the birth we do *[not]* talk about

critical research paper

by *Daniela Franco Montoya*

introduction

Childbirth is a universal and profoundly transformative experience—both physiological and emotional. Yet, its meaning, management, and representation have changed markedly over time, shaped by powerful cultural, social, spatial, and religious narratives that precede and underpin its medicalisation. In Western societies, these narratives have long influenced how birth is imagined, spoken about, and experienced—often embedding ideas of fear, control, and pain into collective consciousness. The hospitalisation of childbirth, rather than being its origin point, can be understood as a spatial expression of these deeper cultural beliefs: environments designed more around authority, surveillance, control, and safety than around the birthing body's instinctive rhythms.

While advances in obstetric care have significantly reduced maternal and infant mortality, they have also reinforced a growing separation between women and their embodied capacity to give birth—transforming a natural and social event into a medical episode. This paper examines the historical evolution of childbirth and the cultural, religious, and spatial forces that have shaped its modern form. It investigates how long-standing narratives of sin, pain, fear and purity continue to influence perceptions of birth, and how these intersect with medical and institutional practices. Ultimately, it argues that reclaiming birth requires re-examining not only the medical systems that manage it but also the cultural narratives, representations, and spatial frameworks that have defined it for long.

Daniela Franco Montoya
24003229

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It accompanies a storytelling art book and an exhibition, which together form the foundation of the overall project.

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history

Childbirth has existed since the origin of humanity; it is the foundation of human continuity. Like any other natural event, it has evolved through culture, religion, and knowledge, yet its essence remains unchanged—raw, primal, and mammalian.

In early societies, women often birthed alone or supported by other women—never men (Brodsky, 2006; Museum of Motherhood, 2020). The *midwife*—from *mid,* meaning 'with', and *wife,* meaning 'woman'—was the most experienced birth attendant. Throughout ancient and medieval times, childbirth remained a social and natural process led by women, with surgeons assisting only in cases of severe complication. Birthing stools, made of stone or brick, featured prominently in birth rituals (Brodsky, 2006).

During the Middle Ages, childbirth was considered perilous, prompting women to prepare for death. Midwives, accused of witchcraft, were often persecuted. Superstitions persisted into the Renaissance, with beliefs linking birth outcomes to omens and maternal behaviour (Museum of Motherhood, 2020). In contrast, Native American birth practices incorporated rituals and upright birthing positions to promote strength and symbolism.

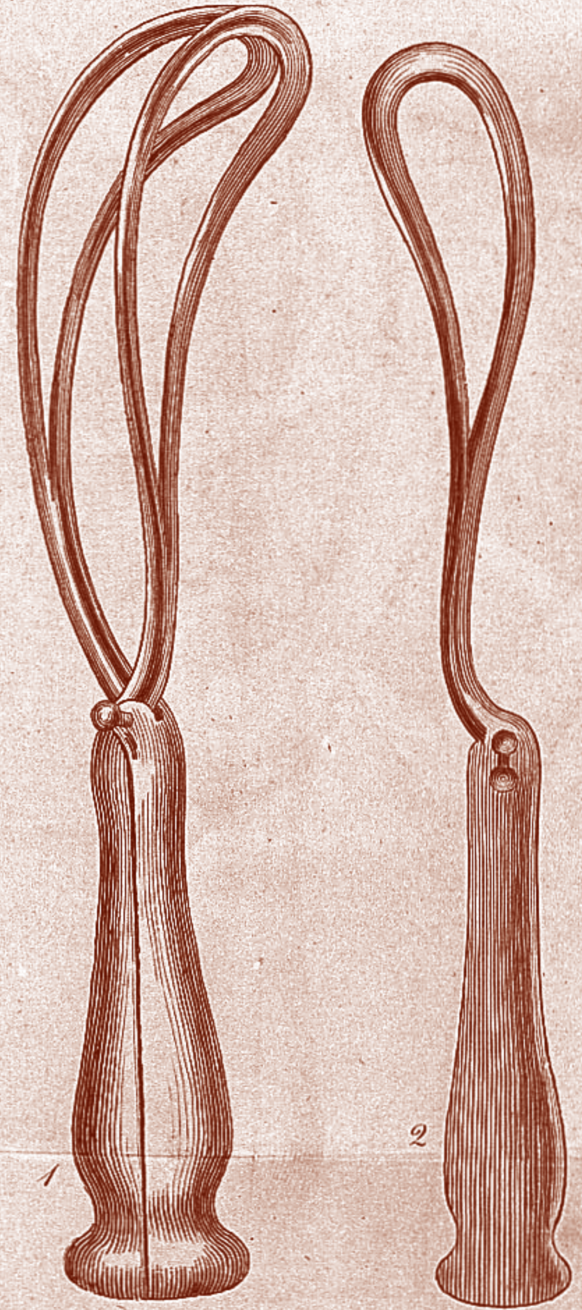
midwife—from *mid*, meaning 'with', and *wife*, meaning 'woman'.

[1]

barber-surgeon

[2]

In Europe, the rise of male practitioners marked a major shift. The *barber-surgeon* guild, founded in 1540, introduced tools such as hooks and forceps, often used without knowledge of hygiene, leading to widespread infections and maternal mortality (Rhodes, 1990; Brodsky, 2006; Cheatle, 2020). The seventeenth and eighteenth centuries saw industrialisation, poor nutrition, and rickets contributing to obstructed labour, increasing surgical interventions (Cheatle, 2020). Obstetric forceps, invented in 1588, became widely used after being kept secret for over a century (Brodsky, 2006; NHS, 2023). By the eighteenth century, male midwives had largely replaced female practitioners, introducing more medicalised approaches to labour (Dickenson, 1903).



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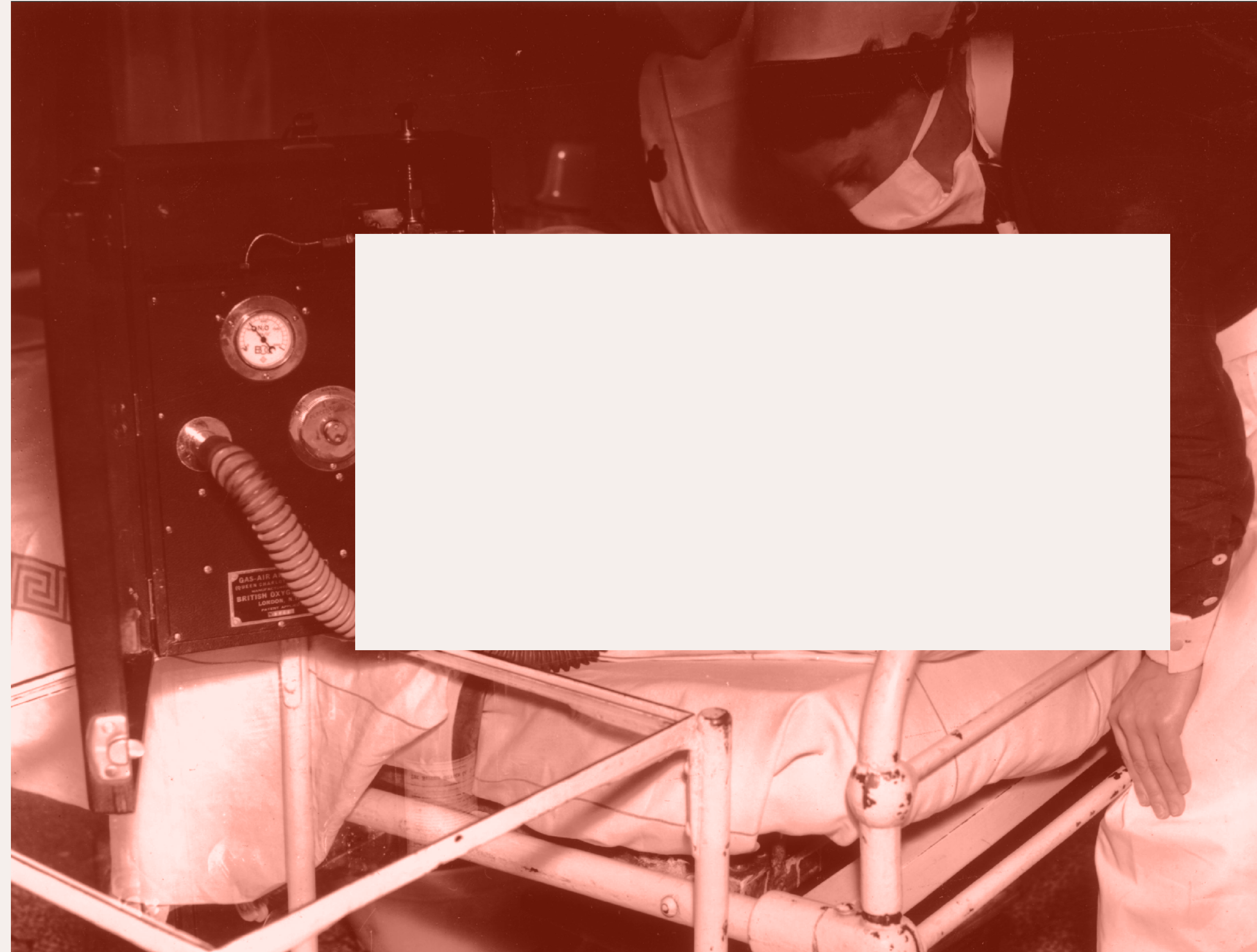
Puerperal fever caused numerous deaths; although Pasteur identified its bacterial origin in 1870, many physicians denied responsibility (de Costa, 2009). By the mid-nineteenth century, unskilled medical interventions were common, resulting in significant maternal and neonatal harm (Cheatle, 2020). Despite evidence showing physicians were responsible for up to 60 per cent of maternal deaths (New York Academy of Medicine, 1933), blame was deflected onto midwives.



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By the early twentieth century, childbirth was increasingly institutionalised, occurring in hospitals under the supervision of physicians. This shift often alienated women from their bodies and natural birthing capabilities, reducing their sense of control over the process while focusing on pain avoidance. During this period, interventions such as *Twilight Sleep* became popular. First developed in Germany and later adopted across Europe and the United States, this method involved administering periodic injections of scopolamine and morphine to labouring women, effectively dulling their awareness of the birth. Women under these drugs were frequently restrained in specially designed beds to prevent self-injury during the induced delirium. While their bodies experienced labour, they retained no conscious memory of the event (Leavitt, 1980).

twilight sleep

‘At midnight I was awakened by a very sharp pain (…) I woke up the next morning (…) the door opened, and the head nurse brought in my baby.’

(Tracy, 1915).

Although *Twilight Sleep* was eventually abandoned, it epitomised the medicalisation of childbirth—transforming it from a natural, home-based event into an institutional, controlled, and clinical process (Leavitt, 1980).

As a counter-response to this medical dominance—and influenced by the broader social movements of the 1960s and 1970s—the *Home Birth Movement* emerged. Midwives once again became integral to birthing care, and there was a modest resurgence of out-of-hospital births. In 1971, American midwife Ina May Gaskin founded *The Farm Birth Centre* in Summertown, Tennessee, where she promoted low-intervention births and empowered women to trust their bodies' innate capacity to give birth without unnecessary medical interference.

Nevertheless, the movement's progress was curtailed by the rapid expansion of medical technology, including the Doppler foetal monitor, ultrasound, and the rising rates of caesarean section (Panazzolo, 2011). By 1975, hospital births accounted for 95 per cent of deliveries—a figure that has remained consistently high ever since (Davis, 2012).

religion

Throughout history, fear surrounding childbirth has been perpetuated by the enduring belief that labour is inherently dangerous and necessarily painful. One of the most influential sources contributing to this perception is *The Bible*—a text whose origins predate any formal medical understanding of childbirth. Within its narrative, pain in childbirth is presented as divine punishment for the original sin, a consequence imposed upon Eve for disobeying God:

‘To the woman he said, “I will make your pains in childbearing very severe; with painful labour you will give birth to children. Your desire will be for your husband, and he will rule over you”.’

This passage, widely known as the *Curse of Eve*, established a powerful theological association between femininity, sin, and suffering. It is not an isolated reference; other biblical texts similarly depict childbirth as an ordeal of pain, anguish, and divine retribution:

‘Terror will seize them, pain and anguish will grip them; they will writhe like a woman in labour. They will look aghast at each other, their faces aflame.’
Isaiah 13:8 (NIV)

‘At this my body is racked with pain, pangs seize me, like those of a woman in labour; I am staggered by what I hear, I am bewildered by what I see.’
Isaiah 21:3 (NIV)

‘She was pregnant and cried out in pain as she was about to give birth.’
Revelation 12:2 (NIV)

‘Pains as of a woman in childbirth come to him, but he is a child without wisdom; when the time arrives, he doesn’t have the sense to come out of the womb.’
Hosea 13:13 (NIV)

Delaporte (2018) observes that several biblical scholars have since questioned the literal interpretation of such verses, suggesting that they may in fact refer to the emotional or spiritual trials of motherhood rather than to physical torment. Despite these re-examinations, the symbolic association between childbirth and suffering has become deeply embedded within cultural consciousness. Even if the original theological intention has been misunderstood or oversimplified, the enduring legacy of these narratives has profoundly shaped collective attitudes, transmitting fear and guilt across generations.

A 2020 study published in the *International Journal of Social Science and Medicine* examined prevailing American perceptions of pain during childbirth among both men and women. When asked about the causes of labour pain, 44 per cent of respondents either did not know or provided explanations unrelated to physiological processes. Within this group, eight per cent attributed labour pain to religious or ideological causes, referencing the biblical narrative of the forbidden fruit and divine punishment. Moreover, 68 per cent of all respondents affirmed that pain holds intrinsic value in childbirth: of these, 73 per cent considered it a necessary or natural part of the process, while three per cent ascribed moral or spiritual significance to it—suggesting, for instance, that:

‘God provided women with labour pain to teach them what hard work feels like.’

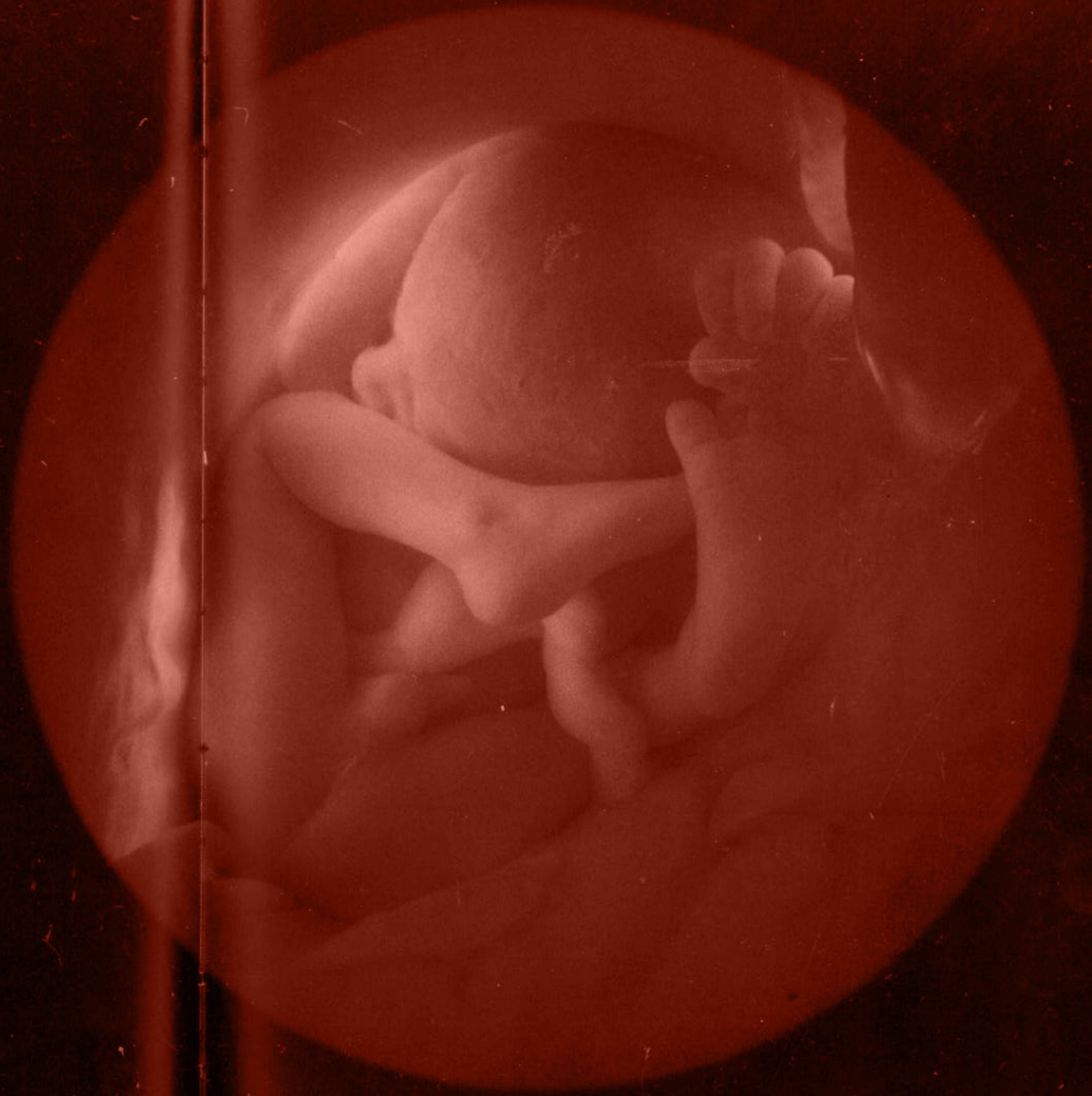
Although the proportion of respondents explicitly linking childbirth pain to religious belief may appear small, its persistence reveals the enduring influence of these ancient cultural narratives. Even when implicit or unacknowledged, such beliefs continue to shape collective understandings of childbirth by reinforcing pain- and fear-centred discourses.

They obscure physiological and psychological knowledge, hinder educational efforts, and perpetuate associations of birth with guilt, suffering, and moral judgement.

Consequently, these narratives limit both women’s and men’s ability to approach childbirth as a natural, embodied, and potentially empowering human experience.

physiology

Birth constitutes the foundation of human existence, and for the majority of women it is a process they are physiologically equipped to navigate both actively and autonomously. During pregnancy, the uterus expands—its muscle layers and fibres thickening in response to the growing foetus. The size of the uterus varies depending on the size of the baby and the volume of amniotic fluid. Anatomically, the uterine wall comprises three layers: the outer, middle, and inner. The outer layer, with its longitudinal fibres, facilitates expulsion; the middle layer regulates blood flow; and the inner layer, with its circular fibres concentrated in the lower uterine segment, enables dilation and the opening of the cervix.



Oxytocin—the ‘*love hormone*’

Oxytocin—the so-called ‘*love hormone*’—is central to this process. Women experience their highest natural surges of oxytocin in three distinct circumstances: during orgasm (to promote reproduction), during labour (to enable birth), and during breastfeeding (to ensure survival). During labour, oxytocin plays multiple roles: calming the woman, reducing stress, mitigating pain, and stimulating uterine contractions that allow the cervix to dilate—the first stage of labour—followed by the descent and birth of the baby—the second stage—and the delivery of the placenta—the third stage—while simultaneously reducing postpartum haemorrhage (Buckley, 2015; National Partnership Org., 2024). Remarkably, the baby also produces oxytocin before and during birth (National Childbirth Trust, no date), creating a physiological synchrony between mother and child that reinforces bonding and mutual regulation.

[6]

However, this finely tuned hormonal cascade is highly sensitive to emotional and environmental influences. When a woman experiences fear or perceives threat, oxytocin release is inhibited and adrenaline—the ‘*fight or flight*’ hormone—surges. This hormonal shift can slow or even halt labour, intensify sensations of discomfort, and increase the likelihood of medical intervention (National Partnership Org., 2024).

Pain, therefore, cannot be understood solely as a physiological inevitability. Although childbirth has long been associated with suffering, British obstetrician Grantly Dick-Read (1959)—a key advocate of natural birth—argued that there is no inherent physiological function within the healthy human body that produces pain in the normal course of labour. He posited that the biological purpose of pain is protective, and that:

‘the only pain stimulus that the uterus can record is excessive tension or actual tearing of tissues’.

fear–tension–pain

Dick-Read questioned whether *'[it] was the nature of labour responsible for the emotional state of woman, or was the emotional state of the woman to a large extent responsible for the nature of the labour?'* His *fear–tension–pain* theory proposed that fear activates the sympathetic nervous system, increasing muscular tension in the uterus, restricting blood flow, and consequently generating pain. According to his model, when fear is removed, tension decreases and pain is significantly reduced. As he stated: *'nothing disturbs the course of natural labour more than fear. Fear is caused and intensified by ignorance. Knowledge of the facts of childbirth reduces the risk of trouble in 90–97 per cent of all labours'*.

After decades of observing and assisting natural births, Dick-Read concluded that the only genuine pain experienced by most women occurs during the final contractions of the first stage, when the cervix completes dilation, and a brief burning sensation in the vulva during crowning. Even these, he maintained, were profoundly influenced by a woman's emotional state and her level of knowledge and preparedness—since fear often stems from the unknown.

'nothing disturbs the course of natural labour more than fear. Fear is caused and intensified by ignorance.'

[7]

Despite the influence of Dick-Read's ideas, his theory has faced extensive criticism. The *European Journal of Obstetrics & Gynaecology and Reproductive Biology* (1995) contended that for most women, childbirth involves severe pain and that anxiety results from, rather than causes, this pain. The authors argued that to deny the reality of labour pain is '*a cruel and callous deception'.* They attributed contraction pain to the mechanical distension of the lower uterine segment and cervix during the first stage, and the stretching of the birth canal and perineum during the second. Additional factors, such as higher maternal weight and larger foetuses, were also cited as contributing to pain intensity. The journal noted that those who dismiss the severity of labour pain often have limited direct experience of childbirth, emphasising that most women in modern hospital settings seek, and often depend on, medical analgesia.

Nevertheless, contemporary evidence and lived experiences increasingly challenge these conventional assumptions. Documentary films such as *Orgasmic Birth* (Pascali-Bonaro, 2008) and *Born at Home* (Banks and Currie, 2024) present narratives that diverge sharply from the dominant pain-centred discourse. These works document women who have not only witnessed but personally experienced childbirth as a powerful, even pleasurable, act—marked by agency, self-knowledge, and emotional transcendence. In contrast to the dominant medical paradigm, these women reframed labour not as an ordeal to be endured but as an embodied and transformative process.

pleasurable act

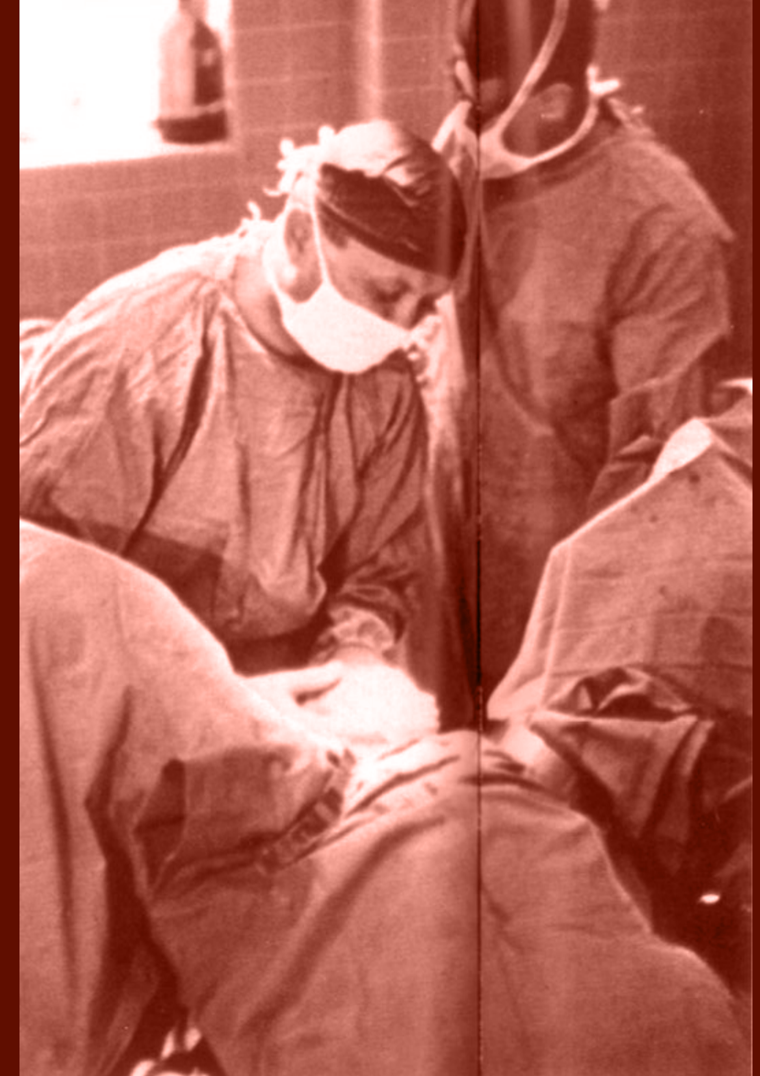
[8]

By consciously fostering environments of safety, trust, and respect—where hormonal, emotional, and physical processes are allowed to unfold undisturbed—they redefined the meaning of childbirth. Their experiences suggest that when fear is replaced with understanding, and control with confidence, the body's natural mechanisms can function as intended. In doing so, these accounts shift childbirth from a narrative of suffering to one of strength, from pathology to physiology, and from pain to profound human experience—where the physical, emotional, cultural, and spiritual dimensions converge in the act of bringing life into being.

Over-medicalisation

The physical environment profoundly shapes human experience, and childbirth is no exception. In most developed countries, including England and the United States, childbirth remains the most common reason for hospital admission. However, hospital settings are often ill-suited to support the delicate hormonal balance necessary for physiological birth. These spaces—characterised by bright lighting, constant machine noise, cold temperatures, and the dominance of medical equipment—are designed primarily around institutional needs rather than maternal comfort. The prominence of the hospital bed, the expectation that women remain supine, and the routine use of monitoring and interventions reinforce a model in which the woman becomes a passive patient rather than an active participant in her own birth.

Hospitals operate according to strict institutional protocols that frequently interrupt and even disrupt hormonal release, emotional regulation, and the natural rhythm of labour—often leading to over-medicalisation. More than 90 per cent of American women receive some form of labour augmentation, most commonly Pitocin, a synthetic form of oxytocin used to induce or strengthen contractions. Because Pitocin intensifies and shortens the intervals between contractions, many women choose epidural analgesia to cope with the pain. However, epidurals can slow the progress of labour, prompting the administration of even more Pitocin to stimulate contractions.



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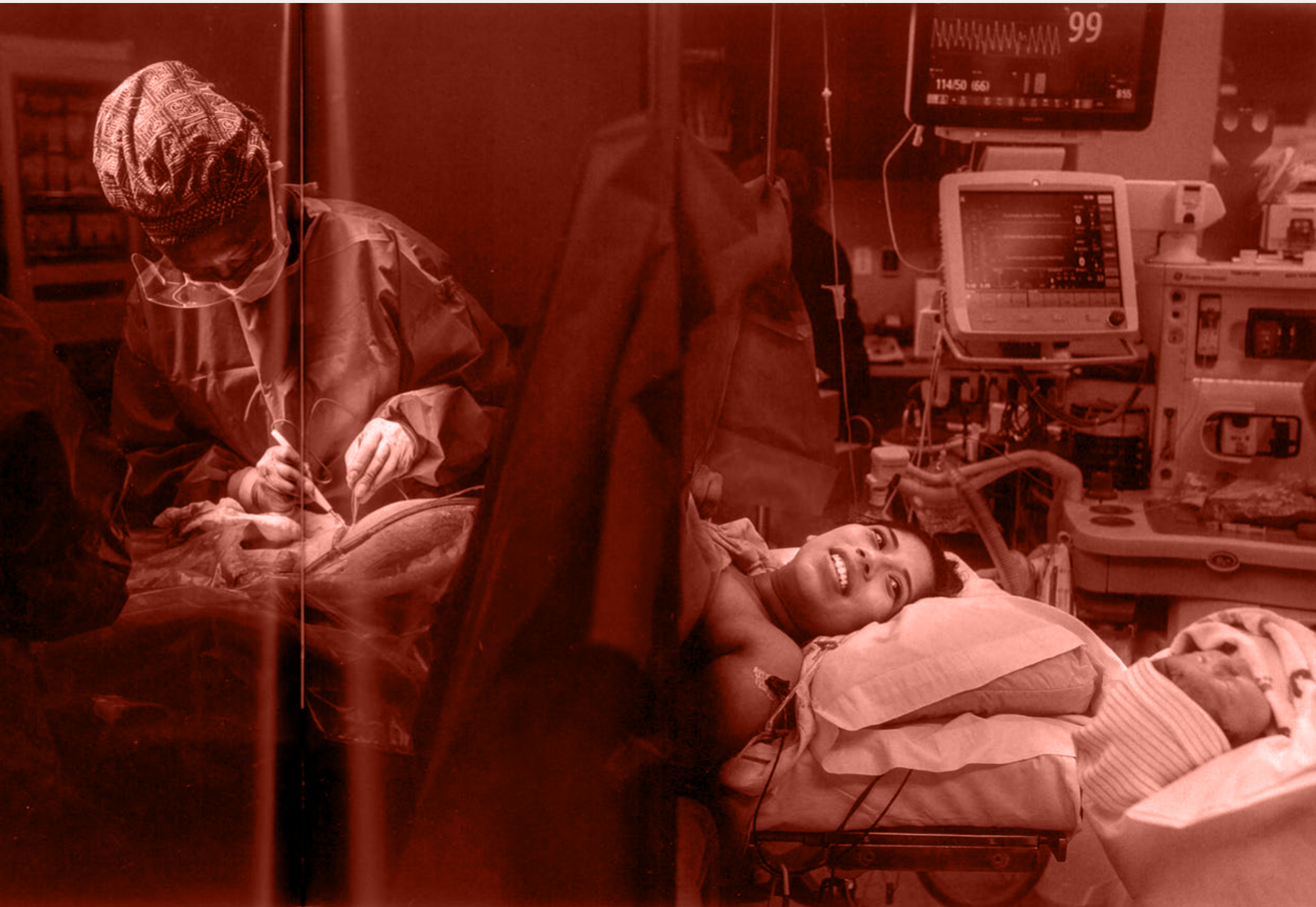
This escalation, often referred to as the *cascade of interventions*, can lead to foetal distress and result in an emergency caesarean section (Panazzolo, 2011; *The Business of being Born*, 2008). The cascade frequently includes continuous foetal monitoring, restricted movement, enforced supine positions, use of stirrups, episiotomy, and assisted delivery via forceps or vacuum extraction—all of which may increase the risk of trauma and complications.

According to the Cleveland Clinic (2018), approximately 45 per cent of new mothers experience some form of trauma during childbirth, often linked to a lack of emotional support, a loss of control, prolonged labour, or an experience that diverges sharply from their expectations. As Shah (2022) asserts, *'the well-being of mothers is a bellwether for the well-being of society as a whole. If mothers are unwell, society is unwell—which is why every injustice in our society shows up in maternal health'*.



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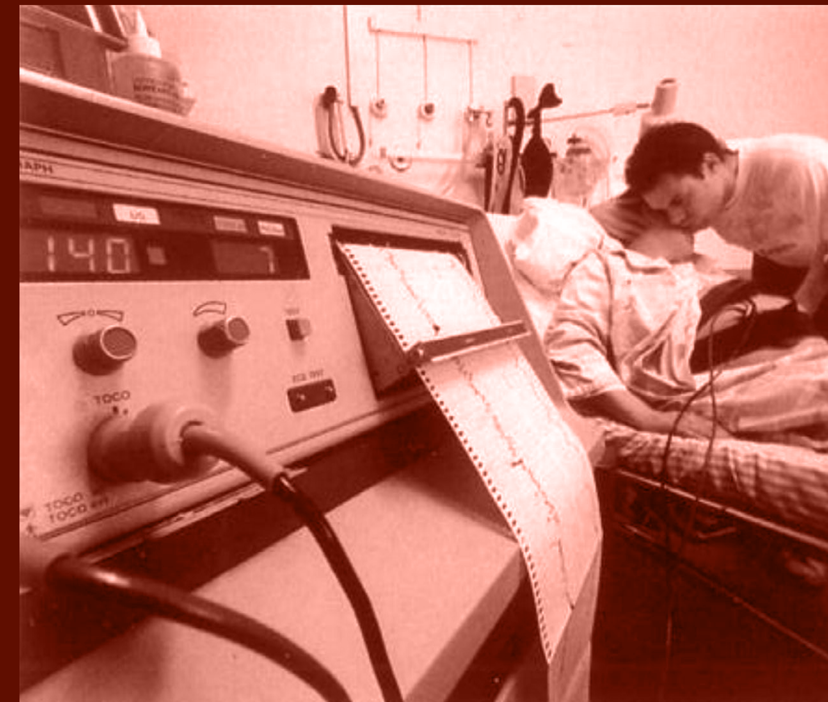
There is a widespread belief that hospital births guarantee safer outcomes for mother and baby, it might be questioned. Reitsma et al. (2020), in a meta-analysis of 18 studies, found that low-risk women who planned home births experienced fewer interventions and adverse maternal outcomes than those who planned hospital births. Women intending home births were 70 per cent less likely to use an epidural, 60 per cent less likely to receive labour augmentation, 55 per cent less likely to have an episiotomy, 50 per cent less likely to have an assisted birth, 40 per cent less likely to have a caesarean section and 40 per cent less likely to experience third- or fourth-degree perineal tears. Furthermore, maternal infections were 75 per cent lower and haemorrhage 30 per cent lower among planned home births.

Similarly, Hutton et al. (2019), in a meta-analysis of 17 studies, found no significant differences in perinatal or neonatal mortality between planned home and hospital births among low-risk women, including rates of NICU admission and the need for resuscitation. If outcomes for babies do not differ significantly, then the most meaningful difference lies in the quality of the mother's experience. Moreover, in the United States, an uncomplicated vaginal birth in a hospital is approximately three times more expensive than a home birth (Panazzolo, 2011).



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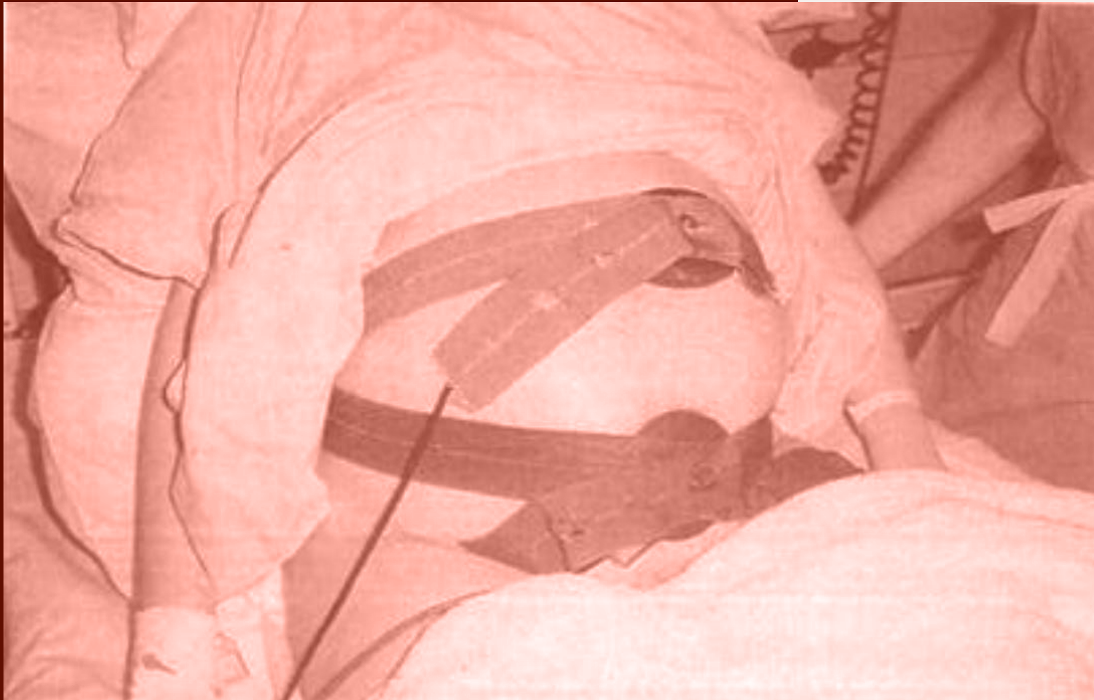
While physical space undeniably influences a woman's birth experience, the *intangible* aspects—emotional, interpersonal, and psychological—may have even greater impact. Feelings of being unheard, a lack of support or information, the perception of lost control and autonomy, excessive fear, lack of consent, repeated vaginal examinations, or the sudden presence of multiple unknown medical staff can profoundly shape a woman's experience. As Johnson (2008) notes, these factors often produce feelings of solitude, apprehension, and disappointment that can overshadow the physical act of birth itself.

Lake's documentary *The Business of Being Born* (2008) critically examines hospital practices in the United States, exposing how misinformation and fear influence women's decisions around childbirth. The film argues that *'for forty to fifty years, what the medical profession has done is convince the vast majority of women that they don't know how to give birth'.* Its message remains strikingly relevant, it is not about women's bodies but more about how they are treated and made to feel within medical institutions.



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Seventeen years after its release, the documentary's critique persists as maternal satisfaction, informed consent, and emotional safety remain inadequately prioritised in hospital-based care. For many women, the memory of childbirth—whether joyful or traumatic—remains vivid throughout their lives. Yet, for the majority, the ability to choose *how*, *where*, and *with whom* to give birth is still constrained by cultural beliefs, policy limitations, or poorly integrated health systems.

Contrary to common assumptions, Panazzolo (2011) found that factors associated with planned home births include older maternal age, higher education levels, higher socioeconomic status, and multiparity. These findings suggest that knowledge, information, and bodily awareness may empower women to make autonomous choices outside dominant medical paradigms. Consequently, reclaiming childbirth from over-medicalisation requires not only better spaces and systems but also a cultural shift—one that restores trust in women's bodies and redefines birth as an experience of strength, capability, and agency rather than pathology.

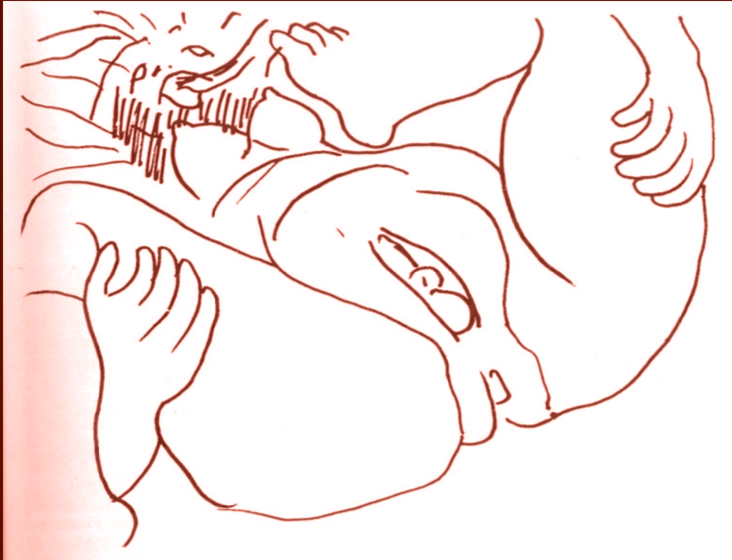
'for forty to fifty years, what the medical profession has done is convince the vast majority of women that they don't know how to give birth'.

cultural belief

Odent (no date), a French obstetrician and pioneer of natural and water births who challenged conventional hospital birthing practices, stated that *'the truth for women living in a modern world is that they must take increasing responsibility for the skills they bring into birth if they want their birth to be natural. Making choices of where and with whom to birth is not the same as bringing knowledge and skills into your birth regardless of where and with whom you birth'.* Odent suggested that if women are to reclaim their births and autonomy, they must inform and educate themselves—that information and awareness are ultimately more powerful than the birth environment itself. Yet, despite such calls for empowerment, societal and cultural beliefs remain some of the strongest obstacles to achieving this.

Mathur, Morris, and McNamara (2020) examined contemporary American cultural beliefs surrounding labour pain among both women and men, revealing that childbirth remains deeply embedded in stereotypes, taboos, and misinformation. When respondents were asked why labour is painful, many relied on non-human or objectifying analogies, referring to the baby and vagina through metaphors such as 'bowling ball', 'watermelon', or 'skillet' for the baby's head, and 'lemon', 'walnut', or 'straw' for the vaginal canal—typified in statements such as:

'it's like trying to push something the size of a watermelon through something the size of a lemon'.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'being stabbed in the abdomen with a machete'

Additionally, nearly half of respondents employed violent or extreme imagery, describing childbirth as 'hell', 'scary', or 'excruciating', and comparing it to 'being stabbed in the abdomen with a machete'. Such metaphors demonstrate how cultural language continues to frame birth through a lens of pain, violence, and fear, reinforcing a discourse of suffering rather than strength.

Similarly, Malacrida and Boulton (2012) explored perceptions of childbirth and birthing choices among Canadian women—both childless and recently postpartum—revealing that such perceptions are deeply intertwined with gendered ideals of femininity, control, and respectability. Many participants expressed discomfort with the 'messiness' of birth, viewing it as incompatible with dominant notions of purity, dignity, and sexuality. Vaginal birth, in particular, was frequently characterised as unfeminine or aesthetically unappealing, described with terms such as 'messy', 'gross', 'icky', 'disgusting', 'not pretty', and 'gooey'. Some respondents associated natural birth with humiliation or a loss of bodily control, while others expressed aversion to its aftermath, including references to postpartum bleeding or incontinence, with one woman stating her resistance to 'spend money on adult diapers'.

A nurse participating in the study articulated this discomfort vividly: *'giving birth isn't beautiful; it isn't a tiny little glistening sweat, dabbed off and then you "oh, I look beautiful" afterwards. It's disgusting. Sorry, I'll probably gross you out—hopefully you will have kids one day—but there's lots of fluid, there's smells, there's people going in and out, and that's just on a normal delivery'.*

[16]

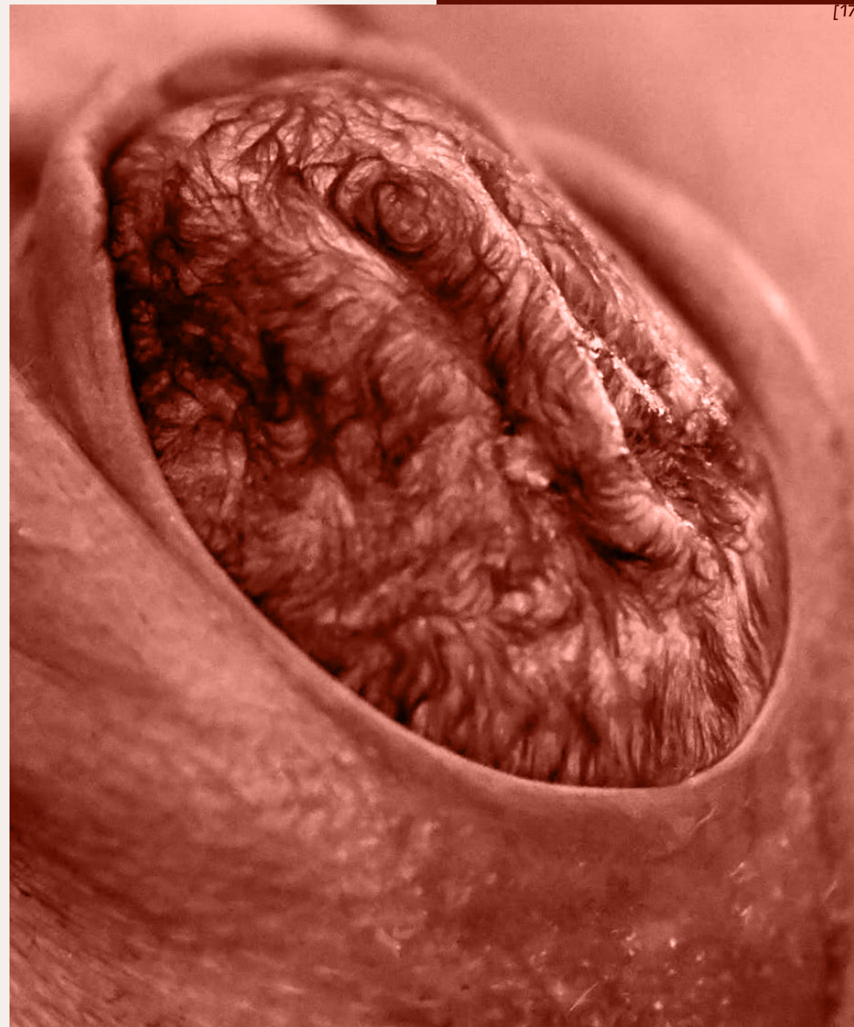
Conversely, other participants perceived vaginal birth as a source of pride, dignity, and fulfilment—an affirmation of the body's natural design and purpose. These women described the process as 'beautiful', 'empowering', 'transcendent', and 'primal', framing it as a moment of embodied strength. They reclaimed childbirth as an act of self-realisation and connection, rather than degradation or loss.

'empowering'

Nonetheless, concerns about bodily changes and sexual desirability after childbirth persisted across both groups. Some participants described the post-birth vagina as ‘floppy’ or ‘used’, and sex after childbirth as ‘like fucking the side of an elephant’ or ‘throwing a hot dog down a hallway’. Several expressed anxiety about giving birth in front of their partners, fearing that the experience might diminish their sexual appeal or sense of dignity: *‘I don’t want my husband seeing me in that situation; there’s a lot of lost dignity in giving birth naturally. (…) I plan to still have a sexual life after I have children’.*

Other women, however, challenged these anxieties, emphasising the body’s capacity to recover and adapt. Some referred to pelvic exercises, such as *Kegels*, while others pointed to the continuation of sexual lives as evidence that recovery exists. A few participants noted their partners’ initial apprehensions—concerns that ‘everything might not go back completely’—while one woman observed that witnessing childbirth had, in fact, deepened her partner’s appreciation: *‘having seen his son being born made me even more beautiful and attractive to him. There’s a whole new level of intimacy that comes with that’.*

‘throwing a hot dog down a hallway’



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Attitudes towards caesarean birth were similarly polarised. Some women described elective caesareans as ‘beautiful’ and ‘dignified’, or justified them by saying they were ‘too posh to push’. Others perceived the procedure as disempowering, disconnected, or even morally inferior—‘copping out of motherly duties’, ‘selfish’, or ‘a lazy way to give birth’.

The stark contrast between these perspectives—despite similarities in age, education, and cultural background—reveals the profound stigma, judgement, and misinformation still surrounding childbirth. These narratives highlight a significant gap in collective knowledge and demonstrate the enduring influence of cultural conditioning on perceptions of birth. The continued reliance on euphemisms and analogies to describe anatomy, the emphasis on sexual appeal and control, and the persistence of terms such as 'sacrifice' or 'undignified' all expose how birth remains a site of tension between nature and culture, purity and taboo, body and identity. Collectively, these discourses illustrate how deeply ingrained beliefs continue to shape the way societies view, speak about, and experience childbirth.

Although birth—and, by extension, death—are among the most universal human experiences, the very events that define our shared humanity, childbirth remains widely avoided in social discourse. It is seldom spoken about, questioned, shared, or reflected upon, both privately and publicly. This silence extends into cultural domains such as art, philosophy, design, and academia. Hennessey (2017) observes that humanity exhibits boundless fascination with all kinds of beginnings—of stars, planets, and life itself—yet, when it comes to childbirth, curiosity and artistic or philosophical engagement abruptly vanish. Visual representations of childbirth are frequently deemed inappropriate for galleries, resulting in its near-total absence from artistic exhibition.

In 1997, British artist Jonathan Waller exhibited *Birth*, a series of paintings inspired by his wife's labour and the birth of their daughter, at the Flowers East gallery in London. On the opening day, one of the pieces was removed for being considered 'shocking', 'offensive', and 'uncomfortable' (*The Independent*, 1997). Hennessey attributes this invisibility to a broader cultural tendency to reject or marginalise the significance of childbirth.

pudenda, the Latin term for the external genitalia—most often applied to the vulva—literally means 'to be ashamed of'.

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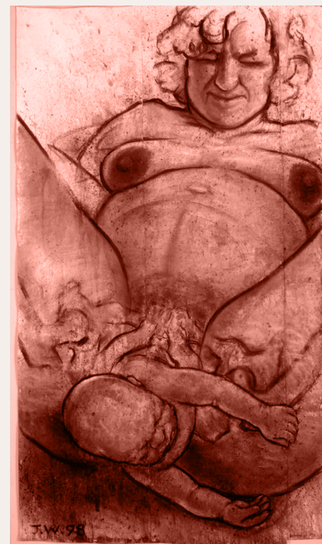

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Similarly, Jansen (2018) argues that the moment of birth is 'frozen and silent' at both social and cultural levels, questioning how many other so-called 'unsavoury' subjects—such as war, sex, and death—have been extensively represented in art throughout history, while childbirth remains largely excluded.

Moreover, Millar and Winick (2021), through their exhibition and publication *Designing Motherhood: Things That Make and Break Our Births*, explore how designs developed over the past 150 years have shaped reproductive health—encompassing (in) fertility, pregnancy, birth, postpartum, and parenthood. The chapter *Birthing Furniture*—one of the briefest in the collection—reveals how inadequately childbirth has been accommodated through spatial design, particularly concerning natural and physiological processes. Strikingly, the only contemporary design they showcase is a single, 'speculative' piece. The authors draw on Altman's observation that the shame surrounding female reproductive health runs so deep that it is inscribed in language itself: *pudenda*, the Latin term for the external genitalia—most often applied to the vulva—literally means 'to be ashamed of'.

reclaiming birth

Karlsdottir and Leap (2025) highlight the importance of promoting positive childbirth experiences as a means of strengthening maternal–infant bonding, reducing the likelihood of postpartum depression, and supporting a healthy transition into parenthood. Yet, since birth remains a subject rarely discussed in social contexts, the first step toward fostering positive experiences is to promote open, inclusive conversations about childbirth—spaces where every type of story is valued, heard, and shared. Only by creating dialogue can social and cultural narratives begin to shift from narrow, fear- and pain-centred discourses to fuller, more nuanced accounts of women's lived experiences.

In an effort to bring these missing perspectives to the forefront—acknowledging birth not only as a medical or physiological event but also as an emotional and cultural one—this project sought to uncover the layers of memory, identity, and language through which childbirth is understood and represented. A small group of women were invited to narrate their birth stories, extending beyond factual details such as place or mode of delivery to capture instead the emotional texture, social and spatial context, and sense of agency surrounding their experiences.

Participants were recruited through personal networks and two WhatsApp groups—one comprising Colombian mothers living abroad, and another formed among parents from a London nursery. These channels allowed for a diverse yet intimate group, balancing geographical and cultural variety with a sense of trust and familiarity conducive to sharing deeply personal experiences. In total, 122 women were invited to participate by writing their birth stories. They were asked to describe childbirth through their own eyes—the emotions, sensations, and essence of that day—and were also welcome to include reflections on pregnancy or postpartum if they wished. There were no restrictions regarding format or length; participants could write freely in the form that felt most authentic to them—a personal narrative, diary entry, poem, or letter to their child. Anonymity was optional and respected; however, all participants chose to have their names included.

diversity of voice

Of those invited, 28 women expressed initial interest, and 15 ultimately submitted their accounts, alongside one written by the compiler herself, who has given birth once. The majority of participants were Colombian (12)—the compiler's nationality—alongside others from Chile (1), Venezuela (1), Argentina (1), and the United Kingdom (1). Their births took place across ten cities in seven countries, including Colombia (6), Chile (1), the United States (3), Canada (1), Italy (1), Australia (2), and the United Kingdom (2). This geographical breadth was deliberately maintained to reflect the diversity of birthing systems and cultural attitudes, and to mitigate the risk of reproducing a single, culturally bounded narrative.

The narratives range from one to six pages in length. Some include self-given titles, while others were untitled.

Their forms vary widely—letters, reflective accounts, and chronological stories—mirroring the diversity of voice and experience.

Some extend into pregnancy and the postpartum period, while others focus exclusively on labour and birth. Two accounts describe a home birth, whereas the remaining experiences occurred in hospital settings. Some births were attended by midwives, others by obstetricians, with participants reporting a broad spectrum of experiences—from unmedicated vaginal births to those involving medical interventions such as labour augmentation, epidural anaesthesia, lithotomy position, stirrups, episiotomy, forceps, and both planned and emergency caesarean sections. Birth presentations included both cephalic and podalic cases, and one multiple birth was represented among otherwise singleton deliveries. The collection also spans emotional extremes—from fear, frustration, and obstetric violence to calm, joy, empowerment, and even transcendence described as 'magic' or 'bloom'.

Importantly, the narratives capture generational diversity. While most accounts occurred within the last decade, one story—belonging to the compiler's mother—dates back over thirty years. Its inclusion introduces a valuable intergenerational dimension, illustrating how discourses, practices, and power relations surrounding childbirth have evolved yet remain tethered to enduring patterns of control and silence. Several participants noted that this was the first time they had written about their birth beyond superficial conversation. For many, the act of writing became an emotional process of remembering, reevaluating, and, in some cases, 'healing'.

fostering freedom, choice, consent, and autonomy.

[23]

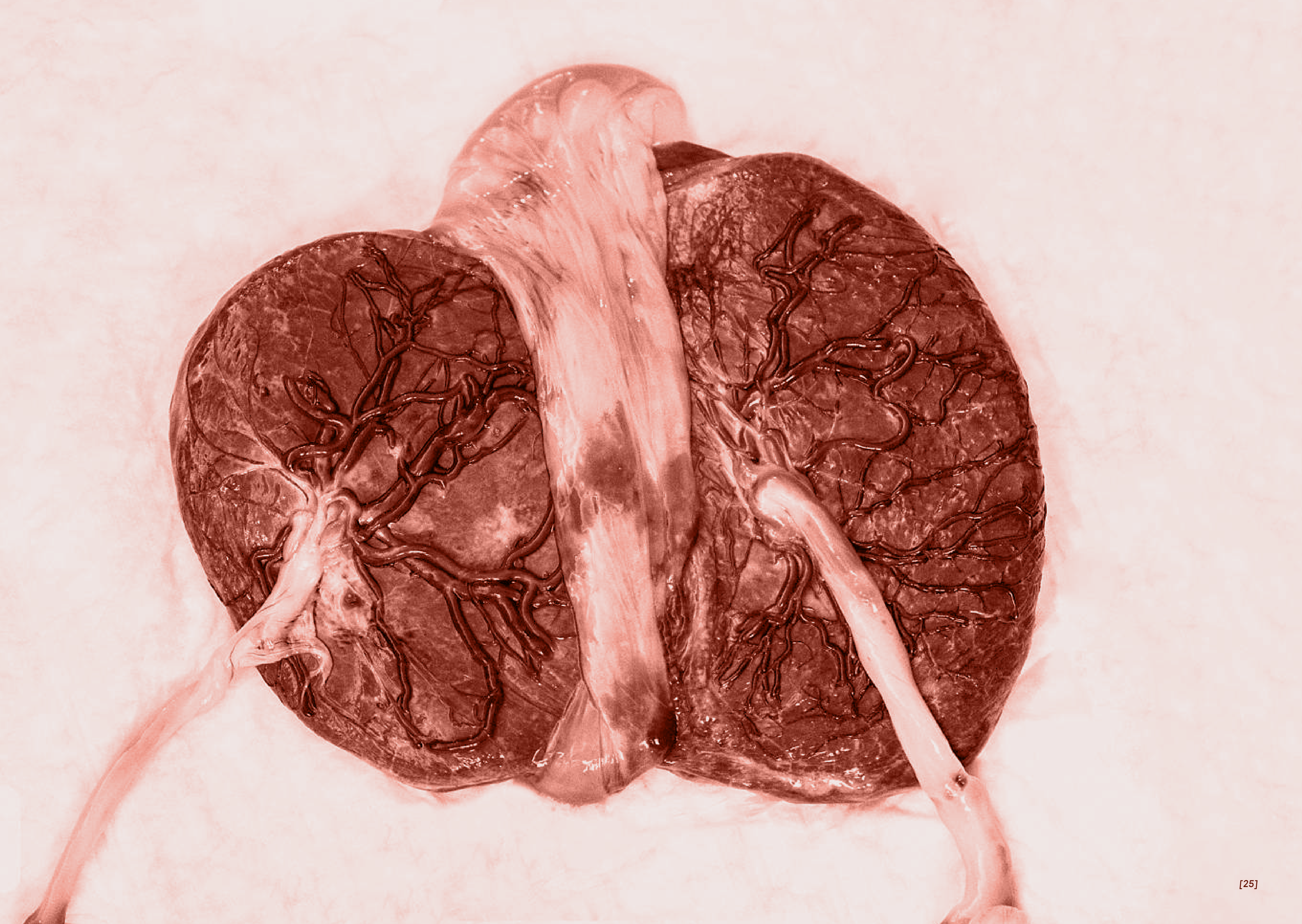
Although this project does not claim to represent all women's experiences, the narratives collectively affirm that childbirth is far more than a biological event. It is a deeply cultural phenomenon, shaped by spatial design, institutional systems, emotional environments, social narratives, inherited beliefs, and interpersonal relationships. The accounts expose the persistence of misinformation, stigma, and silence surrounding birth—how it remains a topic often avoided, medicalised, or fragmented in discussion. At the same time, they demonstrate how understanding, awareness, education, and access to information can transform the experience, reducing fear and unnecessary intervention while fostering freedom, choice, consent, and autonomy. This compilation underscores the need to restore women's voices to the discourse of childbirth.

Childbirth—a process as ancient as humanity itself—unfolds most harmoniously when women are informed, emotionally supported, and free to give birth in environments that honour their physiological and psychological needs. Knowledge empowers women to trust their bodies and instincts, to make autonomous decisions, and to navigate childbirth on their own terms. Yet birth remains a taboo—obscured, silenced, and often misunderstood. To confront this enduring silence, a profound cultural transformation is required: one that unites advocacy, education, and design to reshape not only the systems surrounding birth but also the narratives that sustain them. Progress lies in ensuring access to information, dismantling myths, and fostering awareness that honours the creative, emotional, and spiritual dimensions of childbirth.

Such transformation is not merely a matter of medical reform or policy but of reconfiguring the generational stories we tell about birth—how we perceive it, how we experience it, and how we relate to our own bodies. Change begins in dialogue: in listening, understanding, and sharing the stories that have too long been silenced. By challenging inherited beliefs and reclaiming birth as both personal and sacred, women can redefine it as a deeply human act—one grounded not in fear or control, but in autonomy, dignity, confidence, and connection.

[24]

Ultimately, this reclamation begins with reflection and conversation—with speaking and hearing, spreading and normalising ***the birth we do [not] talk about.***



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