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“Leave your dignity at the door”: Technologies of power and the maternal body

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## **Abstract**

Women in Aotearoa New Zealand are immersed in multiple and contradictory discourses, and create meaning of their lived experiences from within them. Maternity and motherhood are life events and stages that are embedded in gendered social power relations, with the motherhood mandate positioning all women as potential mothers. A literature review highlighted how neoliberalism and biopower both enable and constrain the experience of maternity and mothering. This research aimed to tease apart some of the threads of power that produce sites of tension for women and the maternal body. Semi-structured interviews were conducted with eleven women about their experiences of maternity and motherhood and a feminist post-structuralist discourse analysis was used to understand how gendered social power relations enable and constrain women's experiences. The analysis showed that the neoliberal political landscape impacted on women's experiences, particularly where related to their everyday experience of maternity and mothering. The biomedical becomes the ordinary in an environment of uptake of interventions as the norm, and where a risk-adverse maternity system positions every potential risk as absolute. The expectation on women to perform 'good motherhood' amongst the tensions of biomedical and natural discourses also constrains them to making morally correct choices in an environment where they have limited agency. This research sought to disrupt the status quo of producing women as docile bodies within biomedical power and neoliberalism, and to empower them to continue to resist.

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## Poem

A secret heaviness, the weight of an occupied womb,

Forty tiny fingers and toes.

Every cell produced entirely by me, yet separate.

The dichotomy of intense love and longing; with the guilt of discomfort and sickness.

My body feels right, as a home for these children;

All at once complete and satisfied, yet awkward and afraid.

My womb is separate to me, no longer mine;

As my fetuses turn somersaults and caress each other through a thin veil of membrane.

They are mine, yet they belong to them,

The doctors, with their cloudy spectacles of deficit and disease.

I am to blame if something happens to my children while I protect my own body,

From scalpels and needles that are poised, ready for my weak moment.

I am no longer human, I am a growing room, a machine of incubation.

I am a child, I am blind, deaf, and mute.

A naughty child, refusing to place my signature on their paper,

A vessel of risk, a vagina and a uterus, a difficult patient.

Not a woman. Not a mother. Not a person.



## **Introduction**

The work that follows is the culmination of a lifetime of immersion in maternity stories; the daughter of a midwife, mothers and babies were an everyday part of my childhood experience. Maternity was something ordinary within my family; holidays were planned nine months in advance, and I spent weekends and school holidays sometimes being driven through rural Waikato by my Mum, waiting in the car while she asked whether the family inside were happy to have me inside to meet the new baby, and even regularly getting to have a cuddle with a beautiful newborn. I have memories mingled with black and shrivelled umbilical cords and soft postpartum tummies, slowly separating mother and child. Mealtimes were interesting in a home with a midwife mother and two older sisters; the maternal body was a familiar concept to me. Bodies were discussed and birth was a matter of fact part of dinnertime conversation. Midwifery was part of the household; I watched my mother stitch up banana peels with student midwives as they practiced for the regular task of stitching torn or cut perineums, I was a small child leafing through midwifery tomes with their pregnancy cross-sections and splayed-legged pencil drawings. Within this environment, having children myself was something I considered inevitable, the construct of the maternal body was something I had taken on and positioned myself within from my earliest years, and while I knew about and feared infertility as a possibility, I certainly never considered that I may grow up to not want children of my own.

I did go on to have children, twin girls followed only two years after by a boy, and my experience opened my eyes to a different perspective of maternity.

Previously, I had believed it to be almost a biological necessity. I saw mothering as a natural function, I was a girl! I believed I was made to be a mother and I expected that I would be wonderful at it. Yet trying for a baby, finding that pregnancy did not happen immediately, and then once pregnant discovering that there were two small embryos inside me, I began to realise that the journey was not as simple as I had previously surmised. I lost control of my body, I developed severe morning sickness and spent most of my pregnancy doing not much at all, except incubating my babies. I felt like a machine for growing my children, and I often felt that my efforts were not working, and that I was failing. My focus went inwards; I was constantly aware of the heavy comforting feeling of my future children within my womb, and from the earliest movements I began to wonder about their future, and I both feared and hoped that I was to have relatively little say in who they became. My body stretched and blossomed, I loved my stretch-marked skin purely for what it signified and I loved the alien waves moving across it as tiny feet and knees pushed outwards. I was becoming a Mummy to two little beings, and I felt I knew them. During pregnancy, I had many ultrasounds; I took them up as they were available, and due to intensive monitoring of multiples I saw no reason to resist. I loved to 'see' my babies, and to know that all was as expected. At an ultrasound midway through my pregnancy, we found out the sexes of the babies, and named them Liza Eilish and Briar Mahinārangi, names born(e) of special relationships and histories, a secret Finn and I held close until after they were born. Liza, who occupied the part of my uterus adjacent to my cervix was, from the outset to be born first. She was fairly quiet and subdued, and Briar was energetic and wriggly. I loved them before I knew there were two, from the moment they were a pair of

lines on a stick, two sets of cells growing and changing with unfathomable speed, the signifiers of a potential lifetime of future experiences.

As my pregnancy with twins was considered high risk in our maternity system, I was monitored regularly throughout my pregnancy by both an independent LMC midwife and the Women's Assessment Unit at the regional hospital. At one of these routine visits at approximately 31 weeks gestation, I was told that I would not be going home until my babies were born due to high levels of protein in my urine and rising blood pressure. I didn't feel sick (aside from the constant morning sickness), yet the numbers on the machines and the blood and urine results showed otherwise. The placentae which were nurturing my babies was also now a risk to me; causing my own organs to struggle. The balance of my own health in comparison to my babies' risks if delivered early became the focus, and the following four weeks were spent being watched closely on an antenatal ward for any signs of my own physical deterioration and for any changes in my babies' apparent levels of distress as determined through twice-daily CTG monitorings. My maternal body was unwell due to pregnancy and the feelings of failure were difficult to negotiate. I was torn as I wanted to meet my babies and I wanted an end to the physical and emotional turmoil of pregnancy but I also knew that the longer I could keep them contained within me, the fewer days of hospital care they would need once born. I was desperate to have them outside of my body, yet still wanted to hold them close; I so wanted to mother them instead of incubate them, and to be free of the sickness. I experienced the tension of four hourly blood pressure readings and constant changes of plans. I hated that through being aware I was watching my own choices being removed from me and placed in the hands of people who knew nothing of me and I hated that loss of control.

As the later stages of my twin pregnancy coincided with the Canterbury earthquakes, Neonatal Intensive Care Units (NICUs) throughout the country were at capacity, and as my babies were coming to a safer gestation, I was transferred to another hospital with a Special Care Baby Unit (SCBU) in a neighbouring region. This took me away from my family, away from my husband, away from my social context, and I fought to be transferred to a hospital that was in the same area as some close friends, so that at least my husband would have somewhere to stay, and be able to commute back for work if necessary. Being removed from my support networks, particularly my midwife, made me realise I needed to advocate for myself and my babies, because if I did not I could see that my outcomes would be poor and would not be either what I wanted or needed.

While there, I felt that some parts of my care were becoming less about what was best for me and my babies on either a medical or emotional level, and instead became more about what the obstetricians wanted, with a strong focus on caesarean section. There were no obstetricians who I could build a relationship or alliance with, or who understood (or were interested in) my needs and wishes.

The day I arrived I was given a tour of the operating theatre where I was told I would deliver, probably by caesarean section (CS). As I was a relatively fit and healthy pregnant woman, with no occurrence of CS in my known family history, I resisted the pressure for a CS without a 'trial of labour', after all I had grown up with the ordinariness of maternity and birth, and knew the possibilities. I respected caesarean section as a life-saving measure where needed, but I wanted to avoid both a CS and an epidural if I could. I felt that my body could birth these babies, they were both head down and there was no reason why a vaginal birth

could not occur, and having done my research, I knew that mothers with pre-eclampsia toxaemia (PET) often labour well, with good outcomes for induction of labour. I watched the Braxton hicks contractions several times a day during compulsory monitorings, and I felt them readying my body for delivery. I wanted to do all that I could to limit the stress on my body of recovering from a CS while trying to care for infant twins, and so I advocated for myself, refusing to sign consent forms until I felt interventions such as epidural and CS were necessary.

The authority held by the obstetricians was magnified once I declined their recommended course of treatment. By resisting, I had become a non-compliant patient.

One morning after a terrible night with high blood pressure and a severe headache (both signs that pre-eclampsia was progressing into dangerous territory) I was taken to a delivery room with the understanding I was likely to be induced. When the obstetrician arrived, he told me that I would be given a caesarean section, and when I declined, he performed a violent internal vaginal examination. The pain was excruciating. A man in authority, who was almost a complete stranger, was suddenly violating me with extreme force, protected from view by a surgical drape, yet in plain sight of my husband and mother. Once he had finished his assault on me he said that my cervix was not favourable for induction, but that he had performed a stretch and sweep, and then he left the room.

I had gone through my childhood, my teen years, and my early adulthood as one of the few women who have not experienced sexual assault, only to be raped by the fist of an obstetrician under the guise of a cervical examination. I knew that

this was wrong, I knew that his behaviour was outside of the scope of what was needed, but more than anything I knew that there was nothing I could do about it.

While it came with a price, my resistance was effective. By keeping myself informed and advocating for myself, I secured an ambulance ride back to my local hospital. A few days later I was induced and after three and a half hours of active labour I birthed two babies within 13 minutes of each other, without a CS, without an epidural, and with a respectful medical team waiting quietly away from the action. I had fought the system, and I had an empowering birth experience, while still under the care of a biomedically focused obstetrics team, and still with various interventions. It was possible to safeguard risk and still have my needs met, and once again I felt that my body was capable, and did what I knew it could, given the chance.

Our NICU experience for the following 12 days was emotionally fraught; after holding my babies within me for 35 weeks, I was discharged and sent home, a 30 minute drive away from my babies. In NICU, women are not allowed to sleep next to their babies. No portable beds were offered. No reclining chairs existed for mothers to stay. The closest I could have stayed would have been at a boarding hostel at the other end of the hospital, a long walk from my babies; too far for someone who had been nauseous and vomiting for almost nine months and bed-ridden for a month. I was not allowed to breastfeed more than once every 6 hours as the NICU staff wanted to keep my babies asleep and tube feed them. Their professional belief in my babies' inability to nurse did not waver despite obvious evidence to the contrary; they could and *did* breastfeed when they were allowed to. My babies were given a label of 35-weekers, despite them being a week later in

gestation than was recorded based on my last menstrual period due to my short cycle and early ovulation; shorter than the population norm, yet normal for me. They were classified by a population focused idea of what babies of particular gestations could do, rather than what they were capable of as individuals and as a feeding triad with me. I was not allowed to sleep next to my babies, I was not allowed to pick them up outside of dedicated six-hourly care schedules, or soothe them, or make any decisions for their care. I was given consent forms for the nurses to tube feed them formula through their noses until I had built up sufficient supply of breastmilk within their refrigerators (no small feat with twins, no experience, and no assistance), and I was given consent forms to allow a dummy when they fussed for the breast (instead of being able to nurse them). I was given the forms, yet there was little choice to not sign. I was obedient. I pumped colostrum, and then breastmilk, which was then tube fed into them, then often pulled back out and pushed back in by nurses wanting to see the contents of their tiny stomachs. If the nurses decided that their breastfeeds were not enough, they would top them up with (most often) formula through their tubes. They were heel pricked for blood sugar and bilirubin testing daily.

These babies (while small) were not critically ill. Our reasons for being kept in NICU were “feeding and growth”; both of which would have been more easily achieved at home, with my babies having 24 hour access to my breasts on demand, in a safe and supported environment for me. The risk-based focus on my babies’ wellbeing was something I knew had the intention of the best outcomes for them, yet it felt like a wedge driven between my babies and myself; a risk focus based on unlikely ‘what ifs’ getting in the way of the real daily lived experience of mothering babies.

The culmination of experiences within this time, which I felt should have been the happiest in my life, were so conflicted that I began to see maternity experiences differently from what I believed through my immersion in maternity culture as a natural, right, supported ideal. Hard, yes ... but natural and ordinary. I knew it could be different, but did not understand whether it was me, or the system, or something else entirely that should have changed to meet the needs of my babies and myself. The balance of meeting both the system's requirements and my babies' needs, meeting mine, and ensuring that my babies got what they needed from both the medical system and me was an issue of tension; a desire to do what I believed was 'natural' and 'instinctive', yet also a desire to ensure I did not cause harm to them by denying interventions, even though I felt that many of the interventions were causing them unnecessary harm. I found I could not meet all the requirements on me as a mother; I could not take up all of the medical help offered while still feeling like a 'good mother', I could not understand whether the 'right' thing to do for my babies was to submit or to rebel. I found that no matter what I decided or did, I would be a failure in some way or another, and ultimately that my choices were limited or non-existent.

When my son was born, the experience was different; I was still very unwell with constant morning sickness in pregnancy, and readily took up stronger anti-emetic medicine to allow me to function as a mother to two toddlers. I planned a home birth, but for a number of reasons when I began to labour, Finn and I decided to head into the birthing centre, where I laboured in the birthing pool with only my husband and midwife in the room. My postpartum experience was vastly different to when I had the girls, and Dara Lyndon stayed with me at all times. I breastfed him when he was hungry, and I was in charge of meeting his needs as I saw fit. To

me, he was not all that different to my two babies, born comparatively less than three weeks in gestation earlier. Yet, due to an imaginary line of when to intervene, we were left to get on with establishing our relationship, as a feeding dyad, and as a mother and child.

The contrast was immense and once again I wondered if I had failed my girls somehow by not being pushier, by not just pulling out their naso-gastric tubes and escaping with them. I felt (and still feel) that being left to our own devices at home would have been more beneficial to us. When Liza had a slightly elevated bilirubin level in her blood, she was put on a bilibed, where her tiny body was bathed in UV light; minutely measured and compared to population norms. When Dara's skin was yellow, I lay with him in the sun, and breastfed to push the liver chemicals through his system; no need for measurement or norms to meet his personal needs. Could my way have been better for my babies? I can never know. I do know, however, that being told each time that if I wanted to decline intervention that I would either have dead babies on my conscience (in pregnancy) or that it would be my fault if something bad happened to my babies at any point in their future (in NICU), I had little option but to accept the prescribed procedure. After all, nobody wants to be a bad mother.

In coming to terms with the experiences of my journey into motherhood, it raised particular interests and questions. I wanted to find some resolution to the experience, where I felt there was none. I felt that my experience of the biomedical maternity system was also ordinary; a taken for granted experience of loss of power and control that all women experience. We are all told to "leave our dignity at the door" within birthing conversations. Why must we? Why can dignity not stay

intact just because we are pregnant or birthing? I began to wonder at the gendered nature of the maternity experience and wondered if the same things would happen if they were happening to men. I discovered my identity as a feminist, and some of my questions began to be answered; of course maternity is gendered, and power relations inevitably occur in the spaces between people, and between people and institutions. I wanted to understand more, and to unravel the conflicting pressures of both the accepted 'normal' birth experiences and also the expectation of the uptake of the biomedical by women as decided by others, and how women might resist it. I became more aware of my own experience being a tension between the taking up of the biomedical model and the resistance and eschewing of it. I could not find a clear concept of how I would do things if I had a chance again. The main thing I feel I would do differently is to not allow the medical staff to take my babies away from the birthing room which was supposed to be only as a precaution; as then it became impossible to remove them from NICU. My babies had an APGAR score of 10 and 9 respectively at birth, and both had APGARs of 10 a few minutes after birth. These are perfect scores, and if I had known to reject the offer of precautionary removal to NICU, I would have had my babies home much earlier, or at least would have been able to stay with them on the ward.

In trying to make sense of my experience and the related journey through feminism and the psychology study I have undertaken in tandem with becoming a mother, I have developed a passion for critical psychology and poststructuralist theory, which has given me the resources to question notions of risk and authority, and make sense of my journey into motherhood. I developed a strong network of women in becoming a mother, and through sharing stories I noticed other women's experiences held many parallels to mine. Stories of feeling out of control;

of decisions and of bodies. Stories of feeling mistreated or treated as an object. Stories where the answer seems so simple as to where change needs to occur, yet routines and procedures remain the same. Then I began to understand how power operates in the spaces between people, and how it acts on the actions of our bodies, and I began to see that this is bigger than any of us. It is bigger than one mother, midwife, obstetrician, hospital, or district health board. I began to look at biopower; where population level controls act on individuals irrespective of their personal contexts. I began to understand neoliberalism, where people are considered to all have the same opportunities and are required to take full responsibility for their personal outcomes. This did not fit with my awareness of contextual effects, where certain people in the world have privilege, and where the world does not treat everyone the same. Therefore, I also began to question how power operates to discipline our gendered experiences.

How is society influencing women in ways that lead to these experiences? Women's maternity experiences are linked to a much stronger and wider context of competing discourses within the feminine experience. First we have the pressure to become mothers; an expectation and an assumed inevitability. If we do become mothers, we battle to be "good enough" mothers, and to have "natural" births, to eschew intervention, until there is a perceived risk, when we then have to accept it graciously and in full. We have to be quiet, and compliant. We have to be polite. We are afraid of making noise, we are afraid of defecation during birth, we are not comfortable with our unpredictable bodies, yet we all know of these stories. This is not a silent experience; women talk about our maternity experiences. We leak, we swell, we bleed, we tear, we cry, we scream, we suffer, and then we shut up and get on with it. This made me wonder how interactions

between the medical system, social norms, and our actual lived experiences impact on women. I wanted to understand how the competing discourses that constitute maternity can be unravelled to gain insight into the feminine experience of maternity and mothering. By unravelling the gendered social power relations that constitute maternity in Aotearoa New Zealand, perhaps some possibilities for how to transform the maternal space in a way that is empowering for women may emerge.

We are limited by language, and with the gendered construction of maternity, certain assumptions are made throughout maternity and mothering which imply a biological and gendered femininity, and implicit heterosexuality. People who have experiences within the maternity system that differ from these gendered and biological assumptions (such as transgender and non-binary people, or mothers who are not primarily heterosexual), experience some of the same and some differing power relations within maternity. While this work attends to the experience of birth from perspectives of women who are born biologically female and assume a female gender identity (of any sexuality), this is primarily due to it being the more common experience, rather than an intentional stifling of other experiences.

How can all of these pressures and competing matters of importance be unravelled and teased apart for women in Aotearoa? How can discourses active in maternity, and gender as a whole be understood in a way that meaningful change can occur? How can we whāngai or nurture our mothers? As a society how can we change our perspective on the relationships between women, mothers, bodies, and babies?

## **Chapter One: Literature Review**

“I have never talked to a woman who gave birth that wasn’t traumatised. Everybody wants childbirth to be all pretty and nice, but I’ve talked to a lot of mothers, and if people have this lovely little slipping out experience, I’ve yet to meet them.”

- Eve Ensler (Braun, 1999, pp. 518-519)

### **Neoliberalism**

If we are to understand neoliberalism, an understanding of subjectivity is needed. It is difficult to imagine what life would be like if we were raised in a vacuum; a bubble of impermeable film, with no influence from the outside world. How would we think without hearing and learning language from childhood? How would we understand and experience our bodies? How would we experience emotions? How would we understand the world? Yet we are not situated in a vacuum, and from our very earliest moments, every experience is mediated by sets of filters we are given to view the world through. The ideas and attitudes we are embedded in as part of our social world, and in our consumption of media, all lead to building our own beliefs and understandings of what we know to be true. This is subjectivity. Subjectivity is when we interact with the outside world, and somehow integrate perceptions and ideas into our own identities (Gill, 2008).

In contrast, neoliberalism assumes that every individual has autonomy and responsibility for their choices, without any influence from sociocultural or political power and context (Gill, 2008; McAra-Couper, Jones, & Smythe, 2012). A

neoliberal subject is fully in control of herself, is knowledgeable about her body, and free to make and justify her own choices (DeSouza, 2013). A neoliberal subject, not swayed by the world around her, must take full responsibility for all choices and outcomes in her life, as she has complete agency (Gill, 2008). Examples of where neoliberalism is at odds with women's lived experience includes young women, who prior to any immediate plans of motherhood, privilege the ideal of wife and mother while also positioning themselves as autonomous and responsible for their choices (Jacques & Radtke, 2012); yet the choice of becoming a mother is embedded in many systems of power. By being blind to various systems of oppression (such as culture, gender, and socioeconomic status), the people affected by these oppressive systems are presumed to be responsible for their situation, and the people benefiting from the systems of oppression are privileged further. Neoliberalism therefore benefits people who already experience the privileges of society, and multiplies the effects of oppression on those who are subjugated.

Returning again to subjectivity, within a neoliberal context, once it is assumed that we are immune to any sociocultural influence, our mediated understandings of the world are taken on into our individual understandings of the world. We don these understandings as if they are our own. They become part of our individual realities, influencing our subjectivity (Gill, 2008).

### **Essentialism**

Maternity is often portrayed as an isolated biological occurrence, rather than an experience embedded within many contexts and systems of power. This biological essentialism is common throughout literature about women, and in

maternity in particular. The idea of Cartesian dualism, where there is a distinct separation between mind and body can reduce women experiencing maternity to biological machines (Carter, 2010; Rúdólfssdóttir, 2000), each woman a series of physiological urges and functions distinctly separate from the woman herself. Yet essentialising women to reproductive organs also causes tensions. For example, in research with voluntarily childfree women, the discursive construction of a 'silent body', one that does not have a biological urge to reproduce provides an opportunity for voluntarily childfree women to both reject and embrace essentialism (Peterson & Engwall, 2013). While this may make their own experiences easier to navigate in a society where motherhood is an imperative, by assuming the presence of a biological urge or a biological clock reduces women (mothers or not) to merely a set of urges and organs, and reduces the meaning of women's existence to reproduction. A similar experience can happen for women who experience infertility, with an assumption that their bodies are not 'functioning normally', leading then to feelings of emptiness and isolation (Fernandes, Papaikonomou, & Nieuwoudt, 2006), and positioning them as defective. Reproductive technologies such as in vitro fertilisation also perpetuate essentialism with a (perhaps necessary) focus on biological functioning and fixing the 'problem' with the reproductive machine, and through this process, the essentialising assumption that the body is a set of biological functions is perpetuated (Fernandes et al., 2006).

The focus on vaginas as integral to womanhood within feminist circles could be seen as essentialising, yet as society already fragmentalises and reduces women to our reproductive organs, a knowledge of bodies can be one form of resistance. An understanding of our own bodies could open the opportunity to

integrate our genitals into our whole being (Braun, 1999), and to shift them from their current unspeakable space.

### **The Motherhood Mandate**

The motherhood mandate is a series of sociocultural power relations that make motherhood synonymous with womanhood (Gotlib, 2016; Jacques & Radtke, 2012; Ulrich & Weatherall, 2000), and make an identity as a woman outside of motherhood unthinkable (Russo, 1976). The key requirement of women according to the mandate is to have at least two children (preferably boys) and raise them well, as a 'good mother' (Russo, 1976). With advances in birth control in the last 50 years, the biological inevitability of motherhood within a heterosexual relationship has lessened, yet the sociocultural aspects of mandatory motherhood remain, with pregnancy represented through media as a woman's destiny (Gotlib, 2016; Sha & Kirkman, 2009). Young women may position themselves as free to choose without outside influences (Gill, 2008), and as autonomous subjects, yet they still see their futures embedded in motherhood as dictated by sociocultural pressures; the inevitability of becoming a mother, and being a 'good' intensive mother (Jacques & Radtke, 2012). Raising children 'well' also raises some tensions where this concept is incompatible with women working outside the home, as intensive mothering is an imperative (Jacques & Radtke, 2012). Thus, if a 'good mother' is an intensive mother, this makes 'good mother' a position unavailable to mothers who work outside the home. In this way motherhood is a taken for granted social expectation (Ulrich & Weatherall, 2000), and the presence of fears of wellbeing of a foetus often start in early pregnancy or sometimes as the decision is made to become a mother (if indeed such a decision is made), suggesting motherhood starts in some cases even before the foetus exists (Sevón, 2005).

Women who make the active decision not to have children are often positioned as failures and as selfish (Gotlib, 2016). Yet research into voluntary childlessness highlights how understandings of feminine identities are complex, and inadequately explained by motherhood (Gillespie, 2003). Women without children are 'othered' while embedded in pronatalist society. Even advertising for products not in any way associated with mothering (such as shampoo) are marketed to the 'busy mum' (Gotlib, 2016). In choosing permanent contraceptive options (such as tubal ligation), women are viewed through the biomedical gaze as being too young, or not self-aware enough to have made the choice to be voluntarily child-free. Through these cloudy lenses of biomedical control, women are positioned as pre-pregnant for their entire reproductive lives and expected to make lifestyle choices as though pregnancy has already occurred, regardless of their own choices regarding motherhood (Gotlib, 2016).

Motherhood is often constructed as a natural instinct (Ulrich & Weatherall, 2000); an essentialised biologically determined drive to procreate the human species (Fernandes et al., 2006; Ulrich & Weatherall, 2000), yet this creates a tension because motherhood is also constructed as the outcome of neoliberal decision making which supports women's agency around childbearing (Ulrich & Weatherall, 2000).

Women without children (thus, in a non-normative position; inconsistent with gender roles) score higher on masculine personality traits and lower on feminine personality traits (Newton & Stewart, 2013). The seemingly 'masculine' traits of being critical, sceptical, independent, and avoiding close interpersonal relationships appear more often in women who have reached middle-age without

having children (Newton & Stewart, 2013), which suggests that their childlessness (or child-free status) has required them to move away from socially-constrained ideals of femininity and into socially constructed masculine space. Traditionally 'feminine' personality traits of being seen as nurturing and caring, sympathetic, warm, compassionate, considerate and experiencing close relationships (Newton & Stewart, 2013) are traits often attributed to mothers, and are the traits that middle-aged childless women spoken to by Newton and Stewart (2013) apparently lack. Women who choose not to have children are framed as selfish, unfeminine, and deviant, and women who are unable to have children are framed as unfulfilled and desperate (Gillespie, 2000; Letherby, 1999). Yet making the active choice to not have children opens up using narratives of personal agency as a way to resist (Morison, Macleod, Lynch, Mijas, & Shivakumar, 2015), a resistance not available to women who experience infertility.

Yet, as all of these traits are socially constructed, where women who do not have children are examined through their deficit, focus then shifts from the body to the personality. It is possible to be nurturing and not a mother; there are more ways to do 'mothering' than through having children of your own. Likewise, it is possible to be "fecund rather than motherly" (de Beauvoir, 1993, p. 538). By these supposedly feminine traits not being available within a sociocultural context for women without children, they are positioned as 'less-than' women. If they are not able to authentically have and display loving and nurturing traits, their femininity and their identities as women are then put into question and are interrogated by society. This pronatalist positioning of women as deficit if by choice or circumstance they are not mothers reinforces motherhood as an imperative. Women are also positioned as risky bodies; there is a perceived risk that they will

not become pregnant with increased age and a perceived decrease in fertility (Locke & Budds, 2013), and that they will eventually want to become pregnant, even if they have made the choice not to be mothers (Gotlib, 2016).

The experience of infertility can highlight how motherhood exists as a mandate; when motherhood is wanted and does not happen for women, various socioculturally mediated power dynamics can come to light. Through infertility research, motherhood can be located as an expected stage of development of a (hetero)sexual relationship (Ulrich & Weatherall, 2000). We are socialised to be mothers from childhood and led to equate motherhood with womanhood (Loftus & Andriot, 2012). Motherhood offers us adult status (Fernandes et al., 2006), and due to how heavily gendered motherhood is, when it does not happen it can position women who are unable to conceive as not able to 'do gender' in the way they are expected to (Loftus & Andriot, 2012). When motherhood is seen as a natural life transition, infertility can then position women as having failed at this life transition (Loftus & Andriot, 2012), and can deeply affect their socially embedded lives. Women who have been unable to have children can find themselves rejected and excluded from conversations with other women in social situations (Loftus & Andriot, 2012), and often find themselves retreating to socialise with the men, who irrespective of their parenting status do not often centre conversation around children (Loftus & Andriot, 2012). Even the language of infertility positions women as devoid; infertility is a woman's 'problem'; she is infertile, she is barren (Fernandes et al., 2006; Ulrich & Weatherall, 2000).

Yet the motherhood mandate also has sociocultural boundaries; pronatalism exists for certain groups, and antinatalism for others (DeSouza, 2013;

Gotlib, 2016). After all, in a neoliberal society, a woman should only have children if she can qualify for 'good mother' status. Pronatalist narratives limit women who do not have children to being personally othered and uniquely liminal in ways that are destructive to moral agency (Gotlib, 2016). Being a woman and not a mother then affects the accessibility of taking up a feminine identity (Ceballo, Graham, & Hart, 2015). Thus the 'correct' way to perform femininity within our society is to follow a moral trajectory of inevitable motherhood.

### **Good Mother**

Motherhood is immersed in gendered power relations; one of which is the ideal of feminine selflessness (Chadwick & Foster, 2013) and this comes into play before the baby is born (Sevón, 2005). The mother is expected to be always completely loving of their child (Murray & Finn, 2012), is expected to birth in the morally correct place (for the child), and feed the baby with the morally correct type of sustenance from the morally correct vessel (Chadwick & Foster, 2013). A good mother must always keep a hygienic home, must mother intensively (DeSouza, 2013; Jacques & Radtke, 2012), and must meet particular sociocultural criteria. There are moral obligations to breastfeed or to birth in a particular way. The good mother puts her own needs behind those of her husband and children, yet is still required to develop a strong bond with her children, run a household well, and to cope well (Kahu & Morgan, 2007a). The criteria for 'good mother' seem to change to fit moral requirements, and the expectations are nearly always contradictory, yet we are all still expected to meet them.

Race-based anti-natalism assumes a Eurocentric right to govern the reproduction of indigenous and immigrant women of colour (DeSouza, 2013),

privileging whiteness, colonialism, and individualised value-intensive mothering. While this does a disservice to women as a whole, in particular it further marginalises women of colour. A 'bad' mother is also difficult and non-compliant, and just like 'bad' indigenous or immigrant mothers, will face greater scrutiny, neglect, and regulation (DeSouza, 2013). The requirements of 'good' mothering tend to not be in our individual power, making the status unattainable. Yet 'good mothering' is an imperative, and those who fail are condemned (Mauthner, 1998).

### **Internalised Technologies of Gender**

As already mentioned, maternity is highly immersed in gendered power relations. Since women have been embedded within these for our entire lives, we perform gender in all aspects of our lives, including maternity. The internalised technologies of gender are taken up and resisted in various ways; for example, many couples intend to operate in a more equal gendered partnership, yet women most often take up the role of dominant caregiver and other gendered norms (Schmidt, 2014). The gendered expectation is that mothers will take the primary responsibility for the needs of children, and are expected to cope with childcare and running a household alone (Allen, French, & Poteet, 2016; Fox & Worts, 1999; Mauthner, 1998). The gendered divisions of household labour continue to position women in the centre of domestic responsibility (Allen, French, & Poteet, 2016). Women in a post-feminism generation value autonomy and financial independence, along with equality in a spousal relationship (Kahu & Morgan, 2007a, 2007b), yet this then leads to an expectation that women will work and prioritises work over motherhood. Disciplinary power results in an expectation that women will work and will also be caregivers. This leads to surveillance of women in both working lives and home lives. If gender normativity states that

women must do both mothering and working and do them well, we are immersed in a technology of disciplinary power.

Fathers are considered wonderful if they 'help', yet this supports the assumption that the nurturing of children is primarily (or solely) a woman's job (Schmidt, 2014). By current society having a veneer of gender equality, yet with mothers still taking on a larger burden of unpaid domestic work, gendered social norms put greater pressure on mothers. Mothers often feel responsible for managing the relationship between the baby and father (Schmidt, 2014; Sevón, 2005), yet find themselves experiencing conflict if personally struggling with the expectations of bonding and love of their babies themselves (Mauthner, 1998). The medical model of post-natal depression focuses on women's deficit, and limits an examination of the wider socio-political and structural conditions of mothering in Western societies (Mauthner, 1998). If contextual factors are considered, such as the motherhood mandate, and gendered technologies of power, post-natal depression no longer could be seen as a context-free and neoliberal individual flaw.

A significant focus is also placed on fathers' experiences of birth, or the impact on the relationship between the parents, particularly in terms of the biomedical focus on women's deficit in post-natal depression and posttraumatic stress disorder from birth (Ayers, Eagle, & Waring, 2006; Ayers, Wright, & Wells, 2007; Bell, 2015; Hildingsson, Cederlöf, & Widén, 2011; Iles, Slade, & Spiby, 2011; Johansson, Rubertsson, Rådestad, & Hildingsson, 2012) yet this decentring of women within a heavily gendered experience removes the maternal body from being the focus. Producing knowledge (in itself a technology of power) that locates

postpartum distress at a site of disorder without considering technologies of power occurring in the gendered experience of maternity may seek to improve outcomes but then also places individual women in a position of blame.

I do not claim that men are irrelevant in the experience of producing and raising children, just that by shifting the focus we risk further subjugating women in an experience that is predominantly ours. While relationships will inevitably be impacted by any form of trauma, shifting the focus from the wellbeing of the woman to the wellbeing of her relationship positions her in another site of blame, and reinforces her invisibility.

Maternity is a series of sacrifices of time; the change in employment, care, social life, and breastfeeding make clear temporal sacrifices that are an expectation (Bartlett, 2010). Yet it is important as we examine the socio-political conditions in which motherhood occurs not to position mothers as 'victims' of regulation but to understand the ways that mothers negotiate the possibilities and constraints of motherhood. For example, the felt pressure to get back to 'normal' in terms of a woman's figure supports pregnancy being a transgression of the idealised female body (Bartlett, 2010; Johnson, Burrows, & Williamson, 2004). As women are valued in society for their looks and reproductive function (Johnson et al., 2004) and through technologies of gender, the expectation is on mothers to have a good (heterosexual) relationship to bring a child into (Sevón, 2005).

Internalised technologies of gender are apparent during childbirth, where women's bodies are disciplined according to normalised social sanctions (Martin, 2003). Women are quiet, polite, put others' needs first, and submit to those in authority (Martin, 2003). Women are no more able to deviate from these socially

sanctioned norms during the height of childbirth as any other time in our lives (Martin, 2003). Women often imagine birth from a disciplinary power of the surveillance of the male gaze; we think of what other people will see (Chadwick & Foster, 2013). If we understand reproduction and childbirth as a way of doing gender, then feminine subjectification through the disciplinary power of gender applies to the choices women make in relation to childbirth, whether that is through medicalisation (caesarean section) or naturalisation (homebirth), both differently embedded within the discourse of the 'good mother'. (Chadwick & Foster, 2013).

### **Risk Discourse and the Biomedical Model**

Risk dominates biomedical approaches to maternity, with any level of risk deemed unacceptable (MacKinnon & McIntyre, 2006) within a dynamic of biopower. The disciplinary power of maternity practice has a dominant focus on what might go wrong, and leads to both maternity staff and women taking a 'just in case' approach to maternity care (Bryers & Teijlingen, 2010). Women are drawn into risk discourse through books and resources focused on symptoms and individual responsibility for adverse outcomes (MacKinnon & McIntyre, 2006), and this can lead to feelings of failure and shame, and a belief that poor personal lifestyle is the precursor to problems (MacKinnon & McIntyre, 2006), thus risk discourse disciplines women.

Risk discourse taken up by women is also influenced by family history and childhood, and national traditions of public health (Coxon, Sandall, & Fulop, 2014), and women may be coerced to believe that choosing hospital as a birthing venue is the 'safe' choice, while not attending to the associated risks of potential

interventions (Coxon et al., 2014). For example, women who have had a caesarean section often show disappointment, dissatisfaction, and distress as an outcome of their experiences, with psychosocial repercussions (Lobel & DeLuca, 2007). Anxiety about risk is increased, rather than decreased within the maternity system, resulting in unnecessary interventions (Bryers & Teijlingen, 2010). Women's perceptions of birth as medically risky mean that the hospital is constructed as a rescue from uncertainty (Coxon et al., 2014), and coupled with the normalisation of surgery (McAra-Couper et al., 2012), hospital birth is then the default option in a risk adverse society.

Even in fertility discourse, the increased risk of infertility with increasing age is taken up as problematic by women, rather than their age being just one factor that on a population level may increase the likelihood of infertility (Locke & Budds, 2013). In Locke and Budds' (2013) study, many women who had taken up the risk discourse of ageing equalling infertility, and subsequently conceived in less than ideal times and situations due to a belief in a ticking biological clock. Thus, potential risk becomes absolute risk in the perceptions of women. This appears to be an outcome of the authority of the biomedical model's 'broad brush' approach to risk management (Locke & Budds, 2013), such as expecting all women to require particular tests, for example, the nuchal thickness test.

Even within natural birth discourse, medical options are still mentioned as a safety net, although it is not clear whether the women are mindful of medico-obstetric risks or are influenced by the sociocultural pressures of good mothering and wanting to present themselves as morally responsible. Yet 'natural' discourse can be constructed as another way to take control, with a greater focus on privacy,

dignity, and individual care available (Coxon et al., 2014). There is also a possibility that a focus on natural discourses can then lead to disappointment for women if they find themselves having a biomedically focused birth (Crossley, 2007).

It has been found that previous births heavily influence subsequent choices (Zadoroznyj, 1999), so a snowball effect could be anticipated where an increase in intervention might lead to normalisation. If the focus shifts to a woman centred approach to pregnancy and birth where maternity is seen as a normal life event (until proven otherwise) with the use of a midwife in low technology surroundings (Bryers & Teijlingen, 2010), then presumably outcomes would be better for all. Women have the right to choose where they birth (Shaw, 2007), and if the focus of risk shifts from perceived population level risk to actual individual risk, the outcome is likely to be a re-normalisation of physiological birth with fewer interventions.

### **Neoliberalism, Maternity, and Notions of Choice**

The neoliberal citizen is an individualised subject of a Eurocentric gaze, and the normalisation of maternity within Western discourse is established through the technique of subjectification of maternity that is governed through expert knowledge into the proliferation of intervention. Then follows the emergence of the dominance of foetal rights discourse that places the perceived interests of the foetus before the interests of women (DeSouza, 2013). Likewise, healthist discourse of maternity assumes an enterprising self who takes responsibility for both the maintenance and enhancement of personal health through self-discipline. In this space, the 'subject' owns both the origin and the solution to any health problems (DeSouza, 2013). Throughout the literature, a belief within society of

neoliberal responsibility has been found to affect women's maternity experiences, particularly where women bear the burden of responsibility for outcomes related to the foetus/baby/child (Coxon, Sandall, & Fulop, 2014; Jomeen, 2012; Mackendrick, 2014; MacKinnon & McIntyre, 2006; Marshall & Woollett, 2000; Martel, 2014; Sutherland et al., 2014; Williams, Kurz, Summers, & Crabb, 2013). As interventions into maternity are becoming increasingly individualised through notions of choice and responsibility, then questions about the conditions that enable such choice, especially for women, have become highly contested. McAra-Couper et al. (2012) argued that choice is "limited, constrained and shaped by political, social, economic and cultural interests" (p. 83).

If we take up a position of individual choice during birth, informed consent can appear relatively straightforward. Yet how choice is performed is complex and multifaceted (Jomeen, 2012). Within a neoliberal ideology, choice and control over maternity experiences positions women as active consumers and decision-makers. However there are tensions between the medical model of risk and the discourse of women-centred childbirth. Jomeen (2012) argued that choice is not an equitable concept, and women are not a homogenous group, therefore choice is limited through the "complex and multidimensional nature of women's experiences of childbirth" (p. 61). Thus 'choice' creates a paradox for women as they are assigned both passive and active roles, and through medicalised notions of risk, women's choices are further limited, and if the 'wrong' choice is perceived to have been made, the blame through a neoliberal view lies with the mother (Jomeen, 2012).

Sherwin (as cited in Thachuk, 2007) listed four requirements that would need to be met before informed consent could be attained, and these included

patient competency, a reasonable choice from a set of options provided, disclosure of relevant information, and freedom from coercion. From a neoliberal perspective, these things should be manageable. Yet if we remember sociocultural, biomedical, gendered, and political influences, informed consent seems far more difficult to attain. Patient competency could be contested, as gendered social power assumes emotionality is incompetent, yet one can be emotional and rational at the same time (Thachuk, 2007). The second requirement of informed consent assumes a reasonable choice; yet choice as an ideology of neoliberalism in a risk focused maternity system often means the only choices offered are not reasonable choices (Crossley, 2007), particularly when neoliberal responsibility will again fall on the mother, and this surely constitutes coercion. An example of this would be a woman being told that she should have a caesarean section or she will harm her baby.

Thus choice could be seen as socially constructed and politically constrained, and perpetuated through a discourse of risk (McAra-Couper et al., 2012) and women can only experience situated freedom, that is, freedom to choose, only if other conditions are met (Crossley, 2007). Choice can be both enabling and limiting, for example breastfeeding or home birthing, while ideologically about choice, are legitimated through naturalised discourse as the ethical and morally superior option (Chadwick & Foster, 2013) yet this also limits the agency women have to make particular choices, particularly those informed through biomedical discourse. However, birthing in a hospital with prescribed interventions is also a morally correct choice, so women are once again located in a site of tension.

For example, taking up caesarean section is sometimes constructed as a personal choice. In McAra-Couper et al.'s (2012) research, this appeared to have some support from the biomedical maternity sector, with one obstetrician interviewed claiming no right to refuse a decision a fully informed woman may make to opt for caesarean section (McAra-Couper et al., 2012). Yet on reading an autoethnographic case study of the birth of a woman who had taken up natural discourse and ended up with many medicalised interventions (Crossley, 2007), it seems to be that choice is acceptable if it is choice to take *up* interventions, but not to refuse them.

Often choice for caesarean section is constructed within medical discourse as being in the best interests of the child (Chadwick & Foster, 2013), and when a significantly higher amount of fiscal resources, training, and focus on interventions are available, knowledge of medical interventions is then privileged over knowledge of 'normal' physiological birth (McAra-Couper et al., 2012). Here the focus shifts to intervention becoming the norm, without normal physiological birth being attended to or understood by physicians or those who teach them.

Maternity discourse also constructs the medical route (hospitals, interventions etc.) as a passive decision; a non-decision (Houghton, 2008). When the biomedical discourse is legitimated as the norm, it shows that we are always already medicalised (Malacrida, 2015) as a society. Where the hospital system and its intervention are legitimated through biomedical discourse, women are either coerced into passive participation or actively resist. This reinforces hospital birth as the starting point (Houghton, 2008). When hospital is the norm, the birth centre or home is considered as rebellion, as risky, and as non-compliance (Houghton,

2008). Thus, women can be left exposed to blame if the choices they make are not considered to be the 'right' ones, and positioned as 'bad mothers' if they choose a different option (Jomeen, 2012).

### **Sociocultural Concerns**

The majority of research I have found that addresses women's birthing experiences has been from the perspective of white middle-class women. The experiences of women of colour, indigenous or migrant women have been rendered invisible through the focus on privileging whiteness in the building of knowledge. Women (from a Victorian perspective) were positioned as mothers of the nation (DeSouza, 2013) yet this is problematic, as it privileges and perpetuates colonisation, and supports a colonial white middle class 'norm'. Maternity in Aotearoa New Zealand is predominantly constructed from a Western individualistic perspective, rather than integrating collectivism and whānau into an experience which is in essence the creation and development of whānau (Kenney, 2011). A mismatch between Pākehā-centric models of care and discourses arising within indigenous and migrant cultures can cause conflict for women. Migrant women from South Korea experienced the more casual approach to low-risk pregnancy in New Zealand as disempowering, rather than empowering. (DeSouza, 2014). When cultural norms favour discourses of (for example) risk, with the offer and uptake of antenatal screening as a norm, women may experience a hands-off approach as inadequate care (DeSouza, 2014).

Likewise, current beliefs about 'good mothering' as mentioned above rely on a certain access to wealth or ability, and thus are placed out of reach for women living in poverty or women with disabilities (Betterton, 2002). For example, if we

must feed our children organic food to lessen their chemical burdens as evidence of 'good mothers', then women who cannot afford these luxuries are positioned as bad mothers (Mackendrick, 2014). Precautionary consumption (eco products, lead free toys, cloth nappies) privileges the wealthy and subjugates the less wealthy (Mackendrick, 2014). From a position of middle-class wealth, it may seem that cloth nappies are the cheaper option, yet when a woman does not have access to a lump sum to purchase these nappies, or does not have access to a washing machine, or the power has been cut off, a lot of these seemingly straightforward options are less accessible. Likewise, the construction of breastfeeding as the morally correct choice (Williams et al., 2013) then assumes that all women will have the luxury of not having to work, not necessarily a possibility for women living in poverty. Research shows that working-class women have a more fatalistic view of maternity, and middle class women have a more activist stance to their experience (Zadoroznyj, 1999); the time, inclination, and access to resources to take control of the maternity experience appears directly related to social class (Zadoroznyj, 1999).

### **Sex and the Maternal Body**

This work must include consideration of sex and the maternal body, after all, the assumption is made that if a woman is pregnant she has had heterosexual intercourse, and within media representations, pregnancy also assumes the heteronormative presence of a male partner (Sha & Kirkman, 2009). Yet the maternal body also being a sexual body is unthinkable; pregnant women are often considered as inappropriate objects of sexual interest (Mullin, 2002). The Madonna/whore dichotomy presents women as either asexual or hypersexual (Earle, 2003; Huntley, 2000; Johnson et al., 2004; Musial, 2014); there is

simultaneously a reverence for the position of mother while also assuming that sexual desire will be replaced by the ultimate desire to be a mother (Huntley, 2000). Analysis of maternal sex discourse by way of pregnancy fetish pornography suggests pregnant women are positioned as willing sexual subjects (Huntley, 2000), yet the representation constructs pregnant women as sexual *objects*; after all, it is more socially acceptable if the desire and satisfaction for sex during pregnancy belongs to men. If, however, a pregnant woman is depicted as experiencing desire herself, or feeling sexual, this is unthinkable in society (Musial, 2014) as it disrupts what are considered proper notions of sex and motherhood (Huntley, 2000).

When Playboy centrefolds from a pregnant woman and a non-pregnant woman were compared, demure sensual photographs of the pregnant woman were displayed in contrast to overt sexual photographs of the non-pregnant woman (Huntley, 2000). The pregnant woman's centrefold had an emphasis on marriage and lovemaking, rather than sex for the sake of the woman's own personal desire; a pattern that occurs throughout popular pregnancy literature and guidebooks. Within these popular texts, sex during pregnancy tends to be for the benefit of others (the sexual enjoyment of the partner or endorphins reaching the baby via the placenta), rather than for the woman herself (Huntley, 2000).

The later stages of pregnancy also advertise women's sex, affecting how both men and women interact with visibly pregnant women; a tangible display of sex and gender (Mullin, 2002). Likewise, there is contestation over the meaning of breasts, with a dichotomy between the sexualised and the nurturing breast (Stearns, 1999). The practices of breastfeeding in public helps to illustrate this

dichotomy; an emphasis on covering up, hiding the nipple and an imperative of being discreet places the breast in the male sexual gaze (Stearns, 1999). Yet the focus on breasts needing to be exclusively sexual or exclusively nurturing (Stearns, 1999) rather than a combination of the two produces breasts as belonging to or being for the enjoyment or sustenance of someone other than the woman herself (man, or baby). The presence of a binary or dualism, where the experience must be fully one or the other (sexual/asexual, sexual/nurturing, Madonna/whore) thus creates tensions for women, who are expected to avoid any of these conflicting experiences. To be both sexual and nurturing must be possible, and to be asexual and a mother is unlikely, thus women are set up to fail.

### **The Public Maternal Body**

Women's bodies are subject to dominant ideals of feminine beauty (Bartky, 1998; Johnson et al., 2004; Sha & Kirkman, 2009), and this continues through the maternity experience. Maternity is often considered as the one time in our lives we do not have to conform to Western ideals of feminine beauty (Warren & Brewis, 2004), yet within pregnancy we are still subject to these ideals (Earle, 2003; Nash, 2011) and arguably in many more ways. The pressure of the public gaze renders pregnant women as public property (Fox, Heffernan, & Nicolson, 2009; Johnson et al., 2004; Sutherland et al., 2014) with strangers seeking (for example) to touch women's bellies without the usual social sanctions of acceptable personal interaction with strangers (Johnson et al., 2004; Sutherland et al., 2014). Birth can also place women in the public view (Johnson et al., 2004) with hospital birth often resulting in women's private bodies becoming public to a number of maternity staff.

Pregnancy may offer some reprieve from particular sanctions on our bodies, yet while it may be acceptable to (for example) eat more food, there are acceptable limits on eating and weight gain (Johnson et al., 2004) and these are possibly sanctioned further by rules about appropriate foods and the visibility of pregnancy in the public gaze. Mothers are also increasingly blamed for reproducing obesity in their children through pregnancy (Warin, Zivkovic, Moore, & Davies, 2012) so now it is not only our own bodies that are policed but those of our unborn children as well and thus pregnant women are positioned as responsible for the *future* obesity of their foetus.

Negotiating “in-betweenness”, the period of pregnancy prior to visible pregnancy also creates tension for women living in a society of pressure to conform to bodily expectations (Earle, 2003; Johnson et al., 2004; Nash, 2012) and it compartmentalises women’s bodies; fatness is not acceptable, but a baby bump is (Sutherland et al., 2014). Thus, maternity does not remove the pressure of feminine body ideals, rather it adds yet another layer and site of tension to them.

### **Out of Control Bodies**

Tensions elicited through an essentialised and dualistic understanding of the body can be noticed through the experience of feeling both in control and out of control of the body during maternity. If the body is experienced as autonomous, the woman herself can be assumed to be experiencing maternity as a passive entity. The body is doing the work of (for example) labour, and the woman is separate from that, the body is the driver, and the woman herself is a passenger (Carter, 2010; Sutherland et al., 2014; Warren & Brewis, 2004). Yet the body can also be experienced as accommodating, where if the mind needs (for example) a

break from contractions, the body can comply (Carter, 2010). Yet another experience could be the body and the self being separate, but working together (Carter, 2010). There must be a way to accept the body and the self as being a unified entity without the need for self/body dualism.

The body is not always experienced by women as being out of control and many women assume control over not only their own body, but that of their foetus or child also (Carter, 2010). For example, women often take up (or are expected to take up) the responsibility for their children's environmental chemical burdens (Mackendrick, 2014), obesity (Warin et al., 2012), and sickness. Yet this makes the assumption that being in control is the norm (Carter, 2010), and places the burden of responsibility on women themselves if they are unable to control a (supposedly autonomic) physiological symptom such as high blood pressure. It becomes difficult to accept limitations without taking the responsibility on ourselves (Warren & Brewis, 2004); the individualised responsibility of the neoliberal subject. Therefore, perhaps constructing oneself as an out of control body releases women from some of the burden of responsibility for deviation from expectations; it is better to be seen as weak and out of control than to be seen as uncaring or selfish (Sutherland et al., 2014).

### **The Impact of Maternity Staff**

In Aotearoa New Zealand, Lead Maternity Carer (LMC) midwives provide much of the maternity care, yet they are subject to their own power relations and tread a fine line between the needs of women and the needs of the maternity system; midwives can be seen as 'holding the space' for women (Seibold, Licqurish, Rolls, & Hopkins, 2010). Midwives however, are constrained by the obstetric

model and are subject to patriarchal thinking in terms of biomedical hierarchy (Keating & Fleming, 2009). Keating and Fleming (2009) found that midwives participated in 'UP down' thinking, placing doctors as the most important, senior midwives next, then junior midwives, with women themselves placed at the bottom of the hierarchy; identified as passive and compliant by the midwives interviewed (Keating & Fleming, 2009). This is at odds with much of the literature which positions women as active participants (Baker, Choi, Henshaw, & Tree, 2005; Nash, 2011). Either/or thinking also featured strongly in Keating and Fleming's (2009) research, a series of binaries where the considered options are one or the other; interventionist vs. non-interventionist, hospital vs. home, safe vs. risky. Yet midwives also noted their constraints within the system, and found that even though most had a strong woman focused philosophy, obstetric systems favoured active management of labour and discouraged midwives taking initiative (Keating & Fleming, 2009); yet they were more free to make autonomous decisions at night time, with fewer high ranking staff available. Thus it is easier for midwives to operate in a woman-centred way if they are free from the gaze of higher ranking maternity staff. Time pressures, a risk-adverse culture, and women's expectations are considered by midwives as barriers to normal birth, and likewise, a supportive environment and midwifery attributes including a desire to promote normal birth contribute to outcomes (Carolan-Olah, Kruger, & Garvey-Graham, 2015), as does a focus on women's own resources by midwives (Dahlberg, Persen, et al., 2016).

A culture of medicolegal notions of risk (Seibold et al., 2010) and fear of litigation (Lobel & DeLuca, 2007; Surtees, 2010) leads to an increase in intervention even when maternity carers are philosophically opposed (Surtees, 2010). Midwives in particular therefore work in a framework of advance defence,

where they can cover themselves if their choices are called into question in the future (Surtees, 2010). This then positions midwives as “auditable subjects”, where they perform rigorous self-surveillance and inhabit an imaginary future of potential litigation (Surtees, 2010). Even in more private birthing spaces, midwives are still located within a hegemonic system; there is a biomedical emphasis on risk, and there is a pressure to conform that requires them to participate even if opposed (Seibold et al., 2010). In hospital environments, often risk assessment questions and procedures are repeated by many staff, and this inflates the perception of risk for both the women and staff (MacKinnon & McIntyre, 2006).

Low levels of support from partner and staff, coupled with low perceived control in labour impacts posttraumatic stress disorder associated with birth, and postnatal depression (Czarnocka & Slade, 2000); decreased control and decreased information provision, poor communication, and no opportunity to make decisions all negatively influence women’s experiences (Baker et al., 2005). Posttraumatic stress disorder has been found to originate in many cases from traumatic birth events (Alcorn, O’Donovan, Patrick, Creedy, & Devilly, 2010; Kendall-Tackett, 2014; Leeds & Hargreaves, 2008); yet some research is dismissive of birth trauma leading to postnatal distress, with one study suggesting that other life events are more likely to be the contributors (Cohen, Ansara, Schei, Stuckless, & Stewart, 2004). Likewise, births that are considered traumatic by women are often perceived as routine by clinicians (Beck, 2004); yet trauma is experienced by women so perhaps the practices considered as routine within the biomedical maternity system do not account for how women make sense of them. Trauma can also be experienced without resultant pathology; a woman should not have to

develop PTSD to prove the existence of her trauma, and trauma should still be seen as legitimate even where it does not lead to disorder (Beck, 2004). Discourses of personal choice and agency in maternity literature are also at odds with the actual experience (Rúðólfssdóttir, 2000), where women may read and hear that they have rights to make decisions about their own bodies, and find that they are not supported in this at the time.

Partnership is also key in caring for women in the Aotearoa New Zealand maternity setting, yet the New Zealand College of Midwives model of care supports a Eurocentric approach to maternity and is missing the Māori worldview and the importance of mātauranga Māori in childbirth, and the importance of incorporating Te Tiriti o Waitangi in important issues for Māori women (Kenney, 2011). The needs of Māori women are a priority, and should be considered at all levels of both policy making and care. The colonisation of traditional Māori birth practices and bringing birth into a mainstream biomedical gaze affects Māori women and babies, and the collaboration between by Māori for Māori maternity services and mainstream maternity care should be promoted (Wepa & Te Huia, 2006). Māori women experience inequities in maternity care and outcomes, with a mismatch between need and care (Ratima & Crengle, 2013). They are less likely to receive adequate education and information, are less likely to have adequate culturally responsive care, and have fewer cumulative antenatal visits than non-Māori women (Ratima & Crengle, 2013), along with further inequities at every stage. Young Māori women are seeking care and engaging in health services early in pregnancy (Makowharemahihi et al., 2014), yet these cumulative and multifactorial inequities in all aspects of maternity care affect Māori women's

experiences from the outset, normally at an initial appointment with their general practitioner (Makowharemahihi et al., 2014; Ratima & Crengle, 2013).

Poor treatment of women by maternity staff is also evident throughout the literature (Baker et al., 2005; Kruger & Schoombee, 2010), with overt disciplining of women occurring, such as chastising them for their actions, even in situations where there is important context supporting women's choices (such as the needs of other children or the access to resources), and context is not usually recorded within medical notes (MacKinnon & McIntyre, 2006). Yet again, women who do not conform to the authority of medical care are positioned as defiant or difficult. Psychological, verbal, and physical abuse of women by maternity staff has also been noted within the literature (Kruger & Schoombee, 2010), with refusal of requested pain relief one way maternity staff can act punitively (Kruger & Schoombee, 2010). Vaginal examinations without consent are also often experienced as a humiliating sexual invasion by women; while modesty and sexuality may be disregarded in the maternity process, they are never absent (Rúðólfsdóttir, 2000). It is important for medical staff to remember that the cervix and vagina are sexual organs, not merely the birth canal (Rúðólfsdóttir, 2000).

Some improvements in care for midwives and other maternity carers in practice guidelines require that practitioners must consider their own embeddedness in historical, structural, and social forces and influences, and know and understand their own values (DeSouza, 2013). Improvement of continuity of care and support (Czarnocka & Slade, 2000; Ford, Ayers, & Bradley, 2010; Thachuk, 2007), informed choice (Elmir, Schmied, Wilkes, & Jackson, 2010; Thachuk, 2007), communication (Beck, 2004), and involvement in decision making

(Elmir et al., 2010) are known to enhance women's perceptions of control (Baker et al., 2005; Czarnocka & Slade, 2000; Elmir et al., 2010; Ford et al., 2010), and reduce adverse outcomes such as anxiety and negative mood (Ford et al., 2010). Likewise, the importance of debriefing of all women's birth and maternity experiences is crucial, as many women who experience perceived threat to their (or their babies') safety do not have an immediately intense emotional response (Boorman, Devilly, Gamble, Creedy, & Fenwick, 2014), and would be unlikely to catch the attention of maternity staff with a heightened ambivalence to individual trauma.

### **Summary**

Women are immersed in a system of gendered social power relations influencing their experiences of maternity and mothering, and multiple and contradictory discourses to make sense of our worlds and attribute meaning to our maternity experience. As we are embedded in a neoliberal society where personal responsibility is prioritised, and where contextual layers of subjugation are ignored, women can find themselves positioned in a site of blame for any outcomes related to maternity and mothering. There is a pressure to become a mother, and women who by choice or otherwise do not become mothers are often positioned as 'less-than' women. Once a mother, a woman must be a 'good mother', by meeting a number of (often contradictory) socioculturally sanctioned expectations. Women are not homogenous, and few can meet all of the expected norms, and many of these are out of our control, such as the colour of our skin, or our socioeconomic status, and whether we must work for survival. Internalised technologies of gender are the expectations of correct feminine behaviour which

we see and take on over a lifetime, and these influence behaviour during maternity, including whether a woman feels she can speak up to medical authority.

Within our heteronormative society, the maternal body is unthinkable as a simultaneously sexual body. Sexual pleasure is only deemed acceptable during pregnancy if it is for the benefit of another, and a discomfort relating to sexual vs. nurturing breasts assumes that womens' bodies must fit in a binary; sexual or asexual, sexual or nurturing, Madonna/whore. The maternal body also becomes a public body, with traditional norms of personal physical boundaries becoming unheeded by others during maternity. Women are still subject to ideals of feminine beauty whiles pregnant, and are even expected to police the future obesity of their unborn children. During outwardly visible pregnancy, many women experience uninvited touching and advice from strangers, and during labour and birth women's bodies become public to the maternity staff, without the permission or choice of the birthing woman.

The maternal body is also framed as an out of control body, with an essentialised belief that the body is doing the work, coupled with the expectation that women will take control of and accept responsibility for wellbeing of her foetus. This, in a neoliberal sense, frames being in control as the norm. Within risk discourse and the biomedical model, a population level approach to health through biopower and maintained through disciplinary power influences individual experience; perceived population level risk is taken on without evidence of personal risk. When no level of risk is acceptable, interventions are performed 'just in case', with a growing assumption that pregnancy and birth are medically risky events. A broad brush approach to maternity assumes that the risk belongs to

every individual. Biopower even mediates when women choose to have children, with a belief in a ticking biological clock leading women to believe that the decline in fertility at a population level as women age will necessarily mean a *personal* decline in fertility. Even in natural discourse, a medical safety net is often spoken of, and often choices through a natural discourse are not accepted unless the medical has also been attended to in depth. The notion of risk also influences how women are treated by maternity staff. Midwives are increasingly having to focus on potential future litigation, and thus set themselves up as auditable subjects. While midwives are known to improve outcomes for women, they are limited in their own power within a patriarchal maternity system.

With all of these factors influencing women in maternity, the pressures are immense. The aim of this work is to understand more about women's experiences of these competing discourses and power relations, and to tease apart some of the threads of power which bind women in positions of subjugation within the current society and various systems we are embedded in.

## **Chapter Two: Methodology and Method**

### **Methodology**

This research is conducted from a feminist poststructuralist perspective, with the epistemological assumption that our experiences and realities are socially constructed and are embedded in gendered power relations. This power exists in the spaces between people, and between people and institutions. As discourse knowledge and power coexist and cannot be easily separated, maternity is embedded in social power relations where it is regulated and legitimised through competing discourse. Thus access to knowledge and legitimacy of knowledge are controlled through sociocultural and political power; even this piece of work is immersed in power relations and negotiates the epistemological quagmire of legitimate knowledge. Knowledge itself is produced within this discourse/knowledge/power triad, and is legitimated in and through discourse and gendered social power relations. This research is therefore not considered to be value-free (Gavey, 1989). It is the product of my own passions and experiences, and they themselves are the socially constructed products of the relations of power in which I am embedded. I am not claiming to have wiped my fingerprints from this research, rather I hope to maintain reflexivity and learn of my own sociocultural experiences while I immerse myself in the complexities of maternity discourse and aim to tease it apart and make sense of it. Objectivity is not a goal of this research; I am not attempting to uncover a universal truth. As we are all embedded in relations of power, my interest in this research is understanding how the meanings of maternity and mothering are produced, reproduced and resisted.

Another important aspect of feminist poststructuralism is the articulation of meaning. We cannot express the meaning of our experience without language

(Gavey, 1989) as what we 'know' is discursively constituted and constitutes subjectivity. Because language is always located in discourse, meaning is necessarily a product of socially and culturally embedded power relations and practices. Within poststructuralism, a plurality of meanings is accepted (Gavey, 1989); discourses are multiple and contradictory and offer competing ways of making meaning. Feminist poststructuralism opens up spaces for "disrupting and displacing dominant (oppressive) knowledges" (Gavey, 1989, p. 463) and attending to the function of language in how power is structured enables us to look for opportunities for resistance to it. The focus of feminist poststructuralism is also not on individual experience; as we exist within multiple relations of power, individual experience is one way of gaining understanding of the socioculturally constituted discourses of disciplinary power that act on the actions of our bodies. According to Luce Irigaray, the key to women finding liberation within our patriarchal society is to find our own ways of troubling the existing political focus (Irigaray, 1985). By carving a space for women within society and political forums, our experiences of maternity are conditioned within a system that privileges masculinity. Thus, through this research, feminist poststructuralism is one way I might begin to question and unravel unequal power occurring in experiences embedded in a patriarchal system. By attending to gender, and in particular femininity while being aware of the patriarchal Western society we are embedded in in Aotearoa New Zealand, I hope to trouble the status quo.

**Abject bodies.** In a society dominated by the privileging of positivism, Foucault theorised the body as an empirico-transcendental doublet (Braidotti, 1991; Morgan, 2005), where a biological body is still an organ-ism, a set of organs serving a function (Braidotti, 1991), yet the body is still the site of transcendence

of subjectivity (Braidotti, 1991). Within Cartesian dualism, the mind-body split is a taken for granted 'truth' within dominant discourse, particularly within medical discourse where the body is produced as a machine. Within this framework, the socially constructed aspects of embodied identity and experience are rendered invisible (Morgan, 2005). When sexual difference is focused on, the male/female gender binary is solidified and heteronormativity follows (Butler, 1988). The "feminine is defined as the necessary complement to the operation of male sexuality" (Irigaray, 1985, p. 70).

Some have claimed that gender is based purely in discourse, with there being no definitive difference between the sexes, the body becoming less important in the understanding of gender, however we cannot describe the knowing of our body without using the limits of language available to us (Butler, 1997). Thus, "the body is given through language but is not, for that reason, reducible to language. The language through which the body emerges helps to form and establish that body in its knowability, but the language that forms the body does not fully or exclusively form it" (Butler, 1997, p. 5). The idea of a pre-discursive body, one that existed in its current form prior to and free from the advent of discourse, assumes that our bodies and embodiment of identity are not influenced by our sociocultural and political environments. Yet our identities must be influenced, shaped, and ultimately produced entirely from our lived experiences, which are embedded in discourse. We cannot escape these influences, yet the legitimacy of biomedical knowledge assumes this pre-discursive, asocial, and biological body to be 'real'. In biomedical discourse, women's bodies are positioned as problematic (Morgan, 2005); we are already 'othered' from the seemingly standard male body, so as we approach the biomedical maternity sector,

we are already positioned as defective body machines, with our minds separate from our bodies. “The ‘feminine’ is always described in terms of deficiency or atrophy, as the other side of the sex that alone holds a monopoly on value: the male sex” (Irigaray, 1985, p. 69). Thus, decisions relating to our own bodies are removed from us, as our minds are considered separate from our bodies anyway, and rights and responsibilities are placed into the hands of the experts; those with the access to what might be considered legitimate knowledge. By ignoring the embodiment of identity, the sociocultural and political building blocks that construct our experiences and identities, we are no longer seen as in control of our own bodies. Yet what if both of these discursive constructions of the body and identity could be troubled? If a body is considered either entirely pre-discursive or entirely produced through discourse, we risk oversimplifying and missing the multiple and complex power relations interacting through a tangible body. We cannot relate experience without discourse, and discourse does not exist in isolation from knowledge and power, so its interaction with a pre-discursive body (should it exist) would then add many further layers to embodied existence. Even to attempt to recreate this idea within the limits of the discursive language I have access to risks oversimplifying what may be all of these ideas at once, and yet simultaneously none at all. Perhaps we have not yet created a language to describe embodiment and experience of our bodies. Perhaps the moment this language is created, understandings of embodied experience will yet again shift out of reach; not willing to be limited through modernity. The embodiment of the subject is part of the feminist struggle for a redefinition of subjectivity; subjectivity that is neither biological nor sociocultural but rather an overlap between physical, material, and

symbolic (Braidotti, 2003). This may facilitate a move from what bodies can mean to what bodies can do (Budgeon, 2003).

Feminist theorist Julia Kristeva considers the maternal body to be pre-discursive; to exist apart from relations of power it is embedded in (Butler, 1989); to be beyond language, beyond the symbolic and the semiotic (Ziarek, 1992). Yet while her theory can, in some aspects be considered essentialist due to its pre-discursive assumptions about the maternal body, through her construction of the semiotic maternal chora (from the Greek for space/place/locality), Kristeva refers to particular pre-discursive drives yet situates them as embedded in various bodily constraints, such as family and social structures (Ziarek, 1992). Even a belief in the pre-discursive body cannot escape discourse. Kristeva also troubles the splitting of maternal identity; the self/other experience of producing another person (Ziarek, 1992), of holding another person within oneself, that is not oneself. In the maternal body, the subject and object cease to exist (Zerilli, 1992). Before Kristeva, Simone de Beauvoir troubled the notion of maternity within *La Deuxieme Sexe* (de Beauvoir, 1993), using primarily biological discourse to disrupt the notion of compulsory motherhood, and of a natural and blissful experience of pregnancy (Zerilli, 1992). By positioning the foetus as parasite, and the mother as an often unwilling container, de Beauvoir was able to disrupt the essentialist position of the maternal body being designed solely for motherhood, which was revolutionary in her space/place in post-World War II France. Yet, de Beauvoir's argument was not that straightforward; she positioned the foetus as simultaneously a parasite and as part of the woman's body, and draws attention to the loss of subjectivity and the loss of identity brought about by maternity (de Beauvoir, 1993).

The maternal body is also an object body; it exists somewhere between subject and object, it is simultaneously profane and sacred, it releases socially unacceptable fluids. It exists somewhere between the pre-discursive and the discursive realms. Thus women are positioned as polluted through societal expectations and cultural norms (Raphael-Leff, 1991); the collectors of placental waste products, the containers for the foetuses, the vessels of sociocultural anticipation. This way, the uterus can be a metaphor for the space and place of maternal desire and responsibility, as well as a receptacle for others (foetus, child, male partner, and a society driven by economic constraints). Again, when the foetus becomes the infant, the internal 'invasion' then becomes an external invasion, with the physical demands of mothering (Raphael-Leff, 1991). Likewise, the internal feelings of motherhood are compared to the societal ideal, rendering all women as failures (Raphael-Leff, 1991). So, not only are women the physical vessels for metabolic waste, the predigesters of food for their infants, containers of personal fears and anxieties, but also perpetually the fecund vessels of societal expectation (Raphael-Leff, 1991). If the metaphor of an infant is used to represent society, it feeds off the mother. She is sapped of her own resources to feed it, she is constantly striving to meet the needs and expectations of it, she has little choice about how to care for it, and she must do it for free and without complaint.

Now, with the increase in availability of reproductive technologies and the commodification of pregnancy through the availability of (for example) surrogacy, motherhood and the maternal body becomes even more complex. By 'mother', can we mean the ovarian mother, the uterine mother, the social mother (Braidotti, 1991)? Braidotti (1991) described maternity as akin to medical pornography; the visual act of body parts never being able to describe the multitude of experiences

and feelings associated with that moment. Yet, within our Eurocentric practices of maternity, we seem fixated on the physical process, with little consideration of the feelings of the woman herself or her individual experience. Embodied citizenship considers how public policy positions women in ways such as either being controlled by our bodies, or having control over our bodies (Bacchi & Beasley, 2002). This can be seen in Australian public policy where fertility it is regulated in such a way that even non-medical artificial insemination is deemed an activity needing to be overseen by a doctor, and heavily embedded in medical issues and the prerequisite inclusion of a husband in decision-making. Yet this renders lesbian women and single women invisible, and asserts women's rights to become a mother without attending to women's rights to *not* become a mother (Bacchi & Beasley, 2002). Feminist re-theorisation allows postmodern mothers to move away from essentialised motherhood and feminised identities; no longer restricting women to either motherhood or biological reproduction (Malson & Swann, 2003).

**Performing gender.** "One is not born, but rather becomes, a woman" (de Beauvoir, 1993, p. 281). If the pre-discursive body is considered the sexed body, all gender is embedded in and produced by discourse (Butler, 1986). Gender can be understood as a culturally produced understanding of the sexed body; a process of interpreting bodies in a sociocultural context (Butler, 1986). We have never had the experience of our sexed body in a vacuum, free from gender. Thus we are always already gendered, and gender can be understood as a way of positioning ourselves within historical, current, and future sociocultural norms (Butler, 1986). Thus it is "not possible to exist in a socially meaningful sense outside of established gender norms" (Butler, 1986, p. 41).

We could be understood to experience “three contingent dimensions of significant corporeality: anatomical sex, gender identity, and gender performance” (Butler, 1990, p. 418), and society sanctions those who do not perform their gender ‘right’ (Butler, 1990). While in many ways, Judith Butler may be referring to fitting into socially constructed ideals of what femininity is, this also relates to maternity in that throughout the experience, women must still meet the expectations of our gender. This then problematises where women who have not met particular expectations fit, such as women who have experienced infertility or who have made the choice not to have children.

Inasmuch as we ‘do’ our gender, we also ‘do’ our body (Butler, 1988). We are not merely bodies; we do not merely inhabit our bodies, our bodies participate in the performativity of corporeality and identity. The personal is also inherently political (Butler, 1988). Yet it is important to remember that an experience is still mine even though it also is experienced by others, and in turn, it is important to remember that my experiences also (re)produce gender as defined through sociocultural limits (Butler, 1988). Yet, this does not necessarily strip any of us of agency; we may be performing gender based on a script of sociocultural and political discourse and gendered social power relations, yet we all can enact this in different ways (Butler, 1988) including through resistance.

The performativity of gender through motherhood as an imperative, the motherhood mandate, can be understood in one way through Simone de Beauvoir’s example: “There is no way to directly oblige a woman to give birth: all that can be done is to enclose her in situations where motherhood is her only option” (de Beauvoir, 2011, p. 92). If relations of disciplinary power produce the

expectation that the correct way to 'do femininity' is to mother, and women who do not comply to this expectation are sanctioned socially, culturally, and economically, the concept of agency is disrupted.

**Technologies of power.** The work of Michel Foucault, though not originally from a gendered perspective, can be understood through a feminist standpoint. In 'doing gender', women are embedded in a system of disciplinary apparatus of heteronormativity. Normalisation enacted through disciplinary power produces and reproduces relationships of domination and subordination of masculinity/femininity and men/women. For Bartky (1988), disciplinary power produces women's bodies as docile to produce an idealised feminine subject against the background of bodily deficiency. To maintain heteronormativity, the function of the feminine body is maintained through a relentless process of surveillance. Docile bodies conform, comply, and behave as expected through the systems normativity they are located within. This can be seen in the taking up of various self-surveillance practices (Bartky, 1998) on the body; we endeavour to meet expectations of weight, beauty, and other practices of femininity. The docile body of maternity is a productive and useful body, normalised and disciplined in and through biomedically constituted gendered power relations. The biomedically produced maternal body that conforms is evidence of good health outcomes, and neoliberal citizenship. In this way, women are often coerced through practices of surveillance. Where there is power, there is also resistance, however resistance to such norms render her visible in her non-compliance and social sanctions are enacted to position her as the deviant other.

Jennifer Shaw uses Foucault's *The Birth of the Clinic*, and in particular his conceptualisation of the pathological corpse to demonstrate how the pregnant

body can be pathologised in the same way (Shaw, 2012). While the autopsy rendered the invisible suddenly visible, the advent of ultrasound and other methods of viewing the pregnant body do the same (Shaw, 2012). Modernity's shift towards population level understandings of public health and mortality and morbidity (biopower) has moved women to a position of being the producers of society's future workers. The advent of biopower has also led to a risk-focused society; when every action is able to be assessed for risk based on population statistics, that risk then becomes applied to individuals, with any risk deemed unacceptable (Morgan, 2005).

Foucault considered ways people make themselves ethical subjects; when related to maternity this can manifest in how particular practices such as pregnancy, birth, and breastfeeding may constrain women's positions within sociocultural expectations (Shaw, 2004). When the expectation is a 'good maternal body' and a woman is positioned as having neoliberal agency and responsibilities, then breastfeeding (for example) becomes the morally correct choice for women through disciplinary power (Shaw, 2004). "From a Foucauldian point of view, the norms and responsibilities of good mothering become attached to the actual behaviours and bodies of individuals, who then police themselves against these norms, and by which they are subsequently judged" (Shaw, 2004, p. 105).

**Summary.** This research aims to attend to the socially embodied experience of maternity, and to unravel some of the multiple and contradictory dominant discourses available to women, and to understand how they resist. Feminist poststructuralism provides a framework with which to begin to tease apart the threads of power we are embedded in. By understanding the maternity

experience as being immersed in gendered sociocultural power relations, along with seeking to disrupt dominant views of a pre-discursive biomedical body, opportunities to open up alternative ways of performing gender outside of the dominant heteronormative discourse may become evident.

In the troubling of gender performativity, the production of docile bodies within dominant biomedical discourse through a pressure to comply may also be disrupted. Through resistance and non-compliance, women may find themselves affected by social sanctions, yet if resistance to these pressures becomes widespread, dominant discourse could alter, with women previously positioned as non-compliant and deviant instead being supported. By focusing on the individual needs of women over the population level focus on risk created through biopower, outcomes for women could improve.

## **Method**

**Design.** This was a qualitative research project, with the intention of recognising and disrupting dominant discourses of maternity and correct performance of femininity through maternity and mothering. Feminist Foucauldian Discourse Analysis (FFDA) seeks to unravel the strands of different types of gendered social power relations, disciplinary power, and biopower. Through the combined analysis of meaning across participants, an understanding of the various ways that power acts on the actions of women's bodies, and is enacted by them can be explored. Where there is power comes resistance and therefore an important part of this research is to understand how women resist the power that limits the choices they have, while necessarily needing to negotiate a system that coerces conformity. The purpose of the project is to explore

possibilities to enable change within the social system we live in; by understanding how power works on and through the actions of women in maternity, we can consider changes that might be made to that system to improve outcomes for women.

**Bicultural considerations.** Ko Pirongia te maunga, ko Waipa te awa, ko Ngāti Pākehā te iwi, ko Patrick rāua ko Marie-ann ōku matua, ko Finn taku tāne, ko Liza rātou ko Briar ko Dara āku tamariki, ko Laura ahau.

I am a Pākehā woman, and it was important to me that I underwent a process of learning to ensure I avoided further colonising Māori experiences, with the possibility that individual participants of my research may have Māori whakapapa and that my research intends to serve all women of Aotearoa New Zealand. While my research was not exclusively for Māori participants, nor was it about actively seeking out only the Māori experience, my wish is to be aware of the need to create spaces for Māori voices where possible.

To understand my location in this research, my own whakapapa needs to be attended to. I am the descendent of early settlers in colonial New Zealand, and thus my history is through colonisation and the direct benefit of confiscated Māori land. With my whakapapa and personal experience as such, I support and respect Te Tiriti o Waitangi and endeavour to uphold the manuhiri (Crown) responsibilities in all aspects of my research and life. Adherence to Te Tiriti includes integrating the principles of partnership, participation, and active protection.

To ensure the needs of Māori women were met through this research, I listened to Māori, and learnt how the voices of Māori women in particular have

been silenced within empirical psychological research (White & Fitzgerald, 2010). I set out to ensure that I would maintain a focus on conducting culturally safe (Walker, Eketone, & Gibbs, 2006) work by ensuring great care was taken from an outsider (Bridges, 2001) perspective. As psychology in Aotearoa New Zealand is built on Western foundations, then irrespective of the cultural background of a researcher a power differential is present between the researcher and participant (Constantine, Hage, Kindaichi, & Bryant, 2007; Tassell, Herbert, Evans, & Young, 2012). I am not Māori, there will always be limits to my own understanding, and I hope to continue to grow and stay open to learning and changing behaviours that have been woven through my own experience of Pākehā dominated society.

Kanohi ki te kanohi (face to face) is crucial in research with Māori (Jones, Ingham, Davies, & Cram, 2010; Pere & Barnes, 2009), and this also supports my own experience of strong personal connections, thus all meetings were held in person. Also, returning after analysis with an interpretation of the research respects manaakitanga (Wehipeihana, Pipi, Kennedy, & Paipa, 2013), therefore I am scheduled to meet with each of my participants to the share research outcomes. Another concept I found important to be aware of in the research process was “titiro, whakarongo... korero (look, listen... speak)” (Jones et al., 2010, p. 2); emphasising the importance of leaving space for each participant to share their stories and to ensure that their experiences were respected and valued within the conversation and throughout the research process.

**Other ethical considerations.** This project met the criteria for a low-risk notification according to Massey University Human Ethics Committee (MUHEC)(Appendix A), and therefore the process was peer reviewed by a senior

member of the Massey University Psychology Department (Appendix B). These are not hidden stories as women talk about our experiences of maternity in various contexts; these stories are discussed in coffee groups, internet forums, in public places and in homes, and thus are shared knowledges. While some experiences surrounding birth can be very personal, we also develop ways of talking about sensitive topics without necessarily being overly exposed. Despite this, I made it clear within my participant information sheet (Appendix C) and during the interview that the interview was a conversation, and while I had a few possible prompting questions (Appendix F), the interview could be guided by the participant depending on what they felt was important to discuss about their experience. I also made it clear that the interview could be discontinued at any time. A participant consent form was signed prior to commencement of each interview (Appendix D).

Some participants have histories of mental health difficulties, whether pre-existing, due to birth trauma or postnatal experience, or a combination of these, so mental health concerns were important to keep in mind and I had the means to pass on various support agency details if needed. With each of my participants, we debriefed either immediately after the interview, or within the following few days, in case discussing their experiences had brought up any thoughts or difficulties they may have wished to discuss (which would not be included in the research). In terms of my own ethical safety, I contacted my husband both before and after each interview, so my whereabouts was known. For my psychological safety, although there were many parallel experiences to my own within each interview, and I was aware of thoughts and emotions during the conversation that linked with my own experience, these are thoughts and emotions I am comfortable with, and were

recorded in a diary. Therefore, I felt that I could be an empathetic and understanding interviewer with similar experiences, while not allowing my own experiences to guide those of the participants. I had access to a number of people I could debrief with, and at times I had discussions with these people about my own experiences and what I was learning about myself through my research process.

Confidentiality was maintained through altering of names and identifying factors, and pseudonyms were given. Some participants opted to choose their pseudonyms, but most asked for me to choose pseudonyms for them. I removed all names of partners, children, and maternity carers. Once transcribed, checked, and transcript release forms (Appendix E) signed off by the participants, voice recordings were deleted.

**Recruitment.** A purposeful sampling method (snowballing) was used, where participants were referred through the sharing of my information sheet by friends and acquaintances. I posted my information sheet on Facebook (a social media site) and within 24 hours of posting, I had responses from 21 women interested in participating. Most were from my wider circle of acquaintances, and two were not previously known to me. I started to interview based on accessibility to me (both physical distance, and availability of the participants for interview), and I began analysis after a total of eleven participants were recruited and interviewed. I kept in contact with all respondents via email, and once interviews ceased I contacted those who I was unable to interview and thanked them for their willingness to participate, and gave them the opportunity to request a summary of the thesis once completed.

**Participant diversity.** There is a risk with purposeful sampling of obtaining a homogenous sample. I am confident that the participants who came forward represented a diverse set of situations and backgrounds, and the pool of women who my information sheet reached was large and diverse. I have contacts on social media from a wide range of cultural, socioeconomic, and geographical backgrounds. As my information sheet was also shared outside of my personal network, I believe that a diverse range of people would have viewed it. Many people expressed an interest in participating for whom it would not have been practical to interview (such as people living in the South Island).

Several factors may have influenced people coming forward also, such as people having what they may consider straightforward maternity experiences may be less likely to think their stories are relevant, and conversely people who experienced difficulty during maternity may be also more interested in responding and sharing. I did have several participants, who on responding mentioned that their maternity experiences were very straightforward and may not be of interest to me, and I was able to interview two in particular who expressed this. Also, women who had experienced maternity through pregnancy loss may not have felt their stories fitted the requirements, however one participant who had had three pregnancies and no surviving children did come forward and was interviewed. Likewise, women who had terminated pregnancies either did not come forward, or if they were present amongst the participants, did not disclose or discuss their experiences of termination.

Culturally, the participants were predominantly Pākehā, with one Māori participant, one participant with Pākehā and Cook Island Māori whakapapa (with a

daughter who also had Māori whakapapa), two participants who were Pākehā with children who had Māori whakapapa through their fathers, and one participant who was Pākehā with children who had a Samoan whakapapa. One participant was a Pākehā New Zealander who was a Hungarian refugee as a child. There was an absence of participants from Middle Eastern, Asian, and African descent which would have enriched the available discourses for analysis, yet I am confident that my information sheet reached people from these backgrounds within my networks. There is a possibility that people from various cultural backgrounds may feel less comfortable about discussing personal details about maternity, particularly with a woman of the dominant Pākehā group. There was participant diversity in terms of married, de facto, separated, divorced, children who were the result of previous relationships, solo mothers, mothers who had separated from the father of their children but were in another relationship, beneficiaries, and people from various socioeconomic and relationship backgrounds. As recruitment was through social media, people who do not have access to internet or social media would not have seen the information sheet.

In terms of diversity of birth experiences, there was a higher than usual representation of multiple births (two sets of twins and one set of triplets), as my personal network includes a number of other parents of multiples due to my own experience with multiples. There were eleven participants in total, and 32 children from 27 pregnancies, including three miscarriages, one vanishing twin, and one stillborn baby. The only disclosed miscarriages were from a participant who had no surviving biological children, and from a woman who had a vanishing twin at about 9 weeks with a surviving baby. Due to the prevalence of miscarriage in the wider population, I suspect that there had been miscarriages for other women who

were interviewed, but if there were, these were not disclosed. Twenty-four babies were born vaginally, including three assisted vaginal births (ventouse or forceps). Four babies were birthed by their mothers via caesarean section.

Nineteen babies were born in hospital, and nine at birthing centres contracted by district health boards. The women's maternity care had occurred at 12 different birthing locations; four different birthing centres, and eight different hospitals, over nine different DHBs, most in the North Island but one in the South Island. The ages of the women ranged from their mid-twenties to late forties, and the ages of their children ranged from a few months old through to mid-teens. Participants' ages at the time of their children's births ranged from sixteen years old to late thirties.

**Procedure.** Interviews were conducted mostly in the participants' homes, and in one case in a café due to convenience for the participant. In most cases, I was able to provide kai as a gesture of manaakitanga. I was able to spend time with each participant before and after the interview to nurture a respectful relationship, which in all cases had been cultivated well prior to the interview. The interviews were semi-structured, with some questions (Appendix F) used as prompts for further conversation if needed. Each interview began with another read through of the information sheet, and signing of the consent form. I explained verbally again to each participant that I would be the only one listening to the recording, and that all identifying features such as names would be changed. I also explained that I would be transcribing verbatim, and that they could take the conversation off on tangents as they wished to.

I also asked questions directly related to each woman's experience during the conversations. The first question, "Tell me about your experience of maternity" allowed women to begin the conversation with me in their own direction. One participant was able to speak for approximately 80 minutes without prompts from this one question. Interviews ranged from 40 to 119 minutes long.

I transcribed each interview verbatim, and once completed I emailed the transcript to the individual participant for checking. A transcript release form (Appendix E) was sent by email, and once returned I disposed of the digital voice recordings.

**Method of analysis.** This is a poststructuralist feminist Foucaultian discourse analysis (FFDA). Epistemologically, FFDA seeks to understand how our worlds are constructed in and through discourse, and how language and symbolic processes are the means we have to make sense of our experiences. It assumes that experiences are multiple and contradictory, and reflective of the gendered social power relations we are embedded in (Gavey, 1989; Willig, 2013).

In analysing the conversations in this research, I considered the discourses women were embedded in and that provided them with ways to speak of their experiences. The emergence of three main discourses within these conversations (biomedical discourse, natural discourse, and inevitable and mandatory motherhood) gave me a framework to then search for conflicts between and resistance to these discourses as a way to understand the tensions women experience in maternity. The performativity of gender and subject positions made available to women through dominant ways of thinking about womanhood and motherhood could also then be considered, particularly through the sociocultural

sanctions experienced by women who could not or did not conform to expectations or requirements that authorise the practices of motherhood or womanhood as legitimated through dominant discourse.

I also considered the interactions between discourse, knowledge, and power. In particular, considering whose knowledge was considered legitimate within the three main identified discourses. I looked at how knowledge legitimated through biomedical and natural discourse impacted on the maternity experience.

While embedded in multiple and contradictory discourses, we can also take up or resist various competing subject positions (Davies & Harre, 1982). Positioning occurs when we either take up or are ascribed a subject position (or positions, as they can be multiple and contradictory) within various discourses. For example, one can be positioned as compliant or resistant within dominant discourse, which then has an effect on the social sanctions or rewards available to them. A woman who takes up a subject position as a compliant patient within a biomedical discourse may be able to have additional access to her premature child, yet a woman who takes up a position of resistance may find herself sanctioned through finding access difficult.

An example of my analysis process follows, with a piece of Hannah's story:

"... I said no pain medication at all and I tuned out as soon as they started talking about the epidurals and I thought "nah, that's for"- 'cause my mum used to hassle my aunty for having epidurals she said "ah pft! You know, that's, that's the easy way out I never had one and I had way bigger babies" and [it] was put in my head that

that's a cheat. That you're cheating if you do that so I thought, "no no, I'm not gonna do that" [...] [midwife] came back in and she checked me again, 'cause I kept begging her "please check me" and she said "nah. You're, you're not dilating" and I thought, "I *really really* want an epidural but I don't wanna say it" because I said I wouldn't, I told her I wouldn't and she said to me, "I think we should get you to the hospital and get you an epidural" I said "{sound of relief} Yes, thank you, yes yes yes!" – *Hannah*.

What is evident in this extract is that positioning is not static. This dialogue draws first on natural discourse, with pain relief being dismissed as an option. Women take up and pass on ideas of the 'right' way to birth within natural discourse, with women who take up the pain medication or other biomedical interventions being positioned as 'cheats'. Within natural discourse, there is an assumption that all women can birth vaginally with no pain relief, and that any access to pain relief will harm the baby. Within this discourse, the 'good mother' emerges with the responsibility to eschew intervention and this makes pain relief inaccessible to women embedded in the natural. Likewise, by focusing on the potential risk to the baby of any intervention, the maternal body is produced as risky to the foetus. From within this natural discourse, women seek to meet the criteria of a good mother through a natural birth. If a woman then takes up the intervention, she feels as though she is failing at natural womanhood. Thus tensions develop between natural and biomedical discourses for the woman herself, until the choice is then made legitimate by a midwife through the authoritative knowledge embedded in biomedical discourse. Once the uptake of pain medication is authorised, the responsibility for the decision then moves from the woman to the

midwife. In this way, the woman is subjected to the authority of biomedical discourse, and is not responsible for breaching the conditions of natural discourse. When an authoritative figure such as the midwife makes the option available, choice becomes limited through neoliberal responsibility; she becomes a subject of medical intervention or is positioned as a bad mother.

**Reflexivity.** Within this research, it is important that I locate myself within it, as I was part of creating these conversations with each participant. The narratives were woven between us, myself and each participant, and in a way through hearing other people's stories and seeing similar experiences coming through each piece, my embedded-ness in this research became more evident. I am a mother. I was immersed in the biomedical system during my own maternity experience (particularly during my first pregnancy with twins and a diagnosis of pre-eclampsia). Through this, I took up a number of subject positions within various discourses; I positioned myself as a natural and capable birther, breastfeeder, and mother within a natural discourse, and this contradicted with the subject position also made available to me of patient within a biomedical discourse. Many other subject positions and discourses have become apparent within my own experience through this research, and it has helped to solidify an understanding of how multiple, complex, and contradictory these discourses can be.

### Chapter Three: Analysis and discussion

I have approached the analysis chronologically as a parallel to the temporal aspects of maternity, yet the multiple and contradictory discourses maternity is embedded in do not operate within this temporality. The technologies of power coursing through the maternity experience do not necessarily attend to time in the chronological and ordered fashion we understand within modernity; categories such as 'before pregnancy', 'pregnancy', 'birth', and 'postnatal period' are not isolated and distinct.

#### Becoming Pregnant

**"It wasn't happening"**. A discourse of inevitable and mandatory motherhood envelops femininity just as a metaphoric foetus is suspended in amniotic fluid. The inescapable expectation that women will both want to become mothers and will become mothers with ease positions women who are unable to take up motherhood as 'less-than' women, and marked through their deficit (Loftus & Andriot, 2012; Newton & Stewart, 2013; Russo, 1976).

"Well I suppose it starts a long way back when we first started trying for a baby and after about three years we found that it wasn't happening. I suppose I've always known that I wanted to be a mum so the whole 'maternal' side started way back, but on the flip side of that too, I always have been, and still am... well, not so much now 'cause I know I'm not going to have a baby now... *terrified* of the thought of childbirth {laugh}... and I kind of wonder whether part of that is how the mind's such a huge powerful tool... I've often

wondered whether that could be part of... the whole... it not happening for us?" – *Lucy*

The motherhood mandate (Russo, 1976) emerges as a discourse of inevitable motherhood. Pregnancy is expected to just 'happen' through a natural discourse that is based on the assumption that motherhood is inevitable, which locates the female body as the perpetually maternal body; an essentialised position of femininity being for the primary purpose of producing children. Motherhood is not so much a choice, but a requirement. When pregnancy does not occur, women's bodies are rendered defective, and thus they become faulty bodies.

In a neoliberal society, women are seen as having individual responsibility for their own health and wellbeing (DeSouza, 2013) and so once the body has been positioned as defective a good neoliberal subject is expected to take responsibility for the lack of pregnancy within her own body. By locating the blame within herself, a woman does the work of sociocultural power performing self-surveillance to search out a personal flaw to justify not meeting the expectations of inevitable motherhood. The discourses of imperative motherhood and neoliberal responsibility intersect to limit women's agency. The impacts of involuntary childlessness produce a faulty body incapable of performing dominant discourses of socially correct femininity.

(on making the decision to not go ahead with IVF) "... just sorta talked to [husband] about it and just went well ... nah ... and so that was it really {laugh}. I guess *maybe* from there is where I sort of really went into my time of grieving and mourning and maybe not

just for the lost babies but for the loss of ... being a Mum? ... in that respect?" – *Lucy*

Embedded in a discourse of mandatory motherhood, women may find they have little choice about whether to seek medical intervention and fertility treatment. The social stigma of infertility and non-motherhood creates further pressure for women to be obliged to seek medical assistance. Thus taking up IVF treatment is a dominant discourse so strong for women experiencing infertility that it is an expected choice, which then positions women who choose not to take up intervention as somehow making a choice not to be mothers. Yet, taking up or not taking up intervention still works on the assumption that motherhood is mandatory and inevitable; the consideration that IVF may not work then positions the woman's body as deficit yet again, whether she takes up IVF and is successful, or is not. Thus women experiencing infertility will always be positioned through their defective bodies, even if treatment results in pregnancy. To not be a mother is then to be defective, and a failure of femininity within biomedical discourse and essentialised gender norms. When motherhood is considered essential for psychological wellbeing and happiness, a lack of motherhood is considered as a lack of fulfillment, and once again positions women through their pathological reproduction.

"...frustrating getting to the two and a bit years and not being able to fall pregnant or not falling pregnant when I've spent I don't know how many years on the pill trying *not* to get pregnant, never stopping to think about the time when it *is* time to get pregnant and I suppose maybe just *assuming* that it is just going to happen

because that's what happens to women ... women grow up and get married and have babies and live happily ever after ..." - *Lucy*

With the biological side of mandatory motherhood controlled for through contraception, pregnancy is seen as a timed and planned phenomenon, something that will inevitably happen when the decision is made. Good citizenship is achieved through performing maternity within the expected norms of neoliberalism. With motherhood constituted both within society and for women as a mandatory practice, the potential of not becoming a mother when the time is 'right' is not attended to, and is not explored as a possibility. When internalised technologies of gender are not met, such as in the progression through growing up, marrying, and having babies, a woman's position as a woman may then be called into question (Loftus & Andriot, 2012). If we cannot 'perform woman' we fail at femininity. The use of 'happily ever after' draws on the socio-cultural ideology that the right way to do motherhood is within traditional models of heteronormative nuclear family. This then invalidates other ways of mothering outside of the expected trajectory of womanhood; when the ideology of the nuclear family is so dominant in our socioculturally embedded understandings, there is no other story to draw from and to locate ourselves within. Motherhood is such a compulsory part of adult womanhood that the alternative is not attended to, and non-motherhood creates a significant detour in expected life course.

Lucy's story was one of extended unexplained infertility, and was then followed by three pregnancies in quick succession, which all ended in miscarriage. Experiencing pregnancy loss opened other understandings of motherhood, and further tensions in performance of femininity:

“... A good friend across the road was pregnant when she moved in. I’d see her belly and it was *hard* to see her like that because it was like “oh great, now I’m going to have to watch another big pregnant belly growing when mine’s not”, and then I fell pregnant soon after so then, exciting, exciting, we shared that. But she’s had baby number three now, and to get to the stage where I can actually pick up a baby and not want to cry is awesome. ‘Cause it’s a *horrible* place to be when you can’t be excited for your friends... ‘cause you *should* be excited for your friends when they’re going through amazing things.” - *Lucy*

Here multiple contradictory ways of ‘doing gender’ create tension; as women we are expected to be unconditionally supportive of friends and family, and to put our own needs second through internalised technologies of gender (Martin, 2003). Internalised technologies of gender (such as being polite, nurturing, and selflessness) are taken up as we grow and learn what is expected of us as girls and women. Within natural discourses of femininity, women are expected to nurture others and put their needs first, and here we see the conflict of feeling one way (upset at seeing pregnancy for others when a woman feels she should be pregnant) and having to put across another (having to show happiness for others). If we can pick up and hold a baby without crying, there may be a sense of having progressed in one’s own grief, but this couples with the relief that one can enact these internalised technologies of gender of having to be eternally supportive and happy for others. The tensions that arise from not being able to put aside our own feelings and ‘do gender’ in the way that we have been socially sanctioned to do, to enact gender in the way that is expected in society by being

happy for everyone else while putting aside our own feelings of distress creates an impossible quandary.

“I often do think if I’d had a *proper* chance to grieve and to *deal* with everything, maybe healing would’ve happened a lot quicker? But even the other day I had a friend say, “Oh maybe you haven’t grieved properly” and it’s like, well how do you know? How do you ever know if you have or not? She’s like “I’ll come down and we’ll let off some balloons or something” and with that I just *burst* into tears on the other side of the computer screen, she’s had 11 miscarriages herself, so she understands it, totally gets it and she was completely speaking with love but just the thought of doing it...

I don’t want to.” - *Lucy*

The idea of grieving ‘properly’ suggests there is a ‘right’ way to deal with pregnancy loss. With a process of grieving properly and then healing, there is the suggestion that pregnancy loss is something that can be moved on from or recovered from, with the end goal of getting over it. Society expects early loss not to matter, and expects any infant loss to be speedily recovered from, invalidating grief (Martel, 2014). Even the DSM-5 (*Diagnostic and statistical manual of mental disorders: DSM-5™ (5th ed.)*, 2013) places a set period on grief, with any grief beyond that considered mental illness. The women’s health movement is focused on women’s empowerment, and taking control of health and outcomes, this may then impact on women who experience pregnancy loss, and lead to self-blame for not being able to control for and create the perfect outcome (Layne, 2003). A tension also is evident in foetal loss where the construction of foetal personhood

through symbolic and biomedical (ultrasound) representations is at odds with a biological understanding of embryos in many feminist approaches. Yet denying foetal personhood ultimately denies women's experiences of failed pregnancy (Keane, 2009).

While psychological discourse allows us to take up the idea that healing is possible and is a process that may have occurred differently to how she experienced it, this is resisted by dismissing the belief that there is one proper way to grieve. The symbolic gesture of letting off balloons as a metaphorical letting go of the losses is rejected. What emerges here is that grief of the loss is also complicated by the relationship with inevitable motherhood.

“... because my experience of adoption is a really positive one, it's never phased me thinking about having a child that wasn't born to me but that is mine [...] hopefully I can yeah sort of shed a bit of light and keep it all keep it all good and happy for the child... obviously with Home for Life we would only be legal guardians but her parents would still be legal guardians or whichever child we get would be legal guardians, so it would be about encouraging that relationship with her parents and I think would be hard but also it's necessary because I know if it was my child and for whatever reason they were taken away from me I'd still want to have the ability to have a relationship with them [...] it will be totally heartbreaking if we don't get [potential foster child's name] *but*, again “it is what it is”, nothing we can do to change it and if we don't get her at least in the meantime, we've shown a little girl a

whole lot of love. And that's what it's kinda all about really. She's had an incredibly rough start in life, no child deserves *any* of what she's been through so if we can make even a scrap of difference I think that's ... something". - *Lucy*

Other ways of mothering such as through fostering allow an alternative perspective on motherhood. While planned biological motherhood can be taken on without much thought to the wellbeing of the actual child, here the child's needs are paramount. While personal desires could influence the choice to make oneself available as a permanent foster mother, the importance of putting the child's needs first is attended to in non-biological motherhood. The desire to be a mother can be seen here to be not limited to biological motherhood. Having a positive personal experience of being adopted shows that biological motherhood is a much smaller aspect of maternal desire in situations of infertility compared to motherhood in any capacity. By acknowledging the importance of love in the mother/child relationship, there is an attendance to the prescribed technologies of gender women are expected to fit. So even in a short space of time fostering a child, the performance of motherhood occurs, with the knowledge that it may only be for a short time. By putting the child first and caring about having provided them with love seeks to support internalised technologies of gender and expectations of motherhood, and seeks an alternative route to satisfy the motherhood mandate by intensively mothering in other ways (DeSouza, 2013; Russo, 1976).

**“Not planned, but not unplanned either”.**

“It took two years to get pregnant with our second child [name]and we were going through Fertility Associates [...] it does take a while

for the ball to start rolling if you go to your doctors, and you say you've been trying for six months, and then it's another four or six months before you even get an appointment, so it's more than a year to get there, so if you're older I personally thought that that was quite a long period of time, the waiting time, 'cause for us two years was a long time, like we were starting to get a bit worried {laugh} what's wrong with either of us really!" – Jess

Through a discourse of inevitable motherhood, an assumption emerges that pregnancy will occur immediately, and when this does not occur, time becomes a significant factor. To meet the requirements of the motherhood mandate and inevitable pregnancy, a ticking biological clock (Locke & Budds, 2013) where fertility is considered to decline with increasing age emerges; an example of the operation of biopower, where the legitimacy of population statistics shows a decline in fertility by age being taken up by individuals. Seeking fertility assistance is expected within a discourse of inevitable motherhood, the choice is not there to wait or to decline intervention. With the uptake of fertility treatment, women are under the biomedical gaze and are positioned as defective bodies. This pathologisation of the maternal body positions women as patients; and (re)produces them as docile bodies (Bartky, 1998). Docile bodies will do the bidding of the biomedical authority figures to meet their obligations of mandatory motherhood. To resist would be to be positioned as a failure in both discourses (inevitable/mandatory motherhood and biomedical) and in a neoliberal society, this failure is considered to be the fault and responsibility of the woman herself.

“And so this little girl was {smiling} not planned, but not unplanned either, and I think the same with my other two boys as that, you go along and if it happens it happens and if it doesn’t it doesn’t but we weren’t really... planning on it” – *Anika*

In a discourse of inevitable motherhood, planning becomes a focus. A good neoliberal subject must be responsible for her own health and the health of her potential foetus, with prenatal vitamins and perfect health an expectation on women. A ‘good mother’ plans for pregnancy, and takes up pre-natal vitamins, ensures the stability of her relationship, and achieves financial status to support the child responsibly, so any mother experiencing pregnancy outside of a ‘planned’ situation runs the risk of being positioned as a bad mother (DeSouza, 2013; Neiterman, 2012; Sutherland et al., 2014). Any pregnancy that is not the result of active decision-making that includes the health of a women’s body fit for purpose, is a moral narrative, and resistance can be met with social sanctions. In Anika’s account, the acceptance of pregnancy as a potential but not imperative product of a relaxed relationship may be understood as resistance. By making pregnancy a situation that just ‘is’, enables her to maintain her position as a woman, rather than as a perpetually potential pregnant mother. This could allow space for feelings of acceptance of timing, and has the potential to remove stress around lack of pregnancy. Yet the construction of planned as opposed to unplanned babies is ever present within our sociopolitical landscape. Such a binary limits what can be said about the potential of motherhood as “not planned, but not unplanned either” and the boundaries that hold the inevitability of motherhood in place shows the inadequacy of language to represent meaning.

“so I was about twenty when I got married and then got pregnant four months later. I thought it was gonna take a year ‘cause I was told that it was probably going to take up to a year and you should expect that, my mum had problems and everything but two weeks later, took a pregnancy test and yeah, it was positive. I don’t think I was ready for it, I thought it was gonna take longer and I couldn’t get my head around it...” - *Hannah*

By following family histories of pregnancy, deviations from the norm become unknowable, thus it can become overwhelming if a particular expected natural order is does not happen. Biomedical discourse also assesses family history, with the assumption that there are inheritable patterns. The timing of pregnancy in this narrative affirms the ideology of planning, and at the same time produces a tension between planned but not yet expected.

“With my first that was an accidental pregnancy and that had been when we were in Dunedin and I had got on birth control when I was in Dunedin and then we moved up to Geraldine and got pregnant soon after that, and at the doctors’ appointment to confirm it we kinda go “what the hell do we do!?” and they said “oh, well at your weight you should have been on *two* pills a day”{laugh} nice to tell me... *then*. - *Michelle*

The advent of contraception has enabled women (at least in the West) greater control over their fertility. With the suggestion of weight being a contributing factor to the incorrect prescription, this centres neoliberal responsibility or blame on the woman herself; an implication that fat bodies are

defective and that the body did not take up the contraception as it 'should' if it was a thin body (DeSouza, 2013; Reiger, 2006; Warin et al., 2012). Women are subject to expectations around an ideal feminine body (Bartky, 1998), and within biomedical discourse, focus is on weight as pathology, rather than as an example of normal individual difference that may alter treatment plans or drug doses. Positioning women's bodies as fat defective bodies places the responsibility for both the weight and the unplanned pregnancy on the woman herself.

**Summary.** The tensions surrounding becoming pregnant are evident in these interview excerpts; women must plan, and yet must not plan. They must conceive at the 'right time', whether through age or through their planning, and are positioned as deviant or as defective bodies whether conception occurs, or it does not. A body must not be fat and pregnant; and the responsibility for pregnancy lies either completely with the mother as a neoliberal subject, or completely outside of her as a biomedical patient. When motherhood is considered a natural progression of both life and relationships within natural and mandatory motherhood discourses, women who are unable to or choose not to have children are positioned as deviant. No matter their approach to becoming pregnant or not, they are simultaneously subjects of discourse that limits their agency and responsible for their reproductive outcomes.

### **Finding Out**

'Finding out' was a strong discursive construction running throughout the interviews; mostly meaning finding out about the pregnancy, but in some cases finding out about pregnancy loss. Finding out appears to be external from the women themselves; no mention of late periods or knowing before testing emerged

in the interviews. In this way, knowledge is constituted as coming from an external source, and legitimated through technologies of measurement within biomedical discourse. Women's knowing of their own bodies is not authorised, replaced instead in a trust in tests and ultrasounds to tell us what we may already know. Women's own bodily knowledges come second to the biomedical and the increasing technology around 'confirmation' of pregnancy. This supports the perpetuation of a risk adverse culture and a need for technological or 'expert' proof external to the mother herself. Thus legitimacy of knowledge belongs to the biomedical experts, and women's embodied maternity is commodified through the operation of 'testing' and women are coerced into participating in. The growing market of home pregnancy testing, and ultrasound in non-diagnostic applications (Layne, 2009).

**"We were pregnant"**. Many women in this research used 'we' when referring to their pregnancies. Where the maternal body is constituted through biological discourse a tension between the pregnant 'I' and the non-biological pregnant heterosexual couple. When women's understanding of the maternal body is embedded in the assumption of gender equality, maternal-foetal relations are obscured and yet her femininity endures the physical and sociocultural experience of gender acting through the maternal body. She experiences the tensions of gendered power relations, 'we' do not. She has the physical demands of pregnancy, birth, and the postnatal period, 'we' do not. While women can experience embodied maternity, men are limited to experiencing their impending parenthood mediated through the mother, and often limited to visual representations (Draper, 2002), thus ultrasound is a commodification of maternity that prioritises foetal

personhood and the fathering relationship. It also confirms the 'reality' of pregnancy for women and excludes their embodied experience. (Draper, 2002).

"So we had a scan at seven weeks? And our pregnancy was confirmed at 12 weeks" – *Natasha*

Where once a late period, followed perhaps by a pregnancy test, was considered enough confirmation of early pregnancy, conversation now turns to first trimester scans as confirmation. Once given for dating purposes, and nuchal translucency testing, scanning between 6 and 12 weeks as confirmation of pregnancy seems to support the unspeakability or distrust of women's knowledge; we must see our baby on a screen before we trust that it is there. Thus there is a clash of meaning (diagnostic test, or confirmation of pregnancy) between the biomedical gaze and the experience for women.

With the advent of a belief in a need to confirm a pregnancy through ultrasound, the legitimacy of a woman's knowledge of her own body (a late period) or of a rudimentary test (pregnancy testing) is called into question. Confidence about our bodies and pregnancies is removed through this necessity to confirm pregnancy via ultrasound, and can make us feel we are out of control of our bodies (Carter, 2010; Nicolson, Fox, & Heffernan, 2010; Reiger, 2006). It also positions us as containers; unknowing reproductive vessels must be looked through to know the foetus is there (Betterton, 2002; DeSouza, 2013; Mullin, 2002; Raphael-Leff, 1991; Sutherland et al., 2014). The legitimacy of biomedical knowledge that constructs the pregnant body as a risk to be managed through monitoring and regulating the potential for human life, pregnant women become the objects of

progressive technologies to minimise “potential foetal catastrophe” (Ivry, 2009, p. 199).

“Once we decided I was pregnant four days later kinda thing {both laugh}... [first child] was just over four when we got pregnant, and because I had had hyperemesis with him, one of the prevailing theories at the time was that hyperemesis was related to your gallbladder... so I got booked in for a gallbladder scan and while I was there they said “ooh, would you like to take a peek at the pregnancy?” I said “oh yeah, alright” and they said “ooh, what do you see?” and I said, “I see *two* little black circles” and they said “yes... *TWO* little black circles” and... I laughed half the way home and cried the rest of the way home...” - *Michelle*

With the onset of hyperemesis, the maternal body is also constructed as a risky body in need of intervention ... There is no known cause of hyperemesis (besides its emergence with pregnancy), and it still serves as an enigma to the medical world (Munch, as cited in Neimanis, 2013). The pregnancy alone is not accepted as the cause of the hyperemesis, and while pregnancy itself is not an illness, it can certainly disrupt the body enough for extreme illness to occur alongside it. When the authority of bodily function is contradictory, women’s affective embodiment is made meaningful through deficit.

“... at that scan I was just... *hhhhorrified* to see two babies... and immediately was crying hysterically... “are they both alive?... is this what my life’s gonna be?” Didn’t want two, I didn’t even hardly want *one* but I thought ...mmm... *fine*... I’ll have one more [...] I

knew I only ovulated from one side, so I was like “that’s just *one* baby, one egg” which it was, one egg... at the *beginning* {both laugh}” – *Hannah*

### **Morning Sickness**

**“I can’t even think pregnant without feeling sick”.** Morning sickness, and its authorised condition hyperemesis gravidarum, occurs in many pregnancies. The term “morning sickness” is not a medical illness, but rather is located in women’s knowledge to make meaningful the felt bodily effects of pregnancy in everyday talk. The regulation of morning sickness itself is problematic; it downplays the severity and duration of the sickness, and the lack of a common alternative for the affliction shows its unspeakability. “Morning sickness” is located in women’s knowledges and yet through the delegitimisation of women’s knowledges, it has become a casual term for a spectrum of ‘unwell-ness’. Morning sickness becomes both discursive and affective embodiment and only gains legitimacy through the biomedical gaze that renders women’s symptoms as meeting the threshold for hyperemesis. Morning sickness has a precarious place in biomedical discourse – while vomiting is clearly evident, it is unable to be predictable or knowable and therefore inexplicable. Perhaps as Neimanis (2013) argues, the embodied experience of morning sickness might be both physical and social – “a question of *intersubjectivity* and affective directedness” (p. 226). While it has a biological manifestation, the meaning of morning sickness is discursively mediated.

“I had a really crap first couple of months with morning sickness, which I hadn’t experienced the first time around and I just felt... terrible all the time. Not necessarily throwing up but I *just* felt terrible, I was nauseous all the time and I’d walk around with sea bands on, I was trying every home remedy that anyone could suggest and it just wasn’t working, I was just feeling terrible” –

*Anika*

Within a natural discourse of femininity, the ‘ordinary-ness’ of morning sickness is visible through non-medical women’s shared knowledge of remedies. By trying natural remedies, morning sickness is in the realm of women’s shared knowledges. However, morning sickness also represented women’s out of control bodies, and where there is no relief of symptoms. A tension emerges between the inevitable consequences of pregnancy and access to medical intervention where a woman’s failure to manage her her symptoms positions her as a risk to be managed.

“... I lost fourteen kilos in six weeks and we found an obstetrician who was like “yeah if you lose any more weight you know we’ll organise for you to get Zofran”... and then we couldn’t get hold of her for the next month... {laugh} because she only *worked* there on Fridays... and nobody else would do anything until they’d seen us but they wouldn’t see us for a month until our next appointment and I was losing ridiculous weight and massively dehydrated and all the rest of it and it was just feeling miserable and I mean that was while I was on a couple of antiemetics already... so if I hadn’t

have had *those* from our GP I would have been even worse off [...] we kinda went with the private obstetrician in order to access the funding to be able to get the Zofran.” – *Michelle*

With hyperemesis, additional risks appear, although these are less emphasised in a biomedical discourse. The loss of an enormous amount of weight in a short time in a non-pregnant woman would be considered dangerous, and if a risk focus was taken up in terms of hyperemesis, it would seem fitting that access to medication would be improved. Here a woman’s out of control body becomes a docile body in biomedical discourse, dependant upon authorised access to treatment.

“... pregnancy is so tied up with the hyperemesis I can’t even *think* pregnant without feeling sick... and because I was so ... basically malnourished and things like my stretchmarks are... as wide as my thumb ‘cause I was just really run down, I had no fillings before I had kids, I got my first one after [child’s name] and now I’ve got about six? It’s calcium depletion, from being so sick... and from the vomiting damage... when I was pregnant with the twins I lost my voice for about eight weeks? And they never worked out why specifically but they think it was acid damage to my vocal cords” - *Michelle*

Biomedical discourse becomes the legitimate knowledge to describe the aftermath of hyperemetic pregnancies, and the meaning of morning sickness marks the experience as permanent injury. Maternity injury is often thought of as being related to genitals or reproductive organs yet bringing injury into a wider

view may open spaces for women's experiences to be believed, treated, and supported.

### **Seeing the Baby**

Ultrasound scanning has become a normalised part of the maternity experience in Aotearoa New Zealand, with scans for dating, nuchal thickness screening, anatomy/anomaly screening and growth becoming 'ordinary' in our maternity experiences. The routinisation of the 12-week nuchal thickness scan is contested among medical professional bodies and it is argued that rather than essential for best practice, it has emerged through the increasing technological developments and their commodification where the visual has become conflated with knowledge (Stephenson, McLeod, & Mills, 2016).

Ultrasound is used as an important diagnostic tool embedded in a discourse of risk, yet also contributes to women's experiences of maternity in ways that exceed the medical gaze. Women are not passive consumers of ultrasound technology, but rather ultrasound brings into view the 'reality' of the foetus's existence and development and invokes feelings of awe.

"LQ: And so how did that feel when you saw the beating heart, how was that experience?"

Lucy: It was amazing. It was... yeah, I suppose from trying so long and nothing happening and then, the first miscarriage which was very early on anyway ... yeah it was incredible and seeing it on the screen and the sonographer said, "oh yep, I can see its little heart beating" and it was like "wow, there is actually a baby there" and then even [husband] said "Oh! That's it there! I can see..." And Mum

and Dad were sitting in the waiting room because they'd waited years and years to be grandparents as well... So yeah! It was pretty incredible. And at that stage I sorta thought "sweet there's a heart we're good! This is happening" so it was pretty awful, a couple of months later to have it all turn to custard so to speak" – *Lucy*

In cases of early miscarriage, ultrasound can sometimes become the only experience parents have of their babies, and can enable bereaved parents to construct their embryo as the potential future child (Keane, 2009). Here the shared experience of mother and father in seeing the embryo on screen allowed an experience of shared understanding of pregnancy, and the construction of foetal personhood with both parents feeling confirmation of the existence of a tiny person within his or her mother's womb. This view through the womb brings the understanding of the pregnancy out into the visible realm; bringing the inside out. While positioned again as the vessel for a child, with the glimpse into the womb, in cases such as this it may be the only experience that women can have of 'seeing' and feeling some kind of experience of 'knowing' their unborn child. Images of foetal abnormality do not capture the lived experience of anomalies and loss.

"LQ: Yeah and then presumably after you miscarried the second baby did you have to go in for another scan?

Lucy: [...] It was at that scan that they said "well, we're not seeing a baby that's at the size and everything that it *should* be". [...] It was *awful* because... you know, we had all these dreams and hopes and everything, maybe because it took so long to get pregnant in the first place and we'd already had one miscarriage and that... no it

*was horrific. I was gonna say maybe it wasn't quite as bad but yeah... it was horrible" – Lucy*

The scanning process can be the harbinger of difficult news, as was the case here with baby loss being confirmed at a scan. Ultrasound scanning after miscarriage then also has an important technological and medical function, in providing information to women about the likely success of expectant management of early pregnancy loss (that is, 'allowing nature to take its course'), or whether a surgical procedure might be needed (Sairam, Khare, Michailidis, & Thilaganathan, 2001). The legitimacy of the gaze extends beyond the function of foetus viability and intensifies the social scrutiny of the risk women pose to the developing foetus. The surveillance and regulation of the maternal body extends to the overweight or obese pregnant body where maternal obesity has become a public (moral) health crisis (Parker, 2014). Now, with the public health focus on obesity as an epidemic, women are held responsible for the obesity of their future children both through eating behaviours through maternal nutrition to the foetus (Warin et al., 2012) and in the post partum period.

"I genuinely thought I had a pretty good experience. {sound of recollection} Ohhh... except for the scan. Because I'm bigger... I don't know if the man thought he was funny but... yeah my 12 week scan for [baby's name]... scanning away obviously couldn't see anything, and then said "ohhh, I think there's too much meat and veg in the way and go and... go to the toilet and empty your bladder," and I'm sitting in the toilet going... "{disbelief} did he just say what I think he d-" you know how you replay that in your

head ... “did he just say what I think he said?” and... I pretty much just wanted to get out of there... [...] after that 12 week scan... I was not wanting to go back and have another scan and I remember lying there going... “pleeeeeease don’t let her say anything, just don’t say anything I don’t need this” ... and so you wanna enjoy what you’re seeing but in the back of your mind you’re thinking... “don’t say anything about my size please”. [...] it’s like one experience can ruin it for the rest of them.” - *Ava*

Biomedical discourse focuses on a perceived ‘ideal’ body size with any individual difference that lies outside of the expected ideal being unacceptable and pathologised. Sociocultural policing of women’s bodies already occurs within society, and the amplification of this through an already body-weight focused biomedical maternity system results in women being body shamed and treated as less-than people by maternity (or in this case ultrasound) staff (Parker, 2014). Where weight is a factor for a woman, it is considered through the biomedical gaze as being the cause and the remedy for all other potential problems, even in this case with the ultrasound scanner not gaining a particular view wanted by the sonographer. Where excess weight exists women are held responsible not only for the risk they pose to the foetus, but more extensively as the origin of the obesity epidemic in children (Parker, 2014). The responsabilisation of obesity has led to the classification and management of fat pregnant women as high risk (Ministry of Health, 2012) and intensified medical interventions and increase of foetal surveillance, including more frequent ultrasound scans and obstetric referrals.

“We had the ultrasound early on for the gallbladder, which was when we found out it was twins, another one after that where they checked whether they were di-di or mono-di or the rest. They were di-di, boy girl, of course they were, and then they wanted us to have the nuchal fold test... and I said no to that one because what would we do if one was Down Syndrome and the other wasn't? And we probably wouldn't reduce anyway and I was sooo sick at that stage that anything was hard to do... it's really hard... and then we had the big *long*... twenty, eighteen week kind of one... and that was... *long*... and then our obstetrician actually had a fairly small portable kind of one in his office... and so he liked to do an ultrasound about every four weeks and then getting on to two weeks but I didn't really see the *need*. It seemed to be very much “{deep condescending voice} ooh, this is a benefit of having a private obstetrician is you get to have an ultrasound every time”, kind of proving he's worth his while but what does it tell you? It doesn't tell you anything that a Doppler... it's not like he was taking any measurements or anything like that... it was very much a show pony do your trick now.” – *Michelle*

The decision of taking up or declining the available ultrasound scanning differs for women in different circumstances and even in different stages of the same pregnancy. Here, the decision not to have nuchal thickness scanning related to the biomedical outcome of a decision to terminate, so rather than an

opportunity to “see the baby” which is often the maternal experience, the awareness of the 12 week scan being a diagnostic tool essentially leading to the potential decision to terminate the pregnancy was clearly the purpose of the scan. The woman’s own knowledge about the purpose of scanning, without emphasis on the visual experience, allowed informed decisions to occur. Yet when the obstetrician (seen as having legitimacy of knowledge) had the scanning equipment, the ability to resist became untenable. In being seen by an obstetrician, his authoritative knowledge leaves no room for a woman’s own knowledge. In the movement into obstetric care, the medical imaging then became the norm, even when the woman herself could see its tokenism, and accepting (or not declining) the ultrasound became about performativity, and being a ‘good patient’ under the scrutiny of the medical gaze.

The use of technology is so routine and commonplace that when a midwife does not use it as a routine, she can be positioned as alternative (“greenie”), operating within a natural discourse. This further reinforces ultrasound and similar technologies becoming the norm even in low risk pregnancies, rather than a diagnostic tool where other risk factors are present. Ultrasound can precipitate an ethical quandary and a balance between maternal and foetal risk (Edvardsson, Small, Lalos, Persson, & Mogren, 2015), with some women experiencing anxiety, and while in theory women’s needs are intended to be at the forefront of care, this does not always occur in practice (Åhman et al., 2015).

“[midwife’s name] wasn’t really *keen* on ultrasounds being a *greenie* type person.... But we weren’t sure of dates so I had a very early ultrasound for dating purposes... and then when it came to

doing the nuchal translucency ultrasound [midwife's name] was very clear ... we had a really long conversation about it and she said she has had, clients who have had false negatives and false positives... she doesn't trust it one way or the other... she said if we're going to have the nuchal translucency done... then we need to only do it if we're prepared to go and have further tests... because she doesn't like the fact that there is this... possible false result... and so she said if you're going to go down that road, it means you need to be prepared to have an amniocentesis, and if you're prepared to have an amniocentesis, you need to be prepared that you might want to terminate this pregnancy, and she said that at the end of the day, if you're not willing to terminate the pregnancy... no point having the amnio, and there's actually no point in doing this, because you'll find out at the birth whether there's something wrong or not... so that was quite interesting, and because it had taken us a while to conceive I was *so desperate* to have this baby that it was like, "I don't care what is wrong with this baby, I want it..." of course having HAD that baby {both laugh} ... "I will have EVERY test under the sun" ... but what was really good was that she explained it all and she gave us statistics on the accuracy of this test and she gave us statistics on what could go wrong if we had an amnio and all that kind of stuff and she was able to give us so much information so it was from that perspective I was so well informed..." - Rose

Midwives occupy a space within maternity care that straddles both natural and biomedical discourse and thus are integral to informed decision making (Edvardsson, Mogren, Lalos, Persson, & Small, 2015). By using legitimacy of knowledge in a biomedical sense with strong understandings of biomedical purposes of nuchal translucency testing and further decisions which may be made beyond that, informed consent can occur. With the midwife able to engage in both medical and natural discourses, this opens spaces for women to make sense of their choices.

With the desire to be a mother reinforced by the motherhood mandate, there was a preparedness to have “every test under the sun”, yet also preparedness to avoid nuchal translucency testing if it may lead to a choice she had already made (that termination would not be an option in case of disability). The “*desperation*” to have a baby outweighed the risk of having a child with a disability. Therefore even when the medical is taken up strongly by the woman, it is also embedded in a discourse of mandatory motherhood, and the importance of having a baby no matter what.

**“Everything was cool until we had our anatomy scan”**. The normalisation of ultrasound scanning arises also in the way women speak of their scans. Instead of perceiving a risk-based nuchal translucency test as purely diagnostic, the meaning for women is the confirmation of the reality of pregnancy. Instead of an anatomy anomaly scan at 20 weeks, the scan may be taken up by women as ‘finding out the sex of the baby’. Yet sometimes the perceived and potential risk that the screening is there to detect becomes central to the purpose, as a vital diagnostic tool.

“At 12 weeks we found out that [child’s name] was actually twins so he had a vanishing twin that only made it to about nine weeks [...] everything was cool until we had our anatomy scan at 20 weeks in [place], and at my anatomy scan they confirmed that [child’s] heart only had three visible chambers, and the fourth one was there but very, very small... and the sonographer at the time consulted with the radiologist to confirm that there *was* something that needed to be looked at and then they referred me through to [hospital] to see the cardiac team in foetal medicine to have another scan.” – *Natasha*

Ultrasound scanning as a diagnostic tool monitors high risk pregnancy and suspected foetal anomalies. While most women participate in ultrasound scans, their expectation is that it will affirm good and normal development of their foetus. When pregnancy moves into the realm of biomedical discourse through the risk of medical anomaly for the foetus, natural discourse moves to the background of attention. When concern is for the health and survival of the foetus as a medical necessity, biomedical discourse is easily and readily taken up and drawn from, to improve foetal outcomes. This is an operation of biopower where the normative technology to assess perceived risk at a population level renders actual risk visible, and thus ultrasound scanning performs its function of lowering mortality risk for the particular individual baby and in turn the population as a whole. This can then relieve some of the pressures of embeddedness in other discourses, such as natural discourse, as once biomedical risk has been assessed as actual as opposed to potential, taking up biomedical technology is accepted, recommended, and embraced.

“I was hoping this would be the normal pregnancy compared to my other pregnancy being quite monitored... but I wasn’t 100% comfortable with... {laugh} not having heaps of scans... ‘cause it’s really nice and really reassuring to see your baby really often {laugh}... so... {laugh} as terrible as that is that it was now becoming a high risk highly monitored pregnancy... I was kinda glad because I’ve always found a lot of comfort in seeing my kids even though there could be bad news in any of those appointments... never seen it that way... and I’ve always looked forward to all the extra scans so... yeah, it was quite nice to be able to get them {laugh}... without having to pay for them ‘cause... {laugh} I would’ve been that Mum that paid for all these extra scans {both laugh}... so I didn’t find the extra monitoring and stuff much of an issue, I was used to it and I was quite comfortable with it... and I did look forward to getting to see my baby more so... {laugh}... that was a bonus, not so much a minus in my book!” –

*Natasha*

Almost all of the participants spoke of scans as a positive experience, with pleasure gained from ‘seeing’ the baby. This participant spoke of the possibility of paying for scans, and the increase of biomedical requirement being a bonus due to the pleasure she got from seeing the baby. While the commodification of the maternal body is a consideration in scanning, the scanning experience was overwhelmingly positive, suggesting women’s experiences of scanning relate more to the benefits they experience.

While this participant did not end up having to pay for scans as she had extra ultrasound scanning due to her child's heart condition, by stating that she would have been "that Mum" who would pay for scans opened another avenue to consider in the commodification of pregnancy. Such commodification in low risk pregnancy however has the potential to render pregnancy itself as a risky condition. Some women however become active agents in the routinisation of ultrasound as an extension of the increase of medical interventions in our everyday lives as we take up positions as consumers of technology as a moral responsibility for health. The reasons women value ultrasound however, exceed medical aims and become more about the social meaning such as reassurance, seeing the baby, finding out the sex, facilitating bonding, and acquiring keepsakes (Roberts, Griffiths, Verran, & Ayre, 2015). Likewise, ultrasound can give women a sense of participating in responsible motherhood in managing a 'healthy' pregnancy (Harris, Connor, Bisits, & Higginbotham, 2004). A focus on ultrasound scanning being a check for foetal abnormalities, health, growth, and to see everything was 'normal' (Gudex, Nielsen, & Madsen, 2006; Harris et al., 2004) may also then raise a different expectation of ultrasound for the parents than intended, with insufficient informed consent being communicated by staff or understood by parents (Edvardsson et al., 2016; Garcia et al., 2002). Parents also place a high level of trust in ultrasound, to give them an expectation of a perfect (healthy) baby (Edvardsson et al., 2016), yet with any safety risks or ethical concerns no longer being communicated as they were in the earlier days of ultrasound in maternity (Edvardsson et al., 2016; Garcia et al., 2002). As medical technology progresses, there are also ethical challenges, particularly with an increase in demand for quality assurances of foetal health and wellbeing (Edvardsson et al., 2016). Yet

despite the underlying complex ethical concerns such as consent, and the management of outcomes women participate in ultrasound for reassurance, to alleviate anxiety, to experience some control over knowledge (particularly potential adverse outcomes), and due to the pleasure of seeing their unborn child (Gudex et al., 2006; Harris et al., 2004).

While the individual experience may be positive, the marketing of ultrasound through a “biotourism” metaphor (Kroløkke, 2010) creates new forms of (dis)empowerment for women through the commodification of women’s bodies. Through non-medical ultrasound, the foetus is personified, and the foetus becomes the entertainer (Kroløkke, 2011). The uterus is transformed to a “home”, and gender performativity is also placed on the foetus with discussion of foetal movements centred around gender; if female, she is dancing, if male, he is playing football (Kroløkke, 2011). Sonographer, parents, foetus, and even grandparents participate in the performance (Kroløkke, 2011), where the foetus transforms to baby, the woman transforms to mum, and the foetus is “perfect” (Kroløkke, 2010). Yet this biotourist metaphor is reframed through marketing as a pampering experience (Kroløkke, 2010), and given the focus throughout this research on the pleasure of seeing (and therefore knowing) the baby, the demand appears to be there for this biotourism experience. It is important, however, to balance the interests of both maternal and foetal health, and to remain aware that increases in ultrasound technology use magnifies the foetus, and risks diminishing the focus on the woman herself (Edvardsson et al., 2016).

## The Public Maternal Body

“We’re thinking about having one more... and I’m already worrying about getting *bigg-er* than what I am... like I want to be pregnant but I don’t want people to be like... “{whisper} woah that lady is real big” instead of going... “I am actually pregnant” ... I have this thing like I wanted to get real skinny and *then* get pregnant so then people would know, “yes! I’m pregnant! I’m not just fat!” [...] I just don’t want to people to be like... {judgmental sound} “you’ve put on heaps of weight” when really “I’m actually pregnant and it’s a lovely thing that’s happening to me.” - *Ava*

The pressure for women to maintain expected body sizes and shapes does not cease for pregnancy. Rather, women are under additional scrutiny being overweight and pregnant, as the perceived wellbeing of the foetus is taken over by society, and women are required to reconcile the requirement to feed the foetus while still maintaining a socially acceptable pregnant body (Nash, 2015). With the emphasis on obesity as high risk and as causing nearly every potential difficulty (Fitzsimons & Modder, 2010; Shaikh, Robinson, & Teoh, 2010) and increasing fear around obesity as an unacceptable risk factor, women are even placed in a position of neoliberal responsibility even for the potential future obesity of their unborn children (Harper & Rail, 2012). Biomedical discourse is overwhelmingly negative towards obesity, and while women sometimes construct ourselves within resistant discourses, even women who experience excess weight during pregnancy tend to reproduce dominant obesity discourses such as individual moral responsibility for health of both herself and her foetus (Harper & Rail, 2012). Yet women are aware of and sensitive to their sizes, and maternity professionals should be aware of the

stigma and adjust their approach to talking with women about their size if necessary to mention it at all (Furber & McGowan, 2011). Carers often feel a lack of resources, equipment, and facilities to adequately care for women above average size also contribute to negative outcomes for women (Schmied, Duff, Dahlen, Mills, & Kolt, 2011). While earlier in the analysis obesity was problematic for ultrasound scans, here it is about the social conditions that produce the maternal body as a public body.

Despite the focus on obesity within maternity, there is research contesting obesity as an epidemic, and as having the risk factors that it is claimed to produce (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). Rather, obesity is constructed as a sociocultural issue; a moral panic associated with neoliberalism and negative attitudes towards minorities and people living in poverty (Campos et al., 2006). Campos et al. (2006) framed the obesity epidemic as largely an illusion, and one that benefits certain interest groups such as insurance companies and the weight loss industry, while immense damage is done to those who are stigmatised.

Becoming public property, as occurs during pregnancy, comments on bodies are deemed acceptable. When conversing with a pregnant woman, the dominant discourse often relates to the size of her bump. Negotiating fatness and pregnancy also assumes that one is acceptable (pregnancy) and the other is not (fatness). The visible maternal body and the visible fat body both fall into the public gaze (Nash, 2012), and the limited acceptability of one (pregnant) conflicts with the social unacceptability of the other (fatness) and creates tension. The ability to just be in one's body however it is shaped is inaccessible to larger

women, and poor treatment can result for women from both members of the public and from maternity professionals (Furber & McGowan, 2011).

“I didn’t have a *cute* baby bump, it was like, ohh it was just all baby... and other people would always say, “Oh my God, you’re massive!” but I never felt like that, it wasn’t ‘til... ohh after 30 weeks that I’d be a bit more uncomfortable when I was trying to sleep and stuff like that...” – *Kay*

Women negotiate body changes in a complex sociocultural environment which puts limits on acceptable and unacceptable weight gain. “All baby” is considered acceptable weight gain, and is a way women can be spoken of approvingly with regards pregnancy weight gain (Johnson, 2016). This negotiating of the socially appropriate pregnant body increases the pressures on women through their visible pregnancies (Earle, 2003; Johnson et al., 2004). The ordinariness and acceptedness of public commenting about a pregnant woman’s weight or bump is so embedded in society that it reinforces how apparently acceptable it is in society to attend to women’s visual appearance both during pregnancy and beyond.

### **“It Was As Though I Was a Disease.” Navigating the Biomedical**

Decision making for both women and midwives is influenced by complex political, social, and contextual factors (Noseworthy, Phibbs, & Benn, 2013). The Western biomedical model is embedded in a discourse of risk and risk prevention (Bryers & Teijlingen, 2010), and becomes internalised limiting the meaning of normal and the choices available to women (Darra & Murphy, 2016). Interventions such as induction of post-term women and the routinisation of precise medical

markers gain normative power (Skyrme, 2014). Observation of clinical practice has found many ethical failings in communicating risk, including scaremongering and data manipulation, which then results in an illusion of safety that decrease women's abilities to exercise choice (Skyrme, 2014). Participants within this research often spoke of being "allowed" or "not allowed". The biomedical discourse legitimates practitioner control over the entire process, including how many people the woman wants to be at the birth. Women become subjugated through the authority of obstetric knowledge. If even small decisions are ones that need to be checked and approved by a medical practitioner, then this leaves little space for women to negotiate or resist decisions about interventions such as the uptake of epidural. So if control is taken over decisions that have little impact on the obstetrician (such as number of people at the birth) in such a way that women feel they must comply with other factors to maintain those options, then women become docile bodies, and are coerced into compliance. Yet, supporting a relational model of decision making, with the understanding of choice as a sociocultural experience may allow a more proactive and woman-centric model of decision making between carer and woman (Noseworthy et al., 2013).

"I really didn't want an epidural, and when I said this to the obstetrician he said "ohhh, we'll see how things go" and then he said he would *let* me not have an epidural if they were both head down, that he would scan me when I got to hospital and he would '*let*' me go, without an epidural if they were in the right position... I mean, other women *have had* breech second twin... and you know sometimes they have had an internal version and it was really unpleasant but, you know, they survived and it's their body, it's

their choice, you know? ... um... yeah. "I'll *let* you have one"..."-

*Michelle*

Biomedical discourse positions the obstetrician as the holder of legitimate knowledge; the person with control over decisions, and with the ultimate right to choose how the birth progresses. The woman, even while educated and knowledgeable about various perceived risks is positioned as a docile subject in the decision. The obstetrician may acquiesce to women's choices, but only when they meet the criteria of his expertise. In this way, women's choices are limited as she is subjected to his authority. With the assumption that the obstetrician has the authority to allow (or more to the point, to disallow) any particular choices, women have no agency.

Paternalistic and patriarchal structures are deeply embedded in contemporary practices of technocratic obstetrics, where the authority of biomedical discourse regulates and disciplines the maternal body. Despite neoliberal conditions that enable women/consumers to exercise choices over decision making, including the 'freedom' to pursue a natural birth, women are often only able to choose to give authority to the professional to manage the birth (Walsh, 2007).

LQ: How did you feel about being "*let*" or "*allowed*" or "*not allowed*" to do things?

Michelle: Ohhh, that's so patronising. It's hard too though 'cause at that stage you're *so* exhausted and I mean you *are* hormonal and you're just, yeah. But I think you're not quite yourself at that point

in time so I think you probably succumb to it a bit more than you might at other times? And that's not really fair... but that's quite disrespectful to kind of *rely* on *that*... that people will be more blind at that stage in the game... because, they have that fear of authority..."- *Michelle*

Even where women have knowledge and information about their choices and options, the reality of a maternity system based on increased focus on risk and the normalisation of interventions limit these choices, and make notions of consent and informed choice more rhetoric than reality (Skyrme, 2014). So the routinisation of the intervention, coupled with the illusion of safety within the medical model means experience is subjected to institutional power relations and even midwives are compelled to take up risk discourse within a culture of powerlessness (Skyrme, 2014).

Pain relief is an area of maternity care that highlights weaknesses in how informed consent is obtained. Research has shown that maternity care practices undermine women's consent to or refuse treatment without pressure or coercion. Despite women communicating their pain relief plan in advance of when it might be needed to ensure that women can maintain control of their decisions (Lally, Murtagh, Macphail, & Thomson, 2008), often women are asked to sign consent during labour (Goldberg & Shorten, 2014). While maternity care provision has become increasingly midwife-led, and should offer flexible options for pain relief it has been difficult within biomedical discourse where there is a perceived risk, for women's choices to be legitimated. Pain in labour "is invested with complex social, cultural and political meanings that intersect with women's physical experience"

(Watson, Murtagh, Lally, Thomson & McPhail, 2007, p. 867). Pain relief technologies are also implicated in relations of power, extending control over women in certain ways. The legitimacy of medicalised labour reduces women's sense of autonomy and increases the use of unnecessary interventions. In the following extract, Anika minimises her pain to ensure that she remains a sense of self-control over her preferred birthing plan.

.... "I'm alright I'm alright, please let me still be induced [...] And I probably had a little bit of a headache from {both laughing} getting hit... but I didn't wanna admit that in case they said "No, you're not allowed to get induced."-*Anika*

Skyme (2014) has argued that consent and informed choice is problematic in maternity care. The dominance of biomedical discourse of risk and increase in surveillance diverts attention away from maternal choice in favour of technological advancement and professional expertise. This is particularly evident with regard to induction, which has become so routine in maternity care that it has become normalised through discourse of safety. Of concern is the use of induction based on a medical preoccupation with a "specious due date" (p. 401), especially when there is the potential for an induction to turn a "low risk pregnancy into a high risk labour" (p. 401) and can impact on a woman's birth experience. Relinquishing control to the biomedical system can then affect self-confidence and trust in her own body autonomy, and given the social construction of choice, the socially sanctioned option may be the option that is most available to women (Skyme, 2014). When the final decision rests on the medical staff, women become docile bodies.

“... it’s pretty important to me, some people are happy just to go with the flow but I kinda like to know *why*... and there wasn’t a lot of *why*, just “this is what you need to do, this is what’s happening”, like the induction, it needs to be Tuesday, but of course he was probably only picking Tuesday, if it was *so urgent* why was it five days away? ... because he was working at [hospital] in the weekend so he couldn’t do it then so push it out for five days ... how could it be *so urgent* if it’s five days away?” – *Michelle*

Women’s ability to choose is limited through the normalisation of induction and the lack of adequate information about the risks of the intervention itself (Skyrme, 2014). Even where women are able to question the decision, resistance is often negated through “information steering” (p. 402) rather than an ethical negotiation based on women’s moral right to bodily integrity. By framing induction as necessary and urgent, it appears the importance of fitting into a medical schedule is at odds with the supposed urgency.

Consent and informed choice are also problematic in maternity care for Māori women and their whanau. Biomedical discourse position women as the focus of the medical gaze rather than active agents rendering them as objects rather than partners. This is of concern to Māori women who do not feel that their knowledge, experiences and the decisions they make with their whanau are validated (Kenney, 2011). For Māori, reproduction is both biological and spiritual, and a pregnant woman contains the “creative potential to facilitate the transition of past ancestral qualities to the present” (Le Grice & Braun, 2016, p. 154) and the foetus therefore has the capacity for spirituality.

“...it was as though I was a disease... they were treating a disease, rather than they were treating a pregnant woman, who’s about to create a soul to come into this world. It’s not just a little human, there was this soul attached to this baby, you forget about the emotional and the spiritual and that dimension of it, it’s just purely... medical. “She is [name] blood pressure”... you know, it’s not “she is [name] giving life to a baby who has a history, and who has... siblings and who has an iwi and a hapū and... ancestors”...”-

*Anika*

Biomedical discourse reduces women to essentialised bodies; a series of measurable physiological body responses indicating sickness or risk. The woman’s history and cultural context is ignored within biomedical discourse, and this is particularly so where indigenous knowledge is excluded (Kelly et al., 2014; Kenney, 2011). As a woman with Pacific Island and Pākehā whakapapa, whose baby also had Māori whakapapa, the negotiation of traditional practices and beliefs and the expectations of a Western culture is already conflicting (Abel, Park, Tipene-Leach, Finau, & Lennan, 2001). The importance of the child, not as a medical event, but as a continuation of whakapapa, the embodiment of spirituality and wairua, is not removed from women merely by placing them in a medical location.

Homebirth and freebirth often becomes more about resistance to the loss of context, and reject the medical pathological approach to pregnancy and childbirth, and question the status quo what is considered safe, and what is considered risk (Dahlen et al., 2011). In escaping the bonds of the Western biomedical model,

access to a woman-focused philosophy of midwifery, where personal agency is not rendered passive, and opens the possibility for a “fresh take” on safety that considers social, whanau and practical relationships (Walsh, 2007, p. 222). Midwifery however, is also governed by discourses of risk, so while care for low risk women has potential to open relational spaces, risk management continues to restrict choices for women. Midwifery partnerships with women therefore are embedded in competing discourses that are located both in the partnerships, but also in the spaces of the institution where midwives themselves are accountable to disciplinary and professional power and regulation (Bryers & Teijlingen, 2010; Surtees, 2010).

“... before we found out it was twins and quite early on I had already found the... home birth midwife who I hadn't even got to meet but then I like you know, we had our, first visit planned and all those things, so I called her up and said “{crying} yeah, there's two of them” and she's like “ohhh, well you won't be able to do a home birth then” - *Michelle*

Because homebirthing twins is regulated through risk management choices become limited for women. The authority of the medical model in assessing acceptable risk for most midwives who operate within disciplinary power does not enable them to extend their practice to to twin home birth. The biomedical system implies that rather than women having choices, they are instead given concessions when risk is seen as low. When risk is normalised and interventions are also normalised (Darra & Murphy, 2016; Skyrme, 2014), any resistance has the potential for litigation (Surtees, 2010). Women talk about being ‘allowed’ or ‘not

allowed' to make particular choices or do particular actions within the biomedical system; the decision making becomes that of another outside identity, that of an obstetrician, doctor, midwife, or nurse. Women can be autonomous, but only within the constraints of the very limited risk-focused system.

**“I just expected the medical system to fail me”.** Errors occur in any profession, yet the structure of our biomedical system as a whole is based on biopower, where heuristic, intuitive, and group collective thinking in decision making increase the incidence of errors (Patterson, 2009). Women experience errors during maternity care (Coxon et al., 2014; McKinnon, Prosser, & Miller, 2014; Nicholls & Ayers, 2007), yet midwives and doctors are protected from litigation, even when based on legitimate negligence or malpractice, under the Accident Compensation Act (Accident Compensation Corporation, 2001; Grigg & Tracy, 2013). Women in Aotearoa New Zealand may have the available options to complain about negligence or staff error either directly to the district health board, or to the Health and Disability Commissioner, but from many conversations with women both inside and outside of this research, women are unlikely to make complaints, and those who have made complaints have not often found the response satisfactory. In searching for research on maternity staff errors, academic research into errors made by staff is minimal; and women's voices are missing from any research on negligent birth injury.

Research undertaken with Australian women under the care of obstetricians found that there exists a cultural ambivalence and fear of 'normal' birth in contemporary culture. Such fear is entrenched in the hegemony of biomedical discourse that women navigate in their attempts to control their

birthing experience. Compo (2010) found that women did not believe birth was something that could be controlled and when they placed their trust in their obstetrician, their trust in their own capacity to birth without intervention was eroded. While this is likely to be a similar experience for women in Aotearoa New Zealand who are fully embedded in biomedical discourse, a mistrust in the system based on the experience emerged, at times in resistance to the hypermedicalisation of my participants' maternity experiences.

There were many incidents of staff error occurring throughout the interviews I conducted, and it seems that when women are under the biomedical gaze for a greater length of time, the errors became an expected part of the hospital experience. Research related to physical birth injury (such as pelvic floor, urinary tract, and rectal injury) make it clear that reducing obstetric interventions such as instrumental deliveries (Clarkson et al., 2001; Fitzpatrick et al., 2000) is key in birth injury reduction. One study went as far as to mention that almost all incidences of urinary tract injuries occur at night, and linked this to junior obstetric staff working without direct supervision (Rajasekar & Hall, 1997). Symptoms of birth injury are also rarely volunteered by the women who have experienced them (Fitzpatrick & Herlihy, 2001), and given that a third of women who have a third degree tear had significant anal sphincter injury (Fitzpatrick et al., 2000), and third degree tear is a relatively common occurrence, one wonders whether the lack of reporting of symptoms relates to an acceptance of what living with a maternal body means, even with long-term pelvic floor injuries. The improvement of care by reduction in obstetric interventions and instrumental births, as well as an improvement in communication, patient information, and

recognition, treatment, and follow up of injury has been recommended to help reduce long term impact on women (Clarkson et al., 2001).

Yet, the level of support received from carers has a much greater impact on women's satisfaction and emotional reaction than stressful events during the birth, due to the increase in perceived control reducing anxiety and negative mood (Ford & Ayers, 2009). Likewise, the influences of pain, interventions, and pain relief had a far less direct, powerful, or obvious impact on satisfaction as the behaviours and attitudes of the caregivers (Hodnett, 2002). Perhaps, then, rather than trust emerging from hegemonic biomedical power and an expectation that doctors are to be respected and that they know best (Campo, 2010), a trust built on respect towards the woman as an equal would result in better experiences for women.

"I think I got to the point where... I just expected the medical system to fail me... and just expected it to... I expected the doctors to be crap I expected the nurses and midwives to be crap, you know like... this is just how it is." - *Anika*

With interventionist care becoming an accepted part of the maternity journey, some fairly significant gaps in woman-centred care emerge. The acceptedness of interventions that also produce risk women tend to expect negative outcomes. A need to improve interpersonal relationships between maternity professionals and woman is noted remarkably often in the literature (Clarkson et al., 2001; Ford & Ayers, 2009; Hodnett, 2002; McKinnon et al., 2014; Noseworthy et al., 2013), yet very little research problematise their apparent cascading effects.

While the excerpt above may appear to be from a place of disempowerment, women are not entirely lacking in agency. For example, Kruger and Schoombee (2010) analysed how problematic interactions within hospital maternity care have become sanctioned, normalised and institutionalised where the relationship between midwives (positioned within the hierarchy of biomedical discourse) and women (as docile subjects) reproduce relations of power and powerlessness. While interventions within this system often appear incontestable, women resist such power by seeking alternative birthing spaces (Dahlen, Schmied, et al., 2011; Dahlen et al., 2011; Jackson et al., 2012), and homebirths and freebirths have come to represent the “casualty of a broken maternity system” (Dahlen, Jackson & Stevens, 2010, p. 48). Alternative birthing spaces address the question of care by shifting the problem away from why women do not accept hospital care to “why do we not offer a service that women will accept?” (p. 47). Not all women believe that a hospital birth is the safest option, however when choosing alternative locations that are not medically sanctioned they are often marginalised and socially sanctioned (Lee, Ayers, & Holden, 2016).

### **Decision Making**

Embedded in competing discourses of safety that impact on their choice of birthing location, women have to negotiate the freedom offered in contemporary care and the responsibility for the consequences of their choices (Lee et al., 2016). Conflict can then emerge out of these competing discourses, when one discourse expects an action the other sanctions.

“every piece of paperwork that we got from [hospital] was like

“{excited advertising voice} have you considered the birthing

centres?! [Place and place]!” which I couldn’t *USE*... but it *REALLY* *pissed me off*... like in an envelope that was about twins and things, and you couldn’t use them and kinda put salt in the wound ‘cause I think birthing centres like that are a really great choice for people... but to be made to feel like, “why are you *demanding* [hospital], go use the birthing centre when we won’t *LET* you.” - *Michelle*

Choosing the location of birth in any situation outside a narrow perceived norm is out of reach for many women, and with the routinisation of medicalisation of birth (Skyrme, 2014) there is an incompatibility with neoliberal notions of choice and responsibility. Perhaps with the over-inflation of risk, the routinisation of interventions in birth makes the neoliberal notion of having the power to choose highly contested. Birth place choice however is not neutral but rather it is both material and political (Davis & Walker, 2010). While birthing centers are well established in New Zealand, where there is high risk, biomedical and therefore biomedical discourse and locations dominate and alternative constructions are marginalised. In this way, the hospital setting does not support constructions of the maternal body as competent, nor the woman an active participant. “Normal” as defined by women and midwives includes pain relief, for example, (Darra & Murphy, 2016), however only minimal options for pain relief are available within birthing centres. Birth location is polarised through risk.

**“All that matters is a healthy baby”.** A common construction that many women hear during their navigation of maternity care is “all that matters is a healthy baby,” yet this is a focus on the foetus over the mother, and positions mothers as containers. If all that matters is a healthy baby, all babies with medical

difficulties or disabilities are rendered invisible or unacceptable. Often a healthy baby is not the only goal, and babies with physical or intellectual difficulties are valued members of families, communities, and society. It is possible for people with disabilities to lead long and fulfilling lives, and the way we speak about disability reflects a dominant discourse that reproduces the normal/abnormal binary.

Once foetal anomaly is suspected, often parents suddenly find their antenatal decisions becoming the first serious parenting decisions, particularly in terms of further testing or continuation of the pregnancy (Rempel, Gender, Lynam, Sandor, & Farquharson, 2004). Parents find themselves adjusting to the inconceivable, growing increasingly attached to the foetus, watching for and accommodating the unexpected, and encountering and dealing with new challenges (Rempel, Ravindran, Rogers, & Magill-Evans, 2013). Yet navigating a journey of a child with a congenital heart defect leads to the problematic negotiation of contradictory social norms, in particular dilemmas about termination and foetal personhood (McCoyd, 2007).

“they did a scan, and so she pretty much unofficially went through everything and explained to me what she could see on the scan and she presented the option that they would likely give me the option of terminating this pregnancy because the condition that [child] has is called a palliative heart condition so he will never heal from it, and we will always be maintaining him until he dies but it’s just there’s so little known about it ... we did have to do some research and make a good decision about it...” - *Natasha*

With the decision to terminate made available at later stages of pregnancy in cases of disability, this gives women the chance to make decisions they may not have considered previously, and as always a number of conflicting discourses contribute to these decisions. In particular, mismatches between uptake of pro-choice foetal understandings, and foetal personhood could lead to unexpected tensions in the case of termination due to anomaly (McCoyd, 2007). Ultrasound and prenatal screening of risk factors do not simply provide information, but constitutes a moral tension for women (Stephenson, Mills, & McLeod, 2017). Foetal anomaly invokes a particular tension between women's choice and good citizenship (Lee, 2000). Stephenson et al. (2017) argue that while foetal anomaly emerges within the context of the medicalisation of pregnancy, the ethical issues of termination become about women's choice and obscures the collective discussion between ultrasound and termination. The "apparatus of choice" (p. 78) through the normalised practice of ultrasound protects the institution from the politics of abortion and the ethical decision making becomes an individual responsibility. Here the enactment of biopower operates; screening for anomalies at a population level to identify health pregnancies become the responsibility for individuals.

"the process for me deciding whether or not I was going to terminate mainly rested on... I *had* an idea that as a parent I needed to give my child the best start and that included considering these things if I found that they were disabled while I was pregnant... and I think, in hindsight, if I'd found that out at 12 weeks, which I don't know would've been a possibility I might have terminated... but at 20 weeks, I was so far along ... it was all out there... you're already preparing for them, that it was much different point of view. 12

weeks you always wait on tenterhooks till you get to that time, 20 weeks you're just about there so... I did think about it, I thought about it a lot... I think I gave myself a good two or three days... and the biggest scenario that went through my head about terminating was how I was gonna tell everyone what had happened so, when I'd see people that knew that I was pregnant and that I was having a baby, and they'd ask me how I was going, how I was gonna tell them that I was no longer pregnant. And that was the hardest part..." -*Natasha*

Research into the decision making and bereavement process of women who choose to terminate if their foetus has an anomaly found that women who were pro-choice struggled with the tensions between pro-choice beliefs and experiencing foetal personhood and the stigmatisation of abortion (McCoyd, 2007). The problematic positioning of women who desire a baby within the pro-choice and pro-life debates ignores their feelings of grief and loss of a healthy baby.

In making the decision relating to terminating a baby with a physical disability, giving a child the "best start" may take on a different meaning. This is embedded within discourses of the motherhood mandate, and influenced by the good mother imperative, neoliberalism, and mother blame. If it rests on the mother to ensure the baby has the best start, this shows the difficult positions taken up by mothers, after all, the responsibility for this does rest upon mothers, and the position of "good mother" becomes inaccessible for women making this decision either way, as to some, considering termination is enough to prove 'bad mother'-

hood, and for others, *not* considering or taking up termination also confirms them as a bad mother (Lupton, 2012).

Disciplinary power operates in such a way where women participate in self-surveillance. The potential of having to justify one's choices to others, particularly in such a morally divisive decision as termination, yet again positions women as responsible. With the uptake of ultrasound, we have the potential of learning about anomaly and providing options for women, but at a cost. As soon as the foetus is "seen", foetal personhood positions the foetus as a family member, and as the responsibility of the mother (Harris et al., 2004).

Previously framed as a matter of freedom, and a binary pro-choice or pro-life, the reality of abortion is far more hazy than is often framed in society. The current pro-choice/pro-life binary ignores sociocultural, economic, and social-responsibility issues (Borovoy & Ghodsee, 2012). It does not consider the lack of resources available to support a child with a disability, and given the difference in acceptability of abortion of societies where an understanding of social constraints in providing for children are more widely accepted and understood (such as Japan and Bulgaria), the approach to termination is less woman-centric (Borovoy & Ghodsee, 2012). Society accepts termination due to foetal anomaly within the biomedical model, yet foetal personhood and the differential valuing of fetuses with anomalies (Stephenson et al., 2017) carries the obligation for women to protect their child from harm through disability, and balance that with their social context where they fear social retribution (McCoyd, 2007). Ultrasound as the technology that identifies risk through medical scrutiny is not always precise – the procedure provides information on actual or potential foetal anomaly and the

decision about terminating the pregnancy is complex. The ethical issue here is that it is not always possible to obtain meaningful information about the “foetal anatomy that has been visualised and its implications for pregnancy outcomes” (Stephenson et al., 2017, p. 77).

“and then my husband goes to me {laugh} why don’t we just *not*... {laugh}... so after all of that it was as simple as that. It’s like why not just give it a chance? And if it doesn’t happen then it doesn’t happen, but why do we have to decide *now*. And I *should’ve* been thinking of *that* the whole entire time... I was worried about what people were gonna say... what I had to say to them when I explained it to them, and the reality is I didn’t have to make that decision, we could let nature take its course and see what happened so in the one sentence my husband had made a decision for us and a *huge* weight had been lifted and we just decided that we would go with it and see what happened... I don’t think we ever would have made that decision consciously so we were not going to terminate [child] at all, and we knew that he could come and he might not spend that much time but we were willing to take that risk and we were willing to give him that chance and we knew as long as he had some normal quality of life that we were ok with that and that was enough for me so my first job with being a parent and making sure that my children are able enough to enjoy their life. I think I have ticked the boxes in that regard so yeah. We knew that it would be ok, because there was a quality of life...” - *Natasha*

Changing from having to make the decision to letting nature take its course could be seen as a resistance to pressures to terminate or make particular expected decisions about the legitimacy of the foetus and of foetal intervention (Stephenson et al., 2017). Irrespective of the decision a woman makes, it is considered an individual choice, and any repercussions will remain the mother's responsibility in a neoliberal environment of mother blame (Mackendrick, 2014).

### **The Cascade Effect of Errors and Interventions**

Throughout the literature, a cascade effect of negative experiences and interventions were mentioned. Examples included arriving either too early or too late at the hospital (Eri, Bondas, Gross, Janssen, & Green, 2015) and administration of pain relief (Goldberg & Shorten, 2014; Stark, 2003), although much of the literature mentioned a 'cascade of interventions' in and of itself (Austin et al., 2008; Bryers & Teijlingen, 2010; Coxon et al., 2014; Jackson et al., 2012; Lothian, 2006; Malacrida, 2015; Parker, 2014; Surtees, 2010). This suggests that once one intervention occurs, the likelihood of further interventions being required increases. This is well enough known to feature regularly in both academic work, and in women's maternity stories, yet other cascade effects within the maternity system became apparent during the interviews.

“...my dreams were really crushed that I wasn't allowed to deliver the way I wanted to deliver... and wasn't allowed to have this perfect entry in the world for my baby[...]And so I felt like it had started with this lady, her mistake had thus led to all these other mistakes and because my labour was so fast, baby had come out and was in shock as well because it was so rushed... Where, had it

been different I would've had a slower labour and she wouldn't have been affected so I just felt like there was all these ripple on effects that had happened because of that one lady not caring for me properly." –*Anika*

Here, the cascade starts with maternity staff error or maltreatment, with many 'ripple on' effects cascading into a difficult experience for the woman. Women are aware of the benefits of hospital, while also being aware of the risks of being in hospital, such as risk of errors (Coxon et al., 2014), and of their choices being limited through biomedical discourse (Baker et al., 2005). Once the intervention begins, resistance leads to women being positioned as non-compliant and targets of judgment and misunderstanding (Dahlen et al., 2011). Resistance to the medicalisation of 'high-risk' birth tends to come from women who consider birth at hospital a greater risk than birth at home (Jackson et al., 2012). Yet in the biomedical system, resistance to medical discourse is considered risky and can lead to marginalisation of both woman and midwife (Noseworthy et al., 2013). Women are also known to be more alert to the benefits of their chosen birth place (home or hospital) and more aware of the risks of the other (Lee et al., 2016), which perhaps is amplified when the choice has been removed from the woman through her medical hospitalisation.

"... my midwife gave me pethidene which I had already decided ahead of time that I wanted to avoid interventions unless it was really necessary... and she just basically told me that I should have it and gave it to me... and I still don't know whether I really needed that, and I felt really out of it, and at the time it was like I just lost a

couple of hours there, but she had it in her mind that I wasn't going to last the distance or maybe it was just her routine thing..."- *Jane*

There is an incongruency between maternity carers' perceptions of the informed consent process compared to the experiences of women (Goldberg & Shorten, 2014), where maternity carers claim to have sought and obtained informed consent and yet women reported they did not want to "diobey their providers' request for a consent signature" (p. 148). The normalisation of intervention in maternity care has a coercive effect (Darra & Murphy, 2016). This is supported by literature where an increasing number of midwives in New Zealand consider any vaginal birth (except ventouse or forceps) as 'normal' (Lee Davis & Walker, 2011). Yet 'normal' and 'abnormal' are binary polarising terms (Lee Davis & Walker, 2011), and with midwives seen as guardians of normal birth, the redefinition of 'normal' as interventionist in women-centred care is troubling.

"and it was also her procedure... to bring in an obstetrician just in case I needed a caesarean, which I found really weird... like... she just wanted to be able to tick all the boxes and get everything out of the way... there was no indication that there was any likelihood that I would need a caesarean... [...] so there was no... reason to think that I was gonna need a caesarean but... when I'm all drugged up with pethidene and I could hardly even figure out like what was going on any more, she brings in this, obstetrician and like "I just want you to meet him in case you need a caesarean and you need to da da da da"... I don't know, I can't even remember what she said

because... even at the time I was thinking “why are you telling me this now?”” - *Jane*

Obstetricians’ understandings of the cascading of interventions differ from that of most midwives, with obstetricians not believing that epidurals given early in labour contribute to foetal malpositions, and believing that increasing caesarean section rates are a sign of improvement in obstetric care (Reime et al., 2004). With the administration of pain relief without informed consent, and introduction of the obstetrician with no apparent indication of need could suggest that the midwife subscribed to the biomedical approach to birth rather than a low-tech normal birth (Lee Davis & Walker, 2011). The routinisation of some of the more biomedical approaches to maternity care have also emerged in an environment of increased litigation as a way to safeguard against liability (Carolan-Olah et al., 2015).

In a biomedical discourse based on perceived risk, bringing in an obstetrician ‘just in case’ brings intervention into the forefront of normal care. Bringing an obstetrician in also places the woman under a medical gaze, and pregnancy and pathology begin to intermingle (Shaw, 2012). The decision to bring the woman into the medical gaze may be indicated in some cases, but when a physiological birth is progressing as anticipated, the indication is absent. There is also a suggestion of legitimacy of knowledge, with the biomedical knowledge belonging more in the hands of the obstetrician than the midwife, and most certainly more in the hands of both obstetrician and midwife than the woman. By “ticking the boxes,” birth again is placed in the realm of something that can be controlled and scheduled, increasing potential for coercion and and limits opportunities for resistance.

“LQ: with the pethidene... did you consent to that?...

Jane: I must have.... {laugh}... I don't remember... {laugh} I don't feel as though... I almost wonder whether we'd had a conversation about it previously at one of the later check ups, because she was definitely the sort of person who wanted to get all of her 'i's dotted and 't's crossed and her ducks in a row before the event and I remember having a conversation about possible interventions and we'd been to antenatal classes and knew what they were and they'd warned us carefully about the waterfall effect of when you start one intervention you're more likely to need another and that sort of thing so I was cautious about that and wanted to avoid as much as possible. And I'd said to her, I know we'd talked about how I didn't wanna have anything unless it was really deemed necessary... I don't remember having a conversation about it at the time, and when she gave it to me..."- *Jane*

Risk-focused maternity impacts birth planning, and while conversations may happen in advance of the birth, a sharing of information and gaining of informed consent or informed refusal does not always occur (Lothian, 2006). If women are fully informed of their choices, even if they make one that differs from the maternity carer, the decision is made by the woman (Lothian, 2006). Yet choice is an illusion inside a biomedical risk-focused maternity system, as even when ample evidence supporting birth planning is presented, caregivers often dismiss it in favour of a belief in the authority of the biomedical approach (Lothian, 2006). Caregivers' understandings of pain relief and coping with pain influence the way

they interact with the women, which can then impact women's right to choice (Lally et al., 2008).

The birth plan offers a unique chance to gain information and make decisions about pain relief, and an opportunity in the absence of labour to either work towards informed consent or informed refusal (Lothian, 2006), so a move from informed consent to informed *choice* (Skyrme, 2014) may alter the view of whose decision it really is. Thus legal and ethical understandings of choice and consent are problematic (Skyrme, 2014). If a woman is embedded in biomedical discourse, and subscribes to a view of maternity being a risky medical condition, she is more likely to take up pain relief, yet if a woman views maternity as a natural process, different ways of coping with pain may be preferred (Lally et al., 2008). A mismatch between a midwife embedded in biomedical discourse, and a woman embedded in natural discourse then becomes problematic.

"... she had to leave me and she said "look. I'll, I'll go and order you an epidural on the way out... you'll be fine. I'll send my back up in, you'll be fine." So *she* left... and apparently she ordered me an epidural but the *person* that she *told* was a lady that had had seven natural home births... and she came up to me and she said, "{condescending tone} um... I think that you don't need an epidural... I've had seven natural babies and you can do it. And so if I can do it, you can do it." And I was in such pain, I was at the point where I was just... I was over it. I was knackered, it had been two in the morning all the way through, it was all the way through that

next night, and it was like four in the morning... it had been nearly 24 hours and I was *exhausted...*" – Hannah

When a woman has taken up a position within a biomedical discourse, by choosing to have an epidural, a midwife embedded in a natural discourse then may affect her access to the epidural. Continuity of care is known to improve outcomes and experiences for women (Dahlen et al., 2011; Dahlen, Jackson, et al., 2011; Darra & Murphy, 2016; Schmied et al., 2011), and given lack of continuity of care with staffing changes throughout the birth, the woman's own needs are left behind.

"I kept begging *anyone* that would come and say "where's my epidural? *Please* can I have an epi- I'm *exhausted* I'm so in pain" and they'd say "well, the baby's fine you don't need an epidural, and... I'll go and see and I'll go check" and no-one would come back [...] I'm *so* in such *pain...* that a busload of people could come in right now and I just, I just don't care, I just want an epidural, but I felt like I was going to die" - Hannah

In holding the key for epidural in a system embedded in medical discourse, with the apparent focus on the needs of the baby, the woman herself is rendered invisible. The supposed needs of the "patient" within the woman (the foetus) come first before the needs of the woman herself. Thus the baby becomes the commodity, and the woman becomes the vessel (Raphael-Leff, 1991). The mother becomes a docile body subjugated to intervention. In a neoliberal world where all people are assumed to have agency, rights, and responsibilities, these are difficult to access for the labouring woman.

“‘I’ll just see how dilated you are’... {quietly} it was stupid me paying for-... and he clearly did a stretch and sweep and he kinda smugly said “there, that will kick things off”... and off he went and left me there alone [...] the obstetrician came in at one stage and I remember like, crawling backwards up the bed going “please don’t hurt me”, which was kind of ridiculous, to feel like that at that stage in the game...”-Michelle

Stretch and sweeps and other internal procedures being performed without consent was a common experience throughout conversations with women about their maternity experiences, and often they are performed under the guise of a cervical dilation check. Here, again, lines of consent become blurred. Once one agrees to a particular intervention (a vaginal exam), then within a biomedical setting, consent is not sought all other possible interventions from then on. Vaginal examination has become a taken for granted part of maternity care, and once access has been gained to the woman’s cervix, it becomes apparent that all further consent is not required within biomedical discourse. While refusal of internal examination has been linked to retraumatisation from previous sexual assault (Bailham & Joseph, 2003), and even when the discomfort and violation of internal examination is articulated by women, often women believe that it is a necessary (normal) part of the pregnancy and birth experience (Johnson et al., 2004). Women also are taught as good neoliberal subjects to take responsibility for violence occurring towards them, such as for their choice in maternity carer. If the choice is perceived to have been hers at the beginning, then what may flow on from there (whether it flows on from something she has chosen or consented to, or not) may then feel like her own responsibility within neoliberal discourse. An awareness of a

feeling of violation, having the ability to consider the event in hindsight, and taking the responsibility for the event upon herself then perpetuates shame and guilt for the woman (Lee, Scragg, & Turner, 2001). Feeling more afraid of the pain that an obstetrician inflicted during a non-consented procedure than of the pain that may come from birthing twins can highlight the severity of the violation of a stretch and sweep without consent and acknowledgement. Even in a situation where a woman is highly educated as to what is happening (“he clearly did a stretch and sweep”), the power still belongs to the person considered to hold legitimate knowledge and authority, in this case the obstetrician.

### **Birth in the Public Gaze**

“So I’m naked, get transferred onto the ambulance so the ambulance officers all come, and I’m just like “oh my god... my dignity’s *really* gone *this* time!” {laugh} and I’m freezing cold-, like I was *cold*... ‘cause obviously I’d gotten out of the water, hadn’t really dried myself a lot, and I’d only had the towels on and my bra and that was it. So for me I was just, I felt... horrible and then you’re sitting in your own... blood, it’s not a nice experience, and then you get transferred to the hospital and having to... {strong effort sound} like *lift* your bum up, onto the, the other thing”- Jess

The concept of ‘dignity’ during birth is often contested. We are often told to “leave our dignity at the door” during birth, yet the word ‘dignity’ could be synonymous with ‘privacy’. Loss of dignity and privacy can then be experienced as trauma (Beck, 2004; Ford et al., 2010), despite both dignity and privacy being a requirement of ethical care (Skyrme, 2014). When dignity or privacy was

mentioned by the participants in this research, it was invariably related to lack of continuity of care, lack of consent, and carers not performing the small tasks that make a big difference (such as handing the woman a facecloth, or a comb).

“we had so many people in there... ‘cause we had the obstetrician we had the two midwives we had the student doctor we had a paediatrician for *each* of the twins and I think a nurse for each of the twins as well? But anyway there were lots of people in there seeing all my bits but that’s fine, they ask permission for the student to be there and I was totally cool with that... but yeah there were lots of people...” – *Michelle*

The number of people attending births that are perceived as risky in a biomedical discourse show how embedded the biomedical model is in a risk discourse. Having many different staff attending a birth which often (as was the case here) are quite straightforward births places the maternal body yet again in the public gaze. Seeking permission from the woman for a student doctor to attend the birth, yet not seeking permission for the many other people in the room to attend shows an entitlement based on privileging biomedical knowledge.

Whether the woman wants to be observed by so many people is not something that is attended to, it happens anyway. By giving women no say in the process, our bodies yet again become an object, and we are stripped of the right to decide who sees it. The attendance of maternity staff appear exempt from any right of refusal by the woman. In a hospital environment where medical teams are available at the press of a buzzer, it would surely be in the best interests of women for the team to be limited to only the bare minimum of maternity staff actually

needed, and to have the people who *may* be needed available at the press of a buzzer if an emergency occurs, but away from the birthing space until that need arises.

The use of “all my bits” to describe genitalia also indicates an unspeakability about our own bodies. Women know our bodies, and our genitals, yet the ability and right to speak openly about our vulvas or vaginas is policed through internalised technologies of gender; we are taught that women do not speak of particular things openly (Braun & Wilkinson, 2001). The vagina has both material and symbolic meaning for women, and representations of the vagina as private, or absent in talk making it more difficult for women to claim our rights to our genitals and to keep them away from the public biomedical gaze. If genitals are unspeakable, then perhaps the legitimacy of ‘knowing’ our genitals then moves to the realm of the professional. The doctors assuming a greater understanding of our genitals (even though this is not the case) then also makes them available to the gaze, with little right of refusal. The vagina becomes another site of surveillance of the female body.

“I’d had like umpteen people look at me down there...”- *Jess*

The unspeakability of “down there” represents the vulnerability of women’s bodily integrity especially during childbirth especially where it is continually invaded by obstetrical procedures (Braun & Wilkinson, 2001). Kitzinger (1992) has argued that obstetric procedures such as episiotomy is a form of mutilation that leaves women feeling violated.

“And when they did send me to surgery, I got there about half an hour to an hour before changeover... so I had to *wait* for the changeover... so the doctor that had originally *started* my surgery... *left*... and I got *another* doctor so I didn’t know that I wasn’t getting this *other* doctor looking in me so by the time I got into surgery, I was on doctor number two or three, and then another four *guy*-, there was *guys* in there this time, it wasn’t just *women* nurses... not that it *mattered* cause they’ve seen umpteen vaginas already that night! {both laugh} It was just like, oh my god, another 10 people are looking at me down there. It just was like... “ugh! when will this stop?!”” - *Jess*

Continuity of care is known to be an important factor in ensuring women receive the care they need, and facilitates women’s informed choice (Dahlen et al., 2011; Dahlen, Jackson, et al., 2011; Darra & Murphy, 2016; Schmied et al., 2011), and given lack of continuity of care with staffing changes throughout the birth, particularly when doing an intimate examination increases women’s vulnerability. The medical/male gaze compromises women’s bodily integrity, our vaginas are not ‘normally’ accessible to all.

“But they say it all goes out the window but I don’t think that it *should* have to go out the window, at the end of the day if I don’t want my boob out, I’m not gonna get it out so like, yeah... I think ‘cause they do it all the time it becomes natural to *them* but for me it’s only my second baby so it’s not, ‘natural’ for me” - *Ava*

Within biomedical discourse, it is difficult for women to retain control over the birthing process and therefore their dignity is compromised when they are positioned as the object of the medical gaze. It is widely reported that women emphasise the importance of care that does not expose them physically or emotionally (Widang, Fridlund, & Martensson, 2008). Given the social meaning of women's vaginas, women struggle to preserve their own integrity and are left feeling violated. Within the institutionalised birth space, dignity runs counter culture to current practices (Morad, Parry-Smith & McSherry, 2013). The reclaiming of our own maternal bodies by stating what we will or will not do (such as baring our breasts) is a way that women can and do resist the pressures of what is considered 'normal' within maternity. Individual needs of women and respect for privacy and bodily autonomy need to be considered throughout the maternity process.

### **When Things Go Wrong**

There is little research that considers women's experience of the period between a diagnosis of a baby's death in utero and the intervention. "Carrying death instead of life is beyond understanding" (Malm, Rådestad, Erlandsson & Lindgren, 2011, p. 51). In their study of women's experiences, Malm et al. (2011) found that the most common narrative was waiting in no-man's-land characterised by involuntary waiting, handling the unimaginable, broken expectations and finding the courage to face life. While the death of the baby was confirmed through ultrasound, the women felt located outside the normal into the unrecognisable where they were left to their own devices, and were unable to make decisions about the induction process especially where biomedical authority is not responsible for the emotional needs of the mother (Kelley & Trinidad, 2012).

Gender politics organises how society understands stillbirth (Cassiatore & Bushfield, 2008). Handling the unimaginable in the space between the ultrasound and induction required a performance of gender, and is complicated through social relations where the profundity and significance of the loss is marginalised (Conry & Prinsloo, 2008). Layne (2003) argues that negative reproductive outcomes of women are marginalised through dominant discourses of the inevitability of motherhood. At the very moment of diagnosis, a woman's identity unravels as a mother (Cacciatore & Bushfield, 2008).

“... it was really weird experience because you're so used to everyone in the room when you're having a baby being quite jovial... but everyone was so solemn and quiet... and I remember a few times I tried to get people to laugh 'cause I'm that kind of person, like even though I was going through *hell*... I still didn't want all these other people... to be... hey, you guys should be trying to cheer me up like.” - *Charlotte*

When the inevitability of motherhood goes wrong, women are often subjected to stigmatising silence, and a hegemonic narrative of happy endings positions women as responsible not only for their own grief, but also for the care of others (Layne, 2003). The experience of stillbirth is deeply embedded in discourses of motherhood and individual responsibility requiring women to renegotiate their identities as they avoid stigmatisation.

“And, trying to convince my mum, to wait... 'cause it was early hours of the morning at that stage and she was in [place] with my Step-Dad who was going through his own battles with cancer and

stuff... um, you know, just wait... go to bed... have a sleep... drive in the morning ... don't come now... but, just thinking 'I just need my mum', like all I wanted was my mum." - *Charlotte*

To have a baby die is such a profound loss that many women do not have the language to speak about it and in the gap of loss, women become isolated. The silence is reproduced through social relations where others do not know how to respond. When stillbirths are unspeakable, mother's feelings of grief are intensified. As Murphy (2012) argues, the dominance of the motherhood mandate means mothers who lose their babies not only suffer the loss of the baby, "but also [the position] of a moral mother, that is, mothers who are able to protect and nurture their baby" (p. 480).

### **Leaving the Emergency Decisions to the Woman**

"I said "nah that's it. You need to call an ambulance" and I *do* believe that they kind of *waited* for *me* to initiate that, when *they* should've... *I felt* that *they* should've done it as soon as *her* midwife came in *and* the other one came in... like, there's three midwives that should've made that call before I was bleeding 'cause by *then*... I'd probably bled about a litre already on the table, 'cause they kept counting. I remember seeing out of the corner of my eye one of them, she's like "well that's probably 250 and that's probably another 250", I remember them counting that while I was waiting for the ambulance..." - *Jess*

Considering how often a lack of *informed* consent emerged throughout this work, this account of an emergency due to an unnoticed 3<sup>rd</sup> degree tear and

subsequent haemorrhage helps to demonstrate how women are held responsible for the decisions that enable interventionist practices. Principles of autonomy, agency and the right to choice is not only located in medical ethics, but situated within women's social and cultural location. The neoliberal discourse of autonomy and agency can only be partial. With the normalisation of medicalised birth, women often locate health professionals as holding the key to safe passage (McAra-Couper, Jones & Smythe, 2011). The normalisation of the medicalisation of childbirth both constrains and regulates choice (Crossley, 2007).

The complex relationship between informed choice and consent where there is actual risk is problematic – especially where the focus on risk does not improve outcomes for women. While institutional control over women's birth experiences is undeniable, women are also located within gendered social power relations that discipline women and women's bodies also inform women's choices (McAra-Couper, Jones & Smythe, 2011).

“the doctor came in and did the surgery... or *attempted* to do *her* version of surgery, and she put in probably another few more stitches and put in probably another *ten* more jabs of local anaesthetic and I was like, “you need to send me to surgery I can't cope with this any more”... and I'd probably lost another litre of blood in that time...” - *Jess*

Control over the birthing process contrasts with the chaotic, unpredictable and messiness of birth, and the medicalised context is assumed to provide women with the control and predictability that interventions promise (McAra-Couper et al., 2011).

“I was freaking out I just felt like I was out of control and I couldn’t do anything... and I felt like they *always* needed my permission, I know that you’re supposed to get the patients permission, ‘cause that’s, part of what it is, but I think in those circumstances they need to have said to [husband], “Right! We’re going to take her to surgery “, ‘cause I wasn’t coherent enough to really know when to stop. You could see that I was in a lot of pain, you could see that I wasn’t coping... would you not think, “right, she’s not really with it, we’ll ask her husband ‘do you think she needs to go to surgery?’... not say, once I’ve said “stop! stop! stop!” umpteen times “ohh would you *like* us to take you to surgery?” you know? I felt that it was them just *waiting* for my call... I’d lost control... pretty much... is how I felt”- *Jess*

Choice is an effect of surgical procedures becoming normalised, and being in control becomes located at the site of women’s bodily integrity – the choice between an out of control pregnant body, or the technologically controlled body. Yet there is also a common thread of non-consent; when women ask maternity professionals to stop particular interventions and their requests are ignored or minimised a docile feminine body is reproduced.

### **After the Birth**

“... so I stayed down in delivery and had to wait for this drip and then during the process they were like “oh, do you want some breakfast, now?” and I was like, I’m absolutely starving but I feel like I’m in like the CSI TV programme there’s just blood

everywhere... they'd stuck a catheter in so I felt like I'm sure I was lying on sheets that I'd pee'd on... And there was blood everywhere and everything just *stunk* like it does after you give birth. There was like big blood clots on the ground, there was placenta just hanging out in a bowl on the side, and they were wheeling in a trolley for me to eat breakfast and I was like this just goes against *every single grain* in my body... of eating with blood around, and I wanted to vomit because that was so disgusting but at the same time I was so hungry that I wanted to eat everything on the plate... and so in the end I just gave in and I ate... I was *hinting* at them and it was funny, you'd see like nurses walk in ... and they'd just like walk in and just walk around this maze of blood that was on the floor and I was like "why is nobody cleaning the blood....UP! Like just get a wet wipe and just clean, like just pick the blood clot up at least", it's just, it was *so* disgusting..." - *Anika*

This excerpt has been incredibly powerful throughout the process of this research, and speaks directly to issues of cultural safety. Traditional Māori practices understand a pregnant body as tapu in order to protect both the mother and her unborn baby. According to Te Huia (2015 ) following the birthing process, all bodily fluids should be appropriately destroyed or buried and this becomes a marker of the completion of the tapu process, where noa, or the ordinary is returned. The concept of tapu and noa is important to Māori cultural safety and govern health and hygiene practices. Offering and eating food are often used to remove tapu from all those connected to the birth. Where food is placed in the same location as blood or bodily tissues not only breaches standards of hygiene,

but also cultural knowledge. According to Barlow (2001), “food should not be eaten in the birth environment” (p. 16) as authorised through midwives standards of care. New Zealand midwives are required to take particular responsibility for meeting the healthcare needs of Māori women through a partnership that is culturally safe for women and their whānau. Such a partnership should acknowledge and protect Māori customs and knowledge of pregnancy and childbirth (Kenney, 2009). Where the relationship of tapu and noa is not restored, the normality of noa is difficult to achieve. In the following excerpt, the return to normal requires a particularly long cleansing, that functions to discursively and literally cleanse the body of reproductive ‘dirtiness’ to achieve socially (moral) reproductive normality and motherhood.

“... I finally got to have a shower and I was just in there for at least an hour... and they kept coming in and checking on me because they thought I was fainting again... but I was just like, “nah nah nah I need to get clean”. I just felt so dirty and I think I also felt dirty from this three week, four week process of being in hospital and I felt it was more like a ceremonial thing rather than an actual physical process of getting clean... I just wanted to wash myself of all the trouble and all the pain and all the sadness and I just wanted to sit in the shower and have everything wash away ...” - *Anika*

## **NICU**

“I just didn’t want to learn it. I didn’t wanna learn how to express. I don’t wanna be here expressing just give me my baby and let me *feed her!*” - *Anika*

Breastfeeding in contemporary society is embedded in ideologies of motherhood, and neoliberal responsibility where women are positioned as having the moral and social responsibility for managing risk (Knaak, 2010). Infant feeding can be a minefield of various conflicting discourses and desires, and when mothers are regulated by a third party such as NICU, a conflict is evident between biomedical discourse and natural mothering discourse. Sweet (2007, p. 13) found that women with babies in NICU struggled with their continued desire for breastfeeding to be “natural and satisfying” and the experience of expressing their milk. Women’s desire, embedded in a good mother discourse conflicts with the requirements placed on mothers in NICU (Sweet, 2008), who position women as unable to risk manage effectively without medical intervention. Women, whose newborn babies are admitted to NICU, struggle with the intense emotional care work as they attempt to become ‘real’ mothers where breast is best. Therefore, expressing breastmilk is a site of conflict, where expressing was not by choice, but rather a necessity of the choice of *wanting* to breastfeed (Sweet, 2008).

“I’d had these 40 week babies beforehand who were fine with just drinking little bits of colostrum for the first couple of days and my milk had come in, and then all of a sudden I had this premature baby that wasn’t allowed to... to starve, almost ... she HAD to have this amount of formula and she HAS to put on this much weight every day and if she doesn’t then we have to up the formula and... it was all very controlled and... I just didn’t like it. There was nothing natural about it...”-*Anika*

The good mother discourse also operates through the health of the baby. Good mothers “are seen as having babies who gain weight” which then coerces women into expressing milk to avoid accusations of not providing enough sustenance for their babies and being positioned as a bad mother (Johnson, Williamson, Lyttle, & Leeming, 2009, p. 904)

When the process of becoming a mother is constrained within a medical environment, the transition is unlikely to be experienced as satisfying especially where the institutional culture does not support a mother’s identity as a socially produced good mother. Where the focus of the medical care is on the baby exclusively, mothers are not able to experience the sensation of physical closeness and experience a sense of powerlessness against the institutional authority can lead to a sense of failure. In their study, Flacking, Ewald, and Starrin (2007) found that women with babies in NICU were unable to live up to the expectations of being a good mother, and were unable to articulate how they felt for fear of being positioned as socially inappropriate leading to a sense of shame. In this way, NICU presents the conditions of possibility for good mothering – it becomes the regulating authority for supervising the “conduct and activities of each individual in order to assess, judge and evaluate their performance” (p. 2414) and mothers either fail or succeed the constraints of the institution.

The conflict between medical and natural creates pressures for women that are impossible to meet, as meeting the requirements of good motherhood are unattainable in this situation.

“I just sat in the chair next to the babies most of the time... and I’d either read or just watch them or do their cares ... but... I wasn’t

really allowed to *touch* them or *hold* them or anything for a while [...] it just felt to me like they called the shots and you don't *HAVE* a choice up there, you know, you don't. You don't get to tell them how *you* feel or what *you* want... 'cause it's *their* profession, *they* know better..."-Hannah

Again, the role of the mother within NICU is not one of autonomy. The control held by NICU through its embeddedness in biomedical discourse removes agency from mothers, and limits mothers ability to form a desired relationship with their babies. By doing cares (as authorised by NICU staff), but not being allowed to hold or touch babies, women are reproduced as docile bodies. Mothers' knowledge in this environment is illegitimate; the only legitimate knowledge comes from the 'expert' staff who "know best". Yet, with the disregard of the natural discourse within the biomedical environment of NICU, women are rendered invisible, and their babies become commodities.

"I felt like they were *not* my babies they felt like the NURSES' babies. Like they would say, "*you* do this, and *you* do that, no *don't* touch that, they *need* this" and they'd siphon the milk, pull it back out, have a look how much they'd digested, squirt it back in... heel prick *over* and *over* and the babies would *cry* like their, poor little feet were just like *ribbons*... and it just felt like they were just doing *whatever* they wanted, to *my* babies, and I was just a spectator.

- Hannah

Immersed in biomedical discourse, the position of having active agency becomes inaccessible to women. With medical staff saying the babies “need” a particular intervention, this also creates a tension between being a “good mother” and the biomedical model. If a “good mother” in a natural discourse is an intensive mother, yet the actions that an intensive mother must take up are inaccessible to her, and the knowledge of the biomedical model is considered the only legitimate way, women’s maternal identity is regulated, and she becomes a spectator.

The birth of a baby with a medical impairment goes against the dominant cultural ideal of birth as a ‘happy event’. Among the participants, there was an interesting difference in care when one mother was enabled through the medical system. Being able to have access to her son was not solely immersed in maternity discourse; Natasha’s son has a congenital heart condition, so he was in the care of paediatricians, and thus outside the maternity (and NICU) scope.

“they gave me open opportunities to him so I never felt like I was not *allowed* to be with him, so there was *nothing* to regret in that scenario” - *Natasha*

I wonder if this solitary case of becoming enabled due to different power dynamics within a non-maternity environment? Given that the risk to a child with congenital heart disease is likely different to many children born a few weeks early (and arguably, the risks for children with heart disease are much greater), the contrast for this participant was clear. The junction between maternity and pediatric health opens up a site where newborn babies and mothers may be differently constructed. Little research has been conducted on women’s experiences of maternity and children with birth abnormalities, however it is well

documented that mothers experience distress and hopelessness arising from giving birth to a child with an impairment. In this narrative, a baby born with a health impairment assumes the position of burden of care, and mothers are constructed as daily survivors (Vehkakoski, 2007). The interaction between the medical professional and the mother is taken up in this participants account as her responsibility, the good mother becomes attuned to the movements and flow of information.

“I guess I’m quite respectful of the doctors and stuff and I’m very present when I’m there and I’m there at *all* the right times and I observe all the stuff that is going on so I *knew* when the rounds were, I *knew* when the changes were happening, I *always* made sure that I saw the nurses off as they went and greeted the new nurses and stuff when he was there ... ‘cause I got to stay at [hospital] the entire time he was there so I could *be* there at these times and I made sure I *was*...”- *Natasha*

Taking up the position of responsibility for the burden, this participant meets the criteria for a good mother of a baby who is constructed as the object of medical assessment and treatment. By gaining knowledge of the biomedical model and how it works, the taking up of required ways of being a mother within the biomedical system enables access where more overt resistance may actively prevent it. By quiet observation, knowledge of the system is gained which then enables the woman to gain the respect and support of maternity staff, and perhaps make it evident that she was able to fit into their particular framework as an

apparent docile body (yet, an active participant at the same time). In this way, women may visibly comply to the authority of biomedical discourse as a form of resistance. Being able to stay at the hospital for the duration is at odds with what happens with babies in NICU, where women are sent home as soon as they are personally discharged from the hospital. In her research on the discourses used by professionals working with neonatal impairments, Vehkakoski (2007) found that professionals seemed to be more concerned with the parents of babies born with an impairment than about the children themselves, positioning parents as at-risk, reproducing such children as burdens for their mothers care.

### **At Home**

Legislative changes in Aotearoa New Zealand in the 1990s enabled midwives to take up the responsibility of caring for women under their own authority from pregnancy through to the post partum period. What was significant in these changes was the attention to continuity of care (Davis & Walker, 2010; Grigg & Tracy, 2013). However, there remains a hierarchy within the maternity system which means the relationship between midwives and mothers is not necessarily straight forward. When women find their experiences don't match their expectations, they feel unheard (Fenwick, Butt, Dhaliwal, Hauck, & Schmied, 2010). In this way, women become vulnerable to the constraints of motherhood as a natural and normal transition (Miller, 2002).

“my obstetrician’s midwife didn’t come to the hospital at all  
... they kind of forgot about me for a while ... she came once  
we were home but she was not particularly helpful. The

attitude was very much, “well you’re a second time mum so get on with it!” Never mind that it had been nearly five years and I had *TWO* of them and they were *littler* and *needier* than my first baby... but I ended up on antidepressants at about day four or five...” - *Michelle*

The care and support of women as they transition to motherhood has been studied extensively, from women’s experiences of the quality of care they have received from midwives, midwives understandings of their own postpartum care (Ellberg, Högberg, & Lindh, 2010; Fenwick et al., 2010; McLachlan et al., 2009), and the benefits of a midwife-mother partnership relationship that informs new Zealand’s midwifery practices (Grigg & Tracy, 2013). However, what constitutes care is often embedded in medical understandings rather than the cultural expectations of motherhood in women’s lives (Wilkins, 2005). For example, the six week postpartum care is a medical marker based on biological norms where it is expected that the uterus has returned to its ‘normal’ size (Simmonds, 2002) and as in pregnancy, the postpartum period separates mothers and babies. Where the transition to motherhood is understood as natural and normal, the experiences of mothers continue to be constructed as invisible, misunderstood and oppressed (Ashton, 2008). The positioning of women as natural mothers who are immediately able to care for their babies and therefore are fulfilled as selfless carer and nurturer (Choi, Henshaw, Baker & Tree, 2005; Woollet & Marshall, 2000) immediately able to care for their babies ignores the material reality of women’s lives and the culturally available discourses that construct their experiences. For some women, the

expectation that they should be 'up for it' meant that they were both unprepared for and overwhelmed by new motherhood (Choi et al., 2005).

In their efforts to achieve normality for themselves and their babies, women struggled with asking for help for fear of being revealed as abnormal, despite 'knowing' there was something wrong.

“when you don’t get a good doctor it makes it hard because I knew something was wrong with how much he was spewing... and when I went to the GP she made me feel stupid ‘cause she said “ohhh, this is your second baby, you should know this is normal”... {quietly} but it *wasn’t* normal...”- *Kay*

### **When Staff Meet Women’s Needs**

Research has shown that when midwives offer both physical and emotional support, and show an interest in the mother, then they were more able to process the birth experience (Dahlberg, Haugan, & Aune, 2016). One participant who had a stillborn baby had not yet met her midwife when the events leading to her baby’s birth occurred. Charlotte described the decision about her choice in midwife as the best decision that she had made.

“... it turned out that that was the best decision that I made because... even though I lost Beth and I hadn’t even met her yet, she still came around... and saw me, and supported me for the next few weeks after. Just like she would have... if Beth had lived.”- *Charlotte*

Acceptance of a woman’s own good choices (in this case, the choice of a particular midwife) enable women a sense of agency. Continuity of care,

particularly while experiencing the loss of a child, helps women to form a relationships of trust and therefore accept the expertise and advice of the midwives. Women have reported wanting to be able to have a conversation about their birth experience, preferably with the midwife who was present during the birth (Leap et al., 2010) reinforcing the notion that continuity of care is important for mothers. .

“but then come the time to, give birth she was amazing, she was so good, and then even afterwards, I started... what *now* I know was the start of mastitis ‘cause it was hot... I just rang her up and said this is what my symptoms were... [then at] five o clock in the afternoon she’s bringing me cabbage leaves that *she’s* gone and got from wherever, and some pills to get me started and the script so I can go and get it the next day but she said “start these now” ... just little things. That’s fantastic to me, I thought it was just really great...”- *Ava*

When midwives are attentive to the emotional and physical needs of the mother, women reported feeling less vulnerable to the challenges of mothering and the start of breastfeeding. Breastfeeding occupies a particular space in the relationship between state and individual moral responsibility that operate through technologies of normalisation. While the women in this study attended to the knowledge and expertise of medical discourse, as they began to transition into motherhood, they were also able to take up advice that was “idiosyncratic, personal opinion” women’s knowledge. In this way, midwives were attributed with having a “third kind of knowledge” (Murphy, 2003, p. 452).

## Feeding

The extensive research on breastfeeding is embedded within medical literature, and as a public health concern that focusses on the economic and political 'breast is best' moral ideology (Wolf, 2011) that operates on women's bodies through a productive discourse which positions mothers as machines (Crossley, 2007). Crossley has argued that the medical model's maternal gaze both undermines and alienates women from their own bodies and the unacceptability of women's bodies in their natural state produces modesty that oppresses women's bodily functioning. Biological naturalness which underpins the medical model excludes women's experiences of affective embodiment reducing breastfeeding to 'facts'.

"Ohhh... I'm not a very, open person so when you're breastfeeding and they kinda just... {indicates grabbing boob} {both laugh} get right in there and you're like... "that is *my* boob!" {both laugh} ... "that is not your boob!" I know *they* see it every day but I could never breastfeed in public or anything I'd always cover myself up and for someone to kinda just be *holding* your boob and helping your child's head it's just like... {sound of discomfort} ohhhh..."- *Ava*

Within medical discourse, women are expected to manage the scrutiny of their breasts and breastfeeding therefore presents a precarious site of boundary transgressions (Ussher, 2006; Wall, 2001). Within biomedical discourse, women are not "allowed" to have private bodies in maternity. The public accessibility to women's breasts while learning to breastfeed assumes that exposure within both a natural and biomedical discourse is normal except that this is at odds with

women's own experiences of normality or bodily agency. When a mother experiences difficulties breastfeeding, interventions by midwives become prioritised. In the following extract, the notion of a baby's 'failure to thrive' reproduced a conflict between the moral imperative to breastfeed, and the unattainability of the ideal image of a natural mother.

"when it came to recording the baby's weight, she made a transcription error, which caused another little flow on effect of problems because she wrote it down as ... she was born at 3.57 kilos... and she wrote down 3.75... {LQ: groan} so then 24 hours had passed it appeared that she lost more than 10% of her birth weight or whatever their figure is... so, at that point the midwives at [birth centre] became concerned... they *were* a little bit confused because she didn't appear dehydrated... or not dehydrated enough for that to be right... but it was their suggestion that they start giving her a bit of formula as well... and I was happy enough with that... I already had some concerns about breastfeeding because both my mother and sister hadn't breastfed successfully..." - *Jane*

Breastfeeding being constructed as either a success or a failure shows how the natural mother discourse assumes that a woman who is unable to breastfeed is a failure (Crossley, 2009) is achieved through the medical gaze. The reliance within the biomedical system of norms and charts based on population level perceived risk factors also is further evidence of biopower operating in the maternity experience, and the embodied subjective experience of the mother is overlooked. Because breastfeeding is intimately connected with the natural mother discourse,

it has become a moral imperative, so when breastfeeding does not meet expectations, women blame themselves.

“... when you’re having trouble you’re like, “am I having trouble just because I don’t have enough milk or am I having trouble because I have these negative preconceived ideas and I’ve willed it on myself?”” - *Jane*

Within a neoliberal framework, the responsibility for one’s own body lies with the woman herself, and this leads to the assumption that if there is difficulty it must be the woman’s fault; she must be physiologically defective, leading to mother blame. Natural mother discourse has also been taken up by women who engage in long-term breastfeeding. However, medical discourse assumes that the benefits of breastfeeding are achieved by 6 months, and women who continue to breastfeed become socially sanctioned (Rempel, 2004). The good mother discourse is problematic for these women, they are both affirmed and marginalised according to various risks, on one hand their marginal position is affirmed through mobilising scientific knowledge of nutrition, and on the other their long term practice risks exceeding socially sanctioned norms of motherhood (Faircloth, 2010).

“when I went to see my obstetrician you have to fill in a history with your previous pregnancies... and how long they breastfed for and I put 51 months and they were like {laugh}... “{Macho condescending voice} Didn’t want to give it up, huh?! {condescending laugh}” ... yeah....” - *Michelle*

Motherblame operates through the moral imperative (Crossley, 2009) of breastfeeding, and it is evident that there is immense pressure on women to breastfeed as a marker of their maternal worth, but it is time limited. Breastfeeding for “too long” becomes scrutinised and sexualised through the male gaze.

Again, the expectation that solutions to difficulties such as breastfeeding lie with the mother herself brings additional neoliberal responsibility to the breastfeeding experience. The huge emotional impact of societal pressure and expectations by others and by oneself emerge in media accounts. According to their study, Henderson, Kitzinger and Green (2000) found that despite medical discourse supporting breastfeeding as having the best health outcomes for babies, the mass media does not promote a positive image, reproducing the lack of visibility for breastfeeding women. Indeed the normalisation of breastfeeding is contested in media representations and bottle feeding is presented as less problematic and associated with ‘ordinary’ families, and breastfeeding is associated with middle class and celebrity women. Research has shown that despite the moral regulation of women and breastfeeding authorised through medical discourse, feeding infants formula milk is a common practice, with 90% of women in the UK wholly or partially using formula (Lee, 2007). It appears that despite formula feeding being ‘normal’, women experience it as an act that “compromises their identity as ‘good mothers’” (p. 468).

“I don’t know what will happen when my kids have babies but I’m really gonna tell them, if you have to bottle feed... don’t feel bad about it. {laugh}”- *Jane*

Contemporary discourse of intensive mothering constitutes good mothers through medical, parenting and the state authority so much so that choices for feeding has become discursively suspect (Lee, 2008).

### **Mother Guilt**

Maternal guilt has become so pervasive in Western culture that it has become naturalised. Research that has focussed on motherhood has found guilt as the most prevalent experience for women, since Rich's early research in the 1970s that claimed the feelings of powerlessness, responsibility and judgements of mothers inevitability leads to the affective embodiment of guilt and is inescapable (Sutherland, 2010).

“Welcome to mummyhood, here's your guilt” - *Michelle*

This excerpt sums up succinctly how becoming a mother is embedded in various discourses that all lead to mother guilt or blame. The motherhood mandate constitutes good mothering as child-centered and time-consuming, and the discourse of intensive mothering positions mothers as ‘all giving, all present’ so much so that the identity of a ‘good mother’ “surpasses all other identities” (Sutherland, 2010, p. 312). The commodification of the ‘good mother’ who is expected to balance expert advice, including breastfeeding, economic stability and access to career goals are often conflicting, leading to uncertainty and guilt (Arendell, 2000; Sutherland, 2010).

“so yeah that side of things, becoming a mum is a *huge* thing and just the *juggling act* of being a mum... a *working* mum... and then a wife... and everything that goes with it, is *so* demanding and so challenging, and I do believe society does put a big pressure on

women, returning to the workforce... or not having the money to be able to do things... that's a *big* factor obviously for a lot of people and some people *can* cope with having no money... but we still like to live a little bit comfortably and we still like to go and have a party and go on a holiday or go away for a weekend, we'd still like to be able to do that..." - *Jess*

With the pressure to both take care of mothering and work, women are required to negotiate a space of needing to perform both good motherhood and work success, and in order to meet the requirements of "successful womanhood", a woman must embrace motherhood as central to her identity, and also seek paid work (Kahu & Morgan, 2007b). The contradictory nature of these discourses renders motherhood and work as competing discourses. Both are expected, but whether both can be met to the level of societal expectations, to take up a position as "successful women" is less clear to navigate.

Women in high-level corporate positions show a concentrated version of being required to perform successful womanhood through juggling work and motherhood. Representations of women who 'successfully' combine motherhood and work, have become a marker of egalitarian discourse, and due to the visibility of these women, choice rather than the limits and conflicts of the motherhood mandate is often applied to women in general (Allen, French, & Barnett, 2016, p. 63), where women can "have it all".

"so though I knew I wanted to have kids... I couldn't really imagine beforehand what that would really be like, and when my first one was born, I really remember often sitting there holding her

thinking... {long pause} {crying} "What have I done?" Like... you just care about them so much that you think... I've just opened up a whole bunch of ways to be hurt that I didn't know, 'cause if anything happens to her... it would devastate me... and I still feel like that now. You get used to that feeling after a while but for so long I was like oh my gosh, all those things that could happen to her like... right from the threat of cot death or whatever, some sort of horrible disease or something when they're little and then like but, then your mind starts going to if they get bullied at school or some guy does something terrible to them and breaks their heart or, worse they get mugged or attacked or... just anything, your mind starts going through all these things that could happen in their life that, that you may not be able to do anything about, and that how... I would be more hurt... about things happening to them, than you would be if it happened to yourself? ... {continues crying} I'd put that away, but I remember *so* intensely I can't even stop the emotion... " – *Jane*

Neoliberalism, with an emphasis on risk management and social investment, has seen the expansion of intensive mothering discourse as necessary to children's future intelligence and success, and therefore children become investments (Wall, 2013). Feelings of guilt and the desire to be a good mother becomes constituted through risk of potential as opposed to actual harm to the child, for which mothers are responsible. The pressure of the overwhelming role of motherhood in neoliberal society places mothers in a precarious position of uncertainty.

Not all women experience positive experiences of motherhood, and experience feelings of being overwhelmed, stressed, anxious and so on, and at the same time struggle to fit into the discourse of the good mother. When their expectations don't match the dominant discourse, women often take responsibility for their failure. The conflict between expectations and materiality has led to the pathologisation of women as suffering postnatal depression (Nicolson, 1999).

"I should be able to *do* this! This is what women *do!* {laugh} Women have babies! Why am I not coping?" ..."- *Rose*

The assumption that motherhood is natural has led women to struggle to fulfil their desires to become good mothers and consequently, mothers' whose experiences do not meet the cultural norms become hesitant to disclose how they feel or how to get support, often through the embodiment of guilt, shame and perceived stigma (Kauppi, Montgomery, Shaikh, & White, 2012).

"I think even when I recognised that something wasn't right, I didn't know where do I go to get help? ... *can* I even go to get help from somewhere? ... Do I need to go and contact a therapist, and is that something that I'm going to have to now somehow fund and also the stigma of... I've got a mental health issue here... that part was really hard to... and I never *went* to a mental health professional for help... and then I got through it and then I didn't *need* to... but at the time I wouldn't have even known where to start... where do I go for help..."- *Rose*

Kauppi et al. (2012) found that women who were overwhelmed by the experience of motherhood understood their vulnerability to professional discourse and feared they would be judged as “bad or unfit” mothers and become positioned as “crazy” (p. 58). Women who fear the social repercussions of ‘failure’ can become trapped within their experience as they strive to position themselves according to social and cultural expectations. In the following excerpt, the moral imperative of a good mother who places the needs of childcare above paid work is resisted. The ‘choice’ to return to work became necessary to her well-being. In Braun, Vincent and Ball’s (2008) study, women who returned to work found their wellbeing was enhanced when they were able to separate from their identities as mothers.

“... so for me to return to work it was more a little bit about my sanity... because I was going insane at home... [...] so for me it was like *my* down time, that was *my* world to shut off to... so for *me*, it was important for me to go back to work... because if I *hadn't* have gone back to work... I *do* think I would've gone into a *darker* hole. I *was* heading that way... [...]but not even really my close friends knew how I was feeling... until I had a meltdown... {laugh} and then they actually knew... like yeah so you *can* pretty much do a good front, for your friends and family about what's gone on and, the changes that you've experienced ... and what society portrays it to be.”- *Jess*

Returning to work offers a space in which women experience a position through which they find it easier to cope “against insane odds” and embody feelings of being “much more like themselves” (Braun, et al., 2008, p. 538). The competing

discourses of a good neoliberal worker-citizen and good mother render choice as a moral contradiction. According to Kahu and Morgan (2007b), New Zealand mothers are faced with both conflict and constraint embedded in social policy and cultural discourses of motherhood as they negotiate the power of intensive mother discourse and their identities as worker-citizens, and resolved the contradiction by constructing 'good mothers' as needing time away from their babies. The desire to be in paid work for women's own sake is not always attended to, and a contradictory experience occurs when a desire to be in work for one's own sanity is discursively inaccessible.

### **Cultural Specificity**

The importance of understanding culture as a major influencing factor for experience within a Eurocentric maternity system offers another avenue to unravel social power relations. I remain troubled that in this research I have struggled to bring the specificities of Māori experiences to the analysis. This is in part because the analysis has attended to the gendered social power relations that permeate the maternity experience that is always already Eurocentric. It is also partially because the temporal narrative of the maternity experience is legitimated through medical, and universalised discourse. It is also partially because there were many shared experiences among the participants and to mark particular experience as ethnically different would be to reproduce cultural specificity as 'other'. Because the delivery of maternity services in Aotearoa New Zealand are embedded in the hegemony of the health system, maternity care remains ethnocentric. Despite calls for cultural safety in midwifery education (Ramsden, 1997) cultural inequity is systemic.

Kaupapa Māori research has identified persistent inequalities in maternity services for Māori (Lawton et al., 2013; Makowharemahihi et al., 2014; Ratima & Crengle, 2013). There is an assumption Māori women are failing to present to antenatal services. Rather than understanding Māori as a non-presenting group, and therefore responsible for 'poor' outcomes, Makowharemahihi et al. (2014) argue that systemic barriers at multiple points of contact and fragmentation of services led to Māori women receiving inappropriate maternity care. "The current model of maternity care disempowers young women by failing to provide an appropriate level of access to maternity care, and then blames them for not accessing care' (p. 58). Ratima and Crengle have argued that while barriers to access of maternity services impact on inequities in birth outcomes, Māori women also face barriers to information to make informed choices, and experience inadequate access to culturally responsive care, including whanau-centered services and a lack of Māori midwives. Together these barriers produce multifactorial and cumulative inequalities (Ratima & Crengle, 2013). By ensuring cultural needs are considered and provisions are available, the impact to families can be enormous. While midwives hold particular knowledge of the normality of pregnancy, for Māori, the embodiment of knowledge is accessible through whakapapa, and this understanding suggests that "embodied changes or patterns is not discrete to women or midwives" but rather through whanau, and in particular kaumatua who are the guardians of cultural knowledge and traditions (Kenney, 2011). It is through these whānau narratives, that ritual, and spiritual knowledge come to be necessary for Māori women's wellbeing.

"so with [baby's name]... after his hard night in the PICU before he had his open heart surgery we actually contacted the Kaumatua at

[hospital]. Gosh I think my husband must've rung them at like 5am in the morning trying to get someone to come in and give [baby] a blessing before his op and that was something... I don't know, at the last second we kinda thought we really should do this, because we're not *hugely* spiritual people but, it *felt* like we needed to do something... and it felt really good to do it and we were really lucky that they came up to see him at like, it must have been 7.30, and come and do the blessing and it was *huge*, it was really *huge* for us, we've never actually done it again... maybe we never thought, since we thought that could've been the one time we could've lost him, and we've never really felt that... *helpless?* [...] and we were very *lucky*... that the services were there... and that they were so readily available because you would never think that you could get one at seven o'clock in the morning, but, we did! So, that was one of the best things. I think we would've really regretted it if we *hadn't* managed to get it sorted, and we were very lucky that it happened, so spiritually that was *huge*..." - *Natasha*

While in the above excerpt access to a Kaumatua was accessible, it was not practiced as a necessary part of maternity care where a partnership between midwife, women and whānau is assumed to be continuous. By embracing whānau centred care, some inequities may be addressed (Ratima & Crengle, 2013). Whānau knowledge is also essential to decisions that are made about the placenta. For Māori, understanding whenua requires whakapapa knowledge; the placenta (whenua) links the nourishment of the baby to the land (whenua) and therefore it

is often buried on ancestral land (Abel et al., 2001; Noseworthy, Phibbs, & Benn, 2013).

“the placenta side of things because both of our children we’ve kept our placentas... and they’ve been buried at our urupa, ... with [husband’s] twin brother... but that side of things keeping it and putting it in a nice box I thought that was very respectful, like they treated *that* aspect of it ... I thought respectfully... more so than anything”- *Jess*

In their research on the relationship between women and their midwives, regarding the decision for the management of the placenta, Noseworthy et al (2013) found that women often experienced uncertainty. In the above excerpt, the experience felt respectful and was attributed to a particular midwife. However the experience in the institution itself found that practices were inconsistent. For example, in the excerpt below from the same woman’s interview indicates that cultural inequalities abound.

“Of course [husband] had to wait around the corner, and then *he* felt like *he* was being treated differently, *I* believe because of his skin colour... and then when they saw that his wife was Pākehā it was a different kettle of fish, like they were always “I can take the baby if you like?” [husband] felt like “this is *my* child, I *can* look after *my* child I have got *another* child at home” ... but he felt like he was being judged in a way. And, he didn’t like that at all. He didn’t like that at all.” - *Jess*

A lack of cultural responsiveness within institutional practices is known to contribute to maternity inequities (Ratima & Crengle, 2013). Māori can find themselves treading a line between Eurocentric biomedical understandings of health and wellbeing, and maternity and mothering (Abel et al., 2001). Like Māori, Pasifika migrants in Aotearoa New Zealand also embody whanau knowledge in maternity practices, while also embedded in Western biological understandings of maternity care. Traditional practices were found to be important to immigrant mothers, however New Zealand raised Pasifika women sometimes experienced conflict from their elders who thought they were too influenced by Western understandings. In their study, Abel et al. (2001) found most Pasifika women acknowledged the “symbolic” importance of the placenta and umbilical cord which was either buried or disposed of in the sea (p. 1141).

“the only thing they really do is... we don't keep the placenta ... the bit of the umbilical cord that comes off later on? We bury that, because for them, that was what was connecting the mum to the baby... and they say for like Māori that was what was keeping the baby alive the placenta but the Samoans bury the little belly button umbilical cord because that was what connected the mum and the baby together, which I think's quite nice” - *Ava*

The importance of understanding cultural specificity is important here. The Samoan custom of burying the umbilical cord to symbolise the connectedness to the mother enables a respect of distinct cultural practices in maternity relationships that are wider than the midwife/mother dyad. Transgressing the cultural protocols that are necessary to the health and wellbeing of women and

their children goes against the guidelines for cultural safety in the practice of midwifery in Aotearoa New Zealand.



## **Chapter Four: Conclusion**

The maternal body exists within a contested space; just as the maternal body provides the nurturance and detoxification/waste removal roles for the foetus, it is also the site of the hopes, expectations and demands of society (Raphael-Leff, 1991). At a time when a woman's body is at the mercy of another being (the foetus), society looks through the woman herself to the child, and the woman becomes translucent; visible only as the maternal body relates to her connection with the foetus. The foetus then emerges as a symbol of the performance of femininity. A pregnant woman represents the enactment of her biological sex, and is subjected to disciplinary power that acts on the actions of the gendered body. The regulation of maternity is embedded in multiple and competing discourses that normalise maternity and alienate women from their own bodily experiences and this is especially so in the complex relationship between biomedical discourse of risk and women's embodied knowledge.

The analysis showed that disciplinary power within a neoliberal political landscape in Aotearoa New Zealand impacted on women's experiences, particularly where the active role of neoliberal subjects extends medical interventions into the everyday lives of pregnant and postpartum women. For example, the internalised 'truth' of medical knowledge was evidenced through women's engagement with ultrasound to confirm the reality of their pregnancies rather than trusting their own knowledge of their bodies. Within a biomedical discourse, further avenues of power relations open up and enclose women. With the advent and almost universal uptake of ultrasound, the metaphor of pregnant women being translucent becomes a reality; the woman is not only looked

through, the image is displayed beyond the limits of her body. The commodification of women's bodies and simultaneously foetal personhood is reproduced through ultrasound tourism. While the uptake of ultrasound was mostly experienced as a positive practice, the meaning of the scan exceeded medical aims and was more associated with social meanings related to the women's pleasures of 'seeing' their unborn baby, and affirmed their position as good mothers. The power and influence of obstetric hegemony within institutionalised maternity care acts to control, discipline and disempower women and their affective embodiment; women are coerced into compliance through a discourse of risk.

Biomedical discourse however does not operate outside the norms of gendered social power relations. The motherhood mandate continues to regulate women's maternity experiences. In this study, the contemporary discourse on intensive mothering that constitutes good mothers appears discursively suspect – and resistance to the often competing social and cultural expectations of motherhood are experienced as multiple and contradictory.

The motherhood mandate, the imperative of the good mother, alongside the commodification of maternity and the biomedical gaze intensifies the scrutiny, surveillance and regulation of the maternal body. The social conditions that produce the maternal body as a public body also position women as moral subjects responsible for achieving the biomedical markers that constitute the right size and shape of the pregnant body.

Maternal subject is therefore constituted as a moral subject through gendered social power relations that regulate and discipline the maternal body.

Despite the neoliberal conditions that promote women's decision making within the midwife/mother partnership, institutional power limits women's material choices through the normalisation of interventions. Principles of autonomy, agency and the right to choose is not only located in medical ethics, but also situated within women's social and cultural locations. The neoliberal discourse of autonomy and agency can only be partial. With the normalisation of medicalised birth, women often locate health professionals as holding the key to safe passage. The normalisation of the medicalisation of childbirth both constrains and regulates choice.

Midwives can and do operate in the space between medical and natural discourse and enable women to make sense of their choices, however social and cultural discourse of motherhood permeate ethnocentric practices of maternity care. By ignoring the cultural specificity of immigrants and tāngata whenua, further violence is enacted. Thus, Māori and immigrant women are all subject to further discrimination and poor treatment. Women's resistance to normalised interventions often find themselves marginalised and socially sanctioned, positioned as 'bad mothers'. Disciplinary power operates to render women as docile bodies, and resistance leads women to being positioned as non-compliant. The normalisation of interventions in maternity care has a coercive effect, and raises questions about the notion of informed consent.

In this research process, I have found a way to regain some of my own power, and to see just how heavily so many women's experiences mirror my own. These experiences are ordinary within the maternity system. Not acceptable, but ordinary. They are seldom questioned, and when they are, the questions are often

negated through coercive practices. In many ways, my own location within this research is as an act of resistance over my own experience; what happened to me, particularly when I was raped by the gloved hand of a male obstetrician should not be accepted as normal. What happened to my babies and I when we were separated for no clear reason, purely as a precaution was likewise considered acceptable. When maternity decisions are based solely on assessment of potential risk, then it is women and babies who suffer.

This research has given me a voice to speak back against the commonplace practices of a risk-based and misogynistic maternity system, and to question unnecessary and harmful practices that are commonplace within a system that reproduces gendered inequities. The excerpts included in the analysis include only glimpses of the experiences of the eleven women I interviewed. Throughout my interviews there were many stories which illustrated the many competing discourses women are embedded in throughout the maternity experience, and many narratives of unfathomable systemic abuses; stories of staff incompetence, bullying, and coercion appeared in every account. Acts of resistance were evident throughout the discussions with women, yet the ability to change personal outcomes was limited in many situations. Active resistance immediately positions women as 'bad mothers' both in biomedical discourse and internalised technologies of gender. These technologies of gender assist biomedical discourse in rendering us as docile bodies, and complicit to the power relations we are embedded in.

One woman cannot make much of a difference to a maternity system that is based on biomedical and social constructions of gender and maternity that can be

experienced as damaging. However, I am not one woman. I am each of my participants, each of them is me, and collectively we are women of Aotearoa New Zealand. If these feelings and experiences occur so commonly amongst us then it is our responsibility to make them heard and known. Our knowledges do not have to remain secret knowledges any more, they can be shared, and they can make a difference. We must speak, all of us, and to continue to resist.

### **Limitations**

The limitations of this research are not necessarily clear cut; after all, I am not intending to provide a universal account of all maternity experiences, yet there are still aspects of the work that emerged in particular ways that have limited the discourses available to the women, and thus to me. For example, my final set of eleven participants had not personally experienced a home birth for a number of reasons. Because of this, I feel that there is another dimension to natural discourses that I was not able to fully explore. While the 'natural' did feature as a discourse that many participants drew from, if a few of the participants had experienced low intervention births, and births away from the biomedical gaze, further understanding of various tensions may have become apparent. In continued research, ensuring that mothers who experienced home birth and planned unassisted home birth could perhaps open further avenues to explore.

Another limitation is related to cultural aspects of participants' backgrounds. While my social network is wide and includes women of Asian, African, and Middle Eastern cultures, the absence of these women's experiences within this work is noted and regretted. In further research, I would like to ensure that women from diverse immigrant cultures are also heard and understood.

These women's stories and experiences matter, and it is unfortunate that they are not able to be specifically attended to within this research.

Another limitation to this work is also that a lot of the amazing wisdom and experiences I heard and transcribed were not able to find their way to the final product. Yet, even those pieces of gold that lay on the cutting room floor from each of my participants has contributed to this final product. The women who shared a piece of themselves for the sake of this research each have their fingerprints attached to every page of this work. This is a shared product; a tangible result of women's shared knowledges. Women of Aotearoa New Zealand, we are strong, we can disrupt the gendered social power relations that subject us to gendered inequalities, and we can support each other to be empowered through maternity and into motherhood. We can choose not to place judgment on other women, but rather raise each other up in the many and varied ways of doing femininity and motherhood. This is our history, and now is our chance to ensure it is not our future.

### **A Final Reflection**

In finishing this project, I returned again to the poem which remains unchanged at the beginning of this work. It was the first writing I undertook when I began this research, and now, at the other end of many hours of reading, writing and understanding, it perhaps offers an opportunity for reflexivity that otherwise might be difficult to convey. Throughout my poem, the language of multiple conflicts and saturated my situatedness, the gendered power relations of my place and space of situating being a mother and in the memory of my years of maternity. I now feel further away from gaining real understanding into my own experience

than I was, only now I can see that there is no quick and easy solution to settling the technologies of power that contribute to my own maternity experience. I am able to see now just how embedded I am in these conflicting discourses with only having scraped the surface in my attempts to unravel the systems of power I am embedded in.

In the few years this thesis has taken to write, I have had opportunities to see the contradictory discourses I have taken up and eschewed, pushed away and drawn in, and fought both for and against emerge in the experiences of friends who are embarking on the journey of maternity and motherhood now. When I first began this work, I believed my position was one of immersion within natural discourses of maternity; now, as I emerge out the other side, the sanctions that women experience based on their own embeddedness in these overlapping systems of power become increasingly apparent, and no matter which of these conflicting discourses are taken up at any one moment, I see that there is no 'right' way to navigate the turmoil of the journey into motherhood.

I now see friends who walk this path with similar pressures to my own, and the memories continue to be immersed in this ether of conflicting expectations. While the process of this research has highlighted to me the inadequacies of our maternity system, it also has given me a chance to trouble the position I have taken up, largely within a natural discourse, of the ideal way for maternity to progress. More than ever, I now see the folly of entertaining this consideration even for a moment. Every woman is navigating uncharted waters with all of these varied pressures and expectations influencing the limited choices she has, and I find myself more and more in the position of understanding the uptake of dominant

discourses of maternity, while also enjoying watching the emergence of many forms of resistance to power that is at odds with a woman's own desires and experiences. The more I know, the less I know. I find myself taking up a position of unconditional support for women's choices, and perhaps this is the answer (as much as an answer is possible).

Women deserve support for whatever choices they make from within these conflicting systems of power. If I was to create a utopian idea of maternity and motherhood, while I feel even less capable of such a task now at the end stages of this research than I did at the beginning, I believe that I would build a system where women all have support for their own choices, free of judgement, because it is clear that we all are bombarded by so much information and expectations that this is the strongest form of resistance I feel I have. By supporting other women in their search for balance between resistance and uptake of each of these infiltrating discourses, and by legitimising their choices and small victories of rebellion, women can pull back against gendered social power.



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## Appendices

### Appendix A

#### MUHEC Ethics Screen



**Massey University**

Te Kunenga ki Pūrehuroa

### SCREENING QUESTIONNAIRE TO DETERMINE THE APPROVAL PROCEDURE

*(Part A and Part B of this questionnaire must both be completed)*

**Name:** Laura Quin

**Project Title:** "Leave your dignity at the door": Technologies of power and the maternal body

This questionnaire should be completed following, or as part of, the discussion of ethical issues.

#### Part A

The statements below are being used to determine the risk of your project causing physical or psychological harm to participants and whether the nature of the harm is minimal and no more than is normally encountered in daily life. The degree of risk will then be used to determine the appropriate approval procedure.

If you are in any doubt you are encouraged to submit an application to one of the University's ethics committees.

#### Does your Project involve any of the following?

*(Please answer all questions. Please circle either YES or NO for each question)*

#### Risk of Harm

1. Situations in which the researcher may be at risk of harm.	YES	NO
2. Use of questionnaire or interview, whether or not it is anonymous which might reasonably be expected to cause discomfort, embarrassment, or psychological or spiritual harm to the participants.	YES	NO
3. Processes that are potentially disadvantageous to a person or group, such as the collection of information which may expose the person/group to discrimination.	YES	NO
4. Collection of information of illegal behaviour(s) gained during the research which could place the participants at risk of criminal or civil liability or be damaging to their financial standing, employability, professional or personal relationships.	YES	NO
5. Collection of blood, body fluid, tissue samples, or other samples.	YES	NO
6. Any form of exercise regime, physical examination, deprivation (e.g. sleep, dietary).	YES	NO
7. The administration of any form of drug, medicine (other than in the course of standard medical procedure), placebo.	YES	NO
8. Physical pain, beyond mild discomfort.	YES	NO
9. Any Massey University teaching which involves the participation of Massey University students for the demonstration of procedures or phenomena which have a potential for harm.	YES	NO

### Informed and Voluntary Consent

10. Participants whose identity is known to the researcher giving oral consent rather than written consent (if participants are anonymous you may answer No).	YES	NO
11. Participants who are unable to give informed consent.	YES	NO
12. Research on your own students/pupils.	YES	NO
13. The participation of children (seven (7) years old or younger).	YES	NO
14. The participation of children under sixteen (16) years old where active parental consent is not being sought.	YES	NO
15. Participants who are in a dependent situation, such as those who are under custodial care, or residents of a hospital, nursing home or prison or patients highly dependent on medical care.	YES	NO
16. Participants who are vulnerable.	YES	NO
17. The use of previously collected identifiable personal information or research data for which there was no explicit consent for this research.	YES	NO
18. The use of previously collected biological samples for which there was no explicit consent for this research.	YES	NO

### Privacy/Confidentiality Issue

19. Any evaluation of organisational services or practices where information of a personal nature may be collected and where participants or the organisation may be identified.	YES	NO
--	-----	----

### Deception

20. Deception of the participants, including concealment and covert observations.	YES	NO
---	-----	----

### Conflict of Interest

21. Conflict of interest situation for the researcher (e.g. is the researcher also the lecturer/teacher/treatment-provider/colleague or employer of the research participants or is there any other power relationship between the researcher and research participants?)	YES	NO
---	-----	----

### Compensation to Participants

22. Payments or other financial inducements (other than reasonable reimbursement of travel expenses or time) to participants.	YES	NO
---	-----	----

### Procedural

23. A requirement by an outside organisation (e.g. a funding organisation or a journal in which you wish to publish) for Massey University Human Ethics Committee approval.	YES	NO
---	-----	----

## Part B

### FOR PROPOSED HEALTH AND DISABILITY RESEARCH ONLY

Not all health and disability research requires review by a Health and Disability Ethics Committee (HDEC).

Your study is likely to require HDEC review if it involves:

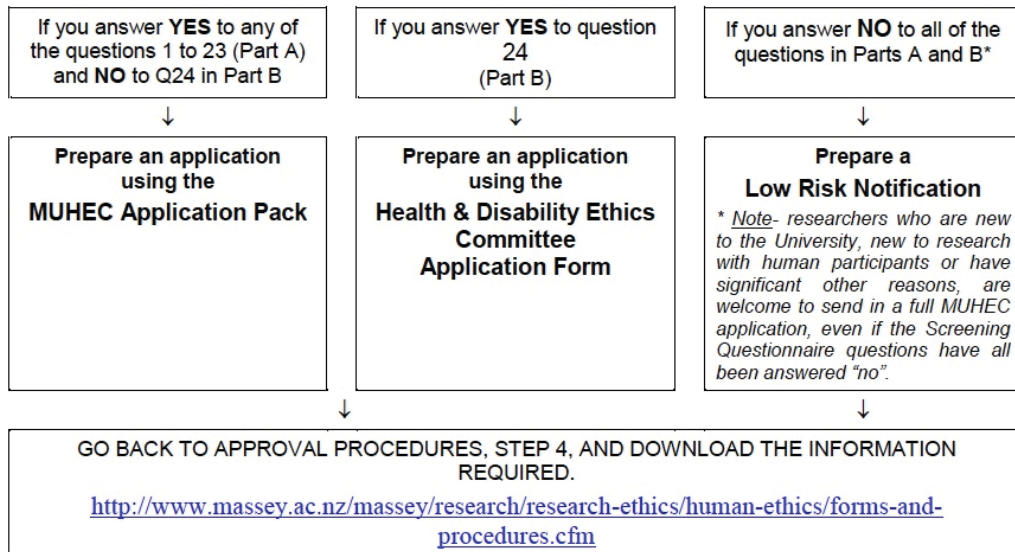
- human participants recruited in their capacity as:
  - consumers of health or disability support services; or
  - relatives or caregivers of such consumers; or
  - volunteers in clinical trials; or
- human tissue; or
- health information.

In order to establish whether or not HDEC review is required: (i) read the Massey University Digest of the HDEC Scope of Review standard operating procedure; (ii) work through the 'Does your study require HDEC review?' flowchart; and (iii) answer Question 24 below.

If you are still unsure whether your project requires HDEC approval, please email the Ministry of Health for advice ([hdecs@moh.govt.nz](mailto:hdecs@moh.govt.nz)) and keep a copy of the response for your records.

24. Is HDEC review required for this study?	YES	<b>NO</b>
---	-----	-----------

Select the appropriate procedure to be used (choose one option):



## Appendix B

### MUHEC Low Risk Notification

(All notifications are to be typed)

(Do not modify the content or formatting of this document in any way)



#### NOTIFICATION OF LOW RISK RESEARCH/EVALUATION INVOLVING HUMAN PARTICIPANTS

*Staff researchers and supervisors are fully responsible for ensuring that the information in this form meets the requirements and guidelines for submission of a Low Risk Notification*

##### SECTION A:

1. **Project Title** "Leave your dignity at the door": Technologies of power and the maternal body  
.....  
**Projected start date for data collection** August 2015 **Projected end date** February 2016  
.....  
*(Low risk notifications must not be submitted if recruitment and/or data collection has already begun.)*

2. **Applicant Details** (Select one box only and complete details)

##### ACADEMIC STAFF NOTIFICATION

**Full Name of Staff Applicant/s** .....

**School/Department/Institute** .....

**Region (mark one only)** Albany  Palmerston North  Wellington

**Telephone** ..... **Email Address** .....

##### STUDENT NOTIFICATION

**Full Name of Student Applicant** Laura Jean Quin  
.....  
**Postal Address** 12 Domain Drive, Ōtorohanga 3900  
.....  
**Telephone** 022 342 5822 **Email Address** laurajquin@gmail.com  
.....  
**Employer** .....

**Full Name of Supervisor(s)** Dr. Leigh Coombes  
.....  
**School/Department/Institute** School of Psychology  
.....  
**Region (mark one only)** Albany  Palmerston North  Wellington

**Telephone** (06) 356 9099 x 85075 **Email Address** L.Coombes@massey.ac.nz  
.....

##### GENERAL STAFF NOTIFICATION

**Full Name of Applicant** .....

**Section** .....

**Region (mark one only)** Albany  Palmerston North  Wellington

**Telephone** ..... **Email Address** .....

**Full Name of Line Manager** .....

**Section** .....

**Telephone** ..... **Email Address** .....

3 Type of Project (provide detail as appropriate)

Staff Research/Evaluation:	Student Research:	If other, please specify:
Academic Staff	Name of Qualification	MSc
General Staff	Credit Value of Research	120
Evaluation	(e.g. 30, 60, 90, 120, 240, 360)	

4. Describe the process that has been used to discuss and analyse the ethical issues present in this project. (Please refer to the Low Risk Guidelines on the Massey University Human Ethics Committee website)

I have consulted with my supervisor Dr. Leigh Coombes with regards any potential ethical issues related to this project, and I have sought ongoing cultural supervision from Missy Katipa (registered nurse) who is the branch manager of Lifeline Waikato. I have access to various organisations such as Lifeline and Voice for Parents. When the assessment of the low risk application was prepared, it was reviewed by a senior member of the School of Psychology staff.

This is qualitative research is from a feminist standpoint, and as such my own experiences as a woman who has experienced maternity are not expected to be removed from the research. I have been focusing on learning reflexivity during my time studying at Massey University, and I always try to question my own assumptions and understandings of the world, knowing that my personal context influences my experience. As such, I do not intend to wipe this research clean of my own fingerprints, but rather to understand that this is for the pursuit of understanding and knowledge, instead of pursuit of some unattainable universal ‘truth’.

I have also done a significant amount of background research of how to ensure a bicultural approach to my work, and for the postgraduate paper 175.730 Professional Practice in Psychology I completed an assignment to A+ level with the title “Conducting maternal body research in Aotearoa: A focus on Te Tiriti o Waitangi”. I would be happy to share this work on request. A focus on partnership, participation, and protection, an understanding of the importance of various aspects of tikanga Māori, an awareness of concepts such as whakamā (embarrassment/shame) that may be present when discussing personal stories. Other ethical bicultural considerations are the importance of face to face contact, continued contact and feedback of progress, and of sharing the ownership of the research with my participants regardless of cultural identity have all been an integral part of my planning. I am also coming to the end of the He Papa Tikanga course through the Open Wānanga, which should support me in a bicultural approach.

Another potential ethical issue is the possibility that focus shifts to the more negative situations in maternity. I have dealt with that by ensuring that my research questions are not directive so I hope that each individual participant can then guide the interview as is right for their own lived experience rather than one based on my own biases or ideas. This then also allows the research to come out as it needs to, without expectation and guidance from me, and I expect to be surprised by what comes of this, which I understand is a sign of good research. My questions are designed not to look for the more harmful aspects that may come out in women’s experiences of maternity, but rather to ask open ended questions about their lived experiences and allow each interview to take the direction it will take through the experience of each participant. These are real stories that are told daily between women, face to face, and through social media. Confidentiality will be attained through protection of files, deletion of identifying factors, and use of pseudonyms.

This thesis is about a chorus of voices that attends to diversity and the discourse analysis will serve to unravel the power relations that act on women in maternity. By working with the transcripts of these lived experiences, a greater understanding of what the biomedically centred maternity system in Aotearoa in particular, and society in general, may be understood.

---

5. **Summary of Project**

Please outline the following (in no more than 200 words):

1. **The purpose of the research, and**
2. **The methods you will use.**

*(Note: ALL the information provided in the notification is potentially available if a request is made under the Official Information Act. In the event that a request is made, the University, in the first instance, would endeavour to satisfy that request by providing this summary. Please ensure that the language used is comprehensible to all)*

The purpose of this research is to collect, analyse, and disseminate stories of women who experience pregnancy, birth, and the early months of motherhood in Aotearoa/New Zealand. Women's experiences can bring to light a number of the influences that act on women and their bodies, such as expectations and pressures from society, and can help us to become aware of approaches to maternity that can empower in some situations and disempower in others. My goal for this research is to be able to draw attention to some of these influences and to consider how women may be supported and empowered in their experiences.

I intend to conduct and record conversational interviews, and then transcribe these verbatim. The types of questions I will be asking are "can you please tell me about your experience of maternity"; "please tell me about your experience of ultrasound and other technology"; "how did you make decisions related to maternity care"; and "in hindsight, what might you change about your experience?" A discourse analysis will then be conducted, to understand and shed some light on the social, political, and cultural power relations that occur in the transition to motherhood.

Please submit this Low Risk Notification (with the completed Screening Questionnaire) as follows:

1. For staff based at either the Palmerston North or Wellington campus; and students whose Chief Supervisor is based at either the Palmerston North or Wellington campus:

**External Mailing Address**  
Ethics Administrator  
Research Ethics Office  
Massey University  
Private Bag 11222  
Palmerston North 4442

**Internal Mailing Address**  
Ethics Administrator  
Research Ethics Office  
Courtyard Complex, PN221  
Turitea  
Palmerston North

2. For staff based at the Albany campus and students whose Chief Supervisor is based at the Albany campus:

**External Mailing Address**  
Ethics Administrator  
Research Ethics Office  
Massey University  
Private Bag 102904  
North Shore City 0745

**Internal Mailing Address**  
Ethics Administrator  
Research Ethics Office  
Room 3.001B, Level 3  
Quadrangle A Building  
Albany Campus

**SECTION B: DECLARATION** *(Complete appropriate box)*

**ACADEMIC STAFF RESEARCH**

**Declaration for Academic Staff Applicant**

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. My Head of Department/School/Institute knows that I am undertaking this research. I confirm that this submission meets the requirements set out in the Guidelines for Low Risk Notifications and that the information contained in this notification is to the very best of my knowledge accurate and not misleading.

Staff Applicant's Signature

Date:

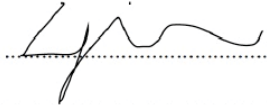
**STUDENT RESEARCH**

**Declaration for Student Applicant**

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Supervisor. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I confirm that this submission meets the requirements set out in the Guidelines for Low Risk Notifications and that the information contained in this notification is to the very best of my knowledge accurate and not misleading.

Student Applicant's Signature

Date: 9/4/2015



**Declaration for Supervisor**

I have assisted the student in the ethical analysis of this project. As supervisor of this research I will ensure that the research is carried out according to the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I confirm that this submission meets the requirements set out in the Guidelines for Low Risk Notifications.

Supervisor's Signature

Date:

Print Name

**GENERAL STAFF RESEARCH/EVALUATIONS**

**Declaration for General Staff Applicant**

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Supervisor. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I confirm that this submission meets the requirements set out in the Guidelines for Low Risk Notifications and that the information contained in this notification is to the very best of my knowledge accurate and not misleading.

General Staff Applicant's Signature

Date:

**Declaration for Line Manager**

I declare that to the best of my knowledge, this notification complies with the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and that I have approved its content and agreed that it can be submitted.

Line Manager's Signature

Date:

Print Name

## Appendix C

### Participant Information Sheet



MASSEY UNIVERSITY  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŪRENGA TANGATA

## ***“Leave your dignity at the door”: Technologies of power and the maternal body***

### INFORMATION SHEET

#### Researcher Introduction

You are invited to participate in a research study conducted by Laura Quin, from the School of Psychology at Massey University as part of a Master of Science degree. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything you do not understand before deciding whether or not to participate.

The purpose of this research is to understand women's experiences of pregnancy, birth, and the early months of motherhood in Aotearoa/New Zealand. Women's experiences can bring to light a number of the influences that act on women and their bodies, such as expectations and pressures from society, family, and friends. Understanding these influences better can help professionals to become aware of approaches to maternity that can empower women in some situations and disempower them in others. My goal for this research is to be able to draw attention to some of these influences and to consider how women may be supported and empowered in their experiences.

#### Project Description and Invitation

This project is designed to learn about women's lived experiences. This means that I hope to look at how women experience the maternity system and the social, political, and cultural environments we all live in and which influence our lives. I would like to invite you to be a part of this study, and would like to work in a collaborative relationship with you and other women to bring attention to your voices and stories, and to find the common threads that link us all as mothers in Aotearoa/New Zealand. This research is for all of us, and therefore it will belong to all participants, and the many other voices you represent.

#### Participant Identification and Recruitment

The recruitment for this study will be through snowball sampling; through various networks of mothers I have links to. Some participants may be known to me already, and some may be recruited by word of mouth through other participants or interested parties. All you need to meet the criteria for selection for this study is your willingness to talk about your experience. You also need to be over the age of 18 at the time of participation, and have experienced the maternity system as a mother or a pregnant woman. I am interested in what you think is important to talk about, and you can share as little or as much of your story as you would like to.

#### Project Procedures

If you decide to take part in this research, we will negotiate a time and place for an interview that is suitable to you. Interviews will take up to 1 to 2 hours of your time. I will then transcribe the interview and return it to you to ensure that we agree on what has been shared. This may take a further 2 hours of your time, and is an opportunity for us to talk about the interview process.

It is not the intention of this research to cause you any distress or embarrassment. However, if you do feel discomfort it is your right to stop the interview at any time. I have experience as a counselor, and will support you to find someone to talk to if this would be useful.

Te Kunenga  
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata  
Private Bag 11222, Palmerston North 4442, New Zealand. T 06 356 9099 extn 65071 F 06 355 7966 <http://psychology.massey.ac.nz>



### Data Management

I will ensure that your identity remains confidential, and all identifying information will be removed from the material that is used. I will also use a pseudonym for each participant, which you can choose yourself if you wish.

Project findings will be shared with you, where requested, through a short summary of findings. You are also welcome to access the full research project once it is completed. Please feel free to contact me or my supervisor for a summary or a copy of the full project.

### Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any point prior to signing off of your transcript;
- ask any questions about the study at any time during participation;
- ask for the recorder to be turned off at any time during the interview;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

### Project Contacts

Please contact me or my supervisor at any point if you have any questions about the project:

Laura Quin (Researcher)  
School of Psychology  
Massey University  
Palmerston North  
Phone: 022 342 5822  
Email: [lauraiquin@gmail.com](mailto:lauraiquin@gmail.com)

Dr. Leigh Coombes (Research Supervisor)  
School of Psychology  
Massey University  
Palmerston North  
Phone: (06) 350 5799, ext 2058  
Email: [L.Coombes@massey.ac.nz](mailto:L.Coombes@massey.ac.nz)

### Compulsory Statement

This project has been evaluated by peer review and judged to be low risk.

Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Dr. Brian Finch, Director, Research Ethics, telephone 06 356 9099 extn 86015, email: [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)

Te Kūnenga  
ki Pūrchuroa

School of Psychology - Te Kura Hinengaro Tangata  
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7966 <http://psychology.massey.ac.nz>

# Appendix E

## Participant Consent Form



MASSEY UNIVERSITY  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŪKĒNGA TANGATA

### ***“Leave your dignity at the door”: Technologies of power and the maternal body***

#### **PARTICIPANT CONSENT FORM - INDIVIDUAL**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Full Name - printed** \_\_\_\_\_

Te Kunenga  
ki Pārehuroa

School of Psychology - Te Kura Hinengaro Tangata  
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9089 extn 85071 F 06 355 7966 <http://psychology.massey.ac.nz>

## Appendix E

### Transcript Release Form



MASSEY UNIVERSITY  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŪKENGĀ TĀNGATA

### *“Leave your dignity at the door”: Technologies of power and the maternal body*

#### AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name - printed \_\_\_\_\_

## **Appendix F**

### **Interview Questions**

Tell me about your experience of maternity.

How did you make decisions about maternity care?

How did you experience your changing body?

How did you experience your changing identity?

How did your experience of technology (such as ultrasound/medical intervention) shape your experience?

How were your cultural and/or spiritual needs met or not met in your maternity experience?

In hindsight, what would you do differently?