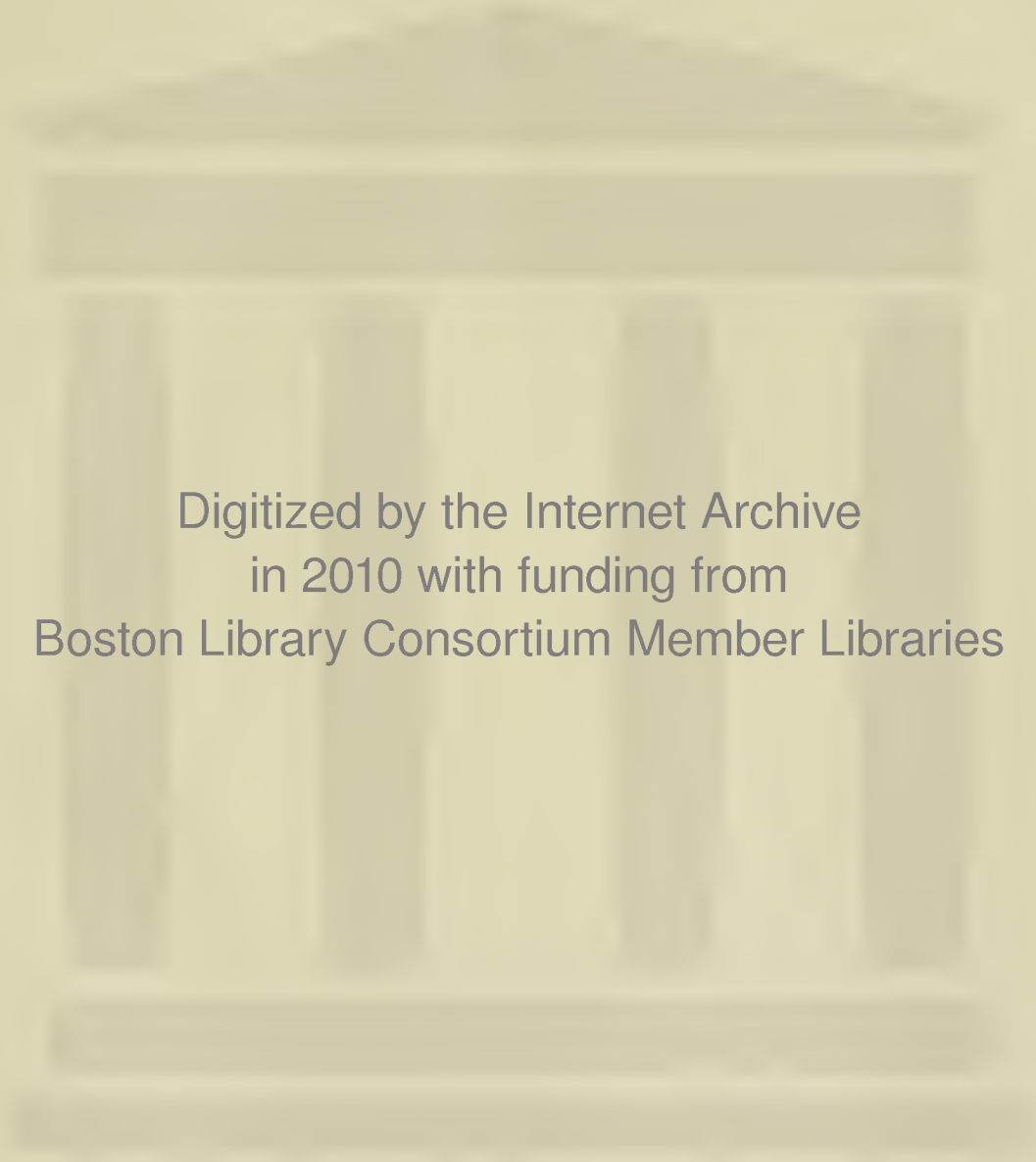

CHILDBIRTH IN AMERICAN MOVIES AND TELEVISION:

PATTERNS OF PORTRAYAL AND AUDIENCE IMPACT

A Thesis Presented
by
VICTORIA L. ELSON

Submitted to the Graduate School of the
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ABSTRACT

CHILDBIRTH IN AMERICAN MOVIES AND TELEVISION:
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MAY 1997

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The author, an independent childbirth educator, systematically analyzed sixty-two American television and motion picture portrayals of human childbirth. She found that many of these portrayals included extreme distortions of time and danger. Comic and dramatic embellishments detracted further from the accuracy of these portrayals.

She also collected ethnographic data on cumulative lifetime effects of such portrayals on viewers, especially as those effects influenced personal beliefs about childbirth. She found that many viewers reported being able to maintain conceptual distance, due to the presence of other sources of childbirth information in their lives, or due to their media literacy. But she also found that a substantial number of viewers self-reported susceptibility to beliefs fostered by media consumption. In many of those viewers, anxiety about giving birth ran deep, in ways that could arguably make those viewers

more susceptible to complications, interventions, and inappropriate choices in childbirth.

The paper also includes background information on media literacy, a discussion of present-day American birth, and suggestions for neutralizing the potentially negative effects of mass media birth imagery.

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INTRODUCTION

A. Relevance of this Study

From the birth scene in *Gone With the Wind* ("I don't know nuffin' 'bout birfin' babies, Miss Scarlett") to the abdominal birth of Arnold Schwartzenegger's baby in *Junior* ("Does my body disgust you?"), American television shows and movies have told the story of childbirth. Like any other form of cultural communication, these depictions both *reflect* cultural beliefs and norms, and help to *shape* cultural beliefs and norms.

Television and movie birth scenes can provide opportunities for viewers to explore their own hopes, fears, and beliefs about giving birth. But viewers without access to alternative forms of education about birth may also absorb counterproductive misinformation. What is being portrayed? And are the images helpful or hurtful to expectant parents?

On March 9, 1995, NBC-TV aired an epidsode of *E.R.* in which a lovely, likeable mother died giving birth, after an extraordinary (and unrealistic) series of errors and blunders on the part of the hospital emergency room staff. Later, speaking to a group of nurse-midwifery students at Baystate Hospital about childbirth education, I heard stories about the effect this program had had on their clientele: "My phone was ringing off the hook." "Those pregnant women were traumatized, and it was hard to reassure them." "I don't think my [childbirth class] students wanted to

admit that they watched it. But when I brought it up, they really had a lot of worries from that." "I'm worried about what might happen to those women in labor, if they're that scared and they haven't talked it out."

Inspired by my colleagues, midwives Rahima Baldwin Dancy and Catherine Stone, I was already using the television birth scene from *Murphy Brown* to teach childbirth educators about systematic disempowerment of laboring mothers and media reinforcement of questionable beliefs and practices. I was also receiving correspondence from childbirth educators and midwives suggesting that mass media play an important role in mothers' perceptions of their own labors.[1]

But the conversation about *E.R.* was the most concrete evidence I had encountered about fictional mass media birth scenes affecting real people -- real pregnant people -- in ways that could affect their bodies, their health care choices, and their medical outcomes.

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[1] For example: Christina W. wrote, "I had to teach [physiological pushing in 2nd stage labor] twice...before [my class] believed there was an alternative to the athletic...forced pushing you see on TV!" Elizabeth M. wrote, "I thought something was wrong with [my pushing efforts] because I thought that what [my care providers] were instructing me to do was supposed to be natural (after all, that's what they show on TV!)" A midwife online wrote about a Donahue show, "Lotsa yuks (the ha-ha kind) but also lotsa "yuchs" to impressionable people formulating their attitudes towards childbirth." Elizabeth B. wrote, "[Here] in Canada, only 40% of pregnant people take any prenatal classes...so it's particularly frightening that these [television and movie] depictions of birth are <u>most</u> pregnant people's primary source of information about birth!!!" A childbirth educator told me that her students feel neglected if there's *not* a crowd and a lot of chaotic activity during their labors, because that's what they've seen on TV. Another childbirth educator told me, "they expect an intense first contraction -- an immediate trip to the hospital, because birth is imminent. The partner definitely fears doing a delivery. They see terrible pain, yelling, swearing, and women hitting their partners. This reaffirms their fear and their desire for 'my epidural.'"

As midwife Ina May Gaskin (1995) put it, "consumers of mainstream television have good reason to have warped ideas about childbirth because of strange enactments of labor and birth in dramatic shows and the continued taboo against seeing the Real Thing. The episode of *E.R.*...that aired on March 9 must have added significantly to the already high national levels of confusion, ignorance, and fear about childbirth." Film critic Sheila Benson (1996) advised pregnant women, "If you hear any combination of the words 'labor' and '*E.R.*,' leave the room...I wish I could remove that whole episode, 'Love's Labors Lost,' from my memory bank -- and *my* children are grown."

Since that conversation at Baystate, I have systematically analyzed 62 television and movie birth scenes. Chapter III demonstrates how portrayals of labor and childbirth often share common themes: immediate panic, a frantic rush to the hospital, rescue by doctors, fathers who are incompetent or absent during labor, mothers begging for anesthesia. Time is distorted and danger is greatly exaggerated. The plot almost always includes a crisis in addition to the labor, to heighten the intensity of the comedy or drama.

An uncritical viewer might make some disturbing generalizations. She might generalize that normal birth is a very quick but treacherous and excruciating medical event during which a mother can expect to be dangerous, endangered, and undignified. If she is powerful, it is only in the threat she poses to men (like "Murphy Brown" strangling two men by their

neckties). She will, however, be saved from her own body by "harmless" drugs and authoritative doctors. Unless, of course, she dies.

Her husband, meanwhile, is likely to faint, to need an immediate appendectomy, to get in a fistfight, or to miss the entire labor except for the last moment.

Having weathered these dangers, the mother will fall in love with her baby to the sweet crescendo of stringed instruments. Her friends will suddenly stop fighting (birth is often symbolic of redemption). But the viewer will learn nothing about postpartum adjustment, which is conspicuously absent from most movie and television portrayals of birth.

There are rare exceptions. The television show *Northern Exposure* offered one of the few birth scenes based on a more woman-centered paradigm, although the mother did not proactively plan her birth that way but was instead "surprised" by it. Another drama, *Dr. Quinn, Medicine Woman,* featured a strong, confident mother.

How much does it matter how birth is portrayed? Does it really affect anyone? In Chapter IV, there are numerous survey quotations demonstrating that media portrayals do indeed help form some viewers' views about childbirth, in ways both positive and negative, with potential impact on their own birth experiences. However, those who have alternative sources of information overriding mass media input are less vulnerable to injurious distortions.

There is, of course, great variation in responses to viewing the same scenes. "What may be frightening for one woman may be reassuring for another" (Robertson 1994:109). I have noticed, in screening video clips, that some members of the audience gasp with indignation while others laugh out loud at the same instant. Thus one cannot generalize about reactions, but one can speculate that certain kinds of imagery will promote more realistic and helpful expectations than others.

Gayle Peterson (1981:5) notes that is is essential for laboring women to have a realistic understanding of what to expect during labor, because "physical complications can be natural developments of a state of emotional distress, as experienced by a woman either unprepared in life and/or childbirth classes for the reality of labor and birth." Such complications may take the form of "flee[ing] from consciousness of the pain through drugs, or...developing a state of distress which is mirrored commonly, psychophysiologically, in uterine inertia, fetal distress, or other physical interpretations of distress."

Realistic expectations facilitate healthy labor, and so does a model of care in which the mother's authority about her own body is respected. Chapter II synthesizes some of the current discourse about birth in America, including the transfer of authoritative knowledge away from mothers themselves, and attempts to reclaim it.

In Chapter V, I will suggest ways to promote more conscious media consumption which may actually reduce fear-based "psychological dystocia" in labor, and resultant complications. Women who have been exposed to empowering imagery may be less vulnerable to the "domino effect" in which one unnecessary medical intervention leads to another, and may experience more effective parent/infant bonding. I believe that respectful portrayal of women meeting the challenges of giving birth should be high on the feminist agenda.[2] The subject of movie and television birth imagery is placed within the greater context of media literacy in Chapter I.

I suggest that improving portrayals, cultivating media literacy, and providing expectant parents with alternative imagery are ways that the negative impact of television and movie stereotypes can be neutralized. But these measures do not constitute a panacea. I want to add mass media to the discourse about who constructs meaning about birth. I hope that we can, as a culture, come up with metaphors about birth that emphasize inner strength (i.e. like a runner's "second wind,") rather than routine rescue ("Knock me out!").

Very little has been written about mass media childbirth portrayals to date, although midwifery journals occasionally write about current media releases, and magazines for pregnant women carry occasional articles. This

[2] Many suffragettes and other early feminists valued freedom from pain in childbirth as liberation from their female fate. They expected pain medications to make them more "equal" to men, and did not foresee how drugs can be used to make women passive and dependent in labor. Even today, feminists have not paid adequate attention to the side effects of medicines on their bodies, their babies, and their control over their own labors.

written study is intended as an educational tool for expectant parents, childbirth educators, other childbirth professionals, students of media criticism, women's studies, and medicine, and the general public. It is accompanied by a lecture and video presentation that includes clips from many television and movie birth scenes. I hope someday to make a documentary video based on this work.

There are many topics beyond the scope of this paper that would be interesting to study. I have not analyzed the history of portrayal of birth, nor have I explored other media besides television and movies. I have not analyzed the portrayal of pregnancy or motherhood in the mass media. I hope that other students of childbirth anthropology will pursue these topics.

B. Author's Background and Agenda

My interest in childbirth began with the birth of my first daughter in 1981. I was 21 years old, married to another 21 year old, barely independent, and greatly subject to influence by others. Labor was the hardest thing I had ever experienced, but I was surrounded by people who believed in me for all thirty hours of it. At the moment of birth, the midwives helped me reach down and bring my daughter up onto my belly, where she stayed for about a year. It was the end of my life as a wimp, and I felt like a

great artist. I can't seem to describe it without using rhapsodic language like "miraculous" and "awesome."

I felt that I had passed through a rite of passage, and that I had a new sense of my own capabilities. This confidence came in handy, as I was immediately met with all the challenges of new motherhood, compounded by both homelessness and the 3-day hospitalization of my baby a month later, and by divorce two years after that. I feel that the experience of well-supported birth was inestimably important in my development as a mother and as an adult. I know that my baby's father was similarly affected.

It was not a cultural "stretch" for me to plan a natural birth at home,[3] attended by midwives and friends. Most of the young mothers I knew had given birth that way, and excellent nurse-midwifery home birth care was readily available, with hospital and obstetrician backup as needed.[4] My husband and I took prenatal classes affiliated with Rahima Baldwin's Informed Homebirth organization.

The positive experience of birth led me to seek certification as a childbirth educator and labor support provider through Informed Homebirth. I have been teaching prenatal classes for 14 years, and I am now training childbirth educators worldwide as Director of Teacher Training for the

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[3] Though my three children were all born at home, which was ideal for our family, I do not suggest that this is the right setting for everyone. There are many factors to consider: availability of care providers and hospital backup, proximity to emergency facilities, medical history, personal preferences, and the level of responsibility one is willing to take.

[4] My first daughter was born in Santa Monica, California. Not all states have such options available; some, in fact, are quite hostile to home birth.

Association of Labor Assistants and Childbirth Educators (ALACE), which was formed in 1995 to take over most of the functions of Informed Homebirth. My job is to help families to prepare for birth and make informed, satisfying choices. Such choices lead to the kind of birth that will have a healthy *physical* outcome for mother and baby as well as a healthy *emotional* outcome for the entire family.

I have noticed that many of my teacher trainees are inspired to join the profession by their own positive birth experiences, while others have had traumatic experiences and wish to use consumer education to protect other women.[5] Still others are inspired by their feminist realization that birth is a defining moment in a woman's life over which she may or may not have authority.

Meanwhile, I have remarried (a family doctor who used to provide midwifery-style care in various birth settings), and I have had two more children at home. I have also had a miscarriage at home, and I am grateful for the spiritual lessons and family bonding that were part of that difficult experience. Two days later, I went to the hospital with excessive bleeding and received obstetric treatment that was probably lifesaving.

My bias is clearly toward undrugged, alert, courageous, loving, spontaneous childbirth. There is ample evidence that this usually leads to

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[5] A sample of the latter: "Many, like myself, have felt robbed, patronized, and devalued by our deliveries. We also feel angry toward ourselves for allowing it to happen that way...it's hard to admit that you are a strong, educated woman of the 90's when you have delegated the responsibilities of this life-changing event to a largely male-dominated industry" (Kathryn Berkowitz, ALACE Teacher Training correspondence).

better outcomes, whether measured in terms of maternal/infant morbidity, emotional satisfaction, or family bonding (see for example Goer 1995; Wagner 1994; Gaskin 1990[1977]; Davis-Floyd 1992; Sullivan and Beeman 1983; Hinds et al 1985; Peterson and Mehl 1980).

That does not mean, however, that I am anti-technology, or unappreciative of the lifesaving potential of obstetric interventions. Many birth activists are frustrated to find themselves pigeonholed this way. Many of my clients, and I myself, have greatly benefited from appropriate, respectful, individualized care, from doctors, midwives, and nurses.

I see it as my "calling" to promote awareness that birth is safer and more satisfying when mothers' own innate knowledge and experience are respected and supported. I see this as part of the constellation of factors that empower women and strengthen families. Thus I am not a dispassionate academic observer but an advocate for informed choice in childbirth.

Television and the movies make my job a little harder, because they can engender fear and reinforce the hegemony of the technocratic/ biomedical model of birth, to the exclusion of the woman-centered/holistic model (for definitions of these models, see Davis-Floyd 1992). But these media can also be used to promote confidence in women's abilities, and I am enthusiastic about opportunities to use the media in these ways.

CHAPTER I

MEDIA LITERACY

A. The Importance of Media Literacy

The internationally recognized definition of media literacy is "the ability to access, analyze, evaluate, and produce communication in a variety of forms." It simply "extends the traditional notion of literacy to include electronic forms of communication." And, "like print literacy, it is a lifelong process" (Leveranz and Tyner 1993). If print literacy consists of reading with comprehension, reading critically, and writing coherently and persuasively, media literacy could be said to consist of reading media "texts" with comprehension, reading these texts critically, and producing media of one's own.

Literacy has long been valued as an essential prerequisite to participation in a free society. Noam Chomsky (1989) asserts, "Citizens of the democratic societies should undertake a course of intellectual self-defense to protect themselves from manipulation and control, and to lay the basis for a meaningful democracy." But today, American culture is so saturated with mass media's audiovisual imagery[6] that critical interpretation of the *printed* media is grossly inadequate for such informed participation.

[6] Televisions outnumber toilets in American households.

In some progressive classrooms, teachers are motivated to provide media education by a sense of urgency about Americans' lack of citizen participation in public life. People do not adequately challenge their news sources, their media role models, even the very notion that "economic growth" and escalating consumerism are ideals worth the cost of environmental degradation and dehumanization. Television and other mass media feel reassuring, even as they nudge our national ethos from valuing work and community to valuing short-lived material goods.

But after forty years of home television, media literacy programs in American classrooms are still rare. (This is comparable to the absence of comparative literature education early in this century, when people read novels for pleasure but did not analyze such "popular culture" in school.) There was a surge in media education in the 1970's, and a revitalized effort is currently underway (Leveranz and Tyner 1993), but most people still don't know what media literacy means.

There is considerable resistance to media education in classrooms, partly because it's a rebellious act on the part of well-trained consumers, partly because "popular culture" (like the novels of yesteryear) is subject to snobbery, partly because it is expensive for schools to purchase up-to-date equipment, and partly because teachers have little training in the subject (Miller 1996).

This illiteracy has its cost. We make assumptions and decisions about our lifestyles, our bodies, our relationships, our elected representatives, and our personal identities without realizing how profoundly we have been influenced by the commercial forces of mass media. This paper will address ways in which expectant parents might be influenced by TV and movies to make medical care decisions that may or may not serve their best interests, and ways in which they might become more discriminating consumers of media-propagated ideas about childbirth. I argue that even emotional responses to labor, conditioned by media consumption, may affect childbirth outcomes.

B. Understanding Conventions

Sut Jhally (1990) offers a (non-childbirth-related) example of media manipulation of emotional responses. Most of us, he says, have never pondered whether diamonds have always been necessary symbols of marriage and undying love. But this is the result of a deliberate construction. In 1938, N.W. Ayers, a New York advertising firm, began its campaign on behalf of the diamond industry. Thanks to Ayers, Americans know that "a diamond is forever," and we know how many months' salary a man is "supposed" to spend on an engagement ring. We don't see a woman friend's new ring as a piece of chiseled rock stuck to a piece of metal, both rock and metal having been extracted from the earth by a (probably oppressed) labor

force halfway around the world, several middlemen ago. We see the ring the way we have been taught to see it -- in a standardized emotional context.

This predictable response is a measure of the most basic aspect of media literacy -- we know what the conventions mean. A convention is a set of codes. We add up the codes instantly and subconsciously, maybe without even remembering having seen the advertisement.

In Chapter III, I will explore some of the conventions in media portrayals of childbirth. I suggest, for example, that the plot convention in which panicked friends or relatives rush the laboring mother to the hospital (I call it "the Mad Rush Motif") is so standardized that viewers find it familiar and unsurprising. This convention reinforces the cultural belief system in which the average length of normal labor is grossly underestimated, even by obstetricians (Albers et al 1996).

However, not everyone interprets the same conventions with the same emotional response. Meaning does not emanate directly and unambiguously from the media (Lewis 1991). An audience is not a simple sponge. Viewers each bring their own experiences to the act of viewing. Thus, in Jhally's example, one viewer might add up the diamond ring, the fuzzy lighting, the silhouette of a sexy young white upper-middle-class couple, the body language suggestive of an imminent kiss, the slogan, the supporting text, and the viewer's previous knowledge of ambient cultural notions about a man's prestige and a girl's best friend, and receive a message about how happiness

lies in expensive material objects, how diamonds are the best possible way to express love, and how life without such a piece of jewelry will be stuck in perpetual inadequacy.

But, needless to say, a South African diamond miner, a recent widow, a jewel thief, or a Buddhist nun might have a different interpretation or a different emotional response. In Chapter IV, I will describe some of the many varieties of audience responses to mass media birth scenes.

C. Critical Analysis

Growing up in America, one can hardly fail to internalize the meanings of mass media conventions. But the next level of literacy requires more effort and offers more rewards. Part of "critical analysis" is "textual analysis:" the application of an understanding of mass media's particular persuasive techniques. This skill can be used to filter media input, allowing one to "read" the mass media with more discrimination. The other part is "audience research," an investigation into the effects of the mass media on its viewers.

I have been endeavoring to improve my textual analysis skills for many years, and to help my children to learn them too. But I have had limited tools. I sometimes sit in front of the television with my children and play "spot the stereotype." We identify minstrels, bimbos, and Rambos. We count how many men are active, and how many women are merely decorative. We count how many men appear onscreen compared to how many women are

visible.[7] My son counted 18 acts of violence in one hour of Saturday morning cartoons. (But that doesn't keep him from watching them every week.)

This is a good start, but it barely begins to foster true discrimination.[8] To deepen textual analysis, a viewer must develop an awareness of the political economy[9] from which the mass media spring. Armed with insight into the flow of money behind the media, we recognize that burgeoning "choice" is an illusion -- with deregulation, we have more channels, but with a shrinking number of owners.

Concentrated ownership means a severe narrowing of the ideological spectrum. The extremely wealthy corporate owners share an interest in fostering a receptive, free-spending "consumerist ethos," in which individual purchase-oriented solutions ("buy sunscreen,") are favored over social solutions ("fix the ozone hole").[10]

These owners also tend to favor tax structures, health care programs, environmental legislation, and economic policies that enhance their own well-

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[7] Studies of television in general reveal a 3 to 1 male-to-female ratio, making *Seinfeld's* ratio of main characters look normal [Lewis 1996]. My own informal tally of performers celebrated in TV Guide's "50 Greatest TV Stars of All Time Issue" (December 14, 1996, Vol. 44 No. 50) revealed a similar ratio: 35 white men, 1 black man (Cosby), 11 white women (including Miss Piggy), 1 black woman (Oprah), 1 white couple (Burns and Allen), and one dog (Lassie).

[8] Personally, I find Susan Douglas' description of "what it means to be a woman in America " perfectly applicable to my own confused media-reinforced self-image. Like Douglas, I feel "simultaneously infuriated and seduced...I yearn for the self-indulgence; I think the self-indulgence is repellent...I want to look beautiful; I think wanting to look beautiful is about the most dumb-ass goal you could have" (Douglas 1994).

[9] Most of the material presented here on the political economy of the mass media is derived from a lecture by Justin Lewis (1996) at the Five College Summer Institute in Media Literacy.

[10] Regarding childbirth, an example of a purchase-oriented solution might be "have an epidural," while a social solution might be "support the laboring woman and help her cope with pain."

being. And since the media can make or break a politician, these owners wield enormous and growing power to shape the "issues" put before the public.

From the point of view of the networks, television programming serves two purposes. The first purpose is to deliver audiences to advertisers. Thus sports that have a "natural" break every eight minutes or so (innings, time-outs) become "popular," and sports like soccer are seldom broadcast, because it's too easy to miss a goal during a commercial. Sitcoms and dramas are formulaically designed to break neatly for commercials, but leave the viewer in enough suspense to stay tuned.[11]

The second purpose is to keep audiences in a buying mood. During the Gulf War, for example, viewing was up but buying was down. So depressing coverage was lightened up with "patriotic vignettes" just before commercial breaks.

Television is dominated by several genres: sports, news, sitcoms, dramas, movies, cartoons, documentaries, nature shows, music videos, variety shows, etc. But advertising commands fully 22% of air time, and is therefore the most dominant form of programming. The needs of advertisers are best served by making the viewers feel inadequate and vulnerable to the belief that owning the right stuff might help.

[11] In the case of portrayals of childbirth, this means time is condensed, making labor appear much shorter than it actually is, and gratuitious plot twists are nearly always added for extra suspense or comedic effect.

The ratings system is skewed by the fact that advertising is aimed at bigger spenders. Programs that cater to wealthy, nonelderly viewers attract more advertisers, and "sweeps week" polls target those viewers. Thus the wealthier consumer has "more votes" in programming decisions. One result is that working class families are underrepresented in the mass media relative to the American population, while wealthy families are overrepresented.

With these economic facts in mind, it should be easier for the critical viewer to consider which questions are not being asked, which issues are not being addressed, and whose voices are not being heard. The critical viewer might notice, for example, that "daring" exposes are merely targeting "little fish," and that their overall effect is reassurance that all is basically well in the world.

A viewer who has explored the political economy of mass media might transcend cynicism ("this is your mind on drugs...yeah right" or "the politician is noisy again") and achieve more relevant criticism ("hey, get this -- the Partnership for a Drug Free America is funded by alchohol and cigarette companies" or "the politician is not addressing adequately the key issues that will affect my life").

Television fits around commercials, and television content fits the needs of advertisers. Commercials are so frequent, and media-fed attention spans are growing so short, that meaningful discourse is compressed into

sound bites. Disparate ideas compete for attention like billboards on a highway: Slim Fast is juxtaposed with Wendy's. Advertisers, the mass media's primary source of income, may withdraw their support from controversial programming or even programming that fails to produce the right consumer mood. Thus one could generalize that "marketing imperatives limit sophistication," and substantive issues are watered down or ignored (Lembo 1996).

For example, there have been several gay and lesbian characters introduced on mainstream shows in recent years. Advertisers tolerate such "innovations" when they stand to profit from the publicity generated by controversy, but they may also buckle under the pressure from boycotts by special interest groups.

In the past couple of years, there were lesbian kisses on *Roseanne, LA Law,* and *Picket Fences;* Ron and Erick got married in Cicely, Alaska, a town founded by lesbians Roslyn and Cicely on *Northern Exposure;* teenager Billy Douglas came out on *One Life to Live.*

But cameras shied away from showing their kisses directly. On *Melrose Place,* "the scene then cut back to the couple as they moved apart. The audience's tender sensibilities had been spared the sight of two men exchanging a loving kiss, although the same episode offered promiscuous (heterosexual) sex, attempted murder, false accusations of (hetero)sexual harassment, and two daughters' recovered memories of childhood sexual

abuse by their father..." (Gross 1994). Needless to say, the kiss sparked controversy, the other sexual and violent parts did not. Only the kiss bucked conventions.

But there have never been so many openly gay relationships on television in the past -- isn't this evidence that the media are growing more progressive over time? No indeed, says Annenberg's Larry Gross (1994), the treatment of these scenes is evidence that 1.) a little controversy is good for ratings, especially useful during "sweeps week;" and 2.) delicate editing sanitizes such "radical" images. We might be lulled into believing that television is a forum for diverse ideas, but there is a tendency for television to try to expand to new audiences while carefully avoiding alienating established audiences.

Meaning is further commodified in the interplay between lived culture and broadcast culture. Lembo (1996) demonstrates how the line between real "homeboys" and hip hop fashion spreads is blurred. We can consume Disney on film, on television, on CD's, on the Web, in stores, or in amusement parks. Mass media *is* our culture, and it can be indistinguishable from other cultural forms.

D. Producing Media

While critical analysis offers more sophisticated tools for critical media "reading," perhaps the most useful tool for deepening one's analytical skills is

to participate hands-on in media production. I agree with the staff of the Five College Summer Institute in Media Literacy that media production is as important a tool for learning media literacy as writing is for learning print literacy.

As a participant in the 1996 Institute, working with teammates on a video project, I gained a deeper understanding of cinematic techniques and conventions because I had to manipulate them myself. I had to think in terms of persuasion, capturing interest, and juxtaposition of images and sounds. I became aware of how time-consuming media production is, and thus how it can be extremely expensive and yet still not reflect the original vision of its creators, who have simply run out of time. I became more skeptical of forms of media that lack credits, in which the makers can remain conveniently camouflaged or magically anonymous.

Critical analysis is more than watching films and videos. It should include discussion of the filmmaker's agenda, the choice of content, the film's emphasis, the missing perspectives, the references to the audience's existing cultural elements, and the manipulation of imagery.

In agrarian societies, beliefs and behaviors were mediated by "institutions such as family, community, ethnicity, and religion...[later,] in the early development of capitalism workers were taught to read but not to write. The skills of reading were all that were required to follow orders and understand the Bible. Contemporary society [where mass media institutions

dominate communication] is in a similar position. While we can read the images quite adequately (for the purposes of their creators) we do not know how to produce them.[12] Such skills, or knowledge of the process, must be a prerequisite for functional literacy in the contemporary world. Basic course work in photography and video production should be required in all high schools. Moreover, while messages can be read adequately, most people do not understand *how* the language of images works. Just as knowledge of grammar is considered vital in learning foreign languages, so the grammar of images (how they work) needs to be integrated into the high school curriculum" (Jhally 1990).

There is mounting evidence that passive consumption of massive (i.e. normal) doses of media imagery has effects ranging from narrowing of gender identities, to changes in the structure of children's play, to chauvinism of visual perception over auditory perception, to the collapse of democratic discourse (Jhally 1990). "The fact that large numbers of people are changing their minds on who to vote for after seeing a thirty-second television commercial says a great deal about the nature of the political culture" (Jhally 1990).

Americans need tools with which to filter this imagery. We need to be able to peek behind the scenes. When we see how narrow an agenda is at

[12] I wonder if a desire to participate in mass forms of communication, and thus to be more than a passive consumer, is behind the drive so many young Americans feel to become "stars." Stardom might be the only avenue we perceive to taking part in a mass media *dialog.*

work, we are (hopefully) driven to find out where more balanced and substantial information can be found. (The Internet is a good source right now, but will it remain relatively uncolonized by commercial interests? [Schiller 1993] Already, America OnLine greets the user with predigested news and commercial information, and other servers are experimenting with free Internet access that is cut off when the user closes the advertising screen.)

The skills of critical analysis are helpful on their own, but experience actually producing imagery deepens these skills immeasurably. When a *passive consumer* of ubiquitous mass media products transforms into an *active participant* in the language of imagery, a vital, lifelong process of literacy is launched.

I suggest that the more a pregnant viewer uses media literacy skills to filter commercially-produced birth imagery, the less likely she is to suffer the consequences of unrealistic media-generated or media-reinforced expectations about labor and birth. (The ethnographic data presented in Chapter IV supports this assertion.)

I also suggest that the cultural influence of the mass media is largely missing from the current discourse about who constructs meaning about birth (that is, who has "authoritative knowledge"). The next chapter is an overview of that discourse, and the balance of this paper is an attempt to add to it.

CHAPTER II

CHILDBIRTH IN AMERICA

A. The Transfer of Authoritative Knowledge

In her groundbreaking work Birth in Four Cultures (1993[1978]), Brigitte Jordan did more than compare childbirth ethnographies cross-culturally. Her work brought childbirth closer to the center of anthropological theory, helping to right an omission that had limited the scope and imagination of all subfields of anthropology. Furthermore, in the revised and expanded 1993 edition of her book, Jordan also illuminated the concept of "authoritative knowledge," which has applications in many aspects of anthropology and related disciplines.[13]

Authoritative knowledge is the result when "one kind of knowledge gains ascendance and legitimacy. A consequence...is the devaluation, often the dismissal, of other kinds of knowing" (Jordan 1993[1978]:152). One may compare "top-down systems [of authoritative knowledge about childbirth], in which the woman herself is granted no authority of knowing" with "lateral systems, in which [authoritative knowledge] is communally shared between the woman and her female attendants" (Davis-Floyd and Davis 1996:114).

[13] The June 1996 issue of *Medical Anthropology Quarterly* was dedicated to Jordan, and all of the articles were relevant to authoritative knowledge in childbirth.

In America at the turn of the century, authoritative knowledge about childbirth accelerated its transference from mothers and their female attendants (i.e. midwives) to male and/or male-trained physicians. These "men-midwives" or "accoucheurs" paved the way for today's obstetricians. As these men "successfully gained control of childbirth from women midwives...[they] redefined childbirth from a natural state to a pathological condition requiring the intervention of surgeons and their instruments and set the pattern for modern aggressive obstetrical practices" (Scully 1993:295).

Today's obstetricians, like their predecessors, derive much of their influence from their relationship with medical machinery. "The obstetrician's access to and control over specialized obstetrical technology reflect and legitimate his authoritative status" (Fiedler 1996).

It would be an oversimplification, however, to suggest that the transfer of authoritative knowledge to a male-dominated group is simply a result of sexist manipulation of power. "Obstetric...practices are driven by imperatives of technology, the industrial process, [and] even capitalistic profit" (Kahn 1995). Midwives are seen as competition for a limited market, and obstetricians use their status to influence legislation, which has been used to create legal roadblocks to midwifery care in many states (Loeks 1993). Insurance companies' reimbursement protocols encourage the use of expensive machinery and procedures. Lawyers and malpractice insurers contribute to a system in which fear of malpractice lawsuits necessitates the

practice of "defensive medicine," in which doctors feel obliged to do everything possible (i.e. every procedure that might appear to prevent poor outcomes) to avoid being sued.[14] Drug companies aggressively market to doctors. A recent doctor surplus has resulted not in lower prices, but in increased numbers of and fees for procedures (Korte and Scaer 1992).

Like Robbie Pfeufer Kahn (1995:137), I do not want "to define patriarchy as a contestation between men and women. The social institution of patriarchy may have arisen...over men's desire to control women's reproductive powers. But by now, patriarchy shapes and misshapes both men and women and can be acted out by either gender. Women can give cesarean scars to other women just as well as men can."

Authoritative knowledge about birth is now held by obstetricians both male and female. At this time, more women than men are entering obstetrics residencies, for the first time in history. It remains to be seen whether these female obstetricians will transform the profession into one in which authoritative knowledge may be shared with the mothers themselves, or whether they will continue the profession's tradition of patriarchal and institutional control over women's bodies.

After a while, says Jordan, prevailing authoritative knowledge comes to seem right and normal, regardless of its relationship with measurable

[14] "77.6% of ob/gyns have been sued at least once...and for many, it's the most stressful experience of their lives" (Korte and Scaer 1992:64). Malpractice insurance carriers may refuse coverage for doctors who try to work outside the most cautious protocols of their profession, thereby reinforcing "defensive medicine" even for doctors who would prefer a less interventive style of practice (Davis-Floyd 1992).

outcomes. *"The power of authoritative knowledge is not that it is correct but that it counts...*[it is] the basis on which [the participants] make decisions and provide justifications" (Jordan 1993[1978]:153; emphasis in original).

In the case of obstetrics, there are many gaps between research and practice. "[Obstetrics] is riddled with paradoxes and inconsistencies that few among its adherents notice...Manifestly, obstetrics is not what it claims to be" (Goer 1995:349). "Authoritative knowledge...is vested in these [obstetric] machines and in those who know how to manipulate and interpret them. This is so despite the fact that the near-universal use of such machines on laboring women in the United States has not resulted in improved birth outcomes" (Davis-Floyd and Davis 1996:238).

This fact has been demonstrated in many large-scale studies (i.e. Prentice and Lind 1987; Sandmire 1990). An anonymous obstetrician puts it bluntly: "Obstetrics is the least scientific of all specialities" (quoted in Korte and Scaer 1992:61).

Those who hold authoritative knowledge tend to marginalize those who hold alternative views (Jordan 1993[1978]:152). The following quote is from the sixteenth (1980) edition of Williams Obstetrics, which is the foremost text on American obstetric practice: "In spite of the remarkable record of safety for the hospitalized expectant mother and her fetus-infant that has been achieved in recent years...there has evolved a small but quite vocal group of dissidents made up of former parturients, their partners, and those

who would attempt to provide care during home delivery. Hopefully, those complaints about hospitalization for which there are real bases can be resolved short of sacrificing the safety that hospitalization for delivery can provide the mother and especially her fetus-infant" (Pritchard and MacDonald 1980:8).

The first fifteen editions of Williams did not acknowledge the existence of birth activists at all, and this quotation granted them little legitimacy. As Kahn (1995:200-248) points out in her study of Williams over the years, it politicizes those with opposing views by labeling them "dissidents," and minimalizes their significant body of written literature by referring only to their "vocal" contributions. Trained and experienced home birth attendants are merely "those who would *attempt* to provide care."

This is a prime example of what Jordan was referring to when she noted that "those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naive, or worse, simply as troublemakers" (Jordan 1993[1978]:152). Meanwhile, Kahn notes that "beginning with the fifteenth [1976] edition, the editors [of Williams] delete[d] *all pictures of a normal, unimpeded course of labor and delivery*" (1995:223; emphasis in original).

Obstetricians, who are trained as surgeons, have so successfully captured authoritative knowledge and the status it confers that they "are in

charge of over 80% of all [American] deliveries"[15] (Guillemin 1993). This group's ability to usurp authoritative knowledge has had its cost.

Birth has become a medicalized and intervention-oriented event. Epidural anesthesia, episiotomy, pitocin, and electronic fetal monitoring are commonplace in American delivery rooms, and each carries attendant risks not always justified by benefits (for examples, see Enkin et al 1992[1989]). While *every obstetric intervention can be helpful when applied judiciously,* the *routine* application of these technologies may confer inappropriate risks (Goer 1995). Robbie Davis-Floyd postulates that while these routinized procedures may have questionable medical benefit, they are useful as rituals in a process of socialization in which the entire family (mother, father, baby) absorbs the cultural values of patriarchy, technology, and the supremacy of "science" over "nature." (Davis-Floyd 1992).

Proponents of low-tech birth agree that the moments of birth and bonding can help to set the stage for the parents' relationship with their child throughout its life. They argue that alert, undrugged mothers and children, undistracted by major surgical or technological interventions, have an emotional advantage right from birth.

The ultimate obstetric intervention, and often the end result of a cascade of lesser interventions, is cesarean section. The cesarean section rate is often quoted as an indicator of trends toward unnecessary

[15] I assume that the other 20% include births attended by other physicians, certified nurse midwives, or home birth midwives, as well as unplanned out-of-hospital births.

intervention. It rose from 5.5% of all U.S. deliveries in 1970, to 16.5% in 1980, and it appears to have leveled off at nearly a quarter of all deliveries in the U.S., with a rate of 24.4% in 1987 and 24.7% in 1988 (Taffel 1990).

"Reasons suggested to explain the...[cesarean section] rate include the greater reliance on childbirth technology in general (some technologies, such as electronic fetal monitoring, falsely detect problems with the pregnancies that result in cesareans [this is one example of the 'domino effect' of obstetric interventions]); a widespread misconception that a cesarean is usually safer for the baby; an increased emphasis on the baby's well-being at the expense of the mother's, fears of malpractice suits, desire for higher reimbursement or time savings by physicians, and women's reluctance to undergo labor" (Shearer 1993).

Gerald Stober, a New York obstetrician, suggests that "the most common cause of cesareans today is not fetal distress or maternal distress, but obstetrician distress" (quoted in Korte and Scaer 1992:132). Robbie Davis-Floyd also suggests that this operation is the supreme symbolic triumph of technology over nature (Davis-Floyd 1992).

Cesarean section carries a risk of maternal mortality of about 1/2,500-5,000, which is at least two to four times higher than the risk of vaginal birth. Complications (i.e. infection, excessive blood loss, transfusions, anesthesia complications, blood clots, accidental injury to other organs, abnormal attachment of the placenta in the next pregnancy, and greater difficulty

conceiving again) are 5-10 times more common than with vaginal birth. Also, many women experience emotional side effects in addition to the burden of caring for a newborn after major abdominal surgery (Shearer 1993).

"Although the infant mortality rate has fallen in recent years, there is no evidence that higher cesarean rates have improved outcomes for mothers or babies. Many other factors have contributed to lower infant mortality, particularly the development of neonatal intensive care. The United States was tied for 24th place in the world in infant mortality in 1989; every other country with lower infant mortality also has a lower cesarean rate" (Shearer 1993:56).

The National Institutes of Health and the American College of Obstetricians and Gynecologists have made recommendations aimed at reducing the cesarean section rate. Still, "the Public Citizen Health Research Group has estimated that over half[16] the cesareans performed in the U.S. are medically unnecessary. In 1987, this resulted in 475,000 unnecessary operations, at an estimated cost of 25-100 maternal deaths; 25,000 serious infections, 1.1 million hospital days, and over $1 billion" (Shearer 1993:58).

Meanwhile, a subculture exists in which authoritative knowledge is held by mothers, their partners, and their midwives or doctors, all of whom frame birth as a normal, natural, nonpathological process. There are increasing numbers of Certified Nurse Midwives (CNM's) practicing in

[16] A comparison of the general US cesarean section rate with the cesarean rates of women attended by qualified midwives would suggest that this is a conservative estimate. In other words, the costs may be even higher than those suggested here.

hospitals who hold this view. (Other hospital CNM's more closely approximate the traditional obstetric views.) And then there are those CNM's, independent midwives, and a few doctors who feel that a woman-centered paradigm is best served in a completely nonhospital environment. Planned home birth[17] takes place in the woman's own family territory (usually with hospital backup as needed), and freestanding birth centers offer a setting and a set of protocols somewhere between home and hospital.

Midwives and parents who participate in planned home births "most deeply trust birth [and] place themselves quite consciously as far out of the reach of the technocratic model as they can get" (Davis-Floyd and Davis 1996:239). In other words, the place of birth is determined by the philosophy of birth.

These midwives are trained in many alternative and medical methods for assisting with childbirth, including intuition (Davis-Floyd and Davis, 1996:237-269), and tend to use pharmacological and surgical interventions judiciously and sparingly. These are people "who supervalue nature and their natural bodies over science and technology, who regard the technological deconstruction of birth as harmful and dangerous, who desire to experience the whole of birth -- its rhythms, its juiciness, its intense sexuality, fluidity,

[17] It is important to differentiate between planned home birth with qualified attendants, unattended home birth, and unplanned (accidental) home birth. Some sets of statistics undiscriminatingly use the outcomes of unplanned home birth to demonstrate that home is not a safe place to give birth. There are numerous studies that show that planned home birth is as safe or safer than hospital birth, due to decreased opportunities for infection and iatrogenic complications (i.e. Sullivan and Beeman 1983; Hinds et al 1985).

ecstasy, and pain... connection is the most fundamental value undergirding their holistic paradigm" (Davis-Floyd and Davis 1996:239).

There is mounting evidence that for midwife-assisted home birth, intervention rates are low, mortality/morbidity rates are low, and maternal satisfaction is high (Gaskin 1990[1977]; Davis-Floyd 1992; Goer 1995; Wagner 1994). Some suggest that because of lower costs, better or equal outcomes, greater emotional and spiritual satisfaction, deeper family bonding, and feminist[18] empowerment, home birth should be considered as the standard of care against which birth in other settings is measured (Baldwin 1992).

One female obstetrician, Bethany Hays, describes her ambivalence about her own role as a bearer of authoritative knowledge and as a setter of care standards. "It is commonly accepted that, as a practicing obstetician in the United States, I am an authority in the realm of birth. I have training in science and technology that allows me to manipulate the tools of modern medicine. This ability has come to be the accepted standard for bringing new human life into the world here in the United States and increasingly in the rest of the world. I, along with my colleagues, create the 'standards of care' that become the basis of legal actions that control physicians and midwives, profoundly affect women in birth, and have trapped us in a model of childbirth

[18] It is interesting to note that while some feminist authors are including childbirth in their analyses, and anthropologists are catching on, the subject is almost completely missing (it is mentioned only in passing) in works like Henrietta Moore's Feminism and Anthropology (1988). I have noticed that a rapidly increasing proportion of the young women I encounter who are interested in careers in midwifery are non-mothers motivated by their feminism.

that is unhealthy and destructive... The need for more technological intrusion when anesthesia is given...continues to reinforce the belief that hospitals and doctors are a necessary part of safe modern obstetrics, and robs birth of its social, sexual, and spiritual significance. Women have gradually given over their own authority in birth to the authority of technomedicine" (Hays 1996:291).

Goer (1995:349-360) is even more adamant about the importance of women reclaiming authoritative knowledge and control over their own birth experiences. She declares, "seen in one light, obstetrics, far from serving the needs of childbearing women, could be described as a kind of sanctioned violence against them...the queerest inversion of all is that we have the quintessential female process being defined and controlled by males according to a singularly male perspective. This in itself would not be so bad, but it is doing untold damage to women, the worst of which is that women have internalized its misogynistic beliefs. My critique of obstetric care (and those of others) derives from a commonly held feminine perspective that would reclaim childbearing as an empowering act, one in which women would be cherished, nourished, supported, celebrated, and respected."

A cross-cultural exploration reveals many examples of modern people successfully utilizing lateral systems of authoritative knowledge about childbirth (i.e. Oaxaca, see Sesia 1996; Maya, see Sargent and Bascope

1996, Yucatan, Holland and Sweden, see Jordan 1993[1977]). These systems tend to be adaptable and resilient, even in the face of disruption by warfare (e.g. Pujehun district, Sierra Leone, see Jambai and MacCormack 1996). Other people are witnessing the rise of obstetricians' authoritative knowledge while midwives continue to safeguard the cultural definition of childbirth as normal and nonpathological (e.g. Japan, see Fiedler 1996).

Hays suggests that "an ideal situation would be one in which physicians and midwives cooperate: the midwife would use her experiential and intuitive skills[19] to empower the woman in the birthing process, and use her medical knowledge to communicate the mother's status and needs to the mother, the family, and the medical staff. She would also serve as the gatekeeper, calling in the physician as a technician to intervene if and only if intervention is truly needed" (Hays 1996:293).

This is the model of birth under which I myself have been privileged to give birth three times. In my role as a labor support provider, I have seen highly technocratic intervention-oriented birth, low-tech spiritually-oriented woman-centered homebirth, woman-centered birth with noninterventive nurse-midwives in a hospital birthing room setting, and other variations. I admire American independent midwives who consciously resist "colonization of [women's] bodies and minds by medical/technological culture" (Luce 1996:9), while agreeing that obstetric technology has its place in the

[19] Elsewhere in her article, Hays (1996:293) points out that doctors *also* frequently use intuition to guide their decision-making, but do not feel free to talk about it.

occasional high-risk situation. These midwives aim for a "union of communitarian birthing systems with the occasionally lifesaving technical expertise of Western obstetrics" (Davis-Floyd and Davis 1996:117) I agree with Hays (1996) that a best-of-both-worlds model is the safest, most satisfying, and most cost-effective approach.

Consumer pressure is the most effective tool in broadening the range of choices available to laboring women. Hospitals respond to women's desires for more empowering birth settings by installing more homelike decor and cabinetry that hides obstetric equipment. When this is accompanied by lower intervention rates and more sensitive, time-intensive models of care, it can indeed help to return authoritative knowledge to women and their families, and to lower intervention and complication rates. But often these cosmetic improvements are superficial, and merely mask the co-optation of holistic values.

Of course, the very notions of choice and empowerment are reflections of privilege. Socioeconomic and ethnic factors affect obstetrical care, and one must be careful not to generalize about women as if they are homogeneous.[20]

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[20] Emily Martin (1992[1987]:xv) originally identified two kinds of patient attitudes toward obstetrical care: a "passive self-perception" and "one attempting to resist passivity." Later she recognized that "taking control...had very different implications for women of different ethnic and class positions." For example, it became clear to her that "techniques of controlled breathing used in prepared childbirth classes were generally taught by and oriented to the sensibilities of white middle-class women. Poor women, or women of color, obliged to take such classes by their clinic, sometimes experienced what they were taught as another form of control." The lesson here is that one cannot generalize about "empowering" or "disempowering" practices. For some women, empowerment means giving birth upright and undrugged, surrounded by loved ones. For other women, empowerment means "I want

Says Paula Treichler, "The real revolution will involve forsaking the knowledge that gender binds women in a magical ineluctable unity and rejecting definitions that ground the reality of birth in what is presumed to be natural and maternal" (quoted in Kahn 1995:278).

British social anthropologist Sheila Kitzinger (1987) advises mothers that "anxiety that stems from being powerless and having other people make all the decisions about you and your baby can be dispelled only by constructive action...improving communication...with your caregivers and changing the balance of power, or changing your caregivers and the environment in which you give birth...You should not have to try and change yourself to fit the system. Somehow you have to change the system to suit your needs." But while this is possible for activism-oriented mothers with resources, inclination, and time, it is not often an option for disempowered women.

Poor women and ethnic minorities have higher rates of infant mortality,[21] obstetric complications, and chronic disease. "A woman's class background, together with her race, profoundly affects the kind of birth experience she will have in the hospital" (Martin 1992[1987]:148). Treichler again: "We need to strengthen feminist political aims: women's right to economic resources, information, self-determination, strategic alliances

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my cesarean and I want it now" (Davis-Floyd 1992). My goal isn't to tell women how to give birth any particular way, only to show them what's possible and what their choices are.

[21] In 1990 in the United States, there were 8.5 infant deaths per 1000 white babies, and 17.6 infant deaths per 1000 black babies (Harper 1994:193).

across race and class, access to appropriate resources, and participation in decision-making about the reproductive process" (Kahn 1995: 278).

Many women are unaware of the existence of choices, and unaware of the possible consequences of giving away authority over their own bodies. Many experience so little command over their own lives that their loss of authoritative knowledge is in character with the rest of their experience. Many are unable to access more than one health care option, due to economics, geography, or local medical politics. Many have no access to prenatal care, good nutrition, support, or prenatal education. These women are often reassured by high-tech, anesthesia-oriented care, and they are more likely to be high-risk and require more interventions.

These individuals are especially susceptible to the models of care that have been accepted and propagated by the culture as a whole. Whatever disempowering medical practices permeate the system, these women are often worse off. They are more likely to be treated by medical students who need to practice interventive procedures,[22] or to receive substandard care[23] because they have no health insurance and no advocacy.

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[22] An obstetrician reports: "I delivered 2,000 babies in my residency...in a big-city ghetto hospital. There the women wanted and needed medication. There was no prenatal education...most of the women were not married and didn't want to be pregnant. They didn't want pain. There was no reward for them to have that child, and so in that situation, if I didn't provide them with anesthesia, I wasn't doing my job. That's what I was there for" (Korte and Scaer 1992:63).

[23] Occasionally, economics work the other way around. Certified Nurse Midwives earn less than one fifth as much as obstetricians, and often see a higher proportion of less privileged women. Since CNM's often provide more woman-centered care, their patients may ultimately benefit.

When the paradigms shift on a cultural level, they trickle down through the classes. Popular culture both reflects and influences the development of these paradigms. In Chapter III, I will show how television and movie birth scenes depict a limited range of options. Furthermore, popular culture in general diminishes the views and needs of women, minorities, and the working class.[24]

Television and movie portrayals of childbirth neglect the viewpoints of underprivileged women, reinforce the dominant medical belief system, and introduce gratuitously high levels of danger that can frighten women into dependence on institutions. They can make narrow concepts of childbirth seem normal.

B. Television and Motion Pictures as Instruments of Normalization

Many expectant parents remain unaware of the existence or advantages of midwifery-style care options for home, hospital, or birth center settings, because they are not often depicted in the popular culture. Women are seldom shown giving birth without at least a Herculean attempt to reach the hospital (and its doctors and equipment), and planned home birth is virtually unknown in television and motion pictures.

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[24] Women are often used as sexual decorations, objects of male competition, or as foils for male-centered plots. Many of the people of color portrayed behave consistently with white culture, or else they are racist stereotypes or clowns. Working class people are seldom portrayed, and when they are, they are often ridiculous (*The Simpsons, Married with Children*). One of the few working class characters, *Roseanne,* has changed her lifestyle since she won the lottery.

Furthermore, movies and televsion serve as effective, if unwitting, reinforcers of the authoritative knowledge of obstetricians and hospitals. Top-down, technocratic systems of authoritative knowledge are frequently depicted and thereby normalized, and viewers seldom see the application of lateral, wholistic systems of authoritative knowledge. The assumptions underlying these depictions are invisible to most viewers.

The normalization of the technocratic system of birth does not stop at our borders. American movies and television are major exports. I suggest that television and movie portrayal of American birth contributes to the acceptance of obstetric beliefs, policies, and procedures that may be inappropriate and even dangerous in other cultural and economic settings.

Indeed, the spread of Western obstetric technology to the Third World is a disturbing trend. The process of exportation tends to be incomplete, so that technicians are available but lack equipment, or vice versa, or conditions are sometimes less sanitary in hospitals than at home. Meanwhile, as "women of other cultures[25] are coming to see the technomedical model as superior to the wisdom of their own bodies" (Hays 1996:292), successful indigenous midwifery systems have been undermined. Women in Jamaica, for example, gave up their own authority and indigenous midwifery system in favor of technomedicine, but the health care system there can no longer

[25] "Other cultures" is a problematic phrase that I do not use myself. Anthropology is still recovering from its history of asking the question "Is everybody like us?" instead of the more interesting and useful "What are the other societies of the world like?" (Moore 1988:188) By studying my own culture, I have avoided this problem, but in drawing cross-cultural comparisons, it is still a potential pitfall.

finance the hospital facilities that provide optimum care (Sargent and Bascope 1996).

C. Pain, Fear, Confidence, and Decision-Making

Trevathan (1996:287-289) suggests that "the transfer of authoritative knowledge from the birthing women to her attendants may have begun as long ago as 5 million years." Bipedalism necessitated a more compact, rigid pelvis, "reoriented so that the inlet was broadest in the side-to-side dimension, the outlet in the front-to-back dimension. The relevant fetal dimensions are also perpendicular...this means that the human infant must undergo a series of rotations in order to pass through the birth canal without hindrance."

This also means that the human infant usually emerges face down. While nonhuman primate infants usually emerge face up, and their mothers can reach down to guide them out, human infants tend to require assistance from someone other than the mother, because if their mothers guided them out, their heads might be bent dangerously backward. A human mother also has a harder time reaching the emerging infant to clear its airway or unwrap its umbilical cord from around its neck (a minor complication that affects about a third of all babies).

The tight cephalopelvic squeeze shared by most primates has been exacerbated in humans by encephalization in the genus *Homo*. Furthermore,

the combination of the bipedal pelvis and encephalized infant head have necessitated that human infants be born much earlier in their developmental trajectory than any other primates. These altricial infants require more assistance at birth, especially with respiration.

In other words, suggests Trevathan, "the evolutionary transformation... into a bipedal hominid first transformed birth from an individual to a social enterprise...selection for bipedalism set hominids on a trajectory toward the elaboration of cultural systems of authoritative knowledge about how childbirth could best be accomplished -- knowledge that often inheres in the social group or in individual birth attendants more than in the mother" (1996:287-289).

The mother needs a clear signal, when birth is imminent, that it's time to seek assistance. "That signal is pain. No other normal body function is accompanied by pain" (Hays 1996:291).

Pain may also have another function. Labor pain stimulates the release of endorphins, which "modify pain, create a sense of well-being, and alter perception of time and place...as soon as the baby is born, the effort of labor ceases and the woman experiences the characteristic euphoric state of high endorphin levels. She is elated, feels a sense of achievement, and is in a positive and receptive state, important for greeting her new baby. It may well be that one of the most important reasons for endorphin production during labor is to ensure this optimal physical and emotional state

immediately after the birth. From the baby's perspective, it is important that its mother is alert, welcoming, and intensely interested in nurturing and protecting her newborn...therefore, experiencing labor together with its pain may be essential precursors for the bonding behaviors necessary for ensuring survival of the infant" (Robertson 1994:90-92).

Pain, which so effectively signals the need for assistance, "has also been the major hold doctors have had on women in childbirth...As the general health and nutrition of [American] women improved, the risks necessitating... interventions became less frequent. Indeed, I wonder if they would have been frequent enough to keep the physician's place in the birth room if it hadn't been for the introduction of anesthesia. Even the brief resurgence of the natural childbirth movement in the 1960's and 1970's [which emphasized the reframing of pain as healthy and normal] ultimately failed due to the development of forms of anesthesia[26] that allowed the mother to be awake and to participate without feeling pain" (Hays 1996:291-291).

Childbirth educators have long acknowledged a relationship between fear and pain. In the 1940's, Grantly Dick-Read described a cycle of fear, tension, and pain, in which a fearful mother tightens her muscles, which exhausts her energies and lowers her pain tolerance, and the resulting pain causes her more fear.[27] This emotional-physical cycle can be alleviated

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[26] It should be noted that epidural anesthesia "has a marked effect on [limiting] endorphin production" (Robertson 1994:93).

[27] Today we understand the physiology behind the fear-tension-pain cycle. The catecholamine hormones adrenalin and nor-adrenalin, which are released in response to fear, cause a drop in oxytocin levels, which in turn causes uterine contractions to slow down

through physical relaxation in labor, through the presence of a calm and reassuring person, and through prenatal education that dispells fear of the unknown (Dick-Read 1944).

Many childbirth education programs since then have drawn on these concepts, together with the belief that pain is healthy and normal but that pain medication is useful and necessary in some cases.

However, many childbirth education programs have been co-opted to adhere to institutional protocols, which often support the use of anesthesia and other interventions in labor. Lamaze's Psychoprophylactic Method is especially "popular [with] doctors and hospital staff because...the laboring woman is in fact in control only of her own behavior, not of the situation or the medical decisions that are being made about how to conduct her labor" (Rothman 1982, quoted in Livingston 1993).

Television and movies have become primary sources of information about childbirth for many people. I suggest that the themes that repeat themselves through countless movie and television births plant themselves in the minds and emotions of a significant number of Americans, contributing to unnecessary and unrealistic fears about childbirth, and reinforcing institutional roles in which doctors monopolize authoritative knowledge.

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or stop. Adrenalin stimulates the circular fibers in the lower third of the uterus to contract, thereby slowing cervical dilation. And adrenalin also reorganizes the blood supply in frightening situations, so that uterine contractions are made more painful by reduced blood and oxygen flow. [Robertson 1994:94-96].

"We are especially influenced by relatives' stories, particularly if they come from women with whom we identify. Movies and television shows about birth may also teach us emotional attitudes and expectations. When there is no other context in which to learn about childbirth, young girls, in particular, may be susceptible to television and movie messages -- whether of strength and joy or of helplessness and danger. These messages can become a script about birth that is stored in the emotional center of a child's brain...Unable to gain... knowledge [about birth from direct experience], most young girls look to movies or soap operas for the story of childbirth" (Peterson 1991:67).

Most childbirth professionals would agree that "a stored memory can be a resource or a hindrance during pregnancy and birth" (Harper 1994:170). Mehl et al (1980) studied "potential important psychosocial predictive factors for high risk childbirth" (including "nonconducive vs. conducive prior acculturation") and concluded that "psychological factors do seem to be associated with complications of labor...to understand the system whereby physical complications of birth appear, it is necessary to include psychosocial factors."

What kinds of fear affect labor, besides those that are associated with pain itself? A woman who is psychologically unprepared for labor may struggle with fear of losing control, fear of loss of autonomy, fear of poor "performance" and consequent loss of self-esteem, fear of mutilation, and

fear of death (Kitzinger 1987:89; Noble 1983:16).[28] Peterson (1991) and Harper (1994) describe ways that body-centered hypnosis and active visualization can make labor easier for these women. Korte and Scaer (1992) describe ways that various psychotherapeutic and self-help techniques might also help.

Some degree of fear is, of course, normal and healthy. Fear, after all, stimulates us to seek the necessary support and information about preventing poor outcomes. When fear has led to one's needs being met, "a healthy or normal fear of the unknown can yield to trust in the universe" (Peterson 1981:169).

Perhaps it could be said that even negative images on television and in the movies help to stimulate self-reflection. Perhaps some women use these birth scenes to consciously discover and work through their fears. Even if this is so, however, I believe that frightening imagery does more harm than good. It is evident that some people have been deeply affected by it, as I will demonstrate in Chapter IV. Some of the quotes in that chapter suggest

[28] Emily Martin (1992[1987]:61-62) compares ways in which various obstetric texts refer -- or neglect to refer -- to the impact of emotions on labor. "Specific studies have shown that aspects of the environment such as light, noise, and movement from one place to another affect the length of labor in humans and animals. Amazingly, this knowledge is not brought to bear on obstetric treatment. For example, if a woman's labor slows down because her contractions are not sufficiently strong...most obstetric texts suggest these causes: the pelvis is too small, the fetus is not positioned properly, or the uterus is too distended...Nowhere is it suggested that a woman's state of mind (fear, anxiety) might have led her to stop her labor, even though, *'in many -- perhaps one-half -- of instances the cause of uterine dysfunction is uknown'* " (Pritchard et al 1985:643; emphasis added by Martin).

that a memory of imagery can be nearly as potent as a memory of lived experience.

CHAPTER III

TELEVISION AND MOVIE BIRTH SCENES

A. Research Methodology

I viewed 62 television and motion picture birth scenes, and studied many variables in each. They were fairly randomly selected: whatever I could rent on video, tape off the television, or borrow from friends and colleagues. Since most were on videotape, I was able to view each one several times, gleaning considerable detail. There were 23 (37%) movie birth scenes and 39 (63%) television birth scenes. Some programs had more than one birth scene, and I counted those as separate birth scenes. Twin births were counted as one birth scene.

There were 24 (39%) comedies, 30 (48%) dramas, and 4 (6%) actual births.[29] This latter group consisted of three documentaries (*The Mystery of Birth* on The Learning Channel, *Miracle of Life* on PBS, and footage of a cesarean section on the Learning Channel) and one celebrity (Marilu Henner) birth scene that was filmed for a TV special called *We're Having a Baby*. Also, there were 2 *Rescue 911* reenactments that were very realistic and may have been combined with actual video footage. There was one

[29] I did not include films from childbirth classes. While these are rich in footage of actual births, they are not viewed by enough people to be considered "mass media."

Tylenol commercial. And, for something completely different, I included Monty Python's satire of high-tech childbirth from *The Meaning of Life.*

Since my professional agenda has to do with emotional and physical health, empowerment of mothers, and amicable relations with spouses/ partners and health care providers, my variables were selected accordingly.

Television Programs

Alien Nation
Blossom
Chicago Hope (2 births, 2 episodes)
Diagnosis Murder
Dr. Quinn: Medicine Woman
E.R. (7 births, 3 episodes)
Family Ties
Fatherhood (Special)
Frasier
Friends (2 births, 1 episode)
Full House
Home Court
Cesarean Documentary
The Mystery of Life
Miracle of Life
Murphy Brown
Northern Exposure
Pointman
Rescue 911 (2 births, 2 episodes)
Roseanne (2 births, 2 episodes)
The Simpsons
Star Trek: The Next Generation (2 births, 2 episodes)
Step by Step
Thirtysomething
Through the River (TV movie)
Touched by an Angel
Tylenol Commercial
We're Having a Baby (Special)

Motion Pictures

Angie
Boys on the Side
Coneheads
A Family Thing
Father of the Bride Part II
Gone with the Wind
Heart and Souls
The Island of Dr. Moreau
Junior (2 births)
Just Another Girl on the IRT
Look Who's Talking Too
Monty Python's The Meaning of Life
Nine Months (2 births)
Now and Then
The Paper
Parenthood
Philadelphia
She's Having a Baby
The Snapper
Truly Madly Deeply

B. Data

The Mothers

There were only two (3%) teen mothers.[30] There were nineteen (31%) mothers who appeared to be in their 20's, thirty-five (56%) mothers who appeared to be in their 30's, and six (10%) who appeared to be in their 40's.

There were forty-eight (77%) mothers who appeared to be of European-American descent, eight (13%) who appeared to be of African-American descent, two (3%) mothers who appeared to be Hispanic (one

[30] Of these, one was a Hispanic-American 13-year-old (*ER*), and one was an African-American 15-year-old (*Just Another Girl on the IRT*).

South American immigrant, and one Hispanic-American) and one (1.6%) mother who appeared to be of Asian-American descent (Keiko on *Star Trek*). Fortunately for diversity, there was one (1.6%) alien mother (*Coneheads*), and one (1.6%) six-breasted mutant goat-woman (*The Island of Dr. Moreau*). There was even one (1.6%) alien male giving birth via abdominal pouch (*Alien Nation*)

In fact, only sixty (97%) of those giving birth were female. In addition to the alien pouch-father, human male Arnold Schwartzenegger (1.6%) made medical history when he gave birth too (*Junior*).[31]

There were sixty (97%) mothers who appeared to be heterosexual. There were two (3%) lesbian mothers and one (1.6%) possibly bisexual mother.

Forty-two (68%) mothers were married. Six (10%) were in committed but unmarried relationships (i.e. they were with their boyfriends), and ten (16%) were single. Both lesbians were in committed relationships and one maintained ties to her ex-husband as well (the father of the baby). I am unclear about the relationship status of the remaining 2.

It is difficult to assess class accurately, even if it were possible to agree on definitions of the various "classes." Based on occupation, partner's

[31] It is theoretically possible for a man, treated with female hormones and implanted with an embryo, to grow a fetus and placenta within his omentum. Women who have conceived and borne children without uteri suffer from an 80% infant mortality rate and a maternal mortality rate of 0.5 to 18%. Such a procedure in a man would be complicated by side effects from the hormone treatment. It would be so risky that doctors agree it would be unethical, and possibly illegal, to try it. And, by the way, unlike Mr. Schwartzenegger, such a man would certainly grow breasts (Alvarado 1994).

occupation, housing, dress, education, and other clues, I estimate that roughly forty (64%) of the mothers appeared to be of middle or upper middle class, while eighteen (29%) appeared to be of lower middle, working, or poor classes. I could not conjecture about the remaining four.

Forty (64%) of the mothers appeared to be primiparous. Eight (13%) seemed to be having their second babies, two (3%) their third, four (6%) their fourth, and one (1.6%) her fifth. I am not certain about the parity of the goat-woman.

Forty-seven (76%) of the mothers appeared to be happy about their motherhood. Four (6%) seemed frightened about becoming mothers, and five (8%) seemed to have mixed or ambivalent feelings. I am unclear about the emotional status of the other six.

Some of the mothers had personal issues complicating their labors. Two of the mothers were exceptionally obnoxious. One was a crack addict who was about to lose custody of her newborn. Two were being held hostage at the time they gave birth. Six had labor pain so extreme they were unable to cope. If there were a spectrum with "confident dignity" on one end and "off the deep end" on the other, more of the births I studied would fall closer to the latter end.

The Fathers and Other Partners

Fathers and other partners participated in many different activities during labor. The following numbers are tallies of activities observed. Thus each father or partner might have engaged in more than one of these activities. Fathers or partners were present in thirty-four (55%) of the birth scenes.

Twenty-one provided encouragement with their words or their presence, nine "coached" breathing etc., thirteen held the mothers' hands or bodies, four videotaped the birth, two blotted their wives' faces, sixteen were terrified, three fainted, two asked too many questions, one attended to his older child, two just watched during cesarean surgery, one experimented with labor pains and positions while his wife was in the delivery room down the hall, one needed oxygen, one died, six had serious doubts about fatherhood, twenty-one were absent, ten were late (one of those had been hijacked at gunpoint), one abandoned his lover and her child during labor, three mourned their dead or dying wives, six were profoundly and fundamentally changed by the experience of participating in the birth of their children, two suffered injuries or illnesses during their wives' labor, four got into fights, six engaged in debates about who was in charge of the labor, two tried to wrest control from doctors, and eight actually delivered or caught the baby (five reluctantly, three confidently).

There were a number of expressions of love between the mothers and their partners. There were ten birth scenes that included hugs or caresses, sixteen included kisses, and five included "I love you's."

However, there were also a number of cases in which laboring mothers attacked or threatened their husbands or partners. Of nine birth scenes that contained verbal attacks, two included the word "vasectomy." There were five mothers who made physical attacks on partners and four who made physical attacks on non-partners (for example, "Murphy Brown" choked two male friends by their neckties, and, in another scene, did unspecified damage to the reproductive organs of one man). Five mothers blamed their partners for the suffering of labor.

In addition to fathers and partners, there were a total of twelve male friends and eleven female friends present at labors.

The Doctors, Midwives, and Nurses

In thirty-eight (61%) cases, doctors, hospitals, and occasionally nurses or EMT's were clearly in charge during labor and birth. In nine (14%) cases, mothers shared power with their care providers, and in four (6%) cases, the mothers themselves were in charge (the male alien "mother" on *Alien Nation*, the car birth on "Blossom," and frontier women on *Dr. Quinn, Medicine Woman* and *Through the River*). In three (5%) cases, friends or relatives were in charge, and in three (5%) cases helpful bystanders were in charge.

There was only one (1.6%) case in which a midwife was in charge (*Truly Madly Deeply,* set in England), although there was another where the midwife was superstitious and counterproductive until the doctor took over (*A Family Thing*). There were four cases in which it was difficult to determine who was in charge.

Thirty (48%) care providers were clearly supportive of the laboring mothers. Ten (16%) appeared aggressive, judgmental, or threatening. There were nine (14%) cases in which the doctors' competence or presence of mind were called into question.

In fifteen birth scenes, care providers exhorted the mothers to "push," and in ten they blotted the mothers' faces. Commonly, nurses, spouses, or friends touched the mother above the waist, and doctors touched her below the waist.

79% of the one hundred professional care providers I tallied appeared to be of European-American descent. 15% appeared to be of African-American descent, 2% appeared to be of Hispanic-American descent, 1% appeared to be of Native American descent, and 3% were mutant human-animal hybrids (thank you, *Dr. Moreau*).

There were forty-six male care providers, and fifty-one female care providers. However, among doctors, males outnumbered females nearly two to one, and among nurses, there were almost no males.

The Birth Settings

Forty-eight (77%) birth scenes took place in hospitals. This includes two in *Star Trek*'s sickbay. This also includes one motion picture that satirized the whole technocratic model of hospital birth.[32]

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[32] In Monty Python's *The Meaning of Life,* the following dialog spoofed machine worship, medicine for profit, and the transfer of authoritative knowledge from mothers and fathers to doctors and institutions.
Nurse: Mrs. Moore's contractions are more frequent, Doctor.
Doctor #1: Good, take her to the Fetus Frightening Room.
Doctor #2: Jolly good. It's a bit bare in here, isn't it?
Doctor #1: Yes...more apparatus, please, Nurse. The EEG and the BP monitor...and get the machine that goes "ping." And get the most expensive machine, in case the administrator comes.
Doctor #2: Lovely, jolly good, that's much much better...
Doctor #1: Yes, that's more like it.
Doctor #2: Uh, still something missing, though...
Doctor #1: Hmm...?
Both Doctors: Patient!
Doctor #1: Where's the patient?
Doctor #2: Anyone seen the patient?
Doctor #1 *(calling)* Patient!
Nurse: Ah, here she is.
Doctor #1: Bring it over here...mind the machines!
Nurse: Sorry, Doctor.
Doctor #1 *(to Mother)*: Come along.
Doctor #2 *(shouting)*: Hello. Now don't you worry!
Doctor #1 *(also shouting):* We'll soon have you -- cured!
Doctor #2 *(waving at Mother):* Goodbye!
Doctor #1: Goodbye! Trip's up!
Doctor #2: Leave it all to us. You'll never know what hit you.
Doctor #1: Can I put the tube in the baby's head?
Doctor #2: Only if I can do the episiotomy.
Doctor #1: Okay!
Doctor #2 *(putting Mother's legs into stirrups, exposing her perineum to the door):* Come in, come in. *(A crowd of assorted onlookers pours in.)* Jolly good. *(A man comes in with them, smiles at the Mother).* Who are you?
Father: I'm the husband.
Doctor #2: I'm sorry, only people *involved* are allowed in here. *(The Father is ushered out.)*
Mother: What do I do?
Doctor #1: Yes?
Mother: What do I do?
Doctor #1: Nothing dear, you're not *qualified.*
Doctor #2: Leave it to us!
Mother: What's that for?
Doctor #2: That's the machine that goes "ping." *(Doctor #1 presses a button, and the machine goes "ping.")* You see? That means your baby is *still alive!*
Doctor #1 *(pointing at another machine, still shouting)*: And *that's* the most expensive machine in the *whole hospital!*

The total number of out-of-hospital birth scenes was fourteen (22%). Usually the non-hospital setting was a dramatic device to heighten the suspense or the hilarity of the scene. For example, four of these took place in cars trying to *get* to hospitals.[33] One took place on an airplane (an accidental premie on *Rescue 911*). Two self-reliant frontier women gave birth in the woods.[34]

Six of the non-hospital birth scenes took place at home. Of these, three were at home by default or accident (*Alien Nation*, a precipitous breech on *Rescue 911*, and a teen birth in *Just Another Girl on the IRT*). Two were at home because they occurred in places or times where hospitals were not available (a poor Black Depression-era rape victim in *A Family Thing*, and Civil War era "Melanie" in *Gone With the Wind*).

Doctor #2: Yes. It cost over three quarters of a million pounds!
Doctor #1: Aren't you lucky? *(Mother smiles and nods.)*

[33] On *Blossom,* panic and joy are mixed. An woman, married to a man who is in the middle of being hijacked to Arizona at gunpoint, is stuck in bumper-to-bumper traffic in a tiny car with three young friends. Two of the friends faint. Blossom, who is the driver and also the father's younger sister, catches the baby. Assorted comments from the young friends: "I love birth...[describes a birth she saw on "General Hospital"]..." "I'm never going out without a condom..." "Oh please, I'm begging you, hold that thing in!"... "[Catching the baby] was the single most incredible experience of my whole life...truly a miracle..." The baby is named Nash Metropolitan Rousseau (the make of the little car, plus his father's surname).

[34] *Dr. Quinn: Medicine Woman* is an example of a frontier woman as a paragon of womanly strength and courage. "Michaela" ("Dr. Mike") rescues her husband Sully in the woods, sets his broken leg, tends the nasty gash on his shoulder, and watches defiantly but helplessly as their Native American friend is taken away by evil Army personnel. Meanwhile, her water breaks. She and Sully give birth under a tree. The cord is around the baby's neck as the head presents. Sully has to summon up his courage to clamp and cut the cord, and Michaela instructs him as she is giving birth. "Dr. Mike" is a role model for other women with lines like, "I guess we have to learn to expect the unexpected;" "Women have been doing this forever;" "Whatever pain I experienced, it disappeared the moment I saw this little one's face." Extended family bonding is very sweet, and "Dr. Mike" quickly recovers her strength.

Only one birth took place at home by conscious choice (though without prior planning), and that was on *Northern Exposure*. Two weeks overdue, "Shelley" was planning to fly to the hospital in Anchorage for an induction. But, guided by whimsical visions, she decided only an hour before the birth that she should gather her close friends, husband, and doctor, and give birth in her own home, the "love grotto" upstairs from the bar. Bonding scenes included both quiet family intimacy and raucous community celebration downstairs in the bar.

That was a last-minute unplanned home birth. There were no planned home births in modern times.

The Costumes

Of the forty-eight mothers who gave birth in hospitals, forty-two wore hospital-issue "johnnies" or other hospital clothing.[35] Two wore nightgowns. I'm uncertain about three. Only on *Star Trek* did a hospital-birth mother wear her own daytime attire ("Troy" wore her uniform; her colleague "Keiko," in another episode, wore a space johnny). The fifteen mothers who gave birth in non-hospital settings wore their own clothes.

Sixteen fathers/partners, all at hospital births, wore hospital "scrubs" or other hospital attire. Nineteen fathers (in mixed settings) wore their own street clothes.

[35] The mother on *Thirtysomething* was told that she "must" wear the johnny.

The Labors

Measuring the length of labor in a television show or movie is a little subjective. It is complicated by the fact that situation comedies have twenty-two minutes to tell the whole story, and many birth scenes (including real births) do not show first stage labor (effacement and dilation, which can take many hours or days in real life, especially with a first baby) but focus on second stage labor only (pushing, which can a few hours). Assessment of emotional tone and difficulty of labor is also subjective, but I relied on cues like dialog,[36] vocalizations, camera angles, lighting, background music, and facial expressions.

I counted forty-nine (79%) labors that appeared to be extremely fast. Of those, at least seven could be called precipitous. Two labors appeared to be of medium length. Of the nine (14%) slowish births, six appeared to equate long labor with prolonged agony. Two were impossible to judge.

While ten (16%) labors were fairly calm, and seven (11%) were mostly upbeat,[37] fourteen (23%) were presented as pure crisis (mostly unresolved after the birth) and thirty-one (50%) included transient crisis followed by happiness after the birth.

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[36] For example, the following bits of the mother's dialog from *E.R.: Baby Shower* helped me to classify this labor as "hard:" "This really sucks...I hate this part...If you don't have a vasectomy, I swear you're having the next one...*I'm* in distress...if I'd wanted a natural childbirth, I'd have stayed home. What'll they come up with next? Natural dentistry?" This dialog is also interesting as one of several examples of backlash against the natural childbirth movement.

[37] For example, the birth scene in "Parenthood" was an extended family love fest.

Thirty-nine (63%) labors looked very hard to me. Fourteen (23%) looked relatively easy. Seven (11%) were somewhere in between. *Roseanne* was tripping on Demerol, having colorful visions of Jerry Garcia, and thus disassociated from her labor. One mother did not register a response on account of the fact that she was already brain dead.

Mothers' vocalizations varied. Many mothers made more than one kind of sound. I counted twenty examples of screaming or screeching, twelve of yelling or hollering, eleven of grunting or "exhale pushing," eleven of gasping or heavy breathing, eleven of remarkably quiet mothers, ten of crying, sobbing, or whimpering, four of calling out a name (i.e. "Scarlett, Scarlett"), three of groaning or moaning, three of the use of the word "ow," three of the use of the word "shit," three of panting, three of Lamaze-style "heeheehoo," two of mothers giving instructions to their helpers, one of a high pitched sound, and one of a mother singing "Blackbird," very loudly.

Twenty-four (39%) mothers labored or gave birth in a semi-sitting posture (more or less halfway between sitting up and lying down). Seventeen (27%) were in a supine (lying down) or lithotomy (lying down with feet in stirrups) position. Four (6%) were both semi-sitting and supine at different points in their labors. Three (5%) sat up mostly straight. Ten (16%) were supine for cesarean sections. I'm not certain about four others.

The music was predictable. While there was occasional use of stereotypically tense, fearful, sad, or adventurous music, most scenes with

newborn babies in them featured gushing, sentimental, romantic, maudlin music (i.e. swelling strings).

Complications and Medical Procedures

There were ten (16%) cesarean sections, for the following indications: breech baby (scheduled), breech baby with body born and head stuck (emergency), placenta previa, apparent placental abruption, mother already brain dead (and heart transplant recipient ready[38]), male "mother" lacks birth canal (and a few other essential female anatomical features), fetal distress, dropping fetal heart rate, and shoulder dystocia. (The Tylenol commercial did not portray the indication for cesarean surgery.)

Six of these cesarean deliveries included epidural anesthesia, three included general anesthesia, and the brain dead mother probably did not require anesthesia.

Ten (16%) mothers loudly demanded medication or anesthesia for labor (typically, "Give me drugs!"; "Give me drugs or I'll kill you!"; or, simply, "Drugs!"). Epidural anesthesia was given to only four mothers for vaginal birth (8% of the vaginal birth mothers), and Demerol to another. But responses to epidurals for vaginal birth were strikingly favorable. In two cases, such medicines were offered by care providers but refused by women.

[38] As the mother's heart is removed, the father says to her, "I can't believe we just had a baby. Doesn't she look great, Camille?"

There were three cases in which laboring mothers requested death: "Shoot me" (*E.R.*'s "Chloe"); "I want to die" (Schwartzenegger in *Junior*); "Smother me with a pillow...do it for sisterhood...do it for Betty Friedan..."[39] ("Murphy Brown").

In addition to the brain dead mother, three mothers actually did die in childbirth. Two stayed that way, but one was later resuscitated. And one was dying of cancer, rendering the birth of her daughter bittersweet.

Wheelchairs, electronic fetal monitors, and IV's were fairly common (6-8 depictions of each). Breech babies, episiotomies, pitocin, prematurity, neonatal suctioning, cord problems, placental abruption, and maternal oxygen administration were less common (2-4 depictions each). Forceps, attempted infanticide, postpartum hemorrhage, maternal exhaustion, meconium staining, metabolic toxemia of late pregnancy, seizures, CPR, and undiagnosed twins were rare (1 depiction each, many of which were from the single episode of *E.R.* in which an unlikely cascade of interventions and errors resulted in maternal demise.[40])

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[39] Ironically, Betty Friedan is active in media literacy education.

[40] *E.R.: Love's Labors Lost* was, by far, the most frightening birth scene I studied. A lovable young couple, deep in love and anticipating their first baby, is destroyed by a doctor's questionable decision-making and the ineptitude of the institution. Here's a synopsis of this unlikely scenario.

Misdiagnosed toxemia brings on eclamptic seizures. The unconscious mother is revived and there is a moment of calm during an ultrasound ("Is that a boy or *what?*").

The OB's are "getting slammed upstairs," so an ER resident, Dr. Greene, induces labor. As contractions come and go, the mother says things to her husband like, "I love you so much...shut up!"

The baby's heart rate drops to 90, and the music goes scary. The mother, 5 cm dilated, requests an epidural, and the anesthesiologist instantly appears. Obstetricians, meanwhile, are nowhere to be found. As the epidural wears off, the fetal heart rate is slow again. The mother is fully dilated, and there is a mad rush to get a baby warmer and resuscitation kit.

The Babies

Boys and girls would have been even at twenty-eight depictions apiece, except that there were two sets of twins, both boys in both cases. (The sexes of four babies were not clear.) A few scenes included appreciative comments about the size of newborn boys' genitalia (from *Nine Months:* "His testicles are very large!")

Seven babies (11%) were sick or physically compromised at birth, including one with birth defects (*Angie*).

The birth of the baby often triggered a reconciliation between two adult characters who had been quarreling.

Chaos follows: big needle, pudendal block, no progress, forceps, episiotomy, oxygen, rising maternal blood pressure, shoulder dystocia. "Oh my God," says Dr. Greene. McRoberts maneuver, fundal pressure, extended episiotomy, posterior shoulder still stuck. "Why can't you deliver this baby?" says dad. "Mr. O'Brien, *please!"* says Dr. Greene, then..."Let her go, it's not working."

More chaos: Zavanelli maneuver pushes the baby back in, cesarean section, total panic, father left out, local anesthetic is the best they can do, mother has another seizure, a tray of sterile instruments crashes to the floor. Dr. Greene asks everyone to calm down. Dr. Greene asks someone to go drag a NICU doctor and an OB down here STAT. Dr. Greene isn't sure of technique. An underling says, "You're asking me?" Dr. Greene replies, "I'm asking God." Placental abruption, mother bleeding out, transfusion, birth, suction, clamp, baby not breathing, infant CPR, baby pinks up, 5 minute Apgar is 8.

An OB attending finally shows up and says, "You should have let me know you were in over your head." Someone says, "Dr. Greene, she's crashing." Chaos again: bleeding, dopamine, "Bag her," mother's blood stops clotting, lidocaine, "Shock her," CPR. Dr. Greene is still desperately and mechanically doing CPR when another doctor says, "It's 30 minutes past too late. I'm calling it...time of death..."

Later, Greene hears a list of his mistakes from his supervisor. Missed preeclampsia, underestimated fetal weight, missed abruption, used forceps on too big a baby, and a "hack job of a cesarean." Greene then has to tell the father, who is busy bonding with his new baby, that the mother is dead.

This episode won an Emmy. In a subsequent episode, *E.R.: Baby Shower,* there is a case of undiagnosed twins. Dr. Greene does a great job despite the doubts of his supervisor. Perhaps this episode, in which 8 mothers give birth successfully in the ER (OB was flooded), was written in response to public outcry about the doubts that the tragic episode had generated regarding both mothers and doctors.

Postpartum "bonding" scenes varied, with twice as many immediate bonding scenes as delayed bonding scenes. There were eighteen mother-baby bonding scenes, twenty-one mother-father-baby bonding scenes, five father-baby bonding scenes,[41] and nineteen bonding scenes that included extended family, friends, and siblings. There were seven scenes in which the doctor got to hold the baby for a while before the parents got their chance, and there were three scenes in which the mother and father bonded and the baby was absent. (Some births had more than one bonding scene, which is why the total is greater than 62.)

Northern Exposure featured a joyous bonding scene. Friends and villagers gathered in the bar downstairs, and at the announcement, "It's a girl," they all cheered. "Murphy Brown," on the other hand, had a solitary and tentative bonding scene. She received a "little visitor" in a plastic box and made very little eye contact as she told her son about her motherly doubts.

Five babies were shown breastfeeding, and no newborns were shown bottlefeeding. While one breastfeeding baby had only positive connotations (in *The Snapper* a nurse gently assists the mother), there were negative connotations or comments for the other four. *Angie* had problems nursing, and felt rejected. The mother on *Blossom* had friends who couldn't handle

[41] There was also a prenatal father-baby bonding scene that bears mentioning. In *Nine Months,* the father is ambivalent about fatherhood (that's the main theme of the whole movie). He is unmoved when he feels the fetus moving in its mother's belly, but when he sits alone with a TV/VCR and views a videotape of the ultrasound, the violins play and the father falls in love with the baby. In the current generation, it is common for parents to see their children on television before they feel them "quickening" inside. This changes prenatal bonding in ways that have yet to be fully explored (Rothman 1993).

the intimacy of the nursing relationship. "Murphy Brown" was mystified by her own breastmilk: "It's like one day you find you can get bacon from your elbow." And "Chloe," of *E.R.,* described her baby's latch-on as "like a staple gun."

Other Themes

Apparently, birth in itself is not interesting enough to keep the audience from changing the channel. There are often other themes and crises complicating it. Many times, the crises divert audience attention from the mother herself.

There is a common theme I call "the Mad Rush Motif." These may be comical or terrifying (or both, as in *Nine Months,* in which the speeding car, driven by the nervous father, causes several accidents and takes all the victims along to the hospital). I counted sixteen mad rushes to the hospital, six mad rushes to the operating room or delivery room, and two mad rushes in which EMT's attempted to reach the mother. That's twenty-four (38%) mad rushes total. Of course, when the mad rush to the hospital fails, we have "the Car Birth Motif," and there are four of those as well.

In addition to hijackings and kidnappings of mothers and fathers, there's a flooded OB wing (*E.R.*), several violations of privacy with video cameras, a set of adoptive parents mourning as the teenage birth mother changes her mind, a doctor worrying about her *own* pregancy (*E.R.*), a

struggle to harmonize a blended family (*Step by Step*), a father with a broken ankle (*Dr. Quinn: Medicine Woman*), and three cases in which two babies are born at once, dividing the attention of helpers (*Nine Months, Father of the Bride Part II,* and *Junior*).

In one documentary (*The Mystery of Birth*), there is footage of a healthy woman laboring very nicely, while an "educational" voiceover adds gratuitous anxiety and drama. The narrator emphasizes the baby's danger and suffering, and belittles the mother's participation. She reminds us that this is "the most dangerous journey in life...Zoe has no control over the speed of her delivery...Zoe can help by pushing with her stomach muscles but it's not essential...women have given birth even when in a coma...the baby's head is forced through the narrow neck of the womb...but until the lungs start functioning properly, the baby can suffer a lack of oxygen...he looks blue... four long inches later, it's a rude awakening into the world."

C. Analysis and Commentary

Television and movie studios are in the business of delivering entertainment to audiences, thereby delivering audiences to advertisers and theaters. To accomplish this goal, they tend to emphasize the dramatic, the outrageous, and the tragic, out of proportion to their appearance in real life.

As a byproduct of this business, people watch TV and movie birth scenes, and are exposed to a mixture of childbirth facts, myths, and

exaggerations. This might be useful, giving future parents an opportunity to explore their own hopes, fears, and beliefs. But when those viewers go into labor, this exposure may have been misleading, frightening, or psychobiologically counterproductive.

Now Playing

If one could create a composite "average" birth scene from these 62 clips, the mother would be a married, white, upper-middle-class,[42] heterosexual woman in her 30's, happy to be having her first baby.

In this composite, the father would be present but distracted. The birth would take place in a hospital. It would be fast and hard. The mother would be semi-sitting, wearing a hospital-issue "johnny,"[43] and screaming. The person in control would be a white male doctor. The nurses would be white women. The baby would be a healthy boy (who looks about three months old). The music would certainly be cloying in the immediate postpartum bonding scene.

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[42] The over-representation of privileged people is common to the mass media in general, due to targeting of audiences with disposable income, and the belief that privileged people like to see "themselves" portrayed [Lewis 1996]. Ethnic diversity is increasing, but portrayals are not yet proportionate to the population. There was no significant correlation between class and birth outcome, although both teen mothers in this study are clearly both lower class and members of ethnic minorities (one Hispanic teen on *E.R.* with questionable parenting resources, and one African-American teen in *Just Another Girl on the IRT* who tries to abandon her newborn).

[43] Robbie Davis-Floyd (1992) suggests that wearing a hospital johnny places the mother in a "sick" role, makes her look like all the other "initiates" sharing the same liminal state, symbolically inverts her most public and private body parts, and prevents her from leaving the building. One birth scene I studied showed a labor so fast the mother barely made it to the delivery room -- but she still had time to change into the johnny.

But this composite scenario doesn't tell the whole story. In these 62 scenes, there were also significant numbers of:

- emergencies,
- disasters,
- unresolved crises,
- frantic rushes to the hospital (I call this the "Mad Rush Motif"),
- car births (when the "mad rush" didn't make it),
- aggressive, judgmental, or threatening doctors and nurses,
- questionably competent doctors and nurses,
- attacks by laboring women on men,
- vehement maternal requests for drugs ("Give me drugs!"),
- whimpering maternal requests for death ("I want to die"),
- actual maternal deaths, and
- sick babies.

The screenwriters aren't making these things up. Some real women *do* punch their partners, some *do* have very fast labors, some *do* require emergency care. But normal birth usually entails a lot of slow, hard work, and few problems. And normal birth is nearly absent in these depictions. Meanwhile, portrayals of rare and frightening complications are plentiful. Confident, dignified mothers are greatly outnumbered by silly, strident, and frightened mothers.

The producers are just doing their job. The purpose of drama is to keep us tuned in till the next commercial. Thus we have interesting variations on normal childbirth: women pregnant by aliens, dying at 300 times the normal rate, being held hostage during labor, or donating eggs to pregnant men. We have refreshing attempts to portray diversity, like showing lesbian or bisexual mothers in loving relationships (5% of the 62; controversy can increase viewership). Perhaps the most remarkable example of "diversity" is the incomparable six-breasted mutant goat woman giving birth (on her back!) in *The Island of Dr. Moreau.*

Who's in Charge?

In most of the 62 scenes, a doctor was clearly in charge of the labor and birth. There were a few cases in which friends, relatives, or bystanders took charge. In a handful of cases, the mother shared power with her care providers. There was only one case in which a qualified midwife was in charge (*Truly Madly Deeply,* set in England). There were four scenes (6%) in which the mother herself was clearly in charge: frontier women on *Through the River* and *Dr. Quinn: Medicine Woman*, the woman who gave birth in a small car on *Blossom,* and the male alien "mother" on *Alien Nation.*

On television and in the movies, doctors are usually in charge of vulnerable women having hard and fast labors in hospitals. These doctors

are mostly male, by a two to one ratio, with female doctors often behaving even more officiously than the male doctors.

In real life, labor usually isn't easy and doctors are often helpful. But these TV and movie doctor stereotypes reinforce and normalize technocratic obstetrics, medicalization of a healthy human function, patriarchal control over women's bodies, and institutional control over a profound family transition. They normalize the transfer of authoritative knowledge about birth away from the mothers themselves (see Chapter II).

Dueling Paradigms

In real life, many women have a limited selection of birth settings and care providers. Their decisions are dictated by geography, economics, or medical politics. But while some women have limited options, we do, as a culture, have a choice of paradigms.

There is a healthy, empowering, alternative standard of care that is almost never portrayed on television or in the movies. In a "woman-centered birth," the mother exercises freedom of choice regarding her setting, attendants, position, rhythm, etc.

Woman-centered (or "midwifery-model") birth "has been proven to reduce the incidence of birth injury, trauma, and cesarean section" (MANA et al, 1997). The mother uses her attendants to support her in giving birth (as opposed to "being delivered").

Perhaps most importantly, the normal pain of childbirth is framed as healthy and bearable. Interventions are not routine, but are helpful in case of complications. There is a calm atmosphere of love and respect for the mother and her natural process. Her partner is more like a lover than a "coach."

Where's Poppa?

Proponents of paternal participation in childbirth will find plenty to celebrate in these birth scenes, as 55% of the scenes portayed the presence of fathers at birth. This reflects the fact that this element of family-centered birth is becoming a cultural norm in America in this generation.

However, many fathers were portrayed as terrified buffoons or as ineffective helpers, and many were conspicuously late or absent. These depictions may provide opportunities for audience exploration of fathers' anxieties about being present and useful at the births of their children, but there were few role models that men would be happy to emulate.

While some couples were portrayed as loving throughout labor and birth, there were many who had relationship problems or even female violence against men during labor. This may reflect the ambivalence some women feel during the pain of childbirth toward the men who impregnated them. Also, it was common for men to explore their own ambivalence about fatherhood and about their effectiveness providing labor support.

One man (not the biological father) displayed his insightfulness about the fruits of labor support at the end of the birth episode in *thirtysomething*. Having been through a long and difficult labor, and having weathered it and bonded deeply with the mother, the man glanced down the hospital corridor at a couple in early labor. The knowing look on his face conveyed how far he had come right through his doubts and fears and out the other side into a more enlightened state.

Time Warp

In most (79%) of the scenes I studied, labor appeared to be extremely fast, even precipitous. Time was severely distorted, and labor was condensed into mere minutes.

A recent University of New Mexico study (Albers, et al, 1996) measured the average length of labor as 19.4 hours *after* the first four centimeters of cervical dilation for a first-time mother, and 13.7 hours *after* the first four centimeters for a second-timer. Those first four centimeters can take hours or days, so the total length of labor may be considerably longer. Thus expectant parents should have a plan for handling precipitous labor, but should put more energy into planning to cope with the many hours of a *normal* labor.

The few labors that were portrayed as longish also happened to look like prolonged agony.

Danger Danger

In addition to distorting time, television and movie birth scenes often exaggerate danger. The mad rushes and the high incidence of near-instant labors feed a feeling that high anxiety is a normal part of labor.

Even documentaries sometimes follow the convention of adding gratuitous danger to normal birth, as in *The Mystery of Birth,* in which the "educational" voiceover adds unnecessary anxiety and drama.

Maternal death was a theme in five of the 62 scenes. Two mothers died in childbirth,[44] one "died" and was revived, one was going to die of cancer soon, and one was already brain-dead at delivery. In addition, one father died (of cancer) at the moment of birth. I suppose that fear of death is right up there with fear of the unknown in the subconscious minds of expectant parents, so it is not surprising that these themes are explored in the media. But some birth depictions go beyond mere exploration, and engender so much fear in viewers (especially pregnant viewers) that the viewers themselves report adverse effects.

The most extreme example of this was that infamous episode of *E.R.*, in which the mother died after a series of medical errors. I interviewed care providers who said their phones were "ringing off the hook" after it aired. That episode is also notable in that it wasn't just women's bodies that were untrustworthy in labor -- doctors weren't even reliable as rescuers. I don't

[44] If 2maternal deaths out of 62 live births were the norm, that would make a national rate of 3,225 per 100,000. The actual maternal death rate is less than 10 per 100,000.

know which is worse: portraying women as victims of their own bodies, or portraying their would-be rescuers as incompetent. That episode delivered a double whammy.

A Little Something

While that program was frightening, perhaps the birth scene on the sitcom *Step by Step* was just as damaging to the pregnant psyche. "Carol" was portrayed as out of control. She demanded drugs during contractions, while between contractions she was a bit more like her sweet self. The laughter on the laugh track was directed at her antics, which included vicious remarks to her husband. Her doctor and her husband seemed unable to cope with her pain or support her emotionally (this was an excellent example of labor as a "beholder's disease"). Her desire to have natural childbirth was interpreted as unnecessary martyrdom (this was one of several examples of backlash against the natural childbirth movement).

Carol was finally pressured into taking "a little something for the pain." The "little something" turned out to be epidural anesthesia. The doctor said, "It's perfectly safe for you, and it won't hurt the baby one bit." (Note: While epidural anesthesia is usually safe and effective, and may be helpful for some women, the peer-reviewed medical literature documents at least 20 risks for mother and baby, ranging from nausea to increased incidence of

surgical delivery to cardiac arrest.) Carol and her team were portrayed as intensely grateful for this intervention.

In labor, "Murphy Brown" was equally ridiculous, miserable, pathetic, and dangerous to men. The producers of those programs missed opportunities to show loving support and maternal confidence. But of course, that's not part of their job description.

I Don't Think So

Inaccuracies are too numerous to list. For example, as a male carrying a baby, for some reason Mr. Schwartzenegger is exhorted to "push" during a cesarean section. Also...

- A 3-month-old doesn't look like a newborn, no matter how much strawberry jam and cream cheese you smear on it.
- There were many babies without umbilical cords or placentas.
- Epidurals *do* have potential side effects ("Step by Step" denied this completely), and most make it impossible to move your legs around (like "Jackie" on "Roseanne").
- Medical procedures and medications should require informed consent.

Drugs and Surgery

Despite all the danger, questionable medical support, and buffoonery, the cesarean section rate in these clips was only 16% (the national rate is currently around 22-24%). The indications for these surgeries were a mixture of reasonable but rare (i.e. placenta previa), controversial (i.e. routine cesarean for breech presentation), and preventable (i.e. poor handling of a shoulder dystocia).

And despite all the requests for drugs ("Give me drugs!"), only 10% of the vaginal birth mothers had drugs administered. But they loved them. "Roseanne" was tripping on Demerol (unlikely!), having colorful visions of Jerry Garcia. Her sister "Jackie," in another episode, stuck a fork in her leg and said, "I'm not having any pain, I had an epidural! See?" And on *Step by Step*, "Carol" breathed a woozy "God bless you" to her anesthesiologist.

In real life, epidurals are administered in up to 80% of American births (Davis-Floyd 1992:115). I suggest that television and movie portrayal of birth as unbearably painful, support as unreliable, and epidural anesthesia as a godsend, may contribute to the popular acceptance and normalization of this intervention.

Up the Down Staircase

While many of the TV and movie mothers were portrayed as giving birth in upright or semi-upright positions that are physiologically sensible,

It is an *advantage* for many, but human adults are capable of forming strong nurturing relationships with children, biologically related or not, at any time.

Murphy Brown exemplified the current concern about the quality of bonding, and carried it to its logical extreme: anxiety about bonding "properly." ("Are we bonding yet? I can't tell.") Just as her labor was policed by her doctor ("If she doesn't concentrate, this could get *complicated*"), her postpartum bonding was policed by her cultural concepts and her fear of failure. It was, perhaps, a concession on the part of TV's most famous single-parent-by-choice, an admission that she might be incompetent after all. But the baby-bliss convention was still upheld: she ended the episode singing to the baby, "You Make Me Feel Like a Natural Woman."

Breastfeeding

One bright spot in this study was the occasional portrayal of breastfeeding, indicating that this practice is coming back into acceptance in popular culture. Breastfeeding portrayals were rare (8% of the clips), and most were sources of jokes or melodrama.

But there were no portrayals of bottlefeeding newborns. This was encouraging evidence that perhaps, despite the aggressive advertising tactics of baby formula companies, our culture is beginning to agree with worldwide nutritional experts that breastfeeding is best.

But Does It Really Affect Anyone?

Birth is a stage upon which competing mythologies are played out. So is television, and so are movies. If our birth customs provide a window into our culture, television and movie portrayals provide a window into our hopes, fears, and beliefs about birth.

Which mythologies do we relate to? Do they have medical, emotional, or spiritual consequences? Chapter IV is the beginning of an exploration of audience effects.

CHAPTER IV

AUDIENCE EFFECTS

A. Research Methodology

After I began studying television and movie birth scenes, I wanted to make sure that my research had validity in people's lives. After all, meaning is more than the product of producers' intentions; meaning requires interpretation by viewers, based on their existing beliefs, their co-viewers' opinions, and their life experiences. If all my conclusions about portrayal of birth were correct, but real people were completely unaffected by viewing these portrayals, then this project would be irrelevant.

So, I informally surveyed groups of teens, expectant parents, and childbirth professionals about their experiences with portrayals of childbirth in movies and television.

The groups surveyed received open-ended questionnaires:

Please list some births you have seen in movies or on TV (real births, drama or sitcom "births.") What were they like? What was the primary emotion?

Do you feel that viewing these births has affected your beliefs, hopes, or fears about giving birth yourself? How?

I have identified four obvious limitations in this survey. First, while many subjects' replies were clear and revealing, others were incomplete or difficult to quantify. The open-question written format has the advantage of confidentiality and freedom from much of the researcher's influence, but it does not afford the in-depth probing of an interview.[45]

Second, there was a relatively small number of respondents. I hope that at some point an improved version of this survey will be conducted with a larger number of subjects.

Third, the respondents were not a random sample of the population, but self-selected in various ways. Childbirth professionals were surveyed while attending training courses in childbirth education and midwifery. Expectant parents were surveyed while attending independent consumer-oriented prenatal classes (which I taught). Thus these two groups had chosen the empowerment-oriented settings in which they were surveyed. Teens (surveyed at their unusual charter high school) were self-selected in that they could choose not to participate if they were not interested.[46]

Fourth, the survey question *"What was the primary emotion?"* does not distinguish between the emotion *portrayed* and the emotion *experienced* by the viewer. In many instances, there was no distinction necessary (for

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[45] Ambiguous or incomplete responses were not included in any of the cause-and-effect statistics listed below, although the total number of respondents does include the writers of those ambiguous answers.

[46] Of about 60 teens invited to fill out questionnaires, only 39 participated, and some of those were very brief or incomplete in their answers.

example, watching a frightened woman in labor often made the viewer experience fearfulness also), but in other instances, there was a clear distinction (as when an experienced mother or childbirth professional felt disgusted by a comedic portrayal of a woman being stripped of her autonomy).

While the survey did not produce the hardest quantitative data, it certainly produced a great wealth of commentary from participants. That is, I believe, its greatest value. I believe that the following survey results help to bolster my argument that TV and movie consumption *does* make a difference in some people's beliefs and feelings about childbirth. However, it is also clear from this survey that many people have considerable "conceptual distance" from these birth scenes because they have other sources of information buffering them.

B. Data

Terms

"frightening" = primary emotions include at least one of the following: panic, fear, pain, screaming, panic, chaos, hatred

"reassuring" = primary emotions include at least one of the following: happiness, excitement, joy, love, beauty

"pessimistic" = afraid of giving birth / believe birth is very painful or dangerous

"optimistic" = looking forward to giving birth / believe birth is beautiful

"neutralizing force" = nonmedia source of information about birth (personal experience as mother / attendant / witness, stories from friends or relatives, books, etc.) OR generally resistant attitude toward media

"unaffected" = subject does not feel that TV/movie birth scenes currently influence her/his beliefs or feelings about birth

"media" = television and motion pictures only (internet, newspapers, etc. are not included in this chapter)

Teens (ages 14-16)

39 surveyed

In general:

Frightening primary emotions in media birth scenes outnumbered and overshadowed reassuring primary emotions. Many respondents reported media portrayal of joy and love immediately after frightening and painful births. 4 noticed that births happen very fast in the media, and 3 complained that portrayals were unrealistic. 4 reported that birth scenes were comedic. 9 feel that media portrayals have contributed to their pessimistic feelings about giving birth, 2 feel that media portrayals have contributed to their optimistic feelings about giving birth, 21 claim that media does not affect their feelings about birth. 2 are conscious of having overcome media's frightening influences through neutralizing factors.

Where simple cause and effect could be inferred:

8 remembered media portrayal of FRIGHTENING primary emotions AND currently feel PESSIMISTIC about birth

2 remembered portrayal of both REASSURING & FRIGHTENING primary emotions AND currently feel PESSIMISTIC about birth

1 remembered media portrayal of REASSURING primary emotions AND currently feel OPTIMISTIC about birth

2 remember seeing FRIGHTENING primary emotions followed by immediate postpartum REASSURING emotions, and these feel that their own births will follow the same pattern

Neutralizing force:

8 remember media portrayal of FRIGHTENING primary emotions AND have a NEUTRALIZING FORCE in their lives AND consider their beliefs/feelings about birth UNAFFECTED by media

7 remembered portrayal of both REASSURING & FRIGHTENING primary emotions AND have a NEUTRALIZING FORCE in their lives AND consider their beliefs/feelings about birth UNAFFECTED by media

Conclusion regarding teens:

It is reasonable to believe that the childbirth beliefs and feelings of 11 teens (28%) have been directly influenced by television and movies, while 15

teens (38%) are able to maintain conceptual distance because of other "neutralizing factors" in their lives. Of those currently unaffected, 2 (5% of total) are conscious of having overcome past media influence.

Expectant Parents (Adult)

10 surveyed

In general:

Frightening primary emotions in media birth scenes outnumbered and overshadowed reassuring primary emotions. 2 respondents reported media portrayal of joy and love immediately after frightening and painful births. 5 noticed that births happen very fast in the media, and none complained that portrayals were unrealistic. None reported that birth scenes were comedic. 1 feels that media portrayals have contributed to her/his pessimistic feelings about giving birth, none feel that media portrayals have contributed to their optimistic feelings about giving birth, 3 claim that media does not affect their feelings about birth.

Where simple cause and effect could be inferred:

3 remembered media portrayal of FRIGHTENING primary emotions

AND currently feel PESSIMISTIC about birth

Neutralizing force:

4 remember media portrayal of FRIGHTENING primary emotions AND have a NEUTRALIZING FORCE in their lives AND consider their beliefs/feelings about birth UNAFFECTED by media

2 remembered portrayal of both REASSURING & FRIGHTENING primary emotions AND have a NEUTRALIZING FORCE in their lives AND consider their beliefs/feelings about birth UNAFFECTED by media

Conclusion regarding expectant parents:

It is reasonable to believe that the childbirth beliefs and feelings of 3 expectant parents (30%) have been directly influenced by television and movies, while 6 expectant parents (60%) are able to maintain conceptual distance because of other "neutralizing factors" in their lives.

Childbirth Professionals (Current and Aspiring; Adult)

35 surveyed

In general:

Frightening primary emotions in media birth scenes outnumbered and overshadowed reassuring primary emotions. No respondents reported media portrayal of joy and love immediately after frightening and painful births. 3 noticed that births happen very fast in the media, and 13 complained that portrayals were unrealistic. 2 reported that birth scenes were comedic. 7 feel

that media portrayals have contributed to their pessimistic feelings about giving birth, 4 feel that media portrayals have contributed to their optimistic feelings about giving birth, 18 claim that media does not affect their feelings about birth. 14 are conscious of having overcome media's frightening influences through neutralizing factors.

Where simple cause and effect could be inferred:

5 remembered media portrayal of FRIGHTENING primary emotions

AND currently feel PESSIMISTIC about birth

3 remembered media portrayal of REASSURING primary emotions

AND currently feel OPTIMISTIC about birth

Neutralizing force:

18 remember media portrayal of FRIGHTENING primary emotions

AND have a NEUTRALIZING FORCE in their lives AND consider their beliefs/feelings about birth UNAFFECTED by media

NOTE: Of those 18, 8 were definitely PESSIMISTIC about birth in the PAST, and attributed this past pessimism to FRIGHTENING media portrayals

3 remembered portrayal of both REASSURING & FRIGHTENING primary emotions AND have a NEUTRALIZING FORCE in their lives AND consider their beliefs/feelings about birth UNAFFECTED by media

Conclusion regarding childbirth professionals:

It is reasonable to believe that the childbirth beliefs and feelings of 8 childbirth professionals (22%) have been directly influenced by television and movies, while 21 childbirth professionals (60%) are able to maintain conceptual distance because of other "neutralizing factors" in their lives. 8 of those currently unaffected (22% of total) are conscious of having overcome past media influence.

Summary of Findings

In each group, the childbirth feelings and/or beliefs of about a quarter of the respondents seem to be influenced by media portrayals of birth, while a larger proportion consider themselves unaffected by media portrayals.

Quotations from Surveys

The following quotations reveal the richness and variety of people's experiences watching mass media birth scenes. Taken as a whole, these quotations provide much more insight into patterns of effects.

Some respondents clearly feel that consumption of mass media imagery has negatively affected their feelings about childbirth.

The primary emotion I recall from media [birth scenes]...is FEAR. I am sure that viewing these births has affected my beliefs, hopes, and fears about

giving birth even though it is not obvious to me how...I just don't see how all the hysteria presented to me my whole life about the dire medical emergency of birth could not have penetrated my beliefs. I'd sure like to break away from all this "bad" emotion...

Student, Boston

I am going to adopt after seeing "The Miracle of Life."

High School Freshman, Hadley MA

Births in "humor sitcoms" seem like they give off happy emotions, while births in dramas are scary, painful, and risky. I think "ER" shows very real like child births. I think that when I see births where the mother get[s] hurt or even dies, I feel frightened about birth.

High School Freshman, Hadley MA

I believe these programs have altered my thoughts on birth because it looks so painful.

High School Freshman, Hadley MA

I remember being younger and being afraid. There is a part of me that has absorbed these ideas and images and I have to fight to get rid of them.

Nanny, Boston

I am afraid that my wife someday will be in a lot of pain and that upsets me.

High School Freshman, Hadley MA

PAINFUL...I would think, from what I've seen, that it would be much too painful for a wimp like me to bear.

High School Freshman, Hadley MA

Some respondents mention mass media's frightening influence on people other than themselves.

The one film that sticks out in my memory was a film shown at the Museum of Science to a class of 5th graders that my daughter attended and I chaperoned. It was a black and white film about 15 years old and quite blunt and unemotional. What was fascinating was that all the girls started to squirm in their seats, and at the end, they all swore they were not having any children.

Student, Boston

I know most of my friends, especially males, think that these "typical" chaos birth scenes [are] how it has to be.

Nanny, Boston

I can't think of a specific scene in a film, but I believe that every "birth" I've seen in movies and on television was simply incredibly painful. I've watched women yelling and screaming in agony...until quite recently I thought of birth as a dangerous, medical procedure. I have a friend who has considered asking another woman to carry her child because she's so terrified of the birthing process.

Student, Boston

Some respondents are aware that media imagery has the power to influence them both positively *and* negatively. Some describe an evolution from fear to courage, all within a context of consumption of imagery.

I am so glad I didn't see "ER" [the Emmy-award winning episode in which the mother died] while I was pregnant (I was at the time). I would have gone into premature labor (by about 10 weeks!!) with sheer panic! I loved "Dr. Quinn [Medicine Woman]." She makes me (and hopefully other women) feel very capable!...We can do this...expect the unexpected...STRENGTH and POWER.

Manager/Mother, Northampton MA

"ER" -- baby lives, mother dies -- I felt empty and so did the father. Yet happy the baby made it. Struggle ahead. Always on TV -- birth happen[s] so fast.

You can't squeeze a 12-72 hour labor into a 1-2 hour show. Videos of actual births and laboring were much more informative and fulfilling. Since I've started watching more birth experiences away from the mass media (real videos not doctored for TV), it has become less scary and even seems somehow possible. I used to feel scared and could not imagine being stretched in two. But, like I said, this is changing.

Research Assistant, Boston

"Miracle of Life" -- viewed in a classroom setting...I felt it was so beautiful and the majority of the students, having contact only through sitcom expression of birth, tended to disagree. I watched the amazing experience as if in a vacuum, isolated from the jeering and foul remarks. Any TV portrayal I had seen aside from that experience was not at all in documentary form and emanated pain and fear as the primary emotions. I was positive screaming and hysterics had to be a part of birth. I have since disregarded any stereotypical portrayal of birth and have been since that moment fascinated by that miracle of bringing a soul into the world. I do believe media affects the general mood of public opinion toward the subject as many are otherwise ignorant.

Student/Aspiring Midwife, Boston

It made birth seem hard but worth it.

High School Freshman, Hadley MA

Most of the fictional births portray pain. Real births on TV portray discomfort, then joy. I feel very privileged [to be female?] *and I can't wait because there's always a sense of pure joy after the birth.*

High School Freshman, Hadley MA

Keiko on "Star Trek..." she was angry with men during the birth, strong, capable. That's the only one I recall. I try to avoid the mass media...I am disturbed by the thought of the births I don't remember seeing being in my subconscious...[and] the state TV induces of not paying attention but letting images percolate in until they show up in your dreams...thus, I don't own a TV any more.

Abortion Counselor, Boston

[Media birth scenes] definitely added a great element of fear and unpredictability...In watching the video...of the actual birth, it was so much more emotional, awe-inspiring, and moving than any other birth I've seen...all of which were drama "births" -- I need to see more actual births.

Jeweler/Mother-to-be, Northampton MA

Some respondents (though these are a minority in this survey) describe their experiences with media portrayal of birth as reassuring.

Documentaries of real births -- revealing -- descriptive -- detailed explanations accompanying the viewings -- They showed the beauty and natural process even through the sterile environment. Made me eager to have this experience myself -- also made me realize that I'd have to ask loud and clear for my preferences to be heard and heeded.

Waldorf School Teacher, Boston

There was an excellent birth on "30something" when "Gary's" partner gave birth, naturally, with no complications, and fairly realistically. It was inspirational.

Childbirth Educator, Long Island

Several respondents describe "neutralizing forces" in their lives as canceling out any effects from media consumption. Such forces may include direct experience of giving birth, experience witnessing birth, stories about birth from friends or relatives, academic study of birth, or skepticism about the mass media in general.

Before I had my own children [media birth scenes] made me feel very scared about the birth process. I always knew I could do it but I was extremely scared of the pain.

Childbirth Educator, Long Island

Horror -- PAIN ... terror!! It [affected me] before I had my first [child]. I thought all births were like TV. I feared my birth more than anything else I'd ever feared in my life.

Childbirth Educator, Northampton MA

Pain, happiness, joy, anxiousness...mostly the mother yelling to get the baby out of her and that it hurts. Sometimes...a mother dies. Seeing births on TV...didn't change anything [for me]. What changes my ideas is my mother's words.

High School Freshman, Hadley MA

The births were really panicky. The families (husbands) always get really panicked and run around a lot. The mothers (once in the hospital bed) go through a lot of pain and screaming. They ask for drugs. I have seen and heard a lot about real birth. But before I didn't want to have children because I was afraid of the pain.

High School Freshman, Hadley MA

The birth is not the thing that changed my views [about becoming a parent?], *it was the children.*

High School Freshman, Hadley MA

"ER" birth -- fear, excitement, triumphant Doctor, ingratiating mother, lots of pressure on mom (Push!)..."Roseanne" -- Jackie's birth, I only remember her yelling for her epidural...These births were more recent than my history of positive homebirths so they have not affected me all that much except to

make me feel isolated and misunderstood from the community at large.

Homemaker, Boston

I've seen a lot of childbirths on TV...the primary emotion[s were] pain and excitement...the best was a c-section on the Learning Channel. I've seen 4 childbirths in real life. For one of those I was a coach. I've seen two girls be born vaginally and twin boys c-section and I coached my best friend through a breech baby girl. I think childbirth will be painful but I would still have kids, and naturally.

High School Freshman, Hadley MA

It's just entertainment.

High School Freshman, Hadley MA

It is just TV.

High School Freshman, Hadley MA

Through education the mysteries have been allayed -- yet thru no help of mainstream TV.

Midwifery Student, Boston

Some respondents, with strong neutralizing forces in their lives, are annoyed or amused by unrealistic portrayals of childbirth.

[Media birth scenes] were fast, rushed, painful, out of control. They either took place in cars or strange places, or in the hospital. They all seem to happen quickly and are never "messy." And despite the short labor and delivery, all the conversations about birth are "I labored for 52 hours with you..." Emphasis on pain and suffering. Before I studied midwifery or actual[ly] had my daughter, and before I talked to real women who had given birth, the births in the media seemed "normal." Now I have read so much, been to births, and given birth, that they seem comical to me.

Mother, Boston

It bothers me that birth isn't being given an honest look -- TV doesn't have enough time for an honest picture of birth. Birth is such an important and common event, why don't more people know how it really happens, or protest against it when it's portrayed inaccurately?

Apprentice Midwife, Boston

I always laugh in disgust at how birth is portrayed -- it is so unrealistic! As if the father could possibly tell the mother how to "breathe" --ugh! No wonder so many women say they swore at their hubbies during labor -- I would too, if he tried to tell me how to act when I am perfectly capable of doing it myself!

Mother, Boston

One respondent expresses discontent with the mass media's capacity to foster unrealistic expectations.

No, [media birth scenes don't affect me,] but some people around me... especially those who haven't had children...expect me to suddenly be in labor and that the baby will be a Gerber baby.

Teacher/Mother-to-be, Northampton MA

Another respondent has, through time, reconsidered the patriarchal assumptions underlying many media portrayals of birth.

Just recently I saw a birth on "Petticoat Junction" where the whole family was waiting in the waiting room while the mom was delivering in the delivery room. Finally the nurse with her little cap on came out and announced the birth. Father went in and mom was all fixed up pretty like she just had a wonderful night's sleep. The nurse brought the baby in wrapped in a blanket. The doctor beams, "Didn't I do a good job?" "Yes, Doctor, you did," was the response. I was repulsed by this show and realized that I must have watched shows similar to that portraying the doctor as the one who "delivered" -- rather than assisted the birth, and as a youngster I probably thought it was just a normal birth. I'm glad I know different now! And the most ironic thing is that prior to the birth, the mother was portrayed as a very self-reliant individual.

Mother/Aspiring Midwife, Boston

Yet another respondent demonstrated awareness that there is sometimes a backlash against the natural childbirth movement in media portrayals of birth.

Recently, an episode of "ER" showed a birth ending in the mother's death. It started with the parents saying they wanted "natural childbirth." So of course

they were punished for their hopes. The primary emotion was crisis and danger.

Childbirth Educator, Long Island

And one young father expressed his dismay that an event as intimate as childbirth was portrayed at all in the mass media.

As much as I am a child of the TV age, I don't view these as reality. I think childbirth should not be dramatized at all...it's too personal. There are some acts or events that shouldn't be viewed on any screen.

Furniture Maker/Father-to-be, Northampton MA

C. Analysis and Commentary

This survey is clearly more useful as an ethnographic source of first-person reports than as a set of hard quantitative data. Despite the inherent weaknesses in its design and implementation, I do believe that this survey has fulfilled its purpose, and that it speaks for itself.

The purpose of this study was simply to ascertain whether media portrayals of childbirth affect people's belief systems about real-life childbirth. That question has been adequately answered. The data suggests that some people are influenced, for better or for worse, by media portrayals of birth. Therefore it is indeed useful to study these media portrayals, to support

media-makers in producing healthier imagery, to teach expectant parents about media literacy, and to offer expectant parents positive imagery that may help offset frightening imagery to which they have been exposed.

The quotes do more, however, than provide a rationale for the media analysis portion of this paper. They suggest that unrealistic portrayals of birth (whether too dangerous or too easy) can make it more difficult for people to prepare for their own birth-giving experiences.

The quotations show how the same viewer's ideas about birth can be influenced in various directions, depending on which programs s/he has been exposed to. Sometimes that viewer's ideas change when they see footage of actual births in addition to the fictional portrayals they had seen earlier.

The quotations even point toward the pro-natal or anti-natal effects of these portrayals: if viewers perceive birth as painful, they may plan not to bear children; if viewers perceive birth as romantic and fulfilling, they may plan their families accordingly.

I am especially interested in the ways that "neutralizing forces" affect viewers' relationships with media imagery. In this study, more people consider themselves unaffected by than affected by media. The mass media are not consumed in a vacuum, and American culture apparently has considerable media savvy (or literacy, or cynicism).

But I suspect that many of those who consider themselves unaffected may simply be unconscious of the effects that movies and television have

had upon them. Adults were more likely than teenagers to identify such effects, suggesting that teens may be vulnerable without having yet developed conceptual distance and insight into the origins of their own belief systems. The quotations above demonstrate that some people have absorbed ideas about birth that they are consciously working to shake off, and thus there is an underlying suggestion that many others have absorbed ideas of which they are not conscious.

Of those who self-reported being affected by movies and television, some were affected deeply. This group might be susceptible to misleading beliefs, hopes, or fears that can affect their own childbearing experiences. In Chapter II, I described ways that fear can influence labor. It is to these vulnerable viewers that I direct the following ideas (Chapter V) for neutralizing the effects of moving-picture imagery.

CHAPTER V

PARTICIPATION IN THE LANGUAGE OF IMAGERY

A. The Truth is Entertaining, Too

There is a wide variety of information and misinformation available in television and movie birth scenes. There are also recurring themes and motifs. Some of these portrayals might affect viewers in helpful ways (i.e. giving them an opportunity to clarify their values pertaining to birth and parenting). Others perpetuate disempowering stereotypes (i.e. mothers who can't handle the normal pain of childbirth, fathers who are incompetent as helpers). Some people, when it is time to give birth, will be affected by having seen these images. Others are less vulnerable to television and movie input, and will maintain conceptual distance from these images.

Chapter III included an assortment of television and movie birth scenes. It described the diversity of characters, situations, and emotions, as well as the homogeneity of certain themes and conventions. It described scenes that might be useful for expectant parents to watch, as well as scenes that might be devastating to a pregnant woman's confidence. It described how birth scenes rarely appear unembellished by plot and character complications.

Chapter IV offered examples of self-reports of the cumulative effects of watching television and movie birth scenes. Taken together, Chapters III and

IV support Peterson's (1991:67) assertions: "We are especially influenced by relatives' stories, particularly if they come from women with whom we identify. Movies and television shows about birth may also teach us emotional attitudes and expectations. When there is no other context in which to learn about childbirth, young girls, in particular, may be susceptible to media messages -- whether of strength and joy or of helplessness and danger. These messages may become a script about birth that is stored in the emotional center of a child's brain. Because birth has been removed from the home and institutionalized, few first-time mothers have any direct experience with childbirth...Unable to gain this knowledge directly, most young girls look to movies or soap operas for the story of childbirth. The film versions of birth carry much greater impact when there is no real, first-hand knowledge available. Unfortunately, normal birth makes a less dramatic script than women delivering unassisted in elevators, dying in childbirth, or enduring rare complications. The message young girls hear is often one of danger, weakness, and fear, rather than strength and empowerment. Even when relatively benign, the media's description of the childbirth process is usually indirect and unrealistic."

Those of us who have given birth in a supportive environment have a hard time imagining any greater drama, comedy, or intensity. Perhaps we are not the only ones who feel that authentic birth scenes can be at least as

fascinating as birth scenes with floods, hijackings, or other gratuitous complexities added on.

Birth is so intense, and so unique among experiences, that no imagery can convey its full reality. But a wider range of images might serve to build confidence in the natural process and in the trusting, respectful relationships that help to improve its physical and emotional outcome.

B. Recommendations to Media Producers

Depending on whether a person has watched a lot of *Chicago Hope* or a lot of *Family Ties,* that person could come to various conclusions about birth. Bearing in mind that some people have no other source of information about childbearing, and are thus vulnerable to misinformation from movies and television, I suggest that producers would do new parents a service if they made some of the following changes:

1. Make birth more central to the story. Refrain from adding crises and other distractions. Emphasize the mother's strength, her partner's love, and a healthy outcome in a greater number of birth scenes.

2. Model maternal behavior that is not victim-oriented. Model care provider behavior that is not rescue-oriented. In other words, show women who labor bravely and well, with sensitive professional support that respects their autonomy.

3. Don't scare the daylights out of pregnant women by depicting birth as a dangerous medical event and care providers as incompetent. Show clear, assertive communication between health care consumers and their care providers.

4. Show a greater variety of upright postures for labor and birth, and don't show the supine or lithotomy positions at all.

5. Continue to increase ethnic, class, and age diversity.

6. Show a wider range of healthy, low, open, unafraid vocalizations. Birth is hard work, and it is unfair to represent it as easy, but it is also unfair to portray so much stress and fear in so many birth scenes.

7. Let more women wear their own clothes, and let more women choose the setting for their birth with greater awareness of alternatives.

8. Stop distorting time so radically! While a handful of births are indeed very fast, most are much slower. A mad rush is seldom needed, and may be dangerous. A mad rush may also adversely affect labor by generating excess tension. Furthermore, the mistaken belief that birth is taking "too long" can lead to unnecessary interventions.

C. Media Literacy and Alternative Imagery

Unfortunately, TV and movie producers are not responsible for making healthy, confidence-inspiring portrayals of birth. For them to do so would be pure public service. It is unlikely that the changes I suggest above will be

implemented in Hollywood in my lifetime. After all, the industry rewarded that ghastly maternal-death episode of *E.R.* with an Emmy! But there are steps that expectant parents, childbirth educators, teachers, and care providers can take to help balance out television and movie stereotypes.

First, there is the cultivation of media literacy skills (as described in Chapter I), helping viewers to becoming more discerning. If *print* literacy consists of reading with comprehension, reading critically, and writing coherently and persuasively, *media* literacy could be said to consist of reading media "texts" with comprehension, reading these texts critically, and producing media of one's own. Literacy has long been valued as an essential prerequisite to participation in democracy. But today, we are so saturated with audiovisual imagery that we must be at least as literate about the moving-picture mass media as we are about the printed word.

Second, images of normal, actual childbirth are available. Many childbirth educators use slides[47] with music, or videos of normal births, to infuse their classes with a feeling of confidence in the natural process.[48] As some of the quotes in Chapter IV made clear, this can help to replace fearful feelings with hopeful ones. Peterson (1981:98) believes that slides provide an "opportunity for hypnotic effect...The visual sense is totally occupied, creating the kind of trance state familiar to movie and television viewers who

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[47] Artemis Productions offers excellent slide sets by Harriette Hartigan.
[48] Such films include *Under Her Own Steam, Special Delivery, Miracle of Life, Birth in the Squatting Position, Gentle Birth Choices,* Injoy Video Library's *Birth Stories, and Five Women, Five Births.*

are unwilling to tear their gaze from the screen for any other environmental stimulus." (Some expectant parents like to rent videos of comedic or dramatic movies about childbirth. Some of these are confidence-inspiring; most are not.[49])

Third, education about childbirth eases that debilitating dread, fear of the unknown. Also, education enables parents to make good choices that can empower them and maximize their chances of having the kind of birth they want. It can help them to choose care providers who can help to restore authoritative knowledge to the mother and family (as described in Chapter II).

Women have created new metaphors for birth that institutions would probably not have generated. Martin (1992[1987]:156-159) lists many such metaphors: surfing, channeling life force, energy rushes, dancing in rhythm and unity, surrendering willingly to the new life, making a journey, running a marathon, climbing a mountain, swimming, skiing, being part of the river of life, an "intimate husband/wife love encounter." She asserts that "key metaphors can buttress existing organizations of experience and practice or show the way to new ones...if birthing is a profound, heightened experience

[49] Steve Martin's *Parenthood* is worth seeing. The birth scene is short but sweet, and the whole movie deals with all sorts of parenting issues, not all of them sugar-coated. *Nine Months,* which focuses on a man wrestling with his ambivalence about fatherhood, is good for a laugh, but not so good as a role model.The climax features two simultaneous births, complete with an inexperienced doctor (Robin Williams!), a huge fight scene, galloping music, inappropriate use of a video camera, foul language, and other cinematic flourishes. I do *not* recommend *She's Having A Baby.* It's got a whiny father and a scary birth scene -- and those are the good parts.

involving deep (often ecstatic) feelings and perception of powerful forces in the world, we would *want* the experience, period."

Expectant parents need to become active participants in the language of imagery. They need to create their own metaphors. They need to find a sense of humor about the absurd things they've seen portrayed. They need to know that they have many choices, both as individuals and as members of a culture.

APPENDIX

SCRIPT FOR PUBLIC LECTURE/VIDEO PRESENTATION

Acknowledgements:

John Harvi, video editing

Harriette Hartigan, photography

JoEllen Cameron, original music

-- Show ER (alien pregnancy) and PAUSE --

When you're having a baby on TV or in the movies, anything can happen. You might be...pregnant by aliens. You might be positively transformed by giving birth...or die. You might be powerful and dignified...or make a fool of yourself. You might have an ordinary birth...or dilate all 10 cm in 3 minutes...or have an emergency cesarean. Your teenage son might broadcast your birth video out over the World Wide Web. If you're Roseanne, you might be tripping on Demerol, having colorful visions of Jerry Garcia. You might even be a man. (Did you see Schwartzenegger?)

As a childbirth educator, I've become aware of the fact that my clients absorb lots of information and *mis*information about birth long before they ever become pregnant.

To get a handle on what they're seeing, I systematically studied 62 birth scenes from television and movies. They were pretty randomly selected -- whatever I could rent, borrow, or steal. Most were fiction, about half comedies and half dramas. 4 were real births, 2 were "Rescue 911" reenactments. 1 was a Tylenol commercial.

While there *is* a lot of variety, there are some very strong repeating *patterns*, too. The average mother is a married, white, able-bodied, heterosexual woman in her early 30's. And when she goes into labor...there is *immediate panic*. At the very first sign of labor, there is often a *mad rush* to the hospital. Labor goes...*fast*, even though this is a first-time mother. It has to be -- a sitcom is only 22 minutes long. One of the most popular labor support techniques is frantic face-blotting. [demonstrate]

Real labor can take anywhere from a couple of hours to a few days.

I'd like show you an *unusual* TV birth, from "Miracle of Life." It's a real birth, but with romantic music added. Time *is* distorted insofar as we don't see the many hours of labor that came before the actual birth, but the pace of the birth scene itself is relatively true to life.

-- Show Miracle of Life (birth scene) --

By the way, in addition to studying the 62 birth scenes, I've also done surveys about the effects of watching a lifetime's worth of TV and movie birth scenes. Sometimes two people watching the same scene respond quite differently. One pregnant viewer found that "Miracle of Life" eased her fears. *In watching the video...of the actual birth, it was so much more emotional, awe-inspiring, and moving than any other birth I've seen...all of which were drama "births" -- I need to see more actual births.* But a teenager viewing the same thing said, *I am going to adopt after seeing "The Miracle of Life."*

So that was a fairly realistic pace. By way of contrast, here are two examples of the common "Mad Rush Motif."

-- Show Fatherhood & Nine Months (mad rushes) & PAUSE --

In addition to distorting time, most media birth scenes emphasize *fear* and *chaos.* One viewer said, *[Media birth scenes are] fast, rushed, painful, out of control.* The producers seem to think they have to add crises -- or else you might not stay tuned past the next commercial.

Maybe the baby's in distress. Or the OB wing is flooded. The baby's father can't get to the hospital on time because he's just been hijacked to Arizona. Or he's *there*, but he's ambivalent about fatherhood. The baby's born prematurely on an airliner somewhere over Texas. Or the doctors are having a power struggle. The mother's been kidnapped. Or the baby's father and the mother's lesbian-life-partner get locked in a broom closet together during an argument. Sometimes, the baby's father faints on the floor.

The media's not making this stuff up -- women *do* punch their partners sometimes, some *do* have very fast labors, some *do* require emergency care. But you'd never know from watching TV that *normal* labor is just a lot of slow hard work. It's a problem of *emphasis* -- they *have* to make it superexciting, because their job is to deliver audiences to advertisers -- TV is an audience delivery system, not a childbirth education program.

In my audience research, a significant number of people reported that they'd come to associate fear with childbirth. For example, a college student said, *The primary emotion I recall from media [birth scenes]...is FEAR. I am sure that viewing these births has affected my beliefs, hopes, and fears about giving birth even though it is not obvious to me how...I just don't see how all the hysteria presented to me my whole life about the dire medical emergency of birth could not have penetrated my beliefs. I'd sure like to break away from*

*all this "bad" emotion...*Another student described the cumulative effects of a lifetime of viewing like this: *I can't think of a specific scene in a film, but I believe that every "birth" I've seen in movies and on television was simply incredibly painful. I've watched women yelling and screaming in agony...until quite recently I thought of birth as a dangerous, medical procedure. I have a friend who has considered asking another woman to carry her child because she's so terrified of the birthing process.*

Speaking of pain, here are two clips. The first shows Murphy Brown, America's liberated mom who can anchor the news and stand up to Dan Quayle. But she can't trust her own body; she's laboring in wilted misery and wishing to die. The second clip is just a small sample of that devastating episode of ER where the mother actually *does* die after a highly improbable series of medical mistakes. That show had midwives' and doctors' phones ringing off the hooks, because pregnant women were traumatized. I suspect it left them unable to trust their own bodies OR their doctors' skills.

-- Show Murphy Brown (miserable scene) --

-- Show ER: Love's Labor Lost (death scene) and PAUSE --

Midwives and doctors found that episode terribly unrealistic. But a teenager in my study was more vulnerable: *I think "ER" shows very real like child*

births. I think that when I see births where the mother get[s] hurt or even dies, I feel frightened about birth.

A mother said, *I am so glad I didn't see [that episode of] "ER" while I was pregnant (I was at the time). I would have gone into premature labor (by about 10 weeks!!) with sheer panic!*

A childbirth educator from New York spotted an example of cultural backlash against natural childbirth: *Recently, an episode of "ER" showed a birth ending in the mother's death. It started with the parents saying they wanted "natural childbirth." So of course they were punished for their hopes. The primary emotion was crisis and danger.*

In real life, fear in labor causes tension, which increases pain, which causes more fear. (We can break this cycle with physical relaxation and information that alleviates fear.) Furthermore, women who are very frightened are more vulnerable to complications and unnecessary interventions. It's like you've got nine months to get ready to swim, and the only thing you've seen about swimming is *Jaws.*

Obviously, I'm a specimen of a subculture that idealizes and promotes natural childbirth. But that *doesn't* mean I think women should have limited

choices. I don't believe that there's a right way or a wrong way to have a baby. I have no problem with people making *informed* choices to use drugs or even major interventions like cesarean section.

But over and over, I *have* seen a lot of women who just wish they'd given it *more thought*. They wish they'd known that alternatives existed, and they wish they'd made more careful decisions that weren't based so much on what they'd absorbed from movies and TV.

So I try to help people with these fears 3 ways. First, I try to help them to view the media with more discrimination. (There's a whole field called "media literacy.") Second, I try to offer them some nice calm imagery that emphasizes women's competence and power. (I'll show you an example later on.) Third, I suggest that they write to Hollywood executives and try to change TV and movie portrayal of birth -- but I'm not holding my breath. That maternal-death episode of ER that we just looked at won an Emmy -- that's what the industry rewards and values.

Here's a nice normal birth with the voiceover reminding us -- gratuitously -- that it's really very dangerous.

-- Show The Mystery of Birth (voiceover) and PAUSE --

Like that one, most TV and movie births take place in the hospital. The doctor is most likely, but not always, a white man. He's in charge of rescuing the mother, supervising the father, and directing everybody else.

It's been that way for a long time. A midwifery student wrote, *Just recently I saw a [rerun of a] birth on "Petticoat Junction..." The nurse brought the baby in wrapped in a blanket. The doctor beamed, "Didn't I do a good job?" "Yes, Doctor, you did," was the response. I was repulsed by this show and realized that I must have watched shows similar to that portraying the doctor as the one who "delivered" -- rather than assisted the birth, and as a youngster I probably thought it was just a normal birth. I'm glad I know different now! And the most ironic thing is that prior to the birth, the mother was portrayed as a very self-reliant individual.*

So the doctor's in charge, but once the baby's born, you're on your own.

-- Show The Simpsons (the Birth of Bart) and PAUSE --

When the mad rush to the hospital fails, the mother gives birth in a crowded economy car that's stuck in traffic *enroute* to the hospital. Here's the "Car Birth Motif."

-- Show Blossom (car birth) and PAUSE --

I didn't encounter *any* planned home births, but there were several scary *un*planned out-of-hospital births. Like the one where a father delivers a precipitous breech on the living room couch, or the one where everybody's snowed in at a remote cabin with a psychopathic escaped convict in the next room.

My study included a couple of out-of-hospital births in situations where hospitals simply weren't available, like in the olden days.

-- Show Through the River (frontier birth) and PAUSE --

Dr. Quinn is another Wonderwoman of the Old Frontier, tending her husband's broken ankle, trying to rescue their Indian friend -- and her water breaks. She tells her husband -- the one with the broken ankle -- how to handle a problem with the umbilical cord as the baby is being born in the middle of the forest. What a role model..."I guess we have to learn to expect the unexpected!"

There was an *un*planned, last-minute home birth on "Northern Exposure."

-- Show Northern Exposure (home birth) and PAUSE --

That birth scene is popular with natural childbirth advocates, because the mother is upright, and making realistic noises, and there's a lot of love and support. So what if they forgot the umbilical cord? Oh well.

Of the 62 births I analyzed, there were a number of requests for anesthesia. A teenager in my survey summed it up accurately: *The births were really panicky. The families (husbands) always get really panicked and run around a lot. The mothers (once in the hospital bed) go through a lot of pain and screaming. They ask for drugs.*

-- Show Nine Months (knock me out!) and PAUSE --

In real life, the natural childbirth movement has been eclipsed by the "epidural epidemic" -- epidural anesthesia is now administered to up to 80% of laboring mothers through a catheter inserted in their backs via a large needle. When the media portray epidurals, they neglect to describe the risks of more than 20 documented possible side effects for mother and baby, ranging from nausea to cardiac arrest.

Carol on Step by Step was coping fairly well with her labor and asking for support, but she got talked into an epidural by *other* people who couldn't tolerate her pain. Notice how the laugh track is used.

-- Show Step by Step (talked into epidural)--

...and that's her 4th baby! Here's another pop culture commentary on epidural anesthesia.

-- Show Rosanne: Jackie (fork scene) and PAUSE --

What if screenwriters chose a different metaphor for that very normal moment in labor when the woman feels she can't go on? What if, instead of "give me drugs" or "kill me now," the woman used an inner strength metaphor, like "hitting the wall" like a runner, or "getting over the hump"? What if she cried, or took a bath, prayed for strength, smooched with her sweetie, or laughed? In another ER birth, the mother belted out "Blackbird" while pushing. It was kind of a joke on a New Age coping method, but by golly she was having that baby *her* way.

Typical vocalizations include screams and hollers, grunts and groans. The mother might be dignified, confident, angry, nasty, scared, silly, submissive,

or unconscious. (On Chicago Hope one mom is literally brain dead -- absent.)

This woman is dignified and feeling *no* pain, but that's because she's giving birth to a mysterious alien.

-- Show Star Trek (birth scene) --

But most women's responses are portrayed as somewhat less dignified on TV and in the movies.

-- Show Home Court (reaction to birth video) and PAUSE --

The laboring mother's husband or partner may be present, absent, or dramatically late. In two of the scenes I studied, the partner is the mother's loving and committed lesbian spouse. (Not because TV is cutting-edge progressive, but because a little controversy boosts ratings.)

I think it's unfortunate that husbands, lovers, friends, and other labor partners are often portrayed as buffoons. Some are helpful and loving, but often, they have enormous problems of their own that keep them from providing effective labor support.

I counted 18 birth scenes in which laboring women made verbal or physical *attacks* on men. That's 29% of the scenes I studied. We're talking female violence against men. Murphy Brown grabs two men by their neckties, Carol on Step by Step threatens an instant vasectomy. (You'll see that scene in a minute, and it's a little confusing because it's from earlier in the show than the clip I showed you earlier. Sorry.)

Some partners are helpful, some are not. Here are some things that menfolk are doing during labor, or having done *to* them.

-- Show Family Ties (comforting),
Roseanne: Jackie (arriving late),
Murphy Brown (trying to understand),
Nine Months (verbal abuse),
Murphy Brown (getting strangled by their neckties),
Blossom (getting hijacked),
Roseanne: Jackie (fainting),
Full House (getting appendicitis),
Step by Step (being threatened w/ on-the-spot vasectomy),
Nine Months (fistfighting) --

Somtimes the man avoids all this by giving birth himself.

-- Show Alien Nation (male alien birth scene)

and Junior (Arnold birth scene) and PAUSE --

So what? So what if media birth scenes are about panic, fear, dependence on institutions, and rescuing women from their own bodies? It matters because some people, especially people who don't have other sources of information about birth, adopt fearful beliefs that can affect their health care decisions and even their physiological response to labor.

But it's important to point out that not every viewer responds that way. Some viewers adopt positive views about birth as a result of their media consumption. One respondent wrote, *There was an excellent birth on "30something" when "Gary's" partner gave birth, naturally, with no complications, and fairly realistically. It was inspirational.* Another wrote, *I loved "Dr. Quinn." She makes me (and hopefully other women) feel very capable!...We can do this... STRENGTH and POWER.*

And then a lot of people claim to be unaffected. Some are skeptical about mass media in general: *It's just entertainment,* said one teenager in my study. *It is just TV,* said another. And some are aware that something in their own experience has made them more immune to media influences. For example, one woman wrote, *Before I studied midwifery or actual[ly] had my daughter, and before I talked to real women who had given birth, the births in*

the media seemed "normal." Now I have read so much, been to births, and given birth, that they seem comical to me.

And one father-to-be in my study thought birth shouldn't be portrayed at all: *As much as I am a child of the TV age, I don't view these as reality. I think childbirth should not be dramatized at all...it's too personal. There are some acts or events that shouldn't be viewed on any screen.*

But birth *is* portrayed, increasingly so, and especially during Sweeps Week. Television and movies *reflect* who we are as a culture, but they also help to *shape* who we are. Birth is a stage upon which competing mythologies are played out, and these mythologies have spiritual, emotional, and *medical* consequences.

Anthropologist Robbie Davis-Floyd describes a spectrum. On one end of the spectrum, *technocratic* birth routinely includes machines and procedures, and the institution is in control. 22% of American babies are born by cesarean section (compared to 7% in the Netherlands, where the infant survival rate is 10% better than ours). Davis-Floyd describes cesarean birth as the ultimate triumph of science over nature. On the other end of the spectrum, she describes *wholistic* birth, which is woman-centered and

woman-controlled. Mind and body are one, mother and baby are one, spirit and emotion are central, and technology is reserved for true emergencies.

Most TV and movie birth scenes portray the dominant, *technocratic* model. But Monty Python doesn't want us to take that model too seriously.

And now for something completely different...a *lampoon* of technocratic birth.

Show The Meaning of Life (ping machine) and PAUSE --

They go on to separate the baby from the mother, and tell the mother that she may experience "*irrational*" depression postpartum.

Nearly all portrayals of birth culminate in a bonding scene, which is typically very sweet, no matter how chaotic the birth was. We'll see some more of Northern Exposure, in which the birth is celebrated with the whole neighborhood. Then we'll see Murphy Brown, who gets "a little visitor" in a plastic box. Poor Murphy has taken bonding theory to its painful extreme, and she wonders if she's doing it "right." And finally we'll see another clip from Nine Months, in which the baby bonds with the doctor for a little while before his parents get to hold him.

-- Show Northern Exposure (immediate bonding),

Murphy Brown (delayed, tentative bonding),

and Nine Months (baby bonds with doctor first) --

-- (25 seconds of black video) --

Every birth is unique. There's no right way and no wrong way to have a baby. But there are certainly a lot of *different* ways to have babies, and movies and TV only show you a few. I worry that children, teenagers, and young adults are especially vulnerable to this cultural warping of a natural body function, because they don't have any real life experience to compare it to, *and* because they watch so much television.

-- Start showing SLIDES --

* = Change slides

Here's just one example of imagery that might be used to help neutralize media-generated fears.* It's one vision of what hard work it is to have a baby AND how people can deal with it creatively and lovingly.*

-- We see labor that starts slowly, and takes a day or two. The mother moves around freely.*

-- She's powerful, beautiful, brave. She *melts* in her body's own rhythms.*

-- Her partner is tender and devoted. Together, they experiment with ways of coping with the hard work, and the pain.*

-- They are well-informed about their choices. They stay home until labor is well established, or perhaps they give birth in their own home.*

-- The mother acknowledges *herself* as the expert birth-giver, and she chooses a midwife or doctor to provide respectful support.*

Birth is so intense, so challenging, that it doesn't *need* floods or chase scenes.* A new human *being* emerges from a strong woman.* Babies symbolize hope for the future.*

Whatever decisions people make about their *own* births, I hope they're *not* based on what they've seen TV or in the movies.* I hope they'll make satisfying choices based on responsible research...and the realities of the human heart.

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