

# **Medicalised Birthing Discourse in British Columbia: Biopolitics, Resistance, and Affective Subjectivity**

by

**Ryan D. Brown**

M.A. (Sociology), Simon Fraser University, 2013  
B.A. (Hons.), Carleton University, 2006

Thesis Submitted in Partial Fulfillment of the  
Requirements for the Degree of  
Master of Arts

in the  
Department of Sociology and Anthropology  
Faculty of Arts and Social Sciences

© **Ryan David Brown 2013**

**SIMON FRASER UNIVERSITY**

**Fall 2013**

All rights reserved.

However, in accordance with the *Copyright Act of Canada*, this work may be reproduced, without authorization, under the conditions for "Fair Dealing." Therefore, limited reproduction of this work for the purposes of private study, research, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.

# Approval

**Name:** Ryan David Brown

**Degree:** Master of Arts

**Title of Thesis:** *Medicalised Birthing Discourse in British Columbia: Biopolitics, Resistance, and Affective Subjectivity*

**Examining Committee:** **Chair:** Wendy Chan  
Professor  
Department of Sociology and Anthropology

**Jie Yang**  
Senior Supervisor  
Assistant Professor

---

**Cindy Patton**  
Committee Member  
Professor

---

**Nicole Berry**  
External Examiner  
Associate Professor  
Faculty of Health Sciences

---

**Date Defended/Approved:** November 27, 2013

## Partial Copyright Licence



The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the non-exclusive, royalty-free right to include a digital copy of this thesis, project or extended essay[s] and associated supplemental files (“Work”) (title[s] below) in Summit, the Institutional Research Repository at SFU. SFU may also make copies of the Work for purposes of a scholarly or research nature; for users of the SFU Library; or in response to a request from another library, or educational institution, on SFU’s own behalf or for one of its users. Distribution may be in any form.

The author has further agreed that SFU may keep more than one copy of the Work for purposes of back-up and security; and that SFU may, without changing the content, translate, if technically possible, the Work to any medium or format for the purpose of preserving the Work and facilitating the exercise of SFU’s rights under this licence.

It is understood that copying, publication, or public performance of the Work for commercial purposes shall not be allowed without the author’s written permission.

While granting the above uses to SFU, the author retains copyright ownership and moral rights in the Work, and may deal with the copyright in the Work in any way consistent with the terms of this licence, including the right to change the Work for subsequent purposes, including editing and publishing the Work in whole or in part, and licensing the content to other parties as the author may desire.

The author represents and warrants that he/she has the right to grant the rights contained in this licence and that the Work does not, to the best of the author’s knowledge, infringe upon anyone’s copyright. The author has obtained written copyright permission, where required, for the use of any third-party copyrighted material contained in the Work. The author represents and warrants that the Work is his/her own original work and that he/she has not previously assigned or relinquished the rights conferred in this licence.

Simon Fraser University Library  
Burnaby, British Columbia, Canada

revised Fall 2013

## **Abstract**

I analyse medicalised birthing in British Columbia to demonstrate contemporary forms of both biopolitical power and resistance. To this end, I offer an approach in which I define the concept of biopolitical resistance using affective subjectivity, with the aim of showing that in addition to appearing as strategic elements in contemporary forms of power affect may also be used to show that practices of resistance emerge from the creative potentials of subjects themselves. In so doing, I hope to contribute to the literature on biopolitics a detailed account of both discursive and non-discursive types of subject formation by focusing on power not merely as a strategic force or effect from above, but also as an ambiguous, non-discursive potentiality that emerges from below in the feelings and sensations of being alive.

**Keywords:** Biopolitics; affect; resistance; affective subjectivity; childbirth

*To my Nanny and Grandad.*

## **Acknowledgements**

The guidance and encouragement provided by Jie Yang throughout this project, as well as her seemingly never-ending patience, must be acknowledged first and foremost. Thanks should be extended to Cindy Patton for being a part of my thesis committee and for her much appreciated consideration of my work in the field of post-structuralism, and to Nicole Berry for her valued input and participation at my defense.

I would also like to thank my parents, sister, brother, and extended family for their continued love, interest, and support, and to my friends who have helped me always to see through the stress and bewilderment during the last two years. And, last but certainly not least, to Zosia Hortsing who, with her uncanny knack for knowing precisely when I needed a delicious late night baked good or a secretly placed note of support and adoration, is the reason why I was able to do any of this in the first place.

# Table of Contents

Approval.....	ii
Partial Copyright Licence .....	iii
Abstract.....	iv
Dedication.....	v
Acknowledgements.....	vi
Table of Contents.....	vii
<b>Chapter 1. Introduction.....</b>	<b>1</b>
<b>Chapter 2. Power, Knowledge &amp; Affective Subjectivity.....</b>	<b>4</b>
2.1. Agonism in Biopolitical Life: Constraint & Potentiality .....	6
2.2. Affective Bodies, Affective Economies.....	11
2.3. Biopolitics, Affective Subjectivity & Medicalised Birthing Discourse .....	20
<b>Chapter 3. Mothers, Fathers &amp; Medicalised Birthing Discourse .....</b>	<b>29</b>
3.1. The Mother: 'I'm in labour, not that machine.' .....	31
3.1.1. The Objectivisation of the Birthing Body.....	33
3.1.2. Childbirth as Controllable: Consumers in the birthing market .....	38
3.1.3. Stressed Femininity: Mothers as emotional, infantilised & maternal .....	44
Emphasis on emotionality .....	44
Mothers as infantilised.....	47
Maternity as obligation .....	49
3.2. The Father: Labour support teams and biological fatherhood .....	53
3.2.1. Partner Labour Support.....	54
Fathering as immaterial labour.....	54
Emphasis on masculinity.....	57
3.2.2. Risky Bodies.....	61
<b>Chapter 4. Affective Subjectivity in Medicalised Childbirth.....</b>	<b>65</b>
4.1. Affective Entanglements: Trust, friendship & responsibility .....	66
4.1.1. Intimacy: Mothers, fathers & neonates .....	67
4.1.2. Collaboration: Mothers and their practitioners.....	71
4.1.3. Self-Confidence: Birth, parenting, and alternative body-knowledges .....	76
4.2. Communities of Affect: Mobilisations of affective life and novel collectivities .....	84
<b>Chapter 5. Concluding Remarks.....</b>	<b>93</b>
<b>References.....</b>	<b>96</b>

# Chapter 1.

## Introduction

The objective of the following analysis is, at its most basic level, to offer a critique of the methodological and theoretical approaches of contemporary biopolitical research by suggesting a way forward for contemplating practices of resistance as a kind of affective subjectivity. In order to do so my discussion will provide a critical examination of the medicalised processes of so-called 'normal childbirth' in British Columbia as a means for offering a general engagement with foundational claims regarding not only the effects of the strategies and techniques of biopolitical power, but also of the experiences of them by affective subjects as well as how these experiences may form the basis of resistant practices in biopolitical regimes.<sup>1</sup> Moreover, I intend to redress a decline that has been evidenced in social science research that focuses explicitly on the experiences of childbirth and childbirth models, as claimed by Brubaker and Dillaway (2009, p. 45). In this spirit, and in the same sense that Foucault (1990) reminds us that human action is not a natural state which power holds in check or an otherwise obscured domain gradually uncovered by knowledge (p. 105), I will contend that medical approaches to childbirth are not simply the result of a slow uncovering of the objective realities of human reproduction. Rather medicalised childbirth is a name given to a history of practice through which our bodies are brought under specific types of surveillance; through which certain affects are intensified, used, and mitigated; and in which the link

<sup>1</sup> What is important here, and is the basis for considering hospitalised childbirth as a subject worthy of such investigation, is how childbirth events can be understood in terms of their felt impact as well as the institutional edifice under which birthing occurs. That is, childbirth is both an event mired in institutional readiness and protocol and one that is interpreted by subjects themselves, largely as a profoundly life changing affective experience. Thus, as it stands as an object of study, childbirth presents two separate strengths for analysis: first it illustrates an example of institutional authority that has a tremendous impact on and authority over the vast majority of deliveries that occur within Canada (CIHI, 2004); second, the event of childbirth presents a highly charged and profound affective experience for all human beings.



between certain types of control and struggle are strengthened (ibid, p. 106). Practices of medicalised childbirth also offer opportunities for describing not only formations of medical, economic, and political power and subjectivation but the presence of a unique drama and plot, with its own combination of protagonists, events, and denouement (Reed, 2005, p. 162), and so the possibility of discerning not the strategies and effects of power alone, but also the subject's experience of power; to, as Bernauer (1987) has suggested, place the imaginative creativity of the ethical self, which appears to have been exiled to the practice of art, at the centre of thought and action (p. 182).

The discussions below of the theoretical, methodological, and empirical elements of biopolitical analysis demonstrate my attempt to rework the investigations of biopolitical life by considering the uses and re-appropriations of affects and affective subjects as analytically significant not only for understanding how they are made the targets of economic, political, cultural, and social forms of subjectivation, but also as opportunities for recognising the emergence of resistant practice from the feelings and sensations of being alive.<sup>2</sup> That is, I posit as a critical point of departure for discussing biopolitical resistance the experiences of an affective subject who is not only constituted *by* power but also constitutes herself through the feelings and sensations of her everyday life, and so attempt to bridge a gap between, on the one hand, those accounts of subject formation that look only to one's relation to power and, on the other, critical accounts of resistance which permit one to see the subject as an active, creative participant in the production of biopolitical power and knowledge (cf. Henriques et al, 1984; Mahoney & Yngvesson, 1992; Mitchell & Rose, 1982; Murphy, 2012). By placing biopolitics and affect in the same theoretical and methodological approach I will show that it is possible not only to see subject formation as a normalising practice, but also to understand the formation of the subject as an experience of the subject herself; I will demonstrate that

<sup>2</sup> This notion of experience in biopolitical life and its importance to conducting biopolitical research finds its genesis in Foucault's later work, in which biopolitics and the ethical subject are initially formulated. In these works, most notably his volumes on the history of sexuality, he suggests that the ethic of the self (i.e. the aesthetics of the ethical subject) is a recognition of "how human life has been experienced and experiences itself, 'where experience is understood as the correlation between fields of knowledge, types of normativity, and forms of subjectivity in a particular culture'" (Bardon & Josserand, 2011, p. 506). In so doing, Foucault carves out a space that I wish to expand on in this thesis, using the notion of ethical subjectivity as a starting point for a discussion of resistance and of affective subjectivity as a theoretical and empirical basis for discerning how human life is experienced.

structures of power are not simply modes of practice which target and govern the actions of bodies and populations, but are also composed of a layered, tonal multiplicity of relations that is produced through and within the unique and ambiguous potentialities of affective subjectivities.<sup>3</sup> Moreover, the intended contribution of my argument to the field of biopolitical research, both theoretically and methodologically, is a design for an approach in which affect is used not only to demonstrate the practices of subjectivation as they occur in contemporary apparatuses of power, but also to recognise that affect theory may offer a valuable empirical tool for demonstrating the emergence of resistance to political, economic, social, and cultural modes of power; it is to show that one ought to examine the dynamic interplays between discursive and non-discursive modes of practice *and* feeling in order to address more fully the relations of power in biopolitical life.

In the discussion that follows, the second chapter will focus on explaining in greater detail the framework that I envision. To do so I have separated it into three parts: (a) a detailed account for defining biopolitics as I will use it presently; (b) a description of affect theory as well as the main premises advocated in my argument; and (c) a discussion of how I will apply these theoretical, methodological, and empirical claims in an analysis of medicalised birthing. Following the description of this framework, chapter 3 will offer an analysis of medicalised birthing in British Columbia, focusing on the institutionalised strategies and techniques of medicalising power. In chapter 4 I will demonstrate how the experiences of affective subjects during medicalised birthing make possible an empirical discussion of resistance in biopolitical analysis, supposing the importance of non-discursive, experiential potential in both affective subjects and affective communities alike.

<sup>3</sup> Affective subjectivity is not the only way forward in describing and analysing struggle in a Foucaultian framework. What is being suggested here is that affective subjectivity offers a valuable and promising space in which a broader, more thorough discussion of such a concept can be formulated.

## Chapter 2.

### Power, Knowledge & Affective Subjectivity

In the analysis below I will demonstrate the importance of broadening the scope for biopolitical research by extending those methods beyond recognising and examining the strategies, functions, and techniques of discursivity alone, presenting biopolitical life as a dynamic relationship between diverse and potentially oppositional discursive and non-discursive forms of power and subjectivity. Specifically, I attempt to contribute to efforts already emergent in the sociological and anthropological literature which support the increasing incorporation of effervescent and experiential forms of life with descriptions of political, social, and economic practices, and more specifically within biopolitical conceptions of life (cf. Adams, 2009; Anderson, 2009; *ibid*, 2011; Anderson & Harrison, 2006; Deleuze, 2006; Eckerman, 2000; Hardt & Negri, 2004; Murphy, 2012; Oksala, 2004; Pottage, 1998; Prada, 2010<sup>b</sup>; Rúðólfssdóttir, 2000; Scott, 2010; Smart, 1998; Stoler, 2009; Venn, 2009). Moreover, I contend that discursive and non-discursive forms of power ought to be read as suggesting certain types of subject formation and that the dynamic between them, specifically as they are expressed in the experiences of subjects when confronted by power, ought to be central to any analysis of biopolitical life.<sup>4</sup> Strategic forms of institutionalised power therefore appear as significant, multiple forms of attempted constraint on subjects and knowledge, but qualify as merely one element of force in an *agonism* which constitutes the relations of power. That is, the

<sup>4</sup> These subjects' experiences of life will be described herein as a kind of *affective* subjectivity, permitting the analysis to depict resistance through subjectivity as a more potential-filled and creative practice not tied merely to discursivity. Moreover, what this portends is that these relations—i.e. political, social, and economic—should not be seen as top-down infiltrations of power, but as dynamic forms of *interaction* between effects and subjects' experiences of those exercises, supposing that power relations are composed of *intentionality without a preset, supplementary subject* (Hoy, 1987, p. 128). Work which describes efforts to move beyond discursive descriptions by involving the productive impacts of a somatic, corporeal subject can be found elsewhere (cf. Desjarlais & Throop, 2011; Eckerman, 2000; Gil, 1998; Henriques et al, 1984; Jackson, 1983; Lyon, 1995; Massumi, 1993; *ibid*, 2002; *ibid*, n.d.; Ngai, 2005).

subject herself ought to be positioned in these analyses as an experiential, somatic subject whose experiences of power comprise unique and productive expressions of an affective life that emerges as the multiple, layered, and inflected event-ness of everyday life.

In order to qualify this analytical and empirical flexibility, however, such a perspective does not intend to be understood as one through which everything is described as occurring at a single level of experience, as in a phenomenological or humanist framework, but rather as occurring at many levels and as a multitude of events varying in intensity, impact, duration, and productive capacity (Bardon & Josserand, 2011, p. 503). It is an attempt to describe a dynamic arrangement that is linked by always different and mutually-constitutive discursive and non-discursive elements, and in which the self arises as a specific, unique potentiality that experiences and expresses strategic forms of power. Analyses which aim simply to describe these relations in terms of discursively-constituted effects being foisted *onto* ostensibly docile bodies—or, subjects—appear then to flatten explanations of the social, political, cultural, and economic into a general analytic of discursivity (Foucault, 1984, p. 380);<sup>5</sup> each arrangement ought instead to be suggestive of the various arrangements that arise in the continuous interplays of discursivity and non-discursivity, for these are intertwined within networks of relations of power that hinge on the possibilities of subjects' experiences and the potentials that exist therein.

My aim, then, is to explain both the ends toward which the institutional systems of medicalised birthing might be aimed—i.e. the specific fractures which a regime aims to address and do away with (Agamben, 2000, p. 35)—and the forms of resistance that may emerge within the ambiguities and potentialities of affective subjects (Smart, 1998, p. 171). Thus, in the analysis presented in the next chapter I will offer two depictions of medicalised birthing: in the first I will demonstrate how power both realises and works to

<sup>5</sup> The suggestion is not that power is constituted as itself constituting everything else and that, therefore, power is the *only* analytic of merit. Rather it is in keeping with Hoy's evaluation of Foucault's conceptual and methodological positioning: that the intention is not to claim that "power is everything;" rather, the purpose is to look "at social relations with the *purpose* of studying power/knowledge configurations, without claiming that social relations could not be studied under different descriptions for different purposes" (Hoy, 1987, p. 137. Emphasis added).

produce mothers and fathers as medicalised and commodified subjects; in the second I will illustrate the productive effects of affective subjects and communities in order to illustrate the potentialities that occur within mothers' and fathers' experiences of power. As examples of the former, I will show for instance that medicalised birthing discourse involves a gendering discourse in which practices of femininity and masculinity are reproduced as necessary conditions for establishing and enforcing best-practices, and which effectively reinforce gendered binaries of emotionality-rationality, maternity-paternity, and immaturity-maturity. For the latter, I will show that the relationships between partners, between partners and care workers, and the relationships parents have with themselves are suggestive of a potentiality through which creative engagements by subjects not derived *solely* from discursive forms of power become possible.

## 2.1. Agonism in Biopolitical Life: Constraint & Potentiality

The approach I am proposing looks neither to forms of consciousness nor to positions presupposed by ideology, but rather to the specific operations of power and affective subjects as dialogically-productive forces, forces which suppose an agonistic set of relations that involve an ambiguous yet continuous provocation between the diverse forces of constraint and potential.<sup>6</sup> Such a proposition suggests not a denial of agency or action, but rather an emotional, psychological, psychical, and biological awareness of the absurdities of the political and ethical conditions in which subjects are found. My intent is therefore not to do away with the body as an impactful entity, as if to

<sup>6</sup> In terms of resistance, what is discussed in this thesis and references the ethical period of Foucault's work is a recognition of the formation of the subject through an ongoing "*agonism*, a *permanent provocation* to the knowledge, power, and subjectivisations which operate on us;" a subject who gains freedom not through inwardness and nature, but through struggle with and stylisation and adaptation of the abstract as it comes to experience the concrete (Bernauer, 1987, p. 182). Thus, the use of affective life as a means for examining resistance points to the significance of ambiguity and potentiality in biopolitical theory and analysis.

regard it as a docile materiality that is merely performed upon and manipulated.<sup>7</sup> It is to provide an explanation for the *productivity* of the subject as a materiality, challenging the limitation set on the unintelligibility of bodily experience by analyses that reify the function of the discursive (Oksala, 2004, p. 110); to problematise a firm line being drawn between textuality and the body's ability to know, without going so far as to account for the body as an alternative epistemological starting point. Moreover, taking up this position is to suggest that power does not refer *simply* to authoritarian impositions upon the counter-hegemonic or counter-ideological practices of resistant subjects. Instead power is but an *attempted* investment of a particular mode or modes of living on the interior of the person (Chan, 2000, p.1063) deployed through certain strategies and techniques that judge, condemn, classify, and determine and are enacted within a milieu of social actions (Foucault, 1990, p. 94/99); without, however, endorsing a view of *either* domination or liberation, but rather of potential forms and effects which are mutually-constituted through intricate, dialogical sets of relational experiences (Smart, 1998, p. 171).

The source and defining quality of the agonism that has been described proposes focusing the efforts of social analysis on a central ethico-political dilemma: of determining the *main* dangers with which an analyst or theorist of social life and structure ought to be concerned (Foucault, 1984, p. 343). Proposing the centrality of danger in this way, however, is not to suppose social, economic, and political relations as necessarily violent, prohibitive, or punitive, for they also emerge in the positive forms

<sup>7</sup> The aversion to a phenomenology that is still interested in the analysis of the experience of bodies is explained by Foucault when he states, "In relation to phenomenology, rather than making a somewhat internal description of lived experience, shouldn't one ... instead analyse a number of collective and social experiences? If one wants to describe the composition of [these], what is the social field, what is the group of institutions and practices that must be historically analysed" (Foucault, 2007, p. 131)?

of assertions, permissions, reflections, responses, and rewards.<sup>8</sup> The fields of relations and the formations of subjectivities that are reproduced as indeed the effects of power should be considered *only* as ambiguities and potentialities (cf. Chan, 2000, p. 1062; Dreyfus et al, 1982, p. 220; Eckerman, 1997, p. 167)—or, what Adams (2009) has described as *regimes of anticipation*—and so the effects of discursivity and non-discursivity each constitutes a force in the multiplicity of the relations of power and supposes a definition of power's effects as ambiguous, potential-filled sets of possible relations (Smart, 1998, p. 170; Venn, 2007, p. 111; Venn & Terranova, 2009, p. 3). Whatever is considered to be its bases (i.e. political, social, economic forms of power, and so on), analyses of biopolitical life ought then to focus on complex, dynamic, and unstable exchanges of force and energy between subjects and modes of power. In this way, discourse appears not merely as an instrument and effect of power, but also a potential hindrance insofar as it is a basis for the possibility of resistance and strategies of opposition (Foucault, 1990, p. 100). It forms a basis for resistance and opposition in the sense that the constitution of constraint presupposes a potential excess of power that is always emergent in the subject's experience. Analytic effort, moreover, should not aim to divide the good from the bad or the accepted from the excluded, as if attempting to understand the social as merely sets of productive and objective binaries, but rather locate in the complex exercises of power a multiplicity of possible subjects, practices, and relations (ibid). In order to properly recognize this complexity within the potentialities of biopolitical life I propose finding within political, social, and economic practices, almost despite all effort to produce singularity and docility, the ways that “we can communicate with others only through what in us—as much as in others—has remained potential” (Agamben, 2000, p. 10); the field of possibilities ought to be regarded as an anticipated virtuality and the strategies of power, once specified, as

<sup>8</sup> While some interpretations may regard the concept of biopolitics as involving a form of *power over*, and so refer to biopolitical authority as inclined to the negative effects of violence, prohibition, and so on, what I envision here is instead akin to what Patton has referred to as a *freedom to*—i.e. a possibility for deconstructing the humanist grammar that appears so integral to biopolitics and the *structures of recognition* that constitute the limitations of subjectivity (Chan, 2000, p. 1066). The notion of a *freedom to* offers an account of biopolitical resistance that extends beyond the confines of discursivity, wherein each force—i.e. power and resistance—constitutes both the limit to and point of possible reversal for the other (Dreyfus et al, 1982, p. 225), and so the forces of power and resistance are more closely associated with *regimes of anticipation* (Adams et al, 2009, p. 249); or, as I will discuss them here, as relations of ambiguity and potentiality.

invoking the essence of potentiality almost despite themselves, for they engage with the unique expressions of bodily experience that exist beneath the recognition of immediate forms of life. Resistance is therefore not simply a negation of discursive practice, but is rather that which is constituted through one's feeling and sensation when confronted by the uniqueness of an event and the subject's experience within it.

Within this assertion is an *economy* of the body's vitality, which is arranged as a kind of apparatus that makes strategic use of affective bodies and affective spaces. In the analysis below, I will highlight, for instance, the ways that within a marketised, autonomised, and responsabilised medical birthing apparatus the strategies of contemporary biopolitics invest in the feelings and sensations of the birthing experience and produce subjects so that they take up the efforts of a particular consumptive bio-economy, properly and safely, and to do so by gaining access to a range of accepted services and products, directives for proper conduct and behaviour, and a system of surveillance for ensuring success (Rose, 2007, p. 4). Patient-clients and their supporters are, for instance, reproduced as consumers of a birthing industry; as investigators who are responsabilised as advocates for both personal and population health; and, as protectors of and investors in the bio-security of themselves, their offspring, and their surrounding community (Braun, 2007, p. 8—11). The body appears as a liminally-productive materiality, as it is made into that through which specific forms of social belonging and political collectivisation may arise, and so it becomes possible to discuss the innateness of human behaviour and connectedness and of the re-appropriation of the body as not simply a conditioning of individuated practices, but also a determination and expression of social relations (Santoro, 2011, p. 76).

However, and this in many ways is the crux of my intentions in chapter 4, the experiences of subjects also provide a way to understand the practices of medical birthing as something which occurs in excess of these normalising models (Randall & Munro, 2010, p. 1498) and it is in this space that affect theory, with its suggestions of bodily experiences, constitutions, and interactivities permits the exploration of the productive effects of resistance according to the potentialities of affective subjects: in the collaborative engagements between patients and carers, which may result in the realisation of the overlooked potential that arises in sensations and feelings of co-enacted and co-operative relationships; in the intimacy shared between partners that



involves a specific and unique bodily experience of becoming a parent and of being a partner, both of which may exceed the functions and strategies which aim to economise, monitor, and control bodies' vitalities (cf. Cvetkovich, 2003). What is necessary is a way to conceptualise whatever possible reactions and responses those subjects might have had within the field of relations, for, as Rudolfsdottir (2000, p. 341) has evinced, discourse suggests the appearance of "complex and often contradictory images and truths" within which potentialities may become productive. With regards to birthing mothers and their subjection to a constant and detailed identification and problematisation of their bodies and birthing environments by a medicalising discourse, attempts to normalise the body must contend with the subject's recognition of herself and of her body's unique experience—i.e. with the potential-filled composition of *her* sensations and feelings that are drawn from how she as an ethical subject is situated historically (i.e. how she finds and feels herself as a cultural, political, social, and economic subject). Thus, there is virtuality in how ethical subjects experience the possibilities of economic and medicalising forms of subjectivation, and so attempted investments made by discursive forms of power may appear as positive or negative, empowering or marginalising, depending on how the subject feels and senses her way through the relations and environments that surround her and which she herself surrounds. The question, as it pertains to the medicalisation of childbirth, will rely greatly on how subjects experience these normalising forces and what influence this may have on the feelings and sensations of resistance as they arise out of the potentiality of the event; on a re-examination of how we are turned into subjects, one that engages not only with institutional practices, but also with the subject's experience of the functions, objectives, and intensities of subject-forming strategies.

Lastly, how bioethics comes to be situated in medical discourse is a significant aspect of how the framework described thus far may be used in this particular type of analysis, for bioethical practices appear not simply as objects that are applied onto and within life, but are rather acts of social life which both shape and are shaped by relations of power. To think of the settings of institutional power—i.e. of the medicalised birth setting—should not be to see them as they present themselves—i.e. as objects and object-worlds—but rather as scenes or events of potentiality in which subjects are created in the vision of the relations of power *and* in which subjects work on themselves

in relation to power (Frank & Jones, 2003, p. 180). This supposes what Oksala (2004, p. 114) has described as the possible dissolution of the subject, according to which experiences are recognised as potentials for resistance by seeing in the very possibility for transgression an unpredictability not simply in the formation of the subject by power, but also in formation of the event by the subject herself. It is important to clarify that while I have highlighted analytical aims, I do not wish to show that techniques of medicalisation ought to be reduced to binaries—i.e. bad or harmful versus good or beneficial—as I would were I to reduce bioethics and medical practices to mere objects of analysis; rather I only wish to problematise them and insist that the body is a contested realm and not simply a docile form couched within technical/scientific discourses (Cheeks and Porter, 1997, p. 110), and to support the claim that economic, social, and political questions are so intertwined with one another as to make no longer sensible any effort to separate them (Hardt & Negri, 2004, p. 78). Resistance, as indeed a contesting form *of* power, is attributable and necessary to the relations of discursive and non-discursive forms of power, insofar as the latter both incorporates and comes up against an inflective, layered tonality that arises out of the experiences of one's subjectivity;<sup>9</sup> it is circulating composites of potential relations and actions that empower and impel subjects to act both on themselves and on the actions of others. The positioning of the affective subject within biopolitical analysis therefore permits the exploration of an autonomy that is to be found in moments where experience and actuality meet (Massumi, 2002, p. 43) and where potentiality may manifest as constraint.

## **2.2. Affective Bodies, Affective Economies**

While the above marks out the body as a contested realm, what remains to be seen is how I will use the concept of affect to define the body specifically. Affect, though there is no standard definition in the sociological or anthropological literature, tends to be used as a reference for the relationship between bodies, bodies and technologies, or the

<sup>9</sup> The notion of inflective, layered tonality takes its inspiration from Ngai's (2005) discussion of ugly feelings, or negative affects, such as envy or paranoia, which she takes as being especially characteristic of catharsis in contemporary art movements. The notion of tone is used to explore the ways in which objective and subjective feelings come into dialectical relation through the experience of aesthetic encounters (p. 30).

forces of the body and discursive knowledges (cf. Jackson, 1983; Lyon, 1995; Thrift, 2004; Wissinger, 2007, p. 232), constituting relations between subjects and exteriority in terms of a dynamic in which bodies are confronted by or come to realize and respond to subject- and object-worlds. What I envision is this body establishing a pressing potentiality, one which exceeds the absolute overwriting of it by way of a specific, describable history, instead hinging on *surpluses* of unique experiences that move between contexts (cf. Anderson, 2006, p. 748; Papoulias & Callard, 2010, p. 34) and supposes an opportunity to examine the body as a creative materiality.<sup>10</sup> I see the body as neither extracted from history nor a *pre*-discursive individuality, but rather a produced and productive experience of actuality, which encompasses and exfoliates the actual alongside the virtualities of everyday life and the reactive sets of continuously transforming relationships we have with ourselves and the world (Gil, 1998, p. 127); not as singled out, but rather as an always collective experience—whether as the experience of an individual or community (cf. Ahmed, 2004; Massumi, 2002, p. 30—31; Stewart, 2007, p. 4). In this way, the body is situated, expressive, and determining—as materiality, as subject, and as event—through its unique combinations of corporeal and visceral shifts in habit and posture and its sensations and feelings of the subject- and object-worlds through which it can perform and in which it can become disruptive (Anderson, 2006, p. 736).<sup>11</sup>

According to Thrift (2004, p. 59) such a turn to an affective understanding of subjectivity is necessary in current sociological theory, for:

<sup>10</sup> The term ‘pressing potential’ is derived from Massumi’s (2002) depiction of the body, which is useful in underscoring the definition of the body that I wish to propose here: the body’s action and expression should be seen as extending into an incorporeal, yet very real dimension of a pressing potentiality that emerges as simultaneously abstract and concrete (p. 31).

<sup>11</sup> Here, affects will be recognised as bodily ‘feelings and sensations’ of individuals and collectives, encompassing any emotional, neurological, and physiological registers of physical and non-physical or conscious and non-conscious stimuli. The notions of feeling and sensation are significant for they do not limit the scope of analysis to either physiological or psychical references, but rather suggest the presence of both in the virtuality of everyday life: feeling poses the question of affect and experience not only in terms of emotional registers, but also suggests the recognition of an unarticulated presence in life or an aura which hangs over us; sensation on the other hand permits the discussion of physiological changes to external stimuli (i.e. the sensation on the skin, of the eye, etc.). Both feeling and sensation, moreover, offer opportunities to consider their emergence in terms of both individualities and collectives, as each can be simultaneously located in both the individual body and in larger social encounters and movements.

distance from biology is no longer seen as a prime marker ... It has become increasingly evident that the biological constitution of being ... has to be taken into account if performative force is ever to be understood.

Examples of affect research, as a result, reflect forms of communication that operate beyond socio-linguistic systems (cf. Desjarlais & Throop, 2011; Jackson, 1983; Lyon, 1995), and so the theory's essential strength is that it permits the body to be understood, quite rightly, as an indispensable empirical tool for not only comprehending but also for locating as politically, socially, and economically impactful myriad forms of bodily communication and knowledge production. And so, while there are multiple concepts and explanations for what constitutes *affective life* and an ambiguity in determining how we should navigate its conceptual implementation (Thrift, 2007, p. 206), these qualities doubly represent that which characterises the strength of affect theory as an analytical tool, for it is the recognition of possibility and ambiguity which permits an awareness of the body's productive potentiality in the relations of power.<sup>12</sup>

Insofar as the body appears as significantly situated it constitutes a "hinge or threshold" for recognising the simultaneity of interiority and exteriority (Wissinger, 2007, p. 255), establishing a space through which subjectivity can be understood as not simply one-dimensional and totalising, via discursivity: it is a chance to appreciate and give merit to the responses and reactions that occur within one's experience and which exceed the purely exteriorising and articulated effects of strategic forms of discursive power. Moreover, affect and affective subjectivity must be seen as exceeding simply the forces of emotional registers, for the emotional appears as a content-filled and qualified intensity that exists in the totalising image of the actual; it is mediated by the discourse of a culture (Jaggar, 1989, p. 159). Affect, instead, is suggestive of a more flexible form of intensity that exists and circulates in excess of whatever content a subjectively-defined fixity may presume (cf. Anderson, 2009; Gorton, 2007; Massumi, 2002; Ngai, 2005). It occurs always as a movement between actuality and potential, between structure and that which escapes it (Massumi, 2002, p. 30—35), and between the interior of a person and that which remains outside, without resorting simply to producing binaries that may

<sup>12</sup> The claim that supposes ambiguity as significant stands in agreement with Anderson (2009) in that we ought to "learn to offer concepts that are equal to the ambiguity of affective [life]" (p. 78).

distinguish between the divided, independent values of each. The positioning of the body makes such a description of affect different from previous paradigms, which have tended to locate the affective subject as a link *between* culture and biology (Wissinger, 2007), as if each offered an object that is isolated and apparent; it avoids a reductionist model of objectivised natural bodies whereupon external forces are inscribed. Thus, the body is not simply the effect of power, though this undoubtedly still presents significant impacts for formations of subjectivity, but is also a materiality that enfolds, reacts, and responds below and as part of conscious attentions (Grosz, 1995, p. 33—38). What this suggests is that as an analytic of individual and trans-individual life, affect refers to a perception of self-perception and the naming and making conscious the sense that one is alive (Massumi, 2002, p. 36); it is a basis for appreciating the spatiality and event-ness of the self-as-body from which emerge individual and collective states and the feelings and sensations of being alive (Anderson, 2009, p. 78). Sociality is therefore not simply that exchange of strategy and subjectivation which occurs on the surface of the relations of power, but is also an economy of interactive, experiential events that reside between, within, and alongside the agonism between power and resistance.

With such a positioning of the body in the analysis of biopolitical life the economy of bodies again appears as significant, for I am supposing that circulations of specific social, political, and economic practices are productive of affective subjectivities and communities (Hardt, 1999, p. 90), but also that collective and individual experiences of social, political, and economic interactions lead to flows of energies between them and, ultimately, a productive energy drawn from non-discursive forms of subject formation (cf. Richard & Rudnycky, 2009; Wissinger, 2007).<sup>13</sup> These affective economies point to connections and exchanges between an affective body and the circulations of affect in object- and subject-worlds, and so the sites upon which are produced potentialities of object- and subject-worlds (Prada, 2010<sup>a</sup>). These economies act, then, as initial links of human interaction that both exceed and occur simultaneous to strategic investments of professionalization, economisation, politicisation, identification, or pleasure (Prada,

<sup>13</sup> Wissinger (2007, p. 250) argues that, “the concept of affect also encompasses the flows of energies that move in and through bodies, creating surfaces and moving bodies as they pass in and through them .... bodies are treated as spaces of investment afforded some insights in the modularisation of the body that is typical of an affective economy.”

2010<sup>a</sup>). As dynamic sets of relations, they are kinds of relational capacities—or biographies—that are shared with people, beings, places, or environments (cf. Ahmed, 2004; Prada, 2010<sup>a</sup>; Richard & Rudnyckyj, 2009) as well as through which communities of affect may be produced and become productive as always-potentiated collectivities (Santoro, 2011).

Indeed as affects coalesce around specific modes of distribution—as, for instance, in the affective economies of medicalised childbirth—the latter requires a location or network in which to do so.<sup>14</sup> Scholarly observations of these affective *spaces* entail, therefore, a shift from the psychic to the situational; to specific compositions of materialities, performances, and protocols for agency (Tygstrup, 2012, p. 198) and so a focus on the operations and exercises of affective subjects as they experience specific strategies of power, though with the added feature of specifying an always-present dynamism between power and subject by interweaving the social with the personal, the mediated with the affective, the discursive with the non-discursive (Ahmed, 2004, p. 28). Analyses of affective economies and, indeed, of biopolitical regimes ought then to concentrate not simply on a politics encoded above and upon life, but also on social, political, and economic subjectivities produced within materialities of life and in which are borne an “unspecifiable may-come-to-pass:” a life defined by the potential of the economies of interactivity and which encompasses unique and complex combinations of the present and resonances of past and future (Massumi, 1993, p. 11; *ibid*, 2002).

Again, however, while it may seem that my description of affective economies appears to propose an ideological neutrality, I do contend that *contemporary* affective economies—and, particularly in the context of medicalised birthing in British Columbia—are especially linked with Western traditions of neoliberal capitalism, and so with effects of inequality, political economy, and capitalistic rationality (cf. Hardt & Negri, 2004; Rabinow & Rose, 2006; Richard & Rudnyckyj, 2009). Specifically the affective economy of medicalised birthing is circumscribed as that through which birthing and supportive

<sup>14</sup> Richard and Rudnyskyj (2009) have described the development of an affective economy as an analytical tool as being driven by the urge to emphasise the relationality and mobility that is inherent in affect, and a deflection of the fixity and individuation of emotions, sentiments, and feelings. In this way, an economy of affect reflects a milieu in which subjects themselves are enmeshed, circulated, and distributed (p. 73).

bodies and their capacities for productive effects become the site for capital investment and the realisation of profit (Wissinger, 2007, p. 233). Thus, a notion of affective *labour* is rightly related to the production of capital and the pinnacle of capitalism's hierarchical labouring forms (Hardt, 1999, p. 90), for the affective states of birthing and supportive subjects are made targets for neoliberal use, manipulation, and production.<sup>15</sup> Moreover, the specificity of those modes of affective labour being produced are central to the analysis of affect in contemporary medicalised birthing, for neoliberalism appears to reproduce affective bodies with a particular focus of re-appropriating and using circulations of affects for the purpose of realising ever-increasing profits, industrialisation (or *informationalisation*), and market reach. For instance, the structural economic shifts of late capitalism have seen an increased investment in specific affective flows related to childbirth, such as those associated with work in the fields of maternity care, representations of pregnancy, labour, and delivery in popular and instructional media, and the uses of affective subjects (i.e. mothers, fathers, and carers) as labourers in birthing events, as each is specifically re-appropriated and mobilised to engage in different ways with various forms of interaction and productions of affect. The outputs or products of affective labour, such as the care and emotive work that is performed by support persons, are made central to the strategic efforts of power, therefore, for certain energies become targeted, located, re-appropriated, and marketised in very specific ways (Wissinger, 2007, p. 235), as I will show in the following analysis.

Insofar as neoliberal affective economies involve productions of many varied forms of labour and immaterial goods, such as specifically identified relationships or preferable emotional states (Hardt & Negri, 2004, p. 200), their productivity results in the establishment of divisions and categorisations of affective labour according to, for instance, the gendering of reproductive labour or the professionalisation and commodification of birthing support. With regards to the former, economies of feminised

<sup>15</sup> Affective labour refers to the practices of a capitalist market of labouring forms wherein a migration has been witnessed from industrial to service jobs, and in which employment descriptions and responsibilities are predicated on higher levels of mobility and skills-flexibility and a focus on the management of knowledge, information, communication, and affect. Affective labour, in this light, can be regarded as referring to forms of *immaterial labour*, such that immaterial products (i.e. thoughts, feelings, actions, and sensations of workers and consumers) constitute a foundational part of the production process (Hardt, 1999).

labour become reproduced by way of the gendering of medicalised birthing discourse, and so labouring practices, generally referred to as 'kin,' 'caring,' 'maternal,' and 'emotional' labour and which are associated with domestic and human reproductive responsibilities and functions, produce goods which are not limited simply to material products, such as clothing, meals, and clean environments (Hardt & Negri, 2004, p. 110; Ministry of Health, 2010), but also include the circulation and distribution of gendered and commodified affects, relationships, means of communication, and acts of cooperation (cf. Jaggar, 1989; Ministry of Health, 2010). Feminist scholarship on emotion and affect is particularly telling here, insofar as it has long claimed that Western traditions of philosophy and science have not perceived an equality in the emotional lives of people; rather, those in dominant positions—politically, socially, economically, and culturally—are seen as holding privileged positions vis-à-vis the use of reason, whereas those in subordinated groups—predominantly these are people of colour and women—are seen as receiving direction from and even required to express emotionality (Ministry of Health, p. 157). Moreover, these practices come to constitute important aspects of the various social, political, and economic relations in the biopolitical lives of feminised subjects beyond the birthing room, such that the gendering of affective labour—e.g. mother-infant attachments or social and political positioning of gendered bodies—can be recognised as efforts to reproduce the specific functions and responsibilities of child-rearing activities and the reification of other feminised forms of affective labour in the private sector. In so doing, reproductions of gendered forms of emotionality and affectivity “blind us to alternative ways of living” (ibid, p. 159).

That said, and this point of departure is central to the analytical position I am developing, there exists beyond these examples of strategic investment the potential that may be gleaned from experiences of labour and delivery by an affective subject herself. For instance, it is critical for any biopolitical analysis of medicalised birthing to recognise a mother as not merely a docile body upon which investments are made, but instead one through which experiences of the relations of power are given unique tonality and inflection and as a result of which new circulations and distributions of affective subjectivity may be realised. In this way, an affective entanglement occurring at the core of various forms of biopolitical resistance can be seen to come to the fore, insofar as it presupposes multiple discursive and non-discursive constitutions of



subjectivity (Murphy, p. 84): on the one hand, affective subjectivity is made a target of forms of contemporary biopolitical apparatuses that attempt to reproduce and use certain kinds of emotionality, responsibility, rationality, communication, and so on; on the other, affective subjectivity, in sensing and demonstrating the impact of one's relation to oneself, represents the presence of potential counter-conducts insofar as subjects experience those modes of power which aim to actualise whatever limitations of the affective self have been strategically targeted.

While there is some disagreement in the literature regarding the practical application of affective economies, all associated forms assume a paradigm involving co-enactment, co-emergence, and co-evolution, for all are underpinned by entangled, bodily processes in need of a specific analytic and conceptual language (Blackman & Venn, 2010, p. 9). Circulations of affect can be said to describe the dynamic mobility of discursive and non-discursive forms of power and, therefore, represent a possible analogue for the *rhythms* through which biopolitical resistance emerges as an alternative productive form of power (Foucault, 2010, p. 185).<sup>16</sup> Thus, affects in this framework are not so much objects that circulate among subjects, but are rather mediums through which subjects circulate unique experiences and the channel in which such circulations are either enabled or precluded (Richard & Rudnycky, 2009). Affect implores us to recognise that within relations of power is an ever-present potentiality for escape—an autonomy of affect as Massumi (2002, p. 35) has described it—for structured things live not simply in relation to that which is apparent and known, but also in relation to what escapes them (*ibid*); it presses us to focus our attentions on the ways in which subjects find themselves in the midst of an ever-present entanglement between circulations of affect as unique experience and as targets for strategy.

<sup>16</sup> In this conceptual framing, the rhythm of events *is* the feelings or sensations of affective space and time within the unique histories of affective subjects, in which a 'mattering of the body' takes place at the level of conscious subject identity, moving and constituting bodies in their movement through and in this rhythm (Wissinger, 2007, p. 231). To affect or be affected is, again, not purely an emotional experience; it cedes emotions and is a dynamic sociality or social productivity (*ibid*, p. 232) in which the centrality of discourse becomes clear, as it is that which produces the point of emergence and location of social rhythm and through which bodies become engaged as affective.

My argument is that the use of affective subjectivity in this way may permit research to suppose that there must be the possibility for an *always more* layered account; not only of what is said, but also of the *felt* and *sensorial* resonance of the strategies and techniques of power once experienced by the subject or groups of subjects. What this portends is to consider the body not as an origin of a pure, undisturbed intentionality, as if it can provide that independent positioning of nature relative to the textuality of power, but rather as a space within which histories are internalised and registered; it is to accomplish a goal suggested by Haraway not to police the boundaries that allow a separation of nature from culture and culture from nature, but instead to be “edified by the traffic” (Haraway, 1989, p. 377). Moreover, invoking the body in this way is not inappropriate within the broader post-structuralist tradition of which the work I am undertaking is a part: its use is seen in a number of scholarly efforts, perhaps most notably in Bourdieu’s (1977, p. 72) discussions of the *habitus*, Deleuze’s work on *becoming*, and Butler’s (1997, p. 406) work on the effects of history in the body’s performative acts (Ahmed, 2006, p. 552—553). Indeed, the Butlerian position is particularly relevant, as she has worked towards understanding the body as a site through which preferences may be realised; that subjectivity exceeds the specific aims of attempted economic, political, and cultural forms of subjectivation, permitting us to explore through the virtuality of everyday life whatever preference we may have for subject positions that are not suggested or permitted by dominant discourse (Rúðólfsdóttir, 2000, p. 338). Moreover, Deleuze’s repositioning of biopolitics through the perspective of his conceptual work on *becoming* is quite informative as a backdrop to my approach insofar as he has proposed viewing the historical conditions of power as merely sets of preconditions, conditions which may be left behind in order to create and, indeed, become something new (Deleuze, 1995, p. 171).

What is particularly significant is that possibilities for resistance go beyond suggesting the presence simply of an *excess* to power, as if the former were always merely a constituted countenance or opposition to the latter. Resistance is not simply made intelligible in relation to power or as an effort to exceed its constraints and limitations, but is also a creative potential of re-appropriation and exploration and, in that way, should be recognised as a form of power in and of itself. What I imagine is an theoretical and analytical perspective that looks to all possible operations—from

institutional practice through to affective engagement—as a means for recognising the ways in which power, knowledge, and subjectivity occur within complex, interwoven, and productive histories, without predicating such an analysis on preset hierarchical arrangements between them; of both the pronounced statements of discourse and the tonal relations of the non-discursive that can be found in moments of contact between and within the limitations of the effects of power and the potentials of affective subjects. The directive is not a flat consideration of the ways that bodies move and are moved by discourse, but rather a description of the dynamics that emerge in the virtuality of the interplay between the strategies, techniques, and functions of the various modes of power and the felt and sensorial resonances in the experience of everyday life (Oksala, 2004). Thus, in the analysis of chapter 4 I will suppose the productive forces seen in the creative potentialities of intimacies between gendered partners as they engage with the feelings and sensations of becoming parents; of the collaborative efforts between mothers and their care-providers as they experience labour and delivery together; and of the self-referential sensations and feelings of being that may be gained in those experiences that push one’s physiological, psychological, and psychical self to new horizons of understanding and awareness.

### **2.3. Biopolitics, Affective Subjectivity & Medicalised Birthing Discourse**

The strength of affect theory, in terms of its being used in biopolitical analyses, is that it offers an empirical tool for describing how contemporary forms of strategic power might target subjects as well as for explaining the relationship an ethical subject ought to have with the self (Foucault, 1984, p. 353).<sup>17</sup> I intend to use the concept of affective subjectivity laid out above to permit the expression of resistance not simply as a vague conceptual necessity in biopolitics, but rather as a multiplicity of experiential events; as a point of entry for continuing, methodologically and empirically, with the objective of freeing subjugated knowledges from hierarchical orders by describing the productive

<sup>17</sup> In terms of Foucault’s notion of the ethical subject affect theory can be understood as providing a specific analytical device for describing how it is that “the individual is supposed to constitute himself as a moral subject of his actions,” (1984, p. 352) for it allows us to show the productive function of non-discursive elements, such as bodily experience.

force of ambiguity and somatic potentiality (Winch, 2005, p. 180); and of actualising relations of power through not discursive strategy alone but in the flows of energy that arise in the dynamic interplay between it and non-discursive forms of power, and particularly how these relations are expressed as experiences of the subject-as-body.<sup>18</sup> I would like to propose an understanding of the flow of power and subjectivity in terms of grasping not simply the structural influences of political, social, and economic power, but also to define the politics of affective subjects as characterising the aesthetics of biopolitical life.<sup>19</sup> In so doing I wish to move beyond a simplification of the production of power and knowledge that depends on discursively-constituted subject-formation alone by looking to the dynamic that occurs between a diversity of affective subjects, the articulations of whom are constituted according to a “flexibility, mobility, and possibility for self-reference” (Gil, 1998, p. 111). The aesthetic of biopolitics refers then to those qualities of feeling and sensation which are emergent in the everyday experiences of power, suggesting the need to, as Stewart (2007) has suggested, render systems of power as part of a plurality; as so many scenes or events in which force is set upon the capacity to affect and be affected and which inflect everyday life with:

The quality of a continual motion of relations, scenes, contingencies, and emergences ... impulses, sensations, expectations, daydreams, encounters, and habits of relating, in strategies and their failures, in forms of persuasion, contagion, and compulsion, in modes of attention, attachment, and agency, and in public and social worlds of all kinds that catch people up in something that feels like *something* (p. 1—2).

What this work represents is an attempted recognition of the significance of affective life—of the sensations and feelings of tactile, sensorial, psychical, and relational experience—in terms of its entanglement with strategic forms of power playing not only a central but necessary function in the production of power, knowledge, and subjectivity and of the ways in which we come to govern ourselves and the actions of others.

<sup>18</sup> In terms of Foucault’s ethical subjectivity and the necessity of resistance in the relations of power, the flow of non-discursive affective experiences may be described as the continuous flows of “mobile and transitory points of resistance” (Foucault, 1990, p. 96).

<sup>19</sup> Prada (2010<sup>b</sup>) has suggested that explorations of biopolitical life *through* affect are particularly appropriate when the social, political, and economic connections and interrelations between aesthetics and contemporary biopolitics are considered. He concludes that affective politics should in fact be understood as the aesthetics of contemporary biopolitics.

Affective subjectivity offers analytical latitude for addressing the interplay between various permeations of strategic power and individual and collective experiences that are always-already vehicles for creative ethical subjects. Moreover the productivity of affective subjects ought not to be considered as if secondary to the events of medicalised birthing discourse. Instead it occurs simultaneous to distinctions of subject-object or inside-outside and is itself an *immanent plane* (Anderson, 2006, p. 736) upon which the relations of power are played out. The notion of an affective subject, therefore, suggests that bodies and pleasures suppose the efficacy of a material-experiential force that is possibly opposed to the effects of normalisation; it demands an approach which sees the affective subject materialise in power while also recognising that the limits of the body's experience can never be wholly defined, articulated, or constrained (Oksala, 2004, p. 102/114). Moreover, in the interest of analysing medicalised birthing specifically, I will begin with but also expands on Foucault's (1988) claims in his volumes on the history of sexuality regarding the development of a medical discourse and its focus on observation, inquiry, pre-emption, and interference.<sup>20</sup> Therefore, while power invests itself within the body of the mother through, for example, procedural standards, systems of clinical surveillance, and diagnostic and prognostic indicators, all of which work toward making her body wholly and objectively visible under a medicalising gaze, the inclusion of affective subjectivity as an empirical device in service of destabilising any reductive account of the subject also necessitates that we consider the productive effect of visceral and experiential forms of resistance, a claim which may be seen to draw its genesis from biopolitical discussions around ethical subjectivity. In describing the dynamic between the strategies of the regimes of medical care and affective subjectivity, I will focus not *only* on how power invests in its subjects with particular modalities for living, but also on the ways in which these modes may also shed light on the limits, excesses, and potentialities of subjects' experiences—i.e. how these relate to the productive impacts of one's ethical positioning as a subject to oneself.

<sup>20</sup> Foucault has claimed that medicalisation implied a certain awareness and knowledge of the world, one which focused its energies and modes of inquiry on analysing a "whole web of interferences" and the aim of which was the uncovering of expected effects in the body and life of an individual. In so doing, Foucault recognised a rigid re-organisation of life and lived environment and presumed a necessary fragility of the body, a preoccupation which required one's constant attention to oneself, one's state, and whatever acts one performed (1988, p. 101).

And so the use of the affective subject exists as a catalysing factor in analysing what may be called *the art of living* – i.e. the relationship one has with oneself as an experience, “as a thing one both possesses and has before one’s eyes [and to] have a relationship with it that nothing can disturb” (Foucault, 1988, p. 65—66; *ibid*, 1984, p. 351). The affective subject is in this way a productive register through which personal histories, biographies, and experiences of practice and sociality permit explorations and creative engagements with modern medical ideas and modern forms of political association (Santoro, 2011, p. 88) and is suggestive of how medicalising discourse is not independent of and isolated from subjects’ non-discursive experiences, but is instead made recognisable by way of a porous and ambiguous dynamic that occurs continuously between them.

Thus, while discourse may appear as a form of knowledge associated with cultural aspects of sociality that are made determinate and predictable, affective subjectivity represents that which is beyond the specificity and articulation of normalisation and is *known* instead as innumerable felt, sensorial qualities of lived experience.<sup>21</sup> Affective economies, moreover, are not simply new avenues through which strategies of power are invested, though they include these forms of re-appropriation and use, but also demonstrate a dimensionality between the aesthetics of experience and the discursive trans-individuality of networked power. Appreciating the complexity and tonality of biopolitical life through affective subjectivity establishes a much needed creative space and a register for the rhythm of events as they occur. Again, this suggests that while the productions and investments of discourse are seen to take place within the constituted operations of social, political, and economic relations it is nonetheless necessary to appreciate the exercises of power not as so many flatly evident and normalised practices but rather as combinations of discursive and non-discursive life that are both pronounced *and* inflected in their coming about as particular events.

<sup>21</sup> In this way, proponents of using affect theory for pursuing the aesthetics of biopolitics underline its co-constitutive and co-enacting premises, suggesting that trans-individual registers are, in fact, discourse and that the tonality of affective experience can be used to demonstrate its aestheticism (Blackman & Venn, 2010, p. 20).

An element which needs to be considered is what, in this arrangement, is the relation between the affective body as described above and medicalising power? The approach I have proposed thus far envisions the body in its materiality as a visceral, creative subjectivity through which experiences of discursive and non-discursive power take place, and simultaneously as one that is produced as knowledge.<sup>22</sup> The body is therefore situated both as a product of and in opposition to specific forms of strategic power, as a mediator between the non-discursive materiality of lived experience and the effects of power, the result of which is the historical configuration of constantly flowing and transforming subjectivities and relations between subjects and between subjects and objects. Thus the body can be defined as a dynamic of informational transmissions—a trans-individuality through which forces or intensities are exchanged across bodies—and the body’s own “potential ‘infrastructure’” (Gil, 1998, p. 111). As it occupies a positionality within and in opposition to power, the body is no longer simply subjective *or* objective, but rather a material and co-constructed form which combines the two and is both constituted by and constitutive of power’s effects (ibid, p. 125). As a result, the dismembering and disunion of the body through medicalised birthing discourse cannot be seen as just a force thrust down upon and accepted at the ready by a composite of docile individuals below, but is rather a style of thought or modality of living that is reinforced and expressed within particular instantiations of medicalising discourse. While the medical model reproduces gendered and marketised subjectivities, such that binaries of femininity—masculinity and logics of consumerist practice become the basis of targeted efforts “largely guided by the concepts of control, predictability, efficiency, and calculability” (Parrat & Fahy, 2003, p. 16), what are also to be considered are birthing events surrounded by the potentialities of energised and productive affective subjects who may infold those strategies, techniques, and functions within the feelings and sensations of, as the examples I offer below will show, intimacy, collaboration, and self-knowledge. Relations of power are therefore more dynamic than simply discursively-defined practices occurring at a single level of experience; they are multi-layered

<sup>22</sup> As power is productive of the knowledges of organic material—including the bodies of subjects—it extends from this logic, and in the particular context of childbirth, that the bodies of childbirth are produced as knowledge(s). And so, what emerges in a discussion about childbirth and power is not a repressive force, a structure which dominates and demands, but rather one that produces the desires and bodies of birthing subjects as well as a subject’s power to (Foucault, 1980, p. 59).

realities in which circulations of affect “seem to persist as a material/immaterial halo” that remains indistinct but nonetheless actualised in a field of autonomy and interaction (Tygstrup, 2012, p. 201). Thus gender, as a targeted materiality of the subject and of the body as an object, appears as a far more dynamic experience of subjectivity, one which straddles the constraints of discursive strategy and the potentialities of subjects’ experiences, for it is both a form of subjection that emphasises cultural orders (i.e. that one can be gendered in the first place) and a form of subjecthood that emphasises the experiences of those cultural orders and ventures to produce reasons for the emergence of resistant practice (Mahoney & Yngvesson, 1992, p. 44—45).

Furthermore, resistant practices are not necessarily associated with individual actions alone and may also be seen in the formations and practices of novel communities of affect, for affective entanglements circulate throughout environments and produce subjects by way of combined resonances of past, present, and future in the collective experiences of everyday life (Murphy, 2012).<sup>23</sup> Through the impressions that remain as traces of one’s affective life, pronouncements of discourse also come to be confronted by the potentialities of affective subjects, and even reshaped *by* the specific, unique combinations of their experiences, as subjects share and experience together. Moreover, as these experiences find new forms of expression *between* subjects and objects, new ethical practices may be established beyond the specific subjects and collectives in whom they first emerged, resulting in complex and interconnected forms of biopolitical life that are comprised of both strategic forms of power and the collective responses, reactions, and re-appropriations by affective subjects. Such forms of affective community may also become productive in the sense that they can be realised alongside and within “already biopolitically charged subject-positions” (Murphy, 2012, p. 14), and thus resistant as collective affective lives become entangled with broader strategic operations of power. That is, insofar as subjects and strategies are always-already entangled in the normalised relations and affective flows of, for example, sexual

<sup>23</sup> What is seen here is a reiteration of the contribution noted in the introduction, for my analysis bridges a gap remarked upon by feminist scholars, between Lacanian-derived explanations that account for subjects’ acts of resistance in terms of their asocial relation to power, on the one hand, and claims which permit the subject to become an active, creative participant in affirming or rejecting the relations of power, on the other (cf. Henriques et al, 1984; Mahoney & Yngvesson, 1992, p. 45; Mitchell & Rose, 1982; Murphy, 2012).



reproduction, motherhood, fatherhood, partnership, medicalised childbirth, fetal and maternal health, and labour support practice, so too does the formation of affective community find itself situated in similar conditions and perhaps confronted by more broadly-defined forms of power.

Prior to analysing the events of medicalised childbirth through the methodological framework outlined above, two further elements need to be addressed: what are intended in the concepts of *medicalisation* and *medicalised birthing discourse*? The term medicalisation has a long history in the works of medical sociology. It has, for instance, been defined as a confluence of factors: that problems being identified are measured using always technical terms which use precise and accepted professional languages; that all languages and actions are applied under the auspices of specific, adopted frameworks or programmes; and that the uses of these accepted programmes or frameworks are directed toward eliminating or controlling experiences or behaviours defined as problematic or risky, for the purpose of establishing and reinforcing social, physiological, and biological norms (cf. Brubaker & Dillaway, 2009; Conrad, 2007; Riessman, 1983). What emerges in the concept of medicalisation is also a treatment not just of subjects who are operated upon using very specific systems of knowledge, but of subjects who adopt and apply on and for themselves those practices of observation and evaluation that are central to the procedures of contemporary medicine and clinical care. The outcome of this additional inter-subjective component, as Waldby (2006, p. 67) has commented, is the production of a contemporary mode of subjectivity that is based on figurations of personal responsibility, risk assessment, and informed decision-making, marking individuals in the midst of a new kind of *novel collectivity*: subjects are, on the one hand, post-genomic, finding themselves tied to broadening forms of biological lineage, responsibility, and providence; on the other, they are made into neoliberal medical subjects who are now entered into a very specific triadic apparatus of a *thinking subject*, who uses informed decision-making models and medical techniques, a *material subject*, or a body upon whom investments are made, and, lastly, a *commodified subject*, who is circulated and worked upon by economies of market-based mediation in order to impact her every decision-making process via a consumerist rationale (Santoro, 2011, p. 87).

In medicalised birthing discourse in British Columbia, in particular, the mother is not either a consumer of marketed birthing goods and services *or* a medical subject who is corralled by a professionalised class of medical experts; rather, she straddles an intersection of both subjectivating biomedical strategies (Murphy, 2012, p. 70), one which aims to produce a neoliberal subject who is partially freed from an ostensibly impulsive, emotional, and maternally-obligated feminised body, and another which attempts to produce a medicalised subject who functions according to the restrictions of a gendered and objectivised body-as-biological-given. A mother's relation to herself, in this arrangement, becomes a core focus of the non-discursive targets of power, for motherhood is produced as an act of inspection, the aims of which are the evaluation of her body as a piece of work or a task to be accomplished so that she might come to know those legitimated ends and rules of conduct that will enable her to *achieve* motherhood (Foucault, 1988, p. 36).<sup>24</sup> Through the strategic practices of medicalised birthing mothers are asked by their labour support teams to focus their attentions on the ways that they are to become mothers and to establish an ethical practice in order to prepare themselves for it; they are not to become mothers simply through the occurrence of childbirth, as if the events of conception, gestation, and birth were sufficient, but rather must learn to be mothers as through a specific modality of gendered, maternal practice. To support these claims, I will offer in chapter 3 analyses of the strategies of medicalised birthing discourse—specifically as mothers and fathers are targeted as medicalised subjects. In chapter 4, however, I will turn my focus to that of the affective subject's potential for resistance, which will be considered in terms of the felt and sensed qualities of intimacy, collaboration, and self-confidence, as well as by an analysis of affective subjectivity as a communal experience.

My critiques of medicalised birthing in the following chapters are not to be understood as claims that the parameters, guidelines, or media representations of subject- and object-worlds in medicalised birthing are demonstrably unethical or malfeasant, either in aim or general effect, or that medical observation ought not to be responsible for the birth of children. Rather it is to problematise the practices of

<sup>24</sup> For a father, too, he comes to know himself in relation to himself, as an object of inquiry and of improvement and so that he might accomplish fatherhood correctly and in a way that is committed to continuous scrutiny and inspection.

medicalised birthing—i.e. to determine what is the main danger—as so many events through which specific economic, political, and social subjectivities are produced and as instances in the relations of power against and in which the resistances of affective subjects may become possible. The effects of the agonism between medicalising power and affective subjectivities will allow us to appreciate that within these is a reciprocity which makes possible the formation of resistance; of resistant *subjectivities* and *communities* that emerge in and as a result of the fissures and contradictions in the relations of power.<sup>25</sup> In so doing, I propose a more nuanced, dialogical, and aesthetic biopolitics and suggest focusing on the variations in ethical subjectivity which emerge within the multiple events of medicalised childbirth and are not recognisable in or strategically produced by dominant forms of strategic power alone.

<sup>25</sup> These affective communities are also related to C.E. Scott's (2010) *communities of action*, which are those that have been formed around transformations drawn from the potentials of *boundary experiences*, and which may lead to the release from or challenging of various types of domination and the exposure of institutionalised forms of oppression and marginalisation that are obscured by practices of normalisation and social acceptance. Moreover, these types of communities emerge not simply from below but more specifically from experience and are demonstrative of the possibilities for producing new ways of knowing and for problematising social norms; that is, for producing *new* political subjects (ibid, p. 26—30).

## Chapter 3.

### Mothers, Fathers & Medicalised Birthing Discourse

Prior to offering an analysis of medicalised birthing discourse, it is important to first emphasise that the focus below is on circumstances of so-called *normal childbirth*.<sup>26</sup> While Caesarean sections and other interventions are increasing in regularity, the analysis here focuses on birthing events that are typical in contemporary maternity

<sup>26</sup> The Society of Obstetricians and Gynaecologists of Canada (SOGC) have released a specific definition of normal childbirth that distinguishes it from natural childbirth and births that involve certain degrees of intervention. Firstly, they describe normal childbirth as a process that is spontaneous in *onset* (this extends to labour *and* birth). Secondly, the child must be born in the vertex position, and is delivered between the 37<sup>th</sup> and 41<sup>st</sup> gestational week. Once the child is born, the SOGC requires skin-to-skin contact and breastfeeding within one hour of delivery. However, these conditions do not preclude the presence of any-and-all complications or interventions, such as postpartum haemorrhage, perineal trauma and repair, admission to the neonatal intensive care unit (NICU), labour augmentation, the artificial rupturing of membranes (if not part of the medical induction of *labour*), pharmacologic (such as nitrous oxide, opioids, and/or epidural) or non-pharmacologic pain relief, managed third stage labour, and intermittent fetal auscultation. However, if any of the following factors are present, then birth is not considered to be normal: elective induction of labour prior to 41 weeks, spinal analgesia, general anaesthetic, assisted vaginal birth, Caesarean Section, routine episiotomy, continuous electronic fetal monitoring for low risk births, and fetal malpresentation (SOGC, 2008, p. 1163—1164).

wards in British Columbia.<sup>27</sup> Though one of the central focuses for the approach I have developed is to determine the ways that birthing practices may allow me to demonstrate how individuals tend to be confronted by subjectivating forces, I do not mean to offer an exhaustive depiction of every possible relation of political, social, and economic power; rather I aim to provide an illustrative analysis of the central themes that emerge in the contemporary practices of a particular sub-type of medicalised childbirth, with the hopes of permitting a discussion of the manner in which individuals are subjectivated by those strategies. Moreover, while my focus is on those experiences that may emerge in British Columbia, it should be understood that I am not pointing to circumstances that are entirely reducible to British Columbian medicalised birthing alone; rather, my findings are suggestive of a Western experience of medicalised birthing. I should note a second limitation: considered below are two subjects who appear in medicalised birthing discourse—the birthing mother and the biological father—and who tend to be cooperatively involved, statistically speaking, in the majority of medicalised birthing events (CIHI, 2004; *ibid*, 2006). While a number of alternative subject positions, such as non-biological fathers, same-sex parents, or parents of children borne via surrogacy, could be described—and indeed would lend themselves well to this type of analysis—the use of birthing mothers and biological fathers bears sufficient data and ensures a reasonable scope for my purposes. In terms of using mothers and fathers in this way, I intend to suppose neither an essentialisation nor a reification of these subject positions; mothers and fathers are offered for purely analytical purposes and I have no intention of directing the reader’s attention to a standard or generalisable definition of motherhood or fatherhood, for each presupposes a great deal of variation. Thus, while I will focus on

<sup>27</sup> While the research for this paper focuses on birthing events in British Columbia, it may be suggested that the guidelines and standards highlighted here are representational of typical Canadian medicalised birthing environments; and while there are differences across provinces, these appear as only nominal in kind, for guidelines and standards tend to come from national and international agencies, such as the Society of Obstetricians and Gynaecologists, the Canadian Medical Association, Public Health Canada, the American Medical Association, the Association of Women’s Health, Obstetric and Neo-Natal Nurses, and the World Health Organisation. While services and products available are not fully standardised and so duplicated despite region, there remains a great deal of similarity as a result of the use and standardisation of associations’ and organisations’ recommendations and research strategies. However, the suggestion of this similarity is not intended to portray British Columbian and Canadian maternity care services as occurring without a great deal of variability, nor is it to assume universality across the province; rather, the intention is to utilise the industry and academic standards of ‘normal childbirth’ in order to narrow analytical scope.

birthing mothers and biological fathers as the targets for strategies of subjectivation, it should be recalled throughout that these suppose only a limited angle from which to view the relations of medicalised birthing.

### **3.1. The Mother: 'I'm in labour, not that machine.'**<sup>28</sup>

As mothers prepare for giving birth and adapt to the role of caring for a new child, what it means to become a mother involves a confrontation with and insertion into sets of ideological practices that surround motherhood (Rúdólfsdóttir, 2000, p. 338). Without suggesting that one can ever know precisely how girls and women conceptualise this *for themselves*, individual women seem to be confronted by a number of political, cultural, and economic strategies pertaining to modalities of motherhood, including how to *do* labour and delivery correctly, what the material conditions of physically being pregnant and giving birth are like, and what it means to become a mother. To begin, the insertion of subjects into these relations of power can be seen most clearly in the basic definitions and uses of terms. For instance, the standard term 'reproduction' has only been in circulation since the 18<sup>th</sup> century and, in fact, references the emergence of the era's fascination with natural history and of organising life within the *species*, suggesting how the practices that surround *reproduction* are specifically intended to "organise thought, politics, and life" (Murphy, 2012, p. 9). In this way, the practices of medicalised birthing discourse appear as not independent of or isolated from the relations through which they are made operational, but are instruments for recomposing "an array of associations, relationships, and institutions" (Santoro, 2011, p. 76): as women engage with this life-changing event *particular* sets of images and truths are set upon her as preferable or less-preferable to others, and certain normalisation strategies reinforcing medicalised discourse appear to be deployed and impinge on mothers' abilities to freely and alternatively experience childbirth and motherhood (Rúdólfsdóttir, 2000, p. 338). Moreover, as Brubaker and Dillaway (2009, p. 41) have

<sup>28</sup> The statement 'I'm in labour, not that machine' is transcribed from a conversation between a birthing mother and a male nursing student, in which the student's attentions appear to be focused primarily on the fetal heart rate monitoring equipment; in response, the mother informs the student that she is in fact the one who is in labour, not the machines to which she has been connected (Quinn, 2008, p. 164).

claimed, medicalised birth is so commonplace in the contemporary experiences of women in the Western, industrialised world that it has become an almost ‘natural’ event, such that clinical surveillance is increasingly the accepted and normal practice through which the bulk of birthing experiences are known (cf. CIHI, 2004; *ibid*, 2006; *ibid*, 2012; PHAC, 2008; PSBC, 2012). While intervention and constraint remain scrutinised within the apparatus, it is certainly the case that continual monitoring, documentation, and evaluation of the events of childbirth and of birthing bodies has consequently become a matter of fact, which in turn has the effect of legitimating very specific modes of action and representation. The processes of observation and assessment can be seen, therefore, as not simply a passive logging of events and proper provision of services, but also as strategic functions and techniques of an approach that “awards power to scientific truth and expert authority” (Rúðólfssdóttir, 2000, p. 339) and works upon the production of modes of social, political, and economic subjectivity.

Many studies have focused on the experiences of labouring women in medicalised birthing environments (cf. Bokar, 1995; Brubaker & Dillaway, 2009; Larkin et al, 2007; Martin, 2003). As a result, I have been able to turn to various studies in order to find depictions of the strategies of power as well as conceptual guides for developing the general parameters of the analysis offered here. In a study that will be central to my investigation of birthing mothers, Rúðólfssdóttir (2000) examines the experiences of young mothers during pregnancy and labour and presents us with 4 strategies that arise in medicalised birth: *the detached body*,<sup>29</sup> *emphasis on emotional instability, practices of infantilisation, and the subjectivation of the fetus*. In following from her account three of these strategies are of particular relevance to the analysis I offer, as they too emerged in my research of medicalised birthing in British Columbia.<sup>30</sup> Firstly, an *objectivisation of mothers’ bodies* will be supposed as occurring quite consistently in the literature. With respect to emphases on emotionality and practices of infantilisation, I will argue that while these do indeed appear, they do so as techniques of a strategy that aims to

<sup>29</sup> In the analysis provided below, Rúðólfssdóttir’s concept of the *detached body* will be discussed as *the objectivisation of the birthing body*.

<sup>30</sup> Rúðólfssdóttir’s fourth strategy, the subjectivation of the fetus, did not appear to offer as much analytical relevance to this particular analysis, and so was not included in the discussion provided.

*emphasise femininity* more generally; moreover, I will show that a third technique can be identified in efforts to emphasise femininity, such that an *inherency of maternal obligation* is reinforced. In contrast to Rúdólfsdóttir's conceptual framework, I will also propose the notion that *childbirth is controllable* as a third strategy. With the intention of offering a coherent analysis, however, the discussion below will follow this alternative order: (a) the objectivisation of the birthing body, (b) defining childbirth as a controllable event, and (c) emphases of femininity.

### **3.1.1. The Objectivisation of the Birthing Body**

A number of authors have focused on the production and impacts of objectivisation in medical approaches to maternity care, all of which reflect variation in discipline, methodology, and perspective (cf. Goldberg, 2002; Lewallen, 2011; Murphy, 2012; Rich, 1976; Rúdólfsdóttir, 2000; Quinn, 2008).<sup>31</sup> Findings in these studies tend to suggest that maternity care is oriented around problematising the functions and effects of the body and, despite statements to the contrary, on determining risks and needs for intervention (Lewallen, 2000, p. 6); indeed maternity care is in this way focused not on the mother's experience of childbirth, but instead on the search for the emergence of biological complications and risks (Goldberg, 2002, p. 447—448). Protocols within medicalised practice, therefore, arise mostly from a dual demand for medico-scientific certainty and the hierarchical structure of clinical oversight (Downe & McCourt, 2008, p. 6; cf. AWHONN, 2011; BCPHP, 1998; *ibid*, 2008; *ibid*, 2010<sup>a</sup>; *ibid*, 2010<sup>b</sup>; Enkin et al, 2000). To the extent that this is the case, the reification of a practical relationship between the minds and bodies of mothers occurs, in which the former represents a rational, cultural side of human experience and interaction, while the latter a natural, impulsive, and problematic materiality in need of rationality, management, and control. Birthing mothers are called on to inform themselves of the rational ways that they can understand the body's irrational and complicating tendencies and, therefore, how they

<sup>31</sup> Objectivisation here is intended to suggest the appearance of the body as that which may be viewed objectively by a detached mind, and is made the focus of efforts to make it wholly visible, transformable, and improvable. Moreover, the positioning of the mother is also opened up to these efforts, as she is expected to use her voice and sensations of her body as instruments of examination in order to provide objective determinations of her past, present, and future conditions (Murphy, 2012).



might develop strategies for controlling it—i.e. a combination of self-help and assisted techniques for dealing with sensations of pain, psychological and emotional distress, and other physiological challenges (BCPHP, 2010<sup>b</sup>; Enkin et al, 1995; *ibid*, 2000). The use of information, provided to them by the medical apparatus into which they have entered, is intended to result in the justification of specific treatments, procedures, and protocols, all administered by medical staff, mothers themselves, or their non-medical labour support person(s). The practices of managing and controlling the mother's body demonstrate how the medical apparatus works to transform and improve her *condition* by first supposing a distance between her mind and her body and then by focusing her attentions on problematising, monitoring, and manipulating the latter's processes and behaviours.

The emphasis of the body's objectivity highlights what is a most central concern in medicalised maternity care: the design of a clinical picture of labour progress that is predicated on the visibility and use of her body in order to gain access to its otherwise obscured indications of risk and complication. A chief assessment tool—the labour partogram (BCPHP, 2010<sup>a</sup>)—is used, for instance, to indicate the progress of labour and the necessary procedures that should be initiated, such as the need for constraint, despite the mother's desire for mobility or alternative positioning (Enkin et al, 2000, p. 291; AWHONN, 2011). This tool provides a graphical representation of labour progress and is used to suggest the need for any number of interventions or procedures, or the lack thereof, and uses physiological indicators in order to manage and document a totalising clinical picture of process and experience.<sup>32</sup> Tools such as these act as proxies for the various devices and techniques that are used to measure maternal and fetal health statuses and allow medical practitioners to design care practices over time. While this information is no doubt vital to the success or failure of practitioners who are providing care, they are also indicative of the exclusions of alternative forms of knowing about the birthing process or the body, for it works to reinforce a very specific, narrow clinical picture that has been adopted and standardised as the *most* demonstrative

<sup>32</sup> To do so the labour partogram allows for an emphasis of changes to the cervix, uterus and birth canal, muscular contractions, and maternal and fetal vitals, as well as the added notation of any other physical variances, abnormalities, or atypical features of behaviour or sensation (BCPHP, 2010<sup>a</sup>).

representation of physical, emotional, and psychological states. As a technique it indicates how a mother's mind is supposedly distanced from her body: she is reproduced as an active participant, responsible for allowing observations and evaluations by others, for observing her own feminised body at a distance, and for making decisions about the use of various modes of surveillance and intervention that may be deemed necessary at various points in the future (PSBC, 2011<sup>b</sup>, p. 9).<sup>33</sup>

Reproduced as objects of inquiry, maternal bodies are made visible through data analysis and technological prosthetics—i.e. the body is not recognised as the mother's, but is instead seen to operate more or less independent of her will and is perceived as an involuntary muscle that performs the labour of birthing automatically (Rúðólfssdóttir, 2000, p. 340). The body comes to be monitored through the evaluative programming of various devices that surround and are connected to her and which themselves are in need of continuous assessment and re-assessment. These demand “careful and individualised observation” (Enkin et al, 2000, p. 287) from the *outside* and through collaborative efforts between mothers and labour support teams.<sup>34</sup> Strategies that are associated with objectivisation permit a mother to know herself in terms of a *specific* modality of motherhood, in which she can claim knowledge of the self as a maternal mind that is capable of comprehending and using strategies, in accordance with health care practitioners, in order to control a body that remains always at a distance.

<sup>33</sup> In the practices of evaluating labour progress, the terminologies used to describe mothers' bodies and actions are illustrative of the strategy to reproduce the body as mechanised through its functionality: in order to assure that labour is in fact taking place and to continue the surveillance of the mother's progress, practitioners are asked to monitor the “mechanism of labour;” that is, practitioners should evaluate her “powers” (i.e. contractions and expulsive efforts), the status of the “passenger” (i.e. the fetus), the structural features of the “passage” (i.e. pelvic structure, soft tissue factors around the vagina, cervix, and into the birth canal, such as the presence of tumours, the status of the bladder, rectum, and vaginal septum), and the maternal “psyche” (i.e. responses to external and internal stimuli) (PSBC, 2011<sup>b</sup>, p. 9). What can be seen in these technical terms and strategies for assessment is that the mother's body is made recognisable through its mechanistic functionality and systems of response; she is made knowable as a vessel for delivery of which power, response, and product are made central.

<sup>34</sup> Medicalised childbirth depends greatly on the information provided by technological devices and measurements. While intuitive and subjective frames are made secondary or even unrecognisable as meaningful data, “medicine depends on the scientific measures generated by fetal monitors, cervical checks, hospital clocks, and birthing diagrams” (Reed, 2009, p. 223) to make claims about appropriate forms of care, including what kinds constraints and interventions may be imposed for the sake of safety and security.

Beyond the visibility gained through technological prostheses, the objectivisation of the birthing body can also be seen in promissory or pact-making practices through which a mother imposes restrictions on how she will treat her body and what she might expect from it. These restrictions are made with the hope of ensuring that she will, for instance, maintain a balanced diet, be physically active, establish trusting relationships with health care providers, call on others for support, and remain at a distance from potentially harmful behaviours or people (Ministry of Health, 2010, p. 12). Promissory practices can also be seen in the inscribing of birth wishes, in which are indicated all of the specific ways that mothers, with labour support teams, will work to control, manage, and overcome as much as possible the body's natural functions and challenges (ibid, p. 56). While the extent to which she can expect to control the body is significantly limited—for instance, her control is limited by a number of genetic or environmental factors—the failure to recognise the separation between her immaterial self (i.e. her cultural self) and her material self (i.e. her natural body) is purportedly a willed failure to overcome the feminised nature of her body and to make herself (and her child) vulnerable to its *mistakes* and the potential it harbours for damaging her child's and family's life chances.

Objectivisation can also be seen in popular representations, such as in depictions of mothers as combatants engaged in a war, their bodies posed as foes to be subdued, or that labour and delivery are analogues for athletic competitions in which mothers' greatest weapons are knowledge of and superiority over their bodies. It is suggested, for instance, that in order to assure a most positive and satisfying birth experience, a mother should arm herself with the newest thinking on labour and delivery from doctors, nurses, and midwives (Patz, 2012); that "birth is a battlefield," a message reinforced by depicting the environment and experience as "a grisly murder scene" (P & N, 2012); that a mother should plan by looking to the experiences and knowledges of professionals in the fields of fitness and sports psychology, claiming that "to *win* you need to train not just your body, but your brain" (Rippel, 2011. Emphasis added), reinforcing the hierarchy of mind over body and that preparation ought to involve a

struggle *against* the body.<sup>35</sup> Representations are of a maternal subject who can be liberated and disciplined only if she manages to cultivate her capacities as a rational thinker and lessens her vulnerability to the impulses of the body (Rúðólfsdóttir, 2000, p. 338). That is, depictions of war, conflict, and competition pose the undisciplined body as a threat to a mother’s otherwise indefatigable ability—however in need of assistance she may be—to understand and control those undisciplined, irrational impulses of her natural materiality.

It is significant to consider not only how influential but, in fact, how abundant these messages are in the lives of mothers and mothers-to-be, especially when bearing in mind the reach and ubiquity of online life, in addition to what are now more traditional forms of media.<sup>36</sup> Furthermore, medicalised birthing discourse plays directly on notions of essentialising rhetoric about the female body’s innate emotionality (Rúðólfsdóttir, 2000, p. 339), and so those services and products that are available to her appear as appropriately-suited to mediating the relationship between her mind and her body, especially when coupled with the productive values of vitality and well-being versus insecurity and risk; indeed, they appear as *necessary* tools for ensuring birthing success. Inclusions of an increasingly assured vitality and a sense of control over risk highlights an important positivity: through the taming of the mother’s body what is witnessed is the productive force of establishing opportunities for her to induce pleasure in the practices of learning, preparing, and securing for the event, in the parental practices that follow, and in the feeling of inducing pleasure in the alienation of the mind from the body (Foucault, 1984, p. 61). The work on the body as an object of medical inquiry is to reproduce it therefore as a positive productive practice within the mind, allowing

<sup>35</sup> These same popular images are echoed in a number of places, including governmental documents for distribution to mothers and families directly. In the BC Ministry of Health informational document, *Baby’s Best Chance* (2010), it is claimed, continuing with the athletics analogy, “labour is like getting ready for a marathon... If you have practiced ... you will be able to choose the [positions, techniques, and rituals] you find helpful” (p. 60).

<sup>36</sup> The ubiquity of these kinds of messages in popular media is significant. Through contemporary media, the behaviours and feelings of mothers are continuously opened up to the strategies of power, inasmuch as more pregnancy magazines, 24-hour news channels, television shows about childbirth and parenting and reports or findings on childbirth have increased opportunities for circulating information on health in pregnancy, labour and delivery; moreover, information is now passed along at an unprecedented pace via online mediums and mobile digital devices (i.e. social media platforms, blogs, RSS feeds, forums, and the near universality of mobile phones and other devices)—a trend which shows no signs abating.

mothers' opportunities to become *better* mothers and *better* passages, despite the body's apparently dysfunctional and complicating potential.

### **3.1.2. Childbirth as Controllable: Consumers in the birthing market**

Attempts to reproduce childbirth as a controllable event are apparent in the strategies of medical objectivisation, for such strategies signify the presence of formidable danger—i.e. the body—that can be mitigated only through acquisitions and uses of appropriate knowledges and techniques. Indeed, the concept of *control* has been central to sociological and anthropological research on birthing—specifically as it relates to feminist scholarship, for which it has perhaps been a chief concern—insofar as the medicalisation of childbirth is offered as a key example of the “usurpation of authority, choice, and control over women’s reproduction” by a masculinised profession (Brubaker & Dillaway, 2009, p. 35; cf. Quinn, 2008). More than this, acts of control go beyond simply gendering bodies through physiological and biological forms of manipulation; indeed systems of surveillance and evaluation are shown to cause disruptions in natural development and diminish mothers’ abilities to listen to and have confidence in bodily rhythms (cf. Brubaker & Dillaway, p. 36; Simonds et al, 2007); the inclusion of seemingly passive observational practices, then, are seen to be consonant with displacing so-called normal birthing experiences, for these devices and practices tend to trump the successes of women and their bodies (Brubaker & Dillaway, p. 37—38).

Strategies which aim to produce childbirth as controllable may be seen to operate through techniques that target mothers as economic subjects, reinforcing a view of the birthing body as an object of medical inquiry and of motherhood as a commodified practice. These techniques are deployed in a number of ways, but perhaps most significantly in the marketisation of knowledge through the multi-sited approaches of childbirth education, which advise mothers to become capable of managing the complex processes and outcomes of birth by obtaining specific knowledges and sets of skills. With relations between subjects being re-imagined in this way, what appears is an assemblage in which,

the entrepreneurial passion of the research, the personalised choice of the patient, and rationalised medical circuits of pharmaceutical research, [coalesce as a] newly emergent moral economy of biomedicine ... [constituting] a regime [of] 'regulatory objectivity', in which trained expertise [is] just one component in a multi-sited, multi-moded itinerary of knowledge-making (Murphy, 2012, p. 71).

In so doing, mothers are made to see the female body, much like Eckerman (2000, p. 158) has suggested, as ultimately untrustworthy, and so self-confidence is gained by consuming now commodified configurations of knowledge about birthing bodies and experiences.<sup>37</sup> By producing herself as an educated subject—i.e. a knowing and acting subject who has committed to the lessons of any number of childbirth education models—a mother emerges as a competent decision-maker and, by developing comprehensive relationships with experts and care practices (Adams & Bianchi, 2008, p. 110; Ministry of Health, 2010; PHAC, 2008), *allows* herself to confront her body's risks as an equipped, competent, and rationalising counterpoint. Inasmuch as birth is represented as an analogue for war, conflict, or competition, therefore, it is a moment of divergence between birthing bodies and mothers' minds that *can* be overcome by appealing to the expertise of childbirth educators and educational materials, a motivation that is further intensified by invocations of danger and insecurity in those cases where the childbirth economy and its resources are ignored or made inaccessible (Enkin et al, 1995; *ibid*, 2000).<sup>38</sup> In the new arrangements of a multi-sited, multi-moded programme of childbirth education it is thus incumbent on mothers to understand, use, and make themselves available to the most current and validated medical thinking and techniques in order to, first, defend herself and her child against the risks and weaknesses of the maternal body (Ellis, 2011; Ministry of Health, 2010; Murphy, 2012; Patz, 2012; PHAC,

<sup>37</sup> Commodities, as the term is used here, should be understood as the distribution and content of the numerous booklets, pamphlets, self-help texts, magazines, and websites, from both the private and public sectors, that focus on providing mothers and their families with up-to-date, verifiable, and easy-to-understand information on childbirth and preparations for labour.

<sup>38</sup> The vitality that is ostensibly protected through the products and services of the childbirth economy are illustrated well by claims that the focus of routine practices of care and of the mother's participation in the provision and decision-making related to them operate under an assumption that without carefully plotted data and protocols about birthing practices the mother makes herself willingly vulnerable to whatever damages may have already been done (Enkin et al, 2000, p. 256).

2009; Rippel, 2011) and, second, to fulfil the responsibilities bestowed on her through a neoliberal modality of motherhood.

Consequently, strategies of control come with a promise: that the acquisitions of appropriate medical knowledges and approaches will make labour and delivery simple and smooth, as if a lack of action is the cause of misfortune or difficulty (Brown, 2011; Ellis, 2011; Ministry of Health, 2010; Rippel, 2011).<sup>39</sup> Moreover, in the event of a negative outcome it becomes possible to look for evidence of its cause in the behaviours of a mother, and to assign responsibility to her if she appears to have failed to properly manage the possibility of complication and risk. Health care options are presented as part of a consumer market, suggesting that a mother's participation is proportional to the control and decision-making authority she may *expect* to have, for informed consumers are granted not only the use of a legitimated voice but also assurances that being informed permits a particular type of managerial control over her body and the experience of birth. Mothers, as a result, are not treated simply as patients, in which case the presence of symptoms and a need for care would *deliver her* to the observations and evaluations of medical treatment; she is also a client who makes demands of her own care and *delivers her own body* for observation and evaluation (cf. Budin, 2008; Ministry of Health, 2010; Rippel, 2011); the various treatments, procedures, and interventions of maternity care come to be offered as commodified options for rational consumers, and thus set alongside other parenting decisions such as purchasing strollers or car seats and selecting day care services (Charlesworth, 2012). Accordingly, a *lack* of knowledge and resources or a glut of incorrect or misleading

<sup>39</sup>For instance, Rippel (2011) makes a pledge that sufficient knowledge acquisition results in simple and successful childbirth: “wrap your brain around these tips and techniques and prepare to sail through labour from the first contraction to the final push.” Moreover, the Ministry of Health (2010) suggests a number of practices for avoiding the risk of preterm birth: mothers and their partners should have regular medical checkups, follow regulated food guide recommendations, avoid the inhalation or ingestion of smoke, drugs, and alcohol, cut back or avoid strenuous work and work hours, and wear car seatbelts in a particular, precautionary way (p. 80). Other sources add to this list a number of additional factors, some of which cannot be avoided and act to further pathologise the problematic of mothers' bodies, stating that women at the highest risk include those who have had a previous preterm birth, who have been cigarette smokers or who have poor nutritional intake, have used fertility treatments, are of African-American descent, have had an infection of the lungs, kidneys, appendix, or genital tract, and who have experienced unexplained vaginal bleeding during second or third trimesters (Brown, 2011).

information seemingly diminishes mothers' overall chances for satisfaction, success, and safety, and has the effect of pathologising and attenuating certain mothers' abilities to supervise potentially-controllable events and oversee the selection of possible preventive or intervening options. Her inability to participate comes to be perceived as an unwillingness to engage in the activities of consumer practice and it becomes possible to question her ability to *become* and *be* a mother. Moreover, the systems of surveillance and control over mothers' knowledges and actions work upon the economy of her affective subjectivity, such that she is made to fear the intrusions of the other (i.e. traditional birthing models and non-scientific approaches and practitioners) and, as a result, fortifies from possible harm the experience of becoming and being a mother (Gorton, 2007, p. 339).

In addition to being consumers of birthing products and services, the commodification of birthing knowledge for the sake of controlling childbirth also demands that mothers be *producers* of material and immaterial birthing goods. Their experiences become targeted for collection, synthesis, and distribution, and are reproduced as products that are rendered recognisable neither as individuated narratives nor as re-telling of lived experiences but as plotted data and evidence in support of medicalised practice (BCPHP, 2008; PHAC, 2008; PSBC, 2011<sup>a</sup>; *ibid*, 2012).<sup>40</sup> In so doing, birthing experiences are gathered and made available as population-level findings and distributed for the purpose of informing educational approaches, governmental policy,

<sup>40</sup> The focus of data collection requires an uncovering of, for example, "the total clinical history, the character of the labour, the gestational age and birth of the newborn, the appearance of the newborn infant, and the early neonatal course [as each provides] some clues to the pattern of events and the likelihood of the long-term effects" (BCPHP, 2008, p. 27). With regards to the latter, the observation of the frequency and duration of breastfeeding, the extent to which skin-to-skin contact was provided and maintained over time, or the responsiveness and vital signs exhibited by the newborn are examples of the early neonatal course (*ibid*). The elements of consideration here suggest that the inclusion of specific aspects for observation and documentation means that other parts of the birthing experience are excluded, for instance the felt, lived experience that might be left out entirely or reduced simply to a numeric value.



and health care protocols (CIHI, 2012);<sup>41</sup> or, as case files in intra- and inter-institutional communication, evaluation, and intervention (BCPHP, 1998), for example between health practitioners during and following birth events or between practitioners and other apparatuses in preparation for defending against possible malpractice claims. Birthing events exist therefore not only within the temporality of labour and delivery but extend from past to present and into the future, re-appropriated and used as caches of coded and analysed statistics and synthesised, recorded *memories* (i.e. patient logs and analytics); birth becomes productive beyond itself and its distribution as data suggests that techniques of commodification make it possible to deploy a productive image of birth as it is experienced by Canadians in general, as well as by mothers who are defined by, for instance, race, sexual orientation, region, or socioeconomic status (CIHI, 2006). Still more, the use of mothers' experiences as data-mined expressions of time, sensation, and outcome allows markets, both already-present and emerging, to re-appropriate these numerous and synthesised biological and affective experiences and to 'hitch' affect and affective subjects to strategies of neoliberal forms of capitalist production (Murphy, 2012, p. 98).

Strategies of controllability and the productive ends of knowledge acquisition suggest a demand for specific modes of subjectivity. For instance, it requires mothers to fulfil certain educational requirements, for comprehending the languages and density of medical knowledge and practice necessitates certain levels of literacy and proficiency in organisational awareness. Equitable positioning between mothers and practitioners may not be so easily occupied, however—and, indeed, may prove improbable when considered in light of professionalised and hierarchical protocols—and, as a result, routine practice may become a primary directive, possibly even despite a mother's supposed authority and autonomy; moreover, knowledge of her body and personal

<sup>41</sup> The key focus of the BC Perinatal Data Registry (CITE) is to gather information about the birthing experience in the form of "standardised antenatal, intrapartum, postpartum, and newborn data on all deliveries and births in BC ... providing an excellent resource for health clinicians, health care leaders, health care managers, policy makers, planners, and researchers". The relevance of the data is determined by standardised measures, which are developed by specialised committees such as the Canadian Task Force on Preventive Health Care (BCPHP, 2008: p. S3). The subsequent data is used to report on trends and variations occurring in terms of perinatal indicators, which are then used to determine the outcomes-based logics offered in a number of childbirth educational practices, including the directives of educational pathways.

experiences, which is accumulated as an analysis of a biological and genetic materiality, is translated into data that may be used as justification for specific manipulations and surveillance, most of which would not appear as recognisably legitimate without the assessments of medical practice. The production of medicalised birthing discourse resides, therefore, not in the equality of subjects, but rather in the mystification of the mother's birthing body and the possession and translation of an otherwise mysterious knowledge of it by an obstetrics-informed system of inquiry, observation, and assessment (Draper, 1997, p. 134).<sup>42</sup>

While challenges to patriarchal practices may have produced a slew of positive benefits for mothers, newborns, and families, a biomedical ideology nevertheless remains as a foundation of the biological thinking in medicalised birthing discourse (Reed, 2009, p. 106). Further still, transformations that are in part concessions to a critical, feminist agenda have often been re-appropriated by the techniques of a neoliberal ideology (Mardorossian, 2003, p. 129). Techniques of childbirth education, which reproduce the view that utilising a specifically medicalising rationale creates conditions of greater autonomy and freedom, also denies the relationship that is present between the production of knowledge and the imported relations of medicalised power: physicians who hold a "trained form of cognition" make motherhood both visible and inaccessible by other means for maternal subjects who appear as inexorably insufficient for interpreting the mechanical objectivity, complexity, and instrumentality of medicalised reproductive processes (Murphy, 2012, p. 70). Medicalised birthing as a specific permutation of the relations of economic, political, and social power permits, therefore, the marking of certain care techniques as "ineffective or harmful," (Enkin et al, 2000, p. 6), of certain bodies as pathologically problematic, of certain knowledge claims as legitimate, and so produces divisions that are inscribed not only into the systems of knowledge but into the materiality of the birthing body itself. Though motherhood,

<sup>42</sup> While overseen by professional care workers mothers tend to find themselves in relations of dependency, especially when considered in conjunction with other forms of marginalisation: medical professions appear as possessors of the knowledge necessary for accessing the cure to the ailment by which they and their child are threatened. In this way, the mother-patient becomes reliant on the various supportive characters that surround her and so cannot be properly understood as a *knowing* subject in the context of medicalised birthing (Johnson, 2008, p. 894).

mothers, and birthing bodies remain contested realms, practices of childbirth education, as particular techniques of the strategy for controlling childbirth, appear as examples of the continuous attempts to make maternal bodies unquestionably subjected, used, transformed, and improved by medicalising power.

### **3.1.3. Stressed Femininity: Mothers as emotional, infantilised & maternal**

Described above are the conditions in which mothers are depicted as individuals in need and capable of using specific modes of education and rationality in order to control and manage the events and outcomes of childbirth. However, as is seen in the convergence of medicalising discourse upon the birthing body in order to maintain control over it, there are limits to this supposed managerial potential, for it is suggested that while the practices of self-help and self-discipline will produce positive impacts in terms of birthing experience and success, the feminised body may nevertheless constrain a mother's ability to control those outcomes and experiences herself. Her femininity, reproduced as an irremediable limitation, can be witnessed in appeals to mothers that they should call upon the assistance of their labour support teams which are tasked with managing the knowledges, procedures, outcomes, and complications *for* her. Presently, I will highlight three techniques of this strategy which arise in the practices of medicalised birthing in British Columbia: (i) emphases on emotionality, (ii) the infantilisation of birthing bodies, and (iii) the obligation of a mother's maternal subjectivity.<sup>43</sup>

#### ***Emphasis on emotionality***

While a mother acquires knowledge in the birthing market and utilises it ostensibly as a free, rational subject, she appears as nonetheless being pitted against her own feminised body, which is regarded as inevitably problematic and irrational and a materiality from which she cannot be *fully* freed; it constrains her potential for success

<sup>43</sup> I do not intend to suggest that the concepts I have offered here are an exhaustive analytical approach to femininity in medicalised birthing discourse. Rather, I mean only to offer them as illustrative examples that are of particular significance and to which others could potentially be added (cf. Rondahl et al, 2009; Savage, 2001; Semenic et al, 2004; Walker et al, 2009).

and satisfaction because of its purported unavoidable volatility, inability to be distanced from emotional experience, and incapacity for pure rational judgment (Rúðólfsdóttir, 2000, p. 344). Protocols of medical care and education centre a great deal on controlling the emotionality of a mother's feminised body. Thus, maternity care practices, such as those focused on providing continuous praise and encouragement, emotional support, and comforting measures, are all applied to impact and produce specific emotional experiences in the mother (Enkin et al, 2000; BCPHP, 2008).<sup>44</sup> What this indicates is that while maternity care is certainly advantageous, for the event involves particular stresses, concerns, and feelings of discomfort, the effects of are undoubtedly reduced by the efforts of nurses, doctors, midwives, doulas, labour support partners, etc., what is also evident is that these efforts are directed by a need to manage a supposedly natural emotional instability in women who, despite their best efforts, remain feminised as immaterial labourers who are inclined to complication and risk.

The directive of these techniques is to focus attention on producing specific, manageable, and positive emotions, suggesting that a significant division exists between the damaging impulsivity of a feminised body left to its own devices and the rational, controlling management of a masculinised system of medical care (Mardorossian, 2003, p. 129). Enkin et al (2000), for instance, contend that the medical environment may be a strange place for a birthing woman, and so fear, pain, and anxiety may be increased by her movement through its space and practices. Given that increased negative emotional response has been shown to have adverse effects on labour progress and outcomes (ibid, p. 249), a central directive of medical care is to overcome the potentially irrational impact of her feminised material self and to deploy the techniques of affective labourers in conjunction with supposed distinctions that can be made between the emotional experiences of mothers-as-feminised-labourers and the rational, masculinised practices of medical support and guidance. Moreover, a mother's access to rationality seems to appear not in her own independent capacity for rational thought but rather in her ability to select or accept the medical assistance that is available to her and to allow the

<sup>44</sup> It has been noted that emotional support is correlated with improved outcomes, including shorter labour times, decreased use of pharmaceutical pain medication, lower rates of operative births, diminished need for labour augmentation, increased likelihood of successful breastfeeding, and an increased satisfaction with the overall birthing experience (AWHONN, 2011, p. 666).

affective labour of supportive care providers to impact her mood, demeanour, and behaviour. Due to the possibility that she might lose herself, become a monster, and abandon her otherwise pleasant manner (P & N, 2012) her rationality is to be found in the ability to pre-acknowledge her emotional vulnerability and to call upon to the system of medical observation and evaluation, through its acts of observing and deploying the flows of affects within and between subjects, to protect her and her child from an otherwise uncontrollable nature.

The objective of these techniques is not the reduction of emotional response altogether, but rather to re-appropriate, produce, and use strategically specific emotional states that are intended to realise certain outcomes; in other words, the intent is to re-appropriate and strategically use affective subjects in an economy of affects for meeting medically-determined ends. Adams and Bianchi (2008, p. 109), for example, have outlined how labour support teams harness emotional experiences that are considered necessary for establishing a greater likelihood of positive and healthy outcomes: immaterial labourers work to produce feelings of trust and confidence, and perinatal nurses, in particular, are positioned so that they may manage mothers' emotional work and produce relaxed, focused, calmed, and comforted birthing bodies. Such practices are performed in light of the expectation that mothers enter hospitals having experienced "months or years of anticipation, fear, and uncertainty" and that hospital admission likely marks the zenith of vulnerability (Enkin et al, 2000, p. 248). Re-appropriations and uses of mothers as affective subjects are, in part, appeals for mothers to "release and express their feelings and desires as political, therapeutic, and entrepreneurial acts" (Murphy, 2012, p. 90),<sup>45</sup> and so mark these circulations of affect as targets for biopolitical power. In so doing the supposedly natural dispositions of mothers' femininity are problematised and made the targets for specific formations of social, political, and economic subjectivity. Efforts by both medical and non-medical attendants, working as immaterial labourers in the production of particular experiences of and relationships with childbirth (cf. Enkin et al, 1995; *ibid*, 2000; PSBC, 2011<sup>b</sup>; *ibid*, 2011<sup>c</sup>; *ibid*, 2012; Reed, 2005;

<sup>45</sup> Affective entanglements are also, according to Murphy (2012), a form of counter-conduct reacting to practices of dispassionate, professionalised, patronising, and even coercive scientific authority" (p. 90), and so constitute a space in which the potential for resistance can be *felt*. In the analysis that will follow in chapter 4, this sensation of entanglement will be key to describing resistance in biopolitical life.

Rúdólfsdóttir, 2000), are themselves strategic techniques for attempting to generate and make use of the affects that circulate in labour and delivery; these efforts aim to homogenise and generalise women's experiences of motherhood by normalising the expressions of emotionality in terms of natural dispositions to weakness or vulnerability, and by reinforcing the authority of masculinised voices of rationality, control, and management. Moreover, these techniques imply the presence of a "natural conception of sex or the social and political body of "woman"" and attempt to subordinate, both during and after birthing events, whatever differences may exist among and within women themselves (Hardt & Negri, 2004, p. 199).

### ***Mothers as infantilised***

Mothers are also made the targets of a second technique for emphasising and problematising femininity, one which aims to infantilise the thoughts and abilities of mothers. Advisories and dialogues are delivered in such a way that mothers' skills and knowledges tend to be reduced to a level of apparent immaturity and innocence, such that they are guided through performing practices and skills that would be part of the routines of normal adults (Rúdólfsdóttir, 2000, p. 345); the guidance and encouragement they receive appears as something more akin to that which is given to children, such as directions for walking, sitting, eating or drinking, and even breathing or urinating/defecating (Enkin et al, 1995; *ibid*, 2000; Ministry of Health, 2010). Thus, the care and attention she receives, while directed toward the worthy task of diminishing the possibility of risk or complication, also works to monitor the mother's body and behaviour so closely as to resemble overseeing the care of undeveloped or under-developed individuals in need of continual observation and praise. Femininity begins to be represented as if involving subjects so overcome that they are no longer recognisable as capable of attending to themselves or of overcoming adversity, and so they are distanced from the masculinised forms of "character, wisdom, and experience that tend to be so *admired* in men" (Bartky, 1997, p. 102). Labour support is not simply a medicalised approach for reducing the presence of physiological or biological risk, but

also “caring work” which focuses on mothers’ proximity to naturalness and on providing her with the necessary protections from her own innate condition (BCPHP, 2008).<sup>46</sup>

The concern over a mother’s bowel movements may be used here to reflect on a secondary condition in the techniques of infantilisation: the defence of mothers’ modesty or innocence, in which purity and humility are taken as evident and at risk of wrongful disruption. Examples of this can be seen in the protections of privacy by doctors and nurses of mothers’ body parts, such her vagina, perineum, pubis, anus, breasts, etc. (Adams & Bianchi, 2008, p. 106): she therefore does not make herself visible to herself, or visible in general, but rather is made visible to specific subjects and objects, and at particular times, all of which are recorded and documented; these acts of vision are legitimated, and only momentarily, as a means of observing and evaluating her body as an object of inquiry and so are performed with the aim of not tarnishing the purity and humility that appear so integral to her femininity. Examples of permission-seeking also hint at the centrality of these qualities: guides inform mothers to go with their urges and not to feel like they cannot exert themselves through their bodies, such as when inclinations to grunt or make guttural noises arise, as a way of increasing comfort or for working through the pains and difficulties of the expulsive phase (Ministry of Health, 2010, p. 70—71); or, she is told that in moments of possible embarrassment, such as cases when the act of pushing is coupled with involuntary flatulence or defecation, she should not feel bad and that doctors and nurses will not be unnerved (P & N, 2012). Mothers are viewed as predisposed to the humiliations of her nature and so assurances must be offered to them to keep their purity and humility intact.

These techniques which suppose purity and humility regard the use of a mother’s senses and behaviours as the uses of “simple instruments,” as if her voice offers the pure expression of her objectivised body (Murphy, 2012, p. 75) and not the voice of a rationalising subject. Practices of infantilisation position the mother not as the interpreter of self-knowledge, therefore, but as a transmitter of an objectivised body and the materiality through which knowledge is produced by the instrumental interpretations of

<sup>46</sup> Specifically these efforts can be seen in the provisions of continuous presence, reassurance, and praise, in the encouragement of fluid intake and regular bowel movements, in the interpretation and communication of her wishes and needs, and in the detailing of how she is or ought to be coping (BCPHP, 2008, p. 28).

her labour support team. The practices of care, when understood as playing on those gendered subjectivities which circulate in the birthing space, become recognisable as not absent of the relations of power through which they are deployed. Strategies which feminise the birthing body, as through infantilisation, work instead to target and take hold of the mother by producing her in the strategic use of her affects and the affective space of childbirth (Tygstrup, 2012); it does so by investing in the resonating affects of multiple sensations of, for instance, dread, embarrassment, anxiety, or fear, and then re-appropriating positive affects by harnessing the productive uses of, for example, feelings of comfort, confidence, trust, or pleasure, all of which are obtained through an abdication to the management and oversight of medicalised birthing practice.

### ***Maternity as obligation***

Strategies which emphasise mothers' femininity suppose a third technique: the invocation of the naturalness and obligations of mothering or maternal faculty. Such techniques arise particularly in two aspects of medicalised birthing practice. First, the focus of a great deal of research has been on the relationship between breastfeeding and early childhood development (PHAC, 2009, p. 157): according to scientific evidence, breastfeeding is viewed not only as best for the newborn's developmental pathway but also as an innately pleasurable and affective behaviour for the mother (Crenshaw, 2004, p. 35—36). Her body, therefore, is made visible not only as a natural, objectivised passage for carrying and birthing children, but also as a natural materiality which is intended for child-rearing functions, the absence of which come to be associated with specific, irremediable risks to neonatal development. Through the replication and comparison of relations (i.e. breastfeeding mothers versus non-breastfeeding mothers), labour support staff are trained to look for the triggering of "mothering" attitudes and for her baby "to look for his mother, find his way to her breast, and breastfeed" (ibid). Moreover, breastfeeding acts are made central to the observational and evaluative practices of medicalised birth (PSCB, 2011<sup>c</sup>) because of the infant's and the mother's supposed internally triggered mechanisms, in which

the newborn's sucking of the ... nipple and the touch of the nipple in the baby's mouth stimulates [both the maternal and neonatal] vagus nerve ... into releasing a large number of gastrointestinal hormones and lengthening intestinal villi to increase nutrient absorption ... coordinating their metabolisms (Kennell & McGrath, 2003, p. 273).



The connectivity of the act of breastfeeding that is central to the development of mother-infant attachment *and* biological development is a key focus for postpartum care, as it evaluates frequency and duration and uses the produced data as part of its overall clinical assessment (PSBC, 2011<sup>d</sup>). Thus, the collection and analysis of these data points are used to render a series of judgments about a mother's and neonate's progress, while the space itself appears as a series of modes of surveillance (i.e. the forms on which data is recorded, the machines and devices that are used to monitor a mother and her child, and the evaluating subjects who circulate around her) and produces certain affective flows between subjects and objects (i.e. of calm, focused mothers in controlled and specially-designed environments). Breastfeeding in these instances is made the target of a re-appropriating strategy; it serves as an example, then, of the ways in which biological practices are re-appropriated as specific modalities of gendered subjectivity, such that *mothering* and *child-rearing* may be coupled not according to socio-cultural custom or convention but are instead inscribed into the very maternal nature of a mother's body.

A second practice that highlights techniques of maternal obligation is the recognition of hormonal balancing, bacterial coupling, and a mother's specific capacity for affective connection, or attachment (BC Women's, 2012; Crenshaw, 2004; Ministry of Health, 2010). The presence and significance of these forms of biological familiarity between maternal and neonatal bodies makes it possible to speak of the inherency of maternal responsibility and the need to activate the development of these relations immediately following delivery. The mother's body is therefore not only that *through* which affective bonds are developed, but also *in* which physical inscriptions of safety, security, and risk-aversion may be located. It is territorialised and made the site of primary responsibility for protecting and nurturing children; a source of responsibility that is embedded not merely in social forms of distinction but rather within the natural functions and processes of a mother's femininity. Thus, what can be seen in claims that "emotional attachment is one of the key factors in raising a happy and confident child" and that healthy attachments involve a newborn's sense of safety, security, and protection on physical, emotional, and psychological levels—all of which are derived from developing a "close and connected relationship" between a mother and her child

(Ministry of Health, 2010, p. 110)—are attempts not only to purport the cultural primacy of these relationships, but more acutely of the inexorability of their natural necessity.

In order to support the development of such a significant form of attachment, medical guidelines establish clearly that postpartum care should be dedicated to providing as much skin-to-skin contact and mother-infant bonding as possible, and it is crucial to create the most protective space around the newborn so that she can remain stable, healthy, and on track in terms of the prescribed developmental pathway (cf. BCPHP, 2008; *ibid*, 2010<sup>b</sup>; *ibid*, 2012; Crenshaw, 2004).<sup>47</sup> The need for this contact is expressed not only in terms of the emotional and personal bond that she and her baby will begin developing (i.e. the affective attachment), but also as a hormonally-balanced transformation that establishes (and continues) the biological connection between mother and newborn (cf. Crenshaw, 2004; Ellis, 2012; Kennel & McGrath, 2003).<sup>48</sup> And so, while procedures and assessments were once done outside of the room and newborns were transferred to hospital nurseries after delivery for continued neonatal care (Crenshaw, 2004, p. 36), in contemporary maternity units assessments and procedures are performed in the mother's room so as to guarantee sufficient time for "mother-infant togetherness" (PSBC, 2011<sup>c</sup>, p. 2; cf. Crenshaw, 2004; Ministry of Health, 2010; PSBC, 2011<sup>b</sup>).

The flesh of the mother and her child are, therefore, liminally productive, in that the reasons for *why* mothers should breastfeed or maintain skin-to-skin contact become

<sup>47</sup> Evaluations and assessments focus, for instance, on the mother's natural production and supply of nutrition in her breast milk and willingness and ability to breastfeed and commence proper latching behaviour; physiological changes are observed in her body and in the body of her child when the two engage in physical contact and assessments are made to measure whether and how she learns to respond to her baby's physical cues (i.e. for food or for comfort) (Crenshaw, 2004, p. 37)

<sup>48</sup> It is incumbent on health care practitioners, therefore, to discuss with mothers the changes in oxytocin levels that happen when she holds her baby skin-to-skin and how this "stimulates 'mothering' feelings as [she] touches, gazes at, and breastfeeds her baby" (Crenshaw, p. 36). Moreover, the significance of the relationship continues beneath the skin, such that "contact provides an opportunity for a baby to be exposed to the normal bacteria on his mother's skin, and decreases the risk of the baby becoming sick due to harmful germs" (Kennel & McGrath, 2003, p. 273). Mothers are specifically responsabilised as being primary care-providers; they are called on to offer *mommy-style* care, by "holding baby close to your cozy chest and heating him up" in the immediate postpartum moments, in order to be sure that he or she adapts safely to a postpartum climate that is likely about 30°F colder than in the womb (Ellis, 2012).

incorporated into specific political and social forms of subjectivity that are produced through the uses of the body-as-mediator (Santoro, 2011). The symbiosis of the relationship with her newborn is made visible in terms of her body's biological functionality and through the politicised practices of mothering; the observation, documentation, and evaluation of the time and frequency at which skin-to-skin contact occurs, or of whether or not latching (i.e. successful breastfeeding performed by the newborn) happened spontaneously and the time at which this happened (BCPHP, 2010<sup>b</sup>) all work upon the mother's body to reify her relationship to herself as mother; that is, between the inscriptions of her biology and the socio-political subjectivity that she comes to occupy as a mother. Moreover, invocations of insecurity and negative health outcomes when considering the actions of mothers in the early hours of postpartum care lead to politicisations of a mother's body, for her very materiality becomes a focal point upon which to produce and deploy various rationalities (e.g. of responsibility versus neglect) and subjectivating strategies (Braun, 2007, p. 8). Mothers' bodies are seen not simply in terms of the amount of control that can be gained over them—i.e. by mothers themselves or by practitioners—but also to discover what her body can *do* and how those capacities may be strategically used, transformed, and improved (ibid, p. 13).

The gendering of subjectivity forms a basis for the production of the social, political, and economic rationalities of motherhood and womanhood in which women are forced to contend with what are described as ostensibly *natural* bodily compulsions and duties to perform significant and developmentally-critical childcare practices. The longstanding effects of this may have considerable impacts in terms of the maternal subject's ability to make alternative claims about the self and future action, and thus causes what may be described as a splitting of her subjectivity (Johnson, 2008): the mother may be compelled to stay home with children, despite alternative motivations to engage in private and public life, or she may be made the target of criticism as her engagements in supposedly non-maternal practices are compared with the neglect or abandonment of her duties and obligations as a mother; she may risk encountering feelings of anxiety, self-doubt, and regret as she attempts to modify her childcare responsibilities, and tensions may increase between herself and her partner as they negotiate the discursive and non-discursive terrain of parenting duties and expectations (Hardt & Negri, 2004; Johnson, 2008; Lock, 2008; Lupton, 2000; Root & Browner 2001;

Weir, 2006; Wolf, 2003). When a mother does overcome such productive effects and engages positively in public life she may, too, find herself confronted by gendered divisions of labour, as it becomes possible to speak of her as ill-equipped in those political, social, or economic roles in which masculinity is prioritised, or, alternatively, as well-equipped when her ostensibly innate feminised qualities appear as possibly beneficial.<sup>49</sup> The possible result of this gendering of certain political, social, and economic practices effectively constrains the possibilities of maternal subjects and their actions.

### **3.2. The Father: Labour support teams and biological fatherhood**

In contrast to motherhood, biological fatherhood is typically absent in the birthing literature and rarely mentioned explicitly—i.e. in instances where they are identified overtly, fathers are often regarded as possibly sub-optimal labour support partners because of their emotional involvement or potential for eliciting negative responses in birthing mothers (Enkin et al, 2000, p. 252).<sup>50</sup> Beyond these instances, fatherhood tends to be spoken of implicitly, as in discussions of a father's role as a supportive *partner*. In statistical analyses, in fact, 'husbands' appear as the most likely non-medical support person to be present during labour and delivery, a claim which may support assumptions that biological fathers comprise a significant number of these partners (CIHI, 2006). While traditional images of fathers may be of a man "pacing... worried like crazy," anticipating news in a hospital waiting room (Martin, 2010), a perhaps more accurate likeness of a contemporary father is as a member of a medicalised labour support team,

<sup>49</sup> Hardt & Negri (2004) contend that forms of labour that are feminised tend to involve a "high affective component ... [and are] given less authority and [pay] less" (p. 111). As specific examples, the authors cite paralegal and nursing work, as these involve constructing relationships with clients/patients and of managing interactive parts of everyday life. Labour which is feminised also tends to be alienating as it involves selling one's ability to facilitate human relationships through acts of intimacy and closeness (ibid).

<sup>50</sup> It will be noticed that in this section there is a tendency to shift from 'father' to 'partner'. The relationship between the two positions is critical to the analysis as referring to fathers through the moniker of 'partner' is identified as part of a key subjectivating strategy. Second, while the use of 'father' and 'partner' is done interchangeably, the subject being analysed here is both a male partner of the birthing mother and a biological parent of the newborn.

where he is coach, advisor, and representative to the birthing mother: wearing hospital scrubs, he stands beside a bed in which his partner lays; he is part of decision-making processes and involved in her and the newborn's care; no longer waiting outside, he is a medicalised labourer who produces immaterial goods such as emotional states and physical or psychological comforts, provides updates on the mother's condition and needs, and establishes communicative links between a mother and the other members of her medical team.

In order to complement the preceding analysis of motherhood and biopolitical power, I will now turn to the biological father with the aim of demonstrating his positionality in medicalised birthing discourse. I consider below the strategies for the production of fatherhood that are most apparent in the medicalised birthing literature: firstly, strategies pertaining to being a *partner in labour support* will be discussed, and which are divided according to two particularly significant techniques: the re-appropriation and uses of *fathering as immaterial labour* and *emphases of masculinity* in his functions as a labour support. Additionally, I discuss a second strategy in which I identify how fathers are positioned in labour and delivery as *risky bodies*.<sup>51</sup>

### **3.2.1. Partner Labour Support**

#### ***Fathering as immaterial labour***

As they enter the medicalised birthing rooms of hospitals, clinics, and birthing centres, fathers are incorporated into the operations and procedures of those systems, as partners in or members of labour support teams. The father carries out a number of responsibilities, all of which work to reproduce the focus of women-centred care and in which he takes on a role associated with managing and interpreting the environment and events of childbirth, coaching his birthing partner, and representing her needs to the medical staff, as best he can (Reed, 2005). His capacity to do so is frequently limited by

<sup>51</sup> These categories are largely derived from the author's own review of the birthing literature (i.e. governmental and professional association publications, as well as popular media sources such as magazines, manuals, and online guides and forums). However, studies conducted by Reed (2005) and Vehviläinen-Julkunen & Liukkonen (1998) provided valuable sources of direction and guidance in developing concepts. In addition to these, studies by Marsiglio (1991; *ibid*, 1993; *ibid*, 2009) and Mardorossian (2003) also complemented my research.

his lack of knowledge and expertise in medical procedures, tools, and protocols, but he is intended to achieve these ends to the best of his abilities and in conjunction with the duties and responsibilities of medical staff. Insofar as this is the case he is welcomed into the space of birth and empowered as an individual who can actively experience and impact the birthing event. However, as a father he may also find himself *d*isempowered as his experience is filtered through the processes of medicalised birth: his presence and usefulness is intended as labour for medical care. In this way, his being welcomed as a partner is an example of the re-appropriations and uses of affective subjects by medical power, for his central purpose is to assist in the production of a specific modality of motherhood, as evidenced above, and to be a contributor to the creation of a cost-effective procedural environment for his labour permits the limitation of operational size without sacrificing observational or evaluative capacity (Hardt & Negri, 2004).<sup>52</sup> A father's labour outputs are made the targets of medicalisation and deployed strategically as commodified services (Wissinger, 2007, p. 235); his labour is a means by which biopolitical regimes deploy relationships and forms of life that are predicated on the uses of inexpensive and flexible affective labour (Hardt & Negri, 2004, p. 110).

Inasmuch as birthing experiences cause life-long effects on mother's psychological well-being and that all effort should be directed to providing continuous support, there is a significant pressure for fathers to be continuously present, as they are made increasingly responsible for the health and well-being of the mother and her child

<sup>52</sup> Hardt and Negri (2004) contend that biopolitical power harnesses the circulation of affective, relational, and communicative practices amongst and within subjects themselves, and as a result transforms flows of affect into the effects of power.

(Mardorossian, 2003).<sup>53</sup> The father is therefore engaged by a variety of medicalising techniques, such as appeals to make promises (Ministry of Health, 2010, p. 57) or the expectation that he will reinforce childbirth education systems (Enkin et al, 2000, p. 251).<sup>54</sup> Nonetheless, his presence in the room is simultaneously a reminder of the ways in which his positioning as an intimate partner and as a father are inadequate when compared with professional care workers, as he is continuously contrasted against the expertise and knowledges of medical practitioners; he is granted access only to the degree that he provides the team with a particular type of support and remains at an emotional distance from the event. The birthing environment may be posited as a significant factor in the development of fatherhood as a future-thinking practice, for a distance becomes perceivable between the father and the mother and her child. The shift in practice in which fathers have become increasingly involved in childbirth has been enacted by focusing the attention of fathers not on the birth of his child and the sharing of that experience with his partner, therefore, but rather on the continual observation and evaluation of the medical conditions of the mother and the fetus. The engagement with this role has the effect of reducing his involvement to providing information to health care practitioners and being a positive, supportive presence for his female partner as she engages with and moves through the medicalised events of her own birth experience.

<sup>53</sup> Coupled with the fact that nursing resources are not quite up to par with the requirements for 1-to-1 support (Mardorossian, 2003, p. 126), the pressure that is exerted on partners to be present is particularly significant in terms of its normalising impact, as biological fathers are expected to enter into and appreciate the birth experience by being supportive of a medicalised surveillance effort for which the central concern is the health of its two patients (i.e. the mother and her child). Such pressure is applied on fathers such that they are made part of a surveillance team overseeing the care of their patient-clients, not their intimate partners. Thus, while fathers have been invited into the birthing room in recent decades, their incorporation as part of a labour support team is significant as this reminds us that the opening up of medicalised birthing to paternal participation involves them in the practices of medicalised delivery, as already constituted, and works to use their affective labour potential to achieve biomedical ends. Their presence cannot be viewed as independent from the economic considerations of the birthing event, such that the care of mothers and the deployments of fathers are done so as a support for the overall medical model and to reduce the demand for 1:1 professional labour support.

<sup>54</sup> The specific practices of labour support include, for example, ensuring continuous presence, reassurance, and praise, offering acts of touching and massaging for comfort, and of encouragement, observation, assistance, and advocacy of her bathing, eating, drinking, and ambulation (Enkin et al, 2000, p. 247).

With respect to reducing the overall cost of maternity care, the father's role appears to have become increasingly prominent alongside shortages in staff and the drive to reduce as much as possible the rising costs of medical products and services, typical of neoliberal policies (BCCEWH, n.d.; Enkin et al, 2000; Hardt & Negri, 2004; Rogers, 2003). The activation of fathers as supportive team members in labour and delivery should be seen not simply as their introduction into the role as useful providers of comfort and support, therefore, but also as options for supplementing gaps in the provision of professional services. Their inclusion appears to be the outcome of two factors: firstly, the presence of a non-medical support partner is demanded by findings related to specific, measurable advantages to be gained by the mother and her child (Draper, 1997; Lis et al, 2006; Meerabeau, 1987; Reed, 2005; Shannon-Babitz, 1979); secondly, his presence provides advantages in terms of the financial efficiencies of birthing practice, for his services can be both necessary to the processes of childbirth and utilised by the medical apparatus at no additional cost. The biological father becomes a target, therefore, for the production of partnership as a form of immaterial labour (Hardt & Negri, 2004) and thus a site for the "production and reproduction of patriarchal and capitalist power" (Mardorossian, 2003, p. 113) in that his inclusion reinforces biomedical and neoliberal dominance in the processes of medicalised childbirth, and he is rendered recognisable as both an essential part of medicalised birthing and ancillary to and composed of the specialised services of which he becomes both consumer and producer; his positioning works to reify both the consumption of health care in the birthing economy and to further underpin the authority of practitioners' pre-eminent cognitive capacity to notice and explain the processes and needs of a mother's experience and care (Murphy, 2012, p. 70).

### ***Emphasis on masculinity***

In addition to the gendering of mothers and motherhood outlined above, partners, too, appear as gendered subjects, for they fulfil the role of supportive labourer as indeed masculinised attendants (i.e. they exhibit understandings of and abilities to apply rationality and objectivity to circumstances otherwise brimming with emotionality). Such forms of masculinisation appear in terms of a father's integration, as a partner, into medicalised birthing practice: he is constituted as a subject who prioritises rationality, objectivity, and management in his experiences of the emotional events of birth, while



remaining at a distance from the direct emotional experiences of both giving birth and of becoming a father. He is asked, therefore, to choose between opposing experiences: one in which he feels the affective connections between himself, his partner, and his child, and another in which he experiences birth as a rational, empowered coach of a birthing mother and through which he strives for feelings of control and security (Reed, 2005, p. 211). Within this distinction, the former is regarded as potentially detrimental, for he may be too emotionally entangled with birth (Enkin et al, 1995; *ibid*, 2000) and therefore vulnerable to impulsivity and irrationality. The inclusion of fathers in the birthing experience is thus predicated on a type of organisational conditioning in which *labour support* reflects the prioritisation of a masculinised medico-scientific model for maternity care and a continuous problematisation of the uncontrolled emotional and personal experience of birth, this time for fathers. The efforts to create a useful distance between practice and emotional expression is therefore a reinforcement of the ways in which partners are used as immaterial labourers in the birthing event: their positioning is to produce particular types of safe, risk-averse, and manageable emotional and relational maternal subjects and to ensure that the communication of these relationships is available and documented as a specific designation of medical practice.

These gendering techniques are recognisable in three specific instances of the birthing event. First, the reinforcement of the mother's positionality as a feminised subject during labour and delivery highlights the partner's role as a counterpoint to a mother's natural predispositions: the father's presence is intended to provide a masculinised form of control over her supposed feminine predilection for irrational and impulsive behaviour (Enkin et al, 2000; Ministry of Health, 2010). It has been shown, for instance, that the feminine/masculine dyad of the mother/father relationship is reproduced in the childbirth literature insofar as mothers are seen as predisposed to their built-in responses, while fathers depend on slow, rationalising considerations of socio-cultural relationships and situatedness (Mardorossian, 2003, p. 128). The problematic impingements of a mother's nature, in terms of becoming overwhelmed by her urges to succumb to anxiety, fear, and surprise (Ministry of Health, 2010), *can* be overcome apparently in the presence of a masculinised partner's supportive acts; fathers, as subjects who may potentially provide this support, are expected then to embed themselves in actions that emphasise rationality and objectivity and to isolate

themselves from impulsive emotional and empathic connections with the mother and her child (Reed, 2005, p. 220). They are expected to strategically use the economy of affects in order to control a mother's reactions, feelings, and objectives, and, in doing so, produce the mother as a normal maternal subject. To be clear, a father's emotional expressions are not perceived as an obstruction, but are on the contrary advantageous qualities that can be used and harnessed by the measured and calculated acts of a rational self.

Secondly, emphases on masculinity arise throughout the postpartum phase, during which time the objectives and concerns of care focus on prioritising mother-infant attachments. While a father is present to "keep the baby warm and stable skin-to-skin," he is only to do so *if* the mother needs temporary relief of her responsibilities, if, for instance, she needs to use a bathroom (Ministry of Health, 2010, p. 73). The developments of motherhood and fatherhood are divided, therefore, according to their association with natural or cultural motivations: the constitution of motherhood develops naturally, needing only the time and space necessary for it to follow its due course; conversely, fatherhood is a rational task, requiring the time, focus, and decision-making faculties in order to get the job done. Thus, while mothering appears as a naturally-occurring phenomenon that is predicated on a continuum of feminised experiences and biological indicators, as described above in terms of the liminality of the female body, a father's parental duties are discussed within the ongoing developments of his rational, socio-cultural life, such that dealing with diaper changes, managing the needs and demands of children and teenagers, and continuing to provide partnership support throughout early and late childhood are indicative of the commencement of his fathering life (Ministry of Health, 2010); it is a set of rational forms of cooperation that began with the supportive function he played as a teammate in his partner's birthing experience (Reed, 2005). The distinction between mothers and fathers appears, then, as a division of attachments, and so the re-appropriation and use of each as differentiated forms of immaterial labour in the economy of affects.

Lastly, and closely connected with the prioritisation of mother-infant bonding in neonatal development, medicalised birthing discourse reinforces the expectation that fathers develop attachments with their children in the slow attenuation of a child's dependency on his mother, marked first by the separation of their bodies following

delivery, then in the physical cutting of the umbilical cord and passage of the placenta and, later, in the end of the association between nourishment and the mother's breast. Thus, the end of a child's attachment to his mother inscribes in the body of the child the slowly expanding relationship that is now permitted to develop between himself and the socio-cultural environment of which his father is a part. Relationships between fathers and their children commence, then, at that junction between connection and separation and proceed through the passages of neonatal, early infant, and childhood development, adolescence, and early adulthood (Ministry of Health, 2010). The passage of the fetus, the cutting of connective tissues, and the act of latching are all marked, again, as liminally productive moments in which are indicated the early formations of political, social, and economic subjectivities for mothers, fathers, and children (Santoro, 2011, p. 76). Constituted in the strategic reproduction of a father's apparent inability to feel natural attachments are the very possibilities of fatherhood; of the qualities and motives that are behind the affective bonds he might establish with his child as they learn of each other, culturally; and, of rendering fatherhood visible as a practice which continues to prioritise the support of naturally occurring mother-infant attachments (Ministry of Health, 2010, p. 73; Reed, 2005).

The masculinisation of the partner suggests that when biological fathers occupy this role they are expected to control themselves, their partners, and the event; they must remain rational, endure stress, and respect the authority of medical power by supporting and taking part in its objectives and recommendations. Fathers find themselves not in triadic relations with mother and child, but instead are next to and supportive of mother-infant dyads; advocates and proponents of medicalised birthing models, in fact, recognise the value of *them*—i.e. the mother and her child—as “a couple” (Crenshaw, 2004, p. 37). While mothers are paired with their children, the connection between them being both affective *and* biological, fathers remain continuously mediated in their relation: they assist in maternal development and reinforce mothers' positioning as primary care providers and biological instruments of neonatal development. While a mother is called upon to re-appropriate her femininity, and so to allow her biological indispensability to be used and controlled by medical power without potentially harmful obstruction, fathers are positioned as rational, managerial representatives of his female partner's ascension out of natural disposition

and potential complication. The father concentrates his efforts entirely on producing specific kinds of relationships and emotions for his birthing partner and on supporting the realisation of specific medically-defined forms of success in labour, delivery, and neonatal development. The techniques of masculinisation appear not to be concerned with the diversity or uniqueness of his experience of childbirth, either as an intimate partner or as a reproductive self, but rather attempt to harness the productive effects of his affective self through his masculinity. Thus, as a father finds himself made part of a labour support team, what occurs is an obfuscation of his reproductive self and the connections he might assert between himself and his partner, and between himself and the child he has conceived *with* his partner. As labour support becomes the focus of his approach (Vehvilainen-Julkunen & Liukkonen, 1998, p. 11) whatever alternative experiences of childbirth may be possible are pushed to the background. While mothers' connections are clearly established at the level of her materiality—i.e. she is designed specifically as a biological materiality for giving birth and for connecting physically and emotionally with her children—fathers' are made visible only through those productive forces of socio-cultural practices in the postpartum phase that help him to “establish contact with the baby” (Vehvilainen-Julkunen & Liukkonen, 1998, p. 11).

### **3.2.2. Risky Bodies**

The strategies of medicalised birthing discourse also appear to target the paternal body as a risky materiality. First, the father's body poses, much like the mother's, a potential biological danger, in that his genetic makeup, physiological traits, and risky behaviours may portend a risk of disorder, disease, or vulnerability.<sup>55</sup> However, unlike the body of the child's mother, his body also poses an additional developmental danger: father-infant bonding supposes a potential subtraction from the time needed for developing mother-infant attachments, the latter having greater significance in terms of neonatal development and maternal health. The riskiness of the paternal body arises, on the one hand, in the context of the availability and use of new reproductive technologies, such as genetic, hormonal, and bacterial testing and

<sup>55</sup> The mother, too, poses the potential of such a danger, as her possible genetic predispositions and vulnerabilities to viral or bacterial infection can be translated into particularly acute risks in need of intervention.

research, which suppose new possibilities for feelings of hope, responsibility, affection, and attachment and operate through contemporary forms of *biosecurity* and political, economic, and social subjectivity (Braun, 2007). On the other, paternal risk appears to emerge in the reification of a neoliberal subjectivity, for as a consumer of biomedical approaches a father invests in his own body and makes decisions according to formulas of risk-aversion and positivity; these effectively mediate the relationships he might form with others and with himself as a father, all according to marketised notions of bio-security and responsibility (Santoro, 2011, p. 87).

The assertion that a father's body is a genetically-defined potential for risk is associated with reproductions of fathers' bodies as biological materialities, through which potentials for and knowledges of disorder and disease become manifest. For instance, the emergence of genetic testing as a factor in the decisions regarding reproduction and the cautionary measures to be taken in labour and delivery allows newly formed responsibilities for parents and expressions of affection within families to become sayable. As these affects are recognised as constitutive elements of fatherhood and circulated in the environments of childbirth, fathers themselves are called upon to make their genetic bodies visible to biomedical evaluations and to determinations about the need for treatment. Strategic deployments of fathers' bodies as sites of bio-security can be seen as part of a larger strategy that seeks to "achieve *certain* biomolecular futures by pre-empting others, and does so in part by reconfiguring in other places relations between people" (Braun, 2007, p. 23). Becoming a father, therefore, comes to be spoken of in terms of the relations between fathers, mothers, and children that are produced not only in the attachments of skin-to-skin or interpersonal contact during and after conception, labour, and delivery, but also sub-cutaneously in the affective relations between men and the virtualities of fatherhood and their reproductive health. In the contemporary post-genomic era, in which "the body is thrown into a chaotic and unpredictable molecular world filled with emergent yet unspecifiable risks" (ibid, p. 7), the father is therefore made into a subject-body through which the potential for feeling secure as a father is extended beyond his own actions and into the virtualities of the genetic codification of the self.

Beyond this form of risk, and with respect to the potential for developmental harm, the father's body becomes a threat in terms of what it *lacks* during the immediate

postpartum phase. While mothers' bodies are essentialised as materialities through which appropriate, safe, and developmentally-sound childcare is done, a father's is of secondary significance or holds a non-essential status; he comes to be seen and to claim to know himself as an assistant or support in the processes of child-rearing and neonatal development, in much the same way that he was positioned as a support throughout the previous stages of labour and delivery. While the mother is told that she must, for instance, keep her child skin-to-skin until he or she finishes a first feeding, and then for as long as possible (Ministry of Health, 2010, p. 73), the father is a body through which ancillary warmth and comfort may be found. Father-infant bonding must not interfere with mother-infant attachments, even while it retains some level of significance, for the latter is a necessary component in proper neonatal development. Moreover, the father's ancillary function as an alternative to the maternal body is not predicated on his being a father to the child, but simply on his being a partner to the mother, and so the reproductive relationship that he has with the child remains at least partially obscured or mediated by his relationship to the birthing mother. Positioning the father as an available partner to a mother's reproductive responsibilities is supported by research that supposes that the impact of maternal attachments is of vital concern, warning against "interrupting, delaying, or limiting the time that a mother and her baby spend together," for doing so may have harmful effects on the child's ability to develop relationships and to breastfeed (Crenshaw, 2004, p. 36; Enkin et al, 1995; *ibid*, 2000).

Associations between fathers' bodies and risks to neonatal development reinforce two aspects in the process of *becoming* a father: firstly, his body does not appear as a necessary materiality to the processes of neonatal development and, therefore, he appears as a subject who may not be a necessary part of a *newborn's* life; the relation of significance in which he appears as necessary, instead, is to provide supportive care so that he might encourage a birthing mother to best fulfil her responsibilities during and after labour and delivery. As a result these associations work to further reinforce his function as it appears throughout the phases of medicalised birthing, which is to be present not for the transformative moments of fatherhood, but to produce, by re-appropriating and using his own immaterial labour, a birthing mother who works correctly, safely, and with as few complications as possible, as defined by the medical apparatus which surrounds her. Secondly, his *parental* role continues to be

mediated through acts of support for maternal experience: he is to share with her an enthusiasm for physical activities and relaxation; to help her have a positive and satisfying birth experience; to attend and participate in childbirth education and medical appointments; to encourage and help her with breastfeeding; and, to assist in managing logistical concerns, as they move from the hospital back to the home (Ministry of Health, 2010). Biopolitical relationships that may emerge as a result of these differentiated and gendered positionalities are quite significant, as the posing of fathers' bodies as substantial risks to neonatal health and development bears a potentiality for producing negative "forms of social belonging" (Santoro, 2011, p. 79). In that fathers are positioned to know themselves not simply as rational subjects, but also as gendered, potential hazards and as supportive partners in the processes of neonatal development, a problematic may arise in which fathers find themselves distanced, affectively, from their partners and children.

## Chapter 4.

### Affective Subjectivity in Medicalised Childbirth

While the strategies and techniques discussed above represent specific targeted attempts to produce medicalised subjects, resistance remains as a pure potential in subjects' experiences of themselves, and so biopolitical regimes ought to be understood as involving a connectedness between divergent moments of biopolitical life (Murphy, 2012, p. 12).<sup>56</sup> My focus in this chapter will be an exploration of these divergent moments, of the potential for resistance as it arises in the sensations and feelings of subjects as they experience the strategies and techniques of biopolitics. In order to do this I will contend that *affective entanglements* are central for explaining how biopolitical resistance may gain traction due to the potential that is produced in the uniqueness and ambiguity of affective life. Moreover, the chapter will close with a brief discussion of the possibility for collectivising and mobilising affective life in the novel formations of *communities of affect*, with special attention given to the role of the internet in such exchanges. I will suggest that these communities offer unique ways for explaining how flows and exchanges of affects gain momentum and reach beyond the bodies and events in which they first arise, and for how they emerge to produce new energies, feelings, and sensations, as well as new solidarities and mobilisations. Furthermore, affective communities offer the opportunity to identify the conditions for not only the collectivisation and mobilisation of resistances, but also for realignments of power to produce new subjectivating strategies as new modes of social, political, and economic

<sup>56</sup> Murphy (2012) argues that these connections between different instances are the divergences which arises in "the history of attachments, proximities, relationships, fissures, and separations *between* different instantiations of biopolitics" (p. 12)



power converge on emergent subjectivities and form around whatever novel communities they may form (Santoro, 2011).<sup>57</sup>

#### **4.1. Affective Entanglements: Trust, friendship & responsibility**

As the strategies of medicalised birth operate on the bodies of mothers and fathers, what appears in the experiences of those practices are potentialities for transforming subjects' experiences of *themselves*; of producing new ways of knowing the self and of contesting the effects of medicalised birthing discourse upon subject formation. Thus, the strategies for producing particular modalities of motherhood and fatherhood, as discussed above, result not only in the production of medicalised subjects, but also in the unique experiences of subjectivation by affective subjects themselves. The presence of power, therefore, supposes not a singularity, but a multiplicity of *potential* subject positions and results in the agonism that exists between power and resistance. By discussing potentiality in this way I wish to show that the concept of affective subjectivity "opens up a way of relating to the surpluses of life that Foucault invoked" and suggest how it is that new ways of living may emerge (Anderson, 2011, p. 2).

Such a conceptual arrangement between power and affective subjectivity is intended as an invitation for discussing alternative practices and definitions of the political,

that do not necessarily rely on the 'successful' discursive symbolisation of a putative identity as their condition of possibility ... of, for example, [alternative] logics of affective intervention enacted through generosity, hospitality, trust, friendship, solidarity, respect, or responsibility (Anderson & Henderson, 2006, p. 335).

<sup>57</sup> Alternative analytical concepts may also be suitable for discussing resistance; offered below is a significant though not exhaustive depiction of affective subjectivity's explanatory power. Many authors have provided methodologies that combine affect and biopolitics but which differ in a number of ways from the model offered presently (cf. Ahmed, 2004<sup>a</sup>; Anderson, 2006; *ibid*, 2009; *ibid*, 2011; Anderson & Henderson, 2006; Massumi, 1993; Murphy, 2012; Ngai, 2005; Prada, 2010<sup>a</sup>; *ibid*, 2010<sup>b</sup>; Stewart, 2007; Tygstrup, 2012; Venn, 2007). The variance in these models is suggestive, I believe, of the ongoing developments in affect and biopolitical studies.

In terms of analysing resistance I will pursue some of these possibilities highlighted by Anderson and Harrison (2006), as they permit the identification and description of specific instances in which the effects of experience as particular forms of life exist in complex relations with discursive orders (p. 334). In the examination below the affects of *trust*, *friendship*, and *responsibility* will be outlined: first, as they occur in specific acts of *intimacy* or closeness between intimate partners; second, in mothers' *collaborative* acts with health care practitioners; and, third, in mothers' and fathers' feelings of *self-confidence* that are derived from alternative body-knowledges.<sup>58</sup>

#### **4.1.1. Intimacy: Mothers, fathers & neonates**

As was suggested above, a great deal of research has been done on the impact that partners may have in labour and delivery (CIHI, 2004; *ibid*, 2006; Enkin et al, 1995; *ibid*, 2000; Ministry of Health, 2010), much of which suggests the central role acts of intimacy have in realising positive health outcomes for both mother and child. Moreover, as feelings of intimacy arise and are re-appropriated as practices of medicalised birthing discourse the specificity of their use is of particular importance insofar as the productive effects of those strategies work to reproduce binaries of masculinity-femininity, rationality-irrationality, nature-culture, control-impulsivity, and security-insecurity; they target the economies of intimate relations between partners and, as a result, invest in the production of modalities of motherhood and fatherhood through the use and re-appropriation of a couple's immaterial labour (Hardt & Negri, 2004). Feelings and sensations of trust, friendship, and responsibility between intimate partner are deployed within and through these acts of intimacy, rendering these strategic re-appropriations and uses as not simply protocols for the administration of health care but also as politicising tactics that operate in accordance with strategies for reproducing neoliberal and biomedical subjectivities.

<sup>58</sup> While Anderson and Harrison (2006) propose four additional affects (i.e. generosity, hospitality, solidarity, and respect), the three affects identified above (i.e. trust, friendship, and responsibility) will be sufficient for making the case that affective subjectivity offers a novel perspective for analysing biopolitical forms of resistance. Moreover, selecting only three was considered a suitable choice given the constraints on space in this thesis.

Simultaneous to the re-appropriations of intimacy by power through the circulating affects of trust, friendship, and responsibility are alternative positions—i.e. alternative logics—that may be taken up as a result of the entanglements that occur between these investments by power and the affective lives of intimate partners. With regards to mothers, experiences of childbirth exceed simplifications of birth as simply medically- and commercially-defined events, which are controllable through performances of education, rational decision-making, and the assistance of expert practitioners, for these events unfold not merely according to the gaze of medical discourse—i.e. through a supposed observational and evaluative relationship between one’s mind and body—but are also transmitted in the milieu of a far more complex, dynamic, and historicised combination of affective experiences. Events of birth are not so easily objectivised, for they are simultaneously attached to the perceiving subject and to the aesthetic objects that surround her affective/affected body. With regards to affective economies in the sensations and feelings of intimacy between a mother and her intimate partner the affective space in which such intimacies may be registered is one defined by “resonances, interferences, and tensions between different affective qualities” (Anderson, 2009, p. 79), and is therefore recognisable as an ambiguous, yet productive potentiality that arises both within the body and in the way that subjects impress upon the affective world around themselves.

Thus, as in Mori’s (2006) account of the sensations of an interior maternity, the formation of motherhood as an identity is not so much one that is made by way of normalising strategies alone, but rather through a mixture of various effects that occur at multiple levels of individuated and shared experience. In addition to discourses and the strategies that surround maternity, femininity, and individuality, there are also circulations of “fantasies, emotions, desires, dreams, and the place where bonds and affections are formed, new relationships made, and ... the fantasised home of the internal baby, soon to become [real]” (ibid, p. 88). The relationship of motherhood to the self is not only that within which discourse is imported and imposed as a material reality, but one through which the tonality of affective life is seen to become productive. The affective subject entangles with power as she experiences it and what results is the productive potential of her “dreams, feelings, unconscious mechanisms, desires, and different realities” (Mori, 2006, p. 89); of the possibilities that are borne from the

uniqueness of an affective life, yet unforeseen until they materialise in a moment, and that become a framing through which the *becoming* of motherhood and the intimacy it may both recall and summon is experienced.

Inasmuch as the production of fatherhood is concerned, I have attempted to show in preceding chapter that biological fathers are made to confront a central choice in childbirth: they are compelled to choose between, on the one hand, the rationality and authority necessary for being a coach or manager of a mother's medical event, and, on the other, sharing in the experiences of birth as a feeling or sensation of connection or attachment; often they walk away frustrated by their failure and unsatisfied with their success in navigating this terrain (Reed, 2005, p. 211). These moments of frustration indicate a crucial contradiction that emerges in the birthing experience—between the effects and experiences of normalising power—for they expose spaces or fissures within the strategic logics of medicalised birthing discourse to the possibility of contesting those dominant practices. While acts of touching, listening, helping, and maintaining eye contact are all intended as forms of immaterial labour for producing certain relationships between mothers and partners, as well as to reproduce the intimacies of fathers as useful tools to be managed by labour support teams (Ministry of Health, 2010), affectively-charged relationships between fathers and their birthing partners exist in excess to these imputations. While attempted investments seek to re-appropriate and use as strategic techniques of power the relations of trust, friendship, and responsibility between partners—i.e. as so many specifically re-appropriated acts of intimacy—these are also combined, perhaps, within broader expressions of an interior *paternity*, which overflows or exceeds those narrowing intentions of power and allows for the recognition of creative spaces in which fatherhood may be formed, it now being constituted also as affective expressions of a more dynamic ethical subjectivity.<sup>59</sup>

For instance, in an excerpt from a first-hand account (Ministry of Health, 2010) a father expresses the depth of his interior paternity:

<sup>59</sup> Studies of the transition to fatherhood by Lis, Gennaro, and Mazzeschi (2006) are also informative here, as the concept of a transition supposes a “specific phase in the development of the individual's personality,” a claim the researchers propose should motivate attempted descriptions of the way “boys become parents” and the “complex development which shapes paternal experience” (p. 106).

The birth of our baby was the most amazing thing we have ever experienced. It was hard work for my wife but she was so strong and in control. I was in awe of her. The moment we first held our daughter will be forever etched in my heart. I'm a pretty tough guy but it brings tears to my eyes just thinking of it (p. 73).

As a new father, he reflects on the ways that the mother's relationship to the child is differentiated by her physical experience of birth, as compared with his positioning as an audience who remained in 'awe of her'. However, the reflection is also one in which he draws together the affective experience of birth between himself and his wife, which is made recognisable through the presence of a physical life (i.e. their baby) in which their bodies find a capacity for connection and unification. Rather than see the physical experience of pregnancy, labour, and birth as providing his wife with a greater and more necessary attachment to their child, the father expresses the potential for the connectivity *they* have with their newborn through the uses of the term 'we' to describe the sensations and memories of labour and delivery. The assertion that the birthing moment finds its way into the composition of his own affective life – that the moment 'will be forever etched into my heart' – suggests a futurity of the affective experience and how it is possible for affectively-charged events to be evocative of the significance that these hold for both transformational potential and resisting strategic forms of power.

Biological fatherhood may exceed the relations set upon it by the strategies of partnership support and the targeting of his body as a risky materiality; for the mother, her objectivised and feminised relationship to the event, as a body ostensibly filled with feminised potentials for irrationality and emotional instability, overflows the medical event, producing a potential for her subjectivity to become framed by the relations through which her experience of birth is made possible. The feelings of trust, friendship, and responsibility that emerge within and through the affective lives of intimate partners, and the "taking place of hope [that] enacts additional figurations of excess," (Anderson, 2006, p. 745) meet in the event, filling the room and the subject positions with sources of potential: the event, as one in which affective subjects occupy affective space, is a momentary capturing of "the seeds of change, connections in the making that might not

be activated or obvious at the moment” (Massumi, n.d., p. 12), but are nevertheless felt within and between the affective sensations of birthing bodies.<sup>60</sup>

Sensations and feelings of touching, massaging, presence, listening, offering encouragement, and eye-contact are all recognisable as spatialised practices of the trust, friendship, and responsibility between partners, and so these exchanges of intimacies between them are irreducible to, though nonetheless the targets of, medicalised power. The energy and attunement that is shared in the presence of one’s intimate partner and co-parent may therefore exceed strategies of normalisation, and the particular engagements of affective subjects may correspond to changes in feeling within the organic moments of a shared affective life (Anderson, 2006, p. 735—736): in the touch or eye-contact between loved ones, in the presence and warmth of a specific body, or in the offering of encouragement by a specific voice or tone are markings and impressions of trust and friendship that cannot be fully re-appropriated by power; of affective histories for which medical notions of responsabilisation are forever inadequate in defining; and, of interior maternities and paternities, uniquely combined, that will always tend to exceed the strict constraints of power’s effects.

#### **4.1.2. Collaboration: Mothers and their practitioners**

Research on childbirth tends to suggest that mothers giving birth in hospital mostly adhere to the norms of medicalised birthing practice (cf. Brubaker & Dillaway, 2009, p. 41; CIHI, 2004; *ibid*, 2006; *ibid*, 2012; Enkin et al, 1995; *ibid*, 2000). What I have hoped to highlight in the preceding sections regarding medicalised labour support, and the controllability of childbirth in particular, are the strategic efforts to protect the autonomy and authority of birthing mothers by supporting specifiable and standardised acts of collaboration between themselves and their labour support practitioners. However, despite attempts to medicalise these collaborative practices, these strategies

<sup>60</sup> This excerpt from an interview with Massumi (n.d., p. 12) was originally a means for describing the weaknesses of judgment in critical theory, in that judgmental reasoning attempts to be “so sure of itself” despite the something being studied always involving the variableness of time and perspective, especially as they occur between things (i.e. researchers and objects of study). The contention, then, appears as suited to the argument made above, in that circulations of affects in institutionalised settings relay a similar relationship between subjects and objects.

are confronted by the feelings and sensations that are emergent in moments of affective interaction between care workers and mothers; that is, in the attitudes and temperaments that comprise the affective economy between them and within the affective environments of inter-subjectivity. The lived reality of the birthing event incorporates, therefore, not only the strategies of medicalised birthing discourse, but is imbued with the tonalities of a “dissonance ... between the philosophic and theoretic claims of the profession in relation to nursing care, nursing practice, and the day-to-day lived realities of nurses and the women who labour with them” (MacKinnon et al, 2003, p. 29).

Transformations of these relations between subjectivities of mothers and care practitioners are based not simply on the interests of client/patient relations and the objectivisation of mothers’ bodies, but also on developing meaningful, intimate relationships that incorporate already-present and long-lasting residues, the significance of which may be felt in the unique art of storytelling that embraces the special, subtle, and emotional components of together experiencing the events of childbirth (Savage, 2001, p. 4); and in the feelings and sensations of empathy between two bodies who are, together, immersed in economies of affect and engaged with one another in the event-ness of a shared experience.<sup>61</sup> Shared experiences developed through collaborative efforts, therefore, cannot be so easily individuated, as if mothers feel the direct experiences of childbirth and practitioners rationally and at-a-distance assist her in managing her efforts and outcomes; rather, practices and ways of knowing employed by subjects materialise and are experienced in the non-discursive, affective atmosphere of childbirth and engaged in as creative potentialities of cooperation and mutual dependence. Moreover, the act of storytelling and the future-thinking it portends indicates that practitioners who are involved in collaborative efforts may come to be incorporated in unique birthing narratives, as these are told, retold, recalled, and re-imagined over time. As a result, professional subjects are confronted by a transformational potential that may be gleaned from the impressions and markings left on and within them, for the experiences of the affective space of childbirth and of others’

<sup>61</sup> To be clear, the economies of affect in collaborative engagements are suggestive not only of positive experiences, such as elation, joy, and amazement, but also of negative affects, such as grief, anxiety, fear, pain, disorientation, and anger.

affective lives become elements in the affective life of each practitioner; they are potentially lifted from the status of rational medical professionals who are precluded by strategies of power from feeling authentic, passionate emotional and affective connection with patients and clients, and are instead made possibly integral to the impulsive flow of affective attachments between themselves and the mothers with whom they have collaborated.

The impacts of collaboration, insofar as these acts may be felt experiences of trust, friendship, and responsibility, may offer opportunities for forms of resistance that are in fact reflected in the organisations of social and bodily spaces, as these indicate the creation of boundaries around and through which the practices of affective bodies may operate (Ahmed, 2004, p. 30).<sup>62</sup> In this sense, the boundaries that are produced by discursive practices of collaboration are vulnerable to the resonances and intensities of affective life, and so collaboration and the affects (i.e. emotional, communicative, or relational states) that are marshalled in by their occurrence may simultaneously become enactments of the flows through which creative potentials for resistance are realised. In the lived experiences of increasingly medicalised birthing processes, relationships between affective subjects may therefore constitute a significant potential for delimiting, and not simply reinforcing, the authority of medico-scientific rationales in birthing practice, for everyday experiences are not simply inundated by strategic power or imposed upon with certain modalities for living, but are also opportunities within which confrontations of strategic power become possible. Instead of presenting the potential of such responses as a problem to be resolved by reassertions of expert authority, a collaborative approach within the setting of medicalised childbirth could also be the basis for establishing feelings of trust, friendship, and responsibility that are both beyond the strategies of a medicalised apparatus and responsive to the unique, complex dynamic that exists between affective subjects. Such a programme would involve, for example,

<sup>62</sup> The events of birth which exceed those of discourse can be seen in the ways that theory and lived experience are not equal in their determination of subject positions and of sensations of power; in terms of the relations between women and their caregivers, then, the excess that is contained in subjects' lived experiences are illustrative of Gadwo's (1994) contention that ethical theory will continuously fail to "establish for women access to their experience [for] even a theory of caring becomes ideology when its author speaks ... as if the theory were speaking, as if its words were more true, more important than the words a woman and her caregiver say with each other in their situation together" (p. 304).



nurses working 'with' power rather than 'against' it, recognizing that they themselves are part of a present in which the task is not to overcome powerful others but to use understandings of the operation and effects of power to further [the engagements of] nursing (Cheeks & Porter, 1997, p. 113)

Central to questions about these kinds of collaborative acts are the impacts of inequalities and power imbalances between subjects. While medicalised childbirth appears as a scientifically-measured and universalisable tool which guarantees standardised assessments, reinforces the prominence of observing and evaluating objectivised birthing bodies, and attempts to enable practitioners to control the situated experiences of labour and delivery (Johnson, 2008, p. 894), affective subjectivity can work toward demystifying the varied, unequal relations between subjects that continue to exist even despite whatever guidelines and parameters for care. For instance, experiences of social, economic, and political factors, such as wealth, race/ethnicity, or age, impact affective subjects' experiences of medicalisation and make possible the emergence of varied *new* histories between affective subjects. What results is the potentiality of collaborative acts, which can open up space for new relations to be felt between subjects who have experienced the mutuality of collaborative relationships and which may exceed those limitations that are set upon them by way of the guidelines, protocols, and recommendations of institutional practice.<sup>63</sup> Through gaining an awareness of and problematising one's positionality and ability to claim to know, what becomes possible is a self-referential dialogue in which those positionalities and claims become opened up to problematisation; to collaborative dialogue that involves contesting forms of knowledge that can produce a potential for creative, alternative ways of knowing that are not confrontational but rather collective and inter-subjective expressions of collaborative intuition. The result of such a model of care is that:

<sup>63</sup> The strength of appreciating power differentials should not occur in terms of whether one has power over other subjects, objects, or practices. Rather differentials point to the legitimation of certain ways of knowing to the exclusion of others and create latent opportunities for understanding that users and authorities are together involved in the processes of power and therefore in the practices of legitimating knowledge; they may afford chances to engage in dialogue that permits subjects to work with the conditions of power, as opposed to simply against them (Cheeks & Porter, 1997, p. 113). Resistance, therefore, incorporates acts of compliance and rejection, and is defined according to re-appropriations of practice (whether as affirmations, negations, or combinations of the two) within the productive assemblages of ethical subjects and ethical communities.

Instead of approaching labour from a perspective of a catastrophe waiting to happen ... professionals [and mothers may] regain their trust in the physiology which enables healthy women to labour and deliver, mostly without interference. Pregnancy and labour [may come to] be seen as normal until proven otherwise (Davis-Floyd, 2008, p. ix).

The conditions of such a collaborative approach would therefore establish the possibility for an experience of childbirth in which a birthing woman's self-knowledge becomes "fostered and the complexities of her life ... considered relevant in her decision-making" (Goldberg, 2002, p. 587).

Collaborative practice has, in fact, become central to debates about childbirth services, for "the production of culturally unbiased nursing knowledge is one of the most significant research issues of this and the next decade" and is crucial for efforts to transform health care so that it works in accordance with "the cultural and societal context within which women live" (Semenic et al, 2004, p. 85; cf. Kornelsen et al, 2003; Larkin et al, 2007; Lewallen, 2011). What is envisioned is a need to rethink, for instance, approaches that focus on objectivisation and emphases of femininity, so that these may work in conjunction *with* mothers' authority over their own bodies and self-knowledge and the potentially boundless variance that this reflects (Rúðólfsdóttir, 2000, p. 348). However, it is important not to overstate the impact of this debate, as it has been suggested that mothers still tend to sense a loss of authority and autonomy in medicalised environments (Brubaker & Dillaway, 2009, p. 42) and that what appears to be the case in the current revised medical model is simply a reiteration of already-dominant medicalised strategies, despite greater likelihoods of non-intervention and a more consistent focus on natural, biological processes (cf. CIHI, 2004; *ibid*, 2006; *ibid*, 2012).

Advocacy for collaboration can, therefore, be seen as an attempt to re-appropriate alternative aspects of affective life (cf. BCPHP, 1998; *ibid*, 2010<sup>a</sup>; *ibid*, 2010<sup>b</sup>; *ibid*, 2012; Enkin et al, 1995; *ibid*, 2000; PSBC, 2011<sup>c</sup>; *ibid*, 2011<sup>b</sup>; *ibid*, 2012), as affects of trust, friendship and responsibility, for example, have been made into new

targets for medicalised birthing strategy.<sup>64</sup> For instance, such strategies are deployed through techniques that analogise birthing with war, conflict, or competition, in which case collaboration is offered as yet another weapon in mothers' arsenals: affects of trust, friendship, and responsibility that are circulated within collaborative environments are re-appropriated and used as functions for producing particular modalities of motherhood and childbirth that are associated with the strategies for producing objectivised, commodified, and feminised bodies. Considering this, alongside what Jordan has contended—that “to legitimise one way of knowing as authoritative devalues, often totally dismisses, all other ways of knowing” (Downe & McCourt, 2008, p. 4)—it would appear fair to suggest that collaboration, and the informed decision-making and teamwork it implies, may be merely reproductive of the strategies of power. And so, while the current state of maternity care and its push for greater maternal autonomy is certainly a positive step for creating new opportunities of engagement, standard concepts that are currently available to maternity care practitioners appear to retain impoverished views of the unique experiences that each birthing woman necessarily has (Goldberg, 2003, p. 587).

#### **4.1.3. Self-Confidence: Birth, parenting, and alternative body-knowledges**

Sensations and feelings of self-confidence throughout labour and delivery can be seen to echo in the aforementioned acts of intimacy and collaboration: for the former, a sense of confidence in one's ability to act intimately and to feel that those acts are impactful appears to be a necessary condition; for the latter, self-confidence is crucial insofar as mothers' abilities to engage collaboratively demands a self-assurance in one's ability to make meaningful contributions to collaborative efforts. Moreover, self-confidence appears as a central element in those strategies of power that I have discussed above, for mothers and fathers alike are both called upon to gain in self-confidence as they navigate, for instance, the expectations of childbirth education and

<sup>64</sup> Maternity care has been reframed greatly over the previous decades to provide support that is designed specifically to meet a mother's needs and is predicated on very specific modalities of respect, information-sharing, participation, and collaboration (BCPHP, 2010<sup>b</sup>).

the requirements of informed-consent models.<sup>65</sup> However, self-confidence also appears as a feeling or sensation that arises in a moment of affective life, through which one might posit the potential for improving the self as if a work of art and in terms of realising the potentialities of one's experiences and the capacity to resist power.

Insofar as spaces for resistance can be located in the contradictions of discourse, a perhaps most significant type that arises is that which occurs in the entanglements between a sense of confidence that one is able to gain by participating in the childbirth education economy and that which may be experienced *in* oneself in unique feelings and sensations of affective life throughout labour and delivery. Csikszentmihalyi's (Humenick, 2006) work on *flow experiences* offers useful direction here, for getting a sense of how self-confidence as an affective and potentially-resistant experience may emerge, as through the agonism between the constitution of the subject by medicalised power and an affective subject constituted by the alternative body-knowledges of the experiential self:

We all have experienced times when, instead of being buffeted by anonymous forces, we do feel ... masters of our own fate ... a sense of exhilaration, a deep sense of enjoyment that is long cherished and that becomes a landmark in memory ... The best moments usually occur when a person's body or mind is stretched to its limits in a voluntary effort to accomplish something difficult and worthwhile ... the organisation of the self is more complex than it had been before ... the self might be said to grow (Humenick, 2006, p. 2).

These kinds of *affective* states—of exhilaration, mastery, enjoyment, adversity, and complexity—may constitute a sense of competence from within oneself and the possible impetus of a peak experience in one's affective life (*ibid*). Formations of alternative body-knowledges, therefore, may produce mothers and fathers who comprehend and become the effects of new, unique kinds of awareness produced in the affective expressions of self-trust and the enjoyment of and in oneself.

<sup>65</sup> The demands of childbirth education models have been noted above and can be found in a number of texts (Enkin et al, 2000; Ministry of Health, 2010; Reed, 2005). The notion of informed-consent, too, is a critical element in the processes of maternity care, as all decisions are formally committed to in the signing of informed-consent documents (Ministry of Health, 2010).

As I demonstrated above, representations in various media of cautionary tones and wills to self-confidence—e.g. references to the difficulties of childbirth and the use-value of childbirth education programmes—tend to be associated with personalised efforts for acquiring medical knowledge as a means of preparation for the difficulties of pregnancy, labour, delivery, and parenthood (Rippel, 2011; Smallwood, 2012). However, a central contradiction arises when it is also stated that “a certain amount ... is out of your control;” that women should “enjoy the moment, do your best, and what is meant to be will happen” (Rippel, 2011); or, that she should resign to the knowledge that despite childbirth education and despite a thorough birth plan, she “may be surprised to arrive at the hospital ... only to find that Mother Nature has a different scheme up her sleeve” (Parker Toy, 2011). Larkin, Begley, and Devane (2007), moreover, have indicated that the ‘process,’ as described by mothers, “involves a productive effort or ‘work’... *and* an unpredictable journey” (p. e54. *Emphasis added*). Within these examples are a recognition of the entanglements between the productive promises of medicalised birthing (i.e. that distance between the mind and body, the use of the medicalised apparatus, and trust in the practitioners of medical care all provide assurances of security and success) and the uniqueness of one’s experience; of the ways in which sensation and feeling—of the tension between strategies of power and the experiences of them—allows alternative positionalities and claims to self-knowledge, hence excluded from pronouncements of a dominant medicalised birthing discourse, to become produced and productive in themselves as resistant forms of subjectivity. Self-confidence, as an affect and, therefore, as a potential, pours into the situatedness of biopolitical power the productive force of one’s affective life; of, for instance, pleasure, shock, sensibility, profundity, disorientation, or even something as simple as a pregnant pause; of the feeling drawn from the moments when something is suddenly thrown together as a something. Self-confidence as a potential-filled realisation of resistant practice occurs not simply as a result of the rationalisations of medicalisation, which permit a mother or a father to feel they have proven their worth, but also “in the actual lines of potential that a *something* coming together calls to mind and sets in motion” and that does “not have to await definition, classification, or rationalisation before [exerting] palpable pressures” (Stewart, 2007, p. 2—3). Affective life, then, extends beyond the

boundaries of a defined medicalised experience that has not been sufficiently problematised.<sup>66</sup>

These aforementioned fissures provide indications of the presence of attempted subjection (Foucault, 1980, p. 97) and suppose not a singular but rather a multiplicity of knowledges, the duplicity of certainty, and the means by which contestation is felt. Entanglements between the strategic efforts of power and the potentialities of affective subjectivity are not, however, demonstrative of a simple break between the two, for self-confidence, as it is both deployed by power *and* felt by the affective subject, occurs as a complex and continuous relation. For instance, in Heyes' study of gendered subjectivities, she highlights paradoxes of normalisation in which "choosing to participate in gendered technologies may enhance our capacities and make us feel more truly ourselves at the same time as it enmeshes us more deeply in normalisation" (Dolezal, 2009, p. 347). And so, as mothers and fathers engage with strategies that attempt to produce pathways for self-confidence (i.e. in focused, calculated, and feminised birthing bodies, or in observant, managerial, and masculinised supportive partners), they also experience their unique feeling and sensation of becoming mothers and fathers—that is, as individuals and as a couple in the midst of *their* affective life. While disciplinary strategies have potentially constraining effects, they also "enhance our capacities and develop new skills ... train us and offer ways of being in the world that can be novel, transformative, or appealing" (ibid, p. 348). Observations of latching behaviour, for example, reproduced in medicalisation as processes of surveillance and assessment, suggests a re-appropriation of breastfeeding insofar as it is used to indicate normalcy and proper development, maternal-infant attachment, and maternal and infant health (cf. BCPHP, 2008; ibid, 2010<sup>a</sup>; PSBC, 2011<sup>c</sup>; ibid, 2011<sup>d</sup>; ibid, 2012). However, the sensations of self-confidence to be discovered when a mother and her child *find one another*, as bodies who feel an affective knowledge of themselves and one another, may

<sup>66</sup> The suggestion that medicalised childbirth has not been adequately problematised is drawn from Brubaker and Dillaway's (2009) work on medicalisation, natural childbirth, and birthing experiences, in which they suggest that "although medicalisation continues to be of interest to sociologists, some of the basic concepts within this analytical framework ... have not been sufficiently problematised" (p. 31). While the focus of the aforementioned research is on the critical examination of medicalised experiences as they relate to notions of 'natural childbirth', it is suggested here that the same can be supposed in cases of medicalised experiences in 'normal childbirth'.

be seen to exceed the approaches of birthing education and the medicalised notions of attachment and normality from which parental confidence is supposed to have been gained. Practices such as these and the alternative body-knowledges they suppose may “yield a joy that feels distinctively and transformatively different from the normalised pleasures we are permitted to have” and arrive as demonstrative of the “emancipatory potential” of affective life (Dolezal, 2009, p. 349). It becomes possible to speak of them not in terms of how they are the same or different from what ought to be—i.e. in terms of the effects of the relations of power—but rather in terms of how they are the particular expressions and determinations of bodies that are made irreducible to the relations that are set within and alongside them. Instead of the confrontations of mind-body relation, it becomes possible to speak of the becoming of motherhood through an “aesthetic sensibility” that marks each cervix, each uterus, each vagina, each birthing event, and each experience as unique (Murphy, 2012, p. 84). A more intimate confidence in the self and in the physiological processes of one’s body can be achieved (ibid, p. 75) and, in this way, a subject allows herself to be elevated beyond the constraints of medicalisation, beyond the ability of the specialist to control and rationalise her as an objectivity, and to instead be the basis of her own knowledge and not simply a bridge between her objectivised body and the rationalising perspective of the obstetrician, physician, nurse, and labour support team.

Such a way of seeing the body and the events of childbirth may allow mothers’ feelings and sensations to become “a primary passage point through which the validity of [biomedical approaches should] to be tested” (ibid). In reported instances in which mothers have felt or sensed this kind of self-knowledge, an indication of its emergence during the birthing experience is in those sensations of “not trying to think too much at all,” of “letting go of those thoughts,” or of trying “to focus, thinking of something pleasant ... really to let go” (Parratt & Fahey, 2003, p. 18).<sup>67</sup> Mothers have indicated, too, that letting go of controlling thoughts provides a way forward in producing positive experiences of childbirth and a creative space in which new birth stories can be realised

<sup>67</sup> Larkin et al (2007) also indicate that birthing experiences can be a unique composition of both letting go and taking command. The combinatory experience of childbirth is indicative of the creative potential of affective subjectivity not simply as acts of rejection, but also as re-appropriations of medicalised practice insofar as they come up against the feelings and sensations of the affective lives of individuals.

(Parrat & Fahey, 2003); a creativity in which objectivisation and success-through-controllability do not come to define, as a totalising logic in the very least, success or failure and satisfaction or disappointment; rather the feelings and sensations of the uniqueness of the subject's experience come into view and are made central to these determinations.

Specific modalities of medicalised fatherhood, likewise, constitute the emergence of an affective state in which sensations or feelings of paternal self-confidence may be derived not from medicalised logics, but rather from the impacts of trust, friendship, and responsibility as they arise in the uniqueness of his affective experiences throughout labour and delivery. While medicalised birthing indicates that his ability to become a father, and therefore his ability to feel confident in his capacity to do so, is limited to a relationship that is monitored and assessed through external observations, such a definition fails to permit his *particular* experience of childbirth; to regard as significant his felt interior *paternity*, in which dreams, fantasies, hopes, and fears are the basis of a relationship that is, in actuality, a continuing experience of an entire affective life that leads up to and continues on after labour and delivery has happened—i.e. a history of past, present, and future feelings and sensations.<sup>68</sup> For example, with respect to the productions of feminised-masculinised binaries throughout labour and delivery, the riskiness of fathers' bodies, in terms of its being set in contrast to the necessity of the female body, works to produce gendered parental subjectivities, as I have remarked above. However, without questioning the importance of breastfeeding or mother-infant attachments in neo-natal care a more varied significance may be attributed to developing father-infant attachments, beyond simply the supportive role that appears to be adopted throughout birth and in the moments of early contact, if we are to look also to

<sup>68</sup> In the discussion of interior maternity Mori (2006) suggests that certainty cannot be guaranteed when considering how well exploratory methods placing mothers under medicalised birthing practices respect the mental lives of mothers; in fact, she states, "We have our doubts and experiences which bring this into question and have discovered that these kinds of interventions can take the mother away from *'thinking'*, from being in contact with her baby still inside her, from feeling the new relationship which is forming, even if this recourse of treatment is certainly aimed at providing support and reassurance" (ibid, p. 89. Emphasis added). Much the same can be said of fatherhood, insofar as the preoccupation with being a supportive labour assistant may detach him from the experience of becoming a father, of having the experience of fatherhood which extends beyond the confines of a medicalising logic that surrounds the partner and the labour support team.



the affective lives of fathers themselves. That is, their experiences may suggest a far more complex relationship between men and the events of childbirth. Moreover, these influences of his affective life may very well impact, both in the long- and short-term, how men feel about fatherhood and how it comes to be perceived in a larger society (Palkovitz, 1985, p. 392), supposing a positive productive effect beyond merely the events of labour, delivery, and postpartum care.

It also appears particularly significant to consider the impacts of increasing uses of reproductive technologies, as these invoke an especially important shift in contemporary practice: while it remains potentially problematic, it may nonetheless be argued that technological advances have made possible new kinds of intimacy between birthing mothers, intimate partners, and children, and new ways of becoming a father or co-parent.<sup>69</sup> Specifically, fathers have become capable of experiencing reproductive processes through prosthetic forms of feeling and sensation, and no longer depend entirely on representations provided by birthing mothers (though mothers' expressions and purely tactile sensations, such as feeling a mother's tummy for kicks, remain very much central to a father's ability to know about pregnancy, labour, and delivery). The various impressions (Ahmed, 2004), or the fantasies, dreams, emotions, desires, bonds and affections, traditions and cultures, traumas, and feelings of hope, anticipation, regret, astonishment, wonderment, or disinterest that may have previously comprised fathers' birthing experience are now imbued with or given new forms of expression in technologically-assisted experiences of medicalised birth. These effectively re-imagine or re-configure how he might, as an affective subject, feel and have sensations of the birth and development of his child and therefore of his becoming a father, and may even

<sup>69</sup> A father is now capable of engaging through the prosthetic experiences of, for instance, sonographic imaging and amniocentesis (Marsiglio, 1991, p. 280), through which he can come to gain a knowledge of fetal health and fetal life that was previously unavailable to him. In terms of possible issues which remain, however, we must not completely disregard the possibility that these same technologies may produce an increased distance between parent and child, for they also establish an intermediated relationship between two bodies.

be related to broader changes in other facets of social, economic, and political modes of living (Dienhart, 2001).<sup>70</sup>

What these examples suggest is that fathers' and mothers' self-confidence, in producing alternative affective attachments in the processes of childbirth, may engage new ways in which biomedical approaches are challenged, for emergent forms of affective life indicate new opportunities for questioning the strategic efforts of social, political, and economic forms of subjectivation. Thus, while medicalised processes and protocols of childbirth are understood as involving specific forms of feminised and masculinised material and immaterial labour, for instance, the objectives of which are healthy newborns and mothers guaranteed by practices of observation, assessment, and, whenever necessary, manipulation, in the experiences of mothers and fathers childbirth may appear as an affective event which exceeds the productive effects of those efforts; it is an affective moment which involves numerous conduits of sensation and feeling, or contact zones, as well as specific overdeterminations of circulating affects and flows of power; it is a moment in which discourse is loaded with a content that is at once steady and unsteady because affective subjectivities, as inflections of the relations of power, are "fractious, multiplicitous, and unpredictable" (Stewart, 2007, p. 3). One must avoid in this, however, essentialising an affective subject's sensation and feeling of self-confidence, as well as affective subjectivity more broadly, as if one's choices are simply consonant with either affirmations or negations of various strategies of normalisation, or as if analysis may be able to pin down precisely what outcomes could be expected in the productivities of affective lives. Rather, I suggest here only that these experiences are demonstrative of possible resistance, such that the potential of affective subjectivity in determining a space for autonomy ought to be appreciated as more significant than the specific content or outcome of any given decision in particular. Resistance, in this sense, is the *potential* to reshape practices of normalisation and to establish the possibility for new statements through the unique experience of one's

<sup>70</sup> Beyond the events of childbirth, recent research also suggests that gendered subjectivities are becoming problematised, for practices of co-parenting are increasingly common (Dienhart, 2001, p. 975). The involvement of fathers in these different areas of pregnancy, labour, delivery, and parenthood are establishing spaces in which fathers may be exposed to new forms of affective life and, therefore, become capable of expressing ethical practices that have hitherto been excluded from dominant discourse.

affective subjectivity; to produce, through the potentials of sensation and feeling, the mobilisation of and scaffolding for novel collectivities.

## **4.2. Communities of Affect: Mobilisations of affective life and novel collectivities**

Mobilisations of affective life are a means by which specific sensations and feelings of experience are deployed both across and within the bodies of affective subjects and spaces, and in which new statements may appear as modes of practice in novel collectivities. What I will explore in this final chapter is how affects move from the localised to the collective, in terms of realising the forms of sociality or community that emerge from the turning out of the community-building potentials of affective subjects as individuals. The pursuit of these *communities of affect* allows for what Anderson and Harrison (2006) have suggested is crucial to the study of affect: to engage with emergences of subjectivity from affective assemblages and with the consequences of these for the experiences of reflexivity, responsibility, intentionality, autonomy, and identity; it is to permit a demonstration of alternative political practices that are not derived from discursively-produced identities alone, but also from affective forms of subjective connection (p. 335).

Through the aforementioned engagements of intimacy, collaboration, and self-confidence, for instance, affects may circulate as new ways of knowing or being able to claim to know and it becomes possible to perceive them in collectivisations of otherwise individuated feelings and sensations; or, in the very least, of feelings and sensations shared beyond the particular moments in which they first arise to the extent that they become productive of new forms of subjectivity. Therefore the feelings and sensations that may be associated with an interior maternity or paternity may provide non-discursive opportunities for producing resistance in the individual acts of labour and delivery (i.e. through the unfolding and narrativisation of the complex experiences of one's affective life in those moments) as well as in the collective experiences that are shared across and within potential communities of affective subjects. What seems to occur in these instances of mobilisation is a composite of multiple, fractious, and unpredictable potentials that somehow become the core of that which is exfoliated by individual

affective lives onto the communicative feelings and sensations of entire communities that lay beyond the discursively-constituted and isolated relationships of the medicalised birthing room. Affects, affective states, and affective spaces in which resistances are realised beyond mere potential may also therefore be exfoliated onto objective and inter-subjective spaces, both of which occur as themselves multiplicities of affective spaces and relations (Gil, 1998, p. 127).

Exfoliations alone, however, are insufficient for explaining the *collectivisation* of affects within these communities, for it is suggestive only of affects being mobile and says nothing of their potential to *move* subjects and objects and for subjects and objects to *move affects*; it fails to address how

the role of feelings in mediating the relationship between individual and collective bodies is complicated [because] the impressions we have of others, and the impressions left by others are shaped by histories that stick, at the same time as they generate the surfaces and boundaries that allow bodies to appear in the present (Ahmed, 2004, p. 39).

Exfoliations between communities of mothers and fathers, therefore, occur not simply as essentialising movements of sensation and feeling between and across affective bodies, as if those are rendered but objects to be moved, but also as the continuous movements of the surfaces and boundaries that continue to be composed *during* affective life and that may become *stuck* to subjects and objects within the particularity and uniqueness of their own histories; they occur not in de-historicised acts of sharing between subjects and objects, but are actually instrumental acts of affective subjects done within a “moment of contact” that is given its contours and parameters by a history of past contacts as well as a sensation of future contacts (Ahmed, 2004, p. 30). The formation of communities of affect may be understood, for instance, as the production of newly-crafted forms of story-telling and the establishment of alternative, more broadly distributed channels for the flows of impressions, and in which mothers and fathers may be able to expand their capacities for connection; in which the feelings and sensations of intimacy, responsibility, and self-confidence appear as predicated not on the engagements of medicalised birthing discourse alone, but also on the creative potentialities of whole communities of affective subjects.

Specific forms of communication between mothers that are not derived simply from the machinations of childbirth education may offer spaces of potential and expression in which non-medicalised, non-marketised voices are permitted an opportunity to establish collective experiences of labour and delivery (Semenic et al, 2004, p. 84). In the context of contemporary birthing experiences, advances in communications technologies figure prominently, for these have transformed the manner in and extent to which individuals communicate, connect, and share (cf. Babble, 2013; Baby Centre, 2012; Circle of Moms, 2013; Father Life, 2012; Fathers-To-Be, 2012; Mr. Dad, 2013; Life of Dad, 2010).<sup>71</sup> The internet appears as significant here, as it suggests the possibility of a more porous medicalised environment that is, in the context of today's world of continuous virtual connection and relationality, extended beyond the aforementioned discursive boundaries set upon birthing experiences. As Braun (2007) remarks, in his discussion of the role of the internet in the commercialisation of genetic material,

the Internet looms large, providing novel possibilities for the sharing of biomedical knowledge and life experience among lay advocates, scientists and clinicians, and for forging translocal communities ... These new de-territorialized 'body-geographies' can be seen to challenge local cultures of health and local etiologies of disease ... providing space for the proliferation of alternative body-knowledges, or for the emergence and organization of new demands on state and capital by individuals and collectives (p. 11)

The experience of birth is currently finding itself opened up to previously unavailable affective flows which arrive ostensibly from the outside and is being made increasingly

<sup>71</sup> To be sure, it is also the case that variations in accessibility and availability are simultaneously suggestive of the cultural, social, and economic divisions that exist in terms of creating gaps in communication according to socio-economic, -political, -cultural factors; as such, it must also be recognised that while modern communications technologies, such as the internet and mobile devices, provide opportunities for opening up contact between affective subjects, these also create new divisions and, therefore, new kinds of distance between subjects. For instance, one's access to the internet or to particular kinds of devices is limited according to a number of socio-economic factors, such as affordability and access to knowledge/skills, and so is suggestive of limitations to the opening-up of communication potential between affective subjects. Moreover, the presence of new divisions, in turn, produces new opportunities for affective subjects to establish novel collectivities through the experiences of technological exclusion or alienation that may arise out of the problematics of the socio-cultural and socio-economic uses of contemporary technological practice.

porous via the making available of the experiences and spaces of birth, for both mothers and fathers, through the possibilities of the internet's virtual channels of connection, networking, and communication. A loose virtual network of venues and routes for communicating the feelings and sensations of affective life now exist, for instance, in online forums and blogs (cf. Babble, 2013; Baby Centre, 2012; Circle of Moms, 2013; Father Life, 2012; Fathers-To-Be, 2012; Mr. Dad, 2013; Life of Dad, 2010), social networking sites, such as Twitter or Facebook, and the increasingly normalised and consistent use of mobile phones in everyday life. No longer is birth isolated from the outside world as when the only connections mothers and fathers had with those not physically present was through the telephone at the hospital, direct but intermittent communication with those awaiting news in the waiting room, or by documenting the birth through photography, video, and personal writing. With access to a virtual community, moreover, many individuals and communities previously excluded from direct experience and communication are now finding a level of involvement that may potentially disrupt *and* interact with medicalised arrangements of affective life and make possible the formation of novel kinds of affective community. The function of one's access to the virtual experience of childbirth may, therefore, be seen as a political, social, and economic act, and so childbirth, when seen through this lens, begins to appear as an act infused with political, social, and economic interests that are related to notions of privacy, individual and group freedoms, and the medicalisation of birthing experiences and spaces, interests which suppose both the existence of barriers to protect and a sense in which novel affective subjectivities and communities become at least possible. Discussions that focus on either criticisms or the permittance of mobile devices and the internet in the birthing room—and therefore one's access to a real-time connection to the outside world—appear as all the more important for they suggest possibilities for articulating new claims about being able to know oneself as a social, political, and economic subject.<sup>72</sup>

<sup>72</sup> The debate surrounding the questions of privacy and how childbirth ought to be shared with various social networks, and how this involves the relationship between social engagement and communication technology can be seen in the advisories of hospital regulation: at BC Women's Hospital and Health Centre (2012), labour and birth guidelines make the case quite clear, stating that "There is a telephone in each room [and to] please ask your family and friends to wait for your support person to call them with news about your labour and birth. Cellular phones

In terms of the divisions of gender and socio-economic status that are produced in medicalised birthing discourse, assemblages of communities of affect may work to break down economic, geographic, social, or cultural gaps, making it possible to overcome certain exclusivities that exist in terms of access to educational services and products in the childbirth economy and even to establish the availability of non-marketised options. Moreover, these new forms of communication between otherwise divided communities have a dual effect of both realising new types of connection between subjects and objects and of making available the opportunity to engage creatively in making real that which may have otherwise remained only as potential. That is, while relations of inequality will likely persist in the boundaries and surfaces of these new forms of social, economic, and political association (i.e. new communities of affect), they remain as important sources of connectivity between otherwise isolated affective subjects. While preparing for and experiencing the effects of normalisation that are produced through the discursive strategies that surround labour and delivery, subjects may, in other words, become affectively associated with one another and active participants in new and previously unavailable bonds of friendship, trust, and responsibility and that may extend beyond the possibilities offered by the market economy and medicalising logics of birthing practice.

What may be imagined here is the production of an 'affective commons,' perhaps around sensations of empathy and its organising potential (Rifkin, 2009). Such a collective can then be perceived as producing collective opportunities for affective subjectivities to respond to the strategies of power via an ameliorated and reconfigured power *to*. As the immaterial halo of affective space extends beyond the isolated hospital environment and breaks through the normalised privacy, sterility, and control that it works to produce, the room gains in porosity and surrounding communities may, having gained access despite whatever previous isolation, find they are increasingly and transformatively involved in the productions of motherhood, fatherhood, family, and community. Most significantly, perhaps, the invocation of risk and insecurity as a means for proposing or enforcing isolation in the medicalised setting may be increasingly

are not permitted inside the hospital." The requirements of the maternity care ward do more than restrict the use of technology, but also identify the subjects who are privileged with first-hand, real-time knowledge and how that information may be distributed and when.

questioned and so become open to new forms of politicisation. Mothers, for example, can expand the circle of connections between themselves and other affective subjects as their feelings and sensations of intimacy, responsibility, and self-confidence not predicated simply on the engagements of medicalised birthing discourse allow them to discover new pathways for sharing, learning, collaborating, and experiencing throughout the stages of pregnancy, labour, and delivery. The voices of other women more than those of professionals, in fact, have been shown to figure most significantly in the experiences of birthing mothers, as knowledge gained from other women can be considered more credible and critically important to birthing mothers than that which is gained from professional sources (Semenic et al, 2004, p. 84). The suggestion that these kinds of connections are significant in the experiences of mothers lends credence to the claim that contemporary forms of *virtual* community can, too, be a way for alternative body-knowledges to find traction in the unique affective lives of individuals. As these technologies provide new virtual conduits for the exfoliations and impressions of affective life and suppose the existence of a previously unavailable basis for the formation of affective communities—e.g. in the context of medicalised childbirth—what is witnessed are new possibilities for subjects to engage creatively with one another and to harness the potential for exceeding the constraints set upon them by forms of social, economic, and political power.

However, while these realms of interaction offer new possibilities for communities of resistance, it is also possible to understand the appearance of a new architecture of human relationships as a source for still more re-deployments of subjectivating strategies, for these potential-filled relations quickly become targets for new forms of surveillance and knowledge production once they are actualised and made visible to power (cf. Rabinow & Rose, 2006). Apparatuses monitor and mine for new sets of data, techniques, and subjects through which to reproduce new strategies for the governance of life itself and a milieu of organisations, businesses, and researchers discover new spaces of control in formations of shared affective life. Within these new strategies, affective lives are reproduced as extensions of the medical apparatus and the newly identified and categorised desires, demands, and insecurities of mothers and fathers are made to be more easily navigated and manipulated. New data points can then be mobilised to establish either previously dominant or even new subject positions that are



reproduced within a continually adapting childbirth economy: new media and evidence exploring trusted methods and personal experiences are collected as *medicalised* information—i.e. data-mined experiences of childbirth that are *given* legitimacy by the assurances of medical science—and are released as exciting, new consumer products and services; the growing demands of birthing mothers and supportive fathers are identified as the bases for new products and services, such as websites and mobile applications, which work to gather still more data on behaviours and expectations and produce a centralised network of affects that can be accessed and used as an adaptive tool in the childbirth market; targeted advertising strategies that can more easily locate and analyse core markets are deployed around centralised consumers who reside in a web of commodified affective energies; and, researchers use newly available information networks to gain a greater understanding of the political, social, and economic behaviours of contemporary mothers, fathers, and their families, having now gained access into the previously private affective economies of mothers and, increasingly, fathers.<sup>73</sup>

The continuation of the agonism between power and resistance emerges then, despite the impacts of biopolitical forms of resistance, as new deployments of power work to identify, categorise, and determine subjects and positionalities via its new points of access to subjects' lives and knowledges. As a result, it becomes possible to define new constraints through the re-appropriation and politicisation of the specific, manageable ways that previously private or unarticulated forms of affective life are made to arise in full discursive view. The use of the internet, as an example of affects' potential in the contemporary context of childbirth in particular, therefore calls into being at least a duality of productivity: the first being a narcissistic, individualising platform upon which the particularities of one's personal story are lived out in virtual space—as if in a theatrical appearance for all to both engage in as audience and performer (Rifkin, 2009)—and the second being a space in which forms of socially affective attachments

<sup>73</sup> Baby Centre (2013), a website which collects stories and research on childbirth and childcare, is an example of this online presence. Moreover, Babble (2012), an online service provided by Disney, is a forum in which open discussions between parents, parents-to-be, and experts is supported. Conversations, articles, and advice columns, for instance, host a number of topic areas, from labour and delivery to diet to fashion to household management. Increasingly, fathers are becoming targets for these kinds of online forums (Popsugar, 2013).

may be felt and sensed, as subjects share affects by way of the open-sourcing of their own and shared experiences as virtualities and entanglements of affective life.<sup>74</sup> With regards to the first, what can be seen are the points at which new strategies may find targets, such as the marketing of online life as a way to engage with an individual's drives for recognition amongst online peers? However, while this perspective finds itself reinforced, so too are new potentialities for resistance produced: the sharing of intimate details and narratives about the experiences of childbirth establish conditions in which new affective attachments may constitute practices of resistance that are mobilised, strategic relations composed around new affective lives, or *novel collectivities*.

In the end, what is critical in asserting the analytical value of affective subjectivity as producing a resistance to power is that doing so is not to suggest the romanticisation of a "purely oppositional knowledge project" (Murphy, 2012, p. 99), much in the same regard that supposing the values of the aforementioned biopolitical regime is not to expose a global logic of biopower, as Rabinow and Rose (2006) have phrased it. Instead, it pursues an explanation in which modes of resistance and modes of power are recursively and circuitously related to one another and to demonstrate by way of analysis those specific points of contact where each appears in full or partial view. It requires the presence of a double action in the analysis of biopolitical relations, for resistance produces forms of expressed contestation against power whilst power works toward the elaboration of new targets of subjectivation; we are called to find in the milieu of power and resistance their complex orders and potentialities and so whatever critical judgments, dangers, and new possibilities may be concealed within their infrastructure (ibid, p. 208). What this reflects, in terms of neoliberalism and forms of subjection, is a recognition of social orders in which individualities and practices that suppose opposing ontological positions enable new ways of living while they simultaneously "reverberate with capitalism's requirement for exuberant territories through which to implant and

<sup>74</sup> The term *virtuality* here is used to describe both the online codification of affective life through, for instance, file sharing, social media, or open-sourced publication, as well as the sense in which the online presence of affective life imbues it with a potentiality that is beyond the locality of the body (i.e. one-to-one communication that occurs in the hospital room, in one's family relationships, or in the specific community (or communities) to which one belongs) and is instead extended outward into sets of relations that are global or, in the least, beyond the realm of interpersonal and proximal relationships.

recycle value” (Murphy, 2012, p. 98). Resistance to medicalisation ought not to be delinked from the orders of medicalisation, as if transformations of social practice from the logics of medicalised birthing may result in a final liberation from power’s effects. Instead resistance is irrevocably connected back to power: new markets, services, products, and choices are assembled around the emergent feelings and sensations of new modes of motherhood and fatherhood and that have now become visible to investments of power and made susceptible to being *shaped* by its reformed strategies (ibid, p. 90—91). Oppositions that arise through formations of communities of affect are not last stands of freed subjects working in congress—or, at least, not that alone—but are instead affective entanglements that make possible novel individual and collective expressions of affective life.<sup>75</sup>

<sup>75</sup> As an example, in Rifkin’s (2009) supposition that an empathic civilisation could usher in a new global consciousness that challenges the standards of individuality now reified under neoliberal capitalism, a new *dramaturgical consciousness* that appears as a centrepiece of the global internet community is potentially problematic as it may induce a “younger generation to global cosmopolitanism and a universal empathic sensibility [while] the same communications technology revolution ... has a dark side that could derail the journey ... into a dead-end corridor of rampant narcissism, endless voyeurism, and overwhelming ennui” (p. 554).

## Chapter 5.

### Concluding Remarks

My intention in this thesis has been to propose a necessary turn in biopolitical analysis and research that supposes affective subjectivity as not only a means for describing the targets, strategies, techniques, and effects of contemporary forms of power, but also for offering explanations of resistance as they present multiple instances of contention against subjugation. Such efforts are done in the spirit of continuing with Foucault's later positioning with respect to the complexities of subject-formation, for, as Eckerman (2000) has contended, his recognition of the multiple constitutions of the self allows engagement with the appearance of anomalies, rather than mere dismissal of them as signs of irrational deviance (p. 167). Affective subjectivity as a form of life that is recognisable in its force of ambiguity and potentiality offers such an account of the anomalistic and of the possibilities that arise from the multiple constitutions of subjectivity, as well as the opportunity to move biopolitical analyses of subject-formation—and, indeed, of biopolitical regimes themselves—beyond reifications of discursivity.

There are, however, several limitations that are present in the analysis that deserve mention and could offer opportunities for future research of this kind. Firstly, the analyses I have offered suppose a specifically heteronormative structure of the family and of intimate relationships, and so a limited representation of affective subjectivity as well as the effects of the strategies of power. Doing so was directed by an objective to accomplish two aims: first, for the sake of representativeness 'mothers' and 'fathers' were selected because they tend most often to be present in medicalised birthing settings in British Columbia (CIHI, 2004; *ibid*, 2006); second, the scope was narrowed for the purpose of maintaining a concise analysis, for I have offered the research in order to demonstrate the viability of the approach I have attempted to construct. As a result of these limitations, further research should focus on alternatives for analysing the

strategies of power and affective subjectivities in the practices and engagements of medicalised birthing discourse, such as same-sex partnerships, single-parents, and formal or informal surrogacy arrangements. For instance, in terms of the critique of father-infant attachments offered above, an interesting analysis may focus on the ways that gay men involved in surrogacy contracts confront those notions of the gendering of biosecurity and of the practices of labour support, as well as the effects of heteronormativity in the protocols of medicalised environments. Indeed, there exists interesting scholarship on gay parenting, which examines the experiences of gay and lesbian partners throughout pregnancy, labour, delivery, and parenting (cf. Bucholz, 2000; Cherguit et al, 2012; Larsson & Dykes, 2009; Lee et al, 2011; Lewin, 2009<sup>a</sup>; ibid 2009<sup>b</sup>; McManus et al, 2005; Rondahl et al, 2009; Spidsberg & Sørli, 2012), which may provide valuable data for continuing with analysing these perspectives, experiences, and circumstances. The use of alternative methods for accumulating data may also offer opportunities for research, as both qualitative and quantitative methods besides document analysis could offer valuable sources of information and analytical breadth.

Moreover, the analysis of so-called *normal childbirth* limits the scope of this work, such that it fails to represent the more varied experiences subjects may have with treatments, procedures, and technologies. As examples, research could be directed toward analyses of subjects' uses of fertility treatments, surgical and non-surgical interventions, and mobile surveillance and data-collection or analysis equipment (Topol, 2011). In addition to these varied experiences with medicalised practices, studies could also turn to analysis of non-medicalised experiences of childbirth. Moreover, in terms of affective subjectivity and resistance, uses of technology and engagements with ostensibly not-normal birthing practices may provide new ways for understanding how affective subjectivity impacts the relations of power and provide an additional framing for the production of affective communities in contemporary settings and experiences. To this end, elaboration of non-Western birthing practices could also offer interesting findings, both in terms of the ways in which power targets and reproduces subjects as well as how affective subjects and communities might determine and mobilise opportunities for resistant practice.

In terms of the objective that I set for the preceding analysis, I have attempted to demonstrate the particular ways in which affect appears both within the strategies and

techniques of power—i.e. for mothers, in the medical objectivisation of birthing bodies, emphases of femininity, and the efforts to control birth, and, for fathers, as practices of supportive labourers and threats posed by masculinised bodies—and in formations of resistance through affective subjectivities—i.e. in the feelings and sensations of trust, friendship, and responsibility as these arise in experiences of intimacy, collaboration, and self-confidence. While the former has been proposed elsewhere (Hardt & Negri, 2004), the latter is an area of emerging interest in both affect and biopolitical scholarship (cf. Anderson, 2006; Anderson & Harrison, 2006; Murphy, 2012; Venn, 2007; Venn & Terranova, 2009) and so the argument that I have offered is intended as a contribution to these ongoing developments and shifts in sociology and anthropology. Moreover, it offers an account for the possibility of resistance and forms of political action in a politics that has been reduced to biopolitics (Edkin, 2007, p. 70—71), for affective subjectivity supposes a continuously opportunistic production of alternatives to the effects of power. In the end I have attempted to expose merely an explanation for the need to explore new formations of collectivity and individuality that emerge in the open, ambiguous channels of feeling and sensation.

## References

- Adams, E.D. & Bianchi, A.L. (2008). A Practical Approach to Labour Support. *The Journal of Gynaecology and Neonatal Nursing*, 37 (1), 106—115.
- Adams, V. Murphy, M. & Clarke, A. (2009). Anticipation: Technoscience, life, affect, temporality. *Subjectivity*, 28, 246—265.
- Agamben, G. (2000). *Means Without End: Notes on Politics*. Minneapolis, MN: Regents of the University of Minnesota.
- Ahmed, S. (2004). Collective Feelings: Or, The Impressions Left by Others. *Theory, Culture & Society*, 21(2), 25—42.
- Ahmed, S. (2006). Orientations: Toward a Queer Phenomenology. *GLQ: A Journal of Lesbian and Gay Studies*, 12 (4), 543—574.
- Ahmed, S. (2008). Open Forum Imaginary Prohibitions: Some Preliminary Remarks on the Founding Gestures of the 'New Materialism'. *European Journal of Women's Studies*, 15 (1), 23—39.
- Anderson, B. (2006). Becoming and being hopeful: Towards a theory of affect. *Environment and Planning D: Society and Space*, 24 (5), 733—752.
- Anderson, B. (2009). Affective Atmospheres. *Emotion, Space, and Society*, 2 (2), 77—81.
- Anderson, B. (2011). Affect and Biopower: towards a politics of life. *Transactions of the Institute of British Geographers*, NS, doi 10.1111/j.1475-5661.2011.00441.x
- Anderson, B. & Harrison, P. (2006). Questioning affect and emotion. *Area*, 38 (3), 333—335.
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). (2011). AWHONN Position Statement: Nursing Support of Labouring Women. *Journal of Gynaecology and Neonatal Nursing*, 40 (5), 665—666.
- Babble. (2012). Top 50 Dad Blogs of 2012. Retrieved from <http://www.babble.com/dad/top-50-dad-blogs/>
- Baby Center. (2013). Baby Center: Community. Retrieved from <http://www.babycenter.ca/community>

- Bardon, T. & Josserand, E. (2011). A Nietzschean Reading of Foucauldian Thinking: Constructing a project of the self within an ontology of becoming. *Organization*, 18 (4), 497—515.
- Bartky, S.L. (1997). Foucault, Femininity, and the Modernization of Patriarchal Power. In Meyers, D. T. (ed.), *Feminist Social Thought* (pp. 93—11). New York, NY: Routledge.
- Bernauer, J. (1987). Michel Foucault's Ecstatic Thinking. *Philosophy & Social Criticism*, 12 (1/2), 156—193.
- Blackman, L. & Venn, C. (2010). Affect. *Body & Society*, 16 (7), 7—28.
- Bokat, N. (1995). Natural Childbirth: From Option to Orthodoxy. *On the Issues: Long Island City*, 4 (1), 36—3.
- Braun, B. (2007). Biopolitics and the molecularization of life. *Cultural Geographies*, 14 (1), 6—28.
- BC Centre for Excellence for Women's Health (BCCEWH). (n.d.). *Solving the Maternity Care Crisis: Making Way for Midwifery's Contribution*. Retrieved from [http://bcccewh.bc.ca/publications-resources/download\\_publications.htm](http://bcccewh.bc.ca/publications-resources/download_publications.htm)
- British Columbia Perinatal Health Program (BCPHP). (1998). *Perinatal Forms Guideline 2: Generic Charting Guideline for Perinatal Care Providers*. Vancouver, BC: British Columbia Perinatal Health Program.
- British Columbia Perinatal Health Program (BCPHP). (2008). *SOGC-BCPHP Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline*. Vancouver, BC: British Columbia Perinatal Health Program.
- British Columbia Perinatal Health Program (BCPHP). (2010<sup>a</sup>). *Perinatal Forms Guideline 4: A Guide for Completion of the British Columbia Labour Partogram* (BCPHP 1583). Vancouver, BC: Provincial Health Services Authority.
- British Columbia Perinatal Health Program (BCPHP). (2010<sup>b</sup>). *Obstetric Guideline 19: Maternity Care Pathway* (February 2010). Vancouver, BC: BC Perinatal Health Program/Provincial Health Services Authority.
- British Columbia Women's Hospital and Health Centre (BC Women's). (2012). BC Women's Hospital and Health Centre: Health Topics. Retrieved from <http://www.bcwomens.ca/HealthTopics/HavingBaby/LabourBirth.htm>
- Brown, T. (2011, November). Special Delivery: What you need to know about bring an early bird into the world. *Pregnancy and Newborn Magazine*. Retrieved from <http://www.pnmag.com/prenatal-health/labor-delivery/special-delivery>
- Brubaker, S.J. & Dillaway, H.E. (2009). Medicalization, Natural Childbirth, and Birthing Experiences. *Sociology Compass*, 3 (1), 31—48.



- Buchholz, S.E. (2000). Experiences of Lesbian Couples During Childbirth. *Nursing Outlook*, 48 (6), 307—311.
- Budin, W.C. (2008). Safely Giving Birth. *Journal of Perinatal Education*, 17 (2), 1—3.
- Canadian Institute of Health Information (CIHI). (2004). *Giving Birth in Canada: Providers of Maternity and Infant Care*. Ottawa, ON: Canadian Institute of Health Information.
- Canadian Institute of Health Information (CIHI). (2006). *Giving Birth in Canada: Providers of Maternity and Infant Care*. Ottawa, ON: Canadian Institute of Health Information.
- Canadian Institute of Health Information (CIHI). (2012). *Highlights of 2010-2011 Selected Indicators Describing the Birthing Process in Canada*. Ottawa, ON: Canadian Institute of Health Information.
- Chan, A. (2000). Redirecting Critique in Postmodern Organisation Studies: The perspective of Foucault. *Organisation Studies*, 21 (6), 1059—1075.
- Charlesworth, J. (June 2012). Is the midwife a status symbol? Midwifery certainly isn't a trend, but it is getting trendy. Are moms-to-be hoping a midwife will make them hip? *Today's Parent*. Retrieved from <http://www.todayparent.com/blogs/on-our-minds/is-the-midwife-a-status-symbol>
- Cheeks, J. & Porter, S. (1997). Reviewing Foucault: possibilities and problems for nursing and health care. *Nursing Inquiry*, 4 (2), 108—119.
- Cherguit, J., Burns, J., Pettle, S. & Tasker, F. (2012). Lesbian co-mothers' experiences of maternity healthcare services. *Journal of Advanced Nursing*, 00 (0), 1—10.
- Clough, P.T. (2010). Afterword: The Future of Affect Studies. *Body & Society*, 16 (1), 222—230.
- Crenshaw, J. (2004). Care Practices that Promote Normal Birth, #6: No Separation of Mother and Baby with Unlimited Opportunity for Breastfeeding. *Journal of Perinatal Education*, 13 (2), 35—39.
- Cvetkovich, A. (2003). *An Archive of Feelings: Trauma, Sexuality, and Lesbian Public Cultures*. Durham, NC: Duke University Press.
- Davis-Floyd, R.E. (2008). 'Foreword'. In Soo Downe (ed.), *Normal Childbirth: Evidence and Debate* (pp. ix—xiii). London, UK: Elsevier Limited.
- Deleuze, G. (1995). *Negotiations, 1972 – 1990*. New York: Columbia University Press.
- Desjarlais, R. & Throop, J. (2011). Phenomenological Approaches in Anthropology. *Annual Review of Anthropology*, 40, 87—102.

- Dienhart, A. (2001). Make Room for Daddy: The Pragmatic Potentials of a Tag-Team Structure for Sharing Parenting. *Journal of Family Issues*, 22 (8), 973—999.
- Dolezal, L. (2009). Self-Transformations: Foucault, Ethics, and Normalised Bodies. *International Journal of Philosophical Studies*, 17 (2), 345—349.
- Downe, S. & McCourt, C. (2008). From Being to Becoming: Reconstructing childbirth knowledges. In Soo Downe (ed.), *Normal Childbirth: Evidence and Debate* (pp. 3—24). London, UK: Elsevier Limited.
- Draper, J. (1997). Whose welfare in the labour room? A discussion of the increasing trend of fathers' birth attendance. *Midwifery*, 13 (3), 132—138.
- Dreyfus, H.L., Rabinow, P. & Foucault, M. (1982). 'The Subject and Power'. In: Dreyfus, H.L. & Rabinow, P. (eds.) *Michel Foucault: Beyond Structuralism and Hermeneutics* (pp. 208—226). Chicago, IL: University of Chicago Press.
- Eckerman, L. (2000). 'Foucault, embodiment, and gendered subjectivities: The case of voluntary self-starvation'. In Alan Peterson & Robin Bunton (eds.) *Foucault: Health and Medicine* (pp. 151—167). Routledge: New York, USA.
- Edkin, J. (2007). Whatever Politics. In Matthew Calarco & Steven DeCaroli (eds.) *Giorgio Agamben: Sovereignty and Life* (pp. 70—91). Stanford, CA: Stanford University Press.
- Ellis, R.R. (August, 2011). Words of Wisdom. *Pregnancy and Newborn Magazine*. Retrieved from <http://www.pnmag.com/pregnancy/words-of-wisdom-2/>
- Ellis, R.R. (2012). Coming Out: Your baby's transition from the womb to the world. *Pregnancy and Newborn Magazine*. Retrieved from <http://www.pnmag.com/pregnancy/words-of-wisdom-2/>
- Enkin, M., Keirse, M.J.N.C., Neilson, J., Crowther, C., Duley, L., Hodnett, E., & Hofmeyr, J. (1995). *A Guide to Effective Care in Pregnancy and Childbirth*, 3<sup>rd</sup> Ed. Oxford University Press: Oxford, UK.
- Enkin, M., Keirse, M.J.N.C., Neilson, J., Crowther, C., Duley, L., Hodnett, E., & Hofmeyr, J. (2000). *A Guide to Effective Care in Pregnancy and Childbirth*, 3<sup>rd</sup> Ed. Oxford University Press: Oxford, UK.
- Father Life, the. (2012). The Father's Life: The Men's Magazine for Dads. Retrieved from <http://thefatherlife.com/mag/>
- Fathers-to-be (2013). Fathers To Be, International: Learning to ride the waves of pregnancy, birth, and early fatherhood. Retrieved from <http://www.fatherstobe.org/default.htm>
- Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977* (ed. Colin Gordon; trans. Colin Gordon, Leo Marshall, John Mepham, Kate Soper). Pantheon Books: New York, USA.

- Foucault, M. (1984). *The Foucault Reader* (ed. Paul Rabinow). New York, USA: Pantheon Books.
- Foucault, M. (1988). *The History of Sexuality, Volume III: The Care of the Self* (trans. Robert Hurley). New York, USA: Vintage Books.
- Foucault, M. (1990). *The History of Sexuality, Volume I: An Introduction* (trans. Robert Hurley). New York, USA: Vintage Books.
- Foucault, M. (2003). *Psychiatric Power, Lectures at the Collège de France 1973 – 1974* (ed. Arnold A. Davidson; trans. Graham Burchell). New York, USA: Picador.
- Foucault, M. (2007). *The Politics of Truth* (ed. Sylvère Lotringer, trans. Lysa Hochroth & Catherine Porter). Los Angeles, USA: Semiotext(e).
- Foucault, M. (2010). *The Archaeology of Knowledge* (trans. A.M. Sheridan Smith). New York, USA: Routledge Classics.
- Frank, A.W. & Jones, T. (2003). Bioethics and the Later Foucault. *Journal of Medical Humanities*, Vol. 24 (3/4), 179—186.
- Gadow, S. (1994). Whose body? Whose story? The question about narrative in women's health care. *Soundings*, vol. 77 (3/4), 295—307.
- Gil, J. (1998). *Metamorphoses of the Body: Theory Out of Bounds*. (trans. Stephen Muecke). Minneapolis, USA: The University of Minnesota Press.
- Goldberg, L. (2002). Rethinking the birthing body: Cartesian dualism and perinatal nursing. *Journal of Advanced Nursing*, 37 (5), 446—451.
- Goldberg, L. (2003). In the Company of Women: Enacting autonomy within the perinatal nursing relationship. *Nursing Ethics*, 10 (6), 581—587.
- Gorton, K. (2007). Theorizing Emotion and Affect: Feminist Engagements. *Feminist Theory*, 8 (3), 333—348.
- Grosz, E.A. (1995). *Space, time, and perversion: Essays on the politics of bodies*. New York: Routledge
- Haraway, D. (1989). *Primate Visions: Gender, Race, and Nature in the World of Modern Science*. New York: Routledge.
- Hardt, M. (1999). Affective Labour. *Boundary 2*. 26 (2), 89—100.
- Hardt, M. & Negri, A. (2004). *Multitude*. New York: Penguin Press.
- Henrique, J., Holloway, W., Urwin, C., Venn, C. & Warkerdine, V. (1984). *Changing the Subject: Psychology, Social Regulation, and Subjectivity*. New York: Methuen.

- Hoy, D.C. (1987). 'Power, Repression, Progress: Foucault, Lukes, and the Frankfurt School' (pp. 123—147). In Hoy, D.C. (ed.), *Foucault, A Critical Reader*. New York, NY: Blackwell.
- Humenick, S.S. (2006). Life-Changing Significance of Normal Birth. *Journal of Perinatal Education*, 15 (4), 1—3.
- Jackson, M. (1983) Knowledge of the Body. *Man*, 18 (2), 327—345.
- Jaggar, A. M. (1989). Love and knowledge: Emotion in feminist epistemology. *Inquiry: An Interdisciplinary Journal of Philosophy*, 32 (2), 151—176.
- Johnson, C. (2008). The Political "Nature" of Pregnancy and Childbirth. *The Canadian Journal of Political Science*, 41 (4), 889—913.
- Kennell, J.H. & McGrath, S.K. (2003). Beneficial effects of postnatal skin-to-skin contact. *Acta Pædiatrica*, 92 (3), 272—273.
- Klossner, N.J. (2006). *Introductory Maternity Nursing, Volume 1*. Philadelphia: Lippincott Williams & Wilkins.
- Kornelsen, J., Dahinten, V.S., & Carty, E. (2003). On the Road to Collaboration: Nurses and Newly Regulated Midwives in British Columbia, Canada. *Journal of Midwifery & Women's Health*, 48 (2), 126—132.
- Larkin, P., Begley, C.M., & Devane, D. (2007). Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery*, 25 (2), e49—e59.
- Larsson, A. & Dykes, A. (2009). Care during pregnancy and childbirth in Sweden: Perspectives of lesbian women. *Midwifery*, 25 (6), 682—690.
- Lee, E. Taylor, J. & Raitt, F. (2011). 'It's not me, it's them': How lesbian women make sense of negative experiences of maternity care: a hermeneutic study. *Journal of Advanced Nursing*, 67 (5), 982—990.
- Lewallen, L.P. (2011). The Importance of Culture in Childbearing. *Journal of Gynaecology and Neonatal Nursing*, 40 (1), 4—8.
- Lewin, E. (2009<sup>a</sup>). *Gay Fatherhood*. Chicago: University of Chicago Press.
- Lewin, E. (2009<sup>b</sup>). How Gay Fathers Dream the Family. *Anthropology News*, 50 (2), 14
- Life of Dad. (2010). The Life of Dad: Being a father isn't always easy, but then again, neither is fantasy football. Retrieved from <http://thelifeofdad.blogspot.ca/>
- Lis, A., Gennaro, A., & Mazzeschi, C. (2006). Transition to Fatherhood. In G.B. La Sala, G.B., Fagandini, P., Iori, V. & Monti, F., *Coming Into the World: a Dialogue Between Medical and Human Sciences* (pp. 103—113). Modena, IT: De Gruyter.

- Lock, M. (1998). Situating Women in the Politics of Health. In Susan Sherwin (ed.). *The Politics of Women's Health: Exploring Agency and Autonomy*. Philadelphia: Temple University Press.
- Lupton, D. (2000). 'A Love/Hate Relationship': The Ideals and Experiences of First-Time Mothers. *Journal of Sociology*, 36 (1), 50—63.
- Lyon, M. (1995). Missing Emotion: The limitations of cultural constructionism in the study of emotion. *Cultural Anthropology*, 10 (2), 244—263.
- Mackinnon, K., McIntyre, M., & Quance, M. (2003). The Meaning of the Nurse's Presence during Childbirth. *Journal of Gynaecology and Neonatal Nursing*, 34 (1), 28—36.
- Mahoney, M.A. & Yngvesson, B. (1992). The Construction of Subjectivity and the Paradox of Resistance: Reintegrating Feminist Anthropology and Psychology. *Signs*, 18 (1), 44—73.
- Mardorossian, C.M. (2003). Labouring Women, Coaching Men: Masculinity and Childbirth Education in the Contemporary United States. *Hypatia*, 18 (3), 113—134.
- Marsiglio, W. (1991). Male Procreative Consciousness and Responsibility: A Conceptual Analysis and Research Agenda. *Journal of Family Issues*, 12 (3), 268—290.
- Marsiglio, W. (1993). Contemporary Scholarship on Fatherhood: Culture, Identity, and Conduct. *Journal of Family Issues*, 14 (4): 484—509.
- Marsiglio, W. (2009). Men's Relations with Kids: Exploring and Promoting the Mosaic of Youth Work and Fathering. *The Annals of the American Academy*, 624 (1), 118—138.
- Martin, B. (June, 2010). *Book Review: How did dad go from waiting room to birthing room?"* The Father Life: The Men's Magazine for Dad's. Retrieved from <http://thefatherlife.com/mag/2010/06/19/how-did-dad-go-from-waiting-room-to-birthing-room/>
- Martin, E. (2003). Giving Birth like a Girl. *Gender & Society*, 17 (1), 54—72.
- Massumi, B. (1993). *The Politics of Everyday Fear*. University of Minnesota Press: Minneapolis, USA.
- Massumi, B. (2002). *Parables for the Virtual: Movement, Affect, and Sensation*. Durham, NC: Duke University Press.
- Massumi, B. (n.d.). *Navigating Movements*. Retrieved from <http://brianmassumi.com/interviews/NAVIGATING%20MOVEMENTS.pdf>.

- McManus, A.J. Hunter, L.P. & Renn, H. (2006). Lesbian Experiences and Needs During Childbirth: Guidance for Health Care Providers. *Journal of Gynaecology and Neonatal Nursing*, 35 (1), 13—23.
- Mills, C. (2003). Contesting the Political: Butler and Foucault on Power and Resistance. *The Journal of Political Philosophy*, 11 (3), 253—272.
- Ministry of Health, BC. (2010). *Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care* Sixth Edition, 2<sup>nd</sup> Revision. Ministry of Healthy Living and Sport (Province of British Columbia): Victoria, CA.
- Mitchell, J. & Rose, J. (1982). *Feminine Sexuality: Jacques Lacan and the Ecole Freudienne*. New York: W.W. Norton.
- Mori, G.F. (2006). The Interior Experience of Maternity. In G.B. La Sala, G.B., Fagandini, P., Iori, V. & Monti, F., *Coming Into the World: a Dialogue Between Medical and Human Sciences* (pp. 103—113). Modena, IT: De Gruyter.
- Mr. Dad. (2013). Mr. Dad. Retrieved from <http://www.mrdad.com/get-advice/expectant-fathers/>
- Murphy, M. (2012). *Seizing the Means of Reproduction: Entanglements of Feminism, Health, and Technoscience*. Duke University Press: Durham, USA.
- Ngai, S. (2005). *Ugly Feelings*. Harvard University Press: Cambridge, USA
- Oksala, J. (2004). Anarchic Bodies: Foucault and the Feminist Question of Experience. *Hypatia*, 19 (4), 99—121.
- Palkovitz, R. (1985). Fathers' Birth Attendance, Early Contact, and Extended Contact with their Newborns: A Critical Review. *Child Development*, 56 (2), 392—406.
- Patz, A. (July, 2012). The New Labour Laws. In *Pregnancy and Newborn Magazine*. Retrieved from <http://www.pregnancymagazine.com/the-big-day/new-labor-laws>
- Papoulias, C. & Callard, F. (2010). Biology's Gift: Interrogating the Turn to Affect. *Body & Society*, vol. 16 (1), 29—56.
- Parker Toy, M. (September, 2011). C-Sections 101: What to expect when the journey to mommyhood veers into surgical territory. *Pregnancy & Newborn Magazine*. Retrieved from <http://www.pnmag.com/?s=C-sections+101>
- Parrat, J. & Fahy, K. (2003). Trusting enough to be out of control: a pilot study of women's sense of self during childbirth. *Australian Midwifery Journal*, vol. 16 (1): 15—22.
- Perinatal Services British Columbia (PSBC). (2010). *Perinatal Services BC Obstetric Guideline 17: Prenatal Screening for Down Syndrome, Trisomy 18, and Open Neural Tube Defects*. Vancouver, BC: Perinatal Services BC.

- Perinatal Services British Columbia (PSBC). (2011<sup>a</sup>). Anaesthetic Complications in British Columbia: 2003/2004 to 2009/2010. *A Perinatal Service BC Surveillance Special Report*, 1 (1). Vancouver, BC: Perinatal Services BC.
- Perinatal Services British Columbia (PSBC). (2011<sup>b</sup>). *Guidelines for Registered Nurses: Core competencies and decision support tools, Management of labour in an institutional setting if the primary maternal care provider is absent*, 2<sup>nd</sup> Ed. (ed. Lily Lee). Vancouver, BC: Perinatal Services BC.
- Perinatal Services British Columbia (PSBC). (2011<sup>c</sup>). *Perinatal Services BC Newborn Guideline 13: Newborn Nursing Care Pathway*. Vancouver, BC: Perinatal Services BC.
- Perinatal Services British Columbia (PSBC). (2011<sup>d</sup>). *British Columbia Community Newborn Assessment*. Vancouver, BC: Perinatal Services BC.
- Perinatal Services British Columbia (PSBC). (2012). *Data and Surveillance*. Retrieved from: <http://www.perinataleservicesbc.ca/dataandsurveillance>.
- Pignatelli, F. (2002). Mapping the Terrain of a Foucauldian Ethics: A response to the surveillance of schooling. *Studies in Philosophy and Education*, 21 (2), 157-180.
- Popsugar Inc. (2013). Circle of Moms. Retrieved from <http://www.circleofmoms.com/top25/daddy-blogs>
- Pottage, A. (1998). Power as an art of contingency: Luhmann, Deleuze, Foucault. *Economy and Society*, 27 (1), 1—27.
- Prada, J. (2010<sup>a</sup>). Economies of Affectivity. Retrieved from <http://caringlabour.wordpress.com> (retrieved on: June 15, 2011).
- Prada, J. (2010<sup>b</sup>). Affective Link, Policies of Affectivity, Aesthetics of Biopower. Retrieved from <http://caringlabour.wordpress.com> (retrieved on: June 15, 2011).
- Pregnancy and Newborn Magazine (P & N). (2012). Labour Surprises: Just when you think nothing can surprise you, labor and delivery serves as a reminder of one of the most important lessons of parenting—it's all just one big surprise after another. *Pregnancy and Newborn Magazine*. Retrieved from <http://www.pnmag.com/prenatal-health/labor-surprises>
- Public Health Agency of Canada (PHAC). (2008). *Canadian Perinatal Health Report, 2008 Ed.* Ottawa, ON: Public Health Agency of Canada.
- Public Health Agency of Canada (PHAC). (2009). *What Mothers Say: The Canadian Maternity Experiences Survey*. Ottawa, ON: Public Health Agency of Canada.
- Quinn, E. (2008). 'The Second Half of the Twentieth Century: Technology-Managed Childbirth' (pp. 137—178). In Brodsky, P.L. (ed.), *The Control of Childbirth: Women vs. Medicine Through the Ages*. Jefferson, NC: McFarland & Company Inc.

- Rabinow, P. & Rose, N. (2006). Biopower Today. *Biosocieties*, 1 (2), 196—217.
- Randall, J. & Munro, I. (2010). Foucault's Care of the Self: A case from mental health work. *Organization Studies*, 31 (11), 1485—1504.
- Reed, R.K. (2005). *Birthing Fathers: The Transformation of Men in American Rites of Birth*. New Jersey: Rutgers University Press.
- Rich, A. (1976). *Of Woman Born: Motherhood as Experience and Institution*. New York: Norton.
- Richard, A. & Rudnyckyj, D. (2009). Economies of Affect. *Journal of the Royal Anthropological Institute* (N.S.), 15 (1), 57—77.
- Richmond, O.P. (2011). Critical Agency, Resistance, and Post-Colonial Civil Society. *Cooperation and Conflict*, 46 (4), 419—440.
- Rifkin, J. (2009). *The Empathic Civilisation: The Race to Global Consciousness in a World in Crisis*. Cambridge, UK: Polity Press.
- Rippel, C. (October, 2011). Training for Labour: Your Step-by-Step Guide to Getting Mentally Fit for the Big Day. In *Pregnancy and Newborn Magazine*. Retrieved from <http://www.pnmag.com/pregnancy/training-for-labor-2/>
- Rogers, J. (2003). Sustainability and collaboration in maternity care in Canada: Dreams and obstacles. *Canadian Journal of Rural Medicine*, 8 (3), 193—198.
- Rondahl, G. Brugner, E. & Lindhe, J. (2009). Heteronormative communication with lesbian families in antenatal care, childbirth and postnatal care. *Journal of Advanced Nursing*, 65 (11), 2337—2344.
- Root, R. & Browner, C. (2001). Practices of the Pregnant Self: Compliance With and Resistance to Prenatal Norms. *Culture, Medicine, and Psychiatry*, 25 (2), 195—223.
- Rose, N. (1989) *Governing the Soul: The Shaping of the Private Self*. London, UK: Routledge.
- Rose, N. (2007). *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century*. Oxford, UK: Princeton University Press.
- Rúðólfssdóttir, A.G. (2000). 'I am not a patient, and I am not a child': The Institutionalisation and Experience of Pregnancy. *Feminism and Psychology*, 10 (3), 337—350.
- Santoro, P. (2011). Liminal Biopolitics: Towards a Political Anthropology of the Umbilical Cord and the Placenta. *Body & Society*, 17 (1), 73—93.
- Savage, J.S. (2001). Birth Stories. *The Journal of Perinatal Education*, 10 (2), 3—7.



- Scott, C.E. (2010). The Birth of Political Subjects: Individuals, Foucault, and Boundary Experiences. *Research in Phenomenology*, 40 (1), 19—33.
- Semenic, S.E., Callister, L.C. & Feldman, P. (2004). Giving Birth: The Voices of Orthodox Jewish Women Living in Canada. *Journal of Gynaecology and Neonatal Nursing*, 33 (1), 80—87.
- Simons, M. (2006). Learning as Investment: Notes on governmentality and biopolitics. *Educational Philosophy*, 38 (4) 523--540.
- Simonds, W, Rothman, B. & Bari, N. (2007). *Labouring On: Birth in Transition in the United States*. New York: Routledge.
- Smallwood, J. (February, 2012). Stage Mom: Know what to expect during each phase of labour. In *Pregnancy and Newborn Magazine*. Retrieved from <http://www.pnmag.com/prenatal-health/stage-mom>
- Smart, B. (1998). 'The Politics of Truth and the Problem of Hegemony' (pp. 157—174). In Hoy, D.C. (ed.) *Foucault, A Critical Reader*. New York, NY: Blackwood.
- Society of Obstetricians and Gynaecologists (SOGC), Association of Women's Health, Obstetric and Neonatal Nurses of Canada (AWHONN Canada), the Canadian Association of Midwives (CAM), the College of Family Physicians of Canada (CFPC), and the Society of Rural Physicians of Canada (SRPC). (2008). Joint Policy Statement on Normal Childbirth. *Journal of Obstetricians and Gynaecologists of Canada*, 30 (12), 1163—1165.
- Spidsberg, B.D. & Sørli, V. (2012). An expression of love—midwives' experiences in the encounter with lesbian women and their partners. *Journal of Advanced Nursing*, 68 (4), 796—805.
- Stewart, K. (2007). *Ordinary Affects*. Durham, NC: Duke University Press.
- Stoler, A.L. (2009). *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense*. Princeton, NJ: Princeton University Press.
- Thrift, N. (2004). Intensities of Feeling: Towards a spatial politics of affect. *Geografiska Annaler*, 86 B (1), 57—78.
- Thrift, N. (2007). *Non-Representational Theory: Space, Politics, Affect*. New York: Routledge.
- Topol, E. (2011, July). Mobile-izing healthcare. Wireless Technologies will continue to revolutionise the industry. *Modern Healthcare*, 2011, July 25 Supplement, p. 52.
- Tygstrup, F. (2012). Affective Spaces. In Agostinho, D., Antz, E. & Ferreira, C. (eds.), *Panic and Mourning: The Cultural Work of Trauma* (pp. 195—210). Boston, USA: Walter de Gruyter GmbH.

- Vehviläinen-Julkunen, K. & Liukkonen, A. (1998). Fathers' experiences of childbirth. *Midwifery*, 14, 10—14.
- Venn, C. (2007). Cultural Theory, Biopolitics, and the Question of Power. *Theory Culture & Society*, 24 (3), 111—124.
- Venn, C. & Terranova, T. (2009). Introduction: Thinking after Michel Foucault. *Theory, Culture & Society*, 26 (6) 1—11.
- Waldby, C. (2006). Umbilical Cord Blood: From Social Gift to Venture Capital. *Biosocieties*, 1 (1): 55—70.
- Walker, D.S., Visger, J.M., & Rossie, D. (2009). Contemporary Childbirth Education Models. *Journal of Midwifery and Women's Health*, 54 (6), 469—476.
- Weir, L. (2006). *Pregnancy, Risk, and Biopolitics: On the threshold of the living subject*. New York: Routledge.
- Wissinger, E. (2007). Always on Display: Affective Production in the Modeling Industry. In Clough, P.T. & Halley, J.), *The Affective Turn: Theorising the Social* (pp. 231—260). Durham, NC: Duke University Press.
- Wolf, N. (2003). *Misconceptions: Truth, lies, and the unexpected journey to motherhood*. New York: Anchor Books.