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► **To cite this version:**

Madeleine Akrich, Bernike Pasveer. Embodiment and Desimbodiment in Childbirth Narratives. *Body & Society*, 2004, 10, pp.63-84. <halshs-00122103>

HAL Id: halshs-00122103

<https://shs.hal.science/halshs-00122103v1>

Submitted on 26 Dec 2006

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EMBODIMENT AND DISEMBODIMENT IN CHILDBIRTH NARRATIVES*

MADELEINE AKRICH & BERNIKE PASVEER

2004, *BODY & SOCIETY*, 10, pp.63-84.

How do women experience childbirth today? What role does the body, their body, occupy in the way they describe it? And to what extent may technology and medical practices be considered as determinant in the shaping of this experience and the positioning of the body within it? While it is true, as many analysts maintain, that western medicine establishes and assumes a body/mind or body/self dualism, the question we want to address here is how the medical practices surrounding most births today have a performative effect on women's experiences of childbirth and cause them to separate or not that which concerns their body from other aspects of the birth: emotional, family or social. Behind this question lie several critical analyses. Authors such as Turner (1992), Bendelow and Williams (1995) and Kleinman (1988) contrast the body as the central object of medicine with a holistic conception of the subject based on a phenomenological or psychoanalytical approach. From their point of view, it was formerly conceivable for medicine to maintain a purely physiological approach when treating mainly acute pathologies. In recent times, however, the large-scale development of chronic diseases or long-term pathologies has necessitated a profound redefinition of medicine, based on a revised conception of subjects who are not split, as in the Cartesian tradition, but unified by their embodiment, as posited by phenomenology:

In other words, the sociology of the body represents a major counter-position to the medical model and to reductionism in sociobiology because, in the concept of embodiment, we can break out of the dualism of the Cartesian legacy, phenomenologically appreciating the intimate and necessary relationship between my sense of myself, my awareness of the integrity of my body, and experience of illness as not simply an attack on my instrumental body but as a radical intrusion into my embodied selfhood. (Turner, 1992: 167)

This critique is based on the hypothesis of strong continuity between medicine as a discipline, medical practice and patients' experiences. It attaches little importance to the work required to superimpose the body as defined by medicine as a discipline, on the corporeal shell of each patient. Marc Berg and Paul Harterink give a striking illustration of this problem in this volume. They point out that even if, as Foucault (1994) showed, after a turbulent history the space of disease merged with that of the body, it was only much later, in doctors' daily practices, that the measuring instruments and tools used to give each patient a body congruent with that defined by medicine appeared. Other studies (Boullier, 1995; Heath, 1993; Hirschauer, 1991; Kapsalis, 1997; Pasveer, 1992) similarly highlight the set of

* The research on which this article draws was supported by both MIRE and INSERM.

operations carried out each time to achieve that superimposition of the two bodies or, more precisely, to bring about the articulation between the body of the 'person' and that of the patient as defined by medicine. Heath and Kapsalis describe, for example, how the embodied know-how of both doctors and patients allows certain gestures required by an examination to be made, when outside these particular circumstances they could be experienced as attacks on the integrity, honour or dignity of the person. Hirschauer (1991) similarly shows how preparations for a surgical operation as such allow the body of the patient-as-a-person to disappear from the scene and a recomposed body, virtually identical to the anatomical body on which the surgeon can practise his or her art, to emerge.

Like these studies, we propose to leave open the question of the body, that is, we make no assumptions on the unity and univocity of the bodies constructed by medical practice; nor do we suppose that women have a body that is already there, underlying all their experiences. More exactly, we propose to follow, in women's narratives, the way in which action is distributed and, in particular, the processes of dissociation–association between bodies and selves. One of the main objects of this article is to describe the kinds of mediation/mediators that afford these different kinds of self–body relations, with various types of agency, medical practice and technology being one of these possible mediations.

For this purpose, we will draw upon recent developments in the sociology of science and technology. Central to this approach is the assumption that a technical device can be described in terms of a scenario, defining a sharing of competences between the artefact proper, its user and a set of social and technical elements constituting their common environment; thus, the sociologist's work consists of following all implied actors (from designer to users) in their various negotiations in order to stabilize a definition of both the technical form of the artefact and the world in which it takes place (e.g. Callon, 1986a, 1986b; Latour, 1991). Through this analysis, the objective of sociology of technology is to provide an account of the way social relations are transformed through the process of innovation, which can be viewed both as description and performance of these relations. To achieve this objective, the analysis draws upon what has been called a 'semiotic turn' (e.g. Akrich, 1992; Akrich and Latour, 1992; Latour, 1992): if one wants to describe the way the innovation process results in a reconfiguration of relations between various entities, themselves redefined through this process, then it is necessary not to make any a priori assumptions as to the number and nature of these entities, but to follow their progressive emergence and consolidation throughout the process. This implies that faced with the empirical material, whatever its mode of production (archives, interviews, observations), the analyst must stick to it, consider it as a world-in-progress – participating in its performance and not simply accounting for it – and try to describe what is at play within this world, thus following the approach developed by semioticians to analyse literary texts. The notion of 'actant' is central there: it designates any entity which, within the text, accomplishes or undergoes any action. It helps not to make any hypothesis about the realism and the solidity of such a construction, but, conversely, to analyse the work necessary to perform it.

In this article, we try to go a step further following this line of analysis: if one accepts the idea that technical devices participate in this shaping of social relations, then it must be possible to show how the way people experience themselves and the way they get a hold on their environment are mediated by technical devices. Instead of focusing on the way technical devices and their world are performed, our concern is to describe how body(ies) and self are performed in birth narratives through the mediation of a number of significant elements, including technical devices. In this perspective, birth narratives, as we pointed out for other kinds of empirical data, are not considered as 'reflecting' reality but as constituting the reality

we are interested in, that is, the woman's childbirth experience.¹ They appear as interesting cases for the general purpose we pursue: giving birth is considered an intimate and subjective experience; it can take place in a variety of technological environments, which provides us with a sort of experimental setting allowing us to track differences in the way subjective experience is mediated by technology. Our approach leads us to a sort of deconstruction of the 'body' itself, defined here as a category through which women construct themselves as subjects.

We draw on a corpus of over 70 childbirth narratives collected in various ways. Most of them derive from open interviews in which we asked women to recount their pregnancy, from the beginning up to childbirth, with particular emphasis on the monitoring of the pregnancy, preparation for childbirth and the birth itself. Some of the women agreed to keep a 'diary' of their pregnancy, which enabled us to follow it step by step, and to conclude with a more or less detailed account of childbirth. Finally, some accounts were sent to us by email in response to a request on an Internet site for parents. We deliberately chose not to select our respondents according to any form of representativeness (class, colour, education, urban or rural, parity, etc.). The idea was not to reveal determinants explaining why the narrative of a particular woman was organized in a particular way (the list of such potential determinants is moreover problematic in so far as it would be difficult a priori to reconstitute the chain linking traditional categories of sociology to the detailed descriptors of childbirth narratives). Rather, we wanted to gain insight into the constitution of women's relationships with their bodies during childbirth. By contrast, the environment in which birth took place was not irrelevant to our study. From this point of view, we have a fairly wide range of configurations, including childbirth at home, childbirth in a hospital with very limited medical intervention, and childbirth with extensive use of medical techniques and equipment, including or not an epidural – currently the most commonly used analgesic method.

In the first part we focus on the onset of labour and the way in which a form of agency is attributed to an emerging entity that we call the body-in-labour. We see, in particular, that this body is constituted through extremely varied mediations, among which obstetrical expertise plays a significant role. In the second part we characterize the different distributions of agency that can be identified in the narratives. In other words, we look at the ways in which the different self/body twosomes are defined, and at their dynamics in time. We then analyse the ways in which professionals intervene in setting up these distributions. Finally, we consider the notion of alienation and try to identify the conditions in which childbirth is experienced as an alienating experience.

ONSET: MEDIATIONS AND THE DYS-APPEARING BODY

On the morning of a day with my sister, a week before the calculated date of birth, at breakfast, I told my husband that I didn't feel very well. My tummy rumbled, and I had slight cramps from time to time. I thought I had been eating something wrong. I just had to go to Amsterdam.

¹ Of course, the narratives we collected are, for each woman, included in a series of narratives, some produced before the one we consider, others produced after it. And of course, in the case of interviews, we are to be considered as more or less active co-producers of the narrative. Moreover, this series is evolutionary: after another experience of childbirth, women might reconsider the way they interpreted their previous experience. But our point is not to reveal the 'truth' of the childbirth experience – which, considering what has just been stated, is nonsense – instead we want to analyse what are the constitutive elements of this experience.

At the appointed place we were having tea, and I had to change my position because my tummy was feeling stiff. I told my sister. I thought that maybe I had done too much the previous days. My sister said: you're not going to give birth at the hairdresser's, are you!? At the hairdresser's in Amsterdam it was very busy but we had lots to talk about so I paid even less attention to these regular recurring 'tummy cramps'.

I was convinced that these were not contractions: I had read everywhere that contractions hurt, and this was nothing. And I had also read that when it comes to recognizing real contractions, one would know right away. Doubt meant: no real contractions. So I thought these were 'precontractions'. My mom had had that too, for a week. With real contractions I would not have managed to sit there laughing in a hairdresser's chair. . . . I thought.

My sister came and asked every now and then how I was doing, and more and more women started to get involved. Some said it was nothing, others said I was in labour. And in the mirror I saw my face turn white (in between cramps) and red (during cramps). The hairdresser saw my face and suggested I time the cramps, and put his watch before me. It appeared that I had cramps every 8 minutes, and he said: call your husband, which I did. I said: they say I am in labour but I don't know. Marcel said: you don't sound like you're having contractions, but why don't you call the midwife? The midwife said: if contractions come every 4 minutes, they're not pre-contractions anymore! So I called my husband and said I was not in labour because I had these cramps every 8 minutes, and I decided to carry on with our Amsterdam trip.

. . . Once inside the car I got really uncomfortable. I couldn't find a good way to sit, and during a cramp I couldn't talk anymore. I started to doubt: these were really hard cramps. What if they were contractions after all?? But I still didn't believe I was in labour, until we started timing the cramps: every 4 minutes!

I called the midwife again, she said: you'd better go home, I'll come and have a look when you're there. . . . Once at home we started to time the contractions. But they were not regular really. Pre-contractions after all? Then the midwife came and watched me and confirmed that I was in labour, and upstairs she did an internal. It appeared that I was dilated 3 cm already!! It occurred to me that I was going to be a mother that day! Good! I was giving birth! (Carole)

This long quote from a birth story, sent to us by email by a woman otherwise unknown to us, shows a series of elements that come up in most interviews. The first is that to decide whether labour has indeed started is not easy. What happens is that the implicit and quite unnoticed body takes the initiative: the woman has cramps and she must interpret them. More exactly, we witness here what Leder (1990) called the dys-appearance of the body. Based on Merleau-Ponty, Leder characterizes the body through a dual regime of absence–presence: a permanent mediator in our way of seeing the world, but simultaneously in the background, both because by hiding its internal functioning it enables us to be open to the outside, and because the presence of the world in us is correlative with a certain form of absence from ourselves. In other words, the organ of perception is necessarily concealed behind the perceived object. In rare situations the body experiments for itself; more generally, however, it reappears as such when something disturbs the usual harmony. In situations of pain, disease, discomfort, or motor or perceptive problems, the body makes itself present; hence, the notion of dys-appearing that we use here.

In Carole's account her body, or certain parts of her body progressively disappear in a pendulum movement. At first her body makes itself present in the form of 'cramps', but she is not sure how to qualify those cramps and tends to think they are ordinary manifestations of the organic body (the 'recessive body' in Leder's terms) which can, after a short phase of adaptation, be pushed to the back of her mind. The insistence of the cramps, and perhaps even more so of her sister, contributes towards the emergence of the body as an entity that is both present and 'foreign' in a sense. Attention turns towards the perception and qualification of these manifestations, which become the subject of a collective conversation. Carole's case is characterized by the multiplicity of actors involved in this process – her

sister, other clients, the hairdresser, her husband and the midwife – but, from this point of view, is just an extreme case of the usual situation. In the vast majority of childbirth narratives the emergence of contractions as a manifestation of a body that is becoming not only present but also active, is mediated by the intervention of actors other than the woman herself. In Carole's account she does not seem to have any particular privilege in the understanding of this process. Her internal sensations are ambiguous – even more so, it seems, than certain external manifestations such as her change of colour during contractions. From this point of view, the mirror is the first objectifying element which sets her, exactly like the other people present, in a position of externality vis-à-vis herself. At times it is even the others who provoke the transition between an 'ordinary' state, characterized by a mute presence of the body, and the entry into labour. They thus constitute the body as an acting entity, and requalify the woman's perception of it. Without the intervention of her husband, Sonia, for example, would probably have given birth at home, unexpectedly:

I wasn't ready, neither physically nor psychologically, because I didn't feel anything. My husband said: don't you think you're going to give birth soon? It's true that I had contractions but since I'd never had them during my pregnancy I didn't know what it was. I had pain low down in my stomach but I didn't know what it was. I thought it was nothing, I didn't want to go. When I got down there and they said: you're going to give birth right now, I was shocked. Apparently I was shaking like a leaf, I wasn't ready to give birth. I hope that next time it won't be like that because it was all too rushed and I wasn't expecting it. (Sonia)

If we revert to Carole's case, a number of devices – the watch and especially the midwife's fingers – are included in the narrative. They all represent entry points into obstetrics and, here again, specify the action under way more and more, and mark the fact that it takes place, in a sense, without the woman's awareness. The agent concerned is not necessarily explicitly designated, but one can assume that the obstetrical knowledge of the different people involved, from professionals to parents, is taken for granted by the professionals. For almost half a century antenatal classes and popularized books for mothers-to-be, at least in western countries, have been part of the scene and have helped to make a 'physiological' representation of childbirth commonplace. This representation consists of a firmly established scenario in which the uterus, the active element, contracts and, by pulling on the cervix, progressively opens it so that the baby can get through. This process defies voluntary control by the mother. From the outset she is merely one of the protagonists, albeit an important one, in the delivery. This dissociation, inscribed in the obstetrical description, is often enacted by women themselves. By carrying out certain gestures recommended by midwives and doctors, they test their own perceptions and enter into an 'objectifying' procedure which enables professionals to relate their sensations to an identified physiological process. Each time the 'test' consists of introducing a third party into the relationship women have with their body: the bath, the towel and the suppository are added to the watch or chronometer used by everyone.

On the Thursday evening I had contractions. In the antenatal classes they'd said: take a hot bath and see afterwards how the contractions go, and so on. I did everything they said and the contractions carried on, they hurt. I said: I'm going to pack my bag and we're going to the hospital. (Amélie)

My waters broke but there wasn't much. My husband said: you're losing your water. I said: no, let's wait. I put a towel like the midwives had said, I looked and saw that that's what it was. (Prisca)

The first cramps started around six thirty on Sunday evening. I wasn't sure if it was the real thing. They carried on and on, so at around ten thirty we called the hospital. I'd had gastroenteritis on Wednesday. They'd told me to take a suppository and to see, if the pain lasted it was that, if it stopped it was because of the gastroenteritis. I did what

they said but the pain carried on. So at midnight we decided to go to the nursing home.
(Charlotte)

While the woman's sensations give her an ambiguous message, 'obstetrics' seems to be an important element in the dys-appearance of the body. The term 'obstetrics' obviously relates here not to an abstract entity, but to a series of practices and embodied know-how whose arrangement varies in relation to both the professional actors and the women concerned. A woman who has already had children has incorporated certain perceptions or sensations and can be a good measurement instrument from an obstetrical point of view, although this cannot be taken for granted since the way delivery takes place varies considerably from one child to the next. Similarly, the apparatus used to make the action of the uterus visible varies from one institution to the next. For example, an internal examination will not produce the same image of the uterus as a monitor connected to a printer that shows the curve of the contractions. In women's narratives the former gives an idea of the effect of the contractions, the dilation of the cervix, but says nothing about the contractions themselves. Hence, a sort of duality between objectification and subjective appreciation is maintained or represented, and for women the question of their articulation arises. The following account, taken from a pregnant woman's diary, shows several forms of apprehension of the process under way, the perceived lapse of time between two contractions, the measured lapse of time, the pain, the 'muscular' sensation and the vaginal examination:

I had the impression it stayed the same, that the contractions were still spread out. Jeanne pointed out that they weren't all that far apart. Bruno looked at his watch: every five minutes. But I knew that the time between contractions meant nothing. I knew that this still wasn't 'it', that is, really labour, yet I thought it really hurt.

I can't remember when Jeanne spoke of examining me, but I think I know more or less what stage I was at. I could feel a kind of tension inside. I let her get on with it. I was scared of being disappointed and I was: 3 cm. Cervix still a bit stiff. Yet that was roughly what I was feeling. But I had hoped for a bit more. (Elena)

The body manifests itself here by its thickness, its opacity. It resists the woman's will, and different forms of attention converge on it without the resulting assessments being superposable a priori on one another. Conversely, the monitoring makes the body talk more 'clearly': behind the curve it is the uterus that is expressing itself live and forcing agreement between the different partners in the situation. Pauline, for example, leaves for the hospital with her husband because, she says, she feels contractions which seem different to what she felt before. But the midwife examining her does not seem to agree: 'she said: there's nothing'. She nevertheless connects her to the monitor: 'And then the contractions were really there. My husband watched the needle of the monitor.' Of course she feels the contractions, for the measuring instrument gives them an unquestionable presence: the contractile uterus is there, somewhere between the participants.

Yet in all cases, at some point in the narrative, the situation is qualified: something is set off, an action is launched that cannot be interrupted before the end, that is, the birth of the child. This action is attributed to the body, at least superficially, and more precisely to the uterus which is the medium. We note in passing that the designation of this acting entity varies during the birth: for most of the delivery women talk of contractions which clearly relate to the work of the uterus, but as the moment of expulsion approaches many women include the child, to whom they attribute the wish to get out. Yet this is not a fundamental change of category, a shift from a physiological level to an emotional one; this 'scenario' is congruent with the obstetrical representation diffused during antenatal classes, in particular, since the need to push that the woman is supposed to feel is related to the pressure of the child's head on the perineum.

The mediations that allow the uterus to be constituted as an acting entity are varied and involve different partners. Most of them are 'informed' by obstetrical knowledge. In other words, medicine as a discipline is inscribed in a set of practices, know-how and instruments which participate in the emergence of the body or the uterus as an entity endowed with a degree of autonomy. Can we, for all that, conclude that the woman is 'split' throughout childbirth, that her body is irreparably separated from her 'self', and that this dichotomy represents an impoverishment of her experience of childbirth, or even a source of suffering?

BODY/EMBODIED SELF

In this section we first show that what is constituted with the dys-appearance of the body during childbirth does not correspond to a disembodied self. Women's narratives deploy two main 'actants': one that effectively relates to the body, the uterus, the constitution of which we have just examined, and the other that corresponds to the 'I' in the narrative and that, far from being just a mind, can be described as an 'embodied self'. We also see that this Body/Embodied Self twosome can change during the same delivery and even from one delivery to the next, and that these changing dimensions can be related to the configuration in which the birth takes place.

Let us turn back to Carole. Home again with the status of a parturient – confirmed by the midwife – she starts, with the help of her sister at first, to do the breathing exercises learned in antenatal classes. Her sister then leaves her alone with her husband. From then on she describes alternate moments: between contractions, when she finds herself in a 'normal' state and when, with music in the background, she discusses the final choice of a name with her husband; and during contractions, when she concentrates on her breathing, accompanied by her husband who squeezes her hand to keep her from 'going astray'. In other words, she goes from moments in which she is in a state of relative indifferentiation vis-a-vis her body – the one that becomes the transparent mediator again of its relationship with the world – to a state of 'dissociation' in which her body-uterus or body-in-labour is 'dys-appearing'. Her 'agency' is correlatively modified. She concentrates on an activity that strongly engages her body, as if, faced with the activity of a part of herself that becomes autonomous, she had to re-embody herself. We note in passing that the body in question extends beyond its usual limits: the body of her husband becomes an extension of her own in so far as the synchronization of her breathing is achieved partly via her husband. Little by little periods of dissociation become more frequent than periods of indifferentiation:

I was looking for distraction more and more. Over our bed there is a work of art from Indonesia: a head with all kinds of pointy things on it and curves. I had to puff at every point and the idea then was to reach as many points as possible in one contraction. This made Marcel almost hyperventilate for when his breath was over, I just carried on for a while. The teapot too worked well: at each of its spots I was to say while puffing what colour it was, so Marcel was surprised when he heard me puff 'yellow', 'blue', 'orange'.

In this scene she is engaged in a reflexive activity, literally. To say 'green' and to hear herself saying 'green' and to recognize it as a description of what she looked at is a kind of echoing or mirroring procedure, in order to check on and maintain an embodied self as opposed to this unusual 'body-in-labour'. This may provide a minimal configuration in which we can talk of 'self' as 'the image one has of oneself' (Kelly, 1992), but we can see how self results from embodied activity. As time passes this activity produces or draws upon an active shrinking of the perceived world, reduced to the details of an ornament or teapot. In another narrative the woman asks for all the lights to be switched off, except a very small one, and for the clock to be turned back. The forced re-enlargement of the perceived world, for whatever reason, may

result in the woman's loss of control and in her being overwhelmed by the contracting uterus.

Eventually this alternation of moments of dissociation/opposition (between embodied subject and contracting uterus) and moments of indifferentiation, is transformed into an active moment of association:

At about 8.30 I had a contraction I couldn't really manage. My body wanted nothing but to push. I couldn't help but push three or four times, and then Marcel puffing in my ear and the hard squeezing of his hands got me back to puffing the remainder of that contraction away. For a moment I was completely freaked out by this violence in me. I didn't realize this was a pushing-contraction and that this was the last phase of the birth. The midwife had to tell me I could start pushing! A new world opened up: pushing felt very different; finally I could really do something! A new world!

At the next contraction I showed for the first time that all this did not really feel very comfortable by saying 'aw' quietly and closing my eyes when. . . . And I also turned back my head and that's why I just missed the moment of Lonneke's birth.

Paradoxically, it is when the 'body-in-labour' imposes on her body a demand that she cannot ignore that she recovers a maximal 'agency'. At last she can 'do' something, she says, as if all the activity she was deploying until then – because she was there only to undo, to oppose the 'body-in-labour' – did not count. In the end, the 'body-in-labour' and the 'embodied self' connect, giving the impression of power. In Carole's narrative we witness the intervention only of her husband and the midwife, as well as certain ordinary objects mobilized during the story. Carole gave birth at home, with the assistance of a minimum number of techniques: the midwife's hands, her foetal stethoscope and the breathing techniques incorporated during antenatal classes. Note that in the region in which it took place this birth is nothing unusual since over a third of all births take place in the same conditions.

In other regions, by contrast, medicalization is the order of the day and is accompanied by routine use of measuring instruments such as monitoring of contractions and the baby's heartbeat, and various drugs such as hormones to regulate contractions, administered by drip, or various analgesics, often administered by epidural. We would like to show how, in such conditions, in a particular case comparable to that of Carole, the body/embodied self twosome is likely to assume different forms. Annie was also having her first baby. She was giving birth in a large, fairly technical maternity ward. She describes the different sensations before and after the epidural which is standard practice in this ward:

I asked for an epidural, I was dilated 5 cm. Afterwards I was far more relaxed. Before, between two contractions I couldn't rest, in fact I panicked, when I felt a contraction coming on, I panicked. After the epidural I could enjoy the moment more, well, I could rest ... the dilation that was happening ... I was more relaxed. I even dozed off for half an hour. I felt better. Because it's true that every contraction, I was scared every time, I was really stressed, and with the breathing, I wasn't managing too well, I really had to force myself to concentrate on my breathing, I really wasn't ... I wasn't comfortable.

In this narrative we see two successive forms of dissociation. Before the epidural, as with Carole, two entities are the subjects of the action: the contractions (of the uterus) and the 'I' of the narration. But, unlike Carole, Annie is unable to maintain an activity allowing her to preserve a form of integrity as an embodied self: she 'panics', she 'isn't comfortable' – expressions which highlight the grip that the contractions have over her and the impossibility of her maintaining a protective dissociation. After the epidural, a new form of dissociation sets in: on the one hand there is the cervix, which dilates under the action of the uterus; on the other there is Annie, in a state of absolute well-being related to the fact that she is able to fall asleep, something that only subjects with a body can do. Dissociation does not isolate the body from a disembodied principle any more than before, irrespective of what we care to call it: spirit, soul, psyche or whatever. The epidural replaces the uterus in the depths of the

recessive body, to use Leder's expression; that is, it makes it inaccessible to the direct perception of the woman while other devices – the monitoring of contractions, the midwife's fingers – make it emerge as an acting entity, visible outside the woman's body.

As a result, the association that is formed in the final phase of Carole's account, between the body-in-labour and the 'embodied self', cannot occur in the same form because the sensation, which allows mediation between the two entities, is eliminated by the epidural. In many narratives we see other mediations deployed, which re-establish this link in other forms:

I didn't feel the contractions at all. So it was the nurse who told me when to push. She looked at the monitoring to tell me when there were contractions. The midwife and the nurse encouraged me: they helped me to push for as long as possible each time. At the end the baby was coming down well but he'd move back between two pushes. The nurse helped me a bit by pressing my tummy. (Valérie)

Just as the action 'breathing in time' was facilitated for Carole by the participation of her husband, whose body became an extension of her own, so Valérie's body is recomposed and extended: the monitoring, the nurse and the midwife are physically entangled in this action of delivering a child. The accounts of Carole on the one hand and Annie and Valérie on the other sketch configurations that are both similar and different. They are similar in so far as they always involve two active entities: the body-in-labour and the 'I' in the narrative. These entities are not defined in advance but are produced in the narrative by a series of mediations. Nor are they stable. The narrative describes the way in which they are recomposed during childbirth and in which they merge and separate in the different phases. From this point of view, and regarding the greater or smaller rift they cause between body and mind in the childbirth experience, practices with limited technological intervention – such as the homebirth described above – cannot be contrasted to practices involving extensive technological intervention. It seems, at least in our world imbued with obstetrics, that childbirth is always related as an experience of duality, although a duality that is in no way Cartesian.

This being so, the configurations described also differ in so far as the mediations at play are profoundly different and construct contrasting distributions of the agency. We could multiply these configurations characterized by the nature of the mediations, although not indefinitely. Some are completely bound to technical devices like, for example, an electric apparatus which gives the woman an electric shock to 'distract' her from the contraction, or the 'pain pump' which enables her to control the administration of an analgesic and thus to construct the mode of presence of the uterus herself. Other mediations relate to incorporated techniques such as haptonomy (communication with the foetus through sensory stimulation) or sophrology, as well as more personal techniques related to the woman's past. Finally, the different actors involved, particularly the partner and professionals, play an important part in the mediation. One of the questions is then the extent to which professionals' practices can or cannot be considered as simply the application of medicine as a discipline. We have seen how, at the start, obstetrical practices performed an acting corporeal entity, the uterus. Can we simply consider that all obstetrical actions are based on this body/person dichotomy and are concentrated on the management of corporeal processes?

DISEMBODYING AND EMBODYING WOMEN: THE ROLE OF PROFESSIONALS

From this point of view women's narratives paint a slightly different picture. The actions accomplished by professionals – midwives and doctors – appear multiple and transcend the

strictly biomedical frame in which certain analysts tend to confine them. More precisely, it seems that their intervention is often situated at the articulation between body and self, and that one of the issues, apart from the degree of 'technologization' at play, is to act on both terms at once, to modify their topography and to make their articulation more, or less, active.

A first set of actions has the effect of producing forms of objectification: certain parts of the body or certain processes based on the body are either detached from their internal perception – the aim is then to separate the perception from the object perceived in order to be able to reattribute the perception to the object – or represented in such a way as to allow their collective appropriation. We saw above that professionals confirm the onset of labour. Through a series of gestures prescribed to the woman or carried out directly by the professionals, they introduce intermediate objects into the woman's relationship with her body and, in a sense, intensify the relationship established through the senses, by transforming it. In this way they produce a certain objectification of the process under way, that is, a contracting uterus. This objectification can be fully accomplished, as for example with monitoring, when the woman's perceptions are disregarded. In other instances it is based on an articulation between sensations and intermediaries, as when the midwife advises the woman to take a bath and thus to test the resistance of the contractions. For the woman it stands to reason that the obstetrical descriptions and sensations she feels relate to the same phenomenon. Hence, the articulation carried out to ensure their superposition, at least partially – a process whose possibly problematic nature depends on the role given to sensations in the objectification process. This articulation is reflected in the fact that, in most cases, obstetrical descriptions are in a sense incorporated by the woman so that it is sometimes difficult for her to untangle, in the sensation itself, direct perceptions and those involving objectification. Thus, a woman who has just been told that her blood pressure is very low, wonders why she is feeling so weak: 'I felt myself going, I don't know if it was because of the result they gave me or because my blood pressure was low. It's the first time I'd felt like I was fainting' (Christine).

In certain cases the objectification may be totally detached from the medical context, as when the midwife or obstetrician suggests that the woman observe in a mirror the arrival of the baby's head on the vulva, or touch the head of the baby about to be born. A new form of duality is thus defined: the woman is in and out of her body, both actor and spectator – something which is not necessarily welcomed:

He asked me if I wanted to see my daughter coming out, I said: no, I want to imagine it the way I have. So he didn't force me. The gynaecologist said: we can see the hair. He called my husband to ask if he wanted to see the head that was starting to show, he said no. Her head came out, I didn't want to see, I wanted to imagine it. (Pauline)

At one point Ria told me to feel the head but I didn't want to do that. She thought that it might make me push more. She took my hand and wanted to let me feel it. I shouted I did not want it. Hans told Ria not to do it if I didn't want to. I found that a bit creepy. I didn't want to see a mirror or anything. But she insisted even when I told her I did not want to feel the head. Then she took my hand and I found that creepy. (Myriam)

Perhaps these negative reactions can be interpreted as the impression women have that objectification is medicalization. They easily accept the idea of being short-circuited in their relationship with their body when it comes to producing, in cooperation with the medical attendants, the objects – detached from themselves – of observation and medical action. Outside this context, some women find objectification obscene because it does not obliterate the relationship between the body and the woman, and it displays, in a radical way, the tension between the body-in-labour – the object of the different participants' attention – and the woman's 'own' body. In other words, for the woman's objectification is generally

associated with a form of disembodiment, that is, the introduction of a separation from the body-in-labour which becomes a shared object to which she does not have special access – even if, as we have seen, the obstetrical body-in-labour and the experienced body-in-labour are constantly re-articulated, to the point of often merging.

A set of other actions can be understood as ways of intervening in the form of embodiment of the self and the relationship between embodied self and body-in-labour, by accentuating or reducing the dissociation, depending on the moment and the circumstances. For example, in a situation described by the woman as one of panic, professionals may have diversified strategies yet ones which all work on this body/self articulation and, in particular, which vary the forms of embodiment. We have seen that Annie found the epidural to be a way of building a protective barrier between the ‘body-in-labour’ and an ‘embodied self’ corresponding more or less to its usual state. Sometimes, direct and sudden physical intervention such as a slap is used to reconstruct a form of embodiment in order to create that distance between the body-in-labour and the self:

I was panicking completely, out of my mind. Know what she did? She slapped me in the face! She was right, it got me out of the panic and I could think again. (Jessica)

Or the midwife helps with the woman’s embodiment by breathing with her, as though they were one:

I knew how to breathe, but the fact of being nervous, of having nobody to support me, was important, one panics, you can’t breathe normally anymore. As soon as there was someone to help me breathe, with me, I carried on properly. (Irène)

Verbalization is another form of action through which the professional can try to modify the body/embodied self configuration. The case of Dominique is interesting in this respect. She had prepared for childbirth for a long time and had practised breathing, in yoga. This enabled her to remain calm throughout labour and to deal very well with the dissociation between the body-in-labour and her embodied self, somewhat like Carole. She managed so well that a sort of ‘ordinary body’ reappeared, unexpectedly: ‘I’m hungry, I’m hungry, I’m tired. And quickly, I can’t take it anymore, I don’t want to push (“Breathe, push, block”, said the midwife). I feel like crying. I can’t feel the baby coming down, I’m fed up’, she wrote, although she could still bear the contractions. At this point the doctor intervened and interpreted the situation, thus enabling her to redefine the balance she had established. Note that this interpretation relates precisely to the nature of the relationship between the body-in-labour and the embodied self.

And here I must congratulate the doctor. He suddenly gave me the missing key: ‘You’re controlling the pain too well, and without the pain you can’t push, because you don’t need to chase it. So take it easy . . .’. I really am grateful to him for that sentence spoken so calmly, so softly. Suddenly everything was better. I pushed and pushed . . . (Dominique)

Finally, the extension of the body and its recomposition is one of the ways in which professionals modify the woman’s relationship with her body-in-labour. We have already seen some examples, whether they concern breathing together or expulsion as a collective action involving the parturient, the midwife, the nurse and the monitoring. Each time, through this hybridization of bodies and techniques, a form of embodiment is reconstructed, which replaces earlier forms undone either by the dys-appearance of the body or by the intervention of certain medical techniques such as the epidural. In the latter case we witness a process of dual recomposition, from this point of view somewhat similar to that described by Hirschauer (1991), with on the one hand the body-in-labour, often fed and regulated by a drip, and the body of the embodied self, comprising professionals and measuring instruments, with the epidural allowing the separation/articulation between the two.

In fact, professionals' intervention in the woman's relationship with her body, as described in the childbirth narratives, is based on two opposite and complementary axes: disembodiment and embodiment. The former enables the body-in-labour to be constituted as a separate entity at the articulation between medical practice and women's sensations. The latter aims to establish and maintain appropriate relations between the body-in-labour and the embodied self. The form of analysis we opted for enabled us to cover all the narratives collected. Despite the variety and even the heterogeneity of obstetrical practices concerned, the panorama thus constructed does not reflect a complete break similar to the one introduced by Katz Rothman, for example, between two contrasting models of childbirth – the obstetrical model and the midwifery model – both concretely reflected in prevailing practices in large hospitals and in homebirth, respectively. A number of significant differences can nevertheless be noted. Some of these differences stem from the more or less explicit nature of the mediations leading to objectification, and from the forms of articulation organized between instrumented representations and sensations. Some are major differences in the nature of the mediations at play in the production of embodiment, and in the capacities for action that they allow. From this point of view, the juxtaposition of the narratives of Carole, on the one hand, and of Annie and Valérie, on the other, is striking. Our analysis prompts us to redefine the meaning and nature of these differences which, in a number of earlier works (e.g. Abraham van der Mark, 1993; Campbell and Porter, 1997; Davis-Floyd, 1994; Katz Rothman, 1982; Kitzinger, 1988; Treichler, 1990) are described as an opposition between a biomedical approach centred on corporeal processes and producing a body/mind dichotomy, and a global approach aimed at not introducing such a separation and at considering the woman as a whole. The biomedical approach can in this case be related to the existence of relations of domination between the sexes, and to men's will to control childbirth and even to steal from women the possibility of self-fulfilment through the experience of childbirth. In other words, the use of modern obstetrical techniques might be inseparable from a form of alienation imposed on women, in the shape of a loss of control over their own bodies which become objects of medical practice. Although we cannot subscribe to this analysis, the fact remains that the question of alienation is relevant. The narratives that we collected describe numerous situations which are far from idyllic and can even be perceived as situations of alienation, in the sense of the imposition of a foreign principle into the intimate functioning of the person. How can these situations be apprehended in the frame of analysis developed here?

ALIENATION: IMPOSSIBLE EMBODIMENT

After six hours of painful contractions spent walking and breathing, Gabrielle finally agreed to the epidural proposed by the midwife:

I felt like sleeping, it was night, I wanted to sleep, it was terrible, I was struggling against sleep because I knew that I was in labour. The thing that connected me to that was the monitoring and the heartbeat, that's all, but otherwise in my body I felt nothing anymore. I was gone, I wasn't talking anymore, it had completely knocked me out, I wasn't talking anymore, I didn't breathe a word.

Esther had planned to give birth at home:

That night, at around 3.45 I had a strong stomach ache. I went to the toilet and then my waters broke. I had learnt at yoga that it is good to eat something before. I went downstairs to make a sandwich and I had another contraction. It hurt so much I couldn't do anything any more; only hold on to something. I soon had a contraction every minute. It all went very fast, I was in much pain, I couldn't think of what to do next and got a bit panicky. I told my husband to set up the bed and call the midwife. She told me to take a shower, lie down for a while and try to hold the contractions for an hour. She would be

there at five o'clock. But I couldn't do anything; it hurt too much. I knelt down and just cried. I couldn't remember a thing I had learnt at yoga.

Two stories, two contrasting configurations but the same expression of powerlessness: Gabrielle and Esther are both glued to the spot; they can neither talk, nor move, nor do anything else. Yet their situations are also very different. While we can acknowledge the destructive effect of pain, the absence of pain and of all sensation, in other words the dis-appearence of the body, as a lack, is not such a common experience. In a sense, Gabrielle's despair seems even stranger. The juxtaposition of their stories nevertheless pulls our attention in another direction, provided we take seriously their common incapacity to 'do' anything at all. In both cases these women's inability to construct a form of embodiment is highlighted. Esther is projected into a world similar to that of torture described by Scarry (1985), in which pain causes the perceived world and the ability to act, to shrink. The body-in-labour is an obstacle to all mobilization of resources enabling the person to cope with the situation, to give herself a mode of being that can oppose that body-in-labour. Gabrielle is in the opposite situation, that is, she cannot construct an active form of embodiment, for the body-in-labour is not accessible. Note that this is a situation similar to that described by Annie, but on which the two women have completely different opinions. For Annie, the fact that the body-in-labour is, in a sense, in the monitoring, 'outside' her, is experienced as a relief and her well-being is shown in the ability to be physically engaged in ordinary activities, like sleeping. For her, childbirth is not a place for personal investment; it is constructed as an eminently collective action which she participates in but does not control. By contrast, for Gabrielle, feeling is correlative with living, with experiencing childbirth. That the only tangible traces of the event under way are external traces is unbearable for her. Similarly, not being able to engage in a physical activity related to the birth amounts to being deprived of all capacity to act.

Curiously, alienation is therefore experienced as the impossibility of maintaining a certain form of active dichotomy, either because the body-in-labour is too present and takes over, or because it is absent. Of course, obstetrical organization is not insignificant here; in particular, the constraints that it places on the course of the birth define a more or less extended space of possible forms of embodiment. As certain critics so rightly argue, the fact of being riveted to a table, attached to a drip, a monitor and an armband, and the fact of not being able to change one's position for fear of 'losing' the signal from the monitor – all part of the ordinary course of childbirth in most maternity wards – severely limit the scope of possible physical activity and thus of forms of embodiment. Hence, the observation already made that, in this context, pain emerges as a phenomenon on which it is not possible to get a grip. The political question therefore seems to us not so much to promote a holistic definition of the parturient or a global approach to childbirth; in fact, actors involved in radically different systems of care demand this 'globality'. It is rather to open the field of possibilities – often very unequally spread out – to women, by taking into account relations between the way in which the body-in-labour is constituted and the forms of embodiment which can or must be associated with it.

To conclude, a few points warrant particular mention. First, we opposed at the beginning two different models of relationships between the body defined by medical practices and the body experienced by the patient. In the first, the medical body purely defined in physiological terms contrasts with the patient body seen as the foreground of all human experience. This leads some analysts to plead for a refoundation of medicine, drawing upon a holistic conception of the subject of care. In the second model, the emphasis is put on the existence of various bodies in relation to specific contexts – production of medical knowledge, medical practices, patients' experience – and on the operations allowing for articulation between

these various bodies, without making the assumption that they should, somewhere, be superimposed on each other. At the end of our analysis, we stand somewhere in the middle of these two lines of analysis: of course, we agree with the idea that medical production of knowledge, medical practices and patients' experience constitute different worlds with their own repertoire and their specific 'bodies'. But, through the efforts made to articulate these bodies and beyond these efforts of articulation, it appears that an irremediable contamination between them already occurred, at least – what was our concern – a contamination of the woman's experienced body by the body set up by medical knowledge. We have seen that, during childbirth, obstetrical knowledge is activated through a number of instruments and gestures, and these practices do effectively perform an acting corporeal entity, the body-in-labour, on which a part of professionals' actions are performed. Nevertheless, it appears that, in many cases, this entity emerges even before any direct intervention of professionals takes place: through a variety of mediations – books, journals, preparation courses, lay discussions – explicit obstetrical knowledge comes to be part of women's world, shaping their perceptions, suggesting behaviours and modes of action, proposing patterns for expression and verbalization, and thus forms part of bodily childbirth experience.

Does this imply that western medicine was successful to the point of performing the dichotomy between body and mind or self in women's experiences themselves? We intended to show that, although it is true that a dichotomy is produced, this dichotomy cannot simply be reduced to one of body/mind: the second term of the dichotomy relates not to a disembodied entity, but to what we have called an embodied self. Moreover, this embodied self is itself actively constructed by the different actors present, including professionals, and through the implementation of specific mediations, some of which are technical. Of course, the various configurations outlined by obstetrical organization result in quite different forms of experience: each configuration defines the nature of the actors involved and their form of participation as well as the role of technical mediations which come into interaction with the particular story of each woman. But in all cases, women's narratives show how a part of professionals' activity is devoted to the detailed management of the articulation between the body-in-labour and the embodied self, and to monitoring their joint transformations.

All these considerations do not imply that childbirth experience always results in satisfaction for women, or a feeling of accomplishment, but rather that a critical glance should not focus on a fixed dichotomization between body and mind or self. We observed that, apart from the variety of existing obstetrical practices, childbirth seems to be an experience of duality, that is, of the presence of a 'foreign' but contained entity. Alienation stems not from the emergence of this duality, but from its possible obliteration, that is, the impossibility of maintaining, through different forms of activity, a sort of 'reflexivity of the body'. A number of situations in life, such as childbirth, disease, physical learning, etc., give rise to what Leder called the dys-appearance of the body, a dys-appearance that is intensified, in the medical domain, by practitioners' work. Taking it from there, the issue seems not to be primarily one of developing holistic medicine, but of reflecting on the way in which certain forms of embodiment can give patients a grip on what is happening to them; in particular, our analysis suggests that a variety in these forms of embodiment linked to specific medical practices in the broad sense of the term (i.e. including the nature of knowledge,² technologies, actors,

² There remains an open question: are these very different obstetrical practices associated with specific obstetrical knowledge? At least, in our previous work (Akrich and Pasveer, 1996, 2000), we showed that

settings involved) should be preserved in order to adapt care to patients and avoid the experience of disease being one of unbearable alienation.

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knowledge-in-action, i.e. the way professionals render explicit their actions, the objects on which they are performed, and the relationships between these objects, presents striking differences

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