



Contents lists available at [ScienceDirect](http://www.sciencedirect.com)

Women's Studies International Forum

journal homepage: www.elsevier.com/locate/wsif



Progressing through labour and delivery: Birth time and women's experiences [☆]

JaneMaree Maher

Centre for Women's Studies & Gender Research, School of Political and Social Inquiry, Monash University VIC 3800, Australia

ARTICLE INFO

SYNOPSIS

In many accounts of birthing in Western societies, a divergence between 'medical time' and 'natural birthing time' is identified as a key point of conflict between women's expectations and experiences and medical protocols for birthing. Obstetrical control, with its focus on delineated birth stages and time limits, is represented in conflict with women's birthing rhythms. Drawing on interview data and contemporary feminist theorisations of time, this article suggests that this model of temporal conflict fails to capture the complexity of birthing time since a sense of temporal progress towards delivery is important to labouring women, as well as part of the medical model of birth.

The data was gathered through individual face-to-face semi-structured interviews which lasted between 60 and 90 min with ten women in Melbourne, Australia. Women birthing drew on formal and informal information sources to situate their embodied experiences, working hard to develop their own timelines for the task of birthing. The findings suggest that women's experiences of birth cannot simply be understood as conflicts between medical timelines, and 'natural' birthing temporalities, since women used communication about time to develop their own birth stories and generate a sense of progress and forward movement towards delivery.

© 2008 Elsevier Ltd. All rights reserved.

Introduction

Birthing is an experience described and understood in time in Western societies. Questions like: 'How long between contractions?'; 'How long do your contractions last?'; 'What time did your waters break?'; 'How long was your labour?' shape both the medical and social discourses about labour and delivery. But contemporary accounts of birthing often focus on tensions in how time is understood and mediated in birth, with medical timelines understood to be generating birthing interventions, sometimes with adverse outcomes for women (Lane, 1995; Rogers-Clark, 1998). Natural birth advocates argue that women's bodies and needs must shape the temporal progression of birth, not medical timelines. This

article explores the experience of birthing time during labour and delivery drawing from an in-depth qualitative study with women, and using contemporary feminist theoretical conceptions of time. It examines how birthing women sought temporal markers that helped them understand their own births by listening to direct and indirect communication during labour and delivery. From the study's findings, I suggest that women's experiences of birthing time are complex and cannot be accounted for using models of conflict between 'medical' time' and 'natural birthing time'. Rather, this small study indicates the need for more nuanced exploration of birthing temporalities.

The development of time limits for each of the birth stages in contemporary Western obstetrical management has been understood to precipitate proactive management that leads to greater incidence of intervention (Lane 1995; Reibel, 2004). It is clear that medical evaluations of risk in childbirth are linked closely to time schedules and that deviations from such schedules are often linked to interventions. This intersection of risk evaluation and defined time periods for each part of labour can be termed 'medical time' where the clock guides

[☆] The author would like to thank Dr Jo Lindsay, Dr Christina Twomey and Dr Vicki Peel for their insights during the writing of this article. I thank the WSIF reviewers who provided thoughtful insights and important comments during the revision phase. This research was supported by a grant from the Faculty of Arts Monash University.

expectations of progression through labour and delivery rather than women's embodied experiences and physiological changes acting as the key guide. Wendy Simonds has argued that these medical definitions of appropriate time periods during birth work to control women's birthing experiences. For Simonds, 'the medical model's conception of time during procreative events is founded upon a view of women's bodies as pathological' (Simonds, 2002, p. 560) and she asserts that while there have been changes to patient autonomy in other regards, 'time-based mechanisms of medical control have proliferated, maintaining the character of the power relations governing births in hospitals' (Simonds, 2002, p. 561). Meg Fox (1989) suggests that obstetric measurement of observable birth signs and the use of time-based labour stages is at odds with the experience of the 'woman in labour [who] leaves behind quantifiable time' (Fox, 1989, p. 127). Fox's argument, like that advanced by Simonds, posits 'medical time', the term I will use to describe medical imperatives driven by the clock, against a pre-existing natural birthing time where birth could proceed according to a 'truly timeless present, a present free from fearful distinctions, the relative time, of reason' (Fox, 1989, p. 133). This 'natural time' can be defined as that generated by the rhythms and actions of the birthing body, in contrast to contemporary birthing which is dominated by time bound medical frameworks (Fox, 1989; Kahn, 1989; Lane, 1995; Simonds, 2002).

This distinction of temporal orders in birthing draws on a broader theorised conflict between lived time and industrial time (Everingham, 2002), which has been exposed and explored by feminist scholars. Modern industrial time with its emphasis on units of product per hour of time spent has often been seen to render much of the work women do, most particularly caring and reproductive labour, as invisible and potentially valueless (Davies, 1990). Some feminists, like Fox (1989), urge a revitalization of a natural, pre-industrial temporality to encompass, reveal and revalue women's reproductive work. Rita Felski, however, contends that women may not be served by simple distinctions between cyclical or natural time, seen as feminized, and 'large-scale narratives of time' or linear time understood as masculine impositions (Felski, 2000, pp. 20–21), since women also construct narratives of development and progress through time. Felski's critique suggests a more complex understanding of time and its gendered implications is required, since 'different ways of understanding time' (Felski, 2000, p. 23) shape women's experiences, as well as men's. Questions of gender, labour and productivity are central to reproduction and are all inflected with our understandings of time. Birth is a 'natural' and social event that involves complex intersecting temporalities for each woman: some rhythmic, some repetitive, some linear. Yet there is always a clear focus on an endpoint; the delivery, although conventional industrial temporalities may be disrupted in this reproductive event. This complexity suggests that the conflict models of time proposed by Simonds and Fox need to be more critically explored in order for us to fully understand women's experiences of time in birth.

Contemporary time and labour for women

Karen Davies (1990, p. 27) identifies the processes of industrialization as critically linked to the development of

new time consciousness in Western subjects, where defined hours of employment and smaller timepieces facilitated the internalization of new time disciplines (Davies, 1990, p. 30). For Davies, this change was inherently gendered; as linear industrial time become the dominant temporal order, and was equated to the production of commodities, women's care and reproductive labour, seemingly lacking definable products, became devalued (Davies, 1990, p. 40). This account of how linear industrial time refigures women's work and experiences is central to the reconfiguration of birth in Western societies. The impact of industrialization and mechanization on birth have been well-documented (Martin, 1987; Oakley, 1984); feminist scholars have identified the ways in which birth processes have come to be seen as mechanical events where women's laboring bodies are part of the reproductive production line (Martin, 1987). And as in all mechanized processes, time management is critical. Medical time, as Simonds (2002) has suggested, regulates interventions, and medical activities, but also shapes experiences of physiological aspects of birth like contractions and dilation. Expectations around time; time dedicated to stages of labour, to the birthing process itself, to recovery time, are clearly medicalized, but are also vitally part of women's embodied experiences. From the assigned moment of conception to the 'due date', through the temporally regulated measurements of the foetus in utero during routine ultrasounds to the timed birth stages, women experience pregnancy and birth in defined medical time-frames. Reiger and Dempsey (2006, p. 371) argue that cultural shifts around birthing 'are inscribed into the material reality of birth giving through institutional and interpersonal practices', which pushes us beyond an understanding of medical time as imposed to a recognition that these are conditions in which birthing occurs. It is for this reason I argue, that the conflicting temporalities model, where the linear time of Western societies is at odds with natural birth (Fox, 1989; Robbie Pfeufer Kahn, 1989; Simonds, 2002) is not adequate to understand the temporal configuration of contemporary birthing experiences. In this study, women drew on multiple temporalities, both medical and non-medical, to construct their own forward moving birthing narratives.

In Karen Davies' (1990, p. 40) analysis of modern temporality, she identifies another temporal order critical to understanding women's work; 'task-oriented or process time'. 'Process time' is not simply linear time, which can be directly equated to productivity measures, or simply cyclical time which has no clearly defined relationship to the completion of tasks. This 'process' time is the amount of time it takes to do what needs to be done. This temporal order is particularly useful to think about birth since, despite the absence of a regulated linear time schedule, it is labour that has an end point in time and a defined outcome. It is work that occurs in a complex and uncertain temporal framework; where physiological progress (from contractions, dilation, pushing) is affected by social, cultural and individual meanings; where time taken and time experienced intersect but are not necessarily the same; where forward movement is often sporadic and interrupted but progress is inexorable. In examining the reports of the women I interviewed, this temporal mode – 'process time' which encompassed both linear time with its forward movement and a more complex and uncertain embodied progression – was most evident in

the accounts. For while linear industrial time sometimes disappeared or became pliable in the processes of birth, this did not mean women entered a natural, organic or cyclical time. Medical activities, as well as their own experiences as subjects in industrial linear timescapes, meant that measuring time was important. These women drew on a range of differing forms of time information gleaned from their carers and their surrounds to create their own process time narratives in labour and birthing.

Understanding process time in birth requires attention to communication with women during birth, since women's sense of the task of birth and the time it will take is connected not only to their physiological experience, but also to the information they receive from their carers. While some women report an internal sense of progress towards delivery that makes communication with others less vital (Halldorsdottir & Karlsdottir, 1996), for most women, communication with caregivers is critical. The importance of this communication has been recognized in changes to birth services in Western countries that have focused on the provision of good information, clear discussion and involvement in decision-making for women. These changes have been identified as important for birthing women's satisfaction and for positive experiences, whatever type of delivery or whatever events occur (Halldorsdottir & Karlsdottir, 1996; Homer, Davis, Cooke, & Barclay, 2002; McCrea, Wright, & Stringer, 2000; Waldenström, 1999; Zadoroznyj, 1999, 2001). But I consider communication is clearly embedded in the temporality. Specific issues to do with epidurals, for example, will be understood differently in antenatal classes than they will be in the midst of painful contractions. A 'normal' period of transition to the second stage may seem intolerably long to the woman involved. The meaning of 'soon' may be profoundly different to the anxious labouring woman and to the attending midwife.

Little attention, however, has been paid to the intersection of communication and temporality, with most studies using general definitions of communication, rather than focusing on when information is delivered and how its timing might affect birthing women (see, for example, Biró, Waldenström, Brown, & Pannifex, 2003; McCrea et al., 2000; VandeVusse, 1999). Good communication between medical carers and birthing women is understood to require attention to the particulars of each birth (Berg, Lundgren, Hermansson, & Wahlberg, 1996; Halldorsdottir & Karlsdottir, 1996) and the nature, quality and style of communication provided are important to women's experience and satisfaction (Fraser, 1999; Homer et al., 2002; Lundgren & Dahlberg, 2002; VandeVusse, 1999). Yet, communication during labour and delivery occurs necessarily in the context of a forward moving embodied process and is therefore related to the temporal orders in play during birth. The relevance of any communication will be determined by the temporal aspects of the birth; whether a woman is able to hear and respond; whether the information being communicated contradicts or is congruent with her physiological experience of the moment.

This present study arose after an earlier study with midwives revealed the use of temporal narratives to assist birthing women. That study found widespread use of temporal markers as part of midwife communication practice (Maher & Souter, 2002). The midwives relied on exchanges

that did not present physiological information alone i.e. 'four centimeters dilated', but generated time-based talk that embedded information in a progressive story; 'you have done most of the work in this first part, next we will...'. These communications clearly linked medical information and medical time to processes of labouring and delivery. These temporally located communications appeared central in this later study too, but the women also relied on comments overheard or exchanged between carers as they laboured, to work out what was happening and where they were in their own birth process. Rather than experiencing conflicts between lived or natural time and medical time in birthing (cf Kahn, 1989; Fox, 1989), the women in this study used all available forms of temporal communication to generate process narratives of birthing; a temporal structure that gave them a sense of the progress in labour and delivery. These findings suggest that more nuanced attention to the complexity of birthing time is important to understand women's experiences and to understand the significance and effectiveness of communication with birthing women.

Method

The aim of the study was to further investigate communication and time in birthing and to generate a clearer understanding of birthing women's experiences during labour and delivery. I recruited ten mothers who had babies that were between three and twelve months old, using posters at maternal and child health centres and snowballing, for a small scale semi-structured in-depth qualitative study of birth experience. Institutional ethical clearance was obtained before the interviews commenced.¹ Each interview was taped and fully transcribed. Initially, key words and concepts were highlighted in the transcripts and similarities were compared to key themes in the literature. Interpretative nodes were developed with the aim of generating new analytical categories defining the connections between birth narratives and birth experience.

This narrative-based approach was adopted to develop a more nuanced understanding of the intertwined issues of time and communication by allowing women to recount their birth stories in their own words. It offered an opportunity for each woman to present the 'who, how and when' of her birth as each element appeared and was important to her. This open approach to data was influenced by Cameron (2001), who suggests that this allows the generation of meaning in participants' own words (see also Blix-Lindström, Christensson, & Johansson, 2004). Open-ended interviews facilitate birthing women bringing up issues of importance to them (Blix-Lindström et al., 2004). Hurwitz, Greenhalgh and Skultans (2004: 2) have argued for the 'newfound maturity [of narrative research in health and illness]', since it offers the opportunity to bring together 'the singularity of personal experience and the generalities of biological structures and mechanisms' (Hurwitz et al., 2004: 3) found in clinical practice; it was very appropriate for this study. Using an open semi-structured interview schedule, I asked only that the women described their birth experience, beginning with the process of going into labour and continuing through to birth, giving only as much detail with which they could feel comfortable. During the interviews, I occasionally asked for a temporal guide i.e. 'what time was

that?', but mostly the women recounted their stories without interruption. At the conclusion of each account, I asked if any comments or communications not already described had been important to them throughout labour and delivery.

The women were all tertiary educated, except for one who had completed secondary schooling. Nine of the ten lived with the father of the baby while the other woman lived with her sister. All the women lived in relatively affluent suburbs with eight owning their own homes in these areas. The women were predominantly Anglo Celtic with two being first generation Australians from non English speaking backgrounds. This small and relatively homogenous group limits the potential for generalization, but this study was designed as a preliminary in-depth investigation which necessitated a small sample size. Half were describing the birth of their second child; the other five were first time mothers. Six of the women had vaginal deliveries, three had emergency caesarians and one had a planned caesarian (for twins). Nine women gave birth in metropolitan Melbourne and one gave birth overseas. All births took place in tertiary hospitals which is commonplace in Australia, where births are overseen by medical teams comprising obstetricians and midwives, with hands-on care and many deliveries being directly managed by midwives. Within this system, women can also choose a private obstetrical practitioner who works within the hospital system but directs the team for her or his patients. In this group of ten women, five of the women had private obstetrical care, and five were managed directly by hospital teams. Four were generally very pleased with the birth experience, four were moderately pleased and two expressed dissatisfaction with how their births had unfolded. The number of interventions ranged from none (one woman) to five. Satisfaction with the birth experience was not related to number of interventions with four of the five women who had interventions being happy with the care they received and with their birth experience overall.

In the discussion that follows, I explore the role of time, medical time and the time of women's experiences and I focus on how this impacts on communication. I examine the role that less formal communication, comments overhead and interpretation of carers' actions played in these women's experiences, and how these communications facilitated the development of process time birthing narratives as these women progressed towards delivery. In these communicative exchanges, women are clearly dealing with a range of institutional structures; in particular, different caregivers who are often hierarchically distinct (midwives and obstetrical registrars, for example) and different degrees of medicalisation according to the number of interventions for each birthing woman. These institutional frameworks will impact on how communication and the various potential temporalities are played and warrant much more sustained attention. Here, I have focused primarily on the women's narratives without seeking to directly map their experiences onto the institutional frameworks in order to maintain the focus on how women sought out knowledge to construct their own temporal narratives towards delivery. My aim is to generate a framework to understand women's own desires for temporal markers that might provide a basis for further investigation of institutional temporalities and women's embodied experiences.

Time, communication and experience

Despite all participants having attended birth classes, and the prevalence of tertiary educated women in the sample, there was almost no use of technical or medical language in describing labours and deliveries. Conventional medical accounts of birth focus on the *first stage* of labour as contractions leading to the required 10 cm dilation of the cervix, followed by a period of *transition* to the *second stage*, which can often be emotionally and physically challenging. The *second stage* is generally identified as the pushing stage preceding delivery. Information delivered antenatally focuses on familiarizing women with the relevant terms for techniques, procedures and options for pain relief, but these categorizations and terms were not used by the women to describe what was occurring while they were in labour. The women's accounts reflected a continuous experience in time, not one punctuated by stages or key milestones. In this sense, the women's accounts did reflect a more organic time frame for birthing than indicated by the technical outline of birth stages, but this did not mean the abandonment of linear time. Instead they relied on other time indicators to generate a sense of progress towards birth. This was most apparent in the story Amanda told about her second birth. She was describing her second labour specifically, but her first labour intruded consistently as relevant to what was unfolding this second time.

Yeah, well I went in wanting a really natural birth the first time. And I think having a bit of a nursing background maybe swayed me towards not wanting an epidural because I didn't want all the things that went with it. And, so I wanted a natural, you know, a natural birth and read up on that and went with my husband and a girlfriend who were my support people and we got through what I would call a very traumatic experience although a very healthy, a natural birth. But it was just awful.

In Amanda's account, the first and the second birth experiences are present and intermingled. The impact of the first 'difficult birth' is necessary to recount the experience of the second. In the final stages of her second labour, Amanda had been assessed and told she was only 4 cm dilated (substantially less than the necessary 10 cm). Amanda says,

Of course, I just thought 'Well that is going to take X amount of hours' or whatever I had in my mind that would be. Whereas if she had said to me, 'look you are only four centimeters, but your contractions are one on top of the other. This is obviously going to happen quickly, or it could happen quickly', and then I would have gone 'oh, okay, well I can probably deal with that in that case'... I just broke down because I thought there is just no way.

Amanda then describes how the anesthetist, who had come to provide the epidural after this information, was talking to the other staff in the room.

And plus the anesthetist is standing there saying, 'I think you should just let this woman have her baby'... I think he said something like, 'it could be in 15 minutes [and] this is going to be over'... And I thought, '15 minutes... I like your timeframe'.

The sequence of events that Amanda was describing shows conflicting timelines affecting her during labour. She received formal communication that it would be several hours before she could expect to give birth. This was followed by the summoning of the anesthetist, which must have taken at least 10 minutes, although Amanda, when later prompted, could not specify how long that had taken. After the anesthetist's arrival, in the midst of intense labour and rolling contractions, Amanda overheard his comment and experienced the shock of a new shorter timeline intruding into her expectation of an extended period of labour. This new timeline allowed her to manage the intensity of the pain, move past the disappointment and work toward the birth of her baby. As well as being responsive to these informal communications in the birthing process, Amanda was very conscious of the time implied in each of those verbal communications and this informed and affected the experience for her. Rather than a conflict between natural birthing time and medical time for Amanda, these two time frames intersected and Amanda developed a 'process time' narrative for what she was experiencing.

In this instance, the specific technical medical information presented was at odds with the informal communication. Amanda was told 4 cm, but heard a shorter timeline, which altered her experience. This distinction between technical information and the communication of events embedded in time found vivid expression in Madeleine's account too, where communication was not presented with timelines she could understand. In the interview, she found herself unable to reconstruct her birthing experience and the process of moving toward her caesarian birth.

I just don't know; I don't now whether I forgot. I just don't know.... There was no conversation. There was nothing and they just told me that. I mean I can't remember. Whether they said to me that it was... I mean they probably did say they were going to do the epidural.

Only the period of time when the anesthetist sat by Madeleine's head during the caesarean section and kept up a commentary about what was happening was clearly imprinted in Madeleine's account of the birth. Madeleine's narrative here was fuller and more settled, because 'there was a guy next to me who... was actually the one telling me what was going on'. When describing her birth, Madeleine felt that information about the procedures had been communicated to her, but these exchanges were not meaningful or grounded in the experience she was having. Because of this, she was unable to gain a sense of what the communicated information actually meant, and what it signified for the progress of her birth. When she was prompted about the time events or interventions occurred, Madeleine had no real recollection of any progress towards the birth. As Madeleine had a planned caesarian to deliver her twins, this loss was not directly related to the lack of the normal physiological indicators of birthing, but was rather linked to her uncertainty about what was happening throughout the surgical procedure. She had no sense of what was coming next and so was unable to generate a coherent 'process time' narrative for her birth experience.

This pattern of seeking to generate 'process time' narratives was evident in all the birth stories, where many

different temporal indicators were critical for women in working out their progress towards birth. Jenny described timelines as assisting her to manage intense periods of labour.

[Susan the obstetrician] really listened to me when I said, 'you know, I am in a lot of pain and the pain is worse than my last labour. It wasn't like this'. And she said 'that is because you are having... your baby is posterior and it will be more painful'. And I said 'I can't keep going with this pain for much longer' and she said 'I am not going to make you go on for much longer, you know, don't worry I just want you to try for a bit longer'. And so umm, she, she was good that way, because she gave me time limits. I found it really good to have time limits.

Julia, too, was relieved that her obstetrician gave her clear limits since 'there was a reluctance on the midwife's part to tell me at certain points... where I was in the dilation'. The obstetrician on the other hand, was clear.

She said that the baby was going to come any minute. So that was good because I had no idea.

These timeframes were not driven by the clock necessarily – as Diana said, 'I have forgotten the times entirely' – but were related to women's awareness of what was occurring around them and where they were in the birthing process. These definitions and interpretations were not technical; they relied on communications that allowed for the production of a coherent sense of progress towards birth. While the efforts to generate a 'process time' narrative did not always work effectively, with mistakes and miscommunication being present, stories of mistiming too show time's importance. Diana's account revealed temporal dislocation as what the staff were doing to prepare and her interpretation of what that meant generated a confused sense of where she was in her labour.

They'd organized the mats because they thought the birth was going to be quite close, so the mat was laid out. So this increased my... my expectations were always running ahead of the actual process with this birth. So, umm, you know, about the whole thing of being in labour and then thinking I was further along than I actually was.

These birth stories reveal a complex temporal framework, far beyond a simple contest between biomedical controls over time and some other natural birthing time. For although the women often expressed their lack of attention to both 'real time' and medical time, they also commented often and gratefully on the re-insertion of time into their birth experiences as the quotations above indicated. Amanda's despair at the assessment of her slow progress was really only alleviated by overhearing the anesthetist's comment about the short time he felt she had left to go. Sally and Diana had to renew and revise their temporal expectations as information and experience changed their understanding. Temporal indicators, which were generally taken from staff 'talking' or activity occurring around them, rather than from any formal communication, served most often to anchor these women in the experience of birth, flag an outcome that often seemed lost in the intensity of labour, and indicate that this intensity would not last forever.

From this preliminary investigation, although *Simonds' (2002)* exploration of time as another mode of control during birthing offers a crucial insight, an opposition between medical time and natural birthing time does not fully encompass the ways in which these women responded to temporal indicators, and sought to give their birth experience shape, definition and a potential ending. These findings suggest that women focus on time in their birthing in a number of interrelated ways and, for the most part, seek temporal indicators about progress towards delivery. For this reason, communication about the birth, or procedures, or likely developments was more easily understood when it was located in a narrative of temporal progression in the birth process.

Mistimed communications

These findings about the significance of process time were further extended by the substantial variation in the effectiveness of direct communication experienced by the women. Louise said 'I didn't think about the fact there would be so much ambiguity'. Her comment points to the fluidity of what constitutes communication in the processes of giving birth. In this study, the women often identified a distinction between the information that was crucial to them and what medical staff communicated. Amanda noted that,

these [midwives] were a little bit more, ummm, they needed to know everything was okay for them to feel that their practice was alright. [But] I didn't let... their meaningful information really impact on what I wanted to do.

Louise felt she was told things she couldn't comprehend, and not informed of issues that were of critical importance to her.

Much of the information that you need to hear, you just can't hear... [Later]... I thought, 'did anybody think to work out if she was posterior while I was in labour?' 'Did anybody think it might be not okay for me to think that I wasn't in labour when I was?'

Sally noted quite clearly that 'the people who communicated least in the surgery were the surgeons;... they told me the bare minimum' about her caesarean section. When pressed on whether she felt they had not explained what was happening or got her consent, she indicated that she had heard the key technical issues being outlined, but had not really gained a sense of what was about to happen or indeed what was actually happening. For example, no-one had explained that a catheter would be part of this process, which was very important to her.

This finding that the formal communication of information did not equal effective communication was further supported by a number of women who indicated that a lack of accurate technical information did not equate to bad communication (see also *Blix-Lindström et al., 2004*). Both Julia and Louise indicated that they had been aware that they were not being told 'everything' at different stages in their labours, but that this had not diminished their sense of connection to the process or their caregiver. Julia said of her

obstetrician that 'she was quite, you know, directive'. She had the sense that her obstetrician edited information and kept focused on the process of moving toward delivery, but felt that this was appropriate.

I realized in retrospect she had been really keeping it [under observation] but not sort of talking to me about it too much because it wasn't really necessary until it happened... I was... very happy to do it that way because that is how I do my own work as well. You have to try and run that balance... of... talking to people but you don't have to unnecessarily [burden them].

Elizabeth said, after detailing the decision to use forceps to deliver the baby,

my obstetrician said 'this is what's going on' and umm, look I trusted her absolutely. We had talked about the alternatives [before] and I just totally trusted her.

Sally talked of silence between her and the medical staff, rather than the exchange of technical information, as an important communication to her that she was moving toward a caesarian birth.

I was just waiting. And I, but I kind of knew.

These women were content to move forward without an extensive exchange of relevant information, based on previous relationships with the caregiver or on their experience in the labour to that point. Technical terms or descriptions didn't constitute key communication. Much greater attention was given to the ways in which communications located them in their progress towards birth; waiting as Sally was, Louise feeling she was in labour and moving forward when she was not.

Signs of progress

In analyzing the narratives, it was plain that women focused on informal communications in the delivery room about progress, even when they were not being addressed. In the narratives, these informal and overheard comments were accorded as much significance as direct communications, and often more, which also shaped my decision to focus more directly here on time and talk rather than the effects of the institutional contexts in which these women delivered. The women recalled many instances of medical talk, generally when carers spoke to each other in the delivery room, that they drew on to develop their own process time narratives of birth. The comment of Amanda's anaesthetist – 'just let this woman have her baby' – was a clear example of this. Even though Amanda was not the intended recipient, she heard and used the communication to move forward. Women also described instances of 'support person talk', either where they were talking with their support people, or where they listened to their support people talking with medical practitioners. In contrast to technical descriptions, which were largely absent from the narratives, these instances of informal communication formed crucial narrative points and were central to the birth stories that women told. They were extremely important in how women interpreted what was

happening to them during birth and where they were in the process of labour.

The significance of these comments, whether directly heard or overheard, runs counter to conventional assumptions that women enter their own private worlds when they give birth (Halldorsdottir & Karlsdottir, 1996). The narratives presented by the women in this study suggest that this 'private world' is only partial as the women recalled and recounted multiple communications throughout the process of birthing. Diana described several different instances when the talk around her impacted on her labour.

They were worried about the baby's heart rate and this is me again sussing out what is going on from listening to their conversations... I realize I was gathering a whole lot of information from what people were saying that wasn't being directed to me.

Later, paying attention to verbal cues, she identified that 'there was a bit of panic going on'. Similarly, Meredith included much of the circulating 'talk' in the labour room as part of her birthing narrative. At different times, she noted the following:

[At this stage], they're talking about me.

[Then] my friend the midwife [is]... saying 'now listen to what they're saying'.

They all started panicking and that really annoyed me.

She finally thought, 'they need to have one person doing the talking'. One of Anna's midwives told her she had the best anaesthetist for her epidural and the movement in her legs was preserved because of that. For Anna, although this was reassuring news, his expertise was in his communicative style; 'he was really nice; he went through a lot.... He'd explain everything really well'. Staff interactions were included in each of the birth narratives. Amanda heard clear disagreements about where she was in her labour, and what needed to occur as a result of these different estimations. Meredith said,

I actually vaguely heard them having an argument about whether they should get the obstetrician to do the stitching and I heard [the registrar] say 'No, I'll do it'. And I remember thinking 'I'm not sure about this' obviously.

During the stitching, Meredith felt 'like they were discussing things and... they [were] not talking to me at all'. Elizabeth even evaluated the mood of one her midwives in part of her narrative, despite the intensity of her labour at the point.

[The midwife] was so grumpy. She was at the end of her shift... She never bothered to check or anything [about what my views were].

For Sally, thorough explanations embedded in constant talk made the movement to a caesarean much less difficult.

[The obstetrician] basically came in and explained. He was very thorough... The person who was preparing me pre-theatre was quite good. She told me exactly what she was doing, when she was doing it. She said 'and what I'm doing

now is blah, blah'... And the anaesthetist was very good at sort of saying 'Can you feel any pain? Is there anything?', you know. 'Can you feel any movement in your legs?'

Other women also identified these periods too, where the communication about progress, even when they were not direct participants became a significant, and positive, part of their birthing experience. Jenny spoke positively about the period when 'my partner... was... talking independently to the obstetrician and then coming back and talking to me'. Louise said,

I heard my partner with me, often saying, asking questions and saying 'how are things going?', and 'what is this about?' And, 'when is the obstetrician coming?' And you know I heard him say that so I just felt fine, you know, I felt, 'right, I don't have to worry about that'.

Julia said, of her obstetrician: 'And she did a fantastic job with, you know, talking me through it.'

In this study, the women maintained a strong awareness of the communications going on around them. Even when they were extremely focused on recounting intense physiological experiences, these comments were woven into their narratives. It was notable that the experience of continuous or rhythmic communication, focused on progress, anchored Elizabeth's birth as it occurred.

Oh, she was just, you know, she was just saying, 'oh you are doing really well, and that is fantastic. You are going to have your baby', you know, 'your baby is coming and it is so exciting' and that. I just... it was so different after she started talking to me like that because I got a bit more focused and I didn't just... I wasn't just... screaming in agony, 'what's going on? This is horrible'. You know, 'I hate this'. I think I did a... I screamed a lot of... 'I don't like it. It really hurts'. You know, it's...oh, it is just awful to think about actually. But she was great, so she was saying, 'yeah, yeah, whatever. The baby is coming, you are doing such a great job and oh, you know, it is really good. And you just, you know, think about your baby and think about how well you are doing and you know. This is going to be over soon' and, yeah, she was really encouraging. And she said things like, while I was having contractions, she said, 'you know, you just get through this because the next bit is much easier, you know, once you start to push it will just feel so different and it won't be so painful. And that is going to be really soon' and you know, just that kind of talk and that, you know.

These informal communications functioned to ground and shape the birthing process for these women and they were clearly linked to temporal progress. Women focused on communication that indicated how long they had to go, when something was expected to occur in the labour or delivery, medical discussions about changes in staff or the arrival of new personnel into the delivery room. Rather than presenting an inherent conflict between birthing time and medical time, these accounts suggest that indicators of temporal progress, gleaned from formal *and* informal communication, offered an important and generally positive tool for birthing women to understand where they were in

their labour and delivery. Women detailed physiological responses to these markers, cited instances where communication grounded them in an otherwise stressful birth, or enabled them, in their view, to progress in their labour. In analyzing the interview data, it became clear that developing a temporal rhythm for the birthing process was important for all the women. Where such temporal indicators could not be gleaned, as in Madeleine's story, recollections of the birth and specific events in the birth process were fragmentary and imprecise.

There was a far greater prevalence of this type of communication in and about time in these birthing narratives than there was of the formal or technical information delivered during labour and birth to these women. This suggests that how we understand the processes of communication during birth; the delivery, reception and definition of information, needs more sustained attention and investigation. The women looked for, and drew on, communication that allowed them to gain a sense of progress in birthing, a temporal location for their endeavors towards the birth of their child. This sense of forward movement, of a definable task that would come to end, was central to all the women here.

Conclusion

Birth stories, as both Cosslett (1994) and Pollock (1999) argue, have always been identified as secret and occurring in language only known to the initiates. But these findings suggest these stories occur in time; linear or medical time, time experienced by women during labour and delivery, and 'process time' (Davies, 1990); the time each birth takes. Rather than expressing conflicts between a natural, organic birthing time and imposed medical time, these women developed their own form of process time, often from informal communications around them, to construct progress narratives for their labours and births. Elizabeth Grosz (1995: 96) has argued that 'there is a common everyday belief in the 'arrow of time', in time's directionality'. She also suggests that while 'time itself has no speed... for it is... the measure of the speed or movement of an object' (Grosz, 1995: 93), it is 'linked to motion: time is the measure of before and after with respect to motion' (Grosz, 1995: 93). For women engaged in birthing, though the intense physical and emotional labour is clearly of the moment – and may not be directly linked to 'medical' time' – forward movement towards the birth of the baby is the ground for their embodied labours. Women's attentiveness to what goes on around them, their responsiveness to markers of temporal progress towards birth – even when these must be gleaned from overheard conversations or even disagreement between staff – indicates that birthing occurs in an intensely social context where 'natural', 'medical' and cultural temporal modes are in play.

For these women, forward temporal movement in birth was positive rather than constraining. They sought indications about time and progress and wove them into their births, both in the retelling and in understanding more fully what was actually happening to them at the time. These temporal narratives were important in determining women's experiences of and satisfaction with their birth experience. These initial findings suggest that time, and communication

in and about time, during birth require more careful mapping. For caregivers, this may mean more focused attention on how they temporally locate their exchanges with birthing women in relation to progress, labour and delivery. Closer attention to the ways in which women bring medical and social temporalities together in their birthing is crucial to fully reflect women's experiences. The forward movement of time, while characteristic of linear or medical time, is not simply imposed on birth, but is rather always present in the embodied subjectivities of birthing women and in the process of birth itself.

Endnote

¹ Ethical clearance was obtained from the Standing Committee Ethical Research involving Humans at Monash University, Australia in 2002.

References

- Berg, Marie, Lundgren, Ingela, Hermansson, Eveleyn, & Wahlberg, Vivian (1996). Women's experience of the encounter with the midwife during childbirth. *Midwifery*, 12, 11–15.
- Biró, Maryanne, Waldenström, Ulla, Brown, Stephnie, & Pannifex, Jan (2003). Satisfaction with team midwifery care for low- and high- risk women: A randomized controlled trial. *Birth*, 30, 1–10.
- Blix-Lindström, Sabine, Christensson, Kyllike, & Johansson, Eva (2004). Women's satisfaction with decision-making related to augmentation of labour. *Midwifery*, 20, 104–112.
- Cameron, Deborah (2001). *Working with spoken discourse*. Thousand Oaks: Sage Publications.
- Cosslett, Tess (1994). *Women writing childbirth: Modern discourses of motherhood*. Manchester: Manchester University Press.
- Davies, Karen (1990). *Women, time, and the weaving of the strands of everyday life*. Aldershot; Brookfield, USA: Gower Publishing Company.
- Everingham, Christine (2002). Engendering time: Gender equity and discourses of workplace flexibility. *Time and Society*, 11, 335–351.
- Felski, Rita (2000). *Doing Time: Feminist Theory and Postmodern Culture*. New York: New York University Press.
- Fraser, Aane (1999). Women's perceptions of midwifery care: A longitudinal study to shape curriculum development. *Birth*, 26, 99–107.
- Fox, Meg (1989). Unreliable allies: Subjective and objective time in childbirth. In Frieda Johles Forman, & Caoran Sowton (Eds.), *Taking our time: Feminist perspectives on temporality* (pp. 123–135). Oxford and New York: The Athene Series, Pergamon Press.
- Grosz, Elizabeth (1995). *Space, time, and perversion: the politics of bodies*. St. Leonards, N.S.W: Allen and Unwin.
- Halldorsdottir, Sigfridur, & Karlsdottir, Sigfridur Inga (1996). Journeying through labour and delivery: Perceptions of women who have given birth. *Midwifery*, 12, 48–61.
- Homer, Caroline, Davis, Gregory K, Cooke, Margaret, & Barclay, Lesley (2002). Women's experiences of continuity of midwifery care in a randomised controlled trial in Australia. *Midwifery*, 18, 102–112.
- Hurwitz, Brian, Greenhalgh, Trisha, & Skultans, Vieda (2004). Introduction. In Brian Hurwitz, Trisha Greenhalgh, & Vieda Skultans (Eds.), *Narrative research in health and illness* (pp. 1–20). Oxford, Massachusetts & Carlton: BMJ Books, Blackwell Publishing.
- Kahn, Robbie Pfeufer (1989). Women and time in childbirth and during lactation. In Frieda Johles Forman, & Caoran Sowton (Eds.), *Taking our time: Feminist perspectives on temporality* (pp. 20–36). Oxford and New York: The Athene Series Pergamon Press.
- Lane, Karen (1995). The medical model of the body as a site of risk: A case study of childbirth. In Jonathan Gabe (Ed.), *Medicine, health and risk: Sociological approaches* (pp. 53–72). London: Blackwell publishers.
- Lundgren, Ingela, & Dahlberg, Karin (2002). Midwives' experience of the encounter with women and their pain during childbirth. *Midwifery*, 18, 155–164.
- Maher, JaneMaree, & Souter, Kay (2002). Narratives of support: Midwifery tales from the delivery room. *Nursing Inquiry*, 9(1), 37–42.
- McCrea, Hally, Wright, Marion E, & Stringer, Maurice (2000). Psychosocial factors influencing personal control in pain relief. *International Journal of Nursing Studies*, 37, 493–503.
- Martin, Emily (1987). *The woman in the body: A cultural analysis of reproduction*. Boston: Beacon Press.

- Oakley, Ann (1984). *The captured womb: A history of the medical care of pregnant women*. New York: B. Blackwell Oxford [Oxfordshire].
- Pollock, Della (1999). *Telling bodies performing birth: Everyday narratives of childbirth*. New York: Columbia University Press.
- Reibel, Tracey. (2004). Normal birth: A thing of the past or the new future for primary health care? *Primary Health Care Research and Development*, 5, 329–337.
- Reiger, Kerreen, & Dempsey, Rhea (2006). Performing birth in a culture of fear: An embodied crisis of late modernity. *Health Sociology Review*, 15, 364–373.
- Rogers-Clark, Cath (1998). Birthing experiences. In Cath Rogers-Clark, & Angie Smith (Eds.), *Women's health: A primary care approach* (pp. 72–81). Sydney, Philadelphia London: MacLennan and Petty.
- Simonds, Wendy (2002). Watching the clock: Keeping time during pregnancy, birth and postpartum experiences. *Social Science & Medicine*, 55, 559–570.
- VandeVusse, Lynne (1999). Decision making in analyses of women's birth stories. *Birth*, 26, 43–50.
- Waldenström, Ulla (1999). Experience of labour and birth in 1111 women. *Journal of Psychosomatic Research*, 47, 471–482.
- Zadoroznyj, Maria (1999). Social class, social selves and social control in childbirth. *Sociology of Health and Illness*, 21, 267–289.
- Zadoroznyj, Maria (2001). Birth and the 'reflexive consumer': Trust, risk and medical dominance in obstetric encounters. *Journal of Sociology*, 37, 117–141.