Women's Perceptions of Childbirth "Choices" : Competing Discourses of Motherhood, Sexuality, and Selflessness

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WOMEN'S PERCEPTIONS OF CHILDBIRTH "CHOICES"

Competing Discourses of Motherhood, Sexuality, and Selflessness

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Women in North America have many childbirth options. However, they must make these choices within a complex culture of birthing discourse characterized by competing knowledges and claims regarding the "ideal birth" as medicalized, natural, or woman centered. We interviewed 21 childless women and 22 new mothers to explore their perceptions of choice and birthing. The women's interviews indicated that their birthing choices are reflective of tensions embedded in normative femininity; conflicting ideas relating to purity, dignity, and the messiness of birth; and contradictions about women's bodies as heteronormative sites of pleasure and sexuality on one hand and of asexual, selfless sources of maternal nurturance on the other. Finally, the women's views reflected understandings of moral and normative constructs about selflessness as a core attribute of femininity and motherhood, particularly in terms of enduring pain as the "proper" means of accomplishing the rite of passage to motherhood. Although all the women described tensions between femininity and motherhood, childless women were more likely than mothers to be worried about achieving ideal, heteronormative sexuality and femininity. Likewise, women who have not yet had children and women who have experienced unplanned C-sections were more likely than those who experienced vaginal births to express that C-section births fail to fully accomplish women's rite of passage to motherhood.

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While women in North America have many childbirth options, ranging from medicalized birth (including planned, non–medically mandated C-sections) to natural birth (optimally conceived of as midwife-attended, drug- and intervention-free vaginal delivery at home), the notion of women's choice in birthing remains a fraught concept. Not all childbirth options are equally available to women, nor are all choices equally viewed as responsible (Klassen 2004). In addition, women make childbirth choices in a complex culture of birthing discourse, characterized by competing knowledges and claims regarding the "ideal birth." At one end of the spectrum are traditional medical views, which emphasize the benefits of medicalization, technology, and risk management (Beckett and Hoffman 2005; Davis-Floyd 2004). At the other end of the spectrum, natural or alternative birth advocates argue that the medicalization of childbirth takes control and power away from women and places it in the hands of obstetricians (Brubaker and Dillaway 2009). The current rise in C-section rates is seen by many natural birth advocates as symbolic of increasingly medicalized birth and as indicative of the increasing power and control of medicine over women's natural place in birth (Lavender and Kingdon 2006). Similarly, feminist critics have argued that the traditional masculinist culture of obstetrical care and the medicalization of childbirth undermine women's autonomy (Lane 1996; Oakley 1984). Despite this feminist critique of the medical model, some feminists argue that the natural childbirth movement is essentializing and can be morally oppressive since some women may experience the natural childbirth movement's strong promotion of medication-free birth as disciplining and controlling rather than empowering (Brubaker and Dillaway 2009).

While problems of medicalization are important components of women's childbirth experiences, our interviews with childless women and new mothers about birthing show that for some women, birth decisions reflect more than just a choice between natural and medicalized options. Drawing on in-depth interviews with 21 childless women (who expect to have children but are not yet mothers or pregnant) and 22 recent mothers, we argue that childbirth is a transitional moment between childhood and adulthood in which birth acts as a rite of passage with strong cultural proscriptions that involve more than simply assessing the merits of medicalized or natural birth or understanding relevant risk factors. Instead, women's birthing choices are related to tensions in cultural framings of femininity

including conflicting ideas relating to purity, dignity, and the messiness of birth. In addition, these framings pose contradictions about women's bodies as heteronormative sites of pleasure and sexuality on one hand and asexual, selfless sources of maternal nurturance on the other. Finally, we examine how these women's birthing choices reflect and draw on moral and normative constructs about pain and selflessness as normative attributes of femininity and motherhood.

MOTHERHOOD AS A SOCIAL CONSTRUCT AND STATUS PASSAGE

There is a significant literature examining motherhood as a social and moral construct. Feminists have actively engaged in denaturalizing the modern way of doing motherhood, arguing that modern, expert, and selfless motherhood is neither instinctual nor natural (Badinter 1981) but is instead a project that requires on one hand intensive instruction and inducements for "good" mothering (Abramowitz 1996; Arnup 1994; Margolis 2001) and on the other hand demanding surveillance and intervention for "bad" mothering (Ladd-Taylor and Umansky 1998; Reid, Greaves, and Poole 2008). This kind of instruction and monitoring extends not only to the act of child rearing but penetrates pregnancy, childbirth, early infant bonding, and breast-feeding discourses (Rapp 1999; Wall 2001). Indeed, even nonpregnant women are constrained and produced by these discourses, as evidenced by medical guidelines instructing physicians to treat postpubescent young women as perpetually potentially pregnant by encouraging them to take folic acid supplements, avoid drinking and smoking, and maintain a "healthy weight" from menarche forward, thus engaging in preemptive "good" mothering (Payne 2006).

It has been argued that motherhood amounts to a status passage from child to woman (Layne 1990), with an attending enhanced social status from the "impotence of childlessness" (Homans and MacCormack 1982) to a socially respected role. Furthermore, the actual practices of becoming a mother and engaging in mothering comprise a set of activities and experiences that shape women into nurturing, caring, and other-oriented people (McMahon 1995). This practice-based production of nurturing, selfless mothers remains normative for all women despite their personal histories and proclivities. Thus, women who are childless, particularly women who choose to be childless, experience proscriptions for failing to become fully adult, fully selfless women through the vehicle of motherhood (Gillespie 2000).

Sharon Hays described modern mothering as a project of idealized "intensive mothering," wherein women are expected to sacrifice themselves and be ever available and engaged in parenting (Hays 1996). This expectation that women will engage in "intensive mothering" does not begin at birth but is a transitional process accompanying menarche, pregnancy, and birthing decisions (Choi et al. 2005). In this discourse, the ideal mother and the ideal, potentially pregnant female are culturally framed as selfless women who have abandoned—or at the very least are prepared to abandon—their former, childlike, and self-centered selves for a higher version of womanhood. Given the pervasive and robust discourses about selflessness, motherhood, and femininity, we felt it important to examine the ways these ideas intersect with women's ideas about what their optimal birth choices should be.

TENSIONS IN DISCOURSES OF FEMININE EMBODIMENT

In addition to discourses of selfless motherhood and the perception of motherhood as a passage to true adult womanhood, other discourses of femininity hold significant sway. Women are persistently seen as their bodies and are subject to a wide range of competing discourses about ideal feminine embodiment (Witz 2000). Women are expected on one hand to remain slim, childlike, and docile and on the other hand to convey an attitude of constant sexual readiness and appetite (Bordo 1995). The idealized feminine body is expected to be blemish free, young, smooth, sexual, tight, and always available for heterosexual viewing and pleasure (Boulton and Malacrida 2012). Against this ideal form of feminine embodiment, it is not difficult to imagine how vaginal birthing can come to be seen as inappropriate because of the stretching and messiness of birth and because of an imagined problem of "matter out of place" (Douglas 1966), which can occur when a baby occupies a vaginal space normalized as solely appropriate to heteronormative sexual pleasure. In an ironic twist, given the current discursive and normative framing of the ideal feminine body as pure, clean, tight, and childlike, the process of vaginal birth can be seen as a violation of feminine purity.

A final paradox that birth choices pose for women in terms of feminine embodiment rests in the notion that for many, sacrifice and pain are normatively understood to be part of birthing and ideal womanhood. This is claimed by some religious groups who bind morality to embodiment through their view that suffering in birth is a legacy of Eve's "fall" and that a "natural" birth, characterized as medication free and vaginal, offers

a means of proving one's worthiness (Vanderlaan 2010). While drawing on different justifications, some of the scientific and medical discourse echoes this coupling of pain with maternal selflessness and goodness. Medical discourse that characterizes women who choose nonmedical, planned C-sections as "too posh to push" conveys the idea that women who voluntarily sidestep the pain of "natural" birthing are somehow eliding their responsibilities, avoiding a necessary rite of passage to womanhood, and sacrificing their babies' health for their own comfort or convenience (cf. Ben-Meir, Schenker, and Ezra 2005; Zulueta 1999).

In our interviews with women about birth choices, women framed their choices or preferences not primarily in terms of medical risks but rather in terms of the tensions they navigate concerning their feminine bodies as heteronormative sites of pleasure and sexuality on one hand and sources of endless, selfless maternal nurturance on the other. They also spoke of negotiating paradoxes of femininity, including tensions about feminine cleanliness and dignity versus animal fecundity and the messiness of birthing. They discussed the uneasy relationship between competing ideals of motherhood as asexual and selfless and the necessity of remaining young, tight, and sexually attractive. Finally, they highlighted conflicting ideas about the maternal status passage to motherhood as expressed in discourse and practice relating to Caesarean versus vaginal birth.

METHOD

Our analysis draws on qualitative, semistructured interviews with 21 childless women and 22 women who had given birth during the previous 18 months, as part of a larger project examining the culture of birthing in Alberta, Canada. The women were recruited through support groups, e-mail lists, postings in public spaces, and snowball sampling. The childless women ranged in age from 18 to 31, and the mothers ranged in age from 24 to 40. The participants were predominantly middle class, and all identified as heterosexual. Of the 22 mothers, all but one were in committed relationships with their children's fathers; of the 21 childless women, 10 were living with partners, two were in committed relationships, and the remainder were single. Their educations ranged from completing 10th grade to holding a medical degree, and their occupations ranged from being unemployed to running a private medical practice. Most of the women were born in Alberta; two were Hispanic, two were First Nations, the remainder were Caucasian, and most identified as Christian or agnostic. In sum, there are significant racial, ethnic, and cultural limitations to this particular sample.

Overview information concerning the childless women's attitudes about the ideal childbirth can be found in Table 1, while comparative information about the mothers' prebirth expectations and their ultimate birthing experiences can be found in Table 2. The term "natural" was used in complicated ways during the interviews; for the childless women who had not yet become acquainted with all the possibilities of intervention, "natural" meant a vaginal birth, without drugs, and without surgery. For the women who had experienced childbirth and had received enough childbirth education to understand which interventions were possible, the concept of natural was defined in more complex ways. For these women, natural birth meant "vaginal, drug- and intervention-free, accomplished at home," but for some women this was further qualified to mean "vaginal and perhaps induced" or "vaginal with episiotomy and drugs," while for others a "natural, but hospital" birth expressed a desire for as little intervention as possible while still calling on the security that they hoped a medical setting would provide (see Table 2). The differences between the nonmothers and the mothers show that pregnancy, childbirth education, and childbirth experiences gave the mothers more nuanced understandings of childbirth. It is also clear that childless women's expectations were more clearly cemented to an ideal type of birth that is vaginal and medication and intervention free. While these findings cannot be taken as generalizable, these women's comments offer important insight into cultural ideas about childbirth and the tensions of feminine embodiment. We provide selected comments from this group in presenting our data to offer insights from as many participants as possible while also representing the thematic perceptions of all the women interviewed.

It is important to clarify our use of language in these tables and throughout this article. Rather than use the terms "elective" or "emergency" to describe C-section procedures, we use terminology that more accurately describes what typically occurs in the labor and delivery process. "Unplanned in labor" refers to decisions made for events such as failure to progress or moderate fetal distress, which are not necessarily indicative of emergencies but that instead could be managed and still result in vaginal births. We use the term "planned, subsequent to C-section" rather than "elective," because to understand such C-sections as freely chosen elides the difficulties that women have in obtaining support for vaginal birth after C-section from medical and birthing professionals and also undermines the anxieties that many women face concerning their and their babies' health in attempting vaginal birth after C-section (C. Morton, pers. comm., 2011).

TABLE 1: Childless Women's Birth Expectations

Name	*Age*	*Birth Expectation*
Natasha	18	Wants to adopt
Melanie	21	Medical, hospital birth, wants planned C-section
Bridget	24	Medical, hospital birth, wants planned C-section
Brooke	20	Medical, hospital birth, considering planned C-section
Hanna	23	Medical, hospital birth, considering planned C-section
Aida	21	Medical birth (hospital, drugs)
Emily	27	Medical birth (hospital, drugs)
Mackenzie	31	Medical birth (hospital, drugs)
Tamara	23	"Natural" hospital birth (vaginal, no drugs or interventions)
Candice	25	"Natural" hospital birth (vaginal, no drugs or interventions)
Samantha	28	"Natural" hospital birth (vaginal, no drugs or interventions)
Marissa	21	"Natural" hospital birth (vaginal, no drugs or interventions)
Holly	25	"Natural" hospital birth (as few interventions as possible)
Beverley	25	"Natural" birth (no drugs or interventions), home or hospital
Tina	27	"Natural" birth (vaginal, no drugs or interventions), home birth
Beatrice	20	"Natural" birth (vaginal, no drugs or interventions), home birth
Alice	23	"Natural" birth (vaginal, no drugs or interventions), home birth
Meredith	26	"Natural" birth (vaginal, no drugs or interventions), home birth
Sarah	26	"Natural" birth (vaginal, no drugs or interventions), home birth
Donna	31	"Natural" birth (vaginal, no drugs or interventions), home birth
Kaylee	27	"Natural" birth (vaginal, no drugs or interventions), home birth

We spoke with childless women and mothers so that we might compare childless women's expectations of an imagined ideal birth and recent mothers' knowledge relating to actual birth experiences. This comparative strategy allowed us to examine tensions between conflicting ideas relating to sexuality, femininity, and motherhood from the perspectives of mothers who have made choices that may or may not have been ideal for them, as

TABLE 2: Recent Mothers' Expectations and Experiences

Name	*Age*	*Expectation*	*Intervention*
Naomi	32	Planned C-section by maternal request	2011—planned, self-selected C-section
Whitney	33	Wanted epidural, scared of pain	2008—unplanned in-labor C-section
		C-section would be acceptable	2011—planned subsequent C-section
Stacy	30	Assumed would "just come out"	2005—unplanned in-labor C-section
		Afraid of episiotomy, wanted drugs	2007—planned subsequent C-section
Kristen	40	Assumed "natural," drugs acceptable	2000—unplanned in-labor C-section
		Declined vaginal birth after C-section—too scared	2003—planned subsequent C-section
			2008—planned subsequent C-section
Lindsey	24	"Natural," but hospital birth	2011—induced, fetal monitor, pain medication, episiotomy
		Drugs acceptable, "whatever it takes"	
Susan	31	Assumed "natural"	2009—induced, continuous fetal monitor, unplanned in-labor C-section
		Didn't want to have expectations	
Helen	40	2007—No plan—didn't want to sabotage self	2007—hospital, midwife/ birth pool
		2009—No plan, birth at home due to "fast birth"	2009—at home, birth tub
Amanda	30	No plan	2010—fetal monitor
		At 8.5 months started to think "natural"	
Tanya	37	"Natural" but hospital birth, no medication	2004—induced, unplanned in-labor C-section
		Agreed to epidural assuming would still be "natural/vaginal" birth	2008—planned subsequent C-section
Sharron	35	"Natural" but hospital birth, no medication	2004—unplanned in-labor C-section
		Agreed to induce, assuming would still be vaginal birth	2007—planned subsequent C-section
Shirley	32	"Natural" but hospital birth; no medication, no intervention, vaginal	2008—unplanned in-labor C-section

(continued)

TABLE 2: (continued)

Name	*Age*	*Expectation*	*Intervention*
Katherine	33	"Natural" but hospital birth; no medication, no intervention, vaginal	2008—unplanned in-labor C-section 2009—planned subsequent C-section
Ruth	28	"Natural" but hospital birth; no medication, no intervention, vaginal	2011—induced, fetal monitor, episiotomy
Nora	30	"Natural" but hospital birth; no medication, no intervention, vaginal	2011—induced, fetal monitor, epidural (postinterview)
Carmen	27	"Natural" but hospital birth; no medication, no intervention, vaginal	2009—induced, fetal monitor, epidural, unplanned in-labor C-section
Andrea	30	"Natural" but hospital birth; no medication, no intervention, vaginal	2011—episiotomy, "laughing gas" for pain relief
Judith	40	"Natural" but hospital birth; no medication, no intervention, vaginal	2011—induced, epidural, pain medication, fetal monitor
Alexis	35	"Natural" but hospital birth; no medication, no intervention, vaginal	2004—morphine 2006—nothing
Lauren	30	"Natural," no medication, water birth for first Second, more worried about pain	2000—induced, episiotomy, fetal monitor 2010—induced, morphine
Louise	30	"Natural" home birth, but because she developed seizure disorder, had to be hospitalized	2009—hospital birth, induced, morphine, epidural
Rita	27	"Natural," no medication, no interventions, vaginal, water birth After C-section, even more "pronatural"	2008—induced, epidural, fetal monitor, unplanned in-labor C-section 2010—home birth (vaginal birth after C-section)
Abby	30	"Natural," no medication, no interventions, vaginal, home birth	2006—intermittent fetal monitor (hospital) 2010—unplanned in-labor C-section

opposed to the perspectives of childless women whose responses informed us of women's relatively naïve expectations about childbirth.

The interviews were semistructured and began with a request for women to tell us about their vision of the ideal kind of birth. This very broad question was followed up with those relating to the women's evaluations of vaginal birth versus Cesarean delivery in terms of risk management, control, and sexuality postdelivery. In their discussion of risk management, most women focused on tensions in normative femininity, rather than on evaluations of medical risk, although this was more pronounced among the childless women than the mothers. While both groups of women spoke about bodily control and dignity more than predictability or control over the medical aspects of the birthing process, this was also more pronounced among the childless women than the mothers.

Data collection, transcription, and analysis were completed through a team research approach, which can facilitate dialogue among multiple perspectives and result in a rich and nuanced analysis (Rogers-Dillon 2005). Following detailed and repeated reading, interview transcripts were thematically and inductively coded using Atlas-ti, a qualitative data analysis software program. In the women's interviews, sometimes explicitly and sometimes less consciously, the women were able to make connections between their embodied experiences and dominant discourses relating to femininity, motherhood, and sexuality. These connections included discourses concerning medical versus natural childbirth, moral and social constructions of motherhood, and tensions in expectations of femininity, all from the perspectives of childless women's position of naïve expectation and the new mothers' insights gained through lived experience.

FINDINGS

Motherhood as a Rite of Passage

When the childless women spoke about the imperative of enduring discomfort as part of becoming a mother, all of them acknowledged and recognized cultural norms that position C-sections as "copping out of your motherly duties" (Melanie), "kind of selfish" (Kaylee), "self-absorbed and vain" (Jones), or finally "a lazy way to give birth [with] no work involved" (Candice). However, for almost half of these women, these negative evaluations about pain avoidance and about C-sections, while understood as normative, were taken up with ambivalence. For example, Meredith said,

> I think that women who do take drugs are seen as having given in, not quite as tough. So there's a … I suppose I see a hierarchy there. You know, someone who can make it through and give birth without the use of any painkillers, well, great, you're supermom. … I guess in my mind, I see women who've had C-sections maybe having taken the easy way, or having given up … but there are other reasons why people have C-sections. I mean, some people, it's necessary, I guess.

In Meredith's comments we can read ambivalence that comes, at least in part, from the experience of having a close friend who "felt cheated from giving vaginal birth" because of complications in her delivery. In turn, this experience gave Meredith the ability to see the unfairness of being negatively judged simply because, as she noted, her friend had "failed to accomplish the ideal birth." On the other hand, we can see consistent slippage in Meredith's language; although she is reluctant to instate a hierarchy, she agrees it exists, and although reluctant to judge, she admits that she sees a C-section as an inferior form of birthing. When it came to describing her own birth expectations, however, there was no such ambivalence; she indicated emphatically that she hopes, and indeed expects, to have a midwife-attended, natural, at-home birth.

It was also clear that most of the childless women understood on some level that the necessity for sacrifice was culturally bound to ideals about the transition to legitimate motherhood. As Kaylee said, "Childbirth is messy. It *is,* you know? It's never pretty. That's a sacrifice you make, that's your rite of passage." She went on to link the idea of bodily sacrifice to fitness for motherhood: "If you're not ready to sacrifice your body for this child, then what *are* you really willing to sacrifice for this child, and why are you having children? … I mean, why wouldn't you want to have your body go through whatever it has to [in order] to give birth?"

Kaylee, like many of the childless women in the study, clearly has adopted ideas relating to sacrifice and pain as a necessary part of the rite of passage to full motherhood; in her framing, the mother who does not make this sacrifice is clearly not entitled to mother.

It must be noted that there was a smaller group of childless women who clearly rejected this normative linking of motherhood and bodily sacrifice, arguing instead that motherhood is more of a lifelong practice. As Donna said, "Bollocks! Would you turn around to somebody who'd adopted and say they're not fully a mother? Mother is nothing to do with the method of birth." Interesting to note, however, even among this subgroup of women, there was an acknowledgment that societal norms remain firm along these lines. For example, Bridget stated that she would have no

problem with having a C-section if necessary, but she went on to say, "I would, [but] that's a horrible thing. Society is just like, 'Women have to deliver vaginally, you're a better mom. … You're failing if you do a C-section.'" Thus, for Bridget and the subgroup she represents, although they may consciously reject the normative linkage of sacrifice to becoming a mother, they also continue to feel its effects in terms of what is culturally expected in childbirth.

For the mothers, the cultural norms connecting the endurance and sacrifice of vaginal birth to full motherhood ranged from self-judgment for "failing motherhood" to clearly understanding that how one gives birth has no implications for one's status as a mother. Among the 22 new mothers, 11 had experienced unplanned in-labor C-sections under medical advice despite their original birthing preferences (see Table 2). For these women particularly, there was a readiness to understand that despite being dedicated mothers, they still were not quite good enough mothers. Katherine, who had an unplanned in-labor C-section with her first pregnancy and a planned C-section thereafter, said, "Part of me wonders … is there something wrong with me in that my body didn't progress in labor naturally. … Maybe I'm not supposed to have babies, maybe I'm not supposed to be a Mom." Of course, many women doubt their mothering regardless of their circumstances. However, in Katherine's comments we hear that, despite her dedicated, full-time, stay-at-home mothering status, the way she gave birth remains the lynchpin of her personal doubts; without a vaginal birth, her concept of herself as a "natural" mother remains incomplete. This sentiment was echoed by Tanya, who also had an unplanned in-labor C-section followed by a planned subsequent C-section. She said,

> I failed in the birthing arena. … My friends are all intelligent women who are in really good shape and they are just such natural moms. Like, they're breastfeeders, and they just make it look so easy. And I think, "I'm the overweight one who had the C-section." It's hard not to compare yourself, but it makes me feel sort of inferior to them.

Elsewhere in Tanya's interview, she spoke poignantly about how devastated she would feel if she learned that someone criticized her mothering because for her there is "nothing I take more seriously, nothing more important to me." Nevertheless, for Tanya, vaginal birth is connected to being a natural mother, and this remains the standard by which she judges herself. Interestingly, she also connects ideal motherhood with another feminine construct, conventional attractiveness. In Tanya's comments we

can hear how the fact that she did not give birth vaginally remains a source of significant self-doubt; in some way, the status passage to motherhood remains, for her, incomplete.

Among the women who had experienced vaginal birth, there was agreement that birthing should, optimally, be vaginal with as little intervention as possible. However, the tone of these women's comments was less judgmental than that of the childless women or even of the new mothers who had experienced unplanned C-sections. Perhaps because these women, despite their success in achieving vaginal births, had nevertheless (as all mothers have) experienced judgment for other aspects of their mothering, they were a bit more flexible about judging unplanned C-sections occurring during labor. Alexis, a woman who delivered vaginally with a doula present, illustrates this attitude:

> Honestly, everybody goes in there with the outcome of having a healthy baby and a healthy mother. It tugs on my heartstrings when you have a woman going in there with a birth plan and they will not deviate from it, because they want to have a certain experience. … I think it is selfish and you have to have flexibility. This is not some science project that you can re-do. This is your child's life.

Alexis's comments reflect an understanding that dominant norms tie women's success at mothering to sacrifice and the natural, but they also reflect a rejection of those norms. Rather, she ties good birthing to child-centered decision making. Thus, she positions selflessness, rather than a specific type of birth, as the marker of a transition to real motherhood. In her framing, the real mother is not necessarily one who undergoes vaginal birth; rather, the real mother is the one who sets aside her own needs in favor of the child's, regardless of what that actually looks like in the birthing room.

Feminine Dignity and the Messiness of Birth

In our interviews, it was primarily childless women who spoke about tensions between norms of femininity as dainty, dignified, and tidy as opposed to loss of control, animal behavior, and the leakiness of the birthing body. Many childless women viewed vaginal birth as a violation of feminine norms, commenting on the vulgarity of vaginal birth as a "messy process" (Candice) that is "gross" (Tamara), "icky" (Aida and Candice), "disgusting" (Bridget), "not pretty" (Melanie), and "gooey" (Candice). As Aida commented, "It'll just be like icky all around, baby's gonna be all

bloody, goo's going to be going everywhere. I mean, it happens to everyone, it's not like it'd be sexy no matter what, because I don't think there's a sexy way to have a baby." We can hear how Aida connects the messiness of birth not only to tidiness and daintiness but also to sexual attractiveness, a topic we explore ahead.

While most childless women based their ideas on media depictions and stories from other women, a few had actually witnessed women in labor. Bridget, a nurse, described vaginal birth as follows: "Giving birth isn't beautiful, it isn't a tiny little glistening sweat, dabbed off and then, 'Oh, I look beautiful' afterwards. It's disgusting. Sorry, I'll probably gross you out—hopefully you will have kids one day—but there's lots of fluid, there's smells, there's people going in and out, and that's just on a normal delivery."

Bridget was concerned that her firsthand account of vaginal birth was potentially shocking enough to discourage the interviewer (who was childless) from ever having children. Bridget's comments reflect how vaginal birth was viewed by many childless women in the study as polluting, undignified, and a thing to be avoided. Similarly, Brooke had "researched a lot about vaginal birth" to learn what the "potential risks to [her] body were." She had decided against vaginal birthing because "that's one of those things that's really humiliating that I'd like to avoid. I like being independent and I also like not spending a lot of money on adult diapers." For Brooke, the messiness of vaginal birth is not limited to the delivery room, or even the bedroom, but runs the risk of persisting across the life course; daintiness and dignity, in her imagination, are simply not recoverable after a vaginal birth.

Melanie, a nursing student who had witnessed both Caesarean and vaginal deliveries, had decided on a planned Caesarean to avoid the messiness of vaginal birth and the matter out of place problem of seeing vaginas as something other than sexual objects:

> I've seen C-sections and natural births and I don't want my husband seeing me in that situation; like, there's a lot of lost dignity [in] giving birth naturally. … And if there's tearing it can be quite severe. … I don't want my husband getting that sort of image, when I plan to still have a sexual life after I have children. … And you're naked … and lots of times stool is passed giving birth … and I don't want my husband to be involved with that.

As do other childless women, Melanie links vaginal birth to a loss of dignity and compromised sexual attractiveness. She also points out tensions concerning matter out of place, where the vagina is privileged as the

site of sexual pleasure and where giving birth vaginally "confuses" matters. This attitude was also expressed by Hanna, who is leaning toward a C-section if she becomes pregnant. She said, "I like sex as totally separated from birth," noting that she would cease having sex after early pregnancy because "as soon as I start to develop that emotional connection to having a baby, I'd be like, 'No way.' Somehow, associating sex with a child is just a big no-no." For both Hanna and Melanie, the multiple natural functions of the vagina are seen as inappropriate, confusing the boundaries between innocent and profane, childlike and sexual. For Melanie particularly, this anxiety was compounded by the expectation that her partner will be present during birth. Thus, ironically, feminist and natural birth advocates' efforts to reclaim birth as a shared experience for parents appear to have created unanticipated consequences for this woman by making the blurred boundaries between the vagina's sexual and birthing functions public through the experience of shared labor.

In contrast to vaginal birth, Melanie described Caesarean delivery as disembodied and hence dignified: "C-sections are just so beautiful. You keep your dignity through the C-section. … Only your abdomen's shown and your husband's up at your head with a big screen in front of your lower half so it's not like he sees anything going on down there."

Melanie's statements reflect the understanding that vaginal birth transgresses multiple norms of femininity that require women to remain contained and demure while also being (hetero)sexually appealing and available. For Melanie, choosing a surgical, predictable birth promises dignity and control and keeps the messiness of birth from polluting or confusing her vagina's "real purpose," which is to facilitate heteronormative sexuality.

It is important to point out that not all of the childless women opined that vaginal birth is undignified. For example, Tamara explained, "It's kind of contradicting to call it undignified. … [It] is quite the opposite, because it's a beautiful, natural thing to have vaginal birth, that's the way our bodies are designed." Similarly, Sarah said, "I believe our bodies were built to do that. … Our bodies have wonderful mechanisms to push the baby out." Finally, Mackenzie described vaginal birth as beautiful. However, she also touched on the tension between cultural ideas of childbirth as noble and divine versus animalistic and profane, saying, "It's kind of beautiful in a way, the natural process of just giving birth through the vagina. … It's one of the big purposes of that for all mammals." Mackenzie's association between women and animals reveals the persistence of patriarchal assumptions regarding women's bodies as animalistic and less than human (Grosz 1994; Weitz 2003).

Compared with the childless women's comments, the new mothers' comments about naturally birthing bodies as divine yet profane were more complicated. For example, Helen described her embodied experience of giving birth as both transcendent and primal:

> It's a very animalistic process [that] got me more in touch with the animal more than anything else ever has in my whole life. … It was primal. … I was somewhere else, like I was not only more in touch with my animal, but also transcended. … And the dignity part—you know what? I mean, it's outweighed by the feeling of empowerment that I got from the experience. There is nothing like it. … When you experience it first-hand it's just such an overwhelming experience.

Helen's description reflects contradictory ideas. She sees vaginal birth as a noble and spiritual event as well as a primal and animalistic experience. Her description of the power she experienced while birthing points out another contradiction embedded in vaginal birthing: It is rarely considered feminine to tap into animal power. Nevertheless, similar to many of the other mothers' narratives, Helen emphasizes birthing as one of the rare moments when the proscriptions of dainty, dependent femininity can be shelved by feelings of empowerment through accomplishing a natural, embodied transition to motherhood.

In contrast, many of the mothers viewed Caesarean delivery as disempowering. For example, Amanda described her vaginal birth as an achievement and a source of "pride" and "self-respect." However, she associated Caesarean birth with a lack of control: "I've never experienced it, but the idea of being strapped to a gurney and having your abdomen cut open—I don't know if dignity is what I would attach to that. … It's just so inhumane. The idea of bringing a human into the world in such an inhumane way is just shocking to me." According to Amanda, surgical birth is not clean and calm but instead absolutely disembodying and thus no longer a proper birth.

While Amanda could only speculate on surgical birth, Carmen, who had a Caesarean following a long labor, offered a description of both processes:

> When I was in childbirth, yeah, I was pooping, I was screaming, I was naked, I had no shame left anymore. But I was still completely in control of my body and I was doing what I felt I needed to do and what my body told me to do. When I got put on the spinal and laid on a table, all of a sudden I went from working hard and listening to my body and doing

> everything, to being a turkey on a platter. To me, that was loss of dignity. Being shaved, being put on a catheter, having these stockings on me for blood clots … there's no dignity in that. That doesn't happen to mothers who have a natural childbirth. … To me, yeah, you're screaming, yeah, you're whatever, but you're still the powerful one.

Carmen explains that the power and control she felt while in labor was attached to successfully accomplishing the transition to motherhood. Therefore, when medical interventions precluded a vaginal birth, she felt robbed of fully experiencing this rite of passage; significantly, in her comment, she refers only to the laboring, pre-Caesarean part of her experiences as actual "childbirth."

Motherhood, Birth, and Sexuality

In addition to tensions concerning dignity and pollution, all the women in the study recognized conflicts between vaginal birthing and feminine ideals requiring women's bodies to be youthful, tight, and sexually available. As with other conflicted constructs of femininity, the childless women were more convinced than the mothers that vaginal birth was incompatible with proper heterosexual femininity. They described the postbirth vagina as "floppy" (Aida) and post-vaginal-birth intercourse as "fucking the side of an elephant" or "throwing a hot dog in a hallway" (Brooke). Juxtaposed against normative ideals of tightness and youthfulness, the post-vaginal-birth body was characterized by these women as old, loose, and as Natasha said, "used."

For most of the childless women, particularly those who preferred a medicalized birth, pregnancy and particularly vaginal birth were seen as antagonistic to the true function of the vagina, which was to provide heterosexual pleasure. For these women, availability for penetrative sex was a strong concern. As Melanie stated, "You can't have sex for like six weeks after your vaginal delivery. I don't think it's that long for C-section." Emily echoed this, saying, "If you have stitches down there, you can't do certain things, like having sex and stuff." For the women who shared this perspective, much of the anxiety did not have to do with the women's desires but instead had to do with providing an optimal sexual experience for male partners, which was presumed to involve penetrative vaginal sex. Furthermore, the idea of not being available carried with it the threat of losing one's male partner. Mackenzie described her reasons for considering a C-section: "If you've ever picked up any kind of men's magazine and read what they write … well, you're not as attractive, you're not able

to please your husband. … I can imagine it would be very painful, and then afterwards you're not able to do the same things, and you're not as well appreciated."

It is noteworthy that concerns about vaginal sex had less to do with women's pleasure than with the normative notion that women should owe their partners sex and that to be unavailable for penetrative sex raises risks for women's relationships. Thus, Emily, who said she would prefer not to have a C-section, nevertheless argued that she understood why women might opt for one:

> That whole concept, you know, of wanting to compete with younger women, knowing full well that their bodies are still intact and they are still, well … one of the things that women would want to take into consideration is that males tend to stray from their pregnant wives. I think that's a factor affecting women, why they don't want to give natural [meaning vaginal] birth.

Emily's reflections remind us that a core discourse of femininity is that women are in competition with each other for male affection, and that women engage in this competition through their bodies, which must remain tight, clean, young, and sexually ready. In this discourse, if the vagina is even temporarily stretched, painful, or unavailable, this poses a threat to masculine fidelity and to feminine competitiveness.

As with other aspects of femininity and birth choices, some childless women were less stringent in their adherence to normative notions of feminine sexuality. Several acknowledged the difficulties that vaginal birth might pose in the short term, but they also argued that this was a problem of short duration or there were ways to work around it. As Donna jokingly stated, "[for a] stretched vagina? Kegels! Suck it up, princess!" Or as Candice opined, "there must be other ways of maintaining their pleasure even after giving birth through the regular canal." For these women, the idea of remaining sexually appealing and available remains central, but they also are willing to imagine that a vaginal birth need not preclude sexuality.

An even smaller group of childless women expressed an attitude that, in fact, birth is what vaginas are supposed to do and that sexual function need not be incompatible with vaginal birth. Marissa said, "I don't know, there's lots of people with more than one child, so it doesn't seem like it [the vagina] would've really changed." Echoing this idea, Kaylee, who is First Nations and adheres to naturalist and spiritual ideas about childbirth, said, "The woman's body is so powerful in its own sense that having that

stretch or whatever, it's not anything, because [birth] is something that's been happening for millions and millions of years, and couples are still together, and I mean there's different ways of sexual activity, where you can compensate for that."

In the comments of this group of women, there is recognition that sexuality is an important part of relationships; however, these women do not see a tight vagina as the sole means of sustaining such a relationship and do not see that vaginal birth will preclude sexuality.

Women who had experienced birth were generally more likely to see sexual and maternal tensions as resolvable. Many of the mothers, particularly those who had experienced vaginal birth, but also those whose births had begun with the hope of a natural birth but ended with medical intervention, were strong believers in the flexibility and power of the vagina to accommodate and reshape itself. These women also mentioned Kegel exercises as a way not only to maintain sexual function but also to avoid incontinence as an effect of vaginal birth. Nevertheless, the women who had experienced C-sections echoed many of the themes voiced by childless women, including worries about sexual performance and availability. Furthermore, two of these women specifically attributed these ideas, and their decisions about birthing, to influences from their partners. Tanya, who hoped for a vaginal birth but had an unplanned in-labor C-section for her first child and a planned subsequent C-section for her second, said, "My husband said afterwards, 'I'm so glad you had a C-section. I was worried about the sex afterwards.'" When asked whether this played into her decision to have a second C-section, she said, "Well, it played into his! He said go ahead, have a C-section next time for sure … and then you don't have to worry about messing anything up!" Echoing this, Naomi's husband supported her decision to have a self-selected, planned C-section because it would "keep the damage to one area, and [because] everything might not go back completely."

It must be noted that partners' perspectives also played into the perceptions of women who did not experience C-sections. Nora, who at the time of her interview was pregnant and hoping for a natural birth, noted, "My husband's worried—I guess he's joking about that, but I think it's a genuine concern for him, but not for me. He says things like, 'Just put an extra stitch in.' But it should be okay; I've been working on my Kegels and stuff."

The message attached to Nora's husband's joking concerns is clear enough that she is making sure to work her body to minimize the effects of birth and sustain his interest. Finally, women's concerns about sexual

availability were not limited to vaginal births. Rita, who had a medically mandated C-section, argued that C-sections were worse for postpartum sexuality "because you feel so bad for so long after a C-section."

In all of these comments, it becomes clear that feminine sexual availability was important to these mothers. However, for a few women, such concerns were seen as evidence of a failure to make the transition to proper motherhood. Whitney, who had an unplanned in-labor C-section, saw women who chose planned C-sections for "cosmetic or sexual reasons" as making bad choices. She said, "It's not about you anymore. It should never have been about you. It always should be about the child. So I think they're selfish and I question what kind of parent they are." Ironically, for women like Whitney, the choice to remain sexually attractive and available by choosing a C-section is not appropriate. In her characterization, to be a true mother, a woman's selflessness must be oriented toward the child rather than the partner or the self. Either way, the woman is positioned as one whose choices are governed by the needs of others.

Finally, two mothers spoke clearly of how, in a mature loving relationship, "that stuff's not going to matter" (Abby). These women expressed that vaginal birth was, in its own way, sexy, describing partners whose response was, "You're so amazing, I can't believe what you've just done" (Abby). As Alexis stated even more pointedly, "having seen his son being born made me even more beautiful and attractive to him. There's a whole new level of intimacy that comes with that. … I gave up my hopes of being a swimsuit model years ago, and so every stretch mark, every piece of skin that wasn't down there before, those are my mommy badges."

Alexis's comments remind us once again that selfless motherhood is a feminine expectation. In her comments, we can understand her sacrifice of her sexy prepregnant self as a heroic gift, given in order to become a good mother.

CONCLUSION

Both childless women and mothers discussed the tensions women navigate between selflessness and sacrifice in relation to different types of birth and norms of feminine embodiment. The interviews reveal the understanding that motherhood is a rite of passage for women characterized by the transition from selfish child to selfless adult, ideally accomplished through the vehicle of vaginal birth. Within this framing, having a vaginal birth, which is associated with pain, is viewed as an accomplishment and the means for a successful rite of passage into selfless motherhood. That being said, for childless women, the belief that pain and

sacrifice are necessary as a passage to real motherhood was stronger than that expressed by women who had experienced childbirth and motherhood, particularly when those women had given birth vaginally. For childless women, eliding the pain of childbirth was tantamount to selfishness and laziness, while for mothers who had experienced unplanned C-sections, vaginal birthing often remained as a standard by which these women judged themselves; for these women, the rite of passage remained in some ways incomplete because this idealized birth had not been achieved. However, for the women who had experienced vaginal birth, there was a clearer conviction that childbirth is only an opening to motherhood.

The interviews also reflect the tensions women must navigate in relation to norms of feminine embodiment whereby women are expected to be demure and reserved, childlike and innocent, and birthing vaginally can be a violation/profaning of that purity and innocence. In particular, the unpleasant smells and sounds and the loss of fluids were cited as reasons vaginal birth is perceived to be messy, undignified, and degrading. Nevertheless, although vaginal birth was viewed—mainly by childless women and by the one woman who had a self-selected C-section—as undignified and unfeminine, the women who had experienced vaginal birth described these tensions as relatively trivial. For these women, the messiness of vaginal birth was not a violation of feminine norms of purity and innocence but represented instead part of the rite of passage to motherhood. For childless women, the specter of losing control and dignity, screaming, leaking, and behaving in an unladylike fashion loomed as a threat to femininity. However, women who had experienced vaginal birth or partial vaginal birth dismissed this purported lack of control and instead described a sense of power and ownership experienced while birthing vaginally.

While vaginal birth is associated with a successful transition to selfless motherhood, it also conflicts with Western feminine norms that require women to be sexually selfless and remain tight, youthful, and constantly available for heterosexual pleasure. Many of the childless women spoke forcefully about the ways vaginal birth conflicts with feminine ideals that require women's bodies to be youthful, tight, and available. Thus, ironically for some of these women, having a Caesarean birth was constructed as a selfless way to maintain their prepregnancy bodies and thus remain sexually receptive and attractive to their male partners. The mothers also spoke about the difficulties women face when negotiating oppressive standards of youthful femininity while simultaneously making the successful status passage to motherhood. However, the mothers' narratives

provide a much more complex and ambivalent picture in relation to vaginal birth and sexuality than do the narratives of the childless women. For these mothers, being sexual and having given vaginal birth were not irreconcilable, and for a small number of women, experiencing vaginal birth enabled them to frame themselves as amazing, powerful women in ways that enriched their gendered self-concept.

The central themes in this article regarding pollution versus dignity, sexuality versus innocence, and the status passage to motherhood are all tied together by the moral imperative for women to be selfless, which is a core attribute of femininity and motherhood. Karin Martin (2003) argues that despite the cultural assumption that women in labor are demanding and self-centered, even during childbirth women try to be polite, kind, and selfless, revealing that they have internalized disciplining ideals of femininity. Our research similarly reveals that women's childbirth experiences and choices are tied to disciplining expectations of femininity. Indeed, selflessness as a normative aspect of femininity and motherhood was reflected in all of the women's opinions about and experiences of births, be they vaginal or Caesarean.

With the notable exception of Martin's (2003) research, which examines cultural proscriptions and norms embedded in representations of childbirth, the majority of feminist research on childbirth has focused on issues of medicalization and social control (cf. Davis-Floyd 1992; Mitford 1992; Oakley 1980, 1984). This article moves research on childbirth in a different direction by examining the tensions women encounter between discourses of femininity and discourses of moral motherhood relating to vaginal and Caesarean birth. These tensions highlight that women's choices are not freely made but instead are enacted within a limiting range of disciplining and competing framings of ideal femininity, sexuality, and sacrifice. Ultimately, these competing discourses leave most women in a position of failed womanhood regardless of the particulars of their birth "choices."

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