

THE PAINFUL TRUTH ABOUT BIRTH?: CONTEMPORARY DISCOURSES OF CAESAREANS, RISK AND THE REALITIES OF PAIN

Dr JaneMaree Maher

Centre for Women's Studies & Gender Research, School of Political and Social Inquiry, Monash University VIC 3800, Australia

janemaree.maher@Arts.Monash.edu.au

ABSTRACT

Contemporary debates around the rising caesarean rates in Australia and in other developed countries focus on issues of risk management and questions of control. There is an additional discussion about modern women's desires to experience the messy and complex aspects of birth. Using Elaine Scarry's (1985) idea of pain disassembling subjectivity and the self, this paper begins to consider why pain is little discussed in these debates and speculates about the role it might play in contemporary birthing experiences.

1 INTRODUCTION

I hear a terrible low moaning; threatening guttural sounds that run for an agonizingly long time before a short cessation, as if a breath has been drawn. As the epidural floods into my spine, a moment of insight – those noises are me.

In Australia this year there have been a number of articles about rising caesarean rates and the phenomena of women who are apparently 'too posh to push'. These public exchanges which centred on risk, choice, privilege and propriety prompted me to consider the role of pain in birth and in discussions about women's birthing decisions. In this paper, I suggest that the medicalized risks which often form the focus of debates (the relative 'safety' of caesarean births in a risk averse culture) need to be augmented by recognition of pain as crucial in women's birthing. I speculate that the relationship between contemporary birthing experiences and pain needs to be more carefully examined in order that we understand the material or embodied conditions where birthing women engage with discourses of risk while 'making' decisions.

2 DISCUSSION

2.1 REPRESENTING BIRTH, RISK AND PAIN

Recent reproductive debates in Western media have focused on the rising caesarean rate in developed nations. In the early part of this year in Australia, a heated debate emerged as women journalists and commentators argued about women's "decisions" for caesareans (Deveney 2007, Hamer 2007, La'Brooy 2007, Martin 2007). Satirist and commentator Catherine Deveney (2007) created a flood of correspondence after she said women seeking caesareans were being 'conned'. But her framing of this issue was clearly aimed at the group who are 'too posh to push'. She was roundly criticized by many respondents, including Michelle Hamer (2007), author of *Delivery by Appointment*

(2006), for her judgments about other women's experiences of birthing and caesareans. The letters, commentaries and responses on this topic came primarily from birthing women; they drew on medical statistics, sometimes on medical expertise and on their own experience to suggest Deveney was judgmental about other women's choices.

If a woman chooses to have an elective caesarean, in the same way another way might choose to have a non-medicated home birth, then why can't we just leave both of them the hell alone? (La'Brooy, 2007, p.13).

Alongside this defense of choice was a vigorous discussion of childbirth risk and where it fell most heavily. The competing merits of caesarean and vaginal births were the key focus with women's assessment of risk presented as central in the caesareans decisions. Vaginal birth was tagged as 'a little wild and out of control, messy and unpredictable' (Hamer, 2007, p. 13). The apparent predictability of caesarean births was seen as one of the key merits for women and for their doctors.

"Our society doesn't tolerate risks or uncertainty any more" says Hamer (Martin, 2007, p.4);
Most mothers set out with the best intentions for a natural birth, but are often swayed when the "risk" word creeps into prenatal discussions (Hamer, 2007, p.13);
No Australian doctor has ever been sued for performing a caesarean birth (Hamer, 2007, p.13).

This discourse is not unique to Australian debates: in late 2006 in *The New Yorker*, Atul Gawande (2006) wrote an article entitled 'The Score: How childbirth went industrial' that generated significant controversy. Gawande argued that childbirth risk can and has been reduced through medical interventions, but that information, and control to understand and mitigate risk has been vital to this achievement. It seems risk can and should only be assumed when control can be achieved or kept. This nexus of risk and control therefore rests on the woman as subject making decisions focused on self control and environmental control of birthing; La'Brooy provides an indicative example of this ideal:

Assuming women are being conned by the medical profession ... implies that women are passive, ill-informed and unintelligent.... All of the mothers and pregnant women that I know are the exact opposite (2007, p.13).

There is an irony inherent in a risk-based discussion focused on contemporary childbirth; in Western countries, we now experience historically low levels of maternal and neo-natal risk in childbirth (Searle, 1996) – perhaps given the health of the general population (although not all groups within it), the accessibility of care and medical knowledge, the lowest we can expect. Yet, these gains in neonatal and maternal health have come as a result of, or are at least significantly linked to the medicalisation of childbirth and the on-going review and monitoring throughout pregnancy and childbirth. As Searle (1996) suggests, this monitoring has the result of embedding the medical model of childbirth and its watchfulness and pathologisation as part of every woman's experience. Although birth is safer, the sense of risk outweighs the reality of negative outcomes (Fisher et al, 2006; Searle, 1996) because we keep checking for evidence of those outcomes. This predisposes us to be 'scared by the what-ifs of childbirth' (Hamer, 2007, p.13).

Each of these articles draws on same key concepts of choice, framed as the expression of an individual's will, control and a pervasive sense of risk. Yet, apart from the brief reference to the supposed 'messiness' of vaginal births, issues of pain and control are not mentioned or are quickly reframed as control and risk, as in the quote below.

[Elizabeth Rourke] was not afraid of the pain. Having seen how too many deliveries had gone, she was mainly afraid of losing her ability to control what was done to her (Gawande, 2006, p.59).

It is only in the phrase 'too push to push' that women's birthing bodies and questions of pain, of fear, of dignity and of self-control, are actually referenced, even though the phrase itself is a metaphor for 'too scared to push'. I cannot consider the class implications of the phrase here; that caesarean rates are highest for women receiving care from private obstetricians in private hospitals, but want to explore the more generalized sense that women have 'lost' capacity to give birth 'naturally'; that living in Western industrial societies, they are removed from the grunt, mess and physical challenge of childbirth. In the next section, I turn to pain seeking to understand the meaning and effect of birth pain in this debate about birthing practices, risk and control. I do so with a sense of hesitation as La'Brooy notes, 'ideological battles over women's bodies' (2007, p.13) are deeply gendered and often construct blame for women and a discussion about pain in birth risks evoking this framework. But I argue that the interlinked themes of risk and control need to be augmented by a more critical account of the birthing subject in pain.

2.2 BIRTH PAIN: EASILY FORGOTTEN?

I am too aware of how intensely painful birth can be to cut myself off from the possibility of an epidural, though I admire those who can (Cassidy, 2005, p.257)

One of the many communicative gaps in birth stories is the experience of birth pain. The oft-quoted axiom that 'women forget or they'd never do it again' reflects this difficulty. Yet, pain haunts birthing and our preparation in Western societies; as Wolf argues there is a 'terror' of 'unbearable pain during labour' (2002, p.366), despite a realistic reduction in the risks of unbearable pain due to available medications. This fear of pain is linked to a fear of loss of control – which many women do identify as a central fear in birth (Fisher et al, 2006; Searle, 1996). Pain will potentially push birthing women into a non-rational space where we become other; 'screaming, yelling, self-centered and demanding drugs' (Martin, 2003, p.54). The fear being articulated is two-fold; that birth will hurt a lot and that birth will somehow undo us as subjects. I consider this fear of pain and loss of subjectivity are vitally important factors in the discussions about risks, choices and decisions that subtend the caesarean and indeed many other reproductive debates, but they are little acknowledged. This is due, in part, to our inability to understand and talk about pain.

Elaine Scarry (1985), in her ground-breaking *The Body in Pain*, argues that pain is desperately difficult to communicate to any other being, since it 'actively destroys [language], bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned' (1985, p.4). Scarry also suggests that pain isolates the subject experiencing the pain, since pain is radically private, engendering distance between self and all others. Another's pain cannot be felt, but also cannot also be understood since it can only be expressed through metaphors and analogies; 'it cuts like a knife'. Pain fragments selfhood and subjectivity – fracturing the control we feel we have over our bodies as Western liberal subjects.

Sara Ahmed (2002) reframes Scarry's insight to give pain a more central and defining role in subjectivity. She suggests that 'pain involves the violation or transgression of the border between inside and outside, *and it is through this transgression that I feel the border in the first place*' (2002, p.21). For Ahmed, pain can disassemble, as Scarry suggests, but it is also a key condition whereby we understand ourselves as separate selves. These two insights seem particularly useful to think about the pain of birthing, which pushes towards a separation of one body into two bodies. 'Pain', Ahmed suggests, 'seizes me back to my body' (2002, p.21), but in the case of birthing pain, the body is

bifurcated and unruly. Birthing works against control over the body; Akrich and Pasveer (2005), examining the birthing narratives of 70 women argue that birthing requires a continuing process of negotiating and re-negotiating the relationship between 'self' and 'embodied self', since the body cannot be silenced or controlled in this experience. For a woman giving birth then, already experiencing a form of embodied subjectivity that is splitting, fragmenting and reforming (Maher, 2002), pain further disassembles the experience of a unified self.

This idea of pain as disassembling the self is particularly useful for thinking about birth pain and is critically important in understanding the development of medicalized birth and interventions. As Beckett (2005) notes in her review of caesarean birth, pain has always been central in changes to birthing practices. Women's desires to avoid pain were crucial in allowing allopathic medical practices into the birthing room; chloroform, the 'twilight sleep', and the epidural are all ways of alleviating pain that women actively sought and that led in turn to other medical interventions. And the relationship of pain relief to a controlled self is an important platform for these changes. Wolf argues changes in the management of pain relief throughout the 19th and early 20th centuries were focused on how women behaved, much more than on how they felt: 'appearance meant everything' (2002, p.374). Martin (2003) argues that the same effects can be observed in contemporary birth stories: women try to stay controlled and thoughtful during birth.

This drive to exclude and/or contain birth pain has a number of profound and interlinked effects; some physiological and some socio-cultural. Fisher et al (2006) suggest that fear, and perhaps fear of pain, will affect the course of labour. Wolf (2002) argues that pain relief has in fact been directed to the wrong part of labour; women feel pain most intensely in the first part – but pain relief is more commonly given towards the end where it may be less needed. Structurally, many identify this disavowal and renegotiation of pain as critically linked to medicalization and to authority in terms of birth and birthing experience. Wolf asks rhetorically 'who, after all, is in a better position to judge the severity of labour pain and the timing of pain relief: a laboring woman or the attending physician?' (2002, p.267), yet it is the physician who allows and administers pain relief. More generally, because of testing, monitoring and new birthing procedures, women are no longer the privileged authorities of their own birthing (Akrich and Pasveer, 2005). The forms of surveillance and technology available mean that decisions are taken on the basis of information gathered independently of the birthing woman. Winnick (2004) traces how the changing language of birth reveals the contemporary situation where women are now delivered of their babies, rather than actively birthing them.

I suggest that it might be useful to think of the embodied birthing subject as working between the experience of pain, which remakes subjectivity and potentially disassembles it, and the structure of birthing, where the woman can no longer easily be the author of her own birth. This unsettled and fluid embodied state seems critical for understanding what 'risk' means in the landscape of childbirth. The fear of disappearance or disaster, of 'negative outcomes' inherent in the risk/choice/decision-making rubric of contemporary birthing, occurs when the body/embodied self/rational self relationship is made precarious by pain. Reiger and Dempsey suggest that 'the capacity ... to endure stress and pain is highly influenced by the context within which it is enacted' (2006, p.369), and for the contemporary women where risk, surveillance and rational appraisal are understood as key aspects of birthing, the disjunction between women's visceral embodied birthing subjectivities and the discourses of choice and risk seems important to acknowledge.

Wolf considers that 'women apparently accepted [the] dubious practice [of second stage pain relief] because they were ignorant of the sensations of birth' (2002, p.383). This distance between women and the sensations of birthing may well be increasing; the opportunity to observe birth is so limited now that it means the first birth most Western women 'see' will be their own. The 'untidiness' and loss of control, that are part of

birthing, may come to seem increasingly shocking and pain is central to this. For when we are in pain, we are not selves who can approximate rationality and control; we are other and untidy and fragmented. When women give birth, they are physically distant from the sense of control over the body that Western discourses of selfhood make central; they are very distant from the discourses of choice that frame the caesarean rates debate. I am not suggesting here that women become irrational in childbirth; many feminist scholars of subjectivity have already established that the 'rational subject' is a fictionalized and gendered account of experience. I am however suggesting that we continue to frame birthing experiences and decisions as if that model of subjectivity were the relevant one and in so doing, we move further away from articulating the realities of birthing, of pain and of the ways in which women engage.

3 CONCLUSIONS

Our deep seated desire to limit risk to babies is the biggest force behind [the prevalence of C-sections]; it's the price exacted by the reliability we aspire to (Gawande, 2006, p.67).

Vaginal births are increasingly seen as risky rather than natural by expectant mums and their doctors (Martin, 2007, p.4)

If pain is central to the construction of self and the borders between self and others, and if birth is always already a profound rupture of the self/other dichotomy, it seems that to take birth pain seriously is to recognize the possibility of a very different form of embodied subjectivity during labour and birthing. While the rising Caesarean is interpreted in terms of the risk-averse culture and there is a consistent focus on informed choices as the way to address rising caesarean rates; 'Hamer believes women should become more educated so they can make informed choices if they are faced with a decision on how to deliver their unborn baby' (Martin, 2007, p.5), we need to be more critical about the illusions of control and rationality that underpin these discussions. The birthing body, where there is pain, fear and tumultuous change cannot be collapsed into the fictional controlled body of Western subjectivity; discussions of risk and choice around birthing need to acknowledge this.

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