Chapter 1

Pasts and peoples

General background

When thinking or writing about any form of pain, I have a tendency to generalise my ideas. I don’t think that I am unique in this respect. This is an inevitable way of attempting to manage an otherwise unmanageable concept. As the reader, though, you should keep in mind the artifice of such a strategy. Pain is above all an individual phenomenon. Only the person experiencing it is able to really know what that pain is like. Other people may think that they know what the pain is like. They may have experienced pain in the same part of the body, or possibly due to a similar cause, in the past. Alternatively, they have witnessed or even provided care for a number of people and think they know what a person who is experiencing this form of pain looks like. All of these people, whether they are experienced or whether they are witnesses, are mistaken. They are making assumptions which are either weakly founded or totally unfounded. Obviously, such unfounded assumptions carry serious implications for the person actually experiencing the pain.

For the present, though, I feel obliged to encourage the reader to keep at the forefront of his or her mind this ‘health warning’:

Do not allow yourself to be lulled into assuming that you know what another person’s pain is – that way lies danger.

This health warning applies not only to modern day experiences and practices. I venture to suggest that such a cautious approach should be applied equally to former peoples in their own times and settings.

In this chapter I plan to trace, first, the ways in which attitudes to pain have developed in certain societies over time. This section does not claim to be comprehensive because there are some societies whose literature is not accessible to me for linguistic reasons. In order to trace these developments, it is necessary to consider the major pain theories, together with significant exceptions. These historical views are then applied to childbearing pain. The second part of this chapter turns the focus to the association between culture and pain-related experiences and practices. This cultural orientation leads, inevitably, to consideration of the meanings which may be attributable to experiences of pain.
Historical attitudes to and interpretation of pain

Ideas about pain and its control inevitably develop as society changes. As a result, even relatively recent ideas quickly become outdated. On the other hand, deeply held, perhaps ancient, ideas about pain in general and specific forms of pain may surface to manifest themselves in certain circumstances. I suggest that an experience as intense as childbirth is one of those circumstances.

Esther Cohen’s analysis (1995) of early historical attitudes to pain demonstrates not only the crucial cultural component of pain, but also the temporal developments within those cultures. In his unique paper, which has stood the test of time, Donald Caton (1985) outlines how some of the attitudinal changes did or did not actually happen. His paper provides a useful framework for this section. Caton traces the gradual change from regarding pain as a mystical or divine intervention, possibly an emulation of a suffering deity, to a natural, secular phenomenon. Simultaneously pain was transformed from being considered generally, if convolutedly, beneficial. It has since come to be regarded as a universally destructive phenomenon.

In prehistoric tribal societies magical influences were held to be responsible for non-traumatic painful experiences (McKenzie & Parris 1997). Beliefs in these magical influences allowed women healers and the shaman or medicine man to assume powerful positions in attributing the cause and necessary punitive actions to remedy the pain. Such mystical convictions were gradually superseded by a trust in or fear of deities. In a similar way, in some cultures pain has been attributed to the absence of balance, or to the frustration of desires (Main & Spanswick 2001).

According to Caton (1985), early Greeks and Jews perceived pain as having a dual role. The first role of pain was to convey divine punishment to those who transgressed. McKenzie and Parris point to ‘the curse of Eve’ (see below) as an example of such divine intervention (1997: 2). Thus Greeks, such as Homer, attributed pain to arrows released by the gods. Such forms of external attribution were not uncommon and were similarly applied to a range of disease processes. The second role of pain in this setting was considerably more positive. Together with punishment, pain carried with it the opportunity for the person to show remorse for whatever ‘sin’ was said to have caused the pain. In this way, the penitent was able to achieve healing through cleansing, which brought redemption from the original transgression.

Similar ideas persisted from the fifth century CE through to the Enlightenment; under Judaeo-Christian influence, pain continued to be interpreted as divine retribution for wrong-doing. Through this powerful link spiritual leaders emerged as comforters and healers. Thus began the long-standing connection between the church and public health. Fundamental to these ideas was the church’s dependence on the dogma of original sin, which materialised in woman’s inherently evil nature (Yee 2003). Inevitably self-inflicted pain was eventually substituted for spontaneous pain in a form of ‘pre-emptive strike’ to prevent disease by appeasing or propitiating the deity. Thus, an element of magical thinking developed. During the Spanish Inquisition this concept was extended to inflict pain on others to achieve their purification (Glucklich 2001). Therefore, pain’s dual role as both punishment and redemption emerges. These combined magical and mystical ideas became
expanded by logic and observation, such as of substances to ease pain. These observations led to suspicions that human-controlled phenomena were involved and not just superhuman agencies. Such observations included public health measures, like isolation, which occasionally limited the spread of bubonic plague.

From about 1600 the age of faith made way for the age of reason. A link became established between the study of nature and the understanding of divine laws. Thus, the scientific approach to knowledge emerged. Divine laws became relatively less significant, to the extent that the contribution of the deity was eventually questioned by the influential thinkers of the enlightenment. Up to this time changing attitudes had resulted in only minimal changes in treatment, because the methods available were so limited.

These two fundamentally important functions of pain underwent a series of transitions, not necessarily synchronously, with the Renaissance, the Age of Reason and the Age of Revolution. But, by the nineteenth century social changes were leading to philosophers, such as Jeremy Bentham (1748–1832), to consider pain as a totally natural phenomenon, devoid of either divine causation or redemptive capacity. With the increasing power of medical practitioners in the nineteenth century, aspirations to becoming a scientific discipline completed the transition to pain being regarded as predominantly secular. Without actually mentioning the terms, Caton implies the association between the changing perceptions of pain and the relative changes in the power base of the occupational groups regarded as professions. He eventually reaches the obvious conclusion that, through the self help and complementary health movements, both the causation and the remediation of pain have been comprehensively secularised through the assumption of responsibility for any pain by the affected individual. Thus, moral or religious interpretations of pain appear to have become largely obsolete in sophisticated settings.

Pain theory

In contemplating the theory on which our understanding of pain is founded, we need to remember that pain theories are precisely that. Their role is to facilitate our understanding of the relationship between two or more variables. Theories, like the comprehension which they engender, are in no way fixed or immutable. Thus, our understanding of pain needs to be regarded as dynamic. In the same way that ‘ropes’ and ‘bells’ (see specificity theory below) currently seem archaic, in the future it is not impossible that ‘gates’ (see currently accepted pain theory below) may similarly be viewed as anachronistic.

Our understanding of pain has clearly increased as human knowledge of anatomy and physiology has developed. I have shown, in the previous section, that there have been other influences; these include religious, philosophical, political and social aspects. In prehistoric settings, attitudes to pain would barely have justified the term ‘theory’.

Bonica and Loeser (2001) outline the role of the ancient Greeks (fourth–fifth century BCE), such as Aristotle, in seeking the underlying sources and mechanisms of pain. The contribution of the brain and central nervous system was variably recognised, competing with the heart for priority. In ancient Rome (third century BCE), Galen was able to recognise nerve fibres as having a role in the transmission of pain sensations. By the Middle Ages, the part played by the central nervous system was being modified by perceptions of humoral functions.
Specificity theory

Although the term was not widely used until after the work of Schiff in the mid-nineteenth century, René Descartes was the original ‘key philosopher’ (Wall 1999: 20) who introduced the concept of dualism, which led eventually to specificity theory. Descartes (1596–1650) sought an anatomical and physiological explanation of the sensation of pain which had been recognised by Aristotle. Descartes employed the newly developed scientific method to find this explanation. By dissection and introspection, he came to regard the human body as no longer the ‘temple of the soul’ as espoused by the all-dominant church. Descartes proposed regarding the human body as a machine, controlled by physical principles (Melzack 1993). His dissections identified nerve fibres, on the basis of which he concluded that a specific system transmits impulses from cutaneous pain receptors to a cerebral pain centre. This mechanism was considered analogous with ‘pulling on one end of a rope makes a bell ring which hangs at the other end to strike at the same instant’ (Wall & Jones 1991). This approach to pain is summarised by the well-known drawing of the ‘Boy with Foot in Fire’. Cartesian dualistic ideas continued to influence knowledge and therapy until well into the late twentieth century (Wall 1999). While Descartes is often blamed for modern mechanistic approaches to health, Mark Zimmerman considers that he does not deserve such a bad press (2005).

In the light of Charles Bell’s (1774–1842) recognition of the separate flow of sensory information through channels in the spinal cord, in 1842 Johannes P Müller developed the doctrine of specific nerve energies. These energies were thought to comprise coded or symbolic messages which could be transmitted only by sensory nerves to the brain. A major flaw in this earth-shattering realisation was the belief that one single sense of touch encompasses all forms of pain.

Maximilian Von Frey developed Müller’s work and combined it with physiological observation and newly introduced staining techniques to identify four types of cutaneous receptor organs or ‘modalities’. This theory persisted in affirming direct links to an appropriate cerebral centre and, on the basis of surgery, such pain ‘pathways’ were identified in the anterolateral or dorsal quadrant of the spinal cord.

The strength of these forms of specificity theory lies in their physiological specialisation. The multiplicity of weaknesses of specificity theory, though, includes the psychological assumption of straight-through transmission and the absence of any allowance for personal or temporal variation in pain perception. This approach to pain has been blamed for the medicalisation of pain and, hence, impeding understanding and more effective remedies (Bendelow & Williams 1998).

Pattern theory

The weaknesses of specificity theory were clearly apparent to clinicians, so a search was begun to illuminate the complexity of transmission. The results comprise ‘pattern theory’.

Following pathological observations, Alfred Goldscheider (in 1894) hypothesised that, together, central summation in the dorsal horn and stimulus intensity are the critical determinants of pain. John Bonica (1990a) referred to this as ‘Intensive (Summation) Theory’, but the emphasis was clearly on the stimulation spatially or temporally of
non-specific receptors. The earliest, or peripheral, pattern theory focused on intense peripheral stimulation being interpreted centrally as pain; physiological specialisation was effectively ignored. The lack of any theory addressing phantom limb/body pain was recognised by William Livingston, who in 1943 refined pattern theory to produce the central summation theory; a pattern of incremental and reverberatory circuits were thought to explain the otherwise inexplicable phantom pain experienced by amputees.

A still more complex hypothesis was advanced by Willem Noordenbos in 1959 in the form of the sensory interaction theory, according to which a rapidly conducting fibre system inhibits synaptic transmission in a more slowly conducting pain-carrying system. This theory further proposed a multi-synaptic afferent system within the spinal cord. Thus, the physiological stage was set for the gate control theory (see ‘Currently accepted pain theory’ below).

**Affect theory**

Integrated into other pain theories is one which for centuries stood alone as the only explanation of pain. This is the ‘affect theory’ of pain, which defines pain as an emotion, rather than as a sensation (Melzack & Wall 1991). Affect theory is closely linked with what Bonica (1990a) termed the ‘Fourth’ theory of pain, which differentiates the neuro-physiological perception of pain from the cognitive aspects of the response to pain, as determined by a range of factors including culture and previous experience.

**Psychological/behavioural theory**

This chronic form of pain reflects disconcerting trends in general psychology, being summarised in terms of ‘pain as behaviour’. It relates to the forms of pain sometimes known as ‘psychogenic’ and incorporates a response to cues which are part of the individual’s environment. These forms of behaviour may be associated with triggers which led to the original pain experience (Fordyce et al. 1988).

**Fear-avoidance model of pain**

This model of pain, formulated by Johan Vlaeyen and colleagues in 1995, may not be unrelated to the psychological/behavioural theory (above). It essentially comprises fear of aggravating pain giving rise to the avoidance of certain beneficial activities (Moffett et al. 2004). Randomised controlled trials using this approach to pain show that it is amenable to non-pharmacological intervention, but that any benefits demonstrated tend to be temporary.

**Currently accepted pain theory**

The pain theory which is most widely and generally accepted was developed during the early 1960s by Ronald Melzack and Patrick Wall (1965). More recently another pain model has been introduced which is particularly relevant to midwifery, which will more appropriately be considered in detail in the light of the discussion on cultural aspects of pain (below).
Gate control theory

It is clear that, in the history of pain theory, the role of the central nervous system was insignificant, to the extent of the cerebral contribution being negligible. This imbalance was redressed by Melzack and Wall in the early 1960s, using new technology which permitted the electronic recording of individual nerve cells’ activity. This work combined Melzack’s study of the psychology of the somatic senses with Wall’s interest in the physiology of the pain pathways to address certain paradoxes in our understanding of pain (Wall & Jones 1991: 129):

- the variable relationship between injury and pain
- that innocuous stimuli may elicit pain
- the location of pain discrete from the site of damage
- pain in the absence of injury or after healing
- changes in the nature of pain over time
- intractable pain with/without obvious cause.

Melzack and Wall built on the already well-recognised phenomenon by which gentle stimulation inhibited pain sensation to draw up the gate control theory of pain (Melzack & Wall, 1965); it explains persuasively the psychological aspects of pain, the physiology of pain transmission and the modulating influences. The gate control theory emphasises the body’s in-built pain control mechanisms and provides a feasible explanation for the non-intervention or low-tech approaches to pain control, including psychological methods, back-rubbing and transcutaneous electrical nerve stimulation (TENS; Chapter 8).

This theory may be briefly summarised thus:

1. The passage of nerve impulses from afferent fibres to spinal cord transmission cells and thence to local reflex circuits and the brain is modulated by a spinal gating mechanism in the dorsal horn. As with all central nervous system (CNS) synapses this transmission is controlled by mechanisms which either facilitate or inhibit the passage of the impulse.

2. The spinal gating mechanism is influenced by the relative amount of activity in large diameter (low threshold myelinated afferent) fibres and small diameter (high threshold myelinated A-delta and unmyelinated C) fibres: activity in large fibres tends to inhibit transmission (close the gate) while small-fibre activity tends to facilitate transmission (open the gate).

3. The spinal cord gating mechanism, which is now thought to operate in a number of sites including lamina 2 of the substantia gelatinosa of the dorsal horn, is influenced by nerve impulses descending from the brain.

4. A specialised system of large diameter, rapidly conducting fibres (the Central Control Trigger) activates selective cognitive processes that then influence, by way of descending fibres, the modulating properties of the spinal gating mechanism.

5. When the firing rate or output of the spinal cord transmission cells exceeds a critical level, it activates the Action System - those neural areas that underlie the complex, sequential patterns of behaviour and experience characteristics of pain. The critical level
is determined on an individual basis by the person’s brain, and is dependent on a range of factors, such as previous experience (Melzack & Wall 1991; Melzack 1993).

The impact of the publication of the gate control theory was ‘astonishing’ in terms of both its vigour and viciousness; although Melzack maintains that its greatest effect lay in its emphasis on the dynamic role of the CNS, especially the brain (Melzack 1993). In the context of childbearing, this theory assists our understanding of how the emotions which childbearing women experience, such as confidence or fear, as well as cognitions, such as knowledge or meaning, affect the woman’s pain experience.

**Further hypotheses**

The gate control theory has impacted profoundly on the subsequent development of both knowledge and its application. The two major effects are that, first, simplistic pain theories are no longer acceptable and, second, an holistic orientation to all aspects of pain is recognised as essential. There has also been some progress with addressing the persisting paradoxes of pain.

**Phantom pain**

Phantom pain is usually considered to be associated with the loss of a limb. Because such pain may occur after the loss of other body parts, such as following mastectomy, it may be known as phantom limb/body pain (PL/BP). The theory of a ‘neuromatrix’ has been developed (Melzack & Katz 2006) which serves to explain the continuing nature of these sensations. This ‘psychological template’ includes cerebral structures and continues to function after the loss of the body part.

This continuing neuromatrix results in sensations of a phantom in most people who lose a part. These sensations are not necessarily unpleasant, but up to 85% of amputees experience pain and may find it distressing, limiting and disabling (Brodie et al. 2007). The neuromatrix theory takes account of previous pain experiences and interventions which have or have not been effective. This orientation makes this theory particularly appropriate to women in labour (Trout 2004). The research in this area tends to be weak in terms of methods and responses. It is clear that distressing phantom pain conditions urgently need more, and more, authoritative, research attention.

**Prolonged pain**

In association with the gate control, observations of small, unmyelinated afferent or C nerve fibres were observed to behave in an unusual way (Wall & Jones 1991). Following an initial episode of acute and severe pain, those C fibres arising in deep visceral or joint tissues were found to show increasing activity, recognised as slowly increasing pain. These authors further suggest some cerebral control of this impulse-triggered prolonged pain. They give as an example the pain of a twisted ankle, which is initially sharp but is followed by a vague ache. It is also suggested that this mechanism may be relevant to surgery.
Alongside the gate control and impulse-triggered prolonged pain mechanisms, Wall and Jones (1991) propose that damaged nerve fibres may engender prolonged pain due to local escape of chemicals normally transported only within the axon. This prolonged pain, termed ‘transport-controlled prolonged pain’, has been attributed to nerve growth factor. Again, C fibres appear to contribute crucially, perhaps by diagnosing a local problem, for which reason they have been labelled ‘chemical pathologists’.

**A midwifery model**

Nicky Leap’s midwifery understanding of labour pain and its control is widely regarded as a development of pain theory (1996). The status of this development, though, is uncertain because of Leap’s focus on the *care* of the woman in labour. Despite this uncertainty and because of this model’s decisive influence on the ideas which are discussed in this book, I outline the model at the end of this chapter.

**Summary**

It is apparent from this discussion that our understanding of pain has developed beyond all recognition since Aristotle and that it is continuing to do so. In the same way as we now understand that pain is not a simplistic concept, we know that our understanding of it must also be multifaceted, multidisciplinary and dynamic. It may be that, in historical terms, an understanding of the nature of pain has not been necessary in order to treat it. This situation is changing and our increasing understanding is facilitating more suitable methods of helping people, and particularly childbearing women, to cope with pain.

**Cultural aspects**

It may be that childbearing and the associated pain are one of the few common experiences shared by the various component groups which comprise the current global society. Although the experience is common, attitudes to it and their expression vary hugely and not invariably predictably. This chaotic situation is further complicated by the varying backgrounds, experiences and attitudes of those providing care during childbearing. In this section, I examine the cultural inputs into and perceptions of this conundrum of pain. I first consider the nature of culture and the factors which have been shown to influence it. I move then to the cultural factors that affect the sufferer’s pain expression and carers’ pain perception. Next are the cultural factors impinging on childbearing in general and the associated pain in particular. The themes emerging from this material are drawn together by considering the meaning of pain.

In considering culture in the present context, it is necessary to draw heavily on North American literature. Such heavy reliance should carry with it a further health warning on the grounds of our transatlantic cousin’s preoccupation with the ‘other’. This leads to a neglect of the impact of what may be termed the ‘dominant’ culture.
The meaning of culture

‘Culture’ is a term which carries many meanings; for this reason it is necessary to contemplate the sense in which I use it. Like so many abstract concepts, culture may exist at a variety of more or less abstruse levels. All too often, assumptions may be made about a person’s culture from his or her physical appearance. This view is worryingly oversimplistic and carries the likelihood of racial stereotyping and racism.

In contrast Charalambos Tsekeris (2008), who studied culture in a Greek context, emphasises culture’s socially-inherited nature and the extent to which it features shared ideals. The complexity of culture is clearer in the unwritten and unstated assumptions and values which determine the behaviour of the members of the relevant group. These assumptions are powerfully influential in controlling behaviour, and may be the only visible manifestation of group membership. While culture describes complex abstractions, terms like ‘ethnic/ity’ are marginally clearer. These terms refer precisely to a person’s racial origin; however, such straightforward terms become less comfortable when the word ‘group’ is added, as this introduces political nuances.

There are certain factors that have been shown to influence culture.

Geography

There is a tendency to consider culture merely in terms of geographical origin. This is one of the traps which ensnared Zborowski in his still ground-breaking work on the cultural components of pain responses (1952). In a New York setting, he collected data on pain expression by patients of four ethnic backgrounds. The groups were selected following discussion with clinical staff, because staff found difficulty coping with the differing reactions to pain. The groups comprised Italians, Jews, Irish and a group long settled in the USA but of northern European extraction, entitled ‘Old Americans’. The data were collected qualitatively by open-ended interviews with patients, observations of them while in pain and interviews with staff caring for them.

Mark Zborowski’s work is frequently and appropriately criticised for his superficial and one-dimensional approach, together with the creation of ‘cardboard characters instead of describing real people’ (Kleinman et al. 1992: 2). Despite such criticisms, Zborowski’s work did break new ground in the study of pain.

Thus, Zborowski made partial use of geographical origin as a proxy for culture; however, others have been more discriminating in their interpretation of geographically based culture (Lasch 2000). Such reassurances, though, leave the reader with concerns that occasionally culture may be used as a method of stereotyping ‘immigrants coming from non-traditional regions such as Southeast Asia and Latin America’ (Lasch 2000: 16). This process is surely counterproductive if individualised care is the aim.

Religion

These two examples (Zborowski 1952; Lasch 2000) show the extent to which culture is associated with geographical origin. This association is supported by an observation made prior to an authoritative attempt to measure the link between pain and culture, which
identified 29 cultural groups whose pain responses had been researched (Lipton & Marbach 1984). Religion and skin colour as well as geography featured as determining characteristics in five groups. Geographical origin and religious persuasion may be thought to be synonymous, but these authors state that such groups are few. The major religions influence culture by, for example, advocating pain acceptance, adopting either prospective or retrospective approaches; examples are the Muslim ‘kismet’ (destiny), Hindu ‘karma’ (reincarnated burden) or the Christian atonement.

The significant relationship between religious persuasion and geographical origin has emerged in North American pain studies (Sternbach & Tursky 1965). The weakness of such research is found in religious persuasion and geographical origin being so similar in their determination of culture that they are interchangeable. This point was brought home forcefully to me when a woman of North African extraction was criticising the NHS staff’s limited understanding. Her comments were unsurprising until she asserted ‘You Christians’. I was taken aback as I certainly do not regard my religious orientation as a prominent characteristic. For her, though, Western European was clearly synonymous with Christian, supporting my argument that culture is inextricably and equally linked, at least in observers’ minds, with religion and geographical origin.

**Education**

With hindsight, I realise that the North African woman was simply applying a cultural stereotype to me, which I considered inappropriate. Thus, the usual stereotyping found in maternity care was reversed. Jo Green and her colleagues (1990) support this contention that stereotyping is invariably unidirectional. The stereotyping on which they focused was the woman’s education relative to her involvement in childbearing decision-making. While their data supported the positive aspects of the stereotypical ‘educated’ woman, this supremely trustworthy study refuted the usual negative stereotypes of the less-educated woman.

**Socio-economic class**

This authoritative study persuaded Green and colleagues that education is inextricably linked to a person’s cultural orientation. These researchers further considered whether social class is associated with education and culture, discussing stereotypes of ‘uneducated working class women’ (1990: 127). They dismiss social class (determined in the classic style by the male partner’s occupation) as not ‘a very good indicator of women’s attitudes’ (1990: 128).

While Green et al. have clearly debunked the myth of the stereotypical ‘working class woman’, James McIntosh’s research (1989) found that she was alive and, if not well, at least residing in Glasgow. McIntosh argued that women in lower socio-economic groups have their own shared perspectives of and attitudes to childbearing which are culture-bound. In his sample of 80 women, half belonged to social class IIIb and the remainder to social classes IV and V. He claimed to have identified the stereotypical working class woman who is ‘less opposed to medical intervention and control and less likely to espouse the cause of natural childbirth’.

The culture of social class was explored prior to a study of women’s reproductive lives by Emily Martin (1989). She believes the crucial difference to be the reliance of middle
class families on paid outside help and support; whereas ‘working class’ families are more likely to be able, or need, to pool their own resources.

The comments by Green, the argument by McIntosh and observations by Martin combine to demonstrate that socio-economic class brings with it a range of features which contribute to a unique culture.

**Gender**

It is not unknown for female health care staff to scoff at men’s limited tolerance of pain. Although possibly politically incorrect, gender differences in pain perception are becoming recognised. The authoritative work of Gillian Bendelow and Simon Williams recognised that the ‘conditioned stoicism’ of men renders them less well able to cope with pain (1998: 207). Clearly, the experience and the expression of pain may be worlds apart. These researchers, however, argue that it is women’s perception of pain as natural, as opposed to men considering it abnormal, which allows women to both tolerate and, only when necessary, articulate pain.

At a more physiological level, the work of Zsuzsanna Wiesenfeld-Hallin in Sweden (2005) sought to investigate the general finding of a greater sensitivity to pain among women. She found differences in the neurological ‘wiring’ which may serve to explain such differences. The rationale which she suggests relates to men’s susceptibility to wounds through their time-honoured roles as hunters and warriors. For this reason, she maintains that men are more vulnerable to somatic pain compared with women, whose reproductive pain is more visceral.

**Other influencing factors**

In the same way as Wiesenfeld-Hallin leads us to contemplate the socio-cultural influences on pain perception, Cecil Helman (2007) focuses on whether the expectations of society lead to cultural acceptance or non-acceptance of pain. His examples include, first, the groups who live in war zones and who accept battle-wounds and their pain as, not merely inevitable, but actually admirable. Moving into a rather different social climate, Helman then suggests that cultures which are able to control pain effectively tend to find pain unacceptable. Thus, certain groups in countries such as the USA ‘welcome analgesic drugs’.

**Culture and pain**

The links between pain responses and culture are well-recognised, as reflected in the widely used though somewhat limited definition of pain, which allows for cultural variations in pain perception:

> An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. (International Association for the Study of Pain 2009)

The cultural variations of pain perception have been demonstrated through a series of research projects undertaken by various disciplines adopting different perspectives. I now review some research findings relating to the client’s expression and the carer’s perception.
**The person in pain**

Focusing on the difficulty of making cultural comparisons of pain expression, Helman (2007) sought to distinguish public from private pain. Public pain involves some form of articulation, whereas private pain foregoes such expression. Exemplifying the latter, he cites the ‘stiff upper lip’ so admired by ‘Anglo-Saxon’ peoples and the anecdotal absence of pain behaviour among warriors. Alternatively, this distinction may reflect either the lack of sensitivity of the observer or a physiological shock reaction, rather than non-verbal/verbal behaviour in the sufferer. Even so, Helman concedes that ‘an absence of pain behaviour does not necessarily mean the absence of private pain’.

The first ‘observations’ of the cultural implications of pain were made by ‘missionaries, travelers and other laymen (and even some medically trained persons)’ (Wolff & Langley 1977: 313). These observations were based on assumptions that so-called ‘primitive’ peoples are less sensitive to pain than their ‘civilised’ counterparts (Morris 1991: 39). Reflecting the thinking then prevalent, genetic inheritance was held responsible. The missionaries and their fellow travellers probably had in mind gruesome initiation ceremonies and other rituals (Soikava et al. 2005). In these ceremonies, apparently painful behaviours typically produce no recognisable pain response in the ‘celebrant’. As distinct from more humdrum everyday pains, these mystical ceremonies demonstrate the significance of culture; thus, the meaning of the situation, event and other unique factors are crucial in the perception, interpretation and expression of pain (Glucklich 2001).

Despite the tendency to draw conclusions about the cultural factors associated with a person’s perception and expression of pain, some anthropologists remain healthily sceptical about the validity of research findings (Wolff & Langley 1977). Exemplifying Zborowsky’s study (1952), these critics bemoan the continuing lack of experimental data supporting a cultural component of pain. They regret the lack of sound anthropological research on pain responses, blaming this on existing experimental studies being anthropologically naïve, and completed anthropological studies lacking the experimental rigour to permit valid conclusions.

As critiqued in ‘Geography’ (above), an unprecedented study focusing on pain and culture sought the differing perceptions, interpretations and expressions of pain by patients and by staff (Zborowski 1952). Zborowski sought to illuminate the acceptability or otherwise of pain behaviour as viewed by staff and patients of differing cultural backgrounds. The immediate spur to this study was the seemingly infinite potential for conflict associated with differing attitudes to pain. Zborowski focused on four ‘ethno-cultural’ groups of patients. The sample comprised: Jews (n=31), Italians (n=24), Irish (n=11) and Old Americans (n=26). Additionally, there were 11 patients of unstated ethnic origin. A qualitative research design involved interviews with the patients, staff and 16 healthy respondents, which were recorded on ‘wire’ and transcribed. There is no indication of how the observational data were organised.

The Italian and Jewish patients had been perceived as demonstrating similar emotional responses to pain, and this was interpreted as meaning that they had a ‘lower threshold of pain’ than other groups. Zborowski found that the situation was more complex than that. Although the responses to pain appeared similar, the underlying attitudes were diametrically opposed. The meaning and implications of the pain were the prime concern of the
Jewish people, whereas it was the immediate experience that concerned the Italians. Thus, analgesia solved the Italians’ problems, but the Jewish people perceived analgesia, not just as no solution, but as actually causing more problems by masking any potentially threatening symptoms. The Italian and Jewish patients were perceived by the American/ised staff as vocalising pain excessively to attract attention. The staff responded to what they considered to be an over-emotional reaction by minimising their assessment of these patients’ pain; thus, articulation was interpreted as histrionics and was counterproductive in gaining sympathy and treatment. Pain expression in these groups further differed according to whether the pain occurred at home or in hospital. The differences were determined by the tendency of the Italians to adopt a more macho and the Jewish people a more manipulative orientation. Thus, although these two groups exhibited similar pain behaviour, it derived from different attitudes to pain, served differing functions and sought to achieve different ends. The Old American patients, however, were perceived by staff as being compliant and demonstrating the stiff upper lip approach to pain. Members of this group thought it pointless to fuss about their pain and believed it necessary to behave like a ‘good American’. This group considered emotional displays counterproductive.

These attitudes suggest a future orientation in the Jewish patient, compared with a present-time orientation in the Italian. Each group of patients expressed confidence in the staff, investigations and hospitalisation; while this was greatest in the Old American, the Jewish patient tended to be more sceptical and pessimistic.

Not surprisingly, Zborowski (1952) identified individual differences between members of each of the four groups and sought the reasons for within-group variation. Some individual differences were attributed to the patient’s degree of ‘Americanisation’, which correlated with the duration of time since the patient, or their forebears, had immigrated. It is generally recognised that the behaviour of migrants changes when they reach their destination. The attitudes and behaviour associated with pain are more deeply held and ingrained than others and, hence, change more slowly. Zborowski observed that the pain behaviour of the Jewish and the Italian patient may be similar to the Old American if the patient is third generation but, although behaviours may adapt, underlying attitudes persist. Also, recognising the individuality of adherence to ‘the old ways’, distinction may be made between ideological and behavioural ethnicity (Brodwin & Kleinman 1987). The latter is the everyday version, whereas the former emerges for ‘religious holidays and political rallies’. The extent to which these forms of ethnicity are amplified by migration remains open to conjecture.

The gradual change in the behaviour of ethnic groups and the even slower change in underlying attitudes led Zborowski to explore how cultural attitudes to pain are transmitted. He concluded that early influences within the family are crucial. He suggests that ‘appropriate’ childhood behaviours are rewarded and, hence, reinforced. In contrast, other more ‘inappropriate’ behaviours are disregarded, or even punished, to obliterate them from the child’s repertoire. In the context of encouraging appropriate behaviour, pain behaviour is likely to have been learned within the family of birth as a coping mechanism. ‘Secondary gains’ act as reinforcers, from which the sufferer benefits; examples include controlling situations, justifying dependency, punishing others and avoiding sex.

Zborowski is certainly guilty of further racial stereotyping when describing certain groups of women as overprotective and rewarding of more dependent behaviour (Kleinman et al. 1992). Zborowski’s creation of ‘cardboard characters’, serving to
dehumanise the subjects and their experience of pain, is also criticised. Despite these limitations, Arthur Kleinman and his colleagues recognise this study’s contribution to founding the study of culture and pain expression, in itself no mean feat.

More recently, aspects of Zborowski’s much-criticised study have been endorsed by researchers in England (McAllister & Farquhar 1992), who also found that people of different cultures adopted differing attitudes to their health problems. Asian women (n=23) were compared with ‘white indigenous’ women (n=14) regarding their perceptions of health/illness causation. The relevant differences, attributed to culture, were that Asian women were less concerned about the causes of illness, and this was associated with greater confidence in medical and other health advisors. The Asian women attributed their health problems to psychological factors, such as stress, and to the UK climate. The white indigenous women, however, were more likely to blame lifestyle, including smoking and employment. These attributions reflect a weakness in this study recognised by the researchers; this is the way that the white indigenous women’s views related to health promotion material to which they were exposed, and which could not be read by many of the Asian women. Despite this, the cultural differences in attitudes to health, identified by Zborowski (1952), appear to be endorsed.

A contrary rationale for cultural differences in pain behaviour depends less on the individual and what they have learned from family than on their experience (Craig & Wyckoff 1987). These writers argue that the person in pain decides consciously whether to articulate their distress and seek help. This decision is based on their estimation, using previous experience, of what best advances their own interests. This interpretation of pain behaviour is reminiscent of the learning-free, forward-looking expectancy theory (Lewin 1935) in which the individual scrutinises all aspects of the situation, including cultural, to calculate how to achieve their most desired outcome. Thus, a decision emerges about whether the pain is made public or kept private. Regardless of the decision, the sufferer conforms to culturally determined rules governing emotional displays, rather than allowing any reflex pain behaviour. Having suggested an alternative to the solely cultural interpretation of variations in pain behaviour, these researchers focus on the dangers of cultural stereotyping in pain assessment. While Zborowski identified major differences in attitudes to health and pain behaviour between cultural groups, he also noted differences within those groups. These inter- and intra-group variations are of a similar magnitude, but the reader is warned that stereotyping reduces their significance and renders care and treatment less relevant to the individual. A phenomenon which may aggravate stereotyping is the preparedness of a minority group to withhold information from the dominant group for fear of being labelled as ‘weak’, ‘mad’ or just ‘different’. These researchers maintained that this applies in therapeutic as well as research settings.

The carer and his or her perception of the client’s pain

As mentioned already (see ‘The Meaning of culture’), concern about the potential for conflict between staff and patients served as the spur to the original, though flawed, study of pain expression (Zborowski 1952). That the attitudes of staff continue to arouse anxiety is demonstrated by continuing research in this area. This anxiety began with research by Lois Davitz and her colleagues (1976), which examined the association between nurses’ cultural backgrounds and their beliefs about patients’ pain. This study found that Korean
and Japanese nurses assessed the physical pain and the psychological distress as equally high. The American nurses were similarly consistently low in their estimation of both forms of suffering. The Puerto Rican nurses, however, linked low levels of physical pain with high levels of psychological distress. In spite of these discrepancies, all the nurses agreed on their estimation of children’s psychological distress as being less than adults. Similarly, they agreed that female patients experienced more pain than males, which may be associated with the totally female sample of nurses.

This research (Davitz et al. 1976) focused on the culture as determined by nurses’ geographical origins. As mentioned already, culture has been shown to include a number of facets, which were neglected by these researchers. Particularly disturbing is their non-recognition of an occupational culture. Reassuringly, such recognition is now demonstrated by North American writers warning of the dangers of ethno-centrism or beliefs of the superiority of one’s own ethnic group (Davidhizar & Giger 2004). The spectre of stereotyping clients to predict pain behaviour emerges. Thus, we are alerted to the likelihood that ‘personal biases can influence reactions’ (2004: 53).

An example of such culturally unacceptable behaviour was identified in a childbearing situation (Bowler 1993). Referring to the phenomenon as ‘making a fuss about nothing’, Isobel Bowler found that midwives, who were invariably Northern European in origin, thought that Asian women made ‘too much noise’ and constantly grumbled about minor symptoms. The continuing existence of such stereotyping is confirmed by Michelle van Ryn and StevenFu (2003).

Although the cultural background of caring staff in terms of their geographical and ethnic origin has been studied, the staff culture \textit{per se} has not attracted as much research attention as it deserves (Green 1993). This contrasts with the culture of the work group, in general, which has been studied assiduously in more manual occupations (Argyle & Colman 1995). One notable exception to this lack of research is found in the ethnographic study of a labour ward (Hunt & Symonds 1996). These researchers reflect on how the culture of hospitals has moved on from the deprivation of the Victorian era, and has been superseded by an open, public and idealised, yet sanitised, atmosphere.

Another, serendipitous, observation of the impact of culture arose out of an evaluation of a Danish Alternative Birth Centre (ABC). Because of the small size of the ABC and its popularity, a number of women had to be refused admission and gave birth in the ‘obstetrical ward’ (Skibsted & Lange 1992: 185). The ABC-refused women matched the women who gave birth in the ABC in their socio-demographic characteristics, but their behaviour in labour and interventions matched the ‘obstetrical ward’ group. The authors appropriately conclude that the staff and environment influenced the ABC-refused women to conform to the obstetrical practice. Thus, the culture of the obstetrical ward staff and the environment in which they practised was demonstrated to have overcome the aspirations and education of the ABC-refused women.

\textit{The carer’s care}

The role of the person providing care has been shown to be pivotal in addressing the problem of the client’s pain. Whether carers accept and function optimally in this role, though, is quite a different matter. Writing about nurses in a postoperative setting, Alfhild
Dihle and her colleagues (2006) recognise that their ‘unique opportunity’ to treat pain effectively may be missed. The attitudes mentioned already contribute to the effectiveness of pain control, but these are aggravated by factors such as inadequate knowledge, incomplete assessment and adherence to a medical model of care (Walker et al. 1995).

The nurses interviewed and observed by Dihle and her colleagues were clearly knowledgeable about the principles of caring for a patient in pain; they were able to explain the appropriate procedures and how scrupulously they followed them. During the observation phase, however, these researchers identified a ‘discrepancy’ (2006: 475) between the nurses’ perceptions of how pain was managed and the reality of the nurses’ performance in practice. On the basis of this discrepancy, Dihle and colleagues argue that it constitutes a barrier to effective pain control. Thus, as well as the two factors mentioned above, ‘the usual traditions or habits’ are more likely than adequacy of knowledge or completeness of assessment to determine the effectiveness of pain management. It is clear that research into pain assessment and the education of carers are of limited value when compared to the culture of the clinical environment.

Culture and childbearing

Having considered the cultural significance of pain to the person experiencing it and to the staff, and before focusing on the cultural implications of pain in childbearing, we examine the cultural importance of childbearing itself. I suggest that the cultural aspects of childbirth have become significant for two reasons. The first relates to the intrinsic importance of birth to all human societies, which may be summarised as the anthropological argument. The second reason relates to a phenomenon currently emerging in the UK, if not in other societies; this is the political connotations of health in general, and childbearing in particular, among ethnic minority groups. These issues are becoming widely recognised and may be linked with accusations of racism.

Anthropology

Preceding her ethnographic study of birth in four cultures, Brigitte Jordan (1978) discussed culture’s contribution to the experience of childbirth. She, first, differentiated the almost inextricable pathophysiological and social components of childbirth. The differing practices and customs surrounding childbirth support her argument that it is the critical nature of childbirth, represented by perceived risks of trauma or death, which lends this event its significance. Thus, unchallengeable packages of childbirth practices become culturally established. The cultural mores which evolve control a diversity of childbirth practices, such as who may be present (Jordan 1978) or what the woman eats or drinks (Cheung 1996).

Jordan also focused on how knowledge of others’ childbirth practices may change or even improve practices prevalent in the West. She argued that experimentation with changing practices, such as medication or birth position, may expose the researcher/practitioner to accusations of unethical practice and perhaps to litigation. She suggested that understanding other cultures’ practices may facilitate the ‘unavoidable change of contemporary ways of doing birth’ (1978: 4).
Emphasising the significance of childbirth, Jordan regretted the absence of suitable data. She blamed this deficiency on the low status and female-oriented nature of birth. Perhaps as more female researchers become involved in this area, easier access and more data will emerge. Currently available data are of poor quality, she maintained, due to researchers’ tendency to assume a medical orientation.

**Politics of culture**

Analysing maternity care provision for ‘black’ women, Anne Phoenix (1990) reminded us that the majority of UK maternity carers are white. Hence, discriminatory attitudes develop and become institutionalised (Ahmad 1993). Such discrimination has been shown to focus on those perceived to be less suitable to bear children, such as the unmarried, the very young and those with children already. Phoenix argues that black women have been stereotyped, particularly as belonging to the latter category, resulting, she argues, in discrimination in the form of institutionalised policies. One example (Phoenix 1990) is the automatic categorisation of black women as ‘at risk’ on the grounds that certain groups have higher perinatal mortality rates (Ahmad 1993). Such categorisation inevitably affects the woman’s care as Asian women’s categorisation is thought to be due to their reluctance to accept care which they consider culturally inappropriate (Parsons et al. 1993). Further examples of institutionalised discriminatory policies include the non-recognition of the need for interpreters, resulting in the husband or son translating the woman’s intimate health history. Another example is staff’s difficulty with non-British names, resulting in confusion and danger (Parsons et al. 1993).

The political nature of culture manifests itself most disconcertingly clearly in the maternal death statistics (Lewis & Macfarlane 2007). Despite being suitably cautious about their data, these authors conclude that for black African women, and marginally less in black Caribbean and Middle Eastern women, the maternal mortality rate is significantly higher than that for white women. Thus, for the former groups of women her culture, in the form of her social situation, is more likely to impact on her survival than her long term health.

**Pain, culture and childbearing**

Having related culture to both pain and childbearing, I now integrate these strands by focusing on cultural aspects of pain in childbearing, about which there is little research (Vangen et al. 1996). This neglect is largely due to Western clinicians, whose childbearing practices are regarded as a ‘gold standard’ by other ‘less advanced’ societies (Jordan 1978: 35). Thus, childbearing has become medically dominated and the woman has become a patient. Jordan further identified that the medical attitude to disease, as another problem to be resolved by intervention, has been applied to pain. The relevance of such an approach is uncertain and was seriously questioned by Jordan.

To support her argument, Jordan compared childbearing women in the USA, Holland, Sweden and Yucatan. Because the American woman must convince her carers that she needs medication to control her pain, she must display her need, leading to high levels of ‘noise and hysteria in American obstetric wards’. Mayan women in Yucatan, though,
accept that pain is part of the childbirth experience. The woman prepares herself for pain, which is regarded as usual, healthy and finite. Jordan found similar attitudes in Holland; Dutch women, she stated, accept childbirth pain and believe that nature will take its course. Hence, analgesia is ‘neither expected or required’ (Tasharrofi 1993). Van Teijlingen (1994) linked British women’s attitudes to pain in labour to their adherence to a medical model of health, reminiscent of the American woman’s (Jordan 1978). To explore this comparison, Senden and colleagues (1988) compared the expectations and experiences of labour pain in women in Iowa (USA) and Nijmegen (Holland). In a sample of 256 women, a large majority of Dutch women (79.2%) did not use analgesia; this applied to only 37.6% of American women. The proportion in each group showing satisfaction with their pain control and the fulfilment of their expectations showed no significant difference. These authors, like Jordan (1978), attributed their findings to the confidence of Dutch women in the successful functioning of their bodies.

In contrast to the observations by Jordan, Bonica (1990a, 1994) reported his unpublished observational data of ‘eight thousand women in the USA and almost three thousand in other countries’. On the basis of these somewhat questionable data he refuted the contention that the expression of pain varies between women in different cultures. The method of collecting these data is not described, so the rigour of Bonica’s approach is uncertain, as is the significance of his findings.

In the same way as other researchers have demonstrated the dynamic nature of culture in terms of the response to pain, Sheila Hunt and Anthea Symonds (1995) recount the changing cultural attitudes to childbirth pain in the UK. In the course of their study of the culture of a labour ward these researchers identified how, in the mid 1930s, the status of birth as ‘natural’ was rejected; simultaneously the pain of birth became less acceptable to women. Thus, attitudes that still prevail in Holland and Yucatan virtually disappeared in the UK. Such attitudes to pain and its control reflect a more longstanding movement towards the acceptance of the medical view of childbearing (Edwards 2005).

The attitude of women in India appears to have much in common with those in Holland and Yucatan (Jeffery 1989), in that the absence of pain control is not problematic but irrelevant. Jeffery’s ethnographic study found that ‘intense’ pain is regarded as beneficial, through the all-too-obvious connection with speedier birth. The articulation of pain is also culturally controlled, through excessive vocalisation being linked with ‘shamelessness’; thus, women are encouraged to ‘accept the pains, calling on God’s name’.

Examining pain behaviour, Schott and Henley (1996) discuss the extent to which racial stereotypes may cease to apply, due to the intensity of childbearing pain or local influences. They comment on the UK tendency to value quiet, elevated to institutional policy (Chapter 12) but which reduces the possibility of a woman using sound as a coping mechanism.

More recent research endorses Jeffery’s observation. In a study of 137 labouring women, significant differences appeared in analgesia use between Pakistani-born (Punjabi) and Norwegian-born women (Vangen et al. 1996). Of the 67 Pakistani women, 30% received no analgesia, compared with only 9% of the 70 Norwegian women. There is no suggestion that the Pakistani women’s labours were any less painful. The researchers emphasised the communication difficulty between the Norwegian midwives and the Pakistani women, a large majority (82%) of whom spoke little or no Norwegian.
Socio-economic backgrounds also differed markedly. The Pakistani women tended to receive analgesia, if any, which required minimal communication or instruction, such as intramuscular pethidine rather than nitrous oxide and oxygen or epidural analgesia. These findings are supported by a recent study in Germany (David et al. 2006) which suggests that Western stereotypes of Asian women may not be accurate; however these researchers do not show whether language or culture, or a combination, are responsible for the differing analgesia use.

Despite the shortage of research-based material on this topic, that which exists shows the considerable variation in and implications of the expression of childbirth pain between and within cultural groups over time.

**Meanings**

Throughout this chapter, the importance of the meaning of pain has become clear. I make no apology for this because of the impossibility of dissociating any pain from what that experience means (Morris 1991: 34). In this chapter the meaning of pain has emerged in the grisly initiation rituals, the celebrant’s interpretation of which constrained his perception and expression of pain. Zborowski (1952) suggested that certain ethnic groups were more concerned with the meaning and implications of the pain than its treatment; however, for others the immediate experience was the major concern. Ascribing a meaning to pain constitutes both a legitimation (Bendelow & Williams 1998) and a coping mechanism, which may apply no less to childbearing pain than to the other acute and more long term forms.

In 2000, I sought to unravel the complexity of labour pain and drew conclusions about the fundamental significance of the meaning which the woman attaches to her pain. This significance included the inevitable negativity with which labour pain is all-too-frequently associated. As Drew Leder observed, pain’s meaning may be the very incarnation of ‘the unhappy, the bad, the wrong’ (1986: 259). This short term negativity may be linked with the longstanding and medically-fostered association between pain, pathological processes and death, which have been linked with punishment, atonement and redemption (Caton 1985; Morris 1991: 36).

Understanding the meaning of labour pain may bring the realisation of physical and emotional achievement, which Lynn Callister and her colleagues termed ‘self-actualising’ (2003: 147). Perhaps disconcertingly, though, as well as providing meaning, pain carries the potential to obliterate the meaning of phenomena which help us to make sense of our lives (Leder 1986).

Since 2000, a phenomenological study in New Zealand has demonstrated the dynamic nature of the meaning of labour pain and the role of the midwife in facilitating the woman’s understanding of the meaning (Vague 2003). This research clearly shows how the woman’s interpretation of the meaning of pain and the midwife’s response to her interpretation develops as the woman moves forward in her labour.

These dynamic developments include not only changes in the woman’s perception of the meaning of her pain, but also changes in her self-perception. The woman’s ability to comprehend the pain of birth and her adjustment, is transformatory in that it brings with it confidence in her ability to mother the new arrival (Mander 2010).
Leap’s midwifery model

Because of pain’s complexity, it is unsurprising that most models (see ‘Pain theory’ above) have over-simplified the pain experience. This observation applies most particularly to childbearing pain. Nicky Leap drew on midwifery expertise to introduce a refreshingly different model of pain. Her qualitative study involved interviews with midwives experienced in attending home births (Leap 1996), on the basis of which Leap proposed the existence of two pain paradigms. Differing fundamentally from previous models, these two approaches were entitled ‘pain relief’ and ‘working with pain’ (Leap 1997, 1998, 2000; Leap & Anderson 2004).

While seeking strenuously not to equate pain relief with the medical model, Leap’s efforts are less than convincing. Pain relief involves early well-meaning offers to the woman of a menu of pain control methods; possibly during childbirth education or else in early labour. Although not intended to, these offers persuade the woman of her likely need for these interventions (Evans 2006). Thus, a self-fulfilling prophecy materialises.

One factor, causatively associated with pain relief, is a staff culture of difficulty in coping with a woman who is clearly articulating her pain:

Some midwives give pethidine because they don’t like the fuss and noise and the agitation and the fact that the woman won’t settle down. I think that sometimes the midwife isn’t coping with the pain either. They think that the woman isn’t and actually they’re not.

Midwife in Leap 1996: 48, her emphasis

Difficulty in coping is aggravated by a low tolerance for noise in labour areas. The result, which some of us have encountered, is the midwife being reprimanded by her colleagues for noises emanating from the birthing room.

Thus, the ‘pain relief menu’ originates as well-meaning, to the point of humanitarianism, but it insidiously carries subliminal messages. This approach becomes increasingly directive; to the extent of persuasion being exerted to encourage the woman’s acceptance of hi-tech pain control. Such persuasion is exerted by staff who had been sympathetic to the woman’s aims and ideals. Thus, the woman is in a ‘double whammy’: let down by her assumed supporters and vulnerable to any persuasion being applied.

The midwives distinguished pain relief from working with pain (Leap 1996: 50). This concept emerged from the midwives’ acceptance that some pain is fundamental to physiological labour. Accepting this reality meant that the midwives were able to acknowledge the woman’s pain and its articulation without assuming pathology or needing to remedy it. The ‘abnormal’ pain of a complicated labour was clearly differentiated from ‘normal’ pain.

Working with pain was tied into the midwives’ philosophy of confidence in the woman being able to birth physiologically. They deplored any diminution of the woman’s confidence in her body and close companions and sought to re-establish that confidence:

If you can build up confidence in women that they can definitely get on and do this, then I think they will. (Midwife Leap 1996: 65)

Unsurprisingly, Leap’s work has contributed significantly to the UK campaign to reinstate the culture of normality of childbirth (Downe 2004).

Thus, through this ground-breaking research, the importance of culture in pain and its control is, yet again, emphasised.