A Chapter From Lamaze History: Birth Narratives and Authoritative Knowledge in France, 1952–1957

Paula A. Michaels, PhD

ABSTRACT

This article analyzes birth narratives gathered during what can be considered a formative period of the Lamaze movement in the West: from 1952 through Fernand Lamaze's death in early 1957. The use of women's birth narratives as an assessment tool is one of Dr. Lamaze's most enduring contributions to obstetric pain management. The early work of Lamaze and his collaborator Pierre Vellay provided a template for studies conducted elsewhere for decades to come. By examining expectations in another time and place, our own standards, so often normalized to the point of invisibility, are thrown into sharp relief. This article addresses the conflicting and contested nature of authoritative knowledge surrounding parturition.

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In 1956, Dr. Pierre Vellay and his wife Aline Vellay-Dalsace published over 320 pages of testimonials from dozens of women who had given birth using the psychoprophylactic method (PPM), popularized in the United States as the Lamaze method of childbirth preparation. In the book's introduction, Vellay claims that "for the first time in medicine, we can say that the subject of experimentation, endowed with oral or written language, expressed her own feelings" (Vellay & Vellay-Dalsace, 1956, p. 10). Although it is difficult, if not impossible, to confirm the bold claim that Vellay and his mentor Fernand Lamaze were indeed the first researchers to rely on qualitative data from parturients for outcome assessment, there is no doubt that they were the first to apply this novel methodology to psychoprophylaxis. Lamaze, Vellay, and their collaborators at the maternity ward of Paris's Pierre Rouquès Metallurgists' Polyclinic, popularly known as Les Bluets, requested that patients write a brief report about their birth experiences. Beyond their scientific merit, Vellay affirmed the persuasive power of patient evaluations, saying somewhat patronizingly that "these reports, in their marvelous simplicity, are a source of great encouragement and hope for women who have yet to give birth" (Vellay & Vellay-Dalsace, 1956, p. 41). Women wrote their stories within one week of giving birth, usually submitting them before they were released from the hospital. Lamaze and Vellay asked women to describe, as journalist Louis Dalmas paraphrases

it, ''their initial skepticism, their surprises, and their joys'' (Dalmas, 1953, p. 11).

From our perspective, birth stories seem, for all their problematic subjectivity, like an obvious and useful source. If one wants to know how much pain a woman experienced during birth, what better way than simply to ask her? But the idea of seeking patient feedback marked a dramatic departure from the attitude of Lamaze's Soviet mentors, who made their assessments of the method's success or failure based on the obstetrician's perceptions of the parturient's control and condition (Vel'vovskii, Ploticher, & Shugom, 1950). It was extraordinarily rare for a Soviet doctor to ask a woman to describe her experience of psychoprophylaxis. Soviet assessments were all strictly mediated by the physician's gaze. In France, as well, asking women to assess their own experiences was met with skepticism and derided as subjective and unscientific (Mayer & Bonhomme, 1953, p. 762). Lamaze and Vellay's decision to embrace women's testimonials as both a scientific measure of efficacy and a tool of popular persuasion marks an epistemological shift to inscribing women's words with scientific validity and merit and constitutes a major French innovation to psychoprophylaxis. In doing so, they appear to have been putting into practice the kind of egalitarianism popular among the Leftist staff and patients at Les Bluets, where maternity ward personnel were encouraged to express their opinions irrespective of rank or seniority (''Réunion de l'équipe,'' 1954). The solicitation of birth stories extended that sense of equality, comradeship, and collaboration from the medical team to the patients.

This article analyzes women's birth stories gathered during what can be considered a formative period of the Lamaze movement in the West: from the first PPM birth at Les Bluets in 1952 through Lamaze's death in early 1957. Birth stories have become an integral and accepted qualitative source for contemporary researchers evaluating the efficacy of a wide range of interventions for obstetric pain relief. The use of this source as an assessment tool is one of Lamaze's most enduring contributions to obstetric pain management. It is worth recovering and reexamining the origins of that approach for several reasons. First, the early work of Lamaze and Vellay provided a template for studies conducted across Western Europe, the United States, and elsewhere for decades to come. Researchers consciously mimicked their approach in an effort to formulate comparable data across national boundaries. Second, these early birth stories shed light on far more than just the method's efficacy understood in narrow terms. They speak to women's aspirations for their childbirth experiences. By examining expectations in another time and place, our own standards, so often normalized to the point of invisibility, are thrown into sharp relief. Finally, we gain insight into the relational position of parturients, husbands, and medical staff during parturition. Testimonials speak to the role that PPM played in women's ability to exert agency and to the ways in which various actors in childbirth practices wielded authoritative knowledge. On this point, I follow the lead of anthropologist Brigitte Jordan, who demonstrates through a comparative approach the ways in which medical authority and technology in the American childbirth model have typically worked to circumscribe women's ability to exert agency (Davis-Floyd & Sargent, 1997; Jordan, 1974/1993). Proponents of psychoprophylaxis in the United States historically have depicted it as intrinsically empowering to women and a vehicle for enhancing female agency and authority in childbirth. Based primarily on published birth stories drawn from the popular and medical French press, this article complicates this depiction of psychoprophylaxis by revealing the conflicting and contested nature of authoritative knowledge surrounding parturition.

Women's testimonials during these early years speak to a variety of concerns. I briefly analyze the ways in which they address the method's efficacy from a physical standpoint, specifically their experience (or lack) of pain during birth. I then turn to an examination of testimony regarding the impact of psychoprophylactic training on the women's psychological state, as indicated by behavior, demeanor, and mood. A discussion of mid-twentieth-century, Western understanding of female psychology frames this analysis. The last section addresses the ways in which women's testimonials speak most explicitly to questions of female power and authority in the context of childbirth experiences at Les Bluets during this formative period.

PSYCHOPROPHYLAXIS AND THE PAIN OF PARTURITION

As one would expect, the single most pressing question that absorbed Lamaze, his team at Les Bluets, their patients, medical professionals, and the general public was what effect, if any, psychoprophylaxis had on the experience of pain during

childbirth. With rare exception, published French birth stories during the 1950s speak of the method's efficacy in extremely positive, though nuanced, terms. A Madame N, who gave birth in June 1952, described the pain as no worse than menstrual cramps, while Madame D testified that she had experienced simply "a vaguely disagreeable feeling" (Lamaze & Vellay, 1952, pp. 6, 9). When asked by a skeptical friend, "so, you didn't feel anything?" one Lamaze patient clarified, "No, on the contrary. I felt everything and it was wonderful!" (Lamaze, 1955b, p. 17). For one Madame G, a couple of difficult moments, particularly during transition, passed quickly, and she maintained her composure and control throughout. She coupled her rather clinical description of physical discomfort with an assessment of her emotional state at that moment as one of "confusion, uncertainty, and fear, which was quickly dissipated by the voice of the doctor, who insisted that I relax and showed me a new breathing rhythm" (Lamaze & Vellay, 1952, p. 5). Madame G does not deny physical discomfort or unpleasant emotions. In fact, by acknowledging them, but minimizing their duration and force, she makes her case for the efficacy of psychoprophylaxis all the more compelling.

Pain was also a central concern for the husbands of women in childbirth education classes at Les Bluets. In the USSR, Soviet men were banished not just from the labor and delivery room, but from the maternity hospital itself. They paced and chain-smoked in front of the hospital entrance, while their wives labored inside. Men remained separated from their wives and newborns for the whole of the week-long lying-in period. In France, as in the United States, men typically walked the halls and remained in waiting areas, called to their wives' side after the baby's arrival. In a major, far-reaching innovation on Soviet PPM practice, Dr. Annie Rolland hit upon the idea of using husbands as what came to be called "coaches." She served a rural population spread thinly over difficult, mountainous terrain. Because of accessibility issues, it was imperative that the husbands be prepared to assist their wives until Rolland could reach them. When she shared this idea with her mentor, Dr. Lamaze, he integrated it into PPM practice at Les Bluets (Caron-Leulliez & George, 2004).

A small number of extant husband-authored narratives reflect a shared concern about their wives' physical well-being and comfort during birth. Like many of the women themselves, the husbands came to PPM preparation with a great deal of skepticism. Eventually, however, they were persuaded by the rational, scientific explanation of how it worked. One Monsieur de Bosh attested that "I saw that this was a scientific method. . . . Moreover, I recognized that the doctor [probably Pierre Vellay] is really scientific and a researcher and does these things for purely scientific reasons" (Vellay & Vellay-Dalsace, 1956, p. 274). Psychoprophylaxis thus dovetailed with mid-twentieth-century faith in the power of science and progress, and men saw in detailed explanations of Pavlovian physiology a persuasive rationale for why such a practice might work, even as it flew in the face of what they had been told all their lives about the pain of childbirth. From their eyewitness accounts, it is also clear that men found personal satisfaction in their newfound role as coaches. As one Monsieur D stated in 1953, "The baby is a being created by a couple, and the husband should not miss out on the privilege of assisting at his wife's side at one of the most challenging moments in life" ("Observations," 1954, p. 112). Monsieur D was eager to be at his wife's side. The birth of their child offered an opportunity to support her and to contribute to the process of birthing their child, notions that would gradually make their way into American birth practices more than a decade later.

ASSESSING THE PSYCHOLOGICAL EFFECT OF PSYCHOPROPHYLACTIC TRAINING

A woman's ability to appear to maintain self-control, of course, brought tremendous comfort to the husband who witnessed the birth of their child. Birth stories trumpeted not only the alleviation of physical pain, but a transformation of the psychological experience of childbirth. Women celebrated the benefits of psychoprophylaxis for their behavior and mental state during labor. A birth that they characterized as "calm"—meaning, one without screaming, yelling, or writhing—embodied the "dignified" birth experience they sought. No longer "something ugly and disgusting," labor became an opportunity for the parturient to demonstrate dignity through her ability to use the power of her mind to conquer her physical sensations (Rolland, 1955, p. 13). The inverse was also true—losing control correlated to a loss of dignity. Thirty-two-year-old Madame G, who gave birth using psychoprophylaxis in November 1952, gives voice to this sentiment when describing how at one moment during

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her labor she faltered: ''I lost control of my breathing and a cry like that of a suffering animal escaped me, the kind of cry that marked a traditional birth'' (Lamaze & Vellay, 1952, p. 5). Madame G here links the expression of pain with animal-like behavior, suggesting something uncivilized, wild, or irrational about such cries. Rolland echoed this imagery, saying that a woman who uses PPM ''acquires a superiority in no longer being a screaming beast by taking a conscious part in birth. . . . The woman attains greater dignity in the eyes of her husband, who sees and admires her effort'' (Coutant, 1954, p. 4). A woman's self-respect here becomes something granted through her husband's gaze as a reward for her good performance, rather than something generated from within by her own evaluation of her experience. Further, I would note that there is nothing intrinsically undignified about the vocalization of labor pain, but there clearly existed a taboo against it among the French medical professionals and mothers who promoted psychoprophylaxis in the 1950s.

In addition to a woman's performance, the notion of dignity derived from a sense of her active participation in childbirth. In choosing PPM over a conventional birth, which at that time in France might or might not have included analgesics or anesthesia, women asserted an active role in their birth experience. Rather than accept the status quo, this self-selecting group of women sought out something that they defined as more desirable, modern, and civilized. As one young mother explained, ''I rejected subjecting myself to suffering like everyone else. It struck me that it was like leaving the television century for the Middle Ages'' (''Les Enfants se portent-ils mieux?'' 1955, p. 32). Regardless of how well PPM worked for them, women rightly found satisfaction in asserting their choice of this alternative approach to childbirth. Thirty-seven-year-old Madame D, who gave birth to her first child at Les Bluets in September 1953, expressed these same sentiments when stating that ''personally, I am proud of not having been a hunk of passive and panic-stricken flesh, but a 'conscious and orderly' being'' (''Observations,'' 1954, p. 98). Proponents hoped that the activity demanded of the parturient in having a PPM birth would translate into other spheres, ''allowing the woman to acquire a less passive attitude toward herself and a more active one toward the world'' to the benefit of both her family and society (Clairbois, 1953, p. 14).

This opposition of a rational, active, modern vision of childbirth to an irrational, passive, backward one tapped into and meshed with then-current ideas about female psychology that originated with Helene Deutsch (1884–1982), architect of a Freudian psychoanalytic theory of the psychology of pregnancy. Deutsch constructs a vision of female psychology dominated by three interrelated characteristics: passivity, masochism, and narcissism (Deutsch, 1945). Women's personalities fall on a continuum, with the feminine woman at one end of the spectrum and the masculine woman at the other. During childbirth ''the masculine-active type of woman. . .wants her delivery to be an active accomplishment on her part. The distortion of feminine activity into masculinity results in complications of childbirth'' (Deutsch, 1945, p. 234). By contrast, passive-feminine women ''blindly follow other people's instructions and, like children, are interested only in getting rid of their fear and being subjected to as little pain as possible'' (Deutsch, 1945, p. 235). Deutsch characterizes a ''normal, active delivery'' as one in which a woman neither seeks masculine domination over her experience of birth, nor exhibits a feminine submission to the aid and intervention of the medical team (Deutsch, 1945, p. 238). In a healthy, mature response to the onset of labor, ''even the most active woman should entirely subordinate herself to the inner forces—a passive, cooperative, patient endurance of the process is her only task'' (Deutsch, 1945, p. 227). The well-adjusted parturient sits at the fulcrum of the active/passive, masculine/feminine continuum, actively engaging in her birth experience through her forbearance and compliance. Deutsch's vision of the ideal parturient behavior—awake, aware, calm, manageable—resonated with the kind of activity touted by PPM's proponents. From the psychoanalytic perspective and fully reconcilable with psychoprophylaxis, the psychologically healthy childbirth experience lay not in ''the exertion of real action over the [childbirth] process, but. . .in having produced, or achieved'' a result: the birth of a child (Vuille, 1998, p. 60). The most effective, productive way to experience that sense of activity was through behavioral self-discipline.

Women's sense of their active participation in their labors comes through in their frequent remarks on the focus and energy required to maintain

control, and on the pride they derived from that effort. Madame P, who gave birth in November 1952 at Les Bluets, noted, for example, that she was "above all happy with having personally participated *actively* in the birth of [her] child" (Lamaze & Vellay, 1952, p. 6; emphasis in original). For one second-time mother aged 27 years, "when the baby emerged, *I was calm and overflowing with joy*. . . . I was assisting *myself in total lucidity*" (Lamaze & Vellay, 1952, p. 10; emphasis in original). A Madame Régnier of Lyon clearly felt empowered by the feeling that "with this method, during the twenty-four hours of childbirth, I controlled the course of my labor" (Churlet, 1953, p. 3). In keeping with the argument of Lamaze, Vellay, and other French proponents of PPM, Madame Régnier and her fellow parturients understood their experience of psychoprophylaxis as one in which they exerted self-efficacy, intervening actively in the course of their own labor. Nonetheless, their sense of activity and agency unfolded within tightly defined behavioral parameters, to which they themselves subscribed, that demanded that women remain calm, largely still, and pleasant, and refrain from any outward signs, whether physical or vocal, of discomfort. Success hinged on performance of a narrow range of acceptable behaviors that conformed to the medical staff's and the parturients' shared perceptions of what constituted dignity in childbirth and, not insignificantly, served to make the staff's work easier.

Despite women's almost universal expression of feelings of empowerment and agency, they depended on the medical staff for their sense of control and competence. Just as their feelings of dignity derived at least in part from external validation from their husbands, so too did their sense of strength and endurance hinge on the medical personnel's positive reinforcement. Women were quick to credit the medical staff, especially their obstetricians, with their ability to maintain the placid exterior required by psychoprophylaxis. Loss or maintenance of control frequently seems to pivot on the absence or presence of supportive members of the medical team, whether it was the midwife, the nurse or monitrice, or the obstetrician (Barontini, 1954; "Observations," 1954, p. 98; Vellay & Vellay-Dalsace, 1956, pp. 55, 67). Confidence and trust in the obstetrician was considered "an important element in the success" of PPM, and women were grateful to childbirth educators and their obstetricians for their help ("Ces Femmes," 1953, p. 8). Laboring with her third child, 26-year-old Madame C experienced some painful contractions when she was alone, but "when the midwife was nearby, everything was better" ("Observations," 1954, p. 101), an observation echoed in contemporary U.S. research on the role of continuous labor support for pain management (Green & Hotelling, 2009). As Les Bluets patient Madame G attests, "[The] doctor returned [to the room], and he again controlled the synchronization of my breathing in such a way that subsequent contractions, even those that were stronger, did not cause me any pain" (Lamaze & Vellay, 1952, p. 5). Going well beyond the kind of support that Madame C leaned on, Madame G here suggests a Mesmer-like dominance of the obstetrician over the parturient, a depiction that undermines psychoprophylaxis's emphasis on the expectant mother's own active engagement in and control over her parturition.

CONTESTED AUTHORITY IN AND BEYOND THE MATERNITY WARD

Even as they sought women's birth stories, Lamaze and Vellay retained the authority to judge the success or failure of a case on the basis of their observations of a parturient's behavior, level of muscular relaxation, and facial expression. They maintained that the whole enterprise was "under the direction of the obstetrician," never relinquishing control or authority over the process of childbirth, for all the talk about women's active role, full participation, and dignity (Lamaze & Vellay, 1952, p. 11). As they wrote in 1953:

> *Each [member of the team] should have a fixed role. The nurse should anticipate the laboring woman's least desire. The midwife should participate very actively, encouraging the parturient and keeping her cerebral cortex alert. The doctor,* an element of control *[emphasis added], will bring a sense of security through his presence alone. It is he who decides if it is necessary to modify the course of labor if there is an obstetric complication. In this* labor hierarchy *[emphasis added] each should therefore be in his place and known to maintain it.* (Lamaze & Vellay, 1953, p. 1197)

Far from the egalitarianism suggested by the solicitation of their patients' birth stories, Lamaze and Vellay are here unequivocal in the investiture of authority strictly in the medical team, with the obstetrician as the unchallenged final arbiter of that authority. They expected parturients to do exactly as Madame Lefeuvre from Toulon did: "I listened

attentively [to the doctor's instructions]. I would be obedient and would do exactly what he told me to do'' (Lefeuvre, 1953). In a seemingly offhand, yet revealing remark, 23-year-old primipara Madame Pretet ''pushed one last time'' during her birth at Les Bluets ''in order 'to help' the doctor'' (Vellay & Vellay-Dalsace, 1956, p. 287), signifying that her activity here is for the doctor's, not her or her baby's, benefit. Psychoprophylaxis did not upend the hierarchy of obstetric authority found during a conventional medicalized birth in France at the time, or, for that matter, in the USSR. To the extent that it may have served as an agent for a dramatic increase in the authority of women in their own birth experiences, psychoprophylaxis clearly belongs, at least from the perspective of the medical community's attitudes, to a later period, when the Lamaze method become intertwined with the American feminist health movement in the late 1960s and early 1970s.

In cases that either obstetricians or women themselves defined as failures, one sees again this deference to medical authority. Like the popular medical literature, in which Lamaze, Vellay, and others often attributed the failed application of PPM to the woman's psychological imbalance, rather than to any physiological, obstetric, material, or personnel factors, let alone to any intrinsic flaw in the method, women too were inclined to blame themselves (Lamaze, 1955a; Lamaze, Vellay, & Hersilie, 1954, p. 136; Vellay & Vellay-Dalsace, 1956, pp. 32, 235). Stories of so-called failed PPM cases teem with regret and self-recrimination. In evaluating their birth experiences afterwards, women were quick to take responsibility for not having practiced the breathing and relaxation techniques enough at home, for not having attended enough of the lessons, or for failing fully to have faith in and rely upon the medical team (Vellay & Vellay-Dalsace, 1956, pp. 146, 260). Madame Richardeau regretted not having ''followed the instructions perfectly not to falter, not to cry.'' Not only was she disappointed for herself, but she recognized ''the effectiveness of this method and that I would have wanted to show myself worthy to the end, and reward the effort of those who taught and helped me'' (Vellay & Vellay-Dalsace, 1956, pp. 249–250). For others, estimations of their own failings yielded feelings of deep regret and even anger. As Madame L put it in 1953, ''an hour after Anne's birth, I was furious with myself. . . . I could not direct myself and control my nerves.'' In her mind, her ''anxious and fearful nature'' precipitated her failure (Vellay & Vellay-Dalsace, 1956, p. 243). No testimonials call the medical staff or the method itself into question.

Women who directed their disappointment and blame inward were a very small minority, as reports coming out of Les Bluets in those first years were almost uniformly positive. Among the vast majority of women who had succeeded using psychoprophylaxis, one sees the exhibition of an authoritative voice both in testimonials and through informal social networks. Lamaze himself promoted women's belief in their power when he solicited their birth stories and inscribed them with scientific merit and persuasive value. Further, he asserted that, as one reporter paraphrased, ''the parturient directs her own labor,'' even though elsewhere Lamaze left unquestioned the role of the obstetrician as captain of a childbirth team that encompassed the medical staff, the parturient, and her husband (M., 1953, p. 1194). The women whose birth stories appeared in the works of Lamaze and Vellay took their authority as real and claimed for themselves the right and responsibility to convey the truth of their experiences (Lamaze & Vellay, 1952, pp. 6–7). The confident voice of women speaking from firsthand experience combined with their marshaling of a medical or quasi-medical vocabulary to make these testimonials at once both accessible and persuasive to women reading these accounts in popular magazines and books (Jeanson, 1954; Karmel, 1959/2005; Vellay & Vellay-Dalsace, 1956, pp. 96, 99).

Informal mechanisms were likely even more influential than published accounts. Women spoke to their friends, relatives, and neighbors. Word spread across France about psychoprophylaxis, and one woman's positive experience could ignite interest in a broad circle around her. Rolland reports that in the village of Soues (Hautes-Pyrénées), where she practiced, women came to her and asked if she thought they ''could do as well as their neighbors'' using psychoprophylaxis. When discouraged from using PPM by another doctor, one mother-to-be came to Rolland and reported telling that physician, ''[You] know, doctor, the whole village has done it. What am I? The village idiot?'' (A. Rolland & P. Rolland, 1954, p. 59). As Rolland explains, in a village like hers

> *from the moment that one woman gives birth using psychoprophylaxis, everything changes. The other women have proof that it's possible, that it's true. . . . I know of a discussion between a doctor and*

a group of women who had attended a neighbor during childbirth. The doctor aligned himself with the perspective of the medical establishment, asserting that painless childbirth does not exist. To his every assertion, the women responded by saying "Yes, but Madame didn't suffer at all!" Very quickly, the women moved to a more active attitude: what their neighbor had succeeded at, they wanted to accomplish also. (A. Rolland & P. Rolland, 1954, p. 64)

In this description of events in one village, we again see emphasis on women taking an active rather than passive role, here well beyond the confines of Deutsch's psychological schema. Seeking a certain kind of birth experience, women like these then became instrumental in coaxing the medical community along in its adoption of psychoprophylaxis, as would be the case in the United States in the 1960s. As Pierre Vellay put it in 1955, it was not medical professionals that made for psychoprophylaxis's dramatic, rapid expansion in the Western world, but "the essential fact that women very quickly understood its value" (Vellay, 1955, p. 4).

CONCLUSION

In the examination of the innovative use of birth stories by early French advocates for psychoprophylaxis, a number of tensions emerge. Psychoprophylaxis is at once promoted as a method for the parturient to seize control over her own labor, and at the same time it adheres to what Lamaze and Vellay term a "labor hierarchy" that invests greatest power and authority in the obstetrician. One sees Lamaze and his collaborators solicit these birth stories and ascribe to them unprecedented authority, yet continue to evaluate the method's efficacy based on their own observations. Birth stories served to supplement these assessments, but they could ultimately be trumped by an obstetrician's understanding of how and why PPM succeeded or failed in any given case. Lamaze left unchallenged the obstetrician's full and final authority over whether, when, and how to proceed as labor unfolded. PPM advocates encouraged women to think of their labors as under their own direction, while at the same time there is little evidence that women's opinions, preferences, or somatic experiences were taken into consideration during the course of PPM births any more so than in conventional births at that time.

One sees a related area of tension between women's deference to medical authority and women's assertion of their own agency. Many were quick to give credit to the staff for a labor that proceeded smoothly, while those who endured difficult labors turned their blame inwards. At the same time, there is abundant evidence that women asserted agency and authority around the promotion of psychoprophylaxis. They did so in seeking out a psychoprophylactic birth, in pursuing and applying their training in the method, and in testifying to their experiences in the media and by word-of-mouth. Their birth stories translated into real power, as they inspired other women to demand that the medical profession accommodate their aspirations for a different kind of birth experience.

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Underneath these tensions, between patient-driven decision making and hierarchical biomedicine and between women's assertion of and deference to medical authority, lies Deutsch's spectrum of activity and passivity. As practiced in mid-twentieth-century France and as previously observed by Swiss sociologist Marilène Vuille (1998), psychoprophylaxis had embedded in it an apparent paradox between the parturient's active engagement and the method's requirement of passive, compliant endurance of labor. Supporters of psychoprophylaxis both within the medical community and among parturients sought to activate women's engagement with childbearing, liberating women from increasingly routine obstetric interventions that ranged from forceps deliveries to anesthesia. There is no question that PPM required preparation, concentration, and effort on behalf of women, or that women themselves exerted agency in choosing and practicing PPM. At the same time, though, the effort demanded of them during the course of labor was largely agreeable, calm, quiet behavior and deference to the medical staff's demands. Women and their obstetricians shared a common vision of a dignified birth characterized by serene, placid, and pleasant comportment. At one of the most

extraordinary, taxing moments in a woman's life, her success was defined by bringing her behavior into line with that which one would expect in the most quotidian of circumstances.

The story of psychoprophylaxis during this formative period, as told through French women's birth stories, raises questions about the current practice of childbirth education and labor support. We have our own, sometimes conflicting ideas about what constitutes a dignified birth experience, female agency, and authoritative knowledge. The case of mid-twentieth-century French proponents of psychoprophylaxis certainly highlights the contradictory and contested nature of these issues, which remain embattled in our own society. This history reminds us that no one approach to childbirth preparation inherently embodies an objectively dignified or otherwise desirable birth, but rather childbirth practices emerge out of a specific, historically contingent constellation of values. Many American women share much in common with those in France who sought a more satisfying birth experience, yet their emphasis on, for example, dignity defined as quiet equanimity seems, when viewed through our eyes, to fit the circumstances of childbirth only awkwardly. Like their French sisters more than a half-century ago, contemporary American childbirth educators and parturients bring culturally constructed notions of dignity, activity, and power to bear on their expectations. Deeper interrogation of these values, of what we mean by words such as agency and authority in the context of childbearing, has the potential, if not to revolutionize our approaches to childbirth preparation and practice, then at least to bring greater consciousness and intentionality to them.

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PAULA A. MICHAELS *is an associate professor of history at the University of Iowa. In addition to numerous scholarly articles, she is the author of the prize-winning* Curative Powers: Medicine and Empire in Stalin's Central Asia *(2003) and is at work on the book* Lamaze: An International History, *forthcoming from Oxford University Press.*