conventional assumptions regarding individualist agency and subjectivity. Reading the large body of feminist studies on childbirth in conjunction with feminist theories of maternal subjectivity *and* poetic and autobiographical women's writing on childbirth and mothering, I came to see puzzling disjunctions and contradictions. Thus, whereas most qualitative studies seemed to represent birthing women (and their talk) as coherent and stable, theories of maternal subjectivity and women's poetic and autobiographical writings reproduced ambivalent, contradictory and paradoxical birthing/maternal subjects. Reading '*The impossibility of motherhood*' by Patrice DiQuinzio (1999) proved to be a seminal moment in making sense of these disjunctions and in influencing the direction this thesis would take.

Thus, heavily influenced by DiQuinzio (1999), I came to see that an individualist model of subjectivity implicitly underpinned most studies of women's birth experiences. While the 'first wave' (1970s–1980s) of feminist research on childbirth was largely embroiled in a 'macro-structural' critique of medicalised birthing, in which concepts such as ideology, institution and cultural systems loomed large (e.g. Rich, 1976; Jordan, 1978/1993; Rothman, 1982; Martin, 1987), from the 1990s onwards research shifted[5] to look at 'agency' in relation to birth (e.g. Davis-Floyd, 2003; Fox & Worts, 1999; Zadoroznyj, 1999; Root & Browner, 2001; Westfall & Benoit, 2004). In this thesis, I argue that both macro-structural birth studies and analyses of birthing agency have largely ignored the complex and potentially contradictory embodied subjectivity of childbirth, largely because they remain, on some level, mired within individualist assumptions. Thus, while 'first-wave' macro-structural birth research can hardly be called 'individualist', this stream of studies is nonetheless (at least tacitly) implicated in the distinction

[2] Two other women (i.e. hospital-bithers) were also interviewed (pre- and post-birth). I draw on these interviews occasionally in my analysis.
[3] One home-birther and one elective caesarean birther were, however, only interviewed once post-birth.
[4] I define 'elective' caesarean birthers as women who choose to have surgical birth for personal, non-medical reasons.
[5] This shift was in large part related to the postmodern or post-structuralist turn in the social sciences, which offered a significant challenge to 'modernist', materialist and Marxist streams of thought.

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between ideology/institution and individual experience/agency rooted within an individualist ideology (DiQuinzio, 1999). Thus, the individual self (and 'experience') is either seen as somehow separate and distinct from ideologies, institutions or socio-cultural contexts (e.g. Rich, 1976) or 'the individual' (and 'experience') is seen as completely determined by wider macro-structural conditions. Reacting against this 'determinist' trend, many researchers turned to discursive, post-structuralist and micro-level analyses, hoping to explore women's 'agency' in relation to childbirth. However, as I will show in chapter three, accompanying this trend is often the inadvertent resurrection of a rational, disembodied and individualist self.

This thesis has several points of departure. The first is Patrice DiQuinzio's (1999) argument that individualist theories or models of subjectivity cannot adequately represent or capture the complexities and ambiguities of maternal and birthing subjectivity, largely because they are modelled on a masculinist ideal of the subject (i.e. independent, autonomous, self-contained and coherent). Furthermore, individualist models of the subject are implicated in numerous problematic binaries, including: body/mind, self/other and individual/cultural, all of which are hazardous to an adequate analysis or representation of birthing body-subjects. Taking DiQuinzio's arguments seriously, the remarkable absence of studies exploring the embodied, potentially contradictory subjectivities of birthing becomes almost unsurprising, largely because the individualist frames that often (inadvertently) underpin research on childbirth make it very difficult to reproduce birthing subjectivities as embodied, ideological, intersubjective and potentially paradoxical. As a result, very little work has been done to explore birthing embodiment or to ask women what birthing *feels* like – emotionally, viscerally, psychologically and spiritually.

It was not, however, only reading contradictory literatures that made me realise that 'something' (i.e. the subjective experience of birthing) was *missing* from academic studies of childbirth. Part of my motivation for doing this study was a desire to 'know' what giving birth was 'really' like. As a woman who has herself never experienced childbirth, I stand out as different from most other childbirth researchers, many of who cite their own birth experiences as the reason for their interest in the topic (e.g. Arms, 1975/1977; Oakley, 1979; Romalis, 1981; Rothman, 1982; Cosslett, 1994; Kahn, 1995; Klassen, 2001a). When interviewing women post-birth, I often felt as though something was missing from their stories. The sense that 'something' about childbirth is being withheld is a common feeling among women who have not given birth (e.g. see Cusk, 2001). Most interviewees did not spontaneously talk about the subjective or emotional *experience* of childbirth. However, being a curious and admittedly voyeuristic researcher uninitiated in the mysteries of childbirth, I consistently asked women to tell me 'what

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birth felt like'[6] and encouraged them to narrate their 'insider's' view of birthing. As Pollock (1999) insightfully points out in her study of women's birth narratives, few researchers have thought to ask women what childbirth *feels* like. In part I believe that this might be related to the fact that most researchers have themselves experienced childbirth. I thus agree with Pamela Klassen (2001a:10) who says, "If I had not given birth…I probably would have asked different questions". Many of the home-birthers in my study were initially startled at being asked questions about 'what birthing felt like' and often seemed to stumble for / over an answer. The difficulty[7] that many interviewees experienced in articulating a subjective viewpoint of birth mirrors studies which have found that women struggle to articulate a 'woman-centred' or insider's perspective of birthing (e.g. Martin, 1987; Sbisà, 1996; Pollock, 1999; Martin, 2003).

This leads onto the second major point of departure for this thesis, namely: that we lack an alternative discourse or language of birth as told *from* the embodied perspective of the birthing woman[8]. In this thesis, I situate and 'make sense of' this line of argument within the theoretical framework of Belgian feminist, Luce Irigaray[9]. In particular, I take from Irigaray the notion that language is ultimately phallocentric, that is: modelled upon a morphology of the male body (Grosz, 1989). As a result, Irigaray argues that women remain confined by patriarchal discourses that construct female corporeality and subjectivity according to a male norm (see Irigaray, 1974/1985a, 1977/1985b). According to Irigaray, women thus lack an adequate language or discourse within which to represent their sexual, corporeal difference. For Irigaray, a central arm of the feminist struggle should be concerned with the development of 'woman-centred' discourses and representations of female sexuality, embodiment and subjectivity. She is careful however never to define or *prescribe* alternative discourses or modes of subjectivity (Grosz, 1989). Instead, Irigaray is involved in a project of trying to 'imagine' ways of speaking/writing/being that work to construct "the female body as a positivity rather than a lack" (*ibid*, pp. 110). In my analysis of women's birth stories, I will be searching for alternative story lines and representations that reinscribe the birthing woman and childbirth in terms *other* to phallocentric representations, ideologies and narratives.

While the lack of attention to birthing subjectivities within childbirth research is, in large part, the result of an underlying adherence to an individualist model of the subject, I believe that there

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[6] In the case of caesarean birthers I concentrated on trying to explore their subjective experience of undergoing birth via *surgical* delivery.
[7] Many home-birthers explicitly expressed this difficulty, telling me repeatedly that the experience was 'difficult to put into words'. Interviewees in other birth studies have reported a similar difficulty in trying to describe birth (see for example, Pollock, 1999; Klassen, 2001a).
[8] While 'midwifery' models (Rothman, 1982) and holistic models (Davis-Floyd, 2003) of childbirth claim to be 'woman-centred', they often reproduce birth as an event of holism and integration for the birthing woman. While important, such models do not adequately reflect the split, ambivalent and contradictory subjectivity of birthing expressed by the likes of women poets and writers (e.g. see Cosslett, 1994).
[9] See chapter four for a more extensive discussion of Irigaray's work.

are also other factors at play in this absence. For example, in my view, the omission of birthing subjectivity from academic scholarship, cultural narratives and women's own birth stories is a reflection of the power of a patriarchal ideology[10] which casts childbirth as a purely biological event, devoid of consciousness, subjectivity or 'mind'. Reading the writing of materialist feminists such as Mary O'Brien (1981) and Maria Mies (1986) and the work of philosopher Virginia Held (1993), enabled me to see that the construction of childbirth[11] as an exclusively 'natural' or biological process is deeply connected to women's oppression. By casting birthing as exclusively an event of 'the biological body', it becomes impossible to see childbirth as "the conscious interaction of a human being with nature, that is, a truly human activity" (Mies, 1986:45). As a result, "human mothers have been swallowed up into biological explanations" and the birthing woman "is seldom thought of from an internal point of view" (Held, 1993:120). In large part, I believe that many feminists have bought into this patriarchal view of birth and therefore either completely ignored the topic or cast female reproduction as the root cause of women's oppression (e.g. Friedan, 1963; Firestone, 1970; de Beauvoir, 1949/1989).

The third point of departure for this thesis is therefore the acknowledgement of childbirth as 'conscious activity' (Mies, 1986) involving potentially complex forms of subjectivity and consciousness. While many feminists have struggled against the view that childbirth is purely a biological process, they have often done so by arguing that birth is a *cultural* event (e.g. Jordan, 1993; Michaelson, 1988; Davis-Floyd & Sargent, 1997). While this has been an important and necessary move, it has, at times, also worked to omit the fact that birth is also an experience of embodied subjectivity. This thesis aims to show that childbirth is deeply cultural, ideological, embodied and 'distinctively human' (Held, 1993), that is: an experience involving complex forms of consciousness, signification and subjectivity.

The 'commonsense' view that birth is purely biological (or 'cultural') is also demonstrated by the extent to which childbirth has been ignored within both mainstream and feminist psychology. As I discuss more fully in chapter three, psychologists have almost exclusively explored childbirth in terms of potential pathologies (e.g. postnatal depression, post-traumatic stress disorder and so-called 'fear of childbirth'). Surprisingly, there is very little psychological work exploring childbirth in terms of experience and subjectivity. Once again, I believe that this is a reflection of the power of a patriarchal ideology which constructs birth as 'all body and no mind', making *a psychology* (or philosophy) of birth seem almost nonsensical.

This thesis thus departs from the following three points: (a) that an individualist model of the subject is an inadequate basis for an exploration of birthing subjectivities, (b) that women lack an

[10] Although I am well aware of the criticisms levelled at terms such as 'patriarchy' and 'ideology', I nonetheless retain them in this thesis as "necessary struggle concepts" (Ebert, 1996:3).
[11] Of course, this also includes pregnancy, breastfeeding and mothering.

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alternative language within which to represent their insider's view of birthing and (c) that childbirth is not only cultural and ideological but also 'distinctively human' (Held, 1993) conscious activity potentially involving complex forms of embodied subjectivity.

Theoretical framework

Once it became clear that this thesis would be arguing against an individualist theory of subjectivity, it became imperative to find or construct an alternative theoretical framework. This was not an easy task and involved grappling with the work of a number of feminists who have offered alternative theories of maternal subjectivity, including: Simone de Beauvoir, Iris Marion Young, Julia Kristeva, Luce Irigaray and materialist feminists such as Nancy Hartsock, Sara Ruddick, Maria Mies and Mary O'Brien. Detailed discussions of these theories are presented in chapter four of the thesis. However, in order to give the reader some idea of the theoretical directions in which this thesis will be moving, a brief outline of my theoretical grid is in order.

Centrally, this thesis aims to combine a materialist focus on ideologies and socio-cultural contexts with a theory of the subject drawn from the post-structuralist work of Julia Kristeva. While my work has always been broadly rooted within feminist post-structuralism, reading the work of materialist feminists such as Teresa Ebert (1996) and Rosemary Hennessey (1993a) radically upset my post-structuralist sensibilities and caused me to question the political and theoretical underpinnings of this research. It took me a long time to work through this theoretical upheaval and for a substantial period I honestly felt as though I had to choose between *either* a materialist/socio-ideological analysis *or* an analysis of subjectivities. However, in the process of writing this thesis, I have moved away from this either/or position and have attempted to create a dissertation that speaks on multiple analytic levels.

Thus, I have chosen to 'go against the grain'[12] of current trends in birth scholarship by reinstating an analysis of ideologies and socio-material contexts within my exploration of women's birth stories. As already mentioned, broad ideological and macro-structural analyses were popular within the 'first wave' of feminist research on childbirth but more recently have been largely dismissed in favour of discursive, micro-analytic studies. In this thesis, I attempt to analyse ideologies and socio-material contexts through women's talk about birth 'choices' and 'experiences', thereby disrupting the accepted distinction between ideology/structures and individual 'experience' operative within many feminist studies on childbirth. Several feminists have however commented on the difficulties involved in attempting to both "affirm women's

[12] Although recently there have been signs of a resurgence of interest in socio-economic aspects of childbirth (e.g. Perkins, 2003; Taylor, Layne & Wozniak, 2004).

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voices …[and] show how these voices, those subjectivities have been culturally constructed by prevailing discourses…" (Cosslett, 1994:3; see also Blum, 1999). Thus, while trying to 'disrupt' the ideology/experience distinction, I do not claim that I will manage to 'overcome' it; instead, these 'levels' will continue to exist in a state of tension throughout the thesis.

My use of the term 'ideology' is guided by the work of materialist feminists (e.g. Ebert, 1996, 2005; Hennessey, 1993a, 1993b; Boulous-Walker, 1998). For these feminists, the concept of ideology is seen as fundamental to a feminist critique (Ebert, 1996). Working within a Marxist understanding of the term, materialist feminists see ideology, not simply as the realm of neutral 'ideas' or as subsumed within the broader notion of 'discourse' (following Foucault), but as the "means by which social differences are signified and maintained or contested" (Ebert, 1996:7-8). Perhaps most significantly, I draw from materialist feminists the notion that meaning always involves material struggle (*ibid*). Thus, unlike 'ludic postmodernists'[13] (Ebert, 1996), materialist feminists are not content to focus only on the disruption, play and contradictions *within* texts but are committed to situating and connecting these textual struggles to 'real-life', material and power struggles taking place *outside* of texts (Hennessey, 1993a). According to materialist feminism, it is in and through ideologies that material contradictions and inequalities are 'smoothed over', silenced and obscured (Ebert, 1996). Ideology critique is offered as a way of 'reading' the gaps, contradictions and disruptions within texts as refractions of structural conditions within socio-cultural contexts (Hennessey, 1993a). Thus, whereas the 'immanent critique' of post-structuralism reads the fault-lines within texts as symptoms of the text's own internal contradictions (there is nothing outside of the text), ideology critique attributes them to contradictions present within the social, material order, "specifically the struggle over gender, class and race inequalities" (Ebert, 1996:13). Thus, according to Ebert (1996:7), materialist ideology critique is defined as:

> …a mode of knowing that inquires into what is not said, into the silences and the suppressed or missing, in order to uncover the concealed operations of power and the socio-economic relations connecting the myriad details and representations of our lives.

A mode of ideological analysis, drawing on the work of the materialist feminists outlined above, will be used in this thesis to try and situate women's talk about birth within material contexts and ideological frames (see particularly chapter six). Thus, eruptions and disruptions within women's talk will be read as, on one level, a symptom of material/ideological 'trouble'. However, at the same time, I will also be drawing on a very different (yet in my view compatible) theoretical

[13] According to Ebert (1996), ludic postmodernism is abstract, idealist and localist; furthermore she argues that by focussing on 'linguistic play' and a 'politics of representation' such theorists have, in effect, abandoned the struggle for social transformation.

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framework in my analysis of birth stories, which offers a different reading of disruptions within texts/subjects.

The key theoretical cog in the alternative model of subjectivity underpinning this thesis is the work of the Bulgarian linguist and psychoanalyst, Julia Kristeva. It is important to point out upfront that I will be following the trend of researchers who have utilised Kristeva's work "outside the psychoanalytic framework Kristeva uses" (Young, 1990b:162; see also Mullin, 2005) and will thus not be exploring the psychoanalytic ramifications of her writings. My purpose in this introduction is not to discuss the intricacies or finer details of Kristeva's theory of the subject[14], but rather to briefly sketch the central contours of her framework.

For Kristeva, subjectivity is "a strange fold" (Kristeva in McAfee, 2004:15) situated like "an intersection or crossroads" *between* the practices of culture, text, ideology and the body (Boulous-Walker, 1998:105). Most importantly, Kristeva theorises subjectivity as both an *infolding* of socio-cultural scripts, ideologies and socio-material contexts and an *outfolding* of bodily energies, drives and rhythms. Key to this thesis is Kristeva's resurrection of 'the body' as a signifying force operating (disruptively) within texts/subjects. Thus, while reading disruptions within texts as, on one level, refractions of socio-structural and ideological 'trouble', this dissertation will also be focussing on another level of (material) disruption within subjects/texts, namely: 'the body' or according to Kristeva, the semiotic mode. Critical to an understanding of Kristeva's theory of subjectivity is her distinction between symbolic and semiotic modes of signification. These two different 'modes' are energies or movements (Grosz, 1989) that produce both meaning and subjectivity. According to McAfee (2004:15) the symbolic can be defined as "clear and orderly meaning" while the (far more slippery) semiotic is "the energies, rhythms, forces and corporeal residues" (Grosz, 1989:43) that are integral to representation and meaning. The constant dialectical play between these two 'modes' produces subjectivities and texts that are always unstable, heterogeneous and contradictory. Kristeva's astounding theory, which in my view goes some way towards 'troubling' the binary between language/discourse and 'the body', helped me to 'make sense of' the 'something more' that seemed to hover between the symbolic lines of women's talk, constantly erupting in the ways in which women *told* birth.

The twin focus on ideological and semiotic disruptions within women's talk about birth will frame the analysis of birth narratives presented over chapters six and seven. Thus, in chapter six I present an ideological analysis focussing on the material contexts and ideologies that both enable and constrain women's talk about making birth 'choices'. Here I openly adopt a more 'materialist' or 'realist' position that assumes that there are structural and economic 'realities' that exist beyond the matter of 'the text'. Chapter seven explores the ways in which home-birthers and

[14] See chapter four for a detailed exploration of Kristeva's theory of subjectivity.

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elective caesarean birthers 'tell' stories of birth. Here I am interested in exploring the cultural-ideological frames within which women embed their birthing stories. Furthermore, I will also be looking for any sign(s) of alternative story lines, which might serve to reinscribe the birthing woman as the central agent of childbirth and which tell her experience from an 'insider's' point of view.

The following section deals with some important contextual literature, serving to frame the thesis both within the South African context and as a study looking predominantly at the experiences of home-birth and elective caesarean birth.

Contexts and background

South Africa and childbirth

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While the majority of childbirth studies have been conducted in 'First World' countries such as America, Britain, Australia, New Zealand, Canada, Holland, Finland and Sweden, recently there has been an increase in historical and anthropological explorations of African birthing (e.g. Hunt, 1999; Thomas, 2003; Allen, 2004). Given the rich tradition of academic scholarship in this country, it is surprising to find that very little published research exists on childbirth in South Africa; work on the *experiences* of both mothering and childbirth thus remain paltry and almost non-existent in the South African context (Walker, 1995; Kruger, 2006). This absence is in all likelihood related to the historical dominance of the 'race question' in both political struggle and academic activism within South Africa, resulting in gender/feminist issues being trivialised and ignored for several decades. Thus, it is only as recently as 2006 that the first edited volume on 'gender and psychology' was published in South Africa (Shefer, Boonzaier & Kiguwa, 2006). There is thus very little *feminist* work that has explored childbirth (or mothering) within a South African context. However, there are encouraging signs that this is about to change[15].

Nonetheless (as is to be expected), there is *some* research that has been conducted on childbirth in South Africa; the majority of these studies are, however, unpublished. Furthermore, most of this research has focussed on isolated 'factors' associated with birth, such as social support (Wolman, 1991; Somers, 1992; Csosz, 1992), the effects of specific medical interventions and types of delivery (Leader, 1977; Du Plessis, 1991; Ceranio, 1993), childbirth for the 'unmarried mother' (Swart, 1993), personal control (Selwyn-Cross, 1991) and cross-cultural aspects of childbirth (Schler, 1952; Baartman, 1983; Brindley, 1985; Chalmers, 1987, 1988, 1990;

[15] For example, I know of several research projects on motherhood and childbirth that are currently in process.

Brookes, 1991). Research looking at women's subjective *experiences* of childbirth is tantamount to non-existent.

Any discussion or investigation of birthing within South Africa must acknowledge the deeply racialised, cultural and (increasingly) class-based divisions that shape, constrain and produce women's highly unequal experiences of maternity within this country. Writing in 1986, Helen Zille produced one of the rare articles exploring the ways in which living within an apartheid system resulted in different childbirth experiences for South African women of different race groups. 'White' (overwhelmingly) middle-class South African women could afford highly specialised, 'First-world' level medical care while the majority of (African) women were subject to a form of severe structural racial oppression in which medical care remained limited or non-existent. This severe inequality was reflected in huge discrepancies between the maternal mortality and infant mortality figures for African and 'white' women throughout the apartheid period (Zille, 1986). Even as late as the late 1990s, maternal mortality figures remained sharply divided by race, with between 156 and 250 deaths per 100,000 births for 'African' women and between 3 and 8 deaths per 100,000 births for 'white' women (Schneider & Gilson, 1999). More than a decade after the shift to democracy in 1994, South African society remains riddled with inequalities that are reflected in the extremely disparate ways in which women of different races and class groups experience childbirth.

For example, the vast differences in skills, resources and technology within private and public health care services continue to mirror and re-entrench apartheid inequalities, with most 'whites' privileged enough to afford private health care and most 'Africans' forced to subscribe to inferior and under-resourced public health care systems. While most obstetric expertise, technology and resources remain firmly entrenched within the private sector, it was responsible for the delivery of only 16% of all births for the year 2000[16] (Health Status & Health Services Report, Provincial Administration of the Western Cape, 2000/2001). The newly appointed democratic government was quick to introduce free maternal and child health care from 1994 onwards, but the gains made in improving maternal health have been small (see Schneider & Gilson, 1999). Recently, an upward trend in maternal mortality rates (from 1999) has been attributed to a growing number of HIV/AIDS related deaths (Fawcus, van Coeverden de Groot & Isaacs, 2005).

Women delivering in *private* hospitals within South Africa have been described as more likely to receive caesarean section than any other group of women in the world (Burns, 2001). Considering the excessively high rates of caesareans in countries like Brazil, where it has been estimated that between 80 and 90% of all women in private clinics give birth via caesarean (Diniz

[16] This figure refers to births within the Western Cape area of South Africa only.

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& Chacham, 2004), this might be somewhat of an exaggeration. However, in comparison with developed countries such as Britain, where caesarean rates are estimated at approximately 21% (Weaver, 2002), the South African rate of over 60% in private hospitals (Rothberg & McLeod, 2005) is without a doubt *one* of the highest in the world. In stark contrast to the highly medicalised private maternity sector, women giving birth within the *public* health care sector in South Africa have been described as rarely being offered any form of pain relief (Jewkes & Mvo, 1997; Abrahams & Jewkes, 1998) and rates of caesarean section remain far lower than in private hospitals (Matshidze & Richter, 1998). Widespread problems of both physical and verbal abuse of birthing women by nurses within the public maternity system have also been reported[17] (Jewkes, Abrahams & Mvo, 1998). For example, drawing on a total of 90 interviews with pregnant and postpartum women who gave birth within the public maternity sector in the Western Cape Province, Jewkes *et al*. (1998) found that participants reported being shouted at, beaten up and deliberately neglected while they were in labour/delivery.

One of the only studies conducted on women's birthing experiences within the *private* maternity system, found that (middle-class, white) birthing women experienced a high degree of medical intervention during their first birth (Humphreys, 1998). Interviewing a total of 20 women approximately one month before birth and 3-4 weeks after birth, Humphreys found (similarly to Oakley, 1980) that whereas all of the women experienced 'boringly normal' pregnancies and expected to give birth 'naturally', all eventually experienced highly medicalised births, at odds with their previously stated expectations. For example, 40% delivered by caesarean section, with a further 40% giving birth via epidural anaesthesia (all instrumental deliveries). A total of 80% made use of some form of pain-relieving analgesia.

The childbirth experiences of women of different classes, cultural backgrounds and 'races' within South Africa are clearly sharply divided. Research exploring, incorporating and contrasting the birthing experiences of women across the spectrum of these divides has yet to be done. Little is known in the South African context about the ways in which different women 'make sense' of their childbirth experiences or the significance of birth in their lives. This doctoral research hopes to explore the ways in which (more or less) privileged women[18] approach the challenges of birth within a maternity system that is highly medicalised and which provides little room for 'alternative' models of birth. Focussing on women who have taken the most 'active' routes in

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[17] Mistreatment, physical abuse and the systematic humiliation of labouring/birthing women have also been reported in other developing countries, such as Benin (Grossmann-Kendall, Filippi, De Koninck & Kanhonou, 2001), Egypt (El-Nemer, Downe & Small, 2006) and Bolivia (Bradby, 1998).

[18] Surprisingly (and in contrast to international trends), *more* research has been done in South Africa on the birth experiences of poor, disadvantaged women than on the experiences of 'privileged' women within the private healthcare system. The study by Humphreys (1998) is one of the only investigations of middle-class birthing in South Africa.

determining the outcome of their birth experiences (home-birthers and elective caesarean birthers), this research explores the subjective experiences of women who have chosen diametrically opposed paths in their negotiation of medicalised birth.

While no research (as far as I know) exists in South Africa concerning the prevalence or practice of self-chosen home-birth, recently a local debate (mirroring international trends) has arisen within medical circles about the ethical issues surrounding childbirth via personally selected caesarean section (e.g. Bateman, 2004; Ncayiyana, 2005; de Roubaix, 2005; Rothberg & McLeod, 2005). This debate has been raging in international circles for almost a decade, ever since a research article was published in 1997 which found that 31% of London obstetricians would choose elective caesarean section for themselves or their partners, even without medical indications (Al-Mufti, McCarthy & Fisk, 1997). A flurry of articles has since been published, with heated arguments either for or against the practice of maternal choice in relation to caesarean section (see Young, 2000; Goer, 2001; Newsome, 2002; Weaver, 2002; McCourt, Bick & Weaver, 2004; Klein, 2004; Hannah, 2004). Both the local and international debate on elective caesarean section hinges centrally around the invocation of women's 'right to choose'. Thus, for (South African) Malcolm de Roubaix (2005), the question of elective caesarean section is essentially about "respect for female autonomy" (pp. 452) in which a woman's "autonomous right to informed choice on her body" (pp. 452) needs to be upheld. According to de Roubaix, "forcing vaginal delivery on a woman is an act of unacceptable and perhaps even cruel paternalism" (pp. 452). These kinds of sentiments are common in the (medical) defence of elective caesareans. Interestingly, there is, however, often little respect shown by medical professionals towards women who 'choose' to give birth at home with a qualified midwife.

In South Africa, *the choice* to give birth at home[19] is not supported or encouraged by the medical profession or wider culture; often women have to face considerable obstacles as part of their choice to have a home-birth. Not least of these is the growing lack of independent midwives who are willing to attend home deliveries. In South Africa, the only recognised and accredited route to becoming a midwife is by training as a certified nurse-midwife; there is currently no 'independent' (non-biomedical) path to midwifery. Women planning to have home-births usually contact one of the small (and dwindling) pool of midwives who have left maternity hospitals to practice independently. These midwives are, however, obliged to practice with the assistance of a 'back-up' obstetrician or gynaecologist who agrees to 'stand-in' in the event of a medical emergency. Home-birthing women are also obliged to consult with this 'back-up' medical

[19] Of course, birth at home with a traditional midwife is part of the historical tradition of many African cultures within South Africa (e.g. see Chalmers, 1987, 1988, 1990). However, this tradition has been substantially eroded, with many African women reportedly expressing an active desire to give birth in hospitals according to 'westernised' norms and practices (e.g. see Chalmers, 1987, 1990; Fouche, Heyns, Fourie, Schoon & Bam, 1998).

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practitioner for a minimum number of consultations. Increasingly, doctors are reluctant to serve as 'back-up' to independent midwives, which means that the practice of home-birth is constantly under threat.

It is thus in contexts of high medicalisation, rampant inequality and a lack of support for midwifery based care and home-birth that the home-birthers and elective caesarean birthers interviewed for this study make their respective birth 'choices'. Before turning to an outline of the thesis as a whole, I want to first make some brief comments about (the limited number of) studies that have looked at home-birth and elective caesarean section. This discussion is offered in the interests of giving the reader some idea of broad patterns within the literature and is not meant as a definitive review. Largely because this thesis takes as its central interest the question of birthing subjectivities, the formal review offered in chapter three does not focus on studies of home-birth and elective caesarean per se.

Home-birth and elective caesarean section: broad patterns

As already mentioned, there is (as far as I know) no published research that has studied home-birthers and elective caesarean birthers comparatively. While research on both of these 'groups' remains relatively sparse within the broader field of birth scholarship, there are more studies exploring home-birth than elective caesarean section. However, at the same time, it is true to say that research on home-birth is often more obsessed with mortality and morbidity figures than with the actual *experience* of home-birth (Kornelsen, 2005). Thus, as Kornelsen (2005:1495) says: "home-birthing women's experiences…remain a largely neglected source of data." The experiences and 'voices' of women choosing to have caesareans for personal reasons have, however, been even more sidelined; thus as noted by several researchers: we do not know 'who' chooses elective caesarean section nor 'why' they do so (e.g. McCourt, Bick & Weaver, 2004; Kingdon, Lavender, Gyte, Cattrell, Singleton & Neilson, 2003).

While the (medical and popular) debate surrounding the ethics of self-selected caesarean continues to rage (e.g. see Kitzinger, 1998; Young, 2000; Goer, 2001; Newsome, 2002; Klein, 2004; de Roubaix, 2005; Rothberg & McLeod, 2005), few researchers have thought to ask women about *their* views, experiences or reasons for choosing surgical birth. In fact, several researchers actually question whether there *are* women who actively make the personal choice to have a caesarean section; thus according to Kristine Hopkins (2000), most (Brazilian) women do not actively seek caesarean birth and it is therefore doctors, not birthing women, who are the most active constructors of "culture[s] of cesarean section" (pp. 739) (see also Gamble & Creedy, 2000).

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The majority of studies looking at elective caesarean sections have pathologised this birthing 'choice'. For example, the recent spate of psychological research looking at 'fear of childbirth' or what has now been coined 'tokophobia' (see Hofberg & Brockington, 2000) has frequently been active in pathologising women who give birth via self-selected caesarean section (e.g. see Ryding, 1993; Hofberg & Brockington, 2000; Zar, Wijma & Wijma, 2002; Saisto & Halmesmäki, 2003). Thus, according to this literature, the choice to have an elective caesarean is highly correlated with the "harrowing condition" (Hofberg & Brockington, 2000:176) or psychological disorder termed 'tokophobia', defined as "an unreasoning dread of childbirth" (*ibid*, pp. 176); most women suffering from this 'disorder' thus "strongly desire an elective [caesarean]" (*ibid*, pp. 176). As a result, elective caesarean birthers *in general* are being associated with this disorder and portrayed as suffering from a host of dysfunctional psychological characteristics, including: generalised anxiety, low self-esteem, depression, lack of support and dissatisfaction with partners (e.g. see Saisto & Halmesmäki, 2003). Many researchers seem to assume that this birth 'choice' represents an underlying psychological 'problem'; thus, according to Ryding (1993:284), "When a pregnant woman asks for an obstetrically unmotivated [caesarean section], counselling is necessary." Researchers also seem to take for granted the notion that such women need to be 'treated' therapeutically in order to 'overcome' their fear of childbirth and be ready to experience what all 'normal' women (should?) want: a 'natural' birth (e.g. Ryding, 1993; Saisto & Halmesmäki, 2003).

The amount of research exploring women's reasons for choosing an elective caesarean and their subsequent experience of the procedure is limited and scant. Thus, while explorations of women's stories about their experiences of elective caesarean section are virtually non-existent, studies looking at women's rationale for choosing surgical birth have been described as riddled with methodological limitations (Gamble & Creedy, 2000). Thus, for example, most such studies have been retrospective and elective caesarean birthers have generally only been interviewed post-delivery (*ibid*; see Ryding, 1993 as an exception). Furthermore, I know of no studies that have followed elective caesarean birthers longitudinally from pregnancy through to the postpartum, tracing the journeys such women make from decision-making to birth experience.

Retrospective studies have found similar themes *vis-à-vis* women's 'reasons' for choosing a self-selected caesarean; for example, most elective caesarean birthers have been found to place a high value on medicalisation and technology (e.g. Davis-Floyd, 2003; Lee, Holroyd & Ng, 2001; Béhague, 2002) and to see caesarean sections as: safer and associated with the best quality care (Lee *et al*., 2001; Béhague, 2002; Béhague, Victora & Barros, 2002), a sign of status (Lee *et al*., 2001; Béhague, 2002; Béhague *et al*. 2002), part of women's power and right to choose (Lee *et al*., 2001) and less likely to result in damage to their sexual bodies (Ryding, 1993; Lee *et al*.,

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2001; Diniz & Chacham, 2004). The limited amount of research assessing the psychological 'outcome' of elective caesarean section has generally found that self-chosen surgical birth is generally 'well tolerated' and associated with high rates of satisfaction (e.g. Durik, Shibley Hyde & Clark, 2000; Schindl *et al*., 2003). However, research by Lee *et al*. (2001) did find that elective caesarean birthers often expressed an inexplicable *sense of loss* after undergoing surgical birth.

Home-birth, like elective caesarean section, is highly contentious and often provokes emotionally volatile responses (e.g. see Klassen, 2001a); for example, some medical professionals go so far as to claim that: "home-birth is child abuse in its earliest form" (Russell cited in Hosmer, 2001:674). Women who choose to have home-births are often seen as 'risk mothers', that is: mothers who engage in practices which are adjudged to be morally dubious and harmful to their unborn babies or children (Viisainen, 2000). Studies have however shown that there is no increased maternal or neonatal risk associated with *planned*[20] home-birth attended by a qualified birth attendant (see for example, Hosmer, 2001; Janssen, Lee, Ryan, Etches, Farquharson, Peacock & Klein, 2002).

Studies conducted in 'First World' countries (e.g. America and Australia) have found that women who *plan*[21] to have home-births have distinctive demographic characteristics; for example they are likely to be older, more educated and have a higher socio-economic status than women who give birth in hospitals (e.g. see Cunningham, 1993; Hosmer, 2001; Klassen, 2001a). They are also more likely to be married, 'white' and 'better read' (on childbirth) than the average hospital-birther (Cunningham, 1993; Hosmer, 2001). Home-birthers have also been found (not surprisingly) to be less receptive to medical technology and to define childbirth as a normal and natural process (e.g. Morison, Percival, Hauck & McMurray, 1999; Klassen, 2001a; Viisainen, 2001; van der Hulst, van Teijlingen, Bonsel, Eskes & Bleker, 2004; Kornelsen, 2005). At the same time, however, they have been shown to have a 'pragmatic' approach to technology, thus generally do not forswear medical screening or the use of particular interventions (Viisainen, 2000, 2001; see also Klassen, 2001a; Westfall & Benoit, 2004; Kornelsen, 2005). Studies have also overwhelmingly found that planned home-birth is experienced as highly satisfying, extremely positive and potentially empowering and transformative (see Ogden, 1998; Morison *et al*., 1999; Klassen, 2001a; Viisainen, 2001).

Studies of the *experience* of home-birth are not numerous; however, recently Klassen (2001a, 2001b) has provided a rich and important analysis of the (retrospective) birth stories of 45

[20] *Unplanned* home-birth is however a completely different phenomenon associated with high degrees of mortality (Hosmer, 2001).

[21] Women who experience *unplanned* home-births are however likely to be younger, less educated and to have a lower socio-economic status than hospital-birthers. Thus, home-birthers as a group are clearly characterised by "significant strands of diversity" (Klassen, 2001a:19). For the purposes of this discussion, 'home-birthers' refer to women who have actively planned to give birth at home.

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North American home-birthers. Exploring the inter-connections between home-birth and religion, Klassen (2001a) found in her study that home-birthing women went to great lengths to make (narrative) meaning from their birth experiences and provided rich metaphorical stories to 'make sense' of the birth process. Showing the complex differences between home-birthing women (a strange mix of New Agers and religious fundamentalists), Klassen contradicts stereotypical notions that all home-birthing women are 'earth mothers' or proponents of 'holistic' philosophies (e.g. see Davis-Floyd, 2003). Instead, Klassen (2001a) shows that the collective known as 'home-birthers' comprises a disparate medley of traditional, conservative, feminist and 'alternative' elements that both "collide and conjoin" (pp. xiii). According to Klassen, home-birthers offer up an important 'cultural critique' through their childbirth practices and beliefs. In the end, despite acknowledging dilemmas and dangers along the way, Klassen interprets the stories and birth practices of home-birthers as representing a powerful resistance movement, challenging biomedical constructions of childbirth, birthing bodies and pain. She shows powerfully the complex creative hybridity of home-birth discourse, in which a range of often contradictory and incompatible perspectives (religion, feminism, 'alternative' health/spirituality, and biomedicine) are stitched together in a "merging of multiple discourses" (pp. 216).

This doctoral study explores birthing subjectivities through stories of home-birth and elective caesarean section. As shown above, detailed explorations of the subjective experience of home-birth and elective surgical birth are scant within the international literature and totally absent from the local, South African scene. By focussing on a 'sample' which includes two highly contentious and sharply contrasting birthing 'choices', this research hopes to be able to ask important questions about resistance, individualist agency and the different forms of birthing subjectivity reproduced within narratives of non-medicalised home-birth and highly medicalised surgical birth. Furthermore, by employing a hybrid theoretical model that conceptualises subjectivity as thoroughly ideological, cultural and embodied, this research aims to analyse, via women's talk, the ways in which ideologies, cultural narratives and phallocentric discourses infiltrate the stories/experiences/subjectivities of (under-researched) 'active' birthers. At the same time, by drawing on Kristeva's theory of the disruptive semiotic body, the multiple eruptions within women's talk will be traced and analysed. Furthermore, I will always be looking for signs of alternative story lines or representations that work to reproduce "the female body as a positivity rather than a lack" (Grosz, 1989:110). The research questions framing this thesis are therefore:

1. How do women *tell* stories of home-birth and elective caesarean section?
2. How do cultural and ideological story lines infiltrate women's talk?
3. What forms of embodied subjectivity emerge within these birth stories?

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4. Are there signs or traces of alternative story lines?

Outline of the thesis

This chapter has introduced the central contours of the thesis, contextualised the study and presented the key points of departure for this dissertation. In chapter two, the study is contextualised further through an analysis of five cultural (and deeply historical) story lines of birth that frame the choices, experiences and narratives of middle-class, westernised birthing women. These story lines are analysed and interrogated by exploring both what they 'bring into being' and what they 'make absent', thereby showing the ways in which these cultural narratives resound with ideological traces.

In chapter three, a substantial literature review is presented, in which psychological and feminist approaches to childbirth are contrasted, showing how each stream of research has conceptualised and studied birth, birthing women and the subjective experience of childbirth. The key argument of this chapter is that the complex embodied subjectivity of childbirth has been largely omitted from both feminist and psychological birth scholarship, largely because the majority of research studies operate within an individualist model of subjectivity. Recent work that has begun to rectify the silence on embodied birthing subjectivities is also reviewed.

Chapter four represents the theoretical 'heart' of the thesis. Building on chapter three, in which an individualist theory of the subject, inadequate to the task of representing embodied birthing subjectivities (DiQuinzio, 1999), was shown to underpin a large proportion of birth research, chapter four presents a number of alternative theoretical frameworks. The alternative theories of maternal subjectivity contained within the work of Simone de Beauvoir, Iris Marion Young, Adrienne Rich, Julia Kristeva, Luce Irigaray and materialist feminists such as Nancy Hartsock, Maria Mies and Mary O'Brien are explored and discussed. A hybrid theoretical model, drawing predominantly on the work of Julia Kristeva but also building on insights harvested from Luce Irigaray, Simone de Beauvoir and the materialist feminists, is put forward as the most potent framework within which to analyse birth stories. Chapter five tells a reflexive narrative of the research journey and covers methodological and analytic issues.

The analytic section of the thesis is spread out over two chapters. In chapter six, an ideological analysis of women's talk about making birth 'choices' is presented. In this chapter, I show how the predominantly 'white', middle-class and Eurocentric positioning of interviewees framed the ways in which they talked about and made birth 'choices'. The notion of 'choice' is itself 'troubled' in this analysis, largely by demonstrating how 'choices' around birth are always situated and ultimately paradoxical. The chapter proceeds by showing how women's talk was

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always embedded within (and in relation to) three dominant ideological frames, namely: patriarchy, capitalism and technocratic medicine.

Chapter seven explores the ways in which women 'told' stories of home-birth and elective caesarean section. Here I show how a medicalised narrative infiltrated the stories (and experiences) of both 'groups' of women. Furthermore, I also show the dominance of an 'outsider's' view of the birth experience, (surprisingly) even in the stories of home-birthing women. At the same time, however, this chapter also works to explore the story lines of disruption that function, in tales of both home-birth and elective caesarean section, to interrupt accepted cultural narratives. These story lines of disruption are shown to be deeply experiential and embodied ways of telling, strongly connected to what Kristeva would call a 'semiotic' mode.

The final chapter of the thesis functions as a concluding reflection. In this chapter, the key arguments of the thesis are summarised and reiterated, methodological issues and limitations are discussed and the significance of birth as a topic of theoretical, feminist and philosophical interest is underlined. Lastly, the chapter also stresses the importance of alternative visions and reflects on the political implications embedded in the home-birth and elective caesarean birth stories presented within the thesis.

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Now that I am forever with child

Audre Lorde (1992:26)

How the days went
while you were blooming within me
I remember each upon each
the swelling changed planes of my body

how you first fluttered then jumped
and I thought it was my heart.

How the days wound down
and the turning of winter
I recall you
growing heavy against the wind.
I thought now her hands
are formed her hair
has started to curl
now her teeth are done
now she sneezes.

Then the seed opened.
I bore you one morning
just before spring
my head rang like a fiercy piston
my legs were towers between which
a new world was passing.

Since then
I can only distinguish
one thread within running hours
you flowing through selves
toward You.

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CHAPTER 2

Situating cultural story lines of birth

> Where are the thousand descriptions of pregnancy and labor, the dreams and consequences of mother-longings in every century, every culture?
> (Phyllis Chesler, 1979:4-5).

> Birth can never be represented by any one type of discourse or narrative, or even from a consistent point of view.
> (Tess Cosslett, 1994:20).

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The belief that childbirth is polarised into two dominant 'models': the medical model and the natural birth model, pervades popular and intellectual thinking about birth. Although the term 'natural' is increasingly under fire and the roots of the notion of 'natural childbirth' (in the essentialist writings of Grantly Dick-Read and others) have been critiqued, the shadow of the 'natural' or 'holistic' birth ideal continues to haunt birth research. The medical hegemony over childbirth is, however, an agreed fact. From the beginning, feminist research on childbirth has taken up a stance *against* medicalised birth and offered up some (often contested) version of 'natural birth' as alternative (e.g. Haire, 1972; Arms, 1977; Rich, 1976; Jordan, 1993; Oakley, 1979, 1980; Romalis, 1981; Rothman, 1982; Martin, 1987; Michaelson, 1988; Cahill, 2001; Kitzinger, 1992, 2002, 2005).

In this chapter, I will be outlining some of the key attempts made by birth researchers to 'chart' the socio-cultural field of birth, particularly those versions which have tried to move beyond the medical/natural birth binary. I will also be tentatively outlining my own 'mapping' of birth by tracing five cultural story lines within which I believe birth is currently positioned and 'made sense of', particularly within middle-class, western socio-cultural contexts. I have noticed these story lines 'popping up' repeatedly within popular childbirth texts, academic literature, women's own writing, everyday conversations and within the stories of the women that I interviewed. Generally, these story lines do not appear as coherent, fully elaborated stories but

rather as pieces of collective, culturally agreed upon stories that have no need to be fully elaborated. In this chapter, I will show how these story lines of birth do not amount to neutral stories, but rather *resound* with ideological traces. In my own 'mapping' of birth, I will thus not be concerned to outline coherent 'models', 'accounts', 'views' or 'discourses' but will instead be asking what different cultural story lines of birth work to construct and silence and also how they potentially position birthing women. I will not be privileging one story line over another or trying to offer up an alternative to medicalised birth, but will be interrogating the ideological traces that run through each story line. The complex (intertwined) relationship between stories and ideology will also be considered.

Mapping(s) of birth

The first *collective* surge of studies investigating birth can be traced back to the 1970s and 1980s when an explosive torrent of critiques, studies and treatises on childbirth were published, mostly in America and Britain (e.g. Haire, 1972; Shaw, 1974; Arms, 1977; Rich, 1976; Jordan, 1993; Oakley, 1979, 1980; Romalis, 1981; Rothman, 1982; Kay, 1982; MacCormack, 1982; Martin, 1987; Trevathan, 1987; Michaelson, 1988). Clearly, this sudden rush of interest in women's birthing experiences was directly related to the resurgence of feminism in the 1960s. Before this dramatic wave of feminist-inspired interest, research on childbirth had remained scattered and sparse. Not much more than a few historical explorations (e.g. Rongy, 1937; Graham, 1960) and anthropological studies (e.g. Engelmann, 1882/1977; Freedman & Ferguson, 1950; Newton, 1955/1977) had been published. This changed dramatically in the 1970s when the aforementioned concerted spate of research (all by women) exposed the oppressive, alienating face of medicalised childbirth. Often these critiques were inspired by personal childbirth experiences (e.g. Arms, 1977; Rich, 1976; Oakley, 1979; Rothman, 1982). From the outset, these studies were written against the medical model of birth and comprised detailed critiques of conventional medical procedures (see Haire, 1972; Shaw, 1974; Arms, 1977), analyses of the patriarchal underpinnings of western medicine (Oakley, 1980; Rothman, 1982; Rich, 1976) and counter-arguments against the culturally received wisdom that medicalised birth equals safer birth (Arms, 1977; Oakley, 1980; Rothman, 1982). In this initial heady spate of childbirth studies one can already discern the now long-standing tendency for feminist work to align with midwifery (and the home-birth movement) in its attempts to argue against the medical model of birth. The contradictions and tensions involved in such a strange marriage (often between traditionalists and feminists) did not go unnoticed by some writers (e.g. Rothman, 1982). The first 'mapping' of childbirth consisted of the polarised medical/natural birth dualism. This dichotomy was already evident in the work of

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Suzanne Arms (1977) and Ann Oakley (1979, 1980). Oakley (1980) was one of the first birth researchers to point at the "ideological face" (pp. 8) of obstetrics and yet also to remain cautious of uncritically embracing a 'natural' birth model. She observed as early as 1979 that 'natural' childbirth prescriptions failed to put women at the centre of birth and noted in 1980 that, "natural childbirth has been colonized by medicine itself" (pp. 36). At the same time, however, Oakley (1980) was working with an understanding of childbirth as (on one level) a "deeply natural" (pp. 7) event. Oakley's (1980) 'solution' to medicalised childbirth includes a return to 'female-controlled childbirth', an end to unnecessary medical intervention and the re-domestication of birth – in effect, a return to 'natural', woman-controlled home-birth. However, Oakley (1980) does not provide us with a detailed analysis of what an alternative childbirth model (e.g. 'female-controlled childbirth') might look like.

The medical versus midwifery model

One of the first sustained attempts at providing an alternative mapping of childbirth was undertaken by the sociologist, Barbara Katz Rothman (1982) in her book, '*In labor: women and power in the birthplace'*. Rothman's 'map' consists of two binary 'models' or 'perspectives' that, in her view, comprise fundamentally different ideas, meanings and 'ways of seeing' birth. She labels these the medical and midwifery models, in effect replacing the 'natural' birth model with a midwifery model. Rothman re-defines the 'natural' childbirth lobby as "the childbirth preparation movement" (pp. 79) and re-articulates it as a consumer movement rather than an oppositional model. She therefore regards 'prepared childbirth' achieved through the likes of the Lamaze method as reformist rather than revolutionary and in effect an extension of the medical model.

Rothman provides a detailed critique of the medical model of birth, locating it within two distinct ideologies. First, the medical model is rooted in "the ideology of technology" (pp. 34) powered by ideals of rationality and control over nature. In this ideological paradigm, the human body is refigured as a machine that can be 'known' and 'controlled' via scientific knowledge. "Problems in the body are technical problems requiring technical solutions" (pp. 34). The mind-body dualism reigns supreme with the body seen as a "collection of parts" (pp. 35) and the mind effectively disappeared from consideration. Rothman argues that this 'ideology of technology' is applied to all medical patients, irrespective of gender. The treatment of *women* patients is however confounded by the existence of a further *patriarchal* ideology that also underpins medicine. In this framework, women's bodies are treated as dysfunctional and as aberrations on the masculine norm. Uniquely female bodily processes such as pregnancy, childbirth and lactation therefore easily become defined as pathological. For Rothman, obstetric medicine is "a mans' eye view of

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women's bodies" (pp. 23) in which masculine values, perspectives and definitions are privileged. Thus, in the medical model, birth is redefined as "a service that medicine supplies" (pp. 39) rather than the active labour of women. Furthermore, the birthing process is *abstracted* from the bodies of women to become a series of medically sanctioned 'stages', timetables and norms.

Rothman describes her 'oppositional' midwifery model as harder "to piece together" (pp. 24). However, in the writing and talk of midwives, contemporary feminist activists and traditional, often religious mothers, Rothman claims to have found a positive alternative to the medical view of birth, namely: a midwifery model in which women are taken as the norm and placed at the centre of the birth process, now defined "as a normal and healthy activity" (pp. 277). The midwifery model is a woman's eye view of birth, in which women are seen as the subjects and doers of birth. Body and mind, as well as mother and infant, are not dichotomised as in the medical model, but are seen as holistic, inseparable units.

For Rothman, this woman-centred midwifery model promises to solve the problems inherent in the medical model of birth. Thus, in Rothman's "pipe dream" (pp. 282) she would simply "do away with obstetrics" (pp. 282) and advocate that midwives take over all responsibility for the care of pregnant and birthing women. In her view, birth with midwives would automatically place women at the centre of their birth experiences. Smuggled into her 'solution' is therefore the implicit view that unmedicated, low technology birth ('natural' birth?) is what *all* women want. It is not thus not surprising that Rothman's vision of birth utopia has elicited criticism from feminists who claim that it is immersed in a privileged, white-middle-class perspective and that, in calling for "a home-based natural birth experience" (Annandale & Clark, 1996:29) it obscures the fact that some women are in no position to make such 'choices' or that others might not want or 'choose' such birth experiences. Rothman's 'woman-centred' version of birth is thus accused of representing the interests of only some women and in effect silencing differences between women.

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Technocratic, holistic and humanistic models of birth

In her initial path-breaking anthropological analysis of childbirth, Robbie Davis-Floyd (2003) made use of a two-model binary grid to 'make sense' of childbirth. This binary consisted of the 'technocratic' and 'holistic' models of birth. More recently, Davis-Floyd (2001) has extended this to include a third 'paradigm' which she refers to as the 'humanistic' model. In her initial analysis, she also referred to the 'natural childbirth' model as a third belief system located somewhere between technocratic/holistic approaches. However, any reference to a 'natural birth' model seems to have completely disappeared from her more recent framework.

Davis-Floyd (1988, 1994, 2003) has written copiously in efforts to provide detailed analyses of the rituals, implicit beliefs, technological artefacts and myths that underpin the *technocratic* model of childbirth. Similarly to Rothman's (1982) analysis of the 'medical' model, Davis-Floyd (2003) argues that the technocratic model is founded on "an ideology of technological progress" (pp. 47) in which techno-science equals status and value and nature is denigrated, exploited and manipulated; furthermore, this 'ideology of technology' is also seen as underpinning post-industrial, technocratic culture more broadly. For Davis-Floyd, childbirth confronts technocratic societies with a unique series of "conceptual and procedural dilemmas" (pp. 60) that are 'solved' or 'managed' through an elaborate sequence of obstetric rituals. For example, because birth is a uniquely female process it constitutes a "conceptual threat to male dominance" (pp. 61), highlighting the fact that men are dependent on women for the reproduction of life. To 'solve' this dilemma, Davis-Floyd argues that *rituals* of childbirth have been constructed to make it appear as though medical professionals (not women) are the real producers of babies. Davis-Floyd also describes how obstetric practices and rituals have served to: re-position birth as a 'private' affair sequestrated from public and cultural visibility, forced birth to be made predictable through the deployment of controlling scientific norms and timetables, neutralised or destroyed the creative energy of birthing women and stripped birth of its sexual and erotic nature.

Davis-Floyd (1994, 2003) has also outlined the underlying approach to the *body* encapsulated by techno-science. In a technocratic line of thinking, the body comes to be seen as a machine and the female body or machine as an abnormal or defective version of the male prototype. This understanding of the female body is seen as foundational to obstetrics. As a result, female reproductive processes are regarded as pathological and "constantly at risk of serious malfunction or total breakdown" (2003:53). Davis-Floyd (1988, 2003) clearly writes from a feminist position of critique against a technocratic (or medical) mode of childbirth. She thus declares in the opening pages of her path-breaking 2003[22] book that she is 'an advocate' of holistic not technocratic birth.

The 'holistic' model that she supports as radical alternative to medicalised birth is defined as "fundamentally different" (2003:158) from the technocratic model. Unfortunately, like Rothman's (1982) analysis of the 'midwifery' model, Davis-Floyd's 'holistic' model remains vague and nebulous in comparison to the sharply analysed technocratic model. Thus, we are given no substantial details concerning the ritual processes, myths or ideologies that might underpin *this* model. Instead, we are simply told that the holistic model is a belief system in which 'the family' is taken as the basic social unit, the body is a seen as a "living organism with its own innate

[22] First published in 1992.

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wisdom" (pp. 156), female reproductive processes are regarded as "healthy and safe" (pp. 156), self and body are interconnected and the birthing woman is understood as a complex spiritual, emotional and physical whole. We do not really get any idea of how this model differs from Rothman's (1982) 'midwifery' model or how it relates to either home-birth or 'natural' birth. For example, all of the women espousing a 'holistic' model of birth were, in Davis-Floyd's (1994) study, women who chose to give birth at home. We might therefore justifiably ask whether 'holistic' birth becomes conceivable only within the context of home-birth. Davis-Floyd (2003) also makes no effort to provide a critique of the 'holistic' model. Instead, holism as ideal model is left standing as a hazy, indistinct and rather romanticised 'alternative' seemingly beyond the realm of critical analysis.

In a recent paper, Davis-Floyd (2001) has amended her 'map' of childbirth to include a third model: the *humanistic* approach. She outlines the 'fundamental' differences between the ways in which the technocratic, holistic and humanistic models define the body, body-mind relations and the different approaches they assume with regards to health and wellness by setting out the 'twelve tenets' of each model. According to Davis-Floyd (2001) underpinning the humanistic model is a drive towards humanising medicine – that is, an effort "to make it relational, partnership-oriented, individually responsive, and compassionate" (pp. 10). This approach is thus characterised as a movement for medical reform which is "less radical" than holistic approaches (*ibid*, pp. 10) but "more loving" (*ibid*, pp. 10) than technocratic medicine. In the humanistic model, body and mind are seen as interconnected and the body is depicted as an organism: a living being that has its own "innate healing powers" (*ibid*, pp. 11) and is responsive to changes in environment and care. It is a 'bio-psycho-social' model in which biological, psychological and social elements are all regarded as significant. This model also champions caring and connected relations between doctors and 'patients' and advocates respect for the patient as a "relational subject" (*ibid*, pp. 11) bound relationally to significant others (i.e. partners, relatives, friends). Core underlying tenets of this model include notions of connection, relationship and balance.

Significantly however, this model nonetheless still endorses technology, medical interventions and standard obstetric protocols with regards to childbirth. The model does, however, ostensibly depart from technocratic medicine in (at least) advocating a willingness to be less interventionist, more open-minded with regards to alternative birth practices and in its emphasis upon kindness, empathy and caring. Davis-Floyd (2003) notes that the 'humanistic' approach to medicine has already had a far greater impact upon technocratic birth (in developed countries) than so-called 'holistic' models. Thus, the past decade has seen the 'humanistic' model making significant progress in reforming a number of technocratic birth practices. This is evident

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in increasing numbers of 'home-like' labour and delivery wards, an increase in midwife-attended births and use of doulas (trained birth companions), the relaxation of medical norms with regards to enforced perineal shaving, the administration of enemas and nil-by-mouth policies, as well as a reduction in episiotomy rates and an increasing support of immediate mother/infant body contact, 'rooming-in' and breastfeeding (Davis-Floyd, 2003). Davis-Floyd concedes, however, that apart from these kinds of positive shifts in particular practices, the core principles and belief system of the technocratic model remains largely unchanged.

Critical discursive mappings of birth

The final two approaches to be outlined in this chapter take up a substantially more *critical* stance in their reading(s) or mapping(s) of childbirth. It is worth noting that both of these researchers work with a post-structuralist/discursive approach in their analyses. Paula Treichler famously declared a 'childbirth crisis' (in America) or what she defined as "significant recent challenges to long-standing, medically managed, hospital-based childbirth" (pp. 113) in 1990. This 'crisis' was described as fundamentally a crisis of *meaning*. In her influential article, she describes three different versions of childbirth at play in this volatile mix. These include: medical, feminist and economic 'accounts'. For Treichler (1990), the 'crisis' surrounding birth is the result of a struggle or war over what gets to count as the (definitive) meaning of childbirth. In her view, each of the three 'accounts' that she describes (medical, feminist and economic), offers a coherent, competing definition of 'reality', of women and of birth itself.

Treichler departs from most feminist accounts by insisting that it is not medicalised birth that is the problem but rather medicine's monopoly of authority, resources and 'linguistic capital' or "the power to establish and enforce a particular definition of childbirth" (pp. 119). The monopoly that medicine has enjoyed in defining the 'reality' of what childbirth 'is' – i.e. a medical event – is the outcome of a historical struggle in which obstetrics fought to gain scientific, political, economic and ideological support. Treichler also makes the critical point that each of the three 'accounts' of birth are 'interested' rather than neutral versions of what birth 'is' or should be. She is thus not content to only interrogate or critique medical accounts of birth; instead she asks whose interests are served or represented by the definitions offered by each 'account'.

Treichler's mapping of the 'childbirth crisis' is also significant because it remains one of the only frameworks to give an economic spin to these debates. She is thus cognizant of the intense economic competition existing in the childbirth arena and notes that if 75% of 'low-risk' American pregnant women gave birth in alternative birth centres (run by nurse-midwives), it

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would amount to economic savings (to consumers, insurance companies and the state) of several billion dollars a year. She also recognises that in an *economic* account, the realm of childbirth constitutes a "birth market" (pp. 127), birth itself becomes a "market commodity" (pp. 131) and birthing women emerge as "independent consumers with rights and free choice" (pp. 128).

Treichler insightfully notes that as counterdiscourses arising out of a struggle with medicine as a dominant discourse, both feminist and economic accounts of childbirth continue to bear the marks of "a dominant structure which continues to shape it, even cannibalize it" (pp. 132). As I have mentioned earlier, feminist accounts of childbirth initially emerged out of an attack *against* medicalised birth and remained for many years preoccupied with such a critique. As a reactionary movement against biomedicine, feminist researchers of birth have often remained far less clear about what exactly they are arguing *for*. The medical/natural birth binary emerged within the work of feminists because of their need to have some kind of alternative with which to 'oppose' medicalised birth.

The final alternative 'mapping' of birth that I want to discuss is that of the literary scholar, Tess Cosslett. In her pivotal book, '*Women writing childbirth*' published in 1994, Cosslett begins the important project of trying to trace the representation of childbirth within the work of women writers. Writing from a broadly post-structuralist position, Cosslett speaks of childbirth *discourses* or *stories* rather than 'models', 'views' or 'accounts'. From the outset, Cosslett is critical of the medical/natural birth binary. Thus, for Cosslett, the taken-for-granted understanding that birth is divided into two opposing 'camps' or stories can itself, "be seen as a powerful, simplifying cultural myth" (pp. 6). She also signals the impossibility of ever accessing a 'pure' version of either story. Her book goes on to provide a critical deconstructive analysis of both the 'natural childbirth' and medical birth stories and asks how they are represented, appropriated and subverted in women's twentieth century fiction and poetry. Cosslett provides us with one of the sharpest critiques of 'natural childbirth' ever to have been published. In this critique she exposes the notion of 'natural childbirth' as a "male ideal" (pp. 10) embedded in a "pseudo-evolutionary" (pp. 10) opposition between so-called 'primitive' and 'civilised' women.

Significantly, Cosslett also identifies a third "marginalised or repressed" (pp. 77) discourse about childbirth that she calls the 'old wives tale'. This discourse refers to "the oral stories women tell each other about birth, especially those told by mothers to daughters" (pp. 109). Cosslett claims that this genre of birth narrative is vehemently reviled in both medical and 'natural birth' discourse. Such 'old wives tales' are thus regarded as repugnant for their "gloom and doom" (pp. 115) attitudes towards childbirth and their emphasis upon the gruesome horror and "pain and drama of the birth process" (pp. 114). It is important to note that the inclusion of 'old wives tales' as a significant childbirth discourse represents the first attempt (in a 'mapping' of birth) to take

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seriously a genre derived from *personal* birth experience. This is a significant development. Cosslett reflects that perhaps the hostility and suspicion shown towards these stories (by medical and 'natural childbirth' exponents alike) is indicative of a "prejudice against the authority of the experience of women who have actually given birth" (pp. 110).

A way forward?

What can be concluded from this tour of childbirth maps? We have seen that feminist research on childbirth has generally constituted a form of *interested* knowledge. We can see this in the early tendency to write in a polemical or even vitriolic vein against the medicalisation of birth. This is not a criticism. On the contrary, it was this very interested stance that enabled feminists to constitute a substantial challenge to medicalisation. The feminist attack on western birth has contributed massively to the implementation of more humane birth practices, the empowerment of birthing women and has also functioned as a check on increasing rates of intervention and caesarean sections in 'First World' countries. Thus, in America the caesarean section rate has stabilised at around 25% and is monitored vigilantly by "large and very vocal groups of birth activists" (Davis-Floyd, 2003:xix). However, in developing countries such as Brazil (and South Africa) that tend to lack a sustained voice of criticism against medicalisation, the rate of caesarean sections continues to climb (*ibid*). The "iatrogenic epidemic" (*ibid*, pp. xix) which western feminists fought so hard against in the 1970s and 1980s, seems to have been exported *en masse* to the developing world, along with a (western) technocratic mode of birth. Furthermore, whereas midwifery is currently experiencing revitalization in many First World countries, it is increasingly a "vanishing occupation" (*ibid*, pp. xx) in the developing world. It is important that feminist birth activists and researchers recognise this "inescapable irony" (*ibid*, pp. xxi) and the interconnection between what is happening in birthing systems across the globe. Considering birth in its global context means a recognition that feminist approaches to childbirth cannot afford to become disinterested forms of knowledge.

Feminist attempts at providing an alternative or coherent 'position' *vis-à-vis* birth are often reduced to offering up various (often 'bioromantic') versions of 'holistic' or 'natural' ways of birthing or simply championing the notion of women's 'choice'. We have seen that in the first wave of childbirth research, feminists tended to take up far more explicit positions against medicalised childbirth (e.g. Oakley, 1979, 1980; Romalis, 1981; Rothman, 1982); in so doing they generally had to argue for a 'midwifery' model or some variety of 'natural' birth. Unfortunately, while bold and convincing in arguing against medicalised birth, most feminist researchers of birth

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have remained fuzzy and unclear regarding what precisely they are arguing for. In the view of Annandale & Clark (1996:30):

> We have an extremely poorly drawn picture of "alternatives"… an alternative is called into existence in powerful and convincing terms, while at the same time its central precepts (e.g. "woman-controlled" and "natural birth") are vaguely drawn and in practical terms carry little meaning.

Most feminists have remained at least somewhat critical of 'natural childbirth'; yet at the same time, most have held onto various (often vague) versions of 'natural', 'holistic' or home- birth as alternative or 'solution' to the problem of medicalised birth. Generally, such writers have been far more clear, thorough and detailed in their analyses of the medical model than in their exposition of alternative models (e.g. Rothman, 1982). With the increasing destabilisation of such 'alternatives' prompted by sharp critiques of 'natural childbirth' (e.g. Cosslett, 1994) and increasing research evidence showing that women themselves might actually find technocratic birth empowering (see Davis-Floyd, 1994, 2003), it seems that a feminist position *vis-à-vis* birth is increasingly likely to come down to a rhetoric of 'choice' (e.g. Turner, 2002). Thus, for example, for Robbie Davis-Floyd (2003), it all boils down to 'choice'. She says, "My position has always been that women should have a full range of choices in childbirth" (2003:xviii) and states that her activist efforts with regards to childbirth are focussed on "keeping open the spectrum of choice" (*ibid*, pp. xviii). Is advocating 'choice' a *critical* enough position for feminist birth researchers and activists? In my analysis of cultural birth story lines in the following section, I will be exploring the merits and consequences of such a feminist valorisation of women's 'choice' with regards to birth. Both of the 'solutions' that have been taken up by feminist researchers (i.e. advocate a version of 'natural childbirth' or champion 'choice') tend to remain mired within a western, middle-class perspective, which nonetheless often presents itself as a kind of universal standpoint. In feminist analyses of childbirth, the location of techno-medicine within a global system of patriarchal capitalism is often overlooked or merely paid superficial lip service.

In the following section, I will be attempting my own 'mapping' of birth. This will not be an attempt to outline coherent 'models' or 'approaches' but will involve the exploration of five cultural story lines that I have identified within writing and talk about childbirth. It is important to stress that this map is in no way definitive or exhaustive but represents my own attempt to 'make sense' of broader (westernised) cultural narratives of birth. In this 'map', I will be outlining the core narrative of each story line, interrogating the absences that they produce, considering how they relate to academic research evidence and asking how they position birthing women. Thus, each story line will be subject to a critique in which I explore the ideological traces that run throughout each narrative.

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Exploring cultural story lines of birth

"Stories are not simply individual productions but cultural and ideological as well."
(Lee Anne Bell, 2003:4)

Along with a turn to text and language, contemporary times have witnessed a considerable 'turn to narrative'. Thus, some say we are currently immersed in an "age of narrative" (Josselson, 1995:31), a time when "stories have…moved to centre stage in social thought" (Plummer, 1995:18). It has been proposed that narrative is a unique 'form of knowing' (Bruner, 1986) and that a narrative structure might lie at the core of human reasoning and cognition (see Polkinghorne, 1995). Some maintain that "human psychology has an essentially narrative structure" (Crossley, 2003:291) and others believe that without storytelling there would be no coherent sense of self, identity or subjectivity (Plummer, 1995). It is thus not surprising that narrative analysis has burgeoned in the last two decades. This 'narrative turn' however enjoys a motley bundle of roots in phenomenology, hermeneutics, psychoanalysis and post-structuralism and a definition of what narrative actually 'is' remains highly contested (Reissman, 1993; Polkinghorne, 1995). For the most part, narrative analyses have tended to focus on the construction of individual identity in and through stories (e.g. McAdams, 1993; Reissman, 1993; Linde, 1993; Crossley, 2000; Byrne, 2003) and have taken the interpretation of experience as their primary goal (e.g. Chase, 1995; Josselson, 1995). Although there is much talk about the importance of linking stories to structural factors, particularly among feminist researchers (e.g. Personal Narratives Group, 1989; Anderson & Jack, 1991), narrative approaches nonetheless tend to remain preoccupied with "the specific experiences undergone by individuals" (Crossley, 2000:40).

The relationship between stories and ideologies therefore remains hazy, generally ignored and underdeveloped by narrative researchers. More recently, valuable efforts to examine the interconnections between stories and ideologies have been initiated by critical race theorists and researchers (e.g. Bell, 2003; Bonilla-Silva, Lewis & Embrick, 2004). For Bonilla-Silva *et al.* (2004), stories are always told within "particular ideological formations" (pp. 556) and are therefore inextricably bound to ideologies. Societies are seen as inevitably "structured in dominance" (*ibid*, pp. 556) making it likely that the stories, discourses or 'truths' of the privileged classes will become established as cultural 'common sense'. Other theorists have already elaborated on the function of 'common sense' as a distinct form of ideology (Billig, 1991). For Bonilla-Silva *et al.* (2004) dominant ideologies can be discerned parading as 'common sense' logic within collective, cultural stories in which different people, in different positions and social contexts, "deploy similar kinds of narratives to explain social reality" (pp. 556). In their analysis of the racial stories that accompany colour-blind racism, Bonilla-Silva *et al.* (2004) focus on *story*

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lines and testimonies as two different types of stories. They define story lines as "socially shared tales that incorporate a common scheme and wording" (pp. 556) and which therefore come close to resembling legends or fables. Story lines are generally based upon:

> …impersonal, generic arguments with little narrative content – they are readily available, ideological, "of course" narratives, that actors draw on in explaining personal or collective realities (pp. 556-557).

In my analysis of cultural birth stories, I will be working broadly within Bonilla-Silva *et al.*'s (2004) definition of story lines. Thus, the story lines to be explored below are not examples of fully elaborated stories with a coherent plot, individual characters and a clear temporal sequence. Instead, characters are more often than not "social types" (*ibid*, pp. 557) such as 'the primitive woman' or 'the midwife' rather than *concrete* persons. In my view, story lines almost always function as fragments, leaving the listener or reader to fill in the missing pieces of logic. Allowing listeners to fill in the gaps themselves by drawing on a common pool of cultural 'truths' or 'common sense', works to make story lines powerfully persuasive 'of course' type narratives. Thus, whole story lines (as assumed truths) can be conjured up simply through the use of key images or catchphrases. Leaving it to listeners themselves to make the logical jumps also allows contradictions within story lines to be successfully obscured. As 'common sense' narratives that work to construct the way things are, should be, or always have been, story lines are inextricably connected to ideologies.

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The age-old story of woman-centred birth

"Where, then, is our tribe of powerful female elders sitting beside the sea – pounding spices, exchanging stories, singing? Not in New York City. Not in the twentieth century. Whereabouts unknown to my circle."
(Phyllis Chesler, 1979:18).

Suzanne Arms (1977) begins her classic childbirth text, '*Immaculate deception*' with a call for the reader to 'imagine' how an 'ancient sister' or "distant ancestor" (pp. 2) might have experienced childbirth. She then launches into a compelling, imaginary story describing the birth experience of an 'ancient sister' living in a hunter-gatherer society. Through this story we are allowed to 'look back in time', all the while catching evocative glimpses of a different way of birthing. In this story, birth is constructed as *part of everyday life*. Thus, the young woman who is about to give birth continues to work hard in the fields. Even when she begins to feel labour pains, she carries on with her daily routine and begins to prepare the evening meal. There is no drama, hurry or panic; the rhythm of everyday life continues. Birth is also constructed as a *woman-centred affair*. We are told that the village men are all away on a hunt. The birthing woman is cared for by 'older

women': her mother, grandmother and the village midwife. These women encourage her, wipe her forehead, breathe with her, 'grunt' approvingly with each contraction and when the time comes, they push with the young woman, as if they too were giving birth. In the story, birth is portrayed as something that a *woman naturally knows how to do*. Although it is this young woman's first baby, we are told that she simply 'knows' when labour has started. She also automatically or instinctively falls into a squatting position, 'knows' (without being instructed) how to breath in rhythm with her contractions, 'knows' when and how to push the baby out and how to change her breathing to facilitate the pushing process. In the story, birth proceeds with very *few interventions* by the midwife. She is described as doing little apart from putting an ear to the woman's belly, cleaning and replacing soiled bedding (a moss and grass mat), pressing on the belly to feel for the infant's position, guiding and supporting the infant's head as it emerges from the vagina and cutting the cord with a "sharpened stone from her pouch" (pp. 6). Everything in this birth story proceeds *normally*, without fuss or complication. After she has birthed the baby, the young woman proceeds to deliver the placenta without undue effort, breastfeed without difficulty and we are told that she will simply continue with her work, the baby slung at her side in a pouch, in a day or so. Thus, three days later, when the men return from hunting, the only visible change in the village will be "the soft pouch the young mother wears as she stoops over her crops…tends the fire and prepares the evening meal" (pp. 7).

This story of hunter-gatherer birth in which childbirth is depicted (in the historical past) as a normal part of everyday life, a woman-centred affair with few interventions in which the birthing woman instinctively and naturally 'knew' how to give birth, is a vivid example of the first story line which I want to discuss in my mapping of cultural birth stories. This story line, which I have labelled 'the age-old story of woman-centred birth', often appears within feminist texts (e.g. Arms, 1977) as the source of a deep yearning or longing for a past historical time in which birth was untainted by medical intervention, controlled by women and empowering to women. The core of this story is that childbirth was 'once-upon-a-time' woman-centred, a positive source of women's power and the basis of a strong female solidarity. This story line often intersects with stories about pre-patriarchal societies, sometimes described as 'matriarchal' in which women were worshipped as 'mother goddesses' and their procreative capacities were revered, celebrated and the source of substantial social authority. There is substantial disagreement among scholars as to whether such matriarchies or gynocracies ever 'really' existed (Rich, 1976) but the image of the 'mother goddess' has nonetheless become a powerful and resonant source of fantasy, speculation and celebration for artists, feminists, witches, psychotherapists, ecological activists and polemicists of the twentieth and twenty-first centuries (Husain, 2000). Stories about matriarchal societies, 'mother goddesses', 'ancient sisters', 'birth goddesses' (Kitzinger, 2000) and

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'Amazons' are particularly tempting and luring for feminists because they suggest that patriarchy is not an inevitable and a-historical fact and that alternative, less oppressive social arrangements are possible. Several imaginary myths or stories have been written re-constructing the possible meaning(s) of women's reproductive bodies and maternity within these kinds of imagined pre-patriarchal communities (e.g. Bachofen, 1967; Briffault, 1927; Neumann, 1955; Mies, 1986; Knight, 1991); most of these imaginary stories have been written by male scholars.

Feminists themselves have had different responses to these kinds of ideas and fantasies. Many would regard these differences as representative of an underlying and longstanding tension within feminism between the tendencies of sameness and difference (DiQuinzio, 1999). DiQuinzio (1999) claims that the entire history of feminist thought is structured by these two competing lines of argument. These two tendencies obviously have very different approaches and beliefs about maternity and female reproduction. Thus, for 'equality-in-sameness' feminists like Simone de Beauvoir (1989) and Shulamith Firestone (1970), uniquely female reproductive processes are the root cause of women's oppression and must therefore be overcome and transcended. 'Equality-in-difference' feminists are far more likely to study female reproduction and regard menstruation, pregnancy, childbirth and breastfeeding as potentially positive sources of female creativity and empowerment (e.g. Rich, 1976; Martin, 1987; Ruddick, 1989; Young, 1990b, 1990c). For difference feminists, the female body and reproductive processes are not inherently responsible for women's oppression, but have rather been colonised, distorted and demeaned by patriarchy. Due to the influence of post-structuralism and the recognition of difference within the category 'woman', woman-centred difference feminism has been thoroughly critiqued and "rather diminished" (Beasley, 2005:61) in more recent times. However, in research on female reproductive processes, difference feminism has (not surprisingly) managed to persist far longer.

The story of 'age-old woman-centred birth' is intimately connected with a woman-centred, difference feminism. In searching for positive, empowering ways to conceptualise women's bodies and procreative capacities, feminists are often tempted to look back with nostalgia to the past. This tendency has been sharply accused of 'bioromanticism' (Pollock, 1999) and criticised for its attempts to try and 'get back to' an underlying 'true', uncorrupted meaning of childbirth (Treichler, 1990; Annandale & Clark, 1996). Feminist researchers or writers of birth who are sympathetic to difference feminism are easily lured by the story line of 'age-old, woman-centred birth' because it suggests that the 'pure', 'original', uncontaminated meaning of childbirth is woman empowering and liberating. The difficulty with attempts to 'get back to' origins and re-discover 'the natural' are that often these very terms and debates hide a multitude of ideological baggage (see Soper, 1995). Another difficulty with this sort of story line is its tendency to

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construct reproduction and childbirth as the primary and essential source of an exclusive female power. Thus, an underlying logic lying behind this story line is that if childbirth could be woman-centred again, women's power would be restored and women would be liberated.

Apart from the image of the female (mother) goddess, this story line is also associated with the figure-trope of the so-called 'primitive' woman. For example, the movement from 'your' ancient sister to 'the' primitive woman is seamless in the work of Arms (1977). Thus, after telling us the story of an imaginary childbirth in hunter-gatherer society, she immediately moves into a discussion of how and why birth was different for 'the primitive woman'. Thus, we are told that the primitive woman was used to long hours of strenuous physical labour, she was 'sturdier', her diet was 'better' and she was immune to diseases of the 'civilised' world. However, it was the 'attitude' of the primitive woman that 'really' separates her from so-called 'civilised woman'. For the primitive woman:

> Childbirth was part of the natural order of things, a commonplace occurrence, and she dealt with it matter-of-factly, instinctively, and without fear…[Her] built-in knowledge of childbirth was something she could not articulate or explain; it was unquestioning, unselfconscious, and uncomplicated (Arms, 1977:11).

This 'primitive woman' is a historical figure but also resonates with a racist and classist ideology in which African, rural, poor and working-class women are taken to be living examples of 'backward' or 'primitive' peoples. Just about everybody has heard the story about the African woman who goes into the bush, gives birth easily by herself and returns to her village with an infant strapped to her back. This story often emerged in my interviews with home-birthers, who seemed to use this trope as a source of inspiration or confirmation that women's bodies are designed to give birth (see also Klassen, 2001a). It was taken as a kind of proof that they (as women) must be able to give birth without medical intervention (just like the primitive African woman). In its reliance on the figure-trope of the primitive woman, the story line of 'age-old, woman-centred birth' overlaps with a 'natural birth' story line, which (as I will discuss later) is heavily reliant on the same imagery.

There is also a tendency for (over-simplified) anthropological research on childbirth within 'traditional' cultures to merge with the story line of 'age-old woman-centred birth'. Often there is a superficial line of reasoning that identifies all birth practices within such cultures as beneficial, wise and closer to the inherently 'good' processes of nature. We can see this, for example, at play in Sheila Kitzinger's (2000) book, '*Rediscovering birth*'. This book is replete with glossy colour photographs of rural Third-World women (often African) breastfeeding, working in the fields with infants strapped to their backs, striding bare-breasted with their infants or giving birth on a bed of leaves. When contrasted with photographs of highly technological western medical birth

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(women in stirrups, attached to intravenous drips and surrounded by medical personnel in surgical garb), a powerful over-romanticised nostalgia is engendered for these more 'primitive' ways of mothering and birthing. In her book, Kitzinger repeatedly contrasts a (western) technocratic way of birth with a woman-centred, social way of birth encapsulated by the birth practices of traditional cultures. This 'social' model of birth resonates strongly with the story line of 'age-old woman-centred birth'. Kitzinger (2000:250) ends her book with the following comment, positively dripping with longing and nostalgia:

> If, through fear or ignorance, we neglect our heritage and allow technocracy to take over, woman-centred childbirth may be lost forever.

What then are the *absences* created by the story line of 'age-old woman-centred birth'? First, this often idealised story line works to over-simplify the recorded history and anthropology of childbirth. It produces the idea that 'original' historical and cultural birth practices are 'all-good', beneficial to mother and baby, non-interventionist and empowering. This is not the case. Birth in traditional cultures is shot through with complex rituals, beliefs, interventions and myths, many of which are *patriarchal*. For example, we know that in some versions of traditional African birth, obstructed or prolonged labour is seen as a clear indication that the labouring woman has been unfaithful during pregnancy, which can turn childbirth into an ordeal in which she is required to 'admit' her guilt (Maimbolwa, Yamba, Diwan & Ransjö-Arvidson, 2003; Chalmers, 1990). Interventions such as episiotomies are also sometimes performed in traditional births "with a sharp-edged reed, a blade, a glass fragment or knife" (Chalmers, 1990:20) when delivery is delayed. In traditional Zulu, Sotho and Pedi birth, colostrum is seen as deleterious and is not fed to newborn infants. Furthermore, in many traditional African cultures, women are required to be stoical in labour and the expression of pain is heavily frowned upon (Chalmers, 1990). Screaming or crying out in labour is seen to reflect badly on the labouring woman's kin (Chalmers, 1990) and also said to lead to infant death (Maimbolwa *et al*., 2003).

The story line of 'age-old woman-centred birth' also works to *silence* the 'shadow of death' that has remained the omnipresent companion of birthing women throughout recorded history. "Maternity, the creation of new life, carried with it the ever-present possibility of death" (Leavitt, 1986:20). In the over-romanticised story of 'age-old woman-centred birth' there is little reference to death or to the dangers and injuries that childbirth could bring (even if rarely). Rather, birth is presented as uncomplicated, 'natural' and often close to effortless when left to the care of women. This story line also makes invisible the high rates of death and complication associated with childbirth in poor, rural, 'Third-World' contexts. Sub-Saharan Africa has the highest rates of maternal mortality in the world, with a ratio of over 900 deaths per 100,000 live births in many

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countries (Buor & Bream, 2004). More than 99% of the approximately 500,000 women who die each year from pregnancy and childbirth related causes are from developing countries (*ibid*). The lifetime risk of dying in childbirth is cited as 1/12 for women in sub-Saharan Africa and 1/4000 for women in Northern Europe (Roth & Mbizvo, 2001). In the 'age-old woman-centred birth' story line these kinds of statistics are nowhere acknowledged (e.g. Kitzinger, 2000). This story line emanates from a middle-class, western, generally white perspective that fails to acknowledge the difficulty and risk of death for birthing women in poor, rural, Third-World contexts. The Third-World woman is instead *appropriated* as a figure-trope confirming the middle-class, western, white woman's conviction that she can birth 'naturally' without medicalisation. The Third-World woman is thus conveniently portrayed as having a 'care-free' or 'matter-of-fact' (see Arms, 1977) attitude to childbirth, which she performs simply, easily, instinctively and without undue complication.

It has been argued that underlying the trope of the 'primitive' African or Third-World woman who is 'closer to nature' is a capitalist patriarchal ideology (Mies, 1986). According to Mies (1986) the historical process (under patriarchal capitalist colonialism) whereby African women were constructed as 'primitive', 'savage' and 'animal' is directly related to the 'civilising' of middle-class European women, who at around about the same time became construed as 'delicate' and 'angelic' 'ladies'. This separation of women into two different 'types': on the one hand, the savage, animal, primitive, hard-working, amoral and sexually licentious African (and to a lesser extent poor and working-class) woman and on the other hand, the genteel, delicate, civilised, angelic, vulnerable, highly moral and sexually frigid European woman, suited the needs of transglobal patriarchal capitalism. Thus, whereas women in the colonies were treated as 'tough' manual labourers and animal-like slave 'breeding' machines whose reproduction was to be controlled on the basis of "capitalist cost-benefit calculations" (Mies, 1986:90), European middle-class women became confined to the bourgeois family and were re-created as *consumers* and *housewives*. Underlying the story of both 'age-old woman-centred birth' and 'natural birth' lies a similar opposition between 'primitive' and 'civilised' woman (Cosslett, 1994).

What then of the academic evidence? Is there support for the story line of 'age-old woman-centred' birth? There is substantial evidence that birth was woman-centred and the source of an exclusively female culture for most of human history (Rich, 1976; Pollock, 1997). Countless historical writers and researchers have shown that childbirth was, until approximately the eighteenth century, exclusively women's business (Shorter, 1982; Leavitt, 1986; Towler & Bramall, 1986; Oakley, 1984; Moscucci, 1990; Cahill, 2001; Massey, 2005). Thus, female midwives and kin have been the traditional caretakers of birthing women for thousands of years

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(Towler & Bramall, 1986). The history of childbirth is therefore, in many senses, the history of midwifery (Rothman, 1982).

However, the fact of historical, female-controlled childbirth has been substantially over-romanticised in the story line of 'age-old, woman-centred birth'. Just because women attended childbirth does not mean that birthing women were exempt from patriarchal control and regulation (Pollock, 1997; Lee, 2002; Aikin, 2003). For example, historian Judith Aikin (2003) has shown that though childbirth was exclusively a woman's affair in the birthing rooms of Germany during the 1600s, men still exerted substantial social control over pregnant and birthing women. Furthermore, although physically absent from the childbirth scene, men still went to great lengths to impose their own patriarchal definitions of childbirth onto women. For example, it was mostly men that wrote the prayer and devotional texts designed to be used by labouring women and attendants. These texts reinforced notions of childbirth pain and suffering as punishment for women's 'sins' and frequently use the language of deformity, damage, death and sin. They superimposed a male, patriarchal view of childbirth onto women's experience. Furthermore, Linda Pollock (1997) argues that 'woman-centred' birthing networks were more ambiguous, "less idyllically nurturing" (pp. 294), more confrontational, transient, regulatory and less supportive than is commonly assumed. In Pollock's (1997) view, the bonds of sisterhood were *not* all embracing and unconditional. Often female attendants at childbirth were more concerned with protecting the (patriarchal) status quo and making sure that all was 'right and proper' than with supporting the birthing woman.

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The story line of birth's medicalisation as progress and salvation

"Into the grinning jaws of death I'd be walking were I a woman of another century. I remember the tombstones in Vermont, New Hampshire, Massachusetts…Beloved daughter of…First wife of…Dead in childbirth…"
(Phyllis Chesler, 1979:109).

The first story line of birth's medicalisation is one of *progress* and *salvation*. This is the dominant 'common sense' way in which the medicalisation of childbirth is understood. In line with modernist notions of scientific and technological progress, the development of western medicine is generally assumed to be a narrative of 'enlightenment', progression and triumph over the ignorant, superstitious and 'backward' practices of the past. In this 'taken-for-granted' cultural view, the development of obstetrics is seen to have successfully 'saved' women from the clutches of death and pain in childbirth. In this story line, women died like flies before the advent of scientific (male) obstetric medicine. Childbirth is thus seen as an inherently dangerous and risky process that requires medical expertise to make it 'safe'. In the commonly accepted story line of

medicalised birth as 'progress and salvation', it is medical breakthroughs that have led directly to the lowering of maternal and infant mortality rates in childbirth. The scientific progression of obstetrics has made childbirth controllable, knowable and safe; medicine has triumphed over both birth and death.

This story line lies behind the now hegemonic medical model of childbirth. It is such a taken-for-granted view that it is almost difficult to find direct evidence for it. Thus, lying as a culturally accepted 'truth' is the idea that for childbirth to be *safe*, it has to take place in a hospital with medical back up. The assumption behind this is that the historical story of medical birth is one of increased safety and less childbirth deaths. Thus, in the personal 'momoirs' (Baraitser, 2005) of Phyllis Chesler (1979), Naomi Wolf (2001), Rachel Cusk (2001) and Sam Cowen (2005), the belief that medical birth equals safe birth lies as an almost unshakeable 'truth' at the centre of their narratives. Although most of these women do question medicalised birth and tentatively try to find alternatives, at the end of the day, the story line of medicalised birth as salvation from risk, complication and death, is too strong. All four of these women thus end up experiencing highly medicalised births. At this point, it is perhaps germane to ask why women have been so easily co-opted into the medical story line of childbirth. If childbirth was for so many centuries a normalised, woman-centred affair, why were women so quick to accept medicalisation?

We know from historical records that women have feared and 'worried' about childbirth for many centuries (e.g. see Langford, 1995). According to Leavitt (1986:14):

> During most of American history, an important part of women's experience of childbirth was their anticipation of dying or of being permanently injured during the event.

The 'shadow of death' has thus been an important structuring dynamic in the psyches of pregnant and birthing women for many hundreds of years (or more). Seen in the context of this death shadow, it becomes far more understandable *why* women might have embraced the promise of safety that medical progress held out. Thus, one version of women's role in the historical medicalisation of childbirth is one of active *agency.* It has become increasingly fashionable (often among feminists) to see women as co-constructers of medicalised birth (Arney, 1982; Leavitt, 1986; Pollock, 1999; Blum, 1999; Hanson, 2004). Many researchers now highlight the fact that it was women themselves who originally invited men (as physicians and male-midwives) into the birthing room (Leavitt, 1986; Shorter, 1982). Shorter (1982) notes that the preference for male birth attendants first began to surface among middle- and upper-class European women in the 1750s. Apparently the ability to procure a male-midwife or *accoucheur* became a 'fashion statement' (Hanson, 2004) as well as a sign of high *status* (Shorter, 1982; Lewis, 1983) probably

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related to the fact that male-midwives charged higher fees (Rothman, 1982). Women were also lured by the promise of life saving male birth technology (obstetric forceps) that female midwives were forbidden from using (*ibid*). At a later stage, birthing women were also seduced by the promise of pain-free childbirth and agitated for access to drugs. For example, in the 1920s, along with a surge in feminist sensibilities came women's demand for the right to the childbirth drug scopolamine, which was more widely known as 'twilight sleep' (Leavitt, 1986; Pollock, 1999). Medicalised hospital birth, replete with scientific 'experts', technology, and pain-relieving drugs, was for many women a symbol of scientific progress, modernization and freedom from their female biology (Blum, 1999). It has also been argued that women were often as invested as men in modernist notions of scientific and technological progress (Pollock, 1999). It could thus be said that women were successfully co-opted into the patriarchal medical model of childbirth largely because it offered them the possibility of escaping death, injury and pain and also because it held out the promise of transcending the tyranny of female biology.

At this point it is, however, critical to recognise the ideological context within which birth became medicalised. Thus, I do not believe it sufficient to conclude (in the interests of resuscitating agency) that women were simply equal co-constructers of the medical model. It is important to remember that by the time male experts managed to infiltrate and colonise childbirth, a patriarchal ideology of the female body had already become hegemonic. From the 1750s onwards, women's bodies had become emblems of "hysterization" (Foucault, 1976/1990:104), insanity, pollution and danger (Ussher, 1992; Segal, 1994; Sbisà, 1996; Lee & Sasser-Coen, 1996). Women's reproductive bodies, in particular, were cast as dangerous, chaotic and irrational and the maternal body became subject to stringent control, dissection and objectification via scientific and medical discourses (Harding, 1998; Massey, 2005). According to Moscucci's (1990) analysis of the historical development of gynaecology in Britain between 1800 and 1929, women became (scientifically) re-defined and re-imagined as:

> …disease or disorder, a deviation from the standard of health represented by the male…not only did women's biological functions blur into disease; they were the source of a host of other psychological disorders, from strange moods and feelings, to hysteria and insanity (pp. 102).

It is likely that many women (and feminists) came to believe these ideological mystifications, seeing their own bodies and reproductive capacities as a source of dirt, shame and oppression. Simone de Beauvoir (1989) has written insightfully about the process whereby women become alienated from their sexual bodies within patriarchy. She did not, however, recognise the

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alienation that women experience in relation to their procreative bodies. In fact, Beauvoir[23] (1989) herself was guilty of reproducing a patriarchal ideology that denigrates female reproduction as part of an animal, non-transcendental brute 'nature'. Thus, for Beauvoir (1989):

> Ensnared by nature, the pregnant woman is plant and animal, a stock-pile of colloids, an incubator, an egg; she scares children proud of their young, straight bodies and makes young people titter contemptuously because she is a human being, a conscious and free individual, who has become life's passive instrument (pp. 495).

This is the calling card of a deeply successful ideology, namely that it manages to distort, invert and co-opt the oppressed to its own imaginings and myths. Phyllis Chesler, writing passionately of her journey to maternity in 1979, makes the following (still pertinent) powerful lament:

> Oh my sisters: Does our mother's flesh so revolt us? Is our female flesh so painful you deny it in the name of women's survival, woman's freedom? (pp. 198).

Part and parcel of the re-imaging of women inherent within the medical story line of 'progress and salvation' is also a re-interpretation of nature and of midwives. In fact, the medical story can only operate 'as progress and salvation' through the ideological denigration of women's bodies, 'nature', midwives and the birth process itself. Thus, according to this story line, before the advent of medical expertise, birthing women were left to the devices of a primitive, uncontrollable 'nature' and to the unskilled (dirty) practices of midwives and old hags. In this story, 'nature' thus no longer appears as a benevolent, inherently 'good' and well-designed force (as in the story of woman-centred birth), but is instead portrayed as dark, uncontainable and inherently dysfunctional. Midwives themselves also become closely associated with dark malevolence, evil, satanic practices, incompetence, dirt and pollution. Ehrenreich & English (1973) have written powerfully about the systematic patriarchal denigration and subordination of female healers, starting over 700 years ago. The witch-hunts in Europe are interpreted as one of the methods whereby female healers (midwives, 'old wives' or 'wise women') were branded as evil 'witches' and subject to control, punishment and in some cases, extermination. For Mies (1986:83):

> …male medicine and the male hegemony over this vital field were established on the base of millions of crushed, maimed, torn, disfigured and finally burnt, female bodies.

[23] I follow the convention used by most critics and commentators of Simone de Beauvoir's work (e.g. Kruks, 1990; Arp, 1995; Simons, 1995, 1999; Moi, 1999; Fishwick, 2002) who refer to Beauvoir rather than de Beauvoir.

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Mies (1986) also argues that the witch-hunts were not remnants of an irrational 'Dark Ages' mentality but deeply intertwined with the emergence of modern society and the rise of both professional medicine and science. The move to portray midwives as incompetent, ignorant and dangerous was already evident in the contemptuous writing of male physicians of the early 1500s (Shorter, 1982). Midwives were depicted by obstetricians as "filthy and ignorant…a relic of barbarism…pestiliferous…her fingers full of dirt and her brains full of arrogance and superstition" (Devitt cited in The Boston Women's Health Book Collective, 1973/1984:593). The midwife as dirty, ignorant old crone *contrasts* with a view of the medical expert as a saviour delivering women from the horrors of childbirth with 'tools' and 'scientific' practices. Even today, this version of anaesthetised, surgical birth replete with sharply scrubbed, white-garbed medical personnel seems to inspire visions of heavenly deliverance. For example, Rachel Cusk (2001) describing a film of a woman giving birth draws on the opposition between uncontrollable and insane animal (female) nature and civilised, almost angelic medicalisation:

> She was not tucked up in bed, ringed by a halo of white-coated doctors and nurses. In fact, she didn't seem to be in hospital at all…The woman paced the room groaning and bellowing, like a lunatic or an animal in a cage (Cusk, 2001:13).

When trying to interrogate the absences produced by this story line, it is important to recognise that the promise of 'progress and salvation' has never made itself equally available to all women. This story line has always addressed itself differently to women of different class and geopolitical positions. Thus, the story of 'progress and salvation' from pain and death has traditionally been reserved for middle-to-upper class (generally white) western women. In order to ease the ideological contradictions inherent in this move, the opposition between 'civilised' and 'primitive' women has been extensively utilised. In order to justify the withholding of (life-saving) medical technology from some women, it has to be argued that these women are somehow 'different' and exempt from the need for 'progress and salvation'. The trope of the more 'primitive' poor, working-class, rural or African woman who is 'closer to nature' is thus employed to argue that such women are 'naturally' hardier, more robust and less 'delicate' than the 'civilised' women of the middle-classes. Women of the middle-classes are constructed as more 'needful' of scientific 'help' because civilisation has made them generally weaker, frailer, more sensitive to pain and estranged them from their 'animal' impulses. In this logic, 'primitive' women simply just 'get on with it' and mostly do not even experience pain in childbirth. The story line of painless childbirth among so-called 'primitive' people is a powerful myth that is not verified by cross-cultural research (Freedman & Ferguson, 1950). It functions however as a

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powerful justification for the withholding of pain-relieving medication from poor women who are unable to pay the costs of medical drugs.

After exploring the logic and core themes inherent in the story line of medicalisation as 'progress and salvation', it is germane to ask whether there is, in fact, academic evidence for the wide-spread cultural assumption that medicalisation has made childbirth safer. Detailed historical investigations have in fact shown that birth's medicalisation does *not* add up to a story of progress or increased safety for birthing women. Irvine Loudon's (1992) masterful international analysis of maternal mortality figures between 1800-1950, shows that the consistent and widespread fall in (western) maternal deaths from 1935 onwards was the result of an interplay of factors and *not* due to the rising rates of medicalised, hospital birth. According to Loudon (1992), the three biggest causes of maternal mortality over history have been puerperal fever, toxaemia and obstetric haemorrhage. All of these have been almost completely overcome in western countries by the availability of antiseptics, antibiotics and blood transfusion, together with adequate antenatal care and blood pressure monitoring. These life-saving innovations are not the result of obstetric medicine but have been the consequence of breakthroughs in bacteriology, the provision of good antenatal care and ready availability of blood transfusions. Obstetric interventions have thus not in and of themselves made childbirth safer and in many cases have simply exacerbated and created problems where there were none (Tew, 1990). Indeed, most of the technological interventions devised by obstetric medicine, including electronic foetal monitors, induction techniques, episiotomies and instrumental deliveries, have been shown to have *iatrogenic* and not life-saving consequences (see Arms, 1977; Michaelson, 1988; Tew, 1990; Nelson, 1996; Wolf, 2001). The story line of medicalisation as 'progress and salvation' is shown by Loudon's (1992) detailed historical analysis of maternal mortality figures, to be a powerful cultural and ideological myth.

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The story line of medicalisation as oppression and patriarchal control

"They shut you up into a hospital, they shave the hair off you and tie your hands down and they don't let you see, they don't want you to understand, they want you to believe it's their power, not yours."
(Margaret Atwood, 1979:74).

"There is no doubt that the history of childbirth can be viewed as a gradual attempt by man to extricate the process of birth from woman and call it his own."
(Suzanne Arms, 1977:25).

The second version of the story of birth's medicalisation is a story of *oppression and patriarchal control*. This has been a *feminist* story line emerging with the first wave of critiques against the medical model in the 1970s. Feminists have interpreted the history of medicalisation as a male,

patriarchal take-over, in which women's reproductive experiences were appropriated and re-defined as abnormal and pathological. This 'take-over' is seen as intimately rooted in a misogynist model actively seeking to disempower and oppress women. Medicalisation is often depicted as a form of social control over women (The Boston Women's Health Book Collective, 1984; Miles, 1991; Cahill, 2001). Sheila Kitzinger (1992) goes so far as to argue that medicalised, high technology childbirth is a form of *violence against women*. She analyses the written accounts (letters) of 345 women who had, by their own accounts, experienced 'distressing' birth experiences and compares their language to the language used by rape survivors. In her analysis, Kitzinger found that the women often used metaphors of rape and, like rape survivors, described experiences of depersonalization, powerlessness, physical injury, abuse and bodily fragmentation. Many feminist studies have shown the deleterious effects of medicalised birth on women (e.g. Oakley, 1980; Martin, 1987; Humphreys, 1998; Maclean, McDermott & May, 2000; Ryding, Wijma & Wijma, 2000; Kabakian-Khasholian, Campbell, Shediac-Rizkallah & Ghorayeb, 2000). This feminist story line has been incredibly important in exposing the patriarchal ideological assumptions inherent in the medicalisation of childbirth.

What is problematic about this story line, however, is that women are often seen as passive victims of medicalisation. Thus, in the logic of this story line, women have been duped into believing that medical birth is safer and that their own bodies are dysfunctional; furthermore, all birthing women are seen as disempowered by the patriarchal medical model. In describing women's gradual loss of control over the birth process, Arms (1977) refers to 'woman' as: "that docile, ignorant, cursed, weak, and dependent victim of deception" (pp. 25) who "willing agrees" (pp. 25) to all of man's medical interventions. Women are also often portrayed as innocents who naïvely 'expect' to have 'natural' birth and end up 'shocked' by hospitalised, medicalised childbirth (Oakley, 1980; Humphreys, 1998; Slade, MacPherson, Hume & Maresh, 1993; Miller, 2005). Naomi Wolf (2001) gives a passionate analysis of the 'misconceptions' that surround childbirth and motherhood. In Wolf's opinion, key information and 'truths' about the realities of maternity are *withheld* from women. Women are thus 'manipulated' and deceived to the point where they can't 'think clearly'. The end result of these myths, lies and secrets is that they become powerless dupes. This story line gives us no answers as to why women might have so willingly accepted medical expertise. The bottom line seems to be that women have been the passive, misled victims of a powerful patriarchal conspiracy.

It also needs to be recognised that this particular feminist story line remains largely a middle-class, western story of childbirth. It coincides with a western, middle-class, often 'white' version of second wave feminism which sees the 'enemy' as medicalisation and patriarchy. It often fails to see that calls for birthing women's liberation from medical control and high levels of

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interventionist technology, are themselves only possible from within a privileged, resourced economic position. It also often fails to recognise that patriarchy itself is linked to other structures of domination, including transglobal economic structures. The medicalisation of childbirth itself emerged within the context of a developing capitalism, which deemed that some women (white, 'civilised', those with money) were more 'deserving' of medicalisation. From the beginning, the medicalisation of childbirth has been split by class divisions.

The call to end medical intervention in childbirth is thus overwhelmingly a western and middle-class refrain. The so-called 'other' women of the world (poor, rural, Third World, African) have not experienced medicalisation in the same way as western, white, middle-class women. Often these 'other' women have been denied the benefit of access to basic life-saving care (antibiotics, blood transfusions) or even just the presence of a skilled attendant. It is ironic that while birth activists in the developed world insist on an end to unnecessary medical intervention, caesarean sections and hospital birth, those in the developing world are often calling for more medical technology and caesarean sections (e.g. Okonofua, 2001; Esen, 2002; Buekens, Curtis & Alayón, 2003). However, with the successful humanistic reforms in hospital birth attained by First World birth activists over the last decade, it seems that interventionist obstetric practices are now being merrily exported to parts of the developing world where an "iatrogenic epidemic" (Davis-Floyd, 2003:xix) is increasingly evident. The strange inversions at play in the 'upside-down' logic of technocratic global birth practices – where those that need intervention don't get it and those that don't need intervention have it forced upon them – is more often than not a (rational) consequence of transglobal patriarchal capitalism. The profit-driven obstetric machinery is thus inevitably looking to extend its influence to new birth markets arising within the developing world. Women in *both* the developed and developing world have suffered (albeit in different ways) within the context of a global birth system that is dominated by patriarchal, capitalist and technocratic ideologies.

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The natural birth story line

The belief in something called 'natural childbirth' remains a persistent and powerful western story line. Although many writers of childbirth admit to its 'slippery' and problematic nature (Arms, 1977; Rothman, 1982), as an ideal and alternative to medical birth, 'natural childbirth' continues to haunt women's stories and feminist analyses. As a cultural story line, 'natural' birth has a clear history, dating back to the 1930s writing of British obstetrician, Grantly Dick-Read. Dick-Read is credited with introducing the term 'natural childbirth' in his 1933 book of the same title. It is important to recognise that at the time that Dick-Read was writing (1930s-1950s), drugged and

anaesthetised childbirth was the medical norm. Although middle-class women (and many suffragists) had initially fought for the right to scopolamine, a drug that induced an altered state of consciousness known as 'twilight sleep', its widespread use paved the way for greater obstetric control over birth and the abuse of birthing women (Leavitt, 1986; Michaelson, 1988). Women labouring with scopolamine lost any conscious memory of childbirth. Their bodies, however, fully experienced labour and birth. Observers reported that women birthing with this drug often behaved violently, thrashing about wildly and screaming in pain (Leavitt, 1986). Women were thus physically restrained and confined in specially designed 'crib-beds' to reduce the likelihood of injury. All conscious awareness of childbirth was completely obliterated. By the 1950s, there were clear signs that women were becoming increasingly dissatisfied with the routine practice of anaesthetised birth. By 1957, letters were appearing in women's publications such as the *Ladies Home Journal*, complaining of widespread cruelty towards women in maternity wards (see Michaelson, 1988). Natural childbirth rhetoric and methods became increasingly fashionable, reaching a height of popularity between the 1960s-1980s.

The so-called 'father' of the 'natural childbirth' movement, Grantly Dick-Read, introduced a philosophy that signalled the beginning of a movement desiring to return active consciousness to the birthing woman (Cosslett, 1994). Dick-Read based his approach on a belief in the perfect, benign and divine design of 'Nature' and an essentialist assumption that childbearing is woman's 'highest calling', ultimate desire and supreme purpose. Due to his belief in 'Nature's' immaculate design, it becomes unthinkable to Dick-Read that childbirth is 'meant' to be painful. Dick-Read thus develops a theory which argues that childbirth in *civilised* societies has become painful because of "superstition, civilisation and culture" (1942/1963:18) which have introduced fear and anxiety into the minds of (civilised) women. This fear and anxiety is the cause of protective tensions in the body, which ultimately result in pain. In Dick-Read's version of 'natural childbirth', the modern, civilised woman, 'corrupted' by culture, approaches birth with fear and thus experiences extreme (unnecessary) pain and distress. In order to experience "the primitive function of childbirth" (*ibid*, pp. 47) naturally, 'happily' and without fear, women must be 'educated' to the processes and principles of natural birth and must 'practice' relaxation and breathing techniques. The male obstetrician (amazingly) thus occupies a central place in 'natural childbirth' as the teacher and instructor who re-educates civilised women to the untrammelled, 'primitive' joys of birthing (Cosslett, 1994).

It is significant that key scenes in Dick-Read's books centre on stories involving 'primitive' and poor women. Dick-Read is, in fact, credited with introducing the 'primitive' woman (as ideal) into obstetrics (Cosslett, 1994). Thus, in his 1933 book, he describes a scene where a 'native' African woman interrupts her work to simply, painlessly and joyfully go into the bush and give

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birth by herself. Furthermore, in Dick-Read's book, *Childbirth without fear*, first published in 1942, he describes the birth of a poor woman living in a dark 'hovel' of destitution in Whitechapel. The baby is born with "no fuss or noise" (Dick-Read, 1963:13), the woman refusing Dick-Read's offer of chloroform. When he later asks her why, she turns to him 'shyly' and says: "It didn't hurt. It wasn't meant to, was it, doctor?" (*ibid*, pp. 13).

It is clear that the story line of 'natural childbirth' shares with the 'age-old woman-centred birth' story a heavy reliance on the trope of the 'primitive' uncivilised woman. In the story line of 'natural childbirth' it is however *male* obstetricians who have to 'teach' middle-class, 'civilised' women the forgotten (once instinctive) art of childbirth. The 'primitive' woman is thus appropriated by both story lines and is remade as a "cultural construct" (Cosslett, 1994:10) that resurrects a pure, joyful, easy and uncomplicated childbirth (and mothering) experience as imaginary ideal. For the 'age-old woman-centred birth' story the 'primitive' usually stands for an instinctive birth power within the bodies of women. In the natural birth story line, however, the fantasy of 'primitive' childbirth often functions as a regulatory ideal that women need to 'learn' from medical experts. Racist, classist and anti-feminist sentiments however remain rooted in both uses of this core trope. It is also important to recognise that the story of the so-called 'primitive' woman who gives birth easily without assistance, is itself a powerful cultural myth that is not corroborated by research evidence. In fact, isolated, unattended birth is a largely unknown or very rare phenomenon across human cultures (Trevathan, 1997).

At its core, 'natural childbirth' discourse carries a central concern that birthing women remain 'awake and aware' active participants in an experience that is seen as woman's crowning glory and primary achievement. The story has been taken up and amended by various male obstetricians (and later, female midwives) all of whom prescribe different 'methods' whereby women can achieve unmedicated, conscious childbirth. The psychoprophylactic approach of the French obstetrician Fernand Lamaze, based upon the Russian Pavlovian tradition, has proved to be one of the most widespread and popular 'methods' of natural childbirth. The method is based on scientific experimentation within the "materialist physiology" (Lamaze, 1958:12) of Pavlov. The quest to find a method, which would make childbirth painless, was already launched in Russia in 1920. By 1951, the "precise, rational and safe" (*ibid*, pp. 12) psychoprophylactic method had been 'scientifically proven' and was enforced in all Soviet maternity wards by official State decree. Lamaze, visiting the Soviet Union in 1951 witnessed the successful implementation of this method and decided to take the method back to "our women" (*ibid*, pp. 14) and teach them how to give birth without pain. Lamaze (as obstetrician) thus secures a central place for himself as the one who both teaches women how to control their bodies/pain and saves them from the 'curse'

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of painful childbirth. The male obstetrician thus enables the birthing woman to experience painlessly, "the most exalting act in her life" (*ibid*, pp.11).

The method instituted by Lamaze included a complex set of breathing techniques and muscle control exercises that were to be practiced by the pregnant woman during an intensive six-week training period or what he calls an 'apprenticeship'. This training is intended to induce a series of conditioned reflexes that work to control the body and suppress pain. The method is thus based upon a strict separation between body and mind. The mind, "carefully educated, steadfast and alert" (*ibid*, pp. 17) in effect controls the sensations of the labouring body. The Lamaze method became particularly widespread in America after it was imported and popularised by dedicated devotee, Marjorie Karmel in the 1950s. The Lamaze method posed no real threat to obstetric power and routine medical procedures and thus was successfully incorporated into technocratic hospital birth in America (Rothman, 1982; Davis-Floyd, 2003). Thus, in Karmel's (1959) description of her 'natural' Lamaze birth in an American hospital, she describes having her membranes ruptured, being strapped into stirrups, induced with oxytocin, shot up with drugs and having to seek 'permission' to push her baby out. In Rothman's (1982) view, the Lamaze method conveniently works to create cooperative and docile patients, who 'behave' themselves, keep quiet and dutifully allow the doctor to deliver their babies.

The American obstetrician, Robert Bradley, is responsible for devising yet another method or approach to 'natural childbirth'. Practicing and perfecting his 'husband-coached' approach from 1947 onwards, Bradley eventually published this method in his 1965 book: '*Husband-coached childbirth*'. This method departs from other natural birth approaches in its determination to place *the father* at the centre of the birth process. Bradley was instrumental in the American lobby to allow fathers access to labour and delivery rooms. In his book, Bradley re-positions fathers as the most important actors in the childbirth scene and defines them as responsible for getting birthing women to 'cooperate' and 'self-control'. His entire book thus addresses *men* as a kind of 'buddy-buddy' and conspiratorial "we"; women are consistently referred to as objects or possessions of men, as in "our pregnant women" (1965/1974:14), "our mothers" (pp. 14), "your wife" (pp. 29) and "this baby factory" (pp. 91). Women's bodies are treated as a fragmented collection of reproductive 'bits'. The uterus thus becomes the "baby box" (*ibid*, pp. 95) and the vagina "the baby door" (*ibid*, pp. 100). Bradley takes the inspiration for his method from witnessing childbirth among animals and as a result, asking why 'the human animal' (i.e. woman) cannot birth painlessly, "peacefully and joyfully…unassisted" (*ibid*, pp. 8). Bradley's solution is 'natural-childbirth training' which will work to eradicate fear, anxiety, superstition, paranoia and pain-inducing bodily tensions and result in "the joyful act" (*ibid*, pp. 20) of unmedicated, 'natural' birth described as "a picture of wholesome togetherness bordering on ecstasy" (*ibid*, pp. 5).

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French obstetrician Frederick Leboyer also made an important contribution to the story of 'natural childbirth'. Leboyer's (1975) approach departs from other treatises in its efforts to position the infant at the centre of the birth process. Thus, Leboyer provides us with a fascinating mythical story about the infant's experience of the birthing process. In this story, the birthing woman and her infant are portrayed as enemies involved in a process of "mortal combat" (*ibid*, pp. 26). The mother's womb is re-defined as a 'prison'; the contractions of her body "crush…stifle…assault" (*ibid*, pp. 25) as the infant "sinks into this hell" (*ibid*, pp. 26) that is the mother's body. The birth process is consistently portrayed as torturous and intrinsically violent for the infant. Leboyer's method is therefore concerned with making the birth experience as gentle as possible for the child; the experience of the mother is seen as irrelevant.

The final approach to 'natural' birthing that I want to discuss departs quite substantially from earlier versions by re-positioning women at the centre of the birth process. This approach is based on the work of the French obstetrician, Michel Odent, whose childbirth clinic in Pithiviers, France has become world famous. Odent, writing in 1984, describes his primary project as wanting "to give birth back to women" (pp. 10) and "restore them to their proper, central place" (pp. 12). For Odent, childbirth is not a medical problem but an integral part of a woman's sexual and emotional life. Odent does not portray himself as a teacher, saviour or instructor but as a facilitator whose role is to intervene as little as possible. Women are seen as the experts in birthing, acting deliberately and instinctively to maximise efficiency and comfort. For Odent, there is a marked change in consciousness experienced during childbirth; women "forget social conventions, lose self-consciousness and self-control" (*ibid*, pp. 12). He calls this deeper level of consciousness the realm of 'instinct'. Although Odent does not seem to draw directly on the trope of the 'primitive' woman, childbirth itself is clearly regarded as a 'primitive' (instinctual) activity. One of the birthing rooms at the clinic is thus not surprisingly called the '*salle sauvage*' or the 'primitive room'. At Odent's clinic, breathing and relaxation techniques are not taught; the birthing woman is instead encouraged to "give in to the experience, to lose control, to forget all they have learned – all the cultural images, all the behaviour patterns" (*ibid*, pp. 26). Odent's approach to birth *is* revolutionary in its focus on the birthing woman as active birth-giver who is free to do things her way – to scream, sing, walk, be still, dance or swim. She is regarded as the ultimate expert who does not need to be 'taught' how to breathe, visualise or relax in order to give birth 'naturally'. Odent has however been criticised by feminists for coming close to re-producing a view of woman as 'animal-like', closer to instinct and 'nature' and thus by implication less acculturated or 'civilised' than men (see Martin, 1987).

When considering all of these 'versions' of 'natural' birth together, it is possible to see similar key themes emerging in the *collective* story line of 'natural childbirth'. For example,

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common to all the versions outlined is the notion that 'natural childbirth' is the highest achievement of womanhood and that motherhood is women's primary and essential (often God-given) calling. Women are thus 'naturally' meant to be mothers and to give birth 'naturally'. Women who take medication during childbirth are, as a result, often judged and regarded as 'inferior' or 'bad' mothers. Childbirth is also constructed as something which 'should be' joyful, delightful, easy, close to painless and full of good cheer. Women who experience difficult, exhausting and painful births thus 'must' be doing something 'wrong'. The reasoning is that they were not 'trained' well enough, they didn't practice 'hard' enough or perhaps they were weak and 'gave in' to fears, superstitions and anxieties. After all, women are supposed to give birth 'joyfully', to breastfeed 'joyfully' and to 'joyfully' take full responsibility for infant-care, child-care, domestic and emotional labour. This is what some feminists have referred to as the 'candy-coated' myth of motherhood (e.g. Wolf, 2001) responsible for a great deal of women's unhappiness after the birth of a child (see Nicolson, 1998, 1999; Mauthner, 2002).

'Natural childbirth' stories also ironically tell *contradictory* stories about what is 'natural'. Thus, while birthing, breastfeeding and mothering are ostensibly regarded as 'natural', instinctive and automatic processes, women are told that they nonetheless 'need' masculine science, 'techniques' and schedules to 'succeed' at these so-called 'biological' processes. Furthermore, none of the 'natural childbirth' methods go so far as to reject normative medical procedures and authority. For example, Bradley (1974:80) stresses that, "Natural childbirth does not ever depart from obstetrical principles; it adds, but never subtracts". In all approaches to 'natural childbirth', women are told that they must always defer to the judgement of their obstetrician (assumed to be the primary birth attendant). Robert Bradley thus cheerfully tells birthing couples to, "let your doctor decide" (*ibid*, pp. 71). Depictions of 'natural childbirth' are also almost always portrayed within a hospital setting (even for Michel Odent) sending a clear message that hospitals are the appropriate setting for childbirth. Contradictory definitions of what constitutes a 'natural' birth also abound. For example, while Bradley carefully defines a 'natural' birth as "the way it is done in nature…anything that deviates…cannot truly be called natural" (*ibid*, pp. 13), he goes on to describe 'natural', 'husband-coached' childbirth as including episiotomies, supine labouring positions, transference to the 'delivery' room, the use of sterile sheeting between mother and newborn and compulsory antiseptic cleaning of the mother's (by implication dirty) hands and nipples.

It is also clear that the story line of 'natural childbirth' is often a powerfully *moral* story. It creates categories such as 'good' and 'bad' mothers and constantly sets women up for potential failure (in childbirth, breastfeeding and mothering) by prescribing a 'right' or 'natural' way to do things. Whereas before 1900 most 'advice' or 'counsel' to pregnant women and new mothers

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would have been given by other (experienced) mothers, in the last century the rise of (usually male) 'experts' of all kinds – behaviourists, psychologists, obstetricians, psychiatrists, psychoanalysts – has meant that women increasingly look to 'scientific', usually male medical experts, for guidance and approval (Klassen, 2001a). These 'experts' have been very influential in constructing motherhood as a kind of 'moral career' in which women have to be vigilant about every choice they make (type of birth, feeding practices, sleeping arrangements, disciplined or permissive mothering) lest it have long-term, psychologically 'damaging' effects on the child (see Riley, 1983).

It is also interesting to note that the rise of 'natural childbirth' rhetoric dates back to the post-war 1950s. We know, of course, that it was in the same historical period that ideas about maternity and women's roles were being sharply re-defined. Thus, there was a strong move to get (middle-class) women back into the home and to full-time, exclusive motherhood. John Bowlby's work, stressing the psychological importance of the constant, full-time presence of the mother and his theory of 'maternal deprivation' became widely known and influential during the same era (Riley, 1983; Blum, 1999). Bowlby's work was also instrumental in feeding a 'bonding craze' in which it was seen as critical and imperative that mothers immediately 'bond' and 'attach' to their newborn infants (Blum, 1999). The 'natural childbirth' movement can be interpreted as one element in a wider ideological impetus to construct 'natural' essential motherhood as women's all important, primary 'duty' and life's purpose.

The story line of 'natural childbirth' is also, of course, an overwhelmingly middle-class, consumer narrative. It is an extension of the longer history of childbirth in which it has always been privileged, middle-class women who, together with male medical experts, have shaped the way in which birth is practiced (Leavitt, 1986). Once childbirth became, in effect, a "market commodity" (Treichler, 1990:131) it was always middle-class women who were offered more 'choices' and 'alternatives' as a result of their more substantial "consumer power" (Pollock, 1999:13). In many senses, the 'natural childbirth' story can be re-interpreted as a consumer movement in which various 'methods' of birth become commodity packages to be purchased. Women 'shop' around for methods that appeal to them, buy the books, the videos, even the T-shirts (Pollock, 1999) and join the obligatory breathing classes, exercise classes and visualisation workshops. Furthermore, the names of 'natural childbirth' gurus like Lamaze, Bradley and Dick-Read potentially reach an almost 'designer label' status – for example, a *Lamaze* birth (like a *Prada* handbag).

In the final analysis, the story line of 'natural childbirth' can be seen as a powerful narrative in which women's subjective state of mind (rather than objectified body) becomes the dominant focal point (Cosslett, 1994). Whereas birthing women are treated as 'all-body and no-mind' in

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classic medical versions of birth, in 'natural childbirth' discourse the mind of the birthing woman is re-articulated as the object of methodological techniques which work to create a 'mind-over-matter' mentality. Through masculinist scientific techniques, women are promised the tools to conquer and control the hitherto paining, uncontrollable and chaotic birthing body and attain a drug-free, 'natural' birth. The onus is thus on birthing women to maintain a mental state which enables them to birth without drugs or surgery. However, because 'natural childbirth' generally takes place in medicalised hospital settings, which come replete with timetables, a lack of support, a series of medical procedures and routines and enforced or ever-ready offers of drugs, shots and interventions, the chance of successfully 'achieving' a 'natural' birth is slim. It is convenient that within the 'natural childbirth' story line, any 'failure' to birth naturally is placed firmly at the door of the individual woman or birthing couple, leaving the medical institution completely absolved of blame or responsibility (Mardorossian, 2003) Thus, either she was not strong enough mentally (or emotionally), her husband was not a 'good-enough' labour coach or her body simply failed her. In the end, the 'natural childbirth' story line could be read as a simple variation on the theme of medicalised birth. The medical model of childbirth might in fact have strengthened or 'renewed' itself in the popularised rhetoric of the ideal, elusive and largely unattainable, 'natural' birth (Pollock, 1999).

A feminist story line of choice

"My position has always been that women should have a full range of choices in childbirth…"
(Robbie Davis-Floyd, 2003:xviii).

"Poor women receive the care that society chooses for them."
(Leavitt, 1986:218).

Feminist angles, stories and lines of argument have already emerged in my exploration of the previous story lines. Thus, we have seen that the story of 'medicalisation as oppression' has functioned as the dominant feminist story of childbirth and that a feminist line of argument has also intersected strongly with the story of 'age-old woman-centred birth'. The critique of medicalisation as patriarchal oppression has been the strongest and most effective feminist story of childbirth, which together with other social movements (e.g. the consumer movement, natural childbirth movement and home-birth movement) has offered a major challenge to western medicalisation. However, threading its way (perhaps imperceptibly) through my discussion of story lines has also been a third feminist story of childbirth: a story line of choice.

Fighting for women's *right to choose* has always been an important ingredient of feminist struggle. The right to autonomy and choice, particularly on issues pertaining to the female body (i.e. birth control, abortion, sterilisation, sexuality) has been a consistent refrain within feminist

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discourse. The reclamation of the female body or 'taking our bodies back' (Dreifus, 1978; The Boston Women's Health Book Collective, 1984) has been seen as an essential part of women's liberation, particularly vociferous during second wave feminism. Catchy slogans such as 'Our Bodies, Ourselves', 'My Body, My Life' and 'Woman's Body, Woman's Right' capture the sense in which the right to control one's own (sexual and reproductive) body stands as one of the core tenets of modern feminism (see Diamond, 1994). Irene Diamond (1994) argues that underlying the feminist effort to ground women's freedom in control over the body, lies a phallocentric faith in the power of 'instrumental rationality' – that is, the belief that the rational mind can conquer the limits of both body and nature (*ibid*). According to Diamond (1994:39):

> Western feminism shares the masculinist culture's vision of the body as an object that can be preserved and improved upon through technological prowess…[and]…is heavily implicated in the separation of mind and body and body from earth that reigns in the West, rarely questioning the patriarchal and racist arrogance in which this language of control is embedded.

For Diamond, the feminist acceptance of control as a *value* is complicit with western relations of domination built on understandings of (female) bodies, earth and living systems as inert matter to be plundered, controlled and transcended. Diamond also notes that 'freedom of choice' should be as much about freedom from "coerced choices" (pp. 56) as freedom to make choices. The plight of many women in the Third World is often made invisible by a limited language of 'freedom to choose', which ignores the extent to which birth control, sterilisation and the latest family planning techniques are often forced upon such women (*ibid*).

In the west, women's struggle for the right to make decisions about and control their own (birthing) bodies has also been a constant underlying thread in the (western) history of changing childbirth practices. Middle-class women, in particular, have been active in looking for ways in which they could control the unpredictable, painful process of childbirth. According to Leavitt (1986) the most active agents of change in childbirth practices have always been middle- and upper-class women and their chosen medical attendants. Other birthing women (poor, working-class, rural, Third-World) have eventually (unevenly) inherited the changes originally initiated by more privileged women (*ibid*). Thus, from the beginning of birth's medicalisation, privileged women welcomed male physicians into their birthing chambers because of the alluring promise that medical men might help them to attain greater control over the birthing process. The introduction of medical interventions (forceps, anaesthesia) seemed to offer the possibility of transcending the grip of a brute and undiscriminating fate or 'Nature' (Leavitt, 1986). The importance of gaining control over the process of childbirth has from the start of birth's medicalisation been overwhelmingly the concern of middle-class women. This trend has continued to the present day, with studies showing that personal control in childbirth, an important

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issue for middle-class women, is not necessarily a concern for working-class women (e.g. Lazarus, 1997). Not surprisingly, working-class women are more often worried about the availability of basic, continuous care (Nelson, 1983). The extent to which a feminist analysis of childbirth remains invested within a middle-class perspective is demonstrated by its overwhelming interest in exploring the issue of control in childbirth practices (Michaelson, 1988).

New developments in obstetric medicine have always been differentially available to women according to social position (including class and geographical location). Stories of agency, choice and control are almost always stories of privilege. It is important to recognise that feminist struggles to afford women more choices in childbirth have often been initiated and dominated by middle-class, privileged (feminist) women. Thus, the right to anaesthesia and pain-relief was seen as a feminist issue and many leaders of the 'twilight-sleep movement' in the early 1900s were also active suffragists (Leavitt, 1986). When American doctors proved slow to incorporate this German-developed mode of pain-relief into their obstetric practice, affluent and feminist women took up 'the cause' and 'the battle' to win rights to the free availability of this method which promised to obliterate pain and the entire childbirth process. However, although the method was instituted, it was affluent women who remained far more likely to be offered twilight sleep. Physicians conveniently believed that it was more 'beneficial' to upper- and middle-class women because of their greater propensity towards nervous disorders and their tendency to suffer more painful births (*ibid*). Poor and working-class women were seen as less needful of pain-relief techniques, because of their lack of 'civilisation', 'easier' births and 'hardy', resilient constitutions. The story line of 'choice', deeply interwoven with a feminist rhetoric of women's rights, has often proven itself confined to the benefits of privileged women.

The tendency for middle-class women to function as prime agents in changing childbirth practices continues today. Just like the nineteenth century women in Leavitt's (1986) study, contemporary upper- and middle-class women are still looking for ways in which they can regain or achieve control over childbirth. The home-birth and natural birth movements have both been dominated by the middle-classes (Michaelson, 1988). Middle-class women continue to struggle for ways in which they can make active decisions about childbirth. Some gain control over childbirth through high-technology, medicalised procedures, others give birth at home with midwives or pay for a private midwife to attend them in hospital. Others are content to write birth-plans and choose specialist doctors who will make the 'right' decisions on their behalf. In South Africa, all of these 'choices' *are* potentially available to women; at the same time they remain 'choices' largely limited to women of the (mostly white) middle-classes.

The feminist story line of 'choice' has a long history among women of the privileged classes. In fact, it becomes difficult to ascertain whether the story line of choice is, in fact, a

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feminist, rational liberalist or middle-class invention. As more studies have shown that women are not necessarily simply 'oppressed' by medicalisation, but that they are often empowered by actively choosing medicalised birth practices (Davis-Floyd, 2003; Fox & Worts, 1999), it has become common for a feminist story line on childbirth to collapse into a championing of each woman's right to choose for herself. The line of reasoning goes something like this: 'it's her body, her birth, her life and hence her choice'. This is clearly a decontextualised, individualised rhetoric that only privileged women can afford. The strength of the feminist story line of 'medicalisation as oppression' was that it remained sharply attuned to the power of ideology and institutions in constraining women's 'choices'. It was also committed to producing detailed analyses of the workings of patriarchal, technocratic ideology within childbirth practices. With post-structuralist and difference critiques flourishing, it has however become difficult to sustain the argument of 'medicalisation as oppression' in which all women are the passive victims of patriarchal medicine (particularly when some women actively desire medicalisation).

A feminist rhetoric of 'choice' is however not the answer. Apart from its roots in a problematic liberal, humanist tradition, in which each 'individual' is seen as imbued with 'agency' and the power to make rational 'choices' (Hughes, 2002), the rhetoric of 'choice' slips far too easily into a non-political account of childbirth. According to Segal (1994), the language of 'choice':

> …inevitably downplays social constraint and inequality [and] serves conservative ends more readily than progressive ones (pp. 305).

This is not good enough in a world where the experience of childbirth is fraught with inequalities. Such a rhetoric would only prove to be a viable and useful story line in a global world in which all women had access to basic medical and health care, adequate food, shelter and amenities and skilled birth attendants – a world where all women had recourse to the full range of childbirth 'choices' (home-birth, water-birth, elective caesarean sections, epidurals) regardless of their ability to 'pay'. Even then, a rhetoric of 'choice' in childbirth would only be liberating in a world where women's reproductive bodies and activities were globally redefined according to a woman-centred discourse. In my opinion, feminist analyses of childbirth cannot afford to collapse into a story line of 'choice' and the valorisation of an agency that is largely confined to the privileged. Although feminist researchers of childbirth often pay lip service to the idea that 'choice' comes from a position of privilege, they do not often go far enough in interrogating the capitalist economic logic that enables and underwrites such 'choices'. We need feminist analyses that are committed to an examination of the three dominant (western) ideologies at play in the global

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childbirth scene: capitalism, technocracy and a patriarchal ideology of women's bodies and reproductive processes.

After-words

The five cultural story lines outlined above function as global narratives within which childbirth is negotiated and made meaningful. I do not claim that this list is exhaustive or that the story lines exist as neatly distinct, 'true' types. Rather, it is clear that they merge, collide and intersect substantially. All of these story lines are, however, western narratives and emerge from westernised perspectives of women, bodies, nature and medicine. The global reach and cultural power of western story lines is considerable. Alternative cultural story lines emanating from countries of the South remain marginalized; where these do appear, they are almost always represented through the lens of western researchers or writers. Generally, these stories are appropriated, re-interpreted through a western perspective and incorporated into dominant western birth story lines. Thus, visions of 'traditional' childbirth, 'primitive' women and 'African' childbirth abound within western narratives of childbirth; each of these tropes remains however refracted through westernised eyes.

In South Africa, these western narratives of childbirth constitute the tapestry of meaning shaping the middle-class, consumer-culture experience of childbirth. The birth experiences of poor, working-class and rural South African women clearly remain structured by a lack of access to the 'choices' that middle-class women are ostensibly 'overburdened' by (Pollock, 1999). In the birth stories of women participants in this thesis, the five cultural story lines outlined above functioned as important positioning frameworks, legitimating devices and justificatory bases for birthing choices. The ways in which women appealed to and used these story lines will be discussed later in the thesis (see chapter six).

Apart from the absences that I have already identified at play within each of the five story lines, it is perhaps pertinent, at this point, to observe that women's own experiences and personal viewpoints remain marginalised within all of these story lines. Although I agree with Cosslett (1994) that we will not find 'pure' or 'authentic' voices within the birth stories of women, I nonetheless wonder to what extent there might be, hidden in-between the logic of dominant story lines, an alternative, experiential story line of birthing? Cosslett (1994) has already hinted at this possibility in her mapping of the 'old wives tale' as a distinctive and marginalised discourse about birth, based upon women's own personal experiences of childbirth. What might alternative story lines, rooted in women's subjective experiences of birthing look like? How do women negotiate

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dominant story lines of birth in relation to the 'actual' birth experience? In my analysis of women's stories of home-birth and elective caesarean birthing (see chapter seven), I will be looking for precisely such alternative ways of 'telling' childbirth, the birthing body and birthing subjectivity. In the following chapter, however, I turn first to a wide-ranging literature review concentrating on feminist studies of childbirth.

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New mother

Sharon Olds (2004:23)

A week after our child was born,
you cornered me in the spare room
and we sank down on the bed.
You kissed me and kissed me, my milk undid its
burning slipknot through my nipples,
soaking my shirt. All week I had smelled of milk,
fresh milk, sour. I began to throb:
my sex had been torn easily as cloth with a knife and
sewn, the stitches pulling at my skin – and the
first time you're broken, you don't know
you'll be healed again, better than before.
I lay in fear and blood and milk
while you kissed and kissed me, your lips hot and swollen
as a teenage boy's, your sex dry and big,
all of you so tender, you hung over me,
over the nest of stitches, over the
splitting and tearing, with the patience of someone who
finds a wounded animal in the woods
and stays with it, not leaving its side
until it is whole, until it can run again.

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CHAPTER 3

Shifting frames: psychology, feminism and childbirth

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Childbirth has been studied from every conceivable disciplinary angle over the last three to four decades. As a result, a variety of methods, theoretical assumptions and agendas characterise studies within this field. Achieving a comprehensive review of this cross-disciplinary literature is thus a nigh impossible task. However, within this rich assortment of studies, treatises and debates, it is possible to isolate feminism as a guiding impetus and rallying point within the literature. Straddling boundaries between anthropological, sociological and historical research on childbirth is thus often a shared commitment to a feminist agenda. Of course, there are pockets of research that have remained completely unconcerned with feminist agendas and debates, particularly within the fields of psychology, medicine and nursing. For the most part, studies within these areas have been concerned with a range of depoliticised and decontextualised 'factors', 'outcomes' and 'pathologies' related to childbirth practices and experiences. Psychological research in particular, brings its own set of interpretative frames, assumptions and methodological imperatives to the study of childbirth. Significantly, it remains one of the only disciplinary fields investigating childbirth that almost completely ignores the feminist critique of medicalised childbirth practices.

In this review chapter, I will be contrasting psychological and feminist approaches to childbirth, concentrating on how each stream of research has conceptualised and 'studied' childbirth, birthing women and the subjective experience of birth. Considering that a central interest of this thesis is birthing subjectivity, it seems reasonable to expect that psychological research on childbirth might provide pertinent insights and findings. I will be arguing, however, that psychology has approached childbirth almost solely in terms of pathology, often portraying the birth event as a harbinger of trauma, depression and irrational fear. Surprisingly, the psychology of birth has rarely been explored in relation to birthing women's first-hand accounts of the subjective experience of childbirth. I will be providing a brief review of some of the dominant tendencies of psychological research on childbirth, in the interests of showing how issues of ideology, material practices and the complex subjectivity of birthing women are effectively disappeared from consideration within this literature.

The overwhelming focus of this chapter will however be on reviewing the large corpus of feminist-aligned birth research. Here I will be attempting to trace how shifting concerns in feminist theory over the last three decades have played out in the arena of childbirth studies and research. I hope to show how some of the most contentious debates in feminism (e.g. essentialism, individualism, sameness versus difference) are highlighted and intensified when researching and theorising childbirth. Arguably the most significant development in feminist theory over the last 30 years has been the (contentious but discernable) shift from modernist to postmodernist feminism or second wave to third wave feminism (see Mann & Huffman, 2005). Feminist-aligned work on childbirth both mimics and mirrors these trends and serves as a kind of reflexive site in which the underlying dilemmas and contradictions of different feminist approaches are potentially exposed (DiQuinzio, 1999). Apart from exploring 'the findings' of feminist childbirth studies, I will also be exploring the varieties of feminism framing the study of birth and asking questions about their assumptions, underlying paradigms and understandings of childbirth, subjectivity and experience.

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A psychology of childbirth?

Generally, psychological research has been more interested in exploring pre-birth (pregnancy) and post-birth (motherhood) experiences than childbirth itself. Thus, many classic psychological studies of the 'transition to motherhood' have treated the childbirth experience as an incidental and largely insignificant event, generally not worthy of more than a few obligatory and superficial paragraphs (e.g. Shereshefsky & Yarrow, 1973; Breen, 1975; Leifer, 1977). This trend has

continued to characterise recent research on the motherhood transition (e.g. Stern & Bruschweiler-Stern, 1998; Bailey, 1999, 2000, 2001).

Traditionally, psychological work has assumed the neutral, disembodied (masculine) individual subject as its 'normal' prototype, with women (when studied) treated as the 'other' or a kind of 'special' deviation from the male norm. Femininity is thus often regarded as a static, unitary identity (diametrically opposed to masculinity) that all 'healthy' women are required to manifest in the same way. It is thus not surprising that a long-standing tendency within the psychological literature is to treat pregnancy and motherhood as uniquely 'feminine' developmental processes, critical to the attainment of a mature, female identity. These 'processes' have traditionally been seen to culminate either in a progressive (i.e. mature femininity) or regressive (i.e. deviant, pathological femininity) psychological formation (e.g. Chertok, 1969). Pregnancy and motherhood are often conceptualised as a series of developmental 'tasks' that women either 'succeed' or 'fail' at (e.g. Leifer, 1977). This understanding is heavily influenced by a classic psychoanalytic reading of motherhood, in which maternity is generally seen as an emotional and psychological 'crisis' requiring adequate integration or resolution *en route* to the acquisition of a 'healthy' and 'mature' motherhood identity (Chertok, 1969). Women who do not 'resolve' the crisis adequately are often labelled 'immature', pathological or 'unfeminine' (e.g. see Kitzinger, 1962). Childbirth is sometimes construed as the dramatic 'peak' of the maternity 'crisis' (Chertok, 1969; Doering, Entwisle & Quinlan, 1980) precariously poised between a 'successful' resolution or a 'damaging' failure to 'integrate' psychic conflicts. The failure to resolve the maternity 'crisis' adequately is usually assumed to lead directly to inadequate and damaging mother-infant relations (Doering *et al*., 1980; Durik, Shibley Hyde & Clark, 2000). The 'successful' resolution of the motherhood 'crisis' is taken to be the happy, contented internalisation of the maternal role (as defined within patriarchy), sufficient 'bonding' and 'attachment' to the infant and general acceptance of a westernised, middle-class, patriarchal mother ideal, in which women are required to be ever-present, long-suffering and solely responsible for the care of infants and children. In this way, psychology as a discipline has been a key contributor in the development of a 'science of motherhood' (Ussher, 1989) in which various experts have dictated what constitutes 'normal' mothering and 'good' adaptation or 'adjustment' to maternity.

The tendency to treat motherhood as a series of developmental 'tasks' *en route* to successful 'adjustment' translates readily into the *pathologisation* of pregnancy, childbirth and maternity. Psychologists have consistently been *most* interested in the so-called pathological or dysfunctional routes to motherhood, with a large body of research traditionally focussing on postnatal depression (Stanton, Lobel, Sears & DeLuca, 2002; Nicolson, 1998). This tendency towards

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pathologisation is, of course, not confined to maternity but in fact characterises most psychological research on women's reproductive experiences. Psychologists have approached menstruation, pregnancy, motherhood, childbirth and the menopause all within a framework of pathology and dysfunction (see Chadwick, 2006). It is, in fact, very difficult to find mainstream psychological research on reproductive issues which is not guilty of pathologisation. Feminist psychologists have, of course, sought to rectify this issue and have been most outspoken in respect of the over-pathologisation of menstruation and motherhood (see for example, Ussher, 1989, 2002, 2003; Nicolson, 1998, 1999). It is, however, surprising that feminist psychologists have been virtually silent on the topic of childbirth. A random search of feminist psychology texts reveals a rather shocking degree of avoidance and silence (e.g. see introductory texts by Donelson & Gullahorn, 1977; O'Lear, 1977; Walsh, 1987; Gergen & Davis, 1997; Stainton Rogers & Stainton Rogers, 2001). This silence continues to hold fast, as evidenced by the complete lack of attention[24] given to childbirth within Jane Ussher's (2006) most recent exploration of the female reproductive body.

Childbirth as a source of trauma and unreasoning fear

Psychological research on childbirth replicates mainstream psychology's broader problem of over-pathologising women's reproductive experiences. Psychologists have thus had very little to say about childbirth as a subjective, psychological *experience*[25], preferring to concentrate on the possible psychological *disorders* associated with birth. There is little psychological work that focuses on women's own stories and understandings of their childbirth experiences; little attempt has been made to listen to women's shifting representations of subjectivity in relation to birthing. Perhaps the marked absence of any substantial subjective psychology of childbirth is related to the widespread cultural assumption that birth is solely a biological affair; a psychology (consciousness, subjectivity) of childbirth might thus seem a contradiction in terms.

Drawing predominantly on a psychological framework of individual pathology, research studies in the psychology of childbirth have thus recently begun to conceptualise childbirth as a source of both irrational, psychopathological *fear* and a possible site for the development of psychological *trauma* or post-traumatic stress disorder (PTSD). For example, tokophobia, defined as "an unreasoning dread of childbirth" (Hofberg & Brockington, 2000:83) was classified as a psychological disorder for the first time in 2000 and has been associated with a wide-range of other psychological 'conditions', including: anxiety, depression, post-traumatic stress disorder and

[24] Jane Ussher (2006) does, in fact, devote *one paragraph* in her (substantial) book to the topic of childbirth.
[25] However, see the work of Joan Raphael-Leff (1991) as an exception.

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bonding disorders. According to the literature, 'fear of childbirth' is comprised of several associated factors, including: fear of pain, previously distressing delivery experiences, fear of being incapable of giving birth, fear of parenthood, particular personality characteristics and previous sexual abuse (Ryding, 1993; Zar, Wijma & Wijma, 2002; Saisto & Halmesmäki, 2003; Hofberg & Brockington, 2000). There is an overwhelming tendency for this research to situate these 'factors' solely within the psyche of the individual woman. For example, pain-avoiding behaviour is seen as associated with a 'neurotic' personality, fear of being unable to give birth is linked to maladaptive fear internalised from previous experiences of trauma, "unconscious aggressive feelings towards the child" or an unplanned pregnancy in which the woman has not psychologically 'adapted' to pregnancy and motherhood (Saisto & Halmesmäki, 2003:203). Furthermore, fear of parenthood is associated with prenatal anxiety and neuroticism and women who experience 'fear of childbirth' as a generalised 'pathology' are reported to share a common (dysfunctional) psychological profile or set of (internal) personal characteristics (Zar, Wijma & Wijma, 2002; Saisto & Halmesmäki, 2003).

There is little or no effort within the psychological literature to situate childbirth within political, social and cultural contexts. Little mention is made of the extensive feminist research that has provided a powerful critique of western childbirth practices and related ideologies. Even the link between 'fear of childbirth' and previously distressing delivery experiences is not situated within the context of iatrogenic medicalised birth practices. Fear of birth that is related to previous birth trauma is constantly assumed to be irrational, illogical and pathological. Instead of recognising the structural and ideological processes that shape, impede and in many ways produce the experience of birth, this research assumes that if there is a problem, it must be located *within* the individual woman's psyche. There is therefore a clear belief that individual women need to be 'treated' for 'fear of childbirth', because it is a problem residing exclusively within the dysfunctional psychological make-up of the 'affected' woman. Childbirth itself is generally assumed to be a static, universal biological event, uncontaminated by cultural beliefs, ideologies and relations of inequality.

Childbirth has also been conceptualised by psychologists as the site of potential psychological *trauma*, with an ever-growing stream of research studying the associated 'risk' factors and sequelae of childbirth trauma. In 1994, childbirth was added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) as a recognised cause of PTSD (McKenzie-McHarg, 2004). Studies have reported postnatal prevalence rates for fully diagnosable PTSD at between 2-6% (Bailham & Joseph, 2003) and have gone on to estimate that a further 24-34% of women are *partially* symptomatic, displaying some symptoms such as 'avoidance', intrusive thoughts or 'hyperarousal' (see Czarnocka & Slade, 2000; Soet, Brack & Dilorio, 2003). A large

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proportion of the literature has found that traumatic responses to childbirth are linked to invasive obstetric procedures (Ryding, Wijma & Wijma, 1998; Lyons, 1998; Maclean, McDermott & May, 2000), a finding mirrored in relation to postnatal depression (see Oakley, 1980; Saisto, Salmela-Aro, Nurmi & Halmesmäki, 2001; Ogrodniczuk & Piper, 2003). Unfortunately, such studies fail to explore the political implications of medicalised childbirth, choosing instead to assume an unquestioning stance *vis-à-vis* obstetric medicine.

Thus, once again, the 'problem' is not the medical intervention itself or the structural context in which childbirth occurs; the 'problem' is the individual woman's pathological response(s). Unsurprisingly, a great deal of research therefore focuses on identifying the 'individual risk factors' that might explain why some women are profoundly distressed after childbirth. Researchers have looked to 'vulnerability' factors such as trait anxiety (Czarnocka & Slade, 2000), a history of receiving psychiatric or psychological counselling (Wijma, Soderquist & Wijma, 1997), previous sexual trauma (Soet *et al.*, 2003), 'dysfunctional' attitudes (Nightingale & Williams, 2000), low coping skills (Soet *et al*., 2003) and low self-efficacy (Soet *et al*., 2003) in order to explain the development of trauma after childbirth. The development of postnatal PTSD has also been linked to concomitant sexual avoidance and frigidity, mother-infant attachment difficulties, possible maternal neglect and parenting problems (see Bailham & Joseph, 2003). Generally, the proposed 'solution' to postnatal trauma is assumed to be psychological counselling (Soet *et al*., 2003; Gamble & Creedy, 2000). In a similar fashion to research on 'fear of childbirth', contextual, relational and structural factors are silenced.

In sum, psychological approaches to childbirth are guilty of pathologising birthing women, often through a ubiquitous individual reductionism. All explanations are thus reduced to the level of the individual woman and political, ideological, relational and socio-cultural factors are completely ignored. There is no recognition of the large-scale feminist critique of the *ideological* model of medicalised birth. Psychological studies of childbirth also seem to have no grasp of the historical and cultural variability of birthing practices and norms, choosing instead to approach birth as an unchanging, a-historical, biological given. All 'problems' and 'difficulties' associated with childbirth are therefore located within the internal psyche of the so-called 'dysfunctional' woman. Underlying these assumptions is clearly an individualistic understanding of the self as bounded, self-contained, stable and coherent. However, although these studies reduce everything to the level of the individual, there is, oddly enough, still no exploration of the subjective, concrete experience of birthing. This is largely because the individual produced by mainstream psychology is an *abstracted* individual, cut off from its locations in material, social and cultural life (Séve, 1975). The only 'individual' that one has direct access to via such psychological work

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is the 'general individual' or according to Séve (1975:25), "the abstract 'homo psychologicus'"; there is little or no sense of the experience of actual, concrete, embodied human selves.

Childbirth as the sum of isolated 'factors'

Other research, which could also be described as psychologically oriented, has focussed on studying women's *satisfaction* with their birth experiences. This research, overwhelmingly conducted by nurses and midwives, has often been driven by the goal of improving maternity care and services for birthing women. Factors which have been linked to satisfaction with the birth experience include: social support (Doering *et al.*, 1980; Fox & Worts, 1999; Waldenström, Hildingsson, Rubertsson & Rådestad, 2004), personal control and decision-making (Fowles, 1998; Hally McCrea & Wright, 1999; VandeVusse, 1999; Gibbins & Thomson, 2001; Viisainen, 2001; Green & Baston, 2003; Baron, Cusumano, Evans, Hodne & Logan, 2004), discrepancies between expectations and reality (Green, Coupland & Kitzinger, 1990; Slade, MacPherson, Hume & Maresh, 1993; Gibbins & Thomson, 2001; Ayers & Pickering, 2005), pain (Fowles, 1998; Hodnett, 2002; Clark Callister, Khalaf, Semenic, Kartchner & Vehvilainen-Julkunen, 2003) and type/degree of medical intervention (Waldenström, 1999; Maclean *et al.*, 2000; Waldenström *et al.*, 2004).

On the positive side, these studies have contributed to a wider recognition of the importance of constant, supportive care giving during labour/delivery and the active involvement of the birthing woman in relation to all aspects of decision-making during childbirth. However, in common with research on 'fear of childbirth' and childbirth trauma, there is little critical interrogation of hegemonic western birth practices within this literature. Medicalised, hospital based childbirth is generally assumed as an unquestioned norm. Furthermore, although interview methods are used more often in this research, women's own accounts of their experiences are more often than not over-simplified and 'made to fit' pre-existing conceptual grids (i.e. 'expectations' versus 'reality'; 'decision-making'; 'control'). For reasons of limited space, it is impossible to cover all of the 'factors' that have been studied in relation to childbirth 'satisfaction'. However, as an issue that is potentially relevant to my analysis of home-birthing and caesarean birthing stories, I will briefly explore how the issue of 'control' has been approached and studied within the literature.

The importance of personal control in relation to the birth experience has been repeatedly demonstrated via psychological studies. Feeling 'out-of-control' during childbirth has been related to the development of postpartum dissatisfaction, distress and possible 'trauma' (Fowles, 1998;

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Hally McCrea & Wright, 1999; Green & Baston, 2003; Waldenström *et al*., 2004), while positive, 'satisfying' evaluations of birth are consistently linked to a positive sense of control (Weaver, 1998; Waldenström, 1999; Green & Baston, 2003). The concept of control remains complex, multifaceted and sometimes paradoxical, with the result that it is difficult to quantify or 'study'. Unsurprisingly, 'control' (particularly in relation to birth) is not well defined, nor are different aspects of control coherently and consistently differentiated. 'Control' has often been conceptualised in quantitative studies largely as a question of 'decision-making' or 'control over' medical interventions (e.g. VandeVusse, 1999; Hodnett, 2002). This over-simplified version has been challenged by feminist qualitative research, which has correctly pointed out that 'control' can mean different things to different women (Fox & Worts, 1999; Viisainen, 2001).

For example, in Kirsi Viisainen's (2001) study, in which she explored the ways in which 21 Finnish home-birthing women narrated their decision to have a home-birth, it was found that women constructed the meaning of 'control' in fluid and unexpected ways. The 'search for control' was found to be a common theme in the narratives. Surprisingly, achieving 'control' (doing things their way) was portrayed as an important part of '*natural*' childbirth. As stated by one woman: "First and foremost the natural in birth means my choice and my decisions" (cited in Viisainen, 2001:1116). However, other studies have found that for some women, 'control' is about the ability to procure pain relief and interventions on demand (e.g. Fox & Worts, 1999). For the 30 (middle-class) women interviewed by Fox & Worts (1999), 'control' meant different things, ranging from control over decisions and the course of labour/delivery, to remaining conscious, awake and aware, controlling and managing pain or keeping the situation under control by allowing hospital staff to take full responsibility and direct the birth experience. It is thus important to recognise that for some women, 'control' is not about avoiding medical interventions, but is dependent on the ready availability of drugs and interventions on demand. As a result of hearing different women's perspectives, 'control' is now widely acknowledged as a multi-dimensional concept. It is thus now common to differentiate between internal control (control of self, body and behaviour) and external control (control over environment and decisions regarding medical procedures, drugs and interventions) (see Weaver, 1998; Viisainen, 2001; Green & Baston, 2003).

For the home-birthers in Viisainen's (2001) study, achieving control over external factors was of the utmost importance and regarded as achievable only outside of a hospital environment. 'Letting go' of body-self control during childbirth was seen as possible only once external control had been achieved. For the ten Swedish women interviewed in Lundgren's (2005) phenomenological study, 'control' was spoken of in a paradoxical fashion. For these women, all of whom had given birth within an Active Birth Centre, childbirth was described as an

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'unavoidable situation' requiring both control and a loss of control. Women described the importance of 'going with the flow', being guided by bodily signals and allowing the childbirth process to be 'in charge'. At the same time, being 'in control' was seen as integral to the process of losing control. Lundgren (2005:349) reports that for these women, "a feeling of having control was important when they were releasing control". This might suggest that a *secure* feeling of control in relation to external factors (environment, support-givers, availability of pain-relief) is required before women can concentrate on the process of birthing (which might necessitate some degree of loss of control). Active support by midwives and partners was also described as a critical enabling factor in allowing the bodily process of birth to proceed (*ibid*).

Some researchers have usefully suggested that a sense of subjective 'control' is inextricably connected to being treated with respect as a person, that is: as an active, fully human subject rather than a dehumanised, passive object (Waldenström, 1999; Green & Baston, 2003). Thus, according to Green & Baston (2003), feeling *cared about*, being consulted, informed and *heard*, regardless of who technically makes the decisions, can imbue a positive sense of empowerment and feeling of 'control' to the birthing woman. This is indicative of the *inter-relational* qualities of control and the ways in which it is always complexly intertwined with supportive care and respectful communication between birthing women and their caregivers (Weaver, 1998). 'Control' is therefore not something that women 'have' or do not have, but is perhaps better conceived of as a dynamic, intersubjective process or "joint effort" (Weaver, 1998:90). Weaver (1998) also hints at the possible interconnections between knowledge, power and control, in which 'authoritative' (Jordan, 1993) or hegemonic forms of knowledge (i.e. medical) translate into the ability to usurp control. Weaver usefully points to the importance of women's own *embodied* knowledge of labour/birth, as well as the knowledge and information they have (usually) acquired through reading and women's networks, which she believes should be recognised and respected within the birthing scene as a source of power and knowing.

In the end, it seems that it is difficult to separate the issue of 'control' from questions of support, communication, respect, ideological practices, information and care. This is the difficulty that faces research that attempts to isolate and measure the 'effects' of discrete 'factors' associated with women's satisfaction with childbirth. Qualitative research that has taken seriously the task of *listening* to women has alerted researchers to the complex, variable, multi-dimensional and potentially paradoxical nature of 'control'. The 'factors' which have been shown to be related to birth satisfaction (e.g. support, control, expectations, pain) are never *experienced* by individual women as separate, coherent 'things', but are part of a more complex totality involving ideological, structural, semantic, subjective and material dimensions. The full complexity of this 'total experience' has however yet to be unravelled by researchers. Thus, even research that has

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investigated childbirth via qualitative techniques might not have succeeded in capturing the contradictory, ambivalent and plural nature of birthing experiences. Julie Stephens (2004) makes a similar point regarding qualitative research on motherhood, which she accuses of 'ironing out' rather than representing, the complex contradictions of mothering. For Stephens (2004), this 'ironing out' is partly a consequence of 'realist' forms of analysis and writing, in which contradictions within texts, stories and accounts are effectively erased. She calls for more 'experimental' modes of investigation to allow researchers to move beyond the current "interpretative impasses" (pp. 93) in the representation of motherhood.

Among other things, the rest of this chapter will be asking to what extent feminist qualitative research on birthing can be said to be guilty of the same degree of 'smoothing over' or 'ironing out' of the childbirth experience. Not surprisingly, feminist research has constituted the most vociferous site at which issues of birthing experience and subjectivity have been explored and debated. In my subsequent review of feminist studies on childbirth, I will be focussing on the ways in which such research has approached, studied and represented women's birthing experience and subjectivity. I will also be exploring the ways in which feminist work on birth has mirrored shifts within feminist theory more broadly.

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Mapping shifts in feminist theory

"No one shares the same narrative of feminism."
(Carla Kaplan, 2001:679)

Before attempting to position (feminist) childbirth research in relation to wider concerns and shifting trends within feminist theory, it is imperative that I first attempt an overview of the dominant and divergent theoretical tendencies that have emerged historically within feminism. Before doing so, however, it is important to acknowledge the complexities and risks involved in any attempt to chart or categorise coherent strands or tendencies within the highly contested field of theory/research that constitutes contemporary academic feminism. Any such overview will inevitably be guilty of some degree of oversimplification or misrepresentation. However, in the interests of 'making sense' of a complex and highly debated body of thought, a route-map provides us with at least some (partial) interpretative framework within which to approach feminist theory.

Traditionally, maps of feminism have characterised shifts within the movement as a series of historical 'waves', the first wave beginning with feminist political mobilisation from the late 1800s and the second wave associated with the renewed feminism of the 1960s-1990s. Recently, a so-called third wave has been identified (Mann & Huffman, 2005). It is well recognised that

falling within the parameters of these 'waves' are multiple, often conflicting feminist perspectives, viewpoints, methods and theoretical affiliations. Second wave feminism has been particularly well mapped, with the classic typology of liberal, socialist, radical and cultural feminism now a rather well-worn cliché. Unsurprisingly, efforts have recently been made to provide 'cutting-edge' maps of the *post*-second wave era (e.g. Dietz, 2003; Mann & Huffman, 2005). For these writers, the past twenty-five years has witnessed a major rupture in feminist theory, in which feminism of the second wave has been challenged, critiqued and thoroughly 'decentred'. In this attempted overview, feminism will be approached as a series of debates and competing story lines, an ebb and flow of arguments, positions and commitments. Apart from the plethora of 'micro' feminisms currently clamouring for voice, including 'lipstick feminism', 'power feminism' and 'DIY feminism' (see Mann & Huffman, 2005), it is nonetheless possible to discern key theoretical debates that continue to structure, enliven and propel feminist thinking.

A structuring dynamic: individualist versus difference feminism(s)

Historically, feminist thought has been characterised by a competing tension between the two dominant tendencies of abstract individualism and difference (Offen, 2000). Others have termed this the sameness versus difference debate (DiQuinzio, 1999), revolving around the binary of identity – difference. More recently, a post-structuralist line of theory and debate has emerged as a third major tendency within feminism. It is this third position that has helped inaugurate the 'third wave' or 'postmodern' shift in feminist theory (Mann & Huffman, 2005; Beasley, 2005). It must be stressed, however, that these three tendencies should not be imagined on a linear continuum of 'progress'. Thus, we have not now reached a point where individualist and difference tendencies have been replaced and 'transcended' by a post-structuralist tendency. Rather, all three tendencies continue to jostle and compete, albeit sometimes in newly packaged forms. For instance, a tendency towards 'individualism' is still clearly at work in new-fangled forms of feminism such as 'power feminism' (Beasley, 2005).

In this over-view, the feminist tendency towards abstract individualism will be referred to as 'individualist feminism', otherwise known as 'liberal' or 'emancipatory' feminism (*ibid*). Individualist feminism privileges the notion of the abstract, universal, gender-free individual and aspires towards equality-of-sameness between men and women. The goal often seems to be the *transcendence* of sex and gender, with traditionally female activities and capacities dismissed or denigrated (Offen, 2000). Underpinning this feminist story line is an *ideology of individualism*, with a particular theory of the subject, the body and agency (DiQuinzio, 1999). The subject

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emerging from this ideological formation is the rational, autonomous, gender-free, disembodied and all-knowing self; furthermore, this ideology rests on a fundamental dualism between body and mind, with the body portrayed as an obstacle to be overcome in the quest for 'pure', objective knowledge and 'truth' (*ibid*). Individualism presents agency as a capacity of disembodied consciousness, unaffected by material, social and ideological contexts and relations.

It is important to recognise that an individualist stream of feminist argumentation has made significant strides in its quest to gain recognition for women's autonomy and individual right to choice and self-determination. However, in privileging the abstract, gender-neutral human individual, individualist feminism is unable to theorise or recognise the specificity of women's embodiment and experiences such as pregnancy, childbirth, breastfeeding and mothering (*ibid*). The requirements of individualist subjectivity, namely: independence, individuation and disembodied rationality, are not always sufficient to capture or reflect maternal experience(s). For individualism, birthing and mothering are automatic and instinctive bodily functions and are therefore, in effect, not exercises of subjectivity or consciousness; they are 'all body and no mind'.

A competing historical line of argumentation, jostling side-by-side with individualist feminism, is a relational or *difference* orientation within feminism (Offen, 2000). Difference feminism emphasises women's rights *as women* (not abstract human individuals) and values what is regarded as distinctively female ways of being and knowing (*ibid*). The 'distinctively female' generally refers to women's childbearing and nurturing capacities and activities. Difference feminism seeks an equality-of-difference with men, where women's rights and autonomy "as embodied, female individuals" (*ibid*, pp. 22) is recognised and respected. The debate between individualist and difference lines of argument stands as a structuring dynamic within the history of feminist thinking. Difference feminism is not, as argued by Beasley (2005), a theoretical perspective that emerged after liberal, individualist feminism (see Offen, 2000). Both historically and contemporaneously, feminist thought is better conceptualised as a crosscurrent of dialectical debates than as a series of coherent, linear and mutually exclusive types or perspectives. The dilemma of sameness (identity) and difference reveals a fundamental tension or paradox at the heart of feminism, that is: how does one affirm women's rights as individual *human* rights and protect and affirm their distinctive rights *as women*? This is 'the dilemma of difference', a paradox with which all feminist work on childbirth and mothering will inevitably collide (DiQuinzio, 1999; Blum, 1999).

Difference feminism, also known as woman-centred, gynocentric, cultural or social difference feminism, is preoccupied with the re-valuation or celebration of women's difference (from men). It challenges individualism on several fronts, including: individualism's gender-

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neutral (and implicitly masculine) subject, its rejection of material, social, historical and relational contexts as in any way constitutive of subjectivity, its privileging of identity, and binary understanding of subjectivity and social relations (DiQuinzio, 1999). Difference feminism also potentially offers more tools for the theorisation of birth and mothering than individualist versions of feminism. Whereas the subject evoked by individualist feminism resembles a disembodied gender-less human individual, difference feminism at least recognises the specificity of women's embodiment and seeks to address, analyse and theorise women's situations, experiences and consciousness (*ibid*). At the same time however, difference feminism is widely criticised for its tendency toward essentialism. Although feminist arguments of difference are associated with a number of theoretical orientations and projects (e.g. object relations theory, Marxism, feminist standpoint theory), they have in common the assumption that there is such a thing as a coherent, a-priori female body and/or feminine psyche. On the basis of this universal female body, feminine psychology or socio-cultural experience of gender oppression, 'women' are seen as a coherent and unified group. When studying or theorising pregnancy, childbirth or mothering, difference feminism's acknowledgment of the specificity of women's embodiment is a critical and indispensable tool. However, at the same time, this very acknowledgement draws us into a number of "difficult paradoxes" (*ibid*, pp. 13). Most importantly, it risks the reproduction of the ideology of 'essential motherhood' (*ibid*).

According to DiQuinzio, essential motherhood, also known as 'exclusive motherhood' (Blum, 1999) or 'intensive motherhood' (Hays, 1996) is a patriarchal ideology that posits childbearing and mothering as an inevitable function of women's biology, 'nature', or evolutionary 'hard-wiring'. Motherhood as the selfless, exclusive, all-consuming, sole responsibility of women is regarded as 'naturally' and inextricably bound to the biological fact that women give birth to children. Women's desires and sexuality are understandable only in terms of motherhood; lesbianism or alternative sexualities are thus seen as deviant and foreign. According to this ideology, all women do or should want to be mothers; voluntary childlessness is seen as a dysfunction or abnormality of normal femininity.

Although feminist appeals to difference usually attempt to challenge patriarchal ideologies of motherhood, often by posing a bifurcated relationship between the experience and the institution (or ideology) of motherhood (e.g. Rich, 1976), they nonetheless risk the recuperation of essential motherhood by retaining the fundamental male–female binary at the core of their analyses (DiQuinzio, 1999). A series of paradoxes – of embodiment, gender and representation – are the inevitable result (*ibid*). These paradoxes include: theorising the specificity of sexed embodiment without resurrecting a naturalised account of gender and recognising the importance

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of women's specific experiences while also critically interrogating the inevitable inter-relations between experience and ideology (*ibid*).

As a result of direct challenges, classic versions of difference feminism splintered into a number of different versions from the 1980s onwards. The concept of difference itself became a volatile and contested point of debate (e.g. Barrett, 1987; Felski, 1997). According to Mann & Huffman (2005), the critique of universalistic concepts of 'woman' offered by 'women of colour', constituted the greatest challenge to classic feminist understandings of difference (as difference between men and women). Women of colour launched scathing attacks on 'the universal woman' represented within (white, middle-class) feminism and argued that it dismissed and ignored differences between women. This challenge became known as 'diversity feminism' (Dietz, 2003), 'intersectionality theory' (Mann & Huffman, 2005) or 'multiple difference feminism' (Beasley, 2005). This line of feminist theory questioned the coherence of the concept of 'woman', the privileging of sex-gender oppression above other forms of oppression and highlighted the critical significance of differences between women according to race, class, sexuality, ethnicity and geopolitical location.

Classic difference feminism was further complicated in the 1980s by the rising influence of the so-called 'French' feminists (primarily Cixous, Kristeva and Irigaray), writing within the context of French post-structuralism, psychoanalysis and deconstructionism. Despite considerable differences between the work of Cixous, Kristeva and Irigaray (who have all been reluctant to identity as 'feminists'), their writing is seen as the basis of what has become known as 'sexual difference' or 'symbolic difference' (Dietz, 2003) feminism. 'Sexual difference' versions of feminism do not argue for 'real' differences between men and women or postulate any essential meaning associated with being a woman (Beasley, 2005). Instead, sexual difference feminism is interested in *symbolic* difference, particularly the ways in which 'woman' or 'the feminine' have come to function as the site of a radical difference or 'otherness' within patriarchal or 'phallocentric' discourse.

A third way: post-structuralist feminism

Cross-cutting through these debates of difference, the emergence of a third major theoretical tendency within feminism can be discerned. The long-standing historical debate between the two dominant strands of feminist thinking, namely *individualist* and *difference* feminism, has been substantially disrupted by the emergence of *post-structuralist* feminism. Drawing on the work of French philosophers and social thinkers, including Jacques Lacan, Michel Foucault and Jacques Derrida, a postmodern or post-structuralist turn was evident in feminism from the 1980s onwards.

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This deconstructionist turn, now arguably the dominant tendency in feminist theory (Ebert, 1996), is associated with a resistance to essential identities, binary oppositions and categories of any kind and the championing of the dissolution of identity and 'the subject'. In its extreme form, identities of all kinds (race, gender, class) are seen as 'regulatory fictions' (see Butler, 1990) produced by dominant discourses. Typically, post-structuralist approaches denounce universalistic or 'totalistic' theories and forswear concepts such as 'patriarchy', 'oppression' and 'liberation', preferring to concentrate on local (micro) theories and a politics of (textual) resistance. Unsurprisingly, the adoption of postmodern or post-structuralist approaches within feminism sparked a fierce 'crisis of identity' or series of heated debates in the 1980s and 1990s. Post-structuralist tendencies, together with the critique offered by 'diversity feminism', posed a significant challenge to the taken-for-granted, unitary 'subject' of second wave feminist thinking. Under the influence of post-structuralist theories, the founding concepts of feminist theory were threatened. Concepts such as 'woman', 'sex', 'gender', 'patriarchy', 'self' and 'truth' have all been subject to stringent deconstructionist analyses in which they have been 'revealed' to be inessential discursive constructions.

While it is clear that individualist feminism strives for the recognition of women's rights as individual human rights and difference feminism seeks to reinstate the political significance of women's rights as women, it is not entirely clear what post-structuralist feminism is fighting for. Clearly, it remains an oversimplification to speak of post-structuralist feminism as if it were one thing. There are, after all, multiple versions and interpretations of post-structuralist feminism. However, theoretical interpretations notwithstanding, it is possible to speak of a post-structural tendency within feminism which remains vague regarding the political strategies and emancipatory alternatives offered or enabled by post-structuralist theories. Thus, whereas some feminists claim that the adoption of post-structuralist theories do not compromise feminist politics (e.g. Lloyd, 2005) and argue instead that a post-structuralist politics of difference opens the possibility for the reconceptualisation of politics itself, it is not always clear what this means in practice (Lurie, 2001). Post-structuralist approaches within feminism have, however, offered powerful tools of critique with which to interrogate feminist practice, theory and identity (Lurie, 2001). The strengths of post-structuralist theory remains the powerful resources it offers for the critique and deconstruction of assumptions and taken-for-granted 'truths'.

According to DiQuinzio (1999), feminist accounts of mothering need to be developed which resist dualisms and offer alternative (non-individualist and non-essentialist) theories of subjectivity. Despite conflicting positions *vis-à-vis* a politics of sameness or difference, both individualist and difference feminism assume a coherent, stable notion of subjectivity, either by positing a gender-less individual or a gendered/sexed self. Individualist and difference feminisms

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are both shot through with essentialism, whether in the form of identity as essence or difference as essence. Can post-structuralist accounts of subjectivity provide better ways to theorise maternal subjectivity?

Intersections between feminist theory and childbirth research

Few systematic attempts have been made to analyse the intersection(s) between feminist theory and research on childbirth. This is surprising considering the extent to which theory and research on childbirth has been both pioneered and dominated by feminist writers and researchers over the last three decades. An important exception is the work of Ellen Annandale and Judith Clark who argued in 1996 that childbirth researchers had 'lost sight' of the key contemporary debates and shifts within feminist theory. They argued that research on childbirth and reproduction more broadly, was premised on the assumption that 'feminism' constituted an "internally coherent body of thought" (pp. 17). In their view, researchers worked only 'tacitly' with feminism, avoiding full engagement with the contestations and debates within feminist theory. Via a post-structuralist critique, Annandale & Clark (1996) identify childbirth research as 'modernist' and predicated on an out-dated binary mode of thinking between men–women and sex–gender. They also accuse 'modernist' childbirth research of universalism (speaking for all women), the valorisation of gender difference, a lack of clear 'alternatives' and an over-emphasis on women as opposed to gender.

For Annandale & Clark, the solution to this modernist stalemate is the adoption of a post-structuralist approach. While offering an extensive critique of 'modernist' research on women's health, Annandale & Clark are however, in their own terms, at best 'tentative' in suggesting how a post-structuralist approach might radicalise the study of reproduction. What they do seem to suggest is that we need to reconceptualise the body and welcome the use of high technology that might help persons "to overcome a gendered notion of their bodies" (pp. 35). They also call for the development of new metaphors for the body (i.e. cyborg) that might destabilize normative binaries. The strategies enabled by Annandale & Clark's post-structuralist position thus seem to be limited to intervention and resistance on a textual or linguistic level. There seems to be little appreciation of the (historical) material and contextual relations that permeate and limit the subversive potential of, for example, 'high technology'. Instead, we are given the impression that 'technology', 'gender' and 'the body' are free-floating discursive constructs that can be glued or unglued at will, all in the abstract interests of 'destabilising' binaries. The question remains whether 'destabilising' binaries at an exclusively discursive level makes any concrete difference to practices and material conditions on the ground.

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A more recent attempt to plot the interface between feminism and debates about childbirth has been offered by Katherine Beckett. In her paper, Beckett (2005) argues that (similarly to shifts within feminism more broadly), there have been three discernable 'waves' of feminist activism around childbirth. The 'first wave' of birth activism refers to early twentieth century feminist campaigns for women's rights to pain relief and drugs. She associates the so-called 'second wave' of feminist activism with the 'alternative birth movement' of the 1960s and 1970s, in which a diverse group of activists from both conservative and feminist orientations launched a powerful critique against the medicalisation of childbirth and advocated an alternative 'natural', midwifery or home-birth based experience. Beckett describes four 'themes' underpinning 'second wave' feminist writing/activism on childbirth, including: birth as a 'natural' event, the iatrogenic and disempowering nature of medical intervention, women's right to choose alternative, midwifery care and the empowering dimension of drug-free, 'natural' birth. The 'third wave' of feminist birth activism is associated with the critique of the discourse, goals and assumptions of 'second wave' activists. This critique is often rooted in feminist post-structuralist approaches.

According to Beckett, this third wave critique has been advanced in relation to five central points. First, post-structuralist writers have criticised the ease with which many 'second wave' activists have invoked the idea of 'the natural' as non-problematic panacea and unquestioningly taken up the mantle of an essentialist, 'cultural feminism'. Thus, instead of binaries being 'deconstructed', they are simply inverted, with 'woman' and 'nature' valorised as privileged terms. Post-structuralist critics argue that the notion of 'the natural' is not beyond critique and needs to be subject to a thorough deconstructive interrogation. For 'third wave' feminist writers, there is no pure or 'authentic' version of childbirth. Instead, "childbirth has no meaning or essence outside of its construction through…discourses" (Beckett, 2005:258).

Second, post-structuralist critics argue that technology is subject to an essentialist interpretation as "inherently patriarchal" (pp. 259) within 'second wave' feminist activism. This obscures the extent to which birthing women themselves sometimes choose technocratic birth experiences and dismisses such choices as simply instances of 'false consciousness' or patriarchal accommodation. For 'third wave' feminists, technology is not automatically equated with patriarchal oppression. Third, critics of 'second wave' birth activism claim to be perturbed by "the idealization of domesticity" (pp. 259) that they see pervading the lingo of the alternative birth movement. For post-structuralist critics, this valorisation of 'home and hearth' reproduces the long-standing, conservative drive to constrain women to the private sphere and also works to obscure the operation of patriarchal power within the domestic scene. Fourth, third wave writers criticise the tendency for second wave activists to treat midwifery and feminism as synonymous, claiming that this leads to a problematically unquestioning stance towards midwifery practice.

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Finally, third wave critics have attacked what they see as the valorisation of pain inherent in second wave accounts of childbirth. They argue that the notion of (natural, drug-free) childbirth as a key, defining point in women's lives and the idea that women do (or should) feel empowered or joyful in relation to (drug-free) birth, is a dangerous romanticisation of women as birth-givers and mothers, which excludes and denies the experiences of many women.

In the rest of this chapter, I will be attempting to plot my own map outlining intersections between shifts in feminist theory and (changing) approaches to the study of birth. Building on both Annandale & Clark's modernist – postmodernist distinction and Beckett's analysis of three 'waves' of feminism and birth research, I will be trying to situate feminist studies of childbirth within the nexus of feminist debates, dilemmas and theoretical positions that I have outlined in the previous section. How has feminist work on childbirth traversed and negotiated the individualist, difference, diversity and post-structuralist impulses within feminist theory? How has the ubiquitous 'dilemma of difference' played itself out within feminist studies of birth? I will be interrogating the (often implicit) feminist frameworks within which such studies operate and mapping the extent to which their frames of reference dictate the way in which birth is approached and investigated. Furthermore, I will also be exploring how the feminist shift towards post-structuralism has affected the ways in which birth is theorised, studied and conceptualised and interrogating the merits and/or pitfalls of such shifts.

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Studying childbirth: feminist frames and findings

"…mothering is a process riddled with paradoxes."
(Bassin, Honey & Kaplan, 1994:14).

When looking at feminist research on childbirth over the last three decades, it is possible to discern key shifts in the research focus, theoretical persuasion(s) and representation(s) of birth and birthing women that have been deployed by feminist researchers. As I have already mentioned in chapter two, feminist work on birth in the 1970s and 1980s was dominated by the critique of (patriarchal/technocratic) medicalisation. Throughout this period, feminist writers produced critically important texts exposing the ideological face of western childbirth practices (e.g. Shaw, 1974; Arms, 1977; Rich, 1976; Oakley, 1980; Romalis, 1981; Rothman, 1982; Martin, 1987; Michaelson, 1988). Most of these writers focussed on the macro-level politics of childbirth, concentrating on the role of larger social (or cultural) structures in the construction of birthing practices. The concept of power underpinning most of this work can be characterised as modernist, in that it generally assumes power to be acting in a 'top-down' and repressive fashion to oppress, subordinate and dominate individual selves (Beasley, 2005). Not surprisingly, feminist

childbirth researchers working within the 'second wave' era of feminism drew upon the 'modernist' framework of thought that was dominant at the time. Thus, many of these writers were keen to unravel the universal features of 'the medical model' of childbirth, locating it within macro-explanatory structural systems (and ideologies) of patriarchy, capitalism and technocracy (e.g. Rothman, 1982; Martin, 1987).

Surprisingly, this stream of research was not very interested in individual women's own perspectives, experiences and ways of thinking in relation to childbirth. Rather, it was generally assumed that dominant ideologies thoroughly determined women's personal experiences. Few of the major books published on childbirth in the 1970s and 1980s were concerned with listening to the ways in which birthing women themselves represented their birth experiences (e.g. see Haire, 1972; Arms, 1977; Rich, 1976; Jordan, 1993; Rothman, 1982). Thus, although anthropologist Brigitte Jordan (1993) would have observed many women giving birth and no doubt listened for countless hours to women (in four different cultures) talking about childbirth, she was not primarily concerned with tracing their subjective experiences of birthing. Instead, Jordan was interested in plotting the distinctive features of different cultural birthing systems.

In this review of feminist birth research, I will be focussing predominantly on studies that have listened to and explored women's *experiences* of childbirth. I will be looking at the ways in which feminist researchers have approached and represented these experiences and interrogating the theoretical frames (individualism, difference feminism and/or post-structuralism) within which these analyses are (often implicitly) located. At the same time, I will be attempting to give an idea of the general (shifting) shape of feminist birth research over the past twenty-five years and the 'findings' that have emerged from key studies.

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Modernist 'takes' on the childbirth experience

Ann Oakley: the pitfalls of individualist feminism

Ann Oakley's (1979, 1980) sociological research on women's transition to motherhood stands as one of the first large-scale research efforts to listen to what (British) birthing women had to *say* about their experiences of (hospitalised) childbirth. These accounts were published as a separate 'ethnography' (Oakley, 1979) in which the passage to motherhood (from conception to five months postpartum) is traced through the words of women themselves. Oakley describes '*Becoming a mother*' as: "a portrait of how it feels to have a first baby in the late 1970s in a large industrial city" (pp. 8). However, although the voices of women make up the bulk of the book,

their experiences are nonetheless 'ironed out' and made-to-fit a linear, chronological trajectory broken up into sequential chapters, from 'in the beginning' to 'lessons learnt'. The same research was also published as a more formal research study in 1980 as, '*Women confined: towards a sociology of childbirth'*.

In her study, Oakley interviewed a total of 55 women four times, twice in the antenatal period and twice in the postnatal period. Although Oakley is critical of psychological work on maternity for its obsession with women's so-called successful or unsuccessful 'adjustment' to motherhood, she nonetheless retains an 'outcome' based approach, labelling 'adjustment' and 'depression' as two of her 'outcome' variables. However, Oakley claims that she is studying women's adjustment to the *cultural* expectations of motherhood (not to an idealised and normative view of femininity). In her study, Oakley assesses 'outcome' by categorising women's responses to a standardised set of questions that are meant to reflect their degree of depression (postnatal blues, anxiety, depressed mood and/or depression), satisfaction with motherhood and feelings towards their infants. In order to connect women's degree of 'adjustment' to social features of the patriarchal motherhood institution, she also investigates six additional factors, including: birth factors, antecedent socialisation factors, baby condition, work conditions, marriage factors and general background, all of which were found to be both statistically and theoretically related to different aspects of 'outcome'.

Oakley's research found that an 'unproblematic' adjustment to first-time motherhood is rare, with only two out of 55 women experiencing no negative mental health outcome, evidencing high satisfaction with motherhood and positive feelings for their babies. According to Oakley, it is therefore 'normal' for women to experience difficulties with the transition to first-time motherhood. In her sample, 24% of the women were categorised as 'depressed' and 84% experienced 'postnatal blues'. The development of both depression and postnatal blues was related to obstetric intervention and dissatisfaction with the birth experience. In fact, Oakley describes the connection between births marked by 'high technology' and subsequent postnatal depression as "one of the most unequivocal findings of the study" (pp. 148).

Overall, there was found to be an exceptionally high rate of medicalised interventions in the sample, with 99% having analgesia of some sort, 52% experiencing instrumental deliveries (forceps or vacuum extraction) and 98% receiving episiotomies. The way a woman felt about her labour was also related to the development of depression. According to Oakley, if a woman "can maintain some sense of herself as the person having the baby" (pp. 176) she might be 'immunized' from a subsequent depression. Other 'outcome' measures were significantly related to social factors. For example, 'depressed mood' was associated with aspects of the (current) social environment, including: housing problems, lack of employment outside the home and

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conflict between the parents. 'Satisfaction' with motherhood was related to antecedent 'socialisation' factors, including 'feminine role orientation' and 'self-image' as mother. In her study, Oakley thus shows that the 'outcome' of the childbirth experience cannot simply be studied within an individualistic, psychological framework. Women's 'adaptation' to motherhood is shown to be inextricably linked to wider social, ideological, relational and medical factors.

A further major 'finding' of Oakley's study is the large gap she found between women's *expectations* of pregnancy, childbirth and motherhood and the *reality* they experienced. Four-fifths of the women experienced the whole process as less positive than they had expected. Thus, 93% described childbirth as not what they had expected and 91% said the reality of motherhood did not fulfil their overly romantic expectations. With regards to childbirth specifically, women felt 'shocked' regarding the unexpected degree of pain involved and the plethora of medical technology and intervention experienced. Thus, few of the women had expected birth experiences marked by episiotomies, instrumental deliveries or labour induction, although in the end the majority received them.

As an aside, it is worth mentioning that almost identical patterns have been found by a recent study of the transition to first-time motherhood (see Miller, 2005), in which British women reported a similar degree of unexpected 'shock' in relation to their birth experiences. Thus, twenty-five years after Oakley's research was published, Tina Miller seems to find that not much has changed for British women as they become first-time mothers. Although Miller does not devote much attention to childbirth within her study, she does report that whereas most of the 17 women interviewed expressed (antenatal) confidence in their ability to have a 'natural' birth, most 'ended up' with highly medicalised births that shattered their antenatal expectations. Several subsequent studies have also found a relationship between the degree to which women's expectations of birth match their experiences and their reported satisfaction with childbirth (e.g. Fowles, 1998; Gibbins & Thomson, 2001; Hodnett, 2002). However, unlike Oakley, few of these studies position this issue in the context of structural and ideological power inequalities.

The groundbreaking quality of Ann Oakley's work is clearly not in any doubt. However, I wonder where her work 'fits' in relation to the broader feminist frameworks outlined earlier. Is she simply a part of a modernist camp of 'difference' feminism? Looking at her work on birth and motherhood more closely, I was surprised to find that it is, in fact, more closely linked to an *individualist* tendency within feminism. In her 1980 book, Oakley rejects the notion of childbirth as a distinctly feminine process and argues instead that it should be approached as a human life event or life transition. Oakley describes the fact that only women have babies as, "the chief methodological stumbling block in the study of women's reactions to reproduction" (pp. 258). Oakley wants to position first childbirth as a life transition similar to other 'human' life events or

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transitions, such as retirement, career change, 'patienthood', undergoing major surgery, living through a natural disaster or being 'institutionalised'. Thus, for example, in Oakley's opinion, "studies of reactions to amputation surgery have some parallels with childbirth" (pp. 212). Oakley thus wants to position her study of childbirth firmly within "the psychology of human beings in general" (pp. 259).

However, as a researcher of the exclusively female processes of pregnancy and childbirth, Oakley finds herself constantly 'walking a tightrope' between the logic of sameness and difference. As she herself wryly remarks, "The trouble with childbirth…is that it only happens to women" (pp. 2). Oakley is, in many senses, trapped within the ubiquitous 'dilemma of difference' so eloquently described by DiQuinzio (1999). Thus, although she wants to stress that women are "first and foremost *human* beings" (pp. 258, emphasis added) and that childbirth is a human life transition, her entire book is nonetheless founded upon the binary logic between men–women and masculine–feminine. Thus, the text is peppered with constant references to 'male society', 'masculine culture', 'masculine personality' and 'the male perspective', all of which function as the root cause of women's oppressed status and as the defining elements of normative 'femininity' and motherhood. Women are thus inadvertently positioned as powerless 'victims' in the face of male power.

Oakley's work is also trapped within the problematic of the sex–gender distinction. Thus, 'nature' and the biological body are assumed to be foundational templates upon which 'socialisation' acts. Although overlaid by cultural and social meanings, childbirth is nonetheless still seen as "a biological event" (pp. 7). The only body that appears in her work is the biological body, overwritten and subjugated by the power of patriarchy and medicalisation. This is characteristic of individualist streams of feminism, which tend to conceptualise embodiment as 'the ground' of subjectivity, 'mind' or experience, relying heavily on a mind–body dualism. Oakley herself hints at the problems this approach creates for research on maternity, when she writes towards the end of her book that she has not given sufficient attention to "the pleasures women have…managed to obtain from motherhood" (pp. 291). Commensurate with an individualist feminist tendency, biological 'sex' and the (embodied) female processes of pregnancy and childbirth are seen to have no inherent meaning, value or significance. Within this framework, reproductive processes are generally only recognisable as sites of oppression.

Oakley acknowledges the paradoxes individualism creates for her work when she writes that "all that has been said derives, in a sense, from a male perspective" (pp. 290), recognising that her research implicitly accepts a male-centred (individualist) paradigm of identity and situates women's reproductive (mothering) experiences at the core of their oppression. This constitutes, in fact, "the logic of the male perspective on motherhood carried to its most extreme formulation"

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(pp. 291). As a women who has herself "enjoyed having children", Oakley personally recognises this logic as "a reductio ad absurdum" (pp. 291). An acknowledgement of this paradox immediately leads Oakley to a re-affirmation of women's (positive) difference:

> And what these contradictions point to, I think, is the considerable task women confront in designing a psychology (not to mention society) that authenticates a female point of view. Reproduction is not just a handicap and a cause of second-class status; it is an achievement, *the* authentic achievement of women…The problem is to reconcile the feminist programme of women's advancement with the subjective logic of reproduction stripped of its masculine ideological transformation: childbirth as seen through women's eyes without the obfuscation of masculine ambivalence (pp. 291, author's emphasis).

This is the 'dilemma of difference' that "all attempts to theorize mothering inevitably encounter" (DiQuinzio, 1999:xv). Oakley is trapped, in effect 'walking the tightrope' between wanting to affirm women as *human* subjects and acknowledge the *specific female* processes of pregnancy and birth. Unable to theorise the specificity of female embodiment, individualist approaches are invariably inadequate for the task of researching the complexities of maternal subjectivity. However, at the same time, the risks of difference are great (*ibid*). Forced to reiterate the (potential) significance of reproductive difference or do violence to many women's experiences (including her own), Oakley collapses into the valorisation of sexual–reproductive difference, positing it as "*the* authentic achievement of women" (Oakley, 1980:291, author's emphasis). Not surprisingly, the tendency towards the valorisation of gender difference characterises most 'second wave' feminist work on childbirth.

Applying gender difference feminism to research on birth

For example, the seminal work of anthropologist Emily Martin (1987), who attempts an impressive 'cultural analysis' of women's experiences of menstruation, childbirth and menopause, can be located within a classic (modernist) 'gender difference' feminism. At the same time, however, her work is also sensitive to differences between women. In her study, Martin draws on a total of a 165 interviews conducted with women in three different life stages (puberty to childbearing, childbearing and childrearing and menopause and beyond), including both middle-class (57%) and working-class (43%) participants. Martin is particularly cognizant of the class-based differences between women's experiences of reproduction.

As a brief aside, it is perhaps pertinent to note the substantial amount of feminist work that has recognised and studied class differences in women's experiences of childbirth. From the 1980s onwards, feminist researchers have pointed to the different priorities, desires and experiences working-class and middle-class women have with respect to childbirth (see Nelson,

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1983; Hurst & Summey, 1984; Mcintosh, 1989; Lazarus, 1997; Zadoroznyj, 1999). Generally, such research has shown that working-class women are less concerned with issues of control and do not value the 'experience' of childbirth to the same degree as middle-class women (e.g. Nelson, 1983; McIntosh, 1989; Lazarus, 1997; Zadoroznyj, 1999).

Returning to Martin's research, it is important to note the influential nature of her analysis of medicine as a cultural system, in which she concentrates on the 'grammar' and metaphors that medical texts use to represent women's bodies. Drawing on a Marxist concept of alienation, Martin identifies medicalised childbirth as a form of alienated labour in which the birthing body is seen as a (dysfunctional) machine and childbirth itself becomes treated as a form of (factory) production. She provides an illuminating description of the representation of labour within obstetrics texts, showing how the work of the birthing woman is reduced to the (involuntary, mindless) mechanical activity of a uterus machine. Similar to factory production, the 'efficiency' of the machine (uterus) is plotted in terms of its 'progress' in time (degree of dilation). Thus, the 'normality' or 'abnormality' of a woman's labour is assessed according to 'Friedman's curve' – a graph depicting 'average dilation curves'. This sets the norms within which the uterus-machine is allowed to labour. Labours which do not proceed at the required dilation rate are regarded as 'dysfunctional' and are either 'sped up' with drugs or interventions or simply aborted via a caesarean section delivery. Within this production-style approach to childbirth, the birthing woman herself is given little active role and is, in effect, reduced to being "a passive host for the contracting uterus" (Martin, 1987:61).

In the interviews that she conducts, Martin finds that women's own talk about reproductive processes mirrors the sense of fragmentation and alienation constructed within medical discourse. Thus, she found that the central image that women used in talking about menstruation, childbirth and menopause was of a disembodied and fragmented self. Corollaries accompanying this image included: notions that bodily processes need to be 'coped with', 'controlled', 'read' or simply 'endured' by one's self. In women's talk about childbirth, Martin found that women "seem unable to resist the underlying assumptions…that self and body are separate, that contractions are involuntary, that birth is production" (pp. 89). This points to the possibility that women themselves have internalised (as truth/reality) the medical version of female bodies and reproductive processes. Martin seemed to find little evidence of an alternative way of talking about birth or the female body within her interviews. Instead, she found that, "women's general images of themselves are chronically fragmented" (pp. 194).

However, Martin also found that the women interviewed cited various strategies of resistance to medicalised childbirth. For example, labouring women used stalling tactics to try and prevent the birthing 'time clock' from starting. They thus delayed going to the hospital or kept

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labour a secret until the last possible moment. Others chose to have their babies at home, according to Emily Martin, "perhaps the most effective tactic of all" (pp. 143). In general, Martin claims to have been struck by the degree of "questioning, opposing, resisting, rejecting and reformulating" (pp. 195) present in women's talk about their lives. Levels of resistance were however class-differentiated, with the most insistent calls for systematic change coming from the working-class women in the study.

Martin's work is grounded in a *standpoint* version of difference feminism wherein women's experiences, situated within the oppressive context of patriarchy, are seen as the (potential) basis of a distinctive critical standpoint. According to this view, people situated at the 'bottom' of status hierarchies are more likely to 'see' oppression and inequality. For Martin, the fact that women inhabit qualitatively different bodies to men means that they continuously straddle the contradictions between private–public, nature–culture and home–work. "Women interpenetrate what were never really separate realms" (pp. 197). Thus, for Martin, women's 'concrete' bodily experiences allow them 'glimpses' everyday, "of another sort of social order" (pp. 200). As a result, the dominant ideology does not fully capture or reflect women's embodied experiences and they are therefore more likely to recognise this ideology as partial or false. In this line of thinking, women's (embodied) experiences, "grounded whether they like it or not in cyclical bodily experiences" (pp. 198) in effect function (potentially) as a foundational vision for an alternative culture or social order. According to Martin, working-class (and black) women experience these disjunctures and contradictions even more intensely because they are usually responsible for the concrete 'housekeeping' of the entire social body (not just their own family). Thus, for Martin:

> The concrete incidents of women's everyday lives can evoke glimpses of other ways of living, other ways of using time, other ways of conveying the sense of menstruation, birth and menopause (pp. 201-202).

However, Martin does not give us a clear idea of how such alternative visions of childbirth (in particular) were present in *women's talk*. She does emphasise the critical importance of the development of new birth imagery, metaphors and symbolism, but we do not get a sense that women themselves used such an alternative language. In discussing 'new birth imagery' she draws mostly on literature and photographs from the alternative birth movement, in which childbirth is portrayed as, for example, a river, a flow of energy (Life Force), a sexual act, a dance or a psychological journey. Martin does not provide many examples of women themselves drawing on such metaphors or images in their talk about childbirth. In my analysis of women's home-birthing stories, it will be shown that women do draw (unevenly) on such imagery in trying to 'make sense' of childbirth. Surprisingly, at the same time, the medicalised narrative of birth

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remained the dominant way of 'storying' childbirth, even for women who chose to give birth at home.

Martin's work is thus clearly positioned within a standpoint version of difference feminism. The strength of such an approach is that it allows women's embodied experiences to be theorised as valuable, potentially empowering (or creative), incommensurate with patriarchal and medicalised ideologies and a source of a liberating alternative consciousness or standpoint. This framework thus goes some way in avoiding a disembodied notion of subjectivity or consciousness (mind-body dualism). At the same time, however, it cannot escape the problem of naturalising a universal and essential reproductive or maternal consciousness (DiQuinzio, 1999). Martin herself acknowledges these dangers in the closing pages of her book:

> One danger in listening…to ordinary women's talk is that we will romanticize women's special ability to see the truth about life, basing this ability on a kind of essentialist, natural proclivity that only women have (pp. 202).

In trying to focus on an analysis of women's reproductive experiences and provide a cultural analysis of medicine as an ideological system, Martin relies on a distinction between experience and structural ideologies (institutions). This is a common strategy deployed in gender difference versions of mothering and reproduction. In fact, it has been pointed out that feminist work on reproductive issues has generally tended to focus either on experience or on macro-level institutions (Blum, 1999). Thus, for Linda Blum (1999) work on motherhood can be divided into two divergent streams or approaches: 'high altitude' work looking at ideologies, discourses and macro-structures or 'grounded' research focussed on 'real mothers' and their experiences. Although Martin tries to provide an examination of both experience and macro-level ideology, her work nonetheless remains far more powerful in its cultural analysis of medicine science than in its portrayal of women's subjective experiences. Perhaps this signals the difficulties of producing work that succeeds in focussing on both subjectivity and larger-scale structural dynamics. More recently, the very reliance on a distinction between experience–institution, usually traced back to the work of Adrienne Rich (1976), has been thoroughly critiqued. For example, DiQuinzio (1999) argues that trying to approach or theorise women's experiences *apart* from institutional and ideological contexts, "oversimplifies the relationship of subjectivity, experience and social contexts" (pp. 213). Furthermore, she argues that this distinction risks slipping back into both an individualist version of self and a problematic theory of embodiment.

Other attempts at providing an analysis of women's subjective experiences of birthing were rare in the 1980s. Written somewhat against the grain, however, is Shelly Romalis' (1981) edited collection, in which she notes the importance of women's personal experiences of childbirth.

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Thus, although she describes the book primarily as a political work, Romalis also wants to keep some focus on "the inner reality" (pp. 5) of the birthing experience and signals the centrality of the female body in this endeavour. One of the chapters in her collection, written by Joann Bromberg, does interesting and innovative work in representing women's "personal experience stories" (pp. 33) about childbirth. Bromberg studies the way in which 16 (white, middle-class) women talk about their experiences of childbirth within (four) small groups of four women each.

Bromberg is interested in the way in which birth is produced within the "folklore of everyday life" (pp. 34), which she theorises as a 'way of knowing' about childbirth. According to Bromberg, this 'way of knowing' is derived from the process of actually giving birth, reflecting on the experience and "juxtaposing beliefs" (pp. 34) about what should or will occur and what does occur in one's own experience. Bromberg uses this data to construct a 'story essay' in which she tries to represent 'spoken stories' as a form of oral poetry. Interestingly, Bromberg finds that while 'bad' birth experiences received the most extensive story elaboration, 'good' or joyous birth experiences were not reproduced in story form. Women who had enjoyed such positive experiences usually made only sparse reference to them, saying for example: "but it was just ecstasy" (cited in Bromberg, 1981:35) and not providing any further attempt to story their experience. Bromberg also notes that other members of the group did not ask for elaboration of these experiences, pointing perhaps to a shared agreement "not to tell or request pleasurable birthing stories" (pp. 35). Bromberg provides little explanation as to what such a 'shared agreement' might mean or how it might function. She does, however, point to the therapeutic quality of stories, suggesting that 'positive' birth experiences might not 'need' to be processed in story form.

This hypothesis is however not corroborated by Lundgren's (2005) study in which ten Swedish women (birthing at an Active Birth Centre) reported that they *felt silenced* by the fact that their good and empowering birth stories did not match the culturally accepted 'horror' story about childbirth. These women described a tendency to keep their 'positive' experiences of birth to themselves and expressed sadness about not being able to easily share their stories. It is, of course, well-known among narrative researchers that the story form itself feeds off 'trouble' and that narratives without complications or turmoil do not generally make for good stories (see Ochs & Capps, 1996; Foster, Haupt & De Beer, 2005). Generally, the 'horror story' genre remains one of the most common narrative forms in which childbirth experiences are transmitted in women's networks (Bergum, 1989; Cosslett, 1994).

On my reading, the only other substantial study investigating women's subjective experiences of childbirth in the 1980s was conducted by Vangie Bergum (1989). Bergum's work, a phenomenological investigation of the 'lived experience' of becoming a mother, is based on a

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realist understanding of experience. In this view, women's stories are seen as a transparent window on their 'true' experiences. Thus, in women's talk, "the lived through meaning of the experience shows itself" (pp. 14). Bergum also works within a modernist gender difference feminism in which 'women' are assumed to be an unproblematic category bound together largely by their experiences of reproduction. "Female existence" (pp. 67) is therefore accepted as a coherent and distinctive way of being in the world that is founded on a common experience of the female body. Thus, by virtue of being potential birth-givers, women have access to a "fundamental source of life and spirit" (pp. 66). No mention is made of the glaring existence of differences between women. Instead, becoming a mother is described as a universal process disconnected from the (material and social) contexts in which women are positioned.

In Bergum's analysis, being a woman and becoming a mother are constantly portrayed as inseparable, in effect disqualifying childless women from 'full' femininity and womanhood. Furthermore, for Bergum, giving birth is a critical "perhaps essential" (pp. 91) moment in the transformation to motherhood. In her study, fully experiencing vaginal (drug-free) labour and delivery is held up as the ideal path to motherhood. Thus, pain in childbirth is described as necessarily facilitating a woman's transformation to motherhood and as something that women ideally should see "as a challenge and opportunity" (pp. 67). Bergum makes little mention of structural and ideological constraints on birth practices, preferring to focus on a depoliticised notion of 'inner experience' and 'lived meaning'. In Bergum's work, which (laudably) remains one of the few studies to focus intensely on the lived phenomenology of pregnancy and birthing, we nonetheless catch glaring glimpses of the dangers of work which disconnects the notion of experience from politics and which unreflexively reproduces an essentialist and prescriptive notion of reproductive gender difference. While the 'inner journey' of becoming a mother has been largely ignored and clearly deserves fuller research exploration, researchers have to be careful about what kinds of theories of self (and experience) they work with or assume. However, seen from a broader perspective, Vangie Bergum's work does mark the beginning of an important shift in feminist research on birth. She is one of the first researchers to apply a phenomenological approach to the study of childbirth, seeking to capture the subjectivity of pregnancy and birthing.

Shifts in feminist childbirth research from the 1990s

From the 1990s onwards, several discernable shifts are evident in the theoretical approaches adopted by feminist researchers in studying childbirth. Commensurate with wider post-structuralist currents within feminist theory, childbirth researchers (unevenly) shifted the focus of their studies from macro-level structures, ideologies and institutions to questions of language,

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discourse, space, embodiment and agency. Two important pieces published in 1990 signal the beginning of these shifts. Paula Treichler's article, already discussed in chapter two, can be identified as the first call for birth researchers to take seriously the theoretical challenges posed by post-structuralism. Treichler places questions of language and meaning firmly at the centre of debates around childbirth and criticises modernist notions of 'reality', 'truth', 'nature' and appeals to a unity of women based on gender difference.

The second seminal piece published in 1990[26] emerges from a different theoretical tradition, but is equally as important in signalling (the beginnings) of a sea change within feminist work on birthing. In her article on the pregnant subject, Iris Marion Young (1990b) explores questions of maternal subjectivity and embodiment. She starts her article with the observation that (maternal) subjectivity is absent and invisible in most writing on pregnancy and notes that the mother has rarely been positioned as a full and active subject at the centre of the pregnancy experience. Starting from this premise, Young attempts to consider pregnancy "from the pregnant subject's viewpoint" (*ibid*, pp. 160), making reference to women's diaries, literary writing and her own personal reflections. Grounded in (yet critical of) an existential phenomenological approach, Young describes richly the 'split subjectivity' of the pregnant subject who is "decentered, split or doubled in several ways" (*ibid*, pp. 160). According to Young, the embodied experiences of pregnancy and birthing offer a challenge to a standard (male) phenomenology of the body, as developed by Merleau-Ponty and others. Although the details of Young's work will not be explored here (see chapter four for a fuller treatment), it is important to note that Young's work represents one of the earliest feminist attempts to apply a phenomenological approach to questions relating to the pregnant and birthing body-subject. More recently, this line of inquiry has begun to develop into a rich body of feminist analysis.

Robbie Davis-Floyd: the turn to agency or the (re)turn to the rational individual?

While the important work of anthropologist Robbie Davis-Floyd can hardly be described as post-structuralist, her 1992 book nonetheless does form part of a growing tendency to focus on issues such as women's individual *agency* in relation to childbirth. Before the 1990s, there was little acknowledgement of women's agency in relation to birthing. Focussing on macro-structural elements of the medical system meant that women were generally (inadvertently) seen as passive and powerless pawns in the technocratic, patriarchal game of biomedicine. Even in Emily

[26] First published in 1984.

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Martin's (1987) work, women's 'strategies of resistance' always seem to refer to actions against the medical model; there is little mention of women being empowered by medicalisation itself.

Davis-Floyd's (1992/2003) study marks a key moment in childbirth research, shifting taken-for-granted assumptions about the positioning of individual women in relation to technocratic medicine. Davis-Floyd begins her study firmly committed to the feminist critique of medicalised birth but finds (to her surprise) deep dissonances between this critique and the stories of women interviewees. Thus, she finds that women were not "raising their voices in resistance…but in varying degrees of harmony and accord" (pp. 5). Interviewing a total of 100 (middle-class and white) pregnant women and mothers, Davis-Floyd focuses on "the cognitive transformation" (pp. 2) undergone by these women as they proceed through the rituals of technocratic birth. Davis-Floyd is interested in what happens when the 'belief systems' of individual women collide with the hegemonic technocratic belief system. For Davis-Floyd, it is the correspondence or non-correspondence between these two belief systems that determine a woman's interpretation of her birth as a success or a failure, as empowering or disempowering.

Davis-Floyd found that 18% of the women were in *full acceptance* of the *technocratic* belief system. Half of these women (9%) found comfort in *handing over* the birth process to medical professionals to control and manage while the other 9% decided to simply *opt out* of the biological birth process completely. These were the women (mostly high-status professionals) who 'scheduled caesareans' or 'demanded' full epidural anaesthesia. These women did not value the process of birth or believe that their bodies were suited for childbirth; birth was simply "something to control, to plan, to manage as actively as they managed their careers" (pp. 195). According to Davis-Floyd, these women generally did not experience pregnancy as positive or joyous, showed no evidence of an 'earth mother' mentality, had no desire to experience 'natural' childbirth and (interestingly) all reported "extraordinarily egalitarian" (pp. 198) relationships with their male partners. A further six percent of the women (all of whom gave birth at home) expressed *full acceptance* of the '*holistic*' model of birth. Half of these women (also high-status professionals) espoused a view of birth as a *natural* part of womanhood, while the other half saw childbirth as a *spiritual process*. These women tended to place a high value on "intuitive bodily knowing" (pp. 202), viewing the body as "the supreme expression of self" (pp. 202).

The rest of the women (76%) were labelled 'women-in-between'. The largest number (42%), were found to have reached (with '*cognitive ease'*) an (after-the-fact) acceptance of the technocratic model. These were women who had gone into hospital hoping for 'natural' childbirth but who came out having undergone highly medicalised births. However, they were not dissatisfied with their experiences nor did they see themselves as failures. According to Davis-Floyd, the critical factor determining this outcome was that these women believed the medical

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interventions they had received were fully "justified, appropriate, and necessary" (pp. 220). A further 15% of the sample managed to maintain '*conceptual distance*' from the technocratic belief system and 'achieved' 'natural' birth within the hospital. Although these women did experience interventions, they nonetheless managed to maintain *interpretative control* over their experience(s). They were therefore able to separate the procedures from their own goals, beliefs and sense of self. A further 10% also managed to maintain 'conceptual distance' from the techno-medical system, despite not having 'achieved' 'natural' childbirth. These women adopted a personal attitude in which they 'turned the tables', so to speak, on hospital rituals. They took up a stance in which technology was positioned as at their own *personal service*. The final group of women (9%) were those that experienced '*cognitive distress*' at the disjuncture between their personal beliefs and technocratic medicalisation. These women emerged from their birthing experiences "feeling like failures" (pp. 227) and having internalised images of themselves as inadequate, useless and hopeless. All of these women are described as experiencing subsequent postpartum depression.

Davis-Floyd's research clearly shows that birthing women do not all take up the same stance in relation to medicalisation. In fact, some women are perfectly happy, even empowered by technocratic procedures. A resounding 70% of the births "occurred in ranging degrees of conceptual harmony with the technocratic model" (pp. 281). For Davis-Floyd, this large-scale acceptance of technocratic birth is understandable in the wider context of a hegemonic technocratic culture, in which technological progress generally equals political and cultural power. Furthermore, because many privileged women have come to find a degree of socio-economic empowerment within technocracy and because it affords them the possibility of escaping the 'tyranny' of female biology, a feeling of 'empowerment' via technocratic modes of birth is not all that surprising. Davis-Floyd seems to have mixed feelings regarding the 'results' of her study. On the one hand, she is a champion of 'choice' and refuses to cast women's (technocratic) preferences within a 'false consciousness' model. On the other hand, Davis-Floyd 'laments' the potential death of "the fundamentally female power of creativity" (pp. 285-286) epitomised by 'holistic' models of birthing. Home-birthers are thus celebrated for their alternative views, which serve to "humanize, personalize, feminize, and naturalize the processes of procreation" (pp. 299).

From the above quotes it becomes easy to see that Davis-Floyd is (implicitly) operating within a feminist gender difference framework. Thus, she makes repeated reference to 'The Female Principle' that seems to be a universal "procreative power" (pp. 286) 'housed' in women's reproductive bodies. For Davis-Floyd, there seems to be only one kind of feminism, a feminism in which women serve as "signifiers of the Female Principle in cultural life" (pp. 286). The

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complexity of multiple feminist positions is reduced to a simple difference feminism in which women are seen to carry an essential 'power' located directly in their birth-giving capacities and in which they enjoy "cosmic significance as birth-givers" (pp. 286). Furthermore, a fundamentally dualist conceptualisation of male–female difference serves as the basis for Davis-Floyd's construction of the technocratic and holistic birth binary. Thus, technoscience is represented as a thoroughly 'male' model: hierarchical, cerebral, mechanical, scientistic, technical and linear; holism is seen as fundamentally 'female': embodied, connected, intuitive, experiential, emotional and subjective.

At the same time, Davis-Floyd's difference feminism seems to come added with a strange twist of individualism. Thus, although gender difference is assumed and valorised, an individualist theory of self seems to underpin much of her writing. The women who emerge in her book seem to approximate, in uncanny fashion, the prototype of the rational, autonomous, disembodied individual. Thus, birthing women undergo 'cognitive transformations' as a result of the degree of 'fit' between the "categories in her mind" (pp. 155) (her 'belief systems') and the technocratic belief system. These cognitive 'categories' or 'systems' are represented as 'real', coherent 'things' situated inside individual women's heads. Davis-Floyd is interested in women's 'responses' to the 'messages' conveyed to them during technocratic birth. The 'psychological' or 'conceptual' outcome of birth thus seems to be determined by cognitive processes happening inside disembodied minds. The birthing woman is seen to have a "cognitive need for an intelligible framework within which to interpret her experience" (pp. 191).

The picture that emerges alongside these descriptions is of a *bounded individual*, located in (but not determined by) social and cultural contexts. This individual thus 'responds' to socio-cultural messages and practices, exercises 'free choice' and interprets experience within a "cognitive matrix" (pp. 191). It is surprising, given Davis-Floyd's valorisation of a 'holistic', integrative model in which body and mind are seen as one, that she (implicitly) reproduces the notion of the disembodied, cerebral individual throughout her book. The complex embodied subjectivity emerging in and through the birth experience is not analysed, commented on or interpreted, despite being richly present within many of the lengthy (written and verbatim) birth stories included in the book. Davis-Floyd's interest is clearly not in the subjective experience of birthing; it is women's assessment and 'responses' to technocratic birth and its eventual 'outcome' that she chooses to focus on.

In the end, notwithstanding an impressive and illuminating set of 'findings', Davis-Floyd's work seems to occupy a strange, incommensurate (theoretical) space in which gender difference feminism and rational individualism make for a rather peculiar set of bedfellows. Commensurate with the 'individualist' tendency within her work, 'agency' is assumed to be a 'capacity' of

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cognition, 'mind' or disembodied consciousness and the exercise of individual 'choice' is championed.

The birthing woman as active agent and consumer

From the 1990s onwards, women's 'agency' in relation to birth becomes an important new research focus (see Davis-Floyd, 1992/2003; Fox & Worts, 1999; Zadoroznyj, 1999; Root & Browner, 2001; Westfall & Benoit, 2004). This shift can be traced to the widespread intellectual movement away from (modernist) macro-studies, 'totalising' theories and 'grand narratives'. In feminist theory particularly, this shift manifests as a discernable tendency to focus on micro-politics and the localised individual subject or "the specific, local, me" (Ebert, 1996:242) rather than the social collective. Thus, there is a move away from looking at structural and ideological features of childbirth and a renewed interest in "women's subjective sense of choice, power and control" (Zadoroznyj, 1999:268). Furthermore, this shift is also related to the growing (qualitative) collection of women's own stories, which were found to be largely incommensurate with the feminist critique of medicalisation. Some researchers have seen this 'paradoxical' disjuncture between feminist positions on medicalised birth and women's own self-reported experiences as 'a call for explanation' (Fox & Worts, 1999).

Written from this 'disjuncture' is the interesting research study by Fox & Worts (1999). Focussing on "the immediate context" (pp. 329) in which birth occurs, Fox & Worts try to find an 'intermediate' space between macro-structural and individual analyses. For instance, they attempt to show how women's choices and experiences of childbirth are 'constrained' by factors that extend beyond medical control and intervention. Via interviews with 40 first-time Canadian mothers, Fox & Worts show that women's reactions to birth and mothering depend on a range of factors beyond whether or not medical intervention is involved. Interestingly, they found a strong relationship between 'resistance' and 'compliance' to medical intervention and the degree of support offered by a woman's partner. Thus, women who had consistent support from partners (before, during and after birth) were the most likely to 'resist' medical intervention. Fox & Worts' understanding of 'support' extends beyond behaviour in the birthing scene; a 'supportive' partner is thus defined as:

> …those who were generally empathic toward the women with whom they lived and shared the women's experiences and responsibilities. Such support was evidenced not only by their behavior during labor and delivery but, more important, by their ongoing involvement in, and responsibility for, housework. Women living with these men could expect that the responsibility for the baby would be shared in the days, weeks, and years after the birth. That ongoing support affected the choices women made during childbirth. (pp. 337).

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Fox & Worts conclude that a lack of social support for new mothers might be directly linked to women's desire for, or acceptance of, medical intervention and pain-relieving drugs during childbirth. Significantly, Fox & Worts insist that addressing the issue of women's birthing 'agency' is dependent on "situating them in their social context" (pp. 343) and drawing attention to wider factors such as women's privatised responsibility for child-care and the lack of support that many women face as they become new mothers.

This attempt to locate 'agency' beyond the realm of the isolated individual is however rare within childbirth studies. Thus, in a similar vein to Davis-Floyd (2003), most research has tended to conceptualise agency as a capacity of the rational, individual, decontextualised subject. For example, Maria Zadoroznyj (1999) analyses the birthing narratives of 50 Australian women, focussing on "the role of childbearing women themselves in negotiating the terms of their birthing and postnatal experiences" (pp. 268). Despite working (at least superficially) with a framework influenced by a post-structuralist focus on language (i.e. the text is peppered with talk of 'representations' and 'discourses'), the rational, volitional individual nonetheless infuses the article. Thus, women are described as 'using' power "to construct a context for giving birth which suits them" (pp. 270). 'Individual agency' is constructed as separate and distinct from 'social structure', culminating in a reproduction of the now (in)famous individual–social impasse. Within her sample of 28 middle-class and 22 working-class women, Zadoroznyj finds (unsurprisingly) that whereas middle-class women display an 'activist' orientation to (first) birth, working-class women are passive and 'fatalist'.

Teresa Ebert's (1996) work stands as an important reminder that the form of subjectivity encapsulated by "the bourgeois isolate" (pp. 242) or 'rational individual' is critically necessary to the maintenance and reproduction of (individualist) patriarchal capitalism. With regards to childbirth, it is interesting to note that along with a heightened research interest in 'agency', there has also been a growing tendency to represent birthing women as active 'consumers'. According to geographer Maria Fannin (2003), obstetric medicine itself (as part of wider political-economic shifts) has been instrumental in facilitating the transformation of the (middle-class) birthing subject from a patient to a *consumer* of childbirth. Fannin provides an intriguing analysis of the emergence of 'homelike' birthing suites within American hospitals, showing how the development of these birthing spaces is inseparable from a neoliberal economic agenda. For Fannin, shifting economic landscapes "are intimated bound to interpellations of new subjectivities around birth" (*ibid*, pp. 515). Thus, isn't it intriguing that at the same time that medical interventions in middle-class hospital birthing are reaching unprecedented heights, a new rhetoric emerges which highlights the birthing woman as a powerful and active consumer agent? We have reason to be cautious here. According to Fannin (2003:529):

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> The discourse of choice and control that situates the birthing woman as a consumer of birth does not necessarily imply autonomy or embodied agency for the birthing woman in the hospital birthing room.

At the same time that 'the-birthing-woman-as-consumer' model does not substantively change medicalised practices, it does place more responsibility for the 'outcome' of birth on the shoulders of birthing women and their partners. For example, Carine Mardorossian (2003) notes how responsibility for the 'failure' to achieve 'natural' childbirth is often channelled *away* from medicalised environments and relegated to the birthing couple. As a result, the couple, "given the illusion of autonomy in decision-making" (*ibid*, pp. 120) via participation in antenatal classes, end up feeling like useless failures when their birth plan implodes. The danger of displacing the critical gaze from structural medicalisation onto 'the immediate context' of birthing women and their partners is also evident in the work of Fox & Worts (1999), discussed earlier. For example, in fingering male partners as the exclusive source of sufficient or insufficient support for birthing women and mothers, wider social and economic structures risk being neatly and conveniently absolved. Furthermore, in tracing women's levels of 'resistance' to medical procedures back to the degree of support offered by partners, the oppressive and ideological contexts within which medical practices often occur become effectively obscured.

Janelle Taylor (2000) argues that the former (potent) analysis of reproduction as a form of industrial production (i.e. Emily Martin, 1987) is no longer viable. According to Taylor, reproduction has more recently come to be seen "as a matter of consumption" (*ibid*, pp. 392) rather than factory production. In an ethnographic study that included observations of obstetrical ultrasound examinations and interviews with more than 100 women, Taylor finds that pregnancy itself has become "a commodified experience" (*ibid*, pp. 392) and a process of (often pleasurable) consumption. For example, Taylor identifies 'the baby shower' – once a ritual in which women gave advice, knowledge and blessings to pregnant women – as a 'consumer rite' in which 'baby goods' are exchanged. Taylor also argues that pregnancy inaugurates the transition to a new model of consumerism, namely the "mother-as-consumer", marking the beginning of "a new, more highly disciplined regime of consumption" (*ibid*, pp. 403). In this maternal consumer model, consumption itself becomes more thoroughly invested with *moral* significance and responsibility, in which expectant mothers are required to exercise constant consumptive vigilance over what they eat, drink or inhale. Taylor also significantly points out that choice(s) over practices of consumption (primarily around food) constitute the primary form of control available to middle-class women. Thus, through 'controlled' regimes of consumption, women are promised 'healthier' babies, 'easier' pregnancies and 'successful' births. Regardless of what 'model' or birthing ideology individual women espouse (i.e. 'natural' or 'medical'), Taylor argues that middle-class women are united by a consumerist approach in which:

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> …a woman demonstrates her powers and her talents as a consumer, and engages in the construction of her identity, by the manner in which she consumes her pregnancy and birth (pp. 406).

It seems therefore that discourses of the 'good mother' have become intimately intertwined with those of the 'good consumer'. At the same time, however, the ideal of the birthing woman as a 'good patient' has not disappeared. For example, according to Zadoroznyj's (2001) examination of 50 Australian women's birth narratives, birthing women acted as both consumers and patients in relation to the (medical) management of their births.

Through Foucauldian lenses: 'internalised technologies' and 'negotiated' resistances

There is a further stream of research which has attempted to re-conceptualise birthing agency along post-structuralist Foucauldian lines. In this view, dominant discourses (structures, institutions) do not stand apart from subjectivity, but in fact *produce* particular forms of self and modes of resistance. As opposed to 'top-down' and 'repressive' versions of power as oppression, power is here conceived of as constitutive of subjectivity: indeterminate, relational and dispersed throughout the social field (Sawicki, 1991; Faith, 1994).

For example, working within a framework that both "draws on and challenges" Foucauldian theory, Root & Browner (2001:195) attempt to show how pregnant women both resist and comply with biomedical injunctures concerning 'good' prenatal behaviour. Interviewing 158 pregnant American women, Root & Browner found women performing a mobile dance between compliance–resistance to biomedical norms and exercising complex negotiations between authoritative and subjugated forms of knowledge. Thus, pregnant women did not 'bow-down' to an all-determining and all-powerful biomedical discourse. Instead, their own embodied forms of 'haptic' knowledge, based on the emotional and sensual (pregnant) body, sometimes served to disrupt 'authoritative' biomedical knowledge(s). As a result, Root & Browner claim that pregnancy is:

> …characterised by a split subjectivity in which women straddle the authoritative and the subjugated, the objective and the subjective, and the haptic as well as the optic, in telling and often strategic ways (pp. 195).

For Root & Browner, there were "telling slippages" (pp. 217) in the ways that women talked about their pregnant selves. Thus, women vacillated (grammatically) between a disciplined, generic, disembodied and biomedically-driven 'You' and an individual, haptic-rich, embodied 'I'

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when speaking about pregnancy. Women attempted to forge 'hybrid' selves by straddling volatile boundaries between embodied knowledge, biomedical representations and moral imperatives. In the end, however, Root & Browner seem to make conclusions incompatible with a Foucauldian view of subjectivity. Thus, they see an enduring, "ever-present and potent individual agency" (pp. 218) in women's accounts, concluding that the hegemonic power of biomedicine "is dependent upon the individual's willingness and ability to evaluate the relevance of its norms for practice in everyday life" (pp. 219). Despite hefty talk of 'discourse', 'resistance' and 'disciplinary practices' are we not here witnessing the resurrection (once-again) of the rational, voluntarist individual?

An intriguing study by Karin Martin (2003) explores how 'internalised technologies' of gender serve to 'discipline' women during childbirth. As a corrective to research that has focused solely on the role of medical institutions in the 'disciplining' of women's birthing bodies, Martin seeks to understand how 'internalised' gender norms constrain and regulate the behaviour of women during childbirth. Martin works from a Foucauldian position in which 'technologies of gender' refer to those practices and discourses which "produce and reproduce our experiences, meanings, and our very selves in the social world" (pp. 56), compelling us to act in appropriately gendered ways and 'disciplining' us from the 'inside out'.

Interviewing a total of 26 white, middle-class American women (from one week to three months post-birth), Martin finds that internalised technologies of gender restricted women's behaviours, made them feel guilty for non-normative behaviours and reluctant to ask for the help that they needed during birthing. She finds that women often described, "doing normative gender while birthing" (pp. 61), trying to be polite, 'nice', selfless, empathic and interested in the needs of others. Women who could not 'keep up' with the demands of these feminine gender requirements and manage the pain of labour, spoke of 'feeling bad' for their outbursts, loudness or 'disruptive' behaviours. Women described these 'out-of-control' behaviours as "nasty, inflexible, crabby, difficult" (pp. 66) even in the context of demanding, tiring and painful labour. Being 'selfless' and 'attuned' to the views and feelings of others also meant that some women looked to their male partners to define their experience and make decisions for them. Interestingly, this 'selflessness' also translated into the privileging of an *outsider's view* of their birth experience. Many women felt that they had 'missed' something because they had not been able to 'see' what was happening during birth. This 'outsider's view' was privileged as the 'real' birth. Thus, Martin suggests that in western, middle-class, medicalised childbirth, "birth has become more real for those with this outsider gaze than those with the lived bodily experience of it" (pp. 64).

Martin finds evidence of gender nonconformity and little description of 'internalised technologies of gender' in the accounts of only three women. Interestingly, two of these three women gave birth at home. Of Martin's total sample, 23 out of 26 gave birth at the hospital, two

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at home and one woman at a birthing centre. Martin calls for more research "to untangle the role of home birth" (pp. 68) in the (internalised) gendered disciplining of birthing women. Martin's research remains significant in its attempt to demonstrate the complex socio-cultural and ideological web within which women give birth; she shows that "birth is something to which we bring our socially interpellated selves" (pp. 70).

Also influenced by the writing of Foucault is the work of Wendy Simonds (2002) who attempts to show how biomedical discourse utilises a particular discourse of 'time' as a *mode of discipline* over women's pregnant, birthing and postpartum bodies. According to Simonds, the medical control of childbirth has not lessened in recent times; it has simply changed in style. Obstetric medicine increasingly manages and controls birthing women via a rigid, 'masculinist', time-based protocol in which all aspects of pregnancy and birth are defined, 'diagnosed' and interpreted. Every phase of pregnancy and childbirth is thus plotted along a normative time-line and is obsessively 'monitored' to ensure that any 'deviations' are detected. Interventions therefore become morally necessary simply on the basis of normative time schedules; there is no longer any 'need' for them to be 'forced' upon women. Simonds makes the illuminating point that: "As medical supervision becomes increasingly omnipresent, it becomes less visible" (pp. 567).

Simonds' fascinating Foucauldian analysis, suggestive of historical shifts in the ways in which obstetric medicine has sought to 'control' childbirth, was pre-empted by the work of William Arney (1982). Arney's book represents the first (ahead-of-its-time) attempt to apply a Foucauldian grid to the historical analysis of the development of obstetrics. For Arney, obstetrics is not a monolithic, unchanging system. Rather, it represents a changing (but coherent) current of discourse(s) and practices that have shifted in three dominant historical movements. Thus, Arney maps out three different 'periods' in obstetric care, each with their own 'logic', conceptualisations of pregnancy/birth, relational and organisational patterns and technological practices. These include: the pre-professional era (up to the end of the 1800s), the professional period (1890-1945) and the monitoring period (post World War Two). Arney argues that in the contemporary 'monitoring' period, obstetric power is more widely dispersed and there is no longer any discernable 'agent' of control. Instead, the structure of monitoring itself has become "the new order of obstetrical power" (pp. 150). For Arney, this represents a Foucauldian shift in which social control shifts from oppressive, 'top-down' discipline to the all-seeing, "normalizing gaze" (pp. 88) of panopticism.

JaneMaree Maher (2003), an Australian researcher, asks interesting questions about how the internalisation of medical models of birthing might impact on the actual physiological, material and embodied experience of childbirth. Maher seems to be searching ('speculatively') for ways to explore how medical discourse *inscribes* itself upon women's birthing bodies,

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experiences and stories. Maher also cites being interested in the ways in which women's embodied birth experiences are 'reinscribing' and re-producing medical discourses "through complex processes of incorporation and re-enactment" (pp. 142). To begin unpicking this thorny set of questions, Maher 'speculates' about how consumer and biomedical models of health (both of which emphasise surveillance and control) might affect the way in which pregnant women both approach childbirth, develop expectations in relation to birthing and retrospectively re-interpret their 'real-life' birth experiences. Although never actually invoking the name of Foucault, Maher seems to be (via Judith Butler) toying with Foucauldian notions of bodies that *materialise* as effects of disciplinary power. Thus, it is not just that birthing women are treated by the medical system as objects, but that birthing women themselves become body-subjects that "materialize these forms of discipline" (pp. 150). Maher describes her long-term project as an exploration of whether concepts of the body-subject as "an active and productive element" (pp. 151) might provide more useful story lines within which women can negotiate the birthing experience.

These Foucauldian-inspired studies represent a potentially important shift in the conceptualisation of power, medical control, agency and subjectivity. Taking seriously Foucault's theory of subjectivity (and agency) as a product of power relations means that the rational, humanist, individual self can no longer be seen as the unmediated locus of meaning and reality. A person's 'choices' and 'experiences' are therefore themselves the product of dominant discourses, narratives and normative practices. Thus, (individual) women's reported desires for, and acceptance of, medicalisation is not sufficient grounds to conclude (as do some 'third wave' critics) that medicalised birth is potentially empowering to women. Studies of women's experiences need to look further than the content (however important) of what women are saying and should interrogate the terms within which these desires, experiences and expectations are narrated. Although several studies have flirted with a Foucauldian understanding of subjectivity and power, few have consistently applied his insights to the analysis of women's birthing subjectivities. The work of Arney (1982), Simonds (2002) and Maher (2003) provide important clues for researchers of childbirth, pointing to a different logic of power, control and 'discipline' potentially at work on and within the bodies of birthing women.

Embodied birthing subjectivity: emerging views

From the late 1990s onwards, there has been a spate of feminist research that has explored *embodied* aspects of women's reproductive experiences. This mushrooming interest in women's pregnant, birthing and breastfeeding bodies mirrors the (post-structuralist) *corporeal* shift in feminist theory more broadly (e.g. see Butler, 1993; Grosz, 1994; Gatens, 1996; Kirby, 1997).

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Strangely, there seems to be more research looking at women's embodied experiences of pregnancy (e.g. Young, 1990b; Schmied & Lupton, 2001a; Maher, 2002; Wynn, 2002; Elvey, 2003; Earle, 2003; Warren & Brewis, 2004) and breastfeeding (e.g. Blum, 1999; Stearns, 1999; Bartlett, 2000, 2002; Schmied & Lupton, 2001b) than of birthing. Often working within a framework influenced by phenomenology, a large proportion of research looking at the embodied aspects of breastfeeding and pregnancy, has flirted with the subversive potentialities of these exclusively female bodily experiences. Thus, there is a definite tendency to see the pregnant body as the prototype of an alternative, liberating mode of embodiment in which binary divisions break down (e.g. Young, 1990b; Elvey, 2003; Warren & Brewis, 2004). Similar themes are evident within research on breastfeeding (Schmied and Lupton, 2001b). Interestingly, feminist studies looking at the embodied experience of birth seem to have been reluctant to utilise the phenomenological approach deployed in studies of pregnant and breastfeeding bodies.

There is a surprisingly sparse amount of feminist research that has focussed on the birthing body or embodied subjectivity. However, particular *assumptions* about the birthing body have nonetheless always been rife within feminist work on childbirth. Thus, riding in conjunction with the medical-holistic birth binary has been the tendency to valorise 'holistic' birth as an ideal in which mind and body, woman and nature, and mother and baby are united as a harmonious whole (e.g. Rothman, 1982; Martin, 1987; Davis-Floyd, 2003; Kahn, 1995). Thus, bodily fragmentation has usually been interpreted as inherently negative and attributed to the alienating effects of medicalised birth (e.g. Martin, 1987; Counihan, 1999). For example, Carole Counihan (1999) uses interviews with 15 American women as they journey through pregnancy and the early postpartum period, to ask whether the embodied experience of birth can be 'empowering' or engender positive transformations in women's relationships with their bodies. Counihan works with the assumption that bodily fragmentation is always a sign of disempowerment, objectification or oppression and wants to find out whether the birth experience can be a 'healing' experience that helps 'integrate' women's fragmented body-self relations[27]. The unacknowledged assumption is thus that a 'whole' and 'coherent' self is healthy, non-alienated and empowered.

As I have hopefully already demonstrated within this chapter, most empirical studies of birth (whether working within individualist, difference or post-structuralist frames) have ultimately worked with an individualist model of the self as a rational and autonomous agent. As a result, even feminists working within a gender difference approach tend to conceptualise the non-alienated, non-oppressed and 'real' feminine subject as stable and coherent. Most qualitative

[27] Counihan (1999) shows, through the use of two case studies, that pregnancy, birth and breastfeeding can be processes through which women redefine their embodied selves and work towards diminishing earlier relations of objectification and body loathing. However, she also concludes that these experiences are not all-curing panaceas for the body image troubles of women.

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analyses of women's talk about birth have, as a result, tended to 'iron out' (Stephens, 2004) their voices and subjectivities so that they are 'made-to-fit' this model of the subject. However, more recently there have been a number of feminist researchers who have begun to paint more complex, contradictory and potentially paradoxical pictures of the construction of embodied birth subjectivities within women's talk or stories about childbirth. For the most part, these researchers work with the understanding that narratives are *constitutive* rather than unproblematic *reflections* of women's birthing experiences.

Splitting or flowing

For example, Tess Cosslett's (1994) work has been groundbreaking in its efforts to highlight the embodied subjectivity of the birthing woman. Drawing on Julia Kristeva's work, Cosslett argues that the maternal body, "two in one, one becoming two" (pp. 8) can radically disrupt the notion of the autonomous individual and potentially function as a site of resistance to hegemonic cultural scripts. In her analysis of women's literary writings on childbirth, Cosslett identifies two dominant models that are used to represent embodied birthing subjectivity, namely: splitting and flowing. In these two 'oppositional' models, the self of the birthing woman is described as either "a flowing process, or…fractured and destroyed" (pp. 132). In the 'splitting' model, the birthing woman is represented as split along multiple axes: between self–baby, body–mind and inside–outside. The birthing body-subject is depicted as fragmented, decentred, dispersed through space, splitting open and disintegrating into strange, absurd, paradoxical bits and pieces. In this model, Cosslett also notes a profound absence of self/subjectivity, in which "the self often disappears altogether" (pp. 133). For Cosslett, this 'loss of subjectivity' is exacerbated by, and in some cases caused by, the medicalisation of childbirth in which the birthing woman is treated as "an assemblage of bodily parts, a mindless object" (pp. 133).

The second, 'flowing' model is the ideal prototype of natural childbirth and 'holistic' birth advocates in which the birthing woman becomes a 'unified' and harmonious whole in and through childbirth. However, according to Cosslett, even this model "is not as simple or as unified as it seems" (pp. 133) when appearing within women's writing. Instead, the 'flowing' and harmonious subjectivity of the birthing woman is usually dependent on *a prior splitting* of the self into two distinct 'parts' or 'actors': a body and a mind, a woman and pain or a 'civilised' and an 'animal' self, that are then involved in a flowing relation or harmonious co-operation. Cosslett's analysis thus seems to suggest that there might be different kinds of splitting potentially experienced by the birthing subject and that the consequences of such fragmentation "may be horrifying [or] it may also be enlarging" (pp. 143). Regardless of the specific implications of the splitting or

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fragmentation experienced by the birthing woman, Cosslett reads childbirth "always [as] a turning-point, a narrative crisis that destroys, confirms or creates a woman's sense of self" (pp. 154).

A paradoxical movement

Similarly to Cosslett, the work of Akrich & Pasveer (2004) portrays embodied birthing subjectivities as fragmented and paradoxical. Drawing on a corpus of over 70 birth narratives, Akrich & Pasveer explore the kinds of body-self that are (re)performed within women's birth stories. They describe the body-in-labour (or pain) as a "pendulum movement" (pp. 68) in which the body swings violently between absence and presence. Contracting in an ebb and flow of movement, the body thus shifts from being powerful, all consuming and ever-present (in-contractions) to being absent (in-between contractions). Drawing on the work of Leder (1990), Akrich & Pasveer describe this body-in-labour as a 'dys-appearance'. They argue, however, that the subjectivity emerging within birth stories does not constitute a *disembodied* self. In their analysis, they identify three different bodies emerging within childbirth narratives: the body-in-labour, an embodied self and a body-without-boundaries. However, the central 'actors' in birth stories are usually the body-in-labour and the embodied self. According to Akrich & Pasveer, the type and degree of medicalisation present within the birth scene impacts upon the form (empowering or disempowering) taken by the 'twosome' of body-in-labour and embodied self. Thus, at times interventions can facilitate *the articulation* between the body-in-labour and the embodied self (for example, when internal sensations and external interpretations match) but on other occasions they can produce *the objectification* of the body-in-labour. Akrich & Pasveer argue that childbirth is always narrated by women as "an experience of duality, although a duality that is in no way Cartesian" (pp. 74). Interestingly, they also argue that an alienated experience of birth is characterised by the *obliteration* of the 'twosome' (or duality) of body-in-labour and embodied self. Thus, "alienation is…experienced as the impossibility of maintaining a certain form of active dichotomy, either because the body-in-labour is too present and takes over, or because it is absent" (pp. 80). Strangely, Akrich & Pasveer are therefore arguing that duality or some degree of fragmentation *is necessary* for an *empowering* experience of birth. In their analysis, childbirth emerges as a complex and *paradoxical* dance or "pendulum movement" (pp. 68) between the body-in-labour and the embodied self, with various forms of association–dissociation or embodiment–disembodiment possible, depending on contextual factors and the kind of medicalisation present. Akrich & Pasveer thus suggest that there are possibly *multiple forms* of birthing subjectivity, depending on the particular kind of relational articulation that is

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achieved between the body-in-labour and the embodied self. Where this 'twosome' *achieves* some degree of association, connection or harmonious synchronicity, Akrich & Pasveer suggest that an empowered form of birthing subjectivity is possible.

Surviving or living

The possible importance of achieving *an articulation* between the body-in-labour and the 'embodied self' in childbirth is confirmed by the research of Marina Sbisà (1996). In her analysis of the talk of 20 middle-class Italian women, Sbisà finds that women reported two central strategies that they used to cope with childbirth, namely either *surviving* or *living* the experience. Using a survival mode meant that women 'bracketed off' the troubling and painful aspects of birth and emphasised 'getting through' the experience. In this strategy, the birthing woman would often attempt to withdraw from her body and focus on surviving (or trying to control) birth from a mental or spiritual plane. These women tended not to tell elaborated stories of birthing; instead, 'troubling' aspects were silenced in order to ensure their own survival as subjects. The second strategy of 'living' the birth experience involved the *articulation of an embodied self* in which women were closely attuned to their bodily sensations and took up a position as the active subject of their own birth experience. Women using this strategy tended to tell their stories using 'action verbs' in the first person, thereby representing themselves as the central, active subject of childbirth. According to Sbisà, the five women who narrated the strategy of 'living' childbirth all gave positive evaluations of their birth experiences.

As part of her research, Sbisà also examines the discursive construction of childbirth within 34 medical advice books. She finds, similarly to other feminist analyses of medical texts (e.g. Martin, 1987; Kahn, 1995), that Italian advice books deny women's own embodied knowledge and reproduce notions of the female body as weak, fragile, unreliable and passive. Childbirth is rarely portrayed as the activity of a fully active human subject and the triad of child, father and doctor often work within these texts to erase the birthing woman from the birth experience. The only discursive space for the elaboration of female subjectivity seems to be within the narrow confines of traditional motherhood and femininity. Sbisà thus works from the premise that women need to produce new representations of female subjectivity and embodiment that *empower* rather than *erase* women's subjectivities. While searching for "a feminine point of view on childbirth" (pp. 371) within women's talk, she finds, however, that women's accounts remained dominated by medical constructions of birth. Sbisà also points to the difficulties that women seem to experience in constructing their own 'point of view' (or representations) about childbirth. She suggests that these difficulties might be related both to the dominance of an outsider's

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(male/medical) perspective on childbirth and the interference of medical technology with female bodily experiences. Several other feminist researchers have similarly described the difficulty experienced by women in trying to find a language to describe the female embodied experiences of birth (Cosslett, 1994; Pollock, 1999; Klassen, 2001a) pregnancy (Schmied & Lupton, 2001a) and breastfeeding (Schmied & Lupton, 2001b; Bartlett, 2002).

Performing bodies, ragged subjectivities

One of the most important texts published on childbirth within the past decade has to be the post-structuralist work of Della Pollock (1999). In her book, '*Telling bodies, performing birth*', Pollock provides an extensive and sustained exemplar of a post-structuralist analysis of childbirth. Focussing on the birth stories of 39 American men and women, collected via 'informal' interviews, Pollock hones in on the ways in which birthing narratives re-produce the maternal body. Pollock remains, however, more interested in the subjectivities and bodies that emerge in the *telling* of birth stories than the 'actual' birth experience. Using an 'ethnopoetic' style of transcription in which participants' words are represented in a long-line style of verse meant to viscerally portray bodily rhythms, speech peculiarities and the necessary embodied features of talk as performance, Pollock shows the "ragged and fleeting forms of subjectivity" (pp. 7) achieved by telling birth stories, which are shown to be laden with absences, subversions, contradictions and silences. Despite working within a radical post-structuralist position in which nothing outside of text, talk and embodied performance is seen as available for analysis, Pollock's book nonetheless hums with a continual sense of 'something more' that threatens to escape between the lines of her text and the interviewee's stories. This 'something more' sometimes manifests as provocative secrets that circulate on the edges of birth stories: "*Need*. Untold desire. Un/desire. Depression. Race. *Shit*. Laughter. Dirty little secrets. Underworlds. Underwords…Slips. Asides." (pp. 192, author's emphasis).

Despite a commitment to resisting typologies of birth narratives, Pollock nonetheless provides a useful grid in which she captures some of the dominant ways in which stories about birth are told. Thus, she describes the 'comic-heroic' story line as the norm of birth storytelling. In this comic-heroic genre, tellers usually flirt and play with ever-present and looming disaster, death and catastrophe, while both teller and audience know that within the bounds of the comic story genre, there can only ever be a 'happy ending'. She refers to this as the 'almost-but' characteristic of birth stories. Pollock also notes the (medicalised) linearity of many birth stories, in which the medical narrative of pregnancy and birth becomes (a dominant) part of women's embodied narratives.

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Although there is a discernable shift from the 1990s to a discursive, constructionist or post-structuralist approach to the study of childbirth, Pollock's work remains, for me, one of the few research studies in which a post-structuralist analysis of birthing is fully sustained. Pollock demonstrates a thoroughly non-essentialist approach to birth, which she achieves largely by focussing solely on the narrative re-performance(s) of birth enacted within the interview scene. Within her work there is little whiff of the ubiquitous sameness–difference dilemma that characterises most feminist work on childbirth; furthermore, by analysing a wide variety of birth stories, including: caesarean birth, birthing by a lesbian couple, abortion, in vitro fertilisation and home-birth, Pollock successfully avoids valorising any one type of birth experience. However, at the same time, by focussing narrowly on the localised 'narrative encounter', the 'pleasures' of telling, and stories which challenge storytelling norms *vis-à-vis* birth, it could be argued that structural and ideological constraints on both the material practice of childbirth and its narration in story form, are somewhat marginalized in Pollock's analysis. Furthermore, despite claiming to focus on the maternal body/subjectivity, by privileging the performative aspects *of telling*, Pollock's analysis does not render a rich portrait of the *embodied subjectivity* of the birth experience itself.

Metaphors of the birthing body

The work of Pamela Klassen (2001a) represents another important attempt to approach the complexities of the birthing body. Klassen's study, published as a book in 2001, is an exploration of 45 women's retrospective home-birthing narratives. In a fascinating chapter in which she explores the *metaphors* used by home-birthing women to describe their birthing bodies, Klassen aims to show how (home) birth represents an important source of "creative conceptualization" (pp. 136) for 'making meaning' about the body, life, death and spirituality. Klassen highlights the importance of paying close attention to the *metaphoric language* used by women in their attempts to translate their embodied birthing experience into words. Drawing on the work on metaphor and the body done by George Lakoff and Mark Johnson, Klassen signals the power of metaphor as a critical tool for 'trying to comprehend the incomprehensible'. Thus:

> Metaphor hovers between direct bodily experience and its categorization, mutually interacting with social and bodily experience both to express those experiences and to structure them (pp. 140).

Klassen shows how home-birthing women drew on a rich range of metaphors to 'make sense' of birth and 'translate' bodily experience into language. According to Klassen, home-birthers were active in creating new and alternative visions of birth and birthing bodies, in effect challenging

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dominant medicalised metaphors of birth in which women's birthing bodies are fragmented into sets of disarticulated and mechanical parts. However, Klassen does caution that these visions are not "seamless utopias" (pp. 141) but are themselves riven by paradoxes and contradictions, including the tension between birthing as an enactment of power (agency) and a confirmation of women's 'natural' role (submission).

The 'bodily metaphors' used by women to describe the birthing process fell into four central narratives, namely: birth as an animal act, intuition and instinct, the God-designed body and the cyborg body. The tendency to liken human birth to 'an animal act' is linked to a line of discourse derived from the 'natural childbirth' movement (see chapter two). Klassen acknowledges the "potentially dangerous alliance" (pp. 141) this narrative sets up between women's birthing bodies and animality, citing its potential to cast women into the position of an animal (less than human) 'other' and entrench birth within a solely biological realm.

The second narrative of 'intuition and instinct' drew heavily on the notion of the (instinctual) body viscerally present "as a speaking voice within a woman's self" (pp. 148). In this 'visionary' story, birth was seen as an event capable of affirming "a woman's natural intuitive powers and her ability to be in touch with her instincts" (pp. 148). The 'silent' voice of the instinctual body was "a voice of resistance" (pp. 148) that had to be carefully listened to. Klassen notes parallels between this story line and the birth philosophy of Michel Odent, whose book '*Birth Reborn*' had been read by several of the women interviewed. Two women reached the point where 'instinct' alone was seen as a sufficient 'guide' in and through the birthing process and they opted to give birth unassisted, without the help of a birth attendant. For some women, searching for one's instinctual self/body was described as a wider journey encompassing spirituality, diet, birthing and life style. For these women instinct was "a learned capacity to listen to one's self and one's body" (pp. 153), functioning within their narratives as an important legitimating device for the birthing decisions that they made.

A third metaphor of the body drawn on was the 'God-designed body'. Women positioned within conservative or traditional religions often invoked this metaphor in order to express their belief that their bodies were perfectly designed by God (or some unknown source) for giving birth. This metaphor relies heavily on a mind-body dualism in which the body is seen as a container for the 'spirit' and is implicitly connected to religious notions of the body as 'sinful flesh' that is to be conquered and denied. For many women evoking this metaphor, birth was seen as a way for them to 'glorify' God and fulfil their inherent, 'God-given' womanly roles as life-givers, mothers and nurturers. The final bodily metaphor used in home-birthers descriptions of childbirth was of a (Godly) cyborg body. Women therefore did not only use the language of 'nature' to make sense of the embodied process of birth but also drew on mechanical imagery.

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The metaphor of the body as a machine was however given a religious twist with God invoked as the 'pilot' controlling birth. Using machine-based metaphors of the birthing body enabled these women, "to place their minds outside of their bodies and to let God fill up the void" (pp. 164).

Thus, emerging within Klassen's study are four kinds of birthing bodies: an animal body, an instinctual body, a 'God-designed' body and a cyborg body. All of these narrative bodies invoke some kind of body-self split, in which 'the body' is 'othered' or objectified as that which is either animalistic, instinctual or perfectly designed. Within Klassen's analysis, there is little indication that home-birthers constructed or evoked any form of *embodied subjectivity* in and through the telling of birth stories.

Summary and key findings

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This chapter has attempted to provide a wide-ranging tour of both psychological and feminist studies of childbirth over the last 30 years. An examination of psychological approaches to childbirth provided a template against which feminist studies could be explored, showing the ways in which psychological studies have tended to pathologise birthing women and produce individualised and decontextualised analyses of childbirth. Furthermore (and paradoxically), despite psychologists' insistent focus on the individual, there is still little sense within psychological research of the (concrete, embodied) birthing woman's subjective experience(s).

I have also tried to show the ways in which feminist research on childbirth has shifted over the past three decades. By attempting to make the feminist frameworks operating within different studies *explicit*, I have explored the ways in which wider tendencies within feminism have shaped childbirth research. Most researchers of childbirth have, however, remained vague about the theoretical underpinnings of their work; theoretical frames remain patchy, assorted and ill conceived. However, given the ways in which these (often implicit) theoretical frames have shaped the ways in which birth has been approached, studied and discussed (which is hopefully evident from the above review), it seems imperative to me that childbirth researchers think carefully about the kinds of theories (of subjectivity, agency, embodiment and experience) that they use to approach the study of childbirth. In the following chapter I will be exploring a range of (mostly feminist) theories that might help to provide a useful alternative theoretical foundation for research on women's birthing experiences.

Focussing particularly on the question of women's subjective experiences of birth, I have also (hopefully) demonstrated that few studies have placed the subjectivity of the birthing women (as she tells her story) at the centre of analysis. All too often women's stories and experiences are 'made-to-fit' pre-existing conceptual grids and the ambivalence, contradiction and contrapuntal

subjectivity of birthing women (hinted at in poetic and literary writings) remains 'ironed out' and 'smoothed over'. I feel that more researchers need to experiment and play with different representational and analytic devices in trying to capture the shifting, complex practice of women telling childbirth. Studies done by Joann Bromberg (1981) and Della Pollock (1999) remain the only two attempts that I know to try and re-present women's birth experiences in innovative and experimental ways.

This study hopes to address some of the gaps identified within this review. In particular, this research hopes (to begin) to explore the shifting re-presentation of birthing subjectivity in and through women's childbirth narratives. Using a range of experimental modes of analysis and re-presentation, I hope to be able to demonstrate some of the paradoxes, absences, contradictions and ambiguities that emerge when women tell about their birth experiences. However, before embarking on this analytic journey, I believe it is imperative (on the basis of the findings of this review) to first explore potentially relevant (feminist) theoretical frameworks that might provide rich and useful ways of approaching and conceptualising birthing bodies, subjectivity and agency.

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The Moment the Two Worlds Meet

Sharon Olds (2004:52)

That's the moment I always think of – when the
slick, whole body comes out of me,
when they pull it out, not pull it but steady it
as it pushes forth, not catch it but keep their
hands under it as it pulses out,
they are the first to touch it,
and it shines, it glistens with the thick liquid on it.
That's the moment, while it's sliding, the limbs
compressed close to the body, the arms
bent like a crab's cloud-muscle legs, the
thighs packed plums in heavy syrup, the
legs folded like the wings of a chicken –
that is the center of life, the moment when the
juiced, bluish sphere of the baby is
sliding between the two worlds,
wet, like sex, it *is* sex,
it is my life opening back and back
as you'd strip the reed from the bud, not strip it but
watch it thrust so it peels itself and the
flower is there, severely folded, and
then it begins to open and dry
but by then the moment is over,
they wipe off the grease and wrap the child in a blanket and
hand it to you entirely in this world.

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CHAPTER 4

Theorising maternal bodies-subjectivities

> The time is right for us to redirect our gaze and explore mother-as-subject.
> (Donna Bassin, Margaret Honey & Meryle Kaplan, 1994:9).

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In the previous chapter, I argued that many feminist studies of childbirth remain vague about the underlying theoretical accounts of agency and subjectivity that they are working with(in). Often the unacknowledged paradigm of subjectivity sneaking in (often) unbidden through the back door is based on an individualist and rationalist identity. DiQuinzio (1999) has argued convincingly that individualist models of subjectivity cannot adequately theorise women's experiences of maternity and has shown how such accounts often work in tandem with ideologies of essential motherhood to deny the existence of maternal subjectivity. Even accounts which privilege gender difference are often guilty of re-producing a coherent, unitary model of female subjectivity (as difference from) that remains ultimately defined by its relation to the (unitary) male norm. Furthermore, it is clear that 'gender difference' approaches risk valorising maternity and reducing women to their reproductive capacities.

In the interests of trying to (re)conceptualise birthing subjectivity in ways that move outside of the inevitable problematic of individualist and difference accounts of maternity, this chapter will explore the work of a number of feminist theorists who have attempted to offer alternative theories of maternal subjectivity. Interestingly, most attempts to theorise maternal subjectivity seem to inevitably also be theorisations of maternal bodies. Finding ways to theorise birthing bodies which manage to eschew both the body as a neutral, biological template (individualism)

and the body as the site of an essential woman's power (gender difference), might well be the starting point for the re-conceptualisation of more complex forms of embodied birthing subjectivities. Furthermore, it will become clear in this chapter that the adequate theorisation of maternal subjectivity *requires* a theory that successfully conceptualises bodies and subjectivities as complexly interwoven and inseparable.

Drawing on a diverse mix of theoretical traditions, including phenomenology, psychoanalysis, French post-structuralism and materialism, feminist writers have theorised maternity in a range of creative and often contradictory ways. It will be shown in this chapter that feminist theories of maternity have presented *conflicting* images of the maternal subject, veering between the representation of pregnant, birthing and mothering subjects as 'split subjectivities' and 'unified wholes'. Different theorists have also give different explanations for so-called maternal 'splitting' or fragmentation. In this theoretical exploration, I will not be presenting a 'totalistic' theory or an all-encompassing model that finally and fully promises to mirror the complexity of women's stories of birthing and mothering. Feminist accounts of maternity will inevitably 'bump into' irresolvable dilemmas of difference and be characterised by ambivalence and many paradoxes and contradictions (DiQuinzio, 1999). A "paradoxical politics" (*ibid*, pp. 28) therefore remains the likely end-result of all feminist engagements with questions of birth and mothering. In this chapter, I will be exploring the work of diverse theorists such as Simone de Beauvoir, Iris Marion Young, Adrienne Rich, Julia Kristeva and Luce Irigaray, as well as a range of materialist or 'standpoint' feminists. These explorations are offered in the interests of unearthing the most useful tools to approach and analyse the complex birthing subjectivities and body-self relations that will be re-presented in subsequent analysis chapters. Before exploring the theoretical material addressing maternal bodies-subjectivities, this chapter will (very) briefly provide an introduction to the recent 'turn to bodies' within feminism.

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The turn to bodies

"To write about the body…is a paradoxical project".
(Gail Weiss, 1999:1).

"Bodies. It all has something to do with bodies."
(Henriette Moore, 1994:17).

Over the last twenty years there has been a discernable shift in feminist theory (and the social sciences more broadly) in which 'the body' or embodiment has become a central point of theoretical investigation. Some have hinted that the rising tide of theories and studies centring on 'the body' is linked to growing intellectual frustration concerning the 'idealist' limitations of a post-structuralist focus on language, text and discourse (Ebert, 1996). Thus, notwithstanding the

'docile' and 'passive' body portrayed in Foucault's early work, 'the body' also emerges as a "point of intersection" (Braidotti, 1994:182), the site and product of power and the source of resistance or agency. The body within Foucauldian theory thus surfaces as the prime site of a resistance in which "the body always exceeds the power-knowledge that attempts to completely control it" (Ebert, 1996:31). For post-structuralists wanting to move away from the abstract and idealist limitations of 'discourse' and keen to 'get to grips' with materiality and the matter 'beyond the text', 'the body' emerges as the "dynamic, mutable frontier" (McNay, 2000:32), "a point of mediation" (Grosz, 1994:20) and "a zone of uncertainty" (Kuhlmann & Babitsch, 2002:433), interceding and overlapping between the discursive and non-discursive, power and resistance, representation and materiality. The body becomes the indeterminate threshold concept, "the crucial term" (Grosz, 1994:19), in efforts to theorise beyond binaries and 'shake up' logocentric knowledge(s), which are, according to Grosz (1994), founded upon the repression and disavowal of the body.

Feminism has (of course) from its inception stood in uneasy relationship with questions pertaining to the significance of sexed bodies (Price & Shildrick, 1999; Chadwick, 2006). Patriarchal ideologies have long justified women's oppressed status by invoking the female body as the (natural) source of women's inferior social position. It is thus not surprising that many feminists have a somewhat ambivalent stance towards the recent surge of interest in 'the body' (e.g. Kuhlmann & Babitsch, 2002; Somerville, 2004). The sex/gender distinction, one of the central conceptual tools of second wave feminism, has long reigned undisputed as the feminist answer to the biologistic legitimation of women's oppression. Splitting off sex (biology, the body) from gender (social and psychological inscription) meant that feminists could argue that women's (sexed, reproductive) bodies were not the source of an inevitable position of (social, political, intellectual) inferiority. However, more recently the sex-gender distinction has come under severe fire from feminists who are attempting to re-theorise the significance of embodiment and looking for ways in which to theorise subjectivity without reproducing mind-body dualism (e.g. Butler, 1990; Grosz, 1994; Gatens, 1996; Moi, 1999; Webster, 2002; Young, 2002). This current of feminist theorising is widely known as 'corporeal feminism' and is described by some as "a major force in feminist scholarship" (Keane & Rosengarten, 2002:261).

Corporeal feminism draws on a wide range of intellectual traditions, including French feminism, post-structuralism, psychoanalysis and existential phenomenology. One of the driving forces behind the corporeal turn in feminist theorising has been 'sexual difference' feminism, usually equated with 'French' feminist theory. For sexual difference feminists, one of the central tasks facing contemporary feminism is the theorisation of sexual difference and the creation of new images and representations of female subjectivity. Heavily influenced by Lacanian

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psychoanalysis and French post-structuralism, 'sexual difference' feminism regards the sexed body as integral to an understanding of women's social and psychical situation(s). The body is thus not seen as a passive, a-cultural object but as "interwoven with and constitutive of systems of meaning, signification, and representation" (Grosz, 1994:18); the body is entangled in complex knots of desire, signification and power. Long suspicious of an Anglophone sex-gender distinction, sexual difference feminists have been more interested in deconstructing the dichotomy itself. For English-speaking feminists taking up the baton of a 'corporeal' theoretical shift, the development of a non-dualist and non-essentialist account of subjectivity – an *embodied subjectivity* – stands as a key theoretical goal (Grosz, 1994; Gatens, 1996). In the interests of advancing such an account, Elizabeth Grosz (1994), for example, offers the model of the Möbius strip, a sideways figure eight image symbolising the endless and indistinguishable contortion and inversion of body into mind and mind into body.

While clearly a useful image, one wonders, however, to what extent it manages to deconstruct the long-abiding logocentric understanding of body and mind as two coherent, privileged and recognisable entities that are somehow added together to make subjectivity. Personally, I remain rather bemused by the very idea of 'the body'. To me it seems impossible to speak of such a 'thing', as if it could ever be isolated and examined apart from consciousness, 'mind', meaning and subjectivity. 'The body' as a generalisable, neutral, static and pure 'thing' does not exist. There is only ever a plethora of bodies (Grosz, 1994; Weiss, 1999). Even for one person, there exist multiple body images, constituted through "corporeal exchanges…both within and outside of specific bodies" (Weiss, 1999:2). It is perhaps important to note (as an aside) that my use of the term 'subjectivity' is drawn from the French post-structuralist term '*asujettissement*', in which subjectivity always refers to a dual, inseparable process of being 'subjected to' (passive inscription) and 'subject of' (active agency). However, somewhat missing from this definition is any reference to corporeality. In my opinion, subjectivity itself remains inseparable from embodiment and cannot be theorised apart from bodies.

Despite its influence, corporeal feminism has been subject to a number of criticisms. For example, it has been accused of theoretical abstraction (Ebert, 1996) and denounced for having little to no bearing on the concrete experience(s) of 'real life', 'fleshy' bodies (Marshall, 1996; Keane & Rosengarten, 2002; Howson, 2005). Written mostly by feminist philosophers, corporeal feminist theory has also been accused of paying little to no attention to empirical studies on embodiment conducted by feminist sociologists, anthropologists and women's health researchers (Marshall, 1996; Kuhlmann & Babitsch, 2002; Howson, 2005). Others have criticised corporeal feminists for a narrow understanding of materiality as merely the indeterminate 'stuff' of bodies and embodiment, ignoring Marxist definitions of the material as "the praxis of labor" (Ebert,

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1996:35) and the re-production of material life. Similarly, Lois McNay (2000) cites the overwhelming emphasis upon the *symbolic* or *linguistic* construction of corporeal identity as a major limitation of recent feminist theorisation of embodiment.

Theorising maternal bodies-subjectivities

"The words are being spoken now, are being written down; the taboos are being broken, the masks of motherhood are cracking through."
(Adrienne Rich, 1976:5).

"…it is time to learn, to begin to speak our mother tongue."
(Shirley Garner, Claire Kahane & Madelon Sprengnether, 1985: 29).

Maternity has long been a source of contention, dispute and division within feminism (Michaels, 1996; DiQuinzio, 1999; Reiger, 1999). While some claim to have identified a recent 'maternal turn' (Flax, 1993) in feminist theory/research, in which increasing numbers of feminists have sought to address, theorise and 'give voice' to maternity, others argue that the issue of motherhood has from its inception been central to feminism (DiQuinzio, 1999). It is widely known that a generalised negativity towards maternity prevailed during much of second wave feminism. For example, the outright derision and hostility towards motherhood within the writings of influential feminists such as Betty Friedan (1963) and Shulamith Firestone (1970) has been widely discussed. However, according to Ross (1995), from the 1980s onwards there has been a notable and steady increase in feminist work "reaffirming and celebrating motherhood" (pp. 398). Increasingly, it has also been recognised that the control, negation and repudiation of maternity stands as one of the cornerstones of patriarchal culture and that the 'institution' of motherhood (Rich, 1976) affects all women, regardless of whether or not they become biological mothers. Feminism thus cannot afford to ignore or over-simplify the issue of mothering (DiQuinzio, 1999).

There exists, by now, several adjacent and at times overlapping feminist theories of maternal subjectivity. A central theme emerging within these theories has been the idea that the maternal subject is a split subjectivity. This idea is a feature of theoretical explorations *vis-à-vis* maternity in the work of diverse theorists such as Simone de Beauvoir, Iris Marion Young, Julia Kristeva and Adrienne Rich. However, while agreeing on splitting, contradiction and ambivalence as core characteristics of maternal subjectivities (particularly in pregnancy and childbirth), such writers have different explanations for the causes and consequences of this 'split subjectivity'. For example, some view this contradictory and indeterminate subjectivity as an impediment to women's status as autonomous subjects, while others see the "unique body subjectivity" (Young, 1990b:171) of pregnancy and childbirth as a transgressive model for an alternative subjectivity.

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Interestingly, empirical qualitative studies looking at women's experiences of childbirth have rarely engaged with the 'split subjectivity' model of maternity foregrounded in these feminist theories. It should be evident from the literature review in chapter three, that most studies have tended to 'iron out' possible contradiction and ambiguity within women's accounts of birth, largely as a result of 'modernist' methods of representing women's voices (Stephens, 2004). As a result, the possibility and meanings of a 'split subjectivity' within childbirth have not been extensively corroborated or explored within qualitative studies (barring the work of Akrich & Pasveer, 2004). However, within the literary, poetic and autobiographical texts of women writers, such as Phyllis Chesler, Adrienne Rich, Margaret Atwood and Doris Lessing, the contradictory, split and profound ambivalence of maternal subjectivity is consistently highlighted and explored. One of the aims of this thesis is to relate feminist theoretical notions of the maternal subject as a 'split subjectivity' to the stories of 'ordinary' women and to explore to what extent women who are not writers, also draw on or re-produce this view of maternal subjectivity. In the pages that follow, I will be outlining various 'bodies of thinking' developed by feminists who have attempted to theorise the (embodied) subjectivity of maternity. I will also be exploring to what extent(s) they advocate and conceptualise pregnancy, birth and mothering as fundamentally split, contradictory and ambivalent subjective experiences.

> *My face in the mirror looked alien to me. My character blurred…I was one and the other at once. It stirred inside of me. Could I control its movements with my will? Sometimes I thought I could, at other times I realized it was beyond my control. I couldn't control anything. I was not myself…Then it was born. I heard it scream with a voice that was no longer mine (Borgese cited in Rich, 1976:161).*

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Simone de Beauvoir: of 'woman', bodies and maternity

"…the strange ambiguity of existence made body."
(Simone de Beauvoir, 1989:728).

For a long time prematurely dismissed and discarded, the work of the '*grande dame*' of twentieth century feminism, Simone de Beauvoir, has recently become the object of renewed interest and theoretical exploration (e.g. Kruks, 1990; 2001; Arp, 1995; Simons, 1995, 1999; Moi, 1994, 1999; Fishwick, 2002). This is perhaps partly related to the corporeal turn in feminism and the belief that Beauvoir's work offers a useful basis for a feminist theorisation of the body. For example, according to Moi (1999:5), "No feminist has produced a better theory of the embodied, sexually different human being than Simone de Beauvoir". Several feminists have argued that Beauvoir's theory of *the body as situation*, influenced by both Sartrean existentialism and Merleau-Ponty's work on embodiment, offers a non-essentialist and non-dualist account of subjectivity/embodiment and enables a powerful alternative to the impasse(s) of the sex-gender distinction (Moi, 1999; Kruks, 2001).

However, on reading '*The Second Sex*' it is difficult not to be struck by its contradictions, uneven arguments and ambivalence, particularly in relation to the female reproductive body. This is often the inevitable result of Beauvoir's use of a mixture of (often incompatible) theories, some of which fail hopelessly as frameworks for the theorisation of women's reproductive embodiment. For example, Sartrean existentialism and Hegelian understandings of (oppositional) self-other relations simply cannot provide adequate bases for the theorisation of maternity (DiQuinzio, 1999). The use of a Sartrean distinction between immanence ('being-in-itself') and transcendence ('being-for-itself'), in which immanence is seen as inevitably tied to a 'lower' realm of brute materiality and transcendence always refers to a 'higher' order of freely chosen, intentional actions, in effect imprisons Beauvoir's analysis within the well worn mind-body dualism, in which the body is denigrated and spurned as the inferior term. However, at other times in the text she also invokes Merleau-Ponty's non-dualist understanding of the body, which clashes horribly with Sartre's immanence-transcendence distinction and results in an uneven and contradictory account of 'the body'.

Thus, on one level Beauvoir remains committed to the notion that "the body is not a *thing*, it is a situation" (Beauvoir, 1989:34, author's emphasis), drawing on and extending Merleau-Ponty's theory of embodiment in her analysis of women. According to this view, 'the body' and subjectivity (as well as social/material contexts) can never be approached in isolation from one another; the 'situated' human being is always an embodied, historical and intersubjective subjectivity (Kruks, 1990). Such a subjectivity is also seen as permeable and irreducible; "the situated subject is an opening" (Kruks, 1990:17), onto the material, inter-relational and socio-historical realms. Subjectivity becomes seen as "a hollow, a fold, which has been made and which can be unmade" (Beauvoir cited in Kruks, 2001:32). As a result, subjectivity or 'consciousness' can never stand apart, 'pure' or separate from embodiment or inter-relation(s) with the world; it is a mobile 'fold' overlapping and conjoining with the sensuous material world (Kruks, 2001), "inextricably entangled in existence" (Bigwood, 1991:62). For phenomenologists such as Merleau-Ponty, the body is a relational, fluid and fleshy permeability that is itself the site of sentient forms of knowing, which arise (pre-cognitively and pre-linguistically) from its perceptual and sensory communion with other bodies and different forms of material and sensual life (Bigwood, 1991; Kruks, 2001). This is the version of (embodied) subjectivity that several feminist writers have hailed as a challenge to biological determinism, dualism and essentialism (e.g. Moi, 1999; Arp, 1995; Ward, 1995; Kruks, 2001; Heinämaa, 2003).

In my reading, however, Beauvoir's work remains fundamentally ambivalent and slippery. Her work is not a totalistic panacea but does offer some important points of departure for a radical rethinking of women's subjectivity. In '*The Second Sex*', Beauvoir argues that woman has come

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to function as the *Other* (for men). Writing from the position of an "existentialist ethics" (Beauvoir, 1989:xxiv), Beauvoir sets out to explain why and how this has come to pass. Aiming to debunk biologistic explanations of women's oppression, Beauvoir acknowledges that there are biological 'facts' but asserts that "in themselves they have no significance" (pp. 34) and do not set up an inevitable destiny for women. According to Beauvoir, we have to look to women's *situation*, "not a mysterious essence" (pp. 714) in order to explain women's secondary status. Thus, a woman is not a being defined by her body or her biological capacities; "woman is not a completed reality, but rather a becoming" (pp. 34). At the same time, Beauvoir repeatedly insists on the biological 'facts' as integral to an understanding of women's situation. Furthermore, it becomes clear on reading Beauvoir that she fingers women's reproductive capacities as one of the key ingredients in the development of her oppression. In her rather dubious account of primitive and nomadic human history, Beauvoir repeats as a steady refrain the idea that, "the bondage of reproduction was a terrible handicap" (pp. 62), and that woman were historically "the prey of overwhelming forces" (pp. 31), which in effect, "imprisoned her in repetition and immanence" (pp. 63). Thus, in Beauvoir's view:

> The fundamental fact that from the beginning of history doomed women to domestic work and prevented her taking part in the shaping of the world was her enslavement to the generative function (pp. 117).

In my view, '*The Second Sex*' portrays women as doubly alienated. Woman is thus alienated both by her *situation* in which she is cast as the *Other* and alienated in and through her *reproductive body*. According to an existential account, all human existence (male and female) is marked by a fundamental ambiguity, but for Beauvoir, woman's subjective existence is also marked by conflict and contradiction (Moi, 1994). Woman is fundamentally conflicted because as "a free and autonomous being" (Beauvoir, 1989:xxxv), she nonetheless finds herself cast as an inessential object relegated to a position of immanence. She thus, "takes herself simultaneously as *self* and as *other*, a contradiction that entails baffling consequences" (pp. 718; author's emphasis). Women are thus "painfully torn between freedom and alienation, transcendence and immanence, subject being and object being" (Moi, 1994:155). Furthermore, in Beauvoir's account, women are also involved in a relation of ambiguous contradiction with the female (reproductive) body, which itself produces a conflict between the interests of women as individual, 'free' subjects and the interests of the 'species' as a whole.

It is thus not surprising that littered throughout Beauvoir's text are mostly negative and at times horrifying images of women's reproductive bodies and maternity in particular. Thus, while displaying a remarkably idealistic and 'phallocentric' understanding of masculinity and male sexuality (Moi, 1994), Beauvoir likens women, for instance, to "the carnivorous plant, the bog, in

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which insects and children are swallowed up" (Beauvoir, 1989:386). Many writers have commented on the problematic treatment of maternity within '*The Second Sex*', which is, according to Moi (1999:66), "haunted by a destructive mother imago". Other writers have emphasised the multiple paradoxes, contradictions and ambiguities which mark Beauvoir's treatment of mothering and have argued that despite its problematic dimensions, it nonetheless remains relevant to contemporary feminist attempts to theorise maternal subjectivity (e.g. Zerilli, 1992; DiQuinzio, 1999). However, what remains ultimately problematic about Beauvoir's approach to maternity is that she assumes that the reproductive experiences of pregnancy, childbirth and breastfeeding are fundamentally and essentially rooted in (dreaded) immanence and are thus devoid of any whiff of creativity, transcendence or self-affirmation. For Beauvoir, giving birth and breastfeeding infants are not *activities*, "they are natural functions; no project is involved" (pp. 63). Furthermore:

> The woman who gave birth…did not know the pride of creation, she felt herself the plaything of obscure forces, and the painful ordeal of childbirth seemed a useless or even troublesome accident (pp. 63).

In colors of blood and air I spin without stopping: colon, foot, eye. By day, by night, for nine months, I weave you: precisely. Faithfully. No wonder I'm slow at other tasks (Phyllis Chesler, 1979:98).

In Beauvoir's (ultimately phallocentric) version of history, woman was enslaved to the 'mere' repetition of life through childbearing while man "transcended his animal nature" (pp. 63) by becoming an inventor of tools and "enlarging his grasp upon the world…he created; he burst out of the present, he opened the future" (pp. 63). Woman, however, remained stagnant, dependent and "closely bound to her body, like an animal" (pp. 65). Thus, according to Beauvoir:

> In no domain whatever did she create; she maintained the life of the tribe by giving it children and bread, nothing more. She remained doomed to immanence, incarnating only the static aspect of society, closed in upon itself (pp. 73).

Maternity and childbearing are thus cast as (original) obstacles to the fulfilment of women's transcendence as fully autonomous, human subjects. Maternity is the one feminine 'function' that is, for Beauvoir, "almost impossible to perform in complete liberty" (pp. 696). While not casting maternity as necessarily the cause of women's oppression, for Beauvoir it is nonetheless an 'essential' biological 'fact' integral to the interpretation of women's general situation. However, is Beauvoir's version of maternity a 'biological fact' or is it, rather, a reflection of a *phallocentric* understanding of women's reproductive capacities as brute, 'animal-like' and devoid of consciousness or subjectivity?

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Rooted within a Sartrean immanence-transcendence (or body-mind) distinction in which matters of the 'flesh' are always cast as inferior to affairs of the mind or consciousness, Beauvoir's account of maternity (as fleshy immanence) is unable to adequately theorise women's subjective experiences of pregnancy, birth and mothering. In her chapter on 'the mother', Beauvoir provides quite an extensive account of pregnancy, while childbirth is mostly ignored. Some feminist theorists have claimed that her account of pregnancy (admittedly inadvertently) succeeds in problematising and resisting dichotomies between immanence/transcendence and self/other (Zerilli, 1992; DiQuinzio, 1999). Thus, for Zerilli (1992), Beauvoir's account of maternity *unsettles* rather than re-produces the universal, modernist subject. What Beauvoir certainly does succeed in doing is representing the heterogeneity of women's responses to maternity. The variability inherent in women's responses to pregnancy, childbirth and mothering is repeatedly emphasised by Beauvoir. Thus, she succeeds in her aim of destabilising normative patriarchal meta-narratives of motherhood (Zerilli, 1992). By utilising a panoply of maternal voices, drawn from novels, letters and diaries, Beauvoir effectively manages to debunk a patriarchal version of essential motherhood in which all women are required to respond 'naturally' to motherhood in the same, uniform and selfless way (Zerilli, 1992). Working within a Hegelian understanding of the conflictual and oppositional relationship between self and other, Beauvoir presents a portrait of maternity (particularly pregnancy) as a process characterised by conflict and struggle in which the mother's (autonomous) subjectivity is at stake. Unsettling blissful, tranquil and 'holistic' notions of the relations between mother and foetus (or infant), Beauvoir re-casts the maternal body as a *battleground* (Zerilli, 1992), in which the conflict between woman as a 'free', human subject and the 'species' is dramatically enacted. The pregnant woman becomes the "prey of the species, which imposes its mysterious laws upon her" (Beauvoir, 1989:498). As a result, the embodied experiences of maternity (pregnancy, birth and breastfeeding) are cast as processes that threaten to induce the loss of women's individual agency and autonomy and are therefore riddled with inevitable traps and ambiguities. Thus, for Beauvoir, the 'split subjectivity' of the pregnant subject is seen as an expression of the fundamental conflict between the interests of the individual woman and 'the species' (or transcendence versus immanence). The pregnant woman, and (by assumption) the birthing and mothering woman, is torn between the fulfilment of autonomous projects and the bondage of her reproductive and maternal body. For Beauvoir, the 'split subjectivity' of maternity is thus not positive, empowering or transgressive, but is an obstacle to woman's freedom. Considering that Beauvoir is working predominantly from Sartrean and Hegelian points of theoretical departure, it is not surprising that

> *In the bursting of your coming, muscle, skin, walls, the smock untied. I leaned back on my hands, my stretched, engorged breasts exposed, laughed, entered a strange stream, a sexual stream, the ecstasy of time and place, a churning like mountains, like seas at the risen continents. I could hear time, a machine sound. I could feel creation, myself in place for the first time (Doubiago cited in Chester, 1989:102).*

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> *But pregnancy is above all a drama that is enacted within the woman herself. She feels it as at once an enrichment and an injury; the fetus is part of her body, and it is a parasite that feeds on it; she possesses it, and she is possessed by it; it represents the future and, carrying it, she feels herself vast as the world; but this very opulence annihilates her, she feels that she is no longer anything (Beauvoir, 1989: 495).*

she ultimately adopts a position in which qualifying as a human subject means approximating the ideals of autonomous agency that are inscribed within individualism. According to DiQuinzio (1999), these (masculinist) individualist theories of immanence/transcendence and oppositional self-other relations, which Beauvoir tries to *impose* upon the experience of pregnancy, inadvertently come apart at the seams, almost as though pregnancy and mothering themselves *resist* being defined and confined within these terms. Thus, the clear distinction between body and subjectivity implied in the immanence/transcendence distinction and the existence of autonomous, clearly differentiated selves assumed by a Hegelian account of self-other, *implode* within Beauvoir's analysis of pregnancy. For example, in Beauvoir's account, the materiality of the pregnant body is clearly portrayed as inducing powerful shifts in *subjectivity*, marked predominantly by paradoxes and ambivalence (DiQuinzio, 1999). It is thus the maternal *body-subject* that becomes "the site of a radical splitting" (Zerilli, 1992:113), demonstrating that 'the body' and consciousness or subjectivity cannot easily be thought apart from one another, particularly in relation to maternity. Furthermore, Beauvoir also produces an account of pregnancy in which she veers violently between *in*voking and *re*voking the idea that transcendence can be located within the 'fleshy' experience of pregnancy itself (DiQuinzio, 1999). For example, Beauvoir writes:

> If the flesh is purely passive and inert, it cannot embody transcendence, even in a degraded form; it is sluggish and tiresome; but when the reproductive process begins, the flesh becomes root-stock, source, and blossom, it assumes transcendence, a stirring toward the future, the while it remains a gross and present reality (pp. 495).

Beauvoir thus hints at the notion that transcendence itself might be a more complex phenomenon than implied by the immanence (body) – transcendence (mind) distinction. Within this distinction, it remains unthinkable that an experience of 'the flesh' (i.e. pregnancy) could itself be the site of transcendence. Inadvertently (perhaps) Beauvoir's examination of pregnancy manages to trouble this assumption and show the complex and inseparable intertwining of body-consciousness-social relations in the 'lived expression' of the pregnancy experience. Thus, implied (but not embraced) within her account is the notion that reproductive experiences like pregnancy are not simply biological events or 'natural', inevitable processes of 'the body'; instead they are complex, often contradictory experiences of *subjectivity*. However, Beauvoir's (attempted) adherence to the immanence-transcendence distinction and her basic abhorrence of the maternal body meant that she was unable to fully acknowledge the potential for positive creativity and transcendence within

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No one mentions the psychic crisis of bearing a first child, the excitation of long-buried feelings about one's own mother, the sense of confused power and powerlessness, of being taken over on the one hand and of touching new physical and psychic potentialities on the other, a heightened sensibility which can be exhilarating, bewildering and exhausting. No one mentions the strangeness of attraction – which can be as single-minded and overwhelming as the early days of a love affair – to a being so tiny, so dependent, so folded-in to itself – who is, and yet is not, part of oneself (Adrienne Rich, 1976:17).

the *activities* of pregnancy, birthing and breastfeeding. For Beauvoir, the reproductive body (as the brute slave of the species) is always at odds with women's transcendent activities as autonomous subjects.

In a (phallocentric) world in which a masculinist model of subjectivity privileging sameness, separation, individualism, coherence and autonomous agency, stands as the dominant prototype for human subjectivity, women's reproductive activities always risk being defined as *other* than human. Potentially expressing a different order of subjectivity upon which mind–body dualisms and ideals of autonomous agency and distinctly bounded selves cannot easily be superimposed, the embodied experiences of pregnancy, birth and mothering serve as situations within which the limits and fallacies of phallocentric versions of subjectivity are potentially exposed.

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But with every day of my pregnancy dragging me into closer awareness of the being in my body, I began to think that his views were based on an abstract ideal of the self and its rights – constituted by men – that simply could not account for pregnancy… I was beginning to wonder whether a pregnant woman was an implicit challenge to the idea of the autonomous 'individual' upon which basic Western notions of law, of rights and even of selfhood were based… Pregnancy, it seemed, required a different kind of philosophy… (Naomi Wolf, 2001:26).

Iris Marion Young: the lived female body

"…rarely does contemporary theorizing of the body concern...the tactile, motile, weighted, painful, and pleasurable experience of an embodied subject..."
(Iris Marion Young, 1990d:14).

The work of Iris Marion Young, appearing 30 to 40 years after Simone de Beauvoir's, both draws on and attempts to problematise the work of existential phenomenologists on 'the body', by looking at women's 'lived experiences' of female corporeality. In a set of articles looking at different aspects of 'female body experience', Young makes a significant contribution to our understanding of the way(s) in which women *live* the female body in the ways that they move, act, orient themselves in relation to space and live the sexually specific experiences of pregnancy and 'being breasted'. Drawing on a rich array of theoretical influences, including Maurice Merleau-Ponty, Erwin Straus, Simone de Beauvoir, Julia Kristeva and Luce Irigaray, Young's work on the lived bodily experience of femininity stands as one of the most significant feminist contributions to a phenomenology of female embodiment.

In her article, '*Throwing like a girl'*, Iris Marion Young (1990a) produces a remarkable and illuminating demonstration of how women's situation as *Other* is materialised and expressed in the very ways in which they orient, position and use their bodies "in living action" (pp. 142). Drawing heavily on Beauvoir, Young argues that the widely accepted difference in the ways in

which men and women (and boys and girls) use their bodies and are oriented (as bodies) in relation to the world, is not a matter of biology or a mysterious feminine essence, but is a manifestation of their situation as *Other*, in which they live in fundamental contradiction as both transcendent subjects and inessential objects[28]. Young's work shows quite remarkably how woman's contradictory status as *Other* and *as subject*, in which woman's body is herself and yet is also something other than herself, is expressed in and through the ways women live, use, move with and orient their bodies in everyday life. According to Young, a feminine style of bodily movement and comportment is itself characterised by contradictions, in which women are torn between living their bodies as subjects or objects, as things or capacities and are often left hovering tentatively between a purposeful 'I can' and a hesitant 'I cannot'. The result is that women typically do not make use of their full bodily potential, underestimate their bodily capacity, generally move in a constricted spatial relation to the world, lack a sense of trust in their bodies, experience their bodies as looked at and acted upon rather than as intentional capacities and generally do not summon the power of their whole bodies in the enactment of tasks, in effect expressing the contradiction(s) of *their situation* as women within patriarchal societies. Living always as the potential object of a gaze that reduces and confines her to an objectified body, women themselves often come to regard and to live their bodies as thing-like objects. As a result, many women live in a relation of distance and discontinuity with their bodies, which manifests and is often expressed as a contradictory, hesitant and inhibited style of corporeal movement, intentionality and comportment. As a result, "the imaginary perspective of these 'others' can come to dominate, even supersede a woman's own experience of her bodily capacities…" (Weiss, 1999:47). Woman is thus a being *dis*continuous with her body; she *is* her body and yet her body is also something *other* than her-self; she is doubled in that *she watches* the (real or imaginary) other *watching her*. Young (1990a) suggests that the feminine subject, which (like Beauvoir) she constructs as a split and contradictory subjectivity, is fundamentally alienated, oppressed and inhibited by this state of fragmentation. The splitting, discontinuity and contradiction of feminine subjectivity is thus seen as undermining women's existence as human subjects.

However, in her later article: '*Pregnant embodiment'*, Young (1990b) presents a radically different interpretation of the contradictory and split subjectivity of pregnancy, which she casts as positive and *non-alienating*. In this article, Young explores the experience of pregnancy, "from the pregnant subject's viewpoint" (pp. 160), arguing that a phenomenology written from the perspective of the pregnant body-subject both challenges and undermines masculinist assumptions

[28] For Young, 'the feminine' refers to "a set of structures and conditions" (1990a:144) delimiting the general situation of woman and referring to the typical way in which their (general) situation is lived by women; individual women can however escape, transcend or live this situation in different ways.

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of a unified subject and an immanence-transcendence distinction. Starting from the premise that the subjectivity of the pregnant woman has been *omitted* from socio-cultural discourses of pregnancy, Young follows Julia Kristeva in arguing that the pregnant subject is "decentered, split, or doubled" (pp. 160) in various ways. For example, according to Young, the pregnant women is split between self and other, between her own body and the (repressed) recollection of her mother's body and between past and future. Furthermore, in pregnancy, the boundaries of the body become fluid, undecidable and permeable, destabilising accepted ideas of inside–outside and challenging the integration of body subjectivity. Thus, the pregnant subject is "myself in the mode of not being myself" (pp. 162) and the inside of the body is experienced as simultaneously both belonging to an other and yet is also my own body. Young's 'fleshy' and evocative descriptions of pregnancy, which begin in and from the perspective of the 'lived experience' of the pregnant body-subject, succeed remarkably in "inscribing the subjectivity of pregnancy" (Boulous-Walker, 1998:149) in a sensuous way. Whereas for Beauvoir, the splitting of the pregnant subject was seen largely as an obstacle to her autonomy and (individualist) subjectivity, Young reinscribes the split subjectivity of pregnancy as positive, non-alienating and as a (transgressive) alternative to the unified, disembodied and coherent subject of individualism. For Young, the experience of pregnancy also challenges the assumption (based in the immanence– transcendence distinction), that the awareness of the material, weighty body is always "an alienated objectification of my body, in which I am not my body and my body imprisons me" (pp. 164). Instead, the pregnant body-subject becomes aware of her body, not as an object, but as "a fleshy relation to the earth" (pp. 166), an awareness which often inspires within the pregnant woman a positive sense of "power, solidity and validity" (pp. 166). For Young, pregnant embodiment is not a static unfolding of a biological process in which the pregnant woman is a passive bystander, "waiting and watching" (pp. 167); rather, the pregnant subject is a dialectic, in which:

As my pregnancy begins, I experience it as a change in my body; I become different from what I have been. My nipples become reddened and tender; my belly swells into a pear. I feel this elastic around my waist, itching, this round, hard middle replacing the doughy belly with which I still identify. Then I feel a little tickle, a little gurgle in my belly. It is my feeling, my insides, and yet it feels somewhat like a gas bubble, but it is not; it is different, in another place, belonging to another, another that is nevertheless my body (Iris Young, 1990b:162-163).

Tonight I descend, tonight I rise. Tonight I am halved, tonight I am doubled. Tonight I lose you forever, tonight I meet you for the first time. Tonight I cheat death. Tonight I die…Palpable, luminous, the Mysteries unfold: arcs of paradox. I can touch them. I am them (Chesler, 1979:107).

> The pregnant woman experiences herself as a source and participant in a creative process. Though she does not plan and direct it, neither does it merely wash over her; rather, she *is* this process, this change (pp. 167, author's emphasis).

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While proclaiming that both pregnancy and childbirth, "entail a unique body subjectivity" (pp. 171), Young pays scant attention to the experience of birthing within her article. Apart from noting that childbirth "entails the most extreme suspension of the bodily distinction between inner and outer" (pp. 163), Young herself largely 'omits' *birthing* subjectivity from her discussion. While providing rich, sensual and visceral descriptions of her pregnancy, Young's own experience of birthing remains curiously absent from her intellectual work.

Adrienne Rich: bodies of experience

"The woman's body is the terrain on which patriarchy is erected."
(Adrienne Rich, 1976:38).

Writing in 1976, feminist poet Adrienne Rich provides in her classic book, '*Of Woman Born'*, a startling and honest portrait of her own highly ambivalent journey through motherhood. Central to Rich's analysis of maternity is the distinction that she draws between motherhood *as experience* and *as institution*. She thus argues that there are two meanings to motherhood; on the one hand there is "the potential relationship" of a woman to her reproductive capacity and to children and on the other, there is the patriarchal institution, "which aims…that the potential – and all women-remain under male control" (pp. xv). According to Rich, the institution or ideology of motherhood functions as a cornerstone of patriarchal oppression and has in effect, "ghettoized and degraded female potentialities" (pp. xv).

My children cause me the most exquisite suffering of which I have any experience. It is the suffering of ambivalence: the murderous alternation between bitter resentment and raw-edged nerves, and blissful gratitude and tenderness (Rich, 1976:1).

An essential element of this degradation has been the definition of female bodies and reproductive capacities according to male interests: "patriarchal thought has limited female biology to its own narrow specifications" (pp. 21). The 'institution' of motherhood thus decrees that children should 'naturally' be the sole responsibility of mothers, requires mothers to be selfless and ever-present, demands mothering from all women, severs the connection between maternity and sexuality and expects that all mothers find automatic fulfilment and satisfaction in (patriarchal) motherhood. Despite the fact that institutional motherhood prescribes and sets the terms within which individual women mother, it is not, according to Rich, identical to the actual lived *experience* of bearing and rearing children. Richly utilising her own experiences of mothering, often in a poetic form, Rich paints a compelling picture which exposes the fundamental contradictions and ambivalence of maternity within patriarchy. According to Rich, it is the institution of motherhood, not the experience, which engenders a 'split' or contradictory maternal subjectivity; it is institutional motherhood that creates an impossible struggle between the affirmation of an independent self and being a 'good'

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> *When I try to return to the body of the young woman of twenty-six, pregnant for the first time, who fled from the physical knowledge of her pregnancy and at the same time from her intellect and vocation, I realize that I was effectively alienated from my real body and my real spirit by the institution – not the fact – of motherhood (Rich, 1976:20).*

(read *selfless*) mother. Rich's poetic descriptions of motherhood are thus filled with the poignant and lingering desire to have her own (non-mothering) self ('myself') returned to her.

Thus, both Rich and Beauvoir conceptualise motherhood as a struggle between the autonomy of the individual woman and her mothering role. However, whereas for Beauvoir, the (biological) maternal function is inevitably the site of conflict (between the individual woman and 'the species'), for Adrienne Rich, it is the patriarchal construction of motherhood that creates this conflict (and it is therefore not inevitable). For both writers, this conflict (or 'split subjectivity') is however seen as alienating, oppressive and as an obstacle to the mother's realisation of autonomous, transcendent agency. The resonance between the work of Rich and Beauvoir is partly a result of their common (and implicit) adherence to an individualist model of subjectivity (DiQuinzio, 1999). Thus, the 'ideal' self portrayed within their accounts is almost always autonomous, intentional and coherently bounded. Furthermore, the distinction between experience/institution, so ingeniously developed by Rich, has been recently identified as itself implicated in the re-production of an individualist theory of subjectivity (see DiQuinzio, 1999). For example, according to DiQuinzio, the distinction implies that subjectivity or experience exists *apart* from or prior to ideologies and socio-structural contexts.

Commensurate with Rich's implicit individualism is also the resurrection of (at times) a dualist distinction between mind–body. The female body, of course, occupies a central position

> *I knew I was fighting for my life through, against, and with the lives of my children, though very little else was clear to me. I had been trying to give birth to myself; and in some grim, dim way I was determined to use even pregnancy and parturition in that process (Rich, 1976:10).*

within Rich's analysis of motherhood, in which it comes to function as the emblem of a latent form of female power that has been silenced and corrupted by patriarchy. According to Rich, it is patriarchy that has constructed the female body as the site of "the most fundamental and bewildering of contradictions, it has alienated women from our bodies by incarcerating us in them" (pp. xv). Thus, the alienation that many women feel in relation to their (sexual and reproductive) bodies is not essentially linked to their biology but is, for Rich, tied to the impossible contradictions imposed upon women by patriarchal societies. Many of these (oppressive) contradictions centre on the paradoxical patriarchal construction of women's bodies as impure, dangerous, dirty and corrupt and the woman-mother as sacred, pure and asexual. For Rich, patriarchal oppression is founded upon and sustained by the control and definition of women's bodies according to male interests. Thus, it is not surprising that Rich constructs the reclamation of the female body as an integral part of women's liberation. Despite Rich's explicitly gynocentric feminism, she nonetheless also operates within an individualist framework that implicitly assumes that 'the body' should be a

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> *The woman's body, with its potential for gestating, bringing forth and nourishing new life, has been through the ages a field of contradictions: a space invested with power, and an acute vulnerability; a numinous figure and the incarnation of evil; a hoard of ambivalences, most of which have worked to disqualify women from the collective act of defining culture (Rich, 1976:90).*

'possession' that the self 'presides over'; thus, "control of our bodies…is a prerequisite" for living "a fully human life" (pp. 21). Implicit in Rich's account is therefore a subtle separation between bodies and subjectivities. According to DiQuinzio (1999), Rich continually slips into theorising the female body apart from women's subjectivity. However, it is probably important to remember that for Rich, it is patriarchy that has dispossessed women of their bodies and created a profound alienation in which women come to live their bodies as separate from their selves. The dualism between (female) body and (female) self is therefore seen as a product of patriarchal oppression. Thus, as well as re-invoking mind–body dualism within her text, Rich is also constantly trying to *repair* the severed connection between mind–body and calling for women to: "think through the body, to connect what has been so cruelly disorganized" (pp. 290). For Rich, the (actual as opposed to culturally warped), female body remains a set of potentialities and resources, which women have yet to 'repossess' and 'think through'. Ultimately then, for Rich, there is an 'uncorrupted' body which can be 'reclaimed' by women, free of the distortions of patriarchal constructions. She hints within her work that an 'authentic' experience of the female body (and of maternity), outside of patriarchal constraints, would be non-alienated, non-contradictory and un-ambivalent.

> *...the mother caring for her child is involved in a continually changing dialogue ...hearing her child's cry, she feels milk rush into her breasts; when, as the child first suckles, the uterus begins contracting and returning to its normal size, and when later, the child's mouth, caressing the nipple, creates waves of sensuality in the womb where it once lay; or when, smelling the breast even in sleep, the child starts to root and grope for the nipple (Rich, 1976:18).*

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Julia Kristeva: disruptive bodies

"A mother is a continuous separation, a division of the very flesh. And consequently a division of language – and it has always been so."
(Julia Kristeva, 1977/1986c:178).

Toril Moi (1986:vi) describes the work of Bulgarian linguist and psychoanalyst, Julia Kristeva, as an endeavour, "to think the unthinkable". According to Roland Barthes, "[she] changes the order of things..." (cited in Moi, 1986:1). Arriving in Paris in 1966, the young Kristeva was already deeply influenced by the writings of the Russian formalists (e.g. Roman Jakobson), and the work of Mikhail Bakhtin and quickly 'made a stir' within French intellectual circles. She has gone on to become one of the leading post-structuralist thinkers of the twentieth century, providing us with one of the most sophisticated theoretical attempts (fusing psychoanalytic and linguistic concerns) to think subjectivity, bodies and language *simultaneously*. While remaining "a somewhat critical fellow-traveller" (Moi, 1986:9) in relation to the feminist movement, an engagement with

Kristeva's work is nonetheless critical to any feminist project which is interested in 'thinking though' subjectivity, 'the body' and maternity.

Central to Kristeva's work is the notion that there is no subjectivity prior to or outside of language (DiQuinzio, 1999). There is therefore no original 'self' or transcendental consciousness that expresses 'truth' via the intentional and transparent act of language (Kristeva, 1973/1986a). It must be understood, however, that for Kristeva, language does not refer to a separate system of (static) words or meanings, but is rather a *signifiying process*, in which both bodily energies ('drives') and social constraints are *transfused* into language and in which the 'speaking subject' both "makes and unmakes himself" (Kristeva cited in McAfee, 2004:14). For Kristeva, there is no stable, unified, coherent 'thing-like' essence that precedes the process of signification; subjectivity itself is a process or a dialectical *movement*; the Kristevan subject is "the subject in process…an intersection or crossroads" (Boulous-Walker, 1998:105).

In Kristeva's work, language cannot be understood or approached apart from the 'speaking being' whose own living energy infuses meaning into language; furthermore, the 'speaking being' cannot be thought apart from language; "there is not a speaking being to consider unless this being is speaking or using language in some way" (McAfee, 2004:14). For Kelly Oliver (1993), one of the central aims of Kristeva's work has been "to bring the semiotic body, replete with drives, back into structuralism" (pp. 3). To achieve this objective, she makes use of two central strategies. First, according to Oliver, Kristeva brings the *speaking body* back into language by insisting that bodily energies and rhythms are an integral part of the signifying process. However, for Kristeva, it is not just that the body makes its way as a dynamic force into language; she also insists that symbolic language is inscribed within the body itself; thus, "the dynamics that operate the Symbolic[29] are already working within the material of the body" (Oliver, 1993:3). In order to grasp Kristeva's theory of subjectivity, it is necessary to understand that for her, the signifying process is made up of two different 'orders' of signification: a semiotic mode and a symbolic mode. These two different 'modes' are energies or movements (Grosz, 1989) that are *both* necessary to the production of meaning and subjectivity. The symbolic can be neatly defined as "clear and orderly meaning" (McAfee, 2004:15) that is denoted by the grammar, syntax and logic of language. The semiotic remains far more difficult to define. According to Grosz (1989:43), the semiotic is composed of "the energies, rhythms, forces and corporeal residues necessary for representation" and refers originally to a pre-Oedipal and pre-linguistic phase before the infant begins to use formal language. This is the phase in which the infant is still immersed in a semiotic *chora* or "rhythmic space" which "is analogous only to vocal or kinetic rhythm" (Kristeva, 1974/

[29] The Symbolic refers to the "order of signification, the social realm" (Oliver, 1993:10), which is comprised of both semiotic and symbolic modes.

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FLASH – instant of time or of dream without time; in-ordinately swollen atoms of a bond, a vision, a shiver, a yet formless, unnameable embryo. Epiphanies. Photos of what is not yet visible and that language necessarily skims over from afar, allusively. Words that are always too distant, too abstract for this underground swarming of seconds, folding in unimaginable spaces… Flash on the unnameable, weavings of abstractions to be torn. Let a body venture at last out of its shelter, take a chance with meaning under a veil of words. WORD FLESH. From one to the other, eternally, broken up visions, metaphors of the invisible (Julia Kristeva, 1986c:162).

1986b:94).

Drawn from Plato, the term *chora* was originally used to refer to that which is both container (receptacle) and source of everything that exists (McAfee, 2004). According to Grosz (1989:43), the Kristevan semiotic *chora* is an "anarchic, formless circulation of sexual impulses and energies traversing the child's body before sexuality is ordered…and the body becomes a coherent entity". These bodily energies, which operate according to 'primary processes' or the immediate gratification of 'drives', work to 'animate' the infant's body "in a series of rhythms, spasms, movements…" (Grosz, 1989:43) which defy rationality, coherence and binary oppositions. It is in this space that the child exists in a non-differentiated orientation towards the maternal body, before it develops clear boundaries between its own body and the body of the (m)other (McAfee, 2004). Thus, this semiotic phase is *anterior* to the Lacanian 'mirror-stage', during which the child moves away from the semiotic and fragmented "body-in-bits-and-pieces" (Grosz, 1989:44) to an understanding (via the image) of the body (and self) as a coherent *gestalt*, separate from the (m)other (Weiss, 1999). It is in this 'stage' that the ground is laid for the binary oppositions between subject and object, self and other, and signifier and signified, and wherein the child first begins to substitute images and representations for the immediacy of its corporeal, lived experience (Grosz, 1989). This is the Lacanian *gap*: the unbreachable abyss between lived experience and representation, between reality and signs (Grosz, 1989).

However, for Kristeva, the semiotic, "a force heterogeneous to rational logic" (Boulous-Walker, 1998:105), remains a constant undercurrent within the symbolic, providing the living energy which converts static words and signs into a sensual matrix of meaning and which continually threatens to disrupt and implode a logic of univocality and coherence. Despite the process of signification being founded (and continually reliant) upon this semiotic mode, without which "our language would have no force; it would be devoid of meaning" (McAfee, 2004:41), the semiotic is violently denied and repressed within the Symbolic order. Because of the close association between the semiotic and the maternal realm or body of the (m)other, the silencing of the maternal becomes, in fact, "the condition of symbolic stability" (Grosz, 1989:49). In Kristeva's theory, both subjectivity and textual relations are constituted by the heterogeneous *dialectical play* between semiotic and symbolic modes. In order to facilitate the analysis of *texts*, Kristeva distinguishes between the genotext and phenotext, which operate in a similar way within the text as the semiotic and symbolic do within the subject. The genotext thus provides, "the non-

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signifying conditions of signification" in which bodily drives circulate within the text in a "pleasure-seeking rather than meaning-laden way" (Grosz, 1989:50). It is "the potentially disruptive meaning that is not quite a meaning below the text" (McAfee, 2004:24) which erupts as repetition, allusion, rhyme, intonation and rhythm. The phenotext, however, functions as the manifest text or layer of meaning that is presented as a rational, logical and univocal discourse. While not all texts draw on these two modes equally or in the same way, the dialectical relations between genotext and phenotext mean that all texts are based upon inherent polyvocality, plurality and indeterminacy (Grosz, 1989). As a result of the unpredictable 'play' between semiotic/symbolic and genotext/phenotext, both the subject and the text are *unstable processes*; the self that is reproduced via a Kristevan logic is thus always heterogeneous (McAfee, 2004).

For Kristeva, both 'the body' and language are *constitutive* of the subject. Her 'subject-in-process' literally "embodies a kind of lived contradiction…[a] state of crisis" in which subjectivity is "poised between the practices of body, society and text" (Boulous-Walker, 1998:107). This is a subjectivity that is crafted in and out of (unstable) contradictory movements and which is therefore always potentially situated in a transgressive relation with the symbolic (Boulous-Walker, 1998). It is important to note, however, that Kristeva does not posit 'a body' that is separate and apart from its symbolic signification; the Kristevan body is never "prior to signification and meaning" (pp. 107). According to McAfee (2004:90):

> Bodies come into play in the signifying process, but signification can never be reduced to bodies. As a folding, language is a process. As a process, it undoes any essentialist notion that the self is a mind apart from its body.

At the same time, however, the body itself is also *not reducible* to language. In the view of McAfee (2004:80), Kristeva's work *unsettles* binary distinctions, so that it becomes impossible to "mark a tidy break between bodies and culture…gender…[and] sex." For Kristeva, subjectivity is *a process* constituted by language *and* the body; it is necessarily embodied, characterised by a crosscurrent of (disruptive) corporeal energies and discharges and always thoroughly sensuous. The instability and contradictory nature of the Kristevan subject is founded upon a constantly threatening bodily crisis, in which the rational, logocentric symbolic is engaged in a struggle with the disruptive, heterogeneous energies of the semiotic. As a result, "subject unity is continually shattered by an unliveable, bodily contradiction returning from the repressed semiotic" (Boulous-Walker, 1998:108). It is as a result of its contradictory nature (its potential 'crisis') that the Kristevan subject always carries the possibility of change, rupture and renewal. Furthermore, because the subject is seen as an *infolding* of the socio-symbolic order, the potential 'crisis' of the subject-in-process is at the same time always potentially a *social* crisis.

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In her work, Kristeva identifies certain "privileged moments of symbolic transgression" (Grosz, 1989:70) in which identity breaks down, including: madness, poetry, maternity and religious ecstasy. *Maternity* thus becomes, for Kristeva, a prime example of an experience that destabilises the notion of the unified, coherent subject (Oliver, 1993). Furthermore, because maternity is part of everyday life and "exists at the heart of the social and the species" (Oliver, 1993:182), it is probably the most shocking and disruptive mode of alterity (otherness). "Maternity is the very embodiment of alterity within" (*ibid*, pp. 183). According to Kristeva (1986c:182-183):

> *In bed, watching you: flesh-bumps, flesh-jumps, abdomen-bubbles, small belly-quakes. With all your might, you appear – dancing! Sporting with me: cooking-bubbles, flesh-walks. What amazing pleasure! (Chesler, 1979:95).*

> …no signifier can uplift it [the maternal body] without leaving a remainder, for the signifier is always meaning, communication or structure, whereas a woman as mother would be, instead, a strange fold that changes culture into nature, the speaking into biology…the heterogeneity that cannot be subsumed in the signifier explodes violently with pregnancy (the threshold of culture and nature) and the child's arrival (which extracts woman out of her oneness and gives her the possibility – but not the certainty – of reaching out to the other, the ethical). Those particularities of the maternal body compose woman into a being of folds, a catastrophe of being…

The maternal subject is thus a threat to the Symbolic order because she embodies *an excess* and an alterity that cannot be logically contained, controlled or explained by the symbolic mode (Oliver, 1993). Furthermore, the *jouissance*[30] of the mother threatens to make her (who exists as the *Other* for man) into a subject (*ibid*). In her essay, '*Stabat Mater*' ('Stood the Mother'), Kristeva (1986c) reads traditional religious constructions of motherhood, particularly the story of the Virgin Mary, as a patriarchal attempt to repress and mask these disturbing and unsettling features of maternity. In this Christian myth, the mother's body is un-sexed and is allowed joy only in pain, grief and suffering (Oliver, 1993). "Milk and tears became the privileged signs of the *Mater Dolorosa* [mother of grief] who invaded the west beginning with the eleventh century…" (Kristeva, 1986c:173). The sexed (and semiotic) body of the mother and her potentially unruly *jouissance* are thus effectively overwritten by the sexless, 'uncorrupted' body of the suffering (and generally mute) Virgin mother. For Kristeva, maternity offers a challenge to the rational, stable humanist subject. Similarly to Beauvoir, Young and Rich, the experiences of pregnancy, birthing and mothering are seen as characterised by a 'split subjectivity'. Thus, she says:

> Pregnancy seems to be experienced as the radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and of an other, of nature and consciousness, of physiology and speech (Kristeva, 1979/1986d:206).

[30] According to Grosz (1989), the term *jouissance* is itself undecidable and refers both to orgasmic pleasure and "a more generally corporeal, non-genital pleasure" (pp. xix).

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According to Kristeva, this 'split' maternal body-subject serves as a prototype of the *subject-in-process*, a subjectivity poised *between* semiotic, corporeal energies, social constraints and the fundamentally alienating signs and symbols of symbolic language. Because the formation of a unified, coherent and rational subjectivity is *founded upon* the disavowal of the bodily fragmentation characteristic of the semiotic or 'polylogical' body (Boulous-Walker, 1998), the 'unified' subject is necessarily always alienated from itself. 'The self' can only exist as a bounded coherence by repressing the unstable criss-cross of energy currents across its body (*ibid*). The subject-in-process, however, is a fragmented, erupting, uncontainable body that "shatters the logical coherence of symbolic thought and language… [reaffirming] the subject as the site of radical contradiction" (*ibid*, pp. 111). According to Boulous-Walker, the full force of this 'polylogical' body can erupt within experiences of pain or illness, affirming the potentially "radical subjectivity of pain" and its ability to "reorder and relocate the subject in relation to the symbolic order" (pp. 111). This is linked to Elaine Scarry's (1985) thesis that the experience of pain involves the 'shattering', 'unmaking' and implosion of language, in which:

Mysteriously, I pull myself together. I feel an impostor. I am not myself. Is this how it will be: me, pulled apart, existing on at least two opposing levels at the same time? With no one comprehending all of the levels? The level of my longing to be alone with you. The level of my longing to be just as I was before you…Am I permanently split apart? Me in one room? You in another? No longer One? Doesn't everyone see how different I am? (Chesler, 1979:133).

> Physical pain does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned (pp. 4).

For Scarry, the experience of pain is "anterior to language" (pp. 4): pre-cultural, pre-linguistic and a 'regression' to an infantile state of being before language is acquired.

While resonating strongly with the Kristevan 'polylogical' body, it is important to note the differences between Scarry's version of the body in pain as a *regression* to an infantile state and Kristeva's notion of the semiotic as an ever-present and integral part of *all* practices of signification. This distinction is particularly important because of the claim by some feminist critics (e.g. Silverman, 1988; Grosz, 1989; Butler, 1989; 1990; Zerilli, 1992; Pollock, 1999) that Kristeva, by associating the maternal body with the (in their view, pre-linguistic and pre-cultural) semiotic or 'polylogical' body, in effect dooms maternity to the (silent, unrepresentable) space of a brute, uncivilised 'nature' or 'mute biologism' and excludes mothers from both the Symbolic realm and being a subject (Ziarek, 1992). For example, according to Zerilli (1992:117), "A female body consigned to such a prelinguistic state [i.e. the *chora*] can never be radical." However, according to Ziarek (1992), these readings fail to appreciate the degree to which Kristeva's work calls into question distinctions between pre-linguistic and linguistic, pre-cultural and cultural. It is

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important to remember that for Kristeva, language is not a universal sign system but is, rather, a signifying *process* in which both the semiotic (as transgression) and the symbolic (as systematicity) are involved (dialectically) in each and every signifying practice (*ibid*). Furthermore, according to Ziarek, the postulation of a semiotic phase as a natural stage in psychic development is itself "only a theoretical presupposition, a theoretical fiction if you will" allowing us to conceptualise and theorise "the moments of undecidability and transformation always already working within the subject and the culture itself" (pp. 96). Ziarek also argues that the *chora* itself is not pre-cultural or pre-linguistic but is a thoroughly, "cultural phenomenon…it consists of the cultural forming and ordering of the drives" (pp. 95). According to Kristeva (1986b:93):

> Discrete quantities of energy move through the body of the subject who is not yet constituted as such and, in the course of his development, they *are arranged according to the various constraints imposed on this body* – always already involved in a semiotic process – by family and social structures. In this way the drives, which are 'energy' charges as well as 'psychical' marks, articulate what we call a *chora*: a non-expressive totality formed by the drives and their stases in a motility that *is as full of movement as it is regulated* (my emphasis).

Thus clearly, for Kristeva, bodily drives and energies are not simply biological givens but are inscribed and constrained by the socio-symbolic order. This resonates with Kelly Oliver's (1993:3) claim that Kristeva "reinscribe[s] language within the body" by arguing that the dynamics of the Symbolic are already at work within the material of the body and within the semiotic *chora*. Thus, it becomes clear that, "the semiotic *chora* also signifies" (Boulous-Walker, 1998:126) and that the semiotic maternal body is not outside or prior to language or signification. At the same time, the semiotic is never a part of the symbolic and it always *exceeds* the logic of the Symbolic order. However, "the fact that it is heterogeneous to the symbolic does not mean that it does not speak" (*ibid*, pp. 127). Thus, the semiotic is not pre-linguistic but is, in Ziarek's reading of Kristeva, "perhaps the most important linguistic force" (pp. 98); it is a disruptive heterogeneity that operates within the linguistic economy. Likewise, the maternal body is a site of heterogeneity and therefore, according to Ziarek, "any attempt to transform the maternal body into a coherent signifying position is a fraud" (pp. 99).

In my view, a large part of the difficulty and complexity involved in analysing the role, function and significance of maternity within Kristeva's theories is that 'the maternal' seems to operate on different levels within her work. For example, on one level, the maternal seems to designate a metaphoric space (akin to the *chora*) that serves as, "the unspoken foundation of all social and signifying relations, 'origin' of all heterogeneity, source and primal object of archaic *jouissance*" (Grosz, 1989:81). According to Oliver (1993), an aim of Kristeva's project is to fill the huge gap left in both Lacanian and Freudian theory that stems from their lack of attention to

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the significance and implications of the *maternal function*. According to both Freud and Lacan, it is the *paternal* function that initiates the child into language and culture. Kristeva's work can be seen as a key (feminist) corrective of the Freudian and Lacanian psychoanalytic legacies. The maternal function that is explored in Kristeva's work should not, however, be simply or automatically equated with women or even with 'real' mothers. In the same way that the Freudian paternal figure does not stand in for 'real' men or fathers, Kristeva's 'maternal function' similarly operates on a metaphoric level. It is perhaps interesting to note the ease with which most of us would accept that the Freudian paternal function operates largely at an imaginary level, while the Kristevan narrative of 'the maternal' has been repeatedly lambasted for a reductive view of (real-life) women and mothers. For example, according to Zerilli (1992), Kristeva is guilty of reducing the mother to the level where "the mother as subject is silenced by being shut up in the unsignifiable maternal space" (pp. 120). Other critics have accused Kristeva of reducing women to maternity, thus, according to Jones (cited in Oliver, 1993:7), "Kristeva still believes that men create the world of power and representation; women create babies." It is noteworthy that one of Kristeva's key arguments is, in fact, that women's oppression can partly be attributed to the fact that (western) discourses of maternity do not separate the maternal function from women (Oliver, 1993). Women and femininity remain therefore inextricably defined in relation to the absence/ presence of maternity. It seems that some feminist criticism of her work itself remains stymied in an overly simplistic association between women, mothers and the Kristevan 'maternal function'. According to Kelly Oliver (1993), Kristeva is, in actual fact, careful within her work to distinguish between the feminine, women and maternity and also argues that the relationship between women and reproduction needs to be critically rethought (not however dis-associated). Thus, on one level 'the maternal' stands in for an imaginary, heterogeneous semiotic space (or *chora*) that is both the source of the symbolic yet always exceeds and potentially disrupts the logic of the symbolic. At the same time, we have seen that Kristeva also explores 'maternity' as a prototype of 'the subject-in-process'. In my view, 'maternity' can be distinguished from the Kristevan 'maternal function' and operates as a process that is far more closely tied to the bodily (and signifying) process of becoming a mother. Thus, according to Grosz (1989:79), "maternity is the splitting, fusing, merging and fragmenting of a series of bodily processes"; it is akin to a 'bodily crisis' that in Kristevan terms is always analogous to a crisis of subjectivity and of language itself. "For what you take to be a shattering of language is really a shattering of the body" (Kristeva cited in Boulous-Walker, 1998:109). The 'polylogical' body of the pregnant and birthing woman is a body that *defies* clear boundaries between subject and object, self and other, nature and culture and inside and outside; "the maternal body constitutes a fold (*pli*) between the natural and the cultural, between the semiotic and the

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Dream without glow, without sound, dream of brawn. Dark twisting, pain in the back, the arms – pincers turned into fibres, infernos bursting veins, stones breaking bones: grinders of volumes, expanses, spaces, lines, points. All those words, now, ever visible things to register the roar of a silence that hurts all over…Yet the eye picked up nothing, the ear remained deaf. But everything swarmed, and crumbled, and twisted, and broke – the grinding continued ... Then, slowly, a shadowy shape gathered, became detached, stood out ... Paradox: deprivation and benefit of childbirth. But calm finally hovers over pain…The calm of another life, the life of that other who wends his way while I remain henceforth like a framework. Still life. There is him, however, his own flesh, which was mine yesterday. Death, then, how could I yield to it? (Kristeva, 1986c:168-169).

symbolic, between identity and its erasure" (Boulous-Walker, 1998:145). As a result it threatens to overturn the logic of the Symbolic order and hints at a 'radical subjectivity', inscribed by contradiction(s), which exceeds and implodes the rational, neatly bound subject of individualism. The maternal body, as a representative of the eruptive and disruptive semiotic which is a part of all signification but which is constantly violently repressed by the symbolic, threatens to expose what has been so fiercely denied and disavowed. Maternity thus potentially threatens to reveal, "that all distinctions between subject and objects, all identifications of unified subjects, are arbitrary" (Oliver, 1993:9). As a result, maternity has to be intensely policed, regulated and controlled. The maternal body "effect[s] an explosion of identity that places the mother on the other side of the paternal law" (Boulous-Walker, 1998:146) and paves the way for a different kind of ethics: a 'herethics' or 'outlaw ethics' founded upon the ambiguous relationship between mother and child during pregnancy and childbirth (Oliver, 1993). Herethics is an ethics which:

> …sets up one's obligations to the other as obligations to the self and obligations to the species. It is founded on the ambiguity in pregnancy and birth between subject and object positions…The other cannot be separated from the self. The other is within the self (Oliver, 1993:66).

Kristeva has also been criticised for failing to inscribe the voices of 'real' mothers' voices within her discussions and analyses of maternity (Gross, 1986; Zerilli, 1992; Boulous-Walker, 1998). For example, according to Boulous-Walker (1998:125), "Kristeva metaphorically reproduces the maternal as a place that is spoken rather than one that speaks". However, within her essay, '*Stabat Mater*', Kristeva (1986c) herself explicitly calls for an exploration of mother's voices speaking about their experiences of motherhood:

> There might doubtless be a way to approach the dark area that motherhood constitutes for a woman; one needs to listen, more carefully than ever, to what mothers are saying today…through their discomforts, insomnias, joys, angers, desires, pains and pleasures…(pp. 179).

Furthermore, within this essay, Kristeva herself inscribes the (semiotic) voice of the mother, drawing on her own experience(s) of pregnancy, childbirth and motherhood in a separate, bolded column situated to the left of the conventional academic text. In this left hand column, Kristeva speaks in a poetic voice, inscribing the *jouissance*, pain, paradoxes and radical contradictions at

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play on and within the repressed and silenced semiotic body of the mother. Through the interplay of these two texts, Kristeva is able to approximate the play between semiotic and symbolic modes (Boulous-Walker, 1998). Thus, in this experimental piece, Kristeva *is* attempting to give voice to the repressed maternal body-subject. This semiotic-poetic voice inscribes the ways in which the maternal experience "blur[s] the borders of self-hood, posing a kind of cataclysm for a woman who has been until then, comfortably situated in the symbolic" (McAfee, 2004:83).

For Kristeva, the maternal body also exists in a privileged relation to the process of *abjection*, defined as: the rejection or expulsion of that which is *other to* or *outside of* oneself (McAfee, 2004). In order for the child to separate itself from the (m)other and take up a position as an autonomous self, the first thing that it has to abject is the maternal body itself. In McAfee's (2004) reading, the infant begins to develop (unstable) borders between itself and others before the mirror stage or the acquisition of language. It does so through *abjecting*, "a process of jettisoning what seems to be part of oneself" in which the infant spits out and expels, "sour milk, excrement, even a mother's engulfing embrace" (pp. 46). It is through this process that the boundaries of the self as separate from the other are first (and always tenuously) erected. The abject, that which is *opposed* to the 'I', is what makes the existence of the 'I' possible at all (Kristeva, 1982). Abjection can thus be seen as a process predominantly about the development and policing of 'clean' and 'proper' boundaries between that which is 'me' and that which is 'not me'. To be a 'proper' and 'sane' subject within the Symbolic order requires the (often violent) expulsion of all that is improper, disorderly and undecidable (Grosz, 1989). At the same time, however, that which is abjected is never fully erased (and thus is not repressed as such) but remains hovering "at the borders of our existence, threatening the apparently settled unity of the subject with disruption and possible dissolution" (Grosz, 1989:71). The abject remains therefore both the condition for stable, symbolic subjectivity and its *unpredictable underside* that continually threatens to dismember and annihilate the subject. The abject also arouses strong sensations within the subject; it is that which makes you want to gag and vomit; it disgusts, repels and fascinates all at the same time: rotting flesh, blood, faeces, curdling milk, saliva, pus. However, according to Kristeva (1982:4):

> It is not…lack of cleanliness or health that causes abjection but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite.

The abject is that which above all threatens the distinctions that found and sustain patriarchal socio-symbolic law and order: distinctions between self–other, subject–object, me–you, inside–outside (Oliver, 1993). "The abject cannot be readily classified, for it is necessarily ambiguous, undecidably inside and outside…dead and alive, autonomous and engulfing" (Grosz, 1989:74).

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According to Oliver, the primary object of abjection is the maternal body (not necessarily the mother as person). To become a subject, the child must draw a clear distinction between itself and its (m)other. However, the child is also filled with longing to remain enmeshed within the maternal embrace; it is an impossible double bind. Furthermore, the maternal body is also a foundational object of socio-cultural abjection (Oliver, 1993). Kelly Oliver argues that because 'the maternal function' is not separated from women or the feminine within western cultural discourses, it is not just the maternal body but women themselves who have become abjected within western societies. Consequently, it becomes critical to build new cultural representations of women and mothers that do not reduce women to maternity (*ibid*).

According to Elizabeth Grosz (1989:72), abjection can also be seen as "the paradoxically necessary but impossible desire to transcend corporeality"; it is a refusal of the subject's existence as matter/body/flesh. In order to retain the neat, orderly boundaries of pure (intellectual and spiritual) consciousness or selfhood, the subject must reject, cover over and disavow its uncontrollable, leaking, bursting, defecating, desiring, bleeding, and spilling body of mortal flesh. The abject is thus that which exposes the subject's inevitable relation "to death, corporeality, animality, materiality" (Grosz, 1989:73); its unavoidable existence as brute, finite matter is intolerable to the symbolic subject and must therefore be *abjected*. Of course, within patriarchy it is women (as well as indigenous people) who have come to be seen *as* body, *as* animal, *as* uncontainable, leaking and corrupted flesh. It is particularly in relation to their *reproductive* capacities that women have been cast as unpredictable, 'other', animal-like, contaminated, polluting and dangerous. Birthing, "the immemorial violence with which a body becomes separate from another body in order to be" (Kristeva, 1982:10) could be described as *the* most fundamental moment of abjection, upon which human existence and society is founded. According to Oliver (1993:57):

> The prototypical abject experience, then, is the experience of birth itself. It is at the birth of the child…that the identity of the human subject is most visibly called into question. Before the umbilical cord is cut, who can decide whether there is one or two? The abject is pre-identity, presubject, preobject. It is undecidable between subject and object, the unruly border, birth.

Thus, the birthing body could be said to represent the most radical form of abjection, "an undoing of the processes constituting the subject" (Grosz, 1989:74), in which the bodily crisis of the subject results in a 'radical splitting' of subjectivity, boundaries implode and the rational, individualist subject is *unmade*. The maternal body thus potentially exposes the fraudulence of phallocentric and individualist versions of selfhood: "as a site of infolding of the 'other and the 'same', the maternal body renders the fundamental notions of identity and difference strikingly insufficient" (Ziarek, 1992:102).

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Through pain and blood and water this thing emerges between my legs, for a short while both inside and outside me (Iris Young, 1990b:163).

In her book, '*Reproducing the womb*', Alice Adams (1994) provides a Lacanian inspired analysis of women's fiction and poetic representations of childbirth, which is in many senses compatible with a Kristevan view of the maternal subject as a 'subject-in-process'. Adams argues that birth often constitutes "a crisis in subjectivity" (pp. 9) in which the (received and assumed) terms of being a subject have to be renegotiated. However, far from representing a universal process, Adams insists that the birth process "is most deeply influenced by social contexts" and therefore women's stories and poems about childbirth "suggest diverse elaborations on basic themes of alienation, identification, and the construction of subjectivity through contradiction" (pp. 11). According to Adams, the birthing body is a body 'shattered' and fragmented, akin to the Lacanian body in bits-and-pieces; it is a Kristevan polylogical body: split, dismembered and bursting open. As a result, the birthing woman's position as a (humanist, individualist) subject is profoundly challenged in and through the childbirth process. The woman giving birth is, according to Adams, embroiled in "internal negotiations" (pp. 15) in which she has to contend with her self, her body split and shattered in/by pain and her contradictory desire(s) to both hold onto and separate from her child. The birthing woman "…does the labour of producing meaning, a meaning that encompasses the giving and taking of life, her unity with the foetus, and her need to separate from it" (*ibid*, pp. 18). Drawing on Lacan's distinction between the symbolic and imaginary orders (rather than Kristeva's symbolic-semiotic modes), in which the imaginary represents the mute, pre-oedipal realm completely anterior to language (Grosz, 1989), Adams describes labour and birth as "a journey outside memory and rational thought" (pp. 20). Adam's birthing woman is thus in a realm *beyond* symbolic language, from where she cannot speak; she can only "produce vagrant sounds, moans and grunts, uttered from a place…far away" (pp. 20). In my view, Kristeva's far more nuanced account of the tangled and interdependent relationship between semiotic and symbolic modes (both of which *signify*) is a more fruitful framework for the exploration of birthing subjectivity than Lacan's imaginary-symbolic distinction. According to the Kristevan view, the (potentially) semiotic/polylogical birth experience is not necessarily beyond expression within the symbolic. For Adams, "she will never be able to express it, even to herself" (pp. 20). However, it is clear that the experience of birth told from the perspective of the birthing woman, as an event potentially replete with paradoxes, contradictions, splitting, fragmentation, unbearable pain and yet potentially ecstatic *jouissance*, has been beautifully and evocatively expressed by several women writers and poets (including Kristeva). Adam's work remains insightful, however, in its portrayal of childbirth as a potentially

I pushed with anger, with despair, with frenzy, with the feeling that I would die pushing, as one exhales the last breath, that I would push out everything inside of me, and my soul with all the blood around it and the sinews with my heart inside of them, choked, and that my body itself would open and smoke would rise, and I would feel the ultimate incision of death (Anaïs Nin in Chester, 1989:152).

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transformative event in which women can "radically reorganize their subjectivity" (pp. 25). According to Adams:

> The power – and the threat of the mother's perspective can be perceived most immediately in the scene of birth. In representing this experience, which is inaccessible to men, a woman may achieve an understanding of the self that is quite different from a man's (pp. 25).

The birthing process is therefore potentially "a space for the reconstruction of self" (*ibid*, pp. 26); it is a place of "inward divisions" (*ibid*, pp. 27), "expanding consciousness" (*ibid*, pp. 29) and "expanded identities" (*ibid*, pp. 28) in which the birthing woman "multiplies identities" (*ibid*, pp. 27) and in which "she is looking into herself, re-examining what it means to be an 'i'" (*ibid*, pp. 27). According to Adams, during labour and birth "the illusion of singular consciousness is shattered; this is the…first step toward a revolutionalized subjectivity" (pp. 119).

> *I look at the doctor pacing up and down, or bending to look at the head which is barely showing. He looks baffled, as before a savage mystery, baffled by this struggle. He wants to interfere with his instruments, while I struggle with nature, with myself, with my child and with the meaning I put into it all, with my desire to give and to hold, to keep and to lose, to live and to die (Nin in Chester, 1989:154).*

Ultimately, Kristeva's remarkable theory of subjectivity and language as intertwining processes in which body, language and social constraints are infolded and enmeshed provides a radical way to think embodied subjectivity *together with* signification (but not reducible to it). Thus, there is no such thing as 'the body' that stands separate and 'pure' from signification. At the same time, however, there is also no meaning or signification without the injection or influx of bodily rhythms, energies and 'drives'. This provides a potentially rich framework within which to frame or understand the forms of subjectivity emerging within women's birthing stories. However, in my opinion there *is* something missing within Kristeva's theory that remains integral to an analysis of women's birthing stories. By this I mean that her account fails to radically interrogate the *phallocentrism* of symbolic language and the extent to which women's (sexual–reproductive) difference cannot be adequately represented within a language that is limited to patriarchal definitions and constructions of women's bodies and experiences. This is, of course, the realm in which the work of Belgian feminist, Luce Irigaray remains the most instructive.

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Luce Irigaray: 'making up' a positive female corporeality

"For, without the exploitation of the body-matter of women, what would become of the symbolic process that governs society?"
(Luce Irigaray, 1985b:85)

"If we keep on speaking the same language together, we're going to reproduce the same history. Begin the same stories all over again. Don't you think so?"
(Luce Irigaray, 1985b:205).

While the work of 'French feminists', Julia Kristeva and Luce Irigaray, is often lumped together under the broad label of 'sexual difference' feminism, their work is, in actual fact, very different and in many senses incompatible (Gross, 1986; Grosz, 1989). Thus, whereas Kristeva is concerned with theorising the differences *internal* to each subject, Irigaray focuses centrally on the difference *between* the masculine and the feminine. Furthermore, while both theorists have been heavily influenced by both Lacan and Derrida, Kristeva remains a far more faithful servant of 'male-stream' psychoanalysis than Irigaray, who is more interested in *deconstructing* the work of male theorists.

The work of Irigaray, who is, according to Margaret Whitford (1991:22), engaged in a process of trying to "imagine the unimaginable", is slippery and "riven with contradictions" (Berg, 1991:50). Her writing is often allegorical and ironic and is characterised by a kind of strategic "deconstructive play" (Lorraine, 1999:21) in which she mimics, parodies and subverts the canonical texts of Freud, Plato, Aristotle and Nietzsche. According to Whitford (1991), "she is more than a little inaccessible…" at the same time, however, her work "refuses to go away" (pp. 4). Space limitations do not allow me to even attempt an overview of Irigaray's extensive oeuvre; instead, I will be focussing here on one of Irigaray's main arguments, namely: that women lack an adequate language for the representation of their difference.

One of Irigaray's central claims is that women are *silenced* by a masculinist model of subjectivity (Lorraine, 1999). Furthermore (unlike Kristeva), Irigaray highlights the patriarchal face of symbolic language, which in her terms excludes and exiles women (Whitford, 1991). Thus, one of Irigaray's key aims has been to expose the phallocentric constructions of women, femininity and maternity inscribed within male philosophy and psychoanalytic thought (see Irigaray, 1985a, 1993). In Grosz's (1989:105) reading, a phallocentric position involves "the use of one model of subjectivity, the male, by which all others are positively or negatively defined". According to Grosz (1989), different models of the relations between the two sexes, in which they are seen either as the same (identical), as opposites, or as complements, are all founded upon a logic of phallocentrism in which the one term (the masculine/men) is taken as the norm against which the other term (the feminine/ woman) is measured or described. These binaries are, in

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Grosz's terms, "as much political weapons as intellectual categories" (pp. 106). Thus, according to Irigaray (1991:67), within a masculinist symbolic order, "being woman means not being a man". For Irigaray, language is fundamentally *sexed*, it is never simply a neutral tool of expression; "The linguistic code, like the modes of exchange, like the systems of images, and representation, is made for masculine subjects" (Irigaray, 1991:64). Patriarchal symbolic language is therefore founded upon 'the masculine', even although it attempts to pass itself off as "neuter, arbitrary and universal" (*ibid*, pp. 66). Patriarchal culture is "based on the primacy of the male, the *homme*, who can function only with others modelled on himself, others who are his mirror reflections" (Grosz, 1989:107). As a result, women can only be represented by means of a symbolic violence that confines them (and their differences) within a masculine economy of sameness (*ibid*). Women are thus in effect silenced; they cannot speak *as* women. While patriarchy does not, of course, prevent women from speaking, "it refuses to listen when women do not speak 'universal', that is, as men" (*ibid*, pp. 126). One of Irigaray's fundamental projects is therefore to assist in forging a space in which women can take up the 'I' of discourse *as women* and "not as a derivative of the male 'I'" (Whitford, 1991:42) and in which women's *specificity as women* is represented in autonomous discursive terms (Grosz, 1989). Furthermore, because women are represented only on models that are masculine and speak in languages that are infused with patriarchal agendas, they are deprived of the possibility of a specifically feminine mode of subjectivity (Lorraine, 1999). Therefore, for Irigaray (1991), the goal of women's liberation should be the becoming of "a free *feminine* subject" (pp. 68, my emphasis) in which women's freedom and autonomy requires "women's right to speak, and listen, *as women*" (Grosz, 1989:127, author's emphasis). According to Irigaray, it is integral that the repression and silencing of the feminine be acknowledged as a central part of the oppression of women (Gross, 1986).

> *Listen: all around us, men and women sound just the same. The same discussions, the same arguments, the same scenes… The same… Same…Always the same…If we keep on speaking sameness, if we speak to each other as men have been doing for centuries, as we have been taught to speak, we'll miss each other, fail ourselves. Again… Words will pass through our bodies, above our heads. They'll vanish, and we'll be lost. Far off, up high. Absent from ourselves: we'll be spoken machines, speaking machines (Luce Irigaray, 1985b:205).*

It is important to note that Irigaray is not interested in building a 'theory of woman' or in prescribing what 'woman' *is* or *should be* (Whitford, 1991). Her writing should therefore not be read as a 'true' or essentialist description of women or femininity, but rather as *strategic* and concerned with exposing what has been erased or excluded by phallocentric representations of women (Grosz, 1989). A great deal has been written concerning Irigaray's so-called *essentialism* (see for example, Jones, 1981; Fuss, 1989; Chanter, 1995); I am not going to repeat these (rather tired) debates here. Thankfully, it seems that the heated feminist furore of the 1980s and 1990s concerning essentialism/anti-essentialism has dried up, largely as a result of the recognition of the possible necessity of essentialism as a strategic position (Stone, 2003). However, according to

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Elizabeth Grosz (1989), Irigaray does not posit an essentialist or biologically determinist view or meaning of women's bodies. She argues, rather, that the body within Irigaray's work is always "a body that is structured, inscribed, constituted and given meaning socially and historically" (pp. 111). Thus, the concept of a 'pure' or pre-discursive body becomes meaningless within Irigaray's theoretical framework. Although Irigaray is trying to cultivate and open up a discursive space in which women and the female body can be thought and represented in woman-centred terms, she resists defining what this alternative mode of subjectivity would or should look like. She does, however, attempt to represent women and femininity in terms *other* than hegemonic phallocentric representations (*ibid*). Irigaray is involved in the critical project of trying to think "the female body as a positivity rather than a lack" (*ibid*, pp. 110). Although women experience their bodies (meaningfully) only in and through the current discursive and socio-symbolic system, there are potentially residues, traces and left-over remains of female corporeality and forms of desire which *exceed* patriarchal constructions and images of women. These are the points of excess that Irigaray seeks to highlight and explore (*ibid*).

For example, in her essay, '*When our lips speak together'*, Irigaray (1985b) offers an alternative discourse of women's bodies and sexuality based upon the metaphor of the 'two lips'. Of all of Irigaray's writings, this essay has probably been subject to the most scathing attacks. Some feminists seem to read the 'two lips' not as a metaphor (e.g. akin to Lacan's phallus) but as a *direct* reference to the female genitals (Berg, 1991). According to Grosz (1989), the metaphor of the 'two lips' is used as an image to disrupt, unsettle and counter phallocentric representations; it is not a 'true' or literal description of women's experience. Berg (1991) argues that the image is chosen for its fundamental ambiguity. Thus, it refers simultaneously to the construction of language and textuality (the lips that speak) and to sexuality (the female genital lips). Furthermore, the metaphor of the 'two lips' creates a way of conceiving of women's sexuality as *autonomous* from and *other* to a phallic model of male sexuality; women's sexuality is (might be?) multiple, diffuse, beyond binary categorisation, fluid and undecidable:

> Kiss me. Two lips kissing two lips: openness is ours again…the passage between us, is limitless. Without end…When you kiss me…the horizon disappears. Are we unsatisfied? Yes, if that means we are never finished. If our pleasure consists in moving, being moved, endlessly. Always in motion: openness is never spent nor sated (Irigaray, 1985b:210).

According to Grosz (1989), Irigaray is attempting here to *dis-place* male models of sexuality and actively inscribe "a positive marking of women's bodies" (pp. 117). Iris Marion Young (1990c) has also done interesting work, inspired by Irigaray, in which she explores ('imagines') what being breasted might mean from a woman-centred position. Young asks how women might experience their breasts "in the absence of an objectifying male gaze" (pp. 190). How would

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breasts *feel*, what would they *mean*, if they were lived "as *our own*, as the sproutings of a specifically female desire" (*ibid*, pp. 190, my emphasis). In her woman-centred 'imaginings', Young describes the breasted body as "blurry, mushy, indefinite, multiple" (pp. 192). Echoing Irigaray, she speculates that a feminine epistemology might favour *touch* rather than sight. Thus, from a *woman's* point of view, breasts matter not because of how they *look* from an outside view, but because of how they *feel* touching and being touched. Seen from a woman's viewpoint, breasts become 'scandalous' to a phallic sexual economy. Thus:

> …in her own experience of sexuality there is a scandal: she can derive the deepest pleasure from these dark points on her chest, a pleasure maybe greater than he can provide in intercourse. Phallocentric heterosexist norms try to construct female sexuality as simply a complement to male sexuality, its mirror, or the hole – lack that he fills. But her pleasure is different, a pleasure he can only imagine (Young, 1990c:194).

These 'imaginings' on the part of both Luce Irigaray and Iris Marion Young, are in my opinion, critically important to feminism. While expressly not prescribing or trying to 'nail down' what woman 'is' or looking for an 'authentic', 'pure' or pre-patriarchal woman's body, these feminists are 'making it up', playing, dabbling and strategically looking for ways to represent women's sexuality and corporeality from an (imagined) female point of view. If we acknowledge that at least part of women's oppression is tied to hegemonic phallocentric representations, then to *intervene* in these representations, to develop *other* kinds of discourse, is surely integral to any feminist project. According to Whitford (1991), Irigaray is "a theorist of change" (pp. 15) who is not content to merely reform symbolic language or to reverse the balance of power between men and women. Instead, Irigaray seeks to effect radical change in the symbolic order by creating a powerful female symbolic that can represent women in women's own terms. According to Irigaray, phallocentric culture is 'monosexual'; thus, to acknowledge the existence of two (or more?) sexes would necessitate a major upheaval of linguistic, epistemological and value systems (Grosz, 1989). As feminists, we therefore need to work (strategically not essentially) within the existing language system to develop and imagine "different ways of knowing, different kinds of discourse, new methods and aspirations" (*ibid*, pp. 126) which exceed, interrupt and disrupt patriarchal representations.

Although Irigaray does not provide a theory of maternal subjectivity, her work is nonetheless critical to my project within this thesis, namely: to interrogate the forms of representation and subjectivity that are re-produced within women's stories about birth. Irigaray's argument that phallocentric language is founded upon the morphology of the *male body* (Grosz, 1989), leaving little to no room for women to speak 'as women' (and to represent the complexity

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of their own embodied experiences) will prove to be an indispensable insight in the analysis and interrogation of my 'data'.

The significance of maternity – the materialist or 'standpoint' view

"The general neglect of reproductive process is itself a historical phenomenon of great interest."
(Mary O'Brien, 1981:43).

The work of materialist or 'standpoint' feminists would perhaps not generally be regarded as relevant to a discussion of maternal bodies/subjectivities. However, on closer examination it becomes clear that 'materialist' feminists such as Nancy Hartsock (1985), Maria Mies (1986), Sara Ruddick (1994) and Mary O'Brien (1981) do, in fact, have quite a lot to say about reproductive 'consciousness' or subjectivity. Their work and ideas about maternal 'consciousness' stands, however, in stark contrast to the phenomenological and broadly post-structuralist work outlined in preceding sections, which is united in its representation of pregnant/birthing/mothering subjects as 'split subjectivities'. Materialist feminists are more likely to portray 'reproductive activities' as experiences in which women achieve a unique sense of unity, wholeness and integration of mind–body, thus marking a radical departure from the images of splitting, fragmentation and alienation offered by the likes of Simone de Beauvoir and Julia Kristeva. Unlike feminist phenomenological and post-structuralist thinking *vis-à-vis* maternity, materialist or standpoint feminists are also often engaged in the project of trying to articulate the possibility of a *collective* women's (or feminist) standpoint grounded within reproductive activity or consciousness. As a result, they are often interested in exploring the (inherent or general) *significance* of the maternal and reproductive activity that women perform.

The approach of materialist feminists to maternity is important on several grounds. First, materialist feminists usually insist that women's reproductive experiences are *conscious human activities* and not merely events of biology. Working from the Marxist view that *material life and activity* structure human subjectivity, materialist feminists regard human practices and activities as both ontologically and epistemologically significant: "activity is epistemology" (Hartsock, 1985:123). Furthermore, feminists such as Maria Mies (1986) argue that fundamental to women's liberation is the full recognition that reproductive activity *is work* and not "unconscious… 'natural' activity" (pp. 47). According to Mies, the patriarchal fallacy that posits women's activities (housework and the carrying, bearing, nurturing and rearing of children) as 'natural' expressions of an innate female biology is integral to the oppression of women. According to this ideological myth:

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> All the labour that goes into the production of life, including the labour of giving birth to a child, is not seen as the conscious interaction of a human being with nature, that is, a truly human activity, but rather as an activity of nature, which produces plants and animals unconsciously and has no control over this process (Mies, 1986:45).

Furthermore, this patriarchal mindset represents men's activities as truly human, conscious and productive forms of labour while women's tasks and practices are seen as devoid of consciousness and determined by their physiology or 'nature'. Similarly, philosopher Virginia Held (1993) argues that the construction of birth as an exclusively biological or 'natural' process is deeply connected to women's oppression. For example, by reducing birth to an event involving only unconscious, biological forces, the status of the birthing women as a conscious human being threatens to disappear or become irrelevant. As a result, "human mothers have been swallowed up into biological explanations" and the birthing woman "is seldom thought of from an internal point of view" (pp. 120). According to Held, childbirth should be re-conceptualised as a 'distinctively human' and potentially transcendent life event.

Third, because pregnancy and birth are seen as conscious activities, they are also seen as potentially *transformative* experiences. Thus, for Hartsock (1985), reproductive activity "changes consciousness" (pp. 237) and is thus potentially the ground for an alternative (collective) worldview or standpoint. Finally, materialist feminists have attacked the valorisation of male labour and *the silencing* of female reproductive labour and activities within philosophy and academia more broadly. For example, Mary O' Brien (1981) criticises the likes of Marx, Engels and Hegel for failing to see that reproductive labour (like all forms of labour) requires "analysis and understanding" (pp. 31). Thus, materialist feminists are often committed to exploring the theoretical and material *significance* of women's reproductive activity. Actual *theories* or *philosophies* of reproduction or birth are almost entirely non-existent (barring the work of O'Brien, 1981) and the tendency to regard pregnancy, birth, breastfeeding and mothering as biological (or 'cultural' processes) has persisted within feminist research. As a result, few researchers have explored the subjectivity, consciousness or wider significance of women's reproductive activities.

However, underlying the work of materialist feminists is often a (surprising) tendency to harbour an individualist and essentialist model of the self in which 'liberated' selves are seen as 'whole', coherent and unified. As a result, non-alienated reproductive activity is generally posited as involving mind-body unity. For example, for Hartsock (1985), pregnancy, birth and mothering are seen as involving a profound and distinctive "unity of body and mind" (pp. 237). Drawing on the work of Nancy Chodorow, Hartsock also suggests that women have a different experience *of self* by virtue of their experiences of mothering and childrearing. Thus, we are told that women's unique construction of self *in relation* (not opposition) to others, results in:

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> …opposition to dualisms of any sort; valuation of concrete, everyday life; a sense of a variety of connectedness and continuities both with other persons and with the natural world (Hartsock, 1985:242).

Surprisingly, Hartsock thus collapses into a view in which reproduction is treated as if it were a sphere *apart* from politics, economics and ideology; women's reproductive activities become, once again, "self-evident, invariable, essential processes" (Ebert, 1996:238). Because materialist feminists generally lack a nuanced theory of embodied subjectivity and work within an implicit individualism, their work often remains mired within a dualist mode of thinking in which consciousness (or subjectivity) is assumed to be solely the province of the rational 'mind' (e.g. see Ruddick, 1989, 1994; Held, 1993). Bodies are therefore usually presented as assumed givens or as the (unchanging) 'basis' for distinct forms of consciousness or meaning that are overlaid upon (static, non-conscious) bodies. Furthermore, these writers often seem to believe that the inherent significance of women's reproductive activities can be discovered or explored *apart* from cultural ideologies, socio-symbolic power relations and patriarchal representations. By positing that there is some sort of *inherent significance* that can either be discovered from, or developed on the basis of, reproductive activities, standpoint theorists often fail to recognise the diverse way(s) in which women themselves live and make meaning in/through these experiences.

Ultimately, the 'consciousness' spoken of by standpoint feminists is a *collective* consciousness and does not recognise the potential heterogeneity in the way individual subjects experience pregnancy, birth and mothering. Attempts to posit an alternative and collective female reproductive consciousness or epistemology are thus often based on over-generalised and romanticised accounts of maternal activities as (in their 'pure' form) experiences of wholeness, integration, non-alienation and unity. Thus, for example, working within a standpoint framework, Emily Martin interprets the bodily fragmentation and alienation reported by women within her study as inevitably and *inherently* negative and detrimental. While some experiences of fragmentation *are* clearly traumatic, detrimental and forged within oppressive modes of representation, I nonetheless wonder whether the reaffirmation of bodily splitting and fragmentation as automatically 'bad' and holism as necessary 'good' is a helpful framework within which to explore birth experiences. Underlying the automatic vilification of split or fragmented subjectivities is the valorisation of 'wholeness' in which the *whole* human being with "all their parts interrelated" (Martin, 1987:164) is seen as the ideal prototype of a non-alienated and non-oppressed subject. In the end, although usually more interested in collectives than individuals, standpoint theories nonetheless often remain implicitly mired within a modernist notion of the ideal (non-alienated) subject as 'whole', coherent and unified. However, despite the problems inherent in materialist feminist approaches to maternal subjectivity, their emphasis on

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birth and mothering as potentially transformative *conscious activities* remains a point of departure for this thesis.

Stitching together a theoretical framework

What then can we draw out of the theories presented in this chapter that can assist in the interpretation of women's birth stories? First, the theory of woman presented by Beauvoir provides an important over-arching grid within which to situate women's narratives. Beauvoir's theory highlights the *oppressive* fragmentation and alienation that women potentially face as a result of their general situation as *Other* within patriarchal societies. This 'situation' (which individual women live in different ways) engenders a number of conflicts and contradictions in which women live *both* as subject and object, as self and as other. This 'fragmented' sense of identity often manifests in an alienated and fraught relationship with the female body in which a woman lives her body as herself *and* as something *other* than (or outside of) herself.

In '*Throwing like a girl'*, Iris Marion Young (1990a) shows powerfully how this conflict and fragmentation potentially *materialises* in the ways in which women and girls *use* their bodies in everyday motion and activities. One would expect, on the basis of the title of her paper, '*Giving birth like a girl'*, that Karin Martin (2003) would be drawing on or extending Young's analysis in her examination of childbirth. However, Martin interprets her data solely within a Foucauldian framework. While this does prove fruitful, her adherence to the broad concept of 'gender' seems to neutralise any analysis of the necessarily *embodied* nature of this 'gender internalisation'; bodies thus become strangely invisible within Martin's analysis; furthermore, the concept of 'gender' seems to become strangely (and disturbingly) free-floating and dis-connected from any basis within patriarchal socio-symbolic formations. Significantly, Martin reports that women consistently privileged the *outsider's view* of their births over their own bodily experience. The 'real' birth was thus seen as located within this outsider's view, so that "birth has become more real for those with this outsider gaze than those with the lived bodily experience of it" (pp. 64). This finding is directly commensurate with Beauvoir's theory of woman as the '*Other*' who experiences her body largely as a thing and privileges the outsider (male) gaze over her own lived bodily experience. Within patriarchal cultures, women *themselves* often come to live their own bodies as thing-like objects, thereby trying to think, act and be a subject "from somewhere outside of their female bodies" (Rich, 1976:291). This does, I think, have implications for the ways in which women approach, live and make sense of childbirth: potentially one of *the* most shattering and intense experiences of female corporeality.

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While Beauvoir's theory of woman as *Other* is rich and insightful, I reject her analysis of women's reproductive bodies as an inevitable obstacle to her autonomy and as a further source of female alienation. Even more vehemently, I reject her definition of reproductive activities as non-creative, animal-like acts devoid of subjectivity, consciousness or potential transcendence. In my view, the *starting-point* for any analysis of women's birth experiences must be the full recognition of pregnancy, birth and mothering as experiences involving complex forms of embodied subjectivity, thus rejecting and challenging the *erasure* of birthing women as subjects 'defined into nature' by hegemonic biological definitions of reproduction. Phallocentric (outsider) representations of childbirth as 'animal', purely biological, devoid of consciousness, 'natural', a brute, degraded, 'lower order' bodily act and as a supremely horrifying (and threatening) moment of abjection, could all be described as potentially alienating constructions (from an *imagined* woman's viewpoint). These constructions are not 'biological facts' but phallocentric *fabrications*. In my view, it is here that the work of Luce Irigaray becomes potentially indispensable.

Drawing on Irigaray, I believe it is likely that birthing women struggle to find ways of representing birth *from a woman-centred position*. Similarly to Iris Young's (1990c) questions (and 'imaginings') about the possible meaning(s) of breasts *outside* of the objectifying male gaze, I wonder what birthing might *mean* if it was lived and articulated from a 'woman's' point of view. Although it is clear that women are constantly telling birth stories, I nonetheless feel that we are *missing* a cultural story line of birthing that inscribes the female body "as a positivity rather than a lack" (Grosz, 1989:110). Here I do not mean to imply that I am searching for the 'true' or 'authentic' meaning of childbirth; I firmly believe that there is no such thing. Rather, I hope to search for excessive moments within women's stories and talk, moments that might offer glimpses of "different ways of knowing, different kinds of discourse, new methods and aspirations" (Grosz, 1989:126) that potentially disrupt and interrupt patriarchal representations of childbirth.

It should be clear from the discussions both within this chapter and chapter three that an individualist model of subjectivity (with its concomitant mind–body distinction) is unable to 'think through' the complex subjectivity of birthing women. Any effort to interpret childbirth as an experience *of subjectivity* has to work within a theory which insists on the tangled and inseparable 'mesh' of relations between bodies, subjectivities and socio-cultural power relations. Both phenomenological accounts of 'situated subjectivity' and Kristeva's theory of the 'subject-in-process' offer such models. The 'situated subject' is thus understood as a *permeable fold* or "reciprocal permeability" (DiQuinzio, 1999:111) in which consciousness, 'fleshiness', inter-subjectivity and socio-historical relations mingle and over-determine the subject, while the

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Kristevan subject is seen as *a contradictory process* (or dialectical movement) "poised between the practices of body, society and text" (Boulous-Walker, 1998:107).

While both of these theories are clearly immensely rich and useful, the phenomenological account remains impoverished on several counts. Most importantly, the phenomenological 'situated subject' lacks an engagement with the linguistic or discursive elements of identity, while Kristeva's theory clearly highlights the inseparability of language and subjectivity. However, unlike other discursive or post-structuralist writers who reduce subjectivity and the body to being the mere effects of discourse, Kristeva offers a far more nuanced account in which language itself is understood as a signifying process, necessarily always infused by materiality and bodily energies. Thus, any clear-cut distinction between 'the body' and language immediately becomes defunct and meaningless. This Kristevan insertion of the body into language and language into the body, promises to be integral to any attempt to analyse or 'think through' the subjectivities of birthing women as represented within their narratives of birth. Furthermore, Kristeva's theory of the semiotic offers radically new ways in which women's (embodied, visceral) talk about birthing can be explored. Most qualitative studies of childbirth have re-presented women's talk as if it were dead, lifeless and disembodied. One of the only exceptions is the work of Della Pollock (1999), who highlights the animated and visceral elements of 'talk as performance'. As a result, it becomes clear within her book that women's talk about birth teems with bodily rhythms, energies, desires, pains, absences and *jouissance*. Kristeva's portrayal of the maternal body as a prototype of a radical subjectivity or 'subject-in-process', capable of posing a challenge (threat) to the unified, autonomous (male) subject, also seems to be a potentially innovative way of framing birth stories. In other words, are there traces of such a transgressive subjectivity to be found within 'ordinary' women's depictions of pregnancy and childbirth? Furthermore, conflicting feminist images representing the maternal (birthing) subject as either a (transgressive or oppressed) 'split subjectivity' or a 'unified whole' need to be interrogated and contextualised within the stories of women themselves. In my analysis, I will therefore be asking what kinds of birthing subjectivities are reproduced within women's stories: fragmented, unified, dual, absent, inter-corporeal or in-between?

Finally, my reading of women's birth stories will always judge emerging (alternative) representations of birthing bodies-subjectivities by the extent to which they manage to *interrupt* and *disrupt* phallocentric images and constructions of childbirth and female bodies. Thus, while utilising a Kristevan theory of the 'subject-in-process', I nonetheless will also be working within Irigaray's (more politicised) critique of symbolic language as ultimately *phallocentric* and moulded upon a morphology of male bodies. I will therefore be looking for ways in which women's talk about birthing might contain residues or traces of a female corporeality or desire

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that *exceeds* the bounds of patriarchal constructions. This is, to reiterate, not a search for the 'true' or 'pure' meaning of women's bodies or of childbirth. Rather, such attempts will stand as efforts to strategically 'make up' (by drawing on the stories and imaginings of birthing women) *other* ways of representing birthing subjectivity and women's corporeality. However, before turning to an analysis of women's birth stories, it is germane to first outline and reflect upon methodological and analytic issues.

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First weeks

Sharon Olds (2004:159)

…The first
moment I had seen her, my glasses off,
in the delivery room, a blur of blood
and blue skin, and limbs, I had known her,
upside down, and they righted her, and there
came that faint, almost sexual, wail, and her
whole body flushed rose.
When I saw her next, she was bound in cotton,
someone else had cleaned her, wiped
the inside of my body off her
and combed her hair in narrow scary
plough-lines. She was ten days early,
sleepy, the breast engorged, standing out nearly
even with the nipple, her lips would do so much as
approach it, it would hiss and spray.
And when we took her home, she shrieked
and whimpered, like a dream of a burn victim,
and when she was quiet, she would lie there and peer, not quite
anxiously. I didn't blame her,
she'd been born to my mother's daughter. I would kneel
and gaze at her, and pity her.
All day I nursed her, all night I walked her,
and napped, and nursed, and walked her. And then,
one day, she looked at me, as if
she knew me. She lay along my forearm, fed, and
gazed at me as if remembering me,
as if she had known me, and liked me, and was getting
her memory back. When she smiled at me,
delicate rictus like a birth-pain coming,
I fell in love, I became human.

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CHAPTER 5

Fits and starts: a journey in/through research

> What method have you adopted for this research? A delicate question…
> (Luce Irigaray, 1985b:150).

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In this chapter, I will be telling stories about the development, false starts and shifts that were an integral part of 'doing' this research project. The stories circulating in and through the process of doing research are often messy, filled with dead-ends and unexpected detours. Usually these stories are not told and research is represented as an uncomplicated, linear and seamless journey. This chapter will attempt to describe (some of) the difficulties, muddles and exhilarations that were part of conducting this research study. Telling the research process as a story (or stories) is also a way to *re-inscribe* the researcher as a concrete, interested and material presence who is always implicated in the forms that a particular research study assumes. This chapter thus attempts to tell the story of my (unlikely) journey into the complex subject matter of childbirth and of my journeys to and with the women whose rich and evocative stories reverberate throughout this research study. Although this chapter will not be an entirely conventional 'methodology' chapter, issues pertaining to research strategies, sampling, transcription and modes of analysis will still be addressed.

Situating knowledge: feminist perspectives

"…feminist knowledge should be accountable knowledge, knowledge which acknowledges and reveals the labour processes of its own production."
(Liz Stanley & Sue Wise, 1993:201).

Although there is no agreed upon (unitary) feminist method or methodology (Banister, Burman, Parker, Taylor & Tindall, 1994; Gill, 1998; Youngblood Jackson, 2003), over the past three decades feminist researchers have been instrumental in challenging positivist (and masculinist) research agendas. For example, feminists have 'troubled' conventional dichotomous understandings of objectivity and subjectivity in which the two terms are seen as mutually exclusive. For example, feminist standpoint theorist, Sandra Harding (1993), has argued that 'strong objectivity' is inextricably tied to 'strong reflexivity', *requiring* the researcher to interrogate the multiple contexts (personal, social, political, ideological) within which research originates and develops. Furthermore, according to Harding, 'strong objectivity' demands that the *subject* of knowledge (i.e. the researcher and the social location within which research is developed) be considered *part of* the object of knowledge and therefore subject to the same degree of scrutiny and interrogation. Harding argues that positivist research displays only a 'weak' form of objectivity, because it limits its examination to the 'context of justification' (i.e. methods and techniques whereby hypotheses are tested) and ignores the 'context of discovery' (i.e. the contexts within which research problems are identified). Thus, in Harding's reconceptualisation of objectivity, subjectivity and the social location(s) within which research is (inevitably) embedded, are seen as critical resources to be interrogated in the interests of *strengthening* objectivity. In contrast to the positivist ideal of 'value-free' research, standpoint theorists are "less concerned by the presence of values than by their origins and implications" (McCorkel & Myers, 2003:202).

However, *achieving* the kind of 'strong objectivity' that comes with 'strong reflexivity' is not easy. Feminist researchers (e.g. Rose, 1997; McCorkel & Myers, 2003) have acknowledged the difficulties involved in specifying *how* one's complex subjective and socio-political positionings and identities motivate and affect the research process and analysis. Thus, it is not surprising that the notion of 'situated knowledge' often seems to be reduced to a kind of 'reflexivity recipe' in which the researcher dutifully recites the various personal identities (i.e. race, class, sex, age, sexuality) that might have played a role in their interpretative work. It is, however, increasingly acknowledged that simply 'ticking off' identities (e.g. 'white', middle-class, heterosexual) does not add up to 'strong reflexivity'. Feminist writers have also written (from a post-structuralist vantage point) about the *impossibilities* of attaining idealised versions of 'transparent reflexivity' in which researchers are expected to be all-knowing agents who reveal the 'truths' regarding their personal investments in their research endeavours (Rose, 1997). Rose

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argues that such versions of reflexivity operate within a problematic conception of the researcher-self as "a transparently knowable agent" (pp. 309) imbued with presumptuous levels of analytical and reflexive powers. For Rose, such antics come dangerously close to constituting "a goddess trick" (pp. 311). While arguing that all attempts to provide 'transparent reflexivity' will fail, Rose however does not advocate dismissing the concept of reflexivity wholesale. Instead, she calls for an alternative reflexivity, in which "contradictions as well as uncertainties…absences and fallibilities" (pp. 318-319) are inscribed in our analyses and writing.

Feminist standpoint theorists' insistence upon the complex, intertwined relationship between knowledge, subjectivity, socio-cultural power relations and politics has had major repercussions for the ways in which 'feminist research' is defined. Thus, although there is no commonly agreed upon or final 'position' regarding what qualifies as 'feminist research', the commitment to interrogating the social and subjective locations within which research is situated, remains common to many feminist guidelines *vis-à-vis* research (e.g. see Lather, 1991; Stanley & Wise, 1990; Fine, 1992; Stanley & Wise, 1993; Burman, Alldred, Bewley, Goldberg, Heenan, Marks, Marshall, Taylor, Ullah & Warner, 1996; Gill, 1998). Thanks to feminist standpoint theory, feminist researchers can no longer (easily) get away with the 'god-trick' (Haraway, 1991) of writing from an all-knowing or all-seeing position. Furthermore, a *feminist ethic* founded upon standpoint principles has been articulated by Stanley & Wise (1993). As part of this 'ethic', feminist researchers are encouraged to recognise the researched *as subjects* (and not merely the objects of research), submit *themselves* to the same level of critical scrutiny imposed upon the researched and concede that their research is not a representation of 'reality' but a "motivated construction" available to further critical analysis (Stanley & Wise, 1993:200).

In what follows, I attempt to provide (inevitably limited) glimpses into some of the 'backstage' stories that underpin this research project. As a kind of 'mapping', I attempt to retrace some of the places, theoretical/personal journeys, wrong turns and detours that I have already charted over the many years spent 'doing' this research.

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A cartography of a research journey

"Being honest can backfire. It goes against all of our methodological training. Being dishonest is easier, but it is a greater sin in terms of the integrity of the research endeavour."
(Jill McCorkel & Kristen Myers, 2003:225).

Beginnings

> Women are often intrigued when I tell them that my dissertation topic is childbirth. They often seem to peer at me a little closer, hoping perhaps to read my face for the 'real' motivations behind this desire to know about birth. They usually want to know 'why' or 'how' this interest came about. Why is a young, single woman without children so interested in childbirth? She must be broody they seem to think. Shame (poor woman) doesn't she know that the only way to really learn about childbirth is through experience? Theory and childbirth don't mix. They pause and think – Is childbirth even a legitimate research topic? A whiff of something vaguely suspicious seems to linger in the air…(Research journal, 22 October 2004).

Many people have been curious about 'why' I am doing a research study on childbirth. When they (inevitably) ask for *my reasons*, I never quite know how to answer them. This is probably because I cannot give a neat and pithy answer; the motivations behind this research are complex, intertangled and far from transparent (even to myself). If I retrace the story, it is correct to say that my interest in childbirth was born close on five years ago in 2002 when I found myself asking: why do people (particularly women) feel *the need* to have children? At this time I was 25 years old and questioning my own desire (or need) to have a child. As a result, I began to ask questions about the 'desire' or 'longing' that many women experience in relation to carrying, bearing and raising children. I felt driven to interrogate this 'need' and to understand it. As a result, I began browsing in the 'parenthood' and 'motherhood' sections of the university library and in no time stumbled upon that great classic by Ann Oakley (1980), '*Women confined: towards a sociology of childbirth*'. It was through reading this book, which so vividly portrayed how many women are disrespected and even violated during the births of their babies, that my sense of *outrage* regarding western childbirth practices was first kindled. I began to voraciously read in the area of childbirth, devouring books about the cross-cultural diversity of birth and hefty historical tomes outlining the historical variability of childbirth practices. In those early days, I cut my teeth on the works of Brigitte Jordan (1993), Suzanne Arms (1977), Adrienne Rich (1976), Judith Leavitt (1986), Irvine Loudon (1992) and Robbie Davis-Floyd (1994). Thus, in some sense it feels as if I didn't *choose* the topic of childbirth in any logical, clear and intentional way; I seemed to stumble upon it. Strangely, other researchers of childbirth have hinted at a similar dynamic; for example, Adrienne Rich (1976) writes: "But I did not choose this subject; it had long ago chosen me" (pp. xvii) and according to Brigitte Jordan (1981): "The plain fact is that I blundered into it. I never chose to study birth. In some sense, it chose me" (pp. 184).

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The one *constant* theme in all my research (conducted over the past eight years) has been a strong feminist commitment. My work has evolved quite radically from roots in sexual violence feminism (during which time I was active in a Rape Crisis Centre) to a questioning of this discourse and a movement towards more of a 'pro-sex feminism' (see Glick, 2000). This shift began with my Masters research (see Chadwick, 2001) and was consolidated by a research fellowship at the University of California, Berkeley, during which time I attended a class on the representation of sex workers in film, taught by a practicing dominatrix (and PhD candidate). At this time, I became interested in pursuing the topic of sex worker subjectivity for my PhD. Generally, my research projects have always focussed on how other women grapple with and find empowering 'alternative routes' to deal with issues that have also been central to my own life (i.e. sexual violence activism, sexuality, female embodiment, childbirth).

It was thus events in my own personal life that initially led me to the topic of motherhood and birth. Thinking deeply about my own desires, fears and ambivalences regarding motherhood put me in the perfect place to be seduced and enthralled by the topic of birthing. Thus, not surprisingly, I was captivated almost as soon as I started reading in this area. My 'white', middle-class, westernised status meant that I sharply identified with the stories of young, birthing women that I read in books by the likes of Ann Oakley and Sheila Kitzinger. I was deeply horrified by the barbarism that many young women (similar to myself) suffered at the hands of the medical system. I was personally deeply affected by these stories. I knew that *I* could so easily have been a recipient of similar acts of (what I then unambiguously thought of as) savagery and I was *angry* about what I read. This research project was thus borne out of events in my own life and fuelled by a strong sense of passionate outrage.

It is not unusual that personal experiences inform and structure research interests. For example, the majority of women researchers studying childbirth have themselves *experienced* birth. Many of these researchers are explicit about this and often link their interest in childbirth directly to their own personal birth experiences (e.g. Arms, 1977; Oakley, 1979; Romalis, 1981; Rothman, 1982; Cosslett, 1994; Kahn, 1995; Klassen, 2001a). Some claim that their research has been facilitated and enriched by the fact that they *share* the experience of birth with their participants. For example, Pamela Klassen (2001a) is of the view that her own experience of home-birth put her (home-birthing) participants 'at ease' and helped engender a kind of "intimate solidarity" (pp. 10) with her interviewees. Furthermore, Klassen also claims that if she had not *herself* given birth, women might have "[given] me less birth story and more birth advice" (pp. 10). She also believes that she would have "understood less of what women *meant* when they spoke of physical sensations such as contractions and the urge to push" (pp. 10, my emphasis).

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For Klassen, "having done it [childbirth] oneself, the other's experience is both more viscerally and mentally comprehensible" (pp. 10).

As a woman who has never been pregnant or experienced childbirth, I cannot claim the same kind of shared intimacy with my research participants. However, I believe that the very fact that I have not given birth helped (in many ways) to facilitate this specific research project. For example, I think that it prevented me from being too heavily invested in any particular kind of birth (i.e. home-birth, hospital-birth or elective caesarean section). Most of the women interviewed were very curious about me, asking if I had children, whether I wanted children and what kind of birth I would choose if I did become pregnant. The very fact that I have not experienced or chosen a particular kind of birth made me acceptable to all of the women that I interviewed. Furthermore, I also believe that my ignorance about the process and lived experience of childbirth was an asset and not a liability in this research. I was thus continually asking women what *they meant* when they described something, how it felt and continually encouraging them to try to 'put into words' the feelings, sensations and experience of giving birth. If I myself had experienced childbirth, I might have been more inclined to assume that I knew what they meant, without asking for these elaborations and descriptions. In the interviews, *they* were always the experts and because the experience of birth was not that easily "viscerally and mentally comprehensible" (Klassen, 2001a:10) to me, I probably encouraged my interviewees to work harder at explaining and describing the birth experience. Thus, retrospectively I have come to see my lack of birth experience as a factor facilitating the 'doing' of this particular research project. In earlier phases I was, however, very worried about my lack of 'experience' and questioned my eligibility (or 'right') to be undertaking this kind of research.

Taking seriously feminist recommendations for 'strong objectivity', it is also important to acknowledge that this research is rooted within a privileged 'white', middle-class social location. This is true of both my own situation as researcher and (most of) the women that I interviewed. The experiences of childbirth that will be explored and re-presented in this thesis are thus embedded in a particular local power structure in which most women do not have access to birthing choices. Thus, in the midst of analysing and exploring birth stories which are awash with 'agency', 'success' and positive outcomes, it is important to remember that these stories are not the norm and that most South African women do not have a similar luxury of 'choice'. The institutionalised inequalities and privileges historically inscribed upon South Africans of different race groups has meant that, twelve years after the turn to democracy, South African women of different race (and class) groups still experience radically different difficulties and challenges during childbirth. However, I nonetheless do believe that this particular research project is important. While it is undoubtedly clear that a lot more research (and activism) needs to

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foreground the birth and mothering experiences of rural, poor, and working-class South African women, it is also true that no research has ever looked at the experiences of self-selected home-birth and caesarean section in this country. In fact, more research has been done looking at the experiences of (poor) women in the public maternity sector, where shocking problems of verbal and physical abuse and neglect have been reported (Jewkes & Mvo, 1997; Jewkes, Abrahams & Mvo, 1998). I believe strongly that the problems facing *middle-class* birthing women, who are unlikely to escape the 'spiral' of (private hospital) medicalisation, which often leads to unnecessary interventions and surgery, and the abysmal conditions within which *poor* women have to birth (often without adequate care, pain-relief or life-saving technologies), are deeply interconnected and in fact, two sides of the same coin. In this thesis, I look at the stories of women who have carved *alternative routes*. I do so in the interests of exploring whether these stories (although undoubtedly inscribed by privilege) might provide us with glimpses of different (more empowering) ways to imagine birth.

Early assumptions and hypotheses

When I began this research I had multiple assumptions about childbirth. Most of these have been challenged and subverted by copious reading and by talking to birthing women themselves. For example, I 'assumed' that 'natural' birth without drugs was what all women wanted. I also believed that pregnancy, childbirth and breastfeeding were 'sensuous' bodily experiences that were potentially 'empowering' to (all) women. Somehow (to my embarrassment) I also had the notion that women who were more sexually 'liberated' (i.e. who experienced orgasms easily and readily) would be more comfortable giving birth and breastfeeding. I think I derived the seeds for this assumption from reading Sheila Kitzinger's (1962/1981) book, '*The experience of childbirth*', in which she argues that childbirth is an extension of a woman's 'psychosexual life' and that the way a woman responds to and copes with childbirth is a function of her 'personality' and feelings about her womanhood and sexuality. At the time, I (unknowingly) had internalised (a lifetime) of cultural-ideological story lines about birth and birthing women, in which, for example: 'natural' birth is seen as 'best', women who do not want 'natural' birth are seen as 'deviant' or 'unnatural' and the reasons for failing to 'achieve' 'natural' birth are seen as residing within the individual woman. Thus, even after I had done a great deal of reading and thinking about childbirth, I still harboured (retrospectively) problematic assumptions. This is clear from my (scattered and haphazard) research journal jottings. For example, in November 2003, before I had even begun the process of finding research participants, I was of the view that women's relationships with their female (reproductive) bodies was intimately connected to the choices they made in relation

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to childbirth. I thus hypothesised that, "how a woman feels/experiences/relates to her *body* is a key ingredient in her choices and experiences regarding birth" (Research journal, 18 November 2003). As a result, I was of the view that women who choose home-birth and caesarean section would have significantly *different* orientations or relations towards their female corporeality. In effect this meant that I thought women who chose home-birth would have 'liberated', empowering and positive relationships with their bodies and that women who chose caesarean sections would have repressive, alienated and disempowering relationships with their bodies. These notions now seem hopelessly over-simplistic and embarrassing. The stories that birthing women have told me have proven these ideas to be misguided and erroneous assumptions.

Shifts, turns and rationale

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In 2003, I conducted a 'preliminary' study (with the help of undergraduate psychology students) in which 77 local women were interviewed retrospectively about their birth experiences (see Appendix A and B for more details). It was on the basis of reading through these interview transcripts (and demographic questionnaires) that I began to see how analytically interesting the two outliers of home-birth and elective caesarean birth were. I realised that most research to date has focussed on the majority of hospital-birthers 'in the middle', who seemed to passively believe (retrospectively) that birthing outcomes were the result of 'luck' or 'chance'. I was also surprised to find that significant numbers of women seemed to be electing to have caesarean sections for personal reasons. Thus, of the 19 elective caesarean sections within the sample, 40% were reportedly self-selected for non-medical reasons. From my (admittedly limited) preliminary data it seemed *possible* that significant numbers of women within certain sectors of South African society (i.e. middle-class) might be *choosing* to have caesarean sections without medical reasons. I knew that there was very little research (internationally or locally) exploring the experiences of such women. I also knew of no study (international or local), which had *comparatively* explored home-birthers and elective caesarean birthers. It was on this basis that my doctoral research project became a study of the experiences of South African women who chose to have either a home-birth or an elective caesarean section.

Table 1: Comparative demographic breakdown of interviewed home-birthers (n=15) and elective caesarean birthers (n=9)

	Home-birthers	**Elective caesarean birthers**
Age		
20-25	1/14	0/9
25-30	3/14	3/9
31-40	9/14	6/9
41+	2/14	0/9
Average age	33 years	33 years
No. of children		
First baby	2/14	8/9
Second baby	9/14	1/9
Third baby	4/14	0/9
Marital status		
Single, no partner	1/14	0
Living with partner	5/14	0
Married	9/14	9/9
Status of pregnancy		
Planned	9/14	9/9
Unplanned	6/14	0/9
Race		
'White'	13/14	9/9
'Coloured'	2/14	0/9
Highest education		
High school diploma	2/14	0/9
Technikon diploma	5/14	5/9
University degree	5/14	1/9
Postgraduate degree	3/14	3/9
Employment status		
At home	6/14	0/9
Full-time employment	2/14	5/9
Freelance work	5/14	2/9
Business owner	2/14	2/9

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I decided to conduct pre- and post-birth interviews, following the women (as far as possible) through the journey from decision-making to actual birth experience. I was not interested in doing only 'retrospective' interviews, largely because I wanted to explore women's *rationale* for their respective birth choices. Because the stories collected by students in the preliminary study had been *retrospective*, I could not be sure whether the active agency or passivity displayed by these women in relation to birthing choices was the effect of the *birth outcome* itself. Furthermore, I was also aware of research done by Jonathan Smith (1992, 1994, 1999) in which women's real-time accounts of the transition to motherhood are compared to their retrospective accounts (at five months postpartum). Smith (1994) finds in this comparison that women's retrospective accounts differed significantly from 'real-time' accounts in that they were imbued with a positive interpretative gloss (exaggerating the positive and downplaying the negative) and also tended to construct events as *a progression* in which disorder, divergence and instability were 'smoothed over' and minimised. I thus wanted to hear women's reasoning for their choices *before* the birth

event. Furthermore, apart from concentrating on how women came to make these birthing choices, I also wanted to make use of the pre-birth interview to explore broader issues pertaining to women's relationships with their bodies. As mentioned earlier, I initially carried assumptions about the importance of women's relationships with their bodies in informing choices around childbirth.

Interview one was thus designed as an exploration of four central issues: the experience of pregnancy, the path towards making a birth 'choice', expectations about the upcoming birth and a kind of 'life history of the body', in which women reflected upon their changing relationships with their bodies from childhood onwards (see Appendix D and F). I wanted to conduct this interview in *late* pregnancy (approximately 7-8 months), so that women could both reflect on the whole pregnancy experience and be in a place wherein they were likely to be focussed upon the impending birth. Interview two (see Appendix E and G) was to be predominantly an exploration of the women's birth stories and also (but less centrally) the early days of motherhood. This was to take place around six weeks post-birth, ideally so that women would have had some chance to recover from the frenzied early days and weeks with a new infant and yet would still have the details of the birth experience 'raw' and fresh in their minds.

Finding pregnant women who were planning on either a home-birth or an elective caesarean birth was challenging and demanded multiple strategies. In order to locate potential home-birthing participants, I contacted eight independent midwives working within the broader Cape Town area. Together, these midwives gave me the names and contact numbers of thirteen prospective home-birthing participants; eleven of these women agreed to take part in the research[31]. A woman hiring out birthing pools referred one other home-birther to me; the remaining three participants responded to an adverstisement that I ran in a local community newspaper. To find elective caesarean birthers I ran a letter in a South African pregnancy magazine ('*Living and Loving*') and in a number of local community newspapers. I also attended antenatal classes at four private hospitals so that I could personally ask women planning on caesarean sections (for personal reasons) to take part in the research. Via this assortment of strategies, a total of nine elective caesarean birthers were secured (see Table 2 for a detailed breakdown).

In the end, a total of 50 interviews were conducted with 26 women. Fifteen home-birthers were interviewed, with one woman only being interviewed once post-birth (a total of 29 interviews). Nine elective caesarean birthers were interviewed; once again, one of the women was only interviewed once post-birth (a total of 17 interviews). I also conducted pre- and post-birth interviews with two women who were simply choosing to have 'regular' hospital-birth deliveries

[31] One woman did not want to participate because she "didn't feel comfortable with being interviewed", while another had already given birth (prematurely) when I contacted her.

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(a total of four interviews). All of the interviews were audiotaped (with permission). Furthermore, all of the women completed a demographic checklist (see Appendix H) and gave their signed consent to participate in the research (see Appendix I). I also had extensive email correspondence with three elective caesarean birthers pre- and post-birth.

Table 2: Breakdown of 'sample' and strategies of sampling used, n=29

Breakdown of 'sample'	
Total number of participants	29
Total number of participants interviewed	26
Extended email contact only	3
Total number interviewed pre-and post-birth	24 (x2)
Interviewed only post-birth	2
Total interviews conducted	50
Home-birthing women	15
Interviewed (pre- and post-birth)	14
Interviewed post-birth	1
Strategy of sampling	
Via midwife referral	11
Via letter to community newspaper	3
Via informal contact	1
Women planning elective caesareans	12
Interviewed (pre- and post-birth)	8
Interviewed post-birth	1
Email contact only	3
Strategy of sampling	
Via letter to *Living and Loving*	5
Via antenatal classes	5
Via letter to community newspaper	1
Via informal contact	1
Other	2
Strategy of sampling	
Via informal contact	2

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The women and me: broad impressions and interview tales

"*…research is a process that affects the researcher most of all.*"
(Susan Krieger, 1991: 152).

On reflection, it is clear that the most enjoyable part of 'doing' this PhD was the interviews that I conducted with the 26 women who form the primary 'data'[32] for this research. These women were all incredibly generous with their time, energies and stories and I learnt a great deal from listening to them. I connected with many and felt enriched and privileged to share in their lives (however briefly). I also often *admired* these women and some have continued to haunt my dreams. Their

[32] I had email correspondence only with three elective caesarean birthers. Although these emails are drawn on occasionally within the analysis (see chapter six), I do not regard this material as 'primary data'.

lives often seem to hold up mirrors within which I am able to see my own life reflected in different ways.

However, it would be disingenuous of me to claim that the interviews I conducted were always and only made up of warmth, positive feelings and mutuality. In fact, to be honest, there were (rare) times that I felt sharply disconnected from interviewees in particular interview encounters. Although feminist researchers have traditionally (and appropriately) emphasised the existence of unequal power dynamics in interviews (and the research process as a whole) and generally assumed that it is always the interviewer who occupies a dominant power position in these encounters (e.g. see Oakley, 1981; Lather, 1991; Opie, 1992), more recently, some feminists have questioned these assumptions. For example, Thapar-Björkert & Henry (2004), critique dualistic conceptions of researcher-researched which take-for-granted that the researcher is always essentially powerful and the researched is always essentially powerless. Adopting a more fluid, Foucauldian view of power, Thapar-Björkert & Henry argue that power dynamics within the research process are "shifting, multiple and intersecting" (pp. 364) and that research participants *do* exercise power in various ways. Thus, they believe that researchers are also potentially vulnerable to being objectified and manipulated by those that they research. This is not a popular line of argument, particularly for feminist researchers who interview and research women. Since the 1990s, feminist researchers have argued that *power* is one of *the* most critical issues for feminist qualitative researchers (Youngblood Jackson, 2003). However, power has been seen almost exclusively as inherent within the researcher. Thus, for example, feminists have (usefully and justifiably) stressed the danger of 'appropriating' those we research (Opie, 1992), 'using' and 'hiding' behind their voices (Fine, 1992) and inscribing our own agendas over those of research participants (Lather, 1991). It seems that it has been largely politically incorrect to talk about the negative emotions that some interviewees (particularly when they are women) are capable of inciting within researchers. One of the few researchers brave and honest enough to tackle some of these issues has been Susan Krieger (1991). Going against the grain of accepted ways of talking about interviews, Krieger reflects (with brutal honesty) about how interviewing *made her feel* and writes explicitly about the (painful) feelings of self-denial, vulnerability and disconnection that can accompany traditional forms of interviewing.

Interviews are unusual social interactions in the sense that it is widely accepted that in a traditional interview, one (designated) person will tell their story or experience(s) and the other will listen and ask questions, but not tell reciprocally of their own experiences. It is true that many qualitative researchers now favour a more flexible view of interviews, in which both participants are (ideally) seen as, for example, "equal partners in coconstructing meaning" (Wood & Kroger, 2000:72). However, this is sometimes difficult to effect, partly because many interviewees seem

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to have internalised a more standard view of what an interview 'is' and sometimes seem unsettled or even irritated if the interviewer talks (too much?) of their own experiences. Furthermore, as researchers, we are also often likely to worry if we do too much talking or sharing during an interview. After all, regardless of our metatheoretical investments, we want to make sure that we have 'good data' to analyse in our research and traditionally our own views as researchers do not qualify as appropriate or relevant 'data'. Thus, although in an ideal world, interviews can be constructed as encounters of equality and reciprocity, in reality this is often not the case. Interviews are actually, more often than not, one-sided interactions in which mutuality is difficult to attain. Thus, although *in theory* I favoured a flexible, reciprocal and conversational style of interviewing for this research project, in reality I often felt that I had erred if I did interject with my own personal experiences(s). In listening to the tapes of interviews (during transcription and analysis), I would curse myself every time I made the 'mistake' of offering my own view or anecdote. Often it seemed (quite correctly) that the interviewee was not interested in my experiences; sometimes this made me feel angry and hurt. Although most of the interviews that I conducted *were* enjoyable encounters, it was often only later when I listened to the interview tapes that I was able to make sense of and re-experience some of the intense emotional responses that interviews and interviewees often seemed to evoke in me. Not all of these feelings were warm, fuzzy and positive. I often found listening to the tapes difficult and they at times evoked painful and embarrassing feelings.

In general, though, the interviews conducted for this research *were* positive and warm encounters. The women seemed to both enjoy talking about their pregnancies, births and babies and having someone who simply wanted to listen to their stories. I was genuinely fascinated by what they had to say and I think they were aware (and gratified) by this. Similarly to Klassen (2001a:10), I found that in general, "talking about [home]birth made these women feel good". However, for some of the women who had not birthed at home, talking about childbirth sometimes evoked painful, intense and sad emotions. Interestingly, I found that women who had experienced more 'negative' or traumatic births (usually neither home-birthers nor elective caesarean birthers) often seemed to *need* to talk about their births more than the women in my two primary 'groups'. For the most part, home-birthers and elective caesarean birthers did not seem to have a great need to tell me their stories. I am aware that there is perhaps something specific to the ways in which these women experience childbirth that renders them less likely to need to tell their stories.

For the most part, the interviews (which lasted anywhere between an hour and three hours) were friendly, easy and thoroughly pleasant, often ringing loudly with the sounds of laughter and giggling. Even now, when I listen to particular tapes, I cannot help but laugh out loud to myself at

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certain moments. In the interviews, I sought to create a space in which the women felt relaxed, important and *heard.* At the start of the first interview, I would usually introduce my research and tell them that I was, first and foremost, interested in *their experiences*. I always started off with broad, open-ended questions (e.g. tell me about this pregnancy?) and usually took cues from the women themselves. Thus, for example, some of the women were uncomfortable *unless* I asked pointed and direct questions. In the post-birth interview, I usually always began by asking the women to tell me 'the whole story from beginning to end'. One of the women (Angela[33]) laughed nervously when I framed the interview in this way and said, "Okay, just, you don't have any specific questions…?". She was (like me) a person who is uncomfortable with dominating conversational space. Later she remarked, "It's quite strange, being the only one doing all the talking". Other women, however, almost completely dominated me in the interviews. I left these kinds of interviews having had little to no space to ask any of the questions on my interview schedule. In these kinds of interviews, I seemed to function simply as *a container* for the interviewees' feelings, words and opinions. I always left such meetings feeling drained, exhausted and overwhelmed. As an interviewer, I believe that it is my role to allow interviewees to set the tone and steer interviews in ways that suit them. Many of the interviewees were highly active in setting their own agendas and guiding the interview in directions that suited them. Ethically, I felt that this was right and proper. In the interviews, I thus usually *went with* the interviewee's train of thought, asking questions which led off what they were telling me. I usually only resorted to my 'interview schedule' when the interviewee ran out of things to say or I was left unsure of what next to ask. I genuinely tried (probably not always successfully) to 'enter into' the world of the women I interviewed. As a result, some women seemed to forget that I was 'an interviewer' and not a friend. For example, after relating some particularly graphic details about her birth experience to me, Angela suddenly seemed to remember who I was (i.e. a stranger, a researcher). She broke off her story mid-sentence (see Appendix J for a guide to transcription notation) and said:

Angela: …I dunno, how much of this are you going to write in your thing? <u>It's all rather personal stuff</u> (laughing) (Rachelle laughs)
Rachelle: You said that you want to (*) see
Angela: <u>Ja, do you mind if I do</u>? (laughing)
Rachelle: No
Angela: Thanks, um ja, <u>I'm sort of speaking to you more like I'd speak to a friend as opposed to thinking you're going to be publishing this stuff</u> (laughing) (both laugh)

[33] See Appendix C for portraits of all of the women interviewed.

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Being able to elicit intensely personal stories and experiences from interviewees' means that as a (feminist) researcher, I am even more ethically bound to carefully consider the ways in which I use their stories. This is where cautionary tales about *the power of the researcher* to appropriate, misrepresent and disrespectfully 'use' the stories of research participants becomes highly relevant. The ways in which we represent and 'use' the "altruistic gift" (Krieger, 1991:153) interviewees give us when they give us their stories needs to be carefully considered on moral and ethical grounds. Ethically, I do feel that it is important that we (as feminist researchers) make (some) attempts to feed the knowledge and insights gained from our studies back to research participants and relevant community groups (see Lather, 1991; Russell & Bohan, 1999).

In general, my broad interview schedule seemed to work well. The one exception was the 'body history' that I attempted as the second part of interview one. Many of the women laughed uproariously when I told them that 'part two' of the interview was about their life-long relationships *with their bodies*. Although I did, in some cases, learn important contextual information about particular women, in general, this part of the interview seemed to go down like a lead balloon. In part, I think it was a result of the problematic way in which I asked questions. I spent most of the time firing direct questions at them about how they 'felt' *about* their bodies during childhood, adolescence, early adulthood etcetera. Treating 'the body' as an object in this way was clearly not a good interview tactic and the women seemed to have difficulty in giving me answers. I also think that *I* was uncomfortable with this part of the interview, in which I asked questions about menstruation and early sexuality; I think that my own sense of uneasiness affected this part of the interview negatively. I think I also felt guilty for 'springing' this part of the interview on participants, largely because I think most assumed that I would only be asking questions about pregnancy and birth.

For me, the most 'enjoyable' interactions with interviewees were usually the post-birth interviews: it was *exciting* to hear 'what had happened' *and* to see the new little babies, who were almost always bundled up close to their mothers. These interviews were also the most unstructured, because I was trying to elicit women's own *stories*. However, I must admit (in retrospect) that I was often guilty of trying to push the women into giving me linear, coherent stories. I realise that I was often trying to 'make sense' of the story *in* the actual interview; this meant that I wanted to have a clear idea of *what happened when*. Della Pollock (1999) acknowledges a similar dynamic at play in her talks with women about their birth stories, in which she admits to often asking questions which "favored the storyness of story…they complied with the rule of plot and action sequence by focusing on *what happened*" (pp. 134, my emphasis). However, instead of regarding this dynamic as 'a failing' or 'a problem' in my research, it will

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become a point of substantial analytic discussion and interpretation in subsequent analysis chapters.

Almost all of the interviews (46 of 50) took place in the homes of participants, largely because this was most convenient for them. This meant that I often had to make long journeys to get to interviews. My travels took me on road-trips all over the greater Cape Peninsula and I regularly travelled 30 kilometres or more to make these meetings. More often than not, it seemed that *home-birthers* lived at some remove from the bustling city centre, congregating along small, coastal villages or inland 'dorps[34]'. In contrast, women planning caesareans usually lived closer to the city. My trips took me along busy highways, lonely, dusty roads, over mountain passes and along quaint, picturesque lanes; I saw familiar and unfamiliar landscapes, often driving in heavy, stormy rains, violent winds and/or burning heat.

The homes of home-birthers were usually warm, colourful and comfortable, often filled with rustic furniture, lots of wood, multi-coloured rugs and cushions, scents of incense, scattered photographs, small sculptures of goddess-like females and Buddha figures. Books were almost always readily visible and generally plentiful and I noticed books on topics such as mythology, sexuality, goddesses, natural medicine, tarot cards, astrology and art. The domestic spaces of home-birthers were often charmingly 'upside-down' and rambling and almost always more comfortable and 'lived-in' than spotless, 'posh', or immaculate. In contrast, the homes of elective caesarean birthers were generally characterised by a sparse, 'less-is-more' type of décor style and were almost always spotless and well ordered, with everything in its place. Two of these women lived in large, opulent homes worth many millions (of rands), perched high above the city with sweeping, grand views of the Atlantic Ocean.

I am, for several reasons, pleased that I was able to visit the homes of my interviewees. First, I believe strongly that being 'on their own turf' made the participants feel more 'at ease' and 'in control' of the interview encounter. Particularly for the home-birthers, I felt that home was a space in which most of the women felt quite powerful. Thus, although I am aware of the powerful feminist critique levelled at the domestic space as a place of oppression and violence, I agree with feminists who have argued that the home can potentially also be a place of resistance or empowerment for women (Klassen, 2001a; Thapar-Björkert & Henry, 2004; Young, 2005). Second, by entering into their domestic spaces, I felt that I learnt (very tangible and material) things about my research participants. Seeing these women in 'their' spaces also undoubtedly enriched and facilitated the interviewing experience. It helped to facilitate cosy, warm and friendly interviews. To this day, I still associate particular women with the spaces in which I interviewed them. There was only one woman in the study whose home I never visited. Both of

[34] 'Dorp' is a popular South African term (derived from Afrikaans) referring to a small town.

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my interviews with her (Hannalie) took place at her workplace. I remember feeling particularly out-of-my depth in these interviews. They took place at the very top floor of a prominent skyscraper in the city centre. After conducting our first interview, I wrote in my journal: "Later as I leave the parking-lot, I turn down a one-way street. Horrible situation. Clearly I do not belong in the corporate heartland of the city!" (Research journal, 6 September 2004). Interestingly, I felt less comfortable and seemed to establish less 'rapport' when interviews were conducted in women's workplaces. Often there were simply more distractions (telephone calls, customers, fellow workers). Furthermore (to me), the spaces seemed less conducive to 'cosy', comfortable chatting. Thus, I distinctly remember sitting across from Hannalie (the hugely successful 'executive'), with her huge and bulky office desk between us, feeling small, alienated and vulnerable. Having to 'report' to reception and wait in the company lounge for Hannalie to come and 'fetch' me, did not feel quite the same as arriving at somebody's home and being greeted at the gate by the interviewee and/or a friendly dog or cat.

In almost all cases, the homes of the women interviewed made for private interview spaces. When I interviewed them, most of the women were either 'at home' resting before the birth or 'at home' with their newborn infants. Usually I conducted the interviews on weekdays, when partners were less likely to be at home. On some occasions, however, husbands or partners were around and often proved to be disruptive. For example, in one of the interviews (with Anke) the husband joined in and ended up giving a lot of his own opinions and in effect 'talked-over' Anke most of the time. Other interruptions and disruptions were generally of a domestic nature. Many of the women had domestic workers bustling around in the background during interviews. Sounds of everyday domestic cleaning thus often served as a backdrop to the interviews. In other cases, toddlers scurried noisily about and demanded their own fair share of attention; often these little ones were fascinated by my tape-recorder and (to my consternation) repeatedly insisted on touching it or picking it up. Fortunately, there were often domestic workers around to distract these children and 'take them off' if they became too disruptive. Decisions regarding appropriate levels of 'disruptiveness' were (of course) in all cases left to the discretion of the interviewee.

Soon after I started the process of interviewing, I remember having a dream about one of the women. She (Jane) was one of the home-birthers with whom I had recently completed interview one. I dreamt that her (home) birth went terribly wrong and that her baby died. This dream signals the fear that I had that 'something would go wrong' with one of the home-births. It felt inevitable to me when I started the research that along the line there would be 'horror' or 'disaster' stories. Somehow, I seemed to expect this particularly from my home-birthing sample. These 'fears' and (unarticulated) expectations reflect my own socio-cultural location within a cultural story line which constructs home-birth as a 'risky', dangerous and potentially life-

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threatening (for the baby or the mother) choice. I am happy to report that my fears, anxieties and dreams were not prophetic and that all of the women who took part in this study birthed healthy and strong babies. Along the way, I must also admit to being *amazed* by the stories that home-birthers told me. After a busy day of interviewing, I would often come home brimming with excitement. Although I have come to be wary of arguments that posit home-birth as the 'best' way (for all women) to birth and desperately want to resist a conclusion which holds home-birth up as *ideal*, I cannot deny the empowering, joyous and often miraculous stories that home-birthers told me. Amidst a cultural norm of birth storytelling in which the 'horror' story looms large, it seems to me that the stories offered by home-birthers offer tantalising glimpses of (some) ways in which birth could be alternatively imagined (in positive and empowering ways).

I must admit, also, that I felt *drawn* to many of the home-birthers and often seemed to feel a strong 'connection' to them. I felt comfortable in their homes, admired them and largely agreed with most of their beliefs and convictions. Many of these women are still in my thoughts. The strong, intimate attachments that interviewers can form with interviewees (often in *imaginary* ways long after the interviews end) are generally not acknowledged by researchers. Entering into the life-worlds (however fleetingly) of the women that I interviewed, both in the interview encounter and then *repeatedly* while listening to tapes, has meant that many of the women have become knitted into my own interior world. I still dream about them. I was intrigued, repelled, amazed and obsessed by many of these women. Often, I wanted *to be* them. I think I even fell in love with some of them. Many of these women inspired me. I felt empowered by the boldness of their lives, which often seemed to declare: "This is who I am, take it or leave it". Although they were in many ways different, home-birthers and elective caesarean birthers shared one central characteristic: they all seemed to have a strong sense of themselves. I admired this in all of them. However, in general I did not feel as connected to the elective caesarean birthers as I did to (most of) the women who gave birth at home. Although I cannot say definitively 'why' this is/was the case, I would guess that my philosophy of life (and birth), as well as my lifestyle (and home), is more similar to the home-birthers.

In comparison to many of the women that I interviewed, I felt (at times) gauche and young, even though I was, on average, only about five years younger than most of my interviewees (see Table 1). Some of the women seemed surprised when they met me – probably largely because I look quite a lot younger than I actually am and do not have the look of somebody who is doing a PhD (whatever such a person looks like). As a result, many of the women adopted a kind of 'big sister' stance toward me and often effortlessly positioned themselves as experienced and 'in-the-know' in comparison to me. For example, after graphically detailing the brutal pain of birthing contractions, one of the women (Lizette) suddenly looked at me (I probably had a shocked

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expression on my face) and gently reassured me, saying "…but don't be *scared* of it hey, it's also an incredible feeling". Seeing me as the uninitiated (childless) and less experienced woman meant that the participants were able to position themselves as 'experts', which might have been empowering for them. Interestingly, this 'expert' positioning was generally missing from pre-birth interviews with *first-time* pregnant women, who seemed to be (like me) un-knowing and completely clueless about the mysteries of childbirth. In the post-birth interview there was, however, often a marked change in the relationship between me and the new mother, where it became clear that she (but not I) had now crossed over into the land of the initiated.

Talk into text: the challenges of transcription

"Transcripts are not simply neutral representations of 'reality' but theoretical constructions."
(Judith Lapadat, 2000:208).

For the most part, the transformation of research interviews into texts is assumed to be an unproblematic process. Many researchers do not even comment on this phase of the research and often a lonely table depicting 'transcription notation' is the only evidence that transcription has occurred at all. More recently, however, some researchers have begun to question the invisibility of the transcription process, arguing that transcription is not merely a mechanical exercise in which interview talk is neutrally *replicated* but is, in itself, an active *construction* of the 'data' (Lapadat & Lindsay, 1999; Lapadat, 2000; Tilley, 2003a, 2003b; Oliver, Serovich & Mason, 2005). The process of converting (messy, lively, embodied, rhythmic) speech into (formal, static, rule-bound) written language is not automatic or self-evident and transcribers are faced with many tricky decisions when trying to decide how to 'write' speech. According to Lapadat (2000) these choices are "both interpretative and political" (pp. 204). As a result, it is now increasingly recognised that transcribers inevitably play a *constructive* and *analytical* role in shaping transcripts and are not disinterested, neutral machines that simply 'capture' data. As noted by Tilley (2003a:757), "the prints of the person transcribing…find their mark on the transcript texts." Not surprisingly, the common practice of hiring *outsiders* to transcribe research material is thus now being questioned (Lapadat, 2000; Tilley, 2003a).

It was only through trying to work with transcribers myself that I learnt what a critical part of the research process transcription actually is. In previous research projects I had transcribed all of my research material by myself and in the process had (unknowingly) developed my own style of transcription, privileging the rhythms and idiosyncrasies of speech over the formal grammatical rules of (written) language. I had great difficulty in trying to convey this style of transcription to the two (professional) transcribers that I tried to work with. One of the transcribers (who in the

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end only transcribed one tape) got really angry with me after I had checked her work and then proceeded to show her all of the places in the transcript where there were 'omissions' or 'errors'. She virtually screamed at me, saying that I would *never* find anyone who could (or would?) do the transcription in the detail that I required. I must confess that I had been completely shocked when I had checked her transcript against the audiotape and found each page littered with (in my view) 'omissions' and 'mistakes'. To be fair, I realise now that it is much easier to transcribe interviews if you have also been an interview participant, largely because you are (usually) less likely to 'mishear' or misconstrue the talk on the tape.

I realised (in my interactions with 'outside' transcribers) that in deciding *how* to represent speech, transcribers have a substantial effect on the final form that a transcript assumes and therefore upon the analysis that results from a close interpretation of this text. There are potentially many different ways in which an interview can be transcribed into text; thus, researchers need to be closely involved in all phases of transcription (even if they 'hire out' transcription work). I realised also that transcription is a *theory-laden* process (Lapadat, 2000; Tilley, 2003a) in which transcribers make *interpretative* choices which both constrain and enable the kind(s) of analysis that can be performed upon transcript texts. Thus, while I did employ one woman (Natalie[35]) who transcribed about 15 of my 50 interview tapes, in the end I actually ended up *re-doing* her transcription work. I realised that, *for me*, the process of transcribing talk into text is too critical to be left to the choices and interpretations of outside others. To ensure the integrity of my research transcripts, I checked each script (sentence by sentence) against the relevant audiotape and in the process had to almost entirely re-construct the transcript text(s).

After I had completed the interviewing process in March 2005, I spent approximately three months embroiled in transcription. Although I had completed some of the transcription during the interviewing phase of my research, most of the tapes (about 40) were still waiting to be transcribed. Transcription was probably the most arduous and painful phase of my research journey (apart from writing!). The work is gruelling, relentless and demands intense concentration. Although it is seldom acknowledged (Tilley, 2003a), transcription is also often *emotionally* demanding work, requiring that the transcriber *enter into* the emotional space of interviewees. For example, Natalie told me that she found the interviews (with Hannalie) so 'intense' that she had to take frequent breaks away from the tape. I found this interesting because it mirrored my own experience within those particular interviews. In listening closely to tapes during transcription, transcribers are *pulled* very intensely, both viscerally and emotionally, *into* the interview dynamic and the subjective life-worlds of interviewees. The work of transcription is thus often *not* dispassionate and detached; in fact, transcribers can become emotionally embroiled

[35] *All names* used within the thesis (except my own) are pseudonyms.

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in and personally *affected* by the work (Tilley, 2003a). For example, after she had transcribed several tapes, Natalie wrote the following to me in an email:

> I must say these tapes have caused me to reflect on my own life choices as a woman. I once stated children is a responsibility that I wished not to have, and that not having children does not make me an incomplete woman. I'm now looking at other reasons within myself for those statements and choices…

In the last contact I had with Natalie, she told me that she had been 'inspired' by the stories of the women on the tapes and that as a direct result, she was taking steps to galvanise her own life and had decided to embark on a PhD.

Several writers have described the transcription process as an important *analytic* step in which researchers begin the interpretative work of 'making sense' of interview data (Lapadat & Lindsay, 1999; Lapadat, 2000; Tilley, 2003a). For me, the process of transcription helped me to develop an *intimate familiarity* with the interview material. I did not, however, take notes during transcription or begin to form any substantial conclusions regarding 'analysis'. In fact, I remember often feeling rather panicky because I wondered what on earth I was going to 'make of' this material. This feeling continued for a long time (well into 'the analysis'). However, I do feel that transcription does give the researcher an important general 'feel' for the 'data', which does *facilitate* the process of analysis.

In retrospect, my approach to transcribing was guided more by a 'naturalized' view of transcription than a 'denaturalized' one. According to Oliver *et al*. (2005), there are two dominant transcription 'modes': *naturalism*, in which (all) utterances are transcribed in as much detail as possible and *denaturalism*, in which the messy aspects of speech (i.e. stutters, pauses, vocalizations) are 'pruned out' or *sanitized* in the interests of 'readability'. Largely because I had experimented with alternative (poetic) ways of re-presenting interview participant's stories (for example, see Chadwick & Foster, 2005) in my previous research project, I was from the outset clear that I wanted to preserve as much of the *idiosyncrasies* of speech styles as possible within my transcripts. I also wanted the rhythm(s) of speech to be respected and not artificially regulated by 'full-stops' and other grammatical devices. Thus, in my transcriptions I tried to re-present as much of the embodied, lively, 'breathy' (semiotic) qualities of speech as possible. The ways in which participant's *used* language therefore became important; for example, were particular words uttered in a garbled and rushed fashion or were they drawn out and spoken slowly for effect? All words and repetitions were transcribed, including 'um', 'hmm' and 'you know' (see Appendix J for a guide to transcription notation).

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Analytic frames

Narrative analysis

"…everyone can tell stories, whereas only academics can find narrative."
(Unni Wikan, 2000:217).

While narrative methods have a long history in disciplines such as anthropology, the last 20 years have witnessed a large-scale 'turn to narrative' across the social sciences and humanities. Some writers thus refer to contemporary times as an "age of narrative" (Josselson, 1995:31), while others argue that human psychology has "an essentially narrative structure" (Crossley, 2000:46) and that the nature of narrative and storytelling is "ceaseless…in all societies" (Plummer, 1995:5). This so-called 'turn to narrative' is coextensive with the broader 'post-structuralist' or 'social constructionist' turn to language, discourse and text within the social sciences, prevalent since roughly the 1980s. Given that multiple theoretical strands of influence are implicated in this narrative turn, it is not surprising that little agreement exists concerning the definition of what narrative actually 'is' or what exactly constitutes a 'narrative analysis' (Reissman, 1993; Polkinghorne, 1995; Chase, 1995). Thus, there are several 'schools' of narrative analysis, influenced by different theoretical currents such as phenomenology, psychotherapy, psychoanalysis, hermeneutics, sociolinguistics, literary theory, post-structuralism and cognitive psychology.

Catherine Reissman (1993) provides a very *broad* definition of narrative, defining it as, "talk organised around consequential events" (pp. 3). However, even this definition is open to contestation, in so far as other narrative researchers have problematised the identification of narrative with *talk*. For example, Cheryl Mattingly (2000:181) asks, "suppose that some stories are not told so much as acted, embodied, played, even danced?" However, notwithstanding competing definitions, it is widely agreed among narrative theorists that (classic) narratives can be identified by the following two central dimensions, namely: temporality and plot. Thus, it is commonly accepted that narratives (as opposed to 'discourses' or rhetorical arguments) are embedded in a *temporal order* (Ochs & Capp, 1996). For example, a 'classic' narrative would usually be told in a chronological order, in which a sequence of events unfold in linear time. Narratives told in this way create a powerful (and reassuring) sense of coherence, continuity and order (Ochs & Capps, 1996) and also re-produce a modernist model of the self as coherent, unitary and integrated. The second defining characteristic associated with (classic) narrative is the presence of a well-ordered plot or, according to Ochs & Capps (1996), a 'point of view'. Narrated events are therefore not only embedded in a temporal order, but are also (usually) linked thematically in a causal chain that ultimately 'adds up' to *a point*. A (good) narrative thus must

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have a point to make, which is realized through the structuring of plots. According to Garro & Mattingly (2000), the most important criteria of a 'good' story is that it must be able to answer the 'so what?' question effectively. The plot is thus the *logic* of the narrative, gives *meaning* to a set of events and serves as the *mode of explanation* for why a story is told in a particular way.

There are several other 'features' associated with narratives. For example, narratives are almost always embedded in story settings, which involve spatial and temporal contexts and a cast of characters (or at least one central actor). Telling a story is also a 'relational act' (Garro & Mattingly, 2000), in that stories (and their telling) always involve dialogue(s) with concrete others, local and cultural contexts and different parts of the self (i.e. between past, present and future selves). It is also widely recognised that 'good' stories (i.e. captivating stories) are usually fuelled by "an *unexpected* or *troubling* turn of events" (Ochs & Capps, 1996:27; my emphasis); the narrative itself often works to resolve the disjunction(s) between what was expected and what transpired. According to Bruner (cited in Ochs & Capps, 2001:145, my emphasis), "trouble is the *engine* of narrative." This feature of narrative has been variously termed: 'trouble', 'the complication', the 'complicating action', 'inciting event', 'initiating event' and/or the 'problematic event' (Ochs & Capps, 1996).

While a 'classic' or ideal type of narrative is characterised by linearity and a coherent plot, there are other forms of narrative that are *not* told coherently, chronologically or with a well-ordered sense of emplotment. Thus, sometimes narrators 'jump around' and shift back and forth between past and present, creating disjointed stories, loose ends or scattered flashbacks. Narratives are also not always final, polished products in which everything is neatly resolved (Ochs & Capps, 2001). Furthermore, the selves produced by stories are not always coherent 'wholes'; sometimes narratives re-produce *divided* and fragmented selves. Ochs & Capps (2001) usefully remind us that narratives occur on *a continuum* and cannot easily be defined according to a fixed set of characteristics. According to Ochs & Capps (2001) social science research predominantly deals with 'classic' narratives, characterised by linearity and coherence; in general, they believe that it is such narratives that are often elicited in research interviews. Narratives on the 'other' side of the continuum, characterised by non-linear organisation, incoherence, uncertainty and fluidity are less well researched and remain difficult to identify or analyse (*ibid*).

Arthur Frank (1995) makes the important point that it is often difficult for interviewers and researchers *to hear* stories that are disordered, rambling and incoherent. As interviewers, we also often try to *impose* narrative order upon interviewees and work hard at 'making sure' that we 'get' a coherent story (e.g. see Pollock, 1999). According to Frank (1995), stories that lack narrative order are often experienced (by the listener) as threatening and anxiety provoking. The teller is also often seen as somehow 'failing' to tell a 'proper' story. In his remarkable analysis of illness

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narratives, Frank (1995) identifies the 'chaos narrative' as an anti-narrative that is told with no coherent causal chain (or plot). Told as a series of urgent and immediate 'happenings', 'chaos' narratives are marked by an 'incessant present' and told *as if* they were being lived. Often the teller of such stories seems 'swept away' and out-of-control; the voice of 'chaos' is characterised by a hurried 'and then…and then…and then' speech style in which the story is constantly being interrupted. 'Chaos' narratives are often associated with (unspeakable) trauma and pain; according to Frank (1995:98):

> The story traces the edges of a wound that can only be told around. Words suggest its rawness, but that wound is so much of the body, its insults, agonies and losses, that words necessarily fail.

Telling stories is also widely recognised as a fundamentally human way of *making sense* (and meaning) and *making self* (Garro & Mattingly, 2000; Kirmayer, 2000). According to Ochs & Capps (2001), the human drive to *make stories* is fuelled by the *tension* between a desire for coherence and meaning and a desire to capture all of the complexities and contradictions of lived experience(s). Narratives are a way in which people can 'make sense' of life experiences that are often lived as ambivalent, conflicted and 'messy'. It is important to remember that "life as lived lacks coherence and plot" (Mattingly, 2000:184) and that stories are never simply unproblematic reflections of experience. To make coherent meaning, individuals usually have to position their inchoate experiences within and against accepted *cultural narratives*. Thus, according to Garro & Mattingly (2000), it is imperative that we distinguish between the details of *individual* (idiosyncratic) *stories* and underlying *narrative structures*. It is here that a distinction between story and narrative does become useful. According to Arthur Frank (1995), a story simply refers to the tales that people tell, while a narrative is a 'general story line' or structural type that can be identified underlying many individual stories. Thus, to make effective stories, individuals draw on shared cultural material; particular story genres (i.e. tragedy, comedy, heroic epic, gossip, old wives' tale) and types of plot are cultural resources (Garro & Mattingly, 2000). Thus, learning to tell (particular kinds of) stories is always a deeply cultural affair that is guided by cultural ideas and rules about what makes 'a proper story' (Garro & Mattingly, 2000). Telling a story about one's personal experience(s) thus always involves making *cultural sense* of events. This is where stories become complexly inter-tangled with cultural ideologies. Although many narrative researchers focus solely on the construction of selfhood and individual experience in and through stories (e.g. McAdams, 1993; Linde, 1993; Chase, 1995; Josselson, 1995; Byrne, 2003), others emphasise the inevitable relations between stories, ideologies and cultural power relations (e.g. Garro & Mattingly, 2000; Reissman, 2000; Bell, 2003; Bonilla-Silva *et al*., 2004). Such researchers stress that stories are always told within particular economic, political and institutional

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contexts and that analysts of narrative must ask to what extent particular narratives *support* or *contest* oppressive social structures, ideologies and practices.

Elliot Mishler (1995) provides a useful way of 'mapping' different approaches to narrative analysis. According to Mishler, there are three different approaches: realist, structural and functional. Researchers who adopt a 'realist' approach to narrative usually focus on the *content* of stories, paying less attention to the ways in which narratives are *assembled* and the *effects* they produce. In this model, stories are seen as transparent and accurate reflections of a series of events. Underlying this approach is a theory of language as a direct, unproblematic *expression* or *reflection* of reality. The second approach to analysing narrative has roots in structuralist and post-structuralist theories and is characterised by a focus on the ways in which narratives are *constructed* as texts. There is often a close analysis of the rhetorical, aesthetic and linguistic features of narratives (i.e. tropes, metaphors, irony, metonymy) that work *to achieve* unity or coherence. For example, drawing on a sociolinguistic tradition, Catherine Reissman (2000) clearly endorses a structural analysis of narratives in which the narrative genres and textual devices used to persuade listeners are analysed. Attending to the interactional context(s) within which narratives are elicited is also considered an important element of analysis. Increasingly, researchers have emphasised the 'performative' quality of storytelling, in which narratives are regarded as 'collaborative performances' or 'dialogic performances' (Reissman, 2000) that are shaped by audiences. The 'narrative event' or 'oral performance' itself has thus become an important site of analysis (Peterson & Langellier, 1997; Reissman, 2000; Garro & Mattingly, 2000). The third approach to narrative analysis focuses on the *functional* characteristics of narratives. Researchers working within this approach thus emphasise the *effects* that particular kinds of stories have. Narratives are therefore viewed as *constructive*, in that they *re-produce* particular versions of the world. Underlying this approach to narrative is a view of language as constitutive of 'reality'. Important questions to ask in this version of narrative analysis are: what *purposes* do stories serve? What *functions* do they perform? What *version* of the world do they endorse/subvert or re-produce? Who has the right to tell particular kinds of stories? Researchers working within this analytic frame are often driven by political motivations (e.g. feminism) and are committed to exposing the 'legitimating function' of certain stories and destabilising so-called 'master narratives' or dominant cultural story lines that serve to reproduce oppressive power relations.

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Pregnant with voices: on finding a 'method' of analysis

"*Listening is hard, but it is also a fundamental moral act; to realize the best potential in postmodern times requires an ethics of listening.*"
(Arthur Frank, 1995:25).

Although the processes of reading and internalising 'the literature', interviewing participants, transcribing interviews and analysing 'data' can never be neatly separated, in order to tell a more-or-less coherent 'story' of this research project, I have collaborated with the taken-for-granted linear myth of the research process. In this section, I try to re-trace the ways in which I grappled with different approaches to analysing women's birth stories.

In my research journal, I made a point of *marking* the beginning of the analytic phase of my research, writing a single line: "Started analysis. Thursday, 7 July 2005." Thereafter, my journal is filled with scrambled and uneven entries documenting the sheer difficulty of trying to 'make sense' of approximately 900 pages (single-spaced) of transcribed text. I remember moments of sheer panic and terror in which I often wanted to curse the fine-grained, detailed birth stories in which somebody was always counting centimetres, minutes and/or hours. What was I supposed to make of these seemingly unremarkable details? In retrospect, I think I passed through an experience similar to Emily Martin (1987), who writes of feeling "only a sort of leaden disappointment" (p. 11) at the start of data analysis and despairing at the 'obviousness' of what her interviewees were saying.

Coming from a background in discourse analysis (Potter & Wetherell, 1987; Parker, 1989, 1992; Burman, 1991; Stenner & Eccleson, 1994) and rhetorical analysis (Billig, 1987, 1989, 1991), meant that I was already largely *au fait* with close, deconstructive textual analyses. However, while doing my research for my Masters degree, I had already become disillusioned with some versions of discourse analysis and 'social constructionism' (see Gergen, 1985, 1994; Burr, 1995; Velody & Williams, 1998; Nightingale & Cromby, 1999), which I felt were too 'discourse determinist', leaving little space in which to seriously consider individual *subjectivity*. In this research, I knew that I wanted to find analytic and representational *strategies* that would enable me to highlight women's birthing subjectivities (as told in and through stories). In the early days of analysing my 'data', I thus began to experiment with the voice-centred relational method or '*Listening Guide*' developed (over a 10-year period) by Carol Gilligan, Lyn Brown and other colleagues at Harvard University.

The '*Listening Guide*' is a psychological method of qualitative analysis that focuses on the triad of voice, resonance and relationship "as ports of entry into the human psyche" (Gilligan, Spencer, Weinberg & Bertsch, 2003:157). The '*Listening Guide*' is rooted in a range of theoretical contexts, including the clinical method as developed by Freud, Breuer and Piaget

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(Gilligan *et al*., 2003), a psychoanalytic understanding of the psyche (as composed of multiple voices), hermeneutics (Brown, Tappan, Gilligan, Miller & Argyris, 1989), the language of music, including concepts such as: voice, resonance, counterpoint and fugue (Gilligan *et al*., 2003) and so-called 'relational' theories which argue that selves develop only in relationship(s) with others (Brown & Gilligan ,1992; Belenky, Clinchy, Goldberger & Tarule, 1986). Seen as *a pathway into relationship* with research participants, rather than a fixed analytic framework (Brown & Gilligan, 1992), the '*Listening Guide'* focuses on "coming to know the inner world of another person" (Gilligan *et al*., 2003:157). This method outlines a series of sequential 'listenings' that are designed to enable the researcher to 'tune-in' and distinguish the different voices (and their resonances) that are embedded within personal narratives. The '*Listening Guide*' works from the assumption that there are always *simultaneously co-occuring* voices (contrapuntal voices) present within selves and stories (Gilligan *et al*., 2003). These voices are seen as often in tension (or contradiction) with each other, with the voices of others or accepted cultural norms. The voice-centred method is demanding and requires the active engagement of the researcher with the 'unique subjectivity' of particular research participants. Researcher reflexivity is an intimate part of the method and the listener (researcher) is required to carefully attend to their responses to the interview and interviewee. There are four basic 'steps' or 'listenings' involved in the '*Listening Guide*', although the method is not 'set in stone' and researchers have adapted the guide in various ways (e.g. see Mauthner & Doucet, 1998; Jack, 1999).

The first step in analysis is 'listening for the plot'. In this 'listening' the researcher is advised to (a) listen for the general plot of the story and (b) reflect upon their own responses to the interview, narrator and story. The first part of 'step one' is common to most versions of narrative analysis and involves attending to the general content (settings, characters, general story line) of the narrative and noting repeated images, metaphors, themes, absences and contradictions. Part (b) of 'step one' brings the researcher's *own subjectivity* into the analytic process by insisting that the researcher identifies and explores their own thoughts, feelings and 'resonances' in relation to the narrative (and interviewee) being analysed. The second step of the '*Listening Guide*' involves following the voice of the '*I*' within the transcript text. By systematically tracing (with a coloured pencil) the word 'I' and any surrounding phrases which include "seemingly important accompanying words" (Gilligan *et al*., 2003:162), the researcher is able to construct 'I poems' which convey "an associative stream of consciousness carried by a first person voice" (pp. 163). Honing in on the 'I voice(s)' in this way enables the listener to hear the way(s) in which interviewees' talk about their selves and moves the shifting and (potentially) contradictory *subjectivity* of the narrator to the centre of the analysis. The third step of the '*Listening Guide*' involves 'listening for contrapuntal voices'. In this 'step' the listener identifies, labels and pulls

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out the different 'voices' within the narrative that relate to the research questions at hand. The key 'markers' of particular voices are also identified and described; for example, Gilligan *et al*. (2003) refer in their example to a 'voice of knowing' which they describe as 'marked' by hesitations, self-interruptions and a repeated refrain of 'you know'. Relationships and resonances between the first person voice and various contrapuntal voices are also explored. The final 'step' is 'composing an analysis' in which the researcher 'pulls together' and synthesises everything that they have learnt about a particular narrator via earlier 'listenings'. This is then 'written up' as an analytic summary or essay in relation to relevant research questions.

I was drawn to the '*Listening Guide*' because of its emphasis upon the shifting, potentially contradictory, and complex *movements of subjectivity* in and through stories. The careful *listening* involved and the concern with participants as active, complex and concrete human subjects, also felt *ethically* appropriate to me. Most importantly, however, I was drawn to the poetic possibilities of the '*Listening Guide*'. Following the experimental work of researchers such as Laurel Richardson (1997), Susan Krieger (1983, 1991), Susanne Gannon (2001) and Cynthia Poindexter (2002), I have tried (not always successfully) in earlier work to experiment with poetic forms of re-presenting interview 'data' (see Chadwick & Foster, 2005). The 'I poems' of the voice-centred method offered a novel, poetic and *analytic* strategy whereby the subjectivity of the interviewee could be highlighted, traced and poetically represented. I am aware that several other narrative researchers have also experimented with alternative ways of representing participants' stories. Given that narrative analysts are more often than not interested in narrative data *as a whole*, it is not surprising that they have tried to depart from conventional ways of representing interview material. For example, Catherine Reissman (1990, 1993, 2000) insists that narrative texts should not be 'fractured' into 'bit and pieces' in the interests of generalizability but that the "sequential and structural features that characterize narrative accounts" (1993:3) be respected. Reissman thus devotes considerable space in her texts to lengthy excerpts from transcripts, which are represented in a long-line, numbered style. The work of James Paul Gee (1985) has also been influential in encouraging alternative ways of representing transcripts. Interested primarily in the *oral* and poetic qualities of narrative, Gee proposes that narratives themselves are often structured in *poetic* lines and stanzas. He has thus developed a 'literary' or 'poetic' style of transcription in which narratives are re-presented in terms of *lines* (idea units containing one piece of new or more focused information), *stanzas* (thematically clustered lines with a matching topic or content) and *sections* (defined by one larger topic) (Peterson & Langellier, 1997).

In July 2005, I began to analyse my interview transcripts following the '*Listening Guide*'. It was a difficult and time-consuming process. It was only once I embarked on this analytic journey that I came to understand how researchers such as Natasha Mauthner and Andre Doucet (1998)

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could have spent *17 months* analysing their 'data' according to the '*Listening Guide*'. It took me two weeks to exhaustively 'analyse' the interview material from *one* participant. Similarly to other researchers who have used the '*Listening Guide*' (e.g. Mauthner & Doucet, 1998; Jack, 1999), I experimented with slightly different analytic strategies. Thus, instead of only crafting 'I poems', I decided to focus on all the pronouns in the transcripts and constructed pages and pages filled with 'pronoun poems', following the use of pronouns such as 'she', 'they', 'you', 'we', 'it' and 'he' as well as 'I' within the stories. Furthermore, drawing on the work of Frank (1995), who identifies the repeated use of an 'and then…and then…and then' style of telling as characteristic of chaos narratives, I followed the use of this phrase where relevant. Thus, in the analysis chapters to follow, I make use of narrative poems in which I represent sections of interview material in poetic form. These poems consist only of the words of participants, spoken in the order in which they were told; some poems focus on the 'I' voice, while others trace the use of particular pronouns (e.g. 'she', 'it').

I must admit that I found the '*Listening Guide*' difficult to apply because of the high degree of reflexivity and repeated, careful *listening* it demanded. Although it is not prescribed in the methodological steps, I treated the audiotape recordings as my prime source of 'data'. I found that it was only by listening to the tapes that I could 'pick up' potentially different 'voices' within the text. However, I must admit that I absolutely loathed listening to these tapes. In listening, I 'relived' the emotional aspects of the interviews far more intensely than I had when I had listened *and* transcribed. In my research journal, I reflected on this process, acknowledging how *painful* it sometimes felt to have to re-experience certain interview dynamics. For example, after listening to one of the tapes, I noted how:

> …she repeatedly spoke over me – silencing me – it reconnected me with something I would rather have forgotten. Painful. Feel a bit pained – I don't like her much in those moments…one gets no sense of this emotional dynamic from simply reading the transcripts…listening to the tape brought things back to the full emotional experience (Research journal, 13 July 2005).

By listening to the tapes in conjunction with reading the transcripts, I realised just how much the transcript actually erased. When voices are translated into text (no matter how detailed the transcription), a great deal of visceral, emotional and kinetic content is simply lost. By listening to embodied, crackling speech on the tapes, the researcher is pulled dramatically back *into* the stories told and the tellers telling them. It is harder to 'categorise' people, simplify their lives into 'themes' or reduce them to 'discourses' or 'texts' when one is carefully and seriously *listening* to their voices. However, although I realised how critically important it was, I was resistant to listening to the tapes all the way through the analytic process. I had to repeatedly force myself to do it. I remember becoming increasingly frustrated (and overwhelmed) by this constant and

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repeated 'listening'; I became sick and tired of having to listen to what *they* had to say; I wanted to have *my say*. I therefore looked forward to the time when *I* would be able to have 'my' voice heard in the written thesis and analysis. However, the processes of listening to the tapes and writing 'pronoun poems' proved, in the end, to be crucial to the development of my analysis. Along the way I was, however, involved in a long process of "groping around in the blind darkness searching for eye-glasses" (Research journal, 20 July 2005). This is, in effect, in an uncanny sense, exactly how *it feels* when one is trying to make *aural sense* of interview material. When we deal with visual transcripts texts, we are far more easily able to simply 'analyse' away the voices and complexities of human persons.

By persisting with the audiotape listenings, I increasingly began to feel that there was somehow a 'voice of the body' that was crackling in and through these tapes. I didn't know how to label it. Was it a voice of *jouissance*? It was not 'the erotic voice' of the body identified within the work of Deborah Tolman (2001). It was, in my view, "something more – bigger – more complex…" (Research journal, 20 July 2005). Increasingly I began to see that:

> Voices are alive. Meaning crackles in-between words: in breaths, rhythms, a myriad of laughters, pauses, spaces in-between, rising and lowering pitch, snapping fingers and gutteral sounds (that are difficult to convert into conventional alphabetical letters). The dance between the interviewee and myself: my interruptions, my nervous laughter, my awkwardness – hanging – suspended in questions that trail off… (Research journal, 16 August 2005).

Searching for ways in which to understand or theorise this embodied 'crackling' or 'voice of the body' I began to read work by 'the French feminists' in the hopes of getting a handle on the concept of '*jouissance*'. This was how I stumbled upon the work of Julia Kristeva. I was simply amazed by Kristeva's theory of subjectivity in which 'the speaking being' is taken as theoretical point of departure. Kristeva's emphasis upon bodily and semiotic energies as an integral part of the 'signifying' process resonated strongly with my experiences in listening to interview tapes. Kristeva's work gave me a theoretical grid within which to make sense of the poetic, affective and visceral force *of the body* within women's birth stories. It also provided a way of theorising the "potentially disruptive meaning that is not quite a meaning below the text" (McAfee, 2004:24) and of approaching the sensual body-subjectivity in/of birth stories which appeared often only as a 'readable absence' or 'aural presence' between symbolic lines. I was also thrilled to have (finally) stumbled upon a post-structuralist theory of subjectivity which, although highlighting the centrality of language, also takes the body ('the speaking being') seriously.

Thus, although the '*Listening Guide'* had given me indispensable analytic strategies and enabled me to focus on the shifting subjectivities and voices of participants, I began to feel increasing disquiet with some of the theoretical assumptions that seemed to underpin the method.

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At this time, I was also reading other work that had used the '*Listening Guide*' method, including the research of Dana Jack (1999), Natasha Mauthner (2002) and Deborah Tolman (1994, 2001). Although this work is very rich, I felt *uneasy* about something that I couldn't quite 'put my finger on'. After grappling with Kristeva's theory of subjectivity, I finally realised that it was their 'realist' representation of 'the self' as a core and unitary 'thing' that troubled me. Although the '*Listening Guide*' actually conceptualises subjectivity as a composite of contradictory and conflicting voices, analyses using the method often still seem to assume that there is an essential self *underlying* these contrapuntal voices.

Thus, although the '*Listening Guide*' and the work of Julia Kristeva ostensibly represent radically different theories of subjectivity and language, in my analysis I created a 'hybrid' model in which certain 'techniques' involved in the voice-centred method (e.g. 'I' poems, pronoun poems and attention to contrapuntal voices) are fused with a Kristevan theory of subjectivity as a movement which is essentially conflicted and contradictory. As I got further into the analysis, I also increasingly felt that the 'techniques' offered by the '*Listening Guide*' were not enough. For example, I felt that the method does not pay sufficient attention to the *structure* or *function* of narratives and tends to focus instead on stories as reflections of 'real' experiences and 'internal' subjectivity. Thus, while the '*Listening Guide*' allows a powerful analysis of shifting subjectivities, I felt that it needed to be supplemented by a focus on the structural and functional aspects of narratives. In my analysis, I therefore made use of the following analytic strategies:

- Reading transcript texts and tracing general story lines, plots and themes
- Trying to analyse my own 'responses' to the stories, interviews and interviewees
- Listening repeatedly to audiotapes and reading transcript texts
- Constructing 'pronoun poems'
- Listening to audiotapes again and trying to identify different 'voices'
- Reading for the 'structure' of the narrative(s) or accounts (i.e. looking for tropes, metaphors, rhetorical arguments)
- Reading for the 'function' of the narrative(s) or accounts (i.e. asking questions such as: what versions of the world do they re-produce? What do they construct, enable or silence? Do they subvert or reproduce the status quo?)

In the following section of the thesis, I move on to look analytically at women's talk and stories about childbirth. Spanning over two chapters, this analysis is comprised of (a) an ideological analysis (see chapter six) of women's talk about making birth 'choices' and (b) a narrative analysis of women's birth stories (see chapter seven).

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Extracts from: 'Natural birth'

Toi Derricotte, in Chester (1989:111)

10:29

going to the bathroom. worse than cramps. can't stop
going to the bathroom. shaking my head over the toilet.
just sit. sit on the toilet. don't move. just shake
your head. try to go so hard. maybe it will go away.
just try. press real hard. *it hurts i can't help it oh*
it hurts so bad!

lie on the bed and can't breathe right. go to sleep and
wake up in the middle of a wave, too late …

what time is it, i can't keep track of time …

fall asleep. two minutes. can't stand the pain. have
to go to the bathroom. feels so ugly pressing down there,
shame, shame! have to go to the bathroom all the time.
shake my head. can't believe it hurts like this and
getting worse.

lie back in bed, just breathe. just relax. watch the
clock. one minute goes so slow. seems like 10:29, the
clock is stuck there, stuck on pain …

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CHAPTER 6

Speaking in ideological tongues: women making birth 'choices'

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> The dominating ideology never dominates without contradiction…
> (Rosemary Hennessey, 1993a:76).
>
> …individuals are never gripped by a singular ideology.
> (Craig Thompson, 2003:82).

In this chapter, I will be providing an *ideological* analysis in which I situate women's talk about home-birth and elective caesarean section within broad material contexts, ideological frames and cultural story scripts. I will be showing how women's stories and talk are *embedded* within three dominant ideological frames (and socio-structural conditions), namely: patriarchy, capitalism and technocratic medicine. These broad socio-structural and ideological frames often ran through women's talk *as traces* or manifested as particular ideological stories (e.g. 'the good mother') within and against which women positioned themselves. I will also be looking at the ways in which women provided a *rationale* for their respective birth 'choices'. Often women would draw on cultural-ideological story lines (see chapter two) as 'story scripts', positioning frames or legitimating devices in order to 'justify' their 'choices' around childbirth.

In this chapter, I will thus be attempting to show the contexts (material and ideological) within which women's birthing 'choices' were located. As a result, this analysis takes up what might be called a 'realist' position, in that it assumes that there *are* structural and economic 'realities' that exist beyond 'the text'. In this analysis, I am thus influenced by the materialist frame provided by feminists such as Teresa Ebert (1996) and Rosemary Hennessey (1993a), who

encourage analytic readings which 'go beyond' the immanent critique[36] offered by postmodernists and which attempt to 'read' contradictions within texts *as refractions* of structural and ideological contradictions. Within this chapter, my approach to analysis is also influenced by the discourse analytic framework expounded by Jan Blommaert (2005), who stresses the importance of interrogating the contexts, conditions and constraints within which discourse is embedded and enabled. Thus, Blommaert (2005:35) encourages analysts to "look inside language as well as outside it" in the interests of enabling an effective analysis of systemic inequalities and power relations. In this chapter (following Blommaert, 2005), I thus often draw on ethnographic details and observations in the interests of *contextualising* the discourse/stories of particular participants.

The chapter will also, however, be engaged in trying to illustrate the ways in which women 'make' birth choices by grappling with a series of shifting and fluid 'ideological dilemmas' (Billig, 1988) which often manifested within their talk as a motile *mélange* of conflicting voices. Thus, while working within a materialist or 'realist' approach to analysis, this chapter also works within a Kristevan understanding of subjectivity as a *fluid process* or *dialectical movement* in which 'the speaking being' is "poised *between* the practices of body, society and text" (Boulous-Walker, 1998:107, my emphasis).

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Capitalist ideology: an absent presence?

"... motherhood is a class marking (and making) as well as racialized moral project..."
(Linda Blum, 1999:11).

It is important to acknowledge that the birthing 'choices' explored within this thesis almost all emanate from within a 'white', middle-class and privileged social location. Although home-birthers and elective caesarean birthers negotiated dominant ideologies differently, often threading contradictory ideological strands in unexpected ways, these women were all located within comfortably middle-class lifestyles and 'situations'. Thus, all (but two) were highly educated and could claim at least some kind of post-secondary school qualification, whether in the form of a college diploma, university degree or postgraduate degree. Many were qualified professionals or successful entrepreneurs. Almost all had the luxury of domestic help, ranging from those who had a domestic cleaner coming in one day a week to those who had full-time 'staff'. Many of the women were willing and able to pay for a wide range of expert assistance to ease their passage into motherhood, including lactation consultants, night nurses, specially trained nannies, chiropractors, physiotherapists and acupuncturists.

[36] Immanent critique refers to a reading (e.g. Derridean deconstruction) which refuses to 'go beyond' the 'matter' of the text and which only "reads the text (…) in its own terms" (Ebert, 1996:13).

Thus, the 'choices' and birth/mothering experiences of many of these women were, in significant ways, dependent on a rich backdrop of support structures, a large proportion of which was provided by *African women* employed as domestic cleaners and childminders. The domestic and mothering labour (fleeting or full-time) provided by African women either provided the women in the study with the assistance (not provided by husbands/partners or wider kin) needed just to survive the demands of motherhood or enabled them to focus on their careers or on providing infants with so-called 'intensive' mothering (see Hays, 1996). In many cases, this support was not acknowledged or discussed in the interviews, even though domestic workers (more often than not) bustled around the homes of the women concerned while we talked, getting on with the business of vacuuming, mopping, washing, polishing, playing with and comforting infants and toddlers. Sometimes, however, this support was recognised for the 'choices' it facilitated and enabled. For example, Erina French, a 35-year old 'home-birther' who works from home as a freelance research consultant, was quite clear about the role that her full-time domestic worker (and childminder), Rosa played in her life:

> Erina: I mean the big thing for me is (*) I have domestic help which just takes a whole lot of problems <u>out of my life</u> #
> Rachelle: Is she [domestic worker] here most days?
> Erina: Um, Rosa's here everyday ja, um, partly because I, I don't, I don't think I could handle being a 100 %, full-time, 24 hours a day mother (R: hmm) I would just be terrible, I would get annoyed and, and resentful (…) um, so Rosa is (*) one of Maddie's primary caretakers and will be for the new baby so, I mean that just (*) immediately frees <u>me up</u> (R: hmm, hmm) for all sorts of things and I never have to iron, for example (both laugh) so um and so there's a lot of those kinds of issues I just don't have to confront, you know, cause I, I can outsource them (R: hmm, hmm) um (…) um (*) and I also I have <u>the choice</u> (*) you know, if I really, if I <u>decided</u> (*) that I actually felt like being a full-time mom and baking and staying at home and making clothes and whatever, I could do that (*) and if I don't choose it, I can also do that, so having (*) having a choice makes a huge difference (R: hmm) and I do have baking-binges *occasionally* (both laugh) and I feel very proud of myself, um (*) ja but for me, it's, it's quite important, that if I choose to play domestic goddess for a while, it's *a choice*
> Rachelle: Ja, and not something that you're fixed in…
> Erina: Ja (giggles) (Erina French, home-birther, interview one).

For most of the women in the study, mothering practices and 'choices' were often enabled by and embedded within a (longstanding historical) South African system wherein the domestic and maternal labour of African women can be purchased for a relatively cheap price (see Ames, 2001 for a sensitive portrayal of these dynamics). It is important to (at least) recognise that the 'choices' of the privileged are often rooted in the *lack* of 'choices' available to those that are less privileged and that the ability to make 'choices' does not usually occur without substantial support structures and sizeable cultural, social and financial resources.

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Interestingly, an 'ideology of capitalism' seemed to evoke less 'dilemmas' for participants than ideologies of patriarchy and technocratic medicine. As a result, it was the ideological positioning of most of the participants within a concrete, material class location (comfortably white and middle-class) that was often the most difficult to 'read' within their stories. Often economic privilege only ran through their talk in the form of fleeting *traces* or *echoes* signalling their middle-class, Eurocentric world-view. Most of the women were situated (more or less) *comfortably* within a middle-class, consumer subjectivity that itself stands as a product of the ideology of late capitalism.

The capitalist consumer birth market: shopping for 'choice'?

"...postmodern consumer culture produces consumers who desire to actively produce their identities and experiences through commodity interactions."
(Craig Thompson, 2003:103).

As I pointed out in chapter three, several writers have remarked on the increasing extent to which (middle-class) birthing women are being constructed as *consumers* of childbirth. This is not terribly surprising within the context of what some have termed 'the postmodern economy' (Thompson, 2003) or global 'consumer culture' (Zukin & Maguire, 2004).

According to Zukin & Maguire (2004), 'consumer society' is a "distinctive product of modernity" (pp. 189) and is connected to both the emergence of a global market economy and the weakening of authoritative and normative powers traditionally enjoyed by religious and state structures. Shifts towards 'consumer culture(s)' have also engendered novel forms of identity and subjectivity in which the idea of a "choosing self" (Slater cited in Zukin & Maguire, 2004:180) reigns supreme. Within a capitalist consumer ideology, the individual is seen as "*free to choose* his or her path to self-realization" (Zukin & Maguire, 2004:180, my emphasis). Agency ('choice') is thus embedded within, and enabled by, practices of consumption. According to Thompson (2003), consumerist logic has also infiltrated medical science, with patients increasingly being seen as 'informed consumers' and medical practitioners as 'service providers'. The recent consumer-oriented twist to conventional medicine also means that traditional, authoritative patient-doctor relationships are potentially undergoing change (*ibid*). Thus, according to Thompson (2003), the 'patient-as-consumer' is ironically imbued *with more power* because of their increasing right to choose. Thompson does, however, concede that medical systems still retain "more intractable [and] modernist" (pp. 103) forms of 'top-down' power wherein the authoritative knowledge and technical expertise of the medical practitioner remains hegemonic,

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pointing to a gap between medicine as a 'consumer-oriented' service and a hierarchical, normalizing system of control.

These kinds of tensions play out dramatically within the childbirth arena, in which obstetric medicine itself has been instrumental in facilitating the shift from conceptualising the birthing woman *as a patient* to seeing her as *an active consumer* (Fannin, 2003). This has been part of the wider 'commodification' (Taylor, 2000; Hanson, 2004) of all aspects of pregnancy and childbirth. While recognising the opportunities for 'resistance' that can accompany consumer-driven forms of subjectivity (see Zadoroznyj, 2001; Thompson, 2003) it is also important to remember that it is often *only* within consumer discourses that middle-class women are accorded any degree of 'choice' and agency (not to mention the plight of poor women) (Taylor, 2000). The case of childbirth is especially fraught. While the medical 'lingo' accompanying (middle-class) birthing is increasingly saturated with notions of 'free choice' and pregnant women (who can pay) are bombarded by a seductive smorgasbord of options, services, drugs and gadgets, unfortunately, once the birth is underway, the birthing woman's power as a consumer often turns out to be no power at all (Fannin, 2003).

The interviews I conducted were dripping with anecdotes about the medical support and encouragement women experienced in relation to their 'choice' to have an elective caesarean section. When it came to elective caesareans, medical practitioners were often portrayed as the most vocal proponents of birthing women's right to 'choose'. For example:

> Hannalie: …that's exactly what my gynae said, 'It's your choice, you've <u>got</u> the choice today, we don't <u>make</u> decisions for you anymore, you've got <u>all</u> the info, you make the decision, we just support you in it' (Hannalie Botha, elective caesarean, interview one).

Curiously, however, this support of women's 'right to choose' was only evident when women were 'making' the choice to have an elective caesarean section (and often did not extend to the right to give birth at home). All of the caesarean birthers in the study reported that their doctors had been supportive of their decision and often seemed 'relieved' when they expressed their desire to have a caesarean section. Of the 12[37] women in the study who 'chose' caesareans, only *one* woman mentioned that her obstetrician had talked her through the benefits and downsides of surgical birth; none of the doctors involved had tried to persuade the women to 'try' for a 'natural' delivery. After their babies were born, three of the 12 women expressed some degree of regret that their doctors had not given them more information regarding the degree of postnatal pain and discomfort involved in having a caesarean section. However, *all* of the nine elective caesarean

[37] Of which nine were interviewed and three were email correspondents.

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birthers *that were interviewed* expressed postnatal satisfaction with their doctors and their decision to have a caesarean.

In contrast to their supportive endorsement of women's 'choice' in relation to elective caesarean, medical doctors usually tried to oppose and disallow women the right to 'choose' home-birth. Many of the home-birthers told me how doctors tried to 'scare' them into birthing in the hospital, usually by (repeatedly) telling them graphic stories about the risks and dangers of home-birth. Many doctors simply refused to support the decision and would not serve as medical 'back-up' for home-births. As a result, most of the women were forced to abandon their 'regular' gynaecologists and consult the few doctors and specialists (referred to them by their midwifes) who were willing to serve as 'back-up' for home-births. Some doctors went so far as diagnosing 'bogus' problems that would necessitate a hospital delivery (e.g. Jolene Wright).

Women choosing caesarean sections often seemed to be particularly embedded within a consumerist approach to childbirth. Thus, for many of these women, finding a like-minded gynaecologist or obstetrician was simply like 'shopping' for a service. Often these women did not necessarily want or need their medical doctors to nurture, 'take care' of them or make decisions for them; they simply wanted an expert who would skilfully and efficiently perform the service for which they were being paid. Thus, as Hannalie Botha put it, "if I pay for a service, then I would like to make my own decisions about it". Women 'choosing' home-birth were less likely to talk about birth in terms of a service to be outsourced to experts; instead, home-birthers were more likely to be looking for a caregiver who would, via support and wisdom, empower them to birth by themselves. For example, Lizette Zimmerman, a 37-year old 'home-birther', questioned the widespread social norm according to which "we" (the middle-classes) routinely hire specialists or experts to do things for us (i.e. build a house, birth a baby):

> Lizette: …why can't we do it ourselves? You know its like building a house, like why must we get builders? Why don't we build it ourselves? Why can't you do it yourself? (Lizette Zimmerman, home-birther, interview one).

Home-birthing women were also more likely *to question* the need for the consumption of endless baby paraphernalia: designer prams, cots, dummies, bottles and baby monitors. However, despite this questioning, they still (somewhat ironically) tended to make full use of these 'goods'. For example, Mandy Van Zyl, a 30-year old film producer and 'home-birther', aspired to living according to a kind of 'back to the caves' philosophy. Thus, for Mandy:

> Mandy: … keep it as simple as you would if you were living in the caves (R: hmm, hmm, hmm) what would you do? Where would your child sleep? (R: hmm, hmm) (…) I mean, now if we didn't have these prams and cots, and baby monitors, and bottles and this and that (R: ja) you know (R: hmm)

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> what, how would we be raising our children? (R: hmm, hmm) and it would be like this (gesturing to the baby asleep in her arms) (R: hmm, hmm) (Mandy Van Zyl, home-birther, interview two).

While espousing this 'back to the caves' mentality as an ideal or guiding principle, Mandy nonetheless still lived in a house guarded by remote control electronic gates, filled with machinery, equipment, the latest technology and participated in the interview while her large, fashionable cellphone rested within comfortable reaching distance. In many ways, home-birthing women seemed to be caught between two worlds: a modern, technological, twenty-first century world which they were forced to live in and a bygone, 'natural' or 'ancient' world which they tried to recreate in various ways (not least in their choice to birth at home). Stephanie Mitchell, a 42-year old 'home-birther' described this tension well:

> Stephanie: I was trying to provide an infant with, with the ancient sense of care (R: hmm) *and* keep up with, with this world (R: ja) and it's impossible actually, you know, which is why I think there are so many bottles and dummies and nannies and things like that (R: hmm) because um it's actually impossible to join the two worlds (R: hmm) of a, of the ancient traditions and time-keeping and being out in the car, on the roads, and shopping or whatever (Stephanie Mitchell, home-birther, interview two).

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While querulous regarding the drive to accumulate and consume baby 'goods', many home-birthers were however nonetheless caught up in their own efforts to re-produce, as 'consuming subjects', particular lifestyle 'brands' and identities. According to Zukin & Maguire (2004), "issues of identity and consumption converge in the concepts of 'taste' and 'lifestyle'" (pp. 181). While the women who chose to have home-births were an assorted and motley bunch and were certainly *not* all hippies or 'New-Agers', at least eight out of the 15 interviewed were actively involved in weaving *distinctively* 'alternative' identities and 'lifestyles' through discursive positioning(s) and patterns of consumption. Interestingly, it was those women who had only ever given birth at home (the other home-birthers had had previous hospital deliveries) that were the most active in trying to forge identities *against the mainstream*.

For many of the women interviewed, *childbirth itself* often became an extension of a broader lifestyle or 'identity project'. Regardless of the type of birth they were planning to have, women often seemed to make birth 'choices' which they believed 'reflected' their identities, way of being or particular 'approach' to life. Thus, some women spoke about particular birth 'choices' as 'me' or 'not me'. For example, 'home-birther' Lizette Zimmerman spoke of elective caesareans as "completely not me" while Jane Brown (another home-birther) described home-birth as "it was me, ja, there was no ambiguity". Similarly, elective caesarean birther Caroline Kohler described herself as simply *not* one of those, "*natural* mothers that are out in public and breastfeed (*) for

four years"; Caroline was quite adamant that, "it's not me". For Hannalie Botha, birth 'choices' were seen as linked to personal 'tastes'; particular birth 'choices' thus 'appealed' to different kinds of people. For example:

> Hannalie: …ja, I think it's definitely a psychological thing, it's you(r), it's got, I think *a lot* to do with your personality.
> Rachelle: You mean what birth choice you're making?
> Hannalie: Yes, I think so (R: hmm) um (*) **definitely** (R laughs) there's *no way* that I, that somebody will convince **me**, that that kind of experience [natural birth] is something that would appeal to me (…) it's an approach (R: yes) I suppose everything from the way you give birth, to the way you raise your child, to the discipline approach that you're going to take (R: hmm) **mine** is all related (R: hmm) I'm obviously gonna adapt, I **know** that (R: hmm) I'm a first time mother, but, it's like I said to people, just as much as, as, people said to me, "How do you know what you want if you haven't had a child?" But I mean, I don't have to do something to know whether I'll *like* it or not, um, (*) I don't have to breast(feed), I don't have to try and breastfeed to know that I won't like it (R: hmm) I don't have to have a natural birth to know that I won't like it (R laughs) I know *myself* (R: ja) I know, I know a little bit about the way I think and what appeals to me… (Hannalie Botha, elective caesarean, interview one).

'Doing' birth in a particular way was therefore often an extension of 'an approach' or a way of living: a *lifestyle*. Birth 'choices' thus seem to have become, along with many of the other consumption and lifestyle 'choices' available to the middle-classes, not only about "how to act, but also about who to be" (Wilska, 2002:196). While many of the home-birthers interviewed *were* into alternative, slightly 'hippie' ways of thinking and living, others distanced themselves from this 'stereotype' of home-birth. It was particularly women who were only coming to home-birth after having already experienced a hospital birth that wanted to distinguish themselves from the societal stereotype of home-birthers as eccentric 'New-Agers'.

In the way(s) that they 'choose' to give birth and to mother their infants, (middle-class) women are thus often engaging in a kind of consumerist, postmodern identity project or 'project of the self'. Largely enabled by a consumerist discourse available to those with economic capital, the majority of women in this study displayed high degrees of agency. Thus, almost all of the elective caesarean birthers displayed a remarkable degree of active agency in *informing their doctors* how they wanted to birth. In contrast to claims within the literature that women hardly *ever* choose to have caesareans for personal reasons (e.g. Gamble & Creedy, 2000; Hopkins, 2000; McCourt *et al*., 2004) and are more likely to be coerced into surgical birth by medical doctors, 10 of the 12 elective caesarean birthers that I interviewed and had email correspondence with, told me that they had made the decision to have a caesarean *prior* to discussions with medical practitioners. Many of the women claimed that they had known for a long time (way before their pregnancies) that they would choose to have an elective caesarean if they did become

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pregnant. Some actively 'shopped around', looking for a gynaecologist who was 'caesar-friendly'. For example, consider the descriptions below:

> Hannalie: …my gynae's very liberal about it, um, three years ago when I moved to the area where I'm staying in now (…) I looked for a gynae there, and I found this gynae, it's a woman (R: hmm) and I went to her, and I said, 'Listen, um, I'm choosing you as my gynae, I'm planning to have children in the next five years, I just want to know, what's your birth philosophy?' And she just said, 'Well', she looked at me and she says, 'Well, **I** don't have to have a birth philosophy, **you have to have** a birth philosophy' (R laughs) so I said, 'Because I **want** an elective caesar' and she said, 'Well, it's **absolutely** your choice' (Hannalie Botha, elective caesarean, interview one).
>
> Karin: I said to her [the gynaecologist] first thing, the first thing I say is, 'Hi, I'm Karin and I want a caesar' and she said, 'Ja, that's fine' (…) so no, she didn't say, 'Do you wanna try and give it a go?' or you know 'Let's do a few hours and if you don't like it we'll section you later'
> Rachelle: She just sort of accepted it?
> Karin: She said, 'Fine, I'll schedule you – what date are we looking at?' (laughs) (…) so she was quite happy (Karin Miller, elective caesarean, post-birth interview).

It is also important to comment on the remarkable relations of equality that many of the elective caesarean birthers seemed to enjoy with their medical practitioners. This was expressed either in their personal (reciprocal) relationships with their gynaecologists or evidenced by their wide network of friends which often included medical specialists of various kinds. Many of the women drew on the advice and opinions of these socially powerful medical friends/experts in legitimising their birth choices. Only one home-birther (Angela Stewart) referred to a network of medical friends. The easy and (ostensibly) equal footing that many elective caesarean birthers seemed to 'take up' in relation to medical professionals is perhaps indicative of the *social capital*[38] that their class positions often afforded them.

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Situating traces: echoes of a Eurocentric, western perspective

"…middle-classness relies on...expulsion and exclusion…"
(Stephanie Lawler, 2005:430).

Finding 'traces' of a global and local economic 'view' within women's stories required a fine-grained analysis. On a first take, the ways in which the stories functioned as refractions of a middle-class, western stance was not visible to me. This is probably because I share a similar

[38] According to Moi (1999), the concept of 'social capital', drawn from the work of French sociologist, Pierre Bourdieu, refers to, "the power and advantages one gains from having a network of 'contacts'...Social capital helps its possessor to develop and increase other forms of capital and may greatly enhance his or her chances of achieving legitimacy in a given field" (pp. 293).

social location and am therefore potentially 'blind' to some of the taken-for-granted assumptions that saturate this worldview. However, after being alerted to the critical significance of the economic by reading the work of Teresa Ebert (1996), I was able to 'read' the transcript texts in a different way. As a result, I began to see that the women's stories *resounded* (sometimes faintly) with eruptions and echoes that revealed their positioning within local and global economic structures. Within the texts, I thus identified five different binaries within which women (at times) positioned themselves: *private* health care versus the *public* or 'State' health care system, *urban* versus *rural*, *First World* versus *Third World*, *western* versus *African* and '*white'* versus '*black'*. Each time that these binaries were invoked, women positioned themselves as: private health care, urban, First World, western and 'white'. Often the fictive '*we*', sprinkled here and there within women's talk, seemed to refer generically to First World, western, middle-class and western people.

According to Lawler (2005), (British) middle-class selves are produced *in opposition* to the poor and working-class. She provides a clever analysis of some of the ways in which the working-class are constructed (in the media) as repellent, 'disgusting' and wholly 'other', setting up neat boundary lines within which 'we' (the middle-classes) can be reassuringly (and invisibly) cast as civilised, 'clean', rational and 'tasteful'. This process, whereby poverty is 'othered', is clearly linked to the Kristevan notion of *abjection*; in this case, poor people become symbols of the horror and chaos that always lurks on the (sometimes fragile) borders of 'middle-classness' and 'respectability' (Skeggs, 1997). Although not heavily elaborated within women's stories of birth 'choices', there were occasions within the texts in which similar dynamics *erupted*. It must be pointed out that these 'eruptions' were infrequent, probably largely because the middle-class, western, First World 'frame' within which the stories were located was so taken-for-granted and assumed.

Thus, for example, the unimaginable 'horrors' involved in birthing within public or 'State' hospitals appeared as fleeting flashes and fragmented allusions within some of the women's stories. One of the elective caesarean birthers that I was in email contact with described the following 'nightmare' that she experienced during her pregnancy:

> I get horrible dreams. The other night I could see David [baby] through my tummy, and he was in distress, as if he could not breath, the next moment my tummy tore and he started coming out, I kept on pushing him back through the opening, I was so devastated about early labour and knowing that he is not fully developed, then I couldn't find anyone to take me to the hospital, my cell [phone] wouldn't work (…) eventually someone agreed to drive me and the only thing I keep on repeating is that I don't want to go to a State hospital, that they must please take me to my private clinic…it was devastating…(Taryn Burger, elective caesarean, email correspondent).

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For Taryn, the horror of being forced to give birth within a 'State' hospital *hovered* as a nightmare on the fringes of her consciousness and remained too terrifying to fully articulate. In a similar vein, for Hannalie Botha, the idea of birthing without private health care insurance and/or within the 'public' sector evoked a chaotic and frightening picture of being out-of-control and without 'choices'. Partly this was related to the fact that Hannalie's sister had given birth *without* 'medical aid' and was, as a result, forced to go through a traumatic birthing 'ordeal'. Consider the following excerpts from Hannalie's 'talk':

> Hannalie: …she [sister] wanted to have a, um, a caesarean, her gynae also said that he thinks it's better, but because she didn't have a medical aid, it's almost like they discouraged her to ha(ve), to have a caesarean section (…) it was a terrible ordeal for her, um, also I think it was the whole thing that she didn't have a choice, she maar [just] trusted the doctor, eventually the gynae didn't even deliver the child, just her normal GP did (R: hmm) the gynae sort of just disappeared into the distance (R: ***Really***?) ja, which was very bad, I thought it was very unprofessional, she says, she thinks, after, after he found out she doesn't have medical aid (R: gasping) he just sort of…it's very unethical (R: that's awful) (interview one).
>
> Hannalie: …you must do it [give birth] in a hospital (R: hmm) because in **any** hospital nowadays, especially certainly, I don't know what it's like in State hospitals, but certainly in private clinics, the environment that they put you in, is, is *very homey* (R: hmm, hmm) (interview one).
>
> Hannalie: …Where you do get these State hospitals where they push and push and push, for you to do it (R: ja, the natural way) and then I think it's (*) I think it's unethical…(Hannalie Botha, elective caesarean, interview one).

While Hannalie's talk within the interviews more broadly repeatedly stressed the point that women today have choices and therefore must make informed decisions regarding how they want to give birth, at the same time, an awareness (seen in the fleeting extracts above) of *another reality* within which women do not have any choices (due to economic circumstances) seemed to *haunt* her story. She was, however, able to expunge and '*other*' this reality as not applicable to *her* situation; as she herself stressed, "my medical aid, I'm Discovery Health (*) pays 100% of private rates".

While almost all of the women positioned themselves within a western, middle-class, urban and First World worldview and simultaneously distanced themselves from respective binary 'others' (i.e. African, Third World, poor, rural) there *were* some differences in the ways in which home-birthers and elective caesarean birthers negotiated this split. For example, while references towards 'African' or 'Third World' ways of birthing were always regarded as 'backward' or shockingly 'primitive' by caesarean birthers, home-birthers were positioned more ambivalently in relation to 'tribal' or 'African' ways of birth. In part, this is due to the different *stances* home-birthers and elective caesarean birthers 'took up' in relation *to time*. For home-birthers, the

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'ancient', bygone and historic world was often seen as imbued with positive values, 'lost' to 'us' in the contemporary world, while caesarean birthers always firmly positioned themselves within the view that the 'modern' world is 'better' and an advancement over the 'backward', antiquated historical past. However, both views of so-called 'tribal' and 'primitive' cultures are, of course, deeply problematic and intimately intertwined with racist and colonial myths about 'rural' or 'tribal' women (Cosslett, 1994).

For example, home-birthers often drew on a '*romanticised*' ideological trope of the so-called 'primitive woman' which I discussed in chapter two as a key image appearing within the cultural storylines of 'age-old woman-centred birth' and 'natural birth'. Home-birthers thus often looked to a mythic version of childbirth within 'tribal cultures' to fortify or legitimise their 'choice' to birth at home without drugs. For example:

> Mandy: …and just really like going about it properly, just really thinking about, in um (*) tribal cultures, when, when active labour starts, the women go and walk as far as they can, until they *can't* walk anymore (R: yes, hmm) and then under the first tree, they're on their own, and they give birth to their children on their own, and I mean we're all women, we're all cut from the same cloth (R: ja, ja) you know, and, and just like thinking about that and how, how it's such a, a within, such an *internal part of us*, and how we really (*) need to handle it, we really need to (*) in my head (R laughs) we need to cope with it and not like try and run from it… (Mandy Van Zyl, home-birther, interview two).

I have already discussed, in earlier chapters, the problematic assumptions that accompany such (misguided) cultural stories about 'tribal' women who supposedly give birth easily and without complication by themselves. It is noteworthy, however, to point out the dual function that this cultural trope serves within Mandy's account. First, this storyline *empowers* Mandy to believe that *she* (just like 'tribal' women) can birth *by herself* without medical technology, drugs or expertise. However, at the same time, by invoking the power to birth as an *essential* part of being a woman: "an *internal part of us*", Mandy reproduces 'natural', drug-free, uncomplicated birth as a regulatory ideal that all women ('we') *should* and *need* to 'get right' and do 'properly'. This cultural trope thus paradoxically both *empowers* and *constrains* women. Furthermore, although evoking the image of the 'primitive' or 'tribal' woman as a mythical ideal, most home-birthers still positioned themselves within a western, technological mode of medical care. For example, while feeling a "strong connectedness" with the Earth and traditional cultures and explicitly valuing the "ways of being" within such cultures which she describes as all but 'lost' to "our culture", Stephanie Mitchell nonetheless firmly locates herself within a First World, western worldview:

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> Stephanie: …if you read Sheila Kitzinger and you read '*Immaculate deception*' they say it ['natural' birthing with a breech baby] isn't a problem, but to find the person, the professional (R: who's willing) because things do go wrong and there are lawsuits, so, and I'm sure out, out in the *rural* areas I could have found a, a Xhosa or Zulu mama (R: hmm) who, but the, <u>the risks are high</u> (R: hmm) you know, so, in the western sort of medical culture you're not prepared to take those kinds of risks (R: hmm) (Stephanie Mitchell, home-birther, interview two).

In this extract, we can see clearly how Stephanie (a 'home-birther') locates herself within a western, First World cultural view. She does this partly by 'othering' rural, African women who live 'out there' and associating their midwifery skills with high (*un*professional) degrees of 'risk' that 'we' (as western and middle-class) are not prepared to take. The racist/patriarchal assumption that 'African' women are 'naturally' good at birthing, breastfeeding and mothering also run through some of the women's stories. For example:

> Ilse: …even *the cleaners*, I couldn't believe it (R laughs) they had a black lady emptying the, the, um, bins and things, and that, at that stage, I hadn't, haven't seen a nurse for quite a while (…) and this black cleaner, obviously they're very good with children, at least this one had a, quite an affection, she almost watched and I, I suppose though she's not allowed to handle the little one's really (R: hmm, hmm) cause she's a cleaner, I dunno (R: hmm, hmm) um, but she really, um, she was interested in what's happening and she [baby] didn't want to latch nicely at that particular moment (R: hmm) and the um, cleaner, actually just gave a few (*) pointers (…) it actually worked very well (R: ***oh really***) *oooh*, she was chuffed (both laugh) very chuffed…(Ilse Van Rooyen, elective caesarean, interview two).
>
> Karin: …I battled with getting her [baby] latched and so it took a while and then one of the black girls came in and I said, "Oh come on sweetie, you girls can *always* do this – <u>come show me how</u>" (laughing) (R: hmm) it was kind of like nipple here and head there and shove the two together so (R: and that worked?) (R laughs) it did work, you know…(Karin Miller, elective caesarean, post-birth interview).

Thus, 'black' or African women are "obviously (…) very good with children" (Ilse) and "can *always*" (Karin) breastfeed. Here we see *traces* of an essentialist, racist ideology that represents (all) African women as exotic 'others' ("they"; "you girls") who, by virtue of their closer affinity to 'nature' (the 'primitive'/the corporeal) are *always* able to effortlessly and painlessly give birth, nurture infants and breastfeed. What is perhaps especially troubling about these extracts is the patronising and infantilising tone that the interviewees[39] 'take up' in relation to African women, who are referred to (rather dismissively) as "Xhosa or Zulu mama[s]" (see Stephanie above), "black *girls*" (Karin, my emphasis), "sweetie" (Karin) and "you *girls*" (Karin, my emphasis). While seen as, on the one hand, 'naturally' expert at more 'instinctive' or corporeal aspects of

[39] It is important to note that I, as the interviewer, am deeply implicated in these interactions and often colluded (e.g. via laughter) with this racial 'othering'.

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maternity, African women were also cast as ignorant and un-knowing in relation to 'educated' versions of mothering. For example, two caesarean birthers insisted that their 'African' domestic workers (who in each case had raised children of their own) complete a series of 'courses' enabling them to engage in *westernised* modes of infant development, play and stimulation.

> Hannalie: …I'm getting a woman out now called Penny Jenkins, she's also a social psychologist, she's going to train Constance [domestic worker] at home for five weeks (…) on motor development and enabling play and you know, she does it all for R1500 and she does CPR training (R: okay) (…) but um, you know, stimulating the child and doing that kind of thing, it's gonna be important for me as well (…)
> Rachelle: Okay, is that with you or…?
> Hannalie: With her (R: with the domestic worker) No, I, I know what to do (R: ja, ja, okay) with her, ja, um, and I mean she's had children of her own but this is a, she's obviously not had those, you know, I also give her magazines to read, she learnt a lot from that (R: ja) she said to me she didn't know this and she didn't know that, because she's got Matric [finished secondary school] so she's completely there (Hannalie Botha, elective caesarean, interview two).

In this extract, we can see how Hannalie positions herself (the 'white', middle-class, educated mother) as better equipped and 'knowing' ("I, I know what to do") in relation to Constance (the 'African', 'poor' and 'uneducated' mother), even though Constance is experienced in childcare and has raised children of her own while Hannalie is a fledgling first-time mother. The notion that 'western' modes of infant stimulation and development are 'better' and more progressive than 'African' practices also runs through Hannalie's talk as silent assumed.

There were other 'eruptions' within the women's talk wherein the assumed 'western' and 'First World' positioning of the participants was exposed. This was often seen in the *global perspective* that interviewees 'took up' in the interviews. For example, quite a few of the women referred to birthing practices in other parts of the world, including: England, Australia, Holland, 'European countries' and a generic 'Africa'. Not surprisingly, home-birthers and elective caesarean birthers took up different stances in relation to global birth practices. Thus, women planning caesareans were more likely to be critical of 'First World' countries where the majority of women made use of national health care services and where practices such as caesarean sections were discouraged. Home-birthers, on the other hand, tended to hold these 'First World' systems up as a more progressive ideal. For example, consider the following two excerpts:

> Caroline: … and if you look at (*) your first world countries like England, Australia, they, it's all *natural* birth, you know, you don't *really* have a big choice (R: no) and, but it's all also money-driven, because your national health services pays and a natural birth is a lot cheaper than a caesar… (Caroline Kohler, elective caesarean, interview one).

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> Jolene: …if you're in a country where, um, like for instance Holland, apparently 60% of the women have home-births (R: hmm) it's because the government sponsers it (R: hmm) you know, and they pay for it, whereas here, it's not, it's a whole different ball-game (…) and I mean it would make sense if um, you know, the government could give people grants, you know like in Australia (R: ja, ja) like in Holland and a lot of these European countries where they do that and they *encourage* it… (Jolene Wright, home-birther, interview two).

While 'taking up' different positions in relation to birth practices within the 'First World', it is nonetheless clear that *both* Caroline and Jolene (and most of the other participants) positioned themselves *within* a global western and 'Eurocentric' geopolitical/economic alignment. When referring to birth practices within the so-called 'Third World', the term *Africa* was used by one of the interviewees as a generic referent to that which is *not* 'First World' and as a result: 'backward', risky, dubious and 'other'. For example:

> Rachelle: So do you think there are any sorts of risks that go with a caesar – of a personal or medical sort?
> Caroline: Absolutely, absolutely, absolutely, I think um medically, if you haven't got a good surgeon or, anything can go wrong (*) your, your spinal block, any of those things, there, there are certainly *big* risks involved but I, I just, I think medically I think we've got (*) I think, I think the risks are *less*, just where we are, maybe if I was in a different country I, if I was up in Africa and someone wanted to do a caesar, I *don't know* (both laugh) if I'd want to do that (laughs) I think I'd, I might just go the natural route or something, but, or get out of there as quick as (R laughs) possible, but I think where we live and our medical expertise (*) I think (*) there's less, there's less risk in a caesar nowadays (R: okay) (Caroline Kohler, elective caesarean, interview one).

The "we" repeatedly referred to within this extract is clearly referring to a middle-class, 'westernised', privileged (and therefore generally 'white') *segment* of South African society. Interestingly, it is almost as if "where we are" and "where we live" ('white' South Africa) is constructed within this piece of talk as not being *a part* of Africa. In this way, despite the 'reality' of living on African soil, 'Africa' is still '*othered*' and a 'Eurocentric' worldview is taken up. Other women in the study also constantly referred to a fictive and mysterious "we", who on closer inspection often signalled participants' invested (and assumed) positioning in a middle-class, 'western', privileged 'white' socio-political-economic location.

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An outsider's eye: tracing patriarchal subtexts

"Turning women into objects is one central means of ensuring their subordination."
(Carole Counihan, 1999:196).

Patriarchal subtexts and ideological images hummed along throughout women's stories, often in piecemeal yet powerful threads, spinning and shaping women's actions, discourse and 'choices' in significant ways. While I came to this research assuming that home-birthers and elective caesarean birthers would have substantially different (pre-birth) relationships with their *female bodies*, I found that *both* 'groups' of women had to wrestle with an outsider's (patriarchal) eye (or viewpoint) of their female corporeality and experience. The outsider's gaze thus often *infiltrated* and suffused women's subjective experiences and imaginings of their bodies. For example, most of the women interviewed for this research told me that they had 'issues' with their bodies, food and weight control and while at least four had histories of eating 'disordered' behaviours, almost all of the women expressed difficulties, frustrations and concerns (at some time) with this aspect of their lives. These issues were common to both home-birthers and elective caesarean birthers. The patriarchal '*othering*' of women, so beautifully explicated in Beauvoir's theory of female subjectivity, often ran as an internalised set of voices and an imaginary (condemnatory) 'outsider's eye' within the women's narratives.

There were thus only *four* women in the study that described histories of being largely unconcerned with issues of weight control and bodily monitoring. All of the other twenty-two women interviewed were involved in (more-or-less) constant projects of dieting, exercising and constant bodily surveillance. The 'external' patriarchal gaze which constructs female bodies as objects often manifested as an 'internal' self-policing within the women's stories; in their talk they thus repeatedly constructed their bodies as 'things' to be rigorously controlled, monitored and suppressed. For example, Maggie McDougal, a 35-year old 'home-birther' (who had a history of exercise addiction) was running 60 kilometres a week before her pregnancy and still managing six to eight hours of exercise a week well into the eighth month of her pregnancy. Other women continued to adhere to strict dietary programmes during their pregnancies (e.g. Lizette Zimmerman and Ilse Van Rooyen). Home-birther Lizette Zimmerman, described her relationship with her body as, "like most women's (…) always constantly on some kind of, watching your, watching what you're eating you know, like kind of starving for 30 years".

For many of the women, pregnancy itself was an anxiety-provoking experience as bodies 'got bigger' and seemed to gain uncontrollable amounts of weight. Contrary to the finding within Lucy Bailey's (2001) study, pregnancy was not experienced by these women as an escape, 'excuse' or

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liberation from a cultural 'tyranny' of thinness. Only one of the women (Ally Collins) mentioned that pregnancy allowed her to 'enjoy' being a bigger size. Similarly to Sarah Earle's (2003) study of (British) pregnant women, I found that "fatness and physical appearance are still significant factors within women's lives during pregnancy" (pp. 245). Some of the women also mentioned a new 'tyranny' of a *pregnant body ideal* in which the image of a super-toned, lithe pregnant body with skinny limbs and a 'pert', compact belly loomed large. The iconic 1991 front cover of *Vanity Fair* magazine[40] featuring a heavily pregnant (but magnificently toned) Demi Moore was mentioned by some of the women as an example of such an 'ideal' image which they could never hope to 'live up to'. For example:

> Stephanie: … I don't relate to the blossoming pregnancy at all (laughs) you know, I so often think of that photograph of Demi Moore and think, well, you know (laughs) she might have done it that way but that's not how I carry my babies (laughing) I carry my babies with a sense of slog, this is something to get through and it is, ja, it has a wonderful result but it's damn hard work and I'm glad this is my last (laughing) (Stephanie Mitchell, home-birther, interview one).
>
> Ally: … I feel, I feel uncomfortable, and especially (*) when you see these pictures, I saw this magazine and there was this pregnant woman and she was, I mean her stomach was big, very big (R: hmm) but she was wearing these white pants and this g-string and like this white, flowing top but she didn't, okay she was in a magazine, but she was brown, brown, she didn't have *one* stretch mark (R: hmm) or *vein* coming out of her stomach (R: ja, ja) nothing and she was like sitting on her haunches, looking very skinny and that just pissed me off (R: hmm) (Ally Collins, hospital-birther, interview one).

A societal double standard regarding pregnant women was also alluded to within the women's stories. Thus, on the one hand, pregnant women who reflect the 'ideal' image of pregnancy: young (but not adolescent), pert, slim, attractive and 'contained' are treated with awe and veneration, while women who do not fill this 'normative' ideal in some or other way are often treated with disdain, contempt and are sometimes openly abused. For example, while 24-year old, blonde, classically beautiful and 'pertly' pregnant Angela Stewart found herself swamped by strangers coming up to her and telling her how beautiful she looked, Stephanie Mitchell, a 42-year old rather 'tired' looking 'home-birther' with, in her words, a "pendulous" pregnancy, found herself the target of a substantial amount of nasty comments and glances:

> Stephanie: … I've carried low and big for a long time and increasingly when I'm out and I'm walking I'm uncomfortable, people watch, um, and they kind of stop and watch me walk past which, which is an interesting experience in terms of being, being visible and I'm not somebody that makes myself visible generally, I'm quite reclusive and quiet, um, so

[40] See Tyler (2001) for an interesting reading of this photograph.

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> I've felt very visible in this pregnancy, um, and have courted a lot of comment from my sixth month, so you know, "When are you going to drop that baby?" kind of thing, because I've looked ready to birth for a long time now, um (*) (…) um but at times I have been, when I'm feeling vulnerable and feeling uncomfortable, then I have allowed myself to be vulnerable to the looks and the comments, um, "This is looking quite gross now, I'm too old for this" kind of thing… (Stephanie Mitchell, home-birther, interview one).

In this extract, we see the powerful effect of a patriarchal 'outsider's eye' which objectifies the (older, non-normative) pregnant woman's body, turning it into a contemptible and 'gross' aberration. Stephanie *herself internalises* this 'outsider's eye' and *looks at herself* and says, "This is looking quite gross now, I'm too old for this". The recognition of herself within the (condemnatory, derogatory) gaze of the other also results in a feeling of *shame* at what her body looks like. Thus, she says:

> Stephanie: … I've felt that I'm almost too old for this, there've been times when I've looked at other, other pregnant women who carry much higher and far more kind of pert and contained, and there I've been hanging out here since month five (…) and feeling, sometimes I feel, in the sixth month feeling a bit embarrassed, um, this is what my body looks like (…) so no, I haven't felt beautiful and flourishing, I've felt, I've felt both physical and emotional discomfort in the **bigness** of this pregnancy (…) I feel like I'm almost too old for this and a bit embarrassed about being too old to be so **hugely** pregnant, um, but ja, the physical discomfort has been an emotional discomfort and its dominated (Stephanie Mitchell, home-birther, interview one).

Drawing on the work of Sandra Bartky, Lyerly (2006) argues that *female shame* pervades women's existence within patriarchal societies and is intimately intertwined with objectifying and demeaning patriarchal *images* of the sexual and reproductive bodies of women. While women are 'idealised' if they are happen to be on the 'right' side of patriarchal ideologies (i.e. young, attractive, slim, 'contained', white, chaste, heterosexual) they are always potentially sliding toward a collision with a patriarchal underbelly characterised by contempt and *disgust* for women's bodies and sexuality. From an early age, girls somehow themselves often internalise a sense of disgust for their female bodily processes. For example, in this study, only one of the women (Angela Stewart) expressed a positive, female empowering interpretation of menstruation; all of the other women described a general feeling of "ugh" and remembered feeling repelled, 'shocked' and disgusted by the onset of menarche.

Many 'home-birthers' talked about their experiences of pregnancy and birth as 'healing' experiences and as 'transformative' of earlier negative and objectifying relationships with their bodies. In line with Carole Counihan's (1999) research, women's experiences of giving birth (in this case at home) was often described as a source of empowerment, in which women came to a

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new 'sense' of their embodied selves. For example, Jeannie Artz, who described a long pattern of living 'outside' of her body and not 'owning' it, believed that a successful home-birth had radically altered her relationship with her body:

> Rachelle: And would you say that the actual birth experience changed any sort of feelings about your body (J: ja) I mean did you feel more positive?
> Jeannie: I think that's actually why you tend to lose weight actually, cause your body image is much better, it becomes more of a *functional*, capable thing, rather than the object of someone else's desire or whatever (R: hmm) you know what I mean, you no longer think about what other people think of you (R: hmm, hmm) it's like your body is a functioning machine…
> Rachelle: Whereas before you would have had a more ambivalent relationship?
> Jeannie: Ja, it was, it was like I didn't want to own this body, yaknow what I mean, I felt much more in it afterwards, enjoying it, ja (interview one).

While it is clear that Jeannie still conceptualises her body as a 'thing', after a positive birth experience she comes to seen her body as *capable* and *functional* and no longer merely an object whose sole purpose is to be gazed at and consumed. Interestingly, Jeannie also describes a post-birth shift in which she comes to enjoy "difficult and challenging" physical exercise and takes up kickboxing:

> Jeannie: …and now I can do things (…) I suddenly got into doing things that were difficult and challenging, and really loving it, you know (R: ja) I mean kickboxing is hard (…) and then [after the birth] I really, really enjoyed that (R laughs) I really, really liked being able to hit and kick and *hard* and run fast and do stuff like that, and it wasn't about winning and it wasn't about having a good body, it was just about being able to do it (Jeannie Artz, home-birther, interview one).

According to Sandra Bartky (1990:85) female shame is "a pervasive affective attunement" in women's lives and results from patriarchal ideologies that reproduce and reinforce:

> …the shame of women's embodiment, the contagion and polluted nature of her sexuality, and her physical impotence as an embodied individual (Lyerly, 2006:103).

Lyerly (2006) argues that childbirth itself can be an event which both intensifies and reproduces female shame or which challenges and counters it. In Jeannie's reflections, we can see how a positive birth can challenge a sense of "physical impotence" (Lyerly, 2006:103) and turn it into a feeling of *power* regarding the competence, capability and capacity of the female body. The embodiment of women's (general) situation as *Other* which often manifests viscerally as a hesitant, inhibited and contradictory relationship with their female bodily capacities (Young, 1990a) thus is *potentially* transformed by an empowering birth experience. However, while potentially enabling a different 'sense' of bodily capacities and embodied power (which is surely

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not insignificant), there is no 'essential' body-self relation that is 'transformed' for all time by a positive birthing experience. Women remain interpellated, positioned and subject to multiple external 'gazes' and 'voices' which, in jostling style, interpenetrate and re-constitute their embodied subjectivity as a constant criss-cross of movement. However, an empowering birth experience does become an important thread in this interweave which women can draw on to re-articulate a more empowering sense of their embodiment. It is not, however, inevitable nor is it an essential, unchanging transformation. Thus, while 'home-birther' Kayla Peterson also believed that she enjoyed a new 'sense' of her body after her first positive home-birth experience, she nonetheless still faced a barrage of ideological interpellations which created a complex hubbub of 'body issues' requiring constant re-positioning. For example, consider the following extracts from Kayla's first interview:

> Kayla: …so it's going to be the last time my body goes through this awesome experience [pregnancy/birth] and um, just how miraculous it is (…) and also what you're capable of as a woman, one woman said to me after birth, she just said, "I feel like superwoman and my body is such an amazing thing, can't believe what it's capable of" and I think it is that, that empowering and um, maybe too we must just try and keep in touch with the fact that our bodies are phenomenal (laughs)
>
> Rachelle: And did you feel that way after the first birth, I mean did it make you feel more positive about your body?
>
> Kayla: I think ja, I think as Dolores [midwife] said, you're almost a bit more forgiving of your body's imperfections because it is so awesome you know, it might not be perfect from the outside but wow, does it function (both laugh)
>
> Kayla: …I think pregnant women are absolutely beautiful, it's so fantastic, but when it's your own body, it's not quite the same (laughs) you look at your thighs and your bum and you think "Oh my goodness" but um, sort of wanting to be more, you know, some women are just beautifully pregnant, they just get this lovely stomach and that's it, I'm not one of those (Kayla Peterson, home-birther, interview one).

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While a positive birth experience undoubtedly *can* (and often *does*) facilitate a more empowered sense of female embodiment, it is clear from Kayla's talk that patriarchal 'eyes' nonetheless continue to infiltrate and mediate women's relationships with their bodies. Thus, while enjoying a new sense of her body's 'awesomeness' and capabilities, Kayla also continues to 'see' her body through phallocentric lenses and still (at times) *looks* at 'it' from an outsider's perspective. While empowered birthing can facilitate a woman's "transformation from object to subject" (Counihan, 1999:197), I would argue that such 'transformation' is never *finally complete* but is constantly shifting, and has to be re-negotiated in tandem with an unending flux and play of ideological images, ideals, refractions and reflections.

Reproducing or resisting patriarchal 'images'

"Nature…carries an immensely complex and contradictory symbolic load; it is the subject of very contrary ideologies…"
(Kate Soper, 1995:2).

When analysing participants' 'talk' about childbirth, it became clear that elective caesarean birthers and home-birthers constructed very different images and versions of birth and the birthing body. For women choosing to have caesareans, a great deal of interview one was spent constructing a picture of so-called 'normal' or 'natural' birth as inherently dangerous and risky as well as *vile* and *horrifying*. In 'rationalising' their 'choice' to give birth surgically, these women repeatedly drew pictures of 'natural', vaginal childbirth as uncontrollable, terrifying and disgusting. The birthing body constructed within the talk of caesarean birthers was constantly a leaking, bursting, defecating, dirty, bloody, out-of-control and uncontainable body, violently *abjected* and *disowned* by these women. Consider the following email extracts:

> How and why elective caesar?
> Frankly, I don't want my 37-year-old vagina stretched for the delivery. I don't want the risks associated with tearing (…) I don't want to push and sweat and moan and swear (…) Her [baby] first view and smells are not of my vagina and potential loss of bowel control. I don't want to lie and pooh in front of anyone. Even if we manage the bowels pre-delivery (Karin Miller, email correspondence).

> I cannot imagine walking around with a day old baby, dealing with lochia [post-birth bleeding] and urinating, all with a stitched up vagina (excuse my bluntness). I know and understand that a c-section involves major surgery but I am willing to take that anytime. Also, one major concern is that sex will not be the same as before having a normal birth and quite frankly that is just too big a risk for me (…) I am a very private person, I will definitely NOT like it if theatre staff stands around while I'm lying legs in the air screaming and shouting like a mad woman (Taryn Burger, email correspondent).

Even in these two email extracts, we can see how a 'nightmarish' version of 'natural' childbirth is constructed, replete with horrifying images of grotesquely stretched, torn, 'smelly' and 'stitched up' vaginas, *uncontrollable* defecation, bleeding and urinating and terrifying images of (mad) women lying in *obscene* positions, like *out-of-control* animals: screaming, shouting, pushing, sweating, moaning and swearing. This is the Kristevan abject body or 'body-without boundaries' *par excellence*, an "uncontrollable materiality" (Grosz, 1989:72) that induces visceral nausea or "sickness at one's own body" (*ibid*, pp. 75) within the subject.

In my view, it is important to highlight the fact that the patriarchal *Othering* of women does not only work by objectifying them as *sexual* objects, but also, I would argue, by constructing the female reproductive body as *Other*. Masculinist ideologies that work to embody women *as* nature, body, irrationality and animality are always closely tied to images, fantasies and representations of the female *reproductive* body. These representations have, of course, not been applied to all

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women in the same way; however, they nonetheless continue to haunt, pervade, infiltrate and sometimes colonise women's own stance *vis-à-vis* their reproductive bodies. In the 'talk' of women choosing caesareans, an outsider male gaze was usually 'taken up' in their representations of 'natural', vaginal childbirth. These women thus often focused on what vaginal birth must *look like* from an outside perspective; even in the email extracts above it is clear that both women are preoccupied with what *they would look like* giving birth (as imagined from the point of view of an imaginary audience): "I don't want to lie and pooh in front of everyone" (Karin) and "I will definitely NOT like it if theatre staff stands around while I'm lying legs in the air screaming and shouting like a mad woman" (Taryn).

While 'home-birthers' tended to associate 'horrifying' images of childbirth with medicalised, *hospital birthing*, women choosing caesareans regarded childbirth itself (and women's reproductive bodies) as *essentially* uncontrollable and terrifying. Thus, for these women, 'natural' childbirth was regarded as inherently chaotic, lewd and savage. Home-birthers, however (unsurprisingly), tended to see 'natural' childbirth as inherently 'good'. Two competing (and paradoxical) views of 'nature' were therefore clearly at work within the talk of home-birthers and elective caesarean birthers. According to Kate Soper (1995), discourses of 'nature' are *characterised* by paradoxes and contradictions; 'nature' thus appears within the cultural imaginary as "savage *and* noble, polluted *and* wholesome, lewd *and* innocent, carnal *and* pure, chaotic *and* ordered" (pp. 71, my emphasis). Of course, patriarchal ideologies have similarly long associated women with both (contradictory) definitions of 'nature': impure, corrupt, dirty, uncontrollable and contaminating *as well as* pure, sacred and innocent (Rich, 1976). In some senses, it could be said (rather over-simplistically however) that 'home-birthers' and elective caesarean birthers predominantly drew on *opposing phallocentric* views of women's 'natural' reproductive bodies.

For elective caesarean birthers, 'natural' childbirth was thus overwhelmingly constructed as a *horror-story*. Women repeatedly emphasised the 'hectic', uncontrollable and *violent* nature of ('natural') childbirth. For example, using the birth experiences of family and friends as 'exemplars' (Feldman & Sköldberg, 2002), Hannalie Botha spent a large proportion of our first interview constructing, what she variously called 'normal' or 'natural' birth, as a "terrible ordeal". For example:

> Hannalie: …uh, the one friend of mine that I know that had a normal birth, she had an epidural, um (*) it wasn't *a home-birth*, but it was still a vaginal birth (R: hmm) and, and, and like <u>she said</u> to me afterwards, this whole pain thing is completely over-rated because, on the caesarean side, because she says, 'I <u>still</u> had pain, I…' she says even after the birth (*) um, because of the fact that um, she, she was <u>cut</u>, she couldn't <u>sit</u> for about three months, you know, she couldn't um, uh, resume her sexual

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> relationship (R: yes, ja) with her husband (R: ja, ja) she says all those things (*) um, had an effect on her, because she chose that, and she says then she'd rather have a cut on her stomach that she can doctor (R: ja, ja) but it had a, it had a psychological effect on her

> Hannalie: And um, ja, and my one friend said to me, the one who had a normal birth, and who breastfed, who's got **serious** postnatal depression **a year** after her baby is, you know, was born (R: ja) um she's on medication for it, and she said that um, she (*) the birth itself was the thing that put her off the most, because of the, the effect that it had on her relationship afterwards, the fact that she had a normal birth, and the pain and everything that she had to go through (…) she says to me, it's a, **her exact words were** um, it's um (*) "it's an embarrassing process to go through, to give normal birth, because you've got **no** control (R: hmm) you, you're left to these people and (*) you have to lie in an obscene position and it's ***animal-like***".

Hannalie's talk (and that of all the other caesarean birthers) was filled with these kind of 'traumatic', horrifying stories of 'natural' birth in which women were always 'cut' ('down there'), torn, damaged, psychologically distressed, depressed and prey to "endless problems" as a direct result of the 'natural' birth process. Furthermore, the last lines of the above extract also point to the fear of 'natural' birth as a process in which women are exposed, shamed, 'made to' take up indecent ('obscene') positions and reduced to an uncivilised animality. It is also interesting to note, once again, the imaginary *audience* that is implied in Hannalie's descriptions: "you're left to these people and (*) you have to lie in an obscene position" evoking an almost (terrifyingly) pornographic kind of scene in which the birthing woman is watched, objectified and dehumanised. Interestingly, the *sexual* undercurrents of many medicalised birthing practices, including the lithotomy or 'gynaecological' position and vaginal examinations or what Bradby (1998) refers to as 'manual penetration', have not often been analysed or discussed in the literature (see Kitzinger, 1992 and Bradby, 1998 as exceptions). Rural Bolivian women interviewed by Bradby (1998) repeatedly spoke of the sexual humiliation they experienced *vis-à-vis* hospital birth practices, and often described themselves as 'like a pornographic movie' for doctors *to watch*.

Images of 'natural' childbirth as undignified and terrifying loomed large in most of the interviews with elective caesarean birthers. For example:

> Sara: …Peter [husband] is *much* happier with a caesar (R: really, okay) he woul(dn't), he couldn't bear to see me go through pain and screaming and the whole thing (R: ja) (Sara Trump, interview one).

> Rachelle: Ja, so this is kind of the cleaner option?
> Sara: Ja, much cleaner (both laugh) it is, I mean there's also the whole issue of um, the indignity of it, I mean I know, like lots of women, millions of women all over the world go through it, but the, just the idea of sitting

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> there with your legs *wide* open and some midwife coming in, sticking her fingers up there every few, like every half an hour, check what's going on, *lots* of people walking in (…) it's something, it's a situation I can't picture myself in (R: hmm, hmm) I wouldn't want to put myself in voluntarily (Sara Trump, interview one).

> Karin: …but just to see the head on the perineum and watching these women [Karin is a nurse] sweating and swearing and threatening all kinds of things, it, and head here and sweat and this big, exposed area, 'ugh – no' (R: okay) you know it was, I think also it's a privacy thing, you don't, I didn't really want anybody just to have a good old eyeball there (R: ja) you know it's all stretched and * (…) I just didn't feel for me I wanted to be that exposed (…) I just emotionally couldn't cope with having to be that uncomfortable and in that position (Karin Miller, post-birth interview).

In these 'images' of birthing, it is quite clear that the women have *internalised* a phallocentric *outsider's view* of childbirth. Childbirth is thus not seen from an insider or female point of view but is imagined through the "objectifying male gaze" (Young, 1990c:190). For example, Sara (in large part) *sees* birthing *through the eyes* of her husband: "he couldn't bear to see me go through pain and screaming and the whole thing" while Karin (drawing on her own experience as a nurse) imagines childbirth *from* the position of the outside (medical) *observer*, in the process internalising *the feeling* of disgust and horror (for women's reproductive bodies) experienced by the imaginary other. It is important (analytically) to note the guttural, horrified and disgusted *reaction* that these descriptions induce in both the women themselves and listeners/readers. As Karin herself says: "ugh – no" signalling the feeling of revulsion that accompanies these horrifying images. In the second extract (with Sara) above, it is clear that while *no direct words* signalling abjection are spoken, both Sara and I share a common understanding in which 'natural' birth is construed as chaotic, 'messy' and dirty and a caesarean section is constructed as 'clean', ordered and containable; thus, I say: "so this is kind of the cleaner option?" to which Sara replies: "ja, much cleaner" and we both laugh.

Unfortunately, by buying into patriarchal ideological constructions that define women's ('natural') birth-giving as *essentially* horrifying and disgusting, these women are discursively disowning their own reproductive bodies and in effect, constructing them as foul, unpleasant, ugly and *abject*. These women have thus (at least in these interviews) to some degree *internalised* (or are colluding with) centuries of patriarchal ideology which has constructed women's reproductive bodies as smelly, dirty, repulsive and uncontrollable and, by positioning themselves within patriarchal discourses, have come to *see childbirth* through the eyes of an objectifying medical and patriarchal gaze. As a means of 'resistance' (which sometimes looks like collusion) caesarean birthers choose to bypass the entire birth process, allow medical doctors to deliver their babies for them and thus retain the integrity of their (private) sexual/reproductive bodies. However, in the process they potentially live in a *relation of alienation* toward their female reproductive bodies.

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For example, running as a faint (barely discernable) trace within Hannalie's first interview was a sense of alienation in relation to her reproductive body:

> Hannalie: ….there's not a lot of women today that actually have natural deliveries, they, they try for natural (R: hmm) and then eventually it ends up being a caesarean, my gynae told me that it was about three in five
> Rachelle: Three in five end up with a caesarean?
> Hannalie: An emergency caesarean, so I dunno, I don't think they make us the way they used to (laughing) (both laugh)
>
> Hannalie: … but I (*) but I respect the people that want to do it naturally (sighs), I just don't have, *it's not that I don't have enough faith* in myself, but (*) um (*) …
>
> Hannalie: …I think it might be, I think it will be a nightmarish experience for me, if I have to go into labour, and have to now (*) rely on my body to produce this baby (laughing) (both laugh) *Ugh*, no (both laugh)

In the above extracts, the slippery, uncontainable meaning often riding between symbolic lines becomes discernable. We can sense the charged, crackling meanings that reside in just a few brief phrases: "I don't think they make us the way they used to (laughing)"; "I just don't have, *it's not that I don't have enough faith* in myself, but (*) um (*)…" and "if I have (…) to now (*) rely on my body to produce this baby (laughing) *Ugh*, no (laughter)". Teeming with bodily energies, these spoken snippets provocatively allude to another (semiotic) level of meaning within Hannalie's talk; the frequent laughter hints at an uncontainable "meaning that is not quite a meaning below the text" (McAfee, 2004:24). Although these phrases are riddled with ambiguous and multiple meanings, it seems to me that a sense of body-self alienation haunts Hannalie's words. Thus, the female reproductive body in general is hinted at being deficient and lacking ("I don't think they make us the way they used to") and Hannalie's own body is constructed as unreliable and *other*; as a result, the very idea of relying on her body to produce "this baby" becomes laughable, ludicrous and appalling ("*ugh*, no"). In some senses, it seems as though Hannalie has (discursively) abjected her own reproductive body, resulting in a potentially disempowering body-self fragmentation: "I just don't have, *it's not that I don't have enough faith* in myself, but (*) um (*)…" When trying to 'read' or 'listen' to Hannalie's talk, I wrote (in the margins) at this very point in the transcript: "*What* doesn't she have? What does she *lack*?

I would argue that the internalisation of patriarchal views and constructions of women's (reproductive) bodies as abject and horrifying, as evidenced by almost all of the elective caesarean birthers, potentially has consequences for the ways in which these women live their (female) embodiment. At the same time, I also do not believe that such women cannot also find other (empowering, positive) ways in which to live in connection with their reproductive bodies. For example, I found that many of the elective caesarean birthers found a new sense of embodied

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knowing and amazement in and through their pregnant bodies. Thus, contrary to the professional 'techno-birthers' within Davis-Floyd's (2003) study, who generally "did not derive any great joy from their pregnancies" (pp. 195) most of the elective caesarean birthers within my study showed a more fluid and at times *joyous* relationship to their pregnant bodies. While (as I will discuss later) the pregnant body (for both home-birthers and caesarean birthers) always evoked ambivalence and contradictory feelings, there was, more often than not, a strong sense of *embodied knowing* and *pleasure* that sometimes erupted within women's talk about pregnancy. For example, consider the following extract from Hannalie's first interview:

Hannalie: …strangely from the beginning of this pregnancy, I felt (*) I just had this sort of inner, me not being somebody that trusts the natural way, but I just had this inner peace that everything was gonna be okay, I did have that (R: hmm) (…) now the baby is actually, um, it doesn't just kick, it actually starts *moving* (…) so I can actually feel it turn (R: ja) and I can put my hand on my stomach and I can actually feel, this must be a knee or this must be a #

Rachelle: It's amazing

Hannalie: It's ***amazing***, you've got this thing inside of you, *last night* I was in the bath, and it had hiccups (R: oh really, laughs) and I was lying with my hand like this (R laughs) and I said to Jan [husband], "feel this" (R: adorable) and it's, it's making that exact sound like you would, you can't hear it, but you can *feel* it (…) I think I'm gonna miss it [pregnancy] a lot (R laughs) (…) now it's very special because nobody can really *share* it, you know, I can lie in the bath, and he'll kick me and I'll *feel* it and I'll smile, because I know, it's just me that can really know it (R: yes, ja)

In this excerpt, Hannalie is clearly discursively constructing *a different* kind of body-self relation that is far removed from her earlier *abject* construction of female reproductive bodies and the sense of *alienation* from her own body that pervaded earlier talk. Thus, similarly to the notion of 'bodily empowerment' (evoked by many 'home-birthers'), I would argue that 'body-self alienation' is also a shifting, fluid and constantly re-negotiated *potential* relationship to the body; it is not an 'essential', unchanging 'state' of being. However, it is important to stress that the (patriarchal) abjection of the female reproductive body evidenced so frequently within the talk of elective caesarean birthers, only serves to open up a discursive/emotional space in which the female body emerges as *a lack.*[41] As mentioned in chapter four, in this research I am looking for ways of talking about birth and women's bodies which inscribe the female body "as a positivity rather than a lack" (Grosz, 1989:110) and have endeavoured to judge all emerging representations by this criteria.

[41] Some feminists have, however, asked whether the image of the 'monstrous maternal' might *disrupt* normative ideals of maternal bodies and offer new, empowering figurations of maternal subjectivity and embodiment (e.g. see Braidotti, 1994; Betterton, 2006).

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Thus, in the talk of elective caesarean birthers, the female reproductive body emerged predominantly *as abject* and as *fragmented*. A *medicalised* version of the female reproductive body as a body fragmented into bit and pieces (see Martin, 1987), therefore appeared quite often within women's talk. Frequently they would speak of their reproductive bodies as a collection of disparate 'parts': nerves, tissues, bones, skin, organs, cervix, birth canal. Interestingly, home-birthers never talked about their bodies in this way. In the talk of caesarean birthers, the body was also often fragmented into a 'clean', legitimate part and a polluted, unclean or abjected part: the vagina, which was almost always referred to *indirectly* in the form of the following euphemisms: "down there", "up there", "lower body" or "birth canal". This 'lower' part of the body was almost always constructed as the seat of multiple unspeakable horrors; it was an 'unmentionable' space in which 'bad' things happened. For example:

> Lola: …I decided that the caesar would probably be less of an impact on my lower body (R: hmm) that's the main reason [for the caesar]
>
> Rachelle: And do you think there're any benefits to having the caesar?
> Lola: For having a caesar (*) um (*) I think not having to worry about what's happening down there (laughs) after the birth (R: ja) is probably, cause I know most women, or some women, have trouble afterwards and I think that's, that's something that I wouldn't want to go through (Lola Cronje, interview one).
>
> I just always thought, I don't want to 'stretch down there' and never be the same vaginally, so I want a c-section (Dee-Dee Jones, email correspondence).

In the talk of home-birthers, the 'horror story' version of childbirth was constructed as a derivative of medicalised, hospital birthing. Childbirth itself was not seen as *essentially* traumatic or horrifying. For home-birthers, medicalised practices and rituals were usually seen as responsible for *making* birth into a horror story. Interestingly, (only) one of the home-birthers adopted a language of euphemisms when describing the sexual/reproductive body and she did so only when talking about the (horrifying) image of birth within a hospital setting:

> Jane: …um, I didn't want to be at the mercy of a million doctors lying on my back with my legs up in the air, it's like "no way", not going there, um, ja, and also I don't like the idea of a male doctor looking at <u>my bits</u> you know (laughs) (Jane Brown, home-birther, interview one).

It was only when speaking *from* within the point of view of a medicalised, outsider's view of birthing that Jane referred to her sexual/reproductive body as "my bits", showing the power of patriarchal/medical discourses to produce discursive spaces in which the female body is represented as a fragmented and objectified body in '*bits* and pieces'. Like the majority of elective

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caesarean birthers, some of the home-birthers also hinted that they wanted to avoid a (birthing) situation in which they became objects to be *watched* by others. For example:

> Angela: …I want, I want people there as support as opposed to spectators, I really don't want people sitting there watching me (R: no, laughing)
>
> Angela: …I think he'd [estranged father of baby] like to be there but you know I showed him pictures of a woman giving birth at the beginning and he ran across the house **screaming** at the top of his voice (R laughs) and I don't need that type of thing (R: no, no) **there** while I'm trying to give birth (R: yes, ja) and I don't want him sitting there watching me and then sort of having to be conscious of him sort of thinking whatever he's thinking, I just want people who are focussing on me and making the process easier (R: okay) (Angela Stewart, home-birther, interview one).

Patriarchal and medicalised images of childbirth in which the birthing woman is objectified and made into a (horrific) *spectacle*, thus circulated within the imaginations of many of the women within this study (whether caesarean birthers or home-birthers). The representation of the birthing body *as abject* often runs through a western cultural imaginary as a collectively shared image (see for example, the 'momair' of Cusk, 2001).

For home-birthers, however, childbirth was not seen as 'essentially' abject or horrifying. In order to position themselves *against* the pervasive image or discursive representation of birth as abject and inherently dysfunctional, home-birthers drew on different meanings of 'nature' and 'natural' childbirth. For home-birthers, childbirth was not a medical condition or an inherently pathological process; instead it was seen as a perfectly natural, normal and healthy experience. A discourse of 'nature' as inherently 'good' and well designed was thus drawn on to legitimise their 'choice' to birth at home. Just like the North American home-birthers in Pamela Klassen's (2001a) study, these women "insist[ed] that birth is a natural process" (pp. 135). However, *appealing* to a discourse of 'nature' to legitimise their birthing resistance, unsurprisingly opened up a Pandora's box of contradictions and ultimately often worked to *reinscribe* problematic, constraining and once-again *patriarchal* views of women, mothering and reproduction. Closely analysing the shifting accounts of elective-caesarean birthers *and* home-birthers has finally enabled me to grasp the Foucauldian point that "resistance ultimately makes the operation of power more effective" (Thompson, 2003:102). For example, subscribing to an essentialist discourse of 'nature' and women's bodies meant that home-birthers also often reproduced 'natural' or home-birthing as the *morally* infused 'right' way to birth or as noted by home-birther, Mandy Van Zyl, "the way it should be done". 'Natural' childbirth was also seen as *important for babies* and often home-birthers constructed their 'choice' to birth at home as largely a (moral, ethical) decision based *on the child*. For example:

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Rachelle: Um, what do you think of the so-called 'opposite' decision (*) basically those who choose to have elective caesarean sections, why do # (A: For no medical reason?) ja, why do you think people do that?
Angela: (*) Humphm (sharp disgust)
Rachelle: And do you know anyone who's done that?
Angela: No, I do, I'm rather **scathing** of it though, I think the whole birth process is important for children, you know coming through and choosing the moment they wanna come out, you know, just even the muscles *contracting*, while you're having contractions, you know **massage** the baby, I mean it's all really important and I think it makes a big diffference on one's life (R: hmm, hmm) how one's born, um, but you know it's their decision, I wouldn't do it (*) out of choice and I don't know why they need to take more drugs (both laugh) but a lot of people don't think, you know, you look at society and they all just blunder along in the dark and are quite happy to do whatever their doctor tells them to do (R: yes, hmm) they don't actually **think** much (R: hmm, hmm) each their own, I suppose (both laugh) (Angela Stewart, interview one).

According to Klassen (2001a:40), birth is "inherently tied to ethical values" because it concerns the life of a new human being solely dependent on the care and decisions of others. Home-birthers and elective caesarean birthers clearly had contrasting and opposing views concerning the 'ethics' of childbirth. Women (in both 'groups') were often equally scathing toward the so-called 'opposite' way of birthing; for example, one home-birther (Lizette Zimmerman) referred to elective caesareans as 'child abuse' while an elective caesarean birther (Sara Trump) referred to home-birth in exactly the same terms. Interestingly, home-birthers only seemed to display such extreme and what some might call 'self-righteous' sentiments *before* they had themselves experienced birth. Actually *experiencing* birth at home often seemed to humble these women.

While elective caesarean birthers had the full backing of the medical system in their birth 'choice', women having home-births enjoyed the support of an incredibly powerful *normative ideology* of 'natural' childbirth. In contrast to the talk of elective caesarean birthers, which was (in interview one) littered with references to 'natural' or 'normal' childbirth, the talk of 'home-birthers' invoked the term 'natural childbirth' *far less often*. However, 'natural' childbirth was often simply *assumed* to be 'right' and 'best' and women often did not feel the need to elaborate or justify why this was the case. As a result, home-birthers made far less attempts than elective caesarean birthers *to justify* or legitimise their birth choice. Often it seemed that simply saying 'birth is a natural process' was a powerful enough justification. As a powerful cultural story line (see chapter two), the normative narrative of 'natural childbirth' as 'best' and 'ideal' often ran as a series of flickering fragments within the talk of *both* elective caesarean birthers and home-birthers. Thus, while caesarean birthers *worked* hard to construct 'natural' childbirth as risky, pathological and traumatic, at the same time, there were also brief flickers in which the story line of 'natural childbirth' erupted as an incontrovertible *ideal*. For example:

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> Hannalie: …there's a lot of people that are completely against a caesarean because they want to have a home-birth, because they want, they think it's natural for a woman to, to give birth (R: hmm) which I suppose it is, but (*) I don't think all women think about it that way (Hannalie Botha, elective caesarean birther, interview one).
>
> Caroline: …but you know if a, if a baby, a natural birth if (*) if all is well and the woman's the right size and the baby's the right size, is probably, is you know, it's the way it's been designed (…) a per(fect) a good natural birth is good, but um…(Caroline Kohler, elective caesarean birther, interview one).

Home-birthers drew on a similar rhetoric, for example: "it's a pretty natural thing" (Angela Stewart); "like it's natural" (Lizette Zimmerman); "it's natural, it's the way things are designed to be done" (Angela Stewart); "this is a natural process" (Maggie McDougal); "it [home-birth] seemed like the most natural thing to do" (Joni Daniels). At the same time, it shouldn't be assumed that 'natural' birth meant one thing to the participants; instead, the meaning of the 'natural' in 'natural childbirth' was often slippery. At times, 'home-birthers' drew on an ideological (normative) story line of 'natural' childbirth; however at other times they also worked to create new, alternative versions of 'the natural' that challenged medicalised discourses. I will be addressing this more fully later in the chapter.

Appealing to 'nature' (however slippery) was a core feature of home-birther's talk. While this appeal served to legitimise a birthing choice that is undoubtedly *against the mainstream* and a critical form of 'resistance' to the dominance of medicalised narratives and practices surrounding childbirth, it also has some less than emancipatory corollaries. Thus, some of the home-birthers also reproduced an essentialist and maternalist version of womanhood, in which *birthing babies* was seen as women's primary calling. For example:

> Mandy: …for fear of sounding so old-school but that is what we're here to do on this earth as women, birth the children (Mandy Van Zyl, home-birther, interview one).
>
> Joni: …like my boss's (*) niece had a baby and she had a caesar and there was no, medically she wasn't (*) it wasn't needed (R: hmm) and I was, "why would you have a caesar if you don't need to?" and then somebody started by saying, "well, she's too posh to push" and I said "Oh my god" (laughing) (both laugh) like *hello*, what are women there for? (Joni Daniels, home-birther, interview one).

The idea that childbirth is a 'natural process' often translates into the notion that reproducing babies is what women are "here to do" (Mandy). Furthermore, these notions also often coalesce in the belief that mothering is women's 'natural' vocation and primary role in life. As I noted in chapter two, the story line of 'natural childbirth' is *morally* powerful in prescribing that ('proper') women are 'naturally' meant to be mothers, will give birth 'naturally', breastfeed 'naturally' and

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'naturally' take primary responsibility for the care of infants and children. Categories of 'good' and 'bad' mothers are therefore created and women are constantly set up for potential failure if they cannot achieve the ideals of 'natural' motherhood. The connection between 'natural childbirth' ideologies and the 'ideology of exclusive motherhood' (Blum, 1999) was sharply evident in the ways in which the home-birthing women within the study often felt 'compelled' to mother their infants according to principles of 'exclusive' motherhood. In the following section I will show how home-birthers and elective caesarean birthers 'took up' different positions *vis-à-vis* an ideology of 'essential' (DiQuinzio, 1999) or 'exclusive' motherhood. At the same time, however, *all* of the women remained (in unstable ways) constrained and interpellated by patriarchal motherhood ideologies.

The allures and traps of patriarchal motherhood ideologies

"…normalizing discourses interpret, evaluate, and regulate all maternal bodies."
(Shelley Park, 2006:204).

While there were some sharp differences in the mothering practices 'taken up' by home-birthers and elective caesarean birthers, motherhood ideologies and ideals of the 'good' mother remained strong currents within all of the women's talk. Generally, however, home-birthers were far more invested in practicing 'exclusive' motherhood than elective caesarean birthers. According to Linda Blum (1999), an 'exclusive' motherhood ideology prescribes that the mother and infant approximate a "special, exclusive" (pp. 5) strongly *embodied* twosome in which the maternal body is constantly *there* and available; (good) mothers are seen as 'instinctively' equipped to fulfil this role and 'naturally' desirous of such a relationship with their infants. Such ideas are strongly connected to what DiQuinzio (1999) calls an 'ideology of essential motherhood' in which selfless, exclusive mothering is seen as a function of women's 'innate' female nature, biology or evolutionary hard-wiring. DiQuinzio (1999) also usefully reminds us that this ideology is not just about mothering but is also about *femininity*, serving to construct motherhood as a requirement of being a 'proper' woman.

Many of the women choosing elective caesareans were sceptical of these kinds of ideas and often 'took up' what looks like a feminist position in arguing that the experience of 'natural childbirth' is not required to be either a 'proper' woman or a 'good' mother. For example:

Caroline: …I really don't think I have to go through the birthing *process* to be a good mother or to feel, "*Hah*, I'm now a real woman", I really don't (R: hmm) (Caroline Kohler, elective caesarean, interview one).

Hannalie: …women have got this <u>idea</u> in their head that if they can't do it naturally, they um, there's something wrong with them (R: ja, ja)

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> they're not good enough (R: ja) and I think that's also something that (*) in today's life, a woman is not known by her accomplishments as a mother, I mean that's only one element of *her life* (R: hmm) you are a person that consists of many aspects. You've got your work, you've got your personal life, you've got your hobbies, you've got your whatever, being a mother is not the be-all and end-all (R: hmm) there's a lot of people that choose not to have children at all (Hannalie Botha, elective caesarean, interview one).

In the extracts above, it becomes clear that in their talk, Hannalie and Caroline are destabilising essentialist notions that women *are* or *should be* a particular way. Furthermore, akin to a kind of 'individualist' or 'equality' feminism, Hannalie emphasises women as degendered *persons*. Many of the caesarean birthers spoke of a 'modern' approach to being a woman that had moved beyond prescriptive and essentialist definitions of women. For example:

> Hannalie: …in today's life, a woman is not known by her accomplishments as a mother (Hannalie Botha, interview one).
>
> Caroline: we [women] have (*) evolved a lot more and (*) than you know a few years ago, you know, there wasn't even a contraceptive pill and (R: hmm) and women were *meant* to go through agony and pain because of what Eve did to Adam (R laughs) you know it's just ridiculous (Caroline Kohler, interview one).
>
> Ilse: …I know that they're [family] definitely for natural birth and that you're not *a woman* if you haven't done it the natural way (…) I would say I'm more modern then in that way (R: okay) instead of being the traditional (R: ja, ja) (Ilse Van Rooyen, interview one).

However, at the same time, several of the elective caesarean birthers were aware of being automatically judged as *not* good mothers because of their decision to bypass 'natural' childbirth. The normative ideology prescribing 'natural' birth as a generic ideal for all women means that a suspicious gaze is immediately cast over women that choose to 'opt out' of this 'natural' process. For example:

> Caroline: …um, strangers funny enough when you sort of say, "Oh no, it's my decision, it's elective" they "*Hahh*" they get, you know, you can hear it's like, "*Huh*, gosh" (R laughs) you know, "she's not going to be a very good mother maybe or something" you know straight away (R: ja) they're prejudiced (Caroline Kohler, interview one).

In some senses, then, the 'choice' to have an elective caesarean section does *destabilise* essentialist and biologistic notions of women as 'naturally' and primarily reproducers and birth-givers. Ideologies of 'essential' motherhood are fundamentally intertwined with a valorisation of pregnancy, childbirth and motherhood as women's 'highest' calling and supreme function. The idea of women simply 'opting out' of 'natural' female bodily processes such as childbirth and

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breastfeeding does, on some levels, disrupt biologistic ideologies of motherhood[42]. However, this destabilisation or resistance is always *contradictory* because it is also often in collusion with patriarchal ideas that women's reproductive bodies are dysfunctional and 'horrifying' and need to be 'managed' by masculinist medical science. Furthermore, women choosing caesareans were not simply and unproblematically engaged in 'resistance' against an ideology of essential motherhood. They remained powerfully interpellated by such discourses and ideals. This was often seen in their decisions regarding breastfeeding.

Interestingly, it was the decision not to breastfeed (at all) that was often harder for women to justify (on moral grounds) than the decision not to go through the 'natural' birth experience. Largely because of a wider (medicalised) discourse that emphasises risk, danger and safety through medical expertise in relation to childbirth, elective caesarean birthers were able to argue that a caesarean was less risky, safer for the baby and therefore ethically sound. However, the decision not to (even attempt) breastfeeding was difficult to reconcile with notions of 'good', *selfless* and morally sound mothering. There were only two women within this study that did not even want to attempt breastfeeding; both were elective caesarean birthers (Hannalie and Janine). In my first meeting with caesarean birther, Hannalie Botha, substantial chunks of the interview were spent talking about her decision not to breastfeed. As soon as Hannalie told me that she had made this decision, she immediately felt the need to reiterate that she was, nonetheless, *still* going to be a 'good' mother:

> Hannalie: …I decided not to *breastfeed* (R: okay) it's, it's too *primitive* (R: okay) it's just, you know, I'm not <u>at all</u> the kind of mother that will give my child to a nanny to look after, <u>I'm very much</u> looking forward to the whole *mothering* experience (R: okay)

In the above extract, we can seen how Hannalie's articulation of her decision *not* to breastfeed, which, according to essential motherhood discourses, potentially constructs her as a 'bad' mother, immediately leads to her trying to confirm that she is "not <u>at all</u> the kind of mother" that will abandon her child to others. Merely expressing the decision not to breastfeed thus immediately positions Hannalie in less than positive ways in relation to dominant motherhood ideologies; she thus feels the need to respond to the (imaginary) ideological voices that would construct her as a selfish or 'bad' mother. Consider the extract below as an example of how choosing *not* to breastfeed clashes with a normative discourse of *selfless* mothering:

> Hannalie: …um, the whole thing about, once again, about the breastfeeding, about milk being, your milk being the best for your baby, if you had a

[42] See recent work by Park (2006) and Brakman & Scholz (2006), which attempt to 'queer' or disrupt the conflation of 'real' motherhood with biological motherhood via an examination of adoptive maternal bodies.

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> wonderful balanced diet, maybe (R laughs) but ***who*** today eats that kind of balanced diet (R: ja) that your child will get all the nutrients #
>
> Rachelle: And once again, it's another thing that you would have to change in your life #
>
> Hannalie: ***Ja***, I mean you, you can't eat certain things (R: ja) you can't (*) ja, ***maybe I'm selfish hey***, maybe it's that (R laughs) I think I'm unselfish enough to have this baby, and to love this baby, but (*) um (interview one).

Without even 'knowing' it, my interjection above helps to (ideologically) position Hannalie as *a selfish mother* in comparison to 'good' mothers who are supposed to be selfless, ever-giving and willing to sacrifice their own needs, comforts and desires in the 'best interests' of their babies/children. Thus, while often resistant to essential motherhood ideologies and scripts, women choosing caesareans nonetheless still often found themselves positioned (deleteriously) in relation to powerful ideas about 'good' and 'selfless' mothering.

Home-birthing women were, in general, strong advocates of mothering scripts that would be commensurate with Linda Blum's (1999) notion of 'exclusive' motherhood. All of these women breastfed their babies for long periods. Many home-birthers who had had previous children told me that they had breastfed for several years (e.g. Jane, Jeannie, Anke, Mandy, Kayla, Sam, Stephanie). Often first babies were only weaned 'off the breast' when the women fell pregnant for a second time. Interestingly, home-birthers however expressed different opinions of breastfeeding, with some women openly telling me how much they loved or enjoyed this part of mothering and others expressing deeply ambivalent feelings about breastfeeding. It was clear that some women simply felt compelled to breastfeed because it was the 'right' (or 'natural') thing to do and did not actually enjoy this part of mothering. For example, when I asked her what she enjoyed most about looking after her baby, home-birther Stephanie Mitchell replied:

> Stephanie: Sjoe, what do I enjoy? I don't enjoy breastfeeding, I enjoy the fact that I'm breastfeeding (…) it's a lot easier [second time] but it's still uncomfortable and you know, I enjoy <u>the fact</u> that I'm breastfeeding but I don't enjoy breastfeeding (interview two).

Stephanie's determination to adhere to a highly demanding mode of 'exclusive motherhood' or what she referred to as "an ancient sense of care", which included: long-term breastfeeding 'on demand', constantly 'being there' to hold, soothe and feed and privileging her baby's rhythms over all else, resulted in her experiencing an almost impossible 'double-bind'. Thus, on the one hand, she felt strongly 'compelled' to mother in this way (the only 'right' way) but on the other hand she also felt constrained, imprisoned and frustrated by this kind of mothering. For Stephanie, 'exclusive' mothering was close to *compulsory* and was seen as the only 'right' and 'proper' way to mother an infant. Thus, according to Stephanie, "I, I'm obviously, um, sticking to his [baby] rhythm"; "I absolutely need to, and it's <u>right</u>, you know, it's absolutely right" and " I feel it's

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essential". We can see from these short extracts of talk how an exclusive mode of mothering operates as ideologically 'obvious', 'right' and 'essential'; we know from key approaches to ideology that ideologies often work by prescribing what kinds of worlds, selves and behaviours are *right*, good, natural, proper and morally sound (see Foster, 1991). As one of the few women in the study without domestic help, Stephanie found a mode of mothering modelled upon a so-called 'ancient' tradition emphasising *constant*, *embodied care*, or in Stephanie's words, existing "in tune" with the baby and "just absolutely being there", almost impossible to provide *on her own*.

This highlights the point made by Bonnie Fox (2001:380) that 'intensive' mothering "requires material and personal resources" often in the form of extended circles of *support*. Furthermore, according to Fox (2001:380), 'doing' intensive mothering is heavily dependent on "the man's approval", requiring a partner that also believes in the importance of this type of mothering, is willing to accept his partner's all-consuming relationship with their baby and who assists in domestic labour and child-care duties. In my conversations with home-birthers, male partners often seemed to fade into the background, with several women making it clear that *they* were the one's who were almost solely responsible for baby-care and domestic chores (cooking, shopping, feeding animals). None of the women even mentioned attempting to approximate 'shared' parenting goals; it was evident that (dictated as 'natural' by essential motherhood ideologies) these women were the primary (and often sole) caretakers of 'their' infants. Often these women were so *driven* by a belief in the 'rightness' of 'exclusive' mothering that they were willing to *sacrifice* just about anything (including their own sanity) in trying to accomplish it. This type of mothering often did not come 'naturally' however; thus, Stephanie Mitchell describes experiencing "a lot of *anxiety* (…) in mothering so intensely" and spoke of "a *daily* battle" between wanting to exist as an independent person and wanting to 'achieve' this 'ideal' kind of mothering. For example:

> Stephanie: …this is Peter's [baby] time to be (R: hmm) it's almost *in* the womb outside the womb, home has become his second womb (R: hmm) and as soon as that is disrupted (*) things just don't work (R: hmm, hmm) but it's accepting that, it's very , very challenging * the whole world at the moment has to fit in with Peter (R: yes) and **when I get that right** then it works unbelievably (…) I've got to keep on *reminding* myself that, I am not a separate individual right now, I have *no* separateness, because as soon as I bind my separateness, he picks up on the tension and he wants *more* (…) so I do a *daily* battle with that in myself, to just *be with him* (interview two).

The kind of 'exclusive' mothering or "ancient sense of care" that Stephanie was trying to 'achieve' almost inevitably set her up in an endless cycle of failure and induced feelings of personal guilt and inadequacy when she didn't 'get it right'. Thus, leaving her baby to cry *once*

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for three or four minutes made her feel "quite sick" because as she said, "it wasn't okay for me to do (…) [it] disconnected me from his needs". For Stephanie to 'do' 'good' mothering, to devote herself 24 hours a day to be completely 'tuned in' to her baby's needs, rhythms and desires, she in effect had to become *selfless* and willing to 'give up' being a separate, independent individual. According to DiQuinzio (1999), the selflessness of mothers stands as a fundamental requirement of 'essential motherhood' ideologies. As Mandy Van Zyl put it, "it's [motherhood] not about ***you*** anymore" and according to Angela Stewart, "it's [motherhood] selfless, I think you have to be selfless in order to do it". Mothering according to the script of 'exclusive' motherhood *does* necessitate selflessness. It is important to pause here and remember that an ideology of 'exclusive' motherhood comes from a particular set of class, race and historical locations. It is not necessarily a universal ideal. According to Linda Blum (1999), the ideal of exclusive mothering is predominantly a white, middle-class and western motherhood script:

> [the] singular mother – with the irreplaceable physical, emotional, and moral responsibility for her pure, 'priceless' child – was and continues to be a white, status- and class-enhancing project (Blum, 1999:9).

Blum therefore found, in her study of white working-class and African-American working-class mothers, that *in contrast* to white mothers, motherhood was not "an individual undertaking" (pp. 152) for the African American women, that they largely rejected breastfeeding and did not regard 'good' mothering as synonymous with 'exclusive' modes of mothering. Blum (1999) also reminds us that the successful achievement of 'exclusive' motherhood usually requires the (often invisible and low-paid) domestic labour of *other*, often poor and easily exploitable 'women of colour', and is therefore overwhelmingly a white, often middle-class ideal.

For several of the home-birthers, 'exclusive' mothering was often constructed as *not a choice* but as a fundamental and absolute necessity. Furthermore, the adoption of an 'intensive' style of mothering was, according to many of the participants, directly related to their decision to birth at home. For home-birther Angela Stewart, birthing 'naturally' at home, breastfeeding and providing 'exclusive' mothering were, on one level, not actually 'choices' at all. As she kept on reiterating (as a kind of mantra) throughout her first interview, these were things "*you gotta do*". Thus, natural birth without pain relief was seen as "just one of those things you've got to do" and 'exclusive' mothering was seen as inevitable because:

> Angela: …I mean you know he [baby] wants you, you know, it's all that matters, he's crying, you gotta be there, he wants milk, you've gotta feed him (R: ja, ja) you know, it's just, you're completely selfless (…) you know you've got to breastfeed (R: yes, laughs) so there's not much else anyone else can do, ja, it wakes up, it wants milk so I suppose *you just do it* (interview one).

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Other home-birthing participants described home-birth and an intensive style of mothering in a similar way: as in some senses *not* actually a choice at all because there really is no other (ethical or 'right') choice to be made. This is akin to what Elspeth Probyn (1993) calls a 'fundamental choice' describing a scenario in which the 'right' choice becomes so 'natural', entrenched and hegemonic that there really is *no choice* at all.

While women who chose to have caesarean sections were also powerfully 'hailed' by ideologies of 'good' mothering, they tended to negotiate motherhood differently to home-birthers. Thus, the two 'sets' of women overwhelmingly 'took up' opposing stances in relation to volatile debates about 'scheduled' versus 'on demand' approaches to infant care. Almost all (eight out of nine) elective caesarean birthers adopted (or tried to adopt) a 'scheduled' approach to mothering[43]. Whereas the majority of home-birthers firmly believed in the ideal of 'exclusive' (on demand) mothering, some of the caesarean birthers openly questioned this mode of mothering. For example:

> Rachelle: So you're definitely going the routine route as opposed to doing sort of demand…?
> Sara: Well, ja, well, ja I mean the demand thing, ja, that's another thing, there's not enough of a plan of action there (laughs) (R: okay, laughs) it's like, I cannot *be* there on demand (R: yes, yes) (Sara Trump, interview one).

Furthermore, generally elective caesarean birthers also spoke of more egalitarian relationships with their male partners than home-birthers. Investing in the idea that childbirth is a 'natural' process and that women are biologically 'designed' to be birth-givers and mothers, often seemed to conjoin with an acceptance that child-care and domestic labour is also essentially women's (or mother's) work and responsibility. However, for both 'groups' of women, help with domestic chores was provided most often by African domestic workers and childminders and not by male partners. Some of the elective caesarean birthers were nonetheless vocal about their *egalitarian* relationships with their husbands (all were married). Hannalie Botha, in particular, seemed to enjoy a remarkably equal relationship with Jan (her husband). For Hannalie, "times have changed" and shared, equal parenting was seen as the new ideal. Her decision *not to breastfeed* was also positioned within this new ideal; breastfeeding was seen as an obstacle to equal, shared childcare. According to Hannalie, "there's no way I'm gonna do it all on my own, it's not just <u>my child</u>". Hannalie was also one of the rare women within the study that took no responsibility for traditionally female domestic labour:

> Hannalie: …I think what people also sort of tend to not understand, is the fact that

[43] In sharp contrast, *all* of the fifteen home-birthers reported 'taking up' more of an 'on demand' approach to infant feeding and sleeping (more compatible with ideals of exclusive mothering).

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> my husband's so supportive, I don't have to cook us dinner, and I don't have to clean the house, and I don't have to do any of those things, and, and I'm not going to do it after the birth *either* (interview one).

However, it must be pointed out that Hannalie's 'supportive' husband was not actually the one *doing* the cooking, cleaning or domestic chores. The couple made use of a cooking service and employed an African domestic worker to do household domestic work. It is likely that Hannalie's position as a *highly-paid* professional (who was, in all likelihood, earning more than her husband) gave her a *powerful* position within the home that many of the home-birthing women (more likely to be 'at home' or engaged in part-time or freelance work) did not have. The 'support' of her husband was, however, often limited to endorsing a scenario in which outside others were paid to do traditionally female domestic labour and Hannalie was not 'expected' to cook, clean or do housework. On an admittedly surface reading of the couples within this study, it seems that women (whether paid or not, domestic workers or live-in-partners) are still overwhelmingly responsible for household domestic labour. Thus, contrary to Hannalie Botha's mantra that "times have changed", perhaps some things haven't changed all that much after all.

An ideology of control and the power of 'what if…?'

> *"…modern science, in its unceasing effort to exert greater control over the processes of life, refuses to accept the basic wisdom that humans are mortal, that death cannot be conquered."*
> (Irene Diamond, 1994:86).

The underpinning of medical models of childbirth within an 'ideology of technology' (Rothman, 1982) or "an ideology of technological progress" (Davis-Floyd, 2003:47) has been widely accepted by feminist childbirth researchers. In this section, I attempt to show how women's 'choices' around childbirth are always made in relation to an ideology of (technocratic) control. Thus, while home-birthers and elective caesarean birthers 'took up' different stances *vis-à-vis* technology, medical science and a modernist narrative of 'progress', all of the women were powerfully constrained, enabled, regulated and interpellated by the heavily loaded, risk infused 'what if…' question posed by obstetric science. In this section, it should become clear that while the 'choice' to have either a caesarean section or a home-birth was often embedded within *different epistemologies* of birth (and life), *both* 'choices' are told as driven by *a search for control* and remained (more or less) embedded in modernist ideals of rational agency, 'informed choice' and control over (female) bodies. At the same time, the subjectivity produced by women making birth 'choices' remained split between, within and against a constant stream of (often contradictory) ideological voices. Furthermore, as I will explore in the next chapter, sometimes

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the visceral and intensely embodied experience of (home) birthing itself led to shifts in women's 'standpoint' *vis-à-vis* control and individual autonomy.

The term 'ideology of control' appears in the work of Irene Diamond (1994) and is used to refer to the widespread belief in modern (western) cultures that technology, science and rationality can conquer (or control) the unpredictable vagaries of nature, body and ultimately life and death. The widespread 'faith' in medical science (and obstetrics) is one part of a broader belief (prevalent since the beginning of 'Enlightenment' thinking in the 1700s) within western cultures that scientific, rational knowledge will lead to 'Truth', liberation, a 'better' world and freedom from illness, deformity and premature death. Of course, the rise of the 'life sciences' (including medicine) is linked to the emergence of a new configuration of power which Foucault refers to as 'biopower' (power over life) (see Braidotti, 1994). *The body* functions as the prime target of 'biopower' and is "located at the center of the techniques of rational control" (*ibid*, pp. 59). Thus, commensurate with an 'ideology of control' is the drive to control, manipulate and regulate the body (particularly the bodies of women). However, according to William Arney's (1982) brilliant Foucauldian analysis, there is (post World War Two) *a different order* of obstetrical power in operation which works via monitoring and surveillance rather than domination and *overt control*. Subjecting pregnant and birthing women to "constant and total visibility" (*ibid*, pp. 89) via the 'normalizing gaze', the power of obstetric knowledge becomes widely dispersed or 'capillary' (everywhere) and productive (rather than coercive), working to produce pregnant and birthing subjects who themselves seek and engage in "technologies of normalization" (*ibid*, pp. 89). Via these (morally imbued) 'technologies', pregnant women actively produce themselves as *ethical subjects* (Root & Browner, 2001). This complicates early feminist views of medical/patriarchal power as external, oppressive and domineering and alerts us to the possibility that power itself now resides *within* and works *to produce* pregnant and birthing subjects who desire and seek monitoring, surveillance and other medicalised technologies. It also confounds the common feminist belief that if women regained control over their bodies, liberation would ensue. If we take seriously the notion that power works within the subject, in large part producing subjectivity itself, then the feminist goal to 'take control' of our bodies begins to look wholly inadequate (but not irrelevant).

As I mentioned in chapter two, many varieties of feminism remain themselves embedded within a rhetoric of control, in which women's reclamation of control *over* their bodies is seen as one of the fundamental rallying points of 'women's liberation' (see Diamond, 1994). Diamond is sharply critical of the acceptance of control *as a value* within feminism; she argues that it is complicit with western relations of domination *built* on ideas that (female) bodies, earth and living systems are inert matter to be plundered, dissected, controlled and manipulated at will. Clearly, a

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language of 'control' is also implicated in reproducing mind-body dualism and the notion that the body is an object to be manipulated and regulated. In what follows, I attempt to show how home-birthers and elective caesarean birthers were positioned, in shifting shades of collusion and resistance, in relation to an 'ideology of control'. I hope to show how this ideology worked by exploring the centrality of *knowing* and *control* in women's talk about making birth 'choices'. Furthermore, I will also be showing how a medicalised 'what if…?' ideological voice often saturated the talk of home-birthers and elective caesarean birthers.

Stitching epistemologies: different ways of *knowing* about birth

"The difference is where you get your information from and what you do with it."
(Lizette Zimmerman, home-birther, interview one).

In some senses, the political history of childbirth can be reconstrued as a battle over epistemology, for example: *can* we 'know' about childbirth? If so, *how* do we know? And *whose knowledge* gets to 'count' as legitimate or according to Jordan (1993, 1997) as authoritative. While a highly medicalised and technocratic obstetric knowledge is now clearly authoritative in most western countries, the once dominant embodied and sensual *haptic* (Root & Browner, 2001) knowledge of women, as well as the age-old knowledge of midwives, are now both largely discredited. The two 'groups' of women in this study generally took 'opposing' views of midwifery knowledge, while a kind of bodily or 'haptic' 'knowing' did *bubble up* in women's talk about their pregnancies and *erupt* powerfully within the birth stories of home-birthers. The experentially rich knowledge residing in concrete women's networks continued to be drawn on regularly in the talk of both 'groups' of women. Thus, most of the women regularly situated themselves (and their birth 'choices') in relation to the experiences and decisions of family, friends and wider circles of women. However, in many ways, the 'choices' of home-birth and elective caesarean birth are located within two different birthing epistemologies or 'paradigms of knowing', which I have called 'technocratic expert knowing' and 'knowing-in-relation'.

Technocratic expert knowing

For women choosing to have caesareans, there was no doubt that medical and technocratic 'experts' were constructed as the ones who *really know* about childbirth and that an expert-driven, technocratic model of knowledge was thoroughly embraced. As a corollary, these women were often dubious about midwives and did not trust them to have adequate, genuine, 'real' knowledge about childbirth. The association (made by elective caesarean birthers) between midwives and

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'dubious' knowledge and between medical doctors and 'expert' or 'real' knowledge is, in large part, about the presence or absence of *technology.*

Unsurprisingly, women choosing caesareans were *far more monitored* in their pregnancies than home-birthers; most of these women therefore had ultrasound scans every time they visited their gynaecologist or obstetrician (all of these women made use of 'specialist' doctors) which usually amounted to a total of approximately *ten* such scans. Furthermore, caesarean birthers also usually reported for 'extra' monitoring, 'scanning' and testing at a local (well renowned) 'foetal assessment centre' or went for further 'opinions' to external 'specialists'; two of the women also had amniocentesis testing. All of the elective caesarean birthers were keen to be 'monitored' as closely and as often as possible. Hannalie, for example, insisted on booking *extra* appointments with her gynaecologist so that she could be even *more* 'monitored'.

Because of less of an engagement with technocratic forms of monitoring, midwives were generally seen as linked to 'dangerous', 'risky' and dubious practices. For example, Lola Cronje was 'scared' of midwives because they do not 'monitor' (via ultrasound scans and medical tests) pregnancies as closely as medical doctors. The fact that (low risk) pregnant women in England have a midwife as primary caregiver was thus seen by Lola as *risky* and dangerous because of a concomitant low level of technological *monitoring*:

> Lola: …you only have a midwife [in England] (R: hmm) you don't have a gynaecologist and I've read somewhere that they have the highest, um, fatality in childbirth (R: really?) in the, in the European Union (R: ja) because of that, um, so no, I'm fairly scared of midwives (laughing) I must tell you (…) I had a friend over there [in England] that had a baby and (*) they scan I think, through the whole pregnancy, they did three scans (R: ja, it is much less) ja, ja, so the pregnancy is not monitored as well as is done over here (…) um (*) there were complications and the baby wa(s) the baby wasn't normal and they only picked that up *late* in the pregnancy, which I think over here would have been picked up quite soon (R: hmm, hmm) so things like that I think is more or less ruled out over here (R: okay, okay) (Lola Cronje, elective caesarean, interview one).

In this extract, we can see how repeated technocratic monitoring is seen as a means whereby abnormalities can be "picked up" and by implication, transcended. Scientific and technocratic knowledge was seen, by all of the caesarean birthers, as an antidote to the 'shadow of risk' which ran through all of the women's talk about childbirth. When Lola says that "so things like that I think is more or less ruled out over here" we are not quite sure what she means. Are the "things like that" that are "ruled out" by regular monitoring 'abnormal' babies or belated diagnoses? Part of a technocratic 'ideology of control' is the need to believe that medical technology can 'overcome' or conquer the horrors of abnormality, deformity and disease. Lola thus puts total

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faith in the ability of repeated monitoring techniques to enable her to know (without a doubt) when there are or are not problems, 'complications' or abnormalities.

The 'choice' to have a caesarean section was regularly and repeatedly constructed by elective caesarean birthers as "a safer choice" (Lola Cronje) than 'natural' childbirth. Looming large within the talk of these women were often the shadowy, unspeakable and incessant threats, dangers and risks (death, deformity, complications) of childbirth. A highly technocratic approach to pregnancy and birth was seen as the 'safest' way to deal with these risks and the best 'guarantee' of a positive 'outcome'. However, the highly medicalised (and coercive) 'what if…?' question ran as a gaping, unanswerable, anxiety-provoking hole within the stories of all of the women within the study, for example: "what if … she wasn't monitored; she gave birth at home; something went wrong; the abnormality wasn't picked up; the baby went into distress; there were complications … what if … what if … what if …?" For caesarean birthers, dangers and risks always emanated from the 'natural' birth process and from the birthing body itself and were never attributed to medical interventions and technology; technology was always *the solution* (the 'saviour') and never the problem. The suffusion of a language of risk within the talk of elective caesarean birthers is illustrated below:

Hannalie: …she [sister-in-law] had a normal birth the first time and then the second time the baby was overdue two weeks, and only the morning when they did the induction and they put the heart monitor on, did they realise that this baby has been (*) is in distress because there's no amniotic fluid left (R: oh) (..) and then they realised if they don't take the baby out <u>now</u>, it's not going to survive, and then I ask myself (R: hmm) now what would have happened (*) if they didn't, you know, if they didn't put the monitor on? (R: hmm) you know, so I dunno, I think these things should be controlled, it's, it's, there's just too many things that could go wrong (R: hmm, hmm) (Hannalie Botha, interview one).

Lola: …I would like to know if something goes wrong that there is help close by, so ja (laughs) (Lola Cronje, interview one).

Sara: …um, ja, I just think that, because of once again, the unpredictability of it [childbirth], um, you don't know if something's gonna go wrong and you dunno how quickly you're going to need <u>to act</u> if something goes wrong and why put your baby and yourself at risk like that? [in a home-birth]? (Sara Trump, interview one).

Women choosing caesareans were also strongly driven to make birth 'choices' which ensured that they would have the best way of knowing exactly what was going to happen *to them* during the birth of their babies and the only sure-footed way to 'know' was seen as opting for an elective caesarean section. Thus, these women repeatedly constructed 'natural' childbirth as unpredictable and un-knowable whereas a caesarean section was seen as completely predictable, containable and knowable. For example:

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> Lola: …she [gynaecologist] can tell me exactly what happens with a caesar, but for normal birth, you never know, you're never sure exactly what's going to happen (Lola Cronje, interview one).
>
> Janine: …you dunno how long it's [natural birth] gonna last, you dunno if you're gonna end up having a caesar in any case (…) so (*) ja, you just don't (*) know what, what's gonna happen (R: okay) (Janine Le Roux, interview one).
>
> Hannalie: …if I have to lie in labour for 8 hours even if I don't feel a thing, it's not about the pain to me, I mean you can give me an epidural, that's how they do it nowadays, numb from the waist down, **lying there** for 8 to 12 hours, not knowing what's going on, would drive me insane (R laughs) (…) there's too much uncertainty (R: ja) there's too many variables (R: too much unknown) (Hannalie Botha, interview one).

These extracts show an investment in an instrumental knowledge in which a high premium is placed upon *prediction,* and control through the manipulation of extraneous 'variables.' A technical, surgical procedure such as a caesarean (as opposed to 'natural' birth) is seen as highly predictable and therefore knowable. Women choosing to have caesareans repeatedly spoke of surgical birth in these terms, to the point where one woman (Karin Miller) referred to a caesarean section as, "really [fitting] into my paradigm of *knowing*." A technocratic or positivistic knowledge in which there is 'a Truth' that is 'out there' waiting to be conquered through scientific methods, machines or technical expertise, was valorised by elective caesarean birthers. They thus went to 'the experts' who could tell them 'the facts' and give them 'real' knowledge about childbirth and their unborn babies. Although these women were highly active in finding the best professionals, and in making the 'choice' to have a caesarean, they nonetheless adopted a view in which 'true' knowledge was seen as residing 'out there' in the expert and in technology. *The birthing woman* herself was thus never seen as *a locus of knowledge* in relation to childbirth.

As I have discussed in earlier sections, 'the birthing body' was overwhelmingly constructed by caesarean birthers as uncontrollable and potentially horrifying. It is thus not surprising that the body itself was never seen as a *source of knowing* in relation to childbirth. Instead, commensurate with technocratic principles, the body (as denigrated matter) was seen as that which must be carefully monitored, managed and controlled. Choosing to have a caesarean can be seen, on one level, as part of an effort to control and suppress the (birthing) body (and all that is associated with it). Surgical birth becomes a way of reproducing and bolstering the notion that rationality and 'the mind' can control, subdue and over-ride 'the (female) body'.

Furthermore, also commensurate with an 'ideology of control' or instrumental rationality was a valorisation of the 'end-product' (the baby) over *the process* of childbirth within the talk of caesarean birthers. The process or 'experience' of childbirth was seen as having no intrinsic worth or meaning. Thus, according to Hannalie Botha, "what's the point of natural birth?" and for Ilse

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Van Rooyen, childbirth was simply "a stepping-stone to get (*) to the baby". This was in sharp contrast to the views of home-birthers, who consistently viewed childbirth as a significant, meaningful and often profound *experience*.

For caesarean birthers, the highly medicalised procedure of surgical birth was also constructed as part of a story line of (technocratic, medical, scientific) *progress*. Thus, a caesarean section was seen as a 'modern choice' and as a safer improvement over the unpredictable and potentially pathological process of 'natural' childbirth. As I discussed in chapter two, the assumption that the medicalisation of childbirth is a story of 'progress and salvation' is embedded within modernist notions of scientific advancement in which western medicine is seen as part of a wider narrative of 'enlightenment' and triumph over nature, the body and the 'backward' practices of the past. For example:

> Caroline: …you know I think we've *progressed* with modern medicine and it's [a caesarean] for me, a choice that makes sense to me (…) you know we've progressed (Caroline Kohler, interview one).

> We are living in a medically advanced country, in the 21st century, and the days of having to endure great pain during childbirth are long gone (Leslie Krynauw, email correspondent).

> Hannalie: …I mean, there (*) medical procedures <u>have advanced</u> so much today, if you look at the way they do a <u>heart</u> operation, they do it differently (R: yes) to the way they did it ten years ago (R: hmm). Why would you then go the normal route, if you, why would you go the old route of a heart operation, if you can go the new route? Why would you have a normal birth if you can have a caesarean section? (Hannalie Botha, interview one).

Positioning themselves *within* a technocratic ideology of control meant that elective caesarean birthers often operated within a definition of childbirth *as a medical condition*, akin to "heart surgery or cancer" (Caroline Kohler) or "a heart operation" (see Hannalie above). The analogy between giving birth and undergoing a heart operation was drawn on several times within the interviews in the interests of arguing for the so-called more 'advanced' way of giving birth: i.e. a caesarean section.

Sharply intertwined with the importance of 'knowing' (via technocratic means) was the *issue of control* for elective caesarean birthers. These women repeatedly and consistently referred to an elective caesarean section as the means whereby they could have the most control *over childbirth*. These women spoke of the importance of planning, predicting and controlling in all aspects of their lives and often spontaneously referred to themselves as 'control freaks' or 'Type-A personalities'. For most of these women, childbirth was another part of their lives over which they wanted to have the greatest degree of control. For example:

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Lola: …I think that [scheduling a caesar] also helps, because you have a specific date you know, tomorrow you'll be a mum (both laugh) because I'm, I'm quite a (*) A-type person, so I need to, I would love to be in control (laughs) so I think that's [a caesarean] (laughing) the most control I can have over giving birth (R: ja, okay) (Lola Cronje, interview one).

Hannalie: …if you're a controlled (*) person, and you plan things, and then (*) a natural birth is a, is a nightmare to you, because there's nothing there (laughing) you can control (R: hmm) and I think in my case, that's a big (*) sort of factor that played a role [in her decision] (R: hmm) (Hannalie Botha, interview one).

For elective caesarean birthers, 'control' in relation to childbirth generally meant being able to *over-ride* the embodied birth experience and remain 'in control' as a rational, disembodied self or 'mind' while their 'lower' bodies were literally 'put to sleep'. Making the 'choice' to have a caesarean and thereby voluntarily 'hiring' a medical professional to perform a technical service (the caesarean) was also part of what these women meant by 'control'. Furthermore, a caesarean section itself was seen as a more 'controllable' procedure which they were able to 'get' information on, prepare for and in which they were able to know, in advance, exactly what was going to happen to them (and their bodies). Having an elective caesarean was the ultimate way in which they were able to plot, plan and control, in linear time, the entire childbirth experience. As mentioned in chapter three, the concept of 'control' is complex and contested in childbirth research and 'control' has more recently been shown to mean different things to different women (Fox & Worts, 1999). The caesarean birthers in this study show that 'control' *vis-à-vis* childbirth can sometimes mean not only control over the utilisation (or not) of medical interventions but also control over the birth process by simply choosing to obliterate it.

Knowing-in-relation

"An epistemology spoken from a feminine subjectivity might privilege touch rather than sight."
(Iris Marion Young, 1990c:193).

What others have called a 'midwifery' (Rothman, 1982; Klassen, 2001a) or holistic model (Davis-Floyd, 2003), I have decided to represent as 'knowing-in-relation'. 'Knowing-in-relation is an 'alternative' epistemology of childbirth which emerged, haltingly and piecemeal, in the talk and stories of home-birthers and which stands, in many respects, in opposition to the technocratic, expert mode of knowing outlined above. Not limited to midwifery knowledge, this fluid epistemology consistently places *the birthing woman* at the centre of a circular, inter-relational matrix of knowing. Thus, in contrast to a 'technocratic' paradigm that constructs women as the *object* of expert knowledge and 'techniques', this orientation to childbirth constructs women as the *subject of knowledge* (but always in-relation to others). In talking about their 'choice' to birth

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at home, home-birthers were often engaged in weaving a different kind of epistemological position in which 'other' (non-technocratic) ways of knowing were constructed. These 'ways of knowing' can be seen as connected to what Nancy Hartsock (1985) calls *eros*, which she redefines as the sensual pleasures involved in creative, generative and competent activities (work/labour). *Eros*, in this conceptualisation, has a twin focus on embodied sensuality and a myriad of connections with others; it is "sensual, bodily, creative, and in community with others" (*ibid*, pp. 255). In trying to articulate an 'alternative' way of approaching and knowing about birthing, women drew on sources of knowledge such as: bodily knowing, intuition, 'nature' and the spiritual realm. Knowing was often portrayed as an ongoing journey or quest – a process rather than a linear, technocratic matter of simply 'finding' *the Truth* or *the facts*.

For example, for psychotherapist Stephanie Mitchell, coming to the choice to birth at home during her first pregnancy was described as a journey of rediscovering or "re-evoking" forms of knowing that in her words "had gone to sleep". Coming from a background in wilderness therapy and with a "strong connectedness to the Earth and (…) traditional cultures", Stephanie and her husband were deeply committed to, in her words, "honouring my, my woman's capacity to carry a pregnancy and birth without medical intervention". This 'commitment' or what she later refers to as a 'belief' in her 'natural' capacity as a woman to give birth successfully, was however in itself not enough. Stephanie thus narrates a journey of exploration in which she describes the importance of reading books such as '*Immaculate deception*' by Suzanne Arms and finding a midwife (also committed to "the natural way") such as Dolores Young. However, rather than 'give' her an external, fact-based knowledge or 'truth', alternative birth literature and the midwife are constructed as 'guides' helping her to 're-evoke' the knowing *within her* that had "gone to sleep". For example:

> Stephanie: …it opened a whole exploration which is where '*Immaculate deception*' and a few other things that I got hold of to read and a midwife like Dolores Young were, were essential because it was a whole, in a way an education, but a re-evoking the natural way that I didn't know, that I intuitively knew, um, so a lot of that kind of reading and really just listening to an inner wisdom, an inner knowing, that there is another way (…) I had a natural capacity to do this thing (Stephanie Mitchell, interview one).

In this extract, we can see how Stephanie constructs an alternative 'way of knowing' that is situated *inside* her (and not *outside* in 'the experts') but that can only be fully *achieved* in and through *connections with others*. Thus, although spoken of as 'the natural way', this 'way of knowing' is not automatic but has to be *regained* and struggled over (with the help of like-minded others). The power of the (medicalised) risk-infused 'what if…?' question however continued to loom large in Stephanie's tale of coming to home-birth. Thus, she speaks of her decision to birth

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at home (the first time) and her belief in her 'woman's capacity' as constantly challenged by 'what if…?' type questions:

> Stephanie: …um, it [decision to birth at home] was very challenged by, then I was 37 and first birth, just literally um culturally that negativity that, that um challenged my confidence quite often, I would feel, "Am I doing the right thing?", "What if something goes wrong?" you know, how can I home-birth and then something goes wrong? (interview one).

Even after an uneventful and successful first home-birth, Stephanie was still plagued by 'what if…?' type questions during her second pregnancy, particularly when it was suspected that she was carrying twins. Stephanie's account shows us the ways in which home-birthers are often situated both 'within and without' in relation to technocratic knowledge. Thus, while choosing to forego all technological intervention in her first pregnancy (including ultrasound sonography), during her second pregnancy Stephanie conceded that technology "has a place".

> Stephanie: …I mean this time round when we had huge angst about twins, we went for scans, you need to know, I mean it's a huge economic thing, and um, being gradually worn down by nausea and feeling "Am I going to do this?" and "I'm 42 this year and what if this is a Down's Syndrome baby?" "What if? What if? What if?" I went for an 18 week scan which was fascinating, absolutely fascinating, once I gave over to it you know, this has a place and it has meaning, um, to know whether there was abnormality, that we needed to aware of and to prepare ourselves, it really has a place (interview one).

Home-birthers were thus often not 'purely' located in an 'alternative' epistemology, but drew on technocratic forms of knowing, particularly in relation to the culturally dominant risk-infused 'what if…?' question. Thus, all of the home-birthers were clear that they would make full use of technology and medical expertise if it became necessary. Similarly to the home-birthers in Kornelson's (2005) study, these women were not against technology per se; they were more strongly opposed to *unnecessary* technological intervention. Some home-birthers, however, remained more opposed to technology than others. For example, Angela Stewart remained sharply against all forms of technology, including ultrasound scans. According to Angela, doctors *do not know* the long-term repercussions of this technology:

> Angela: …I think you know, I mean what am I going to do if there is something wrong? And I think the more one interferes the more likely that there is damage in the baby, you know they say it's [ultrasound technology] linked to remedial difficulties and they don't actually know, I mean scanning hasn't been around for that long, they don't know the side-effects (…) that's why I don't see the point in any medical interference (R: hmm, okay) even cellphones (R: oh really, laughs) (Angela Stewart, interview one).

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In sharp contrast to the association (made by elective caesarean birthers) between medical doctors and expert knowledge, Angela constructs medical professionals ('they') as *un-knowing*. Many other home-birthers expressed a similar *lack of faith* in medical science and knowledge. There was also often a *lack of trust* in medical doctors; for example, Jane Brown adamantly refused to have ultrasound scanning after her (only) scan at 22 weeks because she believed doctors potentially created 'bogus' problems:

> Jane: …I don't have scans at 36 weeks because then they start telling you "Oh your baby's so big and your baby's this and your baby's that" and I'm like "No, thank you" (interview one).

Home-birthers in general thus tried to cut 'monitoring' down to the bare minimum. All of them did, however, have at least *one* ultrasound scan (although Angela Stewart deeply regretted the one that she did agree to). Most of the home-birthers had between one and three ultrasound scans, often saw a 'back-up' gynaecologist or obstetrician only *once* during their entire pregnancies and none had invasive testing such as amniocentesis; the rest of their prenatal care was overseen by a private midwife.

At the same time, home-birthers were always located *in relation* to the dominant technocratic ideology (and not *beyond* it) and even the most vehement 'anti-technology' birthers such as Angela Stewart, regularly made disclaimers such as, "but one needs to have some form of back-up", "look if I need to go to hospital I will (…) I'm not going to be stupid about it". As a further example, another home-birthing couple (Anke and Steve) were upfront about their decision to combine "the best of both worlds" (Steve) and consulted both a gynaecologist, a midwife and a 'sonar specialist' specialising in '3D' ultrasounds to 'make sure' that everything was okay and that they could 'go ahead' with a home-birth. Many home-birthers also told me that they found the few (or only) ultrasound scans they had had 'reassuring'.

Despite their shifting positionality 'within and without' technoctratic forms of knowing, home-birthers (to different degrees) were engaged in a struggle to articulate 'alternative' ways of knowing about childbirth. Home-birthers 'came to' this 'choice' and 'way of knowing' in different ways. For some women, the path to home-birth was an outgrowth of a life journey in which they had come, via particular life experiences, to question medical authority or the normative status quo in general. For example, Jane Brown came to home-birth in the context of struggling with a longstanding chronic disease that was not correctly diagnosed by medical professionals for many years. As a result, Jane had a very strong aversion towards western medicine and made her decision to birth at home in this context. Other women described life experiences in which they came to question normative ways of doing birth in which women were

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disempowered and marginal to the birthing process. For example, as a young adult, Hazel Ray put on a white-coat and infiltrated the local State tertiary hospital, pretending to be a medical student; in the following extract she describes witnessing two women giving birth:

> Hazel: …And anyway, ja so there were two preg(nancies), two births that I saw (R: okay) in hospital, one was a 17 year old and he [doctor] was coming along like a mechanic, ↑feeling her, like how far was she and so on↑, it was like gross to see it, insensitive (R: hmm) and she was shivering away and then there was this little *bergie* [homeless] lady with a stocking over her head holding onto the bed and her legs up and they were saying, "Druk man nou druk" [Push man push] (R: aah no) and she was like "aaaggh" and it was so you know like to me the most gross environment and (R: ja) hos(pital), you don't druk [push] you, you're supposed to go with the rhythm (R: hmm) you're supposed to go with your natural, you don't just sit in the loo **and pooh** (R laughs) you know, you like give it time, you know what I mean (R: ja) it's part of like (*) and uh so, don't quote me (R laughs) but I'm saying that, I'm trying to give that example, that there was no in-touchness with the women who are supposed to be the centre of the whole thing (R: hmm, hmm) (Hazel Ray, sole interview).

Other women 'came to' home-birth after alienating *hospital* birth experiences; interestingly, these women often talked about their (medicalised) vaginal deliveries as 'unnatural' because they were not allowed to fully 'go with their bodies'. For example, for Joni Daniels:

> Joni: …I dunno, it [vaginal birth in hospital] wasn't, it wasn't natural if I can say it that way (R: hmm) it wasn't (*) what my body wanted to do, it was basically forced into (interview one).

The choice to give birth at home was thus, for this subgroup of women, often an attempt to finally "experience the full process of natural birth" (Maggie McDougal). 'The natural' in 'natural' childbirth thus meant, for these women, that the *bodily experience* of birthing would be centred and allowed to unfold without outside interference. 'Natural' childbirth was thus not seen simply as *vaginal* birth. This points to the shifting and often elusive meaning of the 'natural' in the term 'natural childbirth' (see also Viisainen, 2001).

Despite their different paths to home-birth, almost all of the home-birthers interviewed were engaged in the *discursive work* of trying to place the birthing woman (and her embodied experience) at the centre of the childbirth experience; they were often attempting, in bits and pieces, to weave a 'way of knowing' which would privilege the birthing woman's 'point of view' as the central subject in 'knowing' childbirth. In the context of a longstanding (historically male-driven) technocratic epistemology of childbirth in which the birthing woman is consistently portrayed as *the object* of childbirth knowledge, the attempt to centre birthing women *as subjects*, is not an easy endeavour (see Sbisà, 1996). This is in large part because *the language* (stories and

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discourse) used to represent childbirth is already heavily imbued with phallocentric viewpoints (Kahn, 1995). Home-birthers often had to draw on a rhetoric of 'nature' or 'the natural' in order to find some way of positioning themselves outside of a medicalised, technocratic discourse of childbirth. As I have tried to show within this chapter, valorising 'the natural' (a discursive game also shot through with patriarchal ideological baggage) was unfortunately often also accompanied by concomitant positionings within problematic ideologies of essential motherhood.

In attempting to articulate a different 'way of knowing' in relation to childbirth, home-birthers repeatedly emphasised the knowledge of women who have been through the experience of birthing. Thus, midwives were often valorised for this experiential (as opposed to 'expert') knowing. Many of the home-birthers emphasised the comfort of having a caregiver who had a thorough *concrete* and *womanly* knowledge of the birth process. As opposed to the hierarchical, bounded 'expert knowledge' embodied in the medical professional, the kind of knowing produced between midwife and birthing woman was often far more *relational* in nature, with participants speaking of their midwives as "tuned into you emotionally" (Kayla Peterson), "they come along side you instead of sitting across the desk (…) it's more like a sister thing" (Jane Brown), "she moves intimately within my space" (Stephanie Mitchell). Home-birthers also repeatedly spoke of their deep 'connections', 'bonds' or 'special' relationships with their midwives who were variously described as 'angels', 'goddesses' and 'witches' (in a reverential sense). In the following chapter, which looks in detail at the birth stories produced by participants, a *knowing-in-relation* (which was always strongly *body-to-body*) produced *between* the home-birthing woman, the midwife and the home-birthing woman's partner(s), will be presented and explored more fully. This 'way of knowing' was often described by home-birthers in terms of being 'in tune' or 'in touch' with, for example, the body, nature, 'instinct', the unborn baby, and the concrete others that surrounded her (and often became one with her) during the birth experience. In their talk, it struck me that metaphoric references to tactile (in-touch) and aural senses (in-tune) were often more prevalent than the scopic language (privileging the visual senses) which often dominates within the so-called 'specular economy' of the westernised world (Salvaggio, 1999).

In fashioning an (always patchy) alternative 'way of knowing' about childbirth, home-birthers often took up a different relation *to time* than women choosing caesarean sections. As mentioned earlier, while elective caesarean birthers were usually thoroughly located within a *forward-looking* relation to time (i.e. valorising 'progress' and 'advancement'), home-birthers tended to *look backwards* in time (i.e. 'back to nature', 'back to the caves') toward a 'ancient' (romanticised) past in which women enjoyed more embodied knowledge in relation to the birthing process. Furthermore, while elective caesarean birthers generally located themselves within a linear model of time and, for example, remarked favourably on the fact that a caesarean section

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took a predictable, neatly contained amount of time (i.e. half an hour), home-birthers often emphasised the need for a rhythmical unfolding of time within the birth process. Thus, Lizette Zimmerman hoped (in interview one) that her birth would be "calm and kind of rhythmical" while Hazel Ray emphasised the importance of going "with the rhythm (…) like [giving] it time" during childbirth.

Home-birthers were also more likely to speak in a language acknowledging the power of that which *can't be known*. Interestingly, while elective caesarean birthers *never* referred *to spirituality* in their talk about pregnancy and childbirth, several home-birthers did. However, unlike the home-birthers in Pamela Klassen's (2001a) study, there were very few who cited their spiritual or religious beliefs as a clear determining factor in their 'choice' to birth at home. Furthermore, while all (but one) of the home-birthers in Klassen's (2001a) study spoke of childbirth as "a spiritual experience" (pp. 65), many of the home-birthers interviewed for this study clearly told me that birth itself was not 'spiritual' but in fact, the most *material* and embodied experience of their lives. For example:

> Rachelle: And would you say that your birth experience had a sort of spiritual dimension to it?
> Jeannie: (**) Now *that's* a difficult question (R laughs) um…
> Rachelle: I mean you said that you were in a different sort of mental space #
> Jeannie: Ja, but it's a bodily, it's a bodily thing (R: okay) *uh* (*) *no*, I think I was far more physical and material and <u>here</u> than I've probably ever been (R: okay) it didn't, you don't, it's not like (*) I mean I dunno maybe other people feel it differently but it's not like I felt connected to other forces or anything like that (…) it was the most material I've ever felt, you know what I mean, where you're actually completely <u>on this earth</u> (Jeannie Artz, interview one).

However, *the spiritual* was sometimes invoked to refer to that which remains beyond human understanding, rational knowledge and instrumental control. For example, according to Lizette Zimmerman:

> Lizette: …when this baby comes out, or now already, there is an interaction with a spirit and there is physical and spiritual stuff that happens in that process which is just phenomenal and which we know nothing about and we should not interfere with it, we should just let it have power and space and let it unfold (interview one).

As I will show in the following chapter, the birth experience itself sometimes worked to *shatter* existing preconceptions regarding issues such as 'control', individual agency and rational knowing and opened up a space for alternative ways of making sense of selfhood, knowing and agency. In telling stories about home-birth, a language of miracle and mystery was often used to refer to that which is beyond objective, rational knowledge and control. According to Irene

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Diamond (1994), a 'language of mystery' is urgently needed to counter a dominant technocratic language of control; she also refers to this 'language of mystery' as an 'ethic of awe' which "recognizes the limits of human reason, and that nature is not fully comprehensible and may be resistant to our designs" (pp. 54).

A search for control

"In the contemporary world the language of controlling our bodies does not necessarily challenge masculinist power and can easily become a principle of regulation which sustains that power."
(Irene Diamond, 1994:88).

While in many respects 'taking up' different epistemological positions *vis-à-vis* childbirth, home-birthers and elective caesarean birthers were, nonetheless, united by a 'search for control' which often dominated their talk about making childbirth 'choices'. 'Control' was a central issue for almost all of the women[44]. Participants repeatedly stressed the importance of making an 'informed choice' and the talk of both sets of women was littered by this phrase. Making an 'informed choice' by reading, surfing the internet, speaking to 'experts' and to women who had been through the birth experience, was seen as the best way in which they could gain some degree of control in relation to childbirth. *Knowing about* childbirth was thus inextricably intertwined with *controlling* childbirth. However, home-birthers and elective caesarean birthers drew on different kinds of knowledge in making their 'choices'.

Although positioning themselves within different birthing 'paradigms', both 'sets' of women emphasised the importance of *making* a 'choice' in relation to childbirth. Running as a steady refrain throughout the women's talk was the story line of 'choice'. Thus, even if not in agreement with another woman's 'choice', almost all of the women expressed *respect* for the person who was at least active in making a 'choice'. For example:

Erina: …I mean I think for me if, if somebody <u>makes</u> an informed choice, that's fine (Erina French, home-birther, interview one).

Mandy: …it's all about knowledge; it's all about making an informed decision (Mandy Van Zyl, home-birther, interview one).

Lola: …I think it should be your choice, it's your body (*) it's your baby and I think we're all educated enough to make a choice about that (Lola Cronje, elective caesarean birther, interview one).

Joni: …it all bo(ils), it boils down to personal choices as well (R: ja) because (*) you ultimately (*) it's <u>your</u> body, it's <u>your</u> child, it's your life (Joni

[44] There was, however, one exception. Tasneem Davids, a Muslim, working-class home-birther, narrated her journey to home-birth as a search for *care* and not control. In fact, Tasneem never even once mentioned the word 'control' in interviews while the talk of all of the other home-birthers and elective caesarean birthers was littered by it. Space limitations unfortunately preclude a detailed examination of this interesting 'outlier' case.

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Daniels, home-birther, interview one).

I described the story line of 'choice' as a feminist narrative in chapter two. In the above extracts we can clearly see how feminist catchphrases have seeped into the talk of everyday women: 'it's your body, your life, your choice'. However, it is also true that a story line of 'choice' intersects both with a consumer-driven rhetoric and an 'ideology of control' in which the body is treated as an object to be manipulated and controlled. In the ways in which both sets of women talked about themselves and their bodies, there was thus often a discernable pattern of wanting to have *control over* their female bodies, particularly in relation to food, weight and body size. The importance of controlling the body through exercise and diet regimes was mentioned by the majority of women within the study. In the context of longstanding forms of patriarchal power, which have exerted rigorous degrees of external control over women's bodies, it is not surprising to find that issues around personal control remain a sore-point for many women. Thus, for example, pregnancy itself was narrated by some women (home-birthers as well as elective caesarean birthers) *as a crisis of control*.

In contrast to views which try to 'lump' women into different 'orientations' *vis-à-vis* pregnancy and mothering, such as for example, Raphael-Leff's (1991, 1993) model which speaks of three mothering 'types', i.e.: the facilitator (who experiences pregnancy as the ultimate culmination of her identity), the regulator (who views pregnancy as a burden) and the reciprocator (who falls somewhere in between), most of the women interviewed for this study experienced pregnancy *with fluid and shifting ambivalence*. Even the home-birthers walked a tightrope between revelling in the creativity and miracle of the pregnant body and wanting pregnancy to be over so that they could 'become themselves' again. Interviewing many home-birthers in the late stages of their *second* pregnancies might have influenced the ways in which they talked about pregnancy. For example, many home-birthers narrated a shift in their experiences of first and second pregnancy, with many feeling less 'in awe', connected with and celebratory towards the embodied pregnancy experience the second time round. For example:

Mandy: …I **adored** my first pregnancy; I remember I was eight months pregnant and I wrote in my diary as well that I could be pregnant for the rest of my life (…)
Rachelle: And this time hasn't been, you haven't sort of gloried in it as much?
Mandy: Ag no, no not really cause I'm really tired of being **big** now, you know, I'm tired of being big (…) I just don't want to be pregnant again after this (…) I really don't want to be pregnant again, I just want to get my life and my body, just get it back, cause it really does, it's a violation of your body, it is, you've got this little, it's a parasite in the most positive sense of the word, you know, you've got something feeding off of you and taking over your entire existence, ja (Mandy Van Zyl, home-birther, interview one).

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> Jane: …with the first [pregnancy] you're so wrapped up with the wonder of it, the second one you're busy and you kind of just want it over, you know, it's uncomfortable (Jane Brown, home-birther, interview one).

Pregnancy also often challenged the standard relationship of *control over the body* that many of the women were invested in. Being a 'healthy', 'sane' and successful self within capitalist, technocratic and patriarchal societies requires that persons approximate the rational, autonomous, masculinist model of the individual who exercises agency and control and who experiences themselves "as having, possessing and controlling a body" (Featherstone cited in Warren & Brewis, 2004:226). The experience of pregnancy, in which 'the body' "slips its moorings" (*ibid*, pp. 221) and often asserts itself loudly in ways that cannot be easily 'rationalised' or controlled, was sometimes difficult for the women interviewed. For example, home-birther Lizette Zimmerman found that pregnancy was a "harsh awakening" requiring that she 'deal with' the fact that "something **major**" was happening to her body and her self that she was "out of control of". To 'deal with' pregnancy, Lizette instituted a set of dietary changes to enable her to manage and 'read' the pregnant body so that she could actively 'do something' and remain (at least marginally) 'in control'.

> Lizette: …your body changes completely so you've got to be really clear about what's going on with it and what you put in it, um so I've been following that [dietary programme] (…) it helps you on an emotional level because there's something that you can physically **do**, there was something physical that I could do, I could change my diet, while there's nothing I can do about my hormones and my emotional stuff, but the fact that there was something that I could actually do (…) for me there's a, there's a kind of a consciousness that I, I'm still **me**, I'm being the way I want to be, I'm not out of control and eating a hundred cream cakes a day (R laughs) (interview one).

For Lizette, (first) pregnancy was experienced as partly a crisis in *control*, *body-self relations* and *identity*. Finding herself at the mercy of a process that "you are out of control of" means that accepted ways of being a modernist self: bounded, controlled and rational, potentially start to come apart at the seams. Interestingly, the uncontainable changes wrought by the pregnant body also led to Lizette experiencing a kind of mini identity crisis; thus, if I am out-of-control and ruled by the body's unpredictability, then *who am I*? In order to manage this crisis, Lizette had to find ways in which she could assert some degree of active control over the pregnant body and thereby retain a sense that "I'm still **me**, I'm being the way I want to be". For many of the women interviewed, pregnancy was interlaced with dilemmas pertaining to control, identity and body-self relations. For example, 35-year old home-birther Maggie McDougal found that it was only with her third pregnancy that she found a way to 'deal with' the process of pregnancy:

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> Maggie: …I know it's nine months of my life that's a sacrifice, exercise [six to eight hours a week] actually kept all the nausea away, exercise's actually kept the mood swings to a minimum, I think a lot of times in pregnancy a woman, because they actually **lose** control of their body image and they **lose** control of their eating, and they don't exercise, it actually becomes a whole psychological thing that they actually um, they aren't themselves anymore, and you actually start getting more and more angry and emotional and upset whereas this time round I've actually accepted it (…) there's been an acceptance, that things do change (interview one).

Maggie, who describes herself as "a control freak" before the birth of her first baby talked about her earlier difficulty in "**accepting** things"; for Maggie, the experiences of pregnancy, motherhood and a traumatic divorce taught her to accept unpredictability and change and 'let go' of her need for "a set routine": "I've learnt to lose, um, that sense of controlling everything". For elective caesarean birther Sara Trump, the experience of pregnancy was also seen as, in some ways, a lesson in losing control. Her growing and expanding body was experienced as a sharp departure from her pre-pregnant highly disciplined body:

> Rachelle: Okay, how have you experienced your changing body?
> Sara: *Ag* (signs) [uh, I hate that] (both laugh) I *hate* it, cause I've *always* been in <u>good shape</u> (R: hmm) I mean I've always been very, very happy with my body, I went to gym three, four times *a week*, you know, like I've always just felt <u>really</u>, <u>really</u> good and quite attractive and (R: hmm) you know been able to wear *whatever* I want and feel good and it's <u>quite</u> an adjustment but it's not necessarily bad, I mean that I actually think it *really* sort of teaches you a little bit about losing a bit of control and not being too perfect about things (interview one).

In the interviews, women's responses to pregnancy were *shifting* and fluid, veering between a recognition of the amazing, creative, miraculous process of pregnancy, embodied joyous "squirmy feeling(s)" (Sara Trump) in relation to the baby's movements, a feeling of constraint, frustration and being uncomfortable, irritation regarding having to 'deal with' "the **stuff**" (Jane Brown and Stephanie Mitchell) that comes with the materiality of pregnancy: i.e. bodily functions and physical discomforts, a crisis of control and identity and difficulties in accepting the dramatic shift from a pre-pregnant (often disciplined and controllable) body to an ever-expanding and uncontainable pregnant body. Many of the women were used to treating 'the body' as an object to be controlled, disciplined and worked on so that it 'looked good'. Pregnancy often entailed a rude awakening wherein the uncontainability of corporeality loudly asserted itself. For example:

> Rachelle: Um, how have you experienced your changing body in the pregnancy?
> Caroline: It's, it's funny, it's (R laughs) you've got to have a sense of humour but it's, it's not nice, it's, you know (*), it's (*) initia(lly), first you're *really* proud of it and you start getting a little tummy and then it gets bigger and you think, "Oh gosh, I'm really big and I can't get any bigger' and you just, it just gets *bigger* and *bigger* (R laughs) (…) you

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> put on weight everywhere and (R: hmm, hmm) and I think it's nature's *way of* sort of *storing* and you know, knowing its got to feed something and not knowing where the next meal's gonna come (R: ja, ja) and if I could tell my body that we have got a supermarket down the road (laughing) (…) it, it's *your* body, you do, you know, you've always wanted to try and keep in shape and do all these things and you know, look good and everything and all of a sudden you've just got no control, it just does what it wants (both laugh) so I am looking forward to getting back into shape (R: okay) (Caroline Kohler, elective caesarean, interview one).

For Caroline, 'the body' is overwhelmingly seen as an object or a possession of the self ("it's *your* body") to be kept 'in shape', silent and unobtrusive. The gaping mind-body split operating within this model of body-self relations becomes sharply evident when Caroline talks about the pregnant body as the uncontrollable, unknowing, alien-like "*it*" that does its own thing, cannot be reasoned with and which exists on a level far removed from the rational, modernist self.

An 'ideology of control' which is deeply embedded within western, technocratic and masculinist cultures, often manifested within the talk of women as a desire to control and subdue the female body and more specifically, the pregnant body. Although there were differences in the ways in which home-birthers and elective caesarean birthers negotiated a technocratic 'ideology of control', home-birthers were just as driven by 'a search for control' as elective caesarean birthers. Again and again home-birthers mentioned 'control' as one of, or *the* dominant reason, why they were choosing to birth at home. However, for home-birthers, attaining 'control' was often about escaping *the external control* imposed upon birthing women by medical professionals and hospitalised birthing practices. Thus, a major part of 'control' for home-birthing women was being able to have control *over the environment* in which they gave birth. For example:

> Rachelle: Um, why did you decide to go for a home-birth?
> Lizette: Well it's that book, '*Birth without violence'*, so it's being able to be in an environment where I can control it, um, control's a word I'm using a lot, but an environment that's the way I want it to be (…) so the home-birth is so that I can make **sure** that nobody's going to take him away, that it will be gentle, it will be quiet, um, that I can move around and do what I need to do, that my choices that I'm going to have to make throughout that process, I'm going to be able to make calmly and quietly as I need to make them (…) so ja it's to try and stay out of that whole scenario [hospital birth] and when you go through those doors, of a hospital, your chances are, if you go through those doors you have a 65% chance of having a c-section, 65% chance…I will only go through those doors because I've already made that decision at home, I'm going there to have a caesar, I'm not going there to see what my options are (Lizette Zimmerman, home-birther, interview one).
>
> Rachelle: And for you, there's no particular religious or spiritual reasons for planning a home-birth?
> Erina: No (*) no it, it's more (**) to be more in control of the experience and of my environment (…) I do like to be in control of my environment (*) I'm not a control-freak but, but I, I like to have a measure (R: hmm) of control (…) I always say that the primary reason we're [Erina and

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friend] doing this is um (*) a sense of 'we want to be in charge of this experience' (R: hmm) not anybody else (R: hmm, hmm) (*) ja (Erina French, interview one).

Rachelle: So why did you really decide to go for a home-birth, the first time round?
Jane: I wanted control (Jane Brown, interview one).

Several studies have similarly found that the issue of 'control' is central to the decision to give birth at home (e.g. see Morison, Percival, Hauck & McMurray, 1999; Viisainen, 2001; Kornelsen, 2005). For home-birthers, having 'control' translates into "being in charge" (Erina French) by assuming control over the birthing environment, decision-making and birth attendants. Some of the women also spoke about expecting to be able to control *the birth process* itself by sheer strength *of mind.* However, the experience of childbirth (at home) often *shattered* these expectations and sometimes led to new insights about the limitations of an understanding of the self as rational, autonomous and all-conquering (see chapter seven). Thus, home-birthers and elective caesarean birthers *were united* by a common 'search for control' in relation to childbirth. However, this 'search' took different forms and often revolved around different meanings of 'control'. While elective caesarean birthers found 'control' by bypassing the entire birthing process and voluntarily 'outsourcing' it to medical experts, home-birthers achieved 'control' by actively opting out of the hospital system and controlling the environment and relational matrix within which birth was allowed to unfold.

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In conclusion

This chapter has attempted to situate women's birth 'choices' within material and ideological contexts. The contextual 'conditions of possibility' within which women's talk about making birth 'choices' is invariably embedded, was explored in detail. Thus, I have attempted to 'make visible' the middle-class, 'white' and Eurocentric (global and local) locations within which most of the stories were situated. I have also tried to show how patriarchal and technocratic ideologies seep into women's talk, creating ever-shifting subjectivities which are constantly being positioned and positioning and repositioning themselves in relation to a mobile stream of ideological 'voices' and images. I have tried to argue and show throughout this chapter that childbirth 'choices' are never made in an ideological or political vacuum but are always made *in relation* to a complex set of material 'realities' and socio-symbolic ideological interpellations and constraints. As a result, childbirth 'choices' are rarely present as simple or transparent 'transgressive' acts of 'resistance' but are more likely to be complexly overlaid with contradictions, collusions and paradoxes.

Although I have not expressly highlighted the issue of subjectivity within *this chapter* (see chapter seven), I have nonetheless tried to show the ways in which subjectivities are always complex *infoldings* of ideologies, cultural and material contexts. In the following chapter, I attempt to focus on subjectivities produced in and through the telling of birth stories, showing how subjectivity functions as both an infolding (of culture and ideology) *and* an outfolding of bodily energies and lived experiences.

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Extracts from 'Natural birth'

Toi Derricotte in Chester (1989:113)

TRANSITION

the meat rolls up and moans on the damp table.
my body is a piece of cotton over another
woman's body. some other woman, all muscle and nerve, is
tearing apart and opening under me.

i move with her like skin, not able to do anything else,
i am just watching her, not able to believe what her
body can do, what it *will* do, to get this thing accomplished.

this muscle of a lady, this crazy ocean in my teacup.
she moves the pillars of the sky. i am stretched into
fragments, tissue paper thin. the light shines through
to her goatness, her blood-thick heart that thuds like
one drum in the universe emptying its stars.

you can push …

i hung there, still hurting, not knowing what to do.
if you push too early, it hurts more. i called the
doctor back again. *are you sure i can push? are you sure?*

i couldn't belive that the pain was over, that the punishment
was enough, that the wave, the huge blue mind i
was living inside, was receding. i had forgotten there
ever was a life without pain, a moment when pain wasn't
absolute as air.

why weren't the nurses and doctors rushing toward me?
why weren't they wrapping me in white for the white light i was being
accepted into after death? why was it so simple as saying
you can push? why were they walking away from me into
other rooms as if this were not the beginning of
something which the world should watch?

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CHAPTER 7

Telling birth, stitching selves

> Why hasn't anyone told me any of this before? Why isn't the birth process routinely pondered, praised, everywhere? Is this universal fact of human origin an exclusive secret?
> (Phyllis Chesler, 1979:88).

> Birth experience is articulated through pre-existing medical, social and cultural narratives that are reformulated, transformed and often irrevocably shattered through embodied experience.
> (JaneMaree Maher and Kay Souter, 2002:41).

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In this chapter, I provide a narrative analysis of women's childbirth stories, exploring the ways in which home-birthers and elective caesarean birthers tell, make sense of and re-construct the birth experience. In this analysis, I show how birth is told as a dynamic interplay between accepted cultural stories/ideologies and the inchoate, often chaotic lived bodily/emotional experience of birthing, which often emerged as 'story lines of disruption' within women's 'tellings'. The making of birth stories is thus shown to be a dialectical process involving both the *infolding* of cultural stories, ideologies and commonplaces and the *outfolding* of bodily energies and emotions.

In part one of the chapter, I explore the narratives of home-birthers and show how 'clockwork birth' functions as the key "interpretative framework" (Pollock, 1999:131) or 'narrative type' (Frank, 1995) within which women told (home) birth stories. Eruptions of another story line (of home-birth) that places the birthing woman *at the centre* of a nexus of support, knowing and embodied connection, was identified and labelled 'lived birth'. This story was characterised by 'body talk' and was told from the perspective of the embodied experience of the birth-giver. Finally, there were also traces of a third story line of home-birth which constructed childbirth as an experience of undecidability and a shattering or un-making (see Marshall, 1996) of preconceived assumptions *vis-à-vis* control, autonomy and the rational self. In part two of the chapter, I explore the ways in which women narrated the experience of caesarean section. Here I

show the ways in which caesarean birth was told as a contradictory and dynamic interplay between two story lines, namely: a restitution narrative and a chaos narrative.

Part 1: Narratives of home-birth

Before embarking on a detailed and complex analysis of home-birth narratives, I want to remark on the general shape of these birth accounts. First, it is important to emphasise upfront that women's tales about home-birth were, in almost every case, incredibly positive and joyful. For the most part, these stories were saturated with a sense of satisfaction, success and self-affirmation. Overall there were few complications and all gave birth successfully at home, barring one woman (Sam Duncan) who decided a few weeks before the birth to give birth at her local Active Birth Unit instead. None of the women had any regrets about their decision to birth at home and more than one referred to the birth as one of the best experiences of their lives. While only fourteen home-birthers were followed through the process of pregnancy and birth (and one woman was interviewed post-birth), this analysis nonetheless draws on a total of 30 birth stories, as twelve of the women told stories about previous birth experiences in addition to their current birth.

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Clockwork birth

"...it was like clockwork, literally."
(Stephanie Mitchell, home-birther, interview one).

Time	Length of contraction
8:35 P.M.	*68 seconds*
8:42 P.M.	*52 seconds*
8:47 P.M.	*61 seconds*

(from Phyllis Chesler, 1979:107).

"Now, women are bound by the clock rather than by leather straps."
(Wendy Simonds, 2002:568).

Giving birth at home has been hailed as the most extreme form of resistance against medicalised childbirth (Martin, 1987); I was therefore surprised to find that home-birthers almost always drew on a medically derived 'clockwork' script of childbirth when telling me their birthing 'stories'. The 'clockwork' story of birth is a linear and formulaic way of telling birth in which the birth process is 'made sense of' by plotting it as a series of measurements in centimetres (degree of dilation), minutes (time lapse between contractions) and hours. The story literally cannot proceed without regular and repeated references to clock-time and centimetres. Deeply ingrained in a

western cultural imaginary, the story line of 'clockwork birth' is often invoked in television shows and movies; for example, everybody knows the image of the birthing couple who react to the possibility of labour by immediately hauling out the stop-watch and timing contractions. Similarly to pregnancy and breastfeeding (see Simonds, 2002), childbirth is predominantly 'known' by being carved up in relation to obstetric timetables. The 'clockwork' story of birth also dominates childbirth preparation books (often written by female midwives) and teachings at antenatal classes.

The clockwork story is the perfect, 'textbook' version of childbirth which fulfils all the demands of medical norms: the birth is not 'overdue', the amniotic fluid breaks appropriately, labour contractions proceed in a regular, predictable and efficient manner (discerned by 'timing' them) leading to the dilation of the cervix (to ten centimetres) within an appropriate time period, once full dilation is attained the 'urge to push' is present and overwhelming and the baby is delivered spontaneously and rapidly. It is against this normative ideal that the birth process is routinely measured, judged and deemed either functional or dysfunctional. More often than not (particularly within hospitalised birthing), the clockwork story goes wrong and the birthing body (almost inevitably) 'malfunctions' in some or other way, thereby necessitating medical interventions and confirming the patriarchal and medicalised view that women's bodies are prone to 'break-down' and inherently dysfunctional (Davis-Floyd, 2003). The 'clockwork' script of birth is roughly based on Friedman's curve, a "time-motion statistical analysis" (Simonds, 2002:565) of the different stages of labour, developed in the 1950s, which effectively created a series of arbitrary 'norms' whereby the progression of labour could be measured and deviations from these norms could be identified and thus successfully 'managed' (see Martin, 1987). Constructing norms thus has the usual spin-off of creating a horde of potential deficits, disorders, problems and abnormalities for the 'experts' to manage and 'fix'.

It is important to emphasise that when manifesting in the birth stories of women, the clockwork narrative is an 'outside-in' story that often becomes knitted into the woman's storied experience of birth. It is an 'infolding' of a dominant medicalised version of childbirth and the birthing body, privileging an *outsider's* view and knowledge *vis-à-vis* the birth process, which however often becomes a core part of the expectations that women carry in relation to childbirth. It represents a 'way of knowing' and regulating childbirth that is situated outside of the birthing woman: i.e. in the clock, the dilation measurement and the electronic foetal monitoring machine. Nonetheless, the clockwork narrative often becomes part of the way in which women approach and 'make sense of' childbirth in and through birth stories.

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A clockwork script

A clichéd and formulaic birth story recipe was invoked repeatedly by home-birthers. When I asked them to tell me "what happened from beginning to end with the birth?"[45], they invariably delivered a story in clock-time, plotted against conventional medical markers. This story was often scripted along the following kinds of lines: (a) preamble or 'run-up' to the birth, (b) 'is it or isn't it [real labour]?' (c) the point of no return (deciding it is 'real' labour), (d) summoning the midwife, (e) vaginal examination(s) (f) progress through centimetres and against clock-time, (g) the use of a bath and/or other means of pain relief, (h) the breaking of the waters, (i) the pushing stage and (j) the delivery of the baby.

Interestingly, the preamble or 'run-up' to the birth was often the *most elaborated* part of the clockwork story as told by home-birthers. In many cases, the telling of birth began by situating the story in relation to a *due date*. The point of departure for the stories was thus often medically derived. For example:

> Rachelle: Okay, what happened from beginning to end with the birth?
> Erina: Okay, from the start? (R: ja, ja) from the start, well she [baby] arrived one day before her due date (…) uh, her due date was Tuesday the 23rd and she was born at 4 o'clock in the morning on Monday the 22nd (Erina French, interview two).

While generally departing from a medicalised starting-point, the *preamble* was also often characterised as lengthy and brimming with narrative tension. This part of the story often involved some kind of complication, 'trouble' or comic sub-plots. At first take, most home-birthing stories followed a clockwork story line, involving a dramatic 'run-up' and then, once 'real' labour was confirmed, an abbreviated and formulaic set of recipe-like steps. As a result, clockwork-type stories often had an elaborated and entertaining *beginning*, a clearly differentiated, 'happy' *ending* but little to *no middle* (see Pollock, 1999). For example, consider the story below as told by psychotherapist Stephanie Mitchell. This tale is comprised of 'a long story' as a preamble to the 'actual' birth, involving a series of dilemmas that emanated from the breeched position of her baby in the late stages of pregnancy. This 'preamble' is itself made up of several mini-stories, for example: visiting various 'experts' to try and get the baby turned into a 'head-down' birth position, once the baby had been turned, the dilemmas involved in weighing up the risks and deciding where to birth (home or hospital), practicing 'natural' methods of inducing labour and the immediate 'run-up' to the onset of 'real' labour. Once 'labour' is diagnosed, which Stephanie

[45] Of course, it is only clear to me in retrospect that this very question is itself immersed within a clock-time version of childbirth.

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attributes to a clear embodied 'knowing' ("and I knew um") but which was also clearly achieved by timing the contractions ("he [husband] was timing"), the clockwork recipe is easily recited: call the midwife, internal examinations, breaking of the waters and the 'actual' birthing of the baby, which is almost matter-of-fact and completely devoid of any narrative detail: "I sat on his [husband's] legs and at ten to one he was born, um".

Rachelle: How was the birth? What happened?[46]

1. Preamble

Stephanie: *All right well*
there was
there was
quite a run-up
to the actual birth itself (…)
cause we obviously had our heart set
on birthing at home (R: hmm)

um
I carried very very big
a lot of amniotic fluid (R: yes)
and he [baby]
he was very mobile in the womb
and he was either lying *transverse* (R: okay)
or
eventually settled
um
in a breech position

Rachelle: Oh no!

Stephanie: We were horrified

so um
in the 38th week
we went for acupuncture
and
incense burning
on the side of the toe (…)

which is supposed to turn the baby

Rachelle: Oh wow!
Stephanie: but he [acupuncturist] said
that it only really works in the 39th week
but um
I'd carried *so* big
and there were increasing signs
of birthing
so we didn't want

[46] This 'story poem' is constructed verbatim from the transcript; omissions are signalled by (…)

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to leave it
so we went for the
it was a Monday
and nothing happened
he didn't turn
um
so the Wednesday
we went to a paediatrician in town
who does external cephalic versions (R: ja)
um
and that is what we did
we actually had him *turned* in utero
which was a <u>hectic</u> experience

Rachelle: I was going to say actually, how did you experience that?

Stephanie: Well I
I didn't know what to expect
um (…)
he's [paediatrician] got a very different bed-side manner [to usual doctor]
(laughs)
but he
he did the job you know
he literally
within two or three seconds
had *whipped*
Peter's [baby] head <u>down</u>
whipped it down
and into the pelvis
keeghow
down (R laughs) (…)

and then he showed us
how to get the uterus
to contract
↑**"Tweak the nipples, tweak the nipples"**↑
there he is
tweaking my nipples madly
and I'm going into contractions
and Peter's head is being pushed further and further
down into the pelvis
and I left feeling totally
shattered (…)

and anyway
so the next morning
Dolores [midwife] came round
to check
to check if
his head was still down (R: hmm)
and <u>it was</u>
so then um
we
um

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Dolores, Vince [husband] and I
sat here [in the lounge]
and said
"Right, now, now what do we do?" (…)
do we
go
go into hospital
have an induction
and all of that stuff
and at least birth naturally (R: hmm)
because as long as he was
breeched or transverse
it would mean
a definite caesar
and we didn't want to go that route (R: hmm)
so
so do we take the best of the situation
and not be greedy?
or do we say
okay
um
this is where he's at now
his head is down
we
we really want to birth naturally
at home
let's trust the gods (R: hmm)
um
and Dolores talked with us (…)
and she
she
really
just connected
connected with the belief and trust
in natural birth (R: hmm)
and said
we need to just
just trust that things will go well
and if they don't
if he turns
then I'll go in
and have a caesar
so that was those dilemmas
she
she suggested
natural ways to induce labour
making love was one (R: hmm)
um
and drinking castor oil – do you know that?

Rachelle: Yes, yes, did you try that?

Stephanie: Well
the making love was fine (both laugh)
the castor oil was a little bit hectic

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um
at five o' clock Thursday late afternoon
I downed 50 ml of
of castor oil (R laughs)
and at that stage
of the pregnancy
I was *so* huge and *so* uncomfortable (R: hmm)
that invariably at about seven
I would go and lie down and read
cause the *only* way I was comfortable was lying on my side (…)
so
um
I read for about an hour
and the
the Braxton-Hicks contractions had been
they were very very intense
for about two or three months (R: hmm)

it was a very **intense** pregnancy
um
so
between seven and eight
Braxton-Hicks were going
you know
like crazy
I was feeling very very sensitive
after the version

and then
at about eight o'clock
I got up
and went to the loo
and after four months of constipation (laughs)
that suddenly reversed (R laughs)
rather rapidly
after the castor oil

2. <u>The point of no return</u>

and then
just before half past eight
the the
contractions changed
and I knew um
that this was it
and I came through here [to the lounge]
and Vince somehow had had a feeling
as well
because he
he had a couple of reports to finish
before going on paternity leave
and he was **madly** working on his laptop
and
in-between contractions
he was timing and writing down

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and I was doing my thing (…)
and they [contractions] were getting
more and more intense

3. <u>Summoning the midwife</u>

um
at half past eight they started
and we phoned Dolores
at about half past nine
and she said to call her
when they were a minute long (R: hmm)
and she came at eleven (…)

4. <u>Examinations</u>

and she
she did an internal
I was five centimetres dilated
already
and the contractions
by then
I was starting to have to breathe
but it wasn't too hectic
um (…)

5. <u>Breaking of the waters</u>

and then
Dolores gave me the choice
of either
going with the contractions until the waters broke
which could take any amount of time (R: hmm)
or to
to rupture the membranes
then active labour would kick in (clicks fingers) (R: ja)
and I chose that
because I was keen to have
to have
I wanted to birth this little one (R laughs)
and then
we went
we went back to the bedroom
and um
she had some difficulty
rupturing the membranes
they were very tough
and then
the waters just *flooded* (R laughs)
literally flooded
and then
um
active labour kicked in big time
it was about quarter past twelve

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um
that she ruptured the membranes

6. <u>The delivery</u>

and um
came through here [to the lounge]
and had
ten minutes of
of very very intense contractions
Vince formed a birthing stool here (R: hmm)
sitting on the chair
I sat on his legs
and at ten to one
he was born
um

Rachelle: So it was quite quick?

Stephanie: Very fast
it was four and a half hours
all in all
not even
four hours 20 minutes
and it was
it was
very very quick pushing time (R: hmm)
it was about ten minutes of pushing time (…)
um
and Dolores left us at about quarter to four
left us all
in the bed (both laugh)
I didn't sleep at all
I dozed a bit

7. <u>'And that was that'</u>

and that was that
ja
so it was
we couldn't have asked for better
so that
that was that.

The above story told by Stephanie is typical of most of the initial attempts made by home-birthers to 'tell' their birth experiences. In these 'clockwork' tales, the 'actual birth' itself is often almost completely 'left out' of the story and often seemed to function merely as the point at which the ending of the narrative could be clearly and neatly marked off. While the preamble to the birth is full of drama and tension, once labour is finally underway Stephanie's birth story becomes incredibly formulaic, relying heavily on medical measurements and interventions (e.g. the rupturing of the membranes) in order to have any story worth telling. The *experience of birth* as

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lived from Stephanie's perspective is largely missing. Strikingly absent from all stories told within a clockwork genre is any sense of what birth *feels like* from the centre; *the subjectivity* of the woman-in-labour is always largely or totally omitted. The clockwork narrative thus typically produces a series of gaps and omissions, telling birth as a string of clichés rather than as a pulsating, embodied, intensely visceral experience. When telling me stories about their first birth experiences (dating back two to four years) many home-birthers told even more abbreviated, matter-of-fact clockwork narratives, for example:

> Rachelle: How was that birth? [first birth]
> Jeannie: It went on very long, I mean I started with contractions, mild contractions at like 10 o' clock the Wednesday night (R: okay) *and* (*) I went in on the Thursday morning to Lily [midwife] and I said '*{I think I'm in labour}*', I haven't been able to sleep the whole night, something weird is going on, the dog has not left my side' (both laugh) and she said, 'Well, you're smiling and you're walking in here, I'm not sure you are in labour. Let's have a look' and I was about one or two centimetres dilated so she said, 'Okay, go home, when things get a little bit more hectic, phone me, otherwise I'll come in at about four or five o' clock and see how you're doing' so I didn't phone her cause everything was pretty much the same, by the time she came in, I think I was about, maybe about four centimetres dilated, but then we waited like that until about 8 o'clock at night and absolutely nothing changed, so eventually she broke the waters and then, then it started happening, ja, and he came about quarter past midnight (Jeannie Artz, interview one).

In Jeannie's story about her first birth, there is a major *hole in the middle* of the narrative; birth is thus told in relation to the clock and number of centimetres dilated; once again the actual experience of birthing is totally missing. The story is thus told as a (comic) preamble, a series of measurements, the breaking of the waters and suddenly ends abruptly with the matter-of-fact statement that, "ja, and he came about quarter past midnight". This abbreviated version of birth is probably a routine cultural recipe for how one goes about telling the birth experience to friends, family and other interested parties; that is: give the bare outlines, plot the story in clock-time and leave out any inappropriate or 'messy' details relating to the actual intense and profound fleshy-subjective *experience* of being 'in-labour' and giving birth. It is thus perhaps not surprising that women pregnant for the first-time often report experiencing something akin to a "vow of silence" (Cusk, 2001:18) in which childbirth preparation literature and other women seem to constantly avoid actually telling them what childbirth *is really like*. Thus, pregnant for the first-time, home-birther Angela Stewart bemoaned the fact that "no one *really* tells you, like really tells you the nitty-gritty [about birth] (…) you know they all sort of gloss over it".

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‘Reading’ by numbers: decoding the pregnant/ birthing body in the clockwork narrative

Surprisingly, home-birthers often engaged in a great deal of ‘discursive work’ in order to make their birth experiences conform to a clockwork birth narrative. I found that home-birthers were therefore deeply invested in this story line and repeatedly positioned themselves within this script so that they could have some language within which to ‘read’ the birthing body. The clockwork story was often vital in the drive to *make birth intelligible*. In providing a kind of ‘recipe’ that plots a linear and orderly set of events, the clockwork story helps to make the often chaotic birth process, knowable and therefore manageable. By tracing the ways in which home-birthing women make use of the clockwork story to ‘know’ or decode the mysterious entity that is the ‘body-in-labour’ (see Akrich & Pasveer, 2004), it becomes possible to see the fundamental role that cultural narratives play as ‘ways of knowing’ and ‘sense-making’ devices which often serve to manage, regulate and discipline the semiotic, inchoate, experiential body.

The fuzzy, vague, erratic stirrings of the *emerging* ‘body-in-labour’ (*ibid*) was thus often met with frustration and confusion by home-birthers as the usually absent and mute body began to make itself present in often unpredictable ways. Home-birthers usually strove relentlessly to ‘read’ this ‘strange’ body, wanting to make it ‘fit’ within a coherent (clockwork) story line. Being able to reach the point at which ‘real’ labour could be finally ‘diagnosed’ was thus often a major preoccupation of the ‘preamble’ section of the (home) birth story; many preambles therefore centred on the difficulties of trying to ‘read’ the pregnant/birthing body for ‘signs’ of ‘clockwork’ birth. Being able to finally ‘know’ that it was ‘real’ labour was the cue for the beginning of the clockwork story. The clockwork story was often internalised as part of women’s *expectations* of how childbirth would unfold. A limbo-like period of ‘waiting’ for the birth, as well as the irregular, unreadable and erratic ‘messages’ sometimes sent by the pre-labouring body were thus often both experienced as dilemmas for home-birthers. For example, consider the following extract from the birth story provided by Jane Brown:

Rachelle: Okay, well I’m just wanting to hear everything that happened from beginning to end in the story (laughs)

Jane: …<u>Okay</u> (R laughs), um, okay, this baby was due the Friday the 23rd and um (*) but you know my original due date was the 8th so I was sort of hoping it was going to come # (R: earlier?) Earlier (R: okay) And then, the Saturday the week before the 23rd I started having contractions at about 10 o’clock at night and they kept going until 2, so I thought, I was really thinking, okay, maybe this is it (R: yes) but very um, I didn’t phone anyone or anything, because **she** [first baby] was such a long labour and um, it was, um you know I always, I always go fetch a story very far (both laugh) I’ll get to the birth, and um, and ja, I was, I was really anxious, I was really not feeling well with labour at all, and um, and I was actually

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> sort of relieved when it stopped (…) and, and so I had a good chat with Dolores [midwife][47] on Monday when I saw her again for a check-up and she said, 'you know, now just chill about this, what will be, what will be, you don't have to do this perfectly, just relax' (…) so I said, 'okay' and Thursday, the Thursday of that week I woke up and I was just very (*) um irritable and ag, I was so tired of being pregnant and (R laughs) stretch marks are going further every morning and I had a good **cry** on my husband's shoulder (R laughs) and I was supposed to see my sister the next day because she came back that day from England and I just phoned her and said 'Forget it (…) I've had it, I'm finished' and I had a big fight with my daughter about nothing (…) and then the whole day I was feeling quite frantic and, and I went and I did my big shop in the afternoon (R laughs) and dog food and a million errands and I almost went home at one stage because I thought, you know, maybe this is labour, but it was so random (…) I knew something was happening (…) and um, by, at 11 o'clock that night suddenly it was labour, it just became, suddenly it was ja…
>
> Rachelle: So you suddenly knew?
>
> Jane: Ja, it was regular, the contractions were regular, it was, ja, it was labour and the intensity went up quite fast (R: hmm) so by half past 11 I phoned Dolores [midwife], 'Okay Dolores, this is it, I'm in labour' because by then it was about 2/3 minutes apart (R: okay) and lasting about 40 seconds, um… (Jane Brown, interview two).

In Jane's 'preamble', basic markers of the 'clockwork' narrative are once again evident. For example, she begins by locating the story in relation to her (medically given) 'due date' and then proceeds to repeatedly plot her tale within linear clock-time (Friday the 23rd, the Saturday the week before the 23rd , at 10 o'clock, Monday, Thursday, 11 o'clock, half past eleven). Similarly to almost all of the home-birthers, Jane gives a 'long story' about the 'run-up' to the 'actual' birth; as she herself says, "I always go fetch a story very far". Part of this 'run-up' are a series of 'false starts' where Jane is involved in a process of trying to 'read' her body for the signs of 'real' birthing; the 'is it or isn't it [real labour]?' question was an important thread in the clockwork tale told by almost all of the home-birthers. Akrich & Pasveer's (2004) analysis of (over 70) birth narratives suggests that the difficulty of deciding *if and when* labour has truly started was a major issue within the birth stories of almost all women, suggesting that the 'is it or isn't it?' question is not peculiar to the narratives of home-birthing women. In her tale, Jane provides a preamble in which the 'real' birth story (i.e. 'real' labour) is prefigured by a series of comical and anecdotal bits and pieces (she was feeling 'irritable', emotional and 'frantic') that are retrospectively stitched together to become 'signs' of the impending birth. However, only once the contractions become 'regular' (in relation to clock-time measurements), does Jane decide that it is 'real' labour. At this point, the clockwork narrative kicks into full gear as Jane phones the midwife with the news that the contractions are "2/3 minutes apart and lasting about 40 seconds". While many home-birthers claimed that they suddenly just 'knew' when genuine labour had kicked in, this knowing was, of course, constructed retrospectively in their narratives. When examining their

[47] Nine of the fifteen home-birthers had Dolores (pseudonym) as their midwife.

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stories closely, it often becomes evident that many came to 'know' or confirm 'real' labour by using clockwork markers as modes of judgement. Thus, for Jane, when contractions become 'regular' and legitimate according to the clockwork narrative; that is, when contractions could be measured as regular according to the dictums of the obstetric clock: "it was 2/3 minutes apart and lasting about 40 seconds" *then* "it was labour".

Irregular contractions or unreadable 'signs' of birthing were thus often experienced as a frustration of the norms of the clockwork story, which home-birthers somehow seemed to 'covet' (Pollock, 1999). When *making* 'narratives' of their births, home-birthing women thus often seemed to work quite hard to make their births 'fit' a clockwork script, particularly in relation to the 'diagnosis' of 'real' labour. Thus, they themselves often sharply differentiated between what they variously referred to as "silly labour" (Jolene Wright), "practice contractions" (Erina French), "false labour" (Sam Duncan), "the onset of labour" (Joni Daniels) and the 'real' thing which they called, for example: "proper labour" (Angela Stewart) and "full-blown labour" (Maggie McDougal). In their retrospective attempts to 'make' a (coherent) story out of their birth experiences, home-birthers sometimes omitted particular details in the interests of *telling* a 'clockwork' story. For example, Jolene Wright initially told me, in her 'clockwork' story that, "I had a contraction and that was it" signalling a clear and exact starting point for 'real' labour. However, later on in her story she contradicts this version, hinting at a far more nebulous process of trying to 'read' her body for the signs of 'real' labour:

> Jolene: …I was just trying to check that I was like definitely in labour (laughs) (R: yes) don't wanna phone her [midwife] and she comes all the way out here on a Sunday morning (laughs) (…) it's difficult to assess where labour actually (R: ja, where it actually starts) <u>where</u> you can sort of define cause you get silly labour where it's, like mild contractions every now and then (Jolene Wright, interview two).

In order to invoke a 'clockwork' story of birth, in which labour develops 'properly' and efficiently, one has to be able to differentiate between 'real' labour and 'false' labour so that 'the clock' can start ticking at the right time; the ability to accurately 'diagnose' 'proper' labour is thus necessary to maintain the integrity of a medicalised clockwork narrative. For example, if 'labour' *cannot* be finally 'defined', known or 'made to fit' arbitrary medicalised norms, the clockwork narrative itself risks imploding. As a result, obstetrics views all labours which do not progress according to a medical narrative as problematic and dysfunctional (Simonds, 2002); any 'slowing-down' or break in contractions is therefore seen as suspicious and generally 'sped up' via medical interventions. Birthing women in the hospital are particularly vulnerable to the tick-tocking of the obstetric clock and are often given a limited time within which to reach full dilation before they are delivered surgically. While it is clear that obstetric time is used by medicalised institutions as

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a means of regulating, managing and disciplining women's birthing bodies (Martin, 1987; Kitzinger, 2000, 2005; Simonds, 2002), the ways in which birthing women *themselves* draw on such narratives to manage, control and 'decode' their labouring bodies has not been widely explored by researchers.

By bracketing off earlier irregular, *disorderly* and fleeting episodes of contractions as merely 'silly labour' or 'practice contractions', home-birthers thus engaged in active *discursive work* to make their birth experiences 'fit' a clockwork grid and also re-constructed their birthing bodies as orderly and readable. Thus, in the 'preamble' part of women's home-birth stories, the pregnant/labouring body was often presented as a mysterious entity that needed to be 'read', deciphered and *made knowable*. For some women, 'waiting' for the mysterious process of labour to begin was also a difficult and challenging exercise. This must be contextualised in relation to a dominant technocratic 'ideology of control' (see chapter six) that prides itself on the ability to plan, plot and control bodily processes. In fact, it is interesting to note that five (out of fifteen) home-birthers had labour induced by 'natural' or non-invasive methods. This is quite a large proportion considering that home-birthing women (and midwives) are generally assumed to be in favour of allowing labour (and 'Nature') to take its own course. Some home-birthers were nonetheless 'impatient' and restless waiting for the birth process to begin (e.g. Joni Mitchell and Sam Duncan) while others were pressurised by *outside others* to get the process going. For example, Maggie McDougal found that friends and family actually got 'annoyed' with her when her baby was not born according to their calculations:

> Maggie: …I'd had these pains, on-and-off for so long, at the back of my mind it was, I don't wanna, I don't want to get anybody's hopes up because first of all, he's [baby] supposed to be born two weeks early according to everyone's statistics (R: hmm) he was a big baby, supposed to be born two weeks early, so everyday people would phone me, so everybody had this expectation of me, and it's almost like they got really angry with me, I had friends down from overseas who had left by the time he was born and they came down to be here, to see him (R: oh dear) and they were almost like pissed off with me because (R: why don't you do this now) 'why don't you have this baby? (R laughs) if you were in hospital they would've *induced* you, you could have had it already' (Maggie McDougal, interview two).

Thus, for Maggie, failing to conform to the culturally dominant version of 'birth by the (medical) clock' was punished not by the medical fraternity but by 'ordinary' friends and family. This demonstrates the degree to which a clockwork narrative of childbirth has potentially colonised a middle-class, western cultural view of birth. 'Waiting' for childbirth to arrive also became something of a tricky dilemma for home-birther Lizette Zimmerman. This dilemma was

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exacerbated by the fact that Lizette lived in an inland rural 'dorp[48]' and had to make an approximately 90 kilometre trip to give birth at the home of her sister which was situated closer to the city centre:

Lizette: Um
I went
I was due
on the 10th
which was the Saturday
and she [midwife] felt
the week before that
I was quite ready
that everything was looking
quite ready
and because we had
the trip to do
into town
she felt that
it might be a good idea to
on the Thursday
to do a procedure called
the 'stretch and sweep' [method of inducing labour] (…)

anyway so
because of the trip
in and everything
we felt
it would be good to have a certain
level of
I felt
it would be good to have a certain
level of planning
about it (R: yes)
so it would be good
if we could go on the Thursday
we could drop
the
our other child off somewhere
and kind of
we're there
you know
we're in town

so we did that
and then
it was quite a weird experience
then
because then
um
you're kind of *really*
in that waiting

[48] Popular South African term (derived from Afrikaans) that refers to a small town.

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for something to happen (R: hmm)
and little contractions did start happening
then
on the Thursday
but it kept on dying off
dying away

and then
we basically spent
the Easter weekend
um
with like contractions
coming and going
and nothing
really strong and regular
and I was
I was actually quite fine
with that whole process
but waiting is a
quite a difficult thing
for a woman
uh
I don't know if it's difficult
for women
or it's difficult for their partners (laughs)
you know
who kind of want
something to happen now (R: ja)
I was so happily pregnant
that I was
I was quite happy
for the pregnancy to carry on (…)

so um
then on the Tuesday
so it was the Easter Saturday
still nothing had happened
which was the actual
due date
and then it was
the Easter Monday
and then
on the Tuesday morning
actually on the Monday afternoon
we phoned an astrologist
to find out
how things are looking (R: okay)
um
should we
she's a psychic astrologist
should we
should we stay there
it was after the Easter weekend
now the energy was also different (R: okay)
should we come back and wait here

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or
should we stay? (…)

so then
she said
that it was imminent
that the baby was going
to come
and that
there was gonna be
kind-of
quick-and-sudden
there was an element
of quick-and-suddenness
about things
so definitely don't come back home (R: okay)
so that was fine
so then
we *waited*
we thought
that he might come
on that Monday night
but he didn't
Tuesday morning
um
a friend of my sister's
came and gave me
acupuncture
and she felt
that I was holding on
that I was holding onto
the baby (R: okay)
it would be good for me
to kind of let go

Rachelle: And did you agree with that?

Lizette: Um
I didn't necessarily
agree with her
when she said it
but um
if
if I had to think about him
I was <u>happily</u> pregnant
I was happy having him (R: ja)
it was my own
personal
little
love affair
you know (R: sweet)
it was quiet and private
and it was between
the two of us
and I was very comfortable

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with that (R: ja)

so anyway
it was a beautiful day
and I did a bit of
kind of meditation work around
you know
needing to be
brave enough
to let
to let him come out
I wasn't afraid of the birth
at all
it was more that
that I was enjoying
having him
inside
and then
<u>the afternoon</u>
the Tuesday afternoon
um
the midwife came
again
and she again
did the
'stretch and sweep'
she did another one
and she
this time
gave me some * (…)
it's a natural remedy
which also brings on contractions (…)
and um
this
this stuff
I mean you <u>sip it</u>
for like two hours
I was still busy drinking it
when I felt the contractions
coming (R: really?)
ja
so it was very ready
and then
contractions came

Similarly to all of the home-birthing narratives, Lizette's story is comprised of a lengthy *preamble* to the birth which (in her case) revolves around the dilemma of *waiting* for childbirth (and the clockwork narrative) to finally 'kick in'. As women approach their birthing 'due dates', a silent and unreadable pregnant body, which does not work 'by the clock' and which refuses to give any 'signs' of imminent birthing, often becomes, in itself, *a dilemma*. In Lizette's case, similarly to that of Maggie (see page 254), outside others find a period of limbo-like 'waiting' harder to bear

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than the pregnant woman herself; according to Lizette, "I was happily pregnant". The mute pregnant body which refuses to 'play the game' and which does not go into labour at a convenient, predictable and appropriate time however often becomes a 'problem' that has to be manipulated or 'decoded' in various ways. Thus, Lizette's errant pregnant body, which produces contractions that simply 'die off' and 'die away' becomes a point of frustration (particularly for her partner). Instead of looking to medical experts, Lizette and her partner turn to alternative gurus such as a psychic astrologist and acupuncturist in order to have her disorderly body 'read' or interpreted. While Lizette is "enjoying having him [baby] inside" her unreadable pregnant body nonetheless becomes problematic (mostly to others) because it is not 'on time' according to the clockwork narrative of childbirth.

Research by Westfall & Benoit (2004), looking at the views of women who were strongly pro-natural birth (of which 14 out of 27 were home-birthers) on the issue of labour induction, has similarly found that pregnant women are often pressurised by family, friends and midwives to engage in techniques, remedies and "proactive measures" (pp. 1404) to avoid 'prolonged' pregnancy and 'kick-start' the birthing process. Of course, the definition of pregnancies as 'prolonged', 'overdue' or 'late' derives solely from medical definitions that create arbitrary timetables so that women's pregnant and birthing bodies can be more effectively 'managed' and controlled. The very idea of waiting for the birthing process to begin *according to its own time* and rhythm is an affront to a modern, technocratic 'ideology of control' which operates according to the assumption that the body and nature *can* and *should be* tightly regulated. Even in home-birth, where women actively try and distance themselves from medical experts and interventions, the power of the obstetric clock continues to shape the ways in which birth is defined, narrated and 'made sense of'. This 'power' works both as outside pressure (from partners, family, friends and midwives) to get the birth process going and works from within as home-birthing women themselves strive to make the norms of the clockwork story fit their own birth experiences.

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The clockwork story as internalised expectation(s)

Through a careful analysis of the ways in stories about home-birth *were told*, I came to see that many of the women actually seemed to 'go into' the birth experience itself *armed with the clockwork story* as their main sense-making device, 'way of knowing' and expectation-related 'frame' in relation to childbirth. For example, Mandy Van Zyl told me an intriguing story about her first home-birth experience that somehow failed to meet the clockwork story expectations that she carried in relation to childbirth.

Rachelle: What role did Dolores [midwife] play [in her first birth]?
Mandy: (laughs) Um, I was a little baby, in fact I was a big baby, I laboured beautifully, I laboured beautifully, I **loved** labouring, um (*) and then at, at about 7 cm I got into the bath and that was just amazing and then I got stuck on 9 cm, labouring hard and she [midwife] said okay she's going to break my water for me otherwise it's going to be, she first asks your permission, obviously, and that's absolutely, at that stage (*) nothing matters, I promise you (both laugh) so she, which was a horrible, painful, horrible, terrible experience, it was terrible, having the waters broken, I hated it, um, and then obviously that gush brings the baby down even more and suddenly your contractions just come, um, and then the pain was too overwhelming for my body and I, I vomited in the birthing bath so I had to get out and um, so then she said to me, 'Right, you're 10 cm now' now antenatal classes and all the books and all the teachings said at 10 cm you get this, quote unquote 'unbearable, this urge to bear down, nothing can stop this urge from coming and all you want to do is bear down and push', that didn't happen, um, which I was waiting for, I thought, 'Okay, right' cause friends of mine who had given birth a couple of days earlier, this was also part of their story, they said 'ooh, it was just overwhelming, you just had to squat and push you know' and suddenly the vision of pushing a child through the birth canal just, uh, it was almost like a little, like a little shut, like a little gate shut, whooah it just closed down and I just said, 'I can't do this' and that's where Dolores' work really began (…) the pushing stage was a complete nightmare for me, whooah, um (…) I was not pushing this child out, liter(ally), I wasn't, I said, 'you've got to take me to hospital and you've got to cut him out now, because I'm not doing this' (…) um, so eventually she had to, like step-by-step she had to tell me and then at one stage I couldn't (…) I couldn't push (short laugh) unless she **told** me to, I couldn't, for some bizarre reason (…) (Mandy Van Zyl, interview one).

In this extract from Mandy's first birth story, we can see how she too plots her birth experience in relation to the clockwork script. The 'I' in the story is thus often described in terms of the number of centimetres dilated and judged according to medical norms; for example, she speaks of getting "stuck" on nine centimetres. It is at this point in her story that the clockwork narrative goes wrong and is sharply arrested. At the same time, her labouring body seems to fall silent and fails to produce the 'unbearable urge to push' that is a routine and expected part of the clockwork story of birth. The 'textbook' story of labour repeatedly fed to Mandy through antenatal classes, books and the narratives of her friends in which full dilation (at ten centimetres) immediately equals the 'urge to push' fails her completely; somehow she is not in the right story. Mandy describes herself as 'waiting' for this part of the clockwork script to happen, showing how particular cultural stories about birthing can become *knitted into* women's own expectations and experiences of childbirth (see also Pollock, 1999). The birthing body that is earlier encoded and made intelligible through clockwork measurements becomes overwhelmed by the pain that is caused by the artificial rupturing of the membranes ("and then the pain was too overwhelming for my body") and suddenly becomes non-compliant and mute, refusing to play the game of textbook birth. Interestingly, as the expected clockwork story line implodes, Mandy speaks of a "little gate" shutting. In her story, it seems that it is the connection between body and mind (or 'self') that is

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severed or 'shut-down' as the clockwork script fails to materialise. Thus, from this point onwards, the birthing body falls completely silent and there is little to no sense of embodied knowing or connection told in her story. Instead, she becomes totally dependent on the midwife and cannot even push without her say-so. Consider the following poetic representation[49] of the way in which Mandy talks about her self after she describes the "little gate" shutting down:

> I just said
> I can't do this
>
> I laboured really beautifully
>
> the pushing stage was a complete nightmare
> for me
>
> I was not pushing
> I wasn't
>
> I said
> I'm not doing this
>
> I couldn't
> I couldn't push
> I couldn't
>
> I don't know
> I think maybe
> I don't know
> I dunno
>
> I couldn't
> and wouldn't
> push

As the clockwork story 'goes awry', Mandy is left with no meaningful "interpretative framework" (Pollock, 1999:131) within which to make birth and the birthing body *intelligible*. She is left without an alternative way of storying birth and thus experiences a complete paralysis in which she cannot know or act as *an embodied self*. The words used repeatedly to describe her 'I' voice are therefore passive, constrained and marked by a sense of being *unable*, *unknowing* and *incapable*: "I can't … I couldn't … I don't know". The importance of cultural stories as 'ways of knowing' which shape expectations, actions and experiences thus potentially becomes visible through Mandy's tale.

Because a clockwork narrative remains one of the dominant cultural methods of 'storying', constructing expectations and 'making sense' of childbirth, many women are bereft when the

[49] This is an 'I poem' pulling out all of the 'I' pronouns and relevant surrounding words within a particular section of the transcript.

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story line goes wrong or does not materialise during their birth experiences. For example, similarly to Mandy Van Zyl, Jane Brown found that during her *first* home-birth the clockwork narrative *she expected* simply failed to occur. From Jane's story, it also becomes clear that clockwork birth is a fusion of *both* a medical *and* a 'natural childbirth' story line. Thus, for example, because she had read so much about childbirth, Jane speaks of having "quite set expectations" in which mental strength through 'preparing' the mind was seen as a way in which childbirth (and birth pain) could be 'conquered' and 'controlled'.

> Jane: …I thought if you're relaxed enough and if you've read enough and if you do everything right, you know, it won't hurt (both laugh) so I was really taken aback by the real actual (R: ferocity?) ja, and I felt, I actually felt in it that I am doing everything wrong and I am being a complete failure (interview one).

Far from being a *classic textbook* 'natural' birth which proceeds 'like clockwork' and in which pain is over-ridden by relaxation and breathing techniques (see Dick-Read, 1933, 1963) and the correct 'mental' attitude (e.g. Lamaze, 1958), Jane experiences an *erratic* labour with irregular contractions in which she takes 19 hours to dilate to five centimetres. As a result, she feels "very frustrated" and "a complete failure". Here we can see the ways in which 'failing' to live-up to the clockwork ideal potentially leaves women feeling like babies (e.g. see Mandy above) or failures: guilty, infantile, lacking and inept.

While birth researchers have consistently highlighted the discrepancies between women's expectations and the 'realities' of childbirth (and motherhood) as a key ingredient in the psychological difficulties that many mothers experience (e.g. Oakley, 1980; Slade *et al*., 1993; Gibbins & Thomson, 2001; Ayers & Pickering, 2005), 'expectations' have generally been over-simplistically conceptualised as fixed cognitive 'things' that exist inside 'the heads' of individual women. As a result, researchers have believed that 'expectations' can be objectively and realistically measured by getting women to tick off boxes in questionnaires. The degree to which birthing 'expectations' might be located within cultural stories of childbirth (and not in the cognition of individual women) has not been acknowledged in this literature. Space limitations prevent further exploration of this issue within this thesis; however, it is clear that rich avenues for further research exist for investigators who focus on birthing 'expectations' within the rubric of cultural story lines.

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Functions and implications of the clockwork narrative

What then are *the functions* of the clockwork narrative? What does it serve to 'do' or 'bring into being'? What does it make absent? Furthermore, what are *the implications* of this story line for the struggle to articulate a 'woman-centred' perspective of childbirth?

The clockwork narrative is clearly *used* by women (and home-birthers in particular) as a narrative frame or interpretative grid within which to plot, read and make the birthing process (to some extent) *intelligible*. It thus (potentially) serves to give birthing women some way in which they can maintain (a degree of) interpretative control in relation to the often chaotic experience of birth. However, it must be pointed out that the use of the clockwork narrative as a 'way of knowing' is in all likelihood denied to women that give birth in hospital settings, largely because the knowledge that is produced in and through clockwork monitoring is often kept from birthing women in hospitals. For example, first-time mother Angie van der Merwe, who wanted to have a 'natural' birth at a local private hospital, was not given enough information about her own labouring progress to be able to use the clockwork narrative to 'read' or interpret the 'raw' sensations of the birth process. Thus, for example, after being left virtually completely alone for approximately seven hours in her hospital room, Angie eventually demands that the hospital midwife 'does a check':

> Angie: The midwife came to check up on me sort of every hour and then eventually I said to her, "you know, I don't know *what's* happening, can't you do a check now?" (Angie van der Merwe, interview two).

In this extract, we can see that it might be potentially important to the birthing woman (particularly those giving birth for the first time) to have some kind of objective 'knowledge' of "what's happening" to 'hold onto' or use as a way of knowing about, and thus 'managing' the birth experience. In Angie's birth story, which turns out to be something of a 'horror-story', medical experts repeatedly deny her the right to knowledge and information about her own birth process. Thus, unknown drugs are administered through an intravenous drip, machines and monitors give information that she is not privy to and she is never given an adequate reason as to why she eventually has to have a caesarean section. As a result, Angie is left 'traumatised'[50] (in her own words) and bereft after the birth, constantly left wondering what actually happened to her or went wrong during her birth experience.

[50] At the time that I spoke to her (three months after the birth) Angie had been diagnosed as 'postnatally depressed' and was on medication.

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Home-birthers were, however, often able to use the clockwork script to 'make sense' of, 'manage' and locate themselves in relation to the birth process. Importantly, the midwives in the home-birth situation also usually respected and recognised the embodied sensations of the birthing woman, so that clockwork measurements could often be used in conjunction with the woman's own rhythms and embodied feelings. Furthermore, because the clockwork narrative often does produce a decoded, regulated and intelligible birthing body which can help to counter and oppose the lived chaos of the 'body-in-labour', it potentially provides a way of deciphering and demystifying the strange and often alien body that emerges in and through the birthing process (Akrich & Pasveer, 2004). Clockwork measurements and monitoring techniques make the birthing body 'talk' in a rational, orderly language code. Thus, all of the home-birthing women used the clockwork story line to try and make the newly emerging 'foreign', disruptive and seemingly autonomous birthing body *sensible*. As a result, they monitored their pregnant bodies for 'signs' of birthing, took out their watches to time contractions and constantly positioned their 'progress' in relation to a clock-time narrative of birthing. However, when their birthing bodies failed to conform to the script and clockwork birth 'went wrong', home-birthers also experienced the power of this narrative as a (medicalised) normative ideal which 'disciplines' 'wayward' birthing bodies. As mentioned earlier, this mode of disciplining often came both from without (friends, family, midwives) and within (the birthing woman herself).

However, when the birth process did go according to the clock (as it seemed to do in the majority of home-birthing stories), the medically derived clockwork narrative could ironically be used by home-birthers to re-construct childbirth as a perfectly normal and routine process that women's bodies are 'good at'. Considering that a 'horror' story genre of birth storytelling (replete with complications, medical interventions and an unending spiral of 'things going wrong') is, in all probability, increasingly becoming the normative story of childbirth as told by women who experience hospital birth, a (medicalised) clockwork narrative can potentially disrupt a (medicalised) 'horror' story of childbirth.

Home-birthing women thus veered between *using* the clockwork story (when birth unfolded in this way) as a way of *re-constructing* birth as a perfectly normal process and *being positioned by* this ideal (when it went wrong) as dysfunctional and inept. While capable of being used as a narrative mode of resistance to constructions of childbirth as terrifying and prone to dysfunction, at the same time, the use of this narrative also (inevitably) produced a number of problematic corollaries, largely because the clockwork story remains an 'outsider's' perspective on childbirth and does not provide an adequate 'space of enunciation' (Braidotti, 1994) for the articulation of a discourse *vis-à-vis* childbirth *spoken from the body* of the birthing woman.

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Thus, in my view, one of the most problematic aspects of the clockwork birth story line is its ability to marginalise or completely obliterate the complex embodied subjectivity of the birthing woman. Repeatedly I found that when home-birthers positioned themselves and their experiences within this narrative, any sense of how labour and birthing *felt* subjectively, emotionally and viscerally, simply disappeared. Furthermore, any sense of the birthing woman as the *central*, *active agent* in the birthing process seemed to vanish. Clockwork birth is always a narrative told from the perspective of an outsider's medicalised view; it *inscribes* the birthing woman with 'objective' numbers, external clock-time codes and measurements but cannot describe the experience of birth as experienced by the birthing woman herself. As so beautifully expressed by Tess Cosslett (1994:118):

> It is only 'audience' point of view narratives that are able to give single and simple accounts of childbirth: experienced from the centre, that 'centre' becomes diffuse, multiple, fractured.

Thus, while enabling home-birthing women to 'make sense' of childbirth in a linear, rational and orderly manner, the clockwork story does not provide much scope for the telling of birth as a fleshy, visceral, passionate, pounding, potentially consciousness-altering experience. It reduces the birthing body until it becomes a decoded, passive object of knowledge and makes absent the complex forms of embodied subjectivity that women often experience during childbirth.

The predominance of the clockwork story line within the birth stories of home-birthers also illustrates the extent to which cultural-ideological narratives potentially infiltrate and produce particular kinds of (birthing) bodies, experiences and subjectivities. As I have tried to show in this section, a clockwork narrative potentially becomes part of women's expectations and experiences in relation to childbirth. In an interesting 'think-piece', JaneMaree Maher (2003) asks if and how 'biomedical' discourse might infiltrate the birthing body and the childbirth experience. I hope that my analysis of the medically-derived 'clockwork' narrative gives some glimpses of how such an 'infiltration' or inscription is possible. The identification of a clockwork story line as a key "interpretative framework" (Pollock, 1999:131) within which particular kinds of birthing bodies and subjectivities actively *materialise*, shows that a Foucauldian understanding of body-subjects as *the effects* of particular configurations of power can be applicable to an analysis of birthing subjectivities. An 'outside-in' narrative, clockwork birth produces birthing subjectivities as *an infolding* of a dominant (ideal) medicalised prototype of childbirth. However, even this 'infolding' has unintended consequences because the clockwork story was used by some home-birthers as a means of disrupting an equally medicalised view of birth as pathological and horrifying.

It is also important to highlight the fact that a clockwork narrative produces a birthing body-subject that is compatible with ideologies of individualism, technocratic control and patriarchal

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capitalism. By bracketing off and silencing the potentially paradoxical, split and often indeterminate subjectivity of birthing, reducing the birthing body to the status of passive, controllable object, maintaining the integrity of the birthing subject as a rational, linear, self-contained 'whole' and denying the centrality of the birthing woman, the clockwork story works to reproduce dominant relations of ideological power.

The power of clockwork birth as a shared cultural narrative was also evidenced by the efforts that I, as the interviewer, went to in order to 'make sure' participants delivered a linear, clock-time story. While interviewees in most cases offered this kind of narrative of their own volition, in some instances I was active in directing the women towards telling the story in this way. For example, consider the following excerpt from the post-birth interview with Erina French:

> Erina: …and as soon as the contractions started getting a little bit intense (*) and I left it for as long as I could and then I thought, "Okay, now I want to get in the bath" #
> Rachelle: Okay, what time was that?
> Erina: (sighs) It *can't have been* earlier than three, then it was going fast (*) um (*) three, quarter past three, something like that, I could even check, I think I have the details…
> Rachelle: Oh do you?
> Erina: Ja, let me just check, uh, Dolores [midwife] made me a photocopy of the, the folder (R: oh) [Erina goes to fetch file] here we go (**) let's see – ja, okay, she [midwife] arrived at quarter to one (*) uh, she broke my membranes at two (…) um, okay 3:20 am, 'urge to push' present she noted so that was quite #
> Rachelle: So that was after you got into the bath?
> Erina: After I'd got into the bath, I was starting to get little pushing urges, just quite moderate (*) um, so I must have got in the bath at about three, ja, and then she called the back-up midwife at (*) ja, 3:20 am she arrived at 3:45am (interview two).

Throughout this interview, I was active in co-constructing an orderly, sequential and logical account of Erina's birth, in which each part of the birth event was mapped clearly in clock-time and 'added up' as a coherent narrative. Thus, when home-birthing women did depart from a clockwork script, I was often *uncomfortable* and somehow felt like I needed to bring them back to a way of telling birth in which 'what happened when and where' was highlighted (see also Pollock, 1999). However, at other times I also attempted to encourage women to tell birth in 'other' ways, largely by centring their own subjective experience. At such times, I asked women to tell me what birth *felt like*, how they experienced birthing both emotionally and psychologically; in short I tried to get them to describe, in words, what giving birth was like. As a result, while some stories remained dominated by a clockwork telling, others often moved fluidly between different narrative registers, sometimes invoking other, more subterranean ways of telling birth, which subverted and challenged the clockwork norm.

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Lived birth

"If we don't invent a language, if we don't find our body's language, it will have too few gestures to accompany our story. We shall tire of the same ones, and leave our desires unexpected, unexpressed, unrealized. Asleep again, unsatisfied, we shall fall back on the words of men…"
(Luce Irigaray, 1985b:214).

While a clockwork script almost always provided an overarching structure within which home-birth was told, there was, in the stories of some women, another kind of story which seemed to ride between the linear lines of clock-time birth. This was usually told in a breathy, excited, passion-filled voice that often seemed to positively teem with the semiotic rhythms of the embodied birth experience. In this telling, the visceral, fleshy lived experience of birth was centred and the storied text was routinely and repeatedly punctured by bodily eruptions, akin to what some feminists have called *jouissance*. In these accounts, the telling of birth seemed to literally pour out of participants: in detail, at length and a dizzy-like pace, flowing with an abundance of words, energy, pitch fluctuations and semiotically driven vocalizations. This 'busy' and lively 'way of telling' stood in stark contrast to the telling of birth as a clockwork story, which was generally sparsely and blandly expressed via technical, formulaic language and carried little to no sense of embodied energy or *joie de vivre*. Telling birth as if reliving the experience produced a version of birth spoken from the body of the birthing woman. Working as a semiotic force, this mode of telling disrupted the coherence and linear orderliness of the clockwork narrative. In some senses, the voice and telling of 'lived' birth' seemed to function as a Kristevan 'genotext' to the clockwork story, circulating within women's talk in a "pleasure-seeking rather than meaning-laden way" (Grosz, 1989:50). In many ways an 'inside-out' story, 'lived birth' shows the ways in which a conceptualisation of subjectivity as an 'infolding' of ideologies, cultural narratives and socio-structural conditions (e.g. Foucault) is not by itself sufficient. As I will hopefully show in this section (drawing on the work of Kristeva), it is more useful to think of subjectivity as a dual and contradictory process involving both an 'infolding' of socio-cultural structures and ideologies and an 'outfolding' of bodily energies, pleasures and inchoate rhythms.

Birth as body talk: the pleasures of birthing

"One of the most subversive things feminism can do is affirm [the] undecidability of motherhood and sexuality."
(Iris Marion Young, 1990c:199).

When trying to tell birth as a 'raw' and 'lived' experience, home-birthers produced in their talk a strong sense of embodied agency, in which the body-self was reproduced as a living, breathing

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unit or whole. In this story line, the birthing woman became tangible as a strong and empowered embodied subject fully inhabiting and in tune with her body. Without even invoking the term 'the body' (which often immediately signals a relation of distance and objectification), 'lived birth' was told as body talk in which the movements, visceral sensations and embodied emotions of the birthing body-subject became in itself a living, moving story. For example:

> Erina: …I started writing an email because there, there was something I'd, I'd left undone, sort of a work-related thing (…) and um, and then (*) the, the contractions started getting a little bit stronger and I was, I was sort of rocking backwards and forwards on this bouncy ball (…) so I went and I wrote my email quickly (*) and in-between sort of *rocked* between contractions and stuff and then I sent it and she [midwife] said, 'Okay let's do it' [break waters] so she um, broke my waters (*) and there must have been about two litres of fluid that came out (R: gee!) it was *amazing*, it just came and came and came, **the bed was wet** and (giggles) (R: oh my goodness!) towels were *soaked* (R laughs) (…) and then the contractions got quite (*) intense, quick quick after that, so um, and with, with Amy [first baby], all I wanted to do through the contractions was just lie down and chill (R: hmm) and with this little one, I wanted to, to rock, (…) um I just, I walked around, put some music on and I walked around the bedroom and every time a contraction came, I'd sort of **grab** Luke [husband] and rock and then, and that went on for a while, and the contractions kind of got more and more intense, um, and Dolores ran a bath and said, 'Anytime you want to, get in the bath' so I sort of left that until I ***knew*** I really needed to get in the bath and um (…) um (*) I think it was all very unstressful and as soon as the contractions started getting a little bit intense (*) and I left it for as long as I could and then I thought, 'okay, now I want to get in the bath' (Erina French, interview two).

In this extract, Erina 'tells' labour by centring herself (the birthing woman) as a moving, active, feeling and knowing body-self. She does not refer to external dilation measurements or plot (and objectify) her body according to a set of clock-time numbers. Instead, the 'I' that is invoked (repeatedly) throughout this stream of talk comes across as empowered, active and strongly embodied. This is graphically illustrated by pulling out and isolating the 'I' voice statements (and relevant surrounding words) within her talk. For example:

> *I started…I'd…I'd…I was rocking…I went…I wrote…I sent it…I wanted…I wanted to rock…I just…I walked…I walked…I'd* ***grab****…I sort of…I* ***knew…****I really needed…I think…I…I could…I thought…I want*

Erina tells her 'I' as a moving, acting, wanting, needing, knowing and thinking body-self. As opposed to the clockwork story line, in Erina's telling there is little to no sense of division or struggle between a 'body' and a 'mind'. The birthing body 'talks' in urges, desires, 'needs' and movements and the birth process is told from the perspective of the experiential and embodied self. Thus, Erina talks of contractions as "getting a little bit stronger; [they] got quite (*) intense; [they] kind of got more and more intense" and does not play the clockwork game of deciphering

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her contractions according to an *external* interpretative system of minutes, seconds or centimetres but instead focuses on how they *felt*.

Often riding along with a telling of childbirth as 'lived' was a strong sense of embodied joy, pleasure or *jouissance*. This was, commensurate with a Kristevan view of bodies/language, often expressed in the ways in which the semiotic, joyous (birthing) body seemed to become transfused into talk about birthing. For example, in contrast to her first birth (see pages 259-260), Mandy Van Zyl's second home-birth was characterised by a powerful sense of embodied 'knowing' and agency, as well as joy and pleasure.

> Mandy: …um, and then she [midwife] said, 'Alright, so now with the third push, you're gonna crown her' and she said, 'otherwise all your pushes are just going to be in vain (R: hmm) so just push her and crown her, and then we'll work it from there' * and then I decided, just like that, I'm not going, I'm not going half measures, so I just pushed *incredibly hard* on the third contraction, and then pushed her out (laughs)
> Rachelle: Just like that?
> Mandy: (with laughter) Ja, and everyone got quite a fright because they weren't expecting it, it's so funny (…) um, (*) and then Dolores was going, 'yes, that's right, there's she's crowned, OH SHE'S COMING, OH NO, HER HEAD'S OUT, HER HEAD'S OUT (R laughs) OH GOD, YE(s) (laughs) she's he(re)' (both laughing) It was so funny (…) and then still on all fours hey I pushed her out, I pushed her to me, through my legs, and gave her a little ***kiss*** from her mom (Mandy Van Zyl, interview two).

In this extract, Mandy tells a story where she is 'in control' of the pushing process, deciding for herself "just like that" that she is going to birth her baby now (and not follow the midwife's instructions). This is in sharp contrast to her first birth (characterised by a sense of body-self disconnection) where she describes herself as unable to push or do anything without the midwife telling her to. Mandy's account (of her second birth) *disrupts* the common (cultural and medicalised) view that the birthing body is simply 'made up' of a series of 'parts' (e.g. uterus, cervix, vagina) which work *involuntarily* (biologically) to birth babies without the consciousness and subjective involvement of the birthing woman. Mandy *decides* (to birth the baby now), actively *does* it and then *laughs* in the face of the incredulity and surprise of the midwife and other birthing supporters. Infusing her talk is also a strong sense of *jouissance;* at one point she almost parodies an orgasmic-like moment: "OH SHE'S COMING, OH NO, HER HEAD'S OUT, HER HEAD'S OUT (…) OH GOD YE(s)". Against the biomedical birthing body (generally silenced, fragmented and manipulated), the birthing body emerges in the story line of 'lived birth' as powerful, active, tactile and potentially *ecstatic*. Some women also tried to convey this *sense of joy* by invoking particular metaphors of birthing. For example, according to Erina French, giving birth was "like *dancing*":

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Rachelle: What did you like best about the birth?
Erina: …when I was in the bedroom and the lights were low and the music was playing and (*) it was like *dancing*, it was a (*) it was nice (*) (R: that's wonderful) ja, I was bobbing around the room and (*) ja, that was, that was nice (interview two).

The sense of embodied pleasure potentially evoked by birthing was rarely directly expressed by home-birthers. Instead, it emerged 'between the lines' in the thoroughly semiotic and fleshy ways in which words, sounds and phrases *were told*. When I asked directly if there was anything 'orgasmic[51]' about their births, most of the women thoroughly denied any such connection. Mentioning the word 'orgasm' seemed to almost always elicit a 'narrow' heterosexist definition of 'orgasmic'. Thus, although Jolene Wright could "see *why* they [other birthing women] would get to that conclusion" she was adamant that 'orgasmic' was something bound up *with sex* and thus was sharply distinct from birthing. Other women were more open to this interpretation, although also denying it in the end. For example:

Rachelle: …they've actually got this whole site where a lot of women have written stories and they claim that there's a *pleasurable* aspect to birth #
Angela: Ja, one of my mom's friends told me that she had two orgasms while she was giving birth (R: okay) I didn't feel it, well maybe I didn't stop and allow myself to feel it, but I wasn't even thinking about it, no ↑ *I didn't*, no ↑ *I didn't*, no ↑ *I didn't* (R laughs) no, I didn't find it pleasurable I don't think, I mean it was hard work (R: ja) it really was (Angela Stewart, interview two).

While on the surface reading of (the symbolic meaning of) this extract, Angela largely rejects the idea that she experienced anything orgasmic or pleasurable during birthing, there seems to be another level of meaning which emerges through the rhythm, pitch and repetition of the language *as spoken*. Thus, the repetition and sounding rhythm of the words, "no ↑ *I didn't*, no ↑ *I didn't*, no ↑ *I didn't*" hint at an uncontainable and 'other' kind of meaning riding between symbolic lines. In the way in which this phrase is told, it actually comes close to approximating the guttural, high-pitched and rhythmical bodily sounds that often accompany orgasm. Thus, while the talk of home-birthers (particularly when telling 'lived birth') was often infused by the presence of bodily *jouissance*, pleasure, excitement and joy, most women were loath to directly acknowledge the physical pleasure potentially at play during childbirth. Invoking the idea of 'physical pleasure' seemed to be immediately equated with (phallocentric) genital modes of sexuality. Following Irigaray (1985a, 1985b) *the possibility* of a more widely dispersed, fluid, tactile, intercorporeal

[51] This mode of questioning was triggered by my own (mind-blowing) discovery of several Internet sites (e.g. http://www.unassistedchildbirth.com/ecstacy and http://www.unassistedchildbirth.com/orgasmic) containing women's stories about 'orgasmic childbirth' and 'childbirth ecstasy'. This site also contained several photographic images of heavily pregnant women posing in sensual, ecstatic and orgasmic positions.

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At some stage my babe discovers that I have two breasts, and while she suckles on one she stretches out her tiny hand to locate the other one, softly caressing the curve of my breast, brushing past the nipple and then lingering on it, fondling the nipple and feeling it grow in her fingers. Like a lover but more tender, softer, smaller hands, but then rougher as she squeezes the nipple and I have to uncurl her fingers laughingly squirming (Bartlett, 2000:180).

(see Weiss, 1999) and female-centred mode (or discourse) of bodily pleasure, independent of phallic sexuality is, of course, sharply subjugated, denied and silenced by masculinist culture(s); as a result, women themselves often lack such a language or discourse within which to position themselves and their experiences (Whitford, 1991; Lorraine, 1999).

It is of course well-known that patriarchal ideologies work tirelessly to police the borderlines between motherhood and sexuality (Young, 1990c); as a result, any whiff of sensual pleasure or orgasmic-like delight experienced in mothering practices such as birthing or breastfeeding is construed as deviant, pathological and 'bad'. While I am perfectly aware of the dangers at play in celebrating the potential pleasures of maternal activities such as birthing and breastfeeding (e.g. in creating a regulatory ideal), exposing the possibilities of maternal *jouissance* does succeed, on some levels, in interrupting and disrupting the patriarchal shackles which seek to separate motherhood and sexuality (Young, 1990c). However, it is also important to acknowledge that the 'pleasures' possible within (empowered forms of) childbirth are complex and paradoxical, and often involve a dance *between* pleasure and pain. Thus, as one of the home-birthers in Pamela Klassen's (2001a:193-194) study describes so well:

> Pain and pleasure are a continuum, and without the pain, there would not be the pleasure. We wouldn't have a place to slide around…it's [birthing] an intense experience of pain. It's also an intense experience of pleasure, and joy and hope…it's like, it's like living in a different dimension briefly. And that it's a painful process, because it's like two worlds colliding.

Entangled bodies: an *eros* and ethics of birthing

"It was my labour…but…the presence and actions of my partner and the midwife structured it in vital ways – locating me when I was lost in the contractions, helping me with hands and voices to remake 'a birth' out of chaos."
(Helen Marshall, 1996:262).

A story line of 'lived birth' also often evoked a thoroughly sensual depiction of birth in which *listening* and *touching* (as opposed to objective measurements) became central. I refer in this section to an understanding of the terms '*eros*' taken largely from the work of Nancy Hartsock (1985), in which *eros* is reconceptualised as the sensual pleasures involved in concrete, creative activities, involving both embodied sensuality and body-to-body connections with others. In the 'version' of birth as lived, the birthing woman was almost always tangibly and deeply embedded in a matrix of bodily connections with the others supporting and surrounding her. Often the (home) birthing body became, at some points, a 'body-without-boundaries', in which the bodies

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of birthing woman, midwife, partner and supporting others became intertangled and almost indistinguishable. For example:

> Lizette: …you see it was also going with support hey, I mean if you imagine the scene with Paul [partner] behind me, and I'm standing, and my sister's on, at my left leg and the midwife's at my right leg, and my foot was actually on them, on their laps or legs or something, I dunno, but my feet wasn't on the ground cause I kept slipping on the ground for some or other reason (R: ja) so they held my feet (R: ja) and then there's, then there's another midwife who's there next to the other midwife, like say in the middle, and I'm standing and then I would (…) then I would feel the contraction come and then I would go down, and I would say, 'Okay, it's coming' and then you would just have everybody's energy and everybody's attention like on you and it would be '*aahuuhh*' and everybody's '*aahuuhh-ing*' with me (R laughs) and you know and the midwife says, 'Go now, push, push, push, well done – okay, breath out again, breath in and carry on pushing from there' you know and they're all like right there, it's not just, kind of me sitting pushing (R: hmm) like somewhere, everybody's making *a noise* as well so I didn't feel like I was (R: the only one) grunting or anything, like everyone was kind of grunting with me and talking and so… (Lizette Zimmerman, interview two).

As opposed to hospital birth settings, where the birthing woman is often sharply differentiated (from expert staff) as a passive patient and often ends up becoming a kind of 'spectacle' to be watched or body to be practiced upon, home-birthers regularly invoked a birthing scene in which they became the centre of a supportive and strongly embodied (stroking, massaging, holding) hub of intermeshed bodies. As Lizette hints at above, an entangled morass of bodies breathing, moving and grunting in tandem means that the notion of the birthing body-subject as a self-contained, individual and separate entity is challenged: "so I didn't feel like I was grunting or anything".

As mentioned in the previous chapter, home-birthers were, in many respects, actively attempting to construct an alternative epistemology of birth which I coined 'knowing-in-relation'. 'Knowing' in relation to birthing was thus often situated somewhere between the birthing body, cultural stories of childbirth and the midwife. As Erina French put it, "I think that, somewhere between her [midwife] and me, we figured [it] out". Another woman (Jolene Wright) usefully described her home-birth experience as like a conversation between herself and her midwife:

> Jolene: …also, ja, it was quite nice to have somebody there who was having a conversation with me between contractions (laughs) and actually, it was quite bizarre, because we'd be having a conversation and I'd have a contraction and then immediately resume the conversation (both laugh) (…) it helped a great deal cause I wasn't focussing on the contractions and the pain and all that, I was listening and participating in a conversation (laughs) (Jolene Wright, interview two).

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Without using the term 'conversation', many other home-birthers nonetheless invoked a mode of telling in which birth was constructed as a constant (verbal) to-ing and fro-ing (or discursive dance) between the birthing woman and the midwife. The 'voice' of the midwife frequently made its way into home-birthing women's stories and in almost all cases was far more present than, for example, the 'voice' of male partners (who became, in women's narratives at least, largely silent supporters). Women also repeatedly emphasised the importance of the midwife in terms of 'talking them through' difficult parts of the birth experience. The external, comforting and supportive voice of the midwife gave some of the women something tangible to focus on or 'hang onto'. For example:

> Erina: …um (*) I mean there, there was, once there were like three contractions in a row without a break, you know, and that (*) I almost got a bit weepy and then Dolores [midwife] said, 'You know this is hard, I know, you haven't had a break since the last one and it's very sore but you know…' you know, she kind of talked me through it (R: and did that help?) absolutely, you know, also just having a sort of ***voice*** to hang onto, you know it's like a (*) ja, just something to hang onto (R: okay, okay) (Erina French, interview two).

Having her experience recognised ("it's very sore") and reflected back to her seemed to give Erina (and other home-birthers) a way 'through' the intense, often violent and close to overwhelming 'transitional'[52] labour contractions and the often difficult 'pushing' stage. The legitimisation and confirmation of the sensations of her birthing body by outside others can often help the birthing woman to construct and maintain a reflexively engaged embodied self that can counter the chaotic entity that is the 'body-in-labour' (Akrich & Pasveer, 2004). The importance of having 'something to hang onto' emerged often within home-birthing stories. This 'something' could be either a voice (Erina, Mandy), music (Lizette, Sam, Erina), an inanimate (meaning-laden or banal) object like, for example, a crystal (Mandy) or a tap (Kayla) or an (embodied) activity, such as, for example, singing (Sam) or holding and squeezing combs and consciously opening (and relaxing) the mouth[53] (Angela).

Furthermore, in addition to the supportive, mirroring and encouraging voices of others, *the touch* of these self-same others was also consistently and repeatedly invoked by home-birthers as integral to managing and 'coping' with birthing. For example:

[52] 'Transition' refers to the phase in labour in which the birthing woman comes close to reaching full dilation (usually occurring at about two-thirds dilation) before the so-called 'second' stage of labour in which the birthing woman 'pushes' the baby out (Kitzinger, 1981). Transitional contractions have been described as particularly fierce, painful and potentially psychologically overwhelming (*ibid*).

[53] Holding and squeezing combs was practiced by Angela Stewart in order to 'hit' particular acupuncture points, thereby helping to manage pain. Furthermore, in the alternative birth literature, an 'open mouth' is linked to relaxed vaginal muscles. As another home-birther, Hazel Ray, graphically put it, "loose lips [equals] loose fanny".

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Maggie: …somebody was holding my hand, somebody was talking to me, somebody was rubbing my back, somebody was massaging my lower back, it was just the fact that there were people around who, who cared and that touch, you know, I was in the middle of a contraction and Jenny [friend] just put her hand across my back and just pushed gently, into my lower back and you focus on the *warmth* of the massage as opposed to the white pain of the contraction (R: hmm) and it just makes, it just makes it so much easier (Maggie McDougal, interview two).

Angela: …it really helped having my mum and my sister and I had a lady who's sort of very close to us, she's in her sixties, there with me the whole way through and through every contraction they breathed with me and held me and that makes such a difference for the pain, I dunno why, cause every time just, you know one of them would go away and I'd feel the difference in pain (Angela Stewart, interview two).

The language used to tell home-birth thus often 'brought into being' a world in which touching, listening, feeling, singing and dancing reigned over the power of sight, gaze or eye. In fact, home-birthers repeatedly mentioned that they birthed almost completely with their eyes closed throughout the whole birth process, thus inhabiting a kind of 'twilight' world dominated by tactile, kinetic and aural sensations. This 'world' produced an *eros* of birthing, in which the sensual activities of the birthing body (singing, rocking, dancing, walking, bouncing, holding, breathing, groaning, pushing) were privileged and in which the birthing woman emerged as part of an inter-relational matrix of (body-to-body) connections.

Thus, like the home-birthers in Klassen's (2001a) study, the experience of birthing "opened [these women] up to connection" (pp. 196). Furthermore, a story line of 'lived birth' largely reproduced what Arthur Frank (1995) refers to as 'communicative bodies': body-self unities that are oriented "with dyadic desire" toward the body of *the other*, communing "in touch, in tone…in breath" (pp. 49). In the home-birth situation, midwives, partners and other supporters often seem to reach the Frankian "ethical ideal of existing *for* the other" (*ibid*, pp. 49). Midwives, in particular, seem *to care* for the birthing woman in an intensely 'body-to-body' fashion, using their own bodies as material expressions of empathy, tenderness, respect and recognition. For example, Lizette Zimmerman described the following incredibly moving 'scene' from her home-birth:

Lizette: …you know, like there was this one really special [post-birth] scene that I remember that (*) um, they [midwives] helped me out of the bath and I became aware that these two midwives were drying me, with these towels and they were both like kind of drying my legs so it was as though they were kind of *kneeling* almost, in a way, and I was so, it was such an amazing experience, I mean, I really felt that these women, who were taking *care* of women with humility and with respect, *aahg*, it was just, I mean it was *so* powerful, I, nobody's ever *dried* me, being an adult, never mind going down on their *knees* and two women, like kind of *drying* me, you know, and your body's, you're *bleeding* and you're dripping stuff and you're not like not in the greatest shape (R: hmm) and they, they're like there with all your shit and everything (R: ja, that's amazing, ja) that was *so*

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special, that was really, really so special (R: hmm) (interview two).

Caring for birthing women with and through their bodies (as in the above extract), midwives and other birthing supporters potentially create an *embodied ethics*, involving "a communication of recognition" (Frank, 1995:49) in which the body of the other is respected, honoured, held, touched and soothed as a reflection of a shared mortal and bodily humanity.

Thinking bodies, birthing bodies

"She gives birth. With the force of a lioness. Of a plant. Of a cosmogony. Of a woman…And in the wake of the child, a squall of Breath! A longing for text! Confusion! What's come over her? A child! Paper! Intoxications!…"
(Hélène Cixous, 1991:31).

"…here we are civilised society and completely out of touch with the actual process [of birth]…which is intelligent, it's not primitive…"
(Hazel Ray, home-birther).

An important point gleaned from the work of materialist feminists (e.g. Hartsock, 1985; Mies, 1986; Ruddick, 1989; Held, 1993) and discussed in earlier chapters (see chapter four), is the interconnection between the oppression of women and the belief that birthing, mothering, lactating and nurturing are biological events devoid of consciousness, thinking and subjectivity (and therefore not fully *human*). The culturally hegemonic clockwork narrative reinforces this belief, constructing a version of birth in which the birthing woman's complex, embodied subjectivity simply disappears. However, in the 'lived birth' story line, birthing emerges as an embodied activity saturated with conscious reflection, meaning-making and corporeal and intersubjective forms of *knowing*. The birthing body is reconstructed as active, knowing and thinking and becomes, like Alison Bartlett's (2000) 'breasts', present as a "thought-full subject" (pp. 177). Akin to Bartlett's project *vis-à-vis* breasts, I am interested in trying to forge an understanding of birthing bodies as *thinking bodies* and in the process destabilise commonplace views that birth is simply an 'involuntary' set of actions performed by a biological body. Thus, in my 'reading' of women's stories, I remained particularly attuned to moments of knowing, conscious reflection and thinking which erupted in their narratives. As mentioned, a mode of knowing as a *relational process* happening somewhere *between* the birthing woman, her body, cultural stories and the midwife emerged strongly within women's talk.

At the same time, the stories also often reproduced the birthing body as a powerful and articulate *site of knowledge*. Home-birthing women who had previously given birth in hospital settings were clear that the birthing body emerged as a wholly different entity in the (de-medicalised) home situation. Whereas the hospitalised birthing body was often silenced, made

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passive and objectified, at home these women felt that their birthing bodies 'knew' what to do and 'spoke' to them in often clear and intelligible ways. For example:

> Maggie: …in hospital you know it was, you're lying in stirrups, it's, like it's pure anticipation, so like 'When's the baby going to come out?' and it actually seems to take a lot longer (R: hmm, hmm) whereas at home when it's, your body tells you exactly where it needs to be (Maggie McDougal, interview two).

Thus, similarly to home-birthing women within Pamela Klassen's (2001a) study, some participants spoke of the body metaphorically as "a speaking voice" (pp. 148) that talked knowingly to them in visceral and 'fleshy' ways. Of course, this is not to say that women birthing in hospitals do not experience or narrate something akin to an embodied knowing. This bodily knowing is, however, often suppressed, discredited and even violently obliterated by medical practices and modes of knowing. For example, first-time hospital-birther, Angie van der Merwe, also spoke of a birthing body that *knew* what to do; however, sadly, her 'knowing' body was not recognised or respected within the hospital setting.

> Angie: …I, I couldn't understand *why* [I had to have a caesar] everything was, I was nine and a half centimetres by this stage and everything was all go (…) I couldn't understand why I, they just wouldn't let my body do the rest (R: ja) why I had to have all this extra stuff (…) because everything was happening and I felt like my body was working and it knew what *to do*, it was, it's *really* disappointing (Angie van der Merwe, interview two).

Home-birthing women however, often re-perfomed birthing as *knowing labour* in their attempts to tell 'lived birth'. Without even mentioned 'the body' or 'a body', knowing in relation to the birth process was constructed as the embodied knowing of a body-self unity. As an example, consider extracts from Maggie's story below.

> Rachelle: Did you know that this was it [labour]?
> Maggie: I had a very strong feeling, because it was, they were regular and they were getting <u>stronger</u> (R: hmm) every hour they were getting stronger, and I was actually, I was walking and I'd stop and I'd ask, I would start, my legs were starting <u>to buckle</u> (R: hmm) and I'd stop and I'd breath, and I wasn't even timing it because <u>I knew</u> that they were getting closer and closer

> Maggie: …I could feel them [contractions] getting stronger and stronger, so I <u>knew</u> that, I was, it was getting close now (…) I came through here [to lounge] and, cause everything was set up here, came through here and I just, I got a contraction and I just, I squatted and my waters broke (…) when I felt the pressure, when I felt his head coming down, said 'I need to turn around' and as I turned around I just went down and I was in Mark's [partner] legs and I could feel his head coming down (Maggie McDougal, interview two).

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Maggie's 'telling' reconstructs the birthing body-subject as engaged in an intelligent, reflexive and knowing interaction with nature and therefore in the Marxist sense "a truly human activity" (Mies, 1986:45). Maggie is constituted as a thinking and knowing birthing body-subject who 'reads' her body's messages and is constantly embroiled in a process of intelligent negotiation that happens somewhere between physical sensations, embodied actions, cultural scripts and conscious reflection. Thus, it is important to point out that there is not necessarily a 'pure' form of knowing that emanates *unmediated* from the body (Young, 2005); as Helen Marshall (1996:262) notes, "when we try and name our bodily experiences, we are always involved in a dialogue". Furthermore, it is clear from a Kristevan theoretical position that while bodies are always an integral part of meaning-making, meaning itself cannot be reduced to bodies; "as a folding, language is a process" (McAfee, 2004:90). In women's (home) birth stories, birth was often told as a dynamic process of negotiation in which the birthing woman laboured to produce meaning (Adams, 1994) in and through an experience which often transcended neat phallocentric boundaries between body and mind, self and other, biology and culture. Birth was thus not simply a bodily or biological affair. As Angela Stewart said, "the whole process (…) wasn't just physical". In her birth story, Angela narrated a complex series of internal dialoguing happening 'within' her during labour:

> Angela: …I also at one point had to *really*, I wasn't dilating and I thought, you know, 'I've accepted having this child but I really have <u>to choose</u> to have him[54] because I'm not going to get him out if I don't <u>choose</u> to have him' you know (…) I had to really say, '<u>I want you</u>' you know (…) I had to really sort of (**) stop and think and say, 'I'm here, I *really* want you, please come'
>
> Rachelle: So it was a lot of active thought processes?
>
> Angela: Ja, so it wasn't just physical (R: ja, ja) no, sort of you stop and think and you realise, you know, you **know** it's going to change your life completely and yo(u), part of you is hesitant about that (R: hmm, hmm) part of you is hes(itant) (…) it's ***<u>scary</u>***, well it was scary for me (Angela Stewart, interview two).

Thus, emerging strongly within home-birthing stories was often an intense and profound set of "internal negotiations" (Adams, 1994:15) taking place 'within' the birthing woman during childbirth. In the telling of birth as 'clockwork' these sorts of negotiations and dialogues are rarely told. Thus, it was often only when probed to try and tell birth in 'other' ways, that the participants began to speak of struggles, emotions and complex thought patterns swirling about as part of the "expanding consciousness" (*ibid*, pp. 29) of birthing. For many women, it seemed that the experience of (home) birth often did function as a bodily crisis and therefore also a crisis in/of

[54] To contextualise, Angela's pregnancy was not planned and occurred while she was using an intrauterine device (IUD) as contraception.

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subjectivity (Adams, 1994). As a result, (re)constructing complex forms of subjectivity and modes of embodiment became key tasks for most of the birthing women interviewed. In my analysis of the third 'story line' to emerge in home-birthing stories, I trace *childbirth as a crisis* in which normative configurations of subjectivity and the body become shattered and are unmade.

Functions and implications of the 'lived birth' story line

On some level I hesitate to call 'lived birth' *a narrative*, largely because it does not necessarily meet all of the requirements accepted by researchers as defining features of narrative. Thus, this 'mode of telling' was not usually organised with a clear, logical sense of 'plot' or told within any culturally acceptable narrative genres. Furthermore, in this 'telling' there was often little effort made to situate the story in linear time. Instead, events were usually told in a stream of 'happenings', sensations and urges. In many ways, this story line comes close to approximating what Arthur Frank (1995) calls a 'chaos narrative'. At the same time, however, 'lived birth' also departs sharply from Frank's version of the chaos story. It is important to point out that Frank identifies the 'chaos' narrative within stories of chronic *pain and illness*, linking chaos-like 'tellings' to trauma, agony, loss and suffering. While the experience of home-birthing clearly also entailed intense levels of pain, stories of 'lived birth' are not, like Frank's chaos narrative, tracing around an unspeakable horror or in Frankian terms, an untellable wound. As I have tried to show, the 'lived experience' being hailed in this telling of birthing was often overflowing with pleasure, joy and excitement[55]. However, similarly to the 'chaos narrative', which Frank (1995) describes as, in many ways, an '*anti*-narrative', 'lived birth' lacked coherence and was usually told hurriedly with a sense of 'immediacy'. Furthermore, one of the defining features of the chaos narrative, namely: a tendency to constantly (self) interrupt the telling with an, 'and then…and then…and then' style of speech (*ibid*), was often present in the ways in which women 'told' the 'lived birth' story.

While not expressing unspeakable agony or 'trauma', narrating birth *as lived* has in common with 'chaotic' illness narratives the fact that they are both 'ways of telling' intensely visceral *bodily* experiences. Thus, as Frank (1995) notes, "the chaos narrative is probably the most *embodied* form of story" (pp. 101, my emphasis). However, unlike the 'chaos' story of chronic pain and illness, the body produced by a 'lived birth' telling is not 'monadic' and marked by an

[55] Of course, childbirth represents close to a *unique* experience of pain and differs in important respects from experiences of pain arising from illness, disease or physical injury. Thus, as Klassen (2001a) usefully points out, birthing pain has a limited duration, a unique (often predictable) rhythm (contractions come and go), a clear purpose (i.e. the arrival of a new human being) and is often (ideally) endured within the caring embrace of intimate and committed supporters.

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"inability to find recognition and support for the body's pain and suffering" (*ibid*, pp. 103). As I have tried to show in preceding sections, the bodies reproduced in the 'lived birth' story line are *dyadic* and *relational*, defying classic dividing lines between the body of the self and the body of the other. Thus, while not a 'classic' type of narrative characterised by linearity and a coherent plot, the 'lived birth' story is an example of a non-normative, fluid and strongly embodied form of narrative that is, according to Ochs & Capps (2001), sorely under-researched within the social sciences.

What then does the 'lived birth' narrative '*do*' and what are its implications? Most importantly, this story line works to *disrupt* medicalised and phallocentric clockwork narratives and childbirth horror stories. It reinscribes the birthing woman as the *central agent* in the childbirth process and speaks the experience *from* her (always embodied) viewpoint. The radical result is that this narrative is not an outsider's view of the birth process but rather tries to tell birth phenomenologically or "as lived and felt in the flesh" (Young, 2005:7) of the birthing woman. The outcome is that we begin to get some idea of what birthing might mean as a way of 'being-in-the-world' (*ibid*). To reiterate what I have said earlier, this is not part of an attempt to try and define, 'discover', or prescribe once and for all what birthing might mean from an idyllic 'woman-centred' position (see Young, 1990c). A 'pure' language of women's bodies or birthing does not exist. However, in a cultural context in which childbirth is generally defined and interpreted via a phallocentric outsider's view (see chapter six), any story line spoken *from the body* of the birthing woman remains potentially a significant challenge to normative (male-centred) views of birth. Working from Irigaray's (1985a, 1985b) thesis that discourse itself is overwhelmingly modelled upon a morphology of the male body, it remains imperative that we play with, 'make up' (Young, 1990c) or experiment with different ways of talking about and imagining women's bodies and the fleshy female experiences of menstruation, being breasted, sex, pregnancy, birth, breastfeeding, mothering and the menopause.

The eruptions of a 'lived birth' narrative, often riding along with or adjacent to a clockwork script, also demonstrates that hegemonic discourses, narratives and ideologies never operate with total dominance; the clockwork narrative (embedded in medical, patriarchal and technocratic ideologies) is therefore always potentially *exceeded*. Generally, however, an alternative story line of birth as 'lived' did not only operate alongside a clockwork narrative; it was also usually accompanied by another mode of disruption – a different story line that traced around and tried to express the radical *undecidability* of birthing. While the 'lived birth' narrative tended to reproduce the birthing body-subject as a inseparable unity or *whole*, it however often worked in tandem with a different story line which told birthing as *a shattering* or un-making of logic, rationality, body-self unity, language and the singular, coherent 'I'.

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The undecidability of birth

"Which one of us is being born?"
(Phyllis Chesler, 1979:125).

"Through pain and blood and water this inside thing emerges between my legs, for a short while both inside and outside me. Later I look with wonder at my mushy middle and at my child, amazed that this yowling, flailing thing, so completely different from me, was there inside, part of me."
(Iris Marion Young, 1990b:163).

While a 'lived birth' story line emphasised the embodied agency of the living, moving, feeling and holistic body-self, there was, in most women's stories, fleeting snapshots and strangled articulations of a subjectivity in crisis, torn *between* order and chaos, life and death, body and self, me and it, inside and outside, here and there, sense and non-sense. Most women *struggled* to articulate this aspect of the birth experience, often stumbling over words, searching for metaphors or story lines within which to (re)tell the radical undecidability of the birth experience. It was particularly when I asked them to try and articulate what labour and birth *felt like* (as an emotional experience) that home-birthing women seemed to struggle to find words and would often simply fall back on clichés. Many clearly expressed the difficulty of putting what birthing felt like into words. For example:

Angela: …I dunno if I could describe *giving birth*, I mean [how would I describe giving birth?] I mean it's just a phenomenal experience…

Jeannie: …you go into such a mystical space, it's like a completely different head-space, it's very difficult to describe…

Stephanie: …the pain, um, of each contraction which is indescribable * um * but also, but also an emotional experience, um (*) which, I don't even know if there're words to it because it's about *birthing* which is such a *profound*, profound experience (…) um, I don't remember what the question was? (laughs)

Experienced from the inside, childbirth troubles the boundaries between all kinds of accepted binaries and often becomes a situation in which consciousness 'expands' (Adams, 1994), the body and the 'I' become dispersed, multiplied and fragmented and rational logic and sense implode. As Cosslett (1994:118) puts it, "experienced from the centre…[birth] becomes diffuse, multiple, fractured." While home-birthing women often did struggle to 'find words' which could adequately come close to telling or re-making birth as a subjective/emotional experience, their attempts show dramatically that birth is *not* (as patriarchal story lines would have us believe) simply an event of the biological body, devoid of subjectivity. Thus, while most women did initially struggle to find words to describe the birth experience – it was almost as though nobody had ever asked them to do so before – once they 'got going' many did tell complex stories, often

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stitching together interesting metaphors as ways of describing birth. Stories about (home) birth therefore often did narrate complex "internal negotiations" (Adams, 1994:15) in which birthing women worked to construct and maintain complex forms of embodiment and subjectivity. Thus, similarly to Tess Cosslett (1994), I am interested in asking what *other* kinds of subjectivities and body-self relations 'come into being' via women's childbirth narratives. While a clockwork script produced a passive, decoded and largely objectified body and an absent subjectivity, the story line of 'lived birth' produced an experiential, sensuous and interconnected body-self unity. What *other* kinds of subjectivities and body-self relations were reproduced in home-birthing stories?

Shattered subjects, fragmented bodies

"...how many bodies are there, and of what kinds?"
(Helen Marshall, 1996:262).

"i am stretched into fragments, tissue paper thin"
(Toi Derricotte cited in Laura Chester, 1989:113).

According to Akrich & Pasveer (2004), there are *multiple forms* of birthing subjectivity and embodiment possible during the childbirth experience. There is thus no singular, essential or univocal birthing experience. Even the experience of home-birth itself is highly variable, involving different situations and body-self dynamics. However, the experience of (home) birthing often did involve a common crisis of subjectivity, rational agency and normative body-self relations which birthing women negotiated in different ways. Furthermore, women worked hard to stitch meaning (and selves) 'back together again' by invoking a diverse and creative pastiche of storied metaphors.

Several women spoke about their first home-birth experiences as *a shattering* of long-held assumptions about 'control', agency and the power of the rational, disembodied self. For example, after 'triumphing' over chronic fatigue syndrome through "sheer will power", Jane Brown thoroughly expected to be able to 'control' and 'triumph' over (her first) birth in exactly the same way. Instead, she found that her first birth experience was merely a matter of 'survival' in which she had to bear the brunt of an uncontrollable physical onslaught:

> Jane: …it's big, it's not just sore it's big and uncontrollable (…) it's like a big wave, a big wave, it literally feels like it starts here and it just goes '*whoosh*', ja, I literally felt like I was in an ocean, being pounded by these huge waves, one after the other, and you're just surviving, ja (interview one).

Because she had read all the 'right' literature and had 'prepared' for birth by gathering together "enough **facts**", Jane assumed she would easily 'manage' labour and birth. However, as a self

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moulded in a modernist, rational understanding of agency and control, Jane found herself 'undone' by the childbirth experience. Thus, she was "taken aback by the real, actual" process, was frustrated by a birthing body that did not go 'by the clock' and took 19 hours to dilate to five centimetres and felt overwhelmed by the physical and emotional intensity of labour. Furthermore, because she could not 'control' labour by the power of her rational 'mind', Jane remarks that, "I actually felt in it that I am doing everything wrong and I am being a complete failure". Several women narrated similar stories in which the birth experience was represented as an *un-making* of preconceived expectations and assumptions about childbirth, the self and control. While some women worked hard to reconstruct the self as a rational, all-conquering agent *through* their stories, others were left with an altered sense of self and rational control and often drew on 'storied metaphors' as a way of 'making sense' of that which seemed to fall beyond human logic. These narrative metaphors included, for example: birth as a battle or struggle, birth as a journey to the underworld, birth as an authentic experience and birth as a miracle. For reasons of space constraints[56], I am unable to explore this aspect of women's home-birth narratives[57].

While at some points in their narratives women reproduced the birthing woman as a body-self unity – at one with the embodied process of childbirth – at other moments this unified whole seemed to split apart, reproducing a fragmenting birthing subjectivity. Furthermore, while home-birthers often reproduced different modes of embodied subjectivity in their stories, with some offering more univocal accounts, most participants *veered* between three key representations of birthing subjectivity, that is: an absent subjectivity (clockwork narrative), a unified body-self (lived birth) and a split subjectivity (undecidable birth). It is important to note that the 'split subjectivity' of childbirth was experienced in different ways (i.e. positively and negatively), depending on unique features of each woman's birthing situation. Interesting research by Akrich & Pasveer (2004) has found that most narratives of childbirth reproduce a birthing subjectivity that is dual and fragmented; however they argue that this duality is not *Cartesian*[58] in nature, nor is it necessarily alienating or disempowering.

In the view of Akrich & Pasveer (2004), the emergence of an entity which they call the 'body-in-labour', a highly active and irrepressibly present body, always potentially *invokes a crisis* for the birthing woman who is (more-or-less) used to relating to her body as an absent and silent assumed. Similarly to experiences of illness, pain and disease, the body often emerges in labour and childbirth as a powerful, independent force. Birthing women have to find some way of relating to or negotiating this 'body-in-labour'. Drawing on (and extending) the work of Akrich &

[56] Unfortunately, due to word limit pressures, this section of the chapter had to be omitted.
[57] However, see the work of Klassen (2001a, 2001b) who writes quite extensively about the rich 'meaning-making' work engaged in by home-birthers.
[58] They argue that this split is not Cartesian because it is not a dichotomy between a body and a mind but between two forms of embodiment: a 'body-in-labour' and an embodied self.

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Pasveer, it becomes possible to say that the experience of childbirth potentially involves *multiple* bodies, for example: a 'body-in-labour', a clockwork body, an embodied self, a body-without-boundaries and a disembodied self. Furthermore, there are a range of different forms of birthing embodiment possible depending on the relations that are constructed between these body-self configurations (*ibid*). According to Akrich & Pasveer, the degree of empowerment or disempowerment experienced in relation to childbirth depends in large part on the degree of association–disassociation that is achieved between the 'body-in-labour' and the embodied self. Interestingly, they argue that alienation in childbirth occurs when the birthing woman is unable to maintain "a certain form of active dichotomy" (pp. 80) between the labouring body and the embodied self either because the 'body-in-labour' completely dominates or because it is absent (i.e. birth by epidural or via caesarean section). Thus, according to their research, *achieving* a degree of fragmentation or splitting between the chaotic 'body-in-labour' and the embodied self, is critical in the construction of an empowering and positive birthing experience. Women's birth narratives can be read as (on one level) attempts to articulate, negotiate or construct particular forms of birthing embodiment and subjectivity.

Thus, similarly to Akrich & Pasveer (2004), I found that home-birthing stories evoked multiple kinds of bodies and often danced between paradoxical modes of subjectivity. Thus, for example, birthing was narrated as both *out-of-body* and profoundly *in-body*, an experience of disconnection and a profound process of merging (connecting). Home-birthing women often seemed to oscillate between reproducing an embodied self and/or a split subjectivity. Furthermore, women also evoked different forms of subjectivity depending on what part of the birth process they were describing (i.e. early labour, transition, pushing stage). The tendency in much feminist and pro-natural birth literature to describe birthing subjectivities as either unified and whole (and therefore 'good') or split and fragmented (and therefore 'bad') therefore makes little sense. Instead, in their stories, women often reproduced a birthing subjectivity that hovered *between* binary pairs, creating a paradoxical dance between opposing categories. For example, birthing was often constructed as encompassing both sides of the following binaries, therefore rendering the boundary lines between these terms undecidable:

life _____ death
self_____ other
material_____ spiritual
animal_____ human
I_____ she
me_____ it
connection_____ disconnection
inside_____ outside
here_____ there

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one_____ two
open_____ closed
out-of-body_____ in-body
body_____ mind
primal_____ rational
sense_____ non-sense
unity_____ dissolution
singular_____ plural
conscious_____unconscious

First-time birther, Lizette Zimmerman, provided one of the most extensive and illuminating attempts to 'tell' the potentially radical undecidability of childbirth. While at times invoking the clockwork story as a means of structuring her experience, Lizette predominantly drew on a story line of birthing as an undecidable shattering of preconceived assumptions *vis-à-vis* rational control and agency. Having already emphasised the importance of control (over the pregnant body and the upcoming birth experience) in our first interview, the post-birth interview with Lizette found her trying to 'pick up the pieces' after experiencing childbirth as a radical un-making of previous assumptions. Thus, after the birth Lizette found herself firmly believing that no amount of reading or antenatal classes could prepare women for the actual 'real-life' experience of birthing. Her "theoretical idea of the birth" which included the idea that birth could be managed and controlled and that the bounded, rational and singular 'I' would be active and in-control, thus imploded in and through an experience in which she discovered largely that "there's nothing that you can do":

> Lizette: …I don't think there's anything that can prepare you (…) there's nothing that you can do, you can't stand in a special yoga position and you can't breath in a special way, you just have to let um, you just have to let that process happen (Lizette Zimmerman, interview two).

Lizette draws on a story line of birth as *undecidable*, as that which cannot be placed, fixed or adequately translated into a phallocentric language. Instead, birthing is constructed as a process without logic or sense, as she says, "it is what it is". In the following extracts from Lizette's talk, it become possible to see the ways in which her 'telling' brings birth 'into being' as a paradoxical, uncontainable experience which is, for example, both (and therefore neither) there *and* here, in-body *and* out-of-body, disconnecting *and* connecting, devoid of agency *and* full of agency, inside *and* outside.

> (…) the whole experience
> for me
> it was an *out*-of-body experience
> it was
> as though
> the experience was happening

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over there
and I was
over here
it was definitely *out*-of-body
(…) I
was somewhere else

(…) the contractions
they're
they're these waves
that come
at you
there's nothing
you can do
but just tolerate them really
the contractions
you just have to bear

(…) every *three minutes* this like
violent
a minute and a half
contractions
(…) it was *mad*
because it's
like they just *rush*
these contractions
just *rush* on you

(…) you can't
you can't place it
I couldn't place the contractions
to say
they were in my back
or they were in my side
or they were
you don't really feel
where you're feeling it
I couldn't
(…) that disconnection
is a weird thing
because I won't think
I was disconnected in the sense that
– hmm –
that I wasn't connected
with the process
I was completely connected
with the process
but
I couldn't feel
where
it was happening in my body

(…) the pushing part
for me
was fine

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because there was something that
I could do
there's something I could do
I was involved
so
I was very present
and very concentrated
for that
in the pushing part
I was very present
and
in my body

(…) I
I
I was squatting
and
I would go down
every time a contraction would come
and then
I took him [baby]
as he was half out
she [midwife] gave him to me
and I pulled him out
(…) I could feel his
his head
I mean
I can *feel*
that feeling now
of this *soft*
I mean soft-soft
I could feel this warm
soft
hairy kind of
little thing
which I knew
I wasn't touching <u>me</u>
cause I wasn't feeling it
which is quite weird
touching something
in your body
but you don't feel it
um
but I couldn't
no
I couldn't relate to it being
being *a baby* or
I dunno

I
I
I was
like dumbfounded like
you know
that moment before

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your brain kicks in
my brain couldn't kick in:
"this is the date and this is the time and this is what's happening and this is what you're feeling and well, maybe you're feeling the baby's head still inside your vagina like…."
I couldn't feel any of that

(…) and they
were showing me
this thing
but
    you *can't*
you can't relate to that moment
when he comes out
I
it was
it's so overwhelming
it's overwhelming
because
you're busy with the
with the birth
throughout
the birth
I wasn't connected to the baby
I was in my
dealing with my bodily pains
and stuff
and suddenly *there's a baby*
and
all the pain's gone
it's *so* weird
it's *absolutely* weird
suddenly there was this baby
in my hands
so I was like in a
really
I was in like
a numb space
    in-between
like
an in-between space

(…) I mean it's just
it is what it is
(…) it was fantastic
it was *fantastic*
like the most dreadful experience
and the most fantastic
it is
it is
it is
it's like *nothing* that you can
there's no logic
or there's no
it just doesn't belong

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> to this world
> I mean
> it doesn't make sense

Lizette produces a complex 'picture' of birthing subjectivity within her 'telling' of childbirth. Through her talk, we are given 'glimpses' of a *paradoxical consciousness* emerging in and through the birth experience. She reproduces childbirth as an event in which subjectivity is radically reorganised; thus, for example while completely 'connected' with the birth process, Lizette's 'I' is also described as "somewhere else". Subjectivity is therefore constructed as dispersed across spatial boundaries: it is both *there* (in the embodied experience) and *here* (in the free-floating, disembodied 'I'). Lizette also speaks of labour contractions as a violent *external* assault on her bodily/self integrity: they are "these waves that come at you" threatening to shatter or destroy 'the self' as a coherent, rational, bounded entity. Like the women interviewed in Emily Martin's (1987) study, Lizette and almost all of the home-birthers constructed birthing contractions as *separate* from the self. Similarly to Akrich & Pasveer's (2004) 'body-in-labour', the body-in-pain and in-contractions was thus often portrayed as foreign, alien, uncontrollable and wholly 'other'. As a result, many women described a divided consciousness emerging in the labour process, in which the birthing woman became split into a 'normal', rational self and an imploded, disintegrating or disappearing self on the basis of the "pendulum movement" (*ibid*, pp. 68) between contractions and the absence of contractions. Thus, according to Mandy Van Zyl, there are "about 30 seconds in between [contractions] to gather yourself again" and according to Angela Stewart, "it felt [during contractions] like I was going to break in every direction (laughter)" suggesting that in-contractions, 'the self' becomes exploded, fragmented and shattered. Furthermore, consider the following description by Maggie McDougal:

> Maggie: …those 90 seconds of absolute agony disappeared like that, for a minute when I was laughing and joking until the next – ↑**ooh, the next one's coming**↑ (R laughs) and you lose it, for 90 seconds you actually, your head goes somewhere else, and then it comes back and then you're smiling at your friend again, and you're joking, until the next one hits you (Maggie McDougal, interview two).

Thus, mirroring Lizette, Maggie describes her 'head' (or her 'I') as "somewhere else" during the pain of labour contractions. Furthermore, contractions are also constructed as an external assault ("until the next one hits you") on the body-self. In such moments of violent assault, the birthing body itself often becomes foreign, unrecognisable and resists rational ordering and classification. Thus, Lizette "can't place" *where* in her body she is feeling pain or contractions: "I couldn't feel where it was happening in my body"; instead, the body-in-contractions becomes, like Akrich & Pasveer's (2004) body-in-labour, a wholly different mode of embodiment in which the body

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overwhelms and exceeds the 'I', rational categorisation and control. As a result, Lizette comes through an experience in which 'control', commonly understood as an achievement of 'the mind' over 'the body', becomes nonsensical. Interestingly, while labour itself is reproduced as involving a 'split' or dispersed subjectivity, Lizette constructs the pushing stage as involving a completely different order of embodied subjectivity. In this phase, Lizette describes a body-self unity in which the 'I' is 'involved', "very present and in my body" largely because she experiences pushing as "something that I could do". Other home-birthers however had completely different tales in which they told the pushing stage as frightening, overwhelming and the most difficult part of the birth process. This once again iterates the degree to which birth (and home-birth) experiences are neither univocal nor universal. Thus, there is no such thing *as home-birth*; there are only multiple and different kinds of home-birth experiences, each potentially involving different dynamics and body-self relations.

In the extracts from Lizette's talk, she also describes *the strangeness* of the birth experience in that it exceeds logic and accepted modes of 'sense'. The moment of birth itself in which the baby emerges from within the mother's body, "for a short while both inside and outside me" (Young, 1990b:163) is constructed as radically undecidable and beyond rational comprehension. Thus, Lizette touches the head of the emerging baby and says, "I knew I wasn't touching <u>me</u>, cause I wasn't feeling it" describing this undecidable moment as "quite weird, touching something in your body but you don't feel it". In Lizette's story, the moment of birth is confirmed as "between subject and object, [an] unruly border" (Oliver, 1993:57) that functions as a radical un-making of phallocentric or individualistic versions of self, 'troubling' and destabilising fundamental binaries between self and other, identity and difference, inside and outside. Furthermore, the undecidability of birth is beyond rational logic and understanding and as a result, Lizette finds that her 'brain' simply "couldn't kick in" and 'make sense' of childbirth according to the strictures of phallocentric or clockwork modes of reason. As a result she is unable to rationalise birth (away?) by saying that, "this is the date and this is the time and this is what's happening". Importantly, Lizette's efforts to 'tell' the radical undecidability of the birth experience, exposes the extent to which a clockwork script of childbirth functions as a 'smoothed over' outsider's view of birth which is far removed from the complexities, challenges and paradoxes of the birth experience as lived from the 'inside-out'. Her story also illustrates the potential difficulties involved in trying to put *the experience* of birthing 'into words'. As an experience which is undecidably 'in-between' and which produces a subjectivity that is potentially radically different from modernist and individualist models of the self, the complex subjective and 'psychological' experience of childbirth (as split, integrated, paradoxical, undecidable) disrupts, interrupts and exceeds rational, phallocentric discourse. As a result, Lizette

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struggles to 'fit' childbirth into a masculinist language. Describing the birth experience *adequately* thus becomes almost impossible and Lizette can only (will only?) provide elusive phrases, such as: "it is what it is; it is, it is, it is", reiterating *the uncontainable power* of an experience which defies intelligibility and will not be 'disciplined' into the realms of *orderly* symbolic language. Birthing becomes that which simply 'is' and which "doesn't make sense", shattering taken-for-granted 'logic', order and binary categorisations.

The power of the 'it' and the paradoxes of control

"it is what it is (...) it is, it is, it is"
(Lizette Zimmerman, home-birther, interview two).

A careful reading of Lizette's 'telling' of undecidable birth, as outlined in the extracts above, show a repeated reference to that which she calls the 'it'. In my analysis of home-birth stories, I found that all of the women, at some point in their narratives, invoked something that they referred to as the 'it'. For me, this was an intriguing and analytically interesting aspect of their birth stories. However, it was often difficult to ascertain exactly *what* women meant by this term; the precise meaning of this 'it' was thus, in analytic retrospect, often itself *undecidable*. For example, the 'it' could mean several things, for example: pain, the birthing body and/or the birth process itself. Present in most of the home-birthing stories was therefore something which I called (following the voice-centred analysis method) a voice of the 'it'. This 'voice' always conjured up an alien, uncontrollable, all-powerful force radically *other* to the 'I' (or the 'me'), which came to colonise or infiltrate the birthing body-subject during childbirth. Often this 'it' became almost personified, 'doing' things to the birthing subject that were beyond their conscious control. For example, one woman referred to the 'it' as, "it just carried me, it just absolutely took me" (Stephanie Mitchell) while another said that, "it knocked me back (…) it just absolutely knocked me" (Jane Brown) giving the 'it' active, powerful and almost super-human qualities. Some examples of fragments of talk containing the voice of the 'it' are shown in Table 3.

The snippets of talk presented in Table 3 hopefully demonstrate the elusive, slippery and often vague 'it voice' which bubbled up in women's talk about birthing. While Lizette Zimmerman provided the most elaborated story line of *birth as undecidable*, almost all home-birthers drew on the 'it' voice at some point in their narratives. This 'it' voice thus often hovered as a thread across different stories, weaving a marginalised yet thoroughly disruptive story line of birth as an undecidable experience, threatening to collapse some of our most cherished assumptions *vis-à-vis* agency, control, body-mind relations and rational selfhood. Mostly, participants seemed to struggle to articulate this 'it', which seemed, in most cases, to refer to *the process* of birth itself. They would thus often fall back on hollow clichés or cryptic phrases, for

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example: "it is profound; it's quite something; it's amazing", mouthing words which seem to leave only a lingering sense of *absence*, perhaps exposing the inevitable *gap* that exists between linguistic representations and fleshy, chaotic, lived experience (Silverman, 1988; Grosz, 1989).

Table 3: Examples of an 'it' voice within home-birth stories

it was pain like I've never experienced it was a real journey it was profound it it was very profound it was like nothing I could ever have anticipated it it just carried me it just absolutely took me it's hard to verbalise it's like a it's just irrevocable it's a life change it's a life experience it's huge it's very big it happens all over it's very big it is profound (Stephanie Mitchell, interview one).	it's big it's not just sore it's big and uncontrollable it's like a big wave it starts here and it just goes '*whoosh*' (Jane Brown, interview one). it knocked me **back** it was so **intense** it it just absolutely knocked me the force of it it was these **huge** waves of pushing it wasn't **me** it was such a force (Jane Brown, interview two).	it's daunting it's the closest to death and to life I've ever felt it's just unbelievable it's unbelievable it's it's just god-driven it's almost like you're tripping it is unbearable it is unbearable it was just primal it was violent and bare-naked hardcore stripped down to everything it's **insane** it's daunting it's very daunting it's like you're swimming in an ocean (Mandy Van Zyl, interview one).	↑ it was quite an experience↑ it's it's it's really <u>quite</u> <u>something</u> (laughter) it's quite something it was really hard work it's serious labour it's like running a marathon without much training it's incredible it's just mind-blowing it's amazing it's just amazing it's amazing it's just (*) phenomenal (Angela Stewart, interview two).

In many cases, home-birthers stressed the importance of 'giving into' or 'going with' the 'it' in order to enable a positive or empowering birthing experience. Some women only came to this 'realisation' after a difficult first birth experience in which they struggled (in vain) to 'control' the birth process. For example, Jane Brown learnt through her first birth that empowered birthing demands the *relinquishment* of control: "you learn that the thing with birth is that you have to lose control, you can't control (*) the birth". Trying to maintain the rigid 'control' over the body demanded by a individualist model of the self meant that Jane couldn't express pain during her first birth; as she says, "I was too controlled" leading to a strained and frustrated birth experience in which she describes herself as merely 'surviving'. Through the experience of childbirth, many home-birthers narrated a process of coming to a different understanding of 'control' and agency. For example, according to Lizette:

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> Lizette: …I've never been *overwhelmed* with something as much as I've been, ag, I've been overwhelmed with things yes, but not to this extent, not to something *so* huge, and that, that has been a positive experience for me in terms of my body, that my body has this ability to, that there's bigger things than me (R: hmm) um (*) I'm not so in control, I'm not so in charge of like my reactions (Lizette Zimmerman, interview two).

Furthermore, in most (home) birth stories, control was not constructed as something that the birthing woman 'has' or 'exerts' *over* her body, her environment or external 'others' during birthing; instead, a *paradoxical* version of control, in which women gained control by *letting go*, was often invoked by home-birthers. For example:

> Lizette: I didn't feel like I was *out* of control (R: okay) I didn't feel that I was like spinning out of control in *that* way, but I felt that I was <u>in</u> a process, I was on the wave, you know, these waves kept coming and I had entered into that realm and I was <u>there</u> (R: hmm) but that, that realm wasn't my doing or anything like that, but it was up to me to hold the energy and to stay there, I think, so in that way I felt that I was <u>in</u> control, in <u>that</u> way but I mean, it's a different kind of a way, you're not in control of what's happening and you're not in control, but ja, you're (…) but for most of it I was in control as far as I was letting go into the process (R: hmm) (Lizette Zimmerman, interview two).
>
> Jolene: … you have to try and control the pain by giving into it (…) you've kind of got to go with it (laughs) but that is, that is the hard part (R: okay) (Jolene Wright, interview two).
>
> Kayla: …the best description of contractions is like being, riding a wave (…) so I think if you can actually try and embrace that wave as opposed to saying, 'uhh, the next wave's coming and I want to run away' because you actually can't get away, that's the worst of it, once it starts, it's there (…) and Dolores [midwife] would bring me back to that point of saying, 'let's go with the wave' (Kayla Peterson, interview one).

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Many home-birthers (like Kayla above) mentioned the difficulty of being in a situation (childbirth) that they could not stop or run away from. Lundgren (2005) found a similar theme in the birth stories of women who had given birth at an Alternative Birth Centre. Particularly for women who choose to give birth at home or without drugs and medical intervention, birth becomes "an unavoidable situation" (*ibid*, pp. 348) from which there is no means of escape. This aspect of birth immediately nullifies commonsense understandings of 'control', in which an individual exerts *control over* themselves or a situation. As discussed in chapter six, 'control' was a major issue in the lives of most of the women in this study, including those planning home-births. As a result, the 'unavoidable' and inescapable aspect of birthing often initiated a crisis of control. Many home-birthers mentioned the difficulty of being in a situation that they could not voluntarily halt, pause or fast-forward. For example:

> Lizette: …you know, at one, at one stage you *feel* that you just want this to stop, to go away (R: hmm) 'I just wanna go to bed'(R laughs) I remember feeling, 'I just want to go lie down now, I just want everybody to *leave* – I'll carry on again tomorrow, cause I know this baby has to come out, but just let me have a break you know'(R giggles) instead of every *three minutes* this like violent, a minute and a half contractions (Lizette Zimmerman, interview two).

Faced with the 'unavoidable situation' of birth, home-birthers could either fight the process, trying to maintain an artificial sense of being 'in control' or they could try and flow with the process of birthing. Either way, each of these strategies required considerable and complex "internal negotiations" (Adams, 1994:15) and many women told stories in which they veered in and out of these two modes of being during birth. Thus, 'flowing' with the process (or the 'it') was something that, according to most women, had to be continually *achieved* during birthing. Women thus spoke of having to work hard at maintaining particular patterns of thoughts to cope with the uncontrollable and pain-racked 'body-in-labour'. For example, according to Maggie McDougal:

> Maggie: …you know that each time you have a contraction, it's going to end and each, in each contraction that you're having, you're actually stretching more and more and more, so in your mind it's like a whole process of, the contractions are good, they're opening, they're allowing the baby out, and it just, I kept thinking that (R: and that helped?) ja, just focussing, as the contraction's pulling, pulling like this, in my mind I was actually picturing the cervix opening and his head pushing down and pushing down and pushing down (**) (Maggie McDougal, interview two).

Several home-birthers constructed birthing as hard 'work'; however, it is only recently that I have realised that the 'work' they were referring to was *not only physical* but involved a more complex endeavour inevitably including *mental labour*. Conceptualising birthing as complex physical *and* psychological labour assists in debunking (patriarchal) versions of birth that construct it as a purely physiological event, devoid of subjectivity. As Mandy Van Zyl put it, "this one [second birth] was ***hard work*** (*) ***hard***, hard, hard work, just to stay focussed". Often the effort to 'stay focussed' required a combined mix of concentrated thought patterns and visualisations, embodied activities such as breathing or moving in particular ways, the use of objects such as crystals and words of mirroring and encouragement provided by a midwife and/or birthing partners. According to Akrich & Pasveer (2004), birthing women have to work hard during labour to *construct* a form of embodied subjectivity (an embodied self) that can be maintained in the midst of the pain and chaos of the 'body-in-labour'. 'Staying focussed' by employing all of the above strategies constitute ways in which women struggle to hold onto the 'I' and prevent (as some women said) 'getting lost' or 'drowning' within a vortex of pain and contractions. It seems therefore that the birth experience rarely approximates the ideal of holism in which the birthing woman constitutes

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an integrated body-self whole *throughout* the process of birth. Thus, while many home-birthers employed a story line of 'lived birth' in which they reproduced birthing subjectivity as a unified and active movement of a body-self unit, there were always *other moments* within their 'tellings' in which the birthing body-subject emerged as fractured, dispersed and radically split. Thus, 'lived birth' and 'undecidable birth' often functioned as story lines which flickered *on and off* within women's stories, depending on the moment within the labour/birth process being re-evoked or re-told. Thus, in most stories, 'lived birth' and 'undecidable birth' emerged in a kind of *ebb and flow* of movement within women's tellings. These 'story lines' might therefore in themselves re-approximate the 'pendulum movement' between the embodied self and the 'body-in-labour' described by Akrich & Pasveer (2004).

The twin forms of birthing subjectivity identified by Cosslett (1994), namely: *splitting* and *flowing* and the two coping strategies outlined by Sbisà (1996), namely: *surviving* and *living*, clearly have a close relationship with the story lines of 'lived birth' and 'undecidable birth' that have emerged in my analysis. However, in both Cosslett's and Sbisà's interpretations, both 'splitting and flowing' and 'surviving and living' constitute 'oppositional' models or strategies which operate according to an either/or logic. Thus, according to these writers, women experience birth as *only* one or the other of these strategies or ways of being. In my analysis, however, women often told home-birth as a fluid movement *between* splitting *and* flowing, surviving *and* living. A split subjectivity *and* an embodied self thus usually *both* featured within women's stories of home-birth.

Thus, in 'telling' home (birth), women drew on multiple, at times contradictory story lines, including 'clockwork birth', 'lived birth' and 'undecidable birth'. These different 'ways of telling' emerged to construct home-birth stories as a shifting, fluid, and mercurial movement or interweave involving an *infolding* of dominant cultural story lines and an *outfolding* of chaotic lived experience, bodily rhythms and energies. As a result, multiple forms of birthing subjectivity emerged as products of these story lines, including an absent subjectivity (clockwork birth), a unified and inter-sensual body-self (lived birth) and a split and paradoxical subjectivity (undecidable birth). In part two of the chapter below, I turn an analytic eye (ear?) to the stories and 'ways of telling' that emerged within women's narratives of caesarean section.

Part 2: Narratives of caesarean birth

Not surprisingly, women's stories about caesarean birth were radically different from the home-birthing stories analysed above. Considering that most caesarean birthers continued to, at some

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point, frame their experience in relation to *natural childbirth*, it feels appropriate to analyse their stories *in relation* to the home-birth stories already outlined. At the same time, I want to avoid constructing one way of birthing as essentially 'better' than the other. However, in the context of the stories which constitute this 'data-set', in which home-birthing stories were, for the most part, saturated with a sense of satisfaction, empowerment and joy, this is clearly going to be a challenge. At the outset of this analysis, I must thus confess to some trepidation, largely because I do not want to represent elective caesarean sections in an overly negative or condemnatory light. It is therefore perhaps important to stress upfront that although contradictions abounded in participant's stories about elective caesareans, only two of the twelve women (both email correspondents) said that they regretted their decision. The other ten women were, in general, all *satisfied* with their choice and each one said that they would definitely do it again.

However, having said this, *my analysis* will show that there were usually two competing and contradictory story lines at work in narratives of caesarean sections, namely: 'it was good and fine' *and* 'it was horrible and awful'. There was therefore often a radical *disjuncture* between the dominant narrative ('it was all fine') and the experience being told. Thus, like home-birth stories, it was possible to identify a dominant narrative and a story line *of disruption* within women's oral accounts of caesarean birth. As a result, my analysis of caesarean stories will proceed along roughly the same lines as my analysis of home-birth stories, exploring the dominant narrative or 'way of telling' and then searching for story lines of disruption.

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Surgical birth: a restitution narrative

"What does it mean to cut open the human body?"
(Della Pollock, 1999:163).

Caesarean section was overwhelmingly 'told' as *a restitution* narrative. The restitution story is identified by Arthur Frank (1995) as a key 'narrative type' within which illness experiences are narrated. Essentially, this narrative is about the restoration of health, agency and normality in which the protagonist is constructed as ultimately 'as good as new' or as 'back to normal'. According to Frank, the general plot of the restitution narrative runs something like this: "yesterday I was healthy, today I'm sick, tomorrow I'll be healthy again" (pp. 77). The illness itself is therefore constructed as a *temporary aberration* that does not transform or have any *meaningful* impact on the life of the protagonist. Often such narratives work to reinforce or legitimate the 'authoritative knowledge' (Jordan, 1993, 1997) of medical science.

Stories about elective caesarean section are peculiar in that they both are and are not *about birth*. Thus, although culminating in the birth of a new life, they are also stories *about surgery*.

Despite the fact that childbirth is not an illness, the woman who births via an elective caesarean section willingly (and without symptomology) becomes a patient and undergoes a medical operation just like those who undergo surgery because of physical disease or dysfunction. It is therefore not terribly surprising that stories of caesarean birth generally operate along competing and contradictory narratives lines, often riding between the happiness of celebrating a new life and the banality or trauma of medical surgery.

Surgical birth script

In general, caesarean section was told along the following narrative lines: 'I was fine and excited – I had a baby and a caesarean section – I recovered – it was fine and then I was fine again', thus broadly following the logic of classic restitution narratives, which focus on the restoration of health and normality, usually through medical interventions. This narrative was also, like the 'clockwork' narrative, told in a linear and formulaic way, with a clear chronological order. Most of the narratives thus proceeded along the following lines: (a) preamble and/or going to hospital (b) booking in (c) becoming a patient (d) going to the surgical theatre and the administration of anaesthetic (e) the caesarean 'procedure' (f) the baby is born (lifted out) (g) to the recovery room (h) to a private room (i) meeting the baby (j) the next day (k) going home. Although not all of these narrative 'steps' were present in all of the stories, most did follow this 'recipe' in quite a uniform manner. Generally, caesarean sections were told as events of *minimal disruption* momentarily unsettling a broader stability narrative and were not, in themselves, *ever* narrated as responsible for any shifts in consciousness or beliefs. In sharp contrast to home-birthing stories, there were thus no caesarean birthers who narrated their births as 'journeys', 'quests' or as a process of learning, insight or transformation. Instead, 'it' was something that caesarean birthers "had to do" in order to get a baby; thus, as Janine Le Roux said, "just get it done with please (laughs)". Unlike home-birthers, elective caesarean birthers did not find their birth experience *meaningful* and therefore made no attempt to understand it or 'make meaning' through the use of storied metaphors. As Janine said, "it's just something that happened", demonstrating the lack of engagement or involvement that caesarean birthers (unsurprisingly) experienced in relation to the birth experience. As opposed to home-birthers, who experienced birth as an intense *process* connecting them in profound ways to others, their bodies, nature and 'higher' spiritual powers, caesarean birthers experienced and narrated none of these things. For caesarean birthers, birth was experienced as *a procedure*, not *a process*.

Similarly to home-birth stories, there was often a comic 'preamble' or 'run-up' to the birth told within elective caesarean section narratives. In this case, however, the preamble was not

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concerned with the issue of 'waiting for' or inducing labour; obviously the dilemma of 'is it or isn't it [labour]?' was also not part of these women's stories. Instead, the comedy or drama of the preamble was often centred on the 'strangeness' of knowing the precise date and time of the birth. For example:

> Caroline: …we went off [to hospital] and it was, I think it was about six o' clock in the morning or something and we had to be there at seven – and check and do everything and he [husband], he actually still asked me, he said can we just go past his office <u>to collect something</u> (laughing) and it was very funny cause we still, you know, on the way to having a baby, off we went to the office and (both laugh) did what we had to do, it was very strange (Caroline Kohler, interview two).

While 'strange' for some, being able to 'pre-arrange' the birth date and therefore 'plan' and 'prepare' was, for other women, simply 'nice'. In telling me about the 'run-up' to the birth, most women expressed a sense of excitement and joy, almost like a child waiting to open their presents on Christmas morning. For example:

> Hannalie: …I was very excited, ja, I was never nervous, I was just excited (…) I had to be at the hospital at seven, so I woke up at about {four o' clock} (both laugh) and I said to Jan [husband] ↑'<u>There's no point, I can't sleep anymore</u>'↑ (laughing) (Hannalie Botha, interview two).

While the 'preamble' was generally told as lively and comic, with a marked sense of exuberance and joy, displayed through, for example, the rapid, excited, high-pitched speech and laughter of Hannalie above, the rest of the story often seemed to fail to reproduce a similar kind of *jouissance*. Thus, once women became inscribed as hospital patients and the process of medicalisation began, this sense of liveliness and joy often seemed to dissipate. In some cases (e.g. Hannalie) there was a particularly strong and noticeable shift in 'voice', in which the various procedures marking the process of 'becoming a patient' (e.g. being 'ordered' to put on the hospital gown) were told in a slow, low-pitched and deadened voice (in contrast to the former excitable, lively speech). This 'deadening' of voice was also often connected to the loss of agency invoked by hospitalisation. Thus, in Hannalie's 'telling', her voice takes on this heavy, dead-like quality in the places where she talks about becoming a patient. For example:

> Hannalie: …and then they said to me, ‖'Okay, put on your hospital gown‖ and I thought well the caesar's only at ten-thirty, it's now seven o'clock, why do I have to put on..?' ‖no, then they come in and they start prepping you, and they start talking to you, and they fill out all their hundreds and thousands of questionnaires (R: ja) and uhm‖ ↑ in between my phone was ringing the whole time because um (*) I was, ***I was having a birthday***↑ (R laughs)

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Gradually, as the process of medicalisation becomes even more dominant, a voice expressing excitement and joy seems to die off completely within Hannalie's birth story, over-ridden by a set of objectifying procedures in which she finds herself reduced to the level of passive patienthood. The process of medicalisation becomes so dominant in caesarean stories that the birthing woman herself almost ceases to be the active protagonist of the narrative. In general, "she becomes the absent figure in her own story [and] names her self and her body through and for others" (Pollock, 1999:162). This is powerfully demonstrated by the way in which all caesarean birth stories were riddled with references to 'they'. 'They' become the dominant actors within narratives of caesareans, doing things, saying things, and making things happen. For example, consider the following representation of (just some of) the 'they' type phrases present in Hannalie Botha's story:

> *they came … they put me on the trolley … they took me … they said … they put*
> *they do that … they don't want … they put … they give you … they put it in*
> *they put it in … they cover … they're doing it … they gave me … they give you*
> *they give you … they were doing …they were pulling … they put … they lifted him out*

This 'they' is anonymous and depersonalised, referring always to a generic and undifferentiated medical staff. There is thus *not one* instance within any of the caesarean birth stories where a medical doctor is mentioned *by name*. This differs radically from women's stories about home-birth, where birth supporters were always intimate and trusted family members and friends, often referred to by name. Furthermore, within home-birthing narratives, the midwife's presence at the birth was, for example, described as "like having a friend around" (Maggie McDougal) and women repeatedly referred to the midwife by name throughout their stories.

While increasingly stripped of active and embodied agency through medicalisation, caesarean birthers often did manage to 'hold onto' a measure of agency in the parts of their narratives leading up to the administration of the anaesthetic (see chronological steps above). Thus, in their talk, women still expressed a sense of physical/emotional integrity and spoke of a range of feelings, including: excitement, nervousness, sadness, insecurity and calmness. However, once the anaesthetic had been administered and the lower body 'went dead', elective caesarean birthers often found themselves adrift in an experience that was narrated by all of the women as 'weird'. However, in the dominant 'restitution' story line, participants continually constructed the caesarean section or birth as a negligible or fleeting disruption that had not *affected* them in any significant way. At times it seemed as though the women didn't even know how to refer to the birth, thus, for example, did it actually qualify as a *birth experience* or was it a medical procedure? Thus, participants referred to their birth experience as, for example, "the thing" (Sara Trump), a "happening" (Caroline Kohler), "what I went through" (Lola Cronje) and being "done"

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(Karin Miller), all conveying the sense that birth was not an act of agency, it was merely something that was done to them or which happened to them. Thus, not surprisingly, the words 'birth' and 'experience' were very rarely invoked in women's caesarean section stories. Some women even seemed to have difficulty in thinking of their caesareans as a *birth experience*. For example:

> Rachelle: Okay, um and then would you say that the birth was a significant life experience in itself?
> Ilse: *Um* (*)
> Rachelle: Or not really? Was having the, the baby, having the baby more #
> Ilse: Ja, having the baby is definitely more, um, life-changing (R: life-changing) definitely ja (Ilse Van Rooyen, interview two).

Furthermore, when I asked questions about 'the birth', many caesarean birthers understood this to mean the arrival of the baby and not their own personal experience of birth via caesarean section. Interestingly, no such misunderstandings occurred in my interviews with home-birthers, who all understood 'birth' to mean the intensely personal physical, emotional and spiritual process in which they 'gave birth to' their infants. 'Birth' was thus as much (or more?) about their own experience as it was about the arrival of a new life. However, for caesarean birthers, birth was not an experience that they were part of – it was something that was done to them and which was, at the end of the day, about the baby. Whereas the distinction between mother/baby was often blurred and indistinct in women's home-birth stories, with the moment of birth signalling the profound *undecidability* of boundaries between them, women's talk about caesarean birth reproduced a clear and fundamental split between mother/infant commensurate with patriarchal ideologies. Thus, in caesarean birth the "unruly border, birth" (Oliver, 1993:57) *is excised*, and the surgical procedure that replaces it manages to reproduce an individualist and phallocentric logic in which the binaries between mind and body, self and other and mother and baby are consolidated and confirmed.

Although speaking about the experience of caesarean section as 'weird', within the dominant restitution narrative almost all of the women repeatedly insisted that the procedure was 'no big deal', thereby retrospectively *downplaying* the disruptive event (i.e. the caesarean). Thus, for example, according to Janine Le Roux, "it was fine, it didn't bother me you know, when it was over, it was over" and the phrase "it was fine" appeared as a refrain in almost all of the narratives. Interestingly, no home-birther ever referred to their experience of birth as being simply 'fine'. Depending on the expectations that women carried in relation to the caesarean birth, the flat and trite 'okay-ness' of the event was experienced as either deeply disappointing or as in-tune with their desires. Thus, for Hannalie Botha, who expected the birth to be *a climax* of emotion, joy and

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bonding, the caesarean was, in many respects, a disappointment. At the same time, she worked hard to nonetheless construct everything as 'fine'. For example:

> Hannalie: …***but anyway***, *so* I took him home, ***but I was fine***, you know, I was fine the whole time, I never cried, that's the other thing, I thought I was gonna cry when he was born (*) but I was so depleted of emotion because (*) of this medicine in my body (*) there was no emotion present [it was, which was kind of disappointing for me] (Hannalie Botha, interview two).

Other women were, however, *fully satisfied* with their caesarean birth; for example, Caroline Kohler emphasised that she was quite happy with her experience and had never wanted or expected caesarean birth to be anything other than what it was:

> Caroline: …I wasn't actually (*) uh, thinking that I was going to go and have (*) you know (*) dim lights and music and I, I didn't expect that at all, I didn't want that, I just (R: hmm) you know I wanted a (*) clean, professional approach and that's what it was (…) but I didn't, you know, I didn't put that much emphasis on the actual (…) I didn't need the (*) roses and flowers and dim lights and music and stuff (Caroline Kohler, interview two).

Thus, while for some women the restitution narrative ('I was fine, then I had a caesarean [which was fine], then I was fine again') was founded on a loss generated by the absence of that which had been desired or expected, for other women there was no such mismatch or gap. Out of the nine caesarean birthers that were interviewed, the narratives of five women were (to different extents) punctured with "the pain of absence" (Pollock, 1999:162), haunted by the sense that *perhaps* something (special, fundamental, inexplicable) had eluded them or gone missing[59]. Thus, for Linda Matthews, not being able to see the birth and everything else that was happening was part of feeling as if she had somehow *missed* something. For example:

> Linda: …um **you know it's also**, it's like strange *when I*, the things I found out *later* apparently um (*) (clears throat) (*) *because I mean I can't*, you can't see what was going on, once he'd been born, they showed him to me *quickly* but then they took him off (…) my husband told me like afterwards that they actually had to give him [baby] oxygen (…) and I mean this I didn't even know (laughing) I was just lying there, I couldn't see what was happening or anything (…) (**) it's a bit difficult to find out afterwards (…) that you've missed things (Linda Matthews, interview two).

It was always within these types of narratives, founded upon a loss of some kind, that women constructed 'natural birth' as the comparative 'other' which they didn't know, couldn't know or wondered about. Thus, while often working hard to reconfirm 'normal' or 'natural' birth as hectic

[59] Lee, Holroyd & Ng (2001) similarly found in their post-birth interviews with elective caesarean birthers that some women reported feeling as though "they had missed something yet [they] were unable to verbalise what they had missed" (pp. 318).

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and dreadful, constructing it as far worse than a caesarean section, at certain points in their accounts this was spliced with a lingering sense of never being able *to know* exactly what they *might* have missed. For example:

> Hannalie: …I can just imagine, how it must feel like in normal labour, lying there, no there's no way, ***but*** (*) um (*) I must say that (*) I dunno what it's like to give natural birth (…) I mean I was glad that I was spared all the drama [of natural birth] and everything (…) I mean having to lie there, I just, I find it extremely primitive, having to give natural birth (…) no, the caesar was fine, it was the, it was the spinal, um (*) I thought I was going to be more alert, more awake, um, I thought my emotions was going to be intact (*) I would like to know what a natural birth mother says, when they give her baby to her, if it feels like her baby (…) I dunno, it might be different when (*) I think there's a certain amount of hormones that kick in when you give natural birth that maybe makes it easier to bond with your baby – I don't know (R: hmm, hmm) (Hannalie Botha, interview two).

In contrast, home-birthing stories were *never* founded on absence, loss or the sense of something missing but always told birth as the pulsating "gateway of presence" (Pollock, 1999:27) in which new life, understandings, emotional and spiritual connections and conceptions of self were 'brought into being' or, in all senses of the word, '*birthed*'. Home-birthers thus, not surprisingly, never 'wondered' what they might have missed had they given birth in the hospital or via caesarean section.

Although women downplayed the *personal significance* or importance of the caesarean section as generally just something "that had to happen **to get a baby**" (Janine Le Roux), most women still wanted the *birth of their babies* to be respected, celebrated and treated with awe. Thus, several women were perturbed or upset by the attitudes taken up by some medical doctors and staff, who seemed to treat the event as "like another day at the office (laughs) you know, it's not like a big deal" (Sara Trump). In more than one narrative, women spoke about the doctors (sometimes in conjunction with husbands!) not paying sufficient respect to the process of birth:

> Carrie: …they, I mean, I sup(pose) for the gynae, I suppose, it's an everyday occurrence, and they were just chatting away and you know #
> Rachelle: Chatting about?
> Carrie: Every other thing <u>except what's happening</u> (laughing) (R: ja, ja) (Carrie Cohen, interview two).

> Sara: …I think the anaesthetist and Mark [husband] were chatting about golf or rugby at some point and I was like, '**Please**, this is an important moment, can we talk about this some other time?' (both laugh) like talking about rugby and they're busy taking my child out (R laughs) so, just pay <u>attention</u> all of you (both laugh) (Sara Trump, interview two).

An equivalent scenario is simply unimaginable within the context of an *unmedicalised* birth; when a woman is fully engaged in the process of labouring and birthing, like, for example, in the home-

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birth stories explored earlier, it becomes inconceivable that any birth attendant or supporter would talk about banal, everyday matters such as rugby or golf! As so graphically expressed by many home-birthers, the support given by partners, friends and midwives during a home-birth becomes an enmeshed intertangling of bodies, where birth attendants give intense, undivided, 'body-to-body' support to the birthing woman. In contrast, the woman undergoing a caesarean section is sharply separated from others, lying isolated on a table, while a screen is set up to mark her 'head' off from her (lower) body. Ironically, while Hannalie Botha repeatedly constructed 'natural' birth as 'primitive' because the woman is just "lying there" (see extract on page 301), it was caesarean birthers rather than home-birthers who were the ones lying passively immobilised on a surgical table. As portrayed in the story line of 'lived birth', home-birthers described themselves as constantly *moving* within their stories: dancing, walking and rocking.

In a caesarean birth, far less intimate involvement and support is demanded of birth attendants and supporters. While the caesarean birther's body is, of course, the site of copious amounts of (objectified) attention, she is often not treated as a full and whole human being, who is undergoing a significant emotional experience – becoming a mother – in addition to physical surgery. Thus, it became clear from women's narratives that a woman's experience of caesarean birth can be significantly influenced by the actions and attitudes of doctors in the surgical 'theatre'. Often it was the anaesthetist (situated at the woman's head but privy to the surgical action) who either helped to make the caesarean a positive experience (usually by giving her details of everything that was happening) or who turned it into a less than memorable experience. For example, Karin Miller had a "horrible" experience, in large part because of the insensitive and patronising behaviour of her anaesthetist during the birth:

> Karin: …I had the impression that I was going to be paralysed (R: ja) I didn't realise that I would have some sensation, so I lay there and (…) I'm moving my feet, cause I'm thinking, 'Oh my god, I wonder, if they can see my feet moving, they'll know maybe they shouldn't cut' (…) I could feel the pressure but I couldn't feel the pain associated with it, so I said to him [anaesthetist], 'You know what? Um, I can still move my feet – do you know?' and he says, ['Shall I tell you a secret?'] he says, {'We're not operating on your feet'} (R laughs) <u>which is funny now but at the time I</u> (laughing) (*) and he says, 'You know what? We're halfway through' (R: oh okay) so how would I know? I dunno which part of halfway he thought we were through but they'd obviously started (Karin Miller, post-birth interview).

Graphically displayed in this extract is the extent to which the caesarean birther is potentially estranged and 'out-of-touch' with the birth. She cannot *see* the birth, she cannot *feel* the birth and unless somebody gives her moment-to-moment commentary on what is happening at all stages, she potentially remains profoundly disconnected and removed from what might be one of the

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most significant experiences of her life. Some women reported wishing that they had been able to somehow *see* the caesarean – particularly the first glimpses of the baby and its birth. For example:

> Janine: …I would have liked to see it myself (*) (R: okay) I would have liked to see, you know, (…) see her [baby] coming out (R: ja) I would have liked to see that, ja (…) he [husband] saw everything (*) ja, he saw everything and he took photo's, you know I can see on the photo's, you know there's her little hand coming out but it's not the same (R: ja) (Janine Le Roux, interview two).

While women in general have been known to privilege the outsider's view of birth (as the 'real' thing) over their own embodied sensations (Martin, 2003), in the case of caesarean birth there *is* no bodily experience. There is only an outsider's view. It is thus not surprising that some women wish that they could have *seen* what was happening. In addition to not being able *to see*, Janine also found herself treated as a passive object to be 'looked at' and practiced upon. Thus, while she and many other women had spoken of 'choosing' a caesarean in part because they did not want to be 'exposed' and there for all to see (as in natural birth), they nonetheless often found themselves subjected to the (objectifying) obstetric gaze. Janine, who thought, "there would be more dignity to having a caesar" found to her surprise that even in surgical birth, "they will see everything from every angle". Furthermore:

> Janine: …ja ag no, you're just like a doll there, they just do whatever (…) it's like (*) everyone is looking *at you*, you know, you are the centre of the attraction (Janine Le Roux, interview two).

Thus, during a caesarean section, the birthing woman potentially becomes *a passive spectacle* or the object of an intense and depersonalised obstetric gaze. In comparison, home-birthers never talked about being 'looked at' during their stories; instead, they narrated a birthing situation in which they were constantly supported by attendants who breathed and moved with them and in which tactile and aural sensations completely over-rode the visual.

While raising the above 'issues' of feeling, at times, patronised by doctors, objectified and perturbed by the lack of respect shown for their birth experience, all of these women (e.g. Janine, Karin, Carrie and Sara) continued to stress the fact that they had "no complaints" (Janine) and that the caesarean section was "fine", thereby confirming and legitimising their birth choice. Thus, all of the nine elective caesarean birthers that were interviewed stressed that they would make the same decision in the future. While *some* narratives were spliced with a lingering sense of doubt, disappointment or loss, in the end they all worked, on a surface level at least, to reconstruct the decision to have a caesarean birth as the 'right' choice.

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In addition to being potentially estranged and disconnected from the birth procedure, there was also a sense in caesarean stories that women were sometimes emotionally (as well as physically) *removed* from the birth and first moments (and sometimes hours) of their baby's life. In most of the stories, 'the birth' was, in fact, the moment when the baby was held up over the screen for the mother to see. Women spoke of different reactions to this moment. For some, it was emotional and constructed as the highlight of the whole experience: "it was fantastic, we just burst into tears" (Lola Cronje). For other women, however, this moment was either simply banal or incredibly disappointing. For example, Janine Le Roux narrated this scene in a banal and hackneyed style:

> Janine: …I was still, you know, struggling to get, to breath, not really struggling to breath, but it felt like you know something very hard is pressing on your chest (*) so at that stage I was just like 'ja', you know, my husband must go with, just let me breath again and then they brought her, you know all wrapped up and what-have-you and then it was much more, 'Oh you know baby-cute, you know, blah-blah-blah' (Janine Le Roux, interview two).

Others narrated an experience of utter disconnection; for example, Hannalie Botha, whose talk in the 'run-up' to the birth was saturated with a sense of excitement, liveliness and joy, narrated a disturbingly detached response to the first sight of her baby.

> Hannalie: …and then suddenly they lifted him [baby] up and he started crying and then I only saw him, so he was actually out for a minute or two before I knew about it (R: ja) *and* I looked at him (*) *and* (*) ***I dunno*** (…) when I looked at him, it didn't feel like it was my baby, I looked at him and I thought ['Oh my word'] (R laughs) (*) They could have given me a baby off a trolley that came past, it (R laughs) they were like, I said, '*Oh cute*' I said, I think, I think I said, 'Oh cute' (R laughs) and I was like looking, and I smiled (…) I looked at him (*) but once again, I felt so weird (Hannalie Botha, interview two).

Having been very closely 'bonded' with her baby in the womb, Hannalie found to her surprise and disappointment that she had little to no emotional response to seeing her 'real-life' baby for the first time; as she says: "that bond that you have with your unborn baby is not the same bond that you have with the child that they put in your arms". This last remark is illuminating because it emphasises the degree to which Hannalie experiences the baby as the 'product' of the medical and depersonalised 'they'. Furthermore, by saying that the child 'given' to her *by them* was like being given any old baby *off a trolley*, it could be argued that Hannalie is describing a form of *alienated labour*. Thus, just as work within capitalism has become "a means to life rather than life itself" (Hartsock, 1985:122), within phallocentric obstetrics the *potentially* creative and empowering act/labour of birthing has been perverted and subsumed by a desire and concern only for the 'end-

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product' (i.e. the baby). An elective caesarean section, in many ways, represents the ultimate alienation of the birth process. According to Nancy Hartsock (1985), in Marx's view, alienation is fundamentally "founded upon estranged labour" (pp. 122) in which the labouring self is not affirmed but *denied*. Of course, in the case of an elective caesarean, women *themselves* choose to bypass the labouring/birthing process and in many of the cases analysed for this thesis, were thus happy with their 'choice'. Nonetheless, despite it being her 'choice', women like Hannalie were not prepared for the sense of disconnection that they felt in relation to their newborn babies. It is important to point out here that a feeling of disconnection towards a newborn baby is not unique to women who give birth via caesarean section. In fact, anthropological studies have suggested that an initially *guarded and indifferent* response is more typical among new mothers than a reaction of joy or euphoria (see Hrdy, 2000). Furthermore, in the home-birthing stories there *was* one first-time birther (Lizette Zimmerman) who spoke of feeling slightly disconnected from her baby immediately after the birth.

After being momentarily allowed a glimpse of their new infants over the dividing screen, babies were usually whisked away for immediate cleaning, checking and measuring. Soon after, most women were 'allowed' to have their first actual skin-to-skin contact with their babies, who were placed on their chests while doctors finished 'stitching' them up. However, this contact generally did not last for very long (probably about ten to fifteen minutes) before the baby was once again removed and taken 'for observation' while the new mother was wheeled away and forced to 'recover' alone and undifferentiated among other surgical patients in a designated 'recovery room'. Often the new mother was separated from her newborn baby for up to three to four hours; it is therefore not surprising that it was this aspect of the caesarean experience that participants were often the most critical of. Thus, according to Carrie Cohen:

> Carrie: …so they [husband and baby] went off and I (…) was then taken into the recovery area and I must say <u>that</u> to me (*) *that* was horrible because you're just lying there, your baby's taken away from you, and now you're lying there as if, 'Okay well, *I'm* the one who produced this baby and now (*) everybody's <u>running about</u> (laughing) (…) it's like you're there and going, 'Fine, all right, is this it then?' (both laugh) so it was horrible.
> Rachelle: It's a bit of a let-down
> Carrie: *Ja*, I felt very, <u>ja</u> , that's the exact way I felt, very let-down (Carrie Cohen, interview two).

Once again, women were thus often, via hospital practices and 'rules', estranged and alienated from their babies. One of the women, who told one of the most *consistently positive* accounts of her caesarean section, was hospitalised at a clinic that prides itself on being 'baby-friendly'. In keeping with this policy, women are 'allowed' to keep their babies with them (on their chests) with them while they are in the 'recovery room'. Thus, Lola Cronje was never separated from her

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baby, apart from a few minutes right after birth when she was cleaned and checked; (perhaps) as a result, Lola was "totally satisfied" with her birth, describing it as "a wonderful experience".

After spending time in the 'recovery room', women were moved to a private or shared room, where they were usually reunited with their babies (and husbands) and could begin the process of both 'recovering' from their surgery and getting to know their infants. While (like home-birth stories) clearly located in clock-time, it is interesting to note the degree to which caesarean stories also followed a set spatial trajectory, moving around in an orderly fashion from one location to another, in which each 'space' seems to represent a shift in the narrative itself. Thus, women always told caesarean stories marked by a strong sense of movement from one *regimented space* to another, from home to hospital, and then moving around several times within the hospital space itself, for example: administration area (during booking in), private room, surgical theatre, recovery room and private room again, before finally leaving the hospital to go back home. Home-birthing stories, although clearly always already marked by spatial politics (i.e. the choice to birth at home is always potentially political), were told in a more *fluid* ways, usually focussing more on the birthing body moving dynamically *in-space* than on space as a set of relations serving to mark, order and regulate the birthing body.

The theme of 'recovery' was a narrative thread in all caesarean birth stories. While home-birthers generally only touched on this issue, usually as a way of debunking 'horror' stories of childbirth which construct images of torn, stitched and stretched post-birthing bodies, it was caesarean birthers who always narrated some kind of recovery process after the birth. Within the dominant restitution narrative, this recovery was often downplayed and once again (like the caesarean) repeatedly constructed as 'no big deal'. Furthermore, some women constructed recovery as far less painful and less of an ordeal than they had been led to believe, in the process trying to debunk views that recovery after a caesarean is far worse than that entailed in a 'natural birth'. Thus, for example, according to Sara Trump:

> Sara: …they make it sound like *so* bad, like it's the worst option for you and not a good option for the baby and, I mean <u>honestly</u>, okay, I was in pain for the few days I was in hospital and they give you like a morphine thing you can press all the time which is like amazing (…) so that was very, very handy for the first day (…) as soon as I started to feel a little pang of pain I just pressed it (…) and then um, the next day, ja, they give you, strong, a strong version of Panado[60] (…) they're fantastic at the hospital, they come in, they say it's time for tablets and you don't even like have to think about it, they give it to you before you start feeling pain (…) and they give you sleeping tablets which I took every night (…) it's really, *really* not that bad (Sara Trump, interview two).

[60] A commonly used everyday painkiller that can be purchased without prescription in South Africa.

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In Sara's recovery story, she is heavily reliant on drugs of various kinds to make her 'as good as new' and in the process (like in a classic Frankian restitution narrative) serves to reproduce the authoritative power of medical science. The dominant way of 'telling' recovery was thus generally as an uncomplicated process, in which pain was 'managed' by drugs of various kinds. Thus, women described recovery as "it was fine" (Caroline Kohler), "it's not bad at all" (Linda Matthews), "it wasn't that bad" (Janine Le Roux) and "it was fine" (Hannalie Botha). However, 'recovery' was also often as much (or more) about reclaiming embodied agency as it was about actual physical recuperation. Thus, in some of the stories the process of 'getting one's body back', that is, being able *to move* after being immobilised by anaesthetic for up to eight hours, was in many ways a reclamation of agency after having the role of passive patient imposed upon them. It was thus always only after women had regained a form of embodiment (could move their limbs again) that they could 'become themselves' again. Once this 'feeling' and movement returned, women spoke about themselves as being 'fine' and as in a classic restitution narrative: 'back to normal'.

Functions and implications of the restitution narrative

The dominant story line of caesarean-section birth was thus a restitution narrative. In this narrative version, the caesarean was predominantly constructed as 'fine' and as 'no big deal'. According to this mode of telling, the caesarean story was told as a stability narrative, in which everything, from beginning to end, was 'all fine'. This story line thus worked to reproduce a self that emerged as unscathed and unaffected by the so-called 'disruptive' event (the caesarean), which was itself constructed as not really that troublesome after all. However, within the analysis above, it must have become clear that the restitution narrative ('I was fine, I had a caesarean, it was fine and I was fine') was constantly being interrupted by a narrative voice that contradicted the dominant story line, constructing the caesarean experience as horrible and alienating. This 'narrative of disruption' will be explored in the following section.

What then is *the function* of the restitution narrative as told pertaining to elective caesarean section? Clearly, the most important function of this narrative is that it works *to confirm* that the decision to have a caesarean was the 'right choice'. The ultimate 'point' or 'plot' of the restitution story is thus *to legitimate* a birth choice that is often condemned and pre-judged by others. Not surprisingly, all of the caesarean birthers interviewed therefore made a point of emphasising that they would definitely 'do it again'. Furthermore, in a move to reiterate and justify her pre-birth beliefs and arguments about caesarean section, Hannalie Botha peppered her second interview with some of the *same refrains* that had saturated interview one. Thus, for example, she told me

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again that "it's a modern day choice" and that "it's your baby, it's your life, it's you that makes the decision", reproducing the view that the experience of caesarean section had done nothing to change her pre-birth beliefs. In essence then, this story line often worked to produce an *unchanged self*, who simply and quite effortlessly 'was back to normal' after caesarean birth. As a result, it functioned to confirm and reproduce an *individualist* model of subjectivity in which the birthing woman's self remained separate, rational, bounded and immutable. By claiming that an experience, in which 'the body' is 'put to sleep' and invaded while 'the mind' remains 'above it all' (i.e. above the dividing screen) unaffected and immune, is 'fine' and 'not a big deal', the restitution narrative works to reinscribe an individualist ideology in which consciousness is defined as essentially disembodied (DiQuinzio, 1999). As a result, this narrative does nothing to 'trouble' or disrupt a world-view dominated by a technocratic 'ideology of control' in which rational, autonomous agents make choices and are able to control and act free of 'the body' and social constraints (*ibid*). The 'I' reproduced in the restitution narrative thus remains compatible with dominant masculinist, technocratic and individualist models of the self.

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Disconnected birth: a narrative of disruption

While telling a stable restitution narrative in which everything was 'all fine', women were also often at the same time *telling a different story*. This 'other' story often centred on the lived experience of caesarean birth, and in their efforts to 'tell' the complexities of their subjective experiences, women often ended up constructing a story line that contradicted and disrupted the restitution narrative. When spoken in this voice, the caesarean was told as an awful, 'horrible', 'weird', disconnected and at times, a terrifying experience. Often this version of the story was told as a 'chaos' narrative, following Frank (1995). Present in the narratives of all of the nine caesarean birthers interviewed, this 'way of telling' was usually most prevalent when women were trying to narrate the *actual experience* of surgical birth.

Thus, while 'plotting' their accounts of caesarean section broadly within a restitution narrative, the *telling of the experience* itself was usually marked by a chaotic style of narration. Over and over again women told caesarean birth in an, 'and then…and then…and then' style of speech, which is, according to Frank (1995), the hallmark of the chaos narrative. For example, see the poetic representations[61] of (some of) the way(s) in which women told the experience of caesarean section in Table 4. From these extracts, it is possible to see how the 'telling' of the caesarean experience was often narrated as a series of hurried happenings in which the 'I' seemed

[61] In constructing these poetic extracts, I pulled out pronouns, relevant surrounding words and the phrase 'and then' from sections of transcript text.

to become overwhelmed and over-ridden by extreme medicalisation. "Talked over and owned out" the teller of this story line became "even in speaking…spoken for" (Pollock, 1999:162). Thus, this 'way of telling' reproduced an 'out-of-control' birthing woman, "the absent figure in her own story" (*ibid*, 162) who became, in large part, merely the object of external, abstract procedures, techniques, activities and medical interventions. As Frank (1995:103) notes, "the chaos narrative is told when 'it' has hammered 'me' out of self-recognition".

Table 4: Poetic representation(s) of a 'chaos' telling within caesarean stories

I was like incredibly calm I mean I was I was very calm *and then* and then they give you and then you can feel them putting this needle in but there's no pain and then I was like I'm like and then the thing was over so quickly and then they they took her out they said and then (Sara Trump)	they took me and then and then I saw they had and then I was starting to stress I I'm fine and then they had to then I think I did but then I think it was so quick and then (Ilse Van Rooyen)	and then he injected it then he did the spinal and then and then I was in and then I started going numb and um then and then they covered me and then and and then and then they lifted him out I was relieved I heard I didn't know and then suddenly they lifted him up and then (Hannalie Botha)

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In the case of caesarean narratives it is 'they' rather than 'it' which seem to work to largely obliterate the birthing woman from her own experience or story. Far from this being experienced as 'no big deal' or perfectly 'fine' (i.e. the restitution narrative), the chaotic story line often reproduced a birthing women disturbed and disconnected by a procedure in which she became severed from her body. Thus, when 'telling' the experience of caesarean section, *all* of the women spoke of it as 'weird' or 'strange'. The severe *disconnection* experienced during the caesarean was often expressed through metaphor. Thus, some women spoke of the caesarean as "you're living in a movie (…) it's surreal" (Caroline Kohler), "it's like you're basically not even there" (Janine Le Roux) and "it felt like I was watching a movie (…) I wasn't there" (Hannalie Botha). One other woman referred to the caesarean as like being "on stage (laughing)" (Lola Cronje). Pervading

this mode of telling was thus *a sense of detachment*, of being *an observer* and not a participant in the birth. Thus, as opposed to being 'there and present to', some women spoke about caesarean birth as if they were *absent and missing* from the experience. For women who had very low expectations of the birth experience, this was not constructed as an issue or a problem. However, for someone like Hannalie Botha, who had 'expected' to be 'awake and aware' and part of the whole birth situation, this detachment was experienced as incredibly disappointing. Apart from being disconnected and detached from the birth experience, women also narrated an extreme form of fragmentation during caesarean birth in which the body was broken into disparate, unconnected parts: some of which (generally the 'upper' body) could be felt and other (lower) parts which 'went dead'. The result is that women spoke of feeling "like a piece of meat" (Caroline Kohler) and "like a dead pound of (*) flesh" (Hannalie Botha). The birthing body thus became, in a confirmation of patriarchal myths: brute, immanent, uncreative and inert *matter*. However, while evidencing similar themes of fragmentation as the (non-elective) caesarean birthers interviewed by Emily Martin (1987), none of the stories that I gathered contained the images and descriptions of forcible violation (e.g. rape, crucifixion, evisceration) that Martin found. This is unsurprising considering that birth via elective caesarean (as opposed to emergency caesarean) has generally been found to be well tolerated and associated with high levels of satisfaction (Schindl *et al*., 2003).

In telling the caesarean experience, women were also uniform in speaking about the paralyis of their 'lower bodies' after the caesarean as *awful and horrible*.

> Caroline: …you, you can't get up, you can't *move*, so you feel a bit (*) terrible because you've got everybody opening, prodding, looking, checking, people pulling your boob out and baby stuck on and getting a voltarin [injection] up your bottom and, it's just *terrible* (both laugh) (Caroline Kohler, interview two).

> Sara: …I was numb for like, I think it was eight hours afterwards (R: hmm) which is not great (R: no, no) like you just lie there and you've got this catheter in, and all of that, which is weird, I mean they come afterwards and they like, you know, move your legs around and you think like, 'Whose legs are those?' (R laughs) you can't, you cannot feel a thing, you feel like you're in this dream (…) it's just very weird (Sara Trump, interview two).

While constructing the immediate post-caesarean experience as 'weird', 'terrible' and 'not great', evidenced in the above extracts is also the tendency for caesarean birthers to describe the experience as if it had happened to a more distant, generalised 'you' rather than the more personal, immediate 'I'. This might be a way of (discursively) distancing the self from an experience of disconnection and, at times, degradation. Thus, while caesarean birthers were extremely insistent about constructing 'natural childbirth' as a horror and humiliation story,

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replete with uncontrollable, bleeding, torn and stitched bodies in interview one (see chapter six), within the 'narrative of disruption' the experience of caesarean birth was itself often told as horrible and humiliating. For example:

> Sara: …like you *bleed* quite a lot (R: hmm) and like some woman comes in and like changes your panties and your pads and you just feel like, 'Oh my god!' (R laughs) 'This is *really*, *really* weird', I think there were actually two of them because they need two, the one lifts this leg and they like wash you down there and the whole thing, it's kind of weird (Sara Trump, interview two).

> Hannalie: …the worst of it, is that I couldn't move, for a whole day I had to lie in the same position, when they had to move me, they had to like physically, two people had to move me onto my side and back, because you can't move, it's too sore (R: hmm) and you're lying there without any underwear, they put these linen-savers between your legs, and it's bleeding, it's *horrible* (Hannalie Botha, interview two).

Thus, *riding with* the restitution plot, a narrative in which everything was constructed as 'all fine', was an adjacent, contradictory story line of disruption which reproduced the caesarean experience as awful, disconnecting, weird and chaotic and marked by a series of horrible events, all 'tumbling out' one after the other. While many of the participants had chosen an elective caesarean because they wanted to 'be in control' (see chapter six), many described caesarean birth itself as an experience of being 'out-of-control'. Thus, Lola Cronje said, "it's like being out-of-control, you want to move but you can't (…) it's horrible" and according to Hannalie Botha:

> Hannalie: …the whole thing about it that wasn't nice for me was the fact that I couldn't control my body, because they had to physically lift me, and I was a <u>dead</u> pound of (*) <u>flesh</u> you know (R: ja), you, there's no feeling whatsoever (…) (Hannalie Botha, interview two).

For Hannalie Botha, the caesarean was also experienced as terrifying and as a procedure in which she felt 'frightened' and wondered if she was going to die. Furthermore, it becomes evident from the way in which she narrates caesarean birth that the body produced in and through caesarean stories is often an isolated and unconnected *monadic* body, unable "to find recognition and support for the body's pain and suffering" (Frank, 1995:103). Thus, Hannalie constructs a story in which she lies exposed and immobile on a surgical table, feeling terrified, 'out-of-it', drugged, awful and "like I had a bottle of wine"; significantly, according to her narrative, she never communicates these feelings of distress and terror to anybody around her. Instead, she lives her horror utterly *alone*. Other women (e.g. Karin Miller) constructed similar 'pictures' of the caesarean experience in their stories. However, at the same time, women continued to also speak in a voice that reiterated that 'it was all fine'. In order to *demonstrate* the ways in which the story line of disruption worked in a constant and contradictory conjunction with an over-arching

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restitution narrative, I present, in the following section, a narrative poem constructed from the story of Hannalie Botha.

A narrative tension: chaos and restitution within caesarean stories

In order to show graphically the dynamic interplay between contradictory story lines within stories of caesarean birth, I include below a poetic representation of the different 'voices' that jostle and compete within one of the narratives (Hannalie Botha). In this representation, I have concentrated mostly on 'pulling out' the 'I' voice, the 'they' voice and any instances of a chaotic-like 'and then' phraseology (denoting the possibility of a voice of disruption or chaos). The words used are all Hannalie's and proceed according to her own narrative order.

I was very excited
ja
I was never nervous
I was just excited
I'd never thought
I'm having an operation
I just thought
I'm having a baby

and then
we booked in
and
and then
they said
then they come in
and they
and they
in between
I was
I was
having a birthday

I was
I was
and then
and then
and they said
and then
and then um
and ja
then

I started getting very excited
and then
they came
they put me on the trolley

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they took me
and then
they said
and then
and then
he injected it
then he did the spinal
and then
and then
I was in

and then
I started going numb
and um
then
and then
they covered me
and then
and, and then

I didn't know
I mean
I started going numb
(you go numb immediately)
I was under
I was going
I was
I went numb
I thought
(you start feeling numb)
(you can't)

I could
I could
but
but
I was
I couldn't
I couldn't feel

and then
I couldn't control
I was a dead pound
of flesh
and…
<u>anyway</u>
but that was fine
it's not painful at all
it's just
it's weird

and then
I think
I might
I felt like

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I started feeling sleepy
I thought
I'm not
I want
I'm completely aware
I can talk
but
I'm feeling
I had a bottle of wine
and (*) and
my breathing
um (*)
I was breathing
I was like
it felt like
I was watching a movie
I was watching
I wasn't there

I won't do it any different
I'll still do it
I'd still rather do that
um
I now can know
I've been through it
but everything was fine

I said
I can't
at all
I would
but I didn't
<u>at all</u>
I didn't feel
<u>anything</u>
<u>nothing</u>
I didn't feel
at all

I must say
I dunno
I was a bit out of it
I think
I dunno

um
I could talk
but
I felt like
I'm breathing
slower and slower

I'm thinking
'am I gonna die?'
'am I gonna be okay?'

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(laughs)
but everything was obviously fine

and then
they lifted him out
I was relieved
I didn't
I heard
I didn't know
and then
suddenly
they lifted him up
and then
I only saw
I knew

and I looked
and
I dunno
I looked
it didn't feel like
it was my baby

I looked
I thought
I don't know
I said
'oh cute'
I said
I think
I think
I said
'oh cute'

I was like looking
I smiled
and then
and then
and then
I could
I looked at him
I felt so weird
I felt like
I dunno

it was a very fine procedure
I mean
I was glad
I was
I was

but um
ja
I dunno
it felt like

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I was watching
I mean

and then
they took him
and then
I was relieved
I didn't want
I was not coping
I didn't feel

I was feeling horrible
there was no pain
I was
everything was fine
they said
I recovered

I started shaking
I started shaking
I didn't like that
my body
went into shock
it was fine
I was just shaking
I wasn't cold
I was just shaking

I just wanted
to become
a human being again
you know

I couldn't move
I had to
(you can't move)
it's too sore
(you're lying there)
it's bleeding
it's horrible
I thought
I dunno
I'm gonna
I'm immobile
I couldn't move

and then
I
the next day
I got up
it was nothing
I realised
I got up
it was fine
I was fine

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I walked
I put
I washed
I got
I got up and out
I was fine

I fed him
I changed him
it was fine
I got up
I felt better
I could
I looked
I spoke
it dawned on me
I requested
I said
I wanted
I was
I went

I
I
I said
I think
I took him home
<u>but I was fine</u>
I was fine.

In this poetic version of Hannalie's story, the constant movement between two main story lines, namely: 'it was fine' (restitution) and 'it was terrifying and awful' (disruption) hopefully becomes clear. All of the caesarean stories were structured by a similar *narrative tension* (albeit to different degrees) between these competing and contradictory narratives. This tension can be related to a broader struggle that Ochs & Capps (2001) have identified as present within narrative in general, namely: the tension between the desire for a coherent, seamless and culturally recognisable story line and the desire (or need) to adequately try and re-capture the complexities and contradictions of lived experience. In the case of elective caesarean stories, women were often torn between wanting to produce a story which confirmed the 'rightness' of their birth choice (i.e. the restitution narrative) and wanting to 'tell' the complexity of their experiences. However, the ways in which the two story lines 'resonated' with one another differed across women's stories.

For example, in the case of Hannalie Botha above, the two story lines created a kind of unbreachable gap which was never finally 'sutured' within her 'telling'. In Hannalie's case, the 'gap' between the two story lines was also exacerbated by the further gap or disjuncture between her expectations and the reality of the birth experience. As she says early on in her story, "I'd never thought about it like I'm having an operation, I just thought (…) I'm having a baby".

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However, Hannalie finds to her disappointment that the birth is as much about a traumatic and frightening 'operation' as it is about 'having a baby'. Founded on *a loss* of the experience of joy and bonding that she had desired and anticipated, but nonetheless wanting to confirm the 'rightness' of her choice, Hannalie's story is built upon a disjuncture that is never 'stitched together' in her telling. The 'trouble' in her story is that her expectations are not met; however, because Hannalie is intent on legitimating the 'rightness' of her birth choice, her story never provides any hypothesis or reasons why expectations and reality were mismatched. There is thus a gap in the causal chain; the narrative does not 'add up'. Other stories (in which expectations are not met) might, for example, blame the medical profession or denounce caesarean birth entirely. In Hannalie's narrative there is no attempt to 'stitch' or 'suture' the expectations – experience disjuncture. As a result, "there is a hole in the telling" (Frank, 1995:102) that is never resolved. While the disjuncture between the restitution story and a chaos-like 'telling' functioned as a tension within all of the narratives, the sense of 'something missing', a hole in the narrative or an 'untellable gap' was strongest in those stories in which desires, expectations and hopes had not been fulfilled (e.g. Hannalie, Karin, Linda). In stories where women had less defined expectations or where they simply always wanted the whole experience 'over and done with', there was less sense of something lost or grieved. However, the contradictory narrative tendencies of restitution and chaos remained present in all 'tellings' of the caesarean birth experience.

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Selves and subjectivities in caesarean stories

What kinds of subjectivities and selves were reproduced within women's stories of caesarean section? While home-birth narratives engendered (and danced between) three main forms of birthing subjectivity, namely: an absent subjectivity (clockwork story), a unified body-self (lived birth) and a split subjectivity (undecidable birth), caesarean birth stories seemed to work to produce either an *absent* subjectivity (restitution narrative) or a *disembodied* subjectivity. In the restitution narrative, in which everything is narrated as 'all fine' and in which the caesarean is constructed as a minimal and insignificant disruption, there is little space for the articulation of an *insider's view* of the caesarean experience. Just as the clockwork narrative functioned to erase the complex "internal negotiations" (Adams, 1994:15) and paradoxical subjectivity of the home-birthing woman, the restitution narrative worked to 'smooth over' the conflicts, fears and disappointments that many women experienced in relation to caesarean birth. This narrative also reproduced a univocal, coherent and immutable self that remained unchanged and unaffected by the birth experience. Furthermore, the birthing woman does not emerge as a heroic self in and through the restitution story line nor is she the active protagonist or central agent of the narrative.

Instead, it is medical science that emerges as the central actor or hero of caesarean birth when told as a restitution narrative.

While the restitution narrative produced, for the most part, an absent or missing birthing subjectivity, the story line of disruption 'brought into being' a disconnected, disembodied and disassociated subjectivity. While such a 'disembodied' subjectivity is clearly related to the 'split subjectivity' engendered in home-birth narratives, it is also, in many respects, quite different. Most importantly, while the 'split subjectivity' of undecidable (home) birth was usually not Cartesian (i.e. a split between a body and a mind), the disembodied subjectivity created by caesarean birth was always told as a straight body–mind split. In the case of home-birth, most participants weaved a subjectivity split or fractured between *an embodied self* and the *body-in-labour*; according to Akrich & Pasveer (2004) this does not amount to a Cartesian dualism. In stories of caesarean section the very *possibility* of *an embodied self* was obliterated by medication that 'deadened' and paralysed the body. As a result, the woman birthing via caesarean section approximated an extreme and inescapable form of body–mind fragmentation. She was, quite literally, 'stuck' and 'trapped' in a mode of disembodiment and had little to no way of constructing *a form of embodiment* during the birth experience. According to Akrich & Pasveer (2004), alienation in childbirth results when there is no means whereby the birthing woman can construct or achieve an "active dichotomy" (pp. 80) between an embodied self and the 'body-in-labour'. In caesarean birth, the embodied self and 'the body-in-labour' are both completely and utterly *obliterated* leaving only a detached and disembodied 'mind' or 'self'. As a result, following the logic of Akrich & Pasveer (2004), birth via caesarean section is potentially a profoundly alienating experience. However, all women do not experience this potential alienation in the same way. A woman's response to caesarean section depends, in large part, on whether she has constructed childbirth as "a place for personal investment" (*ibid*, pp. 80) or not. For women who do not regard birth as a site of meaning, identity or 'personal investment', caesarean birth is often *not* experienced as alienating, distressing, traumatic or disappointing.

A brief summary

This chapter has provided a detailed narrative analysis of the ways in which home-birthers and elective caesarean birthers *told* stories about childbirth. Both sets of stories were shown to be fundamentally embedded and structured within over-arching *medicalised* story lines (i.e. clockwork birth and the restitution narrative). In these dominant (outside-in) narratives, there was little room for the articulation of an insider's subjective point of view *vis-à-vis* the birth experience. Thus, an 'absent' birthing subjectivity was reproduced by 'tellings' positioned within

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these narratives. However, at the same time, there were also always *narratives of disruption* working within the stories of both home-birth and elective caesarean section. These 'narratives of disruption' usually emerged from the embodied and emotional 'lived experience' of birth itself, working from the 'inside-out' but always operating *in dialogue* with cultural discourses, genres and storied metaphors. In these 'narratives of disruption', birthing subjectivity emerged as complex and paradoxical and in the case of home-birth, potentially undecidable. Thus, in home-birthing stories, the subjective experience of birth was usually told as a *fluid movement* or *process* between a holistic body-self unity and a split and exploding subjectivity. In the case of caesarean birth, women's narratives produced a disembodied subjectivity, which was often experienced as disturbing and in some cases, as frightening and alienating.

This chapter has thus (hopefully) served to illuminate the rich and complex subjectivities that are potentially 'lived' and experienced via childbirth. While we can only ever access 'experience' in and through stories, discourse and other acts of language, a Kristevan theoretical frame has powerfully taught us that the split between corporeality and discourse is false and that the fleshy, experiencing, sensual body always makes its way (sometimes unbidden) into language. In my analysis of birth stories, it hopefully became clear that 'the body' often speaks its own (often disruptive) story in, through and between symbolic, coherent and rational story lines.

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Extracts from 'Natural birth'

Toi Derricotte in Chester (1989:115)

i felt something pulling inside, a soft call, but i
could feel her power. something inside me i could go
with, wide and deep and wonderful. the more i gave
to her, the more she answered me. i held this conversation
in myself like a love that never stops. i pushed toward
her, she came toward me, gently, softly, sucking like a
wave. i pushed deeper and she swelled wider, darker when
she saw i wasn't afraid. then i saw the darker glory
of her under me.

why wasn't the room bursting with lilies? why was
everything the same with them moving so slowly as if
they were drugged? why were they acting the same when,
suddenly, everything had changed?

we were through with pain, would never suffer in our
lives again. put pain down like a rag, unzipper skin,
step out of our dead bodies, and leave them on the
floor. glorious spirits were rising, blanched with
light, like thirsty women shining with their thirst.

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CHAPTER 8

Reflections, implications and 'imaginings'

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> …birthgiving is a dramatic physical event soon out of sight or in the footnotes.
> (Sara Ruddick, 1994:36).

> To face the fundamental ambiguity of existence is to live authentically…
> (Toril Moi, 1994:176).

> What happens when we think of [birthing]…as an intrinsic value, and describe it less as a process of producing a baby and more as a way of being-in-the-world with uniquely interesting characteristics?
> (Iris Marion Young, 2005:10).

In this thesis, I have covered complex, substantial and detailed grounds, weaving together historical, theoretical, popular, poetic, feminist, methodological and scholarly literatures. Along the way I have also detailed and wrestled with many dilemmas, shades of grey and theoretical nuances. Furthermore, the voices of the women interviewed for this study continue to reverberate, at times complicating theoretical and political issues. In this final chapter, it is however finally time to lay aside details and dilemmas and succinctly present the core arguments, significance and implications of this lengthy, multivocal and fine-grained dissertation.

It is germane, at this point, to warn the reader that it will not be my purpose within this chapter to neatly stitch together all of the convoluted strands of argumentation that have emerged within this thesis. While the desire for "nugget[s] of pure truth" (Woolf, 1928/1945:5) continues to haunt me, I nonetheless agree with Patrice DiQuinzio (1999:247) that studies and theories of birth and mothering "will inevitably be characterised by inconsistencies and paradoxes". This should not be read as a nihilistic statement or as a convenient attempt to escape accountability;

rather, in line with the key theoretical thrusts of this thesis, I believe that the acknowledgement of contradiction, ambiguity and paradox open up strategic spaces for the articulation of alternatives. This chapter will thus try and avoid final conclusions and definitive findings; equally it will also try and resist the trap of becoming (once again) mired within sticky (and irresolvable) 'dilemmas'. Instead, I hope to use this space to haul out the central arguments of the thesis, reflect upon the potential significance of studying childbirth and consider the theoretical and political implications of my study.

Summary and reflections

This thesis was born out of a sense of feminist outrage engendered by reading about the disempowering conditions in which many women give birth to their babies. Through this research journey, my outrage has been tempered and complicated (but not dissipated) by further reading. Thus, for example, I became aware of the profound class, race and geopolitical factors impacting upon the ways in which different women across the globe experience childbirth. Copious reading also enabled me to see that most studies of childbirth have concentrated on so-called 'women-in-between' (Davis-Floyd, 2003), that is: middle-class women who hope to have a 'natural' birth in the hospital. Women opting for the more extreme choices of home-birth and elective caesarean section have been largely ignored in the literature. I found the 'acts of resistance' exercised by these particular women analytically intriguing and thus decided to study agency in relation to childbirth by concentrating on these two outlier groups.

Along the way, however, I learnt that 'agency' is a theoretically loaded concept that is often implicated in problematic, phallocentric theories of subjectivity. Thus, instead of showing why some women were able to exercise 'agency' in relation to birth and others seemingly were not, the very concept of agency itself has become 'troubled' in and through this thesis. I will thus be ending this dissertation on a note far removed from my original intentions, beliefs and purposes. Far from shedding light on 'why' home-birthers and elective caesarean birthers transgressed or subverted the system, this thesis has complicated the very concepts of resistance, transgression and agency by showing the complex and paradoxical movements *between* resistance and collusion displayed by both sets of women.

Over a long process of writing, reading and thinking, this thesis has thus evolved to become something *other* than what I originally thought it would be. Following DiQuinzio (1999) and taking up a critique of individualist models of the self has dramatically changed the shape, argument and path of this piece of writing. As I grappled with complex theoretical feminisms, including materialist, post-structuralist and 'French' feminisms and reassessed the substantial

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body of (largely feminist) birth studies conducted over the last thirty years, I began to see that most of these studies (quietly) assumed an individualist model of subjectivity. Along with this model of the subject came many problematic binaries, including distinctions between the individual and the socio-cultural, ideology/structure and 'experience' and mind and body. In chapter three, I provided an extensive review of the literature showing how birth studies have mirrored individualist, difference and post-structuralist tendencies in feminism. I argued, however, that regardless of theoretical orientations, most birth studies have continued to rely on an underlying concept of the self derived from an individualist tradition. According to DiQuinzio (1999), it is impossible for feminist researchers to adequately approach, study or theorise maternity within an "individualist ideological formation" (pp. xii), which she argues is closely linked to the reproduction of both capitalism and patriarchy. Furthermore, within an individualist paradigm, in which subjectivity or 'consciousness' is understood as disembodied, independent of the 'other' and ontologically prior to or apart from culture, ideology and socio-material conditions, the thoroughly embodied and inter-relational subjectivity of the mother always risks becoming invisible (*ibid*).

While individualist modes of feminist struggle for women's rights to autonomy and choice have clearly been necessary and indispensable, the wholesale adoption of such a model of subjectivity *vis-à-vis* childbirth studies is dangerous and politically limiting. As I argued in chapter three, with the shift away from macro-level analyses of birth to studies of birthing agency, increasing numbers of birth researchers seem to be championing 'choice' in relation to childbirth practices. This has, in effect, also become a discernable cultural story line in relation to childbirth (see chapter two). While I (of course) do not argue against the value and importance of the individual's right to choose, this thesis has, in many respects, tried to explore childbirth beyond the realm of the individual self. I am well aware that this move might not always have been popular with my readers.

Attempting a study of women's birth stories that moves beyond an individualist framework was not an easy task. However, I knew from early on in the writing process that the central motif of this thesis was to be birthing subjectivity. Thus, while wanting to move beyond the level of the individual, I also (perhaps paradoxically) wanted to highlight subjectivity. Ironically, it became clear that despite the widespread adoption of an individualist model of self, psychological, feminist and midwifery studies of childbirth rarely painted a convincing portrait of birth from the birthing woman's 'internal' or subjective point of view. Taking seriously the argument that maternal subjectivity is incompatible with an individualist ideology, this absence becomes somewhat understandable. Although numerous studies have focussed on women's 'experiences' of childbirth, underlying this research is often "the desire for a subjectivity that is both coherent,

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unified, and stable and capable in principle of occupying any subject position" (DiQuinzio, 1999:239-240). According to DiQuinzio, the feminist project of affirming and interpreting women's 'experiences' is often saturated with a "desire for individualist subjectivity" (pp. 240).

In my analysis of childbirth scholarship, I also noticed that going hand-in-hand with an individualist model of the subject was generally a tendency to follow realist modes of representation in which the stories and talk of women were reproduced as static, uniform and decontextualised blocks of quotations. The messy, fluid and often contradictory elements of spoken discourse often seemed to be 'ironed out' (Stephens, 2004) and 'made-to-fit' a model of the subject as internally coherent, bounded and fixed. There also seemed to be a radical disjuncture between qualitative representations of women's subjective experiences of maternity and childbirth and literary/poetic women's writing. Thus, by reading autobiographical writings such as Phyllis Chesler (1979) and Adrienne Rich (1976) and collecting pieces of poetry written by women about their experiences of birth and mothering, the ambivalent, paradoxical and contrapuntal nature of maternal subjectivity became audible as an insistent refrain that was simply missing from most qualitative accounts. It therefore became evident that in order to move beyond the level of individualist analyses, a theoretical/methodological overhaul was necessary.

Before reflecting on the process of searching for an alternative theory-method, I want to first make a few comments about the institution – experience impasse within both studies of childbirth and feminism more broadly. The tendency to focus *either* on 'experience' *or* discourse, ideology and macro-structures, has been predominant within studies of birth and motherhood (Cosslett, 1994; Blum, 1999). In large part, this is not surprising given the difficulties involved in attempting an analysis that aims to both affirm and respect women's 'voices' and 'experiences' *and* demonstrate how these self-same 'voices' and 'experiences' are always inextricably interlaced with ideologies, socio-cultural contexts, dominant discourses and power relations (Cosslett, 1994). Sticking to *either* one of these 'levels' is far safer than trying to develop an analysis encompassing both. In this thesis, I have tried to look both at 'experience' and socio-cultural contexts / ideologies. I do not claim that this attempt has been entirely successful and acknowledge that these 'levels' continue to exist in tension throughout the thesis. Thus, I am well aware that my 'ideological' analysis in chapter six is likely to induce moments of discomfort for the feminist reader who could be offended by the level of apparent criticism directed at the 'voices' of women interviewees. I hope that this analysis will not be read as an attack against individuals, but will be understood as an attempt to look beyond the immediate content of what women are saying and interrogate the (ideological, material, cultural) terms within and against which they necessarily must speak.

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I have thus argued in this thesis that in both macro-level studies of childbirth (e.g. Haire, 1972; Arms, 1977; Jordan, 1993; Rothman, 1982) and qualitative studies of women's birth 'experiences', the complex, embodied subjectivity of birth is often absent. In large part, this is often a consequence of working with an individualist model of the subject that is often ultimately complicit in the reproduction of selves compatible with technocratic, patriarchal capitalism. Thus, in order to situate my study outside of an individualist model, I had to search for an alternative theory of the subject. In chapter four, I presented various feminist alternatives to theorising maternal subjectivity, including the work of Simone de Beauvoir, Iris Marion Young, Adrienne Rich, Julia Kristeva, Luce Irigaray and materialist feminists such as Nancy Hartsock and Maria Mies. Most of these theories (barring the work of the materialist feminists) were shown to represent the pregnant, birthing or mothering woman as a split and paradoxical subject. Theorists differed, however, in the degree to which this 'split subjectivity' was embraced as transgressive or denounced as oppressive. Surprisingly, feminist researchers of childbirth have not engaged extensively with this rich body of theoretical work and have largely ignored the complex portraits of maternal and birthing subjectivity sketched by these theorists.

In chapter four, I thus attempted to cover the complexities of these theories, working tentatively towards developing a theoretical mix that was best suited for an analysis of birth stories and subjectivities. Arguing that no one theory stood as adequate by itself, I put forward a hybrid theoretical framework drawing on insights from almost all of the abovementioned theorists. Thus, for example, from Beauvoir's situationist theory, I harvested the notion that bodies, subjectivities and socio-cultural contexts could never be explored in isolation from one another; subjectivities were inextricably embodied, cultural, intersubjective, ideological and historical. From the work of Luce Irigaray, I drew the crucial insight that language itself is infused with patriarchal agendas and is phallocentric, that is: modelled on the morphology of the male body (Grosz, 1989); furthermore, I have also held onto her argument that women lack an adequate language within which to represent their difference. Borrowed from the writings of materialist feminists was the recognition of the critical importance of activity (practice), ideology and material conditions in the reproduction of subjectivities.

However, it was the theory of 'the speaking subject' developed by Julia Kristeva that proved to be most important in the development of this research study. In my view, Kristeva's theory manages to produce a non-dualist account of the subject in which bodily drives, discourse and socio-cultural constraints intertwine to produce inherently contradictory and paradoxical subjectivities that are precariously "poised between the practices of body, society and text" (Boulous-Walker, 1998:107). By conceiving of discursive/subjective practices as always involving the unstable, dialectical play between semiotic (potentially transgressive corporeal

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energies) and symbolic (orderly, rational, socially agreed upon meaning) modes, the binary distinction between 'the body' and discourse is thoroughly troubled. Thus, according to a Kristevan theory, a neat dividing line between bodies, culture and language can never be clearly drawn; the subject thus materialises as a "lived contradiction" (*ibid*, pp. 107) constituted by heterogeneity, movement and indeterminacy. Furthermore, the apparent unity and coherence of the subject is always continually ruptured by bodily contradiction. For Kristeva, the pregnant, birthing and maternal body-subject functions as a prototype of the 'subject-in-process', serving to potentially expose the fallacy of individualist subjectivity. As a result, maternal subjectivity is put forward as potentially transgressive and disruptive, threatening to dissolve logocentric binary distinctions. Kristeva also portrays the maternal subject as an exemplar of an *ethical* subjectivity in which the boundaries between self and other become fluid and indistinct (Mullin, 2005).

It was, however, Kristeva's theory of subjectivity as *both* an infolding of socio-cultural scripts and ideologies *and* an outfolding of bodily rhythms, drives and energies that has come close to serving as *the* theoretical template for this thesis. Her theory enabled me to make (some) sense of the continuous eruptions that I heard in women's talk about birth: a myriad of laughters, rising pitch, whispers, guttural noises, hurried words, slowly uttered words, silences; it also gave me a way of trying to include the fleshy, sensual body *within* my analysis of birth stories. The difficulty of trying to 'get to' the fleshy or 'real' body within social science research has been widely cited. For example, according to Arthur Frank (1995:27) "no satisfactory solution has been found to avoid reducing the body to a thing that is described" within qualitative studies. Feminist writers also repeatedly criticise the work of corporeal feminists for reducing 'the body' to a text that is not 'fleshy' enough (e.g. Keane & Rosengarten, 2002; Howson, 2005). Amazingly, it seems to me that Kristeva's work, which offers some ways through this body – language impasse, has been largely neglected by both non-feminist and feminist work on embodiment[62].

Kristeva's work did not only serve as a *theoretical* template for this thesis; it also became intertwined with my *methodological* approach to analysis. By this I mean that my analysis was largely enabled by the theory of the subject underpinning the thesis. Furthermore, Kristeva's distinction between semiotic and symbolic modes also shaped the way in which I transcribed women's talk and therefore profoundly affected the final analysis. Thus, through doing this thesis I have finally come to understand what researchers mean when they call discourse analysis a 'theory-method' (e.g. Potter, 1997).

[62] For example, in Alexandra Howson's (2005) recent book on embodiment, in which she discusses the work of Michel Foucault, Rosalyn Diprose, Margrit Shildrick, Moira Gatens, Elizabeth Grosz, Luce Irigaray, Judith Butler and Vicki Kirby, Kristeva's work is almost entirely absent, giving the astounding and erroneous impression that Kristeva has nothing to say about 'the body'.

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The theoretical frame within which this thesis is embedded, which draws predominantly on Kristeva's post-structuralist theory of 'the speaking subject' and a more materialist focus on ideology and material contexts, has thus translated into concrete methodological strategies. I have therefore 'read' or analysed women's talk by paying attention to two key levels of disruption that I believe are potentially at play within subjects and texts. The first level of disruption that I looked for was material and ideological contradictions. Here I drew on the work of materialist feminists such as Rosemary Hennessey (1993a) and Teresa Ebert (1996) who argue that contradictions within texts are symptomatic of wider struggles happening on a material or 'real-life' level. Thus, in chapter six, I presented an ideological analysis in which I focussed on the material contexts and ideologies enabling and constraining women's talk about making birth 'choices'. Here I openly adopted a more 'materialist' or 'realist' position, in which I assumed that there *are* structural and economic 'realities' existing beyond the matter of 'the text'.

In this chapter, I showed how the predominantly middle-class, 'white' and Eurocentric positioning of interviewees framed the ways in which they talked about and made birth 'choices'. The local nature of 'the sample' was thus demonstrated, hopefully showing the *particular* material and socio-cultural locations within which the talk and stories analysed in this thesis were embedded. This chapter also tried to trouble the very notion of 'choice', demonstrating how choices around birth are always situated and ultimately paradoxical. Thus, *both* home-birth and elective caesarean section were shown to be far from simple and unproblematic 'acts of resistance'. Instead, both sets of women were subject to multiple and sometimes contradictory ideological positions, which at various times resulted in shifting patterns of collusion and transgression. This analysis thus demonstrated that there is no *pure* or stable space of resistance or transgression, but that subversion itself is often paradoxical. Once again, this should not be read as a statement of nihilism; the *political* implications of this finding will be discussed more fully towards the end of this chapter.

Although chapter six did not make subjectivity a direct focus, this chapter did in fact demonstrate a great deal about subjectivities. Thus, women's talk/subjectivities emerged as shot through with a conflicting stream of ideological voices, which constantly worked to interrupt and disrupt their coherence as unitary, stable subjects. A Kristevan view of the subject as a dialectical movement or fluid process was borne out by my analysis, in which women emerged as complexly and precariously positioned *between* cultural scripts, hegemonic ideological images, bodily energies and socio-linguistic constraints. The ways in which subjectivity materialises as the motile and unstable infolding of material contexts, ideologies and socio-cultural narratives, was hopefully also demonstrated in this chapter. At the same time, because this infolding always

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manifests as an unstable and dialectical process, its effects are always *overdetermined*[63]. Thus, the resistance to technocracy and patriarchy epitomised by home-birth at times collapsed into collusion with essential motherhood discourses; similarly, the collusion with patriarchal images of women's bodies often represented by the choice to have an elective caesarean section sometimes worked to reproduce resistance to biological determinism and essential motherhood ideologies.

The second level of disruption (to subjects/texts) that I focussed on within the thesis was 'the body' or Kristevan semiotic mode, which was signified by the ways in which women actually went about 'telling' birth. Chapter seven thus explored the ways in which women told stories of home-birth and elective caesarean section. In this chapter, I showed how both sets of women predominantly drew on accepted cultural narratives when telling stories about their birth experiences. For both home-birthers and elective caesarean birthers, a medicalised narrative emerged as the dominant way of telling birth. Thus, for home-birthers, birth was almost always first told as a clockwork narrative, signposted by medicalised norms, measurements and timetables; for caesarean birthers, birth was predominantly situated within a medicalised restitution narrative, in which drugs and medical experts were positioned as responsible for making them 'as good as new'. In my analysis of home-birth stories, I also showed, following Pollock (1999), that cultural narratives often work, not only as retrospective sense-making devices, but also potentially as cultural scripts that are inextricably *part of* women's actual, embodied birth experiences. This complicates any view that women's 'experiences' can ever be accessed in a pure form, free of ideology, power relations and socio-cultural story lines.

I also argued that clockwork birth and restitution birth both essentially represented an *outsider's* or phallocentric view of childbirth. Neither narrative was adequately able to tell the birth experience from the perspective of the birthing woman. Thus, in both cases, telling birth within these culturally accepted story lines invariably produced an *absent* birthing subject. While it was shown that both of these dominant narratives were *used* by women to either (in the case of home-birth) make the potentially chaotic birth experience intelligible or (in the case of elective caesarean section) justify the choice to give birth surgically, these narratives nonetheless ultimately work to deny the complex human subjectivity of the woman giving birth. In my interviews with both sets of women, it often (but not always) seemed as though I had to actively encourage them to try and tell their birth experiences outside of these cultural narratives. As Pollock (1999) insightfully points out, women are probably rarely (if ever) asked what it *feels like* to give birth. It is thus not surprising that many women tell birth (at least initially) within the accepted cultural recipes that most people want to hear. However, after being initially surprised at

[63] The term 'overdetermination' means that multiple strands of influence (different ideologies, structures, discourses, voices) potentially produce multiple, unpredictable and at times, contradictory effects (Moi, 1994; DiQuinzio, 1999).

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being asked 'what birth actually feels like', many home-birthers went on to weave creative and meaningful alternative story lines of birthing.

In the case of both groups, I therefore identified alternative story lines that worked to disrupt the dominant, outsider's narrative. For both sets of women, these story lines were deeply *experiential* and in the case of home-birthers in particular, strongly *embodied* tellings. In some ways, I read the tension between dominant cultural narratives and alternative story lines as symptomatic of a broader struggle between a desire for narrative coherence (and cultural intelligibility) and a desire to tell complex and possibly contradictory lived experiences. According to Ochs & Capps (2001), it is this tension that is largely responsible for driving human beings to make narratives. The disjuncture between the desire for narrative coherence and the desire to capture the complexities of experience, also points to the notion that embodied, lived experience ultimately remains *irreducible* to discourse, ideology or socio-cultural narratives. At the same time, however, lived experience can never exist in a 'pure' form anterior to language and cultural scripts.

The tension between telling birth within recognisable cultural narratives and telling the experience "as lived and felt in the flesh" (Young, 2005:7) was a strong feature of the stories of both home-birthers and elective caesarean birthers. Thus, riding disruptively between, beyond or alongside the accepted lines of clockwork and restitution birth were often *other* kinds of stories which evoked a powerful sense of 'something more', something which could not be fully contained or disciplined by hegemonic socio-cultural narratives. This 'something' could be variously termed 'the body', 'lived experience' or 'the semiotic', depending on one's theoretical orientation. For home-birthers, there were two key alternative story lines which placed the birthing woman's subjective experience at the centre of the telling, namely: lived birth and undecidable birth. In these story lines, the complex, paradoxical and sometimes ecstatic *embodied birth experience* was centred and the birthing women emerged as the *central agent* of the birthing process. These story lines are extremely significant, offering a powerful challenge to normative birth narratives that erase the subjectivity of the birthing woman and generally work to reproduce childbirth as an event devoid of consciousness, (ethical, personal and socio-cultural) significance or value.

To summarise, this thesis has argued that analyses of birthing subjectivity have been surprisingly absent from the large and cross-disciplinary body of research on childbirth. Conceptualising subjectivity as a complex *infolding* of ideology, cultural narratives and socio-material contexts and an *outfolding* of bodily energies and lived experience, this study has sought to address and begin to correct this absence. In the following section, I briefly reflect on methodological features of the thesis and consider the study's limitations.

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Methodological reflections and limitations

Engaging in a comparative study of the birth 'choices' and experiences of home-birthers and elective caesarean birthers has ultimately helped to prevent me from falling into any *one* comfortable view or position *vis-à-vis* childbirth practices. Originally I decided to study these women because I was interested in exploring birthing agency. Although this plan was troubled and eventually imploded in and through the process of doing this research, the decision to study these two particular groups of women has proved to be a rewarding one. In many ways, these two birthing 'choices' are representative of the sameness-difference tension within feminism. Each 'choice', in a sense, broadly represents a different feminist strategy, namely: (a) throw off the confines of female corporeality and embrace individualist subjectivity (i.e. have a caesarean section) or (b) embrace sexual difference and female procreative powers (i.e. give birth at home without medication). Throughout the thesis, the views, narratives and arguments of each side have been thrown into relief and counterpoised by the other, creating a constant *frisson* or tension, particularly within the analysis chapters. I believe that this has enabled me to provide a fine-grained and nuanced analysis, constantly split between two birthing 'choices' that represent very different paths for feminism. I am convinced that it would have been far more difficult to sustain a contradictory and multi-sided account of birth if I had interviewed only home-birthers or elective caesarean birthers. By focussing on these two 'groups', this study has also helped to fill an important gap in the literature, where studies of the subjective experiences of either home-birth or elective caesarean section remain few and far between.

The decision to conduct pre- and post-birth interviews also proved, in the end, to be an integral part of this study. Apart from allowing me to develop a greater sense of 'rapport' with the women interviewed, it also formed part of the final logic of the thesis in which women's rationale, arguments and talk about making birth 'choices' (discussed in interview one) formed a substantial part of the analysis (see chapter six). If women had only been interviewed *post*-birth, I feel that this aspect of the thesis would have fallen away, largely because the actual birth story would probably have taken up most of the interview. Following the women *through* the pregnancy and birth process also meant that interviews covered aspects of their journeys (e.g. pregnancy, breastfeeding and childcare), which might have disappeared if I had taken up a more narrow focus on only their birth stories. Many studies of birth have looked at retrospective birth accounts, which sometimes date back over several years (e.g. Martin, 1987; Davis-Floyd, 2003[64]; Pollock, 1999; Klassen, 2001a). In addition to being followed through their current pregnancy/birth

[64] Robbie Davis-Floyd includes both retrospective and longitudinal interviewing within her research.

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experiences, women in my study also often reported on retrospective births[65] (usually dating back two to four years). In my view, women provided far more 'raw' and substantial detail in birth stories that were told in the six-week post-birth interview than they did in stories about births which had occurred some years earlier. Given that part of my purpose in this thesis was to explore the fleshy, lively, corporeal energies at play within women's birth stories, it was, I think, ultimately advantageous to have access to the potentially more convoluted, 'raw' and unformed birth stories that are more likely to be told soon after the birthing experience (see Klassen, 2001a).

As mentioned already, the theoretical framework of the thesis informed the ways in which methods of analysis were utilised within the study. Thus, in tune with a materialist influence, the *ideological* effects of narratives always remained a key focus of my analyses. In my endeavour to try and trace birthing *subjectivities*, the methodological strategies of the voice-centred method proved to be very important. While I rejected the realist and individualist framework within which this method is situated, the use of 'pronoun poems' was critical to the development of my analysis. By playing with different modes of representing women's talk (e.g. pronoun poems and narrative poems), I feel that I was better equipped to show the complex and contradictory subjectivities that materialise when women 'tell' birth. However, although drawing heavily on these techniques, the analyses that I made were always carefully interpreted within a Kristevan theory of subjectivity.

What then about the limitations of this study? One major limiting factor is that the women interviewed were all overwhelmingly middle-class and 'white'; as a result this study follows the trend of most international research on childbirth. However, the study's focus on home-birth and elective caesarean section (as potential acts of resistance) made it difficult to *find* participants from other class or cultural groups. In order to compensate for this limitation, I have made a concerted effort within the thesis to critically interrogate the class, race and geopolitical locations within which women's talk was embedded (see chapter six). A further possible limitation is that the two 'groups' of women interviewed were not well matched. Thus, apart from the fact that *more* home-birthers were interviewed, it is also the case that while almost all of the women choosing elective caesareans were first-time mothers, only two home-birthers were. While I certainly concede that it would have been 'better' had I interviewed more elective caesarean birthers, I don't think that the poor match between first-time and multi-time birth experiences made a great deal of difference to my analysis or findings. As with most studies, my final 'sample' was not necessarily 'ideal'; however, it was the best that I could do given substantial time, logistical and practical constraints. Furthermore, I believe that this 'sample' did provide rich

[65]Thirteen of the fifteen home-birthers interviewed had had previous birth experiences while only one of the elective caesarean birthers had.

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and interesting material, enabling a multi-sided and theoretically complex analysis. In the following section of this chapter, I consider in more detail the potential significance of studying childbirth.

Why *birth*? Significance, implications and contributions

"We have no…philosophies of birth."
(Mary O' Brien, 1981:20).

"Of all life's experiences, the moment of birth is one of the most profound…"
(Carol Poston, 1978:20).

People have often seemed bemused when hearing that my doctoral dissertation is about women's *birth stories*. Studying childbirth often doesn't seem like an appropriately 'heavyweight' academic topic and is often scorned by those embroiled in more 'conventional' areas of scholarship. In my view, the marginalisation of childbirth as a serious, fertile site for intellectual, philosophical and theoretical inquiry continues despite the burgeoning flood of research studies being conducted on the topic. Thus, often it seems as though childbirth studies remain sidelined as a kind of 'specialist' area of feminist research, making little impact upon rich and volatile arguments within feminist theory or intellectual debates more broadly. I have therefore often been amazed by the extent to which birth is 'skipped over' or simply left out of studies looking at women's reproductive experiences (particularly in psychology). Thus, for example, as recently as 2006, Jane Ussher has published a book on 'the reproductive body' in which childbirth receives just one paragraph of attention. Perhaps most incredulous is the fact that Ussher herself seems oblivious to this omission and does not even attempt to provide a rationale as to why birth is sidelined within her analysis.

The extent to which both mainstream and feminist psychology have ignored *birthing experiences* as a legitimate area of study is, in my opinion, a reflection of the power of a patriarchal ideology which views childbirth as predominantly (or exclusively) as a biological or physical event, devoid of 'mind', psychology or consciousness. One of the points of departure for this thesis was the powerful insight gleaned from the work of materialist feminists such as Maria Mies and Mary O' Brien, namely: that the belief that birth is an exclusively natural or biological event or "all body and without mind" (O' Brien, 1981:21) is a powerful cornerstone of women's oppression (see Mies, 1986). Unfortunately, many feminists have themselves bought into this belief and have therefore often either avoided the topic of childbirth completely or denounced all female reproductive capacities as inherently oppressive (e.g. Friedan, 1963; Firestone, 1970; de Beauvoir, 1989). Largely because of the undeniably fleshy, corporeal nature of many female procreative experiences (I think here of birth and breastfeeding in particular), many feminists,

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keen on fighting for women's rights as individualist, rational, disembodied human subjects, have preferred to ignore them.

Furthermore, some feminists might argue that birth is a "temporally limited project" (Ruddick, 1994:40) and that it therefore makes more sense to focus attention on experiences such as mothering, pregnancy or breastfeeding, all of which potentially extend over a far longer time period than birth (e.g. see Mullin, 2005). But *is* birth really only "a dramatic physical event soon of out sight or in the footnotes" (Ruddick, 1994:36), a momentary event that is soon forgotten? Pamela Klassen (2001a) would clearly disagree. For Klassen (and her interviewees), childbirth was not "simply a…moment that comes and goes" (pp. 3) but a profound, potentially transformative experience that became inscribed on a woman's body/subjectivity. Several studies have, in fact, found that the experience of childbirth can produce long-term psychological effects (e.g. see Simkin, 1992) in either a positive (e.g. Ogden, 1998) or negative direction (e.g. see Kitzinger, 1992). The point here is *not* to claim that studying birth is a more worthwhile or significant feminist task than studying pregnancy, mothering or breastfeeding but rather to 'trouble' the notion that because birth is "temporally limited" (Ruddick, 1994:40), it is automatically less important. Furthermore, in addition to childbirth potentially being of more personal and long-term significance to the birthing woman than is routinely assumed, my purpose here is to argue that birth is also imbued with wide-ranging ethical, theoretical and political significance.

Indeed, I would argue, following DiQuinzio (1999), that childbirth constitutes *a key site*, particularly for feminism, at which central theoretical concepts are thrown into relief and potentially redrawn. For example, complex concepts such as embodiment, consciousness, experience, narrative, representation, ideology, subjectivity, choice, agency and intersubjectivity are all potentially implicated in explorations of birth; furthermore, studying childbirth also opens up possible spaces wherein these concepts can be challenged and rethought (*ibid*). Thus, I believe that my thesis is not simply or narrowly 'just about birth', but can also be seen as an attempt to think through (but certainly not resolve) a number of crucial feminist concepts.

Perhaps the central conceptual contribution of this thesis has been its illumination of embodied subjectivity. While theoretical work on embodiment and 'corporeal feminism' have been criticised for failing to consider the empirical work on 'the body' done by sociologists and the like (Howson, 2005), there have been very few *studies* that have actually looked at birthing embodiment (see chapter three for exceptions). Even when such work has been done, it has generally failed to engage with the rich body of theory informing recent work on embodied subjectivity (e.g. Sbisà, 1996; Counihan, 1999). In the midst of repeated calls for more 'fleshy' work on embodiment (e.g. Frank, 1995; Davis, 1997; Howson, 2005), by broadly applying a

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Kristevan theory of 'the speaking subject' to an analysis of birth stories, I feel that this thesis has gone *some* way towards showing that the binary split between 'the body' and language is, in many respects, false. Thus, by employing Kristeva's theoretical grid, I have hopefully begun to show how the fleshy, sensual, experiencing body always makes its way into language, continually erupting between symbolic lines. Furthermore, through an engagement with (and analytic application of) feminist theories of embodied subjectivity (see chapter four), this thesis has hopefully demonstrated that talk of 'the body' as a distinct and coherent entity standing *apart* from language, ideology and consciousness is, in many respects, unhelpful and largely theoretically redundant.

In this thesis, I have thus argued and tried to demonstrate that Kristeva's theory of the body-subject offers a unique contribution to attempts to theorise embodied subjectivity and must admit that the widespread avoidance of her contribution continues to astound me[66]. In important respects, I feel that Kristeva's work also offers some strategies for moving beyond the distinction between the inscribed body and the lived body, which has recently been forged within scholarship on embodiment (Crossley, 1996). Many scholars believe that these two models of embodied subjectivity, drawn from the work of Foucault and Merleau-Ponty, are incompatible and mutually exclusive (e.g. Grosz, 1994). At heart, the inscribed/lived body distinction revolves around the question of agency, thus: is 'the body' a docile, passive product of social inscription or an active, engaged locus of meaning? While the work of Foucault and Merleau-Ponty has been groundbreaking and immensely influential, in many respects serving as the groundswell behind the recent 'turn to the body', both scholars ultimately overplay either the passivity (Foucault) or activity (Merleau-Ponty) of 'the body'. Although Margaret McLaren (2002) has recently tried to argue that Foucault's work *does* offer an account of 'embodied subjectivity', her analysis ultimately works to reveal that, at the end of the day, for Foucault:

> The inside is an operation of the outside; the exterior produces the interior by a doubling, a folding, a reflection back on itself (pp. 84).

By employing a Kristevan theoretical framework, I have tried to argue that embodied subjectivity is not only an 'infolding' of socio-ideological forces (as described above) but *also* potentially an 'outfolding' of semiotic, bodily energies, 'experiences' and activities. The 'inscribed body' and the 'lived body' thus both made their presence felt in my analysis of women's birth stories. In fact, far from being mutually exclusive, I would agree with Nick Crossley (1996) that models of

[66] The (feminist) reluctance to engage with Kristeva's work might be related to the psychoanalytic framework within which her work is situated. Furthermore, while her work is clearly concerned with issues central to feminism, she does not herself identify as feminist. Nonetheless, it still astounds me that the work of male theorists such as Michel Foucault and Maurice Merleau-Ponty is far more widely embraced by feminists than the work of Julia Kristeva.

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the inscribed and lived body are, in fact, "mutually informing and complementary…two sides of the same coin" (pp. 99). In this study of women's birth stories and embodied subjectivity, I have thus tried to heed the call made by Crossley (1996:115) for future work "to trace this relational and reversible tension of body-subject and body-power…and to observe and critique their diverse forms and consequences". In this endeavour, childbirth has been my critical site of investigation.

While it remains for future work to provide detailed explorations of the embodied subjectivities reproduced in other critical sites, childbirth has proved to be a particularly powerful point of entry for an exploration of embodiment/subjectivity. Thus, this thesis has demonstrated (some of) the multiple cultural narratives and ideological complexes that work to construct childbirth as a *key site* of complex power relations. The birthing body has been shown to be a prime target for normative and disciplinary ideologies and narratives, which often work to produce docile (e.g. clockwork) body-subjects. However, at the same time, this thesis has also demonstrated that dominant ideological-narratives are always potentially *exceeded* and subverted (however fleetingly). In the stories of home-birthers, the lived, sensuous, thoroughly *embodied experience* of birthing often served as *the source* of alternative imaginings, metaphors and story lines. Even in the case of elective caesarean section, the *lived experience* of surgical birth often worked to *disrupt* the dominant restitution narrative. Thus, although 'experience' is always filtered through cultural story lines, ideologies and images, there is always 'something more' that cannot be contained or fully disciplined by hegemonic narratives; it is in this delicate and precarious gap that the possibility for new visions, alternatives and imaginings exists. However, these alternative imaginings are themselves likely to be infused with contradictions and paradoxes. This does not make them any less important. With this I now turn to a consideration of such alternative visions, as well as the political implications of my study.

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Politics, imaginings and the importance of alternative visions

"How can we speak so as to escape from their compartments, their schemas, their distinctions and oppositions…How can we shake off the chain of these terms, free ourselves from their categories, rid ourselves of their names?"
(Luce Irigaray, 1985b:212).

What then are the *political* implications of this study? And on what grounds can we judge or make conclusions about the different birth choices examined in the thesis? Some might expect that this thesis, which has argued that subjectivity and resistance are both paradoxical and contradictory, would have little to say about politics or alternative visions. I believe, however, that with the

acknowledgement (and embrace) of paradox comes the freedom *to dare* to offer alternative imaginings, largely because the inescapable contradictions of such alternatives are accepted and acknowledged. In this effort to think through the alternative visions represented by home-birth and elective caesarean section, I am guided and inspired by the work of feminists such as Iris Marion Young and Luce Irigaray.

Both home-birthers and elective caesarean birthers reported high levels of satisfaction with their birth experiences. Does this then mean that both types of birth are potentially equally empowering to women? With the recent valorisation of 'choice' as the political answer to volatile questions about medicalised versus non-medicalised birth practices (e.g. see Beckett, 2005), it would seem that the answer is 'yes'. However, as I have argued in earlier sections of the thesis, merely championing individual 'choice' is not an adequate political strategy for feminist childbirth researchers. Throughout this thesis I have tried to move my analysis beyond the level of the individual self and this discussion will be no different. Thus, although I am fully in support of the right of any individual woman to choose what type of birth she would like to have, my 'imaginings' and explorations of alternative visions must take place on a different theoretical/political level. Thus, it is to the level of *representation* that I now turn. Although I am in perfect agreement with the belief that political battles need to be fought on material and practical grounds, I am focussing here on the level of representation because I believe that it is in this area that my thesis has the most to contribute.

Patriarchal representations of women's bodies as abject, lack and 'Other' saturate the cultural imaginary. According to Luce Irigaray, language itself is phallocentric and moulded upon a morphology of male bodies (Grosz, 1989); Irigaray furthermore argues that women lack an adequate discourse within which to express their difference. Taking seriously these arguments, it is not surprising to find that numerous studies have reported that women generally tell birth within a medicalised narrative and from an outsider's perspective (e.g. Martin, 1987; Cosslett, 1994; Sbisà, 1996, Pollock, 1999; Martin, 2003); few studies seem to have found alternative story lines within which women tell the experience of birth (see Klassen, 2001a as an exception). Although women's oppression does not only take place on a discursive level, patriarchal representations do constitute a powerful component of the continued (often subtle) denigration and 'othering' of women. Furthermore, in this thesis we have also seen the powerful ways in which women themselves can come to 'internalise' these images and fabrications. I would therefore argue that intervention on a representational level should be regarded as a crucial and non-negotiable arm of the feminist struggle to construct more woman-empowering birthing practices.

I believe that this thesis has made some steps in this direction. Thus, I have, for example, tried to disrupt the view that childbirth is a process devoid of subjectivity, consciousness or active,

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thoughtful reflection. By demonstrating, via women's birth stories, the profound, complicated "internal negotiations" (Adams, 1994:15) and complex body-self relations that are constructed and deconstructed during childbirth, the widespread belief that birth is 'all body and no mind' becomes exposed as a phallocentric fallacy. Furthermore, I do believe that the home-birthing stories analysed within the thesis potentially contain powerful examples of alternative story lines and begin to give us some sort of idea of what birth might look like articulated within "women-oriented terms" (Grosz, 1989:109).

For example, in the 'lived birth' story line, the birthing woman emerges as a powerful embodied agent *at the centre* of the birth story. Furthermore, in this way of 'telling', childbirth materialises as an 'entangled eros': active, sensual, body-to-body; invoking a world in which touching, feeling, dancing, singing and listening reign over the power of sight, gaze or objectifying eye. In this space the birthing woman is held, massaged, spoken to tenderly, cared for, respected and honoured and her activity is treated as meaningful and valuable. She (the birthing woman) is often reconstructed as saturated with joy, excitement, *jouissance* and complex forms of embodied pleasure/pain. In the midst of 'lived birth' stories, we begin to get some idea of the phenomenology of birth or how birthing feels "as lived and felt in the flesh" (Young, 2005:7). As a result of the cultural hegemony of medicalised, phallocentric and outsider's views, images and representations of childbirth, any story line that can potentially speak from the embodied and subjective perspective of the birthing woman can serve as a significant challenge to patriarchal and technocratic views of birth. Tales of home-birth also often articulated childbirth as an experience of profound undecidability, in which birthing subjectivity was represented as split, paradoxical and ambiguous.

In line with theorists such as Simone de Beauvoir, Iris Marion Young and Julia Kristeva, this thesis has thus made the claim that birthing subjectivities[67] are ultimately complex processes, involving paradoxical, split, embodied, undecidable, dispersed, ambiguous, ecstatic and disembodied body-selves. As a result, birthing body-subjects potentially serve as *a disruption* to an individualist model of subjectivity compatible with the ideologies of capitalism, patriarchy and technocratic control. Furthermore, this study seems to have confirmed the Kristevan view that the maternal or birthing subject is *a prototype* of an embodied subjectivity that is overdetermined and paradoxical. Here it is important to remember that for Beauvoir and Kristeva, contradiction, paradox and ambiguity are the fundamental and inescapable hallmarks of *human subjectivity*, which therefore makes the birthing body-subject potentially paradigmatic of a 'distinctively human' (Held, 1993) subjectivity. Considering that women's reproductive experiences and

[67] Clearly, there is no one 'type' of birthing subjectivity that all women experience; instead, there are a range of body-self relations possible depending on the situational, medical, personal and intersubjective factors affecting particular births.

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childbirth in particular, have long been represented by patriarchal ideological narratives as 'animal' or '*other*' than human (a realm traditionally exclusively reserved for masculine subjects), the articulation of birthing subjectivities as 'distinctively human' (*ibid*) potentially serves as an important disruption of dominant phallocentric representations. At the same time, it remains critical *not* to over-valorise birth as a source of transgression and transformation[68]. Furthermore, there are potentially other sites in which the contingency and ambiguity of human subjectivity is exposed; for example, Beauvoir (1989) cites sexuality as one such sphere of insight[69]. Nonetheless, the re-theorisation of paradoxical birthing subjectivities as *paradigmatically human* stands as an immensely important political intervention for feminist philosophers and theorists and merits considerable more scholarly attention.

In chapter four, I openly declared that this thesis would ultimately judge emerging representations of childbirth by the extent to which they managed to *interrupt* and *disrupt* phallocentric images and constructions of birth and female bodies; furthermore, in line with Irigarary, I endeavoured to search for representations/images which reproduced the female body and the birthing body as a positivity and not a lack. According to these criteria, I have to conclude that women's home-birthing stories contain far more potential for imagining empowering, alternative conceptions of female corporeality and childbirth than the stories of elective caesarean birthers. While it is certainly true that elective caesarean sections do succeed in troubling ideologies of essential motherhood, disrupting views that pregnancy, childbirth and breastfeeding are 'natural' activities that all women are biologically programmed to desire, the discourses women use to position themselves within this 'choice' (see chapter six) and the story lines they draw on in order to tell the experience of surgical birth (see chapter seven), do not contain empowering images or representations of female corporeality or childbirth. Thus, in justifying their choice to have an elective caesarean, women often reaffirmed phallocentric views of the female and birthing body as abject and lack, reproducing the procreative body as horrifying, vile and animal-like. Furthermore, in their stories of caesarean birth, the birthing body-subject often emerged as passive, objectified and alienated; in some stories the birthing woman emerged as a dehumanised spectacle. Narratives of caesarean were told within medicalised terms and showed little signs of being articulated within "women-oriented terms" (Grosz, 1989:109). In their tales, women often pointed to the trivialisation of their experience (by medical experts), indicating a disregard (and at times disrespect) for the potentially momentous, life-changing and profound experience as lived by the birthing woman. Seeing her body solely as the object of attention, the

[68] Of course, not all women experience childbirth as transformative or transgressive. The caesarean birthers in this study are a prime example of this fact.
[69] Beauvoir however never acknowledges that reproductive experiences such as pregnancy or birth could also be sites in which women realise "the fundamental ambiguity of existence" (Moi, 1994:176).

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emotional and subjective aspects of the birthing woman's experience often seemed to be disregarded by medical professionals.

I firmly believe that aggressively striving for new representations of childbirth, in which birthing women emerge as complex, 'distinctively human' (Held, 1993) subjectivities, and in which the birthing body-subject is rearticulated as the active, empowered, sensual and embodied *centre* of birth-giving, can ultimately have an impact even on the way in which women having caesarean sections are treated by medical experts. Thus, one could imagine (in a new representational order) the caesarean birther being treated as a fully human subject, undergoing an immensely significant emotional and symbolic experience and therefore being treated with respect, dignity and care. The images and visions of female embodiment and birthing bodies that materialise in the alternative story lines of home-birth narratives are capable of disrupting phallocentric representations of the female body as abject, horror and lack. Reproducing the female body as a positivity, these alternative visions can potentially *intervene* in the cultural imaginary and may possibly contribute towards shifts in the ways in which women's reproductive bodies are represented, imagined and ultimately treated. In my view, re-conceptualising birth from the vantage point of the birthing woman (as active, knowing, experiencing body-subject) can potentially empower all women. Thus, with significant shifts to the cultural/representational imaginary, it is possible to imagine all birthing women (even those who choose surgical birth), being treated with dignity, care, attention and respect. The tales of home-birthers, which function as a major challenge to 'horror story' narratives of childbirth, are, in my view, a very important part of the feminist struggle against cultural views that represent the female body as abject, disease or dysfunction.

Of course, the representational politics discussed above does not necessarily do anything to change the often abysmal conditions in which poor, Third World women give birth. This is where struggles on a more material and practical level become important. Given the nature of my study and the overwhelmingly middle-class sample interviewed, it remains for other researchers and activists to say more about such strategies. I do not claim that any of the findings or conclusions I have drawn from this study are universal or equally relevant to all women. Throughout the thesis I have tried to emphasise that this is an exploration of middle-class, westernised birthing subjectivities; a substantial amount of future research is required to explore the birthing subjectivities of women from different social, cultural and class formations.

This thesis has made a contribution towards the important project of reinstating the birthing woman as the central figure in the birth experience. By focussing on the subjectivities reproduced in childbirth narratives, I have tried to rearticulate birth as an experience potentially involving complex and profound forms of embodied subjectivity. While showing the power of

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cultural story lines and ideologies in the reproduction of subjectivities, this thesis has also explicitly looked for alternative story lines, in which childbirth and the birthing body-subject are reimagined or retold outside of phallocentric lenses. The stories of home-birthers have proved to be fertile ground for such alternative visions. While never 'pure' or unproblematic and inevitably riddled with contradictions, these alternative visions remain of the utmost importance to the feminist struggle to develop new, woman-empowering imagery and representations. As Adrienne Rich (1976:288) writes so beautifully:

> To seek visions, to dream dreams, is essential, and it is also essential to try new ways of living, to make room for serious experimentation, to respect the effort even where it fails.

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On the First Night

Erica Jong in Chester (1989:124-125)

On the first night
of the full moon,
the primeval sack of ocean
broke,
& I gave birth to you
little woman,
little carrot-top,
little turned-up nose,
pushing you out of myself
as my mother
pushed
me out of herself,
as her mother did,
& her mother's mother before her,
all of us born of woman.

I am the second daughter
of a second daughter
of a second daughter,
but you shall be the first.
You shall see the phrase
"second sex"
only in puzzlement,
wondering how anyone,
except a madman,
could call you "second"
when you are so splendidly
first …

You are born a woman
for the sheer glory of it,
little redhead, beautiful screamer.
You are no second sex,
but the first of the first;
and when the moon's phases
fill out the cycle
of your life,
you will crow
for the joy
of being a woman
telling the pallid moon
to go drown herself
in the blue ocean,
and glorying, glorying, glorying
in the rosy wonder
of your sunshining wonderous
self.

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APPENDIX A

Demographic characteristics of women in preliminary study, n=77

Age	**Total**	**Percentage**
<20	1	1%
20-25	28	36%
26-30	16	21%
31-40	30	39%
41+	2	3%
(Mean age: 28 years)		
Marital status		
Married	53	69%
Living with partner	5	6%
Unmarried	19	25%
Highest education		
Some high school	3	4%
Completed high school	25	32%
College/Tech diploma	29	38%
University degree	13	17%
Postgraduate degree	7	9%
Employment status		
Unemployed	5	6%
Part-time employment	16	21%
Full-time employment	28	36%
Student	10	13%
Housewife	18	23%
Race		
White	47	61%
Black	17	22%
Coloured	13	17%

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APPENDIX B Place of birth and type of birth reported in preliminary study, n=77

PLACE OF BIRTH		
Public hospital	**14**	**18%**
Black women	10/17	
White women	0/47	
Coloured women	4/13	
Private hospital	**58**	**75%**
Black women	6/17	
White women	43/47	
Coloured women	9/13	
Active Birth Unit	**3**	**4%**
Black women	0/17	
White women	3/47	
Coloured women	0/13	
Home	**2**	**3%**
Black women	1/17	
White women	1/47	
Coloured women	0/13	
TYPE OF BIRTH		
Vaginal birth: no drugs	**17**	**22%**
Black women	5/17	
White women	10/47	
Coloured women	2/13	
Vaginal birth with epidural or other drugs	**26**	**34%**
Black women	8/17	
White women	13/47	
Coloured women	5/13	
Total rate of vaginal births	**43**	**56%**
Black women	13/17	(76%)
White women	23/47	(49%)
Coloured women	7/13	(54%)
Emergency caesarean section	**19**	**25%**
Black women	2/17	
White women	12/47	
Coloured women	5/13	
Planned caesarean section	**15**	**19%**
For personal reasons	6/15	**40%**
For medical reasons	9/15	**60%**
Black women	2/17	
White women	12/47	
Coloured women	1/13	
Total rate of caesarean sections	**34**	**44%**
Black women	4/17	(24%)
White women	24/47	(51%)
Coloured women	6/13	(46%)
Caesarean rate: public hospitals	3/14	**21%**
Caesarean rate: private hospitals	31/58	**53%**

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APPENDIX C

Brief portraits of the women interviewed

- Home-birthers

Jane Brown, 32, is married and lives in a small, modest house in a little, seaside village. She has an Honours degree in Logopaedics but is currently a full-time mother. She already has one child, who was born at home after a long 25 hour labour and is 33 weeks pregnant when I first interview her. Neither pregnancy was planned. Her husband has a PhD in theology and teaches at a theological college. Jane suffers intermittently from Chronic Fatigue Syndrome, but regards her illness as currently manageable.

Lizette Zimmerman, 37, is currently living with her partner (of two years) in a rustic house situated in a small town some 90 kilometres away from Cape Town. The pregnancy was not planned. Lizette has an adopted child, who was previously a street-child. She has a technikon diploma and currently runs a clothing manufacturing business that employs rural, African women. She also owns her own clothing shop that is situated on a trendy street in the city. Her partner is a furniture maker. When I first interview her, Lizette is 34 weeks pregnant. This is Lizette's second pregnancy – her first pregnancy was terminated.

Maggie McDougal, 35, is currently living with her partner (of one year) and two sons from a previous marriage in a tiny house situated in a lower middle class neighbourhood. Maggie is divorced and works as a radiographer at a local private hospital. Her current partner is a sales manager at an industrial shelving company. The pregnancy was planned. Maggie was 32 weeks pregnant when we met for the first interview. Both of her previous births took place in a local private hospital, where she birthed with epidural anaesthetic and her legs in stirrups.

Sam Duncan, 28, is married and lives in a charming, strawberry-coloured Victorian house in a bohemian (and crime infested) suburb of Cape Town. She is originally from Holland, but is married to a South African who works in a local theatre company. Sam is a fully qualified social worker but is currently a full-time mother. She has one daughter, who was born (after a long and painful 21 hour birth) at the nearby Active Birth Unit (ABU) and delivered by a private midwife. She is 39 weeks pregnant when I interview her for the first time. It is a planned pregnancy.

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Tasneem Davids, 28, is a devout Muslim woman married with two children. She lives in a relatively spacious house in a traditionally 'Coloured', working-class suburb of Cape Town. She has no Medical Aid. Tasneem's first baby was born at the local (public sector) Maternal Obstetric Unit (MOU). She found this to be 'highly traumatic' and her second baby was born at home with a private midwife. Her pregnancy was planned. Tasneem's husband works as a tour guide and she teaches Islamic education classes part-time. At the time of the first interview, Tasneem is 40 weeks pregnant.

Jeannie Artz, 35, lives with her partner (of nine years) and their son in a sunny, medium-sized house in a bohemian suburb of Cape Town. She has a degree in Fine Art and works as a freelance wardrobe mistress. Her partner is a freelance sound technician. The pregnancy was not planned and the couple did, at one stage, seriously consider terminating the pregnancy. Her partner has three other children from a previous marriage. Jeannie's first baby was born at home, after an uncomplicated and 'easy' labour. She is 34 weeks pregnant when I first interview her.

Stephanie Mitchell, 42, lives with her husband and daughter in a tiny house situated in a housing complex close to the coast. The pregnancy was planned. Stephanie has a Master's degree in Clinical Psychology, but currently works as a freelance writer and researcher. Her husband is also a clinical psychologist and works as the Director of a local children's home. Stephanie's first baby was born at home after a painful but uncomplicated labour. She is 36 weeks pregnant when we first talk.

Jolene Wright, 35, is married and has two sons. She lives in a comfortable house in the southern suburbs of Cape Town. Both Jolene and her husband have college diplomas in design and jointly own a designer furniture business located in the city centre. The pregnancy is planned. Their previous children were both born in a local private hospital, although in both cases she did most of her labour at home. Jolene is 35 weeks pregnant when I interview her.

Anke de Wit, 34, lives in a small coastal town about 50 kilometres from the city. She is married and has a daughter. Anke has a diploma in Beauty Therapy but works as an administrator at the local private hospital. By the time of our second interview, however, Anke had decided to stop working and be a full-time mother. Anke's husband is a pharmacist, specialising in natural medicine. The pregnancy was planned. Their first baby was born at home after an uncomplicated six hour labour. At the time that I first interviewed her, Anke was 40 weeks pregnant and the baby was born the day after our interview.

Mandy Van Zyl, 30, lives with her partner of three years and their toddler, in a modest house situated in the southern suburbs of Cape Town. Mandy has a degree in commerce and currently works freelance as a film producer. Her partner also works in the local film industry. The pregnancy was not

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planned. When I first interview her, Mandy is 35 weeks pregnant. Mandy's first baby was born at home.

Kayla Peterson, 37, lives with her partner and their daughter in a comfortable-sized house situated in a horse-mad village (about 30 kilometres from the city) close to the sea. She lives in a house flanked by a field of indigenous plants. Kayla is a qualified horticulturalist but is currently working as a full-time mother. Her partner designs book covers and works from home. Their first baby was born at home.

Angela Stewart, 24, lives with her mother and sister in a beautiful house surrounded by large blue gum trees and green forest, in one of the wealthiest suburbs of Cape Town. Angela's pregnancy was unplanned and she was no longer involved with the father of the baby when I interviewed her. As a result of the pregnancy, she had put a hold on her university studies. Angela and her sister were both born at home. When I first interview her, she is 37 weeks pregnant. It is Angela's first pregnancy.

Erina French, 35, lives with her husband and daughter in a lovely Victorian house, situated just down the road from my own home. Erina has a Masters degree in Science and currently works from home as a research consultant. Her husband is an architect. Erina's first baby was born in the local private hospital, in an easy and 'untraumatic' labour, in which she was attended by a private midwife. Erina is 36 weeks pregnant when we meet for interview one.

Joni Daniels, 32, is married and lives with her husband and nine-year old daughter in a tiny house situated in a historically 'coloured' neighbourhood. Joni completed high school and is employed as a personal assistant. Her husband is self-employed. Joni does not have Medical Aid. The pregnancy was planned. Her previous birth took place at a local (public sector) clinic where Joni was induced and gave birth with epidural anaesthetic. She is 39 weeks pregnant when I first interview her.

Hazel Ray, 45, is married and lives with her husband, son, dog and cat in a bright, comfortable, colourful home. Hazel has a Fine Art degree and teaches art classes part-time. I only interview Hazel once post-birth.

- Elective caesarean birthers

Sara Trump, 32, is married and lives with her husband in a large, spacious house with uninterrupted views of the Atlantic Ocean. She is a qualified lawyer and her husband is the Chief Executive Officer (CEO) of a biotechnology company. This is the second marriage for both of them. Her husband has a

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daughter from his first marriage. The couple also own their own wine farm and export wines. Sara is 37 weeks pregnant when I first interview her. It is her first pregnancy.

Lola Cronje, 33, lives with the husband and their Scottish terrier in a stylish but small house in a trendy suburb above the city. She is a qualified architect and her husband is an architect and urban designer, with a PhD in city planning. The couple have been together for nine years. The pregnancy was planned. Lola is 33 weeks pregnant at the first interview. It is her first pregnancy.

Caroline Kohler, 38, is married and lives with her husband (of three years) in a sumptuous and costly house with sweeping views of the Atlantic Ocean. She is a highly successful events coordinator and her husband is an advocate. The pregnancy was planned. Caroline is 32 weeks pregnant when I first interview her. It is her first pregnancy.

Carrie Cohen, 39, lives with her husband in a comfortable, middle-class home in the southern suburbs of Cape Town. She has a technikon diploma and works as a legal secretary. Her husband is a building contractor. It is a planned pregnancy. Carrie is 38 weeks pregnant when I interview her. It is her first pregnancy.

Ilse Van Rooyen, 29, is married and lives in a small townhouse in the northern suburbs of Cape Town. She has a diploma in Beauty Therapy and owns her own beauty salon situated in a busy shopping centre. Her husband is a buyer for a men's speciality store. It is a planned pregnancy. Ilse is 28 weeks pregnant when I first interview her. It is her first pregnancy.

Janine Le Roux, 28, is married and lives in a small townhouse in the southern suburbs of Cape Town. She has a technikon diploma and is employed as a conveyancing secretary. Her husband is a business consultant. The pregnancy was planned. Janine is 34 weeks pregnant when I interview her. It is her first pregnancy.

Hannalie Botha, 30, is married and lives with her husband in the northern suburbs (I never saw her home). Hannalie has a degree in Communication Science and is employed as office manager and company secretary. I conduct both interviews with her in her office in the city centre. Her husband is a manager. The pregnancy was planned. At the time of the first interview, Hannalie was 29 weeks pregnant. It is her first pregnancy.

Karin Miller, 37, is married and lives with her husband and his two children from a previous marriage in Pretoria. I have an extensive email correspondence with Karin throughout her pregnancy and then interview her once, post-birth, when she comes down to Cape Town on holiday. Karin is a nurse,

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specialising in intensive care work. Her husband is a doctor (general practitioner). The pregnancy was (initially) planned. I interview Karin two months after the birth. It was her first pregnancy.

Linda Matthews, 33, is married and has one daughter. She lives in a comfortable, middle-class home in the southern suburbs. Linda is a qualified chartered accountant and does freelance work. Her husband is the general manager of a courier company. Linda's first baby was born by emergency caesarean section in a local private hospital. The pregnancy is planned. She is 33 weeks pregnant when I first interview her.

- 'Other' women interviewed:

Angie van der Merwe, 33, is married and lives with her husband in a tiny apartment in the southern suburbs of Cape Town. Angie works as a research librarian and her husband is completing his PhD in Afrikaans literature. The pregnancy was planned. Angie is hoping to have a 'normal' birth (with epidural) in the local private hospital. She is 30 weeks pregnant when I first interview her. It is her first pregnancy.

Ally Collins, 27, is married and lives in a comfortable middle-class house in a busy town about 50 km from the city centre. She is a high school teacher with an honours degree in Psychology. Her husband is a business owner. Ally is hoping to have a 'natural' birth in the local private hospital. The pregnancy is planned. Ally is 25 weeks pregnant when I first interview her.

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APPENDIX D

Interview schedule for home-birth, interview one

Part 1: Pregnancy and rationale for birth choice

- ✓ How is everything going so far? (with the pregnancy?)
- ✓ Can you tell me a little about the events leading up to your pregnancy ….was it a planned affair or was it unexpected?
- ✓ Before your pregnancy, did you always assume that you would have children one day? Did you always want to be a mother?
- ✓ How did you feel when you learnt you were pregnant?
- ✓ How did others react to the news of your pregnancy?
- ✓ How have you experienced your relationship with your midwife? How did you find her?
- ✓ How often do you go – what happens?
- ✓ Have you had any scans?
- ✓ Do you have a back up plan i.e. hospital/doctor?
- ✓ Can you tell me about the course of your pregnancy till now … what different phases do you think you've been through?
- ✓ How have your emotions/responses to the pregnancy changed over time?
- ✓ Has the pregnancy changed your relationship with others?
- ✓ How have you experienced your changing body? … positive / frightening/ alien?
- ✓ How has this changed over the course of the pregnancy?
- ✓ Have you 'enjoyed' being pregnant so far?
- ✓ Has your pregnancy changed the way others relate to you?
- ✓ Do you feel changed? How?
- ✓ Feelings about being a mother? Your feelings towards your own mother?
- ✓ How do you hope you will be as a mother?
- ✓ Feelings, thoughts about the baby (imaginations)

- ✓ What made you decide on a homebirth? Was it a difficult decision? How did your partner/family/friends react?
- ✓ Reading? Social network support?
- ✓ (If relevant) What was your first birth (or previous births) like? What happened?

- ✓ What do you think of women who choose the 'opposite' – i.e. planned c-section with no medical reasons?
- ✓ What do you think your birth choice says about you as a person? Is it compatible with how you see yourself more generally?
- ✓ What are your expectations regarding the birth – how are these different to the first time round? (if relevant)
- ✓ What kind of impact did your previous birth experience have on you?
- ✓ Did it change you? In what ways?
- ✓ Worries/fears
- ✓ Do you prepare for birth in any specific ways?
- ✓ Did your first birth have any effect on your feelings about your body?

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Part 2: Body history

1. Childhood (up to 10 yrs)
    - ✓ What did you enjoy doing?
    - ✓ Were there any significant events that occurred during this period?
    - ✓ How did you experience 'being a girl' (enjoy; resist; tomboy?)
    - ✓ How did you experience your body? (as a tool; as strong; enabling)
    - ✓ How did you feel about your body?

2. First signs of growing up
    - ✓ At what age did you first begin to be aware that your body was starting to change?
    - ✓ What did you notice?
    - ✓ How did you feel?
    - ✓ How did others react?

3. First menstrual period
    - ✓ What happened?
    - ✓ How did you feel?
    - ✓ What did you do?
    - ✓ How did others react?
    - ✓ How did you feel about your body?
    - ✓ Did it mark a significant change in the way you related to the world?

4. Being a teenager
    - ✓ What did you enjoy doing as a teenager?
    - ✓ Were there any significant events that occurred during this period?
    - ✓ What people were most significant in your life?
    - ✓ How did you feel about your body over this period?
    - ✓ How did you feel about being a girl/woman?
    - ✓ How was your experience of your body different to when you were a child?
    - ✓ What did it meant to have a female body as a teenager (did it make you feel competent, defensive, vulnerable, powerful, sexual?)
    - ✓ How did you experience your sexuality over this period?
    - ✓ Sexual experiences over this period? (good/bad; extensive, limited?)

5. Early adulthood (19-22)
    - ✓ What were you doing over this period?
    - ✓ What kind of a life stage was this? What were your preoccupations?
    - ✓ How did you feel about your body?
    - ✓ How did you experience your womanhood over this period?
    - ✓ How did you experience your sexuality?

6. Adulthood (23+)
    - ✓ Significant events?
    - ✓ What were your preoccupations?
    - ✓ How did you / do you feel about your body now?

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APPENDIX E

Interview schedule for home-birth, interview two

- ✓ The birth story: what happened from beginning to end?

- ✓ Are you satisfied with the birth and the way you handled things?
- ✓ Was it anything like you expected?
- ✓ What was your midwife's role in the whole process?

IF RELEVANT:

- ✓ How did it compare to your hospital-births?
- ✓ Did being in a home environment make you feel less inhibited?
- ✓ What was the difference in the way the midwife handled the birth / compared to hospital midwives /doctors?

- ✓ How did you feel when in labour / giving birth? Were you in a different space? Describe?
- ✓ Describe how the contractions felt and how you dealt with them
- ✓ How did you feel as you approached full dilation?
- ✓ The transition phase…just before the pushing stage? How did you feel? Describe. What were you doing?
- ✓ How did you experience the 'pushing' stage? How did you feel?
- ✓ The delivery… how did you experience the crowning of the baby? Was this painful? Pleasurable?
- ✓ How would you describe giving birth in words?

- ✓ Is there anything that you were disappointed by?
- ✓ What has daily life been like over the past few weeks?
- ✓ Do you feel you are coping?
- ✓ Emotional and physical recovery after the birth?
- ✓ How are you feeling about your body at the moment?
- ✓ Feeding?
- ✓ Childcare practices – do you have a schedule? Where does baby sleep?
- ✓ How are you adjusting to motherhood?
- ✓ What do you particularly enjoy about looking after the baby?
- ✓ Is there anything you don't like about it?

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APPENDIX F

Interview schedule for caesarean birthers, interview one

Part 1: Pregnancy, rationale for birth choice

- ✓ How is everything going so far? (with the pregnancy?)
- ✓ Can you tell me a little about the events leading up to your pregnancy ….was it a planned affair or was it unexpected?
- ✓ Before your pregnancy, did you always assume that you would have children one day? Did you always want to be a mother?
- ✓ How did you feel when you learnt you were pregnant?
- ✓ How did others react to the news of your pregnancy?
- ✓ How have you experienced your relationship with your doctor? How did you find him/her?
- ✓ How often do you go – what happens?
- ✓ Have you had any scans? (How many? Other testing?)
- ✓ Can you tell me about the course of your pregnancy till now … what different phases do you think you've been through?
- ✓ How have your emotions/responses to the pregnancy changed over time?
- ✓ Has the pregnancy changed your relationship with others?
- ✓ How have you experienced your changing body? … positive / frightening/ alien?
- ✓ How has this changed over the course of the pregnancy?
- ✓ Have you 'enjoyed' being pregnant so far?
- ✓ Has your pregnancy changed the way others relate to you?
- ✓ Do you feel changed? How?
- ✓ Feelings about being a mother? Your feelings towards your own mother?
- ✓ How do you hope you will be as a mother?
- ✓ Feelings, thoughts about the baby?

- ✓ Why have you decided to have an elective caesarean section? What are your reasons?
- ✓ Is it a recent decision or have you known for a long time that you would make this choice?
- ✓ What does your doctor say?
- ✓ Partner, family, friends – responses?
- ✓ Do you have any doubts?
- ✓ How do you feel about 'natural' birth?
- ✓ What are the risks of 'natural' birth and a caesarean section? Which is more risky?
- ✓ What do you think of home-birth?

Part 2: Body history

Childhood (up to 10 yrs)

- ✓ What did you enjoy doing?
- ✓ Were there any significant events that occurred during this period?
- ✓ How did you experience 'being a girl' (enjoy; resist; tomboy?)
- ✓ How did you experience your body? (as a tool; as strong; enabling)
- ✓ How did you feel about your body?

First signs of growing up

- ✓ At what age did you first begin to be aware that your body was starting to change?

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- ✓ What did you notice?
- ✓ How did you feel?
- ✓ How did others react?

First menstrual period

- ✓ What happened?
- ✓ How did you feel?
- ✓ What did you do?
- ✓ How did others react?
- ✓ How did you feel about your body?
- ✓ Did it mark a significant change in the way you related to the world?

Being a teenager

- ✓ What did you enjoy doing as a teenager?
- ✓ Were there any significant events that occurred during this period?
- ✓ What people were most significant in your life?
- ✓ How did you feel about your body over this period?
- ✓ How did you feel about being a girl/woman?
- ✓ How was your experience of your body different to when you were a child?
- ✓ What did it meant to have a female body as a teenager (did it make you feel competent, defensive, vulnerable, powerful, sexual?)
- ✓ How did you experience your sexuality over this period?
- ✓ Sexual experiences over this period? (good/bad; extensive, limited?)

Early adulthood (19-22)

- ✓ What were you doing over this period?
- ✓ What kind of a life stage was this? What were your preoccupations?
- ✓ How did you feel about your body?
- ✓ How did you experience your womanhood over this period?
- ✓ How did you experience your sexuality?

Adulthood (23+)

- ✓ Significant events?
- ✓ What were your preoccupations?
- ✓ How did you / do you feel about your body now?

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APPENDIX G

Interview schedule for caesarean birthers, interview two

- ✓ The birth story – what happened from beginning to end?

- ✓ Was it anything like you expected?
- ✓ Are you satisfied with the birth?
- ✓ How did you feel just before, during and after the c-section?
- ✓ What happened immediately after the baby was delivered?
- ✓ What could you see/hear/feel during the procedure?
- ✓ Were you happy with the care you received from your doctor/nurses?
- ✓ What was your hospital stay like?
- ✓ What was your husband's role?
- ✓ Did the birth process bring you closer together?
- ✓ Did you feel in control during the delivery?
- ✓ Was there anything that you were disappointed by?

- ✓ Was the birth a significant life experience?
- ✓ Has the birth experience had any impact on the way that you see yourself?
- ✓ What did you like best about your birth? Least? Would you do anything differently?
- ✓ Did you feel in control or powerful during the birth?
- ✓ Did your medical aid pay? How much did it cost?
- ✓ What has your physical recovery been like? Emotional recovery?

- ✓ How did you feel in the first few days after birth?
- ✓ The first weeks at home?
- ✓ Do you feel like you are coping?
- ✓ How has the breastfeeding proceeded? (if relevant) Have you had a lot of help?
- ✓ Do you feel supported? By whom?
- ✓ How are you feeling about your body at the moment?
- ✓ Do you have a schedule with the baby? Where does baby sleep?
- ✓ How do you think you are adjusting to new motherhood?

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APPENDIX H

Demographic checklist

Name…….

Date of Birth……..

Telephone Number…….

Physical

address……

……

Email address…….

Approximate delivery date…….

Week of pregnancy…….

Planned place of

delivery……...

Marital Status: (tick next to correct option)

Single, no partner

Boyfriend/partner, living separately

Living with partner

Married

If currently with a partner, how long have you been together?

……

Reproductive status: (tick next to correct option)

No previous pregnancy

Second / Third / Fourth pregnancy

Previous miscarriage

Previous abortion

Highest education received

……

Employment status

……

If employed, please indicate what type of work you do:

……

……

If married or living with a partner, please indicate what type of work they do:

……

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APPENDIX I

Consent form

Thank you for considering participation in this research. Please read the following carefully:

This study is interested in documenting the experiences and birth stories of women. The interview material will be used, presented and analysed within my PhD thesis and might also be published as academic articles/reports.

<u>The following conditions will be met:</u>

1. Your real name will not be used in any source (thesis or articles); instead, you will be given a pseudonym through which you will be identified.
2. The information that you divulge will be confidential.
3. Your participation is entirely voluntary.
4. The 'results' or analysis of the interview(s) will be written in the form of a doctoral thesis and may also be published in academic journals – while ensuring you of complete anonymity.

I agree to and understand the terms set out above.

…….. ……...

Participant Date

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APPENDIX J

Transcription notation

Notation	
*	Undecipherable words/phrases
(*)	Short pause
(**)	Long pause
(***)	Very long pause
(…)	Words omitted
you(r)	completion of word in brackets
massive (in bold font)	Words or phrases that are spoken loudly
…	Speech trails off
#	One person talks over the other
{whisper} (in curly brackets)	Words that are whispered
[soft] (in square brackets)	Words spoken softly
Good thing (italicised)	Words that are spoken slowly for effect
Tiny (bolded, italicised and underlined)	Words spoken slowly, loudly and with emphasis
↑ Oh my word↑	High pitched words
‖ then it happened ‖	Low pitched, deadened words
definitely (bold and underlined)	Words spoken loudly and with emphasis
No (underlined)	Words that are emphasised
I really want to (font 8 and italicised)	Words spoken fast
OH NO	Words that are shouted out
Oh my word (Bookman Old Style font and underlined)	Words spoken with laughter in voice
I can't believe it (font 10, italicised and underlined)	Words garbled and rushed over

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