“We just do what we have to”

Exploring gender, motherhood and labour pain in the Netherlands

Master thesis in Sociology – Engaging Public Issues

Student: **Hanneke Helmers** (511677)
Supervisor: **Maja Hertoghs**
Second reader: **Willem Schinkel**
Amount of words: **9792**

Abstract

This research aims to explore how gender, motherhood and labour pain are connected in the Netherlands. By taking the unique labour pain culture in the Netherlands as a starting point, the structures that construct gender and motherhood and the ways these are performed are unravelled. Using feminist theories, concepts and methods, the discourse around labour pain is analyzed and interviews were conducted in order to answer the question: How are gender and motherhood performed in the labour pain culture in the Netherlands?

The results show that women in the Netherlands face high expectations. In the process of labour, but also during motherhood, her own self 'vanishes' and she is expected to sacrifice herself for the sake of her child. In this web of structures and expectations, women don't question the practice of going through labour without pain relief and believe pain is positive and a necessary part of labour. Thereby, pain plays a role in the performativity of gender and (good) motherhood.

Key words

Childbirth; Gender; Gender performance; Motherhood; Labour pain

1. INTRODUCTION

"If you don't have . . . pain in birth, you just totally take out the soul of the whole event" (De Vries, 2005, p. 158).

The Dutch maternity care system receives international attention for its high rate of 'natural childbirths', meaning with low technological intervention. This translates into a relative high amount of home deliveries, a low rate of deliveries with pain medication (Logsdon & Smith-Morris, 2017) and high rates of vaginal births (Zeitlin et al., 2018) compared to other so-called developed countries. Many women in the Netherlands have an explicit wish to have such a 'natural' delivery (Stichting Bevallingstrauma, 2014).

In the Netherlands, there is a cultural framework that values childbirth pain as natural and acceptable (Logsdon & Smith-Morris, 2017). In comparison with other -in many aspects similar- countries, the numbers are striking. A 2007 study about pain relief in the Netherlands and neighbouring country Belgium showed a vast difference in the administration of epidurals, which is the most effective form of pain medication (Wilson et al., 2018). In 2007, only a small minority of 9.6% of all women in the Netherlands received an epidural, whereas in the same year a majority of 66.6% of Belgian women had an epidural during labour. The research pointed out that in Belgium childbirth pain is viewed as controllable and unnecessary, while in the Netherlands pain acceptance is valued as a coping strategy, and pain itself is perceived as an ally in the birth process (Christiaens, Verhaeghe, & Bracke, 2010). Although more women use pain relief today (21% received epidural analgesia in 2018), most of the women in the Netherlands still give birth without medical pain relief (Perined, 2019).

This exceptional situation is perceived as positive and especially as 'normal' by many Dutch women, as illustrated by this quote: *"I think it's a bit how we grow up because we know to be normal and just do what [we] have to"* (Logsdon & Smith-Morris, 2017). An anonymized midwife in a research about childbirth in the Netherlands states: "*In Holland the pain at giving birth is still considered completely normal, and it is considered abnormal if you need pain relief"* (De Vries, 2005, p. 157). Despite the belief that pain is necessary, that it has value and it that is an ally in the birth process, there is also another side to pain. For many women and others with wombs, childbirth is the most painful experience in their life (Bussche et al., 2007). Regardless of the idea that pain is important for the connection or bond between a mother and child, pain can also result in harmful experiences. Many women perceive their delivery as traumatic, and three percent develops a post-traumatic stress disorder (M. H. Hollander et al., 2017). Almost half of the Dutch women who consider their birth experience

traumatic, mention ‘high intensity of pain/physical discomfort’ as (one of) the reason(s) for their trauma (M. H. Hollander et al., 2017).

Why is it that so many women in the Netherlands deliberately choose to go through a possibly very painful and potentially traumatic experience without pain medication? In the past years, several researches have been conducted to the Dutch maternal health care culture. The uniqueness of the Dutch situation makes it interesting to study perceptions of and experiences with labour pain (Klomp, Witteveen, de Jonge, Hutton, & Lagro-Janssen, 2016; Logsdon & Smith-Morris, 2017), pain acceptance and personal control in pain relief (Christiaens, Verhaeghe & Bracke, 2010). These studies come up with different, combined explanations for the unique Dutch maternal pain culture. For example, Logsdon & Smith-Morris (2017) mention (health care) infrastructure as one of the possible explanations: women are primarily attended by midwives. Since part of the costs for giving birth in a hospital (in case of childbirth without medical complication) is not reimbursed by health insurance, this creates a boundary between labouring women and medical interventions like pain medication. De Vries (2005) mentions, among other things, physical characteristics of Dutch women (presented as healthy and large) as one of the possible reasons for the unique labour pain culture. Other explanations mentioned in his book about the Dutch maternity care system are linked to the Protestant Calvinist culture, which creates stoicism toward pain, austerity and thrift (after all, every medical intervention, also pain medication, costs money).

However, studies like these see the choice of women to go through labour pain as motivated by and mediated trough external causes. Although some studies add depth by explaining Dutch female identity through its specific historical context, they do not problematize something very crucial: the construction of the mother.

Feminist thinkers can help to gain a deeper understanding of the Dutch maternal pain culture, precisely by not taking the woman or mother as self-evident bases, but by questioning and problematizing these identities. Looking beyond gender and motherhood as biological realities, one can start seeing that the woman, the mother and pain are part of larger (power) structures of gender and identity.

Like other feminists, rather than taking an essentialist standpoint -namely that gender is grounded within the biological sex or that motherhood is a natural phenomenon- I will look at these identities as social constructs. I will take the standpoint of feminists such as Simone de Beauvoir, who says that no one is *born* a woman, but rather *becomes* one (as described in Ahmed, 2016) and Adrienne Rich (1977) who views motherhood as an institution, a product

of systems of power, rather than something biological or instinctive. I will analyse gender and sex with Judith Butler's concept of performativity: seeing gender as something non-essential and performative. In *Gender Trouble*, Butler (2007) explains gender as a phenomenon that is being produced and reproduced by powers and practices that put and keep people in their gender role. According to Butler, masculine and feminine gender roles are not natural givens, but people are always and everywhere performing or 'doing' their gender. From this point of view, motherhood can also be seen as something contingent, as something that people actively perform.

Using the concept of performativity enables me to look at the identity of the Dutch woman and mother as performed: something that is 'done' through practices such as pain at birth.

In this thesis, I will explore the question:

How are gender and motherhood performed in the labour pain culture in the Netherlands?

To investigate this, I will use the following sub-questions:

- How do notions of gender and motherhood reinforce each other in the Netherlands?
- How do gender norms become visible in the romanticization of labour pain in the Netherlands?
- How does labour pain reinforce ideas about (good) motherhood in the Netherlands?

In order to explore this, I will interview a gynaecologist and a selection of different kinds of people who gave birth, to speak with them about their experiences with and ideas about childbirth, pain and motherhood. By taking the unique labour pain culture in the Netherlands as a starting point, I will analyse the specific ways pain, gender and motherhood are connected and performed.

THEORETICAL FRAMEWORK

As soon as a woman knows that a child is growing in her body, she falls under the power of theories, ideals, archetypes, descriptions of her new existence, . . . which have floated invisibly about her since she first perceived herself to be female and therefore potentially a mother. (Rich, 1977, p. 45)

In this thesis I will focus on the construction of the identity of the woman and the mother, and how in the Netherlands this is done through pain. Using feminist theories, I will first elaborate on gender and motherhood, looking at them as power structures or, as described by Adrienne Rich (1977) an institution. In order to show how the mother comes into being in the Dutch context, it is also important to gain some insight of the field in which pregnancy and labour take place. Thus, I will also look at the specific, material practices surrounding pregnancy, giving birth, pain and motherhood.

The construction of gender

"One is not born but rather becomes *a woman"* (Simone de Beauvoir, 2010, as cited in Hekman, 2015).

In general, 'sex' refers to a biological distinction between female and male, whereas 'gender' refers to the social and cultural roles that are assigned to women, men, girls and boys (Brickell, 2006). In order to understand both sex and gender as non-essential (thus without an underlying truth or essence) but constructed, and as part of power structures, it is useful to start with the theory of Thomas Laqueur (1990, as mentioned in Brickell, 2006). According to him the two-sex model, distinguishing two opposite sexes, occurred in the eighteenth century. Before that, as he shows in his book *Making Sex*, medical documents were dominated by a one-sex model (Geller, 2008). Laqueur argues that biological differences between men and women were invented, made, to justify (social) gender inequality (Brickell, 2006). As Geller (2008) explains Laqueur's work: *"like the concept of gender, sex is historically mutable and socially contingent"* (Geller, 2008, p. 117).

Related to understanding constructivist notions of sex and gender, Michel Foucault (2018) argues that persons become who they are through the structures -such as language, history and society- that they are part of and that they form at the same time. New scientific knowledges, especially within the social but also in the biological sciences, have led to new ways of not only imagining, but also controlling life, as Foucault (2018) explains in Volume 1

of *The History of Sexuality*. Especially sexuality has become such a new object to control life and to manage populations. According to Foucault (2018), these new discourses have not only led to new ways of managing and controlling social life, they have also determined the way we, subjects, understand ourselves.

Doing gender

"As we do gender, we involve ourselves in the ongoing construction of distinctions between 'male' and 'female' and the accretion of social expectations onto those categories. These are then declared 'natural', which in turn legitimates their ongoing existence." (Brickell, 2006)

Although Foucault, as mentioned above, does not so much focus on gender, his work does explain that all subject-formation is part and product of the same knowledge power networks. Judith Butler (2007) is influenced by this notion of subject construction and developed the concept of gender performativity. According to Butler, masculine and feminine gender roles are not natural. However, Butler extends her argument, saying that even biological sex is not an essential basis. According to Butler, all distinctions between men and women, and all social practices and behaviour are contingent and performative (Butler, 2007). People do not naturally behave as men or women: they are subjected to knowledges of masculinity and femininity and constantly reproduce these ideas in their actions, for example through language, gestures and clothing.

Butler states that there is no underlying essence to this. By deconstructing otherwise considered 'natural truths', we can start seeing something abstract as gender as originated in performative, truth producing practices which are being constituted by repetitive performance. Or, to summarize: gender is based on nothing else than the performance of gender (Schinkel, 2014). Adrienne Rich (1977), who wrote *Of woman born* in which she questions the conception of womanhood, but more specifically who and what mothers are, gives an example of this gender performance:

> I have a very clear, keen memory of myself the day after I was married: I was sweeping a floor. Probably the floor did not really need to be swept; probably I simply did not know what else to do with myself. But as I swept the floor I thought: "Now I am a woman. This is an age-old action, this is what women have always done." I felt I was bending to some ancient form, too ancient to question. This is what women have always done. (Rich, 1977, p. 6)

In this book, Rich criticizes the 'institution' of motherhood, which forms the cornerstone of society and ensures that women are made responsible for childcare. When elaborating on how motherhood is being constructed and performed, it is also important to understand the larger structures in which the nuclear family is constructed. Not only Rich (1977) but also other feminist authors (Oakley, 2018; Lewis, 2019; Tardy, 2000) show the connections between motherhood, the economy and the nation state.

The Nuclear Family and the construction of the Mother

"The family [i]s a central agent of women's oppression as well as the major institution in women's lives." (Chodorow, 1979, p. 13)

Over the past two centuries, the identity of women in Europe became more and more entangled with motherhood. The industrial revolution resulted in several changes in the lives of women and mothers. Production moved from the private sphere (households) to the public sphere (factories), the latter reserved for men. The households on the other hand became more and more the responsibility of women and connected to reproduction (Van den Berg, 2013). Oakley (2018) explains that the capitalist system required not only the production of capital, but also of workers and the role of the woman shifted from producers to reproducers. From the late 1800s onwards, while technological advancements freed women from certain time-consuming domestic duties (Sebald, 1976, as cited in Tardy, 2000), childbirth and childcare were more celebrated and connected to esteem. A woman without children was considered a burden, while motherhood created honour for women (Tardy, 2000). Within the small, nuclear family, her 'career' as a mother became more and more specialized (Sebald, 1976, as cited in Tardy, 2000).

In *Of woman born*, Rich (1977) shows how the mother role in the family is connected to all kinds of expectations. Mothers should sacrifice themselves for the sake of their children, maybe even *"let their "autonomous self" die with the birth of their children, working only towards the right individuality for the child"* (Rich, as described by Van den Berg, 2013, p. 211). In her dissertation, Van den Berg (2013) also brings up blaming-the-mother-discourses, in which the mother is responsible for neutralizing all environmental factors for her children. She becomes responsible for the creation of a child's problems and, at the same time, responsible for solving them. Or, as Tardy (2000) writes:

> [Women] are socialized to place aside their own desires, dreams, and even basic needs for sleep, creativity, and personal accomplishment, to fulfill the myth of motherhood. . . . The message is simple: you are so special that it is not possible for the world to continue without you sacrificing yourself. (Tardy, 2000, p. 444)

Rich (1977) wonders why the sacrifice of women and mothers is mostly explained by capitalism: *"Why should* capitalism in and of itself *require that women specialize in this role of emotional salvager[?]"* (Rich, 1977, p.38) She points out that in capitalist as well as socialist systems the mother has a similar role, and explains this by patriarchy. Patriarchy is *"the manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general"* (Sultana, 2012, p. 3).

The sacrifice of mothers does not only take place once her children are born, but already starts during gestation. Lewis (2019) describes this in her book about surrogacy: *"Biophysically speaking, gestating is an unconscionably destructive business,"* (Lewis, 2019, p. 1) because*: "birth injuries are so common that Nature must intend for women to be used up in the process of reproduction, just as a salmon die after spawning."* (Lusztig, 2013, as cited by Lewis, 2019, p. 7).

When studying the relation between gender, motherhood and pain in the Netherlands, it is especially important to understand the unique history of Dutch women. Van den Berg (2013) and De Vries (2005) mention that in the Netherlands families already 'nuclearized' before the industrial revolution and the bourgeois model became the dominant household form for all social classes. In this model, women are expected to become wives and mothers and take care of the house and the children. In the Netherlands this already happened two centuries earlier than in other European countries (Pott-Buter, 1993, as mentioned in De Vries, 2005, p. 150). This longer tradition of women being the centre of the household and the nuclear family than in other 'modern' countries, might explain unique ways of 'performing' gender and motherhood, also when it comes to labour pain.

As Tardy (2000) describes, the idealization of motherhood and the guilt and blame attached to it affect the choices women make, especially when it comes to health care decisions. As described earlier, gender, the nuclear family and motherhood are constructed institutions, or one could say social infrastructures. Let us now look at the *material*

infrastructures in the Netherlands that a person comes into touch with when becoming pregnant.

Obstetrics in the Netherlands

"How have women given birth, who has helped them, and how, and why? These are not simply questions of the history of midwifery and obstetrics: they are political questions." (Rich, 1977, p. 117)

Whereas in other so-called developed countries there is a medical hegemony in which doctors have more power than midwives, in the Netherlands there is a balance in power between midwives and gynaecologists (De Vries, 2005). Different than in other 'Western' countries, in the Netherlands pregnancy and childbirth are seen less as a medical condition, and more as a 'normal', natural process (Christiaens, Nieuwenhuijze, & De Vries, 2013; De Vries, 2005). This perception leads to specific ways in which pregnancy and childbirth take place.

In the Netherlands, pregnant people are attended by a midwife if possible, and by a gynaecologist if necessary - for example when there is multiple gestation or in case of health problems (KNOV, 2014). Although most of Dutch women have the intention to go through labour while attended by their midwife (Stichting Bevallingstrauma, 2014) and almost 80 percent of early pregnancies are attended by a midwife, more than half of the women eventually give birth in a hospital, attended by a gynaecologist because of complications or the need for pain medication (Perined, 2019).

As Rich says, there are politics in these kind of constructions. Also De Vries notices this, when he explicates that there is a "serious, scientific debate" about the 'old-fashioned' way babies come into the world in the Netherlands (De Vries, 2005, p. 181). This debate, by some considered a "tribal struggle" (Volkskrant, 2010), is mainly held between gynaecologists, approaching a delivery in a more medical way, and midwives, representing natural delivery. Professor of gynaecology Bas Veersema, for example, explicates that a 'natural' delivery is a burden and can have devastating effects on a body: *"A woman's body has actually become less and less suitable for giving birth to a child, which can even make her physically and mentally traumatized"* (De Visser, 2020). Gynaecologist Dick Bekedam says: *"[It] is a complicated, precarious process that has been going on for years; it is really a tribal struggle [between hospitals and midwives] with different ideologies*" (Quaegebeur, 2017).

Because the women who are attended by a gynaecologist mostly see them in a later

stage of pregnancy (Perined, 2019), it is not inconceivable that most of the pregnant women are informed about pain and pain relief from other sources than a gynaecologist. Gynaecologists are the only ones who can administer medical pain relief, whereas midwives focus on pain treatment from a woman's 'own power' (through breathing and relaxing) and without medication (KNOV, n.d.).

The 'ideological' debate between gynaecologists and midwives is not only about the wellbeing of mothers and children. This 'tribal struggle' is also about self-interest and maybe even the 'survival' of the profession of midwives: discussions about for example pain medication might not always be in the best interest of the person giving birth. A midwife illustrates this very interestingly: *"I think why Dutch women don't need [pain] relief . . . [is] a combination of culture and the no-nonsense attitude. . . . if this should change, it's a big threat to midwifery"* (De Vries, 2005). The quotes of the gynaecologists and the midwife confirm what Rich wrote in 1977: there are politics in the way people give birth.

RESEARCH DESIGN

To explore how labour pain, motherhood and gender are entangled, and how pain at childbirth is a way to perform gender roles and motherhood, I have used a feminist approach. To get a deeper understanding of the practices and ideas surrounding painful deliveries, I have used feminist theories, concepts and methods during my analysis. As Davis, Taylor, & Furniss (2001) explain, in feminist research women's experiences are central: *"it is research with women for women"* (Davis, Taylor, & Furniss, 2001, p. 336). Although women's experiences have been studied in earlier research about the labour pain culture in the Netherlands, the social construction of the woman and the mother have never been questioned in these studies. Furthermore, in earlier research only the experiences of women have been researched, taking a gender binary as a starting point and based on the idea that only women can give birth. However, not only women give birth. Therefore, in this research, I have broadened this perspective and also interviewed a person with a womb who is not female.

Methods

In order to investigate how gender and motherhood are performed in the labour pain culture in the Netherlands, I have done qualitative research. First, I have analysed parts of the book Veilig Bevallen (Give birth safely), written by famous Dutch midwife Beatrijs Smulders (2001). Smulders has an important voice in Dutch media, gave many interviews about

childbirth and is an advocate of 'natural' childbirth. She sold 250.000 books about pregnancy and childbirth (bol.com, n.d.) and can therefore be seen as an important voice in this area. Apart from that, I have looked at information about pain at childbirth provided by the Dutch organisation of Midwives (KNOV) and searched on online platforms to see how women speak about this.

Furthermore, in order to get rich, detailed information, I have conducted qualitative oral history interviews. These interviews can be used as a tool to let people reflect on particular events and periods in their lives (Bryman, 2015). The focus of the semi-structured interviews was on gender expectations in early and present life, mother- and parenthood, pregnancy and childbirth, with a special focus on pain.

Within feminist research, it is advocated to establish non-hierarchical relationships with participants, meaning with a high level of rapport and a high degree of reciprocity (Bryman, 2015). This means that I did not pretend to be objective or on a higher level as a researcher, but also, when applicable, spoke about my own experiences with childbirth from my own position (being a -white- Dutch cis woman and queer mother). In some cases, the interviews were more like a conversation in which a mutual exchange of experiences and views took place. However, I am aware that my own experiences and believes also colour my views when it comes to the topics in this research. The stories that the participants told me, were analysed from my view, and from a feminist standpoint. Some participants might not consider themselves feminist, have never thought about problematizing their identities as women or mothers and in this research I have done so. This might, after all, put me in the hierarchical -knowing it better- position that I wanted to avoid. I am aware of this contradiction.

Participants

I have spoken to six people, in order to understand their ideas about gender, motherhood and (pain at) childbirth. The participants were people I know directly or through my network. In the analysis, they will be presented with pseudonyms (chosen by themselves) in order to guarantee their anonymity. Apart from interviewing a gynaecologist (Sam) about her experiences when attending women in labour, I have interviewed five people who gave birth. I have tried to make this group as heterogeneous as possible, in order to get access to different experiences and ideas. Four of the participants (Ans, Johanna, Courtney and Mafalda) identify as cis women, one of them (Jimi) as a trans guy. I am very thankful that I was able to interview a trans man for this thesis. He helped me to take my research on a higher level and

enabled me to get different insights, especially when it comes to gender (expectations).

One of the women who gave birth (Mafalda), identifies as queer and also has a child who she did not give birth to herself, therefore having a different view on motherhood than the 'traditional' concept. Two women (Courtney and Mafalda) did not grow up in the Netherlands, hence gave important information about certain expectations that are unique for the Dutch situation. One woman (Ans) lived in a community when she had small children, in which the children were raised and taken care of collectively by a group of adults. Ans gave therefore fascinating views on what she thinks a family and a mother is.

Before starting the interviews, I made sure the participants gave their informed consent. I asked if they understood the content of my research and their role within the research. I explained them that they did not have to answer my questions if they did not want to and that they could withdraw their participation at any moment. Finally, I asked their permission to record the conversation and to use the data from the interviews.

Data analysis

The interviews took place in May and June, typically with approximately one week in between. After the interviews, I would compare the outcomes with existing (feminist) literature about gender, motherhood and pain, in order to make an in-depth feminist analysis. Four interviews took place face-to-face and were recorded in order to be able to transcribe them afterwards. Already during the transcription, I would add codes and insights to the file. Later, I used Atlas.ti to bring more structure to my coding process and to be able to compare different quotes about certain topics. The two last interviews took place through a video call and were also recorded. Due to time restraints, these last two interviews were not transcribed, apart from the quotes that I used for this thesis.

ANALYSIS

In my analysis, I will take the standpoint that gender and motherhood are social constructs rather than biological or essential truths. Or, as Butler (2007) says, as identities that are not fixed but repeated acts of performance. In this chapter, I will show how gender and motherhood are being performed in the Netherlands when it comes to childbirth, and more specifically, pain at childbirth. In my analysis, I will use literature of feminists who wrote about motherhood such as Ann Oakley (2018), Sophie Lewis (2019), Nancy Chodorow (1979) and Adrienne Rich (1977). By first answering the sub questions, I will eventually

answer the question ‘How are gender and motherhood performed in the labour pain culture in the Netherlands?’

‘A baby turns a woman into a mother’

And it is a turning point, a transition, a life crisis: a first baby turns a woman into a mother, and mothers’ lives are incurably affected by their motherhood; in one way or another the child will be a theme for ever. (Oakley, 2018, p. 16)

To answer the question about how notions of gender and motherhood reinforce each other in the Netherlands, we first have to go a few centuries back. Feminist writers as Oakley (2018) and Lewis (2019) show us that childbirth is entangled with the economic system, as is also described in the chapter about the nuclear family in the theoretical framework. Over the past centuries the role of mothers changed as societies industrialized: *“The meaning of childbirth is interlocked with a society’s attitudes towards women. Both reflect its economic system . . . . The production of capital requires the production of workers: thus women’s role becomes not to produce but to reproduce”* (Oakley, 2018, p. 2). Although this text of Oakley originates from 1979, in a context that was different than the neo-liberal context we are living in today - in which women are expected to do more than just reproduce-, Oakley’s ideas can still be recognized in one of the interviews. Participant Courtney (mother of 1), believes: *“It is a woman’s function. A woman has a function to give birth to a child.”* Sometimes, women are already prepared to fulfil this function from a young age, as is shown in the next paragraph.

Reproducing mothers

In this analysis, I am looking at motherhood as a social construct in order to see why women do the things they do. Nancy Chodorow (1979) shows in her study about the ‘mothering’ of women how this is being reproduced cyclically: *“Reproduction of mothering occurs through social structurally induced psychological processes. It is neither a product of biology nor of intentional role-training. . . . Women, as mothers, produce daughters with mothering capacities and the desire to mother.”* (Chodorow, 1979, p. 5)

According to Chodorow, identities of the woman and the mother are being reproduced and maintained by certain actions. This can easily be recognized in the life story of participant Ans (mother of 2). She was the first girl in the family: *“And they were happy, because they had two boys, and a girl is a help in the family.”* She continues: “*I actually had to constantly help my mother. . . . I had to help make beds and take care of the kids. . . . I grew up always taking care and helping. And that's how I received appreciation.”*

Chodorow (1979) and Ans show us that mothering is something that does not start once a woman gives birth, but that it can start -and is performed- already earlier in a girl's life. As an adult, this mothering becomes more and more attached to her identity as a woman. Rich (1977) observes that *"Woman's status as child bearer has been made into a major fact of her life. Terms like 'barren' or 'childless' have been used to negate any further identity. The term of 'nonfather' does not exist in any realm of social categories"* (Rich, 1977, p. xiii-xiv). Although, nowadays, these terms might not be very present in the Netherlands, in the former and following parts of this analysis we see that the identity of women is (still) very much connected to motherhood.

Fulfilling womanhood

The life stories of the participants show how motherhood is connected to gender. Several participants mention how becoming a mother affirmed their womanhood. Ans: *"Suddenly I had big breasts. . . . As an adolescent, boys at school would say I was two peas on a shelf"* - meaning that she had small breasts- *"so in that sense I felt I was not feminine at all. When I became a mother I did [feel feminine]."* Johanna (mother of 1) says: *"Motherhood already makes you a woman. It is something very primal. By becoming a mother, my womanhood is fulfilled. My child and my partner make that I am seen as a woman."*

Jimi (father of 1 who he gave birth to), noticed that his pregnancy made people confused about his identity: *"People warned me: [they said:] ' when I was pregnant, I finally really felt like a woman'. But I did not experience that. I still felt like a guy."* And they connected his pregnancy to motherhood: *"They would wish me a happy Mother's Day."*

These quotes show how motherhood is linked to physical characteristics that, in society, are seen as natural characteristics of women. This connection between motherhood and the body makes it especially interesting to study pain.

Responsibility and sacrifice

Becoming a mother can be a way to change the role of a woman, as is explained by Johanna. Her answer to what makes her a woman is: *"You . . . have a kind of subordinate role . . . or maybe not necessarily submissive but a kind of expectant or receiving role as a woman."* Giving birth gave her a sense of power: "*I remember that [partner] was very impressed"* as did her role as a mother: *"you suddenly feel that you . . . . know better how to deal with that child than that man or the partner who did not give birth to the child. And in that you*

suddenly become… -maybe not superior, but no longer subordinate, because you think: I know better, it is my child, I gave birth."

The quote above shows how motherhood changes the role of a woman, but also gives an impression of the responsibilities women can feel. Mafalda (mother of 2), who was born and grew up in South America, noticed there were high expectations of women and mothers after she came to the Netherlands. Where she grew up, children were the responsibility of the extended family, including grandparents, uncles and aunts: *"All mothers worked, nobody was really there. . . . That mother role was not something important, absolutely not."* In the Netherlands she noticed that especially for women there were high standards: *". . .you have to be a super woman. [You have to be] good at [your] job . . ., [have] the best job in the world. Because you have to get paid well. But [you] also [have to] follow your heart. And have social impact. But also work part-time. And you have to be a very good mother, listen carefully to your children, educate them well, but also [do] important activities: you have to be very cultural, your children have to go to the theater, to museums, you also have to be outside a lot because outside is important, even when it rains. These kinds of expectations really come from here."* And: *"A lot less is expected from men in society."*

In this quote, apart from expectations, one could also recognize sacrifice, as is also expressed by Johanna*: "You have to take care of your child first and then of yourself. . . . sacrifice. As a woman, in motherhood, relationship, just being a woman in this society"* Rich (1977) also expresses this in her book: *"To mother a child implies a continuing presence, lasting at least nine months, more often for years. Motherhood is earned, first through an intense physical and psychic rite of passage -pregnancy and childbirth- then through learning to nurture, which does not come by instinct."* And:*"...her body has undergone irreversible changes, her mind will never be the same, her future as a woman has been shaped by the event*." (Rich, 1977, p. xiv)

That mothering a child implies a continuing presence is also expressed by Ans, who has an exceptional story. As a mother of a young child and pregnant of the second, Ans and her husband decided that they wanted to break with certain social structures. With some other couples and their children, they started a community in which the children were raised collectively, because: *"Children are not property [of their parents], they belong to the world."* In the community, they also tried to break with gender roles and expectations: *"Something had to change in the reproduction. . . . That men are indeed raised too boyish and girls in the carer role, so we wanted to break that."* Although Ans hoped that she could

care for and love all children in their collective equally, she noticed that this was very difficult. *"For both a child and the parent, there is something… I don't quite know what to call it, but there is something of unconditional love. Because you chose it, you are responsible for it, you brought it into the world."* About some other adults in the group, Ans says: "*I found it difficult when they would say: now I have other priorities. We, as parents, could not say that."* She gives an example of this when she tells about another (not biological) mother in the group, to whom Ans' youngest child was very attached: *"If [that woman] had a difficult time, she would just leave for a few years, and then come back. I would of course not do that. I would only have left with the children!"* What Ans shows here, is that she believes that mothering is something unconditional and continuous. It is connected to giving birth yourself: once a mother, you stay a mother.

The paragraphs above show how notions of gender and motherhood reinforce each other in the Netherlands. We see that mothering is something social that is reproduced socially, but also physical, connected to the bodies society considers female, and especially to the bodies who gave birth. A lot is expected of them, they carry a lot of responsibility and even self-sacrifice. In the following paragraphs I will show how this sacrifice becomes visible in practices surrounding childbirth.

Romanticizing labour pain

"I hope women will continue understanding the function and depth of pain during childbirth. Dutch women are tough, and it only lasts 1 day of your life!" (Zitvast, 2016).

When answering the question how gender norms become visible in the romanticization of labour pain in the Netherlands, we see that certain characteristics are linked specifically to Dutch women, as shown by the above quote of Beatrijs Smulders (Zitvast, 2016). This can also be recognised in De Vries' book about maternity care in the Netherlands. He writes: *". . . others suggested that Dutch women were better suited to birth at home because they were bigger and healthier than women elsewhere"* (De Vries, 2005, p. x).

Tough women

Participant Courtney, who was born and grew up in China, affirms the image that Smulders (Zitvast, 2016) and De Vries (2005) sketch of Dutch women: *"They are tough."* Also

Mafalda, who moved from Argentina to the Netherlands as a young adult, addresses this: *"Those are things that almost define the Dutch woman. 'I am tough, I do this myself.' It is part of the Dutch identity. And when I question it, they say I don't understand because I am a foreigner. 'We are strong, we are tough, we know better. We suffer, we do it the natural way.'"*

What stands out, is that these ideas about Dutch women are also linked to 'masculine' qualities. On an online platform, where a woman asks if she should use pain medication, another woman responds: *"Just accept that giving birth is hell. . . . You chose to have another child.* Man up *and think about the beautiful times that will come"* (Ik weet niet wat te doen,pijnstilling of niet? 2019). Participant Ans displays pride about her daughter, who gave birth 'herself' (without pain medication). Ans was present when her daughter was in labour and saw that she was in a lot of pain. In the interview, I asked her how she felt about that. She said: *"She is really tough, she always wanted to be a boy when she was a child."* I responded: *"Funny, you say: I didn't find it difficult to see her in pain, because she is tough. And then you connect that tot the fact that she always wanted to be a boy. But one could think: childbirth is something that women do and what they are good at. But the toughness is not?"* Ans: *"No, I always thought she was born in the wrong body."*

Doing it right

In narratives about pain at childbirth, more paradoxes can be recognized. Pain at birth would be good for the bonding between mother and child (Smulders, 2001; De Vries, 2005), but at the same time, the labouring person should not feel too much pain, because that would mean that she might need pain medication. Mafalda (mother of 2, gave birth to 1) says about this: *"On one hand [they] say how good the pain is, but then during yoga you have to practice to breathe to not feel that pain. Contradicting messages all the time. [Pain] is good, but at the same time [it is] not."*

What Mafalda describes, can be recognized in the information film 'How to deal with contractions' of the Dutch organization of Midwives (KNOV, 2019). Here, we see an animation of a pregnant woman whose contractions have started. We see that, if she does the right things, she will be able to handle the pain. We see examples of these 'right' things: putting her feet up, asking her husband to rub her back, water the plants, taking a walk, listen to music, take a shower. Every time she does this, she gets a thumbs up, and at the end of the film you see a calm, smiling woman with a baby in her arms. The pain is presented as slightly uncomfortable, but easy to handle if you do the right thing. Here, the 'tough' woman can be

recognized. She does not complain, she does not need (medical) help. She knows how to handle this, ánd she is fulfilling her natural duty. This can be connected to Rich's (1977) book about motherhood as experience and institution: the mother is responsible for neutralizing all environmental factors for her children. In the belief that a natural childbirth, without medication, is best for the connection between mother and child, the mother is responsible to handle labour herself, 'on her own', or, as is said in the Netherlands 'with her own powers'.

Pain and good motherhood

When childbirth is over, the pain is often being replaced by overwhelming feelings of relief and endearment . . . You became extremely vulnerable, totally open and real. . . In that situation, you are totally receptive to the child. The pain is like a gate, through which you enter motherhood. Or a gate through which your child will enter your heart. Pain is the initiation of motherhood. (Smulders, 2001, p.176-177).

This quote comes from a chapter called *The Utility of Pain* in Smulders' book *Veilig Bevallen*. In this chapter she describes the function and profits of pain, illustrating it with quotes of women who gave birth and a drawing of a happy woman sitting on a cloud. Smulders writes: *"To let yourself be sedated* [jezelf laten platspuiten] *without a medical reason is not a good idea"* (Smulders, 2001, p. 177). De Vries (2005) quotes a midwife who says: *"[Pain] gives you more connection, bonding, and you can give more offerings. . . . you suffer more, endure more. . . .[If] . . . you don't want that pain, you don't take responsibility of what your body natural-wise does."* (De Vries, 2005, p. 158). The romanticization of childbirth with pain is visible here, but also the disapproval for people who choose for pain medication.

'Pain is embedded in motherhood'

In *Of Woman Born*, Rich (1977) mentions the connection between pain, suffering and motherhood. She notices: *"Pain, like love, is embedded in the ideology of motherhood"* (Rich, 1977, p. 150). In her book, based on the situation in the United States, she also mentions pain in labour: "*As late as the 1920s, it was assumed that the suffering which a woman undergoes in labor is one of the strongest elements in the love she bears her offspring"* (Rich, 1977, p. 164). One century later, this idea is still very present in the Netherlands, as appears not only in Smulders' book, but also on online platforms and speaking with participants for this research.

Participant Sam, gynaecologist in training, says she recognises this romanticization of labour pain as described by Smulders (2001), De Vries (2005) and Rich (1977) when she

attends patients: *"The sacrifice, the pain. It is seen as the best kick off [as a mother]."* To an online discussion about pain medication a person mentions this: "*I found it annoying that they kept asking me if I wanted an epidural . . . no way, for me my child comes first!"* (Pijnbestrijding: een ander geluid! 2014). Sam mentions that almost all labouring women she attends have written a 'birth plan', in which they express their wishes for their (ideal) delivery. *"They almost always say they want it as natural as possible, and that they only want pain medication if it is really, really necessary. Sometimes a woman expresses that she really needs pain medication, but then her partner tries to talk her out of it, because that was not the plan."*

Here, the sacrifice, maybe even vanishing of the self when becoming a mother, as mentioned in the theoretical framework, can be recognized. The wellbeing of the person in labour seems to be less important than that of her child. And that is, as Rich critically describes, one of the assumptions about what a good mother is: *"A 'natural' mother is a person without further identity. . . . maternal love is, and should be, quite literally selfless."* (Rich, 1977, p. 3). Whereas in other practices people would not willingly choose for pain, when it comes to childbirth it seems not to be an issue if the person in pain should be freed from it. Gynaecologist Sam illustrates this with an example: *"We also don't remove an appendix without giving pain medication."*

Jimi, the only male participant to this research who gave birth, *did* make choices in favor of his own wellbeing: *"I think my trans identity and the focus on it contributed to people thinking very much about my wellbeing. Because people thought about this, I had the opportunity to think about my [self], although I found that very difficult. I had breast surgery, so breastfeeding was not possible . . . That was the first very clear choice for myself, because I already knew that I wanted to get pregnant."* He also chose for a cesarean section, a choice that is normally not accessible for pregnant people in the Netherlands unless there is a medical reason. "*And with that cesarean section, I was really choosing for myself."* Because: *"I thought it would be better for my mental state and therefore also for the bond with my child if I did not give birth naturally."* However, although he was -with the help of his environment- able to make decisions that were best for himself, he did feel guilty about his choices: *"I had quite a hard time with that."*

It is fascinating to see that a Dutch trans man *could* disconnect childbirth from the idea that it should be 'natural' and that therefore pain is inescapable, and that his (medical) environment did express worries about his mental wellbeing, whereas this is not recognizes in the interviews with cis women.

Guilt, blame and failure

Some participants link feeling pain to the feeling of having given birth 'themselves'. Ans mentions: *"The pain is just part of it, but it also gives you a feeling that you really did it yourself."* This focus on doing it yourself can be linked to Rich's focus on the total responsibility of the mother for the wellbeing of a child. If there is a perfect way to 'do' childbirth (namely 'naturally' and without pain medication), you can also 'do' it wrong. Sam: *"It is difficult to shift from a natural to a medical delivery, it is then your 'own fault' and that is difficult to accept."*

This is very well visible in the interviews with several participants. Three of them did not give birth in a way that was 'natural' enough according to their standards, and all struggle with feelings of guilt, blame and failure. Johanna could not give birth at home, as she wished: *"The first moment after I gave birth I wondered: could I have done something differently?. . . Could I have done better?. . . He yells a lot, maybe I have done something wrong at the beginning of his life."* Courtney wanted to give birth in a 'natural' way, but eventually gave birth with a cesarean section. About the pain she says: *"I knew it would hurt a lot, because I can imagine a head coming out of a vagina. But that is part of the deal."* The fact that she did not feel this with her body because of the cesarean section, created feelings of disappointment: *"I didn't feel at all what I had expected. Then I [also] suffered a mental trauma [because I did not get enough personal space]. As a result, I certainly could not enjoy [son] the first year. He was a creature I had to keep alive. I did my best."* That the delivery went different than she hoped and expected, created feelings of failure: *"Like a calf coming out of the mother, that is the moment of connection. That is where you become a mother. And that went totally wrong. I did feel a lot of physical pain, but I miss the feeling of the baby coming out of my body. And I also didn't have milk. What a useless mother. I gave birth to a baby but I [could] not offer it anything."*

Also Jimi experiences feelings of guilt, but not because the delivery was not 'natural' enough. He gave birth 6 weeks early, and blames himself for that: *"I worked pretty hard [during pregnancy] and didn't take the rest I should have taken. I don't think that has been beneficial for the pregnancy… I may have been pregnant, but I had to keep proving that I am a guy, that was quite a task. By not thinking enough about [the pregnancy], I have taken too little rest."*

What stands out in the interviews, is that several participants see pain as something that cannot be separated from the practice of giving birth. Courtney says: *"*I *chose to have a child,*

and pain at childbirth is part of that." Ans says: *"Pain is part of the deal."* Mafalda, however, grew up in an environment where, already since decades, most women give birth with an epidural, and so did she when she gave birth in the Netherlands: *"[I] don't like pain. For me it is something physical. It is not an idea or a thought, it is a feeling in my body that I don't like, and I don't see any reason to suffer while I can choose not to feel that pain."* Courtney, who had the explicit wish to give birth in a 'natural' way, says about the moment when she received epidural analgesia (due to the cesarean section): *"Then I received the epidural and all the pain was gone. It was heaven."*

How are gender and motherhood performed in the labour pain culture in the Netherlands?

My analysis hitherto gave different insights that will help answering the question how, in the Netherlands, gender and motherhood are done through pain in childbirth.

My research shows how, over the past centuries, mothering became more and more a specialty of women. The Netherlands has a specific, longer history than other countries in which the nuclear family and the mother have an important role. Participants express that they see mothering as a woman's function. Women 'reproduce' mothers as is explained by Rich (1977), for example by teaching them to fulfill a caring role as said by participant Ans. The analysis shows that motherhood is not only connected to 'doing', it is also connected to 'nature' and sex. Pregnancy and having a child confirms women in their womanhood because of physical changes, as explained by Ans and the example Jimi mentions, or through the role a woman takes as a mother and partner, as mentioned by Johanna. The act of giving birth can also give women a sense of empowerment, it can change their role. Now she is a mother, she carries the main responsibility over her child and she can fulfill a less subordinate role in life, as is explained by Johanna. However, the analysis also shows another side, where gender expectations lead to high expectations and self-sacrifice of mothers.

These gender expectations become more specific when looking at the romanticization of pain at childbirth. There, characteristics connected to the Dutch women become clear: she is tough, she is strong, she can *do* childbirth *herself*, without medical help and without pain medication. Doing the right thing (for your child) and doing it yourself are ways to perform good motherhood. The analysis shows that pain is highly connected to sacrifice, and as the answers to the third sub question show, the ultimate sacrifice a mother can give is connected to pain and suffering.

Giving birth without pain medication is taking full responsibility for the wellbeing of your child. By giving birth with pain, women show not only that they are tough, but also to be good mothers, through self-effacing and self-sacrifice. In the Netherlands, a good mother is someone who is willing to give everything for her child, and she does this on her own.

CONCLUSION

My analysis shows that motherhood is very much entangled with ideas and expectations of women. In the Netherlands, there is a clear discourse in which pain is seen as something positive, as something that cannot be separated from childbirth, it is part of the deal (delivery). High expectations of mothers in the Netherlands result in ideas that mothers should do everything to give their children the best start, and in the Netherlands it is believed that that is done through natural childbirth, in which there is no space for pain relief. If these expectations are not being met, this can result in feelings of guilt and failure.

The image looming in the background of this analysis, is that of women and mothers being trapped in a web of expectations and pressure. On one hand giving birth and motherhood can give a sense of empowerment, on the other hand we can recognize self-sacrifice and oppression. She is expected – and expects herself- to sacrifice herself for the sake of her child(ren) and thereby eventually also society, as is explained in the paragraph about the nuclear family in the theoretical framework. The wellbeing of the mother is not of concern, one could even say that the 'self' of the mother is not even present in these believes. It is remarkable that the two people who *did* take their own wellbeing into account when going through labour are a trans man and a cis woman who did not grow up in the Netherlands.

This research was not conducted to find out if it is good to feel pain when giving birth. Although it is very critical about the practices surrounding childbirth in the Netherlands, and this is partly connected to the role of midwives, Rich (1977), Oakley (2018) and Lewis (2019) point out that it is not per se contributory to the wellbeing of women when pregnancy and childbirth are guided by gynecologists, who's knowledge is more rooted in patriarchal views and knowledge of the woman's body than by midwives, who's practices come forth out of knowledge transmitted by women.

However, as Tau (2017) writes -building on what many other feminists said-, women are often gatekeepers of the patriarchy. They reproduce patriarchal structures, that are often not in the best interest of women. This thesis shows how women go along with ideas about

pain and gender, sometimes without considering their own interests.

Taking the standpoint that giving birth with pain is the best start, could also be seen from another angle. If natural birth and the connected physical pain is likely to cause feelings of, for example exhaustion or even trauma for the labouring person, pain could also be considered an obstacle, rather than an ally for the initiation of motherhood. If this counts for a trans man, why can't we see it like that for all persons in labour, including the ones who consider themselves women?

For the sake of women and others with wombs, it would be good to critically look at the structures and ideas that surround us and that make us do the things we do. 'Women have always done it like this', is not a valid reason to continue along this path of pain and sacrifice. As is described by Lewis (2019), childbirth can be destructive for a body, even deadly, but it can also be mentally traumatizing. Thus, it is important to look at this practice very critically and look to the structures that make people do the things they do. To not question this, is not for the sake of labouring persons and eventually also not for their children.

Some interesting findings came out of the research, that might be worth to investigate further. First, birth practices in the Netherlands seem to be very much connected to the identity of the Dutch woman. Certain characteristics are attributed to Dutch women, and women are proud of that and feel the need to prove that they can meet certain 'Dutch' standards. It would be interesting to investigate this further, using theories about national identity and othering processes.

Second, this thesis is very much focused on the woman, thereby reproducing the notion that gender is binary. However, also people that are man or who do not fit in the gender binary give birth, as is shown by Jimi. His experiences with childbirth turn out to be different than that of the cis female participants who gave birth. It would be interesting to do more research to experiences and structures surrounding pregnancy and childbirth for people who do not identify as women, potentially comparing these experiences with that of cis women.

Finally, almost all participants experienced feelings of guilt and failure. As several participants pointed out, this has very much to do with false expectations. Because there is a big emphasis on the 'right' way to give birth, and women are taught that the 'success' of their labour mostly lies in their own hands, it is easy to experience things as going 'wrong' when they do not go as expected. It would be interesting to investigate how practices such as writing a personal birth plan contribute to these feelings of guilt and failure.

REFERENCES

Ahmed, S. (2016). *Living a Feminist Life*. Amsterdam, Netherlands: Amsterdam University Press.

bol.com. (n.d.). bol.com | Beatrijs Smulders. Retrieved 13 March 2020, from https://www.bol.com/nl/c/boeken-beatrijs-smulders/50573/N/8299/

Brickell, C. (2006). The Sociological Construction of Gender and Sexuality. *The Sociological Review, 54*(1), 87–113. https://doi.org/10.1111/j.1467-954x.2006.00603.x

Bryman, A. (2015). *Social Research Methods* (5th ed.). Oxford, United Kingdom: Oxford University Press.

Bussche, E., Crombez, G., Eccleston, C., & Sullivan, M. J. L. (2007). Why women prefer epidural analgesia during childbirth: The role of beliefs about epidural analgesia and pain catastrophizing. *European Journal of Pain*, *11*(3), 275–282. https://doi.org/10.1016/j.ejpain.2006.03.002

Butler, J. (2007). *Gender Trouble*. Abingdon, United Kingdom: Taylor & Francis.

Chodorow, N. (1979). *The Reproduction of Mothering*. Berkeley, United States: University of California Press.

Christiaens, W., Nieuwenhuijze, M. J., & de Vries, R. (2013). Trends in the medicalisation of childbirth in Flanders and the Netherlands. *Midwifery, 29*(1), e1–e8. https://doi.org/10.1016/j.midw.2012.08.010

Christiaens, W., Verhaeghe, M., & Bracke, P. (2010). Pain acceptance and personal control in pain relief in two maternity care models: a cross-national comparison of Belgium and the Netherlands. *BMC Health Services Research*, *10*(1). https://doi.org/10.1186/1472 6963-10-268

Davis, K., Taylor, B., & Furniss, D. (2001). NARRATIVE ACCOUNTS OF TRACKING THE RURAL DOMESTIC VIOLENCE SURVIVORS' JOURNEY: A FEMINIST APPROACH. *Health Care for Women International, 22*(4), 333–347. https://doi.org/10.1080/07399330119209

De Visser, E. (2020, February 7). 'Een vaginale bevalling is gewoon niet voor alle vrouwen geschikt'. *Volkskrant*. Retrieved from https://www.volkskrant.nl/wetenschap/een vaginale-bevalling-is-gewoon-niet-voor-alle-vrouwen-geschikt~b418ba7f/

De Vries, R. (2005). *A Pleasing Birth: Midwives And Maternity Care*. Amsterdam, Netherlands: Amsterdam University Press.

Foucault, M. (2018). *Geschiedenis van de seksualiteit.* The Hague, Netherlands: Boom Lemma.

Geller, P. L. (2008). Conceiving sex: Fomenting a feminist bioarchaeology. *Journal of Social Archaeology, 8(*1), 113–138. https://doi.org/10.1177/1469605307086080

Hekman, S. (2015). Simone de Beauvoir and the beginnings of the feminine subject. *Feminist Theory, 16*(2), 137–151. https://doi.org/10.1177/1464700115585721

Hollander, M. H., van Hastenberg, E., van Dillen, J., van Pampus, M. G., de Miranda, E., & Stramrood, C. A. I. (2017). Preventing traumatic childbirth experiences: 2192 women's perceptions and views. *Archives of Women's Mental Health*, *20*(4), 515–523. https://doi.org/10.1007/s00737-017-0729-6

Ik weet niet wat te doen,pijnstilling of niet? (2019, November 25). Retrieved 5 March 2020, from https://forum.viva.nl/zwanger/ik-weet-niet-wat-te-doen-pijnstilling-of niet/list_messages/453223

Klomp, T., Witteveen, A. B., de Jonge, A., Hutton, E. K., & Lagro-Janssen, A. L. M. (2016). A qualitative interview study into experiences of management of labor pain among women in midwife-led care in the Netherlands. *Journal of Psychosomatic Obstetrics & Gynecology, 38*(2), 94–102. https://doi.org/10.1080/0167482x.2016.1244522

KNOV. (n.d.). Pijnbehandeling. Retrieved 13 March 2020, from https://deverloskundige.nl/bevalling/tekstpagina/33/pijnbehandeling/

KNOV. (2014, March 10). Verandering organisatie verloskundige zorg vraagt om goede onderbouwing. Retrieved 5 May 2020, from https://www.knov.nl/actueel overzicht/nieuws-overzicht/detail/verandering-organisatie-verloskundige-zorg-vraagt om-goede-onderbouwing/1342

KNOV. (2019, January 9). Film: Omgaan met weeën. Retrieved 9 June 2020, from https://deverloskundige.nl/over-de-verloskundige/subtekstpagina/289/film-omgaan met-weeen

Lewis, S. (2019). *Full Surrogacy Now*. Amsterdam, Netherlands: Adfo Books.

Logsdon, K., & Smith-Morris, C. (2017). An ethnography on perceptions of pain in Dutch "Natural" childbirth. *Midwifery*, *55*, 67–74. https://doi.org/10.1016/j.midw.2017.09.004

Oakley, A. (2018). *From Here to Maternity (Reissue)*. Bristol, United Kingdom: Bristol University Press.

Perined. (2019). *Perinatale zorg in Nederland anno 2018*. Retrieved from https://assets.perined.nl/docs/fc23b860-a5ff-4ef6-b164-aedf7881cbe3.pdf

Pijnbestrijding: een ander geluid! (2014, March 3). Retrieved 5 March 2020, from https://www.oudersvannu.nl/forums/onderwerp/409912-pijnbestrijding-een-ander geluid/

Quaegebeur, E. (2017, May 6). Dick Bekedam: 'Iedere gynaecoloog heeft zijn eigen kerkhof'. *Het Parool*. Retrieved from https://www.parool.nl

Rich, A. (1977). *Of Woman Born: Motherhood as Experience and Institution*. New York: Norton.

Schinkel, W. (2014). *Over nut en nadeel van de sociologie voor het leven*. Amsterdam, Netherlands: Boom.

Smulders, B. (2001). *Veilig Bevallen* (9th ed.). Utrecht, Netherlands: Lifetime.

Stichting Bevallingstrauma. (2014). Feiten & Cijfers | Stichting Bevallingstrauma. Retrieved 10 March 2020, from https://stichtingbevallingstrauma.nl/feiten-cijfers/

Sultana, A. (2012). Patriarchy and women's subordination: a theoretical analysis. *Arts Faculty Jouprnal,* 1–18. https://doi-org.eur.idm.oclc.org/10.3329/afj.v4i0.12929

Tardy, R. W. (2000). "But I Am a Good Mom". *Journal of Contemporary Ethnography, 29*(4), 433–473. https://doi.org/10.1177/089124100129023963

Tau, S. (2017, September 22). Women -- The Gatekeepers Of Patriarchy. *Huffpost*. Retrieved from https://www.huffingtonpost.co.uk/siphokazi-tau/women-the-gatekeepers-of patriarchy_a_23198479/

Van den Berg, M. A. (2013). *Mothering the post-industrial city: Family and gender in urban re-generation.*

Volkskrant. (2010, December 16). Zorg buiten piekuren. *Volkskrant*. Retrieved from https://www.volkskrant.nl

Wilson, M. J. A., MacArthur, C., Hewitt, C. A., Handley, K., Gao, F., Beeson, L., & Daniels, J. (2018). Intravenous remifentanil patient-controlled analgesia versus intramuscular pethidine for pain relief in labour (RESPITE): an open-label, multicentre, randomized controlled trial. *The Lancet*, *392*(10148), 662–672. https://doi.org/10.1016/s0140 6736(18)31613-1

Zeitlin, J., Alexander, S., Barros, H., Blondel, B., Delnord, M., Durox, M., Gissler, M., . . . Szamotulska, K., et al. (2018). *European Perinatal Health Report*. Retrieved from https://www.europeristat.com/images/EPHR2015_Euro-Peristat.pdf

Zitvast, H. (2016, January 4). Pleidooi voor pijnloos bevallen. *Telegraaf*. Retrieved from https://www.telegraaf.nl/nieuws/458099/pleidooi-voor-pijnloos-bevallen

APPENDIX 1: Ethics and privacy checklist

PART I: GENERAL INFORMATION

Project title: "We just do what we have to" - Exploring gender, motherhood and labour pain in the Netherlands

Name, email of student: Hanneke Helmers (511677hh@student.eur.nl)

Name, email of supervisor: Maja Hertoghs (hertoghs@essb.eur.nl)

Start date and duration: April - June 2020

Is the research study conducted within DPAS YES

If 'NO': at or for what institute or organization will the study be conducted?

(e.g. internship organization)

PART II: TYPE OF RESEARCH STUDY

Please indicate the type of research study by circling the appropriate answer:

1. Research involving human participants. YES

   If 'YES': does the study involve medical or physical research? NO

   Research that falls under the Medical Research Involving Human Subjects Act (WMO) must first be submitted to an accredited medical research ethics committee or the Central Committee on Research Involving Human Subjects (CCMO).

2. Field observations without manipulations that will not involve identification of participants. NO

3. Research involving completely anonymous data files (secondary data that has been anonymized by someone else). NO

PART III: PARTICIPANTS

(Complete this section only if your study involves human participants)

Where will you collect your data?

Through face to face and video interviews

Note: indicate for separate data sources.

What is the (anticipated) size of your sample?

6 participants

Note: indicate for separate data sources.

What is the size of the population from which you will sample?

Hundred thousands of people who gave birth in the Netherlands

Note: indicate for separate data sources.

1. Will information about the nature of the study and about what participants can expect during the study be withheld from them? NO

2. Will any of the participants not be asked for verbal or written 'informed consent,' whereby they agree to participate in the study? NO

3. Will information about the possibility to discontinue the participation at any time be withheld from participants? NO

4. Will the study involve actively deceiving the participants? NO
Note: almost all research studies involve some kind of deception of participants. Try to think about what types of deception are ethical or non-ethical (e.g. purpose of the study is not told, coercion is exerted on participants, giving participants the feeling that they harm other people by making certain decisions, etc.).

5. Does the study involve the risk of causing psychological stress or negative emotions beyond those normally encountered by participants? NO

6. Will information be collected about special categories of data, as defined by the GDPR (e.g. racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic data, biometric data for the purpose of uniquely identifying a person, data concerning mental or physical health, data concerning a person's sex life or sexual orientation)? YES

7. Will the study involve the participation of minors (<18 years old) or other groups that cannot give consent? NO

8. Is the health and/or safety of participants at risk during the study? NO

9. Can participants be identified by the study results or can the confidentiality of the participants' identity not be ensured? NO

10. Are there any other possible ethical issues with regard to this study? NO

If you have answered 'YES' to any of the previous questions, please indicate below why this issue is unavoidable in this study.

To get a broad insight on notions about gender, motherhood and pain, it will be very useful to also speak with people who identify as (gender) queer.

What safeguards are taken to relieve possible adverse consequences of these issues (e.g., informing participants about the study afterwards, extra safety regulations, etc.).

_____
_____
_____
_____

Are there any unintended circumstances in the study that can cause harm or have negative (emotional) consequences to the participants? Indicate what possible circumstances this could be.

_____
_____
_____
_____

Please attach your informed consent form in Appendix I, if applicable.

Part IV: Data storage and backup

Where and when will you store your data in the short term, after acquisition?

It will be encoded and securely stored on my laptop

Note: indicate for separate data sources, for instance for paper-and pencil test data, and for digital data files.

Who is responsible for the immediate day-to-day management, storage and backup of the data arising from your research?

I (Hanneke Helmers) am

How (frequently) will you back-up your research data for short-term data security?

It will be backed-up weekly on an external, encrypted hard drive

In case of collecting personal data how will you anonymize the data?

I will keep personal data separated from the rest of the data, and pseudonymize the participants in the research

Note: It is advisable to keep directly identifying personal details separated from the rest of the data. Personal details are then replaced by a key/ code. Only the code is part of the database with data and the list of respondents/research subjects is kept separate.

PART VI: SIGNATURE

Please note that it is your responsibility to follow the ethical guidelines in the conduct of your study. This includes providing information to participants about the study and ensuring confidentiality in storage and use of personal data. Treat participants respectfully, be on time at appointments, call participants when they have signed up for your study and fulfil promises made to participants.

Furthermore, it is your responsibility that data are authentic, of high quality and properly stored. The principle is always that the supervisor (or strictly speaking the Erasmus University Rotterdam) remains owner of the data, and that the student should therefore hand over all data to the supervisor.

Hereby I declare that the study will be conducted in accordance with the ethical guidelines of the Department of Public Administration and Sociology at Erasmus University Rotterdam. I have answered the questions truthfully.

Name student:	Name (EUR) supervisor:
Hanneke Helmers	
Date: 22-03-2020	Date:

APPENDIX 2: Informed consent form

Informatiebrief

In deze informatiebrief informeer ik je over de inhoud van mijn onderzoek, jouw rol binnen het onderzoek en de eventuele gevolgen van je deelname aan het onderzoek. Het doel van deze informatiebrief is het toelichten van je rechten als deelnemer aan het onderzoek, voordat je toestemming geeft voor het gebruik van jouw persoonlijke data. Naast het aanbieden van deze informatiebrief, stel ik je persoonlijk op de hoogte van de verstrekte informatie in dit document.

1. Contactgegevens onderzoeker en scriptiebegeleider

Het onderzoek wordt uitgevoerd door Hanneke Helmers, student aan de Erasmus Universiteit te Rotterdam.
E-mailadres: hannekehelmers@hotmail.com
Telefoonnummer: 06-24989415
Ik verwerk je persoonlijke data onder begeleiding van scriptiebegeleider Maja Hertoghs, die is verbonden aan de *Erasmus School of Social and Behavioural Sciences (ESSB)*.
E-mailadres: hertoghs@essb.eur.nl.

2. Doel van het onderzoek

Het onderzoek richt zich op de vraag hoe pijn bij de bevalling zich verhoudt tot ideeën over gender en moederschap. Nederland kent een unieke cultuur omtrent pijn bij de bevalling. Anders dan in omringende landen, heerst hier meer een idee dat pijn bij de bevalling hoort en iets positiefs is. In dit exploratieve onderzoek zal ik kijken naar deze heersende ideeën over bevallen, pijn en (goed) moederschap, in de hoop meer inzicht te krijgen in hoe deze met elkaar verbonden zijn.

Jouw persoonlijke gegevens zullen niet voor andere doeleinden gebruikt worden dan het beantwoorden van bovenstaande vragen. De persoonlijke data bestaan uit schriftelijke aantekeningen die ik tijdens het interview maak, en uit de transcripties van interviews. Bij voorkeur neem ik de interviews op zodat ik ze kan transcriberen.

3. Wettelijke basis voor het verwerken van persoonlijke data

De wettelijke basis voor het verwerken van persoonlijke gegevens is jouw ondubbelzinnige toestemming. Dit houdt in dat je gegevens alleen gebruikt mogen worden indien je bevestigend en specifiek toestemming geeft voor het gebruik van je persoonlijke data. Omdat het onderzoek zich kan richten op de categorieën seksuele geaardheid en genderidentiteit, dien je expliciet toestemming te geven voor het gebruik van persoonlijke data binnen deze categorieën.

4. Wie heeft toegang tot je persoonlijke data?

Alleen de onderzoeker en de scriptiebegeleider hebben toegang tot je persoonlijke data, en deze worden versleuteld, offline opgeslagen. Daarnaast worden versleutelde back-ups gemaakt. Om je anonimiteit te garanderen, gebruik ik pseudoniemen zodat je identiteit niet achterhaald kan worden.

5. Hoe lang worden je persoonlijke data bewaard?

Je persoonlijke data zullen opgeslagen worden totdat het eindproduct van het onderzoek op uiterlijk 14 augustus 2020 beoordeeld is door de scriptiebegeleider en de tweede beoordelaar. Na deze beoordeling worden alle persoonlijke data verwijderd.

6. Klachten?

Voor algemene klachten over het onderzoek kun je contact opnemen met mijn scriptiebegeleider Maja Hertoghs: hertoghs@essb.eur.nl.
In het geval van klachten of zorgen over het gebruik van je persoonlijke data, kun je je richten tot de functionaris gegevensbescherming van de Erasmus Universiteit: privacy@eur.nl.

7. Wat zijn je rechten?

De toegang tot je persoonlijke data is gegarandeerd; je kunt deze te allen tijde inzien en verifiëren. Daarnaast heb je altijd het recht om je persoonlijke data te laten verwijderen of het gebruik van je persoonlijke data te verbieden. Je hoeft geen vragen te beantwoorden die je niet wilt beantwoorden. Deelname aan dit onderzoek is geheel vrijwillig. Je kunt je medewerking aan het onderzoek te allen tijde stoppen, of weigeren dat je gegevens voor het onderzoek mogen worden gebruikt, zonder opgaaf van redenen.

Geinformeerde toestemming formulier

Met je ondertekening van dit document geef je aan dat je minstens 18 jaar oud bent; dat je goed bent geïnformeerd over het onderzoek, de manier waarop de onderzoeksgegevens worden verzameld, gebruikt en behandeld en welke eventuele risico's je zou kunnen lopen door te participeren in dit onderzoek. Je ontvangt een kopie van dit ondertekende toestemmingsformulier.

Ik heb de verstrekte informatie uit de informatiebrief gelezen en begrepen. Het doel van mijn deelname als een geïnterviewde in dit project is voor mij helder uitgelegd en ik weet wat dit voor mij betekent. Daarnaast heb ik vragen kunnen stellen over het onderzoek en mijn vragen zijn naar tevredenheid beantwoord.

Ik geef vrijwillig toestemming om als respondent deel te nemen aan het onderzoek en ik begrijp dat ik kan weigeren om vragen te beantwoorden. Daarnaast ben ik mij ervan bewust dat ik te allen tijde kan stoppen met deelname aan het onderzoek, zonder daarvoor een reden te geven.

Ik begrijp dat deelname aan het onderzoek gepaard gaat met interviews. Ik geef de onderzoeker toestemming om tijdens het interview geluidsopnames te maken en schriftelijke notities te maken. Het is mij duidelijk dat, als ik toch bezwaar heb met een of meer punten zoals hierboven benoemd, ik op elk moment mijn deelname, zonder opgaaf van reden, kan stoppen.

Ik geef de onderzoeker toestemming om mijn persoonlijke data te gebruiken voor de doelen die in de informatiebrief staan. Mocht er aanleiding zijn om de gegevens te gebruiken voor een ander onderzoeksdoel dan zal opnieuw toestemming aan mij worden gevraagd.

Ik ben mij ervan bewust dat de onderzoeker en scriptiebegeleider mijn persoonlijke data kunnen zien. Zelf heb ik het recht om de wijze waarop mijn gegevens zijn opgeslagen in te zien en te verifiëren. Daarnaast begrijp ik dat ik te allen tijde het recht heb om mijn persoonlijke data te laten verwijderen of het gebruik van je persoonlijke data te verbieden.

Ik begrijp dat mijn persoonlijke data die mij kan identificeren, zoals mijn naam of

woonplaats, niet gedeeld wordt met derde partijen behalve de onderzoeker en de scriptiebegeleider.

Ik begrijp dat mijn persoonlijke data worden opgeslagen totdat het eindproduct van het onderzoek op 14 augustus 2020 beoordeeld is door de scriptiebegeleider en de tweede beoordelaar, en dat mijn persoonlijke data na deze beoordeling worden verwijderd.

Ik geef de onderzoeker expliciete toestemming om te vragen naar mijn seksuele geaardheid en genderidentiteit en het verwerken van deze data in het onderzoek.

Ik heb een kopie ontvangen van dit toestemmingsformulier dat ook ondertekend is door de onderzoeker.

Onderzoeker:

Ik verklaar hierbij dat ik deze deelnemer voldoende heb geïnformeerd over het genoemde onderzoek.

Als er tijdens het onderzoek informatie bekend wordt die de toestemming van de deelnemer zou kunnen beïnvloeden, dan breng ik hem/haar daarvan tijdig op de hoogte op een wijze waardoor ik er zeker van ben dat de informatie de deelnemer bereikt heeft.

Datum:

Handtekening respondent:

Handtekening onderzoeker: