

Joy and Pain: An Affect Studies Perspective on Natural Birth Films

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Abstract

This paper uses discussions of pain, shame, and joy within critical affect studies to examine two documentaries, *The Business of Being Born* (2008) and *Orgasmic Birth* (2008). It argues that, despite its valuable contributions, natural childbirth discourse conveys a troubling message, one that insists on joy over pain, advocates choice rather than systematic change, and perpetuates a problematic dichotomy between “natural” and “medical” birth.

Résumé

Cet article utilise les discussions sur la douleur, la honte et la joie dans le cadre des études sur les effets critiques, afin d'examiner deux documentaires, *The Business of Being Born* (2008) et *Orgasmic Birth* (2008). Il soutient que, en dépit de leurs précieuses contributions, les discours sur l'accouchement naturel transmettent un message troublant. Ce message met plus l'emphase sur la joie que la douleur, et prône le choix plutôt qu'un changement systématique, en plus de perpétuer la dichotomie problématique entre l'accouchement « naturel » et l'accouchement « médical ».

A critical examination of two films advocating natural birth, *The Business of Being Born* (2008) and *Orgasmic Birth* (2008), reveals polarizing and essentialist elements in natural birth discourse. Recent work in affect studies on destabilizing boundaries between self and others, bodies and environments, and good feelings and bad feelings provides a useful basis for a reconsideration of these elements. These two films focus on the meaning of pain, the possibility of joy, and a lurking subtext of guilt in the childbirth experience, more than on health services or other issues related to birth. Rereading these films through affect theory, especially through the work of Sara Ahmed (2002, 2004) and Rosi Braidotti (2004), I interrogate the films' assumptions about nature, choice, and emotions. In the course of this exploration, I suggest how thinking critically about subjectivity, the role of difference, and the transmission of affect influences our response to problems within maternity care.

Framing the Films within Cultures and Critiques of Birth

Birth has long been one location of feminist activist and academic critiques of the medicalization of women's lives and bodies. Medicalization is the process via which non-medical concerns are redefined as medical problems, often with inadvertently harmful, or iatrogenic, effects (Conrad 2007). “Medicalization of birth” refers to the tendency to “turn a normal physiological event into a medical procedure” (World Health Organization 1996). The natural birth movement has also responded to “risk-management,” a pervasive approach to health and other areas of life which, as with medicalization, regulates individual lives and bodies, but tends to neglect social dimensions of health issues. In the case of pregnancy and birth, both medicalization processes and a risk-based approach can lead to intrusive interventions conducted on the often dubious basis of reducing risks

to the fetus or mother. Despite being marginalized, the natural birth movement and the associated midwifery movement throughout North America have made tremendous contributions to shifting the norms of maternity care and birth practices in ways that take women's experiences and preferences into account. The impact of the natural birth movement and the role of midwifery varies between jurisdictions but is arguably particularly strong in Canada, where, as a result of activist midwives and women, most provinces and territories (the exceptions being Prince Edward Island and the Yukon) have integrated midwifery into mainstream healthcare (albeit with some continuing contention in most jurisdictions).

Despite these positive contributions, feminist scholars have identified several unsettling features of natural birth discourses. Sheryl Nestel (1995) critiques the racism inherent in ideologies of birth and pain promoted by the natural birth movement. She argues that, by citing "traditional" practices to promote natural birth, its key advocates have advanced the notion that women in "traditional" societies experience childbirth as fulfilling and safe. She notes, however, that this obscures "the depressing state of the reproductive health of women in many of the countries of Africa, Asia and South America" (1995, 19). Andrea O'Reilly (2001) criticizes natural childbirth discourse for its capacity to negatively inform expectations surrounding birth. She suggests that the idea of a "natural birth" is only intelligible because medical birth looms so large. She argues that it is a counter-discourse that is framed within dominant ideological assumptions about birth as a medical event, "resisting, but never replacing it" (2001, 221). O'Reilly further maintains that the idealized births promoted by natural birth advocates can be impossible to attain. Thus, the discourse of natural birth is "a tyrannical and prescriptive master discourse which belittles and oppresses the very women it claims to empower and liberate. Between the discursive ideal and the 'real' circumstances of birth is inscribed the shame, guilt, and sorrow of the labouring woman" (221). Without putting it so strongly, it is my observation that, while natural birth discourse can be

affirming for those adherents whose births conform to its ideals, shame or disappointment can mar the birth experiences of women who prepare for a "natural" birth but who ultimately require medical assistance.

Two American films, *The Business of Being Born* (2008) by director Abby Epstein and producer Ricki Lake, and *Orgasmic Birth* (2008) directed by Debra Pascali-Bonaro, are emblematic of popular discourses on natural birth. Former talk-show host Lake became politicized around birth after her disappointment with the hospital birth of her first son. Epstein and Lake's passionate film, set in New York, advocates for women's better experiences in birth. It is successful insofar as it identifies problems with mainstream care and provides information about alternatives. However, I critique the film for positioning "natural" versus "medicalized" birth in diametrically oppositional terms, in that it not only gives primacy to individual "choice" without contextualizing the socio-political structuring of available options, but it also uncritically separates the "natural" from the social elements of the birth experience as exemplified by the question posed in the film's synopsis: "Should most births be viewed as a natural life process, or should every delivery be treated as a potentially catastrophic medical emergency?" Many of the midwives, obstetricians, and anthropologists who speak in *The Business of Being Born* are also interviewed in *Orgasmic Birth*, which promotes birth's potential to be figuratively and literally orgasmic. While *The Business of Being Born* has been integrated into birth preparation classes, *Orgasmic Birth* has inspired new classes focused on sexual pleasure during birth.

Reading Birth Discourse through Affect Studies

Ideas about the interplay between subjectivity, the environment, and other people are helpful in understanding how women's feelings about birth can be influenced by social contexts and media texts, and how advocates for appropriate care can consider emotion when destabilizing taken-for-granted messages related to birth. I draw on affect theorists as they identify emotions as socially constructed and reflect on subject-

tivity as rooted in connection to both other people and environments. Especially useful are three theorists: Braidotti (2004) on a subjectivity of becoming based partly in positive affect; Ahmed (2002, 2004a) on pain, affect, and the social; and Elspeth Probyn (2005) on the centrality of shame and its connection to joy. By examining natural birth discourse via affect theory, it is possible to recognize the role of social and political life in constituting birthing subjects and to foreground an ethics of emotion in birth that is critical of poor practices without homogenizing “the good birth.”

The emerging body of work on affect identifies the social nature of feelings, troubles the notion of a bounded subject, and investigates the influence of the environment in forming affect. Many theorists (including Clough 2007) understand affect as a fleeting, unprocessed moment, in contrast to feelings, which are “sensations that have found the right match in words” (Brennan 2004, 5). Ahmed suggests that even those pulsations that feel immediate and direct are socially mediated, so that there is no affect that is not socially shaped (2004a). Affect theorists understand feelings as social rather than individual and explore what this implies for political processes. The boundary between people and their environment(s) is similarly destabilized. Teresa Brennan in particular is adamant that affects “come via an interaction with other people and an environment” (2004, 3).

The thinning of boundaries between people and their environments calls for new understandings of subjectivity. Brennan notes that “the taken-for-grantedness of the emotionally contained subject is a residual bastion of Eurocentrism in critical thinking” (2004, 2) and explores affect as socially and environmentally transmitted. This upsets the idea of self-contained subjects, and necessitates a shift away from the psychology of the individual as a primary way to understand emotions. The alternative subjectivity posited by Braidotti focuses on “becoming.” She demonstrates how, through positive ethical engagement with others and environments, a subjectivity can emerge that is not based on shared identities, but on shifting relationality (2004).

Contexts of Childbirth

One exceptional feature of changes in maternity care in the United States and Canada (as compared to Europe) over the past 200 years was the gradual disappearance of women from the practice of midwifery, as physicians became prevalent as birth attendants (Wertz and Wertz 1977, 46; Warsh 2010). Childbirth was “central to doctors’ attempts to build a practice, earn fees, and achieve some status” (Wertz and Wertz 1977, 67). Historian Cheryl Krasnick Warsh recounts that in 1834, Toronto midwives were considered “respected, skilled, health workers” (2010, 88). By the 1850s, the number of physicians was growing and doctors complained they had to compete with “quacks and midwives” (Warsh 2010, 89). Professional competition led to smear campaigns against midwifery, which were often racist in tone (Warsh 2010). While the rise of physicians as birth attendants was not uniform—for instance, immigrant and Aboriginal communities often continued to be served by midwives of their shared ethnicity—they did ultimately widely replace women midwives. Decades of the near absence of midwives in the United States and Canada meant that the resurgence of interest in midwifery, roughly coinciding with the women’s health movement of the 1970s, was more marginal in North America than in countries such as the United Kingdom, where midwives have had a continued presence and practise both within and beyond hospital departments. Still today, doctors’ concerns about billing and professional exclusivity shape the regulation of midwifery in Canada (Bourgeault and Mulvale 2006) and access to midwives in the U.S., a point raised in *The Business of Being Born*.

In addition to struggles over care-provision models, the treatment of pain has been an area of struggle for women’s health advocates, who have decried both the absence of pain relief during labour as well as its routine use. In the 1930s, British obstetrician Grantly Dick-Read argued that pain in childbirth was a feature of “civilized” cultures, but that birth could be pain-free and natural. He rejected the medical treatment of pain in favour of relaxation techniques to prevent fear, which he believed was at the root of

pain during birth (Rothman 1982, 85). Nestel (1995) maintains that, by focusing on strong babies born to (white) Victorian mothers, Dick-Read's birth movement aligned with a eugenicist focus on "improvement of the race and re-establishment of the empire" (3). Warsh suggests that the focus on the birth experience was shaped by lowering rates of infant and maternal mortality (sharply declining from the 1940s onward). Better educated women planning smaller families wanted safe birth without humiliating care (2010, 118–119). Women demanded relief from pain, leading to the brief introduction in the 1950s of scopolamine, which induced a "twilight sleep" that caused women to forget their pain but could also be fatal. Warsh (2010) emphasizes that the focus on "experience," including planning around pain and lobbying for considerate care, was a concern of the privileged. Many women throughout North America, including rural Aboriginal women, lacked basic access to health care during pregnancy and birth. Nestel identifies similar disparities in the context of the U.S. childbirth reform movement, writing: "At the same time that reformers were attacking indifferent or cruel hospital care, many black women in the segregated south did not have access to medical care or hospital beds" (1995, 9). While in some instances racialized mothers have been subject to additional medical scrutiny (Golden 2005), these examples draw attention to racialized lack of care.

Beginning in the 1970s, a feminist natural birth movement popularizing home-birth, midwifery, and birthing women's autonomy over care decisions coalesced around the ideology of natural birth. While management of pain remains important in a natural approach, pharmaceutical techniques may be rejected as unnecessary or harmful. Instead, pain is managed via a shift in focus, as I explore in greater detail below.

Joy and Pain

In natural birth discourse, pain is often ignored (*The Business of Being Born*) or transformed (*Orgasmic Birth*) in favour of a focus on joy; in the two films under discussion, these processes are associated with homebirth and pleasurable birth. Examining

this tendency via affect theory, I raise questions about diversity among birthing women and birth as a social location. While a medicalized model of childbirth views pain as a problem to treat, natural childbirth discourse constructs pain as something to be embraced or transformed into joy. For example, doula services adopt such names as Birth in Bliss, and contractions are renamed "rushes" or "hugs," focusing on the element of joy rather than pain. Influential midwife and natural birth advocate Ina May Gaskin advises women to reconceptualize pain as "an interesting sensation that requires all of your attention" (2003, 43). In *The Business of Being Born* and *Orgasmic Birth*, short birth scenes, mainly depicting the final stages of pushing and the moment when the elated mother first holds her newborn, focus on a moment of joy, and thus, avoid discussion of pain and its presence in earlier stages of labour. *Orgasmic Birth* goes one step further through the discourse of pleasurable birth during which pain is transformed into pleasure. Drawing on a claim that 20 per cent of women have orgasms during the course of labour (based on an informal study by Gaskin (2003) in which orgasm is loosely defined), *Orgasmic Birth* views childbirth as a positive extension of women's sexual lives. The film's website explains:

Joyous, sensuous and revolutionary, *Orgasmic Birth* brings the ultimate challenge to our cultural myths by inviting viewers to see the emotional, spiritual, and physical heights attainable through birth. Witness the passion as birth is revealed as an integral part of woman's sexuality and a neglected human right. (www.orgasmicbirth.com)

The film aims to transform the intensity often negatively associated with birth—pain—into a positive intensity that is sexual, even orgasmic. The film posits "blissful birth" as a something any woman can strive for and attain, as though orgasm during labour should be a goal for all women, rather than one part of the diversity of the birth experience.

The political tone of *Orgasmic Birth's* promotion, with its reference to revolution and human rights, is at odds with the depoliticiz-

ing and desocializing of childbirth and the focus on individual women's experiences. While "the personal is political" is an important tenet of feminist activism, it has always been linked to social transformation. In both *Orgasmic Birth* and *The Business of Being Born*, the personal is about individual women's choices more than it is about addressing inequities through systemic change, such as improving meaningful access to maternity care services, where access includes choice of provider type, culturally appropriate care, and care whose cost and location is accessible.

Both films are critical of policy insofar as hospitals and technology are coded as "bad." For example, *The Business of Being Born* uses comic music and quick cuts to link a scene about a hospital's frequent use of Pitocin, a synthetic hormone used to induce labour, to a Monty Python skit parodying technical interventions in birth. *Orgasmic Birth* uses a soundscape of bleak, sad music for hospital scenes, which is contrasted to the flowing, calm music of the rest of the film. Both films represent hospital births using technological support as joyless and co-opted. In doing so, these films homogenize women's experiences of hospital births. Many women may feel positive about a hospital setting, associating it with safety and support. Others may not experience home as the safe, nurturing environment it is assumed to be when natural birth proponents advocate homebirth. Finally, the implicit message in the films that equates pain medication in birth with failure, while at the same time advocating choice, is both contradictory and potentially alienating; such a message can potentially produce feelings of shame and, as a result, negative birth experiences.

If diversity was incorporated into these documentaries, the choice of a midwife-supported homebirth would be seen as socially shaped, rather than individually formed. Most women depend on the mainstream health system and may not be interested in or have access to alternatives. Had the films addressed diversity in income, spoken language, access to health insurance, and family support, systemic change to improve meaningful access might be prioritized.

Presenting midwife-assisted homebirths as the alternative to birthing environments in which mothers are subjected to unsympathetic care and unnecessary interventions is particularly problematic in the U.S. context, which is the focus of both films. In the U.S., independent midwifery is not funded or integrated into the health system. Yet even in settings where midwifery care is publicly insured, as it is in most Canadian provinces, access issues exist. For example, if local care is available in rural areas, it is likely to be limited in scope (Kornelsen and Grzybowski 2008).

While the films' focus on joy as linked to births that are "natural" or "orgasmic" has a homogenizing effect, which ignores the diversity of women's desires and experiences, affect theory suggests that moving through pain can be important to ethical intersubjectivity. Braidotti, in describing nomadic sustainable subjectivity, subscribes to transforming negative emotions into positive ones as a way to build ethics and to develop a more complex subjectivity. She highlights the transformative potential of positive affect in developing an ethical and flexible subject. She writes: "What if the subject is 'trans,' or in transit, that is to say, no longer one, whole, unified and in control but rather fluid, in process and hybrid? What are the ethical and political implications...?" (2004, 9). Unlike such arguments about transforming emotions and its possibilities, in the depiction of birth in *Orgasmic Birth*, despite its rhetoric, negative emotions are not transformed but disavowed.

Birth's position in a socially and politically shaped context also influences emotions around it. According to Braidotti, transformation, becoming, and positive ethics are all active processes that take work. She writes: "Affirmation, the result of a process of transformation of negative into positive passions, is essentially and intrinsically the expression of joy and positivity. This is constitutive of the *potentia* of the subject. Such potency, however, is a virtuality, which needs to be materialized in very concrete, embodied conditions of expression" (2004, 201). In one scene in *Orgasmic Birth*, a sexual abuse survivor discusses her experience of pregnancy and birth, and interprets the

positive emotion surrounding birth as a result of complex processes. She describes wanting the birth to feel safe, in the way that her past sexual experiences had not. Describing delivery, she states that, "I felt myself go away, and this woman who knew how to birth a baby came in. I felt transformed." If moving from the negative to the positive is to be truly transformative, the negative has to be something that is worked through. *Orgasmic Birth* includes this moment of complexity, while *The Business of Being Born* presents scenes in which a midwife narrates footage of her own difficult natural homebirth and describes this experience as a source of her empathy with clients. However, those moments of birth that are painful, scary, or difficult tend to be treated as exceptional in these films.

Ahmed considers pain as an affect, hypothesizing that, through pain or pleasure, borders are created that separate us from others, while simultaneously being a location of our connection to others (2002). She posits that, "It is through experiences such as pain that we come to have a sense of our skin as bodily surface, as something that keeps us apart from others, but as something that also 'mediates' the relationship between internal and external, or inside and outside" (2004a, 29). Ahmed pairs pain and pleasure as "intensities" that can direct our attention to our bodies and temporarily reshape our physical form. Because pain is at the boundary/connection point of self and other and reshapes our bodies, it is a location for becoming, an experience where one's self in relation to others can change. In this way, the experience of pain can increase either a sense of vulnerability or a sense of power. Ahmed further argues that pain is shaped by personal histories and by our ability to understand the reasons for and consequences of pain (2002, 6). Understanding pain as having a history and a future is relevant to birth, in that women's attitudes to and feelings about, for example, bodies and motherhood, interplay with the bodily experience of pain. These histories and their consequences are not fixed and cannot be universalized, but require attention as shaping birth experience.

Though it is easy to view pain as a solitary and isolating state, Ahmed suggests

otherwise. She writes that, "It is because no one can know what it feels like to have my pain that I want loved others to acknowledge how I feel. The solitariness of pain is intimately tied up with its implication in relationship to others" (2004b, 23). Ahmed's attention to the contradictory social elements of pain is relevant to the context of birth. Birthing women are situated in the midst of supportive or less than supportive others. Wendy Moyzakis defines the "let down" experienced by women who have negative experiences with midwives as "sanctuary trauma" (2004, 3). The professional affiliation of midwives cannot guarantee ethics, which also require an intersubjective relationship. As Ahmed writes, "An ethics of responding to pain involves being open to being affected by that which one cannot know or feel. Such an ethics is, in this sense, bound up with the sociality or the "contingent attachment" of pain itself" (2002, 24). In birth, pain is doing something—it marks shifts or progress as the body opens, as these authors suggest, in relation to others as well as itself.

Such considerations of pain illuminate how the focus on joy in birth in *The Business of Being Born* and *Orgasmic Birth*, while not misplaced, is overemphasized to an extent that it threatens to universalize an experience that can only be understood as diverse. In Ahmed's interesting consideration of wonder, she describes this state in relation to physical opening—an appropriate metaphor to this discussion of birth. She writes,

The philosophical literature on wonder has not focused on wonder as a corporeal experience, largely because it has been associated with the sublime and the sacred, as an effect that we might imagine leaves the materiality of the body behind. But for me the expansion of wonder is bodily...The body opens as the world opens before it; the body unfolds into the unfolding of a world that becomes approached as another body. This opening is not without its risks: wonder can be closed down if what we approach is unwelcome, or un-does the promise of that opening up. (2004b, 180)

The discussion of risk and the fragility of wonder is crucial. The pain of childbirth can be part of the joy of opening to new life. Yet,

those women who do not wish to experience pain may choose to medicate against it, rather than embrace it or transform it into bliss. Other women may not welcome the world “opening up” before them as they approach motherhood. Particularly in the U.S. context, which is the focus of both films, maternity leaves are often short or non-existent, child-care is poorly supported, and access to healthcare is precarious. In other words, the emphasis on blissful birth ignores the stressful and unsupportive environments in which some women bear children.

Contributing to the primacy of bliss in natural birth discourses is the focus on oxytocin, a hormone produced at various stages during labour. Oxytocin is identified in *The Business of Being Born* as key to natural birth and referred to as “the love hormone” because of its role in sexual response and bonding. The film also describes it as “turning on the mommy brain,” and therefore essential to parenting post partum. The lack of natural oxytocin production during Caesarean and induced births is lamented in these films. For example, in a scene in the *Business of Being Born*, an obstetrician and natural birth advocate discuss C-sections in highly negative terms:

If monkeys give birth by Caesarean section, the mother will not be interested in her baby. It's simple, easy to detect on an individual level. So you wonder, what about our civilization, what about the future of humanity, if most women have babies without releasing this cocktail of love hormones? Can we live without love? (Dr. Michel Odent in *The Business of Being Born*)

Dr. Odent's suggestion that women's bonding patterns can be inferred from behavioural research on monkeys reinforces the notion that women are primarily bodily and associated with nature, rather than reasoning actors. He also locates love in the body, which denies the role of thoughts and intention in creating human bonds. Such an essentialist and uncritical understanding of subjectivity that relies on a Cartesian dualism, in which women and nature are conflated but the mind and body are viewed as separate, can introduce misogyny into a purportedly

feminist project, such as this film. While the goal of both films is to improve women's birth experiences, the link between oxytocin and mother-infant bonding is overstated and can induce guilt. An overly biological model of bonding desocializes the mother-child relationship, in which the social context, including degree of support (family support, prenatal care, and labour support), is also important to how a mother feels about her child. The implicit notion that those women who do not experience an oxytocin rush when they become mothers cannot love does a disservice to a large and diverse group, including adoptive parents and those who give birth via C-section.

Producer Epstein's pregnancy is followed throughout *The Business of Being Born*, and her planned homebirth turned emergency C-section is the film's penultimate scene. Months later, Lake asks her if she feels “ripped off” because she did not have a natural birth. Epstein's answer is equivocal, but some of her dissatisfaction is rooted in the lack of joy and bonding she felt immediately after birth. Given her knowledge of the argument that a lack of oxytocin production during C-sections causes failure to bond, it is interesting to speculate how much this disappointment and perceived lack is social, and how much is biological in nature, while keeping in mind that the social and the biological are intertwined and work together. As Brennan notes, affects “come via an interaction with other people and an environment. But they have a physiological impact” (2004, 11). While current rates of C-section are problematic because they are often unnecessary and can put mothers at risk (Clark et al. 2008), framing the anti-intervention discourse in terms of “love” and the risks to society if mothers do not bond with their infants is also harmful to women, especially to those like Epstein who need interventions despite their subscription to the values of natural birth. The filmmakers stop short of ending the film with this scene. A very short homebirth scene follows, discursively bracketing Epstein's difficult birth as an exception to the preferred birthing “norm.”

Pain, Shame, Subjectivity, and Choice

Natural childbirth discourse responds to women's negative assessment of medicalized childbirth. A positive birth is not defined solely as one with positive clinical outcomes (mother and baby are well), but with positive affective outcomes (mother feels good about her experience). In some North American settings, risks to mother and child in birth have been minimized, and the question of survival can be displaced, to an extent, by more subjective concerns, such as birth experience. As with clinical outcomes, emotional outcomes of birth are produced in the social setting of birth care and support. In considering the role of emotion in social life, Ahmed argues that it is necessary to focus on what emotions do, more so than on what they are:

Emotions do things, and work to align individuals with collectives—or bodily space with social space—through the very intensity of their attachments. Rather than seeing emotions as psychological dispositions, we need to consider how they work, in concrete and particular ways, to mediate the relationship between the psychic and the social, and between the individual and collective. (2004a, 27)

Following this imperative to attend to what emotions do, the following section examines the role of pain and shame in shaping subjectivity.

JaneMaree Maher (2008) writes about pain as an overlooked element in discourses around Caesareans and choice, drawing upon Elaine Scarry's ideas about pain and the undoing or splitting of subjectivity, as described in Scarry's influential book, *The Body in Pain* (1985). While her focus is on media debates in Australia, Maher situates them in the context of debates in the Western media more generally. For example, she cites a *New Yorker* piece and the phrase "too posh to push," popularized in media coverage of British pop icon Victoria Beckham (Posh Spice) and her scheduled C-sections. Maher links a fear of pain to a fear of losing oneself: "The fear being articulated is two-fold; that birth will hurt a lot and that birth will somehow undo us as subjects" (2008, 2). She argues that the subject

works between her bodily experience and the socio-cultural structure of birth, most often within a risk-discourse-dominated medical model. Within this context, the notion of choice or agency as attached to an independent, individual, self-contained subject (as depicted in both documentaries) becomes troubling as a primary way of understanding the decisions women make about care during birth. As Magrit Shildrick argues, both the ideal of rationality and the medical model of health "privilege the unity and clarity of categories," yet rely on "suppressing the diversity and connectedness of everyday experience" (1997, 119). Choice is not a freely made selection from among a variety of equally available options, but rather is highly socially mediated.

In her article, "Choosing Caesarean," sociologist Katherine Beckett contextualizes "choice" as it is used by birth activists: "Given that physician-attended birth has become the norm, [choice] has largely meant the right to choose a midwife-attended, out-of-hospital birth" (2006, 256). This tendency to use "choice" to advocate for a particular model is evident in *The Business of Being Born's* message that women should opt for midwifery care. Choice is better seen as a series of many choices, made in social and cultural settings, just as "natural" and "medical" exist on a continuum (as a natural birth might include augmentation through breaking the amniotic fluids, for example, and hospital births are still often vaginal).

Like pain, shame is a useful place for understanding the role of subjectivity in birth. Shame is deeper than embarrassment, more bodily than guilt. Probyn writes in *Blush: Faces of Shame* that "shame makes us reflect on who we are, individually and collectively" (2005, 8). Anne Lyster suggests that birth "is a locus to which women bring a lifetime of experiences relating to the shame of female embodiment: of demeaning treatment and subordination, of traditions that relate female sexuality to pollution and contagion, and of expectations about what a good woman and good mother should be capable of doing. It is also...a critical locus in which female subjectivity is constituted" (2006, 111). While women's relationship to shame and the

relevance of birth to their subjectivity varies, birth is a focal point for ideas about female embodiment, and ideals of motherhood influence the emotional experience of birth. Drawing on Tomkins' concept of shame as both originating with and preventing interest and joy, Probyn posits that, "Shame illuminates our intense attachment to the world, our desire to be connected with others, and the knowledge that, as merely human, we will sometimes fail in our attempts to maintain those connections" (2005, 14). If shame in childbirth is located partly in a desire to stay in the world despite breaking various taboos (around bodily integrity, appropriate dress, and expected behaviour), working through shame can be worthwhile as a means of reconfiguring the boundaries of female subjectivity.

Shame also points to a lack of dignity. Probyn quotes Tomkins as follows: "The nature of the experience of shame guarantees a perpetual sensitivity to any violation of the dignity of man" (2005, 25). The ethical support of birth involves preventing the violation of dignity; what this means depends on a woman's personal beliefs, attitudes, and cultural norms. If the opposite of shame is dignity, supporting dignity in birth can take many forms. As Lyerly notes, for women with disabilities or common pregnancy-related conditions, technology may be a necessary element in birth and does not need to detract from dignity (2006). Guilt over events during birth can be linked to violated dignity, but shame can also be produced by elements found in natural birth advocacy, such as the hospital scenes in *The Business of Being Born* that discursively link intervention to violated dignity. Creating the conditions for the possibility of dignity can change how birth is experienced. Feminist interventions into birthing policy, education, and practice can be (and, to an extent, have been) part of creating these conditions.

To understand shame as a painful but useful feeling, I return to Braidotti's subjectivity of becoming, in which "humility and flexibility" (2004, 197) are elements of transforming negative energy into positive energy. Her alternative subjectivity emphasizes moments of potential. The moments when we

can move beyond feelings that are not serving us and move towards connection may be fleeting. Finding joy in pain may be momentary, rather than the total experience. *Orgasmic Birth* not only introduces the idea of sexual pleasure in birth, but promotes it as a norm—another unattainable norm of appropriate sexuality for women to strive towards. While the capacity for a more positive emotional experience is worth celebrating, insisting upon joy or bliss as a model for every birth is harmful to birthing women. At the same time, guilt and shame can, if we do not grow beyond them, become paralyzing. Support and environment play a role in shaping a positive birth experience, but we should resist looking for a care model that is right for everyone, as implied in these films when privileging midwife-supported natural birth as a solution to medicalized childbirth.

In thinking through natural birth discourse via affect theory, concepts such as "natural" and "medical" are destabilized. Understanding all births and all birthing subjects as socially shaped, emotional and physical harms as relevant and intertwined, and no woman's situation as marginal or outside of theory, we can discard oppositional and essentialist understandings about "good birth." The important insights of the natural birth movement about the shortcomings of current maternity care services and the need for empathetic support have the potential to inform a policy critique that could improve maternity care more broadly. To do so, it will need to move away from the approaches to pain and choice critiqued here.

References

- Ahmed, S. "The Contingency of Pain," *Parrallax*. 8, 1 (2002): 17–34.
- . "Collective Feelings: Or, the Impressions Left by Others," *Theory Culture Society*. 21, 25 (2004a): 25–42.
- . *The Cultural Politics of Emotions*. Edinburgh: Edinburgh UP, 2004b.
- Beckett, K. "Choosing Caesarean: Feminism and the Politics of Childbirth in the United States," *Feminist Theory*. 6 (2006): 251–275.

- The Business of Being Born*. <<http://www.thebusinessofbeingborn.com/>> Retrieved April 2010.
- Bourgeault, I.L. and Mulvale, G. "Collaborative Health Care Teams in Canada and the US: Confronting the Structural Embeddedness of Medical Dominance," *Health Sociology Review: The Journal of the Health Section of the Australian Sociological Association*. 15, 5 (December 2006): 481–95.
- Braidotti, R. *Transpositions: On Nomadic Ethics*. Cambridge: Polity Press, 2004.
- Brennan, T. *The Transmission of Affect*. Ithaca & London: Cornell UP, 2004.
- Clark, S.L., M.A. Belfort, G.A. Didy, M.A. Herbst, J.A. Meyers, and G.D. Hankin, "Maternal Death in the 21st Century: Causes, Prevention, and Relationship to Cesarean Delivery," *American Journal of Obstetrics and Gynecology*. 199 (2008): 36.e1–36.e5.
- Clough, P.T., ed. *The Affective Turn: Theorizing the Social. With Jean Halley*. Durham: Duke University Press, 2007.
- Conrad, P. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press, 2007.
- Epstein, A., dir. *The Business of Being Born*. NYC Premiere Video, 2008 (DVD).
- Gaskin, I.M. *Ina May's Guide to Childbirth*. New York: Bantam, 2003.
- Golden, J.L. *Message in a Bottle: The Making of Fetal Alcohol Syndrome*. Cambridge, MA: Harvard University Press, 2005.
- Kornelsen, J. and S. Grzybowski. "The Reality of Resistance: The Experiences of Rural Parturient Women," *Journal of Midwifery and Women's Health*. 51, 4 (2008), 260–265.
- Lyerly, A.D. "Shame, Gender, Birth," *Hypatia*. 21,1 (2006): 101–118.
- Maher, J. "The Painful Truth About Birth?: Contemporary Discourses about Caesareans, Risk and the Realities of Pain." The Australian Sociological Association Conference Presentation, 2008.
- Moyzakis, W. "Exploring Women's Descriptions of Distress and/or Trauma in Childbirth from a Feminist Perspective," *Evidence Based Midwifery*. 2 (2004): 8–14.
- Nestel, S. "'Other' Mothers: Race and Representation in Natural Childbirth Discourse," *Resources for Feminist Research*. 23, 4 (1995): 5–19.
- O'Reilly, A. "Labour Signs: The Semiotics of Birthing," *Journal of the Association for Research on Mothering*. 3, 1 (2001): 216–223.
- Orgasmic Birth*. <<http://www.orgasmicbirth.com/>> Retrieved March 2010.
- Pascali-Bonaro, D., dir. *Orgasmic Birth*. 2008. (DVD).
- Probyn, E. *Blush: Faces of Shame*. Minneapolis: Minnesota UP, 2005.
- Rothman, B.K. *In Labour: Women and Power in the Birthplace*. New York: Norton, 1982.
- Shildrick, M. *Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio)ethics*. London: Routledge, 1997.
- Warsh, C.K. *Prescribed Norms: Women and Health in Canada and the United States since 1800*. Toronto: University of Toronto Press: 2010.
- Wertz, R. and D. Wertz. *Lying-In: A History of Childbirth in America*. New Haven and London: Yale UP, 1977.
- World Health Organization (WHO). *Care in Normal Birth: A Practical Guide*. Geneva: World Health Organization, 1996.