A psychoanalytic perspective on hospital midwifery and birth

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This paper looks at hospital midwifery and birth from a psychoanalytic perspective. It is an edited version of a dissertation written for a Masters Degree in Psychoanalytic Observational Studies, undertaken at the Northern School of Child and Adolescent Psychotherapy in Leeds. The paper uses observational material from four births to consider the emotional work of the midwife and the birthing experience.

Keywords: birth; hospital; midwife; mother; women; baby; containment

Introduction

I work as a midwife in a Maternity Unit within a District General Hospital alongside which I have been a student on the Psychoanalytic Observational Studies Programme. I have chosen to write about birth and the work of midwifery because I think they are experiences increasingly disconnected from our everyday lives. People are unfamiliar with pregnancy and labour; birth is considered dangerous and frightening. It is not considered an ordinary process.

A psychoanalytic perspective has facilitated a way of thinking about my work that allows for the expression of the emotional content of the experience of birth and being a midwife. There is an enormous amount of work related to the measurable aspects of pregnancy, birth and babies and midwives are trained from an evidence base that is the bedrock of the science of midwifery. However, I wanted to explore the qualitative aspects (Creasy & Resnik, 2009). I wanted to think about the underneath, the unconscious aspects of what a midwife, the woman and the baby are thinking, feeling and experiencing.

In July 2009 (Guardian, 12 July 2009) midwifery hit the headlines when a senior midwife, Dr Denis Walsh was quoted as saying, ‘Pain in labour is a purposeful thing’. The ensuing discussion focused on epidurals and who was for or against. The media coverage missed the point altogether; Dr Walsh was discussing the idea that the process of labour and the pain involved was part of an experience that, as a whole, has a purpose for the mother and baby (Walsh &
Downe, 2010). In July 2009 (Guardian 19 July 2009) Midwifery again came to the fore when a leading midwife advocate, Michel Odent, discussed women’s pain in labour, and was quoted as saying, ‘All a labouring woman needs is an experienced midwife sat in the corner’ (Odent, 1984). The ensuing response focused on the idea that men were not needed in the labour room. Once again the opportunity to discuss the importance of emotional support and the need to train and retain midwives as specialists in ordinary birth was missed.

This paper is in part an attempt to respond to media coverage that minimises the complexity of the birthing experience. It intends to look at hospital midwifery and birth from a psychoanalytic perspective. It will consider the complex role of the institution within which this work is situated and move on to the core subject: the woman giving birth in a room with the support of a midwife. Finally, it will look at the baby and the experience of birth, with particular emphasis on the concept of containment (Bion, 1962).

Observing organisations

The works of Bion (1961), Menzies-Lyth (1959), De Board (1978), Obholzer and Roberts (1994) and Hinshelwood and Skogstad (2000) have focused our attention on the culture and unconscious working of complex organisations, institutions and groups. Menzies-Lyth’s important analysis of anxiety in institutions (Menzies-Lyth, 1988) illuminates the ways in which nursing staff struggle to master the intense, primitive anxieties stirred up by their everyday work. Their use of defensive techniques such as projection, denial, splitting and regression leads to feelings of intense interpersonal conflict, increasing anxiety and importantly, an inability to think. The hospital organisation also tries to defend itself, against these overwhelming anxieties through the building of social defence mechanisms – separating nurses from patients, developing ‘them and us’ attitudes, denying difficult feelings. At the point where these defences fail, the primary function of the hospital is threatened. Fearing the system will fail, staff then respond with emotional instability, high sickness and poor retention rates.

Such institutional issues remain pertinent to maternity services within which some commentators describe a crisis of care (Kirkham, 2000; Kitzinger, 2006; Stapleton, Kirkham, Thomas, & Curtis, 2002). The rising rate of interventions and the falling rate of normal birth is a concern; more policies and procedures are implemented every day, and an increasing number of bodies are set up to look at failing services (Changing Childbirth, 1993; Maternity Matters, 2007; NICE, 2010). Rising sickness rates and the poor retention rates of experienced midwives is a growing concern (Amnesty, 2010; Downe, 2008). Birth is a primitive experience and we shall see how midwives face powerful emotions. The maternity services and the staff within them are defending against rather than thinking about the work they do (Obholzer & Roberts, 1994) and need to be supported and encouraged to do otherwise. Given the importance of the experience of birth to women and their new infants, it is crucial that the
organisation within which it takes place is a humane, supportive and responsive service.

The emotional drivers for some midwives in the maternity unit may predominantly include a wish to care for and repair people’s bodies or lives. This group tends to be empathetic and sentimental, often influenced by a deeply held need to be cared for themselves. The emotional drivers for other midwives may include the wish to control distress and eliminate suffering, influenced in turn by their need to remain in control and in charge. This group struggles with uncertainty and tries to be logical and detached. Although both groups are similar in that they wish to care for and help others, the two groups differ in the type of culture they develop at work. It may cause difficulty if one comes up against a culture of control when one wants to provide a culture of empathy and vice versa (Johnston & Harman, 2007). This culture clash may cause conflict and be problematic for the work (Kirkham, 2000; Kitzinger, 2006).

Taking control or even being bossy is a defence that I have become familiar with myself. When it becomes difficult for me to tolerate the expression of overwhelming emotions like fear or distress I find myself getting brusque and giving orders. If a health professional cannot tolerate helplessness in themselves or the patient, this can set up difficult relationships. This is particularly the case with midwives and women in labour since much of midwifery involves being helpless and having little control (Hinshelwood & Skogstad, 2000). The very word ‘midwife’ means ‘with woman’. This conveys the idea of staying with or tolerating feelings and emotions like pain and fear rather than getting rid of them. Staying with what the woman needs (not what the system or the worker wants to happen) can be difficult but not impossible (Kirkham, 2000; Kitzinger, 2005; Obholzer & Roberts, 1994).

**Containing the experience**

Emotional containment is a process often observed between mothers and babies which can apply more broadly. It has the potential to transform potentially traumatic events into experiences that one can grow from (Davar, 1996). Women should not expect simply to survive their birth experience; they should also be able to develop through the experience of pregnancy and birth. Those who feel emotionally contained through their pregnancy, birth and early postnatal days are better placed to act as a container for themselves and their new babies (Winnicott, 1958).

Freud (1917) writes that ‘birth is both the first of all dangers to life and the prototype of all the later ones that cause us to feel anxiety’. It is not a peaceful, passive process; one should expect emotional turmoil. There are traumatic birth experiences that can be repaired with good after-care of mother and baby and the containment of overwhelming emotions and there are those that will leave a permanent mark (Winnicott, 1949). To facilitate normality and ameliorate
trauma it is critical to provide a supportive birth environment with a trained midwife who is contained enough to think.

Just as an infant needs containment in its earliest relationships (Likierman, 1988), pregnant women need to feel contained by a thoughtful institution, staffed by sensitive and responsive people. A woman can then take into herself a feeling that she has been cared for and understood which in turn equips her to better contain the experiences of her infant (Waddell, 1998).

As midwives we can increase our awareness of the hospital system and the effects this has on the experience of birth. We can be aware of past relationships and how these influence how one thinks and behaves or feels about another person’s way of thinking and behaving. We can hold the idea that women come to the labour ward with their own histories, experiences and internal conflicts which shape how they experience the institution, the staff, the process of birth and the baby itself. Simply being aware of unconscious influences is useful for our work as midwives and helps us to develop our observational, listening and thinking capacities.

Pregnant women think about their pregnancy and the baby; they attribute feelings and intentions to the foetus and form opinions about it before birth. They develop ideas, feelings and attitudes partly based on their thoughts and experiences of being mothered themselves. A pregnancy may be planned or come as a surprise; it may fill a deeply held desire or feel like an unwanted invasion. It may be the beginning of a new family or an addition to an already existing one. It usually stirs up a mixture and movement of feelings (Raphael-Leff, 1991).

We can see therefore that women do not come alone to the labour ward. They bring with them conscious ideas and unconscious anxieties, past and present relationships, and a lifetime of experiences. It is sometimes difficult to unravel the baby from the mother and the mother from her past. At a time when women are educated for childbirth through classes, books and television programmes and when birth increasingly takes place in hospitals, at one remove from society, observation allows us the opportunity to encounter an ordinary experience that is both intimate and complex. We will see the ordinary fear and pain of childbirth but also some other less familiar emotions: fear of death, anger from unresolved conflicts, shame.

The thinking baby
Mothers have always felt the baby moving but now using ultrasonography we can see the foetus move, roll, bend, walk, thumb suck, breathe, swallow, urinate and yawn in utero. Hearing and response to sound can be shown from 23 weeks gestation (Creasy & Resnik, 2009), taste and smell have been shown to function at an earlier stage than previously thought: increasingly we have a detailed quantitative understanding of the physical human foetus. We know less about the internal world of the infant (Stern, 1985) and whilst we cannot know how the baby experiences the birth process, psychoanalysis has long argued for birth
as the beginning of emotional life (Freud, 1926; Klein, 1946/1975). Infant observation has subsequently found ways to illuminate important aspects of early emotional life both in utero and beyond (Piontelli, 1992).

A midwife is in a unique position. The woman and her partner are in such a heightened state that they live through rather than observe the experience. The midwife watches the mother and baby emerge from their joined interdependent state of pregnancy and sees the baby coming to life. The separated mother and infant join again in an interdependent state that Winnicott describes: ‘At this very early state, it is not logical to think of an individual, if you set out to describe a baby, you will find that you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship’ (Winnicott, 1987).

The observations
I have here selected four observations of vaginal births that were similar in that the women all used pain relief that allowed for participation in the labour and birth. The labours all progressed without intervention and there were no complications at or after delivery with mother or baby. I was the only professional involved in the care during labour and delivery and I had not met them before our meeting on the labour ward. The women each had normal pregnancies with no complicating maternity or medical histories. I am particularly struck by the emergent themes of containment and the experience of birth which bring together my thinking about the organisation, the midwife, the woman and the baby.

Katie
Katie looked younger than her 21 years; more like a girl, she was slight with lank, dark, hair and pale, sallow skin. She looked sad and depressed. Her clothes were worn, grubby and tight, not typical maternity wear. She struck me as uncared for: she didn’t look like a mum-to-be or prepared for motherhood, in fact she looked un-mothered. I greeted her and smiled holding out my arms to take her hand and show her to her room. She looked away from me and did not smile. She looked angry and unhappy.

Katie was accompanied by her mother who talked, smiled and giggled a lot. She was girly in contrast to her sullen daughter. There was a boy with them who didn’t speak or look at me. I was told by Katie’s mother that he was the father of the baby. Katie did not respond. He looked like a naughty, sulking child rather than a man about to become a father. Katie had not attended any classes or many midwife appointments. She had made no birth plans, read no books and talked to no-one, it seemed. She had not thought about the labour.

I examined Katie vaginally: she was in early labour, 2–3 cm dilated. She found it difficult to tolerate the examination, squirming away turning from me.
I thought about the next few hours and how I would need to be aware of the physical changes in Katie’s body through using observation and listening as she was unlikely to be able to tolerate thinking about what was happening inside her. Katie needed pain relief and as I offered her differing solutions at different stages, she believed nothing would work, but always did as she was asked and took what was on offer.

Throughout the labour, Katie spoke to me rudely and at some points in the labour lunged violently at me, ‘No! You get me a fucking epidural now you bitch!’ Despite this she struck me as vulnerable: I felt keen to keep trying in the hope that she might have a more coherent and connected experience than her pregnancy. Katie’s mother was present for the labour and delivery, as was the baby’s father who remained silent.

When Katie began to feel baby’s head in her vagina and realised that this hard head was coming through her she was scared. She screamed as the intense burning and sharp pain of the stretched perineum eased with the delivery of the head, a little. I said, ‘Katie open your eyes and look at me’. She did. I looked her in the eye and said, ‘Baby’s head is out. Ok Katie?’ I was nodding at her. ‘Yes, Yes’, she said, her eyes wide open. ‘Katie, I want you to look down at your baby’. She looked down and immediately looked away then down again at baby and said, ‘Oh God, oh God’. She smiled. I held Katie’s face in my hands very close up looked into her eyes and whispered, ‘Katie you did that! You delivered your baby!’

Katie gave birth to a baby girl. As her midwife I felt I had to do a lot of emotional work—taking in her communications, her anger and fear to enable her to experience the parts of her that could play a creative and constructive part in the birth of her baby. I was exhausted.

Jane

Jane and Paul were an attractive couple who obviously liked each other. They were having their fourth baby and were well prepared and excited. Jane was in the birth pool using Entonox, Paul sat at the side facing her, dangling his fingers in the water and stroking her arm. I chatted to them both, the atmosphere was friendly. Time passed, the contractions became progressively longer and stronger and Paul helped Jane to breathe, reassuring her with words and touch. They were working well as a pair and I was aware of having to sit back, conscious that I did not want to intrude or take over. My role was as the expert in the corner.

Jane became agitated and irritable as the contractions became longer and more painful and her vagina began to open into a birth canal. She apologised to Paul for squeezing his hand but was able to contain much of her own anger and fear in addition to Paul’s sensitive and responsive presence. I could hear the changes in the baby’s heart rate indicating squeezing and movement: the baby was participating in its delivery.
Jane’s body took over; she was involuntarily bearing down and I could see the head starting to descend. She screamed as it emerged from her vagina along with an arm and the upper torso. With the next contraction baby flopped to the bottom of the pool. I reached down and turned baby so that his face was the first thing to emerge from the water. Jane was concerned that he wasn’t breathing.

I felt his chest and his heart rate was good. He was not breathing but the cord was pulsating. I waited and over the next minute his body changed from blue, grey and pale to pink. He wasn’t taking big breaths but the cord was still attached and pulsed. He had his fingers extended and spread out. He did not open his eyes, he was kind of half way to life. He licked his lips and then smoothly took small breaths. By two minutes he was completely pink and breathing gently.

The cord began to change. It went from a fat, thick, blood filled, pulsating cord to a flat, thin, white lifeless thing. By the time the cord had stopped pulsing, baby’s breathing was regular, smooth and easy: the cord was flat and empty.

This felt like an easy birthing experience; I watched and helped only when my expertise was needed. I am unable to recall what this couple looks like as I felt no need to embed them in my emotional brain.

Emma

Emma was a pretty young woman with shiny hair and clear skin. She was flat on the bed writhing and moaning, eyes closed and legs curled up. She was distressed, crying and rubbing her belly. Her boyfriend, Joe, sat on a stool away from the foot of the bed; he looked like a lost little boy. Emma’s mum, Carol, stood next to her attentive and ready to help.

Emma was 5 cm dilated and getting increasingly anxious. She begged her mother for help and Carol looked to me for support before taking her daughter in her arms and telling her she could manage. Carol was strong and supportive but distressed by her daughter’s pain, Joe looked anxious and uncertain. I gave Emma gas to breathe and instructed her carefully. Emma began to breathe the gas and Carol picked up on what I had said and continued. They found a rhythm, with Carol urging her daughter on when she became distressed. When Emma’s cervix was fully dilated, however, she lost control and began to focus on the idea of an epidural. At this point Carol lost confidence and there was an air of panic in the room. She questioned me about my work and was only able to manage her daughter’s anguish once I had contained hers. Confidence restored, she was able to gather Emma together again and the birth continued without the use of an epidural.

Baby’s head slipped out. Then she began to blink, her eyes not fully opening. We waited one minute then a contraction pushed her out onto the bed. The cord was pulsating. Baby wriggled slowly and moved her face and mouth. Her body turned pink very quickly. She did not make a noise. She pursed and moved her lips, her face looked swollen.
This delivery was a happy experience. I had supported a mother to help her
daughter give birth. I felt satisfied but not exhausted. I wondered about Joe and
his role in the labour. I thought he might remain on the periphery not able, or
allowed to participate in his baby’s life. I felt sad when I looked at Joe.

Linda
Linda and Pete had been married many years and their youngest child was 11.
They were confident and comfortable with each other. She was clear that she
wanted to get on and have this baby and was glad labour had started naturally.
Pete was excited and attentive.

Linda was in the throes of labour focused inside, concentrating on what was
happening to her. She would rest between pains with her eyes closed and as the
contraction started at the top of the bump in her abdomen I felt it go from a
relaxed soft uterus to hard and tense. Linda breathed the gas as soon as she felt
the tightening beginning. In out in out in out faster and faster. At the peak of the
contraction it was no longer an easy breathe in, it was an intense sucking through
gritted back teeth, with shoulders pulled up tight to her ears and the breathing
sounded hard and harsh. The baby’s heart rate began to rise from 120 bpm to
135, then 140 to 145.

Linda experienced the pain and tension of labour with Pete. At times she lost
control and faith in her ability to cope with the pain. Pete and I needed to talk to
her and help her through. I cleaned the poo away as it appeared and watched.
With the contraction baby’s head appeared in the vagina and then just got bigger
and bigger until the vagina had disappeared and baby’s head was out. Linda had
her eyes closed and her head on Pete’s arm gritting her teeth and holding her
right leg up as she could no longer put it down with baby’s head between her
legs. Baby’s shoulders and body spiralled out of Linda onto the bed. Linda sighed
and Pete sobbed as they buried their faces into each other.

Baby was grey white in colour with closed eyes and mouth tight shut, both
lips pouting. His legs were straight down but nothing about him was floppy or
lifeless. He had a heart rate of over 100 bpm but had not yet breathed. He was
still attached to the umbilical cord which was thick and pulsating. His eyes were
closed and he squeezed them tighter – this was his first movement into life. His
face subtly began to change colour from grey white to rose pink; he moved
his lips apart then the tip of his tongue appeared. His mouth opened wide, his
tongue curled into a boat shape and his arms straightened spasmodically, jerking
out from his sides with the fingers splayed. His abdomen sank and his chest rose
as he took in a breath. As he breathed in his body and limbs suffused a bright
pink and on the out breath he mewedled.

Linda and Pete were in this experience together and needed me for my
midwifery skills. The atmosphere had intensity and fear. I thought this might be
because the pregnancy was unplanned and Linda thought she might be too old
to manage; she felt there might be a danger.
Discussion
Amnesty (2010), Changing Childbirth (1993) and Maternity Matters (2007) are well-regarded reports showing maternity services under strain or failing. This is not because we lack facilities or equipment or skilled professionals, although there is never quite enough. We have a first-rate health service. These complex issues may be linked to the fact that women have to fit into a system that does not always suit the care they need or want (Changing Childbirth, 1993; Maternity Matters, 2007). If midwives were better supported to tolerate the primitive power of the birth experience and less overwhelmed into action, things might be different. The psychoanalytic idea of being present to the experience without doing anything seems very apt.

Statistics clearly indicate the direction we are taking: in 2010 in the United Kingdom we have a rising Caesarean rate and a home birth rate of less than 2%. Intervention is at a dangerous level (Amnesty, 2010; Downe, 2008; Kitzinger, 2006). Whilst birth is being turned into a risky medical event rather than a human-social experience the problems facing maternity services might be thought of as symptoms of unconscious conflicts within the system (Menzies-Lyth, 1959). A poor fit between the system, the women and birth, systemic anxiety and social defence mechanisms are stifling thinking (De Board, 1978). There is no place for analysis of thoughts or issues that might arise from the work and little long-term planning for the future.

Hospital is a place for diagnosis and the treatment of illness. As these observations show, birth can be terrifying, hilarious, shocking, messy and beautiful, but it is not an illness. When the system and its co-existing groups struggle with different agendas, it is easy to lose sight of the creative experience of pregnancy, birth and motherhood. (Kirkham, 2000; Raphael-Leff, 1991). We appear to have lost touch with what birth looks like and the quiet process of the baby’s coming to life is lost to most.

The process of containment
One way in which the system and the people working in it can be helpful is through the process of containment (Bion, 1962). To provide a containing experience to women in labour provides a good start for the task of motherhood where they in turn will be expected to digest the unprocessed feelings of their infant (Miller, Rustin, Shuttleworth, & Rustin, 1989). We can see the importance of a baby feeling contained when we see the results of uncontained infants (Waddell, 1998) and we know that children with emotional problems from early infancy can develop pathologies that run the length of their life (Daws, 1989; Brazelton & Cramer, 1991). It seems obvious then that the place to start is with pregnancy (FNP Project, 2008).

Each of the four women in the observations told me during her labour that she could not carry on. Each did it differently depending on her capacity to
tolerate pain and her style of communication. The ability to keep going depended on how able they were to contain their feelings and how contained they felt by the system, their birthing partners and the midwife (Raphael-Leff, 1991).

During Emma’s labour her mother contained her fear and anxiety but as the feelings heightened Carol needed containing herself.

“Have you seen lots of babies? I mean, I bet you have! How many babies have you delivered?” asked Carol. I said, “Hmm, I don’t know exactly.” “What do you mean, you don’t know how many babies you have delivered?” demanded Carol. She was annoyed with me. “I don’t know exactly,” I replied. “I have a record but have never counted up.” Carol looked unhappy. I said, “I have delivered lots of babies, probably hundreds; I have been a midwife for a long time now.” I smiled. Carol got up and rinsed a flannel went back to Emma and wiped her face and brow and tidied up the bed sheets. “There you go Emma, look at that, did you hear, she knows what she is doing! She has delivered hundreds of babies!”

Carol had been overwhelmed by Emma’s pain and found it difficult to carry on. She needed to find a way to contain herself and used me as a source of containment for her fear and anxiety. I could tolerate her feelings and because of this she could take in Emma’s feelings and contain them for her (Waddell, 1998).

One might ask why women would bother with containment when epidurals are an option. However, getting rid of the pain does not get rid of the fear or anxiety. There is a fear of pain but there is also the fear of seeing the real baby, the fear of tearing apart, the fear of death, the fear of becoming a mother (Daws, 1989; Miller et al., 1989). Women tell midwives they want to give birth, they want the experience and seem to feel they will grow from facing their fears (Gaskin, 1975) but they do not want themselves or their babies to die: this is their real fear (Freud, 1926; Raphael-Leff, 1991). The pain is bearable and tolerable; it does not kill people. Sometimes a woman in labour needs to be reminded of what the pain and fear is all about. At some moments during Emma’s delivery it was important for her to know why she was suffering this terrible pain and to remember what it was all about.

“I want you to give me your fingers, I want you to feel baby,” I said. Emma inserted two fingers just inside and there was the unmistakable hard head. She said, “Oh, oh.” She was looking at me with wide eyes and a half smile. She quickly withdrew her fingers the look on her face was very moving. Her mum said, “Did you feel it? Did you feel the baby?” Emma said, “I did, I felt her Mum, she’s just there.”

Feeling the baby’s head reminded Emma of what she was doing rather than getting lost in her feelings. She was brought out of her internal world of fears, imaginings and unconscious drives and brought into her external reality (Raphael-Leff, 1991). It is important the midwife remains able to think as she...
can also get lost in feelings and lose reality. The atmosphere in the delivery room can be one of fear and panic but I know these are projected feelings and not reality most of the time (Klein, 1946/1975).

Most women use increasing levels of intervention and relief when their own resources run out as do the staff. I think it is important for women to experience the running out of their resources and to know that they have tried. It is just as important that the staff do not run out of resources and don’t intervene unless really necessary. Katie showed how difficult it is to tolerate the intensity of childbirth and to trust internal capacities.

“Oh fuck I can’t do that, I can’t I just can’t. I want an epidural.” I said, “It’s too late for an epidural at this stage.” “What the fuck do you mean it’s too late? No! No!” Katie screamed at me, she turned around. Kneeling on the bed she fronted up to me very aggressively and screamed in my face, “No! You get me a fucking epidural now you bitch!”

As her labour progressed Katie began to feel that even she could do it, that she could keep going and tolerate her anxieties. I thought Katie wanted something from this experience. Despite her rage, hate and terror she had listened to me throughout the labour; I wondered if these feelings had spoiled things for her in the past. I was able to show her in the way I looked at her and touched her and spoke to her that her feelings were legitimate, tolerable and survivable (Raphael-Leff, 1991).

One way in which a midwife can stay with feelings and emotions and hold on to, or contain the experience is illustrated by this extract from Katie’s labour. I had waited and waited with her, always explaining what was happening and what would happen next. She filled my mind and I let her see this. I watched her closely and told her I was watching her.

Katie was different now she was no longer frantic, more pensive, she was waiting and she could sense that this was a different stage to the labour. She was scared. When a contraction came she reared back as if away from the pain. I said, “Baby is in the birth canal, that’s why you feel like you are going to poo and all you have to do is let go. But it is very difficult because you have to let go into pain”. Katie was listening but didn’t respond she looked terrified and I could feel the fear in the room. I considered saying something but decided just to encourage her to relax between contractions and let her go with the pain.

I hoped Katie might learn that what she had felt was real and that I understood and sympathised. I could see her suffering, tolerate her anger at her suffering and stay with her through it. This is what containment looks like. In this moment, I was the maternal aspect taking in the infants fragmented thoughts and returning them in a way that was tolerable (Waddell, 1998). Katie really thought she couldn’t do it, she thought she was not able to tolerate the experience, but she did.
“Katie look your baby is coming!” She opened her eyes as baby’s shoulders and body slipped out of her vagina. She was wide eyed watching and feeling at the same time. “What have you got Katie?” I asked. Katie smiled and looked at her baby.

All four women struggled to know if they could contain themselves and tolerate their feelings during the labour. The containment of their feelings by a thinking and observing mind helped their labours progress naturally: each delivered her baby. I think these observed births looked like good experiences, where containment facilitated a good foundation for these mothers and babies.

I am aware that there is little mention of Jane in this discussion. Jane and Paul appeared to love and care for each other, they were self contained and able to contain another. They were well prepared and thoughtful. Even with their fourth child they went to classes as they considered each pregnancy and each infant to be unique. Unlike Katie, Jane was embedded in the minds of other people. Whilst I cannot recall Jane’s appearance, I remember every detail of Katie’s face. I remember her smell.

Human females have evolved and are well adapted to give birth and like most other mammals they like to give birth privately (Gaskin, 1975). Women tend to like peace and quiet as this facilitates being able to concentrate on the task at hand, the hard work of breathing through the marathon labour (Kitzinger, 2004). Contractions build over a period of hours getting longer and stronger until the only thing the woman is able to do is feel the pain and get through it. The help needed is both physical and emotional.

An experienced midwife in attendance means the woman has someone thinking on her behalf. The midwife is expected to keep mother and baby safe, to know what to do and do it in a timely and professional manner. The midwife must also care about and for the woman in a simple and ordinary way, like mopping her brow or helping her relax. But sometimes the experience is too much for everyone and even an experienced midwife can get caught up in feelings and feel lost.

“With the next contraction Linda began to panic; she wouldn’t use the gas as Paul tried to get her to. She began to scrabble around on the bed. “Oh my god! I’m so hot I can’t stand it! I’m too hot... Oh no this is too much!” I aimed a fan at her and wet cloths to wipe her face, which I did gently and slowly. I wanted to counteract the panic as it was pulsing out from Linda and Pete. She screamed, “Ah! Ah! It’s stuck I can’t get it out, the baby! It’s stuck. I know it’s stuck I need help.” I said, “Linda I am going to examine you vaginally to see what’s happening.”

I remember Linda and Pete’s panic. I could feel it. I think I went on to examine Linda because I had picked up the panic and was struggling to contain my feelings and theirs. I needed to do something and as the unit was busy I used a vaginal examination to create a space in which to think. I was also balancing risk as Linda had had babies before and was in this way an expert in her own body – I could not ignore the idea of the baby actually being stuck. I gained
information that helped me be certain that all was well. In this way I was able to contain the feelings in the room and in myself which helped me to think.

Observing birth as an experienced midwife is a privilege. I watch a baby emerge from a woman and when my feelings are well contained I can see how my experience and skills help contain the way I feel. The concepts of transference (Freud, 1905) and counter-transference (Freud, 1910) have also informed my thinking about the feelings that arise during the birth process: my own and those which might be projected into me (Klein, 1936/1975). This awareness helps me to think about my reactions and to avoid unnecessary action.

The experience of being born

The observations show that birth is a vital, life-giving experience that mother and baby go through together. It is something we should all be more familiar with. The baby needs to be squeezed, moulded and pushed because this is how its organs are stimulated. Amniotic fluid is squeezed out of the baby’s lungs and gut when it is squeezed through the birth canal; the brain is moulded and pushed to release hormones and chemical messengers into the body (Creasy & Resnik, 2009). There is an agonising separation for the mother, and for the baby a squeezing and squashing through small spaces, then an emergence and finally a coming into life. We saw previously how Linda and Pete’s baby gradually came into the world with a series of tiny movements, subtle alterations and an intake of breath. His cry elicited a response from me, ‘Ah there you are. Well, hello, baby boy’. We also saw how the new parents kissed and laughed. There was a profound sense of relief as if a grave danger had passed.

My experience of babies leads me to think that they are un-integrated people who need containing to integrate the chaos of feeling and being. Their world is immediate to them at the point of birth. It must be a wild, random, assault of sensations as they feel the pressure of gravity, the touch of skin, the feel of air in the throat and lungs. But it appears as if the baby has an imprint in its fabric, a biological understanding, because it does not look a mess of feelings. The baby born normally, skin-to-skin with its mother blinks, looks, licks, moves and turns its head. I see peaceful, active babies and I feel relaxed and calm. When I put these same babies onto the hard surface of weighing scales they cry. In fact they scream, flail and jerk. This looks like a baby in a panic, falling apart. I start moving faster to pick the baby up, to reassure it, I rush to hold a baby in a panic and I feel anxious.

We can see the baby experience skin as a container (Bick, 1968). Firstly its own skin, felt for the first time when it senses squeezing and pushing, then air and gravity. It feels the direct touch of guiding hands. These sensations give the body organ that is the skin a form as well as a function. Its purpose is to define the baby’s edges and to stop it from falling apart. Together the skin of baby and of mother, the physical holding by arms, or a bed, or an abdomen, moulds the
baby together to give it a shape, a boundaried existence, physically and emotionally (Bick, 1986).

**Conclusion**

Observing organisations and observing people in organisations can lead to understanding why things happen in the way that they do. Having worked for nearly 30 years within the NHS, I needed to understand some of the reasons why change was so difficult. I wanted to think about the work of midwifery but kept getting stuck. Thinking about unconscious processes in the work place has helped me to feel less frustrated with the system and more creative in my work.

The observations clearly show the effects of feeling contained for the women. Katie was able to be emotionally present to the experience and shared with me an enormous sense of pride and joy when her daughter was born. Her anger and hatred had been felt and recognised but had not destroyed the experience. Emma’s fear was contained and she gave birth without the need to anaesthetise herself from the experience. Linda was helped to contain a rising sense of panic and fear that she couldn’t do it and Jane and Paul worked together to achieve the birth they wanted, safe in the knowledge that a midwife was emotionally present and available. All four women experienced the birth of their baby in an emotionally live and connected way. In my view the support of an experienced, thinking midwife who could physically stay in the room but also keep their feelings in mind was helpful.

Birth is a physical experience powerfully affected by the emotional state of the institution, the woman, the birth partners and the midwife. It is a primitive and mammalian experience which is a privilege to look at. Women in labour are beautiful, they move like animals swaggering, rolling their hips, throwing their head back and baring their throat. The noises are work-like and purposeful. In all this excitement the baby can get forgotten. Birth is a spontaneous process and the baby has a biological imprint of what needs to happen: it is an active participant moving, turning and rolling along with the mechanical, physical process. Once delivered, life-full-ness suffuses the infant in a new way. It begins to feel and sense its physical self in the real world: a feeling, sensing person communicating with people from the first.

How Katie was held will impact on the way she will hold her own baby. The way in which Emma was talked to will revisit her when she begins to speak to her new infant. How Jane feeds her baby will, in turn be influenced by how she was fed and Linda will respond to her baby’s cries in ways informed by her own experiences. Relationships are what life is all about and I hope to have shown here how those in and around the labour ward can be thought about in ways which foster a different kind of emotional experience. People at a birth are generally participants, but the midwife can be a participant observer. Feeling the intensity of fear and joy and being able to stand outside of the situation and
watch it happen is unique. I wish I were better able to capture the experience in words.

In order to preserve confidentiality, names of places and people have been changed.

References


