Title: Vulnerability in Birth; A negative capability

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Author: Jennifer MacLellan

Institution: ORNIID, Nuffield Department of Medicine, Oxford University, OX3 9DU.

Email and phone: Jennifer.maclellan@ndm.ox.ac.uk 01865 231460

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DR. JENNIFER MACLELLAN (Orcid ID : 0000-0002-6872-5011)

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Vulnerability in Birth; A negative capability

Abstract

Aim

This article explores the literature on women's expectations for birth, the sociocultural context from which these expectations originate and their impact on the interpretation of birth experience.

Background

Childbirth is associated with specific expectations from women with the potential for dissatisfaction if these expectations are not met.

Design

This paper presents a systematic analysis of the concept of vulnerability in childbirth.

Findings

A framework was extracted from the literature that linked the themes of a Discourse of control, Construction of inadequacy, and Shame of exposure to explain the sociocultural origin of dominant childbirth expectations in the literature. The experience of vulnerability unique to the birthing event is suggested as exposing the woman to this underlying contextual framework and impacting the interpretation of her birth.

Conclusion

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This synthesis has exposed the transient experience of vulnerability during birth as a significant contributor to the birthing woman's interpretation of the birth and her place within it.

Relevance to Clinical Practice

An explanatory framework is offered to clinicians that could increase their awareness of sociocultural and historical factors impacting a woman's expectations for birth. Appreciation of the woman's vulnerability in birth, exposing her to the influence of this framework, can assist clinicians to facilitate a quality birth experience for women. Furthermore, supporting women and midwives to accept this experience of birth vulnerability as a 'negative capability', can facilitate an empowering birth experience.

Keywords: Childbirth experience, Feminist Research, Concept.

Aims

This article offers an explanatory framework for the origin of dominant birth expectations described by women in the UK and Europe. How the concept of vulnerability is framed during birth could moderate the influence of this framework and offer insight to the reported discrepancy between women's expectations for and experience of birth.

Background

Childbirth signifies a physical and social transition event in the woman (van Gennep 1960). Physically she transitions from a state of pregnancy to separation of the foetus from her body. Socially she transitions into the category of mother. Transitional experiences expose the individual to a possibility of harm as they travel between social categories (Geertz 1973). The first phase in transition comprises symbolic behaviour as the person prepares to separate from their current status and move to the next. The liminal phase characterises that of transition where familiar frames of reference are removed to facilitate learning about the new role with

the aid of a guide or teacher. Lastly is the incorporation phase, reflecting return to society of the individual in their new status.

If birth is interpreted as representing the liminal phase in transition to the role of mother, familiar frames of reference relating to experience of the body may be challenged by the overwhelming physicality of birth. According to Van Gennep (1960) this loss or perceived instability leaves the woman vulnerable as she becomes sensitive to learning about her new status. The guide or teacher orientating the birthing mother imparts subliminal messages regarding the woman's body, her competence and social positioning. In the current UK and European birthing model, that teacher would be a health professional. As a result of this openness her perception, interpretation and agency can be impacted in an unrealised way, positively or negatively affecting the internalised and narrated experience of birth. If the guiding messages imparted to the birthing woman conflict with her beliefs and expectations of the event, psychological stress can result (Dahlberg & Aune 2013, Soet, Bracke & Dilorio 2003).

Design

This paper presents a systematic analysis of the origin of dominant birth expectations in the literature, synthesis into an explanatory framework and discussion of the impact of framing in the concept of vulnerability in childbirth. It argues that the concepts of control, participation in decision-making and relational support to be linked with empowerment or trauma by their presence or absence, and that they appear to have a long-term impact upon the birthing woman's identity. The complex connections to deeper social processes are discussed and how they impact the woman's interpretation of her birth experience through a lens of vulnerability unique to the transition experience of childbirth.

Methods

A comprehensive literature search was conducted in March 2019 using the bibliographic databases CINAHL, PubMed and the British Nursing Index. The author also searched the reference lists of related articles, reports and review articles. Searches were not restricted by date, but English language only. The search terms used were 'expectations AND childbirth'. The author screened the title and abstract of the records for inclusion. Full records were

assessed for inclusion based on a reading of the full text and quality grading using the Critical Appraisal Skills Programme (2018) checklist for qualitative research. All records were included if they reported women's expectations for childbirth.

Thematic synthesis of qualitative research as described by Thomas and Harden (2008) was used to direct this project. The author read the records and coded the findings of the primary studies. These codes were then organised into related areas to create descriptive themes. These patterns of meaning were then analysed to support wider theorising about the socio-cultural and structural conditions within which women's expectations for birth were embedded, enabling construction of the data (Braun & Clarke 2006). Synthesis of commonalities and contradictions across records brought fresh interpretation to the data with the emergence of analytical themes. These themes of discourse of control, construction of inadequacy, and shame of exposure offered an explanatory framework for women's expectations of birth. The meta theme of vulnerability appeared to moderate the impact of these concepts on the woman's interpretation of her birth experience.

Findings

The themes of discourse of control, construction of inadequacy, and shame of exposure offer an explanatory framework for women's expectations of birth. The meta-theme of vulnerability appeared to moderate the impact of these concepts on the woman's interpretation of her birth experience depending on how it is framed. If birth vulnerability is reframed from exposure to the possibility of harm, to a basis for an ethics of non-violence (Butler 2005), a more positive experience is reported. The dominant birth expectations reported in the literature act as a defence against the transitory vulnerability of childbirth creating a short circuit of violence for the woman in the form of dissatisfaction with the experience.

Core concepts identified by birthing mothers as necessary for a positive birth experience included respectful care, trusting relationship, control, and participation in decision-making (Beaton & Gupton 1990, Ayers & Pickering 2005, Downe, Lawrie, Finlayson, Oladapo 2018, Fisher, Hauck, Fenwick 2006, Melender 2002, Records & Wilson 2011, Renfrew, McFadden,

Bastos 2014, Karlsdottir, Sveinsdottir, Aspelund 2018). These expectations have been taken up by maternity policy promoting control, choice and continuity within maternity care (DoH 1994, 2004, 2016). The experience of such concepts are often associated with positivity, empowerment, satisfaction and reduced anxiety in both the birthing experience (Anderson 2000, Kirkham 2000, Sjogren 2000, Leap & Anderson 2004, Fahy & Parratt 2006, McGrath & Kennell 2008) and the woman's post-partum adjustment (Fahy & Parratt 2006, Stephens 2008). The absence of a combination of these factors has been linked to lasting distress (Soet et al 2003) manifesting as persistent feelings of humiliation, social isolation (Forssen 2012) or failure as a mother (Beck 2011).

The interpretation of the birth experience has the potential to impact upon the woman's future engagement with health services (Bowser & Hill 2010, DOH 2016, Pires et al 2002), their self-esteem (Kennedy et al 2003, Leap & Edwards 2006, Forssen 2012), bonding with their infant and adjustment to parenthood (DOH 2016, Fahy & Parrett 2006, Nicholls & Ayers 2007, Stephens 2008). Such consequences are rarely attributed to the childbirth experience as they manifest after engagement with maternity services is complete, yet women still vividly recall the emotions and experiences of birth after decades have lapsed (Forssen 2012, Bossano, Townsed, Walton, Blomquist 2017). One approach to this debate takes the view of childbirth as an experience rather than an event. While an event may be an important or unusual occasion in one's life, an experience is something that leads to the participant gaining knowledge. Thus the knowledge derived is embodied and occurs in a context of unique vulnerability. Denzin (1992) describes such a key moment as an epiphany. It leaves an enduring impression on one's life and the person is never quite the same afterwards. It can transform one's view of life and be relived within the individual's biography (Wainwright & Turner 2004), acting as a source of disruption in how people create meaning in their world (Becker 1997).

The expectations of respectful care, trusting relationship, control, and participation in decision-making, elements that will afford birthing women protection, revealed a particular conceptualization of health and vulnerability in childbirth care. Evidence of the enduring consequences of women's defence against the consequences of the context of birthing vulnerability emphasise its importance to the interpretation of childbirth (Butler 2005, Martin Tavaglione, Hurst 2014). For example, experience of a safe birthing environment has been found to impact upon the ability to cope during labour, the experience of shorter labours, less

augmentation, fewer interventional deliveries, more bonding behaviour between mother and baby and improved postnatal outcomes (Ayers & Pickering 2001, Baker 2010, Downe, Simpson, Trafford 2007, Gibbins & Thomson 2001, Hardin & Buckner 2004, John & Parsons 2006, Kennedy et al 2004, Klein, Sakala, Simkin 2006, Martin et al 2013, McGrath & Kennel 2008, Proctor 1998, Reed, Sharman Inglis 2017, Renfrew et al 2014, Sydsjo, Blomberg, Palmquist 2015, Van der Gucht & Lewis 2015).

While there is general agreement in the discourse that by the very nature of being human, one is vulnerable (Butler 2005, Cavarero 2009, Diprose 2013, Kemp 2000), there is divergence in the interpretation of its manifestation. The normative definition of vulnerability rises from the Latin root of the word: *vulnus*, which means wound (Drichel 2013). Vulnerability thus emerges as a threat, as an exposure to wounding or the possibility of harm as a result of specific circumstances (Harrosh 2012). Vulnerability is defined in the Oxford dictionary as:

“Exposed to the possibility of being attacked or harmed, either physically or emotionally”

(Oxford online dictionary accessed 21/11/16).

Consequently, the usual response to vulnerability aims to create closure and boundaries against the threat, restoring a sense of control over the threatening environment. Maintaining control featured widely in the literature review of women’s expectations for birth, illustrating interpretation of vulnerability as the threat of harm. If being vulnerable is to be at risk of harm and being perceived as weak, then to be competent and strong is to be invulnerable (Gilson 2011). This positions vulnerability as the problem that Gilson contests, as she sees vulnerability as a condition that can also enable us, as a capability (Gilson 2011, Shildrick 2002). While both viewpoints acknowledge shared vulnerability as a characteristic of being human, the Institution of ‘expertise’ or medico-juridical system governing childbirth assumes an ability to quantify physical indicators of vulnerability, encouraging top down solutions and paternalism. Critics of this approach label the essentialising classification of ‘the vulnerable’, and application of protective measures, to be a form of violence itself (Diprose 2013).

The principal perspective on human vulnerability within medical bioethics is guided by the declaration of Human Rights (Martin et al 2014). The Universal Declaration on Bioethics and Human Rights of 2005 (UNESCO 2005) emphasises in Article 8 the need to take into account the global condition of the human as vulnerable when considering advances of

medical technology. It continues by expanding its definition of vulnerability to include individuals and groups of special vulnerability that require protection and respect of their integrity. Martin et al (2014) operationalise this human rights message by defining 3 moments to support assessment of an individual's vulnerability. These moments are: the reason an individual is vulnerable; the context under which vulnerability may manifest; and finally, the actual manifestation of vulnerability. The reason an individual is vulnerable is what Martin et al (2014) refer to as the interests of welfare. For example, within a childbirth context, this could refer to a desire for caesarean section because of a traumatic first birth, thus the woman is vulnerable if she presents in labour and her request is not considered. A converse example might be a birthing woman's desire for a natural birth with as little intervention as possible due to a fear of encroaching medical intervention and its complications. If she is supported by a midwife who believes in the medical model of birth, the birthing woman is vulnerable to psychological and medical messages that may question her competence, and is physically vulnerable as a result of the checks and measurements of medical protocols that can easily disrupt the rhythm of her labour.

Another reason to ascribe vulnerability using the framework of Martin et al (2014) originates from issues concerning agency. These are values, goals and principles arising from the individual that they wish to protect and that are enacted in their freedom of choice (Martin et al 2014). The frustration of agency can easily impact upon interests of welfare, for example being treated with disrespect may cause serious mental distress. Butler's work (2005) reframes this reductionist bioethical approach to the concept of vulnerability, instead making it the basis for an ethics of non-violence based on corporeal interdependence. She declares the relation between the 'I' and the 'you' to bring the 'I' into existence, and by the reaction to the example of disrespect, to undo it. Thus the 'I' is actually a composition of its matrix of entanglements with others without which it would not survive. Desiring care and receiving something else naturally causes the 'I' to feel exposed and to try to defend itself against the vulnerability. This may include the destructive act of cutting oneself off from its relationality, without which there is no self. Consequently, this defence against vulnerability perpetuates the very violence from which we seek protection (Butler 2005).

Martin et al's (2014) second moment to ascribe vulnerability is in the context that can result in vulnerability. These authors acknowledge this context as created in interaction between an individual and the world, encompassing history, culture and psychosocial interaction. On a macro level, Oliviero (2016) classifies vulnerability as a socio-political creation since

someone or something is responsible for the threat or harm. She emphasises the interaction between an individual and institutions to result in structural conditions that generate vulnerability. This perspective is shared among trans-national feminists who expose the link between systemic disparities and identity-based modes of representation to explain the experience of such structural vulnerabilities among certain communities (Hesford & Lewis 2016). As a part of this school of thought that crosses traditional community and state boundaries, Oliviera (2016) discusses how identity is one of the sites through which vulnerability is both experienced and perpetuated. However, identity can be used as an asset to mitigate against vulnerability as it leads to recognition of a community and opportunities for collective voice, turning it into a positive characteristic. The last of Martin et al's (2014) moments assesses the manifestation of vulnerability. These are summarised to include those unable to protect their own interests, more likely to be exploited, lacking in basic rights, or at risk of unequal opportunity to achieve their full health potential and quality of life. These reasons are actually characteristics of vulnerability intrinsic to all individuals. They have been credited to unequal distributions of power and effects of institutional structure and representation on the lives of individuals (Oliviera 2016).

The experience of vulnerability within a sociohistorical context of birthing was felt in the literature to impact the woman's response to birth and her interpretation of the birth in light of her pre-birth expectations. The data suggests that because of this temporary but intense vulnerability, concepts of control, participatory decision-making and relational continuity carry significant importance to maintain cognitive harmony in the birthing woman. Their complex connections to deeper social processes combine to build a theoretical context of vulnerability unique to the transition experience of childbirth. I have named these explanatory themes as: a discourse of control, the construction of inadequacy and shame of exposure. They are discussed within the context of birth as the liminal phase of social and physical transition of the woman, opening her to a vulnerability unique to the birth experience (Figure 1).

Insert Figure 1.

A Discourse of Control

In a study of more than 8000 pregnant women, Geissbuehler and Eberhard (2002) found women to be afraid of losing control during labour and behaving inappropriately. Loss of control is described by Goffman as stigmatizing (Goffman 1963). An adult must avoid

embarrassing themselves by being out of control in situations where control is expected. Furthermore, they are expected to avoid embarrassing others who may be a witness to their lack of control. This is because one is responsible for how they present themselves. The presentation of self carries a significant influence upon the prioritising of control in labour.

Fear of pain is a significant concern of pregnant women regarding labour (Schytt, Green, Baston 2008, Fenwick et al 2009). Fear of pain in labour is suggested to be a manifestation of the deeper anxiety about losing control during the experience of pain resulting in a sense of inadequacy (Leap, Dodwell, Newburn 2010). Madsen (1994) describes pain free birthing as the ultimate denial as birth pain exists for a reason, marking the physical and emotional transformation of birth. It has been found that an acceptance of pain during childbirth enhances the woman's ability to cope with the pain and maintain internal control of her response to labour (Van der Gucht & Lewis 2015, Karlsdottir et al 2018). An obstetric surgeon from 1847 declared pain as neutralizing the sexual emotions therefore ether should not be offered as it alters the modesty and emotional self-control proper to the female sex (Davis Floyd 2003). While representing an extreme and outdated view, the underlying historical source of women's control of their behaviour is neatly illustrated.

Within a cultural context that supports allopathy, the body is seen as a creation of nature with birth as a constant reminder of our connection with nature. As nature is considered to be unpredictable it poses risk, and therefore to enhance safety it needs control (Skeggs 1997). The risk of the body malfunctioning during birth lies at the heart of obstetrics, with safety privileged over lived experience and birth viewed as normal only in retrospect (Davis-Floyd 2003, Walsh 2010). The institutional culture of risk and accountability that controls current childbirth practice has resulted in the increasing absorption of technical interventions and restrictions into 'normal' birthing, raising ambiguity in its very definition (Clarke, Bowcock, Gales 2007, Downe, McCormick, Beech 2001, Guiver 2004, Hunter 2012, Keating & Fleming 2009, Mead 2004, Romano & Lothian 2008, Scamell 2011, Scamell & Alaszewski 2012). As a result, women's expectations of childbirth have been charted as changing over time to reflect a process involving medical intervention with less control and choice for the birthing woman during their birthing experience (Johansen, Newburn, MacFarlane 2002). The term 'medical colonisation' of childbirth has been coined among some critics to represent this dominant care arrangement, viewing women as a vehicle of reproduction that needs controlled (Davis-Floyd 2003, McLaren 2017).

However, the birthing woman who gives up control to the institution and subjects herself to institutional procedures such as routine cannulation in labour, continuous CTG monitoring, frequent vaginal examination to check labour progress, amniotomy, restriction of food and drink during labour, directed pushing, and encouragement to birth lying on the bed, does not always describe coercion to participate in this model of care. This could be because the knowledge and skills of the technical practitioners are given authority in the risky business of birth (Arendt 1970). The historical promotion of medical supervision and hospital birthing in the UK and Europe as the 'safest' way to birth has become culturally embedded in society to reflect the expected arrangement for birth (Moore 2016). The authority of medical expertise lends legitimacy to the culture of the hospital institution within which it principally operates. It involves culturally rooted behaviours, redolent of Parson's sociological description of the 'sick role' (1951), which requires delegation of responsibility for health to the physicians upon entry into hospital. This role carries accepted behaviours that include compliance with prescribed treatment. This socially learned response to institutional power situates medical knowledge as the precursor to control that has been transposed to birth (Tronto 1993).

However, some birthing women describe these technical interventions during birth to make them feel powerful over the restrictions experienced by nature and as full participants in the higher order of culture (Davis-Floyd 2003).

The regulation of nature, embodied by the pregnant woman, through the imposition of technocratic knowledge reflects the wider structural inequality between women's knowledge of birth and the state sponsored deployment of expertise (Lawler 2014, Rose 1999). Simkin (1996) interprets reliance on medical intervention as a loss of women's personal experience, knowledge and self confidence in birth. She blames the dependence on experts for childbirth knowledge on the increasing mobility of people within modern society, as fewer women learn about pregnancy and childbirth from traditional sources of mothers and female relatives (Simkin 1996). However, Klein (2006) describes women's knowledge as less applicable to this new experience, resulting in reliance on experts to provide education in the new rules for birth. Thus, the vulnerability of birthing women is emphasised by the conflict associated with alternative ways of knowing and that presented by the checks and measures of the technocratic experience. The natural process of birth has been described by Ryan, Todres, & Alexander (2011) as a pre-reflective embodied or emotional way of knowing, with thought and verbalization coming after the emotion had manifested itself in the physical body. This reflects an experiential dimension of knowledge based in the emotions integrating intuition as

the body's participative way of knowing (Ryan et al 2011). Reed et al (2017) surveyed 748 women about experiences of birth trauma. The disregard of embodied knowledge in favour of care provider's clinical evaluation was frequently quoted as a source of distress. Supervision and measurement rituals can result in women losing confidence that they can give birth without medical assistance, losing trust in their bodies (Kitzinger 1978), making dependence on others, instead of the self, a condition of motherhood (Oakley 1980).

The more control in birth is taken over by the technocratic model, the more likely the mother's behaviour will be affected by external and social cues (Dahlen 2010) considered essential for a safe outcome, rather than the internal ones of her own body (Kitzinger 1978). Thus, a crisis in the self has been reported in the childbirth literature, not necessarily from the use of technology itself, but from the implications of its use, challenging agency, control and the woman's belief model of birth (Seel 1986, Walsh 2010). Thus, as birthing women express a need for medical support in childbirth, the obstetric profession demonstrate their reciprocal need for birthing women seeking safety through obstetric management to maintain their professional actuality. This reciprocal relationship perpetuates medical colonisation and control of birth despite reports of increasing dissatisfaction with the technocratic model from women, and an increasing awareness of related negative psychological and social consequences (Benoit, Zadoroznyj, Hallgrimsdottir 2010, Reed, Sharman, Inglis 2017, Soet, Brack, Dilorio 2003, Waldenstrom 2004).

The Construction of Inadequacy

The dynamic nature of mothering and unpredictability of pregnancy and birth emphasise the role of planning and control (Kitzinger 1978). Childbirth is an intensely physical and psychological experience as physiological sensations foreground in one's perception, abating only after the birth of the child. Such intense physicality, in the majority of cases, is not pathological, yet the cultural construction of pain as suffering in our society is transposed to childbirth and appears to conflict with the promotion of non-technocratic birthing (Moore 2016). As one respondent commented in the paper by Savage (2006),

“Childbirth is the only major medical procedure involving so much pain and you are expected not to have anything” (pg16).

This neatly reflects the embedded pathologising of labour as a medical procedure with the associated experience of pain as suffering. Modern obstetrics has been described as child centred (Seel 1986, McLaren 2017) implying an appropriateness of women's suffering to benefit the child. This can be experienced through certain birth model rituals that deny the importance of the mother's feelings during labour, reflecting the loss of status characteristic of the liminal period. Rituals can suggest that if she wants to be a good mother, she must subordinate her own needs and desires to those of her baby. This reflects the experience of humiliating and often painful events as part of the indoctrination of social values as the woman transitions to her new role (Geertz 1973). This experience can stimulate potential for resentment or guilt in the postpartum mother (Seel 1986).

A respondent in the research of Madsen (1984) described her fear of the power of birth and 'what is required of me', implying a fear of inadequacy. Birth is a significant physiological process. Some women are scared, and can feel useless because they are scared (Nilsson & Lundgren 2009). One respondent in the study by Nilsson & Lundgren (2009) described how society does not respect the fact that women may be afraid of giving birth and may not feel a member of the 'women's club'. This sense of inadequacy is exacerbated by the essentialising normal birth movement in its political stance against the medical colonisation of childbirth (Walsh 2010). It emphasises the birthing mother calmly breathing through her contractions in control of her response to the pain of birth (Carson et al 2016). The agony and suffering is not told, impacting women's expectations of childbirth and their psychological preparation for it.

As far back as the 1970's, childbearing women were recorded as wanting to feel valued as a person, to participate in decision making and experience caring communication (Records & Wilson 2011). This desire supports the belief that individuals are socially embedded, where social relations constitute an individual's identity and this is reaffirmed or discredited through interaction with others (Baumeister & Leary 1995). Within the unknown and challenging birth environment, women are vulnerable to their own and the perception of others' expectations of how they should behave. This makes dignity of the self vulnerable to the effect of others (Jacobson 2009). The findings of Fisher et al (2006) reinforced by Aune, Hoston, Kolshus, and Larsen in 2017, emphasised the woman's sense of self as the most influential factor on her birth experience. However, the fear of not meeting those expectations, of feeling inadequate can prompt a shame response. Brown (2010) describes

such a response as withdrawing or keeping silent; seeking to appease or please; being aggressive or blaming. She describes shame as the fear of not being worthy.

The Shame of Exposure

Exposure of culturally intimate symbols during birth that are related to concepts of hygiene and the moral condition outside of the private space, reinforces a sense of vulnerability in the woman as the usual social order is disrupted. Examples include the exposure of the woman's nakedness, genitalia, defecation and blood. Culturally appropriate management of these artefacts during birth take place to remove the sexuality and intimacy from birth and thus the potential stigmatising shame of exposure. This is as much to protect the vulnerability of the birth worker exposed to an intimate experience over which they attempt to have jurisdiction, as that of the birthing woman sharing an intimate experience for which she requires support (Davis-Floyd 2003).

The potentially stigmatizing shame of exposure can be traced back to the Victorian era in England where social stability was seen by the middle classes to be dependent on moral purity in a changing world of industrialisation and population control. The Victorian obsession with sexuality provided a framework for control of the working classes under the guise of morality rather than addressing the more complicated structural issues of class conflict (Skeggs 1997). This shifted moral responsibility to the family and the role of the mother to control and discipline themselves and their husbands and sons. Sexuality also moved into the privacy of the home, with the locus as a fertile one in the marital bed. Proper demeanour of the time valued modesty, avoiding contact with other bodies and with verbal decency sanitizing speech (Foucault 1978). Areas of tact and decency became socially defined, while personal self-control, perseverance and occupation became characteristic of moral citizens (German 1989).

Respectability became linked to a complex matrix of representations of appropriate and acceptable behaviour through advice giving 'norms' and manipulation of consciousness (Skeggs 1997). Deviance from such a moral condition among women confirmed their weakness and held serious consequences for external control of their person (Showalter 1985). The social control of women's behaviour and sexuality is a discussion of its own but holds relevance to this topic due to the subliminal impact on women's expectations and experiences of childbirth in the current model. Denial of the power of nature in a society that

operates on the premise of order and control can impact women's ability and courage to listen to their bodies (Martin et al 2013), and by moving the private to the public reinforces the public performance of expected behaviour (Davis-Floyd 2003).

In the birth territory study by Fahy & Parratt (2006), the negative impact of disciplinary power on the emotional wellbeing and physiological experience of the woman in labour is explored. The configuration of the birthing room emphasises a woman's physical exposure in the surveillant design characteristic of a hospital labour room. This design typically includes bright lights, free access to the room by institutional personnel, with the bed and monitor in the centre of the room. This design facilitates exposure through observation and monitoring of the woman and her labour. Examples of disciplinary versus nurturant power dynamics in the interaction with birth workers further emphasise the woman's emotional exposure and its potential impact on the experience of labour.

The participants of Davis-Floyd's (2003) research described the presence of a conceptually congruent birthing partner as a significant buffer to prevent fusion between the woman's belief model and the technocratic approach of the institution. Within a professional context, this buffering activity has been categorised as the characteristic of guardianship. It refers to the midwife accepting responsibility to maintain an enabling birth space, and has been widely identified in the literature as an essential component in a birthing woman's sense of safety during her labour (Aune et al 2017, Ayers & Pickering 2005, Baker 2010, Bohren et al 2017, Downe et al 2007, Gibbins & Thomson 2001, Harding & Buckner 2004, John & Parsons 2006, Kennedy et al 2003, MacLellan 2011, Martin et al 2013, McGrath & Kennel 2008, Proctor 1998, Reed et al 2017, Renfrew et al 2014, Sydsjo et al 2015, Van der Gucht & Lewis 2015). Within the original birth territory study by Fahy & Parratt (2006), women described themselves as feeling in control of choices that were made where guardianship was evident. However, it is only through linking the findings of Fahy and Parrat to this significant corpus of evidence that a sense of safety can be seen to signpost to the deeper concept of exposure. This safety from exposure in the birthing environment has been found crucial to enable the woman to 'let go' of the need to be on guard and allow her body-in-labour precedence to control the birthing of her baby (Akrich & Pasveer 2004, Anderson 2000, Kirkham 2000, Leap & Anderson 2004).

Vulnerability as negative capability

The literature on women's expectations and experiences of childbirth is vast. There have been attempts to link qualities of the birth experience with satisfaction, however measurement of the presence of these qualities is fraught with difficulty due to their subjective interpretation. Research has shown health professionals and birthing women to have different interpretations of a birth, suggesting the picture of birth satisfaction to be complex. Despite maternity policy supporting the core expectations of choice, control, and continuity there is a key factor impacting the interpretation of their presence and consequently their link to a positive birth experience. My approach to the childbirth literature has uncovered a key contributor to women's interpretation of these important expectations. Viewing birth within a context of vulnerability characteristic of a rite of passage sits as the foundation of an explanatory framework of the unique vulnerability birthing women in the UK and Europe may be exposed to. The socio-cultural origin of the framework makes it unique to a context but raises awareness of the role of interpretation of the birth experience through a lens of vulnerability.

Vulnerability is context dependent, which fits with the modality of childbirth as the birthing woman becomes 'circumstantially dependent upon' the midwife or medical team (Oliviera 2016, Smith et al 2010, Walker 1988). However, the unique vulnerability of birth exposes the woman to a range of sociohistorical elements to which her response may contradict her expectations for birth or impact her interpretation of the birth and her agency within it. On a macro level, Oliviero (2016) classifies vulnerability as a socio-political creation since someone or something is responsible for the threat or harm. She emphasises the interaction between an individual and institutions to result in structural conditions that generate vulnerability.

Drichel (2013) recommends slowing down in the scene of vulnerability and learning to remain within vulnerability's uncomfortable space. By allowing a little uncertainty, attention can be drawn to the potential of vulnerability to open us to being affected and affecting in turn, though we will not know if the end result will be satisfaction or frustration (Gilson 2011). This view defines one's potential by what they do not possess, of being capable to be in uncertainty with a willingness to let what is mysterious remain. This *negative capability*, being in uncertainty without the need to reach for facts, offers a chance to contemplate alternative iterations of vulnerability emerging alongside the rhetoric associating vulnerability with a likelihood of violence. Butler (2014) argues for a deconstruction of the relationship between vulnerability and agency that fuses vulnerability with a context of harm

or injury. She calls for attention to how vulnerability can be activated as a political tool of advocacy and movement by exploring how it is used by ‘differently positioned bodies’ to perform resistance. It has been shown on a community level that engaging those experiencing temporary vulnerability due to a pandemic or natural disaster can empower members, increase trust in decision makers and ultimately reduce the situational vulnerability and associated compromise in welfare or agency interests (Smith et al 2010). When birthing women feel included in decision making, their perception of trust in the health worker to promote their interests increases. This often results in reports of empowerment from the birthing woman (Downe et al 2018).

Conclusion

A lack of awareness of the psychological and sociological vulnerability of a woman during birth could act as a major confounder in the relationship between women’s expectations of birth, and their lasting interpretation of their birthing experience. However, its lack of formal identification or categorisation restricts the depth of analysis present across the discourse and restrains opportunities for theoretical progression and clinical response.

Relevance to clinical practice

Interpretation of one’s birth experience has the potential to impact upon the woman’s future engagement with health services (Bowser & Hill 2010, DOH 2016, Pires et al 2002), their self-esteem (Kennedy et al 2003, Leap & Edwards 2006, Forssen 2012), bonding with their infant and adjustment to parenthood (DOH 2016, Fahy & Parrett 2006, Nicholls & Ayers 2007, Stephens 2008). If vulnerability is viewed as exposure to the threat of harm, expectations will naturally be generated to create closure and boundaries that restore a sense of control over the threatening environment. The application of protective measures could even be a form of violence itself (Diprose 2013). For example, the disregard of embodied knowledge over scientific measurements has been reported as a source of distress among birthing mothers. Furthermore, denial of a Mothers’ feelings in labour can imply her loss of status, stimulating feelings of resentment or guilt. This can be joined with a sense of not feeling worthy if one’s ‘performance’ in labour is judged.

Viewing vulnerability as a negative capability rather than a source of risk can support both the woman and her birth support team to slow down in birth and allow a little uncertainty.

Being open to being affected could support the formation of the longed for trusting relationship between the birthing woman and her midwife, by engaging with the woman in decision making an increase in trust could ultimately reduce the situational vulnerability. Viewing vulnerability as a negative capability is not a rejection of the technocratic model of care, but an opportunity to facilitate the birthing expectations of many women and a positive birth experience.

This synthesis offers an explanatory framework for clinicians that could assist them to facilitate a quality birth experience for women. Supporting women and midwives to positively accept birth vulnerability as ‘negative capability’ can facilitate an empowering birth experience.

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Figure 1: The unique vulnerability of birth.