Relational, selfless, caring, polite, nice, and kind are not how we imagine a woman giving birth in U.S. culture. Rather, we picture her as screaming, yelling, self-centered, and demanding drugs or occasionally as numbed and passive from pain-killing medication. Using in-depth interviews with women about their labor and childbirth, the author presents data to suggest that white, middle-class, heterosexual women often worry about being nice, polite, kind, and selfless in their interactions during labor and childbirth. This finding is important not only because it contradicts the dominant cultural image of the birthing woman but because it reveals that an internalized sense of gender plays a role in disciplining women and their bodies during childbirth. The feminist sociological literatures on birth are concerned with how women and their bodies are controlled, yet they have overlooked this other dimension of control that is not institutional but is a product of how gender is internalized.

Keywords: birth; gender identity; technology; discipline

AUTHOR’S NOTE: This research was supported in part by a Faculty Research Seed Grant from the Institute for Research on Women and Gender at the University of Michigan. I am grateful to Lisa Kane Low and Carolyn Sampselle for our many discussions about and their critical insights into these issues. Thanks also to the editor and reviewers at Gender & Society for helpful comments on this manuscript.

REPRINT REQUESTS: Karin A. Martin, 3012 LSA Building, Sociology, University of Michigan, Ann Arbor, MI 48109-1382.
THINKING ABOUT GENDER AND BIRTH

Most of the feminist literature on childbirth either critiques the medicalized model of birth (Davis Floyd 1992; Katz Rothman 1982, 1989; Kitzinger 1984; Martin 1987; Oakley 1980) or attempts to understand why, when, and which women are able to challenge this model (Davis Floyd 1992; Martin 1987; Zadoroznyj 1999). Briefly, the feminist critique of medicalized childbirth argues that the medical system has great power to shape women’s birth experiences, and this system and its professionals view birth as dangerous, as an ailment needing treatment. Thus, the medical system interferes with a process that is safe and natural and not in need of medical management. This medical system also disciplines women’s bodies. It often requires women to birth in positions convenient for doctors and controls women’s bodily sensations with medication, technology, and institutional rules that are for the woman’s “own good” and the baby’s safety. According to this critique, women lose agency in the experience of childbirth and are disempowered by its medicalization. An experience that is potentially empowering is made alienating and oppressive. In sum, medical institutions and their technologies regulate and control women’s childbirth experiences.

Most of those who make this critique of medicalized childbirth advocate for a natural model of childbirth where women would have more agency in the process. Women would pay attention to their bodies’ signals and follow their bodies’ cues rather than responding to the cues of monitors and medical exams. In this model, women would use their own psychological resources and natural techniques such as breathing, relaxation, or meditation to control pain and would not use pharmacological pain relief.

However, as Zadoroznyj (1999, 269) noted, this natural childbirth model also requires control of the woman and her body, even if this control is not medicalized.

For natural childbirth advocates it is a control that involves disciplinary power over the self, in particular of the mind over the body. . . . Invoking such a range of disciplinary regimes renders problematic the very notion of “natural,” but nonetheless the idea of natural childbirth remains popular in literature, practice and as an ideal to be aspired to.

Yet Zadoroznyj’s critique, which recognizes the power of internalized technologies of the self, does not examine the gendered nature of such technologies. If we look specifically at sociologists studying birth, we see that they also overlook these internalized technologies of gender.

Since the mid-1970s, sociologists have been prolifically studying women in the family and especially women as mothers. This literature suggests that motherhood...
is an identity that profoundly shapes personality and gender (Chodorow 1979), the division of household labor (DeVault 1991; Sanchez and Thomson 1997; Walzer 1999), the relationship to paid work (Garey 1999; Hochschild 1989), politics (Hill Collins 1989), and the relationship to one’s body (Blum 1999; Stearns 1999). Since childbirth socially and psychologically marks most women’s transformation into mothers, it is striking that there is little sociological work on childbirth.

The sociological literature, like much of the feminist childbirth literature in other disciplines, primarily examines the macro and institutional contexts of birth. That is, sociologists have contributed to the larger feminist critique of the medicalization of childbirth their understanding of the macro social context in which birth takes place. Katz Rothman (1982, 1989), for instance, examined how ideologies of patriarchy, technology, and capitalism situate and control mothering, pregnancy, and birth. She argued that the medical models that emerged in a patriarchal culture construct pregnancy, labor, and birth as abnormal conditions needing technological treatment. Others (Nelson 1983; Zadoroznyj 1999) examine how social structure affects childbirth. In particular, they document how social class affects plans for childbirth (finding middle-class women feeling activist and working-class women fatalistic), feelings of control in childbirth, women’s identities, and the management of subsequent births (with significantly more working-class women changing their management of subsequent deliveries).

Some of the sociological literature also looks at the contexts of interaction (Annandale 1988). Recently, Fox and Worts (1999) added an examination of what they call the more “immediate context in which women give birth.” They described this immediate context as one of privatized mothering, where women receive little help and support in mothering from partners, friends, or other family members. This context leads many women to rely on the medical model of birth as patients to get the support they need to give birth as easily and with as much rest as they can before they return to their private domestic worlds where they will bear primary, if not sole, responsibility for the care of a newborn (and sometimes other children). Thus, they argued that women have epidurals when they have little support (husbands, midwives) and because it makes recovery easier. While all of these contexts, macro and immediate, contribute to gendering the birth experience, no one has examined the internalized technologies or sense of gender that women bring with them to birth.

INTERNALIZED TECHNOLOGIES OF GENDER AND BIRTH

Internalized technologies of gender are those aspects of the gender system that are in us, that become us. According to Foucault (1979), just as in our everyday use of the word technology we mean the knowledge, discourses, and practices that construct the material world and our relationship to it, technologies of power produce and reproduce our experiences, meanings, and our very selves in the social world.
We can think of those discourses and practices that constitute us as subjects, as who we are, as internalized technologies of the self. However, these selves are gendered. Therefore, we might think of those technologies that constitute and reproduce our gendered subjectivity, how we think about and understand ourselves as men and women, as internalized technologies of gender.

Gender does not exist only in interactions or in institutional arrangements but also is a deep, internalized part of who we are. It is powerful because we cannot escape such culturally constructed gendered identities. We do not/cannot exist outside of them as we are all socially located selves. Most people feel like men or women, regardless of the social nature of these categories. These identities are how culture disciplines us, shapes us from the inside, and like institutional forms of control, they are powerful in shaping everyday experiences. In particular, these identities are important to any understanding of birth, as it is a gendered event through which the self is often altered or transformed (Zadoroznyj 1999).

Much of the literature on gendered selves might be thought of as describing such technologies of power. Carol Gilligan (1982; Brown and Gilligan 1992), although not a Foucauldian, depicted one internalized technology of gender when describing middle-class women and girls as relational, caring, polite, selfless, and subjected to the “tyranny of nice and kind.” According to Gilligan, women are relational and associate goodness with altruism. In this view, women often feel selfish when they take their own needs and wants into consideration. Gilligan (1982, 169), citing Jean Baker Miller, suggested,

> Women’s sense of self becomes very much organized around being able to make, and then to maintain, affiliations and relationships, and that eventually, for many women, the threat of disruption of an affiliation is perceived not just as a loss of a relationship but as something closer to a total loss of self.

Thus, in Gilligan’s view, many women end up selfless, putting the wants and desires of others ahead of themselves and losing themselves in the process.\(^3\)

Similarly, Fishman (1978) considered the gendered “interaction work” that women do. She described women as responsible for making sure conversations and other social interactions go smoothly. Women ask questions of others, act interested in their answers, introduce topics of conversation when there are lulls in social engagement, and attend to others’ voices and opinions to keep social interactions functioning. According to Fishman, women are quite good at doing this, do it constantly, and are generally responsible for this task.

I argue that these ways of being that Gilligan (1982; Brown and Gilligan 1992), Fishman (1978), and others have identified are internalized technologies of gender that discipline us from the inside out. They produce who we are, even during seemingly natural experiences like birth. Foucault’s (1979) notion of technologies of the self allows us a sharper understanding of these gendered ways of being by showing us how they discipline and control from the inside, how they compel us to act in gendered ways from within.
Understanding gender as an internalized technology is useful in describing why women are nice and kind during childbirth where other conceptualizations of gender fall short. In particular, West and Zimmerman (1987) claimed that gender is not something internalized but something one does. We do gender in interaction constantly, they argued, so that others can fit us into one sex category or another. However, when women are giving birth, their sex is obvious. Why would women continue to do gender in this setting if they were not compelled from within? Understanding gender as an internalized technology is not incompatible with West and Zimmerman’s view. However, West and Zimmerman gave us no indication of how we come to do gender in ways that are not conscious and strategic. They do not allow us to see that as we do gender, we are interpellated by it; it becomes us.

I do not contend that these internalized technologies of gender are the only factors in making women compliant during birth. DeVries (1980), Katz Rothman (1982), and Davis-Floyd (1992) documented the many ways that the medical institution and other factors such as Lamaze techniques (Katz Rothman 1982, 93) make women compliant. Thus, we might say there are external technologies of gender at work as well. For example, many childbirth education programs, including Lamaze and Bradley’s Husband-Coached Childbirth (the two most women in this sample were educated in), encourage husbands’ or dads’ participation in managing the labor and birth. Lamaze childbirth education (Lamaze Childbirth Preparation Association 1998) outlines a “Take Charge Routine,” which is “exactly that,” for fathers to follow when their partner “hits an emotional low.” Similarly, Katz Rothman (1982, 99) wrote that at a conference session of Bradley birth films, not a single film was shown with a woman (lay midwife, physician, or nurse-midwife) as birth attendant. All birth attendants were male doctors or fathers. The father as a “coach,” or “directive” and “supervising,” while the woman is in labor, is clearly playing a traditionalist, patriarchal role.4

However, such institutional control and external technologies of gender are likely supported by these internalized technologies of gender.

Finally, I also hope that my data analysis will encourage us to rethink or “to gender” another standard concept in medical sociology: That the women I describe below maintained normative gendered interactions, expressions, and behaviors while in labor is counterintuitive to Parsons’s (1975) formulation of the “sick role.” According to Parsons, when in the sick role, the sick person is exempt from normal social obligations and social roles. (Although many feminists would contest the term sick role being applied to a birthing woman, culturally, birth is imaged as a sick role since most births take place in the hospital). During birth, normal gendered social obligations were the very things that these women felt compelled to fulfill and that disciplined women and their bodies during childbirth. Perhaps women take on the sick role differently than men do. Or perhaps some femininity looks more like the sick role than the (masculine) social role that Parsons used to con-
ceptionalize it. In either case, my data suggest this concept might be revisited with further research.

I argue that these internalized technologies of gender serve to make birth more difficult for women and often cause them not to ask for what they need while giving birth and/or not to put themselves at the center of the birth experience, something many feminists argue is essential for control over the experience and empowerment from it. There is a large literature that agrees that giving birth is physically demanding and that is written to aid understanding what makes this physically demanding task easier and a (more) positive or even empowering experience for women. Although the usual issues (of provider, length of labor, etc.)5 arose frequently in the interviews, this article does not examine them. Rather, I focus on the gendered mundane, everyday aspects of the birth experience that contribute to making this physically demanding task easier or more difficult.

Using in-depth interviews with middle-class women who provided detailed accounts of their labor and birth process, I argue that internalized technologies of gender such as those described by Gilligan and others are actively at work and are a mechanism of power and discipline that regulate middle-class women’s birth experiences. This aspects of birth has not been examined by researchers interested in attempts to understand power and control in childbirth.

SAMPLE AND METHOD

The data for this article come from a larger project on women’s bodily experiences of birth carried out jointly by two members of the college of nursing, one of whom was also a certified nurse midwife (CNM), and me. During the period from 1997 to 1998, 26 women were interviewed in depth about their labors and births within a week to 3 months of having their first babies. These women were recruited to the study prior to giving birth using posters in doctors’ and nurse midwives’ offices. Participants provided information about their demographic characteristics, childbirth education, and providers at recruitment. At this time, they also answered open-ended questions about what they expected their labor and birth to be like.

All but one of the women identified as white. All but one was married, and all were heterosexual. The women ranged in age from 20 to more than 40 years old. All came from a small city in the Midwest that is predominantly white and middle class. All of the women had some form of medical coverage for their care.

Of the 26, 23 gave birth in the hospital, 2 gave birth at home, and 1 gave birth in a birthing center. The participants’ choices of health care providers varied as well. Twelve were attended by CNMs, 6 by MDs, 6 by both CNMs and MDs usually because their care was transferred during labor to MDs, and finally, the 2 women who gave birth at home were attended by direct entry midwives (sometimes referred to as lay midwives). This provider breakdown is not typical for women nationally. At the national level, approximately 10 percent of women are attended...
by midwives of any type. However, there were many midwives with established practices who worked in the community where the study was conducted, and there was a large CNM practice at the hospital where most of the births took place. Yet CNMs and physicians are different kinds of health care providers. CNMs and direct entry midwives provide support and care to the woman throughout most of her labor. Physicians generally see the woman only intermittently throughout her labor and are present as the baby is born.  

All of the women were also attended by other support people during their labors. These included partners, mothers, other family members, friends, and doulas (experienced birth attendants). Finally, all participants had some form of formal childbirth education or preparation (e.g., Lamaze or Bradley classes).

Eighteen of the women delivered vaginally without any surgical intervention. Seven had cesarean sections (about 25 percent, the average rate of C-sections in this community), and physicians used forceps for one woman’s birth. Fifteen women received pharmacological pain relief, most commonly an epidural. All babies were born healthy.

Factors such as class, ethnicity, and the large number of women attended by midwives limit the generalizability of these findings, particularly as they are likely to shape the internalized technologies of gender that affect women’s experiences of childbirth. Rather than generalizing from this small sample, I use it to bring to the fore a theoretical concern that has been missing in the literature on the sociology of birth. That is, I use these data to suggest that institutions are not the only site of social control of women during labor and childbirth but that internalized technologies of gender regulate and discipline women as well.

Because the larger study from which these data come was focused on investigating how women described and understood their bodily experiences of birth, in-depth interviews seemed the most appropriate form for eliciting these descriptions and understandings. In-depth interviews allow research participants to describe events and feelings in their own words, with their own frames and categories, and at length. The interviews were semistructured and asked the women first to tell their stories of labor and giving birth in detail. Follow-up questions focused on various aspects of the births, especially on the bodily experience of birth, support during birth, and advice to practitioners. The interviews were conducted by the CNM member of the research team in the women’s homes and lasted anywhere from one to several hours.

The interviews did not include specific questions about the types of issues examined here. Rather, descriptions of women’s normative gender interactions or their feelings about not acting gender normatively leaked out in the narrative answers to the other questions. After seeing some of this in several readings of the interviews, I did open-ended coding of the interviews for these issues using QSR-NUDIST. That is, I coded each interview for any passage where the interviewee described any feelings or interactions that were concerned with doing (or not doing) normative gender. I then sorted these passages into categories of concern over normative gender (concern with being nice and relational, being selfless, privileging the masculine...
RESULTS AND DISCUSSION

I use the data presented below to demonstrate how an internalized technology of gender served to restrict these women’s behaviors, made them feel bad about their actions, and made them reluctant to impose on others for the help they needed during the birth process. These women tried to be polite, nice, and kind—to do the interaction work expected of them. Why? I argue that an internalized technology of gender caused them to be concerned about these matters. Such restrictions, feelings, and reluctance were a source of discipline and power over these women’s birth experiences.

First, I demonstrate that these women were often concerned with doing normative gender while birthing. They tried to do interaction work and to be nice, and they continued to attend to others’ perceptions and feelings as much as or more than their own. Next, I examine what happens when this gendered self breaks down, usually at the most difficult point of labor, and describe how women apologize for their deviant gender behaviors at this juncture. Finally, I examine the three women whose narratives contained little evidence of this internalized gender.

The Tyranny of Nice and Kind

The women in this study described labor and birth as a difficult, physically exhausting, intense, demanding, and painful experience. This was true whether they had gone through natural childbirth with no pharmacological relief or they had had an epidural. It was true of the women who had CNMs as providers and those who had MDs. The only factor that mitigated their descriptions of birth as physically demanding was the length of labor. Those who described shorter labors also felt somewhat less pain and exhaustion. In general, these women described labor and childbirth as Zoe did.

First of all, I think probably the most surprising part was, I have a tremendous pain tolerance, so I thought, and you know, you have these ideas of no epidural, natural, this and that, and let me tell you, it was painful, tremendously. Because I thought I did have a tremendous tolerance and about eight or nine hours later I did not.

Despite the physical demands of labor and childbirth, they continued to be nice, kind, relational, and selfless. The women in this sample seemed to be disciplined by an internalized technology of gender of the type Gilligan (1982; Brown and Gilligan 1992), Fishman (1978), and others describe. They describe attempts to
attend to others, to play their usual roles in sustaining conversation, to be polite, and to be empathic, all while managing the pain of labor. For example, Mary reported struggling to be attentive as a doctor talked to her during a contraction. She asked him a question to demonstrate that she was attentively listening, although she really “did not hear a word.”

When the anesthesiologist was in the room, I was just kind of looking at him shaking my head. I did not hear a word he said! And that’s one really funny thing, because I totally remember that. I remember having a couple of contractions while he was there and trying as hard as I could to listen to him but I couldn’t. It’s like I could look at him and shake my head so that he thought I was listening to him, and I even asked him a question after he had stopped saying something. (Mary)

While Mary was concerned with upholding her end of a face-to-face interaction with one of her providers, other laboring women were concerned about “bothering” strangers in neighboring rooms. In these cases, the women were worried about the comfort of others. About one-fourth tried to attend to the needs of strangers. One woman worried about a child who watched her in pain in the waiting room and concocted a story (“tell her I have a bunion”) to cover the pain of labor. Several, like Valerie, say they remembered that they “felt bad” for causing these disturbances for strangers.

I remember between contractions here, I could hear the other people in the next room, and I remember thinking—’cause I was very loud at this point—and I remember thinking I felt bad because I was being so loud and this poor woman in the next room must be thinking awful thoughts about me. And then later the nurse came down and she said, oh, the person next door wants to make sure you were okay and if you had your baby, and so actually she was concerned and not angry that I disrupted her. (Valerie)

Valerie “felt bad” because she was not being quiet and undisruptive as women are often expected to be (Martin 1998). Note that the woman in the room next to Valerie, who was also in the maternity ward either getting ready to give birth herself or having just done so (as stays are limited to 24 hours for a normal birth), was also doing and feeling gender appropriately. She was worrying about and asking the nurses about a stranger giving birth in the next room.

Selflessness

As the above narratives begin to reveal, these women were inclined to put others’ needs ahead of their own even while in labor. Childbirth education of all types tells women that the best way to manage the pain and other demands of birth is to enact a set of behaviors that would be gender deviant in most other situations. The demands of the task of birth are so physical, exhausting, and painful that according to the childbirth education literature, women should focus on what is happening to them
and allow themselves to be self-centered. This education advises that women should have the support of others including physical and emotional comfort. To best make use of such comfort, women should tell their support persons and providers what they want, what feels good to them.

Women are not used to doing these things. Focusing on one’s self and asking others for what one needs are not gender-normative behaviors or usual stances in the world for many middle-class white women. Often, during birth, only certain behaviors made women feel better or allowed them to make it through the labor. Many of these behaviors required them to impose on someone else. They asked multiple people (doctors, nurses, midwives, friends, husbands, mothers, other patients) for things (e.g., back rubs, quiet, lots of information, physical support, patience, promptness, service) for which they would not normally ask. Thus, they often “felt bad” for doing what they had to do or “couldn’t help” but do. Furthermore, they claimed to have felt bad while they were in labor, not merely in retrospect.

And you know, Dan, he’s just trying to be so wonderful, but he’d just touch me lightly or whatever and I’d be, “please don’t touch me.” I would feel like I really shouldn’t do that to him, he really didn’t do anything at all, but it just bothered me a lot. (Janet)

Impositions on others, especially husbands, were hard for women to make, and they often “felt bad,” “rude,” or “selfish” for making them. Some women even changed their behaviors or did not get the help they needed from others because they assumed relational orientations that led them to worry about others more than about themselves even during labor.

And then I didn’t want to wake Paul up yet, because I thought he needed the sleep, even if I wasn’t getting it. So again I waited another two or three contractions. I had to go to the bathroom again. I think in all I got up and went to the bathroom about three or four times. And then I lay back down and the contractions were just so strong. I was just really writhing and actually I was also . . . a couple of them I just started shivering uncontrollably, just trembling all over. And I sort of called Paul. I thought I need his help. He didn’t respond to my voice at first. So the next contraction I just grabbed his hand and just held onto it through the contraction. (Laura)

[Explaining to the interviewer why she finally changed her laboring position] George was crying because I was in so much pain and that made me feel worse. Like I wanted to make him feel good. That’s when I decided to flip over because George was crying and it hurt so bad that I couldn’t stand having him go through that. (Kelly)

The part of this internalized technology of gender that is “selfless” and relational also often led these women to look to their male partners to describe, define, and decide about their experiences during labor, even their bodily ones. Several women decided whether and when to have an epidural based on what their husbands thought or how their husbands described them as feeling. For example, “he thought I was getting tired” or “he could really notice a change so we decided to go ahead.” Also almost half of the women decided to go to the hospital based on when their
husbands said it looked like it was time to go rather than when they felt like it was time to go.

Interviewer: What made you decide you needed to go the hospital?
Kelly: George bugged me enough. I didn’t want to go to the hospital. I was still at the point where I was willing to stay home. I’m like, I don’t want to go in and this not be it. I really want to make sure that’s what’s going on. I want to make sure that they are three to five minutes apart, a minute long, and it’s been happening for an hour.

Interviewer: What made you decide to go to the hospital?
Mariah: Probably Andy. I think Andy was the one, he said, things seem to be getting more intense. [She turns to Andy, who has come into the room, and asks, “Isn’t that right?” “Yeah,” Andy answers.] So I probably would have continued just lying there in bed for a bit longer. But I think I was probably ready to go, or I would have put up more of a fight or resistance to that idea.

Adopting the Other’s Gaze

This selflessness may have led the interviewees to privilege their male partners’ experiences of, and figurative and literal views of, the births. Nearly all said talking with their husbands helped them to remember what the birth was like, and in recounting their birth stories, many women told the interviewer what their husbands or partners said happened. However, women also vicariously experienced their own bodily sensations through their partners’ descriptions of the event. One woman, Monica, recommended that we talk to male partners to understand all of a woman’s experience.

Maybe having my husband in here and hearing his side of it [would help you]. And we have done that. I’ll say, you know, do you remember this, do you remember when they did this? And he’ll say, you know, oh, they did this . . . ‘cause he had such a different perspective on it than I did. So that would be interesting to hear what he had to say, because I think he has a much different . . . He could tell me things, you know, the way they were grabbing her head that obviously I didn’t know and couldn’t see.

As Monica’s narrative begins to suggest, several women felt like they had “missed” the birth because they could not “see” what was “really” happening. When they say this, it becomes clear that what they did not have was the view of the other—their partner’s view, the medical view, and the media’s view. That is, a woman cannot stand between her own legs and see the baby emerge, and thus women (if they did not see this by using a mirror), sometimes felt like they missed the “real” part of the birth. Their own visual and sensory perspective was equated with not seeing “what really happened.” Culturally, birth has become more real for those with this outsider gaze than those with the lived bodily experience of it. Men attending a birth have what Jordan (1997) calls “authoritative knowledge.” They have the knowledge about birth that “counts” or matters, that is socially sanctioned, legitimate. When asked if they thought the use of photographs, video, or audiotape
would help them to recall their birth, several women answered that this might allow them to see better. It would give them the authoritative knowledge that they craved and socially did not possess. For example, when asked if she thought video would help her to remember, Emily said,

That’s why exactly I wanted the tape. It’s because I thought I was really missing out on a lot too. You know, Paul was able to see it and, you know, for him it was a tremendous experience, in just watching it. That part I felt like I kind of missed out on. Because I was in the laboring process and kind of missing out on the watching.

Barbara discussed at length her disappointment in not having been able to “see” her birth.

Interviewer: Did anything surprise you about your birth experience?
Barbara: Well, I didn’t get to see anything. And I thought I’d get to see something. I didn’t get to see the umbilical cord or anything, so it was kind of just, “Okay, this is it and I’m done.” So nothing really, I guess, surprised me. I don’t know.

Interviewer: What do you think about the use of photographs or videos or tapes to help remember?
Barbara: Well, I brought a video camera but the battery died. And I brought a camera, but the film jammed. So I really don’t have a clue. It would have been excellent to have it on tape, because I didn’t get to see anything, but just my luck nothing worked. So I have no idea, but that would have been excellent. I would, I told my mom, I hope one of my friends gets pregnant, so I can see what it looks like, because I don’t know. I just was so excited to see everything and then nothing. So I was real upset that I didn’t get to see anything, and my mom was like, well, you have him and that’s all that matters. But I’m like, yeah but I did all that and nothing. I don’t get to see any of it. So I was real upset.

Interviewer: What kept you from seeing?
Barbara: Well, there’s nothing . . . I didn’t . . . my mom said she used a mirror, but there was no mirror, and I don’t know if it was just me not focusing on looking or if I just, I don’t even know if I could have. ‘Cause I don’t remember even trying to look there. I was just . . . everybody else was like oh, there’s the head, and I can see hair, and I’m like, oh, okay but I can’t get it out any more. So I would have really liked to see it, so I guess there just wasn’t the facilities to see it. But that would have been nice to see something.

Thus, women end up privileging others’ perspectives on their own bodily experiences. This is another way an internalized technology of gender regulates women’s labor and birth. If the “real” perspective on what is happening or has happened is located in another, not in one’s own body, then one is likely to let the other(s) decide how to proceed.

Acting Out

Although these women tried, it was sometimes difficult for them to maintain gender-normative selves throughout labor and childbirth. The internalized
technology of gender sometimes broke down. Women sometimes acted outside of their gendered selves. I examined the data to determine when this happened. Was it dependent on the type (CNM or MD) or gender of the provider? Or gender of the other birth attendants? None of these were fruitful for explaining when the internalized technologies of gender broke down. Rather, these women described "acting bad" or gender nonnormatively when they were at the height of labor's physical demands—usually just before an epidural, during transition, or when pushing the baby out, depending on the unique circumstances of each woman's labor. The women described themselves at these junctures with adjectives such as nasty, inflexible, crabby, difficult, and out of control. For example, Kim felt as if she was acting out or being "difficult" for not accommodating her nurse midwife's suggestion that a different position might make her more comfortable.

I wasn't flexible, I wasn't really flexible about that [moving into the position a nurse midwife suggested]. I said I can't, it's too uncomfortable. And that just felt like it was a driving force. I know I just can't get in that position. And, you know, to the point where I almost felt like I was really being difficult, disagreeable.

When women in this study found themselves "misbehaving" during labor, they experienced themselves as acting outside of their usual gendered identities. They were surprised when they found themselves yelling loudly, cursing, complaining, giving orders, or "losing control."

And that's what kind of surprised me. And I'm not a big whiner but boy I just couldn't... I said to Paul, "I'm going to start crying," and he said "Go on." And I said, "I won't stop." He was just like, "That's okay." And I'm like, "No you don't get it." But yeah, I was really surprised because I was really losing it on that. (Michelle)

Sue and Jill were both surprised and disconcerted because they did not act like themselves. That is, they did not act nice and did not do the gendered interaction work that was so a part of how they understood who they were. Sue said, "I just lost control of what I said and how I felt and what I did. I didn't throw things or anything but I know I said stuff I wouldn't have normally said, which is frustrating a little bit." Jill similarly described her state this way:

And I know I was crabby and I said, I mean, the poor obstetrician walked in and I didn't even talk to him, I didn't even acknowledge him, I just yelled at him, "Aren't you the anesthesiologist?" And I'm not like that at all.

Rarely did these women describe their actions as understandable, justified, or required. This is surprising given that the women described labor and birth as a difficult, physically tasking, all-encompassing experience and given that all of these women took childbirth preparation classes that gave them varying degrees of permission to do any behaviors that would get them through labor and to ask for help from others throughout the process.
One of the most common comments, made by about two-thirds of the women in some form throughout the interviews, is that women “felt bad” when this internalized technology of gender broke down and they were not “nice” during labor. Kate described this sense of feeling bad or guilty about acting outside of her normatively gendered self.

I feel bad when I think about it now. I had my left foot basically on [the nurse midwife’s] hip the whole time, it seemed like, when we were pushing. And I remember one time she walked away for some reason to get something else and I don’t know if I groaned or whatever, but I kind of made it known that gee, you know, where’s my foot support. And so she came right back and let me put my foot there. And then I felt bad afterwards, of course, ’cause I thought, well, gee, you know, she’s kind of small to begin with, and here I am putting my foot on her for two hours. And she stayed over after she had already been on a long shift. So I felt kind of bad, but she was great.

If these women were “nasty,” inflexible, or not open to suggestion; if they were adamant about what they wanted; if they cursed; if they yelled; if they disagreed; then not only did they feel bad about it, but to restore normative gendered relations with others, especially partners and providers, women apologized for their gender-deviant behaviors. Not only did they do this retrospectively, but they recalled many moments where they apologized to the hospital staff and to their support persons for their behavior while in the process of giving birth. For instance,

I mean I feel like I got nasty a couple of times, and I remember apologizing and being told, “Don’t apologize.” And that was nice. It was just nice to . . . the one thing that I really liked was when everyone was just so understanding of me being, feeling awful and being as nasty as I could be. (Jane)

In Jane’s case, as in several other women’s, the medical institution (here the nurses), traditionally seen as the primary source of control over women during birth, did not have to exert control over Jane as she was disciplined herself. She apologized for her nonnormative gender behavior during her labor. Thus, institutions and their personnel do not have to exert as much control when women discipline themselves. Furthermore, such apologies suggest that these women were trying to regulate their behavior and apologizing when they could not. Thus, the internalized technologies of gender never fully broke down, at least not without being quickly restored.

Gender Nonconformists?

As mentioned earlier, three of the women in the sample, Andrea, Jill, and Amy, made little mention of any of these issues. That is, I could find only minimal evidence for an internalized technology of gender in their interview transcripts. When I did, it was primarily passing references to concern about their husbands’ role in the birth or bonding with the baby. There were no descriptions of feeling bad about not being nice or apologizing for one’s behavior. Two of these women also
described interactions that might be seen as challenging gender norms. For example, Andrea took pleasure in her own, out-of-the ordinary cursing and ordering.

[During hard labor] I was always like just, you know, pushing him off or whatever. He thinks this was quite funny and excuse my language, but what I said was . . . he started to do, to try to get me into it one time, he said and I turned and I growled at him, “Fuck Lamaze!” [laughs]. Excuse me. So that’s about as well as that went.

Jill, who gave birth at home, described taking charge of the labor and telling others what she needed them to do. She did this without reservation and without apology. For example, she describes what she did after waking at 1:00 A.M. with regular contractions, saying,

So we got our birth kit out and we put plastic on the chairs and I made him vacuum the floor and I woke Rob [her brother-in-law] up and I made him wash the kitchen floor, and we just got the house all ready.

She also describes holding up her finger several times to signal to her birth attendants that she needed quiet to get through a contraction. At another point, she told her husband to stop reading a book and to pay attention to her and her contractions. She does all of this without apology. No other interviewees told such stories.

One might read Jill’s and Andrea’s narratives as indications of gender nonconformity, as moments where women are not subjected to internalized technologies of gender. However, also note that Andrea apologized for her language in her retelling of her cursing and that some of the “orders” that Jill gave are gendered—she ordered the housework to be done. Thus, both are also subjects of normative internalized technologies of gender. Perhaps these women are different only because the data are not there, and they were not asked about these issues directly. Or perhaps they point to areas where more research is needed. What would resistance to or freedom from technologies of gender look like in this case during labor and birth?

Since two of these women gave birth at home, the other question these outliers pose is whether the hospital is really what is making these women “act nice.” This is difficult to know because it seems just as likely that those women on whom technologies of nice and kind have not operated may be more able and more likely to choose an alternative birth in the first place, thus making it difficult to say which way the causal arrow goes. In some ways, this is most plausible (that not being subjected to technologies of nice and kind make it easier to choose alternative birth), as the women in this sample report focusing on husbands’ needs, apologizing, and being nice before they ever get to the hospital. They are subjected to the tyranny of nice and kind at the moment labor begins, as it is a part of their gendered subjectivity, and they carry this subjectivity with them to the hospital. To untangle the role of home birth, further research examining a greater number of home births is needed.
CONCLUSION

Traditional feminist accounts of childbirth emphasize the institutional control over women’s birth experiences, in particular, the medical control asserted by doctors, hospitals, medication, and medical technology. However, this perspective ignores other forms of power that shape women’s everyday experiences of birth. Power and control are not just institutional or interactional as West and Zimmerman (1987) suggested. Women’s birth experiences are regulated by other social mechanisms, namely, internalized identities and especially, in this case, gendered identities. I explored the internalized technologies of gender that were visible in the birthing room and demonstrated that white, middle-class, heterosexual women in my sample were compelled from within to act in gender-normative ways. None of these women described strategically managing impressions (Goffman 1959). None of them indicated that a fear of being sanctioned by others (West and Zimmerman 1987) or by social institutions produced their normative gendered feelings and behaviors. In fact, the women described being given “permission” to act in gender “deviant” ways or being told not to apologize by partners and practitioners. At the same time, their narratives did include many references to “that’s how I am” or “that’s just not me,” suggesting an internalized technology of gender at work disciplining them during childbirth.

The women express selves that are relational, selfless, caring, polite, and subjected to the tyranny of nice and kind. This gendered identity led them to expend much energy on taking care of others and obeying gendered social norms about politeness while they were in the middle of a profound physical experience that takes considerable energy, agency, and willpower. Technologies of gender kept these women compliant and led them not to ask for what they needed for fear of asking too much of others. When these gendered technologies broke down, usually during the most exhausting and painful parts of labor, these women said that they felt bad about their behavior, and they often apologized for it. Furthermore, in the end, some of these women did not value their own lived experiences and found their husbands’ or doctors’ views of the birth more “real” than their own. Although further research is needed, I suspect that an internalized technology of gender, in combination with medical institution controls and the sick role, lead some women to apologize for being difficult, to attend to social relations, and to be nice while in many other painful states (e.g., aching, bleeding, or dying). Further work revisiting the sick role from a gender perspective might enrich our understanding of this process.

This study can be extended in at least two ways. First, the data are retrospective accounts. While it would be unreasonable to interview women during their labors, ethnographic observation of women during labor and birth potentially could reveal a different story. When interviewed retrospectively, these women could be describing themselves as more concerned about appropriate gender interaction and
relationships than they actually were during birth. Thus, their retrospective accounts could be a way of camouflaging their gender deviance during labor. Nonetheless, when I spoke with several medical professionals (obstetricians and CNMs) who attend births regularly, all said that what I heard in the interviews with the women in this sample are what they frequently hear in the labor and delivery rooms. These are still anecdotal data, however, and an ethnographic account of these issues would be an important addition to the further study of these issues.

Second, my findings are based on a homogeneous sample. The internalized technologies of gender that compel women during birth may vary tremendously by socioeconomic, racial/ethnic, or religious background as well as other cultural and personal factors (Chodorow 1995; Kane Low 2001). Therefore, I hope that this article will stimulate further research in the sociology of birth to examine internal sources of discipline and control whatever their particular form or substance. In presenting these data, I mean to draw attention to how powerful gender is when it is internalized. These women are not foolish or weak because they are concerned about being nice while performing the physically difficult feat of giving birth. Rather, birth is something to which we bring our socially interpellated selves. No matter how natural we try to be, birth is still a social event. Removing the medical institution from birth does not remove its social aspects nor make it natural and therefore free from male dominance, as many feminist advocates of the natural childbirth model imply. Gender is in us, and we bring its power to discipline our bodies, selves, and lives to even the most natural events.

NOTES

1. Fox and Worts (1999) also noted this lack of work on childbirth.
2. Davis-Floyd (1992, 30) acknowledged women’s socialization in passing.
3. Gilligan’s (1982; Brown and Gilligan 1992) work on adult women attempts to revalue this feminine identity. However, her work on adolescent girls identifies the problems associated with having such an identity.
4. While it is impossible to fully survey the materials of childbirth education here to see if what Katz Rothman suggested in 1982 is true today, anecdotal evidence of Lamaze and Bradley courses and a quick look at many of the most popular birthing books suggests that while more women are portrayed as birthing partners (midwives, mothers, friends), husbands and male partners are still coaches who cheer on an agonized woman.
5. The literature consistently finds that women feel best about their birth experiences when they are educated and prepared (Mackey 1990), have a healthy baby, have a short labor, or have a say in the decisions that are made about their care (Sequin et al. 1989). Some argue that women feel best about their birth experiences when they have a completely natural birth (Entwisle and Doering 1981; Kitzinger 1984; Oakley 1980). Others, frequently doctors, argue that when a woman is relieved of the pain of childbirth, she has a more positive experience (Stolte 1987).
6. The type of provider and/or the gender of the provider did not seem to be consistent with whether women felt compelled to be nice or apologize.
7. Kane Low (2001) found that low-income teenagers of a variety of racial/ethnic backgrounds told much shorter stories about their births (as they were focused on what happened once the baby arrived) but that they were most concerned with the niceness of the nurses rather than of themselves. It is difficult
to say if this difference from my sample is a result of age, socioeconomic status, race/ethnicity, or some combination of factors.

REFERENCES


*Karin A. Martin is an associate professor of sociology and women’s studies at the University of Michigan. She is the author of Puberty, Sexuality, and the Self: Boys and Girls at Adolescence (1996, Routledge). She is working on a second book tentatively titled From Black Pants to Bras: Gender and Appearance on Campus.*