The time of birth? : Women’s experiences of time during birth

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Abstract:
In many accounts of birthing, time is presented as a key point of conflict with a divergence between ‘medical time’ and ‘natural birthing time’ impacting on how women give birth. For birthing advocates and health care providers, contestations between obstetrical control, with its focus on delineated birth stages and time limits, and women’s own birthing rhythms are often framed as contests between clock time and natural or organic time. This paper suggests that birthing time cannot be easily divided into competing medical and natural timelines. Instead, women experience a complex ‘lived birthing time’, where medical and clock time intersect with other time indicators such as conversations and events and shape their labour experiences. The study underpinning this paper was a small face-to-face semi-structured interview project with women in Melbourne. These preliminary findings suggest that experiences of birth cannot simply be understood as conflicts between medical timelines, and ‘natural’ ones. ‘Birthing time’ may warrant a much more nuanced exploration to understand how women experience and use indicators of time during labour and delivery.

Introduction
Birthing is an experience embedded in time in Western societies. Questions like: ‘How long between contractions?’; ‘What time did your waters break?’; ‘How long was your labour?’ shape medical and social discourses about labour and delivery. Accounts of birthing often focus on the impact of medical timelines on birth, sometimes suggesting adverse outcomes for women (Lane 1995; Rogers-Clark 1998). This paper explores time during labour and delivery, drawing on a small preliminary qualitative study. The
interview data suggests that women’s experience of birthing time is complex, and the findings do not reveal a straightforward conflict between ‘medical’ and ‘natural’ time during birth.

Medical evaluations of risk in childbirth are linked closely to time schedules and deviations are linked to interventions (Lane 1995). Simonds (2002) argues that medical models seek to control women’s births and that ‘time-based mechanisms of medical control have proliferated, maintaining the character of the power relations governing births in hospitals’ (2002: 561). Fox suggests that the obstetric measurement of observable birth signs is at odds with the experience of the ‘woman in labour [who] leaves behind quantifiable time’ (1998: 127). These critiques of medical time implicitly refer to another temporal order, where birth could proceed according to a ‘truly timeless present, a present free from fearful distinctions, the relative time, of reason’ (Fox 1998: 133).

Examining birth time, Kahn (1998) proposes that the linear time of Western societies, which she describes as industrial time, is at odds with life cycle events like birthing that hark back to an older organic temporal order. This distinction of temporal orders draws on a broader theorised conflict between lived time and industrial time (Everingham 2002) and there is a presumption that natural birthing time is distinct from contemporary birthing practices dominated by medical frameworks (Kahn, 1998; Fox 1998; Simmonds 2002). Felski (2000), however, contends that simple distinctions between natural time and linear time are incomplete even when they refer to gendered life events like birthing - as women do construct narratives of development and progress through time, rather than embedding themselves solely in ‘natural’ time. Felski argues that ‘different ways of understanding time’ (2000: 23) may co-exist, rather than conflict, and women’s experiences are clearly shaped by both ‘natural’ and western, linear, industrial time. Barbara Adams too has argued that ‘social time is body and clock time’ (2004: 101), where the time experienced is determined by the body and the prevailing clock time. These formulations were useful for examining how the women in this study experienced and understood time during birth and while I use this terminology throughout for ease of reference, I am proposing that these distinctions are inadequate to describe women’s experiences of time in birthing.
This study focused on time in birth after findings in previous research projects focused on midwife work showed midwives used time-based narratives proactively with birthing women. They communicated to birthing women what was happening and when. ‘Your baby’s coming soon’; ‘In one hour, we will…’, ‘You’re very close now. I am doing this and then we will be ready’. These findings led me to consider birthing time and focus more closely on time in birth narratives. In contrast to accounts that focus on conflict between lived or natural time and medical or clock time (Kahn 1998; Fox 1998), I found women used time — both ‘medical’ or clock time and informally communicated time markers like ‘soon’ or ‘right away’ — to generate temporal narratives that grounded and assisted them in their birthing.

Method

For the study, I recruited ten mothers who had babies between three and twelve months old, using posters at maternal and child health centres and snowballing, for a small scale in-depth qualitative study of birth experience. Institutional ethical clearance was obtained before interviews commenced and all identifying details have been omitted. Each interview was taped and fully transcribed. The women were mostly tertiary educated and living with the baby’s father. Half were describing the birth of their first child; half the second. Six had vaginal deliveries, three had emergency caesarians and one had a planned caesarian (for twins). Eight were generally pleased with the birth experience and two expressed dissatisfaction. Five of the women had private obstetrical care, and five were cared for by hospital midwifery teams. Interventions ranged from none to five, but there was no link between higher numbers of interventions and dissatisfaction.

Using a semi-structured interview schedule, I asked women to describe their birth experience, beginning with early labour and continuing through birthing, giving as much detail as they liked. This elicited birthing stories where the ‘who, how and when’ were important. In this paper, I focus on time in women’s experiences – although there were other issues of information and time, and talk rather than communication, that were significant. I examine how attentive the women were to all temporal markers as they negotiated labour and delivery. In conclusion, I suggest these findings indicate the value of a more sustained investigation of ‘birthing time’.
Time and Experience

While conventional medical accounts focus on distinct time periods in birth, for example, the first stage of labour as contractions leading to the required ten centimeters dilation of the cervix, and antenatal information familiarises women with these terms, they were not used by the women describing their labours. The accounts reflected a continuous experience in time, marked by events and conversations, not stages and milestones. In this sense, the women’s accounts did present a more organic temporal order, not marked by technical stages. But they relied on other time indicators to generate a sense of progress towards birth. This was most apparent in the story Amanda told about her second birth, with her first labour intruding.

Yeah, well I went in wanting a really natural birth the first time. And I think having a bit of a nursing background maybe swayed me towards not wanting an epidural because I didn’t want all the things that went with it. And, so I wanted a natural, you know, a natural birth and read up on that and went with my husband and a girlfriend who were my support people and we got through what I would call a very traumatic experience although a … healthy… natural birth. But it was just awful.

In Amanda’s account, birthing time in terms of her birth history is already complex as the first and the second births are present and intermingled. The impact of the first ‘awful’ birth is important to the second. In the final stages of her second labour, Amanda was assessed and told she was only four centimeters dilated (substantially less than the necessary ten centimeters).

Amanda said:

Of course, I just thought well that is going to X amount of hours or whatever I had in my mind that would be. Whereas if she had said to me, ‘look you are only four centimeters, but your contractions are one on top of the other, this is obviously going to happen quickly, or it could happen quickly’, and then I would have gone ‘oh, okay, well I can probably deal with that in that case’. … I just broke down because I thought there is just no way [I can go on].

Amanda then describes how the anesthetist, arriving for the epidural, was talking to staff in the room.

And plus the anesthetist is standing there saying ‘I think you should just let this woman have her baby’ … I think he said
something like, ‘it could be in fifteen minutes [and] this is going to be over’… And I thought, ‘fifteen minutes… I like your timeframe’.

Amanda was describing conflicting timelines that affected her during labour. She was formerly told it would be several hours before she could expect to give birth. But after the anesthetist’s arrival, in the midst of intense labour and rolling contractions, Amanda overheard his comment about fifteen minutes and focused on a new shorter timeline. This allowed her to manage the intensity of the labour pain differently, to move past her fear and work toward the birth of her baby. Amanda was very conscious of the timeframe in each of these communications and this informed and affected her experience. In this instance, the specific technical information about birth stages and time was at odds with what she heard, but Amanda worked hard to develop her own integrated time-based narrative for what she was experiencing.

This endeavour to generate useful time-based narratives to understand their own birthing was evident in all the women’s accounts, where temporal indicators were critical. Jenny talks of timelines assisting her to manage intense periods of labour.

[Susan the obstetrician] really listened to me when I said, ‘you know, I am in a lot of pain and the pain is worse than my last labour. It wasn’t like this’. And she said ‘that is because you are having … your baby is posterior and it will be more painful’. And I said ‘I can’t keep going with this pain for much longer’ and she said ‘I am not going to make you go on for much longer, you know, don’t worry I just want you to try for a bit longer’. And so umm, she, she was good that way, because she gave me time limits. I found it really good to have time limits.

Julia was relieved that her obstetrician gave her clear limits since ‘there was a reluctance on the midwife’s part to tell me at certain points … where I was in the dilation’. The obstetrician on the other hand, was clear. ‘She said that the baby was going to come any minute. So that was good because I had no idea’.

These timeframes were not driven by the clock necessarily - as Diana said, ‘I have forgotten the times entirely’ - but were related to women’s awareness of what was occurring around them and where they were in the birthing process. These definitions and interpretations were not technical; they often relied on less formal discussion but they produced a coherent sense of progress towards birth. Clearly, this process of narrative
development did not always work effectively, with mistakes and miscommunication occurring. Diana’s account revealed temporal dislocation as what the staff were doing and her interpretation of what that meant generated a confused sense of where she was in her labour.

They’d organised the mats because they thought the birth was going to be quite close, so the mat was kind of laid out. So this increased my … it was kind of my expectations were always running ahead of the actual process with this birth. So, umm, you know, about the whole thing of being in labour and then thinking I was further along than I actually was.

Sally arrived at the hospital much too early in her labour, relying on information from birthing books and classes and then was confused by the assessment of her labour’s slower progress.

I guess I felt with the information I had been given, it was the right time to go, but for my body, it wasn’t because obviously I needed more time.

But all these comments indicate the role of time was substantially more complex than a simple contest between biomedical controls over time and some other ‘natural’ birthing time. Although the women often expressed their lack of attention to both clocks and medical time, they commented gratefully on the re-insertion of time into their birth experiences as the quotations above indicated. Amanda’s despair at the assessment of her progress was really only alleviated by overhearing the anesthetist’s comment about the short time he felt she had left to go. Sally and Diana had to renew and revise their temporal expectations of delivery as information changed their understanding.

The importance of these time-based communications was vivid in Madeleine’s account too, where she couldn’t easily understand hospital staff as she was birthing in her second language. Madeleine found herself unable to reconstruct her labour and caesarian birth as she had no clear sense of what was happening when.

I just don’t know; I don’t know whether I forgot. I just don’t know…. There was no conversation. There was nothing and they just told me that. I mean I can’t remember. Whether they said to me that it was … I mean they probably did say they were going to do the epidural.
Only the time when an anesthetist sat by Madeleine’s head during the caesarean section and described what was happening was clear. She knew what happened because ‘there was a guy next to me who … was actually the one telling me what was going on’. Louise too found it difficult to reconstruct how things happened and put this down to a lack of ‘full and frank discussion … There were lots of fuzzy edges that I can’t make clear about where the decision points for intervention were’. The lack of time indicators disrupted births in these accounts. Temporal indicators taken from staff ‘talking’ or activity occurring around them were important to anchor these women in the experience of birth, and often to flag an outcome that seemed lost in the intensity of labour.

**Time in the Private World of Birth?**

These findings about women’s connection to the temporal progression of their birth run counter to conventional assumptions that women enter their own private worlds in labour (Halldorsdottir and Karlsdottir 1996) and that concepts of time are an imposed mode of control during birthing (Simonds 2002). The women in this study wanted to know how their births were progressing and they wanted a timeline they could use. They listened hard to gather information that would give them a sense of their progress towards birth. Rather than being in a private world framed by a “natural” non-linear birth time, they experienced their births, at least partly, as bound by the linear time in which they live as subjects in the world.

Elizabeth Grosz has argued that ‘there is a common everyday belief in the “arrow of time”, in time’s directionality’ (1995: 96). She also suggests that while ‘time itself has no speed,… for it is … the measure of the speed or movement of an object’ (1995: 93), it is ‘linked to motion: time is the measure of before and after with respect to motion’ (1995: 93). For women engaged in birthing, though the intense physical and emotional labour is clearly of the moment — and may not be directly linked to ‘medical’ or ‘clock time’ — motion towards the birth of the baby is the ground on which their embodied labours and finally their births are experienced. Women’s attentiveness to what goes on around them, their responsiveness to markers of temporal progress towards birth — even when these must be gleaned from overheard conversations or even disagreement between staff, indicate that they are not in a private world. Instead, women’s birthing seems embedded
and embodied in an intensely social world where ‘natural’, ‘medical’ and cultural affects intersect. The forward movement of time is not imposed on birth, but is rather always present in the embodied subjectivity of women and in their sense of where this process is taking them.

**Conclusion**

Rather than expressing conflicts between a natural, organic birthing time and clock or medical time imposed on them, these women used temporal indicators, often gained indirectly, to situate themselves in their births and to give them a sense of progress towards delivery. They developed their own timelines to manage birth, which reflected a combination of medical time, clock time and their own sense of time passing, and they were attentive to what was going on around them. These findings, while preliminary, suggest that birthing time requires more careful mapping. While time is often understood as constraining contemporary birth, closer examination of women’s stories may reveal more complex temporal frameworks being used by women to manage labour and delivery. At the very least, these stories seem to suggest that the common everyday sense of time’s forward directionality is not interrupted by birthing, but acquires new meaning in this intense embodied experience.

**References**


