Obstetric Anesthesia Abuse: Delivering Us from Evil

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Full Text: Birth as a creative act has always occupied a place of significance in human culture. "The events of childbirth have been sacred to most cultures [bringing us] closer to the meaning of existence than to our day to day routine." (14:380) The social conditions determining the context of birth also serve to determine its meaning and function in a given culture. The woman in travail has always been wrapped round with varying degrees of mystery, control and power politics. In the earliest historical cultures, childbirth was a woman's realm, attended and interpreted by women alone. As patriarchal society began to take over, control of women's reproductive lives and their sexuality was determined more and more by male authorities, even the nature and meaning of giving birth. A woman's primary "rite of passage" in birth became sterile-literally and figuratively-as it came under control of medical patriarchy, to be "replaced by [profitable] external events celebrated with intoxicants or vicarious experience." (14:380) In North America today, most women think that giving birth is difficult and dangerous, too difficult without extensive technology and pain-killing drugs. Where does this belief come from, and whose purposes does it serve? FACTORS IN PAIN PERCEPTION To discuss birthing women's need for pain relief intelligently, one must first examine those factors involved in the perception of pain in general. Pain has been the subject of much scientific investigation since the middle 1800's. It has been determined that pain perception is partly controlled by psychological variables. In traditions of healing other than Western allopathy, there is the concept of "healthy pain," a necessary part of a "healing crisis" where symptoms come to a head before the body turns towards wellness. However, modern medicine considers almost all pain to be "bad," indicating absence of health. We tend to believe that all pain can and should be relieved by medical means, and to "expect relief at very low levels of suffering. This belief is reinforced by hospital procedures which provide pain relief as a first line of therapy rather than as a last resort." (30:83) Most Westerners generally perceive pain as marking a disease state: "Unprofessional persons are always accustomed to associate together the ideas of pain and danger; yet the physician well knows that the most fatal maladies are often the least painful." (45) Subjective pain intensity does not directly reflect the level of stimulation, the extent of tissue damage or the danger to the organism. (40:36) Thomas Szasz argues that pain arises "as a consequence of a perceived threat to the integrity of the body . . .either for objective reasons or for emotional ones." (39:30) [italics mine] Pain is a psychological event: psychogenic pain is psychologically caused (as from tension even when the tension is psychological); organic pain is physically caused. (39:25) The experience is that which we primarily associate with tissue damage or describe in terms of such damage-"cutting," "stabbing," "burning," etc.-but the origin and intensity of pain can be strongly associated with certain attitudes and chains of psychological events, such as hostility, fear, resentment and guilt, especially when expression of these attitudes are unacceptable. For example, a woman's fear of her doctor is unacceptable, therefore she experiences pain, a "conversion symptom," that is her attempt to have her distress brought to light. (39:28) Researchers admit that there is no such thing as purely sensory pain, since all sensation is subject to modification, either at a subcortical level before it is consciously apprehended or after conscious apprehension by the cognitive mechanisms of conditioning, significance and meaning. It is the reaction component, affective and cognitive, that determines the perception of pain. (36:61) Studies of placebo effect demonstrate that it is psychological factors which are responsible for pain tolerance not pain threshold-in other words, one's inner state determines not when pain is experienced, but how well one copes with what one is feeling. (8) One theory of pain, the gate control theory, holds that the central nervous system can only process so much information at a time, so that certain activities

(attention, excitement, anxiety, memory and emotion) can serve to open or close the information gate for other inputs-including pain-generally over the body or more selectively at specific sites. This theory accounts for athletes not being aware of injuries that would cripple non-competitors, of soldiers ignoring wounds that incapacitate surgical patients (36:64), of soldiers tolerating severe battle wounds but complaining of the pain from inept venipuncture. (38:18) It also explains the mechanism of lumbar puncture hydrotherapy for childbirth, whereby a painful injection of sterilized water into specific sites in the lower back totally relieves lower back pain during early labor. Gate control theory holds that pressure on certain nerves can "cut the pain impulses that travel back to the brain and are interpreted as 'pain'," that pressure prevents "part of the message getting back to the brain so that labor contractions are perceived not to hurt as much." (20:31) People cannot develop CNS coping strategies for pain intensity that escalates too quickly, but "more slowly rising temporal patterns [are] susceptible to central control." (38:22) In the West, medicine has systematically emphasized sensory mechanisms and neglected motivational and cognitive contributions to pain. This has rendered drugless therapy for pain suspect-"seemingly fraudulent, almost a sideshow in the mainstream of pain treatment"-despite the fact that suggestion, placebos and hypnosis are known to have a profound influence on pain. (38:22) However, even active drugs work partially as placebos. Drugs are administered with suggestions as to the nature and extent of their effects, and the patient interprets their effectiveness in light of these suggestions. (40:39) In treating pain, physicians consider: * a drug * the permanent and transient physiological state of the patient * the context of treatment * implicit/explicit suggestions accompanying drug administration * the patient's psychological history, which influences: * the patient's response to the context * the patient's understanding of the suggestions * the patient's interpretation of internal sensory changes caused by the above. All but the first two are placebo effects. (40:39) Expectations affect pain experience. Uncertainty concerning future pain causes anxiety and information that reduces uncertainty reduces anxiety. When anxiety about pain is reduced, the subjective experience of pain is reduced. (40:36) Information creating accurate expectations does not affect anticipatory stress, only the level of anxiety, the emotional response to pain, experienced during the painful stimulus. (37:200; 40:37) The more incongruency between the expected pain and the experienced pain, the greater the emotional response. Modification of expectations during pain can reduce incongruency and stop an accelerating distress response. (37) Researchers have concluded that therapy for distress is not equivalent to therapy for high pain. (37:201) This knowledge is already applied in medicine where it is common knowledge that some drugs, like morphine, work only on the psychological dimension by exerting "an influence on the affective or reaction component of pain." (40:37) Expectations, however, are based on meaning as well as information. For example, surgical patients expect unbearable pain and expect to be treated for it because surgery is a disaster for them. For similar wounds, battlefield surgical patients do not expect/need pain relief because their wounds mean survival-that they get shipped home. (36:64) Meaning is also operative in athletic injury pain where the expectation of pain demands its acceptance as being demonstrative of "manliness." (41:130) In contact sports, the ability to tolerate pain is strongly associated with socially desirable traits, and often prior experience proves that the pain itself is not harmful. These examples demonstrate that the social construction of the meaning of pain operates in its perception. The meaning of pain is determined to a large extent by culture. Cultural factors, as ethnicity or religious affiliation, can "impose a differential pain response," (43:147) where cultural expectations determine not only what the pain means, but how much pain is experienced and whether and how response to pain is expressed: "Pain perception is related very strongly to cultural norms about how it is felt, perceived and shown and reinforced by social expectations in a particular social context." (30:83) Pain threshold, the point at which pain is experienced, appears to be similar in all cultures, but the threshold where it becomes unbearable is subject to cultural influence. (40:39) People learn to express pain reaction by observing others' reactions. One chooses a model similar to oneself, but rejects those who are too divergent. (41:142) One study showed that the more people identified with members of another group whose pain tolerance was said to exceed that of their own group, the more pain they could tolerate

beyond their original tolerance threshold. (40:40) In different cultures, identical behaviors may reflect different experiences and identical behaviors may have completely different functions. (43: 149) In "Old American" culture it is expected that pain is reported without emotional reaction. (43:149). Therefore, American hospital staff consider that certain cultural groups overreact to pain, are overly emotional about pain and complain excessively. (43:149) In one study all the mothers, regardless of race or ethnicity, "uniformly saw their pain as more severe than was judged by the staff people." (42:162) After studying birthpain responses among 80 "primitive" groups, one study concluded that pain responses of these groups did not differ from European and American responses. (6) Birthpain is generally expected as part of childbirth in all cultures, yet in some cultures it is not accepted and is alleviated, whereas in others it is accepted and little or nothing is done about it. (41:130) In American culture it would appear that women have been convinced that childbirth will not hurt too much-yielding extreme distress when it does-that if it does the pain should not be accepted but relieved, that the expression of negative emotions (fear, anger, anxiety) around the pain must not be expressed regardless of the level of sensory pain, that childbirth is dangerous and constitutes a "disaster situation" requiring crisis intervention, that the ability to tolerate birthpain is not socially desirable, that women who tolerate birthpain without medication are viewed as "too divergent" to constitute culturally appropriate models for pain expression. Moreover, because of the overwhelmingly widespread use of obstetrical anesthesia, most women do not have the chance to benefit from past experience proving that the pain was not, in fact, harmful, nor that birth can take on a different meaning for them as individuals if they choose different models. As North American culture slowly becomes the global standard, this cultural interpretation is beginning to determine childbirth practice planetwide. THE SOCIOHISTORICAL CONTEXT OF CHILDBIRTH How have North American women come to believe these things about themselves? We must look at social history to understand the specific psychological factors at work, the operating belief systems and then- evolution. White North America was founded on Judaeo-Christian principles. It is likely that these principles have been of great importance in determining the meaning of birth for North American women. It is also likely that these "religious attitudes, insofar as they influence the perception of the physical self, may also color the pain response." (43:150) In Judaism, a mother's health is primary and supercedes all other rules. The birthing mother is viewed as one "whose life is in danger," and anyone who aids her for up to three days postpartum is performing the blessing of "pikuach nefesh," "saving a life." (5:32) A Jewish woman internalizes this culturally enforced stereotype of childbirth as dangerous. Her anxiety increases during pregnancy, increasing her pain in birth, and increasing her desire to use pain reduction measures. There is "no prohibition on the use of analgesia during labor" (ibid.) since her pain has already been made intolerable by her beliefs around the experience of giving birth, and her dependence on outside intervention is already guaranteed. Palestinian women rely on divine intervention, believing that "during the pain of childbirth heaven is . . .open and angels go up and down so that this is a good time for everyone present to make special requests to God. . . .If the labor is long or difficult, it is then easy to make direct requests to God for help . . .women attending the birth should not be noisy or quarrelsome or talk about their own sufferings in childbirth." (30:71) Christian beliefs around childbirth and pain have changed over time. Two major concepts inform the emotional context of birth: the chance for salvation at death, and Eve's sin in the Garden of Eden. Making a definite departure from the Judaic concept of the physical creation as "good" (Genesis 1:25), early Gnostic Christianity, which held that the world was irredeemably evil and that a person could be saved only by being possessed by the divine spirit within, condemned midwives as herbalists. A Gnostic text, Proof of the Apostolic Preaching, states, "the [fallen] angels brought to their wives as gifts teachings of evil, for they taught them the virtues of roots and herbs . . .every sorcery and idolatry, hateful to God." (32:122) This notion was consonant with the Church's developing Paulist concept of the "spiritual body," which served to alienate physical experience of bodily reality from the otherworldliness of God. Gnostics believed in an "original bodily creation that wasn't quite sensual and the resurrection of a body that wasn't quite bodily but had been transformed into a 'spiritual body1." (32:153) The Dichotomy separating women's bodies from their spirituality

has been termed the "primary dogma of patriarchal spirituality, that attachment [to one's body, to one's loved ones] is pain." (11:460)* Likewise, during the European Inquisition, midwives were considered "the worst offenders of all" because they eased the pain of childbirth which was woman's God-ordained payment for Eve's sin. (2) Beginning in 1567, midwives had to swear not to use sorcery or enchantments during labor, only baptism. In 17th century France an invocation to the Virgin was used "stressing the pain and suffering that justifiably ensued from the sinful act of conception," (30:68) or a woman labored with a lit candle and a Rose of Jericho in holy water, the gradual opening of which symbolized the blossoming of Jesus' birth and his resurrection and the woman's body opening for birth. (30:73) Relics of saints, a bell round the mother's waist, the pealing of church bells, the reading of St. Margaret's biography all were means of easing pain and procuring a safe delivery. Images were used for pain relief in America, where Catholic images were replaced by an axe or the husband's scissors in the shape of the cross under the bed to cut the pain. Their religion conditioned women to regard birth as a direct expression of God's will, symbolically expressing the spiritual state of the mother. The "deliverance that really mattered was salvation, not warding off evil spirits in childbirth," (44:23) and women were not to avoid salvation by seeking to avert misfortune or pain. Many 17th century women approached childbed with dread, due to the cultural emphasis on "birth as potential death," (44:212) despite the fact that death was uncommon. Birth was seen as an opportunity to be saved, and women were expected to pray for salvation, "to throw herself on God's mercy for no medicine could ensure her safety." (44:21) Truly religious women rejoiced at the chance to purge themselves of sin and to come closer to their God. The diary of one New England midwife, Martha Ballard, is full of thanksgivings, more than mere mouthings, but an expression of her awareness of where women's help lies in childbed. (44:21) Pain was of little import, though it was expected and inevitable, except for the nobility, who were reputed to be so pure and morally above commoners, that they were said to deliver painlessly in their sleep. (44:113) Women suffered pain here and now in return for reward in the hereafter, a natural response to their lack of opportunity for self-actualization on earth (3:30), except in their role as mother. By the 18th century, there was a new awareness of science-natural laws-coupled with a new version of deity as more distant and more "willing to share control of events with mankind" (44:23). Women became less fearful as they experienced "a new sense of the regularity and reliability of natural processes in birth" (44:24) although there had been no real change in numbers. Physicians, who had begun to monopolize the field, dismissed superstition and religious belief, believing that "direct physical manipulation alone aided birth." (44:32) As midwives were driven out and women's choices began to shrink, they accepted treatment that rendered them childlike and dependent, and acted out current feminine stereotypes of sexuality calling for confinement, concealment, shame and secrecy. (44:101) As these stereotypes evolved toward the upper class feminine ideal of weakness and frailty in the nineteenth century, the myth of peasant women laboring in the fields, giving birth and returning to work immediately was created to elevate 'more civilized' women above the 'animal nature' of the lower classes. Suddenly birthpain was of overwhelming concern. The culture expected real women to suffer, and so they did, from a combination of physiologic causes (corseting, lack of exercise, bad diet, arsenic-nipping for a pale complexion, etc.) and psychological tendencies toward invalidism, since ladies who were "weak, invalided, nervous or subject to fainting spells [were] marked as being above the common clay." (44:111) Doctors began to describe birth agonies as "greater than the terrible agonies of soldiers in the Civil War" as more women appeared to suffer more pain, and, with the use of chloroform, physicians began to treat some women's pain. Women eventually demanded relief for all of them. According to doctors, painless birth was diagnostic of women who were not truly feminine, defective in "proper womanly submission and selflessness." (44:114) A contemporary feminist, Elizabeth Cady Stanton, claimed that if the laboring woman suffered, it was because she was not living sensibly as the equal of a man, according to God's true design. (44:115) Women were caught-either they continued to suffer pain because they weren't sufficiently dependent, or because they weren't sufficiently independent. Given the restrictions imposed on them, the way of dependency won, and women became increasingly dependent on male physicians as they approved

methods to remove birthpain entirely, seeming to take "a kind of aesthetic delight in the efficiencies of the hospital, in its paring away of the economic, social and psychological aspects of birth in order to focus only on the pelvis as a machine." (44:159) In the early part of this century, eugenicists saw painfree birth as a way to "joyfully embrace the ideals of [upper class] motherhood and wifeliness . . .if such women once more regarded delivery as a joyful experience, the Anglo-Saxon race would not 'die out' and women might rediscover the joys of traditional femininity and maternity." (44:152) Over the centuries birth had moved from religion to technolatry, suffering to painlessness, home to hospital, normalcy to pathology. This move led women from dependency upon male deity to dependency on the male medical establishment. Charlotte Tell (35) summed up the evolution of women's attitudes to birth: In those ages when women felt the religious significance of giving birth . . .they so frequently regarded the act as a great, mystical freeing of the life from the womb-not merely a birth but a resurrectionthat they completely lost consciousness of pain . . .as men were sometimes unconscious of their wounds in [holy] battle. Today . . .we are all. . .inclined to think of our bodies, not as instruments of cosmic forces, but as personal possessions . . .To inflict upon the modern woman many burdens and sufferings which a cruder type of woman took as a matter of course is unnatural. INTO THE PRESENT: MEDICINE AS RELIGION, TECHNOLATRY Beliefs are assumptions made about the world, conscious and unconscious, that determine the way people live. (24:312) Religion can be defined as a system of faith and worship where there is recognition of a controlling power entitled to obedience and the effect of this recognition on conduct. (29) Technolatry, faith in and worship of medical technology, is America's answer to religion. Ivan Illich has written about the paralyzing effects of a strong belief in the supremacy of technology. (24:313) Through technology, we are guaranteed a successful outcome-a healthy mother and baby-and natural processes are dismissed. (10:5) Many women now believe in the power of technology . . .their power is outside themselves. Their sense of control is located in external places, rather than with themselves. These beliefs have become . . .internalized and emotionally charged . . .not easily relinquished . . .unless there is an opportunity for the systematic and conscious examination of these beliefs or a crisis situation that demands a new creative response . . .in the same emotional state in which [they] learned these beliefs . . . (24:302) If the argument is made that obstetric technology is responsible for safer birth outcomes, it can be countered by research which clearly shows that obstetricians employ "a nightmare of technical and chemical interventions in the name of safety but without [the support of] sound scientific evidence." (27:xi) Colonial American history shows that excellent birth outcomes were possible without obstetric technology due to an "insistence from the contingencies of the environment that . . .women birth normally and naturally" (24:313), and improvements since have primarily been associated with cleaner water, better hygiene and nutrition. Regardless, modern mainstream American women seek out an obstetrician, "transferring onto a powerful authority figure the responsibility for their own bodies and experiences," (27:xix) under the misconception that this arrangement is necessarily the safest. Before the rise of technolatry, it was accepted that occasionally mothers and babies died, that it was God's will. Mothers were the center of the birth process, because "they had to believe in themselves and in the natural function of giving birth. They could not afford blind faith in technology." (24:302) As obstetrics gradually excluded mothers from their central role in the birth process (27:10), laboring women could choose to give up during birth and let the doctor finish for them. (24:302) Physicians made themselves essential to the birthing process: increasing mothers' pain by immobilizing women on their backs, insisting they give birth in particular, nonphysiologic positions, separating them from supportive home and family, doing the opposite of what is the essence of quality birth assisting, i.e., helping a woman feel secure and at ease. (27:45) Conventional obstetrics "leaves most women no option but to request epidurals and other artificial relief." (27:98) Giving women painkilling drugs and synthetic hormones disrupts the hormonal balance on which spontaneous labor depends, taking birth out of the realms of healthy activity (27:15) and indeed making the physician essential to the process, creating a self-fulfilling cycle. "In the environment of modern obstetrical care women . . .find it harder and harder to give birth naturally and the need for medical intervention is increased . . .while helping a few women with problems,

[it] causes more problems and increased medical interventions for everyone else [which] is very good for doctors [and pharmaceutical companies and hospitals] wanting to make more money . . .but does not serve the needs of the majority of women." (30:97) In fact, any unnecessary use of chemical agents can be considered abusive, since in the huge majority of cases it risks the health of mother, fetus and family without medical or moral justification. The technocracy is using women's "new consciousness"-their belief in their right to a pain-free birth-in the service of the status quo. The demand for anesthesia serves to maintain women's subordination. Liberation depends upon "an emerging consciousness of servitude" (3:143), and the surest way to prevent liberation is to implant false needs which "perpetuate obsolete forms of the struggle for freedom" (ibid.) and provide false satisfaction at the filling of these needs. Thus, the medical patriarchy "calculates how much women will tolerate, to what extent the new consciousness can be exploited . . .for economic gains or to enhance the image of institutions as 'liberal' by extending minor rewards to women, without essentially changing anything." (3:170) Obstetric rituals serve to increase women's dependency, creating false needs "such as the need to lean on father-figures instead of finding strength in the self." (3:143) Those in power then grant transient relief from these false needs-relief from iatrogenic pain-creating "repressive satisfaction," (3:144) repressive in that such satisfaction does not arise from the satisfaction of true needs. What people believe is what they hear, over and over, what they are conditioned to believe will come true. Research has shown that the hypothalamus, the part of the brain responsible for instinctive birth "knowledge" and control, can be accessed by the use of images (as in magic, videos, literature, songs, stories) in psychophysiological techniques (24:316; 28:16). Popular literature from the alternative childbirth movement speaks repeatedly of changing a woman's beliefs system-"a woman's belief about herself and her labor determine the course of that labor" (13:17)-to make it conducive to a normal birth. (24:323) North American women hear mostly terrifying and dehumanizing tales of childbirth, running the gamut from reports of humiliation to maternal death (28:25), which effectively reduce the birth experience to something a mother "has to go through to get a baby." (28:35) "If [women . . .and doctors] only hear that birth is abnormal, then it will become so." (24:302) One of the most insidious corollaries of the rising cesarean rate is the spread of the belief that many women-some believe most womencannot give birth without medical technological, usually male, assistance. The next logical step is to believe that the birth process, itself, is somehow inherently dangerous, and therefore bad. (17:52) Now, since doctors must be God and save us from the evil of our bodies' dysfunctions, they are to blame if something goes wrong. They, in turn, blame the victims by practicing 'defensive medicine.' (10:5) It stands to reason that for men to control women's reproductive lives, they had to make themselves essential to the birth process. By having redefined birth as dangerous and a realm where the helpless woman needs saving, and by having inculcated and reinforced technolatry in society at large (e.g., in Sweden the law guarantees complete pain relief in labor! (27:xvii)), physicians have justified their presence at/created a need for their participation in birth. (31:169) WHAT MAKES BIRTH HURT? In obstetrics, the relationship between obstetrical difficulties and psychological problems has yet to be studied systematically or given wide credence. However, much research combining the social and physiological variables in birth points to an important interplay. One study constructs the model of a woman more likely to have more intense pain in labor as: primiparous, younger, having a history of menstrual problems and abortions, having an indifferent or negative mate, emotionally unstable, having unrealistic expectations of birthpain and the effectiveness of pain-relieving medication, more anxious about her baby's health, using more "affective" rather than "sensory"* words to describe her birthpain. (7:123) Labor length, complications and difficulty of delivery seldom affect pain or enjoyment of childbirth. (26:260). However, it has been found that the amount of anesthesia/analgesia used varies directly with anxiety, and that a first-time mother's measured anxiety at 32 weeks gestation best predicts her use of medication during birth. (7:119) Class preparation helps primiparae deal with early labor, reducing anxiety by creating accurate expectations. Classes do not aid multiparae, whose anxiety is already reduced through prior experience during childbirth, because, despite feeling equivalent sensory pain during active labor and greater sensory pain during pushing than nulliparae,

they experience less affective (and, therefore, total) pain in labor than nulliparae. (22:238) To reduce anxiety and incongruity between expectations and experience, the laboring woman needs attendants whose belief system is compatible with the birthplace chosen by the mother. (24:323) Attendants must be comfortable with a woman's expressions of pain in labor. Good attendants do not require the mother to control her behavior to reduce their own discomfort in witnessing the intensity of her experience. (28:88) "Antagonistic, non-supportive or fearful people should never be allowed at any birth because they undermine confidence." (12:356) Supporting physiological evidence includes findings that endorphin levels are influenced by the hypothalamus, which is affected by "pheromones given out by birth attendants . . .the chemistry of confidence of traditional midwives is . . .very different from the chemistry of fear and doubt . . .in the atmosphere of a modern hospital." (30:86) Despite predictions to the contrary, socioeconomic status does not appear to alleviate birthpain (socioeconomic status varies directly with the mother's sense of security and inversely with her happiness about being pregnant), notwithstanding the increased likelihood of childbirth preparation and spousal presence at the birth. (7:118) Spousal emotional and physical support, or other social support, has been shown to help improve the birth experience (26:260; 25:205) and to reduce the need for interventions, probably due to the predicted increased pain tolerance. The other factor critical to a woman's enjoyment of childbirth is early interaction with her newborn. (25:205) Cognitive processing theory, claiming that "noxious stimuli are processed by two systems"-one to make a mental schema of the painful stimulus and one to produce an emotional response to itexplain the findings of one study (21) where women monitored and reported on the sensory nature/level of their birthpain and/or took Lamaze childbirth classes. Classes were effective in reducing anticipatory anxiety and reducing the affective pain in early labor by providing accurate expectations. Lamaze distraction techniques, which assume habituation and conditioning, were found to be effective only when labor was brief and the mother was passive, but that attentive monitoring was more effective when "adaptation required prolonged self-management" (21:369) as in the more painful parts of labor and the active phase of pushing. Classes did not seem to produce more confidence in mothers' ability to handle labor, the only variable explaining the decreased pain and anxiety of multiparae vs. primiparae, when the sensory pain of active and heavy labor is equal for the two groups. (22:244) All of the studies show that "the increased quantity [frequency] or intensity of noxious stimuli . . .[i]s not responsible for the increased pain perception," (22:244) since it is affective components that determine the increase in total pain. Other studies highlight a mother's confidence as being central to her experience of pain and satisfaction with her birth experience. One article claims that "confidence in ability to handle labor emerged . . .as the most critical variable to the explanation of active labor pain" and that it "may function more powerfully than and independently of childbirth preparation in reducing pain during labor." (22:242) Childbirth classes do not appear to instill confidence, but reduce pain only insofar as they prompt "attitudinal changes [cognitive/affective] toward the labor experience or increased social support." (22:244) Hospitals "work in overt and subtle, conscious and unconscious ways to make . . .women dependent, passive 'good patients'," (17:52) but good childbirth classes can short-circuit this undermining of a woman's confidence by emphasizing birth as normal physiological function. (18:47) Unfortunately, most hospital antenatal classes are based on a biomedical mechanistic approach, where the body is a machine to be controlled by the mechanic-physician. (30:62) Information that used to be held by older women is now "packaged as 'expert advice' provided by professionals and, all too often, classes are just forums in which women are told about the advantages of technology and how it will be used, getting them to accept the technological approach." (30:63) Classes do not concentrate so much on developing positive attitudes and beliefs, but teach women to see labor pain as external to themselves, alienate women from their bodies, and teach them to use resources to battle against themselves-an exhausting and counterproductive use of energy. (28:18) Most classes teach that fear and its expression is unacceptable, as is expression of pain. For a woman giving birth in a hospital, she experiences "a continual inability to protect herself and control the access of others to her body." (33) Expression of pain is felt as the only thing over which she exerts any control, and classes support this focus.

Classes teach that if she is not reacting to pain, she is coping and the pain is "bearable'; if she is crying out, then the pain is 'unbearable'. (31:173) In psychoprophylaxis (Lamaze), behavioral control is equated with situational control, and the woman is rendered a 'good' patient by giving her a task that makes her compliant, quiet and obedient. (31:92) If the birthing woman deals with pain by crying out, she forfeits her right to make decisions, and the doctor makes decisions for her, including as to whether or not she requires pain medication. Painful internal examinations are demanded by the hospital schedule. This iatrogenic pain, inflicted for institutional needs to which the woman has been conditioned by prenatal classes, justifies the medical presence by requiring its medical solution, anesthesia. Anesthesia cements the doctor and woman in an active-passive relationship-doctor makes decisions, defines normal and emergency, works on the mother using forceps or surgery to pull the baby outbecause "a woman who [is] unconscious, semistupefied, amnesiac or simply numb from the waist down cannot . . .experience giving birth as an accomplishment, something over which she had control" (31:177) or in which she actively participated at all. Anesthesia gives rise to a situation in which only the woman's reproductive parts are of interest to her attendants, where she gives her body to her attendants. "She is separated as a person, as effectively as she can be, from the part of her that is giving birth." (33) One study cited "less traditional attitudes toward sex roles" (26:260) as having a positive impact on greater enjoyment in childbirth, perhaps due to a woman's greater self-confidence, less inhibition, better support network and sense of control concomitant with such attitudes. Anxiety and confidence can be interpreted as opposite ends of the spectrum of stress. There are physiological reasons why stress affects pain in labor and the need for pain relief, although many obstetricians forget the lessons of basic physiology. (In 1988 an obstetrician in Women's College Hospital was heard to say, "Stress has no effect on labor.") Psychological stress, in the form of inability to cope with labor pain is a "real stress to which the body reacts, discharging metabolites at an increased rate." (28:11) Labor is hormonally controlled, and the neurohormonal balance is "highly responsive to external conditions and psychological states." (27:15). Adrenaline, our bloodstream's equivalent of fear, tension or anxiety, slows labor mechanically by the withdrawal of blood from internal organs to large muscles and relaxing smooth muscle (the uterus consists of smooth muscle), and hormonally by reducing the output of oxytocin, the hormone that stimulates uterine contractions, and reducing the body's production of its own painkilling anxiety-reducers, endorphins. (18:47;27:14) High adrenalin levels can also reduce blood flow to the foetus, leading to fetal distress and increasing the need for emergency operative delivery. (18:49) Fear also affects the muscular action of the contracting uterus. The longitudinal muscle layer is that responsible for opening a woman up in labor; the circular layer holds the cervix shut and resists the action of the long muscles; the crisscross layer intertwines with the blood vessels that supply the uterus. When a mother is frightened her sympathetic nervous system activates and directly stimulates the circular muscle layer round the cervix, increasing resistance to the opening action of the longitudinal muscles. The sympathetic nervous response also restricts the blood supply to the uterus, preventing efficient elimination of waste. Not enough oxygen is getting through to the uterus, not enough waste is carried away. Her contractions may be powerful, but 'incoordinate,' leading to fatigue and 'failure to progress.' (16:350) This is the classical Fear-Tension-Pain syndrome which Grantly Dick-Read described: "When a woman is anxious and fearful about labor . . .then the labor contractions are felt as labor pain." (16:351) Control appears to be closely connected to satisfaction. Some studies report that the less anesthesia used, the greater a mother's satisfaction with her birth (4; 25; 26) and that "medication in uncomplicated labors results in confusion, lowered awareness, a decreased ability to deal with pain and less enjoyment." (26:263) Unplanned caesareans are more distressing than planned caesareans despite identical sensory pain. (4:441) Cesarean under general anesthesia (usually unplanned) is less satisfying than cesarean under regional anesthesia. (4:439) Planned caesareans are perceived as equally satisfying as vaginal births with anesthesia (4:441) in the more recent research (4:441), whereas older research holds vaginal births without anesthesia the most satisfying of all. (25:203) The disparity in findings could "reflect the increasing use and acceptance of epidural anesthesia" over time at the study sites. That is, epidural anesthesia is so widespread now, that its use

has been normalized, as has planned cesarean delivery. (4:445) Somehow, in order to give birth safely without intervention and with satisfaction, thereby reducing their utter dependence upon [primarily] male resources outside themselves, women must be reeducated as to their ability to do so, as to the desirability and safety of doing so, and be unstintingly supported during pregnancy and birth by caregivers and socially significant others, in order to allay anxiety, build up confidence, restructure the significance of the event to women so that they control what is done to them, their bodies and their babies, and by whom. JUSTIFYING LABOR PAIN Pain in labor stimulates endorphin production, "the longer and more difficult a woman's labor, the higher her endorphin level." (27:15). At birth, this provides an intrinsic reward system. There is also an intimate connection between endorphins and prolactin release, the "mothering hormone" responsible for milk secretion. Using painkillers and synthetic hormones which compete with natural hormones, thereby altering the complex hormonal balance, affects how the mother feels after birth and influences the dynamics of bonding. Cesarean birth reduces endorphin levels as compared to vaginal birth. (27:77) By respecting the hormonal balance during birth, "we probably eliminate many abnormal hormonal fluctuations and thereby decrease the likelihood of postpartum depression" (27:83) which can interfere significantly with parenting. "In good labor, if the woman can bear the pain, the baby will be born. Pain brings the baby. The intense pain is nature's way of insuring that we bond with our baby." (15:195) Birthing drug-free helps to avoid interventions like forceps delivery, cesarean and prolonged separation of infant from mother, all of which have been identified by ethologist Nikolaas Tinbergen as "pathogenic" (i.e., disease-producing) in the etiology of diseases such as autism. (27:84) Ina May Gaskin believes that the rising rates of divorce, child abuse, incest and rape in part reflect our poor system of handling birth. (19:389) "When you put birth in the hands of an elite, especially a male elite that can't possibly understand giving birth, having never experienced it, you wind up with a crazy system," where the dehumanizing methods imposed by the male medical establishment break "the glue available to us in birth as a natural ceremony available to the family and society to hold things together." (19:389) Even well-meaning male views of birth (for example, Leboyer's idea that birth should be gentle and quiet because babies are delicate, or Lamaze's idea that birth need not hurt) do not allow for the power or intensity of labor, which may require yelling and active physicality. These toned-down versions of birth do not see it as a "positive and aggressive natural force which is both intensely powerful and stimulating for the baby," (28:77) the resilient, healthy baby. By interpreting birth as a growth experience, the passage from girlhood into womanhood, pain is accepted as an integral part of the experience. When in pain your whole reality crumbles . . .a woman in labor . . .let[s] go of her girlish selfishness, so that when the baby comes, she will be able to surrender her own needs for baby's first . . .Pain of labor also helps you bond on the baby . . .the more intense your experience is, the more difficulties you have to go through in producing your baby, the more you'll love it . . .some of us need to have more intense experiences to become good mothers. (11:522) A strong association between pain and the baby coming gives rise to a mental schema wherein pain = birth = baby = joy. (11:522) JUSTIFYING OBSTETRICAL ANESTHESIA The right to control the conditions of birth is a feminist concern. (1:489) Even in the scientific literature, validity is granted the idea that a woman's experience of birth is "a model event that colors the rest of [her] life" (4:439) and "if a woman feels she does not perform as expected in giving birth, perception of her capabilities in other . . .behaviors may be doubtful." (25:207) Early feminist dismissal of the positive empowering aspects of birth "did not foresee the complexity and depth of women's role as mothers and its links with both women's strengths and weaknesses, power and powerlessness." (1:489) The medicalization of birth, the expansion of medical authority into previously non-medical areas of women's reproductive experience can be read as a loss of control, reflecting already existing social forces. (1:503) Medicolegal objections that no one violently forces women to give birth in hospital while drugged, that they choose to do so of their own volition, does not mean they have any control over their birth. Under systems of male dominance, "the absence of violence does not ensure the presence of. . .[women's] control over what is done to them." (23:178) The patriarchal forces behind total socialization of modern American women, especially with respect to their own reproductive functions, have so overwhelmed

women's critical judgment in most cases that their sense of reality and self rests on the world as defined and controlled through technolatry. Obstetrical abuse is legitimated by technolatry's myth and ritual. It demands that the women suffering this abuse see as unquestionably "reasonable" even the most bizarre and violent treatment. EMPOWERING BELIEFS Granted, a healthy baby is every parent's priority, but a healthy baby does not equal a healthy experience or a healthy family. (17:55) We can examine modern subcultures where birth is seen as empowering and women seldom have to bow before institutionalized sexism. Purebirth, without intervention and outside of hospital, is counterinstitutional, because it recognizes that what the patriarchal institutions of healing deems "sick," the expression of pain during a healing or growth process, is frequently the signal of incipient health. (3:161) North American women who consciously choose to give birth under their own power do not allow themselves to be lulled or dulled by drugs or procedures "into the sleeping death which is the condition designed for patriarchally possessed women." (3:138) They realize that obstetrical anesthesia abuse deprives them of their power and potency in creativity. Home birth is often the venue of women who "desire to experience birth in a religious manner, [since] hospitals don't have the time or inclination to make birthing a spiritual or religious or even a serene experience." In the American home birth culture a woman "comes to grips with the pain of labor and her own fear of death . . .the result is a sense of power and accomplishment and faith in the natural process." (15:63) The Farm in Tennessee espouses a "cultural belief that birth works." Farm women see and hear that birth works fine without anesthesia, that such birth is satisfying and joyous. As a result, this community boasts a 1.6% anesthesia rate (as compared to about 80% in most North American venues) and a 1.3% cesarean section rate (again, compared to 25% elsewhere). (34) Farm midwives encourage birth as personal growth: You change your concept about yourself when you have a baby. There's a power in you that wasn't there before. If you're knocked out, you don't get the benefit of the experience. (19:393) Michel Odent's birth clinic in Pithivers, France adhered to the principle that women want a "labor that is a personal, intimate and deeply creative experience . . .in which she [can] be her self." (27:xviii) He turned away from managed birth and male views of the experience, instead embracing the "striving, the creative pain, the mystery and the exaltation of natural birth" (27:xx) by providing an atmosphere that "encouragetd] women to give in to the experience, to lose control, to forget all they have learned-all the cultural images, all the behavioral patterns." (27:26) Again, admirably low levels of intervention and complication resulted. Spirit-led Christian midwives in the southern United States view obstetrical anesthesia as standing between women and deity. They believe that Eve would have experienced pain even in the Garden of Eden, that it is the falling away from God that makes pain unbearable. The source of a large part of our pain in childbirth is our personal struggle to surrender to the God-ordained process of bringing forth our babies. We must embrace our physical pain. The more we fight the process the more our perception intensifies the pain, because we have not yet surrendered. That is why it hurts more outside Eden (Genesis 3:16:1 will greatly multiply your pain in childbearing; in pain you shall bring forth children). If we still lived in Eden we would be living closer to God, in full surrender to his design, and our perceptions would not intensify the pain to make it unbearable. When Jesus was crucified at Calvary he paved the way for us to have fellowship with God himself, he felt the pain, and as Christians we understand that God cannot remove the pain without losing our opportunity to learn from it that "the joy that is set before us is worth the endurance." (Hebrews: 10:35) (9) Women following this tradition see "healing" happening during pregnancy and birth through surrender. Kay Ivey, spirit-led midwife, says, "I never think of a woman's contractions as painful, but as empowering her to be healed in the Lord," (9) (7 Timothy 2:15: Woman will be saved through childbirth when she continues in faith, love, holiness and humility) and that God uses birth as a biological opportunity for women to fully embrace a power greater than themselves. Along with superb safety statistics, the common string in these cultures is the ability to gift a pregnant woman with confidence-in herself, her strength, her baby's strength, her attendants and their loving support of her-replacing the aura of fear and mystery encouraged by conventional obstetrics with knowledge and certainty. On every level-physiological, emotional and spiritual-the positive attitude toward birth yields relaxed, confident, satisfied

and empowered women. Mothers treated with respect for their strength will believe in themselves. Women learn "to appreciate [birth pain] as a sign of how strong and well their bodies work . . .[to] confront their feelings about pain and strong sensations from the pelvis." (28:17) These beliefs bring a woman in league with her body, and do not separate the physical from the spiritual/emotional, pain from power, fear from joy, as the patriarchal belief systems of religion and technolatry have done. They allow her to birth with support and without inhibition, encouraging a concept of womanhood that includes a belief in herself as strong and capable. Modern technology is not "bad." It can and has freed us from many fears and inconveniences. But when we allow others to determine the meaning of our lives in its service, we don't allow our biology to lead us into new and enlightening, empowering, realms of experience. Childbirth can bring a change in consciousness which can affect the rest of a woman's life, either for freedom or for enslavement. "In the west we are unused to moving in the realms of consciousness and we have lost our knowledge of how to support someone who is doing so." This knowledge is being rediscovered outside the realm of medical institutions, because physicians dismiss and fear these things and "by giving women powerful analgesics too quickly, they deny them the opportunity to explore and use these dimensions and to find and use their own resources to give birth." (30:86) The abuse of obstetrical anesthesia provides sexist society a convenient, widespread mechanism-supported by women who, having internalized the male myth of their own inadequacy and weakness, demand it-that prevents women from being empowered through birth. Footnote * Women's spirituality presents another view, that attachment is bliss and "if we haven't ever fully experienced a complete attachment . . .it is the lack of and thwarting of attachment which is painful." (11:460) * Affective: torturing, killing, terrifying, dreadful, fearsome, tiring, irritating, nagging. Sensory: cutting, tearing, sharp, cramping, burning, aching, gnawing, pinching, sore. References

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