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BIRTH VISIONARIES: AN EXAMINATION OF UNASSISTED CHILDBIRTH

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by

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Birth Visionaries: An Examination of Unassisted Childbirth

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This exploratory study inquires into unassisted childbirth, the act of giving birth without the presence of any birth professional (doctor, midwife or doula). Unassisted birth is on the radical fringe of alternatives to the dominant techno-medical birth common in American hospitals today. My research questions are what are women's motivations for choosing unassisted childbirth and what is the lived experience of unassisted childbirth? I will answer these questions through nine in-depth interviews and a grounded theory data analysis. My approach comes from a focus on the everyday lived experience of women as problematic as well as insights from anthropology of birth and feminist postmodern sociology of knowledge. This study is relevant to public health policy on pregnancy and birth, to those working on questions of technology and culture, and to those concerned with how biosocial rituals shape embodied experience. My findings also contribute to research about power in contemporary society, specifically how the body can be a site for social control and resistance.

Introduction

“I said something to her like ‘come on out baby it’s okay’ or something like that, and it was like I was just connected to her, I wasn’t having to worry about anybody else, you know we had the lights dimmed, and it was just us, it was the most beautiful, beautiful experience of my life, and everything was calm and it was the way it should have been. We welcomed her into our family in the most peaceful and beautiful environment that we could have. And everything just happened, you know your body knows what to do, and not having to divide your attention between what your body is supposed to be doing and other people who are there, I was able to really see where that labor and delivery process took us, and that was just a beautiful experience”.- Kara’s description of the unassisted birth of her daughter Avery

This quote paints a different picture of birth than our common cultural vision of a woman lying in a hospital bed screaming in fear and pain, cursing at her husband and praying for the doctor to get the baby out. Kara was one of the nine women I interviewed who made the choice to have unassisted childbirth. Unassisted childbirth is planned childbirth without the presence of a birth professional such as a midwife, doctor, or doula. In America today 99% of women give birth in a hospital, of the 1% who do not, some give birth in a freestanding birth center, some at home with a midwife, and some at home unassisted (Block, 2007: xx). Previous research has shown that there is a demand for alternatives to the dominant medical model of childbirth. The natural birth movement that developed out of the 1960s has grown to be even more important as the American way of doing birth has grown increasingly technical and medical. Recent statistics, such as the fact that 30.2% of American women give birth by cesarean section, are raising questions about the safety and effectiveness of our normative way of doing birth (Block, 2007: xx). There are a number public health experts, social scientists, doctors, midwives, doulas, childbirth advocates and mothers who remain highly critical of the technological medical model of birth today; however, these critics remain a minority. The medical

model of childbirth has been made to seem like the natural order of things through social hegemony and institutionalized into medical policy and the law, creating a culture of birth where women have few choices outside of the medicalized hospital model.

Women who birth unassisted are as far from the common medical model that you could get, they represent the extreme rejection of the normative way of giving birth in America. Researchers from the field of anthropology of birth argue that birth is a cultural event shaped largely by social norms. These works importantly investigate how American culture shapes the way women experience pregnancy and birth and what our birth ways reflect about underlying cultural beliefs. While some work has focused on women who reject the medical model and birth with midwives, no empirical study has been done on women who choose to birth unassisted.

The purpose of this project is to research why women chose unassisted birth and what is the lived experience of unassisted birth? Through the lens of these women's experiences, the hegemonic way of doing birth in America is made problematic. What lies beneath it is a complex web of epistemological assumptions of the dominant culture in the Northwest. For thinkers who are committed to the social construction of reality, there is growing movement to move beyond the work of deconstructing the constructions and begin creating new ways of being that challenge oppressive hegemonic norms (S. Pfohl 2008, B. Hooks 1992). Women who have unassisted childbirth are doing exactly that. These women's experiences subvert many of our "taken-for-granted" notions of the female body, nature, medicine, technology, and of the dominant structure of our ways of being, believing, and knowing. This exploration of UC pushes the limits of what is

possible and impossible in birth (*and life*). The stories of my interviewees provide not only critical deconstruction of birth hegemony, but they serve to open conceptual space for discourses of marginalized knowledge. In directly challenging what they have experienced as an oppressive culture of birth, these women's subversive and empowered subjectivities as UC mothers also provide us with a way to understand modern operations of power and resistance.

Theoretical Literature

In the last couple of decades there has been an increase of interdisciplinary interest in women and the body. Michel Foucault contributed extensively to this work with his theories of modern power and the body. Foucault's argued that social order is maintained in the institutions of contemporary society not through corporeal punishment, but through the constant possibility of surveillance. This kind of control is internalized and functions to constantly discipline behavior as people seek to conform to the normative order to avoid social repercussions (1977). The normative order is exercised through epistemes and discourses found in what counts as knowledge. The embodiment of these epistemes set the limits of reality expressed in subjectivity, the way a person relates to their inner self and in their physical embodiment. Foucault argued that this power largely operates through disciplining the body, a discipline that literally invades the body to control its functions and movements. The body was "entering a machinery of power that explores it, breaks it down and rearranges it." This machinery of power sought to produce "subjected and practiced bodies, 'docile' bodies"(1977: 138).

Foucault's conception of power operates not as a unidirectional force, but through social relations and the reproduction of norms, attitudes, and trends. Power is a span of relational forces that operate via "a multiplicity of discursive elements that can come into play in various strategies" to determine which aspects of knowledge and experience are validated as authoritative (Foucault 1977: 100). Power is then intimately connected to knowledge and played out in the discourse of daily life. The discursive and socially constructed nature of this power allows for the possibility of resistance. Resistance and freedom are made possible through the deconstruction of hegemonic epistemologies and the reconstruction of new liberated subjects.

While Foucault's theory of power has been useful to work on women and the body, Foucault is criticized for leaving out the specific disciplined embodiment of women. Feminist scholars argue that our society creates gendered bodies and that the particular powerlessness of women's embodied experience must be brought out of the silence. Dorothy Smith's heritage of women's everyday lived experience as problematic brings listening to women's voices to the center (1987). Feminist scholarship links women's embodied experiences with practices of power, particularly noting the importance of the body as a source of control (Bordo, 1993, Daly, 1990, Hesse-Biber, 2007, Harding, 1991). Studies have focused on a wide range of women's experiences with the body spanning topics such as body image, sexuality, menstruation, aging, pregnancy and birth. Feminists have called for social theory of the body that looks at how women experience their body with an eye on gender and power, paying attention to how

institutions and discourse shape embodied experiences. The female body is investigated not only as a passive object of domination and control, but as an agentic site of resistance.

The medical institution and its discourse has been a long-standing focus for examining how power functions through women's experiences of the body. The medical establishment as a whole is criticized for its 'clinical gaze' which gives doctors the power to define what is natural and healthy, acting as a major form of social control (Foucault, 1973). Jackie Orr adds to this argument that the current medical establishment has created a hegemonic "corporate-techno-medical" discourse (1993). This phrase not only indicates the technocratic aspect of modern medicine, but also its capitalist business interests. The medical gaze is criticized by feminist scholars as being sexist because it considers the female body itself to be problematic (Grosz, 1994, Brennan, 1993).

Scholars have argued that the body serves as a metaphor for Cartesian dualism; a dominant epistemology that associates the female body with unruly nature, emotion, irrationality, sensuality, and loss of control while the male mind is considered masterful, rational, and in control (Bordo, 1993, Grosz, 1994). This view of the female body is interwoven with an increased mechanical view, which poses the body as something to be managed, repaired, and technologically improved upon (Davis-Floyd, 1994). Feminist and postmodern theorists have investigated how the expansion of a male controlled technologically dominated medical system gets into the flesh and shapes women's realities (Brennan, 1993, Orr, 1993, Grosz, 1994). In their examinations of how the body interacts with Northwestern hegemonic knowledge, they argue for the need to overcome the ideology of Cartesian dualism. Instead of its rigid control-seeking framework that

objectifies the world, they call for an epistemology that acknowledges our inability to control the world, honors partial chaotic knowledge, and knowledges that allow for embodied, spiritual, sensual, psychic, and emotional connections (Brennan 1993, Haraway, 1991, Pfohl, 2008).

This vast collection of work focused on both the lived experiences of women and the theoretical examinations of how epistemology interacts with the body have highlighted the gendered politics of women's bodies and brought forward a movement to reclaim women's knowledge and control over their bodies. Childbirth is a prime location for scholars to examine the social and political forces shaping women's embodied experiences and to better understand modern forces of power and resistance. Unassisted childbirth is an example of extreme resistance to the dominant norm of medicalized childbirth today and provides a unique lens through which to see women's lived struggles with hegemony for self-determination and empowerment.

A Brief History of Birth in America

A brief history of birth in America gives the necessary context for understanding the motivations for and the lived experience of unassisted childbirth and the social political implications of this phenomenon. Before hospital birth became the norm in the U.S., most women gave birth at home attended by midwives. Physicians entered the birth arena by the mid 1800s, and by the turn of the century obstetricians had organized a campaign to eliminate midwives from competition of the birth market. They succeeded in gaining legitimacy only for doctors who were licensed by accredited schools (that women and blacks were not admitted to) (Jordon, 1997: 75). There was also a shift towards

medical control of birth, as “delicate” ladies of the upper class feared natural biological process of birth and sought ways to eliminate what they saw as its unpleasant aspects. The introduction of scopolamine in Germany in the 1930s was seen as a modern answer to the problem of birth. Scopolamine was generally understood as a drug that put women to sleep for the entire birth, often referred to as the “twilight sleep” drug. Upper class American women and physicians actively sought this drug, and by 1940s scopolamine was considered the “modern” way to birth. Scopolamine did not actually render women unconscious, it just made her lose her memory, and it led to terrible abuse of birthing women. By the early 1950s horrific tales of abuse of doctors and nurses filled popular women’s magazines and fueled a movement that challenged the medical model of birth. The Lamaze movement, which encouraged women to be awake and aware, emerged as an effort to end abuses of twilight sleep era, and by the late 1960s “natural childbirth” of Grantly Dick-Read and Lamaze challenged dominance of total medical control. 1970s and 1980s rhetoric of “natural” or “prepared” childbirth became the new “modern” way to give birth (Davis-Floyd and Sargent, 1997: 9-11). The most influential books in the early natural birth movement, such as Grantly Dick Read’s *Childbirth Without Fear* (1959), Ina May Gaskin’s *Spiritual Midwifery* (1975) and Susanne Arms *Immaculate Deception* (1975) argue that the medical model creates an atmosphere which makes birth more difficult, painful, and stressful for the mother and child.

The women’s movement has also long been concerned about the politics of childbirth. As part of the movement’s initiative to make the personal political, pregnancy and childbirth were hot topics in second wave consciousness raising and activism.

Feminists rejected misogynistic medical practices and organized women run clinics and women's health book collectives such as *Our Bodies, Ourselves* (1973), they sent a bill to congress: HR 1504 to make hospitals allow the father to be present at birth (1973), and they created international breastfeeding education campaigns like La Leche League (1958)(Baxandall and Gordon, 2000). In this feminist activism, women largely framed the question of birth as an issue of empowerment. Cheryl Lindsey Seelhoff writes in *off our backs*, that advocacy for alternative birth and women's health in general is about the control over social and cultural contexts of childbirth; their concern is "the male supremacist monopoly over material resources and its power to name and define, to establish and enforce male ideas about pregnancy and childbirth"(Vol 36, No. 1). From a feminist power perspective, not only does patriarchal hegemony shape ideas about birth, but the material realities of standard hospital birth make the doctor the active subject in control and turn the mother into a passive object.

During this same historical period the anthropology of birth was born. Brigitte Jordan's groundbreaking work in 1978 *Birth in Four Cultures* led the field of anthropology to focus on childbirth as a subject worthy of in-depth ethnographic fieldwork. This work and other early work in this field led anthropologists to understand birth as never simply a biological act, as Jordan writes "birth is everywhere socially marked and shaped" (1993: 1). Jordan's later work on court ordered cesareans introduced the concept of authoritative knowledge in childbirth (1997). Jordan's central observation was that "for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of

the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both” (Jordon 1997: 56).

Following in Jordon’s path, there was an increase of research that focused on cross-cultural differences in birth as well as studies that primarily focused their critical gaze on the American way of doing birth. While these studies ranged largely in their specific foci, Davis Floyd and Sargent comment that “Such researchers unanimously agree on the narrow and intensely ethnocentric bias in Western, and especially American technomedicine- a system of health care that objectifies the patient, mechanizes the body, and exalts practitioner over patient in a status hierarchy that attributes authoritative knowledge only to those who know how to manipulate the technology and decode the information it provides” (1997:8).

While these early movements in and outside academia led to increases in the choices women had in childbirth, the techno-medical model remains dominant. Robbie Davis-Floyd, a leading expert in the anthropology of birth, examines this notion of technocratic hegemony in American childbirth in *The Technocratic body: American Childbirth as Cultural Expression* (1994). She claims that the hegemonic “technocratic model” or the medical model of birth is a highly technologically and medically managed process that renders female anatomical features and birth as inherently subject to malfunction (Davis-Floyd, 1994: 1127). The female body is viewed as unpredictable and abnormal; birth is understood to be better when the defective birthing machine [mother’s body] is hooked up to other more perfect diagnostic machines (Davis-Floyd and Davis, 1997: 316). Davis-Floyd and Davis argue that the ritualization of technocratic birth

reflects the cultural supervaluation of machines over nature and functions to deconstruct birth into controllable segments, restructuring it as a mechanistic process itself (1997: 316). “Technology assisted reproduction and technobirth...have become formally encoded as the “standards of practice” regarded as authoritative in courts of law” (Davis-Floyd and Davis, 1997: 319).

Jennifer Block’s recent investigative journalism into modern maternity care echo Davis-Floyd’s findings, Block’s book *Pushed* was motivated by what she found to be a troubling statistic, that today one third of births in the US are cesarean sections, compared to only 15% in 1975 (Block 2007: 49, xxv). Block discovered that “the climate, both legal and economic, encourages inductions, cesareans, and drive-through office visits” (2007: 65). In addition to high cesarean rates, Block and other critics of the techno-medical model of birth argue that it is unnecessarily intrusive in a number of ways. These critics argue that common ritualized birth practices are not only unnecessary, but often times harmful. Standard practices today include: antenatal clinic visits, ultrasounds, depilation/shaving, purging/enema, artificial rupture of membranes/ induction by drugs, electronic fetal monitoring, restricted movements of mother/supine position, IV, augmentation drugs (speed up/slow down labor), epidurals and other pain reducing drugs, isolation and exposure of genitals, episiotomy, clock watching, instrument delivery, early clamping of chord, insistence of immediate detachment of placenta, and separation of mother and child after birth (Block, 2007; Kitzinger, 2005; Davis-Floyd and Sargent, 1997; Shanley, 1994; Arms, 1975; Rothman, 1982, Dick-Read, 1959).

Today's natural childbirth movement, stemming from these natural birth, anthropology of birth and feminist roots, is largely centered on advocating for midwifery. There has been a renaissance of midwifery in the last two decades, with midwives being strong advocates of natural birth and offering a practice that attempts to empower women in birth (Midwives Alliance of North America). Contemporary advocates of alternative birth in general disagree on the merits and risks of planned unassisted births. As Block writes, the issue is "extremely divisive for midwives"; some understand it as a plausible alternative, while some harshly criticize it as irresponsible (2007:113-114). While there is currently no data on the frequency of unassisted birth, practitioners and advocates have written a few books on the topic, and there are a number of active websites and chat groups dedicated to the topic. The most public figure and advocate for unassisted childbirth is Laura Shanley, author of *Unassisted Childbirth* (1994). Shanley, a mother of 4 children born by UC, understands it as the best option for women who have faith in themselves and believe that consciousness is power; she explains in the opening pages of her book "In 1976, my husband David and I became aware of the concept that we create our own reality according to our desires, beliefs, and intentions"(1994: xv). Shanley believes that childbirth is an "emotional/spiritual/sexual act" and that "When a woman is physically and psychologically healthy (free from fear, shame, and guilt), babies can often be born easily"(www.unassistedchildbirth.com). Shanley maintains an active website for UC and has been a guest on television and radio shows as well as the subject of printed articles.

The many UC stories and videos on Laura Shanley's website depict a completely different reality of birth than the dominant story. These women are actually *enjoying* birth as a sexual, sensual, spiritual, and connective social process. While some dismiss Shanley's faith in consciousness as "new-age", she is importantly acknowledging the socially constructed nature of reality (albeit she believes she can totally control her social reality). Furthermore, she is suggesting that our socially constructed realities are capable of shaping our lived embodied experience. These ideas are not only connected to findings in the anthropology of birth field, but also to feminist postmodern epistemologies that reject the enlightenment ideas of objective rational truth, and emphasize the social, partial, historical, embodied nature of reality (Clough, 1994; Harraway, 1991; Orr, 1993; Grosz, 1994; Pfohl, 2008; Gordon, 1997; Brennan; 1993).

In the introduction of Davis-Floyd and Sargent's *Childbirth and Authoritative Knowledge*, a collection of works on the anthropology of birth, they call for more ethnographic research on the experience of childbirth, particularly on women's conflicts with authoritative knowledge (1997). They ask what can women's bodies tell us about childbirth and how can we learn to listen? It is in this vein that I embarked on this project, from these women's lived experiences of unassisted birth I hoped to learn about the biosocial process of hegemonic American medical birth and more importantly- resistance to it.

Methods

Sample

UC moms are hard to find population, because they are a small percentage of the general population I could not rely on a representative cross section of society to find my interviewees. Instead I found my interviewees through a mixed methods sampling procedure that began with purposive sampling and then transitioned to a demographics survey to maximize the diversity of my final sample. Because unassisted birthers interact with no institution that keeps records and do not organize in any specific group or manner, I felt that the internet was my best venue to find interviewees. Laura Shanley, the most public figure and advocate for UC, agreed to place my call for interviewees in her weekly email that she sends out to an interested list of recipients. I also got access to a couple of private UC chat rooms, by explaining my research intents to their monitors, and posted my call for interviewees there. There were a few other public websites that had special pages for UC moms where I was able to post my call for interviewees. A yahoo search also uncovered a number of women who wrote articles on associatedcontent.com about unassisted birth, I did a follow up search for unassisted birth there that resulted in 9 members who had written about UC; I sent my call for interviewees to all of these members individually. See Appendix for my call for interviewees and a list of internet locations where it was placed.

I did not expect a large number of women to respond, so I was quick to set up an interview with the first two people who contacted me. Shortly after I realized my mailbox was flooding with responses and I decided to wait until the emails stopped coming to schedule any more interviews. After three weeks of having my notices posted another 40 women contacted me. I sent a small demographics survey to all respondents so I could

maximize the diversity of my final selection of interviewees. See survey questions in Appendix. The survey included basic demographic information as well as a question about birth history because I wanted to interview women who had a variety of birth experiences (hospital, midwife assisted, and only unassisted). I wrote to each woman who contacted me personally, as many of them had written me little stories in their emails or shared personal information that I wanted to individually respond to, plus I felt it was a breach of confidentiality if I was to list all their emails in a mass email. More than anything I was motivated to spend the time to personally respond because I felt appreciative of the generous offer of their free time for my project. I also decided to send a small bio about myself with a couple of pictures to everyone who wrote me. This decision came from a few respondents who requested or suggested that I share more of myself before asking others, who are already socially vulnerable, to talk to me. See appendix for bio.

I received 28 complete returned surveys, of these I put aside any that were from women who were not from the United States, which left me with 26 surveys. Out of these 26 women 19 (73%) had birthed in a hospital prior to their UC, 9 (35%) had birthed at home with a midwife and 3 (12%) had only birthed UC. The majority of these women had some college education, they all had high school diplomas and some had graduate degrees. 22 (85%) were married to men, and 24 (86%) identified as white, 2 (7%) as Native American, 1 (4%) as Native Hawaiian, and 1 (4%) as Peruvian/Chinese/Cherokee/European. They lived in 16 different states, with a mix of rural, suburban and urban hometowns. Most considered themselves religious and

represented a large diversity of religions such as Christians, Unitarians, Orthodox Jews, Pagans, Mormons, and Catholics.

In order to select my next interviewees from this group, I organized the surveys into three categories: women with only UC birth experience, women who had also birthed out of the hospital with a midwife, and women who had also birthed in a hospital. The nine women I ended up interviewing had a broad range of childbirth experiences. Two of the women had only birthed unassisted. Six of the women had given birth in a hospital prior to choosing unassisted birth, and six had given birth with a midwife prior to choosing UC. Experiences with midwife-attended births included hospital, birth center, and home birth locations. The women were born as early as 1959 and as late as 1983. They lived in rural, suburban, and urban locations in states including: HI, NC, KY, CA, AZ, WI, MI and one woman was currently living in Germany but had lived most of her life in the US. Seven of the women were married to men, the other two were partnered with men. Seven of the women identified as white, one woman identified as white/Native American and one as Native Hawaiian. Four of the women had some college education, two had graduate degrees, one had not attended college, and two of the women's education status was unknown (this was because I did my first two interviews before I sent out the demographics survey and I did not ask about their educational background in the interviews). Two of the women identified as Pagans, one as a Messianic Jew, one as a Spiritualist, three as Christian, one as a Reform Mormon/Universalist/Gnostic Mormon Witch, and one as not religious. Three of the women were stay at home moms; others had a range of jobs such as graphic designers, midwives, and business owners.

Data Collection

I conducted nine in-depth interviews for this study. In-depth interviewing was the best method to answer my research questions that focused on the women's personal lived experiences of UC. All of the interviews were done over the phone because none of my interviewees lived in the New England area; one interview was done over skype video chat software that enabled me and the interviewee to see each other as we talked. The structure of the interviews was largely open ended, I wanted to hear their voices about choosing and experiencing UC. As opposed to entering the field with a deductive agenda, I let them set the agenda with their lived experiences. I started each interview by asking how they discovered and decided to have unassisted birth and would let the conversation flow from there. I did have an interview guide with sensitizing questions that I followed loosely as we transitioned from general descriptions to more intimate questions. See Appendix for sensitizing questions. Though I had a list of probes, my follow up questions came from their stories; if for instance there were certain things that surprised me or contradictions within a story, I would ask them to explain these issues more fully. This back and forth interview process enabled the women to shape the interviews around their own experience, but also allowed me to pose questions based on analytical categories that had emerged in prior interviews. I attempted to create interview encounters that felt like equals sharing a conversation as opposed to a hierarchical structure that set me as up an authoritative subject gathering data from my research objects. In addition to allowing the interviewees to talk to me in a more fluid and open format, I also attempted to ensure a

more egalitarian interview process by always sharing myself in the interactive process (DeVault and Gross, 2007:173-188). I began each interview with inviting the woman to ask me anything about myself or the project.

Data Analysis Procedure

I did a grounded theory analysis of my interviews, systematically analyzing each interview and successively developing categories of analysis (Charmaz, 2008). After each interview was fully transcribed I did line by line coding of actions, experiences, thoughts, and feelings. After these initial codings, I wrote memos about themes and processes that could be categories for future analysis. After I had transcribed, coded, and memoed my first three interviews, I reviewed the memos from each and wrote a collective memo that addressed themes that were present in all three, highlighting similarities and differences. I followed this same process for the next three interviews, and then I reviewed the collective memos from 1-3 and 4-6 and wrote again about categories of analysis that emerged from these interviews. This same process was done for the last three interviews culminating in final memos in which categories of analysis grew from a reflexive exchange of themes from early interviews through the last. The themes and analytical concepts that became my research findings and developed into my interpretations emerged directly from the interviews.

Research Findings

Motivations for Unassisted Childbirth- Rejection of the Medical Model

“You know, everybody’s really scared of it [birth in a hospital], it’s very frightening, very traumatizing, and when you think of hospital births you think of being out of control, being in pain, being frightened of dying like that”. -Amber

Each of the nine women had their own unique journey to unassisted childbirth, but one element of motivation that they all had in common was the rejection of the medical model of birth common in hospitals today. For most of the women their rejection of the medical model was based on their own negative lived experiences of hospital birth, which ranged from frustrating to traumatic. These early experiences with the medical model of birth pushed women away from the medical management of birth in search of alternatives. For the three women who had not given birth in a hospital prior to having an unassisted birth, their rejection of the medical model was based on either experiences with doctors during pregnancy and/or an already developed critical consciousness about the medical model of birth.

These women’s most central critique of a medically managed hospital birth is the mother’s lack of control. In the hospital environment, these women felt they did not have control over things they felt they should be able to control during the birth of their child, including choices such as what medical interventions will occur, who will be there (including what doctor will be there), what the woman is allowed to do (her physical mobility, rules about eating/drinking), and what will happen after the birth. Combined with the mother’s lack of control over the birth was a sense of disrespect these women felt from medical experts, embodied partially in their refusal to give women choices but also in their more general treatment of them as patients. Ronii, a UC mother and a direct entry midwife explains:

If women could be respected as intelligent beings capable of making choices and taking responsibility for them, they would probably choose to have some help, but there's no help available to them, that works for them, that treats them like human beings with a brain, capable of making their own decisions.

Even during pregnancy doctors were not willing to be flexible and allow these women to make choices regarding prenatal care, and during the actual birth women's demands were often ignored or outright rejected. Take for instance Amber's first experience with an obstetrician: "he required all testing of all his patients, no matter what it is. And I felt that was very stressful and not necessary. I told him that I didn't want certain things, and he told me basically that I didn't have a choice, and if I didn't consent to all these things he wanted me to do, that he wouldn't see me at all as a patient".

Many women learned early in their pregnancies that they would have few choices about the way they would give birth in the medical model because they were labeled "high risk". Being labeled "high risk" carries many procedural and legal restrictions. Doctors are more likely to require interventions for "high risk" mothers and midwives are often not legally allowed to work with "high risk" clients. For example, Karen was refused services at a natural birthing center because she had a cesarean for her first birth, which automatically put her in the "high risk" category. Ayla explained that her county hospital recently decided to not allow any vbacs (vaginal birth after cesarean section). Ronii was refused services by a midwife because she was carrying twins, which is "high risk". Rachel had multiple "high risk" markers for her last pregnancy: she was in her mid-forties, which would automatically make her "high risk" despite her great state of health, she had blood clotting in prior births and has a cervical condition that would qualify her

as “high risk”. Rachel may not have been afforded the opportunity to attempt a natural vaginal birth if she had gone through the normative medical model of obstetric care.

In addition to the lack of choices, women experienced disrespectful treatment from doctors and nurses. Take for example the following story told by Ronii:

I had a situation with my 4th baby, I had bleeding episode... I called the local OB to get an ultrasound because I was concerned I was miscarrying, and it took a long time to get in there, he insisted on a prenatal visit first... So I went in and had the ultrasound and they didn't see a problem at the time, and I ended up miscarrying. I ended up miscarrying what turned out to be a twin, and I was still carrying a live baby. I knew I had lost one. So we went in and had another ultrasound and checked and sure enough we had another baby in there, but, within the next several weeks I was still bleeding; and I didn't know for certain if I was still bleeding from the miscarriage site, or if I was going to lose the other baby. So we scheduled an appointment, but the appointment we got was weeks down the line, so I called him on the phone and I got his receptionist and I said, “You know I need to talk to the doctor because I need to know what he saw. He had done the ultrasound and he had also done an internal exam, and I wanted to know what the condition of my cervix was”. ...so of course the receptionist couldn't tell me that and he was busy...so a couple of hours later I got a phone call, but it was not the doctor it was one of LPNs from his practice, and I explained to her that I needed to talk to the doctor, cause I needed to talk to the person who had actually looked at my cervix, and she says “You are fine”, and I'm like “Well, I'm still bleeding!”...And I couldn't get her to understand that I want to talk to him, so we waited a couple weeks and I was still bleeding and we went in for the prenatal visit, and he marches in the office and says, “I hear that you're unhappy with me”, and I said “Its not that I'm unhappy with you, it's that I wanted to talk with you”, and he never even let me ask my question, he just said, “you know if you can't take the word of my staff, and they represent me, then we just don't need to be working together”- and he walked out. I mean he never answered my questions, he did not proceed with my visit that day, I was basically kicked out of the office, because I had the audacity to ask him a question. You know, that's just too darn much power, I mean it's ridiculous, you wouldn't let your plumber treat you that way. You know you hire somebody to perform a service for you, you expect them to do their job. And it's part of the doctor's job to answer your questions. I mean this doctor saw me naked, he had his hands inside my body, he looked at my cervix, but he wouldn't tell me what he saw, and when I needed to know that information. I mean, who wouldn't have a UC after that.

Although this had taken place years ago, Ronii's feelings of violation, disempowerment and anger came through clearly as she described the experience to me. Feelings of violation and mistrust were shared by Nani after the birth of her first child. Nani had planned on a natural hospital birth and had discussed her birth plans multiple times with her doctor and was reassured that she would have the freedom to move around, eat, and

have no unwanted medical interventions. When the time came, all of her requests were rejected. She explains her experience and feelings in the following quote:

Despite having stated very clearly in my birth plan that I didn't want any pain medication offered to me, that I knew it was available and I'd ask for it, the nurses all kind of gained up on me and talked me into getting a shot of a drug called nubain. And when I was writing up my birth story, I mentioned that and it was because the nurse had told me it wouldn't be transferred to my baby, and uh, my friend on-line...she was the one to say well that isn't true, and she pointed me to some literature on-line. And when I realized I had been lied to like that, that was really the turning point for me. You know, I trusted these people, to take good care of me, and they lied to me. And I just, the fact that they wouldn't respect my wishes and leave me alone about it, and that they cornered me and finally wore me down to the point of exhaustion, and to lie to me about it, it was just, betrayed was really, how I felt, betrayed by the people I had trusted to take care of me, and that was when I realized I needed to start taking care of myself.

Not all of the women who had medically managed pregnancies and births had experiences that were as traumatic as Ronii's or Nani's, but all of the women felt like they had to fight to get the kind of care they wanted, and even with a fight it was not always achieved. All of the women who had medical interventions in their hospital births felt they were unnecessary and negative experiences. Karen shared with me the following story about her first two births:

My first child was c-section after long labor, I was never seen by doctor until morning, I had cervical abrasion swelling that baby couldn't get passed, but no one knew it was there, I had been pushing against own body, I was told to push. The doctor said 'Oh, you've been pushing all night you should just have a c-section', and being young and naïve I had the c-section. And after that birth I was not happy with it, because I wanted to be awake for the birth, and I was crying when they put me under general anesthesia. When I went and sought out homebirth, I went and got my records and I saw that the c-section was performed with difficulty because the baby's head had begun to mold into the birth canal, so, um, yeah- that was just nasty, so I became an advocate for vbacs [vaginal birth after cesarean section] when I became pregnant with my second child, I was absolutely determined I was not going to have another cesarean. I went to the teaching hospital and found a doctor who was very supportive of me having a vbac, unfortunately I went into labor a month before my due date and my doctor was not there, his partner was there and he was very old fashion and very controlling. He gave me a full spinal and used forceps, and initially I was happy because I didn't have a cesarean, but when I reflected upon that experience I felt like they had taken advantage of me, you know my body was ready to have that baby- and just like having a c-section where the baby was pulled back through [the birth canal] I just had a vbac where forceps were used and a spinal was used and I really felt those were totally unnecessary. I got really angry at those experiences, and that is what made me think of something else.

These kinds of routine interventions common in hospital births are a major reason these women reject the corporate-techno-medical model. As Kara explains:

We, I, wanted a natural birth, no medications unless it was necessary...I have respect for the medical community, I believe there's a lot that they can offer if needed, but in a normal uncomplicated birth, there's no need to have so many interventions...and there are so very few situations in a labor and birth that you need immediate attention if the doctor's haven't caused something.

These women do not object to medical intervention when it is necessary, but they believe the vast majority of medical interventions in childbirth today are unnecessary. Not only are these costly and generally unpleasant interventions unnecessary, these moms believe they are potentially harmful. There is also a shared belief that one intervention usually leads to others:

They go in and get the epidural, and the epidural slows it down, and then they get something to speed it up, and then speeding it up causes more pain so they get another epidural, and then the baby goes into stress and so they get a c-section, and I'm watching this over and over going, Doesn't anybody see that this is a pattern? I mean why are people doing this, it doesn't make any sense to me? -- Rachel

In addition to experiences of unwarranted and unwanted interventions, the highly intensive management of their bodies in birth was something that these women disliked about the hospital birth experience. In the hospital, common diagnostic measurements are used to track labor that keep women largely bedridden and constantly “poked and prodded” (Cheryl). The women I interviewed not only consider these measurements futile for a healthy woman, but they can be incredibly frustrating for the woman in labor. There are strict hospital timelines that the labor must adhere to from when the contractions start to when the baby is delivered; if contractions do not follow the exact expectations of the hospital, or if labor stalls, or if the baby's heart rate fluctuates too much, or if a series of other such tightly measured expectations do not produce the way the doctors want them

too, the woman is usually forced to endure some type of medical intervention. Rachel explains, “The normal is so much bigger than what is allowed in the medical establishment”. Karen impersonated the clinical tone of the hospital staff to make this point in our interview: ““You’re 5cm dilated, and, Well now if you don’t get up to 7 in the next half an hour we’ll have to induce’- it’s like being under a threat”! As explained earlier, the threat of interventions is very real.

If a woman *is* afforded the opportunity to at least attempt a natural vaginal birth in the hospital, the lived experience of its medical management can be frustrating not only because of the lingering threat of interventions, but because what the hospital staff is telling the woman might totally contradict what her body is telling her. Nani recalled the following example of the opposition between her own embodied reality and the doctors and nurses clinical reality during her first birth:

When I felt ready to push, they were telling me I’m not ready, and when I was fully dilated, I didn’t feel the urge to push, but they were yelling at me ‘PUSH! PUSH!’ It was just something I hadn’t wanted at all, having to argue with them about what I wanted, what felt comfortable for me, it just made it an absolutely horrific experience.

This example is reflective of an idea that was repeated in all of my interviews, that your body communicates to you what it needs during the birth process. The problem with medically managed birth is that they do not take into account what the birthing mother is actually feeling, as Cheryl says “*They tell you what your body is doing, and it doesn’t need to be that way*”.

Another issue that drove women out of the hospital was the lack of privacy and the harsh hospital environment. The hospital environment was described as an

unnecessarily stressful and uncomfortable place to give birth. Kara touches on these issues in her explanation of her first birth:

I felt tense the whole time, and I didn't realize until afterwards that it was because I really don't like hospitals. It seems like such an unnatural place to have a baby, you know the bright lights and, it just feels like an alien abduction, it's just the complete opposite of the kind of place you want to be to welcome a new member of your family into life, so I was tense about that, and I really felt like that held me up, and when we got to the hospital there were so many people. My doctor never made it, so the resident on call was there, and whoever was in charge of him, and there were two other residents there, and then there was the nurse on the shift, and like 3 student nurses, and there was the pediatric nurse, and the room was packed with people, and at that point, I'm there, I am going through one of the most intimate times in my life, with an audience. I was like a deer in the headlights. What are all these people doing here? This is supposed to be something special, and private, and yet I'm here for all the world to see, so that was something that was kind of troubling to me.

Another major complaint about the corporate-techno-medical management of birth was the separation of mother and child right after the baby is born. In the hospital birthing experience of my interviewees, their newborns were often taken away directly after birth for various testing and shots, if not for other additional reasons; this was distressful for the mothers and thought to be a very unpleasant way for the children to enter the world. Kara continues in describing the scene right after her first birth:

After he was born they wanted to strip him down and put him under warming lights instead of just letting me hold him in a blanket, and they want to watch him for this and watch him for that and take his temperature and do this and that, and that's the time when you just want to hold your new baby and be a new mom, you know? So, it was very stressful and that's why we wanted to get out of there so fast, it just didn't feel right.

These women think that the bonding that takes place between mother and child, including immediate contact and breastfeeding, are incredibly important for the psychological and physiological development of the baby and the mother. Karen explains that in one of her hospital births they would not let her hold her newborn because her uterus was too soft, she laughed as she explained to me that nipple stimulation helps strengthen the uterus after birth, and if they would have only let her breastfeed it would have solved

everything. Despite her requests for her baby, they would not let her have her newborn until her uterus hardened, so she manually stimulated her nipples herself, minutes later she had the baby in her arms. There was a strong sense among my interviewees that doctors were totally out of touch with the natural childbirth process.

The consensus among my interviewees was that decisions are made in the hospital based on an economic bottom line and the convenience of doctors rather than prioritizing the mother and baby's experience and well-being. Nani explains "doctors and the medical community in general will definitely push you around for their convenience and their budget and their bottom line, and it's our right to not be at the mercy of that". Women associated the bottom line coming from both the threat of litigation and subsequent defensive insurance policies as well as the fact that doctors can charge more for a highly interventive birth than a natural birth. Cheryl explains "The almighty dollar! If you don't have an IV or a cesarean, how are they gonna charge ya? And liability insurance, they feel like- Oh, they don't want someone saying 'they should have had a cesarean'".

In the following quote, Kara explains her perspective on the complicated positions obstetricians are in balancing medical care with pressure from malpractice insurance and how this structures the way medical research and practice is carried out:

The doctors have to carry these astronomical malpractice insurance and pay these rates that are just beyond what we can imagine... they need to quantify everything and understand everything because if the slightest thing goes wrong they need to jump on it- so they can't be held liable if something happens... That's kind of where, what the perspective is- it's a business, they are there to make sure nothing goes wrong, so they assume something is going to go wrong, which makes sense, cause if you're on the look out for something you'll be more aware of the signs that might be a problem.—Kara

In a similar discussion Lia commented on how this defensive practice has created an "understanding gap" where doctors are trained to deal with problems rather than natural

birth. She shared an example she had heard where “at a American Medical Association conference no doctor there had attended a natural home birth”. These perspectives were shared by all of the women I talked too, that the majority of obstetricians are not trained to assist natural birth and that the medical industry creates an atmosphere that encourages techno-medical control and intervention.

The Search for Alternatives

“When I was pregnant with my older one...the woman who taught me cooking talked about home birth and that it could be spiritual, you know, and that’s the first time I heard about that possibility. Cause you normally hear horror stories about birth in general, right? So that opened my eyes, and uh, I decided if she can have that kind of birth, then I’m going to have that too.”- Rachel

After the rejection of the medical model of doing birth, the next step in the journey to UC is the discovery of “the right to birth” as Nani described it. Nani explained “the right to birth” was the right to question the authority of doctors and to believe she has the right to make her own decisions about birth. This discovery of the ability to resist the common understanding of birth and medical authority was the glimmer of light that led each woman down her own unique path of resistance. It was the exposure of other women’s choices to challenge the norm, to dare to ask for something more than a disempowering medically managed birth that gave these women the sense that they could do it too. For one woman this discovery happened before she was pregnant with her first child, for the others this discovery occurred at various times in their motherhood journeys ranging from during their first pregnancies to after they had already had a couple of kids.

For many women midwifery was the first option they discovered on their search for alternatives to a corporate-techno-medical birth, and 6 out of the 9 women birthed with a midwife prior to their UCs. Of the 6 women who had midwifery assisted births they did so in various places ranging from hospitals, freestanding birth centers, and at home and with different types of midwives. The reasons why women chose to go on to birth unassisted rather than with a midwife vary, they include issues such as access, legal and professional restrictions on midwives, and negative personal experiences with midwives.

Legal restrictions remain a major barrier for midwifery in the US today, especially for free standing birth centers (not connected to a hospital) and homebirths. The legal status of midwives varies state to state and access to out-of-hospital birth with a midwife is very limited. For instance, where Ronni lives in Kentucky homebirth is illegal, where Nani lives in North Carolina homebirths are only legal with certified nurse midwives, and there are none registered in her county, and where Cheryl was living in Georgia the closest midwifery center was 1.5 hours away. For women who live in an area where midwives are able to legally attend homebirths, there are growing restrictions on the births they can legally attend. The proliferation of “high risk” categories has greatly lessened the amount of women midwives can legally serve at home. There is a long list of prenatal tests and health standards that a woman must meet in order to qualify for homebirth. As Ronni explains, “If you have anything other than a perfect obstetric history, you have no options in our culture”. Ronni was pregnant and planning to birth with a midwife for when she found out she was carrying twins, at which point her

midwife said she could not be her care provider any longer. As mentioned earlier, many of the women I interviewed would have not been able to have a midwife legally attend their birth because they fell into a “high risk” category, often for things they argue do not actually put them at risk, such as age or previous c-section.

For women who have a perfect health history and are candidates for homebirth, midwives are required to follow increasingly medicalized standards of practice. In the last decade there has been a push to legalize midwifery (mainly certified nurse midwives), which has led the field to become more standardized, meaning that long lists of protocols and routines have been developed and implemented by state laws. Ronni’s personal experience as a UC mom and as a practicing midwife offered great insight into this predicament, she explained:

If I want to remain legal, if I want to follow my state laws, I have to monitor the baby every 15 minutes, I have to check her [the mother] blood pressure regularly, I have to do all these things to her, which to the main-stream woman that’s fine, but to the woman who really values her experience and wants to follow her intuition, that’s a problem fundamentally with her. And the midwife is stuck in a position, you may want to support them the way they want to be supported, you may totally believe they have the right to birth the way they want to, but if you don’t dot your i.s and cross your t.s, if the outcome doesn’t go perfectly, even if the parents are saying “It was our choice, we take responsibility”, it doesn’t matter if they’re not mad at you, the state is!

She goes on to tell a story about a friend, a mother of 7 children, who went to jail for manslaughter because of a breach baby who died during a homebirth, regardless of the fact that the parents pressed no charges and took complete responsibility. This story is not an extreme example, in “2002 the Associated Press reported that 300 independent midwives had been criminally charged, sued, or disciplined in the previous decade...At least 50 had been sentenced to prison” (Block, 2007: 181). It is worth noting that there are a hundreds of midwives that practice illegally and who will break standards to help a

woman achieve the birth she wants, these midwives are truly putting their lives at risk for the service of women (Block, 2008, Davis-Floyd and Sargent, 1997).

Although midwife philosophy seeks to empower the mother during birth, regulations can make this difficult. There was a feeling among some of my interviewees that at a midwife attended birth, the midwife is the authoritative expert in control not the mother. Even with midwives, women experienced power struggles akin to those in the hospital; Ayla's first homebirth is one such case. There reached a point in her birth where the baby's heart rate fell and the midwife wanted to transfer to the hospital. Ayla had trained as a midwife herself and knew clinically that the falling heart rate was not a sure sign of emergency, but rather a potential warning; and she felt physically and intuitively that the baby was fine and she said she did not want to transfer. The midwife did not listen. Ayla recalls the story as follows:

So my midwife had a total freak out on me and said she wanted to transport me and I said "NO!- That's ridiculous, I don't need to transport", and I was glad I had the wherewithal, I mean she even had my husband, at one point, on the phone with 911, I said "There is nothing wrong! Listen to me, I know my body, I know my baby, I know birth- there is nothing wrong". I had to be really forceful at a time I didn't want to be, I wanted to be inside myself and focusing on birthing my baby.

Ayla was able to talk her midwife out of transferring, but only by conceding to her screaming orders to lay on her back (so the midwife could chart heart pumps) and "PUSH! PUSH! PUSH!" the baby out immediately. She exclaimed disappointedly, "I might as well have been in the hospital".

Ayla felt that her midwife's presence compromised her birth instead of improving it. Instead of being able to let her body naturally progress on its own, she was forced to concede to the midwife's agenda. Ayla experienced a strong sense of disempowerment

akin to stories of women in the hospital. The romantic idea of a spiritual midwife who sits in the corner and intervenes only upon request is not the reality of most midwives these women interacted with, in fact I nickname I heard in the interviews, “medwife” captures the suspicions of the medicalization of midwifery.

When asked if they could have an attendant in an ideal world, one who truly respected their expertise and control as the mother, but who could bring the knowledge and experience of having attended many births, women had different opinions. Some said they would love to hire such a person, but the problem is that this character does not exist in the maternity world today. Even if a midwife was not legally required to follow standards of intervention, a midwife still takes on the role of an authority figure, and the most important thing for these women is to ensure that they have control over the birth, with a midwife this becomes contentious. Kara says the following about a midwife she met with but decided not to hire for her birth:

She was still somebody that was subject to her own...you know they always no matter who they are, they have to look out for themselves, and there comes some point where they have to put themselves before you- which I understand and that's fine, but that's not what I needed at my birth. You know if I need medical assistance, I will go to the hospital and I will get it.

While some of the women I talked to immediately ruled out midwifery because it was not accessible, others felt that these limits on the practice of midwifery, even with the best intentions, were not risks they were willing to take.

All of the women I interviewed stressed that the most important thing during childbirth is that the mother feels comfortable with her choice. Some women like the idea of having a skilled attendant, some women feel very comfortable with their ability to handle natural birth and feel more comfortable without anyone. Rachel for example,

prefers to be alone in these sort of intense intimate moments of their life. She felt a midwife was just another person to worry about, whose presence made her feel rushed; she shared the following comments about driving home after her water had broken to birth unassisted:

And that trip back home I remember as being one of the most euphoric in my life, because I was on a beautiful road in Phoenix between the mountains and I was thinking I don't have to call anybody, I don't have to talk to anybody, I was going home and it was just me and the baby, it was such an amazing feeling for me, that feeling of just, you know, going to give birth by myself, and nobody has to be involved in it, it was amazing to me, that trip.

These women are not advocates of unassisted childbirth, all of them said that this was a deeply personal choice that only a woman with the right mindset should make. For women who want a natural birth and have the option to birth with a midwife, this can be a great alternative to the hospital. For these 9 women, UC was the right choice for their family at that time.

The Unassisted Childbirth Experience

Birth being normal, birth being natural, birthing is like breathing...my body is opening, my body is releasing, my body moving doesn't hurt, birth doesn't have to hurt...my baby is growing, my baby is descending, my baby's changing positions, my uterus is strong"- Ayla's birth affirmations

As highlighted by the last two sections, the choice to birth unassisted has many components; it might be described as a combination of being pushed and pulled, pushed away from the medical model of birth and pulled in the direction of a natural and more empowered alternative. Once these women settled on their choice of unassisted birth, they had to convince their partners. Most of the partners were originally reluctant but ultimately agreed to let the women birth the way they wanted. In the end most partners

were great supporters during the birth. Other family members, friends, and acquaintances turned out to be the most difficult people to for these couples. Many women talked about family members threatening to call the police, begging them to not do it, and other such behavior. Women felt that this was a nuisance, but not something that ever made them question their decision. They all had spent a lot of time researching birth and felt that this was the best option for them, people who opposed it were assumed to be deep in the mindset of the hegemonic birth story.

In an unassisted homebirth, the mother can create her own ideal birth experience. There were some ideas that all of my interviewees shared about an ideal birth: being prepared, allowing the body space for an undisturbed natural birth, having the freedom to honor all types of knowledge as they see fit, and having a private and quiet space to connect with one's inner self and with the baby inside. The natural birth experience is understood as having intrinsic value. These women believe the body births best when its natural process is allowed to do its thing. Rachel says "our bodies are magical machines that know how to balance itself, no need to interfere with the natural process, why try to perfect them, just let them be instead of trying to conform and repress them". Describing the body's ability to birth as magical alludes to another theme that was part of the value of an undisturbed natural birth: the idea that women get to experience a sort of miracle in birth. These women were incredibly moved and amazed by the body's ability to produce life. The natural birth experience is understood as being full of physical, psychic, emotional, and spiritual pleasure. Women spoke of the experience being "totally euphoric" (Rachel), and in some cases pain free, with an "incredible high" during the end

of labor (Amber). There is of course incredible exhaustion and pain, but these are viewed as simply part of the whole package, and when you intervene with technology or medicine to take those parts away, you inevitably sacrifice other wonderful birth experiences.

As mentioned earlier, the space for embodied and intuitive knowledge in childbirth was central for many women's UC birth plans. Birth for these moms is a psychic-spiritual-sexual-loving event that gives them a sense of meaningful connection to their own bodies, nature, their partners, and the life they've created. These elements of birth are not prioritized just to make the mother's experience better, but because these women fundamentally believe that the mental, emotional, and spiritual elements of birth strongly affect its physical progression. This holistic understanding of birth is a guiding force that leads women to wanting a UC, because in the medical managed birth the only element of birth that is recognized is the material, scientifically understood physical processes, alienated from anything else.

One of the things every woman stressed as absolutely essential to a successful unassisted birth is being prepared. Being prepared meant a combination of things: having thorough knowledge of the birth process, having knowledge of how to deal with emergency situations, having access to medical care if needed, and having the confidence to trust in the body's ability to birth naturally. The way women educated themselves about the birth process varied, two had the luxury of being trained midwives and 7 of them had the lived experience of prior births, but even those women consulted extra materials in preparation to birth unassisted. Women cleared out all the birth books at their

local libraries, looked up medical journal articles, read midwifery texts, asked doctors and midwives questions, and used many different internet sites. Only one woman had the fortune of having a UC couple as friends for her and her husband to talk to, but the other women found many helpful friends on the internet. There are websites and chat rooms dedicated to UC where expectant parents can ask experienced UC moms questions, read birth stories, see pictures and watch videos; many women cited other UC moms on the internet as their best resource.

All of the women I spoke to had some sort of back up plan in case something went wrong during the birth. These women do not believe that every birth goes perfectly; they do believe they can prepare themselves to handle most complications, but they recognize that problems can occur for which they would need expert medical care. The back up plans mainly consisted of midwives or doctors they could call to come over and ways to get to the hospital. None of the women gave birth totally alone, each person had their partner with them, and often other family members or friends were in the house or a phone call away in the event of an emergency.

The confidence to birth unassisted and let the body take its own natural course was talked about as a major factor in a woman's ability to birth UC. As mentioned before these women argue the most important factor in childbirth is that the woman feels comfortable with her birth environment. The education of the birth process and having contingency plans for emergencies were important parts of this confidence for the women I interviewed. They shared with me their knowledge on how to deal with common minor complications such as a chord being wrapped around a baby's neck or the best positions

to birth a posterior baby. Another part of the confidence was the ability to stop thinking about the things that could go wrong after learning about them. Women talked about how it was important to prepare, learn everything, and then stop thinking. They see that a clutter of fear thoughts in ones head can be detrimental to the flow of birth. The best thing to do once they learned about everything, was to put it on the shelf unless they needed it. There seemed to be a fine balance between having knowledge, and not letting the intellect impede on the body's natural process.

This process is part of a larger project of cultivating a positive mind-body-emotional-spiritual position for the birth that was an important factor to a successful UC. These women believe stress or negative energy is one of the greatest risks to a healthy birth, and share stories of births that were problematic until the woman could flush out what ever negative energy she was holding on to and feel positive and relaxed. Because our society is so drenched in fear with birth, UC moms have to do a lot of unlearning social norms. Methods for doing this ranged from creating collages to put around the house that pictured empowering and pleasurable representations of birth, taking hypno-birth or Bradley method classes, reading other women's positive birth stories, journaling, and avoiding negative images of birth and unsupportive people. This process was definitely conceived of as work that had to be done, these women had to actively cleanse their minds and bodies of the negative cultural messages about their body and the nature of birth. Ayla explains, "I worked very diligently in cultivating my reality". In addition to cleansing the mind of negative thoughts, there was the need to develop a closer relationship to the body, to learn to be in-tune with its messages, to cultivate a greater

mind-body connection. As Nani explains, “we are not taught to trust our bodies”, they had to learn to trust their bodies, to be inside themselves, to “be in your center, trusting knowing what you know”(Rachel).

“Knowing what you know” meant relying on a variety of sources of knowledge in birth. In addition to knowing the mechanics of the natural birth process and how to trouble shoot complications, these women relied on sensual embodied knowledge, spiritual knowledge, and intuitive knowledge in their pregnancies and births. The reliance on sensual embodied knowledge is part of the natural birth philosophy that believes the body knows what to do and will communicate its needs to you. Instead of women saying things like ‘the doctor told me...’ women said things like “I could tell from just palpating myself that he was breech”(Karen), or “I could feel her moving down the birth canal and I could feel her turning”(Kara). Women said they would do whatever felt comfortable to them, thinking that this was what their bodies needed. A couple women explained this process of feeling what your body needs by comparing it to taking a bowel movement, you just know, you can physically feel it, when you need to go, when you need to wait, when you need to push. One of the more amazing examples of the body’s ability to birth on its own was Ronii’s story of giving birth while she was in the hospital for pneumonia. She was terribly ill and was unconscious in a comma in ICU when her body went into labor, she had a completely natural vaginal labor without even being conscious. Her luck of receiving no medical interventions was attributed to her incredibly weak state, she said the doctors did not think her body could handle something like a cesarean.

The sensual aspect of birth was also part of the pleasure of a natural home birth. Unlike a medicated hospital birth, in these births the women actually enjoyed dynamics of the physical process. Listening to their birth stories I found a great focus on these sensual pleasures, the following are a few of the most illustrative quotes:

“There is nothing like the feeling when your baby’s head is coming out of your own body, and you reach down and they are so so soft, I can’t even begin to describe that feeling, feeling soft and hot, and realizing that this is your child you’re birthing”- Karen

“I got that wonderful sensation, um, all of the pain went away, completely and totally, it was completely painless once the first push started happening, and my body just kept pushing and pushing and it felt very good, it felt very good, it was like having a bowel movement, kind of, um, very relieving, just like- oh, that is sooo good”- Amber

“I remember I had this pile of pillows, and I leaned over it and I was able to just let my arms fall and close my eyes and just ride the wave of the contractions, knowing that this is just another contractions closer to meeting my new baby”- Kara

Of course not all sensual experiences were pleasurable, most women did feel pain in labor, but when they talked about the pain it was in terms of its function. Rather than pain they were feeling from unnatural interventions and stress, the pain they felt during their unassisted births was the pain of their body doing something functional, pain that meant they were one step closer to seeing their baby.

In addition to the sensual embodied knowledge that women relied on in unassisted birth, many of them spoke about feeling connected to something larger than themselves during the process. For some women this was a connection to nature, for some a connection to God, for some a spiritual connection to life’s energy- whatever their understanding of a larger force was, this element to life assisted these women with faith. They all made sure to clarify that it was not a blind faith, they did not naively think everything would be okay, they recognized that things *could* go wrong- but they didn’t believe they would. They had immense positive spiritual energy to carry them through

the birth, as Kara describes it “I had felt closer to God during Avery’s pregnancy than I have ever felt in my life...I felt so connected”. This spiritual connection seemed to overlap with the concept of an intuitive connection, they were both ways to express inner senses and knowledge.

My interviewees put a lot of emphasis on how the privacy and freedom of a UC allowed them to go deep “inside themselves” to connect with these inner, spiritual, intuitive energies. It was important to have this space to focus on connecting inner rather than outer, to dive into the deepest parts of their being and find the wisdom and energy for birth there. This process was described as being not only empowering but healing, a way of positively connecting with their female bodies. The ability to trust one’s body, trust the birth process and free oneself of the cultural fear of birth was easier for many women to do in the second or third births than their first.

The privacy of a UC also enabled women who had painful births the ability to mentally go away during the most intense parts of labor. Amber explains her experience at this moment as follows:

Right at the end in natural birth, you kind of go away- your mind is I guess trying to escape the pain, you try to get away from it as much as you can...I hear a lot of women call it labor land. It’s like being on a completely different planet, its like being out of your body, you’re hiding somewhere being inside yourself and just, basically getting through each one, and getting through each one, and resting and then getting through each one. By that time you’re so exhausted, um, you know I wasn’t thinking anything at all, I had no fear whatsoever except of the next contractions, they hurt pretty bad, mine in particular because my baby was posterior which is backwards, which causes very, very, very painful labor.

Unlike a hospital setting or even a midwife assisted birth where other people are forcing the woman’s attention to be mentally present for interaction, in a UC a woman can avoid having to engage with anything but getting through her contractions. Even Amber’s

husband was a distraction at this moment in birth (she was happy he was in the other room most of the time), her explanation vividly depicts what it feels like to have to intellectually engage with someone during these moments of hard labor:

Every time my husband would say something to me, I would have to, it was almost like I had to make this journey back to my body, this long painful awful journey, and then I would have to understand what he asked me, and then I would have to answer him and then I would have to do this whole ordeal of going back to that place I needed to be to get away from it- to escape the pain.

The privacy and freedom afforded in a UC were considered important on other more practical levels as well. Women enjoyed being able to move around in whatever position they felt comfortable, to eat and drink at their leisure, to hop into their bathtubs if they wanted, to have a movie playing in the background, to be in their own beds, to be in an environment where they were able to nest and feel totally comfortable and at peace. Regardless of whether women had painful and difficult labor, many women commented on how surprised they were at how peaceful birth was in such a place. The ease and peaceful qualities of the births were considered not only beneficial to the family, but a kinder way to introduce a newborn to the world.

And it was the most peaceful labor, we spent the whole time in the bedroom, all the kids were in bed, my husband was dozing off, and I'd sit cross-legged in the bed, I'd get up and walk around, and it was Christmas eve and the radio was on and I was just thinking about Mother Mary birthing, and this connection I felt with all birthing mothers everywhere- and there was no one bothering me, no one coming in for vaginal checks, no one trying to run a strip on the baby's heartbeat- there was none of that... and I gave birth to a son who was asleep. I gave birth to this child and his head rotates, and when his body came out and his face turned to me I saw that he was pink and rosy and sound asleep. That birth was so gentle and so quiet and the room was so dark that my boy was born asleep- it was awesome!-Karen

You know, half the night I was totally euphoric, and looking back thinking why couldn't I have had it before, if it's so natural, you know not that I regret it, each of my births I had good births, not like I had horror stories at all- this was just perfect because it was just me, and it wasn't even perfect on any romantic level, it was normal, it was how it can and should be if it fits you, you know, and that's what it was for me. Just a normal thing. -Rachel

It was really really relaxing, the best way to describe it, I felt so calm, and it seems, most people think of the birthing process as a very high energy and amped up kind of thing, and for me it really

wasn't, it was very, low key and, just, no stress, at all, I had no tension whatsoever the entire time. -Nani

I remember I started talking in a really high pitched, you know, as if you would talk to a new born baby, like 'oh my goodness you're so cute' kind of high pitched voice that we tend to use with babies and young children, I said something to her like 'come on out baby it's okay' or something like that, and it was like I was just connected to her, I wasn't having to worry about anybody else, you know we had the lights dimmed, and it was just us, it was the most beautiful, beautiful experience of my life, and everything was calm and it was the way it should have been. We welcomed her into our family in the most peaceful and beautiful environment that we could have.-Amber

Interpretations

"You've thrown the worst fear, that can ever be hurled, the fear to bring children, into they world..." –Bob Dylan, from "Masters of War"

"Making space for the transgressive image, the outlaw rebel vision, is essential to any effort to create a context for transformation".-- Bell Hooks (1992: 4)

The experiences of the women I interviewed illuminate how the radical choice to birth unassisted grows to seem practical given the hostile circumstances of birth environments otherwise available. By illustrating the histories that led these women into this choice, we cannot write them off as crazy deviants but we are forced to take seriously the circumstances of their lives that led to this choice, and the implications it has for American birth and the larger American culture. Despite the rhetoric of reproductive rights in America there is an absence of choice when it comes to the decision of how and where to give birth for many American women. While research has shown that many mothers accept and find security in the medical model of childbirth, those who do not face struggles on many levels. When these women decide that they want something different than a medicalized birth, they are up against not only the social norms of understanding birth as a dangerous event in need of medical control, but also the institutionalization of that norm into hospital policy, insurance policy and the law. The

UC journey is a journey of resistance to the structural and discursive hegemony of medicalized birth and of creative construction of an empowering alternative.

These women's motivations for choosing UC center upon their desire to have control of their birth. For reasons previously illustrated, these women are uncomfortable with the medical establishment having absolute control over their births and they see UC as a way they can achieve control over the birth situation to ensure they have the kind of birth they desire. While the exact details of what they desire differ, what brings their stories together is the refusal of the medical system to grant them the flexibility to have the birth they want. Instead of accepting the normalized way to give birth in the American hospital, these women were determined to find an alternative. The specific natural birth philosophies varied among the women I interviewed, but all of them challenge the medical model and advocate for the safety and enjoyment of a natural home birth. They not only advocate for natural birth, they grant authoritative legitimacy to embodied, physic, emotional, and spiritual dynamics of the birth process that are absent in the medical model. These other ways of knowing are important for the success of the natural birth process as well as for their ability to transcend the physical components of birth and engender the sublime connective elements of the birth experience.

What is fascinating about this process of women going from believing in the medical model to its rejection and subsequent acceptance of a natural birth model is the way it reveals the process of the social construction of birth. While the dominant story of birth as a dangerous event requiring medical management is often understood as the only way of birthing, the experience of these women illuminate how this hegemonic birth

story is only one story out of many that can be told. Furthermore, these women's experiences reveal how changing the way a woman thinks about birth has the power to change the way she experiences birth. It is a prime example of the way our social ideas seep into the functioning of the body, how our ideas become embodied.

The UC view of birth provides a critical illumination of the taken-for-granted medical model. Similar to Davis-Floyd's findings, the experiences of my interviewees reveal a medical system that is totally dependent upon technological diagnostic procedures and strict medical management of birth (1994). The medical model of birth presents the pregnant female body itself as problematic and in need of constant medical supervision and intervention to be capable of birthing a healthy baby. The doctors these women worked with strictly followed a medicalized and technological way of understanding and doing birth that offered little to no flexibility for an alternative vision.

The medical model also leaves no room for women's embodied and intuitive knowledge. A common theme among these women's motivations for choosing UC was that they wanted to listen to their bodies and inner knowledge to guide the birth process instead of an objective medical knowledge. When we prioritize the lived embodied experience of women in birth as I have in this study, their embodied realities highlight the disconnect between what they feel is right and what the medical experts argue is right. For women who trust and value these embodied and inner ways of knowing, it is necessary to find a birth plan where they can be given precedent.

This presentation of women and their interaction with and subsequent rejection of the medicalization of childbirth highlights a number of problematic issues with the way

American birth is normalized today. The medicalization of birth raises questions about how women are made to feel about their bodies and how their bodies become embodied within this context. As mentioned in the literature review, critics of medicalization in general argue that it functions as a force of social control by casting an objectifying gaze onto its subjects; a process that turns people into objects of standardized medical scrutiny and proscribes strict guidelines of the normal. These women experiences reveal a medical view that has normalized women's natural bodies as dysfunctional and imposed management of their bodies in a manner that turns them into docile dependent bodies. Foucault's 'clinical gaze' is glaringly present in these women's experiences; the rituals of medicalized birth function as he warned, they explore, break down, and rearrange the natural functions of birth making women dependent upon the expert medical knowledge of doctors and their superior technology (1973, 1977). Unassisted birth provides a radical new lens to view the normalization of this perspective by totally reversing this way of understanding birth. UC mom's understating of birth as a natural and healthy event which functions best when unhindered by the medical world challenges the assumption of women as necessarily dependent on the medical establishment to birth. Instead of framing women as problematic docile bodies to be managed by technical medical experts, in the UC perspective women become strong independent bodies that are healthy and functional on their own.

In addition to challenging the medical assumption of the birthing body being docile and dependent, UC moms challenge the entire epistemological framework of the dominant medical birth model. The dominant understanding of knowledge as reflected by

the medical system is one that adopts a separation of mind and body and analyzes the body as isolated anatomical parts; it is a deductive mechanistic way of viewing the world. This epistemic framework only considers cognitive rational logic as authoritative and seeks rational measurement and control.

In contrast, UC moms experience birth as a process in which many ways of knowing are authoritative. These women do not reject scientific knowledge, but they believe that this way of knowing is one among many others that are essential to a successful birth. In Stephen Pfohl's work on the social construction of reality, he calls attention to the multiple dimensions of reality that are often dismissed in our hegemonic understanding that focuses only on the cognitive: the narrative, emotional, bodily, moral, aesthetic, sacrificial and haunted dimensions of knowledge (2008: 658). These kinds of marginalized ways of knowing proved to be essential to my interviewee's births. The refusal of the medical model to take these ways of knowing seriously raises concerns about how our society understands birth and the larger human experience. These women refused to have their many ways of knowing subjugated in their births and they found a way to birth that honored these perspectives. For the majority of women who give birth in the hospital environment, what are the consequences of these ways of knowing being repressed? How might all women's birth experiences be improved and empowered when their own subjective experience is granted legitimate authority?

The experience of unassisted birth was described as incredibly empowering by all of my interviewees. In birthing UC they are directly challenging what they have experienced as oppressive forces of control in the medical establishment and oppressive

cultural understandings about women and birth. By removing themselves from being objects of the medical establishment's disciplinary power, they transform themselves into new subjects with freedom, power and agency. It is important to recognize that these women successfully resist domination and empower themselves to experience birth in a totally different reality. From a Foucaultian perspective on power, these everyday locations are the central places where modern power functions. In the choice to birth UC these women are resisting forces of power that cast them as dysfunctional, docile, dependent bodies and creating a new subject of a birthing woman as a knowledgeable, healthy, independent person with an integrated body, mind, and soul.

In addition to creating new forms of subjectivity, the circulation of UC discourse transmits and produces resistant power. Chris Weedon argues that "Discourses are more than ways of thinking and producing meaning. They constitute the nature of the body, unconscious and conscious mind and emotional life of the subject which they seek to govern" (1997:105). The practice of UC and the discourse surrounding it is resistant to the hegemonic way of birthing on every one of these levels. When we take into account the incredible lack of power women are forced to experience in the medical model of birth, UC becomes a revolutionary option for women. The presence of UC discourse stretches our imaginations of what is possible in birth, opening up new conceptual space for people to understand birth.

In Jennifer Block's *Pushed* she criticizes UC moms for what she sees as a "sad militancy...in holding up a woman alone in childbirth as the ideal" (2007: 104). I interpret UC differently. As mentioned previously none of these women believe UC is the

answer for everyone, they are not advocating that all women start birthing unassisted. Instead they believe that in the current birth climate it can be a good choice for women who want an empowered natural birth, especially for women who do not have access to other non-hospital alternatives such as homebirth with a midwife. More importantly, the idea that some women are birthing unassisted is a power force that challenges the misogynistic hegemony of birth today. When we consider the incredibly negative messages about the nature of women's bodies and the subjugation of their knowledge inherent in the epistemic order of the hegemonic birth model, having alternative voices that challenge these epistemologies is absolutely essential to the possibility of women's empowerment in birth and otherwise.

 Illuminating the underlying epistemic order of hegemonic birth and highlighting the possibilities for resistance is not only important to the empowerment of women, but for the possibility of moving humanity in a direction that is inclusive of the many dynamics of life systematically rejected in American epistemic hegemony. The light that these women's experiences shine upon the narrowly constructed dominant birth story begs us to question what other aspects of our human experience are being similarly limited in their constitution? This research suggests that we must continue to do work that challenges oppressive hegemonic structures and illuminates new subversive and empowered subjectivities. In the childbirth world, this work is among many that demand the current medical establishment make changes in policy and practice that will allow women more choices and authority within their maternity experience. The women I have interviewed and the many authors I have cited in this paper are calling for society to

recognize the destructive consequences of the hegemony of techno-medical birth. They are calling for people to deconstruct and reject this misogynistic birth story and begin constructing a new reality. They are visionaries advocating for a birth reality that empowers women, affirms multiple ways of knowing, celebrates the sensual natural body, and engenders connection...for a reality you would want to bring a child into.

Appendix

I. Call for interviewees

Hello everyone, my name is Lauren Brown, I am very interested in unassisted childbirth! I am 25yrs old and from CA, at the moment I have no children- but I definitely hope to in the future. I am currently working on a master's degree in Sociology at Boston College and I am going to write my master's thesis on unassisted childbirth. I would like to ask you to participate in an interview, so that I can learn more about your experience with unassisted childbirth. Even if you are someone who is considering unassisted childbirth, I would love to hear from you. I am interested in finding out what are women's motivations for choosing unassisted childbirth, what is their lived experience of unassisted childbirth, and how women challenge dominant cultural understandings of childbirth? I hope that my work in this project will help educate the general public about unassisted childbirth and enable new parents to make more informed decisions. The interview will take about 60-90 minutes and is completely voluntary and confidential. If you live in the Boston area I would love to interview you in person, or we can do it over the phone. You can choose where and when you would like the interview to take place. I have a more detailed consent form I will give or read you when you contact me. I hope you will decide to participate in the research and I look forward to hearing from you. Please feel free to contact me with any questions about my research project.

Yours very truly,

Lauren Brown

II. Places where Call for interviewees was placed:

Laura Shanley's email list

associatedcontent.com, 9 specific UC authors

iVillage.com, UC message board

birthjunkie.com, UC message board

<http://groups.myspace.com/cbirth>

unassistedhomebirth.com

III. Bio sent to respondents

Hello, I'm Lauren Brown! Here are a couple of recent pictures of me, so you have a face to match the name. The one on the left is me waiting for the train in Boston, where I live (I'm wearing a vintage hat- one of the little things in life that make me smile). The one on the right is me on a summer trip with my family in Costa Rica (my Mom, Dad, and younger Brother-I haven't started my own yet). I grew up in Southern California, but I moved to Boston a year ago to go to graduate school at Boston College- I'm working on my master's degree in Sociology. I went to school for my bachelors at Chapman University in Orange, CA where I studied a combination of Political Science, Sociology and History. Many people ask why I moved to Boston from CA, and my reasoning has two parts: one, just to try something different for a while- I know I want to return to CA to be close to my family when I start my own, and two-because I was interested in studying sociology of birth and was interested in women and gender studies and the Boston area has a lot to offer. Besides going to school I work at an Italian restaurant as a

server and I work for the Women's Studies Program at Boston College as the assistant to the director- so I'm a busy lady!

I moved to Boston with my boyfriend Ben, who is from my same town San Clemente, CA (we met when my parents moved across the street from his about 6 years ago, we've been together for 3 and a half yrs). Ben's Mom had her 4 children at home, which is what sparked my interest in home birth, and led me to find UC. In terms of the kind of person I am, I like to think that I'm optimistic, compassionate, and live life to its fullest. I've always been a strong independent type of lady and I am known for my loud frequent laughter. I find lots of beauty everywhere and find myself drawn to eccentric people as well as calm 'old souls'. I love to cook and eat and am interested and active in the slow food movement, I also love to dance and I'm going to start tango lessons this year with Ben. My favorite author is Isabel Allende and I like all sorts of music, it really moves me. I spend most of my free time enjoying all the loves of my life- Ben, my family, and my 3 best friends who are more like sisters. I definitely want to have kids, sooner than later (when Ben and I are done w/ school and move back to CA- he's also a huge kid lover and is very interested in birth and parenting). I know I want a home birth, but I'm undecided whether or not to have a UC at this point.

Without getting too technical with sociological talk, I chose to do my thesis on UC because I find it fascinating and inspiring. I want to do this project to explore how women come to decide to have UC. I'm really curious about how women's realities are shaped to allow them to challenge the dominant social norm of hospital/medically managed births. I'm not sure exactly in what direction my thesis will go, because instead

of having a specific theory that I'm testing out, I'm hoping to build my story based on yours- what we call in sociology "letting the data speak for itself". My personal goals for the project are to write a masters that is meaningful to me and important for others-not just academically successful, and to spread the word about UC and break down some of the misconceptions about birth in the US today. I hope this gave you a better understanding of who I am and where I am coming from and makes you more comfortable sharing part of yourself with me.

IV. Demographics Survey

What is your date of birth?

Where do you live?

Where did you grow up?

What is your racial/ethnic identity?

What do you do for a living?

Are you married or living with a partner?

If yes, what do they do for a living?

How many years did you go to school?

How many children do you have?

Have you had any non-UC births? If so, what was the birth environment?

How many UCs?

Are you religious? If so, how do you explain your religious identity?

When are the best times for you to find undisturbed time for a 1 hour phone interview?

V. Interview Guide

Where did you learn about unassisted childbirth?

How did you choose unassisted childbirth?

Was UC your best available choice, or your 1st choice?

What specifically were you trying to avoid in hospital birth? (Safety, interventions, privacy, limited choices)

Why not with a midwife at home?

How did your partner feel about UC?

What kind of response did you get from family & friends?

What were the most important factors in this choice?

What sources did you go to, to get information about pregnancy & birth?

Prenatal care?

What was your birth like? Tell me the story of how it happened?

What were your expectations about your birth?

What did you want it to be like?

What were your fears/ did you ever question your choice for UC?

How do you feel about medicine in general?

Do you follow Natural Parenting? (Vaccines, breastfeeding, circumcision etc)

Do you challenge other social norms?

Do you consider yourself a feminist?

Do you participate in any birth advocacy/activism

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