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ANNIVERSARY COLLECTION – PAPER

"*We've Bought a Tens Machine and We're Trying Aromatherapy and Hypnobirthing*": Being Prepared for Labour and Birth?

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This commentary is written to mark 10 years of comprehensive maternal scholarship undertaken across the Journal. In this piece I return to reflect on the gap between women's anticipations of labour and birth and their experiences, as births appear to be becoming more interventionist. This leads me to invite a debate about why this might be and whether it matters?

It still seems to me a remarkable fact that everyone is born. And as I have listened to women and men's hopes and fears as births and new parenthood are anticipated, I'm continually reminded of the enormity of this fact. They too, usually take comfort from this as they contemplate (giving) birth and a new life. Yet, birth is everywhere culturally inscribed, and the biological aspects overlaid with historical, political and culturally shaped practices and knowledges. This was all brought home to me much earlier in my career as a Sociologist, when I lived in the Solomon Islands and Bangladesh. In these residences, I witnessed different practices and assumptions to those I had been familiar with in the UK. In the intervening years, I have used qualitative longitudinal research approaches to explore how journeys into motherhood (2005, 2007) and fatherhood (2010, 2011) are experienced and narrated over time, as children grow (2017). This has enabled me to accumulate stories of transitions and individual/familial growth as a moving picture of unfolding experiences.

The certainty of the fact that everyone is born sits in stark contrast with the *un*certainty of labour and birth. There is so much that cannot be known as first births are anticipated, borne, recovered from, lived with and reflected upon—sometimes for many years after the event. Yet, in more recent years, the list of ways in which birth might be approached has lengthened, providing new 'choices' and a sense of an event, for those approaching it, that can be individually managed and controlled through different practices. It is this increase in labour and birth preparations and options, including 'plans' for birth, that I explore further in this short piece. More precisely, I return to a question about how women prepare for/are 'prepared' for labour and birth, especially for those becoming a mother for the first time. While birth anticipation and preparation are increasingly framed as a longer list of choices, experiences during labour and birth are likely to be framed more narrowly against a backdrop of medical, 'risk' management.

During the antenatal phase of transition to first-time motherhood, practices of agency are mediated in this (experientially unfamiliar) realm. This is done through access to a wider array of information sources and technologies and other professional/practitioner interactions, which reinforce particular ideals

of motherhood and female bodies. How women anticipate and prepare for/are prepared for birth are then premised on widely divergent discourses and ideas about bodies, pain, nature, endurance, medical progress, risk, intervention, hospitals and home. These often contradictory, but also passionately held perspectives underpin preparation advice, expectations and associated practices.

The competing ideas associated with how women *should* prepare/be prepared for birth was brought home to me during a presentation of my 'Transition to Motherhood' research, which I'd been invited to give in 2014.[1] I was asked how I would advise one of my own daughters about birth and pain relief. I made some general comments on the impossibility of knowing how an individual labour might unfold and how bodily sensations are 'felt'. I concluded that I'd advise them to be open-minded and use pain relief if they felt they (really) needed it.[2] My response was greeted by heckling from the floor initiated by a group of natural childbirth advocates who felt my reference to the potential use of pain relief denied the ability of women's bodies to birth a baby. But over many years of research, I am clear that birth is often experienced in ways that have not been planned, imagined or desired and which often run counter to birth plan hopes. The consequence can be that women come through labour and birth feeling a sense of failure or guilt because they needed pain relief and/or other interventions. But this returns me to questions about women's preparation for labour and birth, which have been prompted by findings from my most recent study.

Over the past two years (2017–2019), I have been following 27 women through journeys into *first-time* motherhood,[3] repeating my original Motherhood study (which commenced in 1996) with a new generation of women becoming mothers. The data from this study will provide key comparative materials as the

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[1] 'First baby, newly born family and Maternity & the Newborn Forum', London. June 2014.

[2] I recently had a conversation with one of my adult daughters who said she'd want an elective caesarean were she to be pregnant, and I said she should definitely try for a vaginal birth. I am unclear why I feel so strongly that this should be the route to try, perhaps because I managed it?

[3] 27 women who identified as becoming mothers, joined the study. Of these, 2 were in same-sex, married couples where their wives were the 'carriers' of the baby (in one case carrying the fertilised egg of their wife). This means there were a total of 25 births and birthing women in the study.

same research design has been followed with women being interviewed on three occasions;[4] before the birth (between 7–9 months), in the early weeks following the birth, and when their baby was aged 9–10 months. Although the research design remained unchanged, the broader societal context has, of course, shifted. This includes the advent and rise of the digital world, neoliberal ideals and developments in neuroscience, all of which have contributed to more intensive measures of 'appropriate' and 'good' motherhood/parenthood (Hays, 1996). Legal, policy and biological shifts, too, have enabled new reproductive and caring possibilities during the intervening years. Moreover, theorisations of gendered practices have posed new opportunities for how 'family' (in its multiple configurations) is understood and practised.

The preliminary findings from this most recent study illuminate areas of continuity and change (especially those related to digital connections), but disquiet too. This sense of concern arises from the women's descriptions of more interventionist births. Out of 25 carrying women in the current study, almost half of the women (12/25) had emergency i.e. 'medically-indicted' caesarean births. This is compared to 1 out of 17 women in the original study.[5] A further 8 births in the current study (8/25) involved forceps-assisted deliveries, leaving only 4 births as 'normal' or more straightforward deliveries. These birth experiences sit in stark contrast to the labour and birth journeys hopefully anticipated in the mother's antenatal interviews (conducted at approximately 7–8 months into the pregnancy). In these, women in the current study drew upon a wider array of perceived possibilities and 'choices' open to them. These included hypnobirthing, birth pools, different forms of pain relief, (mentally organised into hierarchies, which hopefully would not be required) and birthing in midwife-led birth centres: but a caesarean birth does not feature in any of their plans. In later interviews, the women describe not taking note of the forceps that had been passed around in the antenatal class. In line with

[4] As far as is possible. New areas were added to the original interview schedule to capture the use of digital resources/social media and knowledge/use of Shared Parental Leave. Otherwise, the research design remained the same.

[5] In addition, there was 1 planned elective caesarean (for twin births) in each study.

the findings in the original study (2005, see chapter 4), 'appropriate' antenatal prepararation is associated with ensuring a 'natural' birth. 'Natural' here is described in terms of manageable levels of 'positive pain', through which control, using breathing and hypnobirthing techniques, could be maintained. Partners, husbands and wives could assist in the event by navigating the birth plan, in which labour and birth have been mapped ("*he can relay that to the midwife*"). But there could be doubts too — "*what if I 'can't do it, what if I need an epidural?*". Happily, for all the women, the births did lead to the delivery of a healthy baby. But their birth experiences left many feeling overwhelmed by the unfolding events of their labour and the birth, leaving them experiencing a sense of personal failure. Not surprisingly, this is an unhelpful place from which to experience first-time mothering and the 24/7 sense of responsibility that descends at the same time *("I said I feel like I've been to war and been shot and beaten up and I'm in recovery mode"*).

So, my intention in this short piece is to initiate and invite a discussion about why the gap between women's anticipations of labour and birth and their experiences and outcomes of these have become even further apart. This raises questions about whether women can prepare for birth and early mothering in ways that ensure expectations more closely align with their eventual experience: and where personal and service-provider responsibilities lie within this reproductive conundrum? These questions coincide with enduring feminist and other debates which have ranged across the maternal terrain of leaky, visceral bodies, pain and essentialism set within cultural and historical moments where patriarchal configurations also lurk. For example, in both studies, the women recognise there are expectations of 'appropriate' antenatal preparation and narrate practices which underscore their preparations for birth, which are implicitly associated with enduring ideals of 'good' motherhood (Miller, 2005, 2007; Oakley, 2018). Contemporary constructions of 'good' motherhood are apparent well before pregnancy and now include navigating limitless sources of digital and other information ("*Going onto different forums is dangerous…I tend to try and go for sources that are a bit more trustworthy*"). There are Apps too, designed to guide, monitor and so reassure women (and men) through conception, pregnancy and beyond ("*Yes, so the Apps are really good and just quite handy…like*

where the baby's positioned"). The average age of a mother at first birth in the UK is edging towards 30 years, with 28.8 years recorded in 2017 (ONS, 2017), which also means women have longer established work and career histories, identities and trajectories before motherhood *("I've always wanted to be a mum, but I just had to get to a certain stage in my career first, before I was happy to take a break"*). Each of these factors can lead women to plan and monitor their pregnancies at a later stage in their lives and in more detailed ways than previously possible, indicating a changing cultural backdrop to birth. But the most significant change between the two studies has been in the number of non-elective—and so individually unexpected and unplanned—emergency caesarean births, which accounted for almost half of the births (12/25) in the current study.

This rise in caesarean births fits an 'alarming' global trend of rising caesarean rates (Wise, 2018; Sandall et al., 2018)[6] Such trends have been explained through factors such as age, obesity, changing physiology of mothers and led to media headlines claiming that 'women are increasingly scared of natural birth' (Telegraph, 2018). Such headlines worryingly oversimplify a complicated relationship of individual agency, structural circumstances, competing information sources and an embodied experience, which cannot be experientially known in advance, but is still expected to be planned. But the question of whether current practices contribute to expectations of birth, which are increasingly unlikely to be met and can leave women feeling they have failed, is a vital one. Could different practices, facilities and birthing possibilities enable women to reduce the likelihood of increasingly medically-interventionist births, as the longer-term outcomes following caesarean births are documented – and is this something women want? (Sandall et al, 2018). The effects of particular pain-relieving drugs 'crossing the placenta' has long been put forward as a reason for women to (try to) avoid pain relief, adding to their sense of guilt when they find birth almost 'unbearable' ("*it turns out you can't breathe a baby out after all*"). Changes in birth experiences and outcomes also return us to the question of what constitutes 'natural' birth and why using pain relief can be viewed as defeatist when it's taken

[6] However, it's important to distinguish between 'medically-indicated' caesarean operations and 'elective' caesareans, although both can involve medical need.

for granted in other procedures that our bodies might endure. There are caveats to be noted about the research sample in my current study from which the findings and my concerns emerge.[7] However, it is the significant differences in labour and birth experiences and outcomes between my two studies, conducted a generation apart, which demands examination. How far are longer lists of birthing 'choices' and 'plans' only illusionary in circumstances where labour is now more likely to end in forceps or Caesarean births—and why/does this matter?

Competing Interests

The author has no competing interests to declare.

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[7] The 27 women in my study 'opted in' as a requirement set by the University Ethics Committee. This has led to a more middle-class/professionally employed sample being recruited. The women are aged between 24–39 years, with an average age of 32.3 years, which is above the average age for first birth in the UK.

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