From Trauma to (Re)Birth: 
The Birth Story as a Site of Transformation

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This essay examines the rhetoric of trauma specifically as it relates to birth. In looking at narratives of women who have given birth, we can clearly see how powerful the shape of narrative is in our lives. Cultural constructs are with us from the very beginning, before we even come out of the birth canal. Birth in American society today still performs the function of stripping women of power as they grapple with the highly medical and technocratic orientation of an experience that is not only physical, but also emotional and spiritual. When looked at in the context of trauma narratives, birth stories point to the ways in which narrative can be used for personal transformation. The relationship between trauma and sociopolitical forces as mediated through discursive practice also becomes evident. The birth story is of particular interest in that it raises questions about the nature of trauma and how, and by whom, a traumatic event is defined.

Many critics have argued that the culture of American birth is disempowering, inhumane, and neglectful of the very real effects of birth on the psyche and on the subsequent mother-baby relationship. Indeed, many women suffering from posttraumatic stress syndrome after enduring difficult deliveries and cesarean sections find that their feelings of sadness, anger, and frustration are often dismissed or ignored. By hearing the birth stories of these and other women, we acknowledge the potential for trauma; we also begin to connect the ways in which the cultural construct of birth actually shapes birth as a traumatic, rather than transformative, event.

Just as a survivor of trauma such as war or rape needs to codify and name his or her experience, to give structure and language to something perceived as unspeakable, women writing about birth also need to find a
language and structure to talk about birth that is empowering and that reflects its impact on more than just their physical selves. They might find themselves confronted with some larger issues, however—issues that have not only personal but also social implications. As one scholar notes, “In this culture mothers are taught to doubt their own perceptions of the bond between mother and child, just as they are taught to doubt their ability to give birth” (Kahn 12). Writer Louise Erdrich observes in *The Blue Jay's Dance: A Birth Year* that the inadequacy of language to shape the birth experience is embedded in the experience of women in patriarchal culture: “Perhaps there is no adequate description for something that happens with such full-on physical force, but the problem inherent to birth narratives is also historical—women haven’t had a voice or education, or have been overwhelmed, unconscious, stifled, just plain worn out or worse, ill to the death” (43).

The language and structure that does exist is medicalized and technocratic. “Technocracy” is defined by anthropologist Robbie Davis-Floyd as “a society organized around an ideology of technological progress” (Foreword xi). While certainly in the last thirty to forty years women have taken more control over their experiences of childbirth, and have more choices than ever, the fact remains that the majority of U.S. births occur in a hospital—that is, a medical setting—under the supervision of a medical doctor. The fact also remains that the cesarean section rate, which dropped for awhile, is now climbing well above the level that the World Health Organization finds acceptable, and that the United States ranks only twenty-third in maternal and infant mortality and morbidity rates.

While of course there will always be some level of risk and fear associated with pregnancy and childbirth, the experiences of women in the United States are a striking contrast to women in other societies. It is this difference that is most telling about the ways that rhetoric shapes an event that in other cultures is seen as not a disease to be surmounted but a transformational moment with psychical as well as physical consequences.

Robbie Davis-Floyd has undoubtedly done more than any other scholar to illuminate how the power of rhetoric has shaped the experience of birth for women in the United States. In *Birth as an American Rite of Passage*, Davis-Floyd defines the medical paradigm of birth as one fraught with rituals. These rituals “work to effectively convey the core values of American society to birthing women,” which are rooted in “our
technocratic society's extreme fear of the natural processes on which it still depends for its existence" (2).

Rituals can be powerful systems by which a person achieves transformation. Transformation through ritual "occurs when 'symbol and object seem to fuse and are experienced undifferentiated whole ... and insight, belief, and emotion are called into play, altering our conceptions ... at a stroke'" (qtd. in Davis-Floyd 16). When a ritual is successful, a person's cognitive structure will "reorganize itself around the newly internalized symbolic complex" (16). "Ritual works by sending messages to those who perform and those who receive or observe it," Davis-Floyd explains. Messages are not sent through straightforward language, but through symbols, defined as "an object, idea, or action that is loaded with cultural meaning" (9). Symbols are powerful because they can tap into the body and emotions, going beyond the rational, working on an unconscious level.

Psychoanalysts, as well as some writers and writing teachers, also are interested in this work of diving into the unconscious. In her essay on a model for writing and healing, Marian MacCurdy draws on neurological research to explain that traumatic memories form an iconic image, a mental picture stored in the limbic system, which gives them emotional weight. These memories, in the form of images, are not easily accessible yet must be tapped to tell the story of trauma. Like symbols, these images are not tied to linguistic or intellectual concepts, but to sensory, iconic representations. Trauma theory researchers conclude that survivors need to do more than just describe events; they need to describe the images that have been encoded. It is only after these images are retrieved and somehow structured into language that the survivor can achieve transformation, where the survivor might be able to move beyond the place where he or she is "stuck." Often, metaphoric language is employed in order to make up for the inadequacy of straightforward description. As we shall see in the birth stories that follow, these metaphors can illuminate much about the experience the narrator is attempting to convey and can give clues to the story's potential for transformation.

According to Marian MacCurdy and Charles Anderson, our culture provides few opportunities for people to process traumatic experience and to complete the normal process of grieving. Yet, the "reexternalization" of an event is necessary to overcome a past trauma. Dori Laub comments, "Reexternalization of the event can occur and take effect only when one can articulate and transmit the story, literally transfer it to another outside oneself and then take it back again" (qtd in MacCurdy and Anderson 6).
Writing or telling a traumatic narrative have as their goals "to recover and to exert a measure of control over that which we can never control—the past" (7).

MacCurdy, Anderson, and others do not, as some might think, see the construction of the trauma narrative as a route back to an "authentic self." Rather, it is a tool of transformation: "The crucial assertion we want to emphasize . . . is that healing is neither a return to some former state of perfection nor the discovery or restoration of some mythic autonomous self. Healing, as we understand it, is precisely the opposite. It is change from a singular self, frozen in time by a moment of unspeakable experience, to a more fluid, more narratively able, more socially integrated self" (7).

Louise De Salvo further emphasizes that the project of writing as healing is not one that attempts to restore a "pure" self; rather, it is a way of reviewing and revising the past, of enacting "shifts and changes as we discover deeper and more complex truths. It isn't that we use writing to deny what we've experienced. Rather, we use it to shift our perspective" (11).

Poet Kathryn Rhett devoted a whole book to this project in writing a memoir of the birth of her daughter entitled *Near Breathing: A Memoir of a Difficult Birth*. The story of the actual birth, which comprises one chapter of the memoir, attempts to connect her medical, intellectual understanding of what's happening with physical sensations and emotional reactions. Referring to the idea of the baby as "tangible, but elusive," she relates her exact movements in early labor: mundane activities like getting up out of bed, reading the paper, and taking a shower. She painstakingly brings us through the next several hours, noting the timing of her dilation, and explaining where the baby is, using medical terminology such as "stations" and as being in position "two centimeters above the ischial spines" (10). The medicalization of the birth clearly has an effect on how connected Rhett feels to the baby. After noting the times fetal heart decelerations were noted, that she is completely dilated, and that they have attached a fetal scalp monitor, she writes, "How anonymous the baby seemed then" (13).

Baby Cade is very sick at birth and is placed into neonatal intensive care for ten days. In her struggle to understand how and why Cade became so ill, Rhett provides us with details that she hadn't consciously noticed at the time, such as the tell-tale meconium stains on her hand and placenta, indicating severe stress. The desire to understand what has happened to the daughter lead Rhett and her husband, writer Fred Leebron, to do medical research.
When Rhett and Leebron have pieced together all the information they can, they begin to acknowledge their anger, because they realize their daughter is a victim of neglect and ignorance on the part of the intern who attended Rhett at her delivery. Rhett begins the task of assiduous note-taking. She will fill notebooks with details about her daughter’s birth in an attempt to re-create and understand it. The notes are not only for legal means, but, she realizes, they are also “a channel for me from past to present. . . . Here I wanted to claim my observations, and know myself as alive in the time between the beginning of labor and the ending of being the mother of a healthy child. I wanted to posit a history which felt as crucial to me as the end result” (157).

Rhett’s narrative bears out the work of researchers into the value of writing as a tool for recovery from trauma. Psychologist James Pennebaker, in his research on the value of narrating a trauma in order to facilitate healing, found that the most productive narratives—that is, those that had the most measurable healing benefits—were those that combined specific, factual details with emotional reactions surrounding the events both at the time of the event and at the time of writing about it. Rhett’s memoir is clearly a combination of these, as she continually shifts between the voices of medical authority and the scared, unknowing voice of a new mother with a sick baby. The memoir is a way of making sense of her experience from the vantage point of someone who now comprehends the damage that has been done to her. It is also important that Rhett’s narrative confirms that her experience isn’t just bad luck but is the consequence of ineptitude and neglect within the medical system, a conclusion that will take on further meaning when placed in the context of other birth stories.

Rhett finds that for the next two years, almost all of her writing “led back to Cade’s birth” (201). She recounts trying to distract herself, but comes to understand that only a full-fledged narration of the birth will do the work of complete transformation. This might be classified as Rhett’s second stage of recovery, which Judith Herman defines in *Trauma and Recovery* as the one in which the survivor tells the story completely with depth and detail. This narrative is key for recovery because it “actually transforms the traumatic memory, so that it can be integrated into the survivor’s life story” (Herman 175).

Rhett seems aware of the power of narrative in recovery from trauma, yet also expresses her struggle to find any closure: “I did want to shape it into a history with an end. I did want to seal off the past . . . [but] her past refused erasure. For me, childbirth would always mean the birth of
Cade, with its attendant darkness and mercy” (196). Because Cade will always be with her, and she will always wonder if her daughter’s health problems might be traced back to her traumatic birth, the specter of the trauma will be a part of the narrative of the self, and of Cade’s life story. Yet, Rhett’s narrative does support Herman’s statement that telling the story transforms it, because, Rhett acknowledges, as time passes, “the story’s proportions changed” (196).

A key part of Rhett’s writing of a full, coherent story of Cade’s birth is claiming a language of her own in which to talk about it. Language, and making associations, is her “liberation.” The memoir is laced with medical terminology, and Rhett’s use of this language signals both their importance and inadequacy. “I knew these words,” she writes, “but didn’t know them precisely. Just as the neonatologist had explained, the vessels in her lungs were closed up” (77). She goes on to give them her own perspective and understanding, weaving together medical language with colloquialisms and a quote from Susan Sontag. The most important association she seems to make is that of the different meanings for meconium. While she initially defines meconium indecorously as “shit,” she later reworks the meaning of it. Meconium comes from a Greek word for poppy, she explains. An older definition of the word is “the milky sap of the unripe seed pods of the opium poppy” (202). In her struggle to make meaning out of Cade’s birth, she finds a link between this definition and its medical definition as “the first fecal excretion of a newborn.” Rhett evokes metaphors to make sense of her experience, connecting the dark poppy flowers to the meconium stains, “the stunning poison spreading in my baby’s lungs, like opium sending her to delirium “ (202). While much of her struggle to understand what has happened involves scientific research and grappling with medical explanations, it is only when she links this language with her own poetic sensibilities that she can finally make sense of the experience. The meconium stain is the central image that Rhett must access and make meaningful through language.

The reconstruction of the narrative by Rhett also serves to portray the severe deficiencies of the medical model and system. It is through this narrative process that Rhett and Leebron are able to own their anger and frustration and see that their baby is a victim of larger, social forces. This is apparent in Rhett’s portrayal of her treatment throughout her labor and delivery. The doctor, who is not her regular obstetrician, breaks her waters without explaining what she is doing or why. When she asks for a drug of her choice, because she believes it will have the least effect on her baby, the doctor refuses and instead offers her an epidural, which she
consents to. Later, when they ask her if they can turn off the epidural, she notes the contrast in behavior: "It seemed funny that they should ask. Since they’d told me not to have demerol or fentanyl, I’d felt entirely under their control" (13). Despite understanding and speaking the medical language, Rhett is forced into passive acceptance under medical authority. When she has to hold off pushing in order to get an episiotomy, she feels angry; coincidentally, the doctor who performs it is someone she has not seen before, creating the impression that she’s being passed around, as if she were a piece of equipment to be fixed. A crucial event happens after the baby is born, though we won’t know how crucial until afterwards—in the same way that Rhett won’t know either. After catching the baby the new doctor asks, "What do I do now?" and is instructed by the nurse, who is at Rhett’s head and cannot see the baby, to give the baby to her mother (15). The baby is soon taken away to be suctioned for meconium. Rhett’s research tells her that the inexperience of the doctor cost her baby her health at birth, because if she had been suctioned immediately she might not have become so ill.

The medical authorities also demonstrate a shocking lack of compassion for Rhett after the birth. When she complains that she can feel the doctor stitching her up, the doctor seems not to believe her. The doctor then continues her conversation with another doctor as if Rhett is not even there. Later, when she is allowed to leave the delivery room (she has been told she cannot leave until she urinates), a delivery nurse fills out paperwork and ignores her. She instructs the doctor to sign papers, and Rhett realizes the doctor had barely spoken to her. With the condition of her baby in question, Rhett finds this treatment distressing, especially given the situation. “They talked to each other as they left the room,” she writes. “Why didn’t they speak to me? I wondered” (25). Later, she will express anger and frustration at her own obstetrician, whom she’d earlier concluded as being “competent,” yet who didn’t even show up for the birth and was always rushing her out of her appointments. After running into her in the elevator at the hospital, Rhett acutely describes the feeling of abandonment with a strong picture: “The way she’d vanished behind the closing elevator door and left us to our messy life felt typical” (132).

Rhett draws another connection in the last chapter of the memoir. She relates here how she spent some time at the age of seventeen in a psychiatric hospital after (we assume) a suicide attempt. Later in her life, Rhett learned that the trend at that time was to hospitalize troubled teenagers at an unprecedented rate, rather than treat them as outpatients. The realization is important because she sees herself as not an anomaly,
but as "part of a national trend. So my case wasn’t special" (204). Coming to an understanding that her experience was the result of a cultural norm is important and empowering for her, and the implication is that her birth experience wasn’t so "special" either.

Though Rhett’s narrative does not by itself directly situate her experience in the context of larger cultural forces shaping birth, it provides powerful testimony when read alongside other birth narratives. It is significant that Rhett does not incorporate this reflection on her hospitalization at seventeen until near the end of her memoir; at first glance it might seem out of place, but on a second look we see that a necessary part of the healing process is situating an experience within a sociohistorical context.

According to De Salvo, MacCurdy, Anderson, and Herman, an essential part of re-creating a traumatic event is the move to reestablish the self in a social framework. In making their stories public, survivors may also be poised to do the work of social change through the work of their discourse. Constructing such testimony might be called "aggressive," as Kali Tal does in her study of literature of trauma, because it is born out of a refusal to bow to outside pressure to revise or to repress experience, a decision to embrace conflict rather than conformity, to endure a lifetime of anger and pain rather than to submit to the seductive pull of revision and repression. Its goal is change. The battle over the meaning of a traumatic experience is fought in the arena of political discourse, popular culture, and scholarly debate. The outcome of this battle shapes the rhetoric of the dominant culture and influences future political action. (7)

The testimony of survivors not only has powerful personal effects; it also has profound potential for effecting social change. Scholar and writer Louise De Salvo saw writing her own story about sexual abuse as an "ethical act" (214). In looking at the many writers who have written about trauma, she concludes that many writers write their stories initially for self-transformation, but end up writing in order to "help heal a culture that, if it is to become moral, ethical, and spiritual, must recognize what these writers have observed, experienced, and witnessed." De Salvo sees this as "the most important emotional, psychological, artistic, and political project of our time" (216).

Stories connect us to and help create community. Sharing narratives of trauma also helps others overcome trauma. Writing these narratives can be seen as "a site at which the social and discursive practices of the
individual, the community, and the larger culture are interrogated and from which they may be effectively altered. The work of healing... depends upon this process” (MacCurdy and Anderson 7). Personal stories of trauma do not only do the work of healing, they also do the work of calling into question the discursive constructs of society. This is painfully clear in the discourse surrounding birth, and in the ways in which language can stifle growth and healing.

One way in which language surrounding birth can be harmful is the use of common refrains that send the message that a woman’s birthing experience isn’t important. This attitude is expressed in such refrains as “It doesn’t matter how the baby gets out” or “You should be grateful.” In a personal essay, Gretchen Humphries, a mother of three and a veterinarian, contests these phrases as not only frustrating but also as instruments of further trauma. She describes how she struggled to understand why she didn’t feel more grateful for her healthy twin boys after having a cesarean. Rather than finding support and empathy, she found herself surrounded with others who did not seem to want to acknowledge the depth of her trauma. She eventually realizes that her feelings about her birth don’t mean she can’t be grateful for her babies, and people who tell any woman otherwise are “telling her that not only is her body broken, but so is her mind” (32). The price for keeping quiet about the rage a woman might feel about her birth experience can be high, causing profound emotional damage. Connecting with other women and hearing their stories was essential for Humphries’ healing process: “There is a vast, hidden ocean of pain in women who have had horrible births but do love their babies and continue to wonder, ‘What is wrong with me?’” She continues: “I was freed by the knowledge that nothing was wrong with me!” She makes a point here of structuring her experience in language that clarifies exactly the depth of her experience, calling it “an assault, a very sexual assault” (32).

Not only telling our stories, but sharing our stories with others and hearing others’ stories is vital to the project of transforming the experience of birth from trauma to transformation. In order to understand how birth has been not only experienced as trauma, but has actually been defined as trauma, we need to have a sense of the historical continuum under which birth has been shaped in the United States.

For most people in the United States, birth is seen as a medical event. Birth takes place in a hospital, under the watch of a medical doctor—usually an obstetrician, who is trained more in problematic birth than in normal birth. Technology such as ultrasounds and electronic fetal moni-
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tors are and have been used throughout the pregnancy to monitor the fetus, which is seen as having a separate identity from the mother. The actual usefulness of such technology is in question—most studies indicate that they may do more harm than good, and that they turn attention away from the mother when she desperately needs attention and support. Drugs are readily available and are often encouraged for pain management over other, safer methods such as the freedom to move and eat and drink, breathing techniques, water therapy, massage, and continual personal support. Until fairly recently, women had little choice in how they gave birth: as soon as they entered the hospital, a laboring woman was forced into a wheelchair, separated from her husband or partner, taken into a room where she was ordered to replace her clothes with a hospital gown, hooked up to an IV, and forced to lay down and stay down for the duration of her labor. A clock on the wall served the purpose of timing her contractions but of also reminding her that she had a limited amount of time she could labor before she was forced into major surgery. She usually was given an enema and had her pelvic area shaved. She might be given pain medication against her will, or be talked into it for the convenience of hospital staff. As she grew closer to pushing, she often had both hands and feet strapped to the bed and was forced to deliver in the lithotomy position—now known to be the worst and most painful position to push in. She was given an episiotomy—a cut in her perineum—whether she needed it or not, and often, because drugs often numbed her and lessened her ability to push, the doctor had to use forceps to get the baby out. After birth she might be allowed to see the baby for a few minutes before being separated from him or her for hours and sometimes days. All of this occurred in a climate of disrespect and hostility on the part of the hospital staff, according to many of the reports of women who gave birth in the 1950s through 70s. Robbie Davis-Floyd sees all of these procedures—now generally acknowledged to be medically unnecessary on a routine basis yet still often used—as tools for socializing the mother into the medical paradigm of birth. These procedures satisfy the criteria for ritual as she defines it, and succeed in conveying the message of “the necessity for cultural control of natural processes, the untrustworthiness of nature and the associated weakness and inferiority of the female body, the validity of patriarchy, the superiority of science and technology, and the importance of institutions and machines” (152).

There is no question that for many women giving birth in American hospitals since World War II, birth has been a deeply traumatizing experience. We know this not because the medical system acknowledges
this, but because the stories of women have been collected in histories such as Suzanne Arms’s landmark exposé, *Immaculate Deception: A New Look at Women and Childbirth in America*, published in 1975. Upon contemplating childbirth, one woman in this text remarks, “When I think of pregnancy I think of being heavy, swollen, lying on a hospital table on my back, my feet in stirrups, my stomach full of stretch marks. People busying themselves around me. I think I’d rather adopt” (52). What’s interesting about this comment is that the woman doesn’t seem to fear the pain of birth itself, but more the experience of lying on a table, being strapped down and ignored, as if she were some medical research subject. All of those things she fears are not natural processes, but cultural constructs. In her book, Arms has a documentary photograph of exactly this scenario: a woman lies on a table while three gown men are occupied with other tasks, none of them looking at her.

For many women in the Arms book, much of the trauma associated with birth seems to be connected with being convinced or forced to take drugs, and as a consequence missing the experience of being mentally present when their babies are born. Melinda Barbee describes her lack of confidence in giving birth, of going in to give birth, being given pills, then waking up to be told she had had her baby. She was so drugged she was apathetic when she was told her baby had been born. Afterwards, she says, “When I took Linda home I began coming unglued. They gave me four pills every four hours, but I felt worse every day. I was hospitalized for three weeks. . . . [Before I gave birth] all I wanted was the end product, a baby. I feel very different now” (Arms 50). Helen Galler reflects on the deep and unreconciled rage she feels toward her birth experience. Depressed after coming home from a drugged birth, she did not have maternal feelings. She says, “I’ve never expressed the rage I feel toward everyone about my birth—my mother, my husband, my doctor, my friends, who never mentioned what it would be like. Myself. I didn’t know how to take care of myself. I didn’t know what to ask for. I gave all responsibility away and gave up” (Arms 86). Galler’s language clearly connects her trauma to the control that was taken away from her.

Other women found the lengthy separation from their babies the most traumatic. “It was six days after birth before I saw my child, because of difficulties he had. And it’s taken three years to build our relationship,” says Helen Swallow (Arms 102).

The stories of these women, and many others, have been crucial in fostering awareness about the cruelty and inhumanity of the medical model of birth. Because of the taboos surrounding sexuality—and, as a
result, pregnancy and birth—many women in this time period lacked a true picture of birth. They were taught that their bodies were dirty and imperfect, and even among women bodily experiences were shrouded in secrecy. Often the only messages women received were those of trauma and pain: “Even when I was a little girl I remember hearing how much pain I’d given my mother during birth,” one woman says. “Grandma joked that she never wanted to see me because I’d caused my mother so much pain. I figure it must be terribly painful to have a baby for her to say such things” (Arms 115). Adrienne Rich comments on this phenomenon as she reflects back on her experiences of pregnancy, birth, and early motherhood in the 1950s:

None of us, I think, had any sense of being in any real command of the experience. Ignorant of our bodies, we were essentially nineteenth-century women as far as childbirth (and much else) was concerned. ... We were, above all, in the hands of male medical technology. The hierarchical atmosphere of the hospital, the definition of childbirth as a medical emergency, the fragmentation of body from mind, were the environment in which we gave birth, with or without analgesia. ... The loneliness, the sense of abandonment, of being imprisoned, powerless, and depersonalized is the chief collective memory of women who have given birth in American hospitals. (176)

What these stories tell us is that the rubric under which women give birth makes it a traumatic event. By defining birth as a medical problem that must be solved in a hospital, with doctors, drugs, and technology, even a so-called normal birth has elements of trauma to it.

The women’s movement of the 1970s gave rise to more options not only for sexuality, but for childbearing as well. Under pressure from feminists, home-birth advocates, and critical consumers, obstetricians, and hospitals now offer more choices. Birthing centers have been installed in hospitals that provide a more home-like environment where women can labor and deliver more comfortably. The fact remains, however, that despite the research that shows midwife-assisted birth at home or in a birthing center is as safe as, if not safer than, hospital birth, overall, the medical model of birth still predominates, as Rhett’s narrative reveals. 3

The story of a contemporary feminist writer also bears this out. In Misconceptions: Truth, Lies, and the Unexpected on the Journey to Motherhood, published in 2001, Naomi Wolf interweaves the story of her first pregnancy and birth with interviews and other research on the culture
of birth in the United States in the 1990s that she undertook afterwards. Like many educated, middle-class women, despite her initial research, her childbirth classes, and other preparation, Wolf did not feel fully prepared for her experience, and still sees her first birth as a traumatic experience. Wolf describes in detail her attempts to create a birth that would allow her the freedom to birth without drugs yet still have the "safety" afforded by the hospital and its technology. She clearly attributes her resulting traumatic cesarean section to the policies of the hospital and to the attitudes of the staff. Despite all her efforts of self-determination and control, her story, summarized below, shows how successful the medical-technocratic system is in enforcing a passive acceptance of the medical model.

When Wolf arrives at the Alternative Birthing Center at three a.m., the nurse who admits her "angrily" orders her to go to the bathroom to stimulate her nipples in order to help hasten labor. "The loneliness and strangeness of being exiled into the bathroom for this activity, which seemed to annoy and embarrass her, made the pain literally unendurable," she writes (135). The nurse’s discomfort with the technique, a routine midwifery strategy to help women dilate, Wolf says, “made me somehow seize up” (136). The nurse then listens to her baby’s heartbeat for less than the requisite five minutes, and thus pronounces the baby in distress, hastening Wolf’s removal from the Birthing Center and down to the labor and delivery rooms, which she has earlier described as having a “slaughterhouse atmosphere” in an account of the hospital tour (100). Wolf’s word choice is especially important in the following sentence, because she pointedly attributes the baby’s distress not to a real biological fact but to human impatience: “With an efficiency that seemed positively startling, she rushed me down to the terrifying delivery rooms I had so hoped to avoid, because, she said, the baby was in distress” (136; emphasis added). Wolf’s narrative thus does the work of reclaiming control over her birth experience and of shifting her perspective on the birth from one that was inherently problematic to one that was made problematic by medical authorities.

The environment she encounters in the hospital halts any progression of labor. Then “the seemingly inevitable high-tech intervention took place. What might have been a normal birth became an emergency” (136). Wolf is convinced to have Pitocin (a drug that induces strong contractions) and an epidural. The language that surrounds her is key to her surrender to the medical model:
I had now been flat on my side, scared, for an hour or so, without “making progress,” as they put it. (They kept saying the words, “no progress” or “failure to progress” and “fetal distress,” a terrifying combination. No medical staffer that I can remember said “You can do this.” I learned later the powerful physical effect words can have on laboring women.) I was also starting to feel uncertain about my abilities to labor well, and of course we were worried above all about the baby. I hadn’t been given a chance to dilate naturally, to acclimatize to the pain gradually. The stronger contractions from the “pit drip” made me feel as if someone were plunging a sword into the ganglia of my spine. I readily accepted the epidural. (136–37)

Wolf clearly lays out the factors that resulted in the full arrest of labor, which results in a cesarean section:

In my delivery, I was an adjunct; I had almost no role. There was nothing I could do to contribute to the birthing process if I wanted to, which I badly did before the epidural essentially neutered my faculties and will. From what we had been told about the monitor’s reading, my husband and I understood that the baby’s life was at stake. No parent would risk the health of his or her child by questioning the procedures the medical establishment had decreed were necessary. . . . I lay passively on the birthing bed, letting them tie and tether me down, and anesthetize me. . . . I did not feel safe in the hospital. I did not feel safe. (137–38)

Wolf lays most of the blame for her traumatic birth on the medical establishment; her language reveals her ability to provide the kind of feminist critique and challenge she has made herself known for in such books as The Beauty Myth. While her experience is by no means unique, her decisive stand against the medical-technocratic paradigm is. Bringing both medical research and a wealth of personal stories into her narrative is crucial to shifting her perspective from her birth as an isolated event to one constructed by the medical model.

The description of Wolf’s actual cesarean section is set off in the book by italic type, marking the experience separately from the rest of the birth story, which weaves together the actual experience with an analytical retrospection. The narrative of the surgery is filled with visual images and metaphors and as a result seems a more direct and unmediated depiction of the birth. It is obvious that this is the site of the image that Wolf must recall and bring into linguistic meaning. She is strapped down to the bed “as if on a crucifix” (138). When she is opened up she feels “a violent but numb tugging, like someone ripping soft dough” (139). After
her baby is taken out, she seems to only recognize the birth from a distance: all she wants is to be “rescued from this cold, bone-hard place” (139). When she complains of cold and begins to shiver, the surgeon asks her to stop in an irritated voice. Wolf’s subsequent disorientation, a result from the drugs and trauma, makes it hard for her to believe her baby is healthy. The narrative of the cesarean ends with a visual description of what she can see reflected in glass doors:

Seven men and women, in plastic goggles and pale green cotton suits, are working. Their gloves are bathed up to the elbow, and their busy instruments are messy, with streaks of bright red. The locus of their full attention is down where my stomach should be. No one notices that I see what their hands are dipped in: my center, an open cauldron of blood. (140–41)

This descriptive section of the cesarean stands out from the rest of the text not only in its typeface, but also in its descriptions of sensations, emotions, and the use of metaphors. Here Wolf has dropped her retrospective, analytical voice and fully evokes horror and emotion for her reader. By using metaphors that seem to have a religious-mystic quality to them, such as “crucifix” and “cauldron,” Wolf evokes not only a rite of passage, but also makes clear how profoundly the experience of the c-section affected her. It is equally clear, however, that, rather than seeing the experience as one that is empowering or necessary in order to attain the Holy Grail—that is, her daughter, whose elongated skull she compares to that of “aristocrats in Egyptian hieroglyphics”—she sees it as forced upon her (140). She continually emphasizes how much at the mercy of the hospital and its staff she becomes within this model. The language she uses evokes the sense that she sees herself as one of the many sacrifices made to the gods of technology. She is brainwashed, in her vulnerable state, into accepting more interventions because of the dictates of what a “good” parent is supposed to do; she does not question the nurse’s proclamation that the baby is in distress because she has given over authority to the medical experts (a position she later challenges); she becomes a victim of hospital policy that requires her to go the “slaughterhouse” of the labor and delivery rooms. The drugs she accepts further forces her into a passive position, allowing the staff to literally tie her down, all in order to be a good patient and a good mother according to the discourse of the medical model. In the end, her memory of the birth is of being “drugged and pinned” and of her recovery as marked by humiliation, and later, depression (141).
While Wolf is able later to reconstruct events and actively challenge hospital procedures that resulted in her c-section, she is especially vulnerable as a first-time mother when she comes up against the authority of the hospital and its staff. She attributes this vulnerability at least to some extent to the lack of personal stories of birth. Sharing her story with others, and hearing stories from other mothers, empowers her and helps her to recognize that her story is not unique: "[Since my first birth I have heard] comparable ordinary traumas among many women I talked to—what I have come to call 'ordinary bad births'” (145).

As she does more research and interviews more women, Wolf realizes how much the experience of birth is mediated by the medicalized, technocratic culture fostered in American culture, a culture that is "dictated in large measure by money and institutional politics that presented itself as the medically objective best-practices of prenatal and childbirth care.” Furthermore, she and other women “thought that the birth stories we recounted to each other, whether easy or difficult or even traumatic, were ours alone, just fate or the luck of the draw” (21).

One place you might expect could be a place for the sharing of stories, childbirth classes—especially those run by hospitals or under hospital supervision—do little to prepare her for labor, as Wolf discovers: “The thing the birth class did not explain to us effectively was the pain of childbirth and what to do about it other than breathe helplessly in its grip or take major drugs simply to cut off sensation” (91). Stories of pain and drugs need to be replaced by stories of courage and challenge, of journeys and transformation: “No one informed me even remotely in our birth classes about the kind of courage you need to tap into during labor. Yet women who are prepared psychologically and physically for extreme pain—prepared, perhaps to do battle—may well be better able to manage the trial of labor with less fear—and possibly with fewer medical interventions” (93).

Novelist Louise Erdrich sees the pain of childbirth as “a meaningful and determined pain, based on ardor and potential joy which can be "deeply instructive" and "change your life” (43). She condemns the treatment of expectant women as "babies having babies"; instead, “we should be in training, like acolytes, novices to high priesthood, like serious applicants for the space program” (12). Here, Erdrich calls for a new metaphorical paradigm, one filled with passionate urgency. Rather than seeing childbirth as surgery, as pain to be passively endured or eradicated, it should be viewed as something akin to running a marathon.
or climbing a mountain; it should move out of the realm of a static trauma and into the world of power and transformation.

Certainly, the story of pain, rather than struggle and challenge, is the predominant story that most American women have heard—and continue to hear—about the nature of childbirth. This story, more than hospital policy, more than patriarchy, more than the training of obstetricians or the lack of midwives, perhaps is one of the strongest forces that have kept the medical model of childbirth the predominant one today. Because the story of childbirth is shaped by the medical model, which defines birth as a medical problem to be solved, many birth stories are stories of trauma.

Birth activist Carolyn Keefe notes that at least twenty percent of women in the U.S. experience some aspect of postpartum depression and as many as thirty percent exhibit signs of posttraumatic stress—“often because of the treatment they receive from the very providers and institutions they have paid to care for them” (34). Keefe explicitly makes a connection between the suffering of these women and their inability to tell their stories:

Sadly, we have such a strong prohibition against women expressing any negative feelings about their births, that many of these women have nowhere to go with these feelings and no acceptable way to express them. Often they turn inward or become defensive or resigned, to protect themselves from this pain and anger. Traumatic birth also leaves emotional marks on babies and on fathers or partners. (“Reflections” 34)

Mental health professionals now recognize that one of the risk categories for postpartum disorders is enduring a “difficult delivery” (Robinson and Stewart 134). In “Postpartum Blues: Depression or Trauma?” Keefe cites recent research that indicates that a traumatic delivery can result in posttraumatic stress disorder, a categorization that should be separated from the vague category of “postpartum depression,” which is often dismissed as “the blues” and a “normal” part of the postpartum period.

In hearing and collecting many stories, Wolf shows that the “traumatic” birth experience is not an isolated case, but the result of a disempowering, technocratic system. She also notes that many of the traumatic experiences women endured were directly affected by their interactions with seemingly heartless doctors and nurses. Rather than attributing dehumanization to “luck of the draw,” we might look at how the education of medical professionals involves dehumanization.
In her study of the rituals of medical training of obstetricians, Robbie Davis-Floyd traces this socialization of doctors to the early years of medical school, in which they are taught basic sciences that seem to have little connection to their future careers. A competitive emphasis, isolation, and enormous pressure operate as a kind of “hazing” for the “initiates” into the medical profession, resulting in a distancing of medical students’ original humanitarian ideals for becoming doctors. As one doctor says, “the whole process of medical education makes you inhuman” (qtd. in Davis-Floyd 257). Thus, while a few isolated stories of traumatic births could be blamed on luck or just a poor choice of physician, the collection of multiple stories of women’s birth experiences provide a powerful testimony to the results of this “initiation” process in early medical training and to the larger corporate-technocratic culture in which most women give birth.

The stories of poor women and women of color also further illuminate the ways in which the current model of birth is disempowering and oppressive. Often these women are more often subjected to interventions like the use of Pitocin, which frequently results in the need for cesareans (Wolf 181). Critics argue that these women are getting even less personal support than middle-class white women, which explains the use of more interventions. These women are often also subjected to racism and classism on the part of the hospital staff. A history of such treatment on the part of the medical professions could be at least partly to blame for what one doctor reports as a profound distrust on the part of people of color for the white-dominated medical system (181).

In an example of how women of color are perceived in the medical system, Cindy Martin recounts giving birth in an Indian Health Services hospital and being greeted with scorn by the nurses when she asks them to share medical information with her. Instead of giving her information about dilation or stages of labor, the nurse tells her “babies come when they want to come.” While this seems to suggest a less medical model, it does little to acknowledge Martin’s need for information and support. Martin offers further perspective of her experience, integrating a later perspective drawn from the work of Susan Bordo:

When I began to cry, primarily because of stress, one nurse stated, “Well, that’s what you teenagers get.” On the surface, it would appear as a comment expressing a general disgust of teenage pregnancy. However, it proved to be an illustration of Bordo’s description of “the mediating racist
Thus, it is not the actual medicine or technology per se that causes problems, but the discourse the woman finds herself in within a medical model that fails to account for the woman’s whole being.

An alternative model of birth that does account for a woman’s whole being is espoused by natural- and home-birth proponents, specifically in the midwifery model of care. This model, according to a pamphlet published by the activist organization Citizens for Midwifery, advocates a “deep respect for the normalcy of birth and for the uniqueness of each childbearing woman and her family.” Care is individualized and pays attention to the physical, psychological, and social well-being of the mother throughout the childbearing cycle. According to Citizens for Midwifery, the “application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.”

Perhaps more than any other advocate of the midwifery model of childbirth, midwife and birth activist Ina May Gaskin recognizes the importance of birth stories in effecting social change. Her book *Spiritual Midwifery* relies as much on the voices of other women as on her own authority. That is, she gives over authority for speaking about birth to the women who give birth. In the fourth, most recent (2002), edition of the book, which was first published in 1975, Gaskin asserts that women continue “to require the knowledge that birth still works and that every woman has her unique way of bringing her baby into the world. One good way to acquire this precious knowledge is to hear or read the birth stories of quite a few women who have given birth” (6–7). Gaskin goes on to discuss the importance of language and words in shaping women’s attitudes toward birth, noting that “[g]enerally speaking, the more comfortable a woman is living in her body, the more easily she gives birth” (7). She implies here that the ease with which a woman feels in her body is directly related to the language she owns to name the parts of her body. The experience of birth for a woman is directly related to how much she resists the naming of women’s body parts as dirty and unclean. She resists declaring any one name for the vagina; she insists on using whatever words she finds necessary for the women she works with because, she
hopes, the more women accustom themselves to the words, the more they can strip them of their “crazy-making power over us” (7–8).

All of the women in Gaskin’s book gave birth at The Farm, a commune in Tennessee. Gaskin taught herself midwifery and later became a certified professional midwife. Many of the women whose stories are recounted in *Spiritual Midwifery* recount births both before and after coming to The Farm. Some of these children were born in a more conventional way, in a hospital; later children were then born on The Farm. The differences between the births are notable. While the hospital births are marked by trauma and crisis, the Farm births are marked by a sense of spiritual transformation. They suggest possibilities for a new paradigm of birth.

One woman, Anita, had already had two babies in a hospital before coming to The Farm. She describes it thus:

> I had been so drugged, even though I had requested not to be, that I missed all of one birth and most of the other. . . . [Birthing at home was nothing at all like] being shaved, sterilized, poked, and strapped down after getting up, getting dressed, and getting to the hospital. Surrounded by strangers, blinded by bright lights, the ultimate indignity was being rendered unconscious and insensible, being deprived of the experience I had looked forward to for so long. . . . (83–84)

The difference is a change in how she is treated, and the control in which she takes over her own experience: “Now, as I began to experience what I recognized to be contractions, I was excited to be an active participant rather than a passive consumer during this baby’s delivery. . . . It was the most conscious-expanding experience I had ever had. The curiosity that had initiated my journey had been satisfied” (83). The difference in language here is remarkable, and consistent with other stories in the book. More than just a litany of details of centimeters, minutes, number of contractions, and shrieking we’ve come to expect from the birth story, Anita describes it as a deeply spiritual, transformational one, a “conscious-expanding experience” and a “journey,” language akin to a person on a hero-quest.

Another woman, Christine, recounts her first two births in hospitals as so traumatic that when she gets pregnant for the third time, she finds the prospect of going to the hospital “even more frightening” than a natural birth. Despite her fears, Christine is able to draw strength and calm from Gaskin. When she falls apart at transition, overwhelmed and feeling
she cannot do it, the midwives gently steer her back to a place where she can manage pushing. Afterwards, Christine experiences “a deep feeling of joy and peace” in her soul (86).

In the midwifery model, even a hospital birth can be transformational. Both Ina May Gaskin and the birthing woman, Carol, recount the first time one of the women under Gaskin’s care had to go to the hospital. Because the baby is coming bottom-first, and Gaskin does not feel she can handle a breech birth, they go to the hospital. Because Gaskin and others from The Farm foster an atmosphere that will extend their principles to the hospital, Carol is still able to have her baby without routine interventions. Carol’s language evokes much of the same vocabulary that is used throughout many of the birth stories in *Spiritual Midwifery*: she refers to contractions as “rushes”; asks, “Is it this heavy for everyone?” and affirms, “it blew my mind.” She calls the experience of labor and pushing as “tripping,” which shows her “where it’s at.” Her experience of birth, like the others, is clearly one of spiritual transformation, a transformation that intimately connects her to other women, as well: “Something more powerful than me was at work. . . . I thought, ‘Amazing! Generations of women have been doing this. That’s how we all got here.’ The trip seemed very precious, very spiritual, sacred, in fact” (43–44).

In a more recent example of how the midwifery model provides a view of birth as transformational rather than traumatic, English professor Ruth Ann Smalley offers the story of her two births in the most recent issue of *Journal for Living: The Magazine for Empowering Families*. This issue is focused on “birth wisdom” and features several birth stories. Smalley, who also edited the issue, notes that many women who have a medicalized birth “know they have missed, even been cheated of, something very profound” (2). Even women who have had “normal” deliveries may feel as if they have missed something, which she attributes to the “fundamentally sacrilegious” medical model of birth (2). Smalley goes on to share her own birth stories, beginning with a miscarriage. The experience she has with a doula (an advocate/support person who accompanies the mother into the hospital) and a certified nurse-midwife for Smalley’s first birth engenders the confidence to plan a home birth for her second child. One of the most insightful lessons of her home birth is that she does not have to consciously push her baby out into the world until the very end. Smalley asks, “After all, if a baby could come into the world with hard work but without forceful straining, what did that mean about other creative projects?” The ultimate lesson is that she becomes
“liberated” from “excessive reliance on expert[s],” quite a feat for someone in academia (5).

Davis-Floyd notes that all of the women in her study who found their births traumatic sought to “rewrite the messages of their hospital births” by utilizing the medium of narrative (244). The birth narrative had both personal and social implications, initiating further exploration; some of these women even became involved in childbirth education and midwifery. As Rhett seems to promise when she closes her memoir with a second pregnancy, these women also found healing through subsequent births, acting as “both the catalysts and the means for the complete reinterpretation of the cognitive content of their earlier hospital births, as well as for the transformation of their own reality models” (245).

Davis-Floyd also emphasizes the importance of the birth story in fostering change: “The importance of childbirth narratives as a women’s speech genre cannot be overstated” (245). She explains how birth stories change as women hear the stories of others, a kind of revision process that gives rise to “the essence of their birth experiences” (245). Just as shaping a narrative alters the teller’s perspective, so can sharing—and critiquing—narratives ultimately reshape discursive constructs.

One way birth stories can be alternatively defined is as “connection myths,” as Julie Tharp calls the birth stories present in the fiction of Louise Erdrich. Tharp concludes that the stories in Erdrich’s fiction act as “connection” myths in that they “explain the basis for connection between people, often people who on the surface have little in common.” In this way characters are able to form their identity in relation to their connections with family and friends (128). This process is vital for the building and maintenance of community in that the birth stories “tell the story of how characters belong. Without these stories, characters drift. Furthermore, when characters drift, the community falls apart. . . . Erdrich’s fictive birth stories are literally about reconnecting, even recreating a disintegrating community.” Erdrich wants “to teach them [the drifters] their origins and bring them home” (128).

If sharing stories is important, so is reshaping the language with which we talk about birth, and Tharp’s study of Erdrich suggests one possibility for this project. Rather than seeing a birth story as a repertoire of medical positions with a few entertaining episodes sprinkled in, such stories should be shaped within a model that celebrates it as a spiritual, transformative event. Women who have had positive birth experiences often compare them to a journey, a quest, or a liberation. Journal for Living attempts to give birth this kind of context when they place the
“birth wisdom” issue as the first in a series on life journeys. Joseph Campbell is here quoted as saying that birth for a mother is a psychological as well as a physical transformation, and that the ways in which “she confronts and maneuvers through those dangers, the paths she chooses to travel across that threshold, are part of her own spiritual birth, and represent her own individual hero’s quest” (Harrison 9–10).

This new paradigm does not leave out the father or partner, either. For a father taking part in a birth that celebrates this journey, it can also be transformative. In a recent issue of *Mothering* magazine, writer and father Dimitri Kaasan describes how participating in the Bradley method (a natural-birthing approach) and in his son’s birth affected him. After a successful, in-hospital natural birth with minimal interventions, Kaasan reflects on how important the preparation offered through the Bradley class was: preparing for the birth was “a way of expressing” love for his son and wife. He raises questions about the potential for a father’s role in his baby’s birth, connecting it to an understanding of the larger social forces at work:

What if more men were to take the question “Is what they’re offering us normal?” and continue asking it as their children progressed through childhood? Could the healthy skepticism fathers cultivate in Bradley training extend beyond the newborn phase? Could fathers—like so many mothers—assume more of a gatekeeping role on behalf of their families? ...Could the “mere” experience of childbirth remind fathers that no practice, policy, or product should be taken for granted—no matter the seeming authority of the institution it offers? (50)

Others also have seen the potential for making birth a site of raising consciousness and encouraging critique. In her study of women’s memoirs of childbirth and early motherhood, Trudelle Thomas argues for the inclusion of life-writing about childbirth and early motherhood in anthologies of women’s writing (where it is, surprisingly, notably absent), in the academic classroom, as well as in other community venues like parenting classes at hospitals and churches. Looking at birth and the discourses around it in a site such as a classroom can be a potent illustration of the power of language, especially if we are to view language as “a way of contending, in all the senses of that word, with the processes through which discourse shapes human thought and social relations in a context of change and struggle,” in the words of Patricia Harkin and John Schilb (6).
Birth stories are an especially rich site for such a project. Since we have all been born, we all have stories to draw on. Looking at how we think and talk about birth reveals much about who we are. After all, “To birthing . . . we bring our histories, our relationships, our rituals . . . needs and values that relate to intimacy, sexuality, the quality and style of family life and community, and our deepest beliefs about life, birth, and death” (qtd. in Pincus and Swenson 435).

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Notes

1. See Harper, especially 9; 52–56, and 64–70; also Wolf, especially 176–80.
2. For a review of some studies on the efficacy of electronic fetal monitors, see Wolf 155–59.
4. A certified professional midwife, as distinguished from a certified nurse-midwife, is a midwife who has been trained as a “lay” or “direct-entry” midwife; her training comes from other experienced midwives, not from hospitals or medical staff. CPMs are battling for legal recognition in many states, including New York State, where I live.
5. Subsequently, Gaskin will become known for a maneuver to turn breech babies, enabling them to be born out of hospital.

Works Cited


