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The Tyranny of Expectations of Post-Natal Delight: Gendered Happiness.

Abstract

This article explores the contested nature of childbirth practices with a historical perspective. The article discusses the modern medical/interventionist model of birth now predominant in the UK and examines the consequences of prevailing norms for women. It includes some reflections on the regulation of pregnancy and the transition to motherhood and notes some counter-cultural movements such as 'free-birthing'.

Introduction

Women become smarter, more beautiful and more fulfilled as a result of becoming mothers, so gendered discourses assure us - we are fulfilling our biological destiny - we'll become 'real' women. Indeed, if we miss the opportunity to procreate we may never feel 'whole' and our 'biological clocks' are clicking away. Whether we ascribe to the stereotypical rhetoric or not, we are saturated with it (MacDonald 2016; Born Online). This article will situate a discussion of the transition to motherhood within a wider exploration of the cultural expectations regarding women, childbirth and maternal receptiveness. It will focus on an examination of why pregnancy, childbirth and new motherhood are not necessarily delightful. Whilst it is acknowledged that biological facts can in some sense ground social values (Moi 1999 p. 41), this article views the pregnant women's body *as a social phenomenon* which should not be regarded as

ahistorical, 'natural' or prediscursive, even though women have always given birth and become mothers.¹

Mothers giving birth may be viewed as being 'liminal' entities because they straddle the line between purity and pollution; self and other and indeed even life and death (Hogan 2008). The transition to motherhood, especially the birthing event, is a particularly contested site with regards to professional power relations, and the application of medical practices: historically every aspect of the event has been potentially highly inflammatory, and subject to rival proscriptions (Evenden 2000; Forman Cody 2005). Differences in birthing rites have been tied to religious affiliations and sensitivities about how birthing should take place and what was deemed appropriate at different historical junctures in terms of ritual and practices (Cressy 1997; Forman Cody 2005). In England midwifery was regulated by the church, as part of its licensing of medical practitioners in general (from 1512, following legislation under Henry VIII). Religious connotations and sympathies could be quite nuanced in terms of their enactments and they often added extra complexity, to an already culturally and professionally contested terrain.

Male 'barber surgeons' began to move into the occupational territory previously inhabited solely by midwives and the new profession of medical obstetrics began to develop (Wilson 1995). The denigration of the professional competence of the other was a feature of these 'professional' groups jostling-up against each other (Loudon 1997); differences between specialised groups were evident in terms of their practices, with obstetrics particularly characterised by active intervention in birth with new technologies such as obstetric forceps, and later the use of chloroform and vacuum suction techniques (known as Ventouse).

Practices which can be counter-productive and illness inducing form part of professional repertoires of behaviour. Such practices with potential iatrogenic outcomes have been, and continue to be, embedded in hospital regimes. They are insidious, widespread and 'normalised'. They are hard for women to resist. The most blatant example of a widespread illness-inducing practice is the tendency of

hospitals to put women into beds, when mobility often helps with managing pain and hastens childbirth. Women may intuitively feel uncomfortable with the practices they encounter in hospital environments, but feel unable to challenge them (McCourt 2009), or may marshal small acts of resistance (Martin 1987).

Small wonder, then, that this highly-contested experience: the management of the pregnancy, the birth itself, along with the transition to motherhood, is also a site of distress for women. The major cause of *maternal* death in Britain today is actually suicide (Oats 2013).² Motherhood does not necessarily come naturally. This article will look the contested nature of childbirth practices and expectations with a historical lens. The article will then discuss the modern medical/interventionist model of birth and the consequences of prevailing norms for women. It will end with some reflections on the transition to motherhood and note some counter-cultural movements.

Doing it Naturally?

Women feel responsible for their babies before they are born and this is a responsibility which is reinforced by health advice and popular baby books: 'Everything you do, feel, and think affects your growing baby in some way' warns the bestselling Miriam Stoppard (1993 front cover quote). In some senses this is true, but the notion of the mother's actions affecting the growing baby sets up a potential conceptual and moral conflict within what is in reality a *maternal-foetal unity* (Elliston 1997). Some women experience the weight of this responsibility keenly. This is not a modern phenomenon. Here is a 19th century example from Countess Dowager Mountcashell (1835 p.1 my italics):

'A pregnant women who desires, to produce an offspring well constituted in body and mind, *should* pay the strictest attention to her own conduct, both physical and moral. She *should* carefully avoid any species of excess, and endeavour to keep her mind in the greatest tranquillity....'

On top of this existential dilemma, pregnant women are plunged into a world of contradictory advice, and possible conflicts with relatives and partners who may

have strong feelings about how things *should* be done. Women are policed, not just by the State through health advice, pre-natal health-check regimes and hospital protocols, but also by relatives informed through and seeking to sustain a variety of community norms; this surveillance can feel oppressive. Some women, who are lucky enough to have the option, feel uneasy about leaving their babies for a few hours at a time with another care-giver and believe that their baby might experience emotional distress during their absence, or that bonding might be disturbed (Figs 1998). Many women believe that their absence could have long-term detrimental consequences, but this is a widespread misapprehension which has emerged out of a reductive use and understanding of object-relations theory, which is not borne out by an analysis of those cultural practices which involve a multiplicity of caregivers (Blaffer Hrdy 1999; Lancy 2014).³ In other words, babies can tolerate several caregivers with equanimity, yet our culture pressurises many women to be the sole or primary care-takers of their infants, to the detriment of the mothers and the potential detriment of the infants.⁴

Some mothers experience a mixture of claustrophobia, shock, guilt and resentment, yet are these abnormal mothers? I'd suggest that post-natal distress is intimately concerned with living up to ideals of motherhood in the face of the exhausting reality and tedium of early childcare, coupled with the deplorable discrimination that women still face as a result of their decision to have a child: from being made redundant, to being written-off as a serious contender for senior professional roles and a myriad of other forms of discrimination (Banyard 2010; Bates 2014). New motherhood can be exhausting; babies vary, but some infants demand two-hourly feeds, for example. This caring is arduous. Breast-feeding can be physically taxing (it can cause painful uterine contractions, stimulate bleeding, cause sore nipples, lead to breast engorgement and leaking if the baby declines to feed). Breasts fill with milk when the baby cries (even separated by the birth there continues an unfamiliar entwinement). Women are also understandably concerned about their infant's welfare. The visceral embodied dependence and utter vulnerability of the infant can be experienced as intimidating and oppressive. Even those women who have placid babies and are enjoying mothering, can get too much - feeling unable to take a break and ending up feeling stifled.

This unique blend of physical capitulation and for many, unprecedented bodily interference and pain, coupled with the weight of societal and familial expectation about mothering, the interruption of and disarticulation from ones former life, and the experience of active discrimination combine to create a truly disorientating and dislocating event for many women, some of whom cannot articulate their feelings - they are *supposed* to be rapturously enjoying their newborn, and indeed, might well also be enjoying their newborn despite this tumult.

It is also the liminality of the experience of the birth which makes it uniquely stressful and subject to contestation. I have argued in earlier work that childbirth, and the rituals and taboos surrounding it, are sites of extreme contestation or liminality or both (Hogan 2008). In the case of liminality, competing discourses find it hard to find purchase on the subject in hand: debates about infanticide and abortion are particularly good examples of this, and the lack of purchase (grip) on the topic is evident in literally centuries of debate on the subject: has a baby whose throat has been cut with a knife been murdered if at the moment of the incision the rest of it's body had not yet been born? Surely, it was as yet an 'unborn child' it was asked by legal commentators in nineteenth century England (Hogan 2008 citing anonymous opinion piece, 1864 in *Social Science Review* p.454).

Conversely, with a profound shift in sensibility, and one which is subject to accord *rights* to the foetus, there have been cases in North America and elsewhere of women who refused 'medical treatment' whilst pregnant who went on to face litigation or moral censure. To give an example, a women who declined a Caesarean and went on to have a dead baby was accused of 'murdering her unborn child', what many of us might regard as a contradiction in terms. Both women [in the example above, and in this case] were actually acquitted, but the argument over both cases was ferocious (Goldberg 2004 p. 2). These transitional or liminal moments are ideologically slippery if you like: indeterminate (Hogan 2008 p. 144).

These are two extreme examples from different historical periods, illustrating quite different sensibilities: a Caesarean section is a potentially life-threatening surgical procedure – hardly an innocuous 'medical treatment' (which makes it seem like a

pill to be taken), and not something to be *imposed* on an unwilling adult. Since when did we consider slicing open our fellow human-beings against their will to be acceptable? Surely this a *profound* violation of a citizen's rights? Mazzoni (2002) is disturbed by modern representations of women's bodies as being 'in the service of the fetus' and Einion (2015) worries about how little critique there is of this increasingly dominant trope.

Conversely, the 19th century idea of the yet-unborn child is quite alienating to us too, when we consider a full-term foetus (indeed, we often hear the phrase 'unborn baby'), but an unborn child had no legal existence in that period, its being clear of the mother's body was crucial to its definition as having independent existence... Cultural contestations are complex and pervade women's experiences of pregnancy and motherhood, from ideas about appropriate behaviours and diet, to what women ought to think or feel... Ambivalence, uncertainty, indecision, or a sense of not getting it right *are not abnormal states, but an almost inevitable reaction to these cultural contradictions*, I contend. Ambivalence as a concept has come to the fore in feminist and other writing on motherhood, partly as a reaction and challenge to the dominant dichotomy of 'naturally' good mothers versus psychologically deficient mad or bad ones (Hogan 2006). There is a range of ways of defining and thinking about ambivalence, but I would suggest that this should be seen as a structural issue, that it is produced by the fact that this is such a contested and liminal space. In many ways our culture is toxic, so it's not surprising that the transition to motherhood is a struggle for many women, or if not a struggle then disorientating.

Women who look for assistance from baby books report being bewildered by conflicting advice. Those who delve into more technical sources such as text-books for help will discover a panoply of theorists who criticise mothers who are 'too well-adjusted' or who meet their baby's needs 'too perfectly', denying their infant the important developmental opportunity of experiencing frustration – there is no such thing as a 'good enough mother'! ⁵

Professional Power Struggles, Unnecessary Interventions and Iatrogenic Outcomes

Everden's analysis of seventeenth-century midwives (via testimonials required for their licencing), is fundamentally positive and stresses the 'decades of practical experience' of the training midwives, who, although excluded from access to certain forms of formal education, possessed expertise which 'extended far beyond the boundaries of academic learning' (Everden 2000 p.64). She suggests that bad accounts were perpetuated by those with a vested interest as this became a contested professional terrain. She concludes that,

'For the great majority of deliveries which were, as now, free from complications, London midwives offered services which were vastly superior, because of their extensive training and practice, to those of male practitioners' (Everden 2000 p.77).

Calling in a male surgeon would have been a desperate measure of last resort, made only for an obstructed labour which could not be dealt with by a midwife because she lacked the necessary tools, or because of her professional oath, which forbade such interventions (Loudon 1997a). In these circumstances, the mother or the infant was likely to die, and instruments for dismembering the infant to remove it in bits could easily fatally cut the labouring women: 'when a labour stalled, texts ordered male surgeons to puncture, crush, and decapitate the foetal head, and pull out the pieces of dead baby with hooks' (Forman Cody 2005 p. 40). There is evidence of midwives also carrying such equipment, but increasingly these women would only undertake surgical procedures *in extremis* and when a male practitioner could not be found.

The male midwives who emerged in the eighteenth century sound like they would be well-worth avoiding. Here is what one articulate midwife wrote at the time,

'every young MAN who hath served his apprenticeship to a Barber-Surgeon, immediately sets up for a man-midwife, although as ignorant, or indeed much ignoranter [sic] than the meanest women of the Profession' (Sarah Stone in *A Complete Practice of Midwifery* (1737) cited Loudon 1997 p.209).

This citation suggests that there was a range of skill amongst midwives – some poor. Despite the fact that the average male-midwife may have been much less skilled than his female counterpart, Loudon notes that by about the 1790s between a third and a half of all deliveries in England were attended by male medical practitioners, following the astonishingly rapid growth of modern obstetrics

(Loudon 1997a). The élite breed of accoucheurs included prolific authors producing graphic illustrations of infants lying in the uterus (often drawn from the cadavers of women who had failed to survive their lying-in hospitals). Loudon's own view on the spectacular success of male practitioners was that it came in the wake of the advance of medical science in the fields of physiology and anatomy coupled with the rise of the surgeon-apothecary, who, as a family doctor, attended to all a family's needs, from the birth of babies to the setting of fractures (Wilson 1995). However, childbirth was an unprofitable side of his business, the lying-in fee not compensating for his time, unless it led to other business (Loudon 1997a); *that there was a financial incentive in supplying additional instrumental interventions was clearly a worrying development and may have led to the over-use of obstetric instruments from the outset...* Certainly, by the twentieth century, general practitioners were using forceps with a general anaesthesia in 50% or more of their normal midwifery cases; they argued that it 'saved time and justified their fee', and also met women's expectations (Loudon 1997a p.217).

Intervention in childbirth in general has been correlated with higher rates of maternal mortality in the UK. At various historical junctures, those women attended by doctors, (rather than by midwives, who were less inclined to interfere), had higher death rates. The affluent women could afford doctors, whereas poorer women expected to 'deliver themselves' with the aid of a neighbour or midwife, only summoning medical aid for emergencies (Loudon 1997 (b) pp.183-184). When this association between medical intervention and higher rates of maternal mortality was noticed in 1851, it was not correctly interpreted; an obstetrician later accounted for it by suggesting that the middle-class women (who had availed themselves of help from doctors) were 'enfeebled by [the] excessive cultivation of the emotional and intellectual elements' causing them to be more lightly to die (Barnes 1887 cited Loudon 1997 (b) p.183). Let us try to imagine the distress of those women who had almost died being told that that their intellectual endeavours were jeopardising their reproductive health.⁶ Loudon suggests that the higher mortality rates in social classes I and II 'was due to their being delivered by doctors, mostly general practitioners, who were much more

likely to undertake repeated vaginal examinations and use instruments frequently in normal labours...' (1997 (b) p.185).

It is salutary to note that childbirth was as dangerous in 1934 as it had been in 1860 in terms of the number of women who died in childbirth in Britain (Loudon 1997). Globally there are still many maternal deaths each year, 99% occurring in developing countries.⁷ Oakley notes a steady rise in the numbers of consultants in obstetrics and gynaecology between 1930 and 1980 and a parallel increase in the number of hospital beds (Oakley 1984 p.218). The biggest growth in the proportion of women having a hospital delivery in Britain was between 1963 and 1972, with the rate rising from 68.2% to 91.4% (Oakley 1984 p.215). Today we have a hospital system which is keen to intervene. Williams is astute on the disempowering aspects of hospital care; this is just a short extract of her detailed analysis:

The patient position is one of subordination and loss of autonomy. On entering hospital the client is interpellated into a specific subject position... The patient is formed by being constructed as the subject of an institutional ideology.... Yet, birth is not a disorder, the woman is not ill, but she is still interpellated into the position of patient.... The woman may be exposed not only to the competing discourses of the midwife and the obstetrician, but also to those of the anaesthetist and of the paediatrician.... A *fait accompli* may then be presented of what 'we feel is best for your baby'. This puts the woman into a very vulnerable position... (Williams 1997 pp. 237-8).

Some commentators suggest that the hospital midwife should be viewed as a maternity nurse 'rather than as an alternative practitioner in her own right' because she or he is so bound by hospital protocols, (Dingwall et al. 1988 p.170), but midwives are perhaps more likely to show cognisance of 'women's self-knowledge' (Pitt 1997 p.227). Work in *The Birth Project* (2015) with midwives, certainly confirmed that some hospital midwives wish to offer women-centered care, but feel thwarted in doing so, by protocols, a shortage of relevant equipment, and temporal pressures.⁸

It is relevant that pregnant and birthing women are ensnared in a power-struggle between different cultural styles of 'doing birth', styles which are at odds with one another and are played out in discourses and practices in ante-natal care and in the

birthing room upon their bodies (Donnison 1988). Modern obstetrical regimes violate women's autonomy and bodily integrity.

Whilst the UK maternal death rate is now extremely low, the long-term consequences of medical practices with iatrogenic results, including traumatic birth experiences, are often overlooked. Indeed, it might be argued that modern child-birthing norms constitute serious violations of human rights for British women.⁹

Mobility

Mobility during childbirth is tremendously important for maternal wellbeing. Birthing stools or chairs of various designs have been used for millennia, as depicted in Egyptian papyri, and in ancient Greek pottery decoration, and other ancient sources including the Old Testament (O'Dowd 1994). In Paris the maternity section of the *Hôtel Dieu* (possibly its oldest hospital) used a bed for childbirth. King Louis XIV purportedly enjoyed watching women giving birth, especially his own mistresses, and favoured the use of the bed as it gave an unobstructed view. It is conjectured that this started a fashion for the use of beds (Dundes 2003).

There are many accounts of birthing stools being used in Britain by midwives and their use appears to have been ubiquitous; women were not confined to their beds for their labour and could move around to assume a preferred position, such as kneeling, crouching, sitting (on another woman's lap, on a chair or stool) or walking or standing (Cressy 1997; Evenden 2000). The actual delivery was often on a bed, but not necessarily. There are also accounts of women being forced out of bed, and made to walk up and down stairs to hasten the process (Forman Cody 2005).

Jane Sharp's text, *The Midwives Book*, of 1671 suggests that when contractions start moderate exercise be taken:

...she should walk easily in her Chamber, and then lye down, keep her self warm, rest her self and *then stir again*, till she feels the waters coming down and the womb to open' (Sharp 1671 p.188).

Countess Dowager Mountcashell in the 19th Century attempted to collate good medical practice into an accessible advice book, and is particularly scathing of a practice she describes as the 'dreadful rule' imposed by male accoucheurs of making women lie on their left side during labour. She notes that she knows of no such practice in other countries and that there are no proven medical benefits of the 'established' custom. She argues that it causes women unnecessary pain. Having not experienced labour pain themselves accoucheurs were not 'aware of the great difference between one position and another in this excruciating state' (Mountcashell, 1835 p.10). Clearly, she is advocating permitting women to move around during childbirth, as being forced to remain still is 'particularly irksome when severe pain produces a desire to vary the posture' (Mountcashell, 1835 p.10). It must be remembered that the many women in Britain would still have been attended by a midwife or friend or neighbour rather than an male accoucheur in this period though reliable global statistics do not exist.

In the twentieth century, as noted, there is an increase in the percentage of hospital births with, 'a tendency for desultory antiseptic procedures to be combined with unnecessary interference in normal labours' (Loudon, 1997a p. 217). One of the forms of 'unnecessary interference' in modern hospitals has been the adoption of supine postures on beds as the norm, coupled with the use of intravenous drips supplying drugs to a vein, usually in the women's wrist, via a catheter in the woman's wrist (to hasten contractions) which restricts movement, or makes movement uncomfortable, as jerking the catheter can be very painful.

What is 'routine induction'? It is the regular use of a medical intervention to start or speed up a labour. There are no advantages to women in 'routine induction', though it may speed up delivery in ways that are helpful to the professionals involved; it is a widespread practice frequently resulting in iatrogenic outcomes (Thomas 1996). Many hospitals have a policy that labour will be induced after a certain number of days after the 'due date' has been passed, without any medical rationale for doing so; other hospitals routinely speed up a slow labour rather than allowing the women's cervix to dilate at its own pace; a slow dilation allows a build-up of natural pain-killing endorphins, so here we see the hospital protocols

working against women's best interests (Thomas 1996). There is also a notional time allocated to the event, so that those who run over this are conceptualised as 'bed-blocking' and midwives feel under-pressure to intervene, even though she or he may prefer not to philosophically; there is also a pressure to be seen to be intervening, *to be seen to be doing something* (Hogan 2016). The procedure of induction often has two components: the breaking of the waters (the rupture of the amniotic sack, called amniotomy), followed by the use of hormones. Amniotomy triggers the release of prostaglandin, which in turn stimulates the uterus to begin contracting, 'It is often the first stop on the runaway train of interventions in labour', cautions Thomas (1996 p. 169). There are quite a large number of potential problems associated with induction, and Nolan (1998) and others have used the phrase 'a cascade of interventions' to try to encapsulate the way that one intervention leads to another and then another. McCourt (2009 p.199) points to the irony that an induction is often performed in order to minimise risks (or at least within the rhetoric of risk management), but that this ignores the scientific evidence on the effects of interventions on the progress of labour which indicate an increased risk.

Routine induction is also linked to higher use of very powerful pain-killing drugs, epidurals being the most efficacious. Though available in ambulatory forms (forms which do not remove capacity to walk), the epidurals which have been customarily available tend to paralyse women and prevent movement. Many women are not aware that ambulatory forms exist, or may be available to them. Furthermore, because 'the necessary muscle tone to push the baby out' is lost following the epidural, instrumental delivery (forceps, ventouse, caesarean section) is much more likely and episiotomy rates are higher (Thomas 1996 p.199).

As Thomas points out, when labour is induced and actively managed, control passes to the medical staff. Women who feel that the induction was unnecessary and unwanted or both, or who felt coerced into agreeing to it, may end up feeling angry, resentful or violated (Thomas 1996; Kitzinger, 2001). In *The Birth Project* a woman, a doctor herself, asked to speak to the duty doctor about the risks and benefits of the suggested intervention, only to find her question ignored and her objection to consenting to the intervention prior to a discussion utterly overruled.

Because of litigation and a move towards 'defensive practice' by midwives and obstetricians, women may be under even more pressure to accept interventions. For example, regular vaginal examinations are recorded and deemed to be evidence of good care (Winter & Duff 2009). As previously noted, they increase the risk of infections and are intrusive and upsetting to many women.

A women can not only end up feeling tied to a bed, when her natural inclination may be to move around, she may also be required to place her feet into stirrups. The Quality Care Commission has been critical of the over-use of stirrups in hospital births complaining about a significant number of women (as many as a quarter of all women having 'natural' deliveries) doing so with their feet elevated above their hips, which is entirely unwarranted unless an instrumental delivery is taking place The Commission felt this was indicative of a production-line approach and disempowering for women (Laurence 2010).

It is not necessary to write an encyclopaedia of interventions and hospital practices to make the point that births can be bewildering, disempowering and violating for the women who experience them. Women who have experienced abuse in childhood are likely to feel particularly vulnerable, but birthing experiences can be disturbing for even the most robust and psychologically well prepared (Montgomery et al. 2015). Nor should the consequences of enduring agony be underestimated (Hogan et al. 2015). This article has taken the example of prohibitions on mobility as the most widespread example of a practice leading to iatrogenic outcomes, along with linked-practices such as 'routine' induction and speeding up labour; however, there are myriad of unhelpful practices at play. For example, babies being taken out of sight immediately after delivery can cause distress to new mothers. In *The Birth Project*, one women is shown on film explaining that after her unplanned C-section her baby was taken away behind her and that she had the idea that there were other babies back there too, and that when they brought the baby back she "wasn't sure he was mine..." Indeed, for a long time she felt the baby was not hers. (Moving the bed so the mother can continue to view her baby, may, in this case, have solved what became a problem of bonding.) Redesigning hospital practices to make them less distressing to mothers

should be a priority and would not be expensive. Too often women's experience of childbirth is rendered both 'marginal and mundane', and the 'technocratic' model of birth can reinforce the women's insignificance (Burton 2015). R. D. Laing makes the polemical assertion that the prevalence of 'unnatural childbirth practices... has led birth, in many places, to be a major psychological disaster zone... (Laing 1983 cited Williams 1997 p. 232).

Euphoric Birth: Quietly Fighting Back

In *Childbirth All or Nothing* (BBC Dec, 2015) four different childbirth styles are juxtaposed. Jo plans a 'free birth' described as birth 'alone and unobserved with no doctor or midwife present'. Jo (37) suggests that like animals, humans need to give birth in a quiet place; that if stressed at all during birth, that labour 'shuts down'. Birth, she asserts, goes best when it is unobserved and undisturbed. The pain is asserted as a rite of passage. Jo argues that in many traditional cultures women giving birth were awarded the "same status as warriors going into battle... that was their rite of passage into womanhood." She is confident, almost euphoric. "It makes you feel invincible. It makes you feel immortal. It makes you feel you can take on anything" ...

Later on we see her enacting a ritual on the banks of the river, on the banks of her boat mooring, which is described as 'blessingway' – a Navajo Native American Indian ceremony which prepares the women for birth.

Mother Rising website elaborates it thus:

'Blessingway ceremonies create a sacred and safe environment where a mother-to-be can explore the challenges and joys that lie before her as she approaches birthing and mothering. Surrounded by the most important women in her life, she gains a sense of power, confidence, and support that will help her rise to motherhood'.¹⁰

In the ritual depicted the women sing and a "strong matrix of power, love and intending" is invoked. A great mother bear is petitioned "to help Jo step into the cave of women-ness to be able to access the power which is within our wombs". Then Jo is invited to "surrender" and allow herself to be held by her friends and she weeps

whist being physically held. Later she describes the experience as “beautiful, amazing, strong, powerful and overwhelmingly loved filled”. It was an intense experience and not quite what the phrase ‘alternative baby shower’ might connote (Burns 2015). The film maker asks if there are any elements of the ceremony which might be regarded as “a bit bonkers”. Jo, good humouredly, says that a “traditional pagan/shamanic ceremony” is “perfectly normal” for her... Talking to the camera, she asserts that all free-birthers are doing is “what is natural and normal for human beings; it’s the crazy hospital thing that I think is the madness...” The birth meets her expectations. She describes it as “simple” and as “powerful because it was so gentle and unobserved”. Her last word is that for many “giving birth is the most powerful event and experience that a woman will ever have and that should not be compromised or sacrificed”.

Kate (35) is going for a hypno-birth which is described, via a male voice-over, with a whiff of condescension in the tone, as involving “daily doses of positive thinking”. Her positive affirmations are shown posted all over the surfaces of her house – on doors or walls: ‘My mind knows how to surrender to my birthing body’. ‘I know my baby feels my calmness and confidence’, says another. It seems simple, “When I’m giving birth all I need to do is relax and breath – nothing else. My body will do the rest” she intones. Her first home birth had been “really beautiful”. She is confident and cheerful, “I want to be able to trust in my body and I suppose challenge my body, almost like *come-on you can do this*”.

The next scene shows Katie lying on her couch in a state of profound relaxation. The voice-over sardonically announces that, “Keen to *avoid the discomfort of birth*, she’s deep-breathing through a session of natal hypnotherapy” (my italics). Her attendant Dot is speaking softly, describing her cervix fully opening and her body giving all the signals, all the signs, that she is going to meet her baby soon... that her body will be able to do what it needs...

In a following scene, when the labour is underway, the midwife speaks briefly to camera and describes Katie as “fab” and explains that because of all her preparation she is coping fantastically, without fear or anxiety, trusting herself to labour and

doing it. The last scene of Katie shows her giving birth in a pool at home; the mood is one of awe as the baby is scooped up and held. She acknowledges that it felt like the hardest thing she'd ever done in her life, but the mood shown is nevertheless serene.

The other two women featured are Anna who has a planned C-Section in a private hospital via a consultant in Harley Street, (will she be fit to fly ten days after her C-Section, asks her husband, Bruce, in their meeting with the consultant) and Lisa who decides not to detach the placenta and carry it around in a bag scented with rose petals and lavender oil, until it detaches naturally.

More complex is Hillary's experience, in *The Birth Project*, who describes using hypnotherapy in her hospital room; she recalls in detail getting into her "quiet place" in her imagination, on a lake in Canada which she knows and with her in her wooden boat is a native American women giving her strength and comfort; the scene is described in great detail, even the sound of the Coots flying overhead is described; she is relaxed and powerful, and gets to almost full cervical dilation without pain relief; when monitors show foetal distress and she consents to emergency surgery she remains calm and composed making conversation with her caregivers as they prepared her for her emergency C-Section.

Discussion and Conclusion

The rhetoric of free choice which frames *Childbirth All or Nothing* is fundamentally misleading. It is salutary to remember that few women give birth outside of hospitals, less than 3% in the UK and of those a minuscule number 'free births'. Jo was assertive and confident, but acknowledges that many 'free birthers' stay under the radar because they are afraid that their children are going to be taken away. The midwife express concern about Jo's choice... "what if?" and suggests that home is not where many women would "feel safe". A research report in the late 1940s stated that most women wanted to have their babies at home (Joint Committee of the Royal College of Obstetricians & Gynaecologists and the Population Investigation Committee, 1948). As noted above, this is part of a large cultural shift in how childbirth is managed. The *British Medical Journal* was still willing to 'arbitrate

decisively' that 'the proper place for the confinement is the patient's own home' as late as 1954 (BMJ 24.4.1954 cited Oakley 1984 p.215).

Modern technological medical/interventionist hospital regimes focus on the baby, often at the expense of women's physical and mental health (Davis-Floyde 2008). Blessingway ceremonies, characterised by Burns 2015 as a form 'new-age cultural consumption' are not well-established in the UK, but hypnobirthing techniques are used by a wide-variety of women who might otherwise eschew new-age culture. Both are women-focussed in their discourses. Blessingway ceremonies aim to 'honour' the experience of birth and celebrate and sustain the expectant woman. They are almost always women-only events and also acknowledge the power of female friendship and female solidarity. A sacred space is generated, through ritualistic activity, such as singing, chanting, intoning spirits or ancestors, making bracelets, giving and receiving massage, drinking herbal preparations or drumming. Burns notes that, 'Discourses of female bonding and a mythology of birth spirituality' are regularly drawn on in blessingway narratives (2015 pp. 788-789) and often involve physical holding of the mother to be. It is through ritual involving touch that her friends may 'channel positive, loving energy into her through the power of touch, for her to draw on for strength during labour' (Burns 2015 p.789). The apparently essentialist and ahistorical aspects of some of these ceremonial activities have made some commentators uncomfortable, but the acknowledgement of birth as a significant life-event must surely be commended? Blessingway ceremonies have the potential to offer women an embodied way of knowing and being outside of the medical framework, and probably help enhance crucial social-support for the new mother by getting a group of women friends to feel intensely involved. Similarly, in hypnobirthing women's bodies are celebrated as capable and women are encouraged to trust their own bodies and perception. The deep relaxation which characterises hypnobirth allows the birthing mother to create her own mental space in the birthing arena.

The first sections of this article have attempted to suggest that breaking off any one aspect of women's birth experience is unsatisfactory and that is the *combination of a myriad of factors which renders childbirth and new motherhood as uniquely*

disorientating and potentially distressing. The article has highlighted the liminal and contested nature of the event as significant. Let us reject the tyranny of the expectation of post-natal delight and acknowledge that pregnant women and new mothers are caught in a web of intersecting and conflicting discourses, practices and expectancies which render the experience unstable; it is not women *per se* who are 'unstable' it is the very terrain, or field, itself.

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NOTES

¹ I would point out that women's experience is heterogeneous and that there are different implications for the words 'pregnancy' and 'motherhood'. This essay does develop a theory, which I hope is articulated clearly enough. Following the work of Simone de Beauvoir, Toril Moi suggests that 'subjectivity is neither a thing nor an inner, emotional world. Thus there can be no 'identity' divorced from the world the subject is experiencing' (Moi 1999 p. 81). I concur. Therefore, to discuss women's experience of childbirth primarily as a pathological response, such as post-natal depression for example, is to reify a complex set of experiences to which women are subject in a deterministic, reductive and oppressive manner. Drawing on field theory, this essay asks the reader to think about the field as highly contested and to think further about what this might mean for women.

² Maternal death is the death of women while pregnant or shortly after pregnancy.

³ Object relations theory is a theory of development, from psychoanalysis, which places great emphasis on interpersonal relations and especially the relationship between the infant and mother for the infant's psychological wellbeing and psychic development. Some of the discourses about mothering place great emphasis on the mother-baby dyad. From the 1940s these ideas became very influential in social psychology and social policy. The notion of 'separation anxiety' became popularised in the 1960s in Britain. Riley notes of Bowlby that: 'He knew that a theory which claimed that to separate children from their mothers might do violence to 'human nature' also embodied a powerful sentiment' (Riley 1983 p.108).

⁴ It is also a potential detriment to the infants, because if they have several regular caregivers and one of them disappears they are less likely to suffer from separation trauma.

⁵ Hogan 2012 for a more detailed critique of particular theories.

⁶ See Showalter 1985 for more on this theme.

⁷ WHO REPORT section 4.1 (p.21). Developing countries account for 99% (286,000) of the global maternal deaths with the sub-Saharan Africa region alone accounting for 62% (179,000) followed by Sothern Asia (69,000). Oceania is the region with the fewest maternal deaths at 510.

⁸ The Birth Project. <http://www.derby.ac.uk/health-and-social-care/research/birth-project/>

⁹ Women over a number of decades have reported feeling unhappy about the way medical professionals treat them, that they feel their emotional needs are not met, that they are 'left uniformed about the procedures being carried out' (a rather telling phrase) Davis 2012 p. 107.

¹⁰ <http://www.blessingwaybook.com> consulted 25.0.15