Unnaturalizing bodies

An ethnographic inquiry into midwifery care in Germany

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CHAPTER 4 — EXPERIENCES AS ACTORS
LABOR PAINS IN CHILDBIRTH CARE IN GERMANY[46]

Abstract
Taking labor pains in childbirth care in Germany as a case study, I develop a practice based notion of experience. Labor pains are sociomaterial experiences and effected actors that are shared and worked with, I argue. Fieldwork reveals an extensive repertoire of possible interventions used to deal with, and to co-enact, continuously shifting actorships of labor pains in childbirth care. These actorships include helpful tools, unproductive sensations, effective work, fruitless investments, products of bodily tension, and pure labor pains. Experiences such as labor pains are not only passively known, felt and done but also take active part in shaping practice.

Keywords childbirth, midwifery, pain, practice approaches, experience, actor

46 Submitted and reviewed

Introduction

Pain has been described as an actor that radically disrupts the possibility of sharing realities (Scarry 1985, 4). This actorship of pain has become widely accepted in social sciences (Gonzalez-Polledo and Tarr 2018; Boddice 2014; Käll 2012; Good 1992; Morris 1991; Leder 1990). In her pathbreaking work *The Body in Pain*, Elaine Scarry (1985) asserts that pain is radically destructive; the only antidote is imagination and its (re)constructive force.[47] Starting from the observation that pain not only destroys language but "is world-destroying" (Scarry 1985, 29), she goes on to argue that these characteristics are strategically deployed when pain is inflicted through torture (Scarry 1985, 46–47).

Scarry has provided an influential conceptualization of the mechanisms of violence. What came to be known as work on pain in general, where pain radically disrupts the possibility of sharing realities, seems to be specific to torture practices and to chronic pain, pains that, according to Scarry, "share the same brutal senselessness" (Scarry 1985, 35, see also 4, 27–59). Torture, but also accident or disease or "breakdown of the pain pathway itself" (Scarry 1985, 35) make the sufferer inhabit an all-encompassing yet cruelly private pain—something that is "overwhelmingly present" to the individual in pain but "almost invisible to anyone else, unfelt, and unknown" (Scarry 1985, 51)—and at allowing the torturer to avoid compassion or resist seeing, feeling, or knowing the sufferer's pain. It is my claim that other pains, in other practices and situations are different.

Labor pains, for example, are not inflicted with the intention to hurt or destroy and they are not persistent. They are better described as (enacted) actors that push participants to *re-act*, to deal with pain in ways that aim at rendering it as bearable as possible. In this article, I argue that labor pains as actors are shareable: they are—and must be—shared through being worked with and worked on in midwifery care practices. In order to show that pains are shareable and to articulate the work they do, a practice-based approach to pain experiences is crucial. In contrast to the torture pains analyzed by Scarry, labor pains are not essentially destructive. They are surprisingly creative, shaping birthing arrangements as well as specific subject positions for women giving birth, as feminist scholar Jane Maree Maher (2010) insists.

47 Whereas physical pain "is an intentional state without an intentional object; imagining is an intentional object without an experienceable intentional state" (Scarry 1985, 164). Imagination objectifies pain, Scarry asserts, thereby shaping a passive and helpless somatic experience into an act of self-transformation.

In Maher's diagnosis, 'Western' childbirth discourses are consumed with concerns about choice and control. The pain of labor is off the radar because pain is not thought to reside easily with subjectivity, Maher explains, referring to Scarry's core argument that pain destroys subjectivity. For the subject position of the autonomous chooser, able to have their body and the world at their disposal, this may be true, Maher concedes. Instead of taking the position that pain destroys subjectivity as the unquestioned starting point, Maher studies how labor pains actually co-constitute subjectivities. She writes that through childbirth pain, "each woman is called back to re-negotiate embodiment and subjectivity anew. And in this re-negotiation, only she can have the authority to speak in and of the pain, the fear and the tumult, to produce the particular embodied subjectivity of her childbirth" (Maher 2010).

I share Maher's interest in studying childbirth pains in ways that may enrich childbirth discourses, but I hesitate to burden women with the privileged "authority to speak in and of the pain" (Maher 2010). Instead I follow her invitation to elucidate pain's active involvement in structuring subject positions in childbirth, which includes many different actors and authorities, asking: What do labor pain experiences become in practice approaches? How do labor pains take shape in women's and midwives' childbirth practices? And how do labor pains act? In order to answer these questions I am inspired by works that investigate care practices with the help of tools developed within the field of science and technology studies (STS) and understand care realities as practical and relational achievements (Moser 2011; Pols 2005; Mol and Law 2004; Akrich and Pasveer 2000). Thinking with STS scholars who have introduced a practice-based notion of experience (Gomart and Hennion 1999), I address a third question in a second step: What can practice approaches learn from labor pain experiences? I suggest understanding these experiences not only as effects (Gomart and Hennion 1999, 225) but also as actors in specific birth arrangements.

Articulating Labor Pain Practices

So far, labor pains have mostly been discussed by childbirth care providers, within their corresponding academic disciplines: midwifery science and obstetrics. Also anthropologists have studied labor pains.

Midwives and midwifery scholars have investigated the 'nature' of labor pains in order to establish a ground for advocating non-medical ways of dealing with them (Lowe 2002; Leap and Hunter 2016, 27–28; Whitburn et al. 2019).

They suggest detaching labor pains from a medical register that defines pain as unpleasant and associates it with tissue damage (IASP 2017). Labor pains have a "physiological purpose" (Walsh 2009, 482)—giving birth to a child—midwifery scholars emphasize. Labor is thus not only experienced as painful, but also as purposeful and therefore pleasurable (Van der Gucht and Lewis 2015, 353–56; Whitburn et al. 2019, 29). "[T]he acceptance of pain during childbirth and the ability to embrace this within normal labour and birth suggests it is psychosocial rather than pharmacological support that is needed to enhance [women's] coping ability" (Van der Gucht and Lewis 2015, 357), so the argument goes. *Working with pain* and *pain relief* are thus introduced as two opposing paradigms. Whereas the medical logic of pain relief is based on the conviction that pain causes suffering and must be alleviated if possible, the midwifery approach of working with pain posits that continuous support from a midwife provides women with the possibility to experience self-confidence (Leap and Hunter 2016, 33–40; Hodnett et al. 2013; Leap, Dodwell, and Newburn 2010; Leap et al. 2010; Walsh and Barclay 2007).

Anthropologists have suggested to understand midwifery-specific dealings with "good" or "normal" labor pains as ways of shaping "natural," "humanistic" or "holistic" births, also through using medical technologies such as pain medication (Davis-Floyd 2018, 3–104; Gleisner 2013; MacDonald 2006; 2001, 265–66). In resonance with the midwifery scholarship on labor pains, the affective and social relationships between midwives and women have been argued to emerge as the most important factors or tools for handling labor pains in ways that create 'good childbirth experiences' (Hodnett 2002, S171; Cheyney 2008, 263; Cheyney 2011, 529–30).

In Germany, most women give birth in a hospital where they are accompanied by midwives and doctors. In 2017, this was the case for nearly 99 % of all women giving birth (Gesellschaft für Qualität in der außerklinischen Geburtshilfe (QUAG) 2019). In antenatal classes [*Geburtsvorbereitungskurse*], held by midwives and reimbursed by the national health care systems, anatomical and physiological basic knowledge deemed relevant for birth is imparted, obstetric interventions during birth, such as epidural anesthesia and caesarian section, are introduced, and breathing and moving techniques are practiced. Equipped with these insights, women go to the hospital, where they have registered before, when they think birth has started. This is the case, as they have learned in their antenatal class, if they have had regular uterine contractions, namely at least every ten minutes for at least half an hour

or if their waters have broken. In the hospital, the actual existence and trajectory, called *progress*, of birth is measured with the help of vaginal examinations which help to determine the opening of the cervix, and the position of the fetus' head (or the *presenting part* which might also be the fetus' bump, for example). Birth progresses regularly if the cervix opens up continually and the child descends progressively and if this happens within a defined space of time. However, what counts as regular differs between the various guidelines and recommendations, between labor wards, obstetricians, and midwives. And so do the decisions what to do, according to the stage of birth, to support the regular proceeding of birth while also rendering the labor pains as bearable as possible. The repertoire of possible interventions reaches from walking or climbing stairs, over bathing, massaging, breathing, and relaxation techniques to various pain medications such as spasmolytic suppositories, intramuscular injections with opiates, or epidural anesthesia.

Childbirth care, rather than reflecting either of these paradigms, working with pain and pain relief, is a syncretic combination of different repertoires, as I argue elsewhere (Skeide 2019, 237–38). Neither locating labor pains a priori within women's bodies nor categorically condemning pharmacological pain relief is a helpful strategy for defining goals and values in midwifery care practices. Further examining the diverse techniques adapted in order to work with pain in labor, seems to be a more promising alternative for reflecting on these techniques and improving them (Ceci, Pols, and Purkis 2017, 54). Labor pain realities may become shareable—and shapeable—if their conditions and different sociomaterial participants become more visible and accessible, or so I hope. Articulating labor pain practices can thus be a means for strengthening midwifery care. As Inge, one of the midwives I accompanied on a labor ward, explained: "You cannot foresee how birth goes—it can push women and children to their limits." Medical interventions aiming at avoiding or easing labor pains cannot be excluded from midwifery practices that aim at helping women and children "to go well through birth," as Inge put it. Instead, drawing on a wide repertoire of diverse sociotechnical techniques seems to be helpful in order to deal with continually shifting labor pains.

The material I work with comes from my praxiographic research (Mol 2002) on midwifery care practices in Germany that I conducted in hospitals, birthing places, and people's homes between February 2015 and March 2016. Praxiography is a methodology developed within the research area created by intersecting (medical) anthropological concerns and analytical tools

with those characteristic for science and technology studies. Pivotal to the praxiographic approach is to understand everything that is—entities such as humans or technical devices or medical standards—as effects of their relationships *done in practice*. Realities are *enacted,* in midwifery care practices as much as in the research practices relating thereto. As a consequence, (labor pains as) subjective experience belonging to individual humans placed in the center of the(ir) world is transformed into a specific effect of, but also actor in, localized sociomaterial arrangements. Labor pains become contextual and specific.

I combined observations of around thirty births with twenty praxiographic interviews (Mol 2002, 15–16) with midwives and women who had recently given birth. In this paper, I present one case, from the (almost always dubious) beginning of labor until the birth of the child, via cesarean section. This case is based on an interview I held with a woman I name Tina two days after the birth of her second child in the hospital in which I was doing fieldwork at the time. I asked Tina: "What happened when you gave birth?", referring to an event, or, more precisely, a series of events, in which Tina, her partner Karl, several midwives and doctors and I, but also different surroundings and things, took part. I hoped this question would allow Tina to describe what mattered to her in the lengthy and exhausting process of giving birth and to thereby become her "own ethnographer" (Mol 2002, 15). Like most of the other women I accompanied during birth and interviewed afterwards, Tina talked extensively about her labor pains. In these terms, Tina's story is exemplary and illustrates that thinking about and with labor pains is not predominantly the result of an analytical preference that I bring to Tina's birthing story. Exemplary is also the position Tina asserts: She did not characterize her experience as 'authentic' knowledge that she possessed because she had lived through that experience (Pols and Hoogsteyns 2016, 42–43), but as a continually changing, practical and relational achievement.

Tina's story shows that I studied midwifery care practices in ways that make of labor pains neither essentially destructive experiences nor limit them to individual bodies, but shape them into various experiences and actors that are, and can be, lived and worked with. The story and its in-depths analysis show how multiple labor pains are brought about in just and only one specific birthing trajectory.

My aim in this article is thus to accept Jeannette Pols's (2005, 2013, 2014) invitation to re-scribe[48] (childbirth) stories that may contribute to thinking about how we may make shared (labor pain) realities possible and also

about what these shared realities allow for. This strategy promises to be more productive for supporting good midwifery care practices than that of creating and hardening divisions—between subjects and worlds, between shareable and non-shareable experiences, and between working with pain and relieving pain models—and thus allow scholars to attend to the complexity of these practices and the different, often contradictory, normativities enacted therein.

Labor Pains Acting

Tina and her partner Karl spent more than two days and nights in the hospital where I was doing fieldwork at the time. They went through almost the entire repertoire of birthing interventions, from bathing to homeopathic treatment to epidural anesthesia and, finally, to cesarean section. Right after the operation, Tina was devastated. She felt that what happened was her fault alone, and she blamed herself for making "such a fuss" about her labor pains. Two days later, I was happily surprised to see Tina waving at me cheerfully in the hallway of the maternity ward. We had a chat and arranged an interview for the next day, early afternoon in her room on the maternity ward.

Labor Pains as Helpful Tools

Answering my question "What happened when you gave birth?", Tina began by saying:

> On Monday we were due. And on Tuesday night I got contractions [*Wehen*][49] at around half past two. But they were easy to bear. First I thought they

48 Jeannette Pols develops Hans Harbers' concept of rescription that he uses in order to emphasize the normative involvements of Science and Technology Studies (Harbers 2005, 265). Pols' empirical ethical research of care practices is based on the insight that how specific situations or practices are known determines what they become. Pols suggests that care realities cannot be, allegedly neutrally, described. Prescribing supposedly good care realities should be based on the values and goals that matter in specific care situations. Scholars studying care practices (or any other) are necessarily involved in their becoming when they write care practices anew—rescribe—creatively and responsibly.

49 It is important to note that the English term labor foregrounds the work that giving birth entails. It also denominates the uterine contractions and pain that are worked with during birth. The German word *Wehe/n* marks the pain that women feel when giving birth. *Wehe* is used as an equivalent to the English term labor. Sometimes *Wehenarbeit* is used in order to emphasize that there is (active) work involved alongside (being in) pain. The medical term *Kontraktionen* foregrounds the functioning of the uterine muscle. When working with Tina's story I realized that she used the word *Wehe/n* throughout, yet referred to very different entities: the contractions that she felt and measured, the different pains that emerged not only from these contractions but also from how they occurred in different arrangements, the process of giving birth etc. I tried to do justice to this diversity by translating *Wehe/n* into labor, labor pains or contractions and by attending to the differences in my analysis.

> would be bowel spasms und I used an enema because I have had the feeling of being constipated for two days. But then they came every thirteen minutes and they came very regularly. And then I thought: "That could also be labor pains [*Wehen*]." And the next day I also had labor pains [*Wehen*], but they were really different in length and frequency. And it was getting more intense only in the evening and we decided Wednesday night at 1 am to go to the hospital.

Initially, labor pains acted as contractions that Tina characterized as "easy to bear." But were these easy-to-bear-contractions really labor pains? Tina was unsure: as she had recently felt constipated, they could have been bowel spasms. In order to find out where exactly the contractions were located—in the uterus or in the bowels—Tina put her feelings to the test. She used an enema as a diagnostic tool to find out: If emptying her intestines stopped the spasms, they stemmed from her bowels. If the spasms continued and got stronger, they were uterine contractions. The latter was the case.

Once Tina has detected the location of the pains, their quantifiable characteristics came to matter. Tina knew that measuring how often and for how long she felt the pains would produce further valuable information for specifying the contractions as labor pains. Consequently, she kept track of her feelings from their onset: at which time they began, when they became regular and when they changed into being "different in length and frequency."

Feeling pain and measuring pain thus can be seen as mutually supportive self-help strategies. Tina adopted feeling-measuring techniques that shaped the contractions into an indicator for the onset of birth and for deciding when to go to the hospital. Labor pains thus acted as helpful diagnostic tools that also took shape in the process. The labor pains as tools were distributed across several sociomaterial participants: Tina's body and bodily sensations, Tina's experiential and obstetrical knowledge, the enema and the clock Tina used for measuring, Tina's partner Karl who decided together with her when to set off for the hospital.

Labor Pains as Unproductive Sensations

With Tina and Karl's arrival at the hospital, the labor pains were distributed differently. They did not act as helpful tools anymore but become unproductive and individual sensations.
Tina continues:

> So we left with five-minute-contractions [*Fünf-Minuten-Wehen*] and arrived here [in the hospital] and got examined. I said: "I need a medical finding [*Befund*] now. If these are not contractions [*Wehen*] that open up the cervix, then I would like to get something for it and go back home." But the midwife said that there were no drugs that could be administered just like that if there was no opening of the cervix.

At home, Tina approached the pain she was feeling in ways that allowed for shaping it into a helpful diagnostic tool. Not just feeling but feeling diagnostically helped qualify spasms as regular and ongoing uterine contractions or labor pains. In the clinical surrounding, an extra criterion was added for detecting labor pains: they needed to "open up the cervix." The vaginal examination[50] was needed to determine the opening of the cervix, meaning that the felt contractions were recognized as a sign of labor only if they were productive. Feeling pain was not of diagnostic value at that point; an obstetrical repertoire that knew labor pains by observing birth-related corporeal changes prevailed. Tina's pains and what they became were distributed among the midwife's examination and the knowledge it produced. In this procedure, labor pains acted as individual, private and also unproductive sensations, an experience that did not allow for objective validation and therefore must reside, unattainably, within Tina's feelings.

When they failed to meet the criterion of productivity, the labor pains affected Tina differently than they had at home. They hurt for nothing. As these pains did not have any effect on the cervix, and thus were not for giving birth, they were disturbing and unnecessary. This is what Tina suggested when she asked to "get something" and "go back home."

In this situation, labor pain indeed resonates with the exceptional character of pain described by Scarry (1985, 5): It "has no referential content. It is not of or for anything. It is precisely because it takes no object that it, more than any other phenomenon, resists objectification in language." This useless pain, enacted as hidden in Tina's body, unrelated and unrelatable, stands in contrast to the emphatically evoked *productive* labor pain in the midwifery and anthropological literature that is *for* giving birth to a child (Whitburn et al. 2019, 31;

50 Vaginal examinations usually mark women's arrival on the labor ward and are performed repeatedly throughout the birthing process. The results of such examinations co-direct the attendance procedures, as clinical protocols suggest a continued opening of the cervix within a defined period of time to be a sign of physiological birth and prolongations to hint to pathological birthing trajectories.

Van der Gucht and Lewis 2015, 350; Gleisner 2013, 111). Not the pain itself but the effectiveness of the uterine contractions seems to inspire this position, which excludes other labor pains that are differently productive, such as the diagnostic pains that Tina tracks at home.

Labor Pains as Effective Work

When the midwife replied that "there were no drugs that could be administered just like that," she also hinted that pain medication does not act without side effects. Birthing takes hours—in Tina's story, even days and nights—and labor pain, however versatile, is a faithful companion in this contingent process. If, when and how to ease labor pains is continually questioned and adapted in clinical birth attendance. Next to pain medication, non-pharmacological, so-called alternative methods of pain relief, such as bathing, homeopathic treatment and physical exercise, are used. This is especially the case at the onset of labor pains in the hospital and throughout birth in non-clinical surroundings, where most pharmacological remedies cannot be administered.

In Tina's case, the midwife first recommended taking a bath in the "pre-labor room" of the labor ward. Bathing was introduced as a technique that aimed at diagnosing and guiding labor while also soothing the pains: immersion in warm water can help to alleviate or even stop contractions if they are not signs of labor or to intensify them if they are. Resting and moving in warm water was expected to ease the pains that Tina felt. Bathing thus represented a good compromise. It met Tina's request for pain relief, thereby acknowledging her sensations, while also aiming to make her body produce effective uterine contractions.

Taking a bath also generated something else: it made the pain act as part of a "comfortable" situation, one that was shaped into the activity of "laboring," as Tina recollected:

> So we stayed in the pre-labor room [a room next to the entrance hall of the labor ward] the whole night and we were laboring and bathing and laboring and bathing [*geweht und gebadet*]. And we felt comfortable [*wohl gefühlt*] there and were being examined [vaginally] again and again.[51]

51 Tina and her partner Karl shared many of the activities in the hospital quite closely, as seen in her use of "we" during the interview.

The "relaxation bath," as it is called, did not merely exert a physical influence on her body by providing warmth and thereby relaxing her muscles. Bathing also created a "comfortable" situation through providing a relaxing environment: The bathtub was in a separate and spacious room in which the lights were dimmed and soft music was played. A pleasant scent of lavender, an essential oil that was added to the water, filled the room. The water temperature was continually adapted by the midwife, so that Tina could stay in the bathtub "the whole night." Here, conditions were crafted that allowed Tina and Karl to "feel comfortable."[52]

In the feeling-measuring techniques and in the cervix examination, labor pains were distributed in a way that situated them within Tina's body and specifically in her womb. Bathing distributed Tina's labor pains so that they became part of the body-in-labor and the environment, which were interrelated and mutually permeable for corporeal states and environmental atmospheres (Mol and Law 2004, 53)[53]. Placing the body in a comfortable environment thus potentially made Tina feel comfortable while the pain was backgrounded. In the pre-labor room, Tina was asked to concentrate on engaging in active work, namely "laboring and bathing."[54] While bathing, the pains were not worked with as tools, as was the case at home. Instead they became what this work consisted of. As pain-labor, they were productive in relation to the progress of the birthing process, and the repeated examinations of the midwife contributed to enact this potential.

Labor Pains as Fruitless Investments

To Tina's disappointment, bathing was not successful in spurring productive contractions. She sighed deeply as she recalled:

> But that night was spent with labor pains [*Wehen*] that did not open up the cervix. So the [child's] head was deeply engaged, the cervix was short and soft but it did not open. And then we were quite exhausted, or me at last,

52 See Driessen (2018) for how care is done in bathing people with dementia in Dutch nursing homes.

53 Using the case of hypoglycemia, Annemarie Mol and John Law (2004) argue that bodies are done in practice. They suggest that a body-in-practice is not necessarily whole, coherent and bounded, and if it is so, this is a practical achievement. When being done, bodies do not necessarily end at their skin boundaries but may extend beyond them (Mol and Law 2004, 57). A body may incorporate "bits and pieces of the world around it, while its action may be shifted out of the body, excorporated" (Mol and Law 2004, 53).

54 Note that using wehen as a verb, to denote an activity, is rather unusual. More common are expressions such as Wehen haben or in den Wehen sein. Tina thus emphasizes that she is doing, instead of having or being in, labor pains (see Mol and Law 2004, 45).

> because it did not progress. But you cannot do more than wait. And then there was a change of shift.

When Tina left the bath and looked back on a night filled with pain-labor and no result, no opening of the cervix, bathing was reduced to a vain attempt at rendering the contractions effective. Tina emphasized, though, that there were relevant changes noticed by the midwife: the shortening and softening of the cervix as well as the engagement of the child's head indeed showed progress towards birth. However, these results were rather frustrating in light of the effort invested and the time passed since the labor pains began. The pain-labor did not seem to be worth the hassle, and Tina surrendered: "You cannot do more than wait." These seemingly fruitless investments left Tina and Karl "exhausted."

Similar to Tina's and Karl's arrival at the hospital, the vaginal examination and its findings foregrounded the objectively detectable effects of labor and separated these effects from the pain, from the hurting. When Tina worked with and on her pains at home and shaped them into work when bathing, she could not know if these pains were also effective in opening up the cervix but she could deal with them, feel them and hope for them to be productive. When the midwife examined her cervix, labor pains were enacted as uterine contractions whose effects could not be known by Tina herself, and her preparatory work and sensations were made less relevant and her and Karl's possibilities to work with pain or to shape labor pains into work were shifted away from them. Labor pains were instead transformed into the shape of unreliable actors. As such they were divided into two constituent and competing versions: labor as an opening of the cervix and pain as hurting. Before the vaginal examination the relation of these versions was open to diverse possibilities and handling pain as hurting in helpful ways was foregrounded.

Labor Pains as Products of Bodily Tension

With the staff's change in shift in the morning, the next midwife took over. In order to gain an impression herself, she examined Tina again. Since the findings were still the same, she had another strategy to offer, as Tina explained:

> So she proposed something homeopathic, something to relax [*entkrampfen*]. I certainly was very tense [*angespannt*]. The first midwife

> had also noticed this. And the second midwife gave us a homeopathic remedy and brought us to a room on the gynecological ward in order to sleep. And this really removed [*weggemacht*] the contractions [*Wehen*]. I only had one per hour and I slept for two hours. That did me good.

The homeopathic 'stimulus' aimed at helping her to relax took center stage. As Tina mentioned—and as she repeated several times during the interview—she "certainly was very tense." This was not her observation alone, she assured me, as the two midwives "noticed this" as well.

The homeopathic treatment, and how Tina framed it in her narration, adds a new actorship of pain to her birthing trajectory. The unproductive pain that Tina felt was staged as a product of Tina's tensed body. The causal relation between tension and pain that is established here resonates strongly with a theory of the so-called Fear-Tension-Pain Syndrome. This theory was made available internationally to obstetricians, midwives and the greater public through the work of Grantly Dick-Read, a British obstetrician and advocate for natural childbirth. In *Childbirth without Fear*, Dick-Read writes that "[t]he fear of pain actually produces true pain through the medium of pathological tension" (Dick-Read [1942] 1961, 35).[55] In the childbirth care practices I witnessed, tensed bodies were commonly thought to make giving birth more difficult by rendering contractions ineffective and intensifying labor pains. Tension was thus counteracted in different ways. This is also the case in Tina's story, where bathing and homeopathic treatment were applied in order to relieve bodily tension through also calming a fearful and restless mind and thereby relieve pain. The aim was to either allow the cervix to open or the body to rest for further contractions.

Here, labor pains are coproduced by mentally induced bodily tensions and thus become objects of the intervention. Tina engaged enthusiastically in this new strategy, allowing her body-in-labor-pain (see Akrich and Pasveer 2004, 66) to be affected by the homeopathic treatment, to "relax" so that the contractions were "really removed."

55 Dick-Read's ([1942] 1961, 18) idea is that hurtful pain is not 'naturally' part of giving birth but a cultural phenomenon: "Superstition, civilisation and culture have brought influences to bear upon the minds of women which have introduced justifiable fears and anxieties concerning labour. The more cultured the races of the earth have become, so much the more positive have they been in pronouncing childbirth to be a painful and dangerous ordeal. Thus fear and anticipation have given rise to natural protective tensions in the body, and such tensions are not of the mind only, for the mechanism of protective action by the body includes muscle tension." Astonishingly, his theory continues to inspire childbirth education programs around the world.

When the labor pains got stronger, to the point of being "unbearable," Tina asked for pain medication again. The opioid she received did not calm the pains. The pains intensified instead and got even worse to bear. Tina shrugged, and hypothesized: "Maybe [it was] because of the relaxation setting in at that point." The pain medication helped to create ambiguous relations between differently constituted bodies: Tina's body relaxed and painful contractions or 'tensions' of Tina's uterus augmented.

Whereas the homeopathic treatment targeted Tina's body as a unity, one that was either relaxed or tensed, the opioid helped to shape Tina's body into at least two contrasting and yet cooperating entities: a relaxed body-uterus (Akrich and Pasveer 2004, 70–71) and a tensed uterus-body. Similarly to the homeopathic arrangement, in which Tina's labor pains were understood as an embodied state of fear, namely tension, the opioid arrangement located pain in Tina's body. Whereas the homeopathic treatment helped Tina's goal—pain relief—to be achieved and produced a seemingly coherent body, the opioid acted as an antagonist that increased the labor pains and created divisions between different versions of bodies (Akrich and Pasveer 2004, 72). In the latter case, pain was granted an actorship that seemed to be independent of Tina's will and beyond her ability to intervene in.

Pure Labor Pains

In the further course of birth, the pains gained more and more prominence until they became continuously present. At a certain point, Tina's labor pains indeed risked becoming 'overwhelming,' as she emphasizes:

> And then I got real labor pains [*Wehen*]! Now I know what labor pains [*Wehen*] are! They hurt awfully and they did not stop at all. The uterus was so very sensitive. I got contractions [*Wehen*] every time I peed, every time I was examined. But we came one centimeter further and my water broke. When the midwife that attended us the night before arrived for her night shift and saw the state I was in, she suggested an epidural. Because then I was in labor [*unter der Geburt*] so that one could finally do something.

The state in which Tina was, namely overwhelmed and exhausted by what was finally acknowledged as "real labor pains" and the lack of sleep, was co-enacted by the epidural suggested by the midwife. Labor pains that

"hurt awfully and did not stop at all" provoked her cervix to open and her water to break. The pains became "real" as they had objectively determinable effects. The epidural contributed mainly to bringing this reality about.

Paradoxically, Tina's labor pains became "real" when an intervention was made to eliminate them, or, more precisely, when they were eased and became a lot easier to handle. At the same time, interventions and their conditions such as the epidural and obstetrical signs of labor (opening of the cervix, break of waters) gained reality—"one could finally do something"—when the labor pains, finally, were successfully soothed. Furthermore, what helped Tina to get to "know what labor pains are" was that they were made to disappear or backgrounded with the help of the epidural. The epidural thus helped to give reality to Tina's experience, to acknowledge the "state" she was in, namely "in labor," as she explains. At this point, the epidural became a means for meeting Tina's expectations and goals, for valorizing her feelings, and for approving her investments.

With the help of the epidural, which was "exactly right," as Tina says, and an intravenous infusion of oxytocin, Tina's cervix dilated fully by the end of the night. As the pains were eased, labor took its course, acting seemingly independently from Tina's participation: "We slept and rested while the contractions did their work [*Wehen haben gearbeitet*]," Tina added. As much as the presence of labor pains did not indicate reliably the effectivity of the hurting, the (quasi)absence of labor pains did not necessarily mean that there was no laboring. The labor pains that acted as unproductive sensation in the beginning of labor then turned into their opposite: pains were productive and yet hardly felt. In both arrangements, objective criteria that defined the effectivity of labor were foregrounded while pain was sidelined. These criteria contributed to disassociating labor from pain. But, as Tina explained, they also became re-associated: the contractions were productively co-directed by the oxytocin, because the epidural helped Tina sleep and let the "contractions [do] their work."

In this arrangement, undoubtedly the most technical and medical one, labor pains were not "to the individual experiencing it overwhelmingly present, more emphatically real than any other human experience, and yet [...] almost invisible to anyone else, unfelt, and unknown" (Scarry 1985, 51). Instead labor pains were made "overwhelmingly absent" to Tina while also "visible and knowable to anyone else" present. Tina's labor pains did not act on herself alone but were distributed over the relations between medications

and their technical infrastructures, such as cannulas and tubes, beds and tables, clinical surveillance techniques such as vaginal examination or electronic fetal monitoring, midwives and doctors, Tina's partner Karl and Tina's body. In and through diverse sociomaterial relations, the pains became visible and knowable.

In the end, Tina explained, the midwife who arrived in the morning "was not satisfied with the position of the child's head." She called in a doctor who shared the midwife's concerns. "So they advised us to end this via a cesarean section and we agreed immediately," Tina concluded.

What Can Practice Approaches Learn from Labor Pain Experiences?

As this praxiographic analysis shows, labor pains are experiences and actors that are 'followed' and worked with, and thereby enacted, in midwifery practices (see Leap and Hunter 2016, 38). Labor pains are creative actors; instead of destroying the world (Scarry 1985, 29), they shape many different worlds. In Tina's story, we can see how labor pains can co-shape many different birthing arrangements and co-structure the participants' positions in various ways. Labor pains are not merely physiological and pleasurable but may act as helpful tools, unproductive sensations, effective work, fruitless investments, products of bodily tension and pure labor pains. Each actorship involves specific surroundings, devices, knowledges, words, techniques, bodies and worlds. And each version of labor pains crafts particular, not psychosocial but sociomaterial relations between various participants while also emerging from these relations. Labor pains are not subjective experiences but experiences that are shared relations-in-practice.

Whereas subjective experience has been an important analytical category in (medical) anthropology, understood as the fruit of people's privileged access to their individual realities, it has become suspicious in science and technology studies (STS). One of the core maneuvers in recent STS works consists of not differentiating a priori between things, words and humans but to show how entities become what they are in relation *to* other entities. This maneuver decenters human subjects and thereby detaches them from their privileged rights and competences in knowing the 'object-world.' In practice-based approaches in STS, scholars have often avoided relying on the concept of experience to analyze practice.

Emily Gomart and Antoine Hennion (1999) suggest that this turn away from experience may have been hasty, arguing that certain practices need a notion of experience in order to become understandable. They have introduced a notion of distributed experience. Instead of understanding experience as either a product of an active, reflexive and sensorial human subject or as passive effect of the social structures and material objects this subject is confronted with, they study experiences as effects of collective and emerging events. Gomart and Hennion analyze the experience of passion produced through amateur practices by exploring drug and music lovers' relations to their appreciated objects. They suggest that such practices of passion may teach us about events in which action is distributed over the relations or "attachment[s]" between several different participants: people and their objects of pleasure, devices and settings (Gomart and Hennion 1999, 221). Users surrender active-passively to drugs or music by skillfully crafting their attachments and, in so doing, preparing actively for the drugs or music to "take over" (Gomart and Hennion 1999, 242).

Gomart and Hennion's work shows that experiences are a means for analyzing what matters to people. Practice approaches should thus attend to experiences. Labor pains are a case to think with, allowing us to follow Gomart and Hennion's invitation to study a specific experience in conjunction with a practice-based repertoire in order to both specify the repertoire and understand the practices under investigation. Labor pain stories help to develop some of the ideas laid out in Gomart and Hennion's study, taking a next step by regarding experiences as effects of events or practices that become actors as well. In this case, feelings and experiences are so demandingly present and so variable that the differences they (are made to) make merit attention in themselves. Birthing practices differ from the "connoisseur's practice[s]" (Gomart and Hennion 1999, 243). The dynamics of the latter suggest that high investments lead to well-earned rewards, namely joyful passions. In giving birth, labor pains are not necessarily sought as an experience in themselves, an "unanticipated gift" (Gomart and Hennion 1999, 222), but labor pains are there, reliably, as a concomitant of giving birth. They impose an obligation to be dealt with, no matter if women and their surroundings are prepared to do so or not.

Like feelings, labor pains participate actively in shaping the conditions under which they are brought about while also being shaped by the efforts that are invested into handling them. The labor pains I discuss here are both

more reliable and more erratic than the desired endpoints of Gomart and Hennion's passionate amateurs. As constantly shifting and temporary actors, it is difficult to see labor pains in terms of a continuously growing expertise. Instead of deepening the experience of labor pains, birthing practices rather 'contain' the experience of pain by working with, on or against it in order to render labor pains livable. Labor pains are not an end in themselves. Each of their diverse actorships brings about new possibilities and challenges that need to be dealt with. In the childbirth care practices recounted by Tina, the joint efforts are not directed towards being "seized and taken over by a potentialized exogenous force" (Gomart and Hennion 1999, 243), but instead consist of materializing labor pains in order to allow them to become concrete, relatable, shareable and malleable. Labor pains cannot be allowed "to take possession of the self" (Gomart and Hennion 1999, 221). This might make giving birth without anesthesia impossible. "Working with pain" (Leap and Hunter 2016, 38) co-shapes pain's multiple and rapidly changing identities. Labor pains are unavoidable sociomaterial challenges and efforts rather than achievements initiated and pursued by human actors (Gomart and Hennion 1999; see also Mol and Law 2004).

Re-scribing labor pains as both experiences and actors permits us to see how pain co-structures subject positions in childbirth practices and sheds light on an important participant—pain—that is commonly evaded in childbirth discourses (Maher 2010). Labor pains are felt and hurtful experiences are part of childbirth practices. I show here that labor pains also act through being felt in particular ways, most obviously when labor pains become tools in feeling-measuring techniques but also when pains turn into objects of treatment. This practice-based approach to labor pain experiences complicates and situates experience as an analytical category, while avoiding re-centering the individual human subject. Labor pains are felt, known and done, and they make Tina—and others—participate in situations and respond in different ways. Labor pains are distributed over a set of actors who activate and maintain Tina's engagement in shaping the birthing arrangements and her labor pains. In the epidural arrangement, for example, labor pains are distributed in ways that make other actors besides Tina and her pain to take over and direct the labor process.

Studying experiences and feelings may help anthropological and STS-inspired practice approaches to better understand how care practices are constituted. The experiences themselves are not only active-passively

known, felt and done but also take active part in shaping practice. A practice approach to care cannot do without a notion of experience, as the case of labor pain experiences in birthing care practices helps make clear.