

The Poetics of Childbearing: Revelations of an Other World

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With the ascent of obstetrics, gynecology, and psychoanalysis, the childbearing woman's subjectivity has been increasingly eclipsed by that of her child-to-be. This article describes the sociohistorical understanding of childbearing and shows how it has become intertwined with four women's lived experiences of pregnancy and birth based on diaries and interviews they completed for this study. The participants' childbearing experiences revealed an ambiguous, sensual symbiosis between themselves and others that threatens the Western notion of a free-floating, solipsistic subject exemplified in fetal photographs and ultrasound images.

*The gestation and fruition of life which can take place in the female body—
has far more radical implications than we have yet to come to appreciate.*
—Adrienne Rich, *Of Woman Born*.

The Poetics of Childbearing

Three images come to mind when I think about the origins of human life as depicted in popular culture, medicine, and psychoanalysis. The first is Lennart Nilsson's prenatal photography where the fetus appears like an astronaut alone against a black sky. In such images, the pregnant woman appears *out of the picture* even though the picture would have been impossible without her. In the second image, prevalent in the United States, the childbearing woman is birthing on her back on a table in a hospital, tangled with the wires of a fetal monitor and an intravenous drip; she is depicted as an inefficient machine that needs a doctor and an efficient staff to help her produce the best "product" (Martin, 1992; Davis-Floyd, 1992). In the third image, derived from Sigmund Freud, (1925/1963d) the child is merely a penis substitute to allay the anatomical wound of being castrated. Each of these images metaphorizes the childbearing woman in a new way: in the first, she is the "space" of life; in the second, she is a dysfunctional machine; and in the third, she is a castrated creature.

Feminist writer and poet Adrienne Rich would consider these derogatory metaphors part of the institutional story of childbearing. In her landmark book, *Of Woman Born: Motherhood as Experience and Institution*, Adrienne Rich (1986) says that we have confused *women's own stories* of their childbearing experiences with the *institutional story* of childbearing. The institutional story emerges from the influential and authoritative

discourses, practices, and places of childbearing within Western culture, from obstetrical texts in medical libraries to birthing rooms in hospitals. The institution is not a particular building that pregnant women enter; rather, it is a sociohistorical framework of childbearing that psychologists and obstetricians have instituted and endorsed. Within this story, childbearing women's experiences have been absent or discounted.

This article tells a new story of childbearing by adopting a research method that I call poetics. The purpose of poetics is to articulate the ambiguity of women's lived experiences as they unfold within the sociohistorical context. I begin with a sociohistorical hermeneutics by reading three prevalent childbearing metaphors—space, machine, and castration—as texts that portray the world that childbearing women inhabit. Second, to explore how they experience this world, I compare and contrast the sociohistorical hermeneutics of childbearing metaphors with four women's experiences of pregnancy and birth to determine the extent to which the childbearing metaphors in medicine and psychology accurately portray their lived experiences.

Many works have already investigated the impact of childbearing metaphors on women's experiences: For instance, Dubow (2011) and Duden (1993) explore the spatial childbearing metaphor; Wolf (2003), Block (2007), and Davis-Floyd (1992) explore the mechanistic metaphor; Rich (1986) and De Beauvoir (1949/2009) explore the castration metaphor. Nevertheless, they focus primarily on one metaphor. The aim of the poetic approach in this article is to show *how all three of these* metaphors are inextricably intertwined with each other and women's childbearing experiences. The result is a new story that changes how we see childbearing women as well as medicine and the origins of psychoanalysis.

*The Institutional Story of Childbearing:
How Childbearing Became Man's Business*

Since 1965 when Lennart Nilsson pioneered prenatal photography, fetal images have pervaded documentaries, developmental textbooks, and magazines such as *Life*, *Time*, and *Newsweek*. The editors of *Life* included Nilsson's photograph of the lone fetus, *How Life Begins*, in a collection called *100 Photographs that Changed the World*. According to the editors, they chose the photograph because "Nilsson's painstakingly made pictures informed how humanity feels about...well, humanity" (Sullivan, 2003, p. 171). Their ellipses are telling, for like the photograph, they reflect the omission of childbearing woman; the statement suggests that she has been excluded from humanity while the fetus' humanity is focal. The loss of

the childbearing woman's humanity in such photographs began centuries ago when she lost her status as the exclusive authority on childbearing.

In the seventeenth century, the birthing woman's body became metaphorized as a malfunctioning machine that must be controlled through male intervention (Merchant, 1989). Consequently, in birth, a realm where woman had always been an active and autonomous subject, she became regarded as a passive object subjected to mechanistic laws best understood by men. Men became "experts" on an experience they could never have and excluded the birthing woman's knowledge, experiences, and perspectives from their obstetrical sciences.

This shift arose from the new belief that the birthing woman, like nature, needed human intervention to function properly. Nature was no longer viewed as a magical and powerful force that one must obey, but as an entity to control and conquer. Likewise, birth was no longer a natural event where men were excluded, but an unpredictable and dangerous event that necessitated the expertise of men. Just as rituals and restrictions about tampering with the earth were lifted for miners during this era, so were rituals and restrictions that prohibited men from tampering with the birthing process. Removing mining restrictions allowed men to reap profits from exploring the inner recesses of the earth (Merchant, 1989). Likewise, seventeenth century male barber-surgeons and physicians realized that they could profit by exploring the hidden recesses of a birthing woman and thereby expand their practices and monopolize midwifery. (Wilson, 1995). As men became interested in the birthing process, traditional female midwives were increasingly discredited.

Discrediting midwives was not a new phenomenon. It had begun during the Inquisition when many were burned at the stake for witchcraft (Ehrenreich & English, 1973). In fact, the manual used by the Inquisitors to identify and prosecute witches, *The Malleus Maleficarum*, written by Heinrich Kramer and James Sprenger (1486/1971), linked midwifery with witchcraft. In addition to claiming that midwives regularly killed children and offered them to the devil, Kramer and Sprenger (1486/1971) also *accused midwives of healing*, which they considered even more dangerous. Witch hunting authorities concluded that such women's healing *powers must be derived from the devil* because women had been prohibited from studying at the University. Otherwise, without an education, how could she possibly know how to cure another?

Defending herself with the *ample experience* she developed from her training as an apprentice attending births would not redeem a midwife; the Church authorities cast suspicion on empirical approaches that relied on the senses rather than on faith or doctrine. They surmised

that the devil worked through the senses (Kramer and Sprenger, 1486/1971). Thus, midwives, who acquired knowledge through their senses, were especially susceptible to the corruptive powers of the devil.

Given that midwifery is based upon an empirical apprenticeship, one might assume that the scientific revolution would have empowered the midwives' practices. After all, philosophers such as Francis Bacon (1620/1994) advocated scientific knowledge derived from empirical approaches. The empirically oriented scientific revolution, however, did not improve the plight of midwives. The empiricism espoused by its leaders, such men as Bacon and Harvey did not include the everyday experiential approach that midwives utilized. Instead, their empiricism necessitated a formal education denied to women (Ehrenreich & English, 1973). In fact, during this period, male physicians and barber-surgeons struggled to abolish traditional midwifery models and to develop man-midwifery as a new science founded upon the discoveries of anatomy and dissection, subjects already esteemed in the Universities. In the 1700s when surgeons began establishing midwifery programs based on formal training in the anatomical sciences, women were excluded even though they had historically always been the exclusive practitioners of midwifery. So while midwives were not burned at the stake once the scientific revolution and the enlightenment emerged, they would eventually be exiled from their own profession by male physicians and man-midwives who took over by deeming them ignorant and unfit for the required education.

Without the formal education, economic resources, and political influence of their male counterparts, midwives could not defend themselves from the slander levied against them (Wertz & Wertz, 1977). Despite such disadvantages, however, midwives did not disappear from the European birthing scene. Furthermore, in countries such as the United Kingdom, Scandinavia, and the Netherlands, midwives not only survived, they eventually thrived. In fact, with the exception of the United States, midwives have been the primary attendants at births in almost every country (O'Dowd and Philipp, 1994).

Anthropologist Sheila Kitzinger (2000) traces midwifery's demise in the United States back to the 1760s when the American colonists began turning away from midwives to distinguish themselves from the old European way of birthing. Ironically, later, during the Victorian period in America, pregnant women of the middle and upper classes preferred man-midwives because they were educated "European-style." They also preferred male attendants because they were generally perceived as more educated and competent (even if this was not the case). Furthermore, by charging three to four times more than traditional midwives,

man-midwives found favor with the middle and upper classes who equated a great expense with prestige and wealth (Knibiehler, 1993).

This shift from female midwives to male obstetricians profoundly affected the milieu of birth for American women of all classes. Through monopolizing the profession of midwifery, male obstetricians monopolized not only the meaning of birth, but also *the meaning of being a childbearing woman*. As Wertz and Wertz (1977) explain:

maleness became a necessary attribute of safety, and femaleness became a condition in need of male medical control... (p. 72)
Further, as an initiation rite for women, birth became a moral test and a physical trial in which the male doctor, not merely the company of women, judged a woman's passage into adult society. (p. 73)

In addition to excluding women from the medical professions in the nineteenth century, physicians began excluding them from attending the births of their closest female companions. Up until the nineteenth century, birth was still considered a special occasion where women expressed their mutual love and care by assisting each other during and after it. In addition to a female midwife, toward the end of her pregnancy a woman invited her mother, friends, relatives, and neighbors to attend her birth. Upon her request, once labor pains began, her husband summoned the women she had invited—usually about five women. When the women arrived, her husband, as well as any other men, were required to leave the area. The female attendants then prepared what was called a lying-in chamber: curtains were drawn, keyholes covered, and candles lit, creating a womb-like milieu. In this sheltered space, the female companions nurtured the pregnant woman during birth and until one month afterwards (Wilson, 1995).

The women who attended to the birthing woman were called *god-sibs* which meant “Siblings or Sisters of God.” Eventually, the word “god-sibs” became contracted into the word “gossips” (Kitzinger, 2000; Wilson, 1995). By the eighteenth century, the meaning of gossip extended beyond birth companions and referred to the idle chatter that some believed characterized any female gathering. This derogatory meaning emerged from men's negative associations to the lying-in period, a custom which some of them resented. Far from quiet, the lying-in period was noted for its jovial atmosphere, infused with leisurely talk and laughter. Referring to this ritual, a man in 1683 wrote “for gossips to meet... at a lying-in, and not to talk, you may as well damn up the arches of London Bridge, as stop their mouths as such a time. ‘Tis a time of freedom, when women... have a privilege to talk

petty treason” (qtd. in Wilson, 1995, p. 30). Apparently, lying-in was a time of freedom, perhaps one of the only times of freedom accorded to women.

However, as male physicians continued to compete with midwives and to challenge their authority along with the authority of experienced mothers, the communal nature of birth began to change:

Indeed, nineteenth century doctors, possibly feeling ill at ease under the watchful eyes of many women, were inclined to urge the removal of all from the delivery room except one, a hired nurse or a friend who would obey the doctor’s orders. (Wertz & Wertz, 1977, p. 5)

In addition to excluding female companions from the delivery room, physicians also discouraged women from discussing sexuality, pregnancy, and childbirth with each other. According to historian Amanda Banks (1999), pregnancy was no longer an acceptable topic of polite conversation. When pregnancy and birth were discussed, people used euphemisms such as storks and cabbage patches. In fact, both pregnancy and the pregnant woman were banished from everyday discourse and life. Banks says that women endured pregnancy in a “contrived seclusion” during which they rarely shared their experiences with other women (p. 49). Following from this, sexuality, pregnancy, and childbirth were transplanted from a woman-centered world to a male-centered one. The renowned nineteenth century neurologist S. Weir Mitchell, for example, forbade his female patients from discussing their health with anyone but him. Moreover, he also discouraged them from asking him too many questions.

The silence that shrouded women’s experiences in the nineteenth century was a relatively new phenomenon. It sharply contrasts the loud and festive milieu within which women gave birth prior to the seventeenth century, amongst their closest female companions (Wilson, 1995).

The dwindling of female midwives, the loss of female supports, and the withholding of information by physicians, suggests that women had no one to talk to—no more gossips with whom to discuss sex, pregnancy, or birth. They were thus excommunicated from discussing what were undoubtedly momentous events in any woman’s life, especially during a time when femininity was defined by maternity.

Freud: The Hysteric’s Gossip

The silence that shrouded woman’s reproduction paved the way for Freud to build a science of being a confidant—a professional “gossip”—to women. Rather than discourage his female patients

from talking as S. Weir Mitchell had, he encouraged them to speak about whatever came to them. When women had the occasion to discuss whatever came to mind, as Freud had so invited, they often discussed reproductive issues. Freud noted in the case of Dora:

I have already indicated that the majority of hysterical symptoms, when they have attained their full pitch of development, represent an imagined situation of sexual life—such as a scene of sexual intercourse, pregnancy, childbirth, confinement, etc. (Freud, FN 1905/1963a, p. 94)

These were all issues no longer allowed in polite society, but that surfaced—in words or deeds—during the course of analysis. Anna O. staged a pregnancy. Dora read about pregnancy, childbirth, and virginity in an encyclopedia to quell her sexual curiosity. She enacted a childbirth fantasy, Freud says, through a “supposed” attack of appendicitis. Moreover, according to Freud, her nurturing relationship with children revealed maternal longings.

Psychoanalysis, which by Freud’s own account originated with cases of hysteria, has ever since been linked with sex, pregnancy, and birth—all of which had recently been transformed by obstetrics and gynecology. The interconnections of hysteria, sex, pregnancy, birth, gynecology, obstetrics, and psychoanalysis are best expressed in the following syllogism: *hysteria is to psychoanalysis as pregnancy and childbirth are to obstetrics and gynecology.*

In obstetrics, gynecology, and psychoanalysis, women found themselves in the same position: confined to a reclined position that conveyed that they were ill and that male expertise could save them. Before the rise of the man-midwife, women *birthed upright in a squatting or kneeling position*, against a stool or hammock, with female birth attendants supporting them. Later, when men and women changed positions as childbirthing authorities, the birthing woman’s position *literally* changed from being upright to horizontal. This shift metaphorically conveys the birthing woman’s loss of authority, autonomy, and control during birth; it also signifies illness. While women delivered babies on a birthing bed, hysterics delivered symptoms in a horizontal position on Freud’s couch.

Freud (1905/1963a) even referred to himself as a gynecologist when describing his approach to hysteria. Gynecology was respected enough professionally in Europe and America that he defended the sexual frankness of his prefatory remarks in case of Dora by saying, “I will simply claim for myself the rights of the gynaeologist” (p. 3). He later extended his defense, describing how his psychoanalytic work is similar to that of a gynecologist:

It is possible for a man to talk to girls and women upon sexual matters of every kind without doing them harm and without bringing suspicion upon himself, so long as, in the first place, he adopts a particular way of doing it, and, in the second place, can make them feel convinced that it is unavoidable. *A gynecologist, after all, under the same conditions, does not hesitate to make them submit to uncovering every possible part of their body.* The best way of speaking about such things is to be dry and direct.... (1905/1963a, p. 41, emphasis added)

Like the gynecologists and obstetricians of his day, Freud did not hesitate to “*uncover every possible part*” of girls and women. According to medical historian Elizabeth Fee, such sexual metaphors of woman (and nature) as something to be “unveiled, unclothed, and penetrated by masculine science” have been prevalent since the sixteenth century (qtd. in Sargent & Brettell, 1996, p. 2). Professional pioneers languaged their discoveries with the bravado of a man breaking a woman’s hymen, entering ‘virginal’ territory and colonizing a strange fertile land. Obstetricians had broken the taboo of entering the birthing chamber and had penetrated the vagina with forceps; gynecologists had broken the taboo of peering into the vagina and had probed it with the speculum; and now Freud (1905/1963a) broke the taboo of *listening* to women’s “most secret and repressed wishes” (p. 2).

By listening to women, he acknowledged the inadequacies of the anatomical-physiological sciences. To solve the riddle of hysteria, he instead developed a science that involved turning away from *physiological* causes toward *psychological* causes. Unlike his predecessors, Freud did not uncover every part of women’s bodies. Rather, he uncovered every part of their “minds”—that is, through listening to their words, he analyzed their dreams, feelings, thoughts, and perceptions. He thus became a confidant to women in a world where relationships among female supports—gossips—were strained by cultural changes.

In the case of Dora, he also describes himself as a “conscientious archeologist” who was striving to “bring to the light of day after their long burial the priceless though mutilated relics of antiquity” (Freud 1905/1963a, p. 7). Like an archeologist, Freud unwittingly excavated hidden fragments of women’s childbearing past that were manifesting themselves in the body and discourse of hysterics during the Victorian Era. He recognized early on, for instance, the connection between hysteria and witchcraft, acknowledging that during the Middle Ages hysterics had been condemned as witches. In a letter to Fliess, he also drew parallels between his theory of hysteria and the medieval theory of possession:

What would you say, by the way, if I told you that all of my brand-new prehistory of hysteria is already known and was published a hundred times over, though several centuries ago? Do you remember that I always said that the medieval theory of possession held by the ecclesiastical courts was identical to our theory of a foreign body and the splitting of consciousness? (1985, p. 224)

Freud also noted that the confessions of both witches and hysterics involved phallic symbols—sharp instruments such as pins, needles, and knives. For Freud, these phallic symbols signified a *sexual trauma that had been repressed* and had now reemerged in a new form, possessing the woman's body like a demon that takes over until she can no longer function.

When Freud wrote again to Fliess the following week, he reported that he had ordered the *Malleus Maleficarum*. As stated earlier, this was the manual used by the Inquisitors to identify and prosecute witches; it contributed to the downfall of midwifery by linking it with witchcraft.

Despite Freud's stated intention to delve further into the parallels between witches and hysterics, after this letter it seems he never did (1985, p. 224). If he had, he may have discovered that witches of the Middle Ages and hysterics of the Victorian Era shared more than torture from phallic symbols, bodily possession, and the splitting of consciousness; both of these conditions arose during a similar sociohistorical context regarding medicine.

The persecution of 'witches' emerged at a time when male physicians strove to exclude the majority of women from practicing medicine except for midwifery (Ehrenreich & English, 1973). Similarly, the diagnosis of hysteria emerged at a time when obstetricians and gynecologists strove to exclude women from practicing midwifery. Persecuting women as witches and diagnosing them as hysterics both coincided with women being *excluded from professions* where they once *possessed power and authority apart from men*. Now, instead of possessing authority, they were increasingly finding themselves "possessed" by male medical authorities who excluded them from practicing medicine and turned to surgical castration to heal them.

Castration: The Social Mutilation of the Childbearing Woman

Ovariectomy, often called female castration, was first performed in 1850 to remove a cyst. By the 1870s, however, gynecologists began removing ovaries to cure a variety of pathological behaviors including hysteria, excessive sexual desire, and aches and pains with no organic cause. (Laqueur, 1990; Ussher, 1989). By 1906, a gynecologist estimated that

150,000 had been performed in the United States alone. Men, in contrast, were rarely castrated except for criminal insanity or to treat prostate cancer (Ehrenreich & English, 1978). Castration was thus a woman's condition.

Accordingly, Freud explained that, the girl "accepts castration as an established fact, an operation already performed." (1923/1963b, p. 171). His words, "*an operation already performed,*" sound like Freud meant castration as an actual surgical event. However, he was not referring to surgery but to a *genital trauma* inflicted at birth by being born female and, consequently, without a penis. Freud said that when a girl first notices her difference, she thinks that she will grow a penis, she denies its absence, or she thinks of her clitoris as the "penis-equivalent" (1933/1965, p. 146). Eventually this changes when she realizes that she *is* castrated and will *never* grow a penis. Freud says thereafter the girl notices not only that she's castrated but "*its significance too,*" meaning her inferiority (p. 155).

The girl realizes that not only has she been castrated, but so have all women. Castration is thus a universal characteristic among women. When the "universality of this negative character of her sex dawns upon her," Freud says that "womanhood, and with it also her mother, suffers a heavy loss of credit in her eyes" (Freud, 1931/1963c, p.192). Conversely, her father and men become idealized when she realizes that they can provide what women cannot: the penis and impregnation which enable her to improve her value and worth through childbearing.

And so within psychoanalysis we learn that with each generation, a mother passes to her daughter the same castration, rivalry, and attempts to substitute a penis with a child that her mother had inflicted upon her. And each generation of mothers and daughters will further deprive each other of the phallus, the emblem of power. The mother cannot provide the phallus to her daughter so the daughter must turn to her father. Likewise, the daughter cannot provide the phallus to her mother so the mother must turn to a son. Both signify each other's deficiencies. At best the daughter can provide her mother with a grandson. He becomes their only hope to heal their mutual wounds of castration.

Reflecting on terms such as castration and the child as a penis substitute, Rich (1986) chastises Freudian analysis for its "tone-deafness in the language" (p. 201). Freud and his followers, she says, overlooked the ways that women are "socially mutilated" (p. 202). For her, castration is a metaphor for not only the ways in which women are disempowered, but the ways in which they can also disempower each other, particularly mothers and daughters. Simone de Beauvoir (1949/2009) describes how mothers disempower their daughters in the *Second Sex*:

The disgust they feel for their sex could incite them to give their daughters a virile education: they are rarely generous enough to do so. Irritated at having given birth to a female, the mother accepts her with this ambiguous curse: "You will be a woman." She hopes to redeem her inferiority by turning this person she considers a double into a superior being; and she also has a tendency to inflict on her the defect she has had to bear. (p. 562)

Enraged and disgusted by their mothers' social mutilation, Rich (1986) says that daughters then turn away from their mothers toward men. They dread becoming like their mothers, a condition she calls "matrophobia":

Matrophobia can be seen as a womanly splitting of the self, in the desire to become purged once and for all of our mothers' bondage, to become individuated and free. The mother stands for the victim in ourselves, the unfree woman, the martyr. Our personalities seem dangerously to blur and overlap with our mothers'; and in a desperate attempt to know where mother ends and daughter begins, we perform radical surgery. (p. 236)

The mother becomes the daughter's nemesis from whom she must free herself. She achieves this through "radical surgery" which consists of severing the symbiosis between herself and her mother. The psychoanalyst and linguist Julia Kristeva (1989) indicates that such radical surgery is not only valuable but necessary: "For man and woman the loss of the mother is a biological and psychic necessity, the first step on the way to becoming autonomous. *Matricide is our vital necessity*, the sin-qua-non condition of our individuation" (pp. 27-28, emphasis added).

To survive and thrive, the daughter, like a son, must sever the umbilical relation to her mother. During pregnancy this becomes especially difficult, if not impossible, since childbearing can reawaken the daughter's identification with her mother and thus threaten her individuation. Furthermore, in becoming a mother, she longs for her own mother and wishes to protect her. Nonetheless, she must kill her mother to save herself. The only alternative to matricide, Kristeva believes, is depression, which she calls "putting to death of the self" instead of the mother (p. 28).

If *matricide is an antidepressant*, as Kristeva suggests, then we can credit scientists and media venues for protecting us from the contours of the mother's flesh in fetal photographs. Within such images, the mother *has ceased* to exist, whereas the fetus emerges as an astronaut in space, a victorious hero freed from the mother's body. To grow up and

become civilized, in Western culture, means to turn away from one's mother and identify with the father (Rich, 1986, p. 198). In obstetrics and gynecology, civilization means identification with the "manly" pursuits of science and technology; in psychoanalysis civilization means identification with the father. Either way, these disciplines begin with the unquestioned assumption that we must get rid of mothers, or at least disempower them, in order to preserve ourselves as individuals.

*Being a Nothingness:
Institutional Metaphors as Lived by Childbearing Women*

Davis Floyd's (1992) research suggests that women take up institutional metaphors in multiple ways—some resist, some submit, and some adapt to them. To explore ways in which women's childbearing experiences concur with, contradict, or transcend the sociohistorical metaphors, I collected descriptions of women's lived experiences of pregnancy and childbirth through diaries and interviews.

Four white women ranging from 30-44 participated in this study. The pool of participants for this study was not culturally and ethnically diverse as I had hoped. Nonetheless, they did vary in educational background. Of the four participants who completed the study, one earned a master's degree, two earned associates' degrees, and one never attended college. Although all four women were in committed relationships, three were married and one unmarried. All lived with their partners. Three participants were first-time mothers employed full-time throughout their pregnancies. For the fourth, this was her fourth pregnancy; she home-schooled her other three children. The women were scattered among three different New England states: one lived in northern Massachusetts, one in eastern Connecticut, one in southern Connecticut and another in southern Maine.

Despite their differences, the participants' experiences confirmed that the sociohistorical metaphors were not simply ideas about their childbearing experiences; rather they were inextricably intertwined with them. According to the philosopher Paul Ricoeur (1975/1997), metaphors make "ontological commitments" about what it means to be in the world (p. 249). In this way, the ontological commitments of metaphors have existential consequences—they affect the childbearing woman's ways of being in the world. Writer Helene Cixous (1976/1981) boldly claims that men have "flaunted" their metaphors like "banners throughout history" (p. 47). From the sociohistorical hermeneutics stories, I conclude that the banners read: the childbearing woman does not exist.

In their diaries and interviews, all four participants of this

study— Tammy, Anna, Mandy, and Heidi¹ —described how they no longer felt significant after giving birth. During an interview, for instance, Tammy explicitly stated that she felt like she no longer existed. She had been discussing how she felt closer to her mother throughout her pregnancy and after giving birth. Then, after a long sigh, she said:

We're closer in that way because she wants to see the baby all the time. *But I don't think I exist anymore.* Honestly, we talk 99% of the time just about the baby. Before it wasn't about the baby, *it was about me.* It's about the baby now. (p. 424)

Her words stunned me. She summarized what I had encountered in sociohistorical metaphors of childbearing—the erasure of the childbearing woman's existence and the emphasis on her baby.

Mostly though, her pronouncement stunned me for personal reasons. During Tammy's interview, I realized that I had behaved similarly toward my sister. Like Tammy's mother, I had unwittingly negated my sister's existence in our conversations after she gave birth. When I called her, I no longer greeted her with, "Hi Lori, how are you doing?" Instead I asked her about the baby. Then, *if I remembered*, I asked about my sister, as if she had become an afterthought. Realizing that I had participated in the cultural negation of my sister as a person distinct from her baby troubled me. Besides the hypocrisy I felt for behaving this way toward my sister while critiquing others in my research for doing the same, I realized how entrenched the disavowal of the childbearing woman's existence as a human being has become in everyday life.

The other participants also felt that their existence had been negated or diminished by others. Anna, like Tammy, expressed feeling secondary to her baby after giving birth. When she arrived home from the hospital, she was dismayed to discover that no one, besides her husband, was helping her in the way that she had envisioned. During her pregnancy she had envisioned women, specifically her mother and sisters, caring for her after giving birth. But that didn't happen. Instead of being offered the soda, tea, and toast she expected, Anna's mother and sisters "attacked" her with questions about what she wanted them *to buy for the baby rather than what they could provide for her* (p. 462). These circumstances disappointed and vexed Anna.

Heidi, who was pregnant for the fourth time during this study, explains what Anna and Tammy may have been feeling. "With the first baby," she says, "I think it's really common to feel blue with the buildup and the showers. Then your husband goes back to work and you still have to learn to do this by yourself with no family. Who

wouldn't be blue?" (p. 533). Moreover, she says that new mothers underestimate the needs of their newborns. She explained that it is easy to become resentful, to feel "touched out" as though one's "emotional tank" is empty (pp. 537 & 502). She uses these words to express how new mothers feel depleted from giving so much day and night to meet the needs of their children without receiving care from anyone else.

Mandy, for instance, felt "physically and emotionally drained" with only a few minutes to herself each day during the first few weeks after giving birth. Although she loved being at home with her baby, Andrew, she explained that she missed feeling a "sense of importance" (p. 497). She distinguished the importance she felt as a mother from the importance she derived from work:

It's only natural that my baby would need me and that I would be important to him, but it's a different thing to be important to an organization.... They don't have to need me, but it's just natural that Andrew would need me. I've earned being needed at work. (p. 497)

Mandy's words suggest that while she feels important to her son and to her husband, she *doesn't feel as important in the world*. Worldly importance *must be earned* and, apparently, mothering does not earn that importance.

Mandy's words summarize an experience that the other participants hinted at—feeling *less important* to people within the larger culture, people other than their babies and husbands. Conversations between my sister and I, and those between Tammy and Anna and their mothers, suggest that the childbearing woman loses her place as a *subject* in discourse. The baby literally replaces her as the subject of conversation. Moreover, she feels that the baby has become the exclusive *subject* of her life. As Tammy put it, "I don't think I exist anymore."

Struggling to Be Heard

When Tammy told her doctors that she feared her extraordinary pain meant that she might miscarry, they explained that "it's just the baby growing." A week later she called again because the pain was unbearable. Once again the doctors reassured her that her pain was from the baby growing until she became angry and demanded that they check again. After an ultrasound, the doctor realized Tammy had kidney stones and a bladder infection. Tammy had known that *something* was wrong. Yet initially the doctors were unwilling to listen to the significance of her experiences. Thus, Tammy found herself frustrated and angry in a world where her experiences were discounted.

Similarly, when Anna had been experiencing intense cramps along with a watery, bloody discharge, she called her doctor concerned that she was in labor and that her water had broke. Her doctor told her to visit the office. When she arrived, she explained to the doctor that she had timed the contractions and that they “didn’t seem regular” (p. 454).

After examining her, he assured her that her water had not broken and she was merely experiencing Braxton-Hicks contractions, explaining that such contractions were not “real” but that they could be very painful and Anna would “just have to endure this pain, that’s all there is to it” (p. 452).

“I’m afraid that I’m not going to know if I go into labor,” Anna told him.

“Oh no, you’ll know,” he replied (p. 454).

Convinced that she was not in labor, they scheduled an appointment for a Cesarean section for the following week.

That night and the next day the contractions worsened. Anna comforted herself in any way she could: relaxing by taking a bath, squatting on the toilet, talking to her husband on the phone, and crying from the pain. She didn’t think that she was in labor because when she measured her contractions, they didn’t fit the designated pattern detailed in her childbirth book or in her doctor’s description of contractions. After twenty hours of “irregular contractions,” when she could no longer bear the pain, she finally decided to call the doctor again. He told her to come in and that if labor had started they would schedule a Cesarean section earlier than they had planned. By the time she arrived at the hospital, the nurse checked her cervix and realized that Anna was fully dilated and, therefore, ready to push. She had been in labor the entire time.

Anna panicked when the nurse told her that she could not have a Cesarean section since her doctors had previously told her that she would never be able to deliver vaginally because of a prior surgery. Despite this, she delivered her son within twenty minutes without complications. Afterwards, she could not believe the ease with which her son “flew” out of her, especially since she never attended any childbirth classes (p. 457).

Although Anna expressed no complaints about her obstetrician, her story, like Tammy’s, reveals the subtle ways in which obstetricians disregard childbearing women’s experiences. Tammy and Anna, for their part, did not initially question the authority of their doctors. They presumed that their doctors *must know* since they earned professional degrees that provided them with specialized knowledge and tools. When it became apparent to these women that despite this training their doctors were wrong, they found

themselves disturbed. Tammy's and Anna's situations reveal the intrinsic ambiguity of birth and life—sometimes no one, no matter how educated they might be, knows what is happening. Tammy and Anna turned to the doctors to eradicate this ambiguity by clearly answering their questions: “What is wrong?” and “What should I do?” Tammy acknowledged that:

I really want all the answers to come from them and not me because I didn't go to school for anything. For me to guess and I'm right, you kind of wonder sometimes why they don't know this. They're doctors and they got all the big money. (p. 402)

Like Tammy, Heidi initially believed that costly care meant better care. She said that for her first pregnancy she chose an obstetrician because she thought that the “best care was the most expensive and involved” (p. 517). Her opinion changed, however, as a result of her experience with her obstetricians. She said that the doctors treated her as though she was “high-risk” and like she was an “idiot” (p. 518). After this experience, she decided to go to a family practitioner who described seeing birth as a natural part of family life rather than as a disease. During her fourth pregnancy, to know as much as she could about obstetrics, she stayed up late each night reading *Williams Obstetrics*, stating that “I have seen doctors stop treating me like some pathetic little patient. I get more respect because I know this stuff” (p. 505).

Mandy, like Heidi, also informed herself as much as possible about obstetrics during her pregnancy. She devised a birth plan which included the following: being upright during birth, eating and drinking, and forgoing the use of electric fetal monitoring and an episiotomy. When she discussed this plan with her doctors and supported it with evidence from research, she said her doctors initially agreed to it. However, when she gave birth, Mandy ended up in bed, permitted no food or drink except for ice chips, hooked up to an electronic fetal monitor, and she had an episiotomy. When Mandy's sister, Heidi interceded to advocate for Mandy's wishes, the doctor and the nurse did not uphold Mandy's birth plan.

For instance, despite her birth plan the doctor told Mandy that she must have electronic fetal monitoring and that she could only have ice chips. When he left the room, Mandy's sister told her that Mandy did not have to do what the doctor told her. Mandy reported that the doctor must have been listening through the door or on an intercom because he returned to tell Mandy's sister that if she “didn't shut her mouth he was going to call security and get her out of there” (p. 487). Mandy expressed her fear during that moment:

I was saying [to her] “I don’t want to make enemies here. I don’t want them to slice me open because you provoked them.” I just really wanted to beg her... “please just don’t make enemies because this doctor was about to wheel in this tray with all these stainless steel instruments that looked really scary.” (p. 487)

The obstetrician possessed the authority to challenge and disregard Mandy’s wishes regardless of their prior agreements and despite the evidence Mandy had presented. For instance, the doctor’s unwillingness to allow Mandy to birth upright was not based on any evidence that birthing horizontally improves the health of the mother or child, since no such evidence exists. Her doctor told her that he did not want her to birth in an upright position because he had a “bad back” (p. 486). Thus, his stricture was not based on scientific evidence, but on his personal convenience.

Unlike Tammy and Anna, Heidi and Mandy *questioned the authority* of their obstetricians. Questioning his expertise, however, did not empower them. Mandy was still forced to give birth according to his protocols. When she and her sister argued otherwise, Mandy not only felt slighted, she felt threatened that such a provocation might lead the doctor to “slice her open” (p. 487). Meanwhile, the physician effectively silenced her sister. Mandy said of the situation, “I couldn’t afford the energy to care too much” (p. 487) and “I felt the disappointment, but I was in no real mood to argue. I mean, you just roll with whatever you’re faced with” (p. 489). Robbie Davis-Floyd (1992) suggests that Mandy’s resignation to her doctor’s wishes arose from the inherent vulnerability of the birthing process:

The “opening” that occurs during birth is quite literal—a birthing woman’s cervix must dilate to a diameter of ten centimeters in order for her baby to be born—while the stress, anxiety, and pain of the labor process are often enough in themselves to ensure simultaneous category breakdown and psychological opening. (p. 39)

Heidi’s reflections on her previous birthing experiences supports this. She says, “when you’re in labor, your opinion is very malleable. You forget why you wanted certain things” (p. 518).

Bearing the Pain

As the childbearing woman’s cervix opens and thins, her vulnerability and pain intensifies. At times the participants felt hopeless, helpless, and unsure of their ability to move through labor. Desperately,

they sought a way out, but they knew there was no reprieve. During the period of “transition” when the cervix dilates to 8-10 centimeters, the participants felt inconsolable. Tammy thought that she was dying, Mandy wished she could jump out of the window, and Heidi believed that she would forsake her identity by seeking pain medication, thereby, contradicting everything she believed about natural childbirth.

In his book *Medical Nemesis*, Ivan Illich (1976) suggests that this existential malaise inevitably arises from pain:

When I suffer pain, I am aware that a question is being raised....Pain is the sign for something not answered; it refers to something open, something that goes on the next moment to demand, What is wrong? How much longer? (p. 142)

In addition to the questions Illich lists, other questions were raised for the participants during birth: *Am I dying? Do I still want to live amid this pain?* These questions reveal the connection between pain and death. As the psychologist F. J. Buytendijk (1943/1962) says, “Pain is death’s shadow” (p. 27-28). The participants’ doctors and nurses attempted to banish death’s shadow by diminishing the existential significance of the participants’ pain: telling them to breathe differently, to consider pain medication, or in Tammy’s case when she screamed from excruciating pain during birth, a nurse told her “keep your mouth quiet and stop yelling.”

Tammy turned to her partner Matt and said, “I’m going to kill her.... *I’m dying.*”

“Calm down, Tammy,” her doctor told her.

“Get the baby out of me, I’m dying!” (p. 421)

In telling Tammy to shut up and calm down, her nurse and doctor did not simply try to hush her pain, but her life and death concerns. Tammy really believed that she was dying.

Heidi calls this struggle with birth and death the “dark side of motherhood.” She says that through her own births and those of her close friends she has experienced this dark side:

It’s all the stuff that our society is afraid to talk about—birth and death... For me I think the whole thing is conscious acceptance that when we begin playing this game of reproduction there’s no guarantees. (p. 501)

The participants' experiences suggest that their doctors and nurses encouraged them to deny the dark side of childbearing by acting as though their obstetrical rituals could guarantee safety. Furthermore, by avoiding the concerns about death during childbirth, medical professionals eradicated dimensions of childbirth pain that defy scientific explanation.

Unlike the weeks of gestation or the dilation of the cervix, pain cannot be measured objectively. It is purely subjective. In denying the significance of the participants' pain, the doctors and nurses denied the participants' subjectivity. During pregnancy, when Tammy's obstetrician told her that her pain was "just the baby growing," he dismissed Tammy's own personal evidence that something else was wrong.

When Anna's doctor told her that her pain signified Braxton-Hicks contractions, which are defined in *Williams Obstetrics* as "palpable but ordinarily painless contractions," he implied that her pain was not significant enough to count as evidence for "real" contractions (Cunningham et al., 2001, p. 26). And finally, when Mandy's nurse told her, "don't be a hero, now what kind of drugs can we give you," she undermined Mandy's explicit statement that she wanted to forgo medication (p. 486). She also suggested that Mandy *could not cope* with her contractions without medication. As Mandy struggled with the question, *can I endure this pain*, the nurse tried to answer it for her—*do not* be a hero. When the doctors and nurses denied the significance of the questions raised by the participants' pain, the participants felt slighted as *human beings*. Illich (1976) says that medical professionals treat pain as a problem to solve by reducing it to "a list of complaints that can be collected in a dossier" (p. 146). Healing, in contrast, calls for compassionate acceptance of the questions raised by suffering. Allowing the ambiguity of such questions to arise without trying to answer them, preserves a person's humanity; conversely, when medical professionals strive to silence these questions by solving them for the childbearing woman, they negate her humanity and what she can teach us about being human.

The Primacy of Childbearing: Revelations of Another World

Heidi said that she believed that when women become pregnant they see the world anew. She explained how the world becomes weightier when a woman decides to bear a child:

I think a lot of pregnant women can watch the news and just start crying. This is as big as life gets—it's like birth and death.... When you're pregnant you look at this life as someone who's about to create another human being who will live in it. (p. 506)

Following from this, Heidi attributed the pronounced crying that some childbearing women experience during pregnancy to this new relationship with the world. While all four women reported crying more often during pregnancy, the other three mostly attributed these tears to hormonal shifts. Heidi, however, believed that hormones “cause the pregnancy to be maintained but I think its bringing a new life into the world period that makes you look at these things this way” (p. 506).

Buytendijk (1943/1962) would agree. He writes that “to weep for anger, joy, wonder, or delight, besides being an act of self-surrender, is also a recognition of the concrete power of the situation” (p. 143). Indeed, when the women interviewed described crying during pregnancy, they said that their tears arose in relation to concrete situations, for example: being bedridden, reflecting on the death of loved one, or feeling overwhelmed by work. Although Mandy, Anna, and Tammy implicitly acknowledged the connection between the events happening in their lives and their urge to weep, they all believed that hormones heightened that connection. Furthermore, they expressed wanting to hide or retreat when they cried. When describing her urge to cry, Mandy explained, “I just want to hide in my bed and pass the time until the feeling goes away. I didn’t want Mike to see me feeling that miserable” (p. 475).

Tammy also wished to hide her tears from her husband. When explaining the “depression” she experienced when her doctor told her that she must refrain from work and sex and remain bed-ridden, she says, “I try to be smiley and happy all the time because it’s not Matt’s fault. He doesn’t want to come home and see me cry everyday” (p. 404). Anna also expressed the urge to hide when she found herself crying as the hormones “kicked in” after giving birth (p. 460).

While Anna and Tammy attributed their own weeping to hormones, they found themselves puzzled when their partners wept. Since they couldn’t attribute their partners’ weeping to hormones, they deduced that their partners’ tears revealed their connection to the situation of becoming a father. Whereas these women described their own crying as weak, they seemed proud when their partners cried. For them, their own tears designated the weakness of succumbing to a hormonal reaction, while their partners’ reflected an intimate relationship to them and to their future children.

Tears: The Interpersonal Waters

The participants’ reflections about their husbands’ tears and their urge to hide their own, left me contemplating the tears I shed while engaged in this research project. I cried when I read the participants’

diaries. I also cried at times during the interviews when they cried. When I tried to hold back the tears, my throat ached. Holding back was painful, and yet like the participants I felt an urge to restrain my tears, or at least to hide them. But why? An answer began to form in an unlikely place, Simms' (2008) description of breastfeeding her daughter:

I made milk, smelled like milk, was sticky with this stuff that was me, but not me, which produced in me the need to give it away. Keeping it myself was painful, impossible...The miracle was that she and my body were one, that she, more than I myself, controlled what my body made in milk. (p. 11)

Just as her daughter's body beckoned her to make milk, the participants' joys and sorrows beckoned me to make tears. The tears were mine and yet not mine. They were mine in that they flowed from my body, but they were also the participants' tears—their joy and sorrow flowing through the ducts of my eyes. Likewise, the milk that flows from the mother's nipples is her child's hunger surfacing through her body.

Just as milk nourishes the infant, tears nourish the other. My tears were an elixir of empathy saying to the participants, *I am with you*. Through these tears, I felt a momentary oneness with the participants. And yet like them, for a moment I wanted to hide my tears as though *caught* in some act. This urge to hide arises from a desire to avoid being caught in a moment that discloses an intimate intertwining, akin to the urge to avoid being caught in an erotic act. Tears, like milk, are a testament to our carnal coitus with others and the world. They are the inter-flesh, the inter-being that arise from a self carnally intertwined with another. Indeed, the other moments we associate with “being caught” are all moments that reveal a sensual symbiosis with the world: urinating and defecating reveal an intertwining with the earth through food and drink; sexual encounters reveal an intertwining with another; and pregnancy reveals an intertwining with the child-to-be. These intimate moments reveal our carnal symbiosis with others and the earth.

No one symbolizes this symbiosis more than the childbearing woman. Her fecund body epitomizes sensuality through her swelling belly, the leaking fluids from her womb, the tears from her eyes, and the milk from her breasts. She is intimately tied and bound to others, the world, and her flesh. Like the earth itself, she *is* the sensual symbiosis of self and other, the carnal thread from which human existence unfurls.

No wonder, then, that the philosopher Maurice Merleau-Ponty often used pregnancy to describe the ambiguity and the intrinsic

complexity of existence (1945/1962; 1964/1968). Pregnancy is his metaphor for the *gestalt*—a configuration in which the whole exceeds the sum of its parts. The ambiguity inherent to the “gestalt” arises from the alternating perceptions of the irreducible figure-ground relationship, best exemplified by pregnancy. As an irreducible whole, pregnancy cannot be fully comprehended in terms of the pregnant woman or in terms of the unborn child since they form a whole larger than themselves, a relational whole. When either mother or child is made figural, the whole of pregnancy cannot be understood. Pregnancy, like existence, has multiple meanings and profiles that cannot be reduced to a single disclosure. The philosopher M.C. Dillon (1997) says that when we try to reduce the figure-ground relationship into one or the other, we “arrive only at constructs, things which are literally imperceptible” (p. 60).

The institutional story of childbearing leaves us with just that—a construct of being human that includes the fetus but excludes its mother. The fetus, as celebrated on the cover of magazines such as *Life*, *Time*, and *Newsweek*, has become an *emblem of human consciousness*—a solipsistic being divorced from others, the unknown, and the flesh. Alas, it is not just the childbearing woman who has been deleted from popular depictions of the origins of human existence. All those significant to the childbearing woman — her partner, her parents, her friends and neighbors—are also out of the picture. Thus, no one *other than* the fetus exists. All traces of otherness have been abolished.

Contrary to free-floating homunculi afloat in a vast nothingness, human origins are inevitably mired in others, especially mothers and fathers. In this way, the philosopher Paul Ricoeur (1950/1966) says that birth casts a shadow upon the notion of freedom:

My birth does not mean only the beginning of my life, but also expresses its dependence with respect to two other lives: I do not posit myself, I have been posited by others. Others have willed this brute existence which I have not willed. (pp. 433-434)

Ricoeur’s passage suggests that attempts to delete the childbearing woman from the origins of life, could be efforts to preserve the cherished image of the unambiguously free human being bound and beholden to no one. Instead of being free from others, Ricoeur indicates that we might owe very our existence to others, especially to our mothers, for better or worse.

The only way people get to earth is through a woman willing to bear a child. She is the way to life, the *only* way as of yet. As such we could say that she *is* the origin of life. Heidegger (1971) says that “the

origin of something is the source of its nature” (p. 17). Following this, we could say that as the source of life’s origins, woman reveals part of its nature or essence. Thus, she does not simply disclose what it means to be pregnant and give birth, but what it means to be human.

Toward A New Ontology

Originally, I envisioned this study as a first step toward developing ontology of woman as distinct from man. As woman’s indisputable difference, childbearing seemed a good place to start elucidating the structure of being a woman. I now envision childbearing as the foundation for a more complete human ontology. What I assumed to be the most unique part of being a woman, in the end, expressed the most essential part of being human—the ambiguity of the sensual symbiosis between self, others, and world. However, this study is just a small step in that direction.

The sociohistorical and poetic approach of this study could be extended to women who choose to give birth at home with midwives “outside” of the medical institution of hospitals and obstetrics. Midwifery proposes a different metaphorical world than obstetrics—one that does not reduce childbearing women to dysfunctional machines, one that sees them as earthly beings possessing a trustworthy corporeal intelligence. Following from this, a study on childbearing women birthing at home with midwives might sharply contrast the results of this study.

In addition, extending the sociohistorical and poetic method of this study to women of different racial, ethnic, and sexual backgrounds as well as ages would also clarify different ways that women’s experiences are similar or different to the institutional metaphors. According to anthropologist Emily Martin (1992), collecting diverse descriptions of women’s reproductive experiences reveals many “visions of life, different for different women and powerfully different than the reality that now holds sway” (p. 203). We need to listen to their diverse stories—both within and beyond the institutional metaphors of childbearing—to allow their joys and sorrows, blood and pain, hopes and fears to teach us what psychologists have forgotten about being pregnant *and* being human.

Notes

¹ I have changed the participants’ names and all identifiable information to preserve their confidentiality. The page numbers that follow the participants’ quotes refer to my dissertation (Giguere, 2004).

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