Part II

SPECIFIC CONCEPTS
10

BIRTH

Christina Schües

Birth, puberty, and death are live-changing events that are recognized in culturally and socially different forms. In many cultures, birth is accompanied by special rituals and ceremonies. The technology and medicine-oriented Western culture embraces only few medical and social particular rituals but has largely standardized childbirth, approaching it with a “fear-based” attitude within a discourse of risk (Davis-Floyd 1994: 24). Understanding birth as a risky transition for the mother and the child leads to fear and an urge to put it into a medical practice. Practices of birth vary concerning the decision whether birth takes place in the hospital (98% in the United States), in a birth center (about 10% in the Netherlands), or at home (about 20% in the Netherlands). And these practices differ strongly concerning the process: birth can be “natural,” labor-induced, or cesarean, experienced with pain-relief medication or without, in inherently high-risk conditions, and it can end in stillbirth. In the 19th century, the birth practice was taken from the hand of midwives and put into the hands of male physicians. Philosophers have critically debated the “natural” birth movement as well as birth under medication (Kukla 2005, 2011; Lyerly 2006; Purdy 2001).

Despite these differences, we are all born. However, the fact that humans are born has rarely been at the focus in the history of philosophy, which has instead emphasized death and human mortality. The concept of birth had rather been seen as a metaphorical concept in which birth is imagined, like Plato did, as a cognitive act by philosophers or as a divine act of creation by male gods (Plato 2000: 7. book; Plato 1980: Speech by Diotima; Tyler 2000), and it has been considered as the birth of a subject that takes place without women. Hobbes, for instance, writes to “consider men as if even now sprung up out of the earth, and suddenly, like mushrooms, come to full maturity, without all kind of engagement to each other” (Hobbes 1841: 109). Since the 1980s, several feminist works have criticized the neglect of birth as a philosophical concept, the denial that humans are born from women, and the appropriation of birth for masculine action (Irigaray 1985; Young 1990; Cavarero 1998; Schües 2008: Chs. 1–3). Thus, “giving birth” has been transformed metaphorically into the path to knowledge (Plato’s way out of the cave) or the technical production of a bomb (“It’s a boy!” announced Edward Teller, co-developer of the hydrogen bomb, when it was first successfully tested). Martin Heidegger is one philosopher who has at least referred to “birth,” but by a concept of “being thrown” into the world. It is a basic characteristic of being-there (Dasein), whose “there” is already presupposed as being-in-the-world (Heidegger 1996: 127). Yet, in the overall conception, even Heidegger “forgets” the notion of birth and interprets being-there one-sidedly as being-towards-death.
Heidegger’s student Hannah Arendt, however, insisted upon recognizing the centrality of natality as opposed to the traditional privileging of mortality. She posits the concept of natality, the capacity to begin because of being born, as a foundational fact of politics and action:

Philosophically speaking, to act is the human answer to the condition of natality. Since we all come into the world by virtue of birth, as newcomers and beginnings, we are able to start something new; without the fact of birth we would not even know what novelty is, all ‘action’ would be either mere behavior or preservation.

(Arendt 1958; Arendt 1970: 82)

Thus, considering birth means recognizing its dual nature as a biological event within nature and as an existential transformation within human society that provides the foundation for creative action. Human beings are thus born in a double sense: “He is new in a world that is strange to him and he is in process of becoming, he is a new human being and he is a becoming human being” (Arendt 1968: 185; also Schües 2011). The first aspect refers to the new relation of the child to the world as a human being, and the second aspect refers to the state of becoming that a child shares with other living beings such as cats and dogs. So we can say that, in respect to life, biological life, that the child is a human being in the process of becoming and developing. In respect to the world, the child is a newcomer to a world that existed before him and will continue to exist after his death. Since human beings are born and introduced to the world, they will spend their life in light of this particular beginning. “Human parents [. . . ] have not only summoned their children into life through conception and birth, they have simultaneously introduced them into a world” (Arendt 1968: 185).

Since birth and life have so many different aspects and meanings, they are approached by a variety of different perspectives. Most often, however, they are discussed in the context of medical ethics, but this focus is too narrow to grasp the multilayered dimensions of birth and life. A hermeneutical and phenomenological approach is more appropriate for a philosophy of medicine because it is the task of phenomenology to disclose and unfold the meaning of experiences and the basic structures of the different physical, social, and cultural dimensions of a particular theme such as birth and life. In general, phenomenology takes on the challenge to reveal the “prejudices” and “taken-for-granted presuppositions” that go unnoticed in our unreflective experiences, yet that guide the praxis of human conduct (Husserl 1982; Toombs 2001; Merleau-Ponty 2012: XX–XXXV).

The Beginning

It is not easy to define when a human life begins. Some people believe that it begins with conception, whereas for others it begins with the implantation of the embryo, and still others take life to be a form of continuing development. The moral status of a fetus or a newborn will depend on arguments about individuality, continuity, or potentiality (Guenin 2008). Answers to the question of when human life begins are mostly oriented toward physiological and biological aspects of the neural development of the brain, religious beliefs about the sanctity of human life, as well as political and ethical concepts of the dignity of the human embryo. Ethical debates about the right to live or the question of whether a fetus may be taken for research are closely related to the understanding of whether a fetus is seen as human, on the way of becoming human, or potentially human.

When people are asked about the beginning of their life, they usually think about their life in relation to the world they live in, to the earth and society. They tell about where they come from and who gave birth to them. Every living human being has been born from a woman.
But, concretely, everyone is born in a particular place and time, and from and with at least one particular person—their (biological) mother (Rich 1976). Birth means the beginning of life on earth and in the world. However, it is not the absolute beginning of a human being, because her being is also real prior to her birth. Birth localizes the person who is born within familial, social, and cultural relations in the world; it puts her in a generative context and a familial biography. Birth marks the biological and social changes between generations and their continuation, because the arrival of a newborn brings a new generation to light. The prenatal existence of the child and the pregnancy of her mother is part of a family biography that can be talked about. When people consider where they come from, the circumstances of the time before the birth is often part of the biography.

We cannot remember our own birth. Epistemically, our own birth is located between withdrawal and apodicticity. With the term “withdrawal” I refer to the fact that one cannot remember his or her birth, because it is excluded from our own memory. The term apodicticity refers to a certainty that can be demonstrated, such as the existence of someone. Though birth is withdrawn from inner reflection or memory, I am sure that I was born because I exist. I exist; therefore, I must have been born. I am a natal being. Because of being born, the infant is directed towards the outer world in its three-dimensionality. By this new perspective, intentionality sets in. In Husserlian phenomenology, the term intentionality stands for the directedness of consciousness to meaningful things, objects, or events. Being conscious of something means to constitute something as an object of sense experience. Hence, intentionality means the structure of being-directed-toward-something-as-something. Birth, as such a unique event at the beginning of life-in-the-world, posits the possibility of intentionality as “an essential characteristic of each person through which she can initiate the constitution of sense, give birth to sense” (Schües 1997: 245). Hence, birth is the fundamental condition of the possibility of intentionality. It brings the individual in a relation towards the world.

Birth is a social and political fact that is—at least in most countries—recorded in official documents, celebrated at birthday parties, and talked about as an important beginning in life and of life. Birth belongs to the human condition, yet it is contingent because not all human beings who live prenatally will necessarily be born. Some will die before their birth, for instance, because they are aborted. Whether a child is born lies in the hands of others—of physicians, the pregnant woman, or also society. It is also determined by circumstances and conditions like the health of the embryo or the pregnant woman. Hence, birth is a contingent fact of life and society. Even though we do not directly remember our own birth, we know about our own birth because people have told us about it and because we infer our own birth from the birth of others. A person’s own birth not only accompanies one as a date in documents but also in the sense of being born from someone and with other people who remain as relatives, if not as the family one lives with. These coordinates of being born from and with a particular person and at a particular place remain parts of an individual’s personal history. They make people structurally special. Because of these concrete structural coordinates and constellations, every human being is different. Hence, birth constitutes not only a basic relationship among human beings, but it also denotes a plurality among people in the world. Plurality means here that each person is different from every other person alive or who has previously lived; these basic differences are due to the fact of being born in different times and places, and from and with different persons.

Disruption and Transformation

Birth means a disruption and a transformation. It disrupts the life of the woman who gives birth to the child and of the persons for whom a child is born. When a child is born, a mother (of that child) is also born and, at least most of the time, a family is (re-)manifested. With birth,
a pregnant woman is transformed into a mother, a man is transformed into a father, and family members are transformed into grandparents, siblings, uncles, aunts, or cousins. Each of these roles is based on societal norms governing what to do or expect. For the child, birth disrupts the continuity of her development. Being born means not living anymore in the inner-bodily connectedness with the pregnant woman, the becoming-mother. Hence, birth for the child means a transition from the intrauterine position to the extrauterine situation in the world, a transformation from living in the womb, with a surrounding wall and in a maternal-fetal relation, to a life in the world and in concrete different relationships and contexts. Thus, transformation can be understood as a fundamental leap from one existential mode of being to another, from prenatal existence to the natal existence of living in the world and of being able to mentally and physically direct oneself towards other objects and beings; that is, having intentionality (Schües 1997). Because of its new spatial location, from the moment of being born, the newborn directly faces other human beings; all objects, humans, voices, and things are in a distance or come closer; they are presented in different perspectives.

The disruption of birth can be understood in different senses and from different subjective perspectives. It can be understood, first, from the perspective of the woman giving birth—that is, birth as birthing, labor, and delivery at the end of pregnancy. Second, there is the perspective of the child who is born—that is, birth as partus or parturition, as the culmination of the development inside the woman’s uterus and as the end of the internal bodily connection and the beginning of external bonding with the mother and other persons. And, third, it can be seen from the perspective of an observer, whether the woman who delivers the baby or others—that is, birth as a process in its different phases.

Obstetricians and midwives categorize the process of birth in four phases: (1) the early phase is marked by the onsets of contractions and labor pains; (2) the active or transitional phase involves the dilation of the cervix; (3) the fetal expulsion phase is characterized by the descent and birth of the infant; and (4) the final phase is the placenta delivery. These phases of birthing are talked about in birth preparation classes and are undergone in the routine of a normal birth regardless of whether it takes place in a hospital, a birth center, or at home. Yet, these birth phases refer to what is considered “normal.” “A normal physiologic labor and birth is one that is powered by the innate human capacity of the woman and fetus” [ACNM (American College of Nurse-Midwives), MANA (Midwives Alliance of North America), and NACPM (National Association of Certified Professional Midwives) 2012]. The term “normal” refers to a birth procedure that does not need medical intervention. The idea of a normal physiologic birth procedure delineates certain factors and benchmarks that define optimal processes, a supportive environment and birth setting, as well several biological, psychological, physiological, or educational conditions of women in labor.

The Relational Structure of Prenatal Existence and of Being Born

There is an ontological distinction between the maternal-fetal relation and the relation after birth, but there are different views about whether or not the pregnant woman and the fetus are separate entities. Even if one is ontologically committed to the idea that a pregnant woman and her fetus are two distinct entities, there remains the question of how these entities relate to each other biologically. The answers to this question indicate the assumptions and values addressed. The “immunological paradox of pregnancy” holds that even though the fetus is foreign to the female body, it is “paradoxically” not rejected (Moffett and Loke 2004). The “foreign fetus model” implies immunologically either that the woman is hostile to the fetus or that she is a passive victim of fetal invasion. Either way, one is inclined to believe that there is a conflict between the woman and the fetus. The mother’s immune system must suppress the
foreign body (similarly to organ transplantation), or the fetus resembles a parasite that invaded the mother’s body in order to sustain itself and grow. The problem is that the metaphors of “parasite,” “foreign,” or “victim” ignore the genetic ties and reduce the biological complexity of pregnancy and maternal-fetus relation (Howes 2007). These metaphors are also used in social and psychological discussions about the prenatal relation. Perhaps it can be considered as a symbiotic relation; “they are two, and yet one. They live ‘together’” (Fromm 1956: 19).

When the birth takes place, then the prenatal relation is disrupted and replaced by a new relation. A birth means a beginning; the beginning is a relation. This relation takes place between the (biological) mother and the child. It is a concrete, finite relation to another existing person. It is a contingent yet irreplaceable relation; the relation between the pregnant woman and the fetus was conditioned by particular biological and social factors, and it could be ended any time; yet it is unique in kind and necessary for the development of the child. The primacy of the relation in the world is shown with the appearance of the newborn, and it affirms the unity of existence and appearance (Cavarero 1997). When a child is born, it is looked at and—if it is not too exhausted, sick, or sedated—it can look back. This first gaze may ground such a first relation. All human beings who are born have experienced the concrete development and mode of this primary elemental relation with at least one person. Regardless of whether this relation has been continued or ended, lived in love or disappointment, with care or neglect, in compassion or superficial interest, it marks the threshold between the inner and the outer, between partus and bonding. If a child is given to someone else after birth—as in the case of adoption or surrogate motherhood—then the first elemental relation is disrupted.

Being born means that a child has undergone the transition from the prenatal being-with to the postnatal, worldly being-with; that is, the delivery is a release from the symbiotic relation with the pregnant woman to the primary relation with the mother and others in the world. However, this first elemental human relation of “nurturing, clothing, and accommodating” already begins during the pregnancy and with the supportive care of the mother, family, and others. Without this relation and care, a child would be just “flesh and bones”, a piece of reality not invested with any significance or meaning” (Thöne 1998: 121). The Norwegian philosopher Arne Vetlesen formulated an insight in 1995 that has an importance in reference to developmental psychology. He emphasized that the first interpersonal relationship, the mother-child dyad, is characterized by “asymmetry and non-reciprocity.” Being the “recipient of unconditional support is [. . .] the first experience made by the human person. And it is thanks to the experience of having been an addressee that we develop the cognitive-emotional capacities required to become a giver” (1995: 379). The times of prenatal being, birth, and postnatal life in the world are times when the child is cared for in many different ways. Traditionally, such care took place in the emotional realm of day-to-day life. With the rise of reproductive technologies, starting with ultrasound screening and continuing with genetic testing of the fetus, the notion of care at the beginning of life has shifted more and more towards medical supervision. If prenatal existence is seen in terms of a symbiotic relation with the becoming-mother, then the pregnancy of a brain-dead woman would mean that the fetus is no longer in such a relation. In a case like this, ontologically speaking, there are two reductions at work: the fetus is reduced to a biological entity of “flesh and bones,” and the pregnant woman is a mere fetal “container” (Purdy 1994; also Lindemann Nelson 1994).

The Traces of Birth

Is birth—the prenatal being and the postnatal beginning of existence—forgotten? Certainly, we do not remember our birth explicitly or reflectively. However, since we exist we are certain we were born. Though the birth itself is withdrawn from our reflective memory, human beings
have, as the French phenomenologist Maurice Merleau-Ponty and the psychoanalysts Otto Rank and Franz Renggli argue, a “bodily memory.” The memory of the body lies in between consciousness and the physical body; it shows itself in our daily bodily movements and rhythms about which we do not need to think or be conscious of (Fuchs 2011; Merleau-Ponty 2012).

One’s own birth and pre- and postnatal experiences cannot be explicitly remembered, but they took place as pre-reflective experiences that left their traces on the body. Hence, one’s own birth is forgotten yet is bodily inscribed as a trace of a particular lived-through pre-reflective experience. This means that our self can only be expressed by our body. Our lived body is always begun before we become conscious of ourselves. Birth in its phases remains as the anonymous past of our presence incorporated into our habituated body. Merleau-Ponty echoes this thought in reference to our relation to the world:

To be born is to be simultaneously born of the world and to be born into the world. The world is always already constituted, but also never completely constituted: In the first relation we are solicited, in the second we are open to an infinity of possibilities.

(Merleau-Ponty 2012: 480)

This situation is ambiguous because it includes determination and openness. That is, birth had left its bodily traces in the body. Though they cannot be represented, nevertheless they have their meaning in their silence, a silence that sometimes “speaks” but never with words. Hence, the human conditions are influenced by these traces, and they form the habituated body. Since the habituated body brings the past into the world of presence, the body shapes the “real world” and the actual body. This silence—which can also be called, following Merleau-Ponty, “anonymity”—accompanies all experiences and is even inherent to perception and memory. As Merleau-Ponty describes it: “One perceives in me, and not I perceive” (2012: 223). Therefore, being born is located principally in the realm of anonymity as a silent trace of bodily memory. It is a realm of past that, if I search my representational memory, seems to be external to my self-consciousness. In memory, the differentiation of the habituated and the actual body, our own and the other, has always already taken place. Birth is the beginning of difference. And this basic difference, which touches upon the beginning of the beginning, remains silent and incomprehensible, a pure silent experience, an event that might acquire its meaning later in an afterthought (Husserl 1977: 38). I imagine myself, my body, and the world as already preexisting, and I grasp my birth as a “pre-personal horizon” (Merleau-Ponty 2012: 223).

Birth as Trauma?

The psychoanalysts Sigmund Freud and his student Otto Rank believed that each person’s birth leaves a trace in his or her subconsciousness that can be understood as bodily memory. Freud supposed that the existential angst experienced during the birth process presents the basic form for all later fear: “The act of birth, moreover, is the first experience with fear, and is thus the source and model of the emotion of fear” (Freud 1921: ch. 5, fn 1). Rank notably put forward the notion of “trauma of birth,” that one’s own birth is engraved in the subconsciousness and hence has a crucial importance for the psychological development of a human being. The notion of trauma—a notion that lies at the center of trauma and therapy research—describes an intense fear and experience of panic similar to a “near-death experience” (Renggli 2001: 43, my translation).

Rank did not only want to use this concept of birth trauma to ground psychoanalysis “biologically,” he also sought to explain with it all neurotic symptoms and creative capacities. In his view, the meaning of the trauma of birth is profound because it is “a real substratum for all
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psycho-physiological connections and relations” (Rank 1993: 54). In contrast to Freud, Rank believed that the individual can reproduce “the individual intrauterine posture, or peculiarities relating to one’s own birth”; consequentially, he predicated a “womb phantasy” (Rank 1993: 84, 83). In this perspective, regardless of whether birth took place naturally or as a cesarean delivery, the perinatal separation from intrauterine being within the womb of the mother is inevitably traumatic. Rank’s theory leads to three consequences. First, Freud’s father-centered approach is reevaluated and the mother and mother–child relation is given a central place in theory. Rank thereby emancipates himself from the paternalistic and androcentric dogma of the history of ideas (Roazen 1974: 380–395). Second, he postulates the thesis of the trauma of birth, which is brought about by the experience of injury subconsciously inscribed on the body and which can be repeated in particular life circumstances. Third, the pain and fear of separation is the basis for the suppression, or forgetting, of birth.

Birth as Transition

Rank’s theory is not without its critics. The pediatrician and psychoanalyst Donald Winnicott describes the “experience of birth” and argues that the child who is not yet born is already able to prepare herself for her birth. Being seen as an active entity, she collects and catalogues nonvolatile bodily experiences (Winnicott 1990: 143ff.). His argument is that the fetus already has the capacity to psychologically structure the influences that it undergoes.

Birth can be experienced as a traumatic experience or as a valuable transition, depending on the different temporal and contextual possibilities and ways in which the birth is prepared for and takes place. A normal birth—that is, the transition from the not-yet-being-born to being-born—is not necessarily traumatizing from the perspective of the neonate. The normal transformation in birth can be characterized in the following ways. First, the infant experiences a radical discontinuity of being regarding different somatic, auditory, or tactile sensations, but it has developed capacities that help it to bridge these breaks in continuity. Second, the infant has bodily memories about subconscious sensations and impulses that are formed in the phase when it lived in unity with itself and the world, the inner and outer (Leboyer 2009: 64). Third, the mechanical and temporal aspects of the birth procedure are important for the question of whether birth is experienced as a trauma or as a valuable transition. It is best if the transition of birth is neither sudden nor delayed. If it is too sudden, then the child is unprepared; if it is delayed, then it is frustrated.

In light of these three aspects, we can see birth as being initiated by the infant itself. It can initiate impulses of movement and the transformation of birth when it has reached the necessary level of biological, physiological, and psychological maturation. These impulses emanate directly from the liveliness of the child (Winnicott 1990: 144). Hence, for Winnicott, the infant “gives” the impulse for being ready to be born. The birth as a transition is a particularly valuable experience for those persons born “normally.” If the birth begins too early or too late or if the birth is complicated and problematic, then the child might suffer fear and distress, and hence experience a birth trauma. Winnicott, like Leboyer, therefore advocates a “birth without violence” (2009). The goal of this approach is to arrange for birth to be a smooth transition from prenatal to postnatal being, from an intrauterine world to the extrauterine world. For instance, if the cord is not cut too soon, then the infant can take its first breaths without being shocked by respiratory distress, and then it can experience a smooth transition from the one form of being before and during birth to the form of being in the world as a rich experience for its psychological development. The prenatal world and the postnatal world differ insofar as the latter is characterized by contradictions, such as hard and soft or cold and warm. For Leboyer, birth is understood as a “perinatal leap,” which is important and valuable
for the infant’s development if it is done properly and the baby is welcomed in a room that resembles as much as possible the inner womb, with dimmed lighting, warm temperature, and soft tissues. Both positions—birth as a trauma and birth as valuable natural transition—take it as a psychological fact that birth is continued as bodily memory.

Social and Medical Perspectives

Pregnancy, birth, and other life-changing events are understood from very different perspectives and interests. A child can be delivered by vaginal birth or cesarean section. In the 1970s, the rate of cesarean section was below 5% in the United States; by 2006, the rate had risen to over 30% (Lake 2012; Osterman and Martin 2014). There are several important reasons for the likelihood of a cesarean section. First, medical reasons lead to more labor interventions (for instance, by continuous fetal monitoring or epidural analgesia). Second, for social and psychological reasons, enhancing women’s own ability to give birth and supporting a midwifery model of care has a low priority. Third, sometimes the option of a vaginal birth is simply not offered. Fourth, some individuals, society, and institutions have high tolerance for surgical procedures, because of time and organizational constraints. Cesareans are easier to plan, shorter, and more profitable for the hospital (Childbirth Connection 2015). The example of the cesarean rate shows that the question of how a child is born and how a woman gives birth to her child depends upon many different factors that are not only medical but also social and psychological.

This observation leads to two further observations. First, decisions for surgery or for medication are not only made on the basis of medical indication but also out of social or economic interests, organizational structures, or cultural convictions. This observation, however, presupposes already that birth takes place within a medical context. And this thought leads, second, to the observation that birth itself has not always been regarded as an issue for medical praxis. The pregnant woman is (usually) not sick, and birth is not a disease. However, today it is normal that pregnancy and birth are supported, accompanied, and monitored by the medical practice and its standardizations.

Medicalization is a notion that describes the critical determination of a social transformation in the second half of the 20th century. It encompasses the critique that realms of life that had originally been external to or only marginally part of the medical praxis are now seen as medical phenomena or problems (Conrad 1992; Ullrich 2012). Medicalization denotes a process “by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders, and are managed and overseen by medical professionals who are the authorities on that process” (Mullin 2005; Conrad 2007: 4). People are now used to the medicalization of the beginning and end of life, to pregnancy as “medicalized hope” (Duden 1993; Ullrich 2012), as a disruption to health requiring expert medical intervention (Mullin 2005: 54). If pregnancy and birth are understood in terms of health or illness, then they are subject to medical intervention and risk management, which are contingent and depend on social and institutional processes. An example of the contingency of risks and interventions and its dependency on social attitudes was already discussed above in relation to the different rates of cesarean births.

Reproductive medicine in the form of in-vitro fertilization (IVF) or genetic prenatal diagnostics has become part of everyday life. For about 30 years, the philosophy of medicine has discussed the social, psychological, ethical, and political dimensions of medical access to the body of the women and the fetus, and to genetic familial relations and kinship. Most pregnant women easily accept and undergo noninvasive tests (such as DNA tests from the mother’s blood or ultrasound); some also accept invasive testing (such as amniocentesis or chorionic
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villus sampling), although it entails a risk for the fetus. The availability and routinization of noninvasive genetic prenatal testing (NIPD) has the cultural effect that pregnancy is seen increasingly as an inherently risky and perilous process. Accordingly, pregnant women are inclined to disengage from their fetus and keep the relation “tentative” until tests come back negative (Katz Rothman 1993; Mitchell 2001; Kukla 2008). It also has the potential to raise new questions of economic and social impact, of eugenics and of “wrongful birth”—that is, the objection to children being born that will unduly burden their parents and the health care system (de Jong et al. 2010; Greely 2011; Schmitz 2013). NIPD has the potential to change not only the realm of prenatal diagnosis but also procreation and parenting practices in general, because it opens the way for new and cheaper technologies (including next-generation sequencing, microarrays, and exome sequencing) to test human life. It will normalize the idea of the genetic transparency of the future generation for the broader public and not just for high-risk families. Ontologically, in the context of reprogrametics, pregnancy and birth are increasingly becoming an issue about future health.

The consequences are that parenthood becomes an option, while the medical practitioner and expert become part of family planning, including the decision for or against a pregnancy and birth after prenatal tests have been performed. Prenatal and perinatal practices become a discourse of risk and medical options. The medical perspective focuses on the embryo and the fetus, on its health and physiological development. From the perspective of becoming a mother, this medical view is part of her context of being pregnant; yet she also has other perceptions. At the beginning of pregnancy, women would talk about themselves as being pregnant and how they feel about it. Later, often even before women feel the child moving, they refer to it as “my child,” or “my son” or “my daughter.” For future parents, the fetus is already their “baby.” Lynn Morgan observes that often the “social birth” precedes the biological birth into the world (1996: 59).

From the Private to the Public

Unborn children are often already given a name and today can be seen in ultrasound photos, which are then shown around to family and friends. The unborn child is moved into the visual sphere. A “pregnant turn” takes over the becoming-parents. It consists of concern about the results of diagnostic tests, about the aestheticization of the pregnant body as a sign of a new lifestyle, which can be called a “pregnant icon” (Matthew and Wexler 2000: 195). Both trends break the taboo on the visibility of what was once private and hidden. Representations of the pregnant belly could already be found in the early 1990s, and then achieved greater prominence with such pregnant cover girls as Brooke Shields on the cover of Vogue in 2003, Christina Aguilera in 2008 on Marie Claire, and Claudia Schiffer in 2011, also on the cover of Vogue. They prepare the shift from the private to the public of the inside of the womb. And, insofar as the prenatal and postnatal female bodies are supposed to look alike, they support the social idea of strategic control and power over one’s body. Heidi Klum, the queen of the “after-baby body,” illustrated this by modeling for Victoria’s Secret five weeks after the birth of her son.

The medical attempt to make the uterus transparent has its counterpart in the social shift from the private to a public “fetal celebrity” (Barlant 1997: 124; Nilsson 2006). Examples for this are “schools” for prenatal education with music and foreign languages or medically non-indicated four-dimensional ultrasound for public viewing of the fetus. This shift from the private to the public, from the inner to the external realm, can also be seen on YouTube or television, in the two-hour Birth Night Live broadcast from a British hospital’s maternal unit or the U.S. series Birth Day and Deliver Me!, which follow women through late pregnancy and
childbirth (Tyler 2009). The interested spectator can view countless homemade video clips, especially about natural and unassisted births. These films have thousands of views after only a few months online. The visualization of birth, which was traditionally hidden in the private sphere, has become a public event that can be shared, commented on, and even be clicked with likes and dislikes. Birth and the beginning of life are now part of the media and public world. You are born and your pictures are already waiting for you.

Conclusion

Birth marks a beginning and relation not only for the infant but also for the persons to whom it belongs and who care for it. The concept of birth implies a transition from the prenatal to the postnatal existence of the infant in regard to its relations. The understanding of these relations between the pregnant women and the fetus, and the mother, father, siblings (and others), and the child is part of an interdisciplinary and historically changing discourse and its interpretations, experiences, and practices in the private and public, medical, social, and cultural realms.

References


## Further Reading

Davis-Floyd, R. E. (2004) Birth as an American Rite of Passage, Berkeley / Los Angeles: University of California Press is a lively written analysis about the technocratic model of birth, of its cultural variations and women experiences.


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