Home Birth in the United States and the Netherlands: Understanding Women's Experiences of Stigma, Nature, and Trauma

A DISSERTATION
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF THE UNIVERSITY OF MINNESOTA
BY

Rachael Beth Kulick

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

Kathleen E. Hull, Advisor

December 2013

Acknowledgements

I thank my advisor, Kathleen Hull, for her patience, compassion, and confidence – both in me and in this project. Kathy, your feedback and questions have improved this dissertation immensely. So too have your reminders that my embodied experience of childbirth – first as a doula and an observer and later as a mother – are legitimate sources of knowledge, one of the many ways I have come to know about my field.

To Phyllis Moen whose courses on gender, health, work, and the life course were my introduction to rigorous and interested (as opposed to disinterested) social scientific inquiry. I thank you for sharing your story and for teaching me that our biographies shape our research just as our research shapes us.

To Joachim Savelsberg whose course on the sociology of knowledge contributed early on to the development of my "sociological imagination," whose own international comparative work has been an inspiration, and whose first questions whenever we met were, "Rachael, how are you? How is your family?" Talking with you always reminds me that I am my work, but I am also more than my work.

To Raymond de Vries who introduced me to the Dutch case and who has deeply informed the kinds of questions I ask and how I interpret the world. One of the first times I called Ray, I addressed him as Professor De Vries. He replied, "Student Kulick, must we be so formal?" Thus began a warm and collegial relationship for which I am incredibly grateful.

I thank the many researchers and administrators in the Netherlands who facilitated my access to midwifery practices in that country. Especially to Marianne Nieuwenhuijze,

Evelien Spelten, Margreeth van der Meijde, Yvonne Beishuizen, and Mieke Damen. And to Diety de Vries for arranging for me to observe at a well-baby clinic.

For outstanding research assistance, I am indebted to Melanie Daglian, Danielle Hegseth, Stephanie Weir, and Esther Ijzer.

Without generous funding from the following government agencies, universities, and organizations, this project would not have been possible: U.S. Department of Education (Foreign Language and Area Studies Fellowship), U.S. Department of State (Fulbright Program), National Science Foundation, University of Minnesota (Department of Sociology, Life Course Center, Graduate School, Center for German and European Studies, and European Studies Consortium), Indiana University (West European Studies), P.E.O. International, and the Nederlandse Taalunie.

A special thank you to my Dutch professors Jenneke Oosterhoff at the University of Minnesota and Esther Ham at Indiana University and to my instructors at the Nederlandse Taalunie Zomercursus in Zeist, The Netherlands and Hasselt, Belgium.

I am most appreciative of the friendships I have developed during graduate school. The dissertation groups I have participated in with Alexandra Stein, Heather Hlavka, Erika Busse-Cárdenas, and Vania Brightman Cox have enriched my life in so many ways.

To all the midwives who participated in this study. Thank you for opening your practices and your hearts to me. To the women who invited me into their lives and their homes to document and celebrate the births of their children. I have learned so much from you about how to be a researcher and a mother.

And, finally, to my family. To Don and Abigail and to Mary Ann, Jim, Mara, Adam, Jennifer, and Chris. Thank you for your unconditional love and encouragement. To my mother, Bernadette, who died in 1988. I miss you. To my son, Alvin. Being with you grounds me and brings me calm. And to Aaron. Thank you for taking this journey with me – as friends, as partners, as parents. I love our life together.

Dedication

This dissertation is dedicated to Aaron and Alvin.

Abstract

This is an ethnographic study of contemporary home birth in the United States and the Netherlands. Data include (1) fieldnotes collected at prenatal appointments, births, postpartum visits, and professional meetings, (2) transcripts from pre- and post-birth interviews with pregnant women as well as interviews with midwives, and (3) textual materials including statements by medical and midwifery associations and books by leaders of the natural birth movement. Analysis reveals three key components of women's experience: stigma, natural birth, and trauma.

Home birth in the U.S. is seen as risky behavior and women who plan such births are labeled risk mothers. Women cope with this stigma by employing isolation and secrecy, attempting an education campaign, or seeking comfort in a family tradition of alternative approaches to health. In the Netherlands, home birth is part of the mainstream health care system. In the absence of stigma, structures for collaboration between midwives and physicians facilitate relatively smooth interactions.

An international discourse of natural birth informs a "script" for how to accomplish home birth in the U.S. This script emphasizes a warm, dark, and quiet environment, continuous labor support, and the achievement of an altered state of consciousness. A different script operates in the Netherlands – one that focuses on home birth as ordinary (as opposed to extraordinary) and is based on a tradition of independent midwifery, insurance industry support, and professional postpartum home care.

Home-to-hospital transport is a traumatic experience in the U.S. – not so much because of the obstetric complications that necessitate the transfer as because of the

disruption of beliefs and values that occurs when women move from the midwifery to the biomedical model of care. In the Netherlands, non-Dutch women with a medicalized view of birth experience a similar rupture between their worldview and a system that promotes unmedicated, low-intervention birth.

Table of Contents

List of Tables

List of Figures

CHAPTER 1
INTRODUCTION

Writing this dissertation has been difficult. Partly, this was due to my own experience of planned home birth – I felt isolated and stigmatized during pregnancy, had a traumatic home-to-hospital transport during labor, and suffered from both postpartum depression and childbirth-related post-traumatic stress. But even before that, my research had led me to a deep pessimism. The U.S. system of birth seems even more polarized and its outcomes even less impressive today than when my role models began their work in the 1970s.

Currently, 41 percent of birthing women experience attempts to medically induce labor, 83 percent use one or more types of medication for pain relief, 62 percent receive intravenous fluids, 47 percent have bladder catheters, and 31 percent are given synthetic oxytocin to speed up labor (Declercq et al. 2013). One in three babies is born by cesarean section, 11.7 percent are preterm, and 8.1 percent are low birthweight with significant disparities by race and ethnicity – for example, 10.5 percent of babies born to non-Hispanic white mothers are preterm while 16.7 percent of babies born to non-Hispanic black mothers are preterm. (Martin et al. 2013). Despite a decades-long critique of hospital birth practices and physician-led care, the vast majority (98.7 percent) of births still takes place in hospitals and physicians attend 92 percent of all births. From the point of view of those who want to see disparities shrink and birth become less medicalized, it would seem that change is occurring in the wrong direction.

One of my mentors, Raymond de Vries, published *Regulating Birth* in 1985. In the preface to the second edition, he wrote,

> My analysis [in the first edition] gave me little cause for optimism, but I stubbornly clung to my belief that careful study of earlier efforts to improve the position of midwives – looking at what worked and what did not work – would provide the information needed for the creation of an independent and successful profession of midwifery in the United States. It was my naïve hope that by 1996 *Regulating Birth* would be nothing more than a curiosity: evidence that there was once a time when midwife-attended birth was the exception, when even healthy women in labor were "managed" with continuous electronic fetal monitoring and anesthesia, when those choosing to have their babies at home were accused of child abuse. Sadly, my book remains relevant. (De Vries 1996:xviii-xix)

More sadly still, De Vries' book remains relevant today as the medical management of birth continues unabated and a new cadre of scholars and activists work to decriminalize home birth midwifery and develop regulatory schemes and licensing laws that do not destroy the autonomy or uniqueness of the profession (Craven 2010; Pope and Fisch 2013).

The current rhetoric surrounding U.S. home birth is often hyperbolic and filled with disdain. One prominent online blogger regularly writes columns claiming that home birth midwives and advocates have "blood on their hands" and are "ignoring the growing pile of tiny bodies" (Tuteur 2011b). This author is not an obscure voice constrained to the blogosphere. She is a Harvard-educated obstetrician-gynecologist who is a quoted expert in mainstream media outlets including *National Public Radio* (Stein 2012), *Time Magazine* (Tuteur 2011a and 2011c), the *Los Angeles Times* (Khazan 2011), and *CNN* (Park 2010).

The discourse in academic circles is slightly less virulent, but heated nonetheless. In the most recent issue of *The Journal of Clinical Ethics*, for instance, Chervenak and colleagues (2013b) write that "it is incompatible with the ethical concept of medicine as a profession for any attendant to planned home birth to represent himself or herself in any

way as a healthcare professional" (p. 190). Other authors in the same special issue on place of birth write about women who plan to birth at home being "harassed" and "belittled" (Fineberg 2013) and treated by physicians in ways that are "punitive" (Wendland 2013). This is consistent with my experience – both as a participant-observer and as a pregnant and birthing woman.

At the same time, the system of home birth in the Netherlands – the only developed country that did not impose nearly universal hospitalization of childbirth during the mid-twentieth century – is under unprecedented attack. Home birth researchers in other parts of the world have always pointed to the Netherlands as a ray of hope, an anomalous case that demonstrates the safety of home birth on a large scale and serves as an example for reform. Indeed, this is why I initially became interested in studying maternity care in the Netherlands.

In late 1990s, I was coming to understand the medicalization of women – their bodies, their life cycles, and their lived experiences – as a form of social control and I wanted to understand how women protest and resist this control. I learned about self-help gynecology and home birth and I started writing short pieces about feminist women's health movements (Kulick 2009b), abortion and contraception (Kulick 2009a), occupational professionalization (Kulick 2006), and midwifery (Kulick and De Vries 2008).

Always wanting to have one foot in the academic world and one foot in the "real" world, I worked at Planned Parenthood and later became a certified birth doula (i.e., labor assistant). Before beginning my dissertation research, I attended births for two years as

both an independent doula and as a staff member in the labor and delivery unit of a Minneapolis hospital. Often disheartened by the obstetric care I participated in, I thought that an observational, ethnographic study comparing childbirth practices in the U.S. and the Netherlands would be the perfect way to show a U.S. audience what was possible and how maternity care could be improved.

I took my first trip to the Netherlands in 2005 to attend a conference on Dutch maternity care as a model for Europe. I boarded a plane to Amsterdam with a suitcase and a copy of the Lonely Planet's guide to the Netherlands. I did not have a hotel reservation and I spoke no Dutch. The conference was transformative and when I returned home, I enrolled in a Dutch summer language institute. For the next three years, I undertook an intensive study of Dutch language and culture – studying at Indiana University, the University of Minnesota, and the Nederlandse Taalunie (Dutch Language Union). On every trip I took to the Netherlands – in 2005, 2006, and 2007 – I met with midwives and midwifery educators. In 2008, I returned to carry out the research for this dissertation.

In 2002, when I began reading about maternity care in the Netherlands, the home birth rate was 31.9 percent (Centraal Bureau voor de Statistiek 2013). When I attended the midwifery conference in Amsterdam in 2005, the rate was 31.6 percent. By the time I started fieldwork in 2008, the rate had declined to 28.4 percent. The most recent data have the home birth rate at 20.8 percent and falling.

Already in the 1990s – in the face of a home birth rate that had dropped from two-thirds of all births in the 1960s to only one-third by the 1990s – Wiegers and colleagues (1998a) expressed concern about the future. They wrote,

> A minimum proportion of home births may well be necessary to keep the home birth option viable. Once that line is crossed, the home birth rate may drop quickly and resemble that in surrounding countries. No one knows exactly what proportion, if any, should be regarded as critical, but any further decline in the home birth rate is likely to bring this limit closer. (P. 196)

Surely, with a rate that now stands around 20 percent, the Netherlands is reaching that tipping point.

Wiegers and colleagues (1998c) wrote about the importance of risk selection, interprofessional cooperation between midwives and physicians, and the availability home health aides to assist with deliveries and provide postpartum care as essential for the maintenance of the Dutch system of home birth (p. 1511). They also pointed out the important role of social factors such as the "confidence of family and friends in home birth" and the generally "wide acceptance" of home birth within the culture (p. 1510-1). Amid recent headlines which claim "*550 dode baby's per jaar minder is haalbaar*" (550 fewer dead babies per year is feasible), this wide acceptance is most certainly eroding (Effting 2010).

Part-way through my fieldwork in the Netherlands, a fellow researcher commented, "It's a great time to be studying home birth in the Netherlands, Rachael – unless, of course, you care about home birth." The Dutch maternity care system and culture of birth are changing rapidly and there is much to be learned from this case study, but I no longer believe that the Netherlands has all the answers or that the Dutch system is necessarily something to be emulated. I have been cured of my naïve romanticism – so

much so that when I became pregnant while living in the Netherlands and was faced with the decision about where to give birth – home or hospital, the United States or the Netherlands – I chose home birth in the U.S. I made this decision for many reasons, but not least among them were the relative autonomy of U.S. home birth midwives who practice outside the mainstream health care system and the particular content of their knowledge and style of practice which are directly related to their marginal, countercultural position.

Recently, I have had cause for restrained optimism. First, in Minnesota, where I live and conducted the bulk of my U.S. fieldwork, home birth midwives have come out of hiding. When I started my research in the early 2000s, I had a difficult time locating midwives and those I did find were often nervous about talking to me and suspicious of my motives. Today, an internet search for "home birth midwife Minnesota" returns a number of websites and resources, senior midwives are regularly approached by women who want to train as apprentices, and the number of midwives has increased significantly in recent years. A documentary film is even being screened about the home birth experience in Minnesota (Kuznia 2013).

Part of the explanation for midwives' higher profile is that they are no longer operating in the legal grey area that had them worrying about possible prosecution for decades. Home birth in Minnesota – like in many other parts of the U.S. – was virtually eradicated during the early part of the twentieth century (Leavitt 1986; Sullivan and

Weitz 1988; Wertz and Wertz 1989; Rothman 1991; Borst 1995; Rooks 1997).[1] The breastfeeding and natural birth movements of the 1960s and 70s brought with them a small resurgence, but the midwives who began practicing at that time operated largely underground. This changed when state legislation was passed in 1999 making licensure possible for direct-entry midwives who are certified by the North American Registry of Midwives (Minnesota Statute, Chapter 147D).[2] Prior to that, a 1906 law required midwives to produce either a diploma from a school of midwifery approved by the Board of Medical Examiners (BME) or to sit for an examination in order to gain licensure. Since the BME no longer offered an exam and did not recognize any educational programs, it was impossible for modern midwives to become licensed under the old law. Indeed, the last license granted under that law was issued in 1938.

The current statute is quite favorable to midwives. It allows for voluntary licensure which means that midwives can practice in the state with or without a license. It also gives them significant control over their scope of practice by leaving much unspecified in the law and instead referring to a Standards of Practice document crafted and regularly updated by the Minnesota Midwives' Guild. The Minnesota law is certainly not perfect. It is a source of contention among midwives and perhaps even a codified means of subordinating midwives to the medical profession (see De Vries (1996) for a description of this process), but it does seem to have given many midwives the confidence to practice openly.

[1] The tradition of home birth lasted longer in the rural south and southwest largely as the result of racism and the systematic denial of "modern" health care to African-American and Latina women (Holmes 1986; Logan 1989; Smith 1996; Fraser 1998; Buss 2000).

[2] For a comprehensive discussion of the Minnesota state law see Lay (2000) and Lay and Dixon (2006).

Second, all the attention paid to home birth can be interpreted as a sign of its power and the significant challenge it poses to the biomedical model of obstetrics. For example, the home birth rate in the U.S. increased by 29 percent between 2004 and 2009 – that is, it went up from 0.56 to 0.72 percent (MacDorman, Mathews, and Declercq 2012b).[3] In the pages of the *American Journal of Obstetrics and Gynecology* this was described as a dangerous "recrudescence" or outbreak – something to be stamped out (Chervenak et al. 2013a). Given that home birth represents less than one percent of all births in the U.S.,[4] it may appear that the opposition it inspires is disproportionate to its size. However, when we acknowledge that giving birth at home is not simply the expression of a preference for place of birth, but a rejection of the tenets of biomedicine and the agreed upon social order, this intensity is more understandable. Home birth demonstrates a lack of respect for the supremacy of technology over nature and masculine over feminine. This is why what could otherwise be viewed as the deviant behavior of a small subset of women evokes such intense emotion.

A final source of hope is that home birth is reemerging in other places such as the UK, Canada, and New Zealand and a well-organized home birth research agenda is beginning to crystalize. The Birthplace in England Research Programme sponsored by the National Perinatal Epidemiology Unit, the Canadian Birth Place Study funded by the Canadian Institutes of Health Research, and the Midwifery Science Board

[3] In Minnesota, home births increased by 66 percent between 2004 and 2009 – from 0.51 to 0.85 percent (MacDorman, Mathews, and Declercq 2012a). The most recent data indicate at home birth rate of 0.9 percent in Minnesota (Martin et al. 2013).

[4] Among some subgroups (e.g., non-Hispanic white women) the rate is closer to one percent (MacDorman, Declercq, and Mathews 2011) and in some states (e.g., Montana, Vermont, and Oregon) the rate is now over two percent (Martin et al. 2013).

(*Wetenschapscommissie verloskunde*) in the Netherlands are examples of research efforts that are starting to fill knowledge gaps that have, until recently, allowed for unbridled criticism of home birth practices and inappropriate interpretations of data regarding outcomes.

HOME BIRTH AND MIDWIFERY IN THE U.S. AND THE NETHERLANDS[5]

The U.S. and the Netherlands are both outliers when it comes to maternity care. In most developed countries childbirth takes place in the hospital, women are attended by midwives under physician supervision, and obstetricians are called upon to provide care in complicated cases. The unique systems in the U.S. and the Netherlands make for theoretically interesting cases.

In the U.S., nearly universal hospitalization is the norm. This is consistent with the organization of care in most other developed countries. What is distinct about the U.S. system is who delivers care – not where that care is delivered. The majority of prenatal, intrapartum (around the time of birth), and postpartum care is provided by obstetricians. Using physician-specialists as primary care providers for healthy women with uncomplicated pregnancies is almost unheard of in other parts of the world.

In the Netherlands, a significant number of births take place at home with assistance from midwives who are members of the mainstream health care system. Dutch midwives are generally not under the supervision of physicians – except in a newly emerging model of hospital-based midwifery (Wiegers and Hukkelhoven 2010). At the same time, the division of labor that has been negotiated between midwives and

[5] A version of this section was previously published in Kulick and De Vries (2008).

physicians specifies that independent midwives are only to assist healthy women with uncomplicated births. As a byproduct of this agreement and of the changing definitions of "healthy" and "uncomplicated," midwives provide the bulk of prenatal and postpartum care, but are responsible for less than half of all births (Wiegers 2009). Thus, the Netherlands differs from most other developed countries both in terms of where care is delivered and how that care is divided between midwives and physicians.

A Brief History of Home Birth and Midwifery in the U.S.[6]

During colonial times, childbirth for European immigrants was a female affair (Wertz and Wertz 1989). Births took place in homes and were attended by midwives and female friends and relatives who provided technical, emotional, spiritual, and domestic support. Midwives practiced within a system of municipal licensure that was inconsistent across municipalities. Licensure, when and where it did exist, was typically linked to character rather than to training or demonstrated expertise.

During this period, men were generally prohibited from involvement in childbirth except in extreme emergencies during which the role of male physicians was limited to surgical intervention when the mother or the fetus was either dead or dying. A rivalry was developing, however, between female midwives and so-called man-midwives (who later became known as obstetricians). Many decades would pass before male childbirth attendants became the norm.

[6] For a more thorough investigation of the history of midwifery and childbirth in the U.S., see Litoff (1978) and (1986), Leavitt (1986), Wertz and Wertz (1989), Borst (1995), and Rooks (1997).

Between 1750 and 1950, childbirth both professionalized and medicalized (Leavitt 1986; Borst 1995). Three shifts took place during this period: (1) the primary birth attendant shifted from midwife to physician, (2) birth moved from the home to the hospital, and (3) the rate of medical intervention increased. There are many explanations for why birth shifted from the hands of midwives to the hands of physicians.

First, physicians were quickly professionalizing. They were establishing medical schools, forming professional organizations like the American Medical Association, and outlining a code of ethics that regulated intra- and interprofessional relationships. At the same time, they were experiencing growing power and authority and were experiencing success in limiting practitioners such as midwives and chiropractors who did not share their ideology or sociodemographic characteristics.

The decline of midwifery, however, was not caused exclusively by powerful physicians forcing midwives out of maternity care. Societal changes also led to devaluation of the traditional knowledge and skills of midwives in favor of the expert, scientific knowledge purportedly held by physicians (Borst 1995). Women began turning to physicians because they could offer interventions such as anesthesia and forceps that midwives generally did not employ.

The shift from midwife- to physician-attended birth largely preceded the move from home to hospital (Leavitt 1986). As such, physicians were attending births in homes – and using anesthesia – for decades before maternity care became institutionalized within hospitals. Nonetheless, the shift from home to hospital was a welcome change for some women – particularly middle-class white women – who saw it as an opportunity to

expand their sphere beyond the home and as a respite from domestic life. Hospital birth was not necessarily pleasant or safe, however. Infection was common and in the years immediately following the move from the home to the hospital, maternal mortality did not improve.

Across social and historical time and space, various knowledge systems have been mobilized to explain the phenomenon of birth. By the early- to mid-1900s, the biomedical model – characterized by the use of hi-tech devices and procedures, active intervention and management, and a focus on the pathology of pregnancy and birth – had become ascendant. The 1960s brought a critique of medicalized birth and the articulation of an alternative to biomedical dominance that came to be known as the midwifery or holistic model (Rothman 1991; Davis-Floyd 2001). This model advocated limited intervention in the birth process, a focus on the normalcy and safety of pregnancy and birth, and shared decision-making power between birthing women and their attendants.

Dissatisfaction with medicalized birth also led to a natural birth movement. While the movement brought changes to hospital birth such as allowing male partners to be present and promoting conscious (as opposed to sedated) childbirth, many conclude that key components of movement were co-opted. The last quarter of the twentieth century was marked simultaneously by the gradual reemergence of midwifery and demands for unmedicated, unintervened with birth on the one hand and the increasing use of anesthesia and surgical birth on the other. These trends illustrate the polarization that surrounds birth in the contemporary U.S.

A Brief History of Home Birth and Midwifery in the Netherlands

Historians point to the early regulation and training of midwives as important precursors to the modern Dutch maternity care system (Van Lieburg and Marland 1989; Marland 1993). During the seventeenth and eighteenth centuries, municipalities were already regulating midwives, offering training courses, and administering competency examinations. Many midwives worked in private practice, but most towns also appointed *stadsvroedvrouwen* (municipal midwives) to care for pregnant women within their jurisdictions. In the nineteenth century, regulatory oversight and training moved to the national level. Rather than marginalizing midwives – a strategy used elsewhere in Europe and the United States – Dutch leaders sought to incorporate them and use their skills to improve the health and safety of mothers and babies.

In terms of formal, academic training, Dutch midwives are some of the most highly educated midwives in the world. Their historic claim to autonomy of practice is based, in part, on this legacy. State schools of midwifery were established in the late 1800s. These programs, initially two years in length, were intended to replace the tradition of training by apprenticeship and produce a more uniformly trained workforce. In the 1920s, a third year was added and in the 1990s, the curriculum moved to four years. Midwives are trained in prenatal and postpartum care of the mother, care and evaluation of the newborn, management of physiological (*fysiologisch*) birth, identification of situations that pose high or increased risk of complications, and, most recently, the conduct of scientific research. Along with increasing education, the tasks permitted to midwives expanded over the course of the twentieth century to include

external correction of malpresentation, administration of medicines, drawing blood, and suturing perineal tears.

Certainly, early regulation and formal training of midwives cannot fully explain the shape of modern maternity care in the Netherlands and many have asked: Why – in this high-income, developed country with an advanced medical system – has home birth not been abolished and have midwives not been brought under the control of physicians? After all, this is what happened in all other developed countries during the twentieth century. Historians and social scientists have offered a number of additional explanations including legislation and insurance policies that privilege midwives over physicians, a unique system of postpartum home care provided by professional maternity care aides (*kraamverzorgenden*), ideological commitment to the fundamental physiology of pregnancy and birth, and a system of risk selection and screening that sorts pregnant women into primary and secondary care trajectories (Van Teijlingen 1990; Hingstman 1994; Wiegers, Van der Zee, and Keirse. 1998a; De Vries 2004).

De Vries (2004) focuses on how Dutch history, politics, and, in particular, culture have come together to create and sustain this distinct model of care. He points to the early nuclearization of the family and a uniquely Dutch conception of home. The Dutch were the first among their European neighbors to develop the concept of nuclear family, build single-family residences, and adopt the bourgeois family model as the dominant family form. Even within this bourgeois model, Dutch women enjoyed substantial freedom and influence within the family. Cultural (some say Calvinist) attitudes toward pain and an ongoing aversion to the use of pharmaceuticals for pain relief (Kooiker and Van der Wijst

2003) also likely stemmed the development of a medicalized form of birth. Further, a high value placed on thriftiness, a downplaying of heroic intervention, and a strong emphasis on social solidarity over individualism were all important in shaping maternity care and maintaining childbirth as a normal physiological process best accomplished at home in the hands of women.

METHODS, DATA, AND ANALYSIS

I began this project with a relatively straight-forward question: What is it like to give birth at home in the U.S. (where home birth is deviant and where the practice of home birth midwifery is, in many states, criminalized) and the Netherlands (where home birth is normative and home birth midwifery is an integral part of the mainstream health care system)? I wanted to understand – from the perspective of the pregnant and birthing woman – how the experience differs under these distinct sociocultural conditions. To do this, I developed a comparative, ethnographic research design oriented around participant-observation and semi-structured interviews. I carried out this research in Minnesota between March 2007 and July 2008 and in the Netherlands between August 2008 and June 2009.

While formal data collection ended in June 2009, my insight into the experience of planned home birth continued to grow – specifically as I prepared for the birth of my own child born in August 2009. I incorporate this overlapping life experience into the dissertation – going so far as to use fieldnotes I recorded about my own pregnancy and birth and excerpts from a pre-birth interview that a colleague conducted with me as

sources of data. As you read, you will occasionally come across a section about "Rachael's" experience. I have given all the participants in the study pseudonyms – except for me. My feminist approach to ethnography means not only that I conduct research with the goal of producing a text that is about, by, and, largely, for women, is attentive to issues of power, diversity, agency, and constraint, and rejects the scientific model of an objective, disinterested researcher (Aune 2012), but also that I see my own embodied experience (both when I am observing others and when I am more explicitly the subject) as a source of knowledge.

Research in Minnesota

After working as a doula for two years and attending 65 births in that capacity, I decided I was ready to begin my research. The project received approval from the Institutional Review Board at the University of Minnesota in March 2007.

The first task was to recruit midwives into the study. I began by compiling a list of Minnesota midwives who assisted in home deliveries. I then mailed letters of invitation to participate in a research study. I received very few replies. So, I adopted a new approach – meet midwives face-to-face, introduce myself, and tell them about my work. I attended monthly home birth "meet-ups," midwifery training workshops (e.g., a course on placentas and complications of the third stage of labor), a Standards of Care meeting in which members of the midwifery community gathered to update their practice guidelines and protocols, and a meeting of the Minnesota Council of Certified Professional Midwives. This process led to a number of fruitful collaborations. In the

end, I conducted six in-depth interviews and followed the practices of four midwives. Of the midwives who participated in the study, four were in solo practice, two were in duo practice, and all but one were both certified by the North American Registry of Midwives and licensed by the state of Minnesota (see Table 1).

Table 1. Study Participants: Minnesota Home Birth Midwives

Name	Type of Practice	Certified	Licensed	Interview	Follow Practice
Clara	Solo	Yes	Yes	Yes	Yes
Deirdre	Duo (with Jennifer)	Yes	Yes	Yes	Yes
Joan	Solo	Yes	Yes	Yes	No†
Sheila	Solo	Yes	Yes	Yes	No‡
Jennifer	Duo (with Deirdre)	Yes	Yes	Yes	Yes
Jacqueline	Solo	No	No	Yes	Yes
Totals				**6**	**4**

†Joan agreed to let me follow her practice, but time constraints prevented me from doing so.
‡Sheila assisted Clara at one of the births I attended while following Clara's practice.

When midwives joined the study, we figured out a date range during which I would work with them (e.g., May to December 2007 or January to June 2008). They then looked at their schedules to see which women under their care had due dates in that period. They informed those women about me and the study and asked whether they were interested in learning more. Women who said "yes" either contacted me directly or gave their midwife permission to give me their telephone numbers. We spoke over the phone and then arranged a time to meet in person. These first face-to-face meetings usually took place in the women's homes or in coffee shops. I told them about the study and my background and they asked me questions. If they wanted to go further, I provided them with informed consent forms and they decided which parts of the study they wanted to participate in. The study included pre- and post-birth interviews as well as observation at

prenatal appointments, births, and postpartum visits. Most women who joined the study participated in all aspects and considered me a member of their "birth team."

At the end of the first meeting, we scheduled a pre-birth interview. Pre-birth interviews lasted approximately 90 minutes and were conducted, again, in the women's homes or in coffee shops. The interviews covered questions such as: How did you find out about home birth? How are people in your family responding to your decision to birth at home? What are your plans and expectations for labor and birth? And, tell me about your midwife. How did you find her? How is she being paid? Is she licensed or certified? Are these things important to you? Why or why not? All interviews were recorded and transcribed.

After the pre-birth interview, I started attending prenatal appointments either in the woman's home or in the midwife's office. Historically, midwives provided almost all of their care in women's homes. Increasingly, however, they are establishing offices and holding prenatal appointments – at least until the last month of pregnancy – there. At prenatal appointments, the midwife, the pregnant woman, oftentimes her partner, and I would sit in chairs or on cushions on the floor for the first half of the appointment and talk. Sometimes the couple's older children would also attend and the midwife usually had a basket of toys in the room or a corner dedicated to children's play. The woman would provide a physical and emotional "check-in" and the midwife would ask questions and offer support and education. I would listen, observe, participate in the conversation, and take notes. Then, the more clinical aspects of the appointment would take place –

blood pressure check, standing on the scale, palpation of the woman's belly, listening to fetal heart tones, etc. Appointments typically lasted one hour.

As the woman's due date approached, we made a plan for how she would contact me when labor began. Sometimes the woman or her partner would call me. Other times the midwife kept me abreast of developments. In any case, I usually arrived at births at about the same time the midwife arrived. I observed as the midwife conducted physical assessments and provided labor support. When needed or requested, I also provided support in the form preparing meals, filling birth tubs, caring for older children, providing therapeutic massage, charting, handing the midwife supplies or equipment, and, after the birth, cleaning bathrooms, changing sheets, and doing laundry. Births lasted anywhere from a few hours to a few days and occasionally involved transport from home-to-hospital due to obstetric complications or maternal exhaustion. In cases of transport, I would stay with the woman, her partner, and her midwife until the baby was born.

During the first week postpartum, I would accompany the midwife as she made visits to the woman's home and/or hospital room in the case of transport. I observed as the midwife conducted physical examinations of mother and baby, went over the details of the labor and birth, and offered lactation support. Often the final appointments – around weeks three and six – returned to the midwife's office and I observed some of these visits as well.

Following the week six postpartum appointment, the woman and I would arrange for a post-birth interview. These interviews, like the pre-birth interviews, usually lasted about 90 minutes. The interviews were recorded and transcribed. They almost always

took place in the woman's home and she was often breastfeeding and/or holding the infant for most of the interview. The post-birth interview was quite open-ended and included questions such as: Tell me about your labor and birth. What would you do differently, if you were to give birth again? What are your biggest challenges now? And, what kind of support are you receiving?

At prenatal appointments, births, and postpartum visits, I always took notes. Sometimes, I wrote constantly – writing down what was happening and recording dialogue verbatim. Other times, I simply made "jottings" – short notes intended to jog my memory when I sat down to write more extensive fieldnotes later. Often, I would spend my mornings in prenatal appointments or conducting an interview. Then, in the afternoon or evening, I would type up my fieldnotes or begin the work of transcription. Interview transcripts and birth fieldnotes often took multiple days to complete. For most births, for example, I ended up with fifteen to twenty pages of notes. Table 2 provides a summary of the data collected with birthing women during the Minnesota part of the dissertation.

Table 2. Data Summary: Minnesota Birthing Women

Name	**Pre-birth Interview**	**Prenatal Appointments**	**Labor and Birth**	**Postpartum Appointments**	**Post-birth Interview**
Sarah	No	No	Yes	Yes (1)	Yes
Lauren	Yes	No	Yes	Yes (1)	Yes
Faith	Yes	Yes (1)	Yes	Yes (1)	Yes
Krista	Yes	Yes (2)	Yes	Yes (3)	Yes
Emma	Yes	Yes (6)	Yes	No	Yes
Lisa	Yes	No	Yes	Yes (2)	Yes
Jolene	Yes	Yes (6)	Yes	No	Yes
Michelle	Yes	No	No	Yes (2)	Yes
Jessica	Yes	Yes (4)	Yes	Yes (1)	Yes
Kelly	Yes	No	Yes	Yes (1)	Yes
Totals	**9**	**19**	**9**	**12**	**10**

As indicated above, ten birthing women participated in the study. I collected demographic information from them during the interviews. This was a racially homogeneous group – all but one woman in the study were white. It was also a well-educated sample – all had some college education, most had a bachelor's degree, and three women had some graduate-level training. All the women in the study were heterosexual and all but one were married. They ranged in age from 26 to 37 years and had between zero and four children at the start of the study. Their family incomes ranged from $22,000 to $95,000 per year. These characteristics are relatively consistent with what existing literature says about home birthing women. That is, they are more likely to be white, older, married, and well-educated (Johnson and Daviss 2005; MacDorman, Declercq, and Menacker 2011; MacDorman, Mathews, and Declercq. 2012b). One area in which this sample differs from the average is in terms of parity. Previous research shows that compared with hospital births, home births are more common among women with several previous children (MacDorman et al. 2012b). In this study, however, eight out of ten participants had only one child or had never given birth before. Table 3 provides an overview of the demographic characteristics of the Minnesota study sample.

Table 3. Demographic Information: Minnesota Birthing Women

Name	Age	Race/ Ethnicity	Religion	Education	Marital Status	Family Income	# of Children	Prior Birth Experiences
Sarah	32	White	None	Bachelor's degree, enrolled in master's program	Married	$95,000	1	Planned hospital birth with certified nurse-midwife, c-section
Lauren	32	African-American	None	Bachelor's degree, some professional training	Married	$63,000	1	Planned home birth, home-to-hospital transport, c-section
Faith	27	White	Christian	Bachelor's degree	Married	$50,000	3	Two home births, one adoption
Krista	37	White	None	Bachelor's degree	Married	Upper middle class	1	Home birth
Emma	27	White	Lutheran	Associate degree	Married	$35,000	1	Home birth
Lisa	35	White	Unitarian	Two bachelor's degrees	Married	$62,000	0	n/a
Jolene	26	White	Undecided	Bachelor's degree	Married	$22,000	0	n/a
Michelle	31	White	None	Master's degree	Long-term co-habiting	$40,000	0	n/a
Jessica	28	White	Christian	Some college	Married	$28,600	0	n/a
Kelly	28	White	Independent Apostolic Lutheran	Bachelor's degree	Married	Not specified	4	Two planned hospital births, one home birth, one home-to-hospital transport for prolonged labor

Research in the Netherlands

I began laying the groundwork for research in the Netherlands during trips in 2005, 2006, and 2007. I met with independent midwives, health care researchers, and administrators at two of the three schools of midwifery in the country – the *Academie Verloskunde Amsterdam Groningen* (Midwifery Academy of Amsterdam and Groningen) and the *Academie Verloskunde Maastricht*. As a byproduct of these conversations, I received letters of invitation to conduct research in the Netherlands. Midwifery academy staff also agreed to secure "placements" for me with two midwifery practices – one in the south of the country and one in the north.

The first practice I was assigned to was located in the southern province of North Brabant. It was a group practice of three midwives. A student midwife was also interning with them during the period of my observation. The midwives had an office on the ground floor of a small medical building that also housed other primary care providers such as a physical therapist and a counselor. An office assistant worked for the practice scheduling appointments and managing referrals to other care providers.

Like in Minnesota, the midwives looked at their client list and determined who was due during my time with them. They then provided information to these clients about the study. The office assistant would regularly update me regarding who wanted to learn more about the study. She would tell me when their next scheduled appointments were and I would meet them at the office. We would exchange names and shake hands in the waiting room and then go to one of the examination rooms to discuss the study. If, after our conversation, a woman was still interested in joining, I would present her with

informed consent forms, she would choose which parts of the study to participate in, and we would arrange for our next meeting.

Finding a second practice to work with was quite difficult. The internship coordinator at the academy in Groningen was tasked with finding a placement for me, but none of the practices she spoke with were willing to take on a researcher. They expressed concern that I would be one more *onbekend gezicht* (unfamiliar face) for their clients to get to know. It is important to note that these were all group practices. After many weeks, a midwife in solo practice in the province of Friesland heard about my study. She had a sister who lived in the U.S. and had attended her sister's planned home birth. The birth required transport from home-to-hospital and this midwife, Charlotte, experienced firsthand the discrimination home birthing women and their midwives face in the U.S. She was, therefore, very interested in learning more about my work. We met at her home one evening and felt an immediate connection. She agreed to take me on as a researcher and observer in her practice. She also became my midwife – as I was about four months pregnant at the time. Table 4 provides information about the midwives who participated in the Netherlands portion of the study.

Table 4. Study Participants: Netherlands Midwives

Name	**Type of Practice**	**Interview**	**Follow Practice**
Charlotte	Solo	Yes	Yes
Kara	Group	Yes	Yes
Eva	Group	Yes	Yes
Marlies	Group	Yes	Yes
Pauline (student)	Group	Yes	Yes
Totals		**5**	**5**

The research process worked differently in the solo practice in the north than it had in the group practice in the south. Charlotte told all her clients that I was observing in the practice and asked whether I could sit in on prenatal and postpartum visits. Everyone agreed. They were used to having student midwives present and thought of me in much the same way. Charlotte also told them I would be calling to tell them more about myself and my research and to ask whether they would like to do an interview or have me present at the birth. She gave me a list of names and telephone numbers and I called them one-by-one. In the end, twelve women participated in various aspects of the study. I recall the recruitment conversation I had with Frauke, in particular.

> Rachael: Would you like to hear about the study?
>
> Frauke: Yes.
>
> Rachael: What do you already know? What has Charlotte told you?
>
> Frauke: I don't know anything. Just tell me.
>
> Rachael: I am a medical sociologist working on a doctoral degree at the University of Minnesota in the United States. I started the research phase of my program in 2007 – working with midwives in the U.S. I observe prenatal appointments, go with the midwife to the birth, ride along to postpartum visits, and do prenatal and postpartum interviews. Do you have questions?
>
> Frauke: No. It is clear.
>
> Rachael: Would you like to be involved?
>
> Frauke: Yes.
>
> Rachael: With everything?
>
> Frauke: Sure.
>
> Rachael: I can be present at your prenatal and postpartum visits and come with Charlotte to the birth?
>
> Frauke: Sure.

Women were often this frank – whether they were joining the study or declining participation. The next step was to go over informed consent documents and set up a time for an interview.

All pre-and post-birth interviews – at both fieldsites – took place in women's homes and were conducted in Dutch. They typically lasted 50 to 60 minutes – significantly shorter than in the U.S. I attribute this difference primarily to the normative nature of home birth in the Netherlands. Dutch women simply did not have as much to talk about as women in the U.S. There was one exception, however. My interview with a Swedish woman birthing in the Netherlands lasted about two hours. She had lots say about the system and she was grateful for the opportunity to be able to discuss her concerns with another "outsider." All interviews were recorded and transcribed. Some were transcribed verbatim in Dutch. Others were simultaneously translated into English and transcribed. I did all the translation.

My fieldwork in the Netherlands was considerably more observation than participation. During office visits (usually 15 to 20 minutes long), women began by sitting across a desk from the midwife for a verbal check-in. Also at the desk, the midwife took the woman's blood pressure. Then they would move to the scale and examination table. At my first fieldsite, the midwives placed a chair for me in the corner of the room – about six feet away from the consultation desk. I sat in that chair for a couple weeks and then decided to change locations. I moved my chair to sit next to the pregnant woman at the desk and I followed her and the midwife to the exam table. I rarely took notes while in the room and instead wrote vigorously after every appointment.

At births, I kept a small notebook in my pocket and jotted down key events, times, and pieces of dialogue. I wrote more extensive fieldnotes either at home or at a library the day after the birth.

I also observed additional aspects of the Dutch home birth system. I attended midwifery training courses and conferences, spent a number of full days following maternity care aides (*kraamverzorgenden*) in women's homes during the first week postpartum, observed visiting public health nurses conducting hearing and other newborn screening tests, and accompanied women to well-baby visits at the public health clinic (*consultativebureau*). I also shadowed both a physician and a nurse at one of these clinics. These experiences are accounted for in the column labeled "other postpartum care" (see Table 5).

Table 5. Data Summary: Netherlands Birthing Women

Name	**Pre-birth Interview**	**Prenatal Visits**	**Labor and Birth**	**Postpartum Visits**	**Post-birth Interview**	**Other postpartum care**
Gerda	Yes	Yes (4)	Yes	Yes (3)	Yes	Yes (1)
Monique	Yes	Yes (4)	No	No	No	No
Sabine	Yes	Yes (3)	No	Yes (4)	Yes	No
Jolanda	Yes	Yes (4)	Yes	Yes (2)	Yes	Yes (1)
Margo	No	No	Yes	Yes (2)	Yes	Yes (1)
Trudi	Yes	Yes (3)	Yes	Yes (2)	Yes	Yes (1)
Nadine	No	Yes (1)	No	No	No	No
Hilke	Yes	No	Yes	Yes (1)	Yes	Yes (1)
Aukje	No	No	Yes	Yes (3)	Yes	No
Imke	No	No	Yes	Yes (3)	Yes	No
Margreet	Yes	No	Yes	Yes (1)	Yes	No
Liesbeth	No	No	Yes	Yes (2)	Yes	No
Frauke	Yes	Yes (2)	Yes	Yes (1)	Yes	No
Mieke	Yes	No	Yes	Yes (2)	Yes	No
Sophie	No	Yes (2)	No	No	Yes	No
Antje	Yes	Yes (2)	No	No	Yes	Yes (1)
Astrid	No	No	Yes	Yes (1)	No	No
Catharina	No	No	No	No	Yes	No
Totals	**10**	**25**	**12**	**27**	**15**	**6**

Eighteen women participated in the Netherlands portion of the study – six in North Brabant and eleven in Friesland. The participants in North Brabant were mainly of Dutch ethnicity and either Catholic or non-practicing Catholic. Two were married, three were long-term co-habiting, and one was single. In Friesland, most participants were Frisian and identified as Protestant, Reformed, or Christian. Almost all the women in Friesland were married. These characteristics are typical for the regions. Fourteen of the eighteen study participants were either giving birth for the first time or had only one other child. The women ranged in age from 22 to 39 years. The mean age of women at the birth of a first child is approximately 29 years old in the Netherlands (United Nations Economic Commission for Europe 2012). This is significantly older than in the U.S. where the mean age of first birth is about 25 years. Women in the study ranged in education from high school, to post-secondary vocational and professional training, to research-oriented university education. A summary of the demographic characteristics of the Netherlands sample is provided in Table 6.

Table 6. Demographic Information: Netherlands Birthing Women

Name	Age	Ethnicity/ Nationality	Religion	Education	Marital Status	Family Income	# of Children	Prior Birth Experiences
Gerda	31	Swedish	None	Gymnasium in Sweden[a]	Long-term co-habiting	Self-employed	1	n/a (child from partner's previous relationship)
Monique	22	Dutch	Catholic	MBO[b]	Single	Currently not working	0	n/a
Sabine	30	Dutch	Non-practicing Catholic	Universiteit[c]	Long-term co-habiting	Not specified	0	n/a
Jolanda	29	Dutch	Non-practicing Catholic	HBO[d]	Married	€65,000	1	Home birth
Margo	30	Dutch	Non-practicing Catholic	HBO	Married	€68,000	2	Two planned primary care[e] hospital births, one transferred to secondary care[f] due to preterm labor
Trudi	33	Dutch	Catholic	MBO	Long-term co-habiting	Average	1	Planned primary care hospital birth
Nadine[g]	--	--	--	--	--	--	0	n/a
Hilke	36	Frisian	Reformed	MBO	Married	Not specified	2	Planned hospital births[h]
Aukje	27	Frisian	Not specified	MBO	Married	Not specified	1	Home birth
Imke	33	Frisian	Protestant	MBO	Married	€60,000	1	Planned home birth transferred to hospital for prolonged rupture of membranes

Table 6. Demographic Information: Netherlands Birthing Women (continued)

Name	Age	Ethnicity/ Nationality	Religion	Education	Marital Status	Family Income	# of Children	Prior Birth Experiences
Margreet	30	Frisian	Reformed	HBO	Married	€35,000	1	Planned primary care hospital birth b/c no midwife in area, transferred to secondary care for post-dates induction
Liesbeth	26	Dutch	None	MBO	Long-term co-habiting	Not specified	0	n/a
Frauke	39	Frisian	Protestant	MBO	Married	Not specified	1	Home birth
Mieke	28	Dutch	Christian	HBO	Married	Not specified	0	n/a
Sophie	29	Frisian	Christian	HBO	Married	€42,000	0	n/a
Antje	36	Frisian	Protestant	HBO	Married	Not specified	1	Planned primary care hospital birth b/c no midwife in area
Astrid[g]	--	--	--	--	--	--	0	n/a
Catharina	39	Dutch	Protestant	HBO	Married	Not specified	3	Two planned primary care hospital births b/c no midwife in area, one home birth

[a] Gymnasium – secondary/high school education
[b] MBO (middelbaar beroepsonderwijs) – vocational training for work in sectors such as construction or secretarial support
[c] Universiteit (university) – research-oriented post-secondary education
[d] HBO (hoger beroepsonderwijs) – professional training for work in sectors such as engineering, management, and education
[e] Primary care births are conducted under the supervision of a midwife or a general practitioner. They may take place in the home or the hospital. Women with normally-progressing pregnancies and births must (with very few exceptions) give birth in primary care.
[r] Secondary care births are conducted under the supervision of a gynecologist. They take place in the hospital. Women with complicated pregnancies and/or births must give birth in secondary care.
[g] Nadine and Astrid did not complete the demographics form or participate in the interview portion of the study.
[h] During our prenatal interview, Hilke was having contractions. In fact, she gave birth the next day. Therefore, we kept the interview short and I did not learn many of the details of her first two births – such as whether they took place in primary or secondary care.

Process of Analysis

After I completed fieldwork, I spent a number of months typing up handwritten fieldnotes and transcribing interviews. I did a lot of this work while in the field, but much remained after I returned home. Between 2008 and 2010, four research assistants helped me in this endeavor.

In early 2010, I began working on something I called an ongoing memo document. Each morning, I would open the document, scroll down to the bottom of the page, insert the date, and being typing. This was a kind of theoretical memoing – linking things I had observed in the field to broader sociological concepts. During this process, I rarely returned to my fieldnotes or transcripts. Rather, the goal was to capture the ideas that were floating around in my head. I wrote in a stream-of-consciousness fashion and tried not to edit or judge my ideas. This process took many months and produced a document that was approximately 150 pages long.

Next, I returned to my fieldnotes and transcripts. I went through every piece of data collected during interviews, prenatal appointments, births, postpartum visits, midwifery workshops, and professional meetings. I organized these electronic documents in a systematic way – labeling them by date, participant's name, and type of data (e.g., pre-birth interview or postpartum visit).

I then printed a hardcopy of the ongoing memo document and started coding it for concepts. After coding, I physically cut the document up with scissors and sorted the pieces into envelopes labeled with concepts such as "birth ecologies," "altered state,"

"binaries and dualisms," and "natural birth." Only a subset of the concepts is represented in the dissertation.

I also printed the fieldnotes from every birth along with the transcripts from all pre- and post-birth interviews. I coded these documents as well – using both codes that developed out of the theoretical memoing process and new codes that emerged from the transcripts and fieldnotes themselves. With envelopes full of theoretical musings and fieldnotes and interview transcripts coded for particular phenomena, I began making decisions about which concepts to move forward with.

Starting with "altered state," I (re)entered a literature review stage. Scholarly reading I had done to this point clearly informed my creation of the "altered state" code, but now I wanted to know more about how social scientists think about people's experiences of an altered state of consciousness – not just (or even primarily) in childbirth, but in other areas of life as well such as prayer, extreme sports, and artistic performance. I used a similar process with other concepts.

Thus, analysis was inductive and iterative with considerable dialogue between theory and data. The structure of the dissertation reflects this methodology. It is organized around three broad concepts – stigma (part I), natural birth (part II), and trauma (part III). Each part has its own literature review and draws on multiple sources of data (e.g., fieldnotes, interview transcripts, and textual material) to illustrate how a particular concept is constructed in the field and how it is experienced by birthing women and their attendants in different social settings. Each part also introduces a number of sub-concepts

such as coping (with stigma) and altered state (as central to the enactment of natural birth). Empirical data and theoretical insights and formations are deeply interwoven.

OVERVIEW OF CHAPTERS

Part I deals with stigma and consists of three chapters. Chapter 2 is an analysis of U.S. authoritative medical discourse on home birth. In this chapter, I evaluate recent position statements issued by the American College of Obstetricians and Gynecologists and the American Medical Association. Using a sociological definition of stigma derived from the existing literature, I illustrate how the ideas and policies delineated within these documents construct planning a home birth as a risky behavior and actively work to label, stereotype, and discriminate against women who fail to comply with medical advice to birth in a hospital or other accredited facility. In chapter 3, I examine how home birthing women in the U.S. cope with the stigma of being labeled a risk mother. Drawing on in-depth interviews as well as personal experience, I outline three coping styles. I argue that being forced to cope with the chronic stress of stigmatization is morally unacceptable. Finally, in chapter 4, I address home birth in the Netherlands. Based primarily on fieldnotes, I present a picture of medical interactions in the absence of stigma. I also describe structures for collaboration between midwives and physicians such as the Dutch obstetrics manual (*Verloskundig Vademecum*) and obstetric cooperation networks (*verloskunde samenwerkingsverbanden*).

Part II centers on the concept of natural birth. In chapter 5, I present an analysis of natural birth discourse from the 1930s to the present. Focusing on conceptual and

rhetorical shifts in the characterization of mind-body relations, I identify three discursive periods and highlight an emerging trend in which childbirth is no longer described as natural or primitive, but as ecstatic and transcendent. In chapter 6, I use fieldnotes from one representative birth to demonstrate how natural birth discourse is transformed into practice in the U.S. context. I argue that the discourse informs a script for how to properly "do" home birth and that this script is organized around three features: environment, labor support, and an altered state of consciousness. I theorize a three-stage process by which women enter, inhabit, and exit an altered state. In chapter 7, I suggest that home birth in the Netherlands is not "natural birth" insofar as it is not a self-conscious enactment of the international natural birth discourse. Instead of analyzing home birth in the Netherlands through the lens of natural birth, I follow an inductive approach and allow the fieldnotes themselves to highlight important elements of the Dutch system such as the trend away from a solo and toward a group practice model, insurance industry support for home birth, and the role of professional postpartum home care. I end the chapter with the argument that in the face of cultural and structural changes, Dutch women have an increasing need for continuous labor support that often goes unmet. This lack of labor support threatens the viability of unmedicated birth at home.

Part III of the dissertation is about trauma. Chapter 8 begins with a review of the literature on birth trauma and childbirth-related post-traumatic stress. I then suggest that home-to-hospital transport is, by definition, a traumatic experience in the U.S. – not so much because of the obstetric complications that necessitate the transfer as because of the

disruption of beliefs and values that occurs when women must move from the midwifery to the biomedical model of care. I observe that the transition from home-to-hospital does not typically cause trauma in the Netherlands – though it may decrease satisfaction. Instead, in my sample, it is non-Dutch women with a medicalized view of birth who most susceptible to birth trauma as experience a significant rupture between their medicalized worldview and a maternity care system that promotes unmedicated, low-intervention birth.

I conclude with a description of how I came to choose home birth for myself. Given my particular location and biography – as a sociologist who studies birth, as an American living in the Netherlands – how did I decide to plan a home birth in Minnesota? What factors were especially important in my decision-making process? I end with recommendations for the future of birth. I argue that midwives should be the primary care providers for most women, that out-of-hospital births (in homes and in birth centers) should be supported, and that low-tech, high-touch, embodied forms of prenatal and intrapartum care must be protected as they can help women deal with the central dilemmas of birth (i.e., how to deal with pain, fear, and uncertainty) while also providing safety, respect, and autonomy for birthing women and their children.

PART I

STIGMA

CHAPTER 2
U.S. AUTHORITATIVE MEDICAL DISCOURSE: CONSTRUCTING HOME BIRTH STIGMA

Erving Goffman's (1963) *Stigma: Notes on the Management of Spoiled Identity* marked the beginning of the contemporary stigma concept. Goffman's essay inspired a rich research tradition in sociology and social psychology. Over a half-century, the stigma concept has been elaborated and refined and it has proven useful for understanding a wide range of phenomena including epilepsy (Scambler and Hopkins 1986; Schneider 1988; Jacoby 1994; Kleinman et al. 1995), mental illness and schizophrenia (Phelan et al. 2000; Yang et al. 2007), gender and ethnic identity (McCoy and Major 2003), exotic dancing (Lewis 1998), and sex work (Scambler 2007; Scambler and Paoli 2008). Evidence of the concept's continued relevance can be found in the fact that articles on stigma have been included in recent *Annual Reviews* of both sociology (Link and Phelen 2001; Pescosolido 2014) and psychology (Major and O'Brien 2005; Hinshaw and Stier 2008).

There are two broad approaches to thinking about stigma (Major and O'Brien 2005). According to a social constructionist view, stigma is a label created and applied by society. This approach is grounded in the observation that stigmatized attributes and characteristics vary by culture and change over time. An evolutionary approach suggests that "in order to avoid the potential pitfalls that accompany group living, humans have developed cognitive adaptations that cause them to exclude (stigmatize) people who possess (or are believed to possess) certain attributes" (Major and O'Brien 2005:395). The social constructionist and evolutionary approaches to understanding stigma are not

necessarily incompatible. As Major and O'Brien (2005) suggest, "even if there are evolved mechanisms that precipitate exclusion of certain social categories across cultures, … cultural beliefs can dictate which attributes within those social categories are stigmatized and the specific content of the stereotypes that are attached to those attributes" (pp. 395-6).

The stigma body of research faces two primary criticisms. First, some argue that stigma studies are too often conducted by social scientists who do not belong to the stigmatized group and, as a result, the theories generated are "uninformed by the lived experience" (Link and Phelan 2001:365). Second, stigma research tends to have an individual-level focus. It emphasizes the stigmatized person – her perceptions, experiences, and outcomes – and pays less attention to stigmatizers and those doing the discrimination (Fiske 1998; Sayce 1998; Link and Phelan 2001). Further, it places an "inordinate focus on individual actors as the sole source and recipient of stigma" thereby underestimating the role of collective and macro-level units as producers of structural discrimination (Yang et al. 2007:1531).

Part of this focus on the individual may be the byproduct of methodological bias. Survey methodology is the most commonly used methodology in the field of stigma research (Link et al. 2004) and it is particularly well-suited to "assessing stigma dimensions located within the individual" (Yang et al. 2007:1531). Yang and colleagues (2007) suggest that anthropological and ethnographic methods can inform the social dimensions of stigma – both its construction and its consequences – as well as ground analyses in "lived experience" in a "local social world" (p. 1528).

The current study is well-positioned to overcome these key criticisms. My multifaceted position in the field as researcher, participant, observer and member of the stigmatized group helps ground my findings in lived experience. Additionally, the ethnographic design of the study allows me to see the construction and consequences of stigma at multiple levels.

COMPONENTS OF STIGMA

According to Link and Phelan (2001), the concept of stigma applies "when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold" (p. 367). Recent studies also suggest that emotional reactions (Link et al. 2004) and moral experience (Yang et al. 2007) are significant in the stigma process. In this chapter, I analyze U.S. authoritative medical discourse regarding home birth using a "components of stigma" framework. In particular, I examine official statements issued by the American College of Obstetricians and Gynecologists and the American Medical Association between 2008 and 2011.

This analysis illustrates the social construction of home birth stigma. It describes how "pregnant woman planning a home birth" has been *labeled* "risk mother" and how this label is attached to negative *stereotypes* of irresponsibility and selfishness. It reveals how labeling and stereotyping have produced a cognitive *separation* between "us" and "them" and led to a *loss of status* – from good or *moral* mother to bad mother – for women planning to birth at home. The analysis shows the powerful *emotional reactions* – feelings of fear, anger, danger, and uncertainty – associated with home birth for both the

stigmatized and the stigmatizers. It demonstrates individual and structural *discrimination* that accompany home birth and, finally, it examines the tentative *power* relations within which this process unfolds.

HISTORICAL CONTEXT OF THIS STUDY

Interviews and fieldwork for the U.S. portion of this study were conducted between March 2007 and August 2008. The release of Ricki Lake and Abby Epstein's (2008) documentary film, *The Business of Being Born*, made this a tumultuous year in the history of U.S. home birth. The film elevated home birth in the national consciousness and led to statements by both the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA) in which they articulated their opposition to home birth. Lake and Epstein's film, the responses by ACOG and the AMA, and the media coverage that followed led to a situation in which women planning home births no longer had to imagine what opponents thought of them and their values. They read about it in newspapers, saw it on television, and heard their neighbors talking about at the mailbox.

In direct reference to Lake, ACOG (2008) published a statement that read, "childbirth decisions should not be dictated or influenced by what's fashionable, trendy, or the latest cause célèbre" and the AMA (2008) approved a resolution stating,

> Whereas, There has been much attention in the media by celebrities having home deliveries, with recent *Today Show* headings such as *"Ricki Lake takes on baby birthing industry: Actress and former talk show host shares her at-home delivery in new film"* …
>
> therefore be it

> RESOLVED, That our American Medical Association support the recent American College of Obstetricians and Gynecologists (ACOG) statement that "*the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex" ...*

Echoing debates of the early to mid-twentieth century, authoritative medical discourse pitted educated and safe physicians against uneducated and unsafe midwives. It touted technology over nature and progress over tradition. In prior incarnations of the midwife debate, however, the home birthing woman was seen as a victim of poverty, of race-based discrimination, of the fraudulent, predatory midwife or, simply, of tradition. In 2008 – with high-tech, hospital-based maternity care services provided by physicians assumed to be readily available – a woman planning a low-tech birth at home with the assistance of a midwife was now seen as making a conscious choice. This element of choice opened the door to the stigmatization of not only the midwife, but of the pregnant woman herself.

LABELING

Physicians have long been considered legitimate labelers of human difference (Freidson 1970b; Conrad and Schneider 1992; Scambler and Paoli 2008; McGann and Hutson 2011). During the twentieth century, physicians gained jurisdiction over more and more aspects of human life – including reproduction and childbirth – and their authority to label grew. This was part of the process of medicalization – that is, "the expansion of medical jurisdiction, authority, and practices into new realms" (Clarke et al. 2003:161).

Scholars during the first wave of medicalization studies (e.g., Freidson 1970a and 1970b; Szasz 1970, Conrad 1975 and 1992; Conrad and Schneider 1992; Zola 1972)

concluded that the medical profession was fast becoming "a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law" (Zola 1972:487). While it is clear that the medicalization of society was "one of the most potent transformations of the last half of the twentieth century in the West" (Clarke et al. 2003:161), the role of physicians in that process has changed over time. In particular, their power has declined in recent decades as insurance companies, consumer advocacy groups, and pharmaceutical and biotechnology companies become new "engines" of medicalization (Light 2000; Conrad 2005 and 2007). Nonetheless, physicians have retained an important role as conferrers of diagnosis – as labelers – to which a blossoming sociology of diagnosis is a testament (Jutel 2009; McGann and Hutson 2011).

One of the labels physicians – and especially obstetricians – have jurisdiction over is the label of "risk mother" (Wrede 1997). Wrede distinguishes between "risk pregnancies" which physicians and technology are responsible for identifying and managing and "risk mothers" who engage in ill-advised behavior and, in general, do not comply with medical advice. The category of risk mother has traditionally included women who smoke (Oaks 2000), use illicit drugs (Radcliffe 2009 and 2011), or consume alcohol (Armstrong 2003) during pregnancy. The list of risk behaviors, however, seems to be expanding with conditions such as being overweight (McNaughton 2010) or divorced (May 2008) increasingly framed in terms of the risk they pose to the fetus. Likewise, planning a home birth has been added to the growing list of risk behaviors.

Kukla (2010) describes the discriminatory consequences of the risk mother label. Her analysis of public health warnings – from labels on bottles of alcohol and packs of cigarettes to signs posted at amusement parks and work sites – suggests that pregnant women are given a choice "between excluding themselves from public spaces and forgoing basic services, or taking on the identity of the reckless mother willing to 'voluntarily' impose 'unnecessary risks' on her child" (Kukla 2010:323). Because authoritative medical discourse is premised on the idea that childbirth is inherently risky and unpredictable and, therefore, requires continuous monitoring of both the woman and the fetus in a high-tech setting in which surgery is immediately available, women who voluntarily choose to give birth at home are seen as imposing unnecessary risk their children. When it comes to place of birth, the editors of the Lancet (2010:303) write and Chervenak and colleagues (2013a:35) repeat, women "do not have the right to put their baby at risk."

STEREOTYPING, SEPARATION, AND STATUS LOSS

The next component of stigma is stereotyping. Stereotyping occurs when "dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes" (Link and Phelan 2001:367). Two key stereotypes are regularly attached to the risk mother label: irresponsibility and selfishness. As Viisainen (2000) writes, "Those who go against medical advice for hospital birth, have to deal with the moral danger of labeling and stigma consequent to their 'irresponsible' behaviour" (p. 794).

The stereotype of selfishness is evident in the 2008 ACOG statement on home birth which reads, "The main goal should be a healthy and safe outcome for both mother and baby. Choosing to deliver a baby at home, however, is to place the process of giving birth over the goal of having a healthy baby." This language serves to create a cognitive separation between "us" (those whose goal it is to have a healthy baby) and "them" (those whose goal it is to have a particular kind of birth experience).

ACOG's 2011 statement (reaffirmed in 2013) further raises the stakes on this kind of selfishness. The report counsels ACOG members that

> Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. (P. 425)

With this new rhetoric, women who plan to birth at home are not simply placing "the process of giving birth over the goal of having a healthy baby," they are voluntarily choosing to increase the risk that their infant will die. This claim is based on the primary conclusion of a meta-analysis of existing home birth studies conducted by Wax and colleagues (2010).

The Wax study is very controversial. After its publication, the *American Journal of Obstetrics & Gynecology* (*AJOG*) dedicated an entire Letters to the Editor section to the controversy (Davey and Flood 2011; Gyte, Dodwell, and Macfarlane 2011; Johnson and Daviss 2011; Kirby and Frost 2011; Sandall, Bewley, and Newburn 2011; Wax, Pinetter, and Lucas 2011a and 2011b; Zohar and De Vries 2011), *Scientific American* published an overview of critiques of the study (Hayden 2011), and *Medscape* published a point-by-point dissection of its methodology in which the authors write,

> The statistical analysis upon which this conclusion was based was deeply flawed, containing many numerical errors, improper inclusion and exclusion of studies, mischaracterization of cited works, and logical impossibilities. In addition, the software tool used for nearly two thirds of the meta-analysis calculations contains serious errors that can dramatically underestimate confidence intervals (CIs), and this resulted in at least 1 spuriously statistically significant result. (Michal et al. 2011)

In response to such criticism, *AJOG* convened a panel to review the Wax article. Members of the panel, selected by the journal, attempted to recreate the study's findings for three outcomes. The panel's results differed from those of the published study in all three cases. However, according to the journal's editors, "there was no difference in (1) the direction of the point estimate of the pooled odds ratio or (2) the overall 'statistical significance' of the result" and, therefore, there was no justification for retraction of the article (American Journal of Obstetrics and Gynecology 2011:e20).

Perhaps more troubling even than the problems related to methodology and analysis is the way in which the study's findings are presented – specifically which findings are highlighted and which are deemphasized. In addition to finding that planned home birth is associated with a significant increase in neonatal mortality, Wax and colleagues find that it is also associated with fewer maternal infections, hemorrhages, and lacerations than is planned hospital birth and that infants born at home experience less frequent prematurity, low birth weight, and assisted ventilation. Moreover, they found that planned home and hospital birth had similar perinatal mortality rates.

How can it be that planned home and hospital birth have similar *perinatal* mortality rates, but that home birth is associated with a far greater *neonatal* mortality rate? Michal and colleagues (2011) point to a non-standard definition of perinatal mortality used by the Wax team which led to problems of comparability across studies

and an inaccurate interpretation of the results.[7] Even if these criticisms were unfounded and the Wax study was overwhelmingly viewed as methodologically sound, there would remain the fact that Wax and colleagues (as well as ACOG in its dissemination of the study's results to patients and the public) highlight only *one* finding from their analyses while downplaying information about increased maternal and infant morbidity associated with hospital birth and offering a dissatisfying explanation for the "apparent discordance" of findings regarding perinatal and neonatal mortality rates (Wax et al. 2010:243.e6).

It is not my intention to provide further critique of the Wax study or to provide a definitive assessment of home birth safety. Rather, this chapter serves to demonstrate that knowledge production is a sociopolitical process embedded in power relations and that a gap in knowledge does not impede a stigmatization project. On the contrary, it may, in fact, help to fuel it.

Ultimately, being labeled a risk mother, stereotyped as irresponsible and selfish, and deemed separate or different from those whose goal it is to have a healthy baby comes with a loss of status. The woman planning a home birth moves from being a good or moral mother to being a bad mother. Good mothers are "self-sacrificing, nurturing, and compliant with medical advice" (Oaks 2000:77) while risk mothers "fail to live up to the societal ideal" and become "morally discreditable" (Murphy 2012:417).

[7] Typically, perinatal deaths are defined as those occurring during childbirth (i.e., intrapartum) and the first seven days of life. Neonatal death statistics, by contrast, generally include deaths of liveborn infants (i.e., no stillborn or intrapartum deaths) that take place within the first 28 days of life. Wax and associates use the standard definition of neonatal death, but an atypical definition of perinatal death – one that includes both stillborns and those who die within the first 28 days.

EMOTIONAL RESPONSE AND WHAT MATTERS MOST

According to Link et al. (2004), strong emotional response is a hallmark of stigma. Both stigmatizers and the stigmatized experience feelings of anger, fear, and uncertainty. Given that home birth accounts for less than one percent of all births in the U.S., it may seem that the emotional attention devoted to it is out-of-proportion. However, one has to consider that it is not just the 0.8 percent of births that take place at home that are at stake (Martin et al. 2013). Rather, stigmatized practices "threaten what matters most" at a societal level (Yang et al. 2007; Yang and Kleinman 2008:399).

There are many opinions about what, exactly, in the larger culture is threatened by the practice of home birth. Below, I discuss two particularly compelling theories. I do not see these as competing viewpoints. Both offer insight into what is threatened and why home birthing women and the midwives who attend them are stigmatized.

The first view, inspired by the work of Michel Foucault (1985 and 1995), focuses on pregnant female bodies as supersaturated sites of regulation, monitoring, and social control (e.g., Martin 2003 and Lupton 2012). According to this school of thought, when home birthing women remove their pregnant bodies from the panoptic gaze – specifically, from the gaze of the medical profession – they resist discipline by biomedical discourses. They also reject some of – or particular forms of – the self-surveillance expected of members of modern societies and especially of pregnant women.[8] Therefore, home birth and the women and midwives engaged in it threaten social order, social control, and social reproduction.

[8] While they may resist discipline by biomedical discourses, the home birthing body is not undisciplined or free from self-surveillance. Rather, it is controlled by another discourse – the discourse of natural birth. See

Robbie Davis-Floyd offers another take on "what matters most." According to Davis-Floyd (2001 and 2003a), the U.S. is a technocratic society. That is, it's "core value system is strongly oriented toward science, high technology, economic profit, and patriarchally governed institutions" (Davis-Floyd 2001:S5). Large social institutions – including the health and maternity care systems – are "primary socializing agents for the inculcation of mainstream American beliefs and values" (Davis-Floyd 2003a:65). They are, therefore, organized around the core value system. Viewed through this lens, the woman who opts out of hospital birth is evading the social responsibility to raise one's child with good, American values.

Davis-Floyd (2003a) goes on to argue that "even more profound indoctrination of society's core values can be accomplished with adults in special, intensely ritualized situations" (e.g., military training, medical school, and hospital birth) (p. 66). To engage in ritual, she writes, "is to feel oneself locking onto a set of cosmic gears which will safely and inevitable crank the individual right on through the perceived danger to safety on the other side" (p. 14). To give birth at home, then, is to reject the collectively-held belief that participation in hospital-based obstetrical procedures offers protection from danger and, especially, from death.

Ritual is often about providing continuity and maintaining the status quo, but it is also an important element of social change. According to Davis-Floyd (2003a), "advocates of home birth have been working to create entirely new rituals for birth – rituals that enact profoundly alternative beliefs about the nature of both birth and reality

---

Arney 1982, Zadoroznyj 1999, Martin 2003, and Part II of this dissertation for a more thorough treatment of this argument.

itself" (p. 17). When home birth is understood as an eschewal of the dominant value system and as the conscious enactment of an alternative value system, it becomes increasingly clear why it prompts strong feelings of fear and anger and leads to discrimination.

DISCRIMINATION

To understand stigma-related discrimination, we must ask "Do those who might confer stigma control access to major life domains like educational institutions, jobs, housing, and health care in order to put really consequential teeth into the distinctions they draw?" (Link and Phelan 2001:376). With respect to maternity care, the answer to this question is, "yes." Physicians represent one group that controls access to health care and their labeling of home birthing women as risk mothers has discriminatory effects – both at the individual and at the structural level.

Individual Discrimination

Individual discrimination with respect to home birth takes place via doctor-patient and home birth midwife-mainstream provider interactions.

Doctor-Patient Interactions

I planned to give birth at home, but transferred to the hospital after three days of labor. After giving birth, I could not tell when I needed to void my bladder. The physicians who treated me in the hospital suggested my bladder had been distended during labor and,

therefore, needed to be retrained. While I was in the hospital and for weeks after I got home, I went to the bathroom on the clock – every one and a half to two hours. I logged my fluid intake and my urine output.

A few weeks after the birth, I made an appointment with a gynecologist who had special training in urology. My husband went with me to this first appointment. It went quite smoothly and I was surprised by how little an issue was made of the fact that I had planned to birth at home. The gynecologist seemed compassionate – like she wanted to help me solve this problem.

I went back for a second visit – by myself. I saw the same doctor and this time our interaction was totally different. We hardly even talked about my bladder. Instead she spent most of the visit telling me how my midwife had terribly mismanaged my pregnancy and labor and how, had I been her patient, she would have induced me at 37 weeks when my bladder started bothering me. She said that she hoped I would make an "informed decision" about place of birth and labor management the next time I got pregnant.

Toward the end of the visit the conversation came back around to the bladder problems I was having. The gynecologist said, "I'm going to give you this self-catheterization kit to use at home." I was hesitant about self-catheterization. I had ongoing pain from a third degree perineal laceration[9] – pain so severe that I often could not sit and had to nurse my baby lying down. I was not interested in using a catheter multiple times per day. Furthermore, I did not think it was necessary. I had already undergone a test to assess my ability to empty my bladder by simply using the toilet.

[9] A third degree perineal laceration extends from the vagina into the anal sphincter.

Emptying the bladder was not a problem. The problem was that I had lost the normal sensation of bladder fullness and was having to urinate on the clock instead of "by feel." She downplayed my resistance to catheterization and handed me the kit without even showing me how to use it. I felt like I was being punished. I did not use the kit – though I was later billed $30 for it – and I never went back to the clinic.

Reflecting on this experience, I do not think it is a coincidence that my first visit was so markedly different from the second. At the first appointment, we were building rapport and trust. Perhaps, with this established, the physician felt less inhibited at our second meeting. Further, gender is important in the stigmatization of home birth. My husband's presence at the first appointment likely provided a layer of protection from judgment – or at least the open expression of it.

About that second appointment, I later wrote,

> What really hit me hard was when she told me that I was just lucky that my son wasn't sicker than he was. I didn't know how to respond. I was confused. Something didn't feel right, but I couldn't put my finger on it. I played the conversation over in my head as I left her office and walked to my car.
>
> Then it dawned on me. My son was not sick. He was born perfectly healthy. She simply assumed that my baby was sick because she knew that I had planned a home birth and had transferred to the hospital. I felt like I had been blind-sided, run over.

Many women in my study described some version of this kind of interaction – an interaction that left them feeling, initially, like bad mothers who had put their children's lives at risk and, later, angry, when they realized that they had been labeled and stereotyped and that the physicians they sought out for medical care were using their power to shame them. The work of De Vries and colleagues (2009) corroborates this finding. They write that those who participate in home birth in the U.S. – and in other

developed countries where home birth is stigmatized – often find that "hospital-based caregivers are reluctant to offer support to home birth mothers and are prone to scolding women whose care is transferred to the hospital" (p. 36).

Home Birth Midwife-Mainstream Provider Interactions

Part-way through her pregnancy, Sarah switched from a hospital-based certified nurse-midwife who was a member of a large obstetrics practice to a home birth midwife. She signed a release of records form with the medical practice and then her home birth midwife was supposed to be able to formally request her records. Sarah reported that her new midwife, Clara, was hesitant to make the request. According to Sarah,

> Clara had this other patient that transferred to Nancy (my old midwife) and she wanted to send her a thank you card first. She was uncomfortable with requesting the records because she thought Nancy was going to give her a bad time about doing an HBAC (home birth after cesarean). So, she put it off and when she finally did it Nancy called her up and basically said she was putting the baby at grave personal danger and if we had to transfer to the hospital where she worked –which was the closest hospital to our house – she would go after Clara's license. She would look at every action that was taken on the birth and find out where Clara had messed anything up and go after her license.

In the end, Clara decided she could not continue as Sarah's midwife. After years of academic training and apprenticeship, she had only recently established her own midwifery practice and the threat to her license, her livelihood, and the legitimacy of her profession was too great. At 37 weeks of pregnancy, Sarah was forced to switch care providers again – this time to a home birth midwife who had chosen not to become certified or licensed in the state of Minnesota.[10] The interaction Sarah describes between

[10] Licensure is distinct from certification. Individual states license direct-entry midwives and a national body (either the North American Registry of Midwives or the American Midwifery Certification Board) confers certification. Therefore, it is possible to be certified without being licensed. It is also possible to be

Nancy (the certified nurse-midwife) and Clara (the licensed certified professional midwife) highlights a long and complicated history between nurse-midwives and direct-entry midwives (see Davis-Floyd 2006 for a detailed history). The later introduction of the midwife who has been attending births for close to a decade – but who chooses to remain uncertified and unlicensed – points to divisions among direct-entry midwives as well, particularly over issues of regulation.

Both the *doctor-patient* and the *home birth midwife-mainstream provider* interactions described above are discriminatory. They are examples of a person in a position of power who controls access to essential human services shaming or issuing threats. Many birthing women and midwives have direct experience with this kind of individual-level discrimination, but even when women do not have personal experience, the *fear* of shaming and judgment has discriminatory effects. Because the risk of stigmatization is so great and the fear of shaming and discrimination so debilitating, many women planning home births avoid mainstream medical care during pregnancy – even for non-pregnancy-related issues.

The women in this study are not hostile to biomedicine across the board. They do, however, have a post-biomedical mindset. That is, they "do not entirely deny the usefulness of biomedicine, but challenge its hegemony via alternative systems of knowledge" (Klassen 2001:776). They seek health care providers who respect their values and long for a health care system characterized by "mutual accommodation" (Jordan 1993).

---

neither certified nor licensed. As certification is usually required for licensure, it is generally not possible to be licensed, but uncertified.

Structural Discrimination

In addition to individual discrimination, structural discrimination causes problems for pregnant women planning a home birth. Drawing on the work of Corrigan, Markowitz, and Watson (2004), Yang et al. (2007) describe intentional structural discrimination as when a "decision-making group of an institution intentionally implements policies that reduce opportunities for a particular group" (p. 1527). In this section, I provide three examples of intentional structural discrimination: (1) the inability of midwives to secure collaborative care agreements with physicians and hospitals, (2) health insurance reimbursement policies that deny coverage for home births and related services, and (3) state laws that prohibit home deliveries by direct-entry midwives.

Collaborative Care Agreements

ACOG's 2008 policy paper on home birth states that is "does not support programs that advocate for, or individuals who provide, home births." In 2011, the organization clarifies that it "does not support the provision of care by lay midwives or other midwives who are not certified by the American Midwifery Certification Board"[11] (American College of Obstetricians and Gynecologists 2011:427). It is important to note that many states license midwives who receive certification from a board other than the American Midwifery Certification Board (AMCB) – that is, from the North American Registry of

[11] The American Midwifery Certification Board (AMCB) confers the certified nurse-midwife (CNM) and certified midwife (CM) credential. Certified nurse-midwives are nurses with advanced training in midwifery. They are licensed in all 50 U.S. states, the District of Columbia, and U.S. territories. Certified midwives have a bachelor's degree in a discipline other than nursing and master's level training in midwifery. They are recognized in 5 U.S. states (New Jersey, New York, Rhode Island, Delaware, and Missouri). 19.5 percent of home births are attended by midwives certified by the AMCB (MacDorman, Mathews, and Declercq 2012b).

Midwives. Therefore, ACOG is suggesting that its members not support legally-practicing, state-licensed health care providers.

ACOG's lack of support for home birth, generally, and for non-AMCB midwives, in particular, creates a precarious situation in which most home birth midwives are unable to establish formal agreements for collaborative care with physicians and hospitals. This is problematic for women planning home births as, even by ACOG's (2011) logic, home birth safety seems to be improved when midwives are well-integrated into the health care system and have existing arrangements with physicians and hospitals for consultation and home to hospital transport (pp. 426-7).

While it is true that home birth midwives can rarely establish *formal* agreements for collaboration, there are some physicians who are supportive and midwives have also developed informal channels to try to smooth the way for transfers of care. For instance, when my husband and I transferred from home to hospital during labor our midwife suggested that we go to General Hospital – widely known as natural birth-friendly. Our midwife, Rose, called the hospital before we left and spoke with the charge nurse. Rose described our situation and asked if we could be assigned to a labor and delivery nurse who would be sympathetic to our concerns. When we arrived at the hospital, we were greeted by a nurse who had given birth at home herself. Through these informal channels, Rose was able to secure a transfer of care that was as emotionally safe and supportive as possible.

Health Insurance Reimbursement Policies

In crafting their policies regarding the reimbursement of costs related to prenatal care and childbirth, health insurance companies often look to medical associations for guidance. When ACOG deems home births dangerous and labels women planning to birth at home risk mothers, structural discrimination in insurance coverage results. For example, Aetna Group[12] cites both the ACOG (2011) statement and the Wax et al. (2010) study as important in the framing of its policy that reads, "Aetna considers planned deliveries at home and associated services not medically appropriate" (Aetna 2012:1). As a general rule, Aetna does not, therefore, cover home births unless "mandated by law under plans subject to state mandates." Other companies have similar policies and women in my study spent a lot of time on the phone with their insurance companies and calculating the costs of home versus hospital birth. In the end, most of them expected to pay "out-of-pocket" for all the costs associated with home birth.

Faith, for instance, had been budgeting for her home birth for six months. During our pre-birth interview I asked her what sorts of questions she had for midwives during the interview process. She said she had a "whole list of stuff" including,

> Faith: The experience that they had had with insurance. Not that that was my number one concern because if I don't get any money back from insurance that's just the way it goes, but it's always nice to ask and see if maybe there's a possibility that I get anything back.
>
> Rachael: So you and your midwife are going to try to bill?
>
> Faith: Yeah. Trying to … We'll see what happens with that. I'm not worried about it. It's something we budgeted for. I worked during the tax season this year to make the extra money.
>
> Rachael: What do you do during the tax season?

[12] Aetna Group is the fourth largest health insurance company in the country according to U.S. News and World Report (2011).

> Faith: Prepare taxes. I worked at night while my husband stayed at home with the kids, which was nice. That's how I made the whole amount to pay for the home birth. It's worth it to me. And really, when you compare it – if you look at the deductible for the year and the hospital bill, because they might pay 85% and you have to pay 15%. Well I got a letter from the hospital – because I started my prenatal care with a doctor – and, anyway, they sent me a letter, the hospital did, saying what their typical charge was and it's like $11,000 just to have a vaginal birth and if you figure insurance covers 85% and you pay the remaining 15, that's something like $1600. Then you add the high end deductible, which is like $3000, and you're going to have to pay a ton of money. So, it kind of evens out.

Many women in the study budgeted and negotiated payment plans with their midwives. Some even bartered. During our post-birth interview, I asked Emma whether she submitted any claims to her insurance company for reimbursement. She said,

> Emma: No, because my insurance was all the same as with my first child and she looked it over and said no, you won't get anything.
>
> Rachael: Who looked it over?
>
> Emma: My midwife. Knowing that those insurance companies wouldn't cover her stuff. 'Cause she's tried. And I believe the policy said that it's not covered.
>
> Rachael: Did you do anything special to try and save up the money?
>
> Emma: No, but our midwife wanted Ryan (my husband) to build a bunch of stuff – the log stuff. So, she bartered with us – or with Ryan, I guess – and he built that desk in her office and then a couple end tables. And he's got stools he's working on for her now. So that's knocked down a big chunk of the price, and I don't even know where we're at anymore. I asked her a couple of times what we owed her. And she just kept ordering more wood instead of answering me [Laugh].

In Minnesota at the time of my study, $3000 was an average "global fee" for home birth midwifery services. This fee included all prenatal visits, labor and delivery, and care for the healthy mother and newborn during the first six weeks postpartum. It did not include any baseline blood work or sonograms. Many home birthing women forego these tests all together. Some pay out-of-pocket to have their midwife do a blood draw

and send the specimen off to a laboratory for analysis.[13] Others make an appointment with a mainstream health care provider for blood work, prenatal testing, and screening and then that provider's office bills the insurance company.

For an uncomplicated, healthy pregnancy, women like Emma and Faith can reasonably barter with their midwives or work additional hours to save up money. If complications arise, however, and a transfer of care becomes necessary, costs quickly rise and become unpredictable. My husband and I, for instance, had to weigh serious financial questions during labor.

I remember sitting together in the bedroom – me, Aaron (my husband), Rose (our midwife), and Miriam (her apprentice). It was a warm August evening. The sun had recently set. The lights were out in the house and everything – especially faces and figures – seemed vague and soft at the edges. Rose and Miriam had just returned from a walk. They wanted to give me and Aaron some time alone. When they returned, they rejoined us in the bedroom and I asked, "So, how did my urine look?" They had done a urinalysis before they left on their walk. "Honestly," said Rose, "not great. You're exhausted."

I do not remember the exact conversation that followed, but I do recall asking if she thought we should go to the hospital. She said, "Yes." We asked, "Where should we go?" She replied, "General." We moved on to talk about what interventions they would offer and I decided what I would say yes to and what I would decline. IV fluids? Yes. Pitocin? Yes. IV antibiotics? Yes. Epidural? I'd see how I felt after the Pitocin was started, but we all agreed that an epidural and some rest might give me the energy I

[13] Not all midwives offer this service or have access to medical labs.

would need to push my baby out. That was the end of the conversation – quick and straight-forward.

Aaron called our insurance company before we left, but their customer service office was closed for the day. We were not pre-registered at the hospital. We were not affiliated with a clinic or a physician. We realized that if our insurance company did not cover at least part of the cost of the birth – especially if it wound up being a c-section – we would be in serious financial trouble.

In comparison to the $3000 fee typical of home birth services, the cost of hospital birth in Minnesota in 2009 (the year I gave birth to my first child) ranged from $8,094 for uncomplicated vaginal birth to $20,301 for a cesarean section with complications (U.S. Agency for Healthcare Research and Quality 2010).[14] My husband and I were well aware as we packed our bags and walked out the door that we could return home $20,000 or more in debt.

As I write this, I am embarrassed. I worry that readers will think I was irresponsible. I am afraid they will think, "If you ended up in debt, it's your own fault. Why didn't you call your insurance company ahead of time?" First, I was so immobilized by stigma and fear that I could not bring myself to make the call. I had read my insurance policy and it did not cover home birth. How, then, it dealt with home-to-hospital transfer was unclear, but I had worked with enough women and midwives over the years to know that talking to someone at the insurance company rarely cleared things up. After

[14] It is important to remember that the home birth fee is a "global fee" that includes prenatal, labor, birth, and postpartum care for mother and newborn during the first six weeks postpartum. The hospital birth charges include labor, birth, and care of the mother during her hospital stay. The charges do not include prenatal care, postpartum care of the mother after discharge, or care of the newborn.

numerous conversations with their insurance companies and their employers' human resources departments, most women in my study decided to just take their chances and hope that they would not need to transfer. Moreover, if a transfer decision had to be made, we were going to make it based on what made the most medical – and not monetary – sense. In an emergency, we would go to Memorial Hospital – close to our home, known for high-risk obstetrics, and connected to a children's hospital. In a non-emergency, we would go to General Hospital – further away, but known for natural birth and with one of the lowest c-section rates not only in the state, but in the country.

In the years since I gave birth to our son, my husband and I have gained some distance from the stigma of being "home birthers" and we have started to think about having a second child. My husband has tried to talk to our insurance company about how we could deal with this kind of situation in the future – I still cannot bear to make the call. His questions have been met with confusion. "The way it usually works," he has been told, "is that you have a clinic that you go to for prenatal care and that clinic is affiliated with a particular hospital. You don't just pick a hospital and go to it." He responds,

> I understand, but we are planning to birth at home and our midwife is not part of a clinic. So, if we need to transfer to the hospital in labor, what do we do? How do we know which hospitals we can go to? What if we go to an "in-network" hospital, but get assigned to an "out-of-network" physician? How can we find out what our co-pay will be and what percentage of the total cost of the hospital stay we will be responsible for?

No one has been able to provide an answer. The system is not set up for this. As we look forward to having another child, we know almost as little as we did the first time about how to plan for the possibility of home-to-hospital transport.

State Midwifery Laws

The legal status of direct-entry midwifery is complicated in the United States (Pope and Fisch 2013). As of May 2011, direct-entry midwifery was either unregulated or functionally illegal in 24 U.S. states and the District of Columbia (Midwives Alliance of North America 2011).[15] ACOG and the AMA would like to make home birth midwifery more difficult – if not illegal – in even more states. In 2008, the American Medical Association resolved to "develop model legislation in support of the concept that the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex." This "directive to take action" was interpreted as the start of a concerted effort to outlaw home deliveries.

The status of the AMA's model legislation is unclear at this time, but it does not seem to be gaining traction. There are a number of reasons why efforts to develop and successfully lobby for legislation prohibiting home deliveries may not be gaining support in state legislatures. One reason has to do with power.

POWER

According to Link and Phelan (2001), "stigma is entirely dependent on social, economic, and political power" (p.375). Because power is essential to the processes of

[15] According to the Midwives Alliance of North America (2011), 26 U.S. states have some form of legislation regulating the practice of direct-entry midwifery (i.e., making it legal and offering either mandatory or voluntary licensure). In the remaining 24 states and the District of Columbia, direct-entry midwifery is unregulated which means that direct-entry midwives have "no legal, regulatory protection." In nine of these states, direct-entry midwifery is legal by judicial interpretation or statutory inference. In 4 of these states, it is not legally regulated, but also not explicitly prohibited. In 2 states, it is legal by statute, but licensure is unavailable. And, in 9 states and the District of Columbia, it is prohibited by statute, judicial interpretation, or stricture of practice. These last two categories – "legal by statute but licensure is unavailable" and "prohibited by statute, judicial interpretation, or stricture of practice" – direct-entry midwifery is *functionally illegal*.

stigmatization and discrimination, there are reasons to believe that home birth in the U.S. may not remain stigmatized forever. First, physician power is in decline and, second, the power differential between stigmatizers and the stigmatized is not very great.

Social scientists suggest that the "golden age of doctoring" has come to a close and that public disillusionment with medicine may be growing (McKinlay and Marceau 2002; Pescosolido, Tuch, and Martin 2001). Even as the medicalization of society seems to be accelerating, the relative power of physicians in the process is waning (Light 2000 and 2005; Conrad 2005 and 2007). Other actors such as biotechnology and medical device firms, pharmaceutical companies, and health insurance groups are playing larger roles in the process of medicalization. Thus, it is quite possible that this decades-long decline in power has left ACOG and the AMA without as much clout as they previously enjoyed.

I hypothesize that the narrower the power differential between stigmatizers and the stigmatized, the more difficult it is to get the stigma to "stick." Trends suggest that it is a relatively elite group of women – white, college-educated, older, and married – who are driving the growth of home birth. Given that these women are members of the dominant U.S. cultural group, it may prove difficult to label them as "other" and stigmatize them over the long term. In the current environment, however, women cope with the reality of stigma in various ways.

CHAPTER 3
COPING WITH STIGMA: STRATEGIES OF ENGAGEMENT AND DISENGAGEMENT

There are long traditions in sociology, psychology, and social psychology of studying how people respond to stress (e.g., Lazarus and Folkman 1984; Thoits 1995; Carver and Connor-Smith 2010). A distinction is often made between involuntary and voluntary responses. Involuntary responses are unconscious or preconscious and include physiological arousal (e.g., sweating or increased blood pressure), emotional arousal (e.g., anger), intrusive thoughts, and impulsive action (Compas et al. 2001). Voluntary responses, on the other hand, involve "conscious volitional efforts to regulate emotion, cognition, behavior, physiology, and the environment" (p. 89).

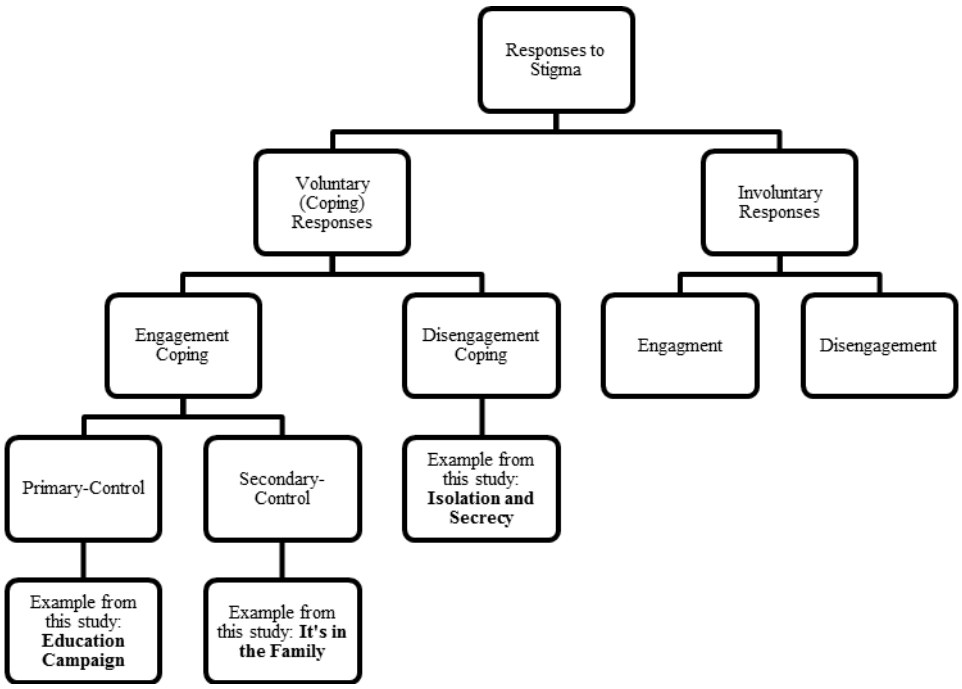
Some researchers consider both involuntary and voluntary responses to be methods of coping. Others categorize only voluntary responses as coping. In any case, there is broad agreement that some responses to stress seem to be automatized while others are under conscious control. While both types are important and likely influence one another, I address only volitional efforts in this chapter.

Coping is usually discussed in relation to three types of stressors: life events (e.g., death of a parent), chronic strains (e.g., disability), and daily hassles (e.g., traffic jams). Drawing on the work of Miller and Kaiser (2001), I treat stigma as a special type of stressor – a kind of chronic strain. In response to this strain, people develop coping repertoires informed by factors such as developmental stage, past experience, available resources, sensitivity to stigma, and degree of "stigma consciousness" (Pinel 1999).

Because such factors change over time, coping can best be thought of as an "ongoing dynamic process" (Compas et al. 2001:88).

Coping responses can be characterized by either disengagement or engagement with the stressful event or problem (Compas et al. 2001; Miller and Kaiser 2001). Disengagement coping involves denial of prejudice and/or avoidance of situations in which stigma is likely to be relevant. Engagement coping is oriented toward gaining either primary or secondary control over the situation. Primary-control engagement coping involves efforts to change the situation and/or one's reactions to it. Secondary-control engagement coping is focused not on change, but rather on adaptation and acceptance. Participants in this study exhibit all three forms of coping – disengagement, primary-control engagement, and secondary-control engagement (see Figure 1).

Figure 1. Theoretical Model of Responses to Stigma[16]



[16] Based on Compas et al. 2001 and adapted from Miller and Kaiser 2001:77.

COPING RESPONSES OF STUDY PARTICIPANTS

Women in this study cope with home birth stigma in three ways: (1) via isolation and secrecy, (2) by waging an education campaign, and (3) by devaluing mainstream practices and focusing on a family tradition of home birth. These response types map onto Compass and colleagues' (2001) general model of coping with stress and Miller and Kaiser's (2001) model of coping with stigma, in particular. The "isolation and secrecy" response exemplifies an avoidance style of disengagement coping, the "education campaign" response is an example of primary-control engagement coping, and the "family tradition" response can be understood as a form of secondary-control engagement coping (see Table 7).

Most study participants exhibited a dominant approach to coping. Two women, however, employed a more explicitly "hybrid" approach. Hybrid approaches are informed by past experience, involve the strategic deployment of techniques to fit particular situations, and illustrate the dynamic nature of coping.

Table 7. Dominant Coping Responses of U.S. Study Participants

	Coping Response		
Participant	***Disengagement Coping: Isolation and Secrecy***	***Primary-Control Engagement Coping: Education Campaign***	***Secondary-Control Engagement Coping: Family Tradition***
Krista	X		
Sarah	X		
Rachael	X		
Michelle		X	
Jolene		X	
Jessica		X	
Faith			X
Kelly			X
Emma			X
Lauren†	X		X
Lisa†	X		X

†Hybrid coping approaches.

Disengagement Coping: Isolation and Secrecy

Many people attempt to disengage from the stress related to their stigmatized status. Disengagement coping strategies generally include avoidance of situations in which stigma may be a problem, denial or minimization of prejudice, and wishful thinking (Compas et al. 2001; Miller and Kaiser 2001). The women in this study did not deny or minimize prejudice or engage in wishful thinking. Their disengagement coping strategy was one of voluntary avoidance.

As Miller and Kaiser (2001) write, "If stigmatized people cannot avoid or find alternatives to situations in which stigma may create stress, they may withdraw socially" (p. 80). This was true of some of the women in this study – including myself. They found that basic avoidance was insufficient. They felt or experienced prejudice and discrimination everywhere and their avoidance escalated to social withdrawal and isolation.

Disengagement coping strategies are linked to increased psychological distress and physical symptoms such as hypertension leading some to suggest that disengagement coping is maladaptive. Miller and Kaiser (2001) disagree, in part. They argue that there are situations in which "avoiding highly prejudiced people may be an excellent strategy, particularly if the stigmatized person has little to gain by interacting with these people" (p.81). Unfortunately, women planning home births cannot always avoid interaction with prejudiced people and when they are forced from avoidance and withdrawal into interaction the stress can overwhelm their capacity to cope.

Krista: I Can't Escape

When I asked Krista to tell me about how people were reacting to her plan to birth at home, she talked about feeling judged and stereotyped as selfish. She said,

> "I'm having a home birth." It gets the same response as "I slaughtered a small puppy down the street for supper last night." You know. You can't believe it. You just can't believe the response you get. And you almost always – it's exactly what an excellent campaign has taught people – that I am selfishly … That's my favorite part, that it's so selfish to have a home birth. That I'm being selfish in doing this outrageous thing and why would I risk the life of the baby.

To cope with this stigma, Krista started avoiding social interaction. Even the most mundane tasks – like crossing the street to retrieve her mail – began to feel life-threatening. She told me, "I was actually ambushed last week." I asked, "What do you mean?" and she recounted,

> This neighbor I hardly know said, "So, you're getting close!" And she says, "Where are you having the baby?" And she goes, "Wow, I never even considered having my child anywhere but the hospital." And I was having contractions at the time, so it wasn't like I could run. I had to kind of wait it out, you know? So [laugh], I'm standing there and I'm getting a) really angry and b) really very hurt. And I can't escape. I can't leave at that moment. I'm kind of holding on and then she goes, "two of my children needed help from my hospital. They could have, who knows what could have happened if I wasn't in the hospital." So, finally, I'm like, "Well, good to see you!" And I crossed the street and went back inside. When I told my husband about the conversation, he was like, "Why didn't you say anything? Are you ashamed of your home birth?" I'm like, "I'm not ashamed. I just don't want the baggage." People just can't get over it. They just have to keep cycling through it. They just have to go over it and over it and over it. I can't escape it! You know?

Krista felt trapped in this situation. She wanted to flee, but social conventions and preterm contractions would not allow it. Her avoidance strategy failed and she was stuck in what she perceived as a hostile interaction.

Krista had experience dealing with the stigma of being a "home birther." This was, after all, her second home birth. Nonetheless, during the last weeks of pregnancy, she found herself moving from avoidance to almost complete withdrawal. She told me, "I

actually found myself wondering if I might have agoraphobia because I didn't want to go outside." Unlike Krista, Sarah was new to this world.

Sarah: We Didn't Tell Anybody

Sarah had her first child by cesarean section. In describing the situation to me, she said,

> He was not a planned cesarean. He likely did not need to be a cesarean … But I wasn't educated enough to be mad about it. We just thought, "Baby lived. We lived. Everything went great! Wasn't looking forward to an operation, but he was in trouble and so the midwife and doctor knew best."

When she became pregnant with her second child, Sarah returned to the same hospital-based midwife. According to hospital policy, however, midwives were not allowed to attend vaginal births after a prior cesarean section (VBAC). So, the midwife referred Sarah to an obstetrician. The OB had a track record of VBAC success, but "gave the impression that other partners in her practice were not as supportive." Less than three months into her pregnancy, Sarah felt like she was being set up for another cesarean. One provider even suggested that Sarah "should really look at scheduling a c-section because then [she] could make sure to get the OB and anesthesiologist [she] wanted."

Prior to this introduction to the politics of VBAC, Sarah was completely satisfied with her first birth experience. Now, she started to question it. What if that first c-section had been avoidable? What if a second c-section was now inevitable – not out of medical necessity, but due to a "legal and political process"? It was at this point that Sarah discovered the International Cesarean Awareness Network (ICAN). Starting with ICAN's website and local chapter blogs and listservs, Sarah began researching cesarean prevention and hospital VBAC policies. As she told me during our postpartum interview,

"I did probably three to five hours of reading a night and became just intolerably militant – to the point where I couldn't even stand to be around other pregnant people because I just got too opinionated."

As the months went by, Sarah read through stacks of books and made appointment after appointment with mainstream maternity care providers.

> We looked at five other midwife groups. We looked at other hospitals. We looked at VBAC statistics for the Twin Cities. With each hospital group, I went in and met with someone … It was hard. It was really hard. And we sort of went through this transition from "people who have babies at home are crazy zealots" to "people who have babies at home are medical refugees and we might be one of them."

Sarah and her husband David agreed, "If you would have told us that we were going to have a home birth at the beginning of the pregnancy, we would have told you, 'Crazy people do that!' But we're the crazy people now."

After finalizing the decision to birth at home, Sarah found herself avoiding potentially problematic social interactions and deflecting the questions of friends and family members. When I asked how people in her life responded to her decision to birth at home, Sarah said, "We didn't tell anybody. Well, we told a couple of people." They told David's mother, for instance, because she was going to watch their older child during the birth and they "wanted her to be able to wrap her mind around it beforehand." But they did not tell David's father or their friends and neighbors. They said,

> Sarah: Mostly we just didn't want to hear people's feedback. It took us a long time to get to this point.
>
> David: We didn't want to have to convince people.
>
> Sarah: I had done hundreds of hours of research. I did not want to hear someone's off the cuff opinion about our decision.

Sarah and David followed a "don't tell" policy and, for the most part, it worked. When their daughter was only a week old, they celebrated a birthday party for their older son. Fifty or so friends, relatives, and neighbors came by and when they told them that the baby had been born at home "they were like, 'Oh no, what happened?'" Sarah and David had to explain that it was a planned home birth and not an emergency.

During my pregnancy, I found myself wishing I could follow a similar strategy. I would keep my birth plans to myself and only after the baby was born – safe and healthy – would I tell people he had been born at home. There was just one problem. People in my life know that I am a doula and that I assist at and do research on home births. If I wanted to avoid questions and judgment, I would have to hide my pregnancy all together.

Rachael: I Need to Insulate Myself

I spent the first seven months of my pregnancy in the Netherlands. There, my desire for a home birth was uncontroversial. So, I had no problem sharing the news of my pregnancy or my hopes for a home birth with Dutch people I knew. It was the responses of people in the U.S. that I worried about. Since my changing body was not available for friends, colleagues, or acquaintances in the U.S. to see, I simply did not tell people I was pregnant. At the time, this seemed like the only way to protect myself. Thinking about it now makes me sad. I did not get to celebrate my pregnancy and I felt alone and inauthentic in my relationships.

I even considered staying in the Netherlands to give birth. I had health insurance, I had a midwife, and I was renting a house. But, for me, this would not have been a home

birth. It would have been a birth in a house – in a residential dwelling – and I wanted to be *home*. Therefore, at twenty-eight weeks of pregnancy, I boarded a plane and headed back to Minneapolis.

Returning to the U.S. was stressful. Not only did I have the typical culture shock of someone returning home after nine months abroad, I also had the particular shock of leaving Dutch home birth culture and reentering the toxic U.S. environment. My husband noticed a profound difference in both my mood and my behavior.

As Davis-Floyd (2003a) writes, pregnant women "feel a very real need for social acknowledgement and cultural alignment to give meaning and order to this often chaotic and bewildering experience" (p. 66). At a broad social level, I felt only disapproval. I also feared judgment on a more micro level. Yang and colleagues (2007) find that stigmatization – even the *fear* of stigmatization – by closely bonded people is especially painful. I found this to be true and that fear prevented me from talking to even my closest friends.

I recall a hot afternoon in early July. Almost nine months pregnant, I sat on the couch on my patio, took a deep breath, and dialed a friend's telephone number. We started with some simple small talk and then I said,

Rachael: I have some news.

Friend: Yes.

Rachael: I'm pregnant.

Friend: Oh, congratulations! When are you due?

Rachael: Next month.

Friend: What? Next month? I can't believe it! Why didn't you tell me?

She, of course, assumed I was planning to birth at home and while she was supportive, she did not have any personal experience with home birth. Her well-meaning questions – "So, tell me how it works. Will a doctor be there? What will you do if something goes wrong?" – only served as evidence of my deviance.

A week or two later, I asked a fellow researcher to interview me using the same questions I posed to other women in the study. About home birth as a form of deviance I said, "Most of the time, I like deviating or being a little deviant, but it's been really hard while I've been pregnant – to be so much deviating from the norm. It was so calm and easy and reassuring to not be deviating at all in the Netherlands." I talked a lot about how, in the Netherlands, I felt like I could just be myself. To birth at home did not require warding off attacks on my character, attending a support group, participating in a listserv, joining a new community, or creating a new identity. "I want to be the same person," I said. "That has been the most important for me."

She followed up by asking if I was doing anything special to prepare for the birth. I replied,

> Rachael: No. Not really. And that was a very conscious decision for me – to *not* do prenatal yoga, prenatal childbirth education classes, read a million books, watch a million videos. I didn't want to do any of that …
>
> Vania: But you didn't need to, right? You'd read them, you'd seen them.
>
> Rachael: Well, I suppose that's true. I've been to childbirth education classes, I've been to prenatal yoga classes, I've been to a hundred births, I've read the books. But that's not why … I didn't want to go to prenatal yoga class where you sit in the beginning and everybody goes around and says how many weeks pregnant they are and where they are having their baby. I didn't want to have to say, "at home." And have people say, "Oh, that is so brave of you. I would love to do that, but I'm too afraid." Or "I could never do that." That is what most people say to me. "Oh, that is so brave" or "Oh, that is so bold." It is not that they are not being supportive, but I don't like that kind of comment.
>
> Vania: Because the underlying message is that there is a reason to be brave or bold.

> Rachael: Right. So, I very consciously didn't do any of that … I haven't had people really voice, "Oh, you shouldn't do that" or "That's dangerous." But I just know that that is out there – that that is the mainstream way of thinking about it. And I don't want to come anywhere close to it. I feel like I very much need to insulate myself so that I don't come even *close* to where that rhetoric or assumption is.

At the time of the interview, I did not understand the degree to which I had isolated myself and withdrawn from society, but Vania could see it quite clearly. She pressed,

> Vania: I'm just wondering, why wouldn't you seek community versus …?
>
> Rachael: I … I just … hmmm.

I thought for a moment before answering,

> Rachael: I didn't want to have to answer people's questions. I didn't want to have to explain or justify to anyone what I was doing.
>
> Vania: So it has been a really individual, focused time. Not community. Trying to remove yourself.
>
> Rachael: Uh huh.

Before I became pregnant, home birth was something I studied, not something I did. I had been an advocate, but I had never had to confront – in such a personal and identity-threatening way – the fact that my values and beliefs did not align with those of dominant U.S. society. Even the women in my life who supported home birth – intellectually and ideologically – did not *do* home birth. I felt different. I did not know where I fit, with whom I fit.

This is a key feature of the lifeworld of women who experience isolation and alienation around their decision to birth at home. They do not know – personally, intimately – other people who have done this. They are not integrated into a community in which giving birth at home is a normal activity. This is also true for those who take an

"education campaign" approach to coping with stigma. The education campaigners, however, respond to this lack of personal experience not with silence and withdrawal, but with engagement.

Primary-Control Engagement Coping: Education Campaign

In sharp contrast to the women who coped with stigma via voluntary avoidance and social withdrawal, Michelle, Jolene, and Jessica told others about their plans and sought opportunities to explain their rationale. They believed that by replacing fear and speculation with what they saw as more accurate information about home birth, they could effectively influence the situation. Through engagement they hoped to not only reduce their individual experiences of stigma and discrimination, but also to change the larger culture of birth – one person at a time.

Michelle: The Business of Being Born

During our pre-birth interview, Michelle told me that she did not know anyone who had had a home birth. It was not until she was pregnant and reading books about natural childbirth that she came across the idea herself. She said, "I guess I never really realized that it was an option and I think a lot of women probably feel the same way. It is sad more women don't know about it. I think if people were more informed and educated that more people would definitely have home births." Here, we see the first indications of Michelle's "education campaign" approach.

I went on to ask,

> Rachael: Given that you didn't know anyone who had done it, how are people responding when you're telling them what you're doing? Are you being secretive about it?
>
> Michelle: I'm not being secretive at all. When I tell people that I'm having a home birth, I immediately explain why and I give them the statistics on women that have home births – they're less likely to have problems, lower rates of episiotomies … So, I don't just say I'm having a home birth and leave it at that. I tell them why.

Michelle was doing more than just telling people that she was planning to birth at home and laying out her rationale. To skeptics, in particular, she was also handing out copies of the film, *The Business of Being Born* (2008). During our post-birth interview she told me,

> Giving people that movie, *The Business of Being Born*, is good. We got a few copies of it to give it to people. Somebody that my partner works with just thought it was the stupidest thing that I was doing home birth and so we gave it to them … I think people really don't know, really have no clue about home birth and what the statistics actually show. I didn't know prior to becoming pregnant, until I did my research. It's just not something you really hear about.

It seems that Michelle's efforts paid off, at least with her mother. Michelle's mother, Carol, was present for our post-birth interview and I asked,

> Rachael: So, Carol, can I ask you how you felt about the idea of a home birth? Were you comfortable with it from the get-go?
>
> Carol: Not really. You just worry about, you know, like when Michelle was born, she stopped breathing right after she was born and they took her away and I was just so concerned and I thought, "Well, what if something like that happens and she is at home?" But then we talked.
>
> Michelle: *The Business of Being Born.*
>
> Rachael: *The Business of Being Born*?
>
> Carol: When I saw that, it made more sense. It is like, "Well, yeah, you know, women have been having babies for centuries on their own. It was much more comfortable." And then I found out that the midwife doesn't just show up with a towel and say, "Oh, I'm here." So, I was fine with that. I mean you're still concerned, but you can be concerned when they're in the hospital, too.

Through conversations with Michelle and through watching *The Business of Being Born*, Carol moved from fear of the unknown to a sense of being informed. This does not mean that all of her worry disappeared with her new knowledge. However, she no longer sees physicians and hospitals as providing ultimate safety and midwives and the home as being categorically unsafe. She has a more nuanced view. She sees that risk and safety can be found in all places of birth.

Jolene: Birthing Blog

In another take on the education campaign approach, Jolene and her husband added a home birth section to their personal blog to provide answers to the commonly asked questions of their friends and family members. During our pre-birth interview, I asked Jolene how people were responding to her plans to birth at home. She said,

> Jolene: Well most people have been pretty accepting.
>
> Rachael: Really, okay.
>
> Jolene: Not like, "Oh, that's great!" Just a few people have been like that. But most people are like, "Okay, so how far do you live from the hospital?" That type of thing … People would bring up you know like … sanitation. Which I thought was odd and I actually did a lot of research about it. We ended up writing this two-part home birth blog just to clear it all up.
>
> Rachael: Which your friends and family read?
>
> Jolene: Yeah. Yeah. And everyone really enjoyed it.

In *Birthing Blog, Part 1*, Jolene introduces her readers to her plans for a home birth. She writes,

> As all of you already know, around the 6th of May, using all the guts and gusto of my womanly body, I am expecting to deliver a tiny person (yet not so tiny for the likes of a vagina) into this world. What some of you might not know (although, if you know us very well at all, you won't be surprised) is that we will be bringing said tiny person not into a clean, white hospital, but into our dimly lit, gypsy-esque, iTuned, living room. Yes,

> a home birth, and if timing goes well, we are going to add 800lbs of water to the mix in the form of our very own, internet-purchased birthing tub. For those of you who couldn't care less about birthing and babies and such, abandon this blog right now (if you haven't already) … For the rest of you, here is why.

She then offers her rationale and references numerous international reports that decry the high c-section as well as infant and maternal mortality rates in the United States.

Birthing Blog, Part 1 ends like this,

> I realize there are some oft brought up factors that were not fully addressed. For example, what of the question of pain relief/drugs, sanitation, or, heck, if "something" just plumb goes wrong? In my opinion, these questions merit the special treatment of hard facts. This stat-filled blog installment is currently under construction and will be brought to you via Birthing Blog, Part II.

As advertised, *Birthing Blog, Part II* is filled with statistics and citations. It addresses three main questions: (1) Isn't childbirth excruciating? What about pain relief? (2) How could a home be sanitary enough? and (3) What if something goes wrong? It cites Childbirth Connection's (2006) *Listening to Mothers II* survey and Henci Goer's (1995) *Obstetric Myths versus Research Realities* along with statements by the British House of Commons Select Committee on Maternity Services, the Coalition for Improving Maternity Services, and the American Public Health Association. What is especially obvious and noteworthy is Jolene's academic approach. Both Jolene and her husband, Adam, are well-educated college graduates with a clear cultural critique. They draw on scientific studies to support their argument and they hope that their use of "evidence" will solidify the legitimacy of their beliefs.

Jessica: The Power of One-on-One Conversations

Jessica's education campaign did not take the form of a public blog or the distribution of documentary films. She took a route grounded in one-on-one, interpersonal communication. I interviewed Jessica twice during pregnancy. During the first interview, she said that she and her husband "were encountering firm resistance" to their plan to birth at home. During our second interview, she told me, "It's a little different now than it was then even. They're much more accepting."

When I asked her to say more about what had changed, she gave an example of a friend – a nurse anesthetist who is very "medical" with a "basic hospital approach" – who has become "excited for my home birth and has been Googling midwives." According to Jessica, this friend's perspective changed so dramatically that "she might have a home birth when she ever gets pregnant."

Jessica also described a family get together in which her husband, Mike, overheard his father and two friends discuss the merits of home birth. Jessica recounted,

> So, Mike's dad and my friend and her husband were talking and they started talking about home birth. And Mike said he was listening to them, and his dad is so for it and my friend Angie is like so for it, they've all changed their mindset about it now that they've heard the good things about it and it's not such a radical idea to them.

She went on, "I'm happy to help change people's mindsets about it. So, now, you know, they can decide whatever they want to do, but at least they feel more like they have an option instead of just accepting the hospital as the way it is. So, it's good now."

According to Miller and Kaiser (2001), primary-control coping strategies are not without costs. They can be time consuming and exhausting. As Lisa, another study participant, suggests, "I haven't, at this point, had the time and energy to really feel like I

could get out there and try to educate other people." Further, research suggests that individual and collective action risk "social upheaval and alienation" (p. 84).

Michelle, Jolene, and Jessica did not seem to experience these negative side-effects. The targeted education campaigns they waged helped rally support and brought friends and family members on board with their plans. The key here is that these three women carefully selected those whom they wanted to educate. They concentrated on closely bonded family members and friends whose opinions mattered deeply to them. Their efforts at social change were modest and localized.

Secondary-Control Engagement Coping: Family Tradition

Unlike the education campaign strategy described above, secondary-control engagement coping is not oriented toward changing the status quo, the opinions of others, or even one's own emotional reactions. Rather, it tends to involve distraction, acceptance, and/or cognitive restructuring (Compas et al. 2001; Miller and Kaiser 2001). Cognitive restructuring occurs when one (1) moves responsibility for negative feedback or poor outcomes from oneself to the prejudice of others or (2) devalues domains in which one's group is negatively appraised. Acceptance along with the later form of cognitive restructuring – devaluing the domain of biomedicine, in particular – were especially relevant for those with a "family tradition" response to home birth stigma.

It is worth noting that study participants who used "isolation and secrecy" or "education campaign" coping strategies also engaged in cognitive restructuring and a devaluation of Western allopathic medicine. What is unique, however, is that people who

have a "family tradition" approach are surrounded by significant others who think the same way they do. This, in effect, creates a *buffer zone* – a space in which beliefs, values, and practices that are stigmatized in the broader society feel and, in fact, *are* normative. Women in this group tend to compare themselves to fellow in-group members rather than to a vague and amorphous "general society." As a result, they feel less alienated and more integrated than do those who do not reside in a buffer zone.

Faith: Home Birth is All I Really Know

When I asked Faith how she found out about home birth, she replied, "Home birth is all I really know." She described herself as a second generation home birther and said that she learned from her mother.

> Faith: [My mother] had her first home birth in 1990. So, that's how I found out about it. It's kind of in the family, I guess. She found out about it because I guess she was kind of crunchy and kind of hippie. I think she had read that book, *Spiritual Midwifery*, and that's how she found out about it …
>
> Rachael: And then, how did you decide that home birth was right for you?
>
> Faith: When I had my first, my mom she was like really, "You need to have a home birth." She pretty much wouldn't hear of anything else. I kind of resisted it, but at the same time I felt like it was the best thing. After it happened, I was so glad that I had done it. I was in labor for three days and if I had gone to the hospital, they might have done stuff to me because it took so long. Then I was really happy that I had had the baby at home. In the ten year space between my kids, I kind of thought about other options, but the more I read and researched and everything else, I was just like, "I can't have a baby in the hospital. I couldn't do it." Every time I've gotten pregnant, I've thought about a hospital birth and then I'm like, "No, I can't do it."

When I asked who she talks to about home birth, Faith described a self-protective strategy of engaging primarily with people she knows to be supportive. She once talked with a friend who said, "I really like the security of knowing all the high-tech equipment is around." Since that conversation, Faith has been more proactive about seeking out

people who share her views. She says, "I mostly just talk about it with people on the Internet or my stepmom now." In this way, Faith dabbles in the disengagement strategy of voluntary avoidance, though it is not her dominant response.

Kelly: Home Birth Runs in My Family

Like Faith, Kelly also has a family history of home birth. During our pre-birth interview she told me that home birth "has been kind of something that has run in my family." She went on to say,

> My aunt has had a few home births … uhm, actually I had a couple aunts that had home births. I think for the most part my grandma had hospital births. She did not enjoy them. And back then, you know, they strapped you to the table and the husband couldn't come in the room and she was all by herself and she was trying to push by herself and just … it was an awful experience for her. And so I think … as soon as she got done having kids, she realized the importance of these things. She got more into the more holistic things. It was around the time when I was born, she got into massage reflexology and she got a reflexology certification.

Kelly's grandmother has been an important influence in her life. She even came to Kelly's home in early labor to perform reflexology on her feet. With her grandmother as a model, Kelly has come to significantly devalue Western allopathic medicine. In issues related to pregnancy and childbirth – as well as in other realms of her life – she now favors "holistic" and "natural medicines" and healing practices based on "a more Eastern philosophy."

Kelly's story is illustrative of life in a buffer zone. First, she has family members who share her devaluation of biomedicine and obstetrics. Perhaps more importantly, however, she has a personal biography dominated by "being different." She grew up in

the fundamentalist Independent Apostolic Lutheran Church and she described her religious beliefs and practices like this,

> We just live simply. We don't wear crosses. We don't have crosses in our church because we think Jesus carried that burden for us – we don't have to carry that around on us. We don't dance and we don't drink because that can lead to more temptation. And the more temptation, the worse your life is – more complications. And you don't need that in your life. So we just don't. We live simply.

I asked Kelly if she thinks her religious life is related to her choices around birth. Initially, she said, "Not so much." As she continued talking, however, she reconsidered. She said that her spiritual upbringing taught her to accept her difference and not place too much value on the beliefs and ideas of others. She said,

> I was raised so unique and people didn't really treat me like I was an outsider. They just treated me like I was a little different, but I wasn't outcasted by people. I don't know if it's because we were taught to be just strong about it and accept it and you know. I don't know if it's maybe because I was raised unique. Maybe I'm preprogrammed to think unique and out of the box, because I realize that not everything that everybody says is fact, and that I don't have to accept or conform to other people's thoughts. So, I guess it's kind of formed me a little different, I suppose. We just live simply and not worry about what other people do or say.

Kelly's religious and early family life shaped her immensely. Her training to not simply "accept or conform to other people's thoughts" and "not worry about what other people do or say" is essential to her ability to cope with the stigma and discrimination associated with the decision to birth at home. Because she grew up in a religious tradition that is not well understood, she has had years to develop a sense of self that is not based on comparisons to mainstream culture.

Emma: My Mom Opened My Eyes to the Idea

Emma did not initially see herself as someone who would birth at home. It was not an automatic or obvious decision for her. Her mother – a "very earthy" woman – "kind of

opened [her] eyes to the idea." Emma's mother, Sally Jean, had standard hospital births in the 1980s and when I asked Emma if she knew what labor and birth were like for her, she said, "Horse shit." Sally Jean had – and has – a belief system consistent with home birth and she hopes her daughter can have more satisfying and empowering experiences than were available to her.

I asked Emma to describe exactly how her mother introduced her to the idea of home birth and she said,

> My mom sent me to one of the Childbirth Collective[17] meetings. I didn't know what it would be and I felt totally out of place there. Everyone was in tie-dye and dreadlocks and you know, all this, and I had a Gap sweatshirt on and I'm like, "I don't belong here. I totally don't belong here." But everybody was so nice and they were talking about how great it was to do home births or have a doula.

After the meeting, Emma brought up the idea of a home birth with her husband. His initial reaction was, "No. Hell no. Absolutely not! We're not doing that." Nonetheless, he agreed to go to a Childbirth Collective meeting and, according to Emma, "By the end of the thing he was like, 'Yep, this is for us. I see why you want this now.'"

In addition to introducing Emma to the idea of home birth, her mother also played an important role at the births of both of her grandchildren. In fact, both boys were both born at her house. Part-way through one of my interviews with Emma, her mother joined us and the two reminisced about the birth of Emma's first child – a real family affair.

> Sally Jean: It was just hilarious because all of a sudden all the clothes came off. Fast. Like in a moment of panic, exhilaration, whatever it was. It was like, boom! Has to come off!
>
> Rachael: [laugh]

[17] The Childbirth Collective is a Minnesota-based organization of midwives, doulas, and other supporters of natural birth who offer informational meetings and workshops for pregnant women. At the time of my study, the Collective had chapters in three parts of the state.

> Sally Jean: And I just remember laughing to myself saying, "Oh, she's never going to hear the end of this." And it was hotter than heck, you know, and she was just doing great. Didn't care – "Get that sheet off my leg!" Blah, blah, blah! You know – sticky, sweaty.
>
> Emma: I didn't tell about the ice water either.
>
> Sally Jean: And we had a big bowl like this, big bowl of ice water. And her stepmom and I just kept mopping her down. It was so hot. We had a little fan going 'cause I didn't have air conditioning. So, we're just mopping her, literally, with cold ice water, you know. Soothing. Keeping her cool. And she loved it. She doesn't like to be hot, you know.
>
> Rachael: Oh, it's miserable.
>
> Sally Jean: So, we did that for a long time and no inhibitions whatsoever. She's become a different woman – as she was told she would be. She didn't believe it 'til she got there. And, so no guys, you know, Dad and Jonathan – did you tell her that? Her dad and her brother were downstairs –
>
> Emma: They were in the kitchen.
>
> Sally Jean: They're down helping in the kitchen, you know. In and out and they poked their noses in and out. … She didn't want them right with her – naked and all that. So, this baby comes out. And the second – she's been working really hard, you know, not talking – and the second the baby comes out, no sooner does the midwife lift that baby to her belly than she goes, the first thing she said is, "Get Dad and Jon!" Like, immediately. Like the first thing that came to her head was that she couldn't go any further without those two guys in the room.
>
> Emma: [laugh] And mom goes, "Uh, can we cover you up?" I was like, "Nope, hurry up!"
>
> Sally Jean: "I don't care!" She says, "I don't give a rip." [laugh] So, they came up and we're all in this little room [laugh] … How special for Jonathan, her brother. He was so honored to be there. To witness a completely normal, natural event, you know, without there being any inhibitions whatsoever. Very nice.

Watching Emma and her mom go back and forth – laughing and reveling in their shared memories – I caught a glimpse of what pregnancy could be like for women planning home births in the U.S. if home birth were destigmatized. For a moment, I could envision a future in which the buffer zone occupied by a handful of women is no longer a buffer zone, but the ecology we all inhabit.

Hybrid Strategies: Different Circumstances, Different Approaches

People are not limited to just one coping strategy. Indeed, they develop a coping repertoire over time and they deploy different strategies with different people under different circumstances. Lauren and Lisa exemplify the use of what I refer to as "hybrid" strategies. Their stories illustrate the dynamic nature of coping.

Lauren: Family Tradition and Selective Silence

At the time of her participation in the study, Lauren was a community organizer, a mother, a member of an attachment parenting group, a doula, and an aspiring midwife. She told me that home birth and other natural parenting practices (e.g., extended breastfeeding and co-sleeping) feel normal to her. She knows that in the larger culture these practices are rare and controversial – she is not in denial (i.e., using a denial strategy of disengagement coping) – but in her day-to-day life they feel normal, natural, and supported.

Lauren's family members provide one source of support for her alternative beliefs and practices. During our pre-birth interview, she told me about how her family received her decision to plan a home birth with her first child. She said,

> My mom and my entire family completely supported it. They'd known that I wanted to be a home birth midwife for years beforehand anyway. My mom had been a birth partner for friends at home in the 80s and stuff like that. My parents started out as hippies when they first got together. So, it was no big deal at all. They were like, "Well of course that's what you are going to do. That's what Lauren does." … My mom was a La Leche League leader – of course you nurse your baby, of course you use cloth diapers, of course you have your baby at home if you can. My mom and dad had had all natural births with us. They were in hospitals, but very much not medicated – labored at home, my dad caught me when I was born. My older brother has three kids and with his first kid his wife had an epidural. The second one they labored at home and she went to the hospital, pushed

> the baby out, was there for an hour, and left. The third one was born at home. They are like totally attachment parenting, home birth, natural birth people.

In addition to support from immediate family members, Lauren and her husband are embedded in a broader community of support. When Lauren was pregnant with her first child, she and her husband owned a home and were renting rooms to fellow community organizers. They told their roommates about their plan to birth at home and their roommates responded, "Cool! Someone's going to have a baby here. Right on." Describing her free-spirited style at the time, Lauren said,

> [Our roommates] lived upstairs and we lived downstairs. It was very surreal to have them there [while I was in labor]. It didn't bother me, because at that point I was so like, "Anyone can come. Sure. No problem. Want to learn how to check a cervix? You can check my cervix. I don't care. We're going to run around naked and have our baby in the house." I had no inhibitions whatsoever. What a time that was!

During the course of her first labor, Lauren transferred to the hospital and gave birth by cesarean section. While in the hospital, her roommates "made tons of casseroles and stuffed noodles and froze them." Thinking back on this she said, "It was so sweet. They were supportive."

When she became pregnant with her second child, Lauren experienced more vocal opposition to her decision to birth at home. In fact, she, herself, initially rejected the idea. She started her prenatal care with a nurse-midwifery group and was planning to birth in the hospital. Part-way through her pregnancy, however, she realized that mainstream maternity care – even with a nurse-midwifery practice – was so out-of-step with her values that she was unable to proceed. She found herself distraught, angry, and crying after every prenatal appointment. When she switched to a home birth midwife, she felt much more confident and at peace, but the decision came at a cost.

Because of the controversy in the U.S. surrounding vaginal birth after a previous cesarean section, Lauren felt like she could not be as open about her home birth plans as she was during her first pregnancy. "Early on in my pregnancy," she recalled,

> a family member said, "You're not going to try for a vaginal birth are you? Babies die. They drown in their blood." … So, we just don't even talk about it with them. They think we're going to the hospital. We haven't told them that we are. We haven't told them that we aren't. They just asked us last week, "So, when you go into labor, do you want us to come watch Zack?" I said, "Oh, my mom's coming." They don't need to know.

In response to this kind of negative feedback, Lauren developed a selective silence approach. She told her mother and her brother about her switch from a hospital- to home-based midwifery practice. "Otherwise," she said, "we haven't told a lot of people."

Lisa: Alternative Health and Environmentalism

Lisa did not know much about birth before becoming pregnant. Her mother had not talked about it while she was growing up and she did not have many friends with children. "Home birth," she told me, "definitely does not run in the family." Instead, her introduction came through reading online blogs. She said, "I didn't have a lot of pre-conceived notions about birth is painful and loud and terrible in the hospital, but just to read those [blogs], it was like, 'Oh, that could be an easily managed process that could happen at your house.' … It was eye-opening."

Soon, she found herself planning a home birth. When I asked how her family members reacted, Lisa described a family history and a coping strategy similar to that of the "isolation and secrecy" copers. She said, "I don't have any relatives that have done it or anything like that. My relatives all think I'm crazy [laugh]. They're right, I think – but we just don't talk about it much."

Lisa also avoided talking about her birth plans with coworkers. At one point – because insurance coverage for home birth is complicated and because the logistics of hospital billing are unclear if a transfer of care becomes necessary – she had to have a discussion with the benefits manager in her human resources department. She resisted saying too much, however, because she got the sense that he disapproved. She said, "I would rather just, you know … not get into it."

Lisa does not rely exclusively on an avoidance coping strategy, however. Connections she has made during a lifetime of involvement in alternative medicine and environmentalism give her access to significant support and provide the kind of buffer zone that her family does not. Regarding her background in alternative healing, Lisa said,

> In the last 20 years or so I've been really interested in herbal medicine and self-healing. I've gone to alternative practitioners and have seen a naturopath. I had always done that kind of stuff. So, [choosing a home birth midwife when I became pregnant] wasn't a big jump for me.

When I asked how long she had been active in environmental issues, she replied,

> Probably, as long as I can remember. When I was in junior high my parents sent me to – or even when I was younger – we went to this nature camp which I loved as a kid! Then, when I was a teenager, I was a volunteer. When I was in college, I went back and worked for a summer as an intern – teaching, doing environmental education kinds of things.

Lisa draws clear a connection between her experiences in nature and her penchant for alternative medicine. For years she worked for the National Park Service – living in the rural Midwest and exploring the islands of Lake Superior. About this time spent "stranding [herself] in the middle of nowhere" she said, "I had a lot of time to read [laugh], go to the library, do research, and stuff like that." She sees this period in her life as part of a trajectory leading her toward "self-healing kinds of things."

Lisa had not known for sure that she would have children. It was not a life goal. But after becoming pregnant, the decision to work with midwives and birth at home felt obvious and consistent with the rest of her life. While she did not have a family history of home birth, she found that her pre-existing networks provided much-appreciated social support.

*****

My analysis of women's coping strategies during pregnancy reveals three key insights regarding their experience. First, women successfully cope with stigma during pregnancy. They are resilient and innovative. While their efforts are sometimes a source of alienation and distress, they can also lead to increased support and a sense of social integration.

Second, women do not choose coping strategies in an à la carte fashion. Not every strategy is available to every woman and the strategy (or strategies) she has access to is dependent on a host of variables including demographic characteristics, individual biography, personality, temperament, sensitivity to stigma, and degree of stigma consciousness. Moreover, no particular coping strategy is better than another. Women cope in whatever ways they can with the resources they have available and *all* volitional efforts to deal with stigma are "coping."

Finally, women planning home births in the U.S. (and in most other high income countries) expend considerable time, energy, and resources dealing with stigma during pregnancy.[18] While ongoing research and debate must be fostered, the relative safety of

[18] It is important to note that the descriptions of coping presented in this chapter are based on the experiences of women planning home births in Minnesota where direct-entry midwifery is legal and where,

home birth and midwifery care has been documented by a sufficiently large and interdisciplinary body of literature. Therefore, continuing to suggest that prophylactic hospitalization, high-tech monitoring, and medical intervention constrain the risk inherent in childbirth and do not introduce additional iatrogenic risks (or to acknowledge iatrogenic effects, but justify them as the cost of safety) is unwarranted. Moreover, labeling women who plan to give birth at home as "risk mothers," stereotyping them as irresponsible, selfish, and uneducated, and suggesting that they do not care about the health and safety of their offspring is unacceptable. Destigmatizing home birth is a worthy endeavor for many reasons not least of which is to free women from this burden in order that they may invest their resources in ways that are more productive and beneficial to themselves, their children, and the larger society.

In the next chapter, I turn my attention to maternity-related medical encounters in the Netherlands and examine the formal structures that shape those interactions. Because home birth is generally not stigmatized in the Dutch health care system, coping with stigma and dealing with discrimination are not central tasks for pregnant women or midwives. In the absence of stigma, *samenwerking* (collaboration between health care professionals) emerges as a core concept and how to work together becomes the distinct challenge.

---

especially in urban centers, substantial home birth support networks exist. I would predict that the degree of stigmatization felt by women in "illegal" states is even more traumatizing.

CHAPTER 4
HOME BIRTH IN THE ABSENCE OF STIGMA: THE CASE OF THE NETHERLANDS

The home birth rate in the Netherlands is significantly higher than in any other developed country in the world. More importantly, for the purposes of this study, it is the only developed country where home birth is *normative*. By that I mean, it embodies a shared value, it relates to people's sense of what ought to be, and it contributes to social cohesion. Contrast this sense of normativity with the experience of stigma described in the previous two chapters. In the U.S., home birth is deviant and to participate in it is to break social norms, reject widely held cultural values, and inspire conflict.

I talked to a lot of people about home birth when I was living in the Netherlands. Almost everyone I met – including venders at the *groentemarkt* (farmers' market), the proprietors of the bed and breakfast where I stayed when I first arrived, the realtor who helped me find a small house to rent, and the woman who fitted me for a *tweedehands fiets* (second-hand bicycle) – wanted to know what an American woman was doing living in a small town in the Netherlands and speaking Dutch. This inevitably led to me say something like, "I'm here to study home birth and I learned Dutch because I didn't think a woman would let me be at something as intimate as the birth of her child if I didn't speak the language." In response, person after person told me that while they knew that women in the U.S. gave birth in the hospital with pain medication, "women in the Netherlands give birth at home." Of all my casual conversations, only one person told me that home birth was not, in fact, the norm. Following an evening maternity care program

at a hospital, I spoke with a gynecologist who told me, "Most foreigners get it wrong. The majority of Dutch women give birth in the hospital."

Both statements are true. The average person will still tell you, "Dutch women give birth at home." And, in that sense, home birth remains the cultural norm. It is, however, no longer the statistical norm. In the 1960s, the home birth rate hovered around 70 percent (Centraal Bureau voor de Statistiek 1993). When I started traveling to the Netherlands in 2005, the national rate was approximately 32 percent. By the time of my fieldwork in 2008 and 2009, the rate had declined to less than 24 percent and the downward trend continues (Centraal Bureau voor de Statistiek 2013). In this chapter, I examine two levels at which the persistent cultural normativity of home birth in the Netherlands is especially relevant – at the micro level of interpersonal interactions during medical encounters and at the more macro level of interprofessional relations.

OVERVIEW OF DUTCH MATERNITY CARE

Two Line System

The Dutch maternity care system is organized into two "lines." Healthy women with normally-progressing pregnancies receive care in the *eerstelijn* (first line) from *verloskundigen* (midwives) and *verloskundig actieve huisartsen* (obstetrically-active general practitioners). All first line providers are trained in the provision of home birth services and they expect the majority of their clients to birth at home.

Women with certain preexisting conditions and those who either develop or are at higher risk of developing complications are followed by gynecologists[19] in the *tweedelijn* (second line). Most women who see a gynecologist are referred by their first line care provider for consultation. A referral does not mean that the woman will stay in the second line for the remainder of her pregnancy. Most commonly, she will have a consultation or treatment and then return to the first line. There is evidence that some women are seeking care from gynecologists without medical indication or referral, but this is rare (Maassen et al. 2008).

Midwives provide the bulk of maternity care services in the Netherlands. They are the default care providers in the first line[20] and are increasingly employed in the second line as well. According to Wiegers and Hukkelhoven (2010) the proportion of second line births attended by a midwife increased from 8.3 percent in 1998 to 26.06 percent in 2007. A study of 1,248 pregnant women with due dates in April 2007 (about a year and a half before the start of my fieldwork) showed that, overall, 87.5 percent of women reported seeing a midwife during pregnancy while 35 percent saw a gynecologist and only 2.8 percent saw a general practitioner (Wiegers 2009).[21] Moreover, 71 percent of the women

[19] In the U.S., the convention is to call a specialist physician who provides maternity care services an obstetrician or an OB/GYN. In the Netherlands, she is simply called a *gynaecoloog* (gynecologist).
[20] This was not always the case. Decades ago, many general practitioners (GPs) were involved in maternity care. A regulation known as the *primaat* changed this. Passed in 1941, the *primaat* created a special status for the midwife and gave her priority over maternity care for healthy women by virtue of the way reimbursement was structured for women insured by the *Ziekenfonds* (sick funds). Under the new arrangement, if a midwife was present in a community, she became the default provider of maternity care services – not the GP. This was the source of much strain between midwives and general practitioners. Over time, fewer and fewer GPs were able to offer maternity care to their patients and today the list of obstetrically-active GPs is relatively small. The *primaat* no longer exists (it ended in 2001), but its effects are well-established in Dutch society. For additional information on the history of the *primaat*, see De Vries (2004:104-16).
[21] The numbers sum to more than 100 percent because some women see more than one care provider during pregnancy – usually a midwife for the majority of the prenatal care and a gynecologist for a consultation.

surveyed said that a midwife was the care provider most involved during labor and birth and 90.9 percent said that a midwife cared for them during the postpartum period. These data provide a sound approximation of who is providing maternity care services in the Netherlands around the time of my fieldwork.

The results of the Wiegers (2009) study also illustrate the complexity of the "care paths" women follow through the Dutch maternity care system. For instance, 58.5 percent of respondents experienced at least one referral between the first and second line. And while 41.5 percent of respondents remained in primary care for the whole of pregnancy, labor, birth, and postpartum, only 31.3 percent gave birth at home (slightly higher than the national average in 2007) – reflecting the fact that receiving care in the first line from a midwife or GP does not mean that a woman will give birth at home or even that she intends to do so. Since the 1970s, Dutch hospitals have allowed midwives and GPs to use their labor and delivery facilities for clients with physiological births and women in first line care have been able to choose either a home or short-stay hospital birth (Wiegers, Van der Zee, and Keirse 1998a; Wiegers et al. 1998c). Therefore, it is not possible to deduce intended place of birth from "line" or type of care provider. This is quite different from the U.S. situation in which it can reasonably be assumed that a woman seeing a direct-entry midwife plans to give birth at home.

Risk Selection

Risicoselectie (risk selection) is the basis of the two line system. It depends on the following assumptions: (1) there exist both *fysiologisch* (physiological or normal) and

pathologisch (pathological or abnormal) pregnancies and births, (2) physiology or low risk "should be assumed unless signs, symptoms, obstetric, or medical history point to increased risk," (3) well-trained midwives are capable of detecting risk in pregnancy, labor, birth, and the postpartum period, and, finally, (4) when pathology or increased risk is detected, timely referral to the appropriate level of care is possible (Bais and Pel 2006:209). The very concept of risk selection is controversial. In fact, in the U.S. and most other developed countries, modern obstetrics is based on the converse theory that all pregnancies and births are pathological – or at least potentially pathological – and obstetrical emergency can present at any time, without warning.

The idea that childbirth is inherently pathological was well-articulated by Joseph DeLee, professor of obstetrics at Northwestern University and author of the textbook *The Principles and Practice of Obstetrics* (1913). In the inaugural issue of the *American Journal of Obstetrics and Gynecology*, DeLee (1920) wrote,

> If a woman falls on a pitchfork, and drives the handle through her perineum, we call that pathologic – abnormal, but if a large baby is driven through the pelvic floor, we say that is natural, and therefore normal. If a baby were to have its head caught in a door very lightly, but enough to cause cerebral hemorrhage, we would say that it is decidedly pathologic, but when a baby's head is crushed against a tight pelvic floor, and a hemorrhage in the brain kills it, we call this normal, at least we say that the function is natural, not pathogenic.
>
> In both cases, the cause of the damage, the fall on the pitchfork, and the crushing of the door, is pathogenic, that is disease producing, and in the same sense labor is pathogenic, disease producing, and anything pathogenic is pathologic or abnormal.
>
> Now you will say that the function of labor *is* normal, that only those cases which result in disease may be called abnormal. Granted, but how many labor cases, measured by modern standards, may be so classified? (Pp.39-40)

At the 1920 annual meeting of the American Gynecological Society, DeLee (1920) introduced his prophylactic forceps operation for routine delivery as a technique

to prevent and repair the damage caused by childbirth. The discussion that followed was vigorous and filled with dissent (American Gynecological Society 1920:77-83) – some voicing concern about "the harm which may be done by meddlesome methods" (p. 77). Nonetheless, DeLee's basic premise – that childbirth is pathologic and pathogenic – formed the cognitive foundation of early American obstetrics.

There are signs that this way of thinking may be losing sway in the U.S. In 2012, an editorial in the *American Journal of Obstetrics and Gynecology* (*AJOG*) began,

> Pregnancy and birth are physiologic processes, unique for each woman, that usually proceed normally. Most women have normal conception, fetal growth, labor, and birth and require minimal-to-no intervention in the process. (Lawrence et al. 2012: 147).

In midwifery research circles, the fact that pregnancy and birth were described within the pages of *AJOG* as "physiologic processes" requiring "minimal-to-no intervention" was, as one researcher put it, "almost unbelievable." That Dutch obstetrical theory and practice has long distinguished between physiological and pathological pregnancies and births and has never categorized *all* pregnancies and births as pathological could be considered radical in cross-national perspective.

MEDICAL INTERACTIONS IN THE ABSENCE OF STIGMA

Between Patients[22] and Providers

Both cases described in this section involve healthy women with unproblematic pregnancies who were receiving prenatal care from first line midwives. As discussed

[22] I use the term "patient" here because U.S. medical sociology often terms these interactions "doctor-patient" or "patient-provider." However, pregnant women in the Netherlands are usually referred to as *cliënten* (clients) in the first line context. Women may become patients in the second line, but pregnancy, in and of itself, does not inevitably lead to or connote patienthood.

above, this does not necessarily mean that these women were planning home births, but a second line care provider would know with certainty that the referring midwife offered home birth services and that a home birth was well within the realm of possibility for the woman sitting in his or her office.

Gerda

Gerda is at a prenatal appointment about three and a half weeks before her due date. The exam begins with Gerda and Kara, the midwife, sitting across from one another, a large desk between them. Kara asks, "Any complaints today?" Gerda replies simply, "No." They quickly move on to the activities of a typical prenatal exam. Very little cuing is necessary as Gerda has been receiving prenatal care for many months. The appointment proceeds like a choreographed dance.

Still seated, Gerda places her arm on the desk and Kara take her blood pressure. Then Gerda stands up and walks to the scale. She reports her weight to Kara and moves to the exam table. She lies down on her back and pulls her shirt up and the waistband of her pants down to expose her abdomen. Kara palpates her belly to assess fetal position and the engagement of the fetal head in the pelvis. She uses a Doppler to listen to fetal heart tones. Normal. While Gerda is readjusting her clothing, Kara retrieves Gerda's urine sample[23] from the desk and takes it to the sink. She dips a urine test strip into the

[23] At this clinic, women receive a cup at one of their initial prenatal appointments. In this cup, they are to bring a urine sample to every subsequent appointment for analysis. Not all midwives agree that regular urinalysis is helpful. One midwife I worked with said that research suggests that testing urine every week does not improve care or outcomes. Therefore, she only tests a woman's urine if it is medically-indicated (e.g., if a woman has elevated blood pressure).

small plastic cup. “Fine,” she says as she pours the urine down the sink and washes her hands. Then both women move back to the desk.

Kara asks, “Any questions? Anything you want to talk about?” Gerda asks one question and Kara offers an answer. Kara pauses and then asks again, “Anything else?” Gerda hesitates. “No,” she says, “just …” Gerda goes on to explain that her partner has made it to the final round of an athletic competition.

> Gerda: Only 25 people in the whole world get this far and he has to be away for a week to ten days around my due date. He … *we* … cannot pass up this opportunity. It could change our lives.
>
> Kara: How about if we schedule an appointment with a gynecologist to see if an induction is possible?
>
> Gerda: Yeah, that sounds good.

Kara writes a referral letter that Gerda is to give to the office assistant on her way out. The assistant will call the gynecology clinic and make the appointment. Kara talks a little bit about how it will be good if Gerda's partner can be present for the birth and then the week he is gone, Gerda’s mother and the maternity care aide[24] can help with the baby. “*Prima*,” they both agree. Problem solved.

Gerda was one of the first women to join my study in the Netherlands. As I was following her, everything felt strange and new. I was regularly surprised and confused – as I was upon leaving this appointment. “What?” I thought. “A home birth midwife suggesting induction without medical indication? A woman in her care feeling pleased at the suggestion?” I clearly was not in the U.S. anymore. This prenatal appointment

[24] The *kraamverzorgende* or maternity care aide is a unique feature of the Dutch maternity care system. The first line maternity care aide is called to a woman’s house when the birth is imminent. She assists the midwife during delivery and then remains for the first hour or two after the birth. She returns each day for the first week to assess the health of mother and baby, to offer instruction and support with infant care and feeding, and to do household tasks such as meal preparation, vacuuming, laundry, and dishes.

marked the start of a gradual realization that "home birth" and "midwife" do not mean the same thing in the Netherlands as they do in the U.S.

In the Dutch context, home birth is not a goal in and of itself and the "natural" is not prioritized above all else. Referrals to the second line are usually the result of medical conditions. This referral, however, was for social and cultural considerations. The situation with Gerda's partner was seen by her midwife as relevant as was the fact that while Gerda has lived in the Netherlands for many years, she is Swedish and not Dutch. In Sweden, as in most developed countries, birth in the hospital with pain relieving medications is the norm (for an overview of the Swedish maternity care system see Nelson and Popenoe 2001). Thus, Gerda's social and cultural needs take precedence over the goal of having a natural or home birth.

On the day of Gerda's initial consultation with the gynecologist, I ride my bike to her house and we drive together to the medical center. Once at the hospital, we follow the signs to the *poliklinieken* (outpatient departments). Gerda checks in at gynecology clinic. The receptionist asks for her insurance card and the records from her midwife. We take a seat in the waiting area. After about fifteen minutes, the receptionist brings Gerda a medical chart and tells us to go down the hall to waiting room number three and place the chart on the shelf.

A few minutes later, we are called back to the gynecologist's office. When we enter the room, the doctor – a slim, middle-aged woman – stands up and extends her hand. "Hello," she says, "I am Irene Aalders." We shake hands and sit down around a desk. Dr. Aalders read aloud what the midwife has written on Gerda's referral form. Dr.

Aalders comments, “It is too bad your partner needs to be out of the country when the baby is due, but I understand how important this competition is. You are in a difficult situation.” Then she asks if Gerda is interested in induction. “Yes,” Gerda replies. Dr. Aalders describes the induction process and ends by saying, “you can give nature a hand (*een handje geven*), but you can't guarantee anything.” As an American observer, I take note of both the physiological approach that underpins Dutch obstetrics (even when discussing non-medically-indicated induction) and the conspicuous absence of stigma and discrimination surrounding midwifery and home birth.

Rachael

While in the Netherlands, my midwife refers me to a dermatologist for evaluation of a possible Lidocaine allergy. Lidocaine is frequently used in obstetrics (e.g., for local pain relief during perineal repair and as a component of epidural anesthesia). If I am, indeed, allergic, it will be important make arrangements to have other medications available.

On the day of my appointment, I arrive at the hospital and register at the front desk. I then follow the signs to the dermatology department. I check in for my appointment and sit down in the waiting room. Soon I am called back to the exam room. My husband is visiting from the U.S. and we go back together.

The *co-assistant* (resident), calling me “*Mevrouw* (Ms.) Kulick,” motions for us to take the two chairs in the room and she sits on the exam table. I hand her the letter from my midwife detailing the situation. She reads the letter and then asks me to describe my previous reaction to medications in the –caine family. She listens patiently and then

leaves the room to consult with the supervising dermatologist. They both come back and inform me that it is possible to test for Lidocaine allergy in pregnancy. They will talk to the pharmacy department and figure out when I can come back for the skin test. Their office will call me with the time and date of my next appointment.

Like the fieldnotes from Gerda's appointment, this exchange illustrates many features of the Dutch health care system – its mix of formality (e.g., referring to me as Ms. Kulick throughout the entire visit) and informality (e.g., the dermatology resident sitting casually on the exam table and Gerda's gynecologist introducing herself using her first name), the location of specialty care within hospital complexes, and the gatekeeping and continuity of care role of the first line provider. The entire visit felt odd to me given my American sensibilities and socialization, but it also felt good, straightforward, like I was being taken care of. Some call the Dutch system paternalistic[25] – and perhaps it is – but, for me, it felt reassuring. When I compare my experience at the dermatology clinic in the Netherlands to my experience with an endocrinologist in the U.S., the difference is pronounced.

Over a decade ago, I was diagnosed with a thyroid goiter, likely related to an autoimmune disease that usually leads to hypothyroidism. I have been followed by an endocrinologist ever since. My thyroid hormone levels have always been within normal limits, but pregnancy changes normal thyroid function. Therefore, my midwife in the

[25] One way to describe and compare health care systems is on a spectrum from individual choice on one end to professional paternalism on the other. In a U.S./Netherlands comparison, the U.S. is closer to the choice end of the spectrum and the Netherlands closer to paternalism. The Dutch system, however, is increasingly organized around a "logic of choice" (Mol 2008). See Maarse and Meulen (2006) on the marketization of Dutch health insurance and increasing "consumer choice." See also Mol (2008) for an analysis of the "logic of choice" in health care and her introduction of an alternative logic – a "logic of care."

Netherlands monitored my thyroid hormones and when I returned to the U.S. I made an appointment with my endocrinologist.

During this appointment, the endocrinologist chided me for not undergoing what he saw as standard obstetrical screening procedures. Given his medical specialty, he was particularly concerned about gestational diabetes and was displeased with the fact that I had not had routine (by U.S. standards) ultrasound and glucose testing. When I asked whether I had risk factors that would make those tests particularly useful he said, "No, it is just standard care." In labeling my care as *sub*standard, he was simultaneously issuing a critique of the Dutch maternity care system, American home birth midwifery, and my own judgment.

I had seen a number of endocrinologists over time and I had, in the end, decided to make this man *my* endocrinologist because of his generally non-interventionist approach. When others suggested irradiating my thyroid or starting me on synthetic hormones, he said that was not necessary and suggested we just "wait and see." I liked the fact that he came out to the waiting room to call his patients back to the exam room, that he sat with me at a desk during the interview portion of our visits as opposed to having me sit on the paper-covered exam table, and that he was the one to take my blood pressure and place his fingers on my wrist to count my pulse. This, to me, seemed like a radical affront to the standard division of labor and ritual practice of American health care. For these reasons I thought, "This is the guy for me." But, as I have seen over and over again, obstetrics is different. And even this man – who challenges the status quo

every time he walks out to the waiting room – found midwifery care and a resistance to obstetric testing and screening unacceptable.

Unlike in the U.S., the fact that I was seeing a midwife was a non-issue for the physician-specialist I saw in the Netherlands. I was simply treated for the issue at hand. Further, knowing that I would not experience stigma or discrimination in the Netherlands related to my planned place of birth empowered me to be more proactive in seeking health care and planning for eventualities.

Between First and Second Line Midwives

Historically, midwives have worked in the first line of the Dutch obstetrical system providing primary care to healthy women with uncomplicated pregnancies. Since 1995, the number of midwives working in hospitals (i.e., in the second line) has increased at least threefold (Wiegers and Hukkelhoven 2010). Below, I describe interactions between midwives in these two lines of care.

Nadine

Nadine is 41 weeks pregnant (i.e., one week past her due date) with her first child. She comes to the midwife's office for a routine prenatal appointment. According to my fieldnotes, "Nadine has quite a few things going on today." A combination of high blood pressure, potential rupture of membranes, large baby, and 41 weeks gestation lead Charlotte, the first line midwife, to refer Nadine to the *verloskamers* (delivery rooms) at the hospital.

Charlotte explains her rationale for the referral to Nadine. She then calls the hospital delivery rooms and talks to the head midwife – informing her that she is sending in a client for evaluation. The exchange is collegial and respectful – part of the day-to-day practice of obstetrics in the Netherlands. Charlotte then inputs information from today's appointment into her computer and prints out a new, fully up-to-date *zwangerscapskaart* (prenatal record) and hands it to Nadine. She also types and prints out a consultation letter that Nadine is to give to the second line providers when she arrives at the hospital.

Charlotte instructs Nadine to go home, have lunch, pack a bag for the hospital, and then head over. There is no specific appointment time and no need to rush. They are just expecting her sometime this afternoon. They will listen to the baby, do an ultrasound, try to assess whether the membranes have ruptured, and then make a plan. Nadine asks Charlotte's opinion.

> Nadine: Will they keep me at the hospital or send me home?
>
> Charlotte: They will probably keep you and likely induce. They'll see whether your cervix is ripe. If not, they'll probably introduce a prostaglandin gel. If the cervix is ripe – or if it ripens with the aid of the gel – they will start IV oxytocin to induce labor.

Nadine is upset. She begins to cry and thanks Charlotte for her care. "I am mourning the loss of my beautiful home birth with my husband and trusted midwife," she says. Her husband gets out of his chair and squats by her side while she cries. She turns to face him. They sit – forehead to forehead – and he puts a hand on the back of her head. He whispers to her.

Margo

Recounting the early hours of her labor, Margo says,

> I felt a few little contractations. That was around 4pm and around 4:30, but it seemed innocent, benign. At 4:45 I went to the bathroom and then, all of a sudden, the contractions really began. They quickly became stronger and stronger. We had planned to go get some *frietjes* (fries), but I said to my husband, "You don't need to get anything for me. In my opinion, it has begun. Go quickly." Our son wanted to go with him, but then I said, "Don't go. We're calling the midwife."

Margo and Kara, the midwife, agree to meet at the hospital at 6pm. Margo is planning a first line birth at the newly opened *verplaatste thuisbevalling suites* (relocated home birth suites) of the local hospital. She and her husband call their parents and a few friends who are coming to watch their older children. Their friends arrive within minutes and "between two contractions," says Margo, "we sprinted to the car!"

When they arrive at the hospital, Kara is already there. She has checked in at the security desk and picked up keys for one of the *verlossuites* (birth suites). With her she carries all the equipment and supplies she would bring to a typical home birth. They walk together to the birth suites which Margo describes as "cozy and comfortably furnished."

Upon internal examination, Kara discovers that Margo's cervix is dilated to 8 centimeters. She decides to break the bag of waters. The amniotic fluid is green from meconium (the baby's first stools). According to the *Verloskundig Vademecum* (Dutch Obstetric Manual), this is an indication for transfer of care from the first to the second line. Therefore, Kara picks up the phone and calls the *verloskamers* (delivery rooms) to let them know she is bringing in a client.

Around this time, Kara calls my cell phone. She says that Margo is in labor and that I should meet them at the *verloskamers*. I ride my bike to the hospital, walk upstairs to the maternity ward, and ring the bell. A nurse comes to the door. I introduce myself.

> Rachael: Hi, I'm Rachael Kulick. (I extend my hand. We shake hands.) I'm a student from the United States. I'm following Kara, the midwife.
>
> Nurse: Kara! (She calls down the hall and then turns back to me.) What a coincidence that she was standing right there.

Kara greets me in the hall and escorts me to Margo's room. She introduces me to Margo's husband, Remco, who is busy making a ham sandwich. Then she says, "and here is Margo *hard aan het werken* (working hard)." Margo is in the middle of a contraction. Lying on her left side with a pillow between her legs, she does not look up. I set my bag and jacket down in the corner of the room and take a seat on an adjustable stool that is sitting beside a small table. Medical personnel in the room include the second line midwife directing the birth, the second line *kraamverzorgende* (maternity care aide) assisting the midwife, a gynecologist *in opleiding* (in training) making an ultrasound to assess fetal position, and a medical student observing. All are wearing white coats and hospital badges. Kara is dressed casually in a brown long-sleeved t-shirt and blue jeans.

The *kraamverzorgende* has a few things to prepare before the birth and asks Kara to take her place supporting Margo's leg during pushing. Kara, who had previously been standing in the back of the room, moves to Margo's side. She says to Margo, "Listen very closely to Gerthrud (the second line midwife) for instructions during the delivery." Kara could have officially gone home after thick meconium in the amniotic fluid required a transfer of care. She was no longer responsible for the birth, but, she later told me, she wanted to stay and it was a quiet month in the practice.

I do not think that Kara would stay for the birth if it happened today. While she tried to make clear to Margo that Gerthrud was in charge, some might argue that her mere presence complicated a clear line of *verantwoordelijkheid* (responsibility). The practice of first line midwives providing continuity of care in the hospital after a medical issue arises is sometimes referred to as the *verlengde arm constructie* (extended arm construction). The practice was never officially sanctioned, but it occurred informally for many years. In 2007, however, the Royal Dutch Organization of Midwives and the Dutch Association for Obstetrics and Gynecology issued a joint statement declaring the end of the *verlengde arm constructie* (Koninklijke Nederlandse Organisatie van Verloskundigen and Nederlandse Vereniging voor Obstetrie en Gynaecologie 2007). Many midwives I spoke with were trying to get into the habit of leaving the hospital shortly after a transfer so as to facilitate a clear demarcation of responsibility. They were also discussing this with their clients prenatally so they would know what to expect if a transfer of care became necessary.

At Margo's birth, the interaction between the first and second line midwives is uncomplicated. In fact, after Kara provides an initial report of the situation, there is very little interaction between them at all. The birth simply becomes the responsibility of the second line midwife and Kara steps aside. In our postpartum interview, Margo described the hospital staff as *hartstikke lief* (incredibly nice, lovely) and *verzorgend* (caring, nurturing). About Kara's presence, she said it was *superfijn* (super fine, wonderful). "I liked being able to always see her," she confided. "My husband also found it nice – to have someone we knew and recognized there."

Between First Line Midwives and Second Line Gynecologists

Astrid

Charlotte arrives at Astrid's house around 9am. Astrid is 8 centimeters dilated, but the baby is still high in the pelvis. Charlotte listens to fetal heart tones. They are low. Charlotte gets Astrid onto her left side – low. Right side – low. Hands and knees – low. Standing – still low. The fetal heart rate does not get above 100 beats per minute.

Charlotte decides to call an ambulance. Over the phone she specifies "with haste." She then calls the hospital to let them know she is on her way with a client. The gynecologist asks if Charlotte is thinking about a c-section. Charlotte replies, "No, not right now." A few minutes later, she phones back to say,

> Charlotte: Yes. I think you may need to prepare for a c-section.
>
> Gynecologist: Okay. We're ready for you.

Astrid is transported to the hospital by ambulance. Her partner follows in his car, Charlotte in hers. Once at the hospital, the gynecologist listens to fetal heart tones for a few minutes. They recover briefly to the 130s and then dip again. The gynecologist decides to go ahead with the cesarean section. Forty-six minutes from the time the ambulance arrives at Astrid's door, the baby is born.

Regarding the midwife-gynecologist interactions described above, there are two important points. First, Charlotte is able and expected to call the ambulance service without fear of persecution or prosecution. Second, when Charlotte speaks with the gynecologist, her professional opinion and the information she provides are considered authoritative – thus allowing the hospital to prepare an operating room for a possible

cesarean section. Both of these things improve the quality of care Astrid receives and decreased the time from the initial suspicion of fetal distress to the birth of the baby.

Charlotte stays at the hospital to receive a report on the baby's condition. He had Apgar scores of 8 (out of 10) at one minute after birth and 9 at five minutes. Such high Apgar scores suggest that the baby was likely not in distress and the gynecologist says that, in retrospect, the c-section may have been unnecessary. This is not an overly heavy conversation – more of an off-handed comment – but what I interpret is an ability for care providers to express doubt and acknowledge the uncertainty of medical practice.

(Im)perfection

I observed others being openly vulnerable and reflexive about their practice as well. For instance, the day after Mieke gave birth, Charlotte and I went to her home for a postpartum visit. Charlotte rang the doorbell. Mieke's husband, Jan, answered. Immediately, we heard the baby crying upstairs.

Charlotte: What a beautiful sound!

Jan: Yep. They are upstairs. You know the way.

We walked upstairs and found Mieke sitting in bed nursing her new baby. After Charlotte offered some breastfeeding advice, we all – Charlotte, the maternity care aide, Jan, and I – pulled up chairs and sat around the bed. Charlotte went over the *medisch verslag* (medical report from the birth). She talked about a dip in fetal heart tones that came right after she ruptured the membranes. She said, "Sometimes that happens, but I have *spijt* (regret) that I broke the bag of waters. I should have been more patient."

She later told me that it felt good to be able to be honest with Mieke and Jan. I found it refreshing that she was able to express regret without a threat of retribution or litigation. According to De Vries (2004:175-9), the Dutch system is much less oriented around malpractice than is the American system and Dutch maternity care providers pay a fraction of the cost American OB/GYNs pay for liability insurance.

Another midwife I worked with shared a similar mentality regarding (im)perfection. One afternoon, I was accompanying Marlies as she drove around doing postpartum home visits, we got to talking about the controversial topic of risk selection. I asked,

> Rachael: What do you say to people who say that it is impossible to do *risicoselectie*, that you never know what you're going to get at birth – especially with first-time mom – so, everyone should be in hospital – at least for the first birth – just in case?
>
> Marlies: You also don't know how things are going to go if you get on the highway and drive to Amsterdam. I can't guarantee that a baby will be born healthy without *afwijkingen* (anomalies). What I am responsible for is doing my job well and correctly. Statistics don't bear out that hospitalization improves outcomes. *Risicoselectie* isn't perfect, but we do it as well as we can. We do our jobs well and we work well with other providers.

De Vries (2004:163-6) writes about this phenomenon in *A Pleasing Birth*. He suggests that one of the explanations for the shape and organization of the Dutch maternity care system is a deep national ambivalence about heroism. De Vries writes that while other nations have great towering monuments to national heroes, the Dutch have "*Het Lievertje*, a 30-inch-tall statue of an anonymous child" and a small statue of Anne Frank (p. 163). He argues that "gynecology in the Netherlands reflects this Dutch tendency to downplay the heroic" (p. 165). In his interviews with physicians, he found a general reluctance to think in terms of heroism or to express pride in intervening in ways

that could be described as heroic. In one interview in particular, a physician said, "doctors think with a little bit of relativity about their own duties and possibilities. We are not so much heroes, we do our best" (p. 166). This sounds, to me, very much like the gynecologist telling Gerda that she cannot guarantee a successful induction, like the gynecologist questioning the necessity of Astrid's c-section, like Charlotte saying to her client that she had *spijt* for artificially rupturing the membranes, or like Marlies unapologetically stating that she cannot guarantee anything in birth except that she will do her job well.

While Dutch culture and maternity care are organized, to some degree, around concepts of risk – risk selection, risk reduction, and risk management – there is no suggestion that risk can be minimized to zero. Instead, people are called upon to do the best they can as individuals *and* as a society (e.g., via rigorous and state-supported midwifery training programs and constant efforts to improve health care delivery especially where first line, second line, and emergency care intersect) while also acknowledging the frailty of human life and the inevitability of failure. This is, by no means, a way of eschewing responsibility or of avoiding hard facts about problems in the system. It is, however, a mindset that leads Dutch researchers, practitioners, and policy makers to ask different questions, generate different solutions, and produce different outcomes than their American counterparts. Instead of asking "Is home birth safe?," the question becomes, "What do we need to do as a society – as a care system – to ensure the safety of home birth?"

Between First Line Midwives and Emergency Medical Personnel

Frauke

Frauke successfully gives birth at home, but then develops painful *na-weeën* (i.e., uterine contractions after the birth of the baby and the placenta). At first there is a little bit of joking. Charlotte says, "If we didn't know better, we'd think there was a second baby coming." The tone changes over time and Frauke pleads, "Someone help me!" Charlotte answers, "There is nothing we can do except stay by your side. *Heftige na-weeën* (powerful or violent after pains) are more common after a second birth."

Frauke is lying in a single bed she rented from the home health care store. Her husband is sitting in a wicker chair holding their daughter, a concerned look on his face. Charlotte is standing right beside Frauke – frequently checking her blood loss. She feels Frauke's uterus. It is well-contracted. A few minutes later, Frauke passes a large clot – about the size of a placenta. Charlotte asks the *kraamverzorgende* (maternity care aide) to weigh it – 500 grams. Frauke feels immediately better. Everyone hopes that the excruciating pain of the *na-weeen* is over.

Time passes and Frauke is starting to look pale. She is also very tired. She cannot keep her eyes open. Charlotte takes her blood pressure and keeps her fingers on Frauke's pulse. Her blood pressure is normal, but her pulse is high. After administering an injection of synthetic oxytocin and using a catheter to empty Frauke's bladder, Charlotte decides to call an ambulance. She says that she is not sure if it is really necessary, but high pulse can be a *voorloper* (early sign) of shock and while Frauke's blood loss is okay

at this point, she does not want to have to wait 20 to 30 minutes for the ambulance to arrive if Frauke passes another clot.

At 1:30 in the morning, the doorbell rings. Charlotte goes downstairs and opens the door for a man and woman from the emergency medical service. She says, "You do not need to bring in a gurney. She probably just needs an *infuus* (IV)." The two emergency medical technicians (EMTs) follow Charlotte upstairs. When they enter the bedroom, they shake hands all around. "Congratulations, congratulations," they say to the parents. "Is it a boy or a girl?"

Then they get out a small machine for taking vital statistics. They attach electrodes to Frauke's chest, wrap a blood pressure cuff around her arm, and place a pulse oximeter on her finger. The machine records her vitals intermittently for the next 15 minutes or so. They also start an IV.

We all stand quietly watching the machine. Blood pressure remains fine. Pulse increases to 150 and then starts to decrease. Charlotte and the EMTs talk.

> Charlotte: Should someone in Frauke's condition eat and drink? What is your opinion?
>
> Emergency medical technician (male): If someone is truly in shock, then no. But, someone in her condition, if she can, food and drink can only help.
>
> Charlotte: Okay. I thought so, but wanted to ask your opinion.

The maternity care aide goes downstairs and prepares a tray. She comes back up and offers Frauke some tea and *ontbijtkoek* (spiced breakfast cake). They tease her that she has an IV in her hand and *ontbijtkoek* too. The mood lightens and the female EMT asks about the baby. "What is her name?" Everyone makes small talk while we wait for the IV fluids to drip into Frauke's arm.

At 1:40am, Charlotte decides to give a second injection of Pitocin. The male EMT agrees. “It is a good idea,” he says. “Not urgent, but a good idea.” When the IV is done, the EMT prints out a record of Frauke’s vitals from the machine and hands the printout to Charlotte. They agree that there is no reason to transport to the hospital. Charlotte thanks them for coming and for their help. They say, “It was nice – nice and relaxed.” They offer congratulations again to Frauke and her husband and leave.

The maternity care aide goes downstairs to get *ontbijtkoek* and beverages for everyone. Frauke’s husband hands the baby to her and she attempts to breastfeed. Charlotte asks the maternity care aide if she can stay for two more hours to make sure that Frauke remains stable. “Call if anything changes,” she says, “and record the additional hours of work, of course.” Charlotte and I prepare to leave. It is about 2:45am. We will return later in the day for a postpartum visit.

While the EMTs were at Frauke’s house, I was moved by the cooperation between them, the midwife, and the maternity care aide. When one of the EMTs hung the IV bag from a hook on the ceiling, I was reminded of a birth I had attended in the U.S. In that case, the woman also needed IV fluids and the midwife hung the IV bag from the bedroom window blinds. That, however, is where the similarities end. At the U.S. birth, the direct-entry certified professional midwife (CPM) called a certified nurse-midwife (CNM) to come start an IV. Administering IV fluids was outside the scope of practice for the CPM. As the CNM was leaving, she said to the CPM, “If you end up going to the hospital, pull out the IV and put on a Band-Aid.” What a different world.

STRUCTURES FOR INTERPROFESSIONAL COLLABORATION

The interactions described above demonstrate a relative absence of stigma related to home birth and midwifery in the Netherlands and a high degree of interprofessional cooperation, but one must be careful not to romanticize the situation. De Vries and colleagues (2009) suggest that stories about pregnancy and birth in the Netherlands often

> present cozy pictures that can lull us into assuming that Dutch caregivers simply know how to get along, and that mothers instinctively know how to give birth. But in reality, the coziness of Dutch birth is the product of a system of rules, regulations, educational programs, and arrangements between professionals … The elements in this system are constantly reviewed, argued over, and negotiated. (Pp. 38-9)

Samenwerking (collaboration, cooperation, or, more literally, working together) is at the heart of this system. The term represents a concept, a set of processes, and a general disposition that resonates across many spheres of Dutch life. It is the product of history, culture, and the environment (Shetter 2002; De Vries 2004). It is the result of government policies, professional training, and ongoing interprofessional negotiation at the national and local levels. In my observation, the behind the scenes work of obstetrical *samenwerking*, in particular, is difficult. It includes heated discussions and the balancing of competing interests and ideologies. Formal structures – namely, the *Verloskundig Vademecum en indicatielijst* (Dutch Obstetrics Manual and List of Obstetric Indications) and *verloskundige samenwerkingsverbanden* (obstetric cooperation networks) – bring stability and reliability to the process and enable providers in primary, secondary, and emergency care to interact ways that appear seamless to the client or outside observer.

Dutch Obstetrics Manual

Timely and smooth referrals between the first and second line are essential to the operation of the Dutch maternity care system. According to De Vries et al. (2009), "without some sort of organization and control, these back-and-forth referrals would quickly become confusing, if not dangerous" (p. 40). Furthermore, without jointly agreed upon rules to govern the behavior of obstetrical care providers, there would be no way to prevent gynecologists from keeping the clients referred to them from the first line or to discourage primary care midwives from managing more complicated cases themselves (p. 41). The *Verloskundig Vademecum* (Dutch Obstetrics Manual) provides these guidelines.

The manual is described as "*voor ons, door ons*" (for us, by us) (College voor Zorgverzekeringen 2003:7). It is cooperatively produced by representatives of the three obstetrical professional organizations in the Netherlands – the *Koninklijke Nederlandse Organisatie van Verloskundigen* (Royal Dutch Organization of Midwives), the *Landelijke Huisartsen Vereniging* (National General Practitioner Association), and the *Nederlandse Vereniging voor Obstetrie en Gynaecologie* (Dutch Association for Obstetrics and Gynecology). Together, they define physiology and pathology and, via a *verloskundige indicatielijst* (list of obstetric indications), instruct midwives and physicians on which conditions should be dealt with in the first line and which require consultation with or transfer of care to the second. Above all, the manual plays an important role in establishing the boundaries of professional jurisdiction and generating a "degree of

cooperation between midwives and physicians" that is unheard of outside the Netherlands (De Vries et al. 2009:41).

The idea for a list of conditions that indicate the need for specialist care and hospital birth can be traced back to 1930 and an obstetrics text written by Dr. De Snoo (De Vries 2004:116). Between 1930 and the publication of the current *Vademecum* in 2003, a number of lists were circulated including the 1959 *Kloostermanlijst*,[26] the 1987 *Verloskundige Indicatielijst*, and the first *Verloskundig Vademecum* published in 1999 (see De Vries 2004:116-37; Treffers 1993; and College voor Zorgverzekeringen 2003 for more on this history). The various lists enjoyed differing degrees of "buy in" from midwives, general practitioners, and gynecologists over the years. The two most recent lists – published in 1999 and 2003 as part of broader obstetric manuals – were consensus documents that, unlike some of the earlier lists, received strong support from all three professional organizations involved.

The current manual is based on seven principles (College voor Zorgverzekeringen 2003:13-4). Among them is the idea that first line midwives and general practitioners are responsible for providing care to women with normally-progressing pregnancies and for the identification of pathological situations while second line providers oversee pathological pregnancies, births, and postpartum issues. Additionally, the parties agree that

> medicalization of obstetrical care must be avoided or discouraged. On the basis of this principle, the Commission is of the opinion that the possibility of *thuisbevalling* (home birth), in addition to *poliklinische bevalling* (short-stay, midwife-led hospital birth) and

[26] Named after the famous Dutch gynecologist Gerrit-Jan Kloosterman.

> *klinische bevalling* (gynecologist-led hospital birth), must be able to continue to exist and, where possible, should be promoted. (P. 14)[27]

When reading the *Vademecum*, it is clear that the assumptions underlying the Dutch maternity care system are quite different from those that undergird other systems around the world.

The 2003 *Vademecum* is divided into two parts. Part one offers advice and policies to promote interprofessional cooperation and develop mutual standards regarding pressing contemporary issues such as ultrasonography and perinatal audits. Part two is the list of obstetric indications. The list is referred to as a "*kant en klaar product*" (College voor Zorgverzekeringen 2003:7) That is, it is ready to be used "as is" in daily practice. Obstetric indications are divided into six groups. Within each group is a set of conditions. I list the groups below and offer examples of conditions that fall into each group.

1. Preexisting conditions, not gynecological (e.g., epilepsy, diabetes, multiple sclerosis, hypertension)

2. Preexisting conditions, gynecological (e.g., abnormal pap smear, women exposed to DES before birth)

3. Obstetrical history (e.g., previous pre-eclampsia or HELLP syndrome, premature birth in a previous pregnancy, previous child with congenital anomaly, previous postpartum hemorrhage, previous fourth degree perineal tear, previous postpartum depression)

4. Arising or determined during pregnancy (e.g., anemia, bladder infection, sexually transmitted infection, drug use, extra-uterine pregnancy)

5. Arising during birth (e.g., malpresentation, unusual blood loss, placental abruption, retained placenta, fever, meconium-stained amniotic fluid)

[27] The original Dutch reads, "medicalisering van de verloskundige zorg moet voorkomen of tegengegaan worden. Op grond van dit uitgangspunt is de commissie van mening dat de mogelijkheid van de thuisbevalling, naast de poliklinische en klinische bevalling, moet kunnen blijven voortbestaan en waar mogelijk moet worden bevorderd."

6. Arising during the postpartum period (e.g., abnormal blood loss, psychoses, deep vein thrombosis)

For each condition (e.g., previous HELLP syndrome), a course of action is prescribed. Courses of action are organized into four categories: A, B, C, and D. If a condition is assigned an "A," that means that care for a woman with that condition should be provided by a first line midwife or general practitioner. "C" conditions require ongoing care by a gynecologist. "B" conditions are *overleg situations* or situations requiring consultation with the second line. Finally, women with "D" conditions can remain in the first line, but are considered ineligible for home birth because the transport risk is seen as too high. Thus, "D" conditions require birth in the hospital, but they remain under the direction of a first line practitioner.

During my fieldwork in the U.S., I observed meetings of a coalition of direct-entry midwives who were revising their "Standards of Care" documents. Among these documents were five appendices that listed:

1. Contraindications for home birth based on health history (e.g., epilepsy or sickle cell disease),
2. Contraindications for home birth based on conditions identified during prenatal care (e.g., rubella during the first trimester or persistent pregnancy induced hypertension),
3. Situations or conditions requiring consultation with a physician (e.g., suspected multiple gestation or unresolved anemia),
4. Situations or conditions requiring consultation with another midwife (e.g., history of post dates pregnancy or long labor), and
5. Situations requiring hospital transport (e.g., heavy meconium staining or umbilical cord prolapse).

These documents were in many ways similar to the Dutch *verloskundige indicatielijst*. The difference was that the midwives in the U.S. were only talking to each other. They

had no interlocutor, no group of physician-counterparts with whom to discuss and negotiate the terms of referral. This, of course, allows them to maintain a high degree of control over their practice protocols, but it also means that they are shut out of the mainstream health care system. The authors of the Dutch obstetrics manual, on the other hand, include both physicians and midwives and they make it clear that "various parts of the manual (e.g., the B-indications in the list of obstetric indications) can only be optimally achieved within a structured partnership" (College voor Zorgverzekeringen 2003:8).[28]

Obstetric Cooperation Networks

The Dutch Obstetrics Manual and List of Obstetric Indications put down in writing a set of *richtlijnen* (directives) for care providers. It is the job of the *verloskunde samenwerkingsverbanden* (VSVs) to translate those directives into action at the local level (Koninklijke Nederlandse Organisatie van Verloskundigen 2012). VSVs are made up of midwives, gynecologists, and obstetrically-active general practitioners. In some localities, the VSV may also include representatives from other medical specialties (e.g., pediatrics or perinatology) and/or the *kraamzorg* (postpartum care) industry.

I observed one VSV over the course of three months. Fieldwork included two *bestuurvergaderingen* (steering or executive committee meetings), one meeting of the local midwives, two *refereeravonden* (continuing education evenings), one tour of the *verplaatste thuisbevalling suites* (relocated home birth suites), and two post-meeting

[28] In the original Dutch, the passage reads, "verschillende onderdelen uit dit Vademecum (bijv. de B-indicaties uit de Verloskundige Indicatielijst) zijn alleen optimaal te realiseren binnen een gestructureerd samenwerkingsverband" (p. 8).

receptions. My observations provide important information about the invisible scaffolding that supports and shapes everyday interactions between pregnant women, midwives, and physicians. As three months is a short time in the life of a VSV, this is an area ripe for further inquiry.

Steering Committee Meeting

The *bestuurvergadering* begins at 6pm. We meet in a conference room at the local hospital. A few tables have been pushed together to form a rectangle in the center of the room. We help ourselves to soup, sandwiches, and warm beverages provided by the hospital catering staff and then find seats around the tables. The physical environment both sets and reflects the tone of the meeting. The seating arrangement is non-hierarchical – no one's opinion matters more than another's. The food and drink are simple and ordinary. The feeling is one of a "brown bag" discussion or a working lunch.

Present are first line midwives who represent the local *kringen* (circles, regions, or catchment areas) as well as three second line care providers – a hospital-based midwife, a gynecologist, and a pediatrician. Committee members are friendly and polite, but do not spend much time on small talk or extraneous issues. Shortly after taking their seats, they are called to order by the *voorzitter* (president or chairperson) who reviews the agenda for the meeting and then goes around the table soliciting issues for the VSV to consider.

The writers of the *Vademecum* acknowledge that no one document can address all the issues that will inevitably come up in daily practice. Moreover, they recognize that technology and the state of knowledge change over time. Therefore, one purpose of a

VSV is to discuss issues that are not covered in the *Vademecum* and to find solutions – evidence-based, to the extent possible – that work at the local level. As the chairwoman goes around the table, committee members raise the following questions: What is the appropriate level of care for women taking SSRIs (selective serotonin reuptake inhibitors, a particular class of antidepressants)? Do they need to be in the second line? What does the scientific literature say about how to care for women with a body mass index over 30? How should we be advising our clients on the hot-button topic of pain medication? Is there interest in the creation of a shadowing program in which first and second line care providers follow each other for a day or a week to build respect and understanding? No answers to these questions are proposed. They are simply recorded for consideration at future meetings. After this initial round of comments, the discussion moves to current agenda items.

The first issue concerns the protocol for returning clients to the first line after a consultation with a gynecologist finds no pathology. A first line midwife describes a situation that has come up in her practice.

> First line midwife: The gynecologist says to the patient, "There is nothing wrong. You can now choose if you want to stay here in the second line with me or go back to your midwifery practice in the first line."
>
> Other first line midwife: There should be no choice. The gynecologist should send the woman back to the first line. That is in the best interest of the client, the system, and the division of labor.
>
> Another first line midwife: We also have to work for our *botterham* (bread).

The issue is discussed – but not resolved – before the group moves on to the next item on the agenda.

The conversation shifts to a local shortage of *kraamverzorgenden* (maternity care aides). Most women are guaranteed 49 hours of postpartum home care under their insurance plans, but many are getting less than that. In fact, many are receiving only *minimaal zorg* (minimal care). Minimal care includes 24 hours of medically-oriented care for mom and baby spread over eight days. The question at hand is whether this situation is requiring midwives to do more. The first line midwives agree that it is – especially in the realm of breastfeeding support – but it is hard to quantify.

They move to issue number three – the development of a *kraamhotel* (postpartum care hotel). A company based in another part of the country wants to open a *kraamhotel* in the community. Their research indicates that there is a market for it. First line midwives are frustrated because there has been very little consultation with them. They say they want openness and transparency.

> Second line midwife: Why are you opposed to this? What are you afraid of?
>
> First line midwife: That before we know it, they will be hiring midwives and doing births at the hotel as well.

An action step is agreed upon. The VSV will write a letter to the company that is seeking to build the facility. It is the duty of the VSV to make sure that the *kraamhotel* is, above all, for the good of the client.

This portion of the discussion forefronts interprofessional rivalry and concerns about jurisdiction and finances. The particularities discussed at the meeting are a reflection of the historical time period and local situation, but the threats to the first line and affronts to the expectation of collaboration are not new. Rather, they are longstanding problems between the first and second line and between care providers and industry.

The steering committee meeting ends with a final *rondvraag* (round of questions and comments) which allows members to articulate lingering concerns. The chairwoman has been taking notes throughout the meeting. She will make sure that the necessary items get onto future agendas. A date and time for the next meeting is also set.

As a non-Dutch observer, I was struck by three aspects of this meeting. First, I was taken aback by the candor of the exchanges. De Vries (2004) would likely attribute this, at least in part, to a cultural emphasis on *bespreekbaarheid* (i.e., the idea that "nothing should be outside the realm of discussion, everything should be *bespreekbaar*, or 'speakable'") (p. 171). Second, I was surprised that the conversation did not devolve or breakdown around contentious issues. I have come to understand that the *vergadering* (gathering, meeting) – a culturally-specific format for negotiation, consensus building, and the maintenance of social solidarity – allows for the discussion of difficult topics (De Vries 2004:170-1; De Bony 2004 and 2005). Finally, it looked to me like very little got resolved at the meeting. I had to remind myself that these meetings occur every one to two months as part of a long history and ongoing conversation. Perhaps the most important function of a VSV meeting is the promise of future collaboration.

Continuing Education Evening

After the steering committee meeting, we move to the hospital auditorium and join a larger group of midwives, gynecologists, and medical residents for a *refereeravond*. Tonight's discussion focuses on perinatal audits. A regional audit is currently underway and 2009 will mark the start of a national audit.

The first speaker of the evening describes the regional audit practice. Every perinatal death of a baby born over 500 grams, at least 22 weeks gestation, and at least 25 centimeters long is examined by a commission composed of a first line midwife, a second line midwife, a gynecologist, a gynecology resident, a pathologist, and a pediatrician. The goal of the examination is to identify substandard care at three levels: (1) the *zorgvrager* (care requester/patient), (2) the *zorgverlener* (care provider), and (3) the *zorgorganisatie* (care organization).

The second speaker overviews a case in which a 16 year old gave birth to a baby with hydrops fetalis. After examining the medical file, it was determined that the mother was young and a smoker – potentially evidence of substandard care at the level of the patient. These characteristics, however, were not related to the cause of death. Therefore, the commission ruled that there was no substandard care.

The third speaker presents a case in which the commission identified substandard care by both the patient and the providers. The woman involved was overweight and a smoker – both characteristics likely linked to the cause of fetal death. Regarding the providers, it was determined that the first line midwife was too slow in transferring the woman to the second line for preeclampsia. Once transferred, the gynecology resident did not take seriously enough a malfunction of the fetal heart rate monitor and was, therefore, too late in getting a gynecology consult. No substandard care was found on the part of the organization, however. This stimulates some conversation among audience members regarding the difference between substandard care on the part of the care provider and the care organization. It is clarified that substandard care on the part of the organization

includes situations like a woman needing a cesarean section, but all operating rooms being occupied or a woman requiring emergency transport and the ambulance taking exceedingly long to arrive. There was no such issue in this case.

The final speaker is a pathologist who discusses issues that still need to be worked out. For instance, how can patient and public health education be improved so as to decrease substandard care (e.g., smoking, teenage pregnancy, or older maternal age) on the part of patients? And what will be done when substandard care is discovered among providers or within the health care organization? As an American steeped in a litigious culture and surrounded by talk of medical malpractice, I notice that there is no reference to legal action.

Perinatal mortality is a prominent issue in the Netherlands right now. In fact, reports of a perinatal death rate that is either higher than or not declining as fast as in other European nations (EURO-PERISTAT Project 2008) have sparked the most recent round of attacks on home birth and the organization of the Dutch maternity care system. There are some, both inside and outside of the Netherlands, who have tried to causally link unacceptably high perinatal death rates to the prevalence of home birth and the two line system. A recent study, however, finds that "the relatively high perinatal mortality rate in the Netherlands is driven more by extremely preterm births than births at term" (De Jonge et al. 2013:1011). Since home birth is only planned for term infants, the idea that the practice of home birth is a driving factor in the relatively high perinatal mortality rate does not hold. The authors of the study go on to write that "Although the PERISTAT data cannot be used to show that the Dutch maternity care system is safe, neither should

they be used to argue that the system is unsafe." Leaders in midwifery research argue that universal hospitalization – a frequently proposed solution – is no panacea (Hutton 2011; De Vries and Nieuwenhuize 2011, De Vries and Buitendijk 2012). Safety in childbirth cannot be simplified to place of birth. It is far more complex and probably lies in the kind of interprofessional collaboration in which Dutch obstetrical providers are so experienced.

*****

In 2005, I traveled to the Netherlands for a conference titled "Midwifery in the Netherlands: A Prospect for Future Development in Europe." Conference organizers offered the following description for would-be participants,

> The Dutch midwifery system is renowned worldwide for its ability to preserve pregnancy and childbirth as a normal life event. Central to the care approach is the *Vademecum* (Obstetric Manual). This unique conference will share the Dutch philosophy. An emphasis on the important role of the *Vademecum* in preserving *(sic)* unnecessary medicalisation will be discussed, offering a real opportunity for the development of independent midwifery in Europe. (Sanders 2004)

Almost as soon as this conference touting the Dutch system as a model for all of Europe came to a close, it was becoming clear that not all was well in "Mecca for midwives" (Rothman 1993:201).

In 2011, Pols articulated an increasingly common sentiment. "The Netherlands," he wrote, "is the homebirth paradise no more and few international delegations will be visiting the Low Countries to see how delivery care is organized there" (p. 19). I agree with Pols and others that there is trouble in paradise. In 2008, I wrote in my fieldnotes, "I feel like I am witnessing the slow death of home birth in the Netherlands." In 2009, I came back to the theme and wrote a memo titled "The Beginning of the End?" in which I

detailed many of the threats to the Dutch way of birth. I described the perinatal mortality debate, the consolidation and centralization of hospitals, the decades' long shift away from solo and duo midwifery practice toward a group practice model, and the increasing use of and reliance on disembodying technologies such as ultrasonography by both midwives and pregnant women (Pasveer and Akrich 2001).

While I agree that the Dutch maternity care system has problems and is facing tremendous challenges, I have come to a different conclusion about what this means for observers from other countries. I argue that in this time of uncertainty and upheaval, there is all the more reason for international delegations to visit the Low Countries. I cannot predict what the Dutch maternity care system will look like on the other side of this soul searching, but I am certain that both midwives and physicians will have roles to play and that *samenwerking* will remain a foundational principle of the care system.

Brigitte Jordan and Robbie Davis-Floyd – mothers of the anthropology of birth – both emphasize the importance of collaboration in creating "birth systems that work" (Jordan 1993:138-9; Davis-Floyd et al. 2009:448-9). Collaboration between U.S. physicians and home birth midwives seems all but impossible in a culture in which "obstetricians, other concerned physicians, midwives and other obstetric providers, and their professional associations" are urged to "refuse to participate in planned home birth" and to respond to women's questions about home birth with "evidence-based recommendations against it" (Chervenak et al. 2013a:31). There has, however, been progress in the creation of collaborative care models between physicians and certified nurse-midwives in the U.S. (e.g., Avery, Montgomery, and Brandl-Salutz 2012 and

Waldman, Kennedy, and Kendig 2012). And maternity care providers in other high-income, English-speaking countries such as the UK, Canada, and Australia are also deeply engaged in these kinds of conversations (e.g., Saxell, Harris, and Elarar 2009; Downe, Finlayson, and Fleming 2010; Heatley and Kruske 2011; Vedam et al. 2012).

Still, the Netherlands is the only developed country in the world where midwives and physicians have, for centuries, worked side-by-side as autonomous yet interdependent providers. They have developed structures to facilitate their cooperation and, especially as their system is strained and challenged, this is where the rest of the world can learn from them. If Dutch midwives and physicians can work through this crisis and forge a new path forward – a path that maintains home birth as a safe, satisfying, and unstigmatized option – women in the Netherlands who plan to give birth at home will not become "tainted" or "discounted" like their counterparts in the United States (Goffman 1963:3). They will continue to be free to enter into motherhood as "whole and usual" persons.

PART II

NATURAL BIRTH

CHAPTER 5
MIND, BODY, AND THE DISCOURSE OF NATURAL BIRTH

> "Korotun, it's me. Fatumata."
> I searched her tense face. She seemed far away, as if her spirit had drifted beyond the horizon.
> "Fatumata," she blurted and her eyes opened wide. She grabbed my hand. "Fa …"
> She was cut off by a contraction. Her body was no longer hers; she had to submit to its will. (Holloway 2007:108)

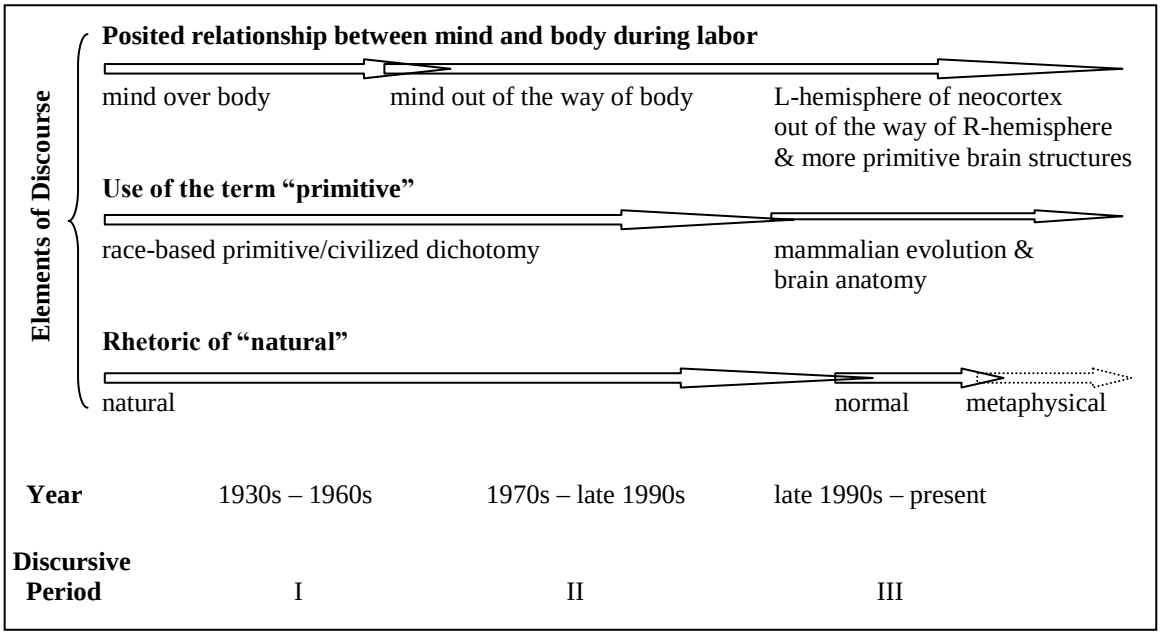
This description of a woman in labor – her spirit/self seeming to disappear, overcome by the sensations of her material body – comes from Kris Holloway's (2007) memoir about her time working with a midwife in Mali. I witnessed this phenomenon over and over again while in the field in the United States. I read about it in childbirth guides and midwifery textbooks, I heard midwives and their clients discuss it during prenatal appointments, and I listened to women's experiences of it during postpartum interviews. I came to see it as a hallmark of unmedicated home birth.

When I moved to the Netherlands, however, I found a general lack of emphasis on this kind of mind/body dissociation – so much so, that I started to think of what I had witnessed in the U.S. as the enactment of a particular childbirth discourse, a discourse that does not resonate in the Dutch context. In chapter six, I dissect the performance of home birth in the U.S. Before I do that, however, I must ask: What is it that U.S. women and midwives are enacting? What discourse informs their practice? The answer is "natural birth."

In this chapter, I analyze the discourse of natural birth from its inception in the 1930s to the present. Focusing on how natural birth experts characterize and explain the relationship between mind and body during labor, I identify three discursive periods that can be described as (1) mind over body, (2) mind out of the way of body, and (3) left

hemisphere of the neocortex out of the way of the right hemisphere and more primitive brain structures or what I term the "neoscientific turn." This investigation reveals changes over time in the way experts use the word "primitive" and their affinity for the term "natural." It also shines light on an emerging trend – a shift away from a rhetoric of naturalness and primitiveness all together and toward a new conceptualization of birth as ecstatic and transcendent (see Figure 2).

Figure 2. Trends in Natural Birth Discourse, 1930s to the Present



DATA

Drawing on the interdisciplinary academic literature on childbirth, recommended readings from midwifery and childbirth education organizations, and my own fieldnotes and interview transcripts, I identify six *core* figures in the natural birth movement – Grantly Dick-Read, Fernand Lamaze, Robert Bradley, Ina May Gaskin, Michel Odent, and Sarah Buckley. In addition to books written by these authors, I also analyze five texts

that are particularly relevant for participants in this study and/or especially illustrative of the discursive periods I describe in this chapter. These additional texts I term *specialty* (see Table 8).

Table 8. Books Included in the Dataset

Author(s)	Core or Specialty	Year of Publication	Title	Author(s) Background
Dick-Read, Grantly	Core	[1944]1972	*Childbirth without Fear*	English obstetrician
Lamaze, Fernand	Core	[1956]1984	*Painless Childbirth*	French obstetrician
Bradley, Robert	Core	1965	*Husband-Coached Childbirth*	American obstetrician
Gaskin, Ina May	Core Core Supplemental	[1977]1990 2003 2011	*Spiritual Midwifery* *Ina May's Guide to Childbirth* *Birth Matters: A Midwife's Manifesta*	American midwife†
Odent, Michel	Core Supplemental	1984 2009	*Birth Reborn* *The Functions of the Orgasms: The Highways to Transcendence*	French obstetrician
Buckley, Sarah	Core	2009	*Gentle Birth, Gentle Mothering*	New Zealand/ Australian general practitioner
Davis, Elizabeth	Specialty	1981	*A Guide to Midwifery: Heart and Hands*	American midwife†
England, Pam and Rob Horowitz	Specialty	1998	*Birthing from Within: An Extra-Ordinary Guide to Childbirth Preparation*	American midwife (England) ‡ and psychologist (Horowitz)
Frye, Anne	Specialty	2004 Vol. II 2010 Vol. I	*Holistic Midwifery: A Comprehensive Textbook for Midwives in Homebirth Practice, Volumes I and II*	American midwife†
Davis, Elizabeth and Debra Pascali-Bonaro	Specialty	2010	*Orgasmic Birth: Your Guide to a Safe, Satisfying, and Pleasurable Birth Experience*	American midwife (Davis) and doula (Pascali-Bonaro).
Walsh, Denis and Soo Downe	Specialty	2010	*Essential Midwifery Practice: Intrapartum Care*	English midwives and professors of midwifery

†Gaskin, Davis, and Frye are direct-entry midwives.
‡England is a nurse-midwife.

DISCURSIVE PERIOD I: MIND OVER BODY

The fathers of natural birth include three obstetricians – Grantly Dick-Read of England, Fernand Lamaze of France, and Robert Bradley of the United States. Dick-Read's 1933 publication, *Natural Childbirth*, is often cited as the original statement on natural birth and in the 1930s and 40s any reference to natural birth almost certainly was a reference to the Read method. In the 50s, Lamaze introduced his "psychoprophylactic method" and Bradley's "husband-coached childbirth" followed in the 1960s.

While the three fathers disagreed – sometimes vehemently – on how best to achieve natural birth, they all agreed that birth is not an inherently pathological, dangerous, or painful phenomenon in need of medico-surgical management, but, rather, a normal physiological function of the healthy human body – a process the female body is, indeed, designed for. This concept was a radical departure from the prevailing ideas of the day. It was, in part, a reaction to standard obstetrical practices in England, France, and the U.S. which included isolating, sedating, and restraining women during labor, rendering them unconscious during delivery, and employing operative methods for routine vaginal birth.

Natural birth was, however, more than just a reaction to the medicalization of birth. It was also "a means of expressing anxieties about the social, economic and political upheavals of the 20th century" (Moscucci 2003:168). In particular, early British pioneers of the natural birth movement were concerned about the "pathological effects of civilisation" (Moscucci 2003: 172). They believed that civilization may actually render women incapable of physiological childbirth and that women's emancipation threatened

the future of society as well-to-do women abandoned their essential roles as mothers and homemakers. Natural childbirth suggested that the distinguishing characteristics of modern civilization were the development of culture and the dominance of logical, rational thought – both of which were said to cause fear and anxiety around childbirth and, as a byproduct, tension with its resultant pain and difficulty with the birthing process. Thus, civilization itself and, by extension, the modern thinking brain were hypothesized to be the root causes of the perceived maternity crisis.

The Read, Lamaze, and Bradley approaches were all based on the idea that the modern brain interferes with the instinctual behavior that brings about smooth and efficient labor. Thus, they sought – each in his own way – to retrain the civilized human mind through prenatal education and to alter culturally-produced responses to labor through a variety of breathing techniques, visualization, body positioning, and labor support. They claimed that women who followed their prescriptions for natural birth could avoid pharmaceutical pain relief and experience the pain- and intervention-free births their "primitive" counterparts achieve "naturally."[29] Perhaps more importantly, adherence to a natural birth regimen was argued to produce better mothers, stronger families, and healthier societies.

The Problem with Civilized Birth: Culture and the Mind

The first wave of natural birth discourse contrasted modern or "civilized" human birthing practices with practices of non-human animals, ancient humans, and contemporary

[29] According to Jasen (1997), natural birth is built on a myth of painless childbirth among primitive peoples that is "quite apart from the realities of aboriginal life" (p. 391).

"primitive" or "uncivilized" peoples. Dick-Read, for instance, observed that his English patients generally had much difficulty with childbirth and required extensive medical intervention. By contrast, "the women of Africa" gave birth instinctually and easily (Dick-Read 1972:313). Dick-Read came to believe that instinct had been displaced by culture in the civilized woman and that the "activity of the mind" was her greatest obstacle to achieving natural birth.

Bradley (1965) put it this way,

> To anyone like myself who grew up in God's great outdoors and witnessed the birth process in animals, other than human, the inevitable question is bound to arise: Why do all other animals peacefully and joyfully give birth unassisted? Why can't the human animal do this? What makes the difference? (P. 8)

Bradley answered that the problem lies not in the anatomy or physiology of the modern human being, but in "the conscious mind of man" which is so susceptible to culture and socialization and can interfere with or "act as a cover-up to the underlying animal brain" (p. 180). Therefore, a central goal of the Bradley method was to teach women how to behave like non-human animals during labor and birth in order to circumvent the conscious mind and avoid the maladaptive behaviors human culture has produced.

Bradley (1965) believed that women must create a "deliberate 'do nothingness' of the body during contractions" (p. 42). Because the mind could not be similarly relaxed – except, perhaps, during sleep or in a state unconsciousness – women were instructed to occupy the mind during labor. Bradley wrote,

> She should select the earliest and most pleasant memory from her childhood and deliberately dwell on this happy little experience … Early childhood states of trust and total dependence on others were accompanied then by automatic physical relaxation … Recalling and reliving happy days in the mind's eye during uterine contractions helps her to dissociate from the pulling feeling in her back and lower abdomen. (p. 42)

This quote, in addition to illustrating an infantilizing of women and a paternalism that was common in Bradley's day, articulates a need to "dissociate" the mind from the body. One cannot get rid of the mind, but she should strive to put it to good use. This line of reasoning is even more prevalent in the work of Fernand Lamaze whose techniques, imagery, and conceptual apparatus dominated the first wave of natural birth discourse.

Retraining the Modern Mind and the Ascendance of the Lamaze Method

Neither the Read nor the Bradley methods were particularly well-suited to existing hospital practices. They posed too much of a challenge to prevailing assumptions, hierarchies, and care routines. Lamaze's method for producing unmedicated, low-intervention birth, however, was relatively palatable to medical personnel and amenable to hospital routine (Davis-Floyd 2003a, Leavitt 2009; Rothman 1991). It cannot be overlooked that many women were satisfied with the results of Lamaze training and were grateful that the method offered an alternative to standard obstetrical procedures. In fact, the book that popularized the method in the United States was titled, *Thank you, Dr. Lamaze: A Mother's Experiences in Painless Childbirth* (Karmel 1959).

Lamaze's method was inspired by techniques he witnessed in 1951 while on a medical tour to the Soviet Union. For the women he was accustomed to attending in labor, "a contraction was the signal of pain and pain there resulted" (Lamaze 1984:143). The women he observed in Soviet hospitals, however, had gone through a Pavlovian-style training program designed to override this typical response pattern. For them, a contraction was "accompanied by the normal perception of a sensation," but "it [was] no

longer the signal for pain" (p. 143). After returning home, Lamaze designed his own method for producing a relaxation (as opposed to pain) response to uterine contractions.

My own mother used the Lamaze method when she gave birth to me in 1977. In the delivery report she filled out after the birth she wrote,

> Don and I went to the doctor's office Wednesday for my 9:30 appointment. I was having a lot of trouble sitting – the baby was very low. I walked through my contractions. They were now about 8 minutes apart.
>
> The doctor checked me. He said I was dilated to 3, totally effaced and the baby was at station +2. He said we should check in at the hospital at noon.
>
> From noon until 2:00pm I was allowed to walk around. So I walked through my contractions. Sitting or lying was very difficult since the baby was so low. At 2:00pm the doctor broke my bag of water. I had to lie in bed from this point on. It was difficult for us to know when to start breathing as contractions were not registering correctly on the monitor. I used the slow chest breathing with effleurage as long as I could.

The specialized breathing techniques and light abdominal massage (effleurage) are hallmarks of the Lamaze method. In the same report, she was asked, "To what extent were you able to maintain control of your labor and delivery? All the time, most of the time, part of the time, a very short time, not at all." She did not provide an answer.

Lamaze suggests that "a good cortical control is the most important factor required" and that, in childbirth, the brain "can be compared to the head engineer in a perfect central power station" (p.136). He goes on to describe the woman who has "responded to" and successfully "adapted herself" to labor as characterized by "full and active consciousness" (p. 143). As I demonstrate below, the second and third waves of natural childbirth discourse focus on the need to suppress or turn off the modern brain and enter an altered state of consciousness – a near inversion of the Lamaze message.

DISCURSIVE PERIOD II: MIND OUT OF THE WAY OF BODY

In the 1970s and 80s, Ina May Gaskin of the United States and Michel Odent of France reinvented the discourse of natural birth. They returned to some of the ideas of Dick-Read and moved forcefully away from the Lamaze method that, by now, was seen as exchanging external, pharmaceutical control of women for internal, psychological control. Some critics even argued that Lamaze-style "awake and aware" hospital birth was a form of false consciousness (Rothman 1982) – as inhumane as the "knock 'em out, drag 'em out" obstetrics that preceded it (Bradley 2008:xvii).

Historically speaking, Gaskin and Odent emerged as thought leaders during a period of anti-war activism, second-wave feminism with its women's health movements and self-help gynecology, and the decline of the "golden age of doctoring" (e.g., McKinlay and Stoeckle 1988, Pescosolido, Tuch, and Martin 2001, and McKinlay and Marceau 2002). Their philosophies upset the entire organization of maternity care and the taken-for-granted hierarchies that placed masculine over feminine, culture over nature, and mind over body. Their ideas deviated from the discourse of the first wave in two key ways: (1) they shifted authority in childbirth from doctor and husband to midwife and birthing woman (i.e., from male to female) and (2) they explicitly rejected the concept that the mind should be used to keep the body in control during labor.

Ina May Gaskin: On Hurricanes, Monkeys, and Rational Thought

Ina May Gaskin, an American midwife, is regularly referred to as "the most famous midwife in the world" and "the midwife of modern midwifery" (e.g., Right Livelihood

Award Foundation 2011; MacEnulty 2012). Her entry into the profession was somewhat of an accident – serendipitous perhaps, but not sought. According to her account in *Spiritual Midwifery* (1990), she began attending births while travelling across the country with, Stephen Gaskin, whom she later married. Stephen Gaskin was a counterculture guru who was giving lectures around the U.S. and a caravan of about 300 people were accompanying him. Over the course of five months, they travelled from San Francisco to Tennessee where they eventually settled and formed an intentional community called The Farm. A number of female members of the caravan were pregnant when they set out from San Francisco and they gave birth along the way. Ina May Gaskin became the de facto midwife in the group. She had no formal training in obstetrics, but she was well-educated and one of few women in the caravan who had given birth before.

The group believed in self-sufficiency and thought that if they were going to raise their own food and build their own homes, they had better be able to birth their own babies as well. They were critical of mainstream maternity care practices and were "looking for a better way" (Gaskin 1990:17). Once settled in Tennessee, the group developed a maternity center and became the face of the modern U.S. home birth movement. Since they were eschewing the system of hospital birth entirely, there was no need to conform to the demands of hospital routines and organizational structures. New practices and discursive forms were available to them.

A review of Gaskin's writings shows that her language for describing women in labor changes over time. In her early work, when Gaskin (1990) describes transition, she writes, "rational thought may leave her … Assure her that this is temporary and that her

brains will return shortly – they are currently in her bottom" (p. 347). "The mother's state of consciousness," she goes on,

> goes through a very great change during the first stage of labor … She becomes less of an individual personality and more like an elemental force – like a tornado, a volcano, an earthquake, or a hurricane, with its own laws of behavior. (P. 348)

Gaskin counsels the midwife,

> You have to find out the laws of this tropism, whatever aspect of it you are faced with, and work within them, because you can't reason with an elemental force, and you can't predict what it will do. Don't expect a lady to be reasonable while she is having a baby. (P. 348)

There are two aspects of Gaskin's description of the woman in transition that I want to draw attention to: first, the place of reason during childbirth and, second, the metaphor of birthing women as elemental forces.

Gaskin tells us that birthing women are not rational. Their brains leave them and a midwife must relinquish the notion that a woman in labor can be reasonable. For Gaskin, the brain or the mind is not exactly disembodied (i.e., divested of a body or corporeal existence) during childbirth. It is still deeply rooted in the body – in the woman's bottom, to be precise – but a brain no longer located in a head is not capable of rational thought. This leads us to a key premise of post-Gaskin natural birth: When birthing naturally, a woman's brain leaves her head and rational thought becomes difficult, if not impossible. This premise is repeated over and over in the natural birth literature published after the 1970s.

What is especially noteworthy is Gaskin's explanation for why women lose their capacity for reason. Gaskin likens birthing women to elemental forces. In *Spiritual Midwifery* (1990), women become tornados, hurricanes, volcanoes, and earth quakes and

such forces of nature have innate and involuntary (i.e., tropistic as opposed to reasoned) responses to stimuli.

In her later writings, Gaskin develops new imagery of women as primitive. She instructs, "Let your monkey do it" and explains that "letting the primate in you do the work of labor is a short way of saying not to let your over-busy mind interfere with the ancient wisdom of the body" (Gaskin 2003:242-3). Years later, she further elaborates,

> One of my specialties during the early days of cultural development at The Farm was teaching "civilized," "educated" women how to behave like indigenous people – actually, like any other mammal. I often found it easier to take the shortcut of explaining to women that we all have an inner primate, and that this is the part of ourselves that we need to access when we are in labor. "Let your monkey do it" became the phrase I used to say to those intelligent, often competitive women who, by force of habit, used to try to "think" their babies out. I continue to find it helpful to introduce pregnant women who have the usual cultural fears about giving birth … to their "inner ape" or "wild woman." (Gaskin 2011:37)

The shift in language – from women as elemental forces to women as primates – is not unimportant. The underlying assumption about women's transformation from human beings who respond to stimuli in the environment based on thought, perception, and reason to non-human entities that respond based on innate tendencies or instinct remains intact, but the imagery and moral undertones associated with "woman as monkey" are different from those associated with "woman as tornado."

Imagery of the inner ape or primitive woman is reproduced in much of the natural birth literature and an important critique of natural birth is that it romanticizes the experiences of aboriginal women (Jasen 1997), working class women (Martin 2001; Moscucci 2003), and "others" deemed primitive. This rhetoric relies on European and North American assumptions associated with a long history of imperialism, exploitation,

and racism. In this way, the discourse serves to preserve and perpetuate a primitive/civilized dichotomy (Brazile forthcoming; Klassen 2001).

Michel Odent: On Primitive Birth and the *Salle Sauvage*

Michel Odent led the maternity unit at Pithiviers state hospital in France from 1962 to 1985. During this time, he introduced birthing pools and a home-like birthing suite that he called the *salle sauvage* or "primitive room" (Odent 1984:10). When discussing his observations of women laboring in the *salle sauvage*, Odent (1984) writes, "women seemed to forget themselves and what was going on around them during the course of an unmedicated labor … They get a faraway look in their eyes, forget social conventions, lose self-consciousness and self-control" (p. 12). This quote speaks directly to the idea that the (social) self somehow disappears or is eclipsed by the (natural) body during unmedicated labor. In fact, a floating away or suspension of the self is seen as a primary indictor of a woman's entrance into the natural realm.

Odent's natural birth is characterized not only by a loss of self-consciousness and a lack of adherence to social conventions (i.e., a shift away from the realm of culture to the realm of nature); it is also deeply associated with primitiveness. Odent (1984) describes it like this,

> After seeing how much tribal births filmed in New Guinea and South Africa resembled births in our own *"salle sauvage,"* I became even more convinced that there was some universal component in the behavior of mother and newborn, and that – given the right kind of environment, where she could feel free and uninhibited – a woman could naturally reach a level of response deeper within her than individuality, upbringing, or culture. (P. 13)

Odent asserts that civilized women can achieve – or "regress" to – this kind of primitive birth experience via a carefully controlled environment and the presence of a supportive woman (i.e., a midwife) who's goal it is to disturb the woman and the process as little as possible. Instead of emphasizing the need to retrain the modern mind, Odent suggests that under the right conditions the veneer of culture is naturally pulled back to reveal an authentic human animal who already knows how to respond to the sensations of labor.

Odent (1984) wrestles with some of the moral implications of relying on a discourse of primitiveness. He writes,

> I have found it very difficult to describe this shift to a deeper level of consciousness during labor. I had thought of calling it "regression," but I know that the word sounds pejorative, evoking a return to some animal state. "Instinct" is a better term, although it, too, resonates with moralistic overtones … Furthermore, the word "instinct" is often unfavorably contrasted with reason – women are said to be "instinctive," men "rational" – as if one could not be instinctive and rational at the same time. But there is nothing shameful or sexist in recognizing that instinct plays a part in our behaviors, especially those that exist at the intersection of nature and culture, such as lovemaking, labor, or the newborn's search for the mother's nipple. (P. 13)

Despite his misgivings, he is, nonetheless, unable to come up with an alternate way of explaining women's behavior during unmedicated labor.

Elizabeth Davis: On Surrender and Letting Go

Elizabeth Davis is an American home birth midwife and educator. Her guide to midwifery, *Heart and Hands,* is now in its fourth edition and has been a staple for direct-entry midwives since its initial publication in 1981. One of Davis' most important contributions to the second wave of natural birth discourse is the idea that women must actively let go of control and surrender to the forces of labor.

In the first edition of *Heart and Hands* (1981), Davis writes of active labor, "It is definitely a time of shifting gears, a time of giving in and letting go" (p. 96). In a more recent edition, she is even more explicit. She writes, in order to "tune into our instinctual birthing wisdom, we must first turn off the neocortex, our thinking and reasoning aspect" (Davis 2004:111). These passages reveal Davis' understanding of how the natural body comes to displace the self. It is not enough for women to experience the sensations of labor unmedicated or to labor in a carefully constructed environment (e.g., warm, dark, and quiet a la Odent's *salle sauvage*). To effectively make the shift in consciousness characteristic of – and even a prerequisite for – natural birth, the woman her*self* must actively and intentionally allow the shift to happen. She must "deliberately let the forces of birth take over" and "turn off" the rational, thinking brain (p. 111). When women are successful in this pursuit, "social masks fall away" (Davis 2004:117) and they develop "a softness, a rosiness and glow about them as true essence/true nature is revealed" (Davis 1981:99).[30]

It is important to point out that the self does not disappear for the entire labor and birth. Its presence shifts over time. In general, the self is present during pregnancy and early labor. As labor intensifies, the self recedes. This can be read both as the intensity of labor *forcing* the self to withdraw and the active submersion of the self as *allowing* labor to intensify. The self is then quiet and far away during active labor and transition and it reemerges during second stage or pushing. About the reemergence of the self, Davis (2004) writes, transition is "a peak, out-of-body experience that prepares and rejuvenates

[30] In the 1981 edition, Davis does not use the term "social masks" and in the 2004 edition she changes "true essence/true nature is revealed" to "deep beauty is revealed." Bringing together the wording from both editions highlights the contrast between the social and the natural.

the mother for the back-in-the-body, reentry phase of pushing and birthing" (p. 117). Moreover, pushing represents the movement "from passive surrender to active participation" and "this is the most striking energetic shift in labor, the time when the mother's identity and body consciousness return anew" (p. 119).

Davis' work fits squarely within the second wave of natural birth discourse. She operates from the premises laid out by Gaskin and Odent and adds an emphasis on the active role women must take in letting go of control, surrendering to the body, and, literally, turning off the modern brain. Pam England further develops this "let go and turn off your brain" concept.

Pam England: On How to "Lose It" in Labor

Pam England is an American home birth midwife with the certified nurse midwife (CNM) credential. She is the creator of the childbirth preparation program, *Birthing From Within*®. In her book by the same name, England and her co-author Rob Horowitz (1998) distinguish three kinds of knowledge women have about childbirth: modern, unconscious or conditioned, and primordial. Modern knowledge is "being savvy about the medical and hospital culture and how to give birth within it" (p. 3). It is a strategic, tactical kind of knowledge that helps women work toward a low-intervention, unmedicated birth experience within a medicalized system.

Conditioned knowledge is a product of passive "schooling" and the unconscious uptake of cultural assumptions that happens by virtue of being a member of a society (England and Horowitz 1998:4). England's conditioned learning is what sociologists

refer to as socialization. England urges women to conduct an "emptying" or "housecleaning" of the mind during pregnancy in order to become aware of the content of the conditioned knowledge, to assess the utility or harm associated with holding onto unconscious beliefs, and, ultimately, to free oneself of preexisting ideas (pp. 4-5). England offers exercises to assist in this process. She encourages women to complete the exercises a number of times during pregnancy in order to achieve deeper and deeper understanding and a more open mind. Over time, this will produce "naturalness" (p. 5). Citing Zen master Shunryo Suzuki (1970), England argues that naturalness is not something that comes "naturally" to the modern human being. Instead, it is something we must work on (p. 5). England's program of prenatal preparation, then, is specifically designed to help women achieve a state that is paradoxically *unnatural* for the modern human – that is, a state of naturalness.

Primordial knowledge is "that innate capability which modern women have but must rediscover" (England and Horowitz 1998:3). Rediscovery requires liberation from unconscious beliefs (as described above), but also involves actively letting go of control. England has no interest in teaching women how to be "calm, confident, and controlled in labor" (p. 129). In fact, she has an entire chapter titled "Out of Control: How to 'Lose It' in Labor" (pp. 129-132). Moreover, she urges women to "stop thinking" (p. 127). According to England and Horowitz (1998),

> It is only after her logical, rational, verbal left-brain comes to a screaming halt, that her intuitive, unconscious right-brain takes over to carry her through a journey that can't be navigated intellectually. (P. 181)

In England's work, we see rearticulated many of the core concepts of natural birth discourse. First, there are two kinds of childbirth – cultural/civilized birth and

natural/primitive birth. Second, women with primary socialization in "civilized" societies cannot birth naturally without special retraining (first wave discourse) or un-training (second wave discourse) of the mind. Finally, in order to achieve natural birth women must enter an altered state wherein the body is not controlled by, but is rather free from the mind. As accentuated by Davis and England, the conscious mind (a product of culture) must temporarily be turned off or overridden by the primitive brain and the body (i.e., nature). As much as natural birth experts in this period may hope to convey a message of mind-body interconnectedness, language and history constrain them. The body over mind/mind out of the way of body rhetoric remains deeply rooted in the idea that the mind is a distinct part of the human being that can be dissociated from the biological organism.

DISCURSIVE PERIOD III: THE NEO-SCIENTIFIC TURN

The neo-scientific approach to natural birth emerged in the 1990s and became a dominant form of the discourse by the mid-2000s. Sarah Buckley is an important contributor to this discursive shift. About Buckley, Odent (2005) writes,

> [She] is precious, because she is bilingual. She can speak the language of a mother who gave birth to her four children at home. She can also speak like a medical doctor. By intermingling the language of the heart and the scientific language she is driving the history of childbirth towards a radical and inspiring new direction.

Others who have adopted this "bilingual" approach include: (1) key knowledge producers from the second wave of natural birth discourse, (2) direct-entry midwifery educators in

the U.S., (3) academic midwifery researchers outside of the U.S., especially in the UK and Australia,[31] and (4) childbirth researchers in the social sciences.

The neo-scientific approach draws on and also participates in the production of an international, interdisciplinary body of research. Key components of the message include:

1. The human brain is made up of different parts that have different functions and developed at different times in evolutionary history.

2. Childbirth is a primitive, biological function. Therefore, knowledge about how to give birth is located in the more primitive parts of the human brain.

3. These parts of the brain are also responsible for the release of hormones that produce the altered state characteristic of natural birth.

4. When it comes to childbirth, the newest part of the brain (the neocortex) primarily interferes with the workings of the more primitive brain structures and, when engaged, makes childbirth more difficult and less efficient.

5. In order for our ancient, evolutionary, embodied knowledge about childbirth to be fully expressed, the neocortex (especially its left-hemisphere which is associated with reason and logic) must be suppressed or, at the very least, not over-stimulated.

6. A decrease in neocortex activity can be facilitated through specific labor support measures (e.g., massage, acupressure, or warm water immersion) and a carefully constructed birthing environment (e.g., quiet, low light, privacy, and warmth).

This is not a different story, really, from the one told by Gaskin and Odent in the 1970s and 1980s, but it has been rearticulated using the language, conceptual frameworks, and styles of argumentation characteristic of the biomedical and natural sciences. Further, it shifts natural birth discourse from one in which science and biomedicine are devalued to one in which demonstrated mastery over the scientific method and the deployment of scientific data is viewed as evidence of legitimacy.

[31] It may be that researchers in the UK and Australia do not use this approach any more than academic midwifery researchers in other developed countries, but that their work is more accessible to a U.S. audience because it is published in English.

Sarah Buckley and the Hormonal Orchestration of Undisturbed Birth

Sarah Buckley is a family physician with special training in general practice obstetrics and family planning. She was born in New Zealand in 1960 and has practiced medicine in both New Zealand and Australia. She worked in a home birth practice for several years and has, herself, given birth at home. Buckley is known for her theory of undisturbed birth which, she writes, "does not necessarily mean unsupported or solitary birth" (Buckley 2009:97).[32] It does imply, however, that care providers should strive to intervene as little as possible.

Buckley (2009) believes that "anything that disturbs a laboring woman's sense of safety and privacy will disrupt the birth process" (p. 96). She argues that almost all obstetrical practices are disruptive and, therefore, make birth more difficult and dangerous than it needs to be. Modern obstetrics, she writes,

> has created an entire industry around the observation and monitoring of pregnant and birthing women. Some of the techniques used are painful or uncomfortable, most involve some transgression of bodily or social boundaries, and almost all techniques are performed by people who are essentially strangers to the woman herself. All of these factors are as disruptive to pregnant and birthing women as they would be to any other laboring mammal – with whom we share the majority of our hormonal orchestration in labor and birth. (P. 96)

Thus, to improve the efficiency of labor and increase safety for mother and child, we should rely not on medical monitoring and management, but on the innate wisdom of women's bodies which has been "refined" over the course of human evolution (p. 97).

[32] Anthropological research shows that solitary birth is exceedingly rare – both in modern times and over the course of human history (Trevathan 1987 and 1996). There are a few notable exceptions: (1) relatively isolated societies in which birthing alone is a long-held cultural ideal (e.g., Konner and Shostak 1987 and Sargent 1989) and (2) small groups of women in countries like the U.S. and the UK who participate in unassisted childbirth as a "conscious rejection of social norms and institutions" (Freeze 2008:42).

According to Buckley (2009), it is the hormonal orchestration of birth, in particular, that has been honed over tens of thousands of years and that modern medicine has little understanding of or appreciation for. When birth is unmedicated and undisturbed, a predictable cascade of hormones is released from the brain. These hormones regulate the birthing process and "take us into ecstasy – outside (*ec*) our usual state (*stasis*) – so that we enter motherhood awakened and transformed" (p. 97). Undermining or in any way attempting to override the neurohormonal control of labor puts women and babies at risk.

Buckley suggests that the contemporary emphasis on pharmaceutical pain relief during childbirth is especially problematic. The use of pain medication requires intensive monitoring and intervention thereby making undisturbed birth impossible. The medications themselves also interfere with the natural hormones of labor. Buckley (2009) writes, "like a marathon runner, a woman's task in birth is not so much to avoid the pain – which usually makes it worse – but to realize that birth is a peak bodily performance, for which our bodies are superbly designed" (p. 98). Just as the runner's pain is moderated by endorphins that produce the so-called "runner's high," so too is the laboring woman aided in her exertion by a combination of hormones.

Second Wave Gurus Make the Neo-Scientific Turn

The neo-scientific approach has deeply permeated the world of natural birth. Again, it is not so much a new philosophy, but rather an extension or evolution of second wave

discourse. In fact, Michel Odent is a driving force in this shift and Gaskin and Davis both cite his work regularly. Gaskin (2003), for instance, writes,

> [Odent] distinguishes between the neocortex – the newer, rational part of the brain, which plays a role in abstract thought – and the primitive brain, which governs instincts. The primitive brain, or brain stem, is also considered to be a gland that releases hormones. All female mammals, including humans, release a certain number of hormones such as oxytocin, endorphins, and prolactin in the process of giving birth. Stimulation of the neocortex, on the other hand, can actually interfere with the birth process by *inhibiting* the action of the primitive brain in hormone release. (Gaskin 2003:171)

And Davis (2004), refers to Odent when she writes that in order to "tune into our instinctual birthing wisdom, we must first turn off the neocortex" (p. 111). While she forwards a similar idea in her earlier work, she does not use the word "neocortex." This change in terminology is directly related to the scientification of natural birth discourse.

Anne Frye and U.S. Direct-Entry Midwifery Education

Anne Frye has written *the* textbook for direct-entry midwifery. Frye was a student midwife in the late 1970s and she began writing educational materials for midwives in the early 80s. She is best known for her two volume (with a third volume planned) *Holistic Midwifery*. Frye's *Holistic Midwifery* is to direct-entry midwives what *Varney's Midwifery* is to nurse-midwives or *William's Obstetrics* is to obstetrician-gynecologists – that is, the definitive guide to the discipline. Along with Gaskin's *Spiritual Midwifery* and Davis' *Heart and Hands*, Frye's *Holistic Midwifery* volumes I and II are primary references for the North American Registry of Midwives' written examination that direct-entry midwives must pass prior to receiving the Certified Professional Midwife credential. Therefore, how Frye writes about natural birth is significant. She is an important creator and transmitter of the discourse.

Like others before her, Frye describes women's responses to unmedicated labor as a kind of altered state. Drawing on the work of Buckley (2003 and 2009), hormones play a central role in Frye's explanatory apparatus. They are chiefly responsible for the shift in consciousness that takes place during active labor and transition. According to Frye (2004), these hormones – including oxytocin, beta endorphins, epinephrine, norepinephrine, and prolactin – are secreted in all "live-bearing mammals by the middle, or limbic, brain, a more primitive part of the brain than the rational neocortex which is dominant in modern humans" (p. 259). The quieting of the neocortex allows more primitive brain structures to move into a dominate position from which they can function unencumbered and release a cocktail of hormones conducive to labor.

Helping women reduce neocortex activity during labor, then, has become an important goal for midwives and other labor support people (e.g., doulas). Comfort measures such as massage, acupressure, and warm water immersion (Frye 2004:260) along with a peaceful and private birthing environment (p. 324) aid in quieting the neocortex and "[set] in motion the hormones of labor, which enhance progress, and endorphins, which help women deal with pain and enter the altered state of consciousness common to labors that progress easily and without complications" (p. 324). Conversely, talking, bright lights, and a sense of being observed stimulate the neocortex and are said to contribute to the secretion of hormones that impede labor progress.

Frye argues that, physiologically-speaking, a woman should not actually require much labor support in an optimal birthing environment. However, she also recognizes the cultural component of childbirth and the importance of socialization. She writes,

> When these environmental needs are met and the woman can allow herself to let go into her primitive, instinctive brain, where her knowledge of how to give birth resides, she usually does not require active support. She simply opens to the energy and has the baby. However, due to intensive cultural programming regarding the dangers of labor and the response to labor of individual women, some will require more active support than others in order to let go sufficiently to allow labor to advance. (Frye 2004:324)

Like Davis, Frye suggests an active role for women in making the shift from neocortex to primitive, instinctive brain dominance. A woman *allows* herself to *let go*. This "allowing" and "letting go" becomes part of the equation for producing the altered state and, ultimately, the successful natural birth. First, a woman needs a conducive environment. Second, depending upon her "cultural programming" she requires a degree of labor support. Finally, she must actively "allow herself to let go into her primitive, instinctive brain" (p. 324).

An unfortunate side-effect of this understanding of how natural birth is achieved is that women, themselves, can be construed as impediments to natural birth. That is, if a favorable environment is provided, appropriate labor support and comfort measures are offered, and medical or pharmaceutical intervention nonetheless becomes necessary, the woman may blame herself for the failure to accomplish natural birth. Women in the U.S.-portion of my study feared that they would not be able to fully let go and they worried that they did not trust deeply enough in the process. They saw the overly-engaged brain (i.e., neocortex) as a primary cause of complications during labor.[33]

[33] This is a key difference between the U.S. and Dutch participants in the study. In general, the Dutch women did not express such fears nor interpret the failure to birth at home as a failure of the self.

Academic Midwifery in the UK and the Normal Birth Research Agenda

University-based midwifery in the UK[34] has become an important producer and transmitter of "normal birth" research.[35] In fact, in 2005, the Royal College of Midwives (RCM) officially launched its Campaign for Normal Birth and a number of doctoral candidates at UK universities are conducting research in this area. In 2007, Wiley-Blackwell began publishing the normal birth-oriented *Essential Midwifery Practice* series with the aim of providing up-to-date, evidence-based information to practicing and student midwives. The series editors along with the editors of the individual volumes are all UK-based researchers and midwives.

In the edition that deals with issues related to labor and birth (Walsh and Downe 2010), Soo Downe (2010) –professor of midwifery, chair of the RCM Campaign for Normal Birth, and founder of an international normal birth research network – writes that the book is "informed by newly emerging knowledge about the impact of networked bodily systems, and neurohormonal feedback loops that operate under hormonal influence" (p. 22). A main thrust of the volume is that birth is a conversation between biology and consciousness (Schmid and Downe 2010:160). It is an interaction between universal human physiology "ruled by the unconscious functions of the brain" and culture and cognition (p. 160). It is a dialogue between the cortex and neocortex that is mediated

[34] The UK is, of course, not the only source of normal birth research. Midwifery researchers in many other developed countries are also active in creating a science of midwifery and promoting normal birth. The research coming out of the UK, however, is particularly well-developed and accessible to an American audience.

[35] The term "normal birth" has replaced "natural birth" in some circles. It deemphasizes the search for a natural, original, or primitive birth and reframes the discussion as a quest for understanding the normal, universal physiology of unmedicated, uninterfered with birth.

by the hormone-secreting limbic system. "During normal labour, under this hormonal control," write Schmid and Downe (2010),

> the neocortex is depressed, and the parasympathetic nervous system is dominant. If she is left to work with her bodily responses, the woman tends to respond in an unconscious, emotional, and instinctive manner. In these circumstances, birth is an unintentional, involuntary and uncontrollable process that cannot be predicted for an individual woman. (P. 162)

This excerpt is a crystallization of the neo-scientific approach to understanding and explaining the phenomenon of natural – or normal – birth. The approach is not limited to midwifery and the health sciences. It has spread to other disciplines as well – including the social sciences and medical humanities.

Diffusion into the Social Scientific Study of Birth

Sharon Moloney is a Ph.D. researcher. She holds a master's degree in women's studies and a Ph.D. in social work and community welfare. She is a research fellow at James Cook University in Australia and she also has a counseling and hypnotherapy practice. While her work is not part of the natural birth "cannon," I include it here because it articulates many assumptions of the neo-scientific approach and illustrates the diffusion of that discourse into the social science literature on birth.

Moloney (2006) describes what is necessary for women to enter the altered state characteristic of successful natural birth. First, she describes a shift from left-brain (logical, rational) to right-brain (intuitive) dominance.

> For female physiology to function at its peak during labour, right brain processes need to temporarily eclipse left brain functioning, to enable the birthing woman to make the interior journey into that altered state of consciousness in which her instinctive body knowledge tells her how to birth her baby safely. (Moloney 2006:44)

Next she details the role of hormones in the production of the altered state.

> In order for our hormonal blueprint to function optimally during labour, the mid-brain and right hemisphere of the neocortex need to take precedence over the left hemisphere. When this occurs, these mystical substances have potential to detach us from our identification with ego, and induce an altered state of consciousness. (Moloney 2006:45)

She describes her approach the study of childbirth as guided by a new "quantum scientific paradigm" (Moloney 2006:45) quite apart from an "old scientific discourse" which posited the body as a machine, separate from the mind. Downe (2010) frames this shift in thinking as away from positivist, linear models toward understandings of biological processes based on theories of complexity and chaos (e.g., Merry 1995; Gleick 1987; Kernick 2002; and Downe and McCourt 2008). She predicts that these alternative ways of thinking will become more mainstream as scholars across the many disciplines that study childbirth (e.g., midwifery, the social sciences, and the medical humanities) develop proficiency in these new models.

It is important to remember that natural birth was also described using the language of science during the first discursive period. Science was, of course, the "native language" of the fathers of the movement. Second wave discourse sought to elevate other sources of authoritative knowledge such as personal experience and intuition (Jordan 1993 and Davis-Floyd and Sargent 1997). The third wave, however, is marked by a return to scientific ideas and explanations – albeit within a new paradigm.

This time, the discourse is being created and deployed largely by women, academic midwives, and like-minded social scientists. It is possible that this neo-scientific approach will open the door to new possibilities for birthing women, provide legitimacy for natural/normal birth practices, and advance the profession of midwifery.

On the other hand, over-reliance on the language and cognitive frameworks of science may serve to limit the conversation or narrowly define what is relevant or of value. Much of the natural birth movement has been aimed at liberating birth from science and biomedicine. As such, it is possible that this neo-scientific turn may be detrimental or counter-productive to the movement's broader goals.

EMERGING TREND: CHILDBIRTH AS ECSTATIC, TRANSCENDENT, AND ORGASMIC

Recently, normal birth discourse has begun to deemphasize naturalness and primitiveness and focus instead on a rhetoric of birth as ecstatic (Frye 2004), transcendent (Odent 2009), and orgasmic[36] (Pascali-Bonaro 2008; Davis and Pascali-Bonaro 2010; Buckley 2010).

In *The Woman in the Body* (2001), anthropologist Emily Martin asks: (1) Why must we must see women "as engaged in a 'natural' lower-order activity" and (2) "Why can we not see them as engaged in higher-order activity" (p. 164)? Responding to the early work of Michel Odent (1984), she writes,

> By all accounts, what Odent has done for women's birthing experience is extraordinary. One has only to compare the visual iconography of birth in a hospital[37] to the strong, active, upright vision of women at Pithiviers to see the dramatic difference. But the cost

[36] Orgasmic birth is the idea that labor and childbirth are part of a woman's full sexuality. The concept of orgasmic birth grew in popularity following the 2008 release of Debra Pascali-Bonaro's film, *Orgasmic Birth: The Best Kept Secret*. It is not, however, a new idea. Helen Wessel coined the term "birth climax" in her 1963 book *Natural Childbirth and the Christian Family*. Others writing from an explicitly Christian perspective have also described birth as the culmination of marital love between a husband and a wife (e.g., Moran 1981 and 1997; Griesemer 1998). Writers with a more secular or broadly spiritual approach have also drawn parallels between the experiences of sex and childbirth (Bradley 1965; Baker 2001; Gaskin 1990 and 2003; Jones 1988; Morgan 2002; Shanley 1994).

[37] Here Martin refers to her Figure 25 of a woman lying supine, feet in stirrups, body draped, and her face obscured.

> is high. Odent finds it impossible to provide women this new setting for birth without describing what happens to them in it as a return to an animal-like, childlike state. (Martin 2001:160)

Martin does not challenge the idea that a shift in consciousness – in which the self recedes and the body surfaces – takes place, but she is critical of the explanation of the phenomenon as natural or primitive. Indeed, experiences of a loss of self-consciousness are described in very different terms when they accompany, for instance, ballet performance (Aalten 2004; Kleiner 2009), martial arts (Green 2011; Wacquant 2006), yoga (Smith 2007), or prayer (Winchester 2008).

Advocates, for decades, have also struggled to find a way of talking about birth that allows for mind-body integration and does not impose or reinforce the idea that the mind and the self are separate from the body. Martin (2001) too identified the pervasiveness of a language of fragmentation and alienation in women's birth narratives and she longed for a new vision of women as "whole human beings, all their parts interrelated, engaged in what may be the only form of truly unalienated labor now available to us" (p. 164).

I am not overly optimistic that this shift in discourse will bring about a future like the one envisioned by Martin – a future in which mind-body unity replaces mind-body separation and birthing women are seen as engaged in "more essentially human, more essentially cultural forms of consciousness and activity" (p. 164). For many women, non-medicalized childbirth is inconsistent with the rest of their lives and, even if it resonates cognitively, is almost impossible to achieve given the social organization of modern maternity care. In a recent interview, Gaskin discussed the concept of ecstatic, orgasmic birth.

> "I mean, it's not a guarantee," she said, shrugging her shoulders and smiling, "but it's a possibility."
>
> "It's the only way I can think to market it to (this) generation." (Loller 2008)

In the next chapter, I turn to questions of how home-birthing women in the U.S. transform the various discourses of natural birth into practice. I conceptualize discourse as a kind of living script women learn and adapt during the prenatal period, enact in the performance of birth, and attempt to reassemble into a coherent narrative during the postpartum period as they assess their performance and work to integrate their birth experiences into a new sense of self. Not surprisingly, actual births often deviate from natural birth ideals leaving women to deal with inconsistencies, ambiguities, contradictions, and sometimes even trauma (see chapter 8).

CHAPTER 6
HOME BIRTH IN THE U.S.: ENACTING NATURAL BIRTH DISCOURSE

Robbie Davis-Floyd (2003a) was a pioneer in conceptualizing all childbirth practices – "primitive" and biomedical, at home and in the hospital – as rites of passage that communicate a society's core values and its basic assumptions about women. Her classic analysis of standard obstetrical procedures in U.S. hospitals reveals an American society that values technology over nature and assumes the fundamental deficiency and pathology of women's bodies. Melissa Cheyney (2011) builds on the foundation developed by Davis-Floyd and brings Davis-Floyd's work back home – "where," Davis-Floyd (2011) writes, "I always wanted it to be" (p. xi). Instead of asking what values and assumptions are communicated through standard hospital birth procedures, Cheyney interprets home birth practices.

Cheyney's analysis incorporates three schools of thought – semiotic, performance, and praxis. Employing a semiotic approach, Cheney reads ritual action for messages communicated to initiates during the rite of passage. She discovers ideas about the sufficiency of nature and about women – not medical experts, institutions, or technologies – as "reproducers of babies" (p. 42). A performance perspective, leads her to argue, however, that ritual is about more than indoctrination and the transfer of values from the group to the individual. It "goes beyond molding participants," she writes, "as participants often create rituals and use them to modify their worlds" (p. 35). Finally, she emphasizes the political aspects of ritual and shows her readers "how positions of domination and subordination are modified and resisted" (p. 35). From the vantage point

of ritual-as-praxis, she argues that home birth practices are, in fact, "transgressive insofar as they intentionally challenge and, in many cases, invert mainstream obstetrical messages" (p.49).

The argument I put forth in this chapter is informed by the work Davis-Floyd and Cheyney, but is also distinct. I conceptualize home birth practice as the embodiment of values and beliefs accomplished in the U.S. through careful enactment of a natural birth script. This script (described in chapter 5) has three main components: *environment*, *labor support*, and *altered state*. The script tells us that the birth environment should be warm, dark, and quiet and that labor support should be continuous and tactile. Management of the environment and the provision of labor support are intended to produce a sense of privacy and safety in order to facilitate the achievement of an altered state from which birth can unfold easily and without complication.

Below, I analyze fieldnotes from one representative birth to illustrate how natural birth discourse is translated into practice. I then investigate the altered state in more detail and propose a three-stage process by which women enter, inhabit, and exit this state.

KRISTA'S BIRTH

Krista and her husband, Jeff, are expecting their second child. Krista is 37 years old and Jeff is slightly older. They are both white, non-religious, college-educated creative professionals. Krista is currently a stay-at-home mother to Sage, age 2½ years.

The night Krista's labor begins she calls my cell phone at 8:51pm. "I think I'm in labor," she says. "My contractions are 10 to 13 minutes apart. I'm trying to be cautious about calling people. I want to be sure. But it is looking like tonight might be the night." Around 10:00 pm, Krista's midwife, Jacqueline, calls. "I just want to give you a heads up that it sounds like Krista is in labor. I'm going to check in with her again around 11pm." At 11:01pm, Jacqueline calls again. "I'm heading over to Krista's house. Come whenever you want to." A few minutes later, Krista's husband Jeff calls.

> Jeff: There is a lot of activity over here. We'd love to have you if you can make it. Sage is sleeping. So, we'll leave the front door open and the light on. Just come right in.
>
> Jeff to Krista: Do you want the birth ball?
>
> Jeff to Rachael: Can you bring the birth ball?
>
> Rachael: Sure.

I pump up my birth ball (a large inflatable exercise ball that women use to sit on or lean over during labor) and drive over to Krista's house.

Environment

When I arrive, Jacqueline is in the living room going through her equipment and getting organized. Around midnight, we go into Krista's bedroom. The room is dark and Krista is lying in bed. Jeff is sitting in a chair and stroking her hair. The bedroom walls are painted a leafy, spring green and floral-patterned curtains are drawn over the windows. Across from the bed, there is a dresser topped with baby supplies. A tall, narrow table stands beside the dresser. On the table sit three candles along with a photo of Sage and a pad of paper Jeff has been using to record contractions. Jacqueline sets her paperwork and watch

on the table. At the head of the bed is a small wooden nightstand with an antique lamp and a box of tissues. From a CD player comes the sound of ocean waves.

According to Cheyney (2011), candlelight and calming music are "common components of in-home labor care that capitalize on ritualized sensory manipulation to help women cope with the pain while simultaneously defining the laboring space as sacred, special, or out of the ordinary" (p. 39). Krista and Jeff have created the "proper" natural birth environment.

Jacqueline palpates Krista's belly and listens to fetal heart tones using a Doppler monitor. Krista is having pain in her lower back during contractions and asks me to massage and apply pressure to her back. I climb onto her bed and sit behind her. Krista requests a heating pad. Jacqueline goes to the kitchen to heat a large tube sock filled with rice.

Krista is nervous. She had "excruciating back labor" with her first child and is afraid this birth will be equally painful. Her anxiety mounts. When Jacqueline returns she says,

> Krista: I feel like my heart is racing.
>
> Jacqueline: Do you want me to listen to your heart?
>
> Krista: Yes … No, not right now. Can you leave the room? I feel like I can't contract when I'm being watched.
>
> Jacqueline: Of course.

Like she did with candles and nature sounds, here again we see Krista manipulating her environment – this time to create the privacy described in the natural birth literature.

A few minutes later, however, she feels her heart racing again and calls out for Jacqueline. Jacqueline comes quickly and listens to Krista's heart with her stethoscope.

> Jacqueline: It sounds perfect – strong, slow, steady.
>
> Krista: It feels like it is racing.
>
> Jacqueline: It may feel like that, but it sounds really good. Really strong.

Krista decides to walk around a bit. She and Jeff walk out of the bedroom, through the kitchen, and downstairs to the basement. Sitting in the living room, Jacqueline, Ashley (Jacqueline's assistant who arrived a few minutes ago), and I discuss Krista's labor. We agree that it seems like she is in early labor. She is still talking a lot between contractions and appears "very analytical and intellectual about the whole thing."

> Jacqueline: Oh, what's his name? That French obstetrician …
>
> Rachael: Oh, yeah. Doesn't his last name start with an O? O …?[38]
>
> Jacqueline: Yes, Odent. Michel Odent. He has that clinic in France and he says that some women want to birth in a cave. Some women *think* they want community – social birth – but really they just want to give birth in the cave.

Jacqueline is referring to Krista feeling "too observed" upstairs and, thus, moving downstairs to be in the dark, cave-like basement. She suggests that Krista thinks she wants the community of women – the midwives and doulas – around her, but she may be "one of those women who do better alone."

> Jacqueline: Downstairs, I hope she has enough space and privacy to let her labor really take over.
>
> Ashley: Should we see if she needs anything?

[38] This was long before I began my formal analysis of natural birth discourse. I was only starting to become familiar with the "gurus."

Jacqueline: No. Let them be.

This is an example of home birth practice not only enacting, but directly invoking natural birth discourse. Other midwives I worked with did this too. For example, while Faith labored in the bathroom with her husband, her midwives engaged in "backstage" talk (Goffman 1959) – discussing, among other things, Jessica Mitford's (1992) *The American Way of Birth*. Deidre, a midwife I attended a number of births with, frequently talked about Michel Odent and Sarah Buckley during prenatal education classes and, occasionally, in labor. Other midwives cited Emily Martin's (2001) *The Woman in the Body* or Elizabeth Grosz's (1994) *Volatile Bodies* and almost everyone I spoke with – midwives and pregnant women alike – quoted Ina May Gaskin. These women were well-aware that they were not just doing "what comes naturally," but also enacting ritual aimed at re-creating birth and re-inventing tradition. Their goals were nothing short of overthrowing notions about the supremacy of technology over nature and upending gendered hierarchies (Cheyney 2011).

When Krista comes back upstairs she is cold and shaking. Good! Now she is in active labor.

Labor Support: Mothering the Mother

Krista needs almost constant pressure on her back. Ashley and I trade off sitting behind her as she lies in bed or standing behind her as she rocks her hips and sways from side to side. When we are not in the bedroom, Jacqueline, Ashley, and I move between the kitchen table and the living room. Jacqueline charts and drinks a cup of tea. Ashley reads

a novel. I take notes. Off and on we curl up under blankets on a couch or chair and close our eyes. The space feels very intimate.

Shortly before 3:00am, Krista calls from the bedroom, "Jacqueline, can you come feel the position of the baby? I am starting to get back labor?" Jacqueline goes into the bedroom and palpates Krista's belly.

Krista: Should we use the rebozo[39] to try to get the baby into a better position?

Jacqueline: I don't think it is necessary. You are doing everything right.

Around 3:30am, Krista and Jeff go back to the basement. Thirty minutes later they return. Krista's vocalizations are louder. Ashley follows them to the bedroom. From the living room I can hear Krista say, "Ashley, thank you so much for staying with me." A few seconds later, sounding exasperated and sad, she says "I am so tired. So tired."

Around 5:00am, Jacqueline and I go into the bedroom. Krista looks exhausted and a bit pale. She says, "Bucket!" Jeff reaches underneath the bed for a bucket and holds it as Krista throws up.

For the next two hours, we sit together in the bedroom – encouraging Krista to take small sips of an electrolyte beverage, bringing bits of food to her mouth, applying pressure to her sacrum, massaging her feet. Around 7:00am, Jeff and Krista's friend, Naomi, arrives. Sage should be waking up any minute and Naomi is going to take care of her today.

As Cheyney (2011) reminds us, in the hospital, focus at this time us on machines. People gaze at the output from the tocometer picking up uterine contractions and the

[39] A rebozo is a long, woven shawl. Midwives and doulas use them during pregnancy and labor to gently "sift" or "jiggle" the woman's abdomen. The goal is to relax uterine ligaments thereby allowing the fetus to rotate into an optimal birthing position.

ultrasound transducer monitoring the fetal heart. Nurses come into the room to adjust these monitors and stand at a computer, charting. The fetal heart beat – thump, thump, thump, thump – fills the room.

When I was working as a professional doula, I came to refer to this as "nursing the machines." One birth was particularly illustrative. An obstetrician came into the labor and delivery room, conducted a cervical check and said, "That baby's head is right there. She's complete." She walked to the computer and typed "10" (as in 10 centimeters dilation), but the computer recorded "5." At this point, instead providing hands-on care to the woman whose baby, as the obstetrician reported, was literally "coming out," the demands of bureaucratic record-keeping kept the two nurses in the room standing at the computer trying to fix the technical problem. The woman cried out, "Can I push? I have to push! Why, when my body feels like this, can I not push?" From a sociological perspective, this represents the ultimate "irrationality of rationality" (Ritzer 1983).

In the home setting, however, the absence of high-tech monitoring devices allows the focus to remain on the person as care providers engage in what is called "mothering the mother" (Klaus, Kennell, and Klaus 1993). The idea is to "initiate women into their new roles as mothers by modeling compassionate caregiving and supportive behaviors" through "one-on-one, continuous physical and emotional support" (Cheyney 2011:39). Mothering the mother is time- and energy-intensive, but midwives and doulas see it as important – if not necessary – because it "communicates to the mother that, though the main work of birthing is hers, she is not alone" (p. 39).

Altered State

At 7:22am, Ashley coaxes Krista from her side onto her hands and knees. Krista has been avoiding upright positions like standing, squatting, and hands and knees and Ashley interprets this as Krista being afraid to take her labor "to the next level" or unwilling to "surrender." The concept of surrendering to one's body or to the labor is central to natural birth discourse. Elizabeth Davis, for instance, describes active labor as "a time of giving in and letting go" (Davis 1981:96) and suggests that women must "deliberately let the forces of birth take over" (Davis 2004:111). Anne Frye (2004) similarly writes that when environmental needs are met and appropriate labor support is provided, women can "let go" and "allow labor to advance" (p. 324).

Jacqueline seems less concerned about whether Krista is sufficiently letting go. When Ashley finally succeeds in getting Krista into a hands and knees position for one contraction, Krista says,

> Krista: It really hurts.
>
> Ashley: I know. You can do it.
>
> Jacqueline: Where does it hurt, Krista?

As I have witnessed at other births, Jacqueline rarely tells women to move into a particular position. In her question – "Where does it hurt?" – I hear Jacqueline articulating trust in the body – trust that the body knows what it needs. Perhaps the pain Krista feels is not a good thing. Instead of indicating labor progress, maybe it means that hands and knees is not a useful position at this time. Ashley does not have that same kind of approach nor does she have Jacqueline's years of experience.

After one or two contractions on hands and knees, Krista lies back down on her left side – suddenly silent and motionless. According to my fieldnotes, "She is making an 'O' with her mouth. She looks sort of ecstatic or orgasmic. Not exactly like she's experiencing pleasure, but not pain either. This goes on for a few minutes." Ashley, who cannot see this because she is sitting behind Krista, starts to say something. Jacqueline puts her pointer finger to her mouth – "shhh" – and just watches Krista. One of the emerging trends in natural birth discourse is the de-emphasis on primitiveness in favor of a rhetoric of ecstasy (Frye 2004), transcendence (Odent 2009), and orgasm (Pascali-Bonaro 2008; Davis and Pascali-Bonaro 2010; Buckley 2010). This moment during Krista's birth illustrates this quality of normal physiological birth.

A few minutes later, Krista seems to reemerge from her altered state. Her mind returns to her body and she and Jeff get up to go down to the basement. As they walk through the kitchen, Krista is overcome by a strong contraction. She turns to face Jeff, drapes her arms around his neck, and hangs. After the contraction, she looks up, wide-eyed, and says, "The baby's coming out!" It is 8:07am.

Pushing and the Birth

Upstairs, in the converted attic, Sage is starting to stir. Naomi goes upstairs, gathers Sage up, and whisks out of the house. They will spend the morning at a Buddhist prayer group. Meanwhile, Jacqueline and Ashley help Krista back to the bedroom and, around 8:25am, Krista feels an urge to push. An hour later, after listening to fetal heart tones, Jacqueline says, "Krista, I need you to breathe for your baby. The head is really getting squished. I

need to you take a deep breath. With the next contraction, I want you to visualize birthing the head."

The head is not born with the next contraction or the one after that. So, Jacqueline asks Krista to move back to hands and knees. It is painful, but Jacqueline reassures her, "You can do it. You are going to have this baby!" With the next contraction, the entire baby emerges with one push.

Jacqueline helps Krista into a sitting position and lifts the baby from the bed to Krista's hands. Krista has a few minutes to revel in her accomplishment and enjoy her baby before there is more work to be done – the birth of the placenta, first attempts at breastfeeding, and the newborn exam.

Later, as Jacqueline gets Krista up to the toilet and continues to monitor her blood loss and the tone of her uterus, the rest of us remake the bed, straighten up the bedroom, wash dishes, clean the bathroom, and start a load of laundry. Jeff makes breakfast – toast and scrambled eggs. Krista eats and showers and, once she is back in bed and tucked in with her new baby, Jacqueline goes over postpartum instructions.

> During the first eight to ten days you and the baby should really be in bed or on the couch. Your job is to eat, sleep, and nurse. If you try to do more than that, you'll slow your recovery. Monitor the baby's wets and poops. You can keep track on this log. You'll want to look for signs of jaundice …

Jacqueline leaves Krista and Jeff with written instructions and says she'll be back tomorrow to check on them. They can also call any time – day or night. As we leave the house just before 2:00pm, some 14 hours after we first arrived, Sage and Naomi are coming up the path. Sage asks excitedly, "Is the baby here?"

THEORIZING THE ALTERED STATE

A low sensory environment and continuous labor support serve many functions in U.S. home birth – chief among them is the facilitation of an altered state of consciousness which is marked by an upending of typical self-body relations. For most people, the body is usually "absent" or in the "corporeal background" (Leder 1990). Only occasionally are we aware of our bodies and in these moments they tend to "dys-appear." That is, they come to the fore in problematic ways (e.g., in the form of pain).

Building on Leder's (1990) work, Akrich and Pasveer (2004) suggest that the body dys-appears during labor. When this happens, a twosome consisting of a body-in-labor (often described as a contracting uterus) and an "I" (not simply a mind, but rather an embodied self) emerges (p. 71). As labor progresses, women become so overwhelmed by the body-in-labor that they often experience a loss of *self*-consciousness. They become, in Kleiner's (2009) words, "unself-conscious" – especially when childbirth is unmedicated.

My data suggest that women generally move through three stages of self-body relations during home birth. First, they resist the body-in-labor and employ a number of strategies in an effort to maintain an embodied self. When these strategies ultimately fail, women end their opposition and surrender to the body. Finally – usually around the start of pushing, but sometimes not until after the birth of the baby – the body and self are reintegrated thus ending the experience of an altered state.

Stage 1: Resisting the Body-in-Labor

As women transition from early to active labor, "periods of dissociation [between the body-in-labor and the embodied self] become more frequent than periods of indifferentiation" (Akrich and Pasveer 2004:72). In the face of an increasingly present, active, and seemingly autonomous body, women often try to maintain *self*-consciousness. They do this in many ways.

In Krista's case, her care providers wondered whether her remaining "very analytical and intellectual" along with avoiding upright postures were signs of resisting the body-in-labor. Other women engage in the "active shrinking of the perceived world" as a way to prevent themselves from "losing control" (Akrich and Pasveer 2004:72). Priya[40] offered an example of this.

Priya is a Ph.D. biologist and self-described "ABI" (American-born Indian). She has two children. Her first child was born at home in the Netherlands while her husband, also American, was working as a postdoctoral fellow. Her second child was born in a birth center in the U.S. During our interview, she told me, "In the Netherlands, we lived across the street from a drawbridge. I was watching the bridge go up and down knowing that my contraction would be done by the time the drawbridge went back down." Such strategies for shrinking the perceived world help women resist being overtaken by the body, but, as England and Horowitz (1998) tell us, this opposition cannot last forever. "With few exceptions" they write, "mind and ego melt into the background" and women "surrender" to the body in active labor (p. 181).

[40] Priya participated in an interview-only study in which I recruited women who had given birth in both the U.S. and the Netherlands to talk about the differences they experienced in the two systems.

Stage 2: Ending the Opposition

There is significant variation in how women experience and perform this act of surrender. Sometimes the body-in-labor dominates so completely that the embodied self is forced deep below the surface. Other times a woman actively wills the self into the background in order to make room for or call forth the body-in-labor. Some women exhibit long periods of self-body dissociation characterized by foggy transitions between phases in which the body has priority and those in which the self takes precedence. Others oscillate more quickly between body- and self-dominance, the ease of transition suggesting a self that is resting patiently nearby. For some there even comes a realization that the body is not separate from the self and that the power they feel inside (i.e., the body-in-labor or the contracting uterus) *is* them – is the "I" (Arms 1998).

Many women struggle during labor to let go of the mind. As Gaskin (2011) suggests, modern American women are not accustomed to getting in touch with their "inner primate" and they often "try to 'think' their babies out" (p. 37). Lauren was keenly aware of this. Her first planned home birth ended in home-to-hospital transfer and a cesarean section. She worried that an inability or unwillingness to let go during her second labor would lead to another hospital birth. During our post-birth interview she told me,

> I can look back now at both of my births, but specifically during my second because I'd worked so hard to do it … to get out of my head, like that was my mission for the pregnancy. I had to get out of my head into my animal part.

For Lauren, letting go of the self and allowing the body-in-labor to take over was the central challenge of labor.

Ending the opposition came more easily for Kelly. She had given birth to four children before participating in the study and she seemed to accomplish self-body dissociation with relative ease. When I asked her about it, Kelly expressed considerable certainty and competence. She said,

> I go right inside my head … I mean right in the middle of my head and that's exactly where I am … where I just space out to what's happening with the whole pain thing. And my … my mind. I separate the two. I separate my mind and my body. And I just let my body relax and let my mind just … just drift, in a floating state right inside the middle of my head. And I can feel it. It's kind of – it's almost like a fuzzy feeling.

Kelly went on to tell me about how she experienced self-body relations during the last few moments of her birth. It was the middle of the night and she was in her bathtub surrounded by her husband, her sister, her midwife, her midwife's apprentice, and me, but she did not want to give birth before her older children were present. So, while she felt and incredible urge to push, she actively engaged her mind to work against this bodily sensation until the older children were roused. At that point, she ended her opposition.

> I was ranting inside. Ooh … it was incredible. But I know I was holding that in. As soon as Nolan – Nolan was the first one to walk into the bathroom – as soon as he got there, I thought, "Okay, I'm going to just, I have to start pushing 'cause I cannot hold this baby. I'm just going to let this go and just let my body do what it's going to do." And, you know, I didn't try to push at all. I just let my body do it.

After the surrender – the natural birth literature suggests – the birth should follow quickly and easily. This is what Kelly described and Krista's birth too seemed to follow this pattern. Ashley got Krista to hands and knees – a symbolic ending of the opposition. Krista then collapsed back onto her side and had a transcendent experience (recall her lying silent, motionless, and forming an "O" with her mouth). Afterward, she got out of

bed and, within minutes, was totally overcome by the feeling of her baby descending in her pelvis. She started pushing shortly thereafter.

Stage 3: Reintegration

Midwives and social scientists alike have observed that the self seems to reenter the body shortly before the start of pushing. Elizabeth Davis (2004), for instance, describes the transition from dilation to pushing as "a peak, out-of-body experience that prepares and rejuvenates the mother for the back-in-the-body, reentry phase of pushing and birthing" (p. 117). Akrich and Pasveer (2004) note that "in the end, the 'body-in-labour' and the 'embodied self' connect, giving the impression of power" (p. 73). When I trained as a doula, I was taught to identify a woman in transition by this reintegration. The woman looks up, she takes in her environment, and she says to the people around her, "Are you okay? Do you need a glass of water? Are you hungry?" She has a few moments, my fellow trainees and I were told, when the room comes back into focus and the world comes back to her. Then, she turns inward again and births her baby. This is exactly what I saw at Sarah's birth.

Sarah's Birth

I arrive at Sarah's house around 8:00pm. Steph, Sarah's doula, is filling the birth tub. She has attached a garden hose to the kitchen sink and is running water from the kitchen to the dining room where the tub is set up. She also has pots of water boiling on the stove. She will add them to the pool to bring the temperature up to 96 degrees Fahrenheit. Jacqueline, the midwife, does her initial assessment and I bring Sarah a glass of crushed

ice. She holds my arm for support as we move from bathroom, to bedroom, and, finally, to the birth tub.

At 9:46pm, Sarah is squatting in the pool, her arms resting over the side. Steph turns on some relaxing music. Sarah flips over in the water. Sitting with her back against the side of the tub, she slowly raises her head, opens her eyes, and looks around the room.

Sarah: I don't know that girl over there.

David [Sarah's husband]: That's Rachael.

Sarah: Oh, hi.

Rachael: Hi, Sarah.

Jacqueline: This baby decided to come before we all got to meet.[41]

For the last hour and forty five minutes, Sarah has exhibited intense inward focus. During this time, her mind/self seemed far away. Now, looking around the room, it is as if the woman has reentered the body.

As quickly as it returns, it disappears again. "I'm cold," she says as she flips back over in the water. For twenty minutes, she alternates between a squat and a runner's lunge. At 10:07pm, the baby's head begins to crown. The head is born at 10:13pm and the body follows at 10:14pm. After the birth, Sarah resumes a sitting position and Jacqueline lifts the baby out of the water and up to Sarah's chest. Sarah, completely present, says, "I hope you breastfeed better than your brother did."

[41] Around 37 weeks of pregnancy, Sarah changed care providers. Her new midwife, Jacqueline, told her about my study and Sarah said I was welcome at the birth. We were all scheduled to meet for a prenatal appointment in a few days, but her labor started before we had a chance to meet face-to-face.

Lauren's Birth

When I arrive at her house, Lauren is in active labor. She is sitting in a birth tub in her bedroom. Her husband, Richard, is sitting outside the pool – near her head. Their dog sits patiently beside him. Jacqueline, the midwife, is observing the labor and intermittently monitoring the fetal heart beat. Heather, acting as both doula and midwife's assistant, is charting. I slip quietly into the room and take a seat on the bed. I have been tasked with videotaping.

Lauren rests between contractions. According to my fieldnotes, "She is not falling asleep, but is really going inward. Not responding very much to her surroundings." When the birth is imminent, Lauren pleads, "Someone help me. Help me, please." Richard whispers in her ear. Jacqueline says,

> Jacqueline: We're here with you. You can do this. You are so strong.
>
> Lauren: But you're not getting him out!
>
> Jacqueline: That's your job. You can do it.

Lauren and Richard's son, Zack, comes into the room. He had been downstairs in the living room watching a children's video. He crawls up into my lap.

Lauren feels her bag of waters release. She says, "My water broke." Soon, the head is born. Lauren puts her hand on the head and says she can feel the ears. Jacqueline reaches into the water and says, "Nuchal hand."[42] Heather charts. The rest of the baby follows quickly. Lauren is so proud. She says, "I did it! I can't believe I did it!"

[42] "Nuchal hand" means that the baby's hand is by his/her face.

Zack gets down off the bed and goes over to look at the baby with his mom and dad. Jacqueline covers the baby with a towel and briskly rubs his back. She uses a bulb syringe to suck mucus out of his nose and throat. The baby sneezes.

We hear someone enter the house. It is Lauren and Richard's friend, Paloma. She has come over to watch Zack. He goes downstairs to play.

Lauren's face contorts. She is feeling significant cramping. The placenta is coming. Jacqueline helps to deliver the placenta and then places it in a big pink Tupperware bowl.

Jacqueline, Richard, and I help Lauren – still holding her baby – out of the water and onto the bed. She is starting to feel dizzy, weak, and short of breath. "Why do I feel this way?" she asks, her head falling backward onto the pillow. Jacqueline, examining the placenta, says, "Talk to your baby. Take deep breaths." Jacqueline removes trailing membranes[43] and gives a firm abdominal massage to encourage Lauren's uterus to contract. Lauren, almost delirious from the pain of the euphemistically called "massage," reaches for my hand. When the pain subsides, she looks at me as though she is seeing me for the first time.

Lauren: Rachael.

Rachael: Hi, Lauren.

Lauren: You made it.

For Lauren, mind and body reconnected immediately after the birth as she held her new baby and took in her accomplishment. Her focus at that time, however, did not

[43] "Trailing membranes" occur when part of the amniotic sac is retained in the uterus or vagina following the birth of the placenta.

extending much beyond the boundary of the birth tub. Before she had a chance to broaden the range of her awareness, the self was displaced again as the body forcefully resurfaced with the pain of the uterine massage. As the pain diminished, the body slipped back into the corporeal background. She was able to take in the whole room and experience more sustained reintegration of body and self. She returned to a state of relative indifferentiation.

*****

Fieldwork in the Netherlands helped me develop the concept of U.S. home birth practice as an enactment natural birth discourse with a special emphasis on the achievement of an altered state of consciousness. In the Netherlands, I regularly observed women and midwives deviating from what I though was *the* script. They rarely co-created a *salle sauvage*, engaged in hours upon hours of hands-on labor support, or cultivated an altered state. And, yet, they still accomplished birth at home. I do not mean to suggest that women and midwives in the Netherlands do not follow a script – it is just not the same script. Further, I would not say that they are unconcerned about environment, labor support, or altered state – it is just that home birth is not so fragile for them, not so dependent on constructing and maintaining an ideal set of conditions.

CHAPTER 7
HOME BIRTH IN THE NETHERLANDS: NOT NATURAL BIRTH, JUST HOME BIRTH

I have started to say that home birth in the Netherlands is not natural birth; it is just home birth. By that I mean that the practice of home birth in the Netherlands is not an enactment of the natural birth discourse described in the previous two chapters. This is due to a number of social, cultural, and historical factors. One important factor is that home birth in the Netherlands was never eradicated. Childbirth, as a matter of public and professional policy, was not universally hospitalized during the mid-twentieth century as it was in every other developed country. This is not to say that childbirth in the Netherlands was not medicalized – it is just not yet so hyper-medicalized as to call forth a natural birth discourse as a form of protest or resistance. Thus, while some particular women and midwives in the Netherlands draw upon elements of international natural birth discourse, at a societal level it does not have much resonance.

Below, I use fieldnotes from a number of births to (1) elucidate the features that are of central importance to the practice of home birth in the Netherlands, (2) demonstrate that natural birth prescriptions for environment, labor support, and an altered state are not a key focus, and (3) make the case for an increasing need for continuous labor support among Dutch women in the context of a changing maternity care system.

TRUDI'S BIRTH

Trudi and her partner, Marc, are expecting their second child. They are both 33 years old and the parents of Ineke, age 4. Trudi is a secretary and Marc is a *tegelzetter* (tiler). They

live in a single-family home in a mid-sized town in the southern province of North Brabant. They both identify as Catholic and are ethnically Dutch.

Trudi's story highlights five key structural features of home birth in the Netherlands: (1) the trend away from solo and toward a group model of midwifery practice, (2) the choice of home or short-stay hospital birth for low-risk women with care provided by the same first line midwifery practice regardless location, (3) the relatively small geographic range/catchment areas of Dutch midwives, (4) insurance industry support for and participation in home birth, and (5) the *kraamzorg* (postpartum home care) system. Additionally, her story illustrates that the enactment of natural birth ideals regarding *environment*, *labor support*, and *altered state* are not primary goals of home birthing women or midwives in the Netherlands.

Group Practice

On the day of the birth, Trudi calls my cell phone around 6pm. She says, "I just got off the phone with Kara [the midwife]. I'm going to talk to her again in an hour and then I'll call you back. But … I think I'm in labor." All midwives give their clients *belinstructies* (calling instructions). After 37 weeks of pregnancy, women are to call the practice – day or night – if the baby seems to be moving less than usual, they start having contractions, their water breaks, they experience any bleeding, or if they feel uneasy in any way. These calls are routed to the midwife who has the *dienst* (i.e., the midwife on duty). She assesses the situation and makes a plan with the woman about how to proceed. In Trudi's case, they decide to be in touch again in one hour.

When Trudi calls back around 7pm, Kara suggests passing the *dienst* on to Pauline. Pauline is officially on-call starting at midnight, but it seems likely that the birth will go past midnight. More importantly, Pauline, who had been a student midwife at the practice for many months, is eager to attend her first birth as a fully-credentialed midwife. Trudi feels a little bit nervous about Pauline's relative youth, but she knows that she cannot choose who will attend her in labor. She agrees to the plan.

It is important to contextualize this situation within the trend away from solo and duo practice and toward group midwifery practice in the Netherlands. In 1980, 67.6 percent of midwives were in solo practice, 23.5 percent in duo practice, and 8.8 percent in group practice (Hingstman and Kenens 2010:15). By 2008 (the year in which Trudi gave birth to her second child), 4.9 percent of midwives were in solo practice, 12.2 percent in duo practice, and 83 percent in group practice. This has been a dramatic change in the way home birth services are delivered.

The conventional wisdom suggests that group practice may be beneficial to midwives by increasing opportunities for consultation with colleagues, allowing for better work/life balance, attracting young women to the field, and retaining them during their early years of family-building. Issues of recruitment, retention, and burn out have been especially pressing in recent decades (De Vries 2004; Wiegers 2007). In the 1990s, there was a shortage of midwives. This led to high caseloads, long hours, and job dissatisfaction. In 2000, midwives organized a strike. Lawmakers, convinced of midwives' excessive workload, increased the capacity of the midwifery schools and

lowered the standard caseload for full-time midwives. The group practice model also became more popular.

Recently, investigators have started to examine the effects of practice size on pregnant and birthing women. Fontein (2010) finds that women receiving care in group practices are more likely than those in solo or duo practices to be referred to the second line, experience medical interventions, receive pharmaceutical pain relief, and have unplanned cesarean sections. My data seem to support Fontein's findings. Study participants in the group practice followed relatively complicated care trajectories with multiple care givers during labor, transfers from the first to the second line, and medical interventions (see Table 9). Study participants in the solo practice followed somewhat more straight-forward "care paths" (Wiegers 2009) (see Table 10).

Solo practice, however, is not without its problems for midwives and birthing women. Charlotte, the solo practice midwife I worked with, was on-call twenty-four hours a day, seven days a week and she almost never took a vacation. She was occasionally called away from the office to attend a woman in labor and would then have to reschedule an entire day of prenatal and postpartum appointments. This was not hugely problematic, but it was disruptive. It was also not unusual for her to receive a call from a client in labor while she was at another birth. This happened three times while I was with her. Once the woman on the telephone reported meconium-stained amniotic fluid and Charlotte sent her to the hospital. Twice she went straight from one birth to the next. Every so often, two births overlap so completely that she has to call another midwife in the area to attend the second birth.

I am careful to not over-generalize or oversimplify the findings from my study. In addition to practice size, other factors such as type of community (suburban vs. rural), geographic location (North Brabant vs. Friesland), ethnicity, country of origin, and issues of selection may be at play. Nonetheless, examining the care trajectories of women in this study through the lens of practice size is informative.

Table 9. Care Trajectories for Netherlands Study Participants in Group Practice

Participant	Attendant During Labor	Attendant Responsible at Birth	Planned Place of Birth	Actual Place of Birth	Interventions/ Complications During Labor	Interventions/ Complications During Immediate Postpartum
Gerda	Multiple 2nd line midwives	Gynecologist	Hospital (labor & delivery (L&D) unit)	Hospital (L&D unit)	Induction, epidural anesthesia, episiotomy, vacuum-assisted delivery	Infant to pediatric unit
Monique	Marlies	Marlies	Home	Home	Unknown†	Unknown
Sabine	Marlies at home	2nd line midwife	Hospital (L&D unit)	Hospital (L&D unit)	Transfer to 2nd line for IV pain medication, episiotomy	None
Jolanda	Kara by phone and Eva at home	Eva	Home	Home	None	None
Margo	Kara in relocated home birth suite	2nd line midwife	Hospital (relocated home birth suite)	Hospital (L&D unit)	Artificial rupture of membranes (AROM), transfer to 2nd line due to meconium-stained amniotic fluid, episiotomy	None
Trudi	Kara by phone and Pauline at home	Pauline	Hospital (relocated home birth suite)	Home	None	Intramuscular (IM) oxytocin, perineal repair

† Monique participated in the interview and prenatal/postpartum observation portions of the study. I was not present at her birth.

Table 10. Care Trajectories for Netherlands Study Participants in Solo Practice

Participant	Attendant During Labor	Attendant Responsible at Birth	Planned Place of Birth	Place of Birth	Interventions/ Complications During Labor	Interventions/ Complications During Immediate Postpartum
Liesbeth	Charlotte	Charlotte	Home	Home	None	None
Margreet	Charlotte	Charlotte	Home	Home	AROM	IM oxytocin, perineal repair
Imke	Charlotte	Charlotte	Home	Home	None	4th degree perineal tear, hemorrhage, perineal repair and blood transfusion at hospital
Aukje	Charlotte	Charlotte	Home	Home	None	None
Nadine	Gynecologist	Gynecologist	Home	Hospital	Induction	Unknown
Hilke	Charlotte	Charlotte	Home	Home	None	IM oxytocin
Frauke	Charlotte	Charlotte	Home	Home	None	IM oxytocin, urinary catheterization, IV fluids
Mieke	Charlotte	Charlotte	Home	Home	AROM	IM oxytocin, 3rd degree perineal tear, transfer to hospital for perineal repair
Sophie	Gynecologist	Gynecologist	Home	Hospital	Preeclampsia, induction, AROM, epidural anesthesia, c-section	Infant to pediatric unit
Antje	Jeanette†	Jeanette	Home	Home	Unknown‡	Unknown
Catharina	Charlotte	Charlotte	Home	Home	Unknown‡	Unknown
Astrid	Charlotte	Gynecologist	Home	Hospital	Fetal heart rate decelerations, c-section	None

† Jeanette is a midwife from a nearby solo practice. She covered Charlotte's clients for one day while Charlotte was on vacation.
‡Antje and Catharina participated in the interview and prenatal/postpartum observation portions of the study. I was not present at their births.

Place of Birth and Attendant

Around 7:30pm, Trudi calls me back and says, "I'm not sure if this is it. It might pick up. It might slow down. But, if you want to come over, you're welcome to. You can spend

the night here." I pack a bag and ride my bike over to Trudi's house. When I arrive, Marc answers the door and welcomes me in. He is tidying up the kitchen and letting the dogs out. Trudi is lying on one of the couches in the living room. Her daughter, Ineke, is sleeping on another couch. She did not want to leave her mom to go up to bed.

Trudi is having contractions every few minutes. She is calm and is practicing the "flank breathing" she learned in prenatal yoga class.[44] We watch television together and talk.

A little while later, Marc's father, Gerard, arrives. He is going to spend the night. That way, when Trudi and Marc leave for the hospital they will not have to worry about Ineke. Their plan is to birth in the *verplaatste thuisbevalling suites* (relocated home birth suites) at the local hospital. Trudi will stay home until she is in active labor. At that point, the midwife will either come to the house to assess the situation or meet them at the hospital. Women like Trudi – with normally progressing pregnancies – can choose home or short-stay hospital birth and, regardless of location, they are attended by the same first line midwifery practice.

Gerard sits down on one of the couches and starts watching an Ajax soccer game. Marc offers him a beer and then goes upstairs to set up the sleeping accommodations for the night. Gerard is going to sleep in the *zolder* (attic), I'll be in the baby nursery, Marc will sleep in Ineke's room, and Trudi will be in the master bedroom with Ineke who "can sleep through anything."

When Marc is done getting things organized upstairs, he comes back down and picks Ineke up off the couch. With eyes still closed, she whimpers, "mama." Trudi talks

[44] I attended this prenatal yoga class as part of my fieldwork.

to her – letting her know that she is still there. Satisfied, Ineke wraps her arms around her dad's neck and he carries her up to bed. Shortly, Trudi, Marc, and I also head upstairs.

Small Catchment Areas

Around 10:45pm, Trudi pokes her head into my room. Marc and Ineke are both asleep.

> Trudi: I think I'm going to call Pauline. What do you think?
>
> Rachael: If you feel like you should call, you should call.
>
> Trudi (on her cell phone): Hi Pauline. My contractions are about five minutes apart now. Regular. Painful.

Pauline says she is on her way and a few minutes later the doorbell rings. Trudi and I go downstairs to let Pauline in.

Pauline is able to get to Trudi's house so quickly because Dutch midwives have extremely small catchment areas compared to those of U.S. home birth midwives. In the U.S. it is not unusual for a midwife to drive 45 minutes or even an hour to attend a birth. In the Netherlands, midwives rarely drive more than ten to fifteen minutes to reach a client. Small geographic range is related to at least two factors. First, compared to the United States, the Netherlands is a very small country with a high population density. According to the World Bank (2013), the population density of the Netherlands in 2011 was 495 people per square kilometer while the population density of the United States was 34 people per square kilometer. Moreover, because greater than 85 percent of women in the Netherlands see a midwife for at least part of their pregnancy – compared to one percent of women in the U.S. who see a home birth midwife and approximately 8

percent of women who see a hospital-based midwife – there are far more midwives per capita in the Netherlands than in the U.S.

Upon her arrival, Pauline says she would like to check Trudi's cervix. We go upstairs to the baby nursery and Trudi lies down on a mattress on the floor. Pauline performs the exam.

> Pauline: How do you feel about having a baby at home?
>
> Trudi: What do you mean?
>
> Pauline: You're about 8-9 centimeters and I don't think it is a good idea to get into the car. I think we should have the baby here.

Trudi is overcome with emotion. She covers her face with her hands. She is crying, smiling. She can't believe she is so far along. She takes a few minutes to compose herself. Then she gets up and goes to Ineke's room.

> Trudi: Marc, wake up. I'm 8 to 9 centimeters. We can't go to the hospital now.
>
> Marc (confused and disoriented): What time is it? How did you get so far along? Why didn't we go to the hospital earlier?
>
> Trudi (breathing heavily with contractions): Things went … *really* fast.

Pauline enters the room.

> Marc, I understand you are upset, but her labor progressed really quickly. I think we should stay here to deliver the baby. It is, of course, your decision, but if we are going to go to the hospital we need to leave right now. I do not want to deliver a baby in the car.

Marc, now more awake, agrees that they should stay home. He is just thrown off. This was not the plan. Here, we see, again, that first line births can happen at home or in the hospital with the same care provider. In fact, some women do not even decide where they will birth until they are in labor.

Insurance Industry and System of Postpartum Home Care

Trudi's contractions are coming right on top of each other now. She is moving between Ineke's bedroom, the bathroom, and her bedroom. Marc moves Ineke to her own bed and Pauline starts preparing for the birth in Marc and Trudi's room. She also calls the *kraamzorg* (professional postpartum home care) company to request assistance at the birth.

I ask Pauline how I can help and she asks me to get a few things out of the *kraampakket* (birth kit). She is frustrated by the kit. It does not contain as many supplies as she needs. Trudi had informed her insurance company that she was planning a *poliklinische bevalling* (outpatient delivery) and, therefore, they sent her a modified birth kit. We eventually ran out of absorbent pads. This is why another midwife in my study suggests that all her clients tell the insurance company they are planning a home birth. That way, if they end up birthing at home, they will have enough supplies.

Trudi is standing beside her bed, head bowed, focusing on the contractions. This is as close as I see her get to a U.S.-style altered state. Pauline puts a disposable absorbent pad on the floor. Just in time. With the next contraction, Trudi's water breaks. Pauline expects that Trudi will be pushing soon. She asks if I can "time" and she coaxes Trudi onto the bed. Pauline has a birth stool (a gift from her grandfather when she graduated from midwifery school), but she has little experience using it. At this point in her career, she is most comfortable with supine or side-lying deliveries.

Marc climbs onto the bed and sits beside Trudi who is lying on her back. She is wide-eyed. She looks at Pauline.

Trudi: I'm scared.

> Pauline: Listen to me good, Trudi …

I did not write down exactly what Pauline said next, but her voice sounded authoritative. I remember thinking that her confidence would give Trudi confidence.

Trudi pushes with the next contraction. The scared, out-of-control feeling is gone from the room. Within ten minutes, the head is starting to crown. I record times:

> Head born: 11:46pm
> Shoulders: 11:47pm
> Body: 11:47pm
> Oxytocin (intramuscular injection): 11:48pm
> Placenta: 11:54pm

The new baby is lying on Trudi's chest covered in blankets. Trudi is elated. She is cooing at the baby and smiling at Marc.

After the birth of the placenta, Pauline asks me to help her straighten up the bed a bit. We slide a clean absorbent pad under Trudi and all the used items go into one of two *emmers* (buckets) – one for disposables, one for washables. Around this time, the *kraamverzorgende* (maternity care aide) arrives. She assists as Pauline assesses Trudi's perineal tear and prepares to place stitches.

Pauline's cell phone rings. It is Kara calling to ask how everything is going. Pauline gives her a brief update and says she will call back if she needs anything. Around 12:35am, Pauline calls Kara.

> Pauline (to Kara): Trudi has a difficult tear. It is not deep or especially bad, just not straight-forward to suture. I'm not quite sure how to finish and would like your opinion.

Kara comes right over. She arrives at 12:50am and helps Pauline complete the suturing.

When the stitching is complete, the *kraamverzorgende* changes the bed sheets and brings up drinks for everyone along with a towering plate of *biscuit met muisjes* (bread rusks spread with butter and sprinkled with sugar-coated anise seeds) – pink, for a girl.

Around 1:40am, the baby's cries wake up Ineke who comes into the room and crawls into her dad's lap. They watch as the *kraamverzorgende* diapers and dresses the baby and then gets her to the breast. Ineke climbs into bed with her mom and watches as Trudi breastfeeds the baby. Ineke smiles and giggles.

Pauline, the *kraamverzorgende*, and I go downstairs and leave the family together. We sit at the dining room table and Pauline completes her paperwork – both Trudi's medical chart and the *kraamplan* (postpartum care booklet). After a cup of tea, we go back upstairs. Pauline gives Trudi and Marc postpartum instructions and tells them we will return in the afternoon for a postpartum visit. The *kraamverzorgende* will stay for another hour to monitor Trudi and the baby, help with breastfeeding, and get the laundry started. A new maternity care aide will arrive at 8:00am and will be with the family for the rest of the week.

The Dutch system of *kraamzorg* is unique in the world and is seen as essential to maintaining the Dutch way of birth (De Vries 2004; Van Teijlingen 2004; Wiegers 2006). Most women receive 49 hours of professional, in-home postpartum care over a period of eight days. Twenty-four hours over eight days is considered the bare minimum necessary to protect the public health. The total number of hours a particular woman receives depends on her level of insurance, her health status, her personal preferences, and the availability of *kraamverzorgenden* (maternity care aides) in the area. Just as there were

midwife shortages in the 1990s, so too have there been shortages of maternity care aids in some parts of the country during recent years.

Maternity care aides have three years of vocational training and are responsible for monitoring the health of mothers and babies. They report any signs of pathology to the local midwifery practice. In addition to clinical tasks such as monitoring blood loss and vital signs, maternity care aides also assist with infant care (e.g., feeding, sleeping, and bathing) and household duties (e.g., laundry, cleaning, cooking, and caring for older children). In the Netherlands, postpartum home care is understood to be necessary for the health and safety of women and infants as well as for the development of confident mothers (Herschderfer, Sneeuw, and Buitendijk 2002).

Environment

When I analyze my fieldnotes from Trudi's birth, I am struck by the degree to which to the birth environment does not match that described in the natural birth literature and, more specifically, does not look like home births I attended in the U.S. At one point during Trudi's birth, I wrote, "All the lights are on upstairs except in Ineke's room. There is no attempt to create a *salle sauvage*." This was true of many births I attended in the Netherlands. Midwives turned on lights and spoke in normal (i.e., not hushed) voices. Maternity care aides rang the bell in the middle of the night instead of rapping lightly on the door. I was repeatedly surprised when the "rules" of the natural birth environment were violated.

At Hilke's birth, for instance, I wrote, "We're in the bathroom. Lights on. It is bright. Not pretty candlelight." Likewise, at Mieke's birth, the lights were on in the bathroom as she labored in the tub well after midnight. I was also surprised by the way Charlotte, the midwife, talked with Mieke's husband, Jan, while Mieke was in a focused state of transition. In my fieldnotes I recorded,

> Sounds to me like she is in transition. Not chatty between contractions anymore, just closes her eyes and rests in between. Very intense focus …
>
> Mieke, still lying in the bathtub, starts grunting a little bit with contractions. Charlotte does a vaginal exam and feels her cervix. Almost 10 centimeters. There is a little bit of a cervical lip on top. Charlotte tries to push the lip around the baby's head during a contraction. Mieke finds this very painful. It doesn't work. Charlotte says, "Okay, let's wait another hour and see what happens."
>
> Mieke shifts her concentration back to her labor. Charlotte asks Jan about his work.
>
> Charlotte: So, what do you do?
>
> Jan: I'm an engineer. I work on the mechanization of processes at factories and production plants.
>
> I watch Mieke and wonder if she finds the chit chat distracting or annoying. I can't read anything on her face.

While the environments in which Trudi, Hilke, and Mieke gave birth did not mimic the *salle sauvage* – warm, dark, and quiet – they did, nonetheless, produce intimacy and emotionally safety. Perhaps, in the Dutch context, there is no need to follow the natural birth script when the ultimate goal – a sense safety and security – can be produced without it.

Labor Support

At Trudi's birth (as well as at other births I attended in the Netherlands), I saw very little of the labor support I am used to seeing in the United States. There was little massage or

other therapeutic touch and women did not expect, nor could midwives provide, continuous companionship from a relatively early stage of labor. Compared to women in the U.S., women in the Netherlands are expected to be relatively self-sufficient during labor. This is, perhaps, a cultural expectation, but it is also a logistical imperative.

The standard full-time caseload for Dutch midwives is 120 births per year (Wiegers 2007) while most U.S. midwives take on fewer than 30 clients per year with even the busiest midwives rarely attending over 50 births per year (Cheyney 2011:24). Additionally, Dutch midwives have such small catchment areas that they can easily check in on a woman in labor, return home or to the clinic, and stay at the woman's home only after labor has become quite active. U.S. midwives, by contrast, regularly drive 45 minutes to be with a woman and, even if her labor is not particularly well-established, they may be hesitant to leave. It is easier to sleep on the woman's couch or go for a walk in her neighborhood than to spend hours on the road. U.S. midwives also believe they gain information about a woman's progress by "labor sitting" and their presence is often perceived as necessary to buoy a woman's confidence that she can give birth without medical intervention.

Dutch women do not expect nor can Dutch midwives provide the time-intensive labor support that characterizes U.S. home birth practice. Moreover, many Dutch midwives are not trained nor interested in providing that kind of emotional and physical support. One midwife in my study said, "I don't think I could be a midwife in the U.S. – too much hand-holding!" Another midwife told me, "I wouldn't normally stay at this point, but I don't expect any other births in the next few days." Additionally, the fact that

home birth midwifery is a legitimate profession in the Netherlands may make it seem inappropriate to engage in intimate physical contact or to sleep on a woman's couch in the name of offering continuous labor support.

The professional status of midwifery manifested itself in numerous ways in the field. At the macro-level, I observed that there is publicly-subsidized funding for midwifery education and I sat in on hours of lectures and practicum. There exists national policy regarding salary and caseload and insurance billing codes reflect the realities of home birth. Midwives also have offices in medical buildings alongside other first line care providers like psychologists, physical therapists, and family practitioners.

At births, I observed of a more subtle gauge of professionalization – apparel. I noticed that midwives always kept their shoes on at births and they wore "regular" clothes – no yoga-style stretch pants and t-shirts. Marlies, a middle-aged midwife in my study often wore long skirts and pumps and at Yolanda's birth I recorded, "Eva [the midwife] is wearing blue jeans, black knee-high boots, and a black slouch neck sweater that comes down to mid-thigh – very cute, very stylish. She puts a white plastic apron over her clothing for the delivery." *Kraamverzorgenden* even wore uniforms similar to nursing scrubs.

Shoes, uniforms, and plastic aprons are indicators of the way home is constructed as a work site for maternity care providers in the Netherlands. As such, the state comfortably extends its arm into the home to regulate this work environment. I observed such regulation in the form of the *bedverhogers* (bed risers). National occupational health and safety standards dictate that a parturient woman must raise her bed to at least 65

centimeters. This rule is meant to prevent back injuries among midwives and maternity care aids. While the U.S. Department of Health and Human Services (National Institute for Occupational Safety and Health 2010) provides safety recommendations for home health care workers who provide services to people who are ill, elderly, or disabled, it is difficult to imagine a future in which home birth is so well integrated into U.S. maternity care that the home is considered a work place for midwives and physicians, its safety for such practice regulated by state agencies.

Altered State

In addition to the lack of a *salle sauvage* atmosphere and the time-intensive, hands-on labor support that is characteristic of U.S. home birth, there was also no concern about whether Trudi had achieved a sufficiently altered state of consciousness. Around 10:45pm, when Trudi called Pauline to tell her she thought her labor was really progressing, I wrote in my fieldnotes,

> Altered state: I don't see it. Trudi says she thinks she is going to call Pauline. She asks my opinion. I tell her to call if she feels like she should call. From my experience, I'm guessing she's not too far along. 4-5 centimeters. She's having regular contractions, but she hasn't really gotten into "the zone." She's still 100% lucid. I don't see her as in a rhythm yet.

I later added, "My preconceived notion of what it takes to give birth unmedicated and at home … wrong!" It is not that home birthing women in the U.S. always achieve an altered state, that women in the Netherlands never do, or that there are even clear lines of demarcation between states of consciousness. It is, however, absolutely the case that the cultivation of such a state is particularly linked to a natural birth discourse that overlaps so thoroughly with U.S. home birth as to almost be one and the same.

Perhaps one could argue that Trudi's birth went too fast for me to observe the kind of labor support I am used to seeing in the U.S. Perhaps the speed also limited the degree to which she entered an altered state. The pace of labor is certainly a factor, but it does not tell the whole story. Even births that proceed more slowly – with midwives and the maternity care aides present in the home for a longer period of time – look different in the Netherlands than they do in the U.S.

LIESBETH'S BIRTH

Liesbeth, in labor with her first child, lies on a single bed rented from the *thuiszorgwinkel* (home health supply store). The bed is set up on the lower level of her home, in a room that usually functions as an office. Her partner, Remco, sits beside her in a chair. He strokes her hair and kisses her forehead. The midwife, maternity care aide, and I sit side-by-side along the wall – in chairs we brought in from the dining room. It is midday. Natural light fills the room. The atmosphere is quiet and peaceful.

With eyes closed, Liesbeth breathes deeply, rhythmically. As a contraction builds, her legs begin to shake, her breathing speeds up and becomes shallow, she moves her feet, and she occasionally says "ouch" or lets out a low groan. She holds on to Remco's hand and keeps her eyes closed. When the contraction subsides, she lies still again. Her breathing slows and deepens. She rests.

We can hear in her grunting and see on her face that Liesbeth has started to push a little bit with contractions. She does not ask for permission and Charlotte, the midwife, does not give any instructions. As Liesbeth's pushing efforts become more strenuous,

Charlotte moves closer to her and places a warm washcloth on her perineum, saying, "Perfect. That is just right." The maternity care aide remains sitting – hands folded in her lap, head bowed. Liesbeth and Remco stay in the intimate world they have created – forehead to forehead.

Over time, Liesbeth becomes quite present during contractions – moaning, crying. She is lying on her side and Charlotte encourages her to lift her top leg "to make for room for the baby." The maternity care aide puts on a pair of gloves and then sits back down. Waiting.

The baby's head is no longer moving back up into the birth canal between contractions. It is staying down. Liesbeth says that her bottom burns. "Yes, it will," says Charlotte. The birth unfolds very slowly, smoothly. The perineum has lots of time to stretch. The head crowns. The head is halfway out. The head is born. Time of birth 1:59pm.

The umbilical cord is wrapped two times around the baby's neck. Charlotte unwraps him and lifts him to Liesbeth's chest. Holding her baby, Liesbeth transforms before our eyes. Gone is the woman who said in early labor, "I can't do this. How much longer?" and in her place is a woman who declares proudly, "Nou, dat heb it toch maar snel gedaan! (Well, I sure did that quickly!)" We all laugh.

Remco starts to cry. He leaves the room. The maternity care aide follows him to the kitchen and brings him back. Charlotte says, "It is not every day that you see your first child get born. It is alright to be emotional." Remco kisses Liesbeth. Charlotte feels the umbilical cord. It has stopped pulsating. She clamps the cord and Remco cuts.

Remco: Should we call people?

Charlotte: First the placenta.

As we wait for the placenta, Remco and Liesbeth look at their baby, look at each other, and talk.

Fifteen minutes after the baby is born, Liesbeth pushes out the placenta. Charlotte examines Liesbeth's perineum for tears. Nothing – not even the tiniest tear. After two recent tears requiring transport to the hospital, Charlotte says, "This is a gift. I must say, I do like the completely intact perineum!"

Charlotte examines the baby – cranial sutures, ears, eyes, nose, palate, suck reflex, chest, hands, penis, testicles, feet, spine, anus, walk reflex, weight, length, head circumference. Good. Everything looks good. Charlotte hands the baby to the maternity care aide to be diapered and dressed.

Liesbeth: Should we wash him?

Maternity care aide: Not until tomorrow. Today, just dry him.

Charlotte: He smells so good. Allow time for the *huidsmeer* (vernix: white protective substance that covers the skin) to soak in.

The maternity care aide dresses the baby in a *rompertje* (onsie or body suit), a pair of pants, a shirt, and a hat. She wraps him in a towel and hands him back to mom. Charlotte helps get the baby to Liesbeth's breast. He latches and has a strong suck.

The maternity care aide offers everyone a cup of tea. Charlotte, the maternity care aide, and I take our tea in kitchen. As we sit around the kitchen table, Charlotte comments on how *fysiologisch* (physiological) the birth was, how good it was that Liesbeth had not taken childbirth education classes and, instead, had just done what came naturally.

Liesbeth and Remco call their parents. Remco's mom arrives right away. She goes immediately to the baby and the new parents. She comes out of the room with tears in her eyes – "very happy," she says, "very proud." Liesbeth's parents arrive shortly. They bring a gift for the baby and a large-capacity coffee-maker saying that Liebeth and Remco will need to be able to make lots of coffee for visitors. They start brewing a pot and the grandparents sit down on couches in the living room – talking, laughing, congratulating one another. Charlotte and I prepare to depart. The maternity care aide will stay for another hour or so and we will all return in the morning.

In the story of Liesbeth's birth we see that (1) the environment is calm and peaceful, but not particularly reminiscent of Odent's *salle sauvage*, (2) the professional labor support is attentive, but not overly emotional or hands-on, and (3) an altered state seems to be accomplished, but is neither discussed nor self-consciously cultivated. This assessment of Liesbeth's birth seems consistent with Anne Frye's (2004) assertion that when an unmedicated woman perceives her environment to be safe and secure, she "can allow herself to let go" and "usually does not require active support" (p. 324). This may, however, be changing.

EVIDENCE OF THE INCREASING NEED FOR LABOR SUPPORT IN THE NETHERLANDS

Women in the Netherlands may be developing a need for more intensive labor support than the current system provides. One piece of evidence I see for this is the emergence of the doula. In the fall of 2008, I was a participant-observer at a doula training course in the

Netherlands. I also spoke with practicing doulas who were members of the group "doula.nl." According to their website (Doula.nl 2013),

> The birth-doula is a relatively new phenomenon in the Netherlands. We've always had a very good support system for (home) births with midwives and specially trained nurses. In recent years, this system has eroded and births have become more medicalized, so that now many Dutch women feel the need for an extra person to accompany and support them and their partners during the early hours of labour.

Popular pregnancy magazines are also increasingly featuring articles about doulas. At one point during Trudi's labor, I offered to give her a massage. Trudi said, "I'd love it if you'd rub my back for a few minutes." I massaged her shoulders, neck, head, sacrum, and back. Then, I squeezed her hips during a contraction.

> Trudi: That felt *heerlijk* (glorious, wonderful). Where did you learn that?
>
> Rachael: In my doula training.[45]
>
> Trudi: You're a doula?
>
> Rachael: Yes.
>
> Trudi: What? I can't believe it. I just read about doulas in *Zwanger* – or one of those magazines. I thought it sounded really good. So, this is what a doula is. I'm so excited!

Shortages of midwives and maternity care aides in recent decades created an opening for and perhaps even necessitated the emergence of doulas to fill this care gap.

Changes in cultural ideas regarding the safety of home birth and the importance of medical monitoring and intervention may also be affecting Dutch women's labor support needs. Pasveer and Akrich (2001) caution that home birth is not something that happens naturally. "It is (or has become)," they write, "just as much an obstetrical arrangement as the 'technical' deliveries elsewhere" (p. 236). As such, women and their bodies need to be "trained" into birth at home and as low-touch, disembodying practices such as

[45] I trained as a doula in the United States in 2003 and practiced as a birth doula from 2005-2010.

ultrasound find themselves more and more comfortable in the world of primary care obstetrics, women and midwives may actually lose their ability to do the deeply embodied and relational work of birthing at home.

Frye (2004) also suggests that when women become socialized into the pathology of birth and the insufficiency of their bodies – as is increasingly the case in the Netherlands – more active labor support is required (p. 324). Deirdre, a U.S. midwife, sees very clearly that the form and content of her midwifery practice is shaped by culture. She says,

> I have many things on my mind. For one, the primal shift thing – and the underlying hormonal surge that *must* happen to allow the shift to happen and the hormonal shift *only* happening when the environment is properly maintained (dark, privacy, permission, and willingness to be an animal). But there's also the bigger cultural environment to contend with and our mamas must be prenatally debriefed and reeducated to create the proper environment in their heads … If we lived in a world where women didn't need such intense reeducation, we probably could modify the midwifery model a bit.

Perhaps women in the Netherlands are developing a need for prenatal reeducation and more intensive hands-on labor support. The Dutch model of midwifery care may have to be modified in response to new cultural realities.

*****

Women and midwives in the U.S. are engaged in the creation of an alternate reality and they often operate outside the boundaries of mainstream society. Perhaps, then, it should come as no surprise that the environment, interpersonal interactions, and mental and physiological states associated U.S. home birth seem so otherworldly. In the Netherlands, on the other hand, home birth is part of *this* world. It is *gewoon* (common, ordinary).

Further, Dutch home birth – both as an institution and as an individual experience – has a relatively solid or stable feel to it. This perception may very well be false. One

midwife I spoke with in the Netherlands said she thought Dutch midwives would "sleepwalk into the end of home birth," blinded by their own sense of security. In the U.S., by contrast, the vulnerability of midwives and home birth is a given. Already once eradicated, their reemergence is sometimes described as a "recrudescence" (Chervenak et al. 2013a) – as if it were a disease. Under these precarious conditions, the individual woman's successful home birth is always threatening to dissolve, to slip between her fingers. In the next chapter, I write about what happens when home birth "fails" – when a need for medical intervention arises and a transfer to the hospital becomes necessary.

PART III

TRAUMA

CHAPTER 8
UNDERSTANDING THE RELATIONSHIP BETWEEN HOME-TO-HOSPITAL TRANSFER AND TRAUMATIC BIRTH IN THE U.S. AND THE NETHERLANDS

BIRTH TRAUMA: A REVIEW OF THE LITERATURE

Many life experiences are traumatic. According to the American Psychiatric Association (2000), a traumatic event is one that

1. Happens suddenly and unexpectedly.
2. Disturbs one's sense of control.
3. Disrupts beliefs, values, and basic assumptions about the world and others.
4. Is psychologically distressing.
5. Can overcome a person's normal ability to cope.
6. Is not necessarily a major disaster, but generates powerful emotions.
7. Is associated with fear, helplessness, and sometimes perception of life-threatening danger.
8. Can develop into post-traumatic stress disorder (PTSD).

It was not until the mid-1990s that research started to coalesce around the idea that (modern) childbirth could be a traumatic experience (Menage 1993[46]; Ballard, Stanley, and Brockington 1995; Allen 1998; Ayers and Pickerling 2001). Once recognized as a legitimate source of trauma, researchers quickly honed in on issues of prevalence.

Prevalence

There is now international consensus that about one third of women experience childbirth as traumatic (Olde et al. 2006) and one to two percent of women in developed countries experience PTSD in the weeks and months after giving birth (Ayers et al. 2008). The numbers may be even higher in the United States. In a nationally-representative U.S. sample, nine percent of women screened positive for full diagnostic PTSD following

[46] Menage was one of the first to find that obstetrical and gynecological procedures can be experienced as traumatic and lead to the development of PTSD. She did not write about birth trauma specifically.

childbirth and 18 percent exhibited elevated levels of post-traumatic stress symptoms or partial PTSD (Beck et al. 2011).[47]

PTSD first appeared in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III, American Psychiatric Association 1980). The label was initially used to describe a conglomeration of symptoms (e.g., flashbacks, nightmares, avoidance, emotional numbing, and anxiety) experienced by war veterans and survivors of rape. It is now applied to a wider range of experiences and has become the focus of the scholarly literature on birth trauma. It is the outcome of interest in most quantitative studies and efforts to predict, detect, and treat it drive much of the research on birth trauma.

Predictors

After questions of prevalence were sufficiently answered and after PTSD emerged as the outcome of interest, researchers started trying to identifying predictors of childbirth-related PTSD. Two review studies are particularly informative (Olde et al. 2006 and Andersen et al. 2012). They show, first, that there are many contradictory findings in the literature. Some studies find, for example, that unplanned pregnancy, postpartum hemorrhage, fear of birth, being a first-time mom, or long labor are associated with the

[47] The study did not control for preexisting PTSD. Therefore, it is unclear whether the PTSD symptoms observed were due exclusively to the birth experience, related to prior trauma, or a combination of both. According to the National Institute of Mental Health (2012), about three percent of the U.S. adult population suffers from PTSD during a given 12-month period. Even if three percent of the women in the sample had preexisting PTSD, the incidence reported in this study would still be significantly higher than previous estimates. The study's authors note that in any case "the clinical significance is that 9 percent of mothers screened positive for meeting the diagnostic criteria for PTSD after childbirth as either an initial traumatizing event or as a re-traumatizing event" (Beck et al. 2011:222). This is a serious public health concern.

development of PTSD while other studies find no significant correlation. While specific risk factors have been difficult to isolate, three categories of predictors have emerged: (1) preexisting psychological factors (e.g., prior depression, anxiety, sexual abuse, or PTSD), (2) objective obstetrical factors (e.g., unplanned operative deliveries including the use of forceps, vacuum, or cesarean section and negative infant outcomes such as preterm birth or stillbirth), and (3) subjective experience of labor and birth.

The most recent wave of studies repeatedly finds that a woman's subjective experience is the number one predictor of post-traumatic stress symptoms and also a mediator of the other factors (Slade 2006; Andersen et al. 2012; Garthus-Niegel et al. 2013). For example, two women with no history of depression or anxiety have their labors medically induced followed by vacuum-assisted delivery. For one woman, the experience is traumatic. For the other, it is unproblematic. Or two first-time moms begin labor spontaneously, receive Pitocin to speed up the labor and epidural anesthesia for pain relief, and experience the vaginal delivery of a health infant. One woman is elated. The other is traumatized and later develops symptoms of PTSD. Subjective experience helps explain these differences.

Subjective Experience

In quantitative studies, subjective experience is often summarized by answers to survey questions such as: How frightened were you? How would you rank your overall experience? How well taken care of were you? (e.g., Garthus-Niegel et al. 2013). The qualitative literature has focused on identifying themes based on the content of narratives

provided by women with self-described traumatic birth experiences. The studies are generally retrospective and women are recruited – often over the Internet via birth trauma support groups – to participate in postpartum interviews or to submit narratives electronically. Researchers then use inductive or grounded-theory type methodologies to identify themes.

Beck (2004a), for example, collected stories from 40 women (28 in New Zealand, 8 in the U.S., 6 in Australia, and 3 in the UK). Her analysis identified four themes related to the birth trauma experience: (1) To care for me: Was that too much to ask?, (2) To communicate with me: Why was this neglected?, (3) To provide safe care: You betrayed my trust and I felt powerless, and (4) The end justifies the means: At whose expense? At what price? Many women in Beck's study believed that "the safe arrival of a live, healthy infant symbolized the achievement of clinical efficiency and of professional and fiscal goals" and that their traumatic experiences were "glossed over and pushed into the background as the healthy newborn took center stage" (p. 34). They felt abandoned, violated, and stripped of their dignity (p. 32). Some described their experiences as rape or abuse.

There is an effort to recognize some women's birth experiences as a form of rape. Kitzinger (1992), for instance, writes that "women who experience birth trauma use similar language, describe similar feelings, and have similar physical injuries to those who experience rape and sexual violence." She suggests that like other types of rape, obstetrical rape is intertwined with power and that "by threatening [a woman] with the baby's death, obstetric power is legitimized" (p. 73). Others have similarly found that

women, in describing their traumatic birth experiences, use phrases like "powerless," "violated," "lump of meat," "threatened," "wanting this to end," and "against my will" (Beck 2004a; Richland 2008; Thomson and Downe 2008). Davis-Floyd (2003a) does not explicitly use the word rape, but her analysis of cervical examinations is evocative of sexual assault. She writes, "to have a series of strangers sticking their hands through her vagina and deep into her cervix approaches the extreme of opposition to a woman's usual ideas of appropriate relations between herself and society" (p. 113).

Thomson and Downe (2008), also find similarities – in terms of rhetoric, emotions, and physical experience – between birth trauma and other forms of abuse. Their analysis of in-depth interviews with 14 women in the UK suggests that type of delivery (e.g., operative versus uncomplicated vaginal) is not linked to the subjective experience of abuse, rather "fractured inter-personal relationships with caregivers" emerge as the overarching theme (p. 268). Women report being disconnected, helpless, and isolated. They feel, in short, "annihilated from societal regard." Thomson and Downe (2008) and Beck (2004a) both make the point that many of the situations that the women describe as traumatic are seen as routine or clinically normal by their care providers.

A recent meta-ethnography (Elmir et al. 2010) compares themes uncovered across ten qualitative studies (Allen 1998; Ayers 2007; Ayers, Eagle, and Waring 2006; Beck 2004a, 2004b, 2006; Beck and Watson 2008; Moyzakitis 2004; Nicholls and Ayers 2007; Thomson and Downe 2008). Elmir and colleagues (2010) find that women who describe their births as traumatic report feeling invisible, feeling out of control, and being treated inhumanely. In the months and years after the birth, they describe (1) feeling trapped by

memories, flashbacks, and nightmares, (2) experiencing a rollercoaster of emotions including anxiety, panic, and depression, and (3) feeling disconnected from their babies and/or partners.

On a positive note, Elmir and colleagues (2010) also find that breastfeeding provides an opportunity to heal and gain confidence as a mother. This is consistent with my data and my personal experience. After suffering a traumatic birth, breastfeeding was the primary way that I (re)gained confidence in my body and my ability to mother. When my midwife weighed my son at our six-week postpartum visit, I remember feeling overwhelmed with pride that every ounce he had gained since birth was a product of my breastmilk. My midwife reminded me that *every* ounce – not just the ounces gained since birth – was a product of my body and my hard work. I breastfed until my son was three years old and it remained an important source of confidence and connection.

Expectations

Expectations seem to matter for how one experiences and appraises childbirth (Green, Coupland, and Kitzinger 1990; Slade et al. 1993; Wijma, Soderquist, and Wijma 1997; Hodnett 2002; Beck 2004a; and Hauke et al. 2007). According to Hodnett's (2002) review of 137 scholarly reports, personal expectations is one of the four most important factors – along with support from caregivers, the quality of the caregiver-patient relationship, and perceived involvement in the decision making process – in determining how women evaluate their childbirth experience. These four factors seem to override

many other influences including age, socioeconomic status, ethnicity, birth environment, pain, and medical interventions.

There is a very small segment of the literature in which expectations and birth trauma come together in the same study. For instance, embedded in their studies of birth trauma more generally, Wijma, Soderquist, and Wijma (1997) find that differences between expectations and the actual event is one predictor of birth trauma and Beck (2004a) argues that "mothers' perceptions of birth trauma can be based not only on the event, but also on their unmet expectations regarding the event" (p. 35). Hauke and colleagues' (2007) study of 31 Australian women finds that unmet expectations about having a natural, intervention-free, fulfilling, and vaginal birth are related to a negative appraisal of the birth experience. They also find that those most likely to describe their experience as positive have expectations or goals such as "to go with the flow" or "to have a healthy baby." Hauke and colleagues suggest that women *should* be able to expect a low-intervention, vaginal birth that is fulfilling and empowering, but acknowledge that given the "current technocratic birth experience that is the feature of westernised maternity care" this expectation is rarely met (p. 243).

Limitations of the Literature

An overemphasis on identifying risk factors of, detecting, and treating[48] PTSD following childbirth is problematic for women. First, some argue that the medicalization of

[48] Effective treatments for childbirth-related PTSD are still under investigation. Debriefing (Bastos et al. 2009), counseling (Gamble et al. 2005; Gamble and Creedy 2009), cognitive behavioral therapy (Ayers, McKenzie-McHarg, and Eagle 2007), and eye-movement desensitization and reprocessing (Sandström et al. 2008; Stramrood et al. 2012) are all being evaluated as possible treatment options.

childbirth is one of the causes of birth trauma. To further medicalize the experience (i.e., to frame it in terms of individual risk factors, screening, detection, and treatment) may cause additional harm. Moreover, it leads to a situation in which other facets of the phenomenon – including cultural (e.g., beliefs, values, norms, meanings, and practices) and structural/organizational elements – are under-recognized and under-studied.

Second, limiting the scope of inquiry to PTSD means that the experiences of upwards of 30 percent of childbearing women who describe their births as traumatic, but who either do not develop or are not formally diagnosed with full-blown PTSD, are not given sufficient attention. As Thomson and Downe (2008) argue, the focus on pathology and PTSD has actually gotten in the way of understanding the underlying causes of traumatic birth.

Many of the investigators most intimately involved in the study of birth trauma from a diagnostic or psycho-medico perspective see these shortcomings and have called for a broadening of scope "beyond diagnostic PTSD" to include a range of psychological experiences and outcomes (Ayers et al. 2008:246). They have acknowledged their tendency to "psychologize" – to focus on individual psychological characteristics as predisposing factors as opposed to aspects of the event, the environment, or the organization (p.246). They see "a need to account for the subjective experience of birth" and "to recognize social, organizational, and cultural influences on the birth experience" (p. 247). In short, they are calling for a sociologically- and medical humanities-informed approach to understanding birth trauma.

Contributions of this Study

This dissertation makes a number of theoretical and methodological contributions to the study of traumatic birth. First, it continues the process of unpacking the black box of "subjective experience." I ask: What does the subjective experience of traumatic birth look and feel like? Previous studies address this question using surveys, interviews, and birth narratives. To these data sources, I add direct observation and fieldnotes recorded during two years of participant-observation. These data allow me to paint an intimate picture of traumatic birth – especially useful in moving the conversation beyond PTSD symptomatology.

Next, this dissertation provides a sociological approach the phenomenon. Most research on this subject takes place within the disciplines of psychology, psychiatry, nursing, midwifery, and obstetrics. It is discussed on the periphery of anthropology, but is almost unheard of in sociology. A search of the database *Sociological Abstracts*, returns only one study on birth trauma published in a sociology journal (Rosenthal 2006). Interestingly, Rosenthal did not set out to study traumatic birth – nor did I, for that matter. She was conducting postpartum interviews with women for a study on prenatal genetic counseling and when she asked them, "Is there anything in particular you want to tell me or share?" women started talking about their traumatic experiences. Rosenthal was surprised and shocked by the stories she heard and felt compelled to write about them. One purpose of this chapter is to continue the work Rosenthal began by (1) bringing sociological concepts to the conversation about birth trauma and (2) bringing the subject of birth trauma to sociologists. I look to culture (especially beliefs and values),

social structures, and the organization of health care systems for information about why and when women experience birth as traumatic. This is not to say that individual psychological or obstetrical history is irrelevant, but rather that it is not enough.

Furthermore, with the exception of work by Cheryl Beck of the University of Connecticut, the vast majority of research on birth trauma in high-income countries is conducted in Europe, Australia, and the UK. To the body of literature largely informed by the experiences of European women, I add a rich description of what birth trauma looks like in the U.S. I also add a comparative component – investigating similarities and differences between the U.S. and the Netherlands.

Finally, this study focuses on a new population. To my knowledge, no other study of traumatic birth has looked specifically at women who intended to give birth at home nor has a study isolated this subgroup out of a larger sample to investigate their particular experiences. This is not surprising, given that home birth is so rare in developed countries – with the exception, of course, of the Netherlands. Since much of the research is quantitative and since home birth rates hover around 1 percent in most developed countries, it would be exceedingly difficult to find a sufficiently large group of women who not only planned to birth at home, but who planned to birth at home *and* experienced their birth as traumatic.

HOME-TO-HOSPITAL TRANSFER IN THE U.S.: TRAUMATIC, BY DEFINITION

The vast majority – 88 percent – of planned home births in the U.S. and Canada are successfully completed at home (Johnson and Daviss 2005).[49] That is, of all the women who plan to birth at home, only 12 percent transfer to the hospital during labor or shortly after delivery. The majority of these transfers are preventative with only 3.4 percent of all home-to-hospital transfers deemed urgent.

Transfer is far more common during labor than in the immediate postpartum period. Eighty-three percent of all transfers occur before delivery and the most common reason for intrapartum transfer is failure to progress. Failure to progress can be described as dilation (first stage failure to progress) or pushing (second stage failure to progress) "only to a point and then … a slowing or an arrest of progress toward delivery" (Cheyney 2011:125). Postpartum transfers occur due to complications such as maternal hemorrhage, retained placenta, or respiratory problems in the newborn.

Finally, transfer is more common among primiparous than among multiparous women. In fact, when examined by parity, first-time mothers have a 25.1 percent transfer rate while women who have previously given birth vaginally have only a 6.3 percent rate of transfer.

Theorizing the Home-Hospital Divide

Davis-Floyd's (2003b) work serves as the theoretical starting point for most qualitative studies of home-to-hospital transfer. She asserts that in the U.S. context, "biomedicine

[49] Johnson and Daviss (2005) examine home birth across the United States and in two Canadian provinces.

and home-birth midwifery exist in separate cultural domains and are based on overlapping but distinctively different knowledge systems" (p. 1912). These knowledge systems – and their representatives – rarely interact except during a transfer. As such, transfer is theoretically interesting and transport stories provide a window into what happens when "an ascendant knowledge system and a devalued one must interface" (p. 1913).

Davis-Floyd (2003b) finds that when the dominant (biomedical) and subaltern (midwifery) knowledge systems come face-to-face, a spectrum of "articulations" is produced. She labels three points along a continuum: *disarticulations*, *fractured articulations*, and *smooth articulations*. During a transfer, midwives are forced to reach out "fingers of articulation" to hospital staff (Davis-Floyd 2003b:1913). These fingers can be totally dismissed (as in the case of disarticulation) or fully clasped by a "biomedical hand" (as in the case of smooth articulation). Smooth articulations – characterized by cooperation and mutual respect between midwifery and biomedical practitioners – are rare, but have the potential to produce positive transfers and "mandorla" experiences in which "two irreconcilable opposites are overlapped into a sublime whole" (Johnson and Davis-Floyd 2006:469).

The type of articulation depends heavily on the biomedical side of the equation. According to Davis-Floyd, "the hegemony of obstetrics has forced midwives to educate themselves in its ideology and assumptions, protocols and lexicon to enhance their chances of successfully interfacing with it and of being able to defend their actions in its terms" (p. 1925). Unlike direct-entry midwives, those who operate from within the

biomedical domain can choose whether and how much to take the counter-hegemonic system into account (p. 1913).

Miller (2010) and Cheyney (2011) conducted interviews with midwives, labor and delivery nurses, and physicians in an effort to understand how smooth articulations among U.S. providers could be facilitated and encouraged. They examined how transfer feels from both the midwifery and biomedical points of view and their work reveals that transport situations are emotionally difficult for everyone involved. Biomedical practitioners, in particular, fear encountering life threatening complications, hostile interactions, and noncompliant patients. Regarding noncompliance, in particular, they worry that patients – who by planning a home birth have already demonstrated lack of compliance with medical advice – will reject the very medical monitoring, procedures, and interventions they deem necessary to provide safe and effective care.

Of the nine births I attended during the U.S. portion of my fieldwork, two were traumatic and both involved non-emergency home-to-hospital transport. In the context of U.S. home birth, it is virtually impossible to disentangle traumatic birth from transport – they almost always go hand and hand. I argue that the trauma associated with home-to-hospital transport is not due to prior psychiatric history or objective obstetrical complications (though they may certainly exist). Rather, trauma results primarily from the disruption of "beliefs, values, and basic assumptions about the world and others" (American Psychiatric Association 2000).

In this chapter, I employ the following logic:

> If birth practices are the enactment of particular constellations of culturally-specific beliefs and values (Jordan 1993; De Vries et al. 2001a; Davis-Floyd 2003a) and

> If those beliefs and values associated with planned home birth in the contemporary U.S. represent a "radical critique" of standard hospital obstetrics (Davis-Floyd 2003b:1913) the enactment of which constitutes a "systems-challenging praxis" (Cheyney 2008) and
>
> If trauma can be defined as the disruption of "beliefs, values, and basic assumptions about the world and others" (American Psychiatric Association 2000),
>
> Then, a planned home birth that transfers to the hospital is, *by definition*, traumatic.

Anatomy of a Home-to-Hospital Transport

In this section, I focus on Jolene's birth story – occasionally adding information about Lisa's experience. Both transports – along with my own – followed the basic anatomy outlined below.

> *Phase 1: Typical Home Birth*
> *Phase 2: Gradual Development of Abnormality*
> *Phase 3: Midwifery Management and Intervention*
> *Phase 4: The Transport Conversation and Mourning the Loss of the Home Birth*
> *Phase 5: Moving to the Hospital – Articulations, Resistance, and Compliance*
> *Phase 6: The Birth – Oscillating Between Disappointment and Joy*
> *Phase 7: Postpartum Integration and Processing*

Previous studies of transport focus on what I term "Phase 5." I extend the scope of analysis in both directions – examining what happens at home both before the move to the hospital and after discharge.

Phase 1: Typical Home Birth

Home births that transfer to the hospital generally start out like typical home births. They look like the perfect enactment of natural birth discourse with regard to *environment*, *labor support*, and efforts to achieve an *altered state*. Take, for example, these fieldnotes from the early stages of Jolene's labor:

> 1:15pm: A birth tub is set up in the living room. Even though it is daytime, the room is dark. The sun barely peaks through the closed blinds. Jolene is in the water – moaning

> quietly, low vocalizations, eyes closed. There is music playing in the background. I hear the clanging of the radiator and the sound of Jolene's arms moving rhythmically through the water. Water droplets fall as she lifts her hands.
>
> 1:34pm: Jolene gets up to go to the bathroom and Adam (her husband) goes with her. He supports her as she walks. He whispers to her.
>
> Deirdre (the midwife) puts towels and baby blankets in the oven.
>
> 1:36pm: On her way back from the bathroom, Jolene stops to breathe through a contraction. She gets on her hands and knees on the kitchen floor. Adam puts a pillow under her knees and rubs her back with downward strokes as she exhales.

Phase 2: Gradual Development of Abnormality

As time passes, it becomes increasingly clear that Jolene's labor is not following a normal trajectory. Midwives are comfortable with a wide range of "normal," but Jolene's labor progress is pushing the boundaries.

> 2:42pm: A vaginal exam shows that Jolene's cervix is thicker on one side than the other. Deirdre remains positive. "But it is thinner overall," she says. "More open. Making progress." Jolene returns to her inward focus and Deirdre holds up four fingers to me – indicating four centimeters dilation. We are both surprised. Jolene is showing all sorts of signs of transition – throwing up, shaking, the way she is vocalizing, her behavior. Why does her dilation not seem to match these outward signs?

At this point, the presence of abnormality is creeping into everyone's consciousness, but Deirdre holds off on intervention choosing instead to gather more information in order to assess and diagnose the problem.

> 2:50pm: Deirdre listens to fetal heart tones. The baby has changed position. The heart tones are in the lower left quadrant. She does another cervical check. 5 cm.
>
> Deirdre: Jolene, you are way open. I think that when this baby finds the right position, finds the way out, you're just going to cruise.

Deirdre is starting to articulate her diagnosis – malpresentation of the fetus – and over the course of the next hour, she moves from watchful waiting to active intervention. Around 3pm, I recorded, "Standing beside Jolene, Deirdre seems to me like a protective

presence. Not really 'doing' anything – not fixing anything. Just being present." At 3:51pm I wrote, "Deirdre to Jolene: Why don't you get into a squat. Bring that baby down." And at 3:55pm: "Why don't you just put your head back and sleep for a few minutes." The stage of active management and intervention has begun.

Phase 3: Midwifery Management and Intervention

Over the next few hours, Deirdre and her assistant, Kathryn, have Jolene try various body positions and movements to help the baby into a more optimal position. Nothing seems to work. Jolene pleads with the baby, "Work with me. You have to help me. I can't do this alone." Deirdre monitors fetal heart tones along with Jolene's physiology. As long as both look good and there is hope of resolution of the problem, they will persist.

Jolene has been vomiting. This is normal during active labor – and usually unproblematic – but Jolene has a history of dehydration with vomiting (e.g., with the stomach flu). Despite Deirdre's best efforts to keep fluids and electrolytes in her, Jolene starts to get dehydrated and exhausted. Deirdre consults with a colleague (a certified nurse-midwife) and asks her to come and assist in starting intravenous fluids. Everyone agrees that this is the last effort to get Jolene "over the hump" to birth this baby at home. If the baby does not come quickly after Jolene receives the IV fluids, they will transfer to the hospital.

The second midwife arrives and starts an IV. According to my fieldnotes, "Jolene's spirits are much better. The IV is clearly helping her. She is smiling, joking. She is present again." But this is not enough. The baby is still malpositioned.

Phase 4: Transport Conversation and Mourning the Loss of the Home Birth

At 11:43pm, Jolene has a contraction standing up. She then lies down on her right side in bed. Deirdre checks her blood pressure and her pulse. Both are normal. Jolene says,

> Jolene: I can't do it. It won't stop.
>
> Deirdre: I'm hearing you. Jolene, are you feeling any urge at all to push?
>
> Jolene: No. [breathing deeply] Shit. Fuck. Shit.

The reality is setting in now. This baby is not coming out at home. A few minutes later, Deirdre listens to fetal heart tones with the Doppler. She says, "I'm feeling like heading to the hospital might be the best thing. The vomiting is just too much. It is best to get you there when you are physiologically still in good shape."

Now begins the mourning of the home birth. Jolene says, "I'm sorry." She is saying this to Adam, to herself, to the baby, perhaps. She cries. "It's okay," she says. "I know it's okay. At least I did it this far." Jolene hyperventilates with the next contraction and Deirdre puts an oxygen mask over her mouth and nose. Adam and Deirdre assure Jolene that there is nothing to be sorry about. "You have done a fantastic job," they say. "Sometimes you just need some help."

About the transport conversation in her case, Lisa recalls,

> My midwife breaks it to me that I should probably go to the hospital. I cry; say I don't want to go, that I want to have the baby HERE … We pack up, one of the assistant helps – sends me off to car, hugs, etc. I am huggy, crying a bit, but resigned.

Women who transfer to the hospital often label themselves bad mothers – not because they failed to follow authoritative medical advice, but because they were incapable of achieving natural birth. This is sometimes seen as a personal failure. Talking about this during our postpartum interview, Jolene said, "I remember feeling some

shame. I couldn't make it happen, you know, on my own. Sort of like it was my fault. I didn't really believe that, but I just … I don't know." And Lisa asked, "Why did my body not work right? … Maybe I didn't let go and sort of surrender myself enough to it. I don't know."

Transferring to the hospital can also feel like failure as a mother. Many women articulate something along these lines, "I wasn't able to give my baby what he deserved – a quiet, calm, nonviolent entrance into this world." Thus, while women who transfer from home-to-hospital may adamantly disagree with the medical rationale for *why* they are bad mothers, they often reach the same conclusion.

Phase 5: Moving to the Hospital – Articulations, Resistance, and Compliance

At this point, Deirdre tells Adam to go get some stuff together and she calls the labor and delivery unit of the hospital. She speaks to the charge nurse and explains that she is a certified professional midwife who is bringing a woman into the hospital – a planned a home birth. Deirdre says it is not an emergency. The baby sounds good and the mom is stable.

Jolene and Adam live very close to the hospital. They ride in Deirdre's car and Kathryn and I walk. We all enter through the emergency room. A security guard gets us a wheelchair and calls for an escort to walk us up to labor and delivery. Deirdre says that is not necessary. She knows the way. Jolene does not want to sit down. She knows that the wheelchair symbolizes illness and the transition from woman to patient (Davis-Floyd 2003a). She resists.

Women resist the transition to the hospital and the value system it represents in many ways. Lisa, for instance, refused to change into a hospital gown and wore, instead, her pajamas. It was not until she was prepped for a c-section that she relinquished her clothing. At that point, she recalls "I had to put on a regular hospital gown and take off my necklace and earrings. I was calm and collected ... We discussed my regular socks (could stay) and I could keep in my hair tie (under a lunch lady hat)."

According to Davis-Floyd (2003a), hospital practices have both medical rationales and ritual purposes. The medical rationale for wearing a hospital gown is that it makes it easier to monitor and examine a woman during labor, gives access to her back for the administration of epidural anesthesia, and can be easily changed when soiled or removed in case of emergency. Ritually, it serves to removes a woman's identity and autonomy, converts her genitalia from private to public, and marks her as a kind of inmate dependent on and unable to leave the institution.

Lisa and her husband resisted the belief system of the hospital in other ways too. In the operating room, Lisa asked the surgical staff to keep the birth "sacred, holy." In the days after the birth, she ventured out of her room as little as possible. She did not want to see the nursery. She did not want to be contaminated by the medical world around her. She and her husband tried to create, in their room, a sanctuary – a sacred place of refuge and protection to keep out the profane. Friends came to visit. They sat in a circle, passing the baby. They draped fabric over the television and clock. According to Lisa, they really "hippie'd out the place."

Despite her protest, Deirdre insists that Jolene sits. It is a long walk. We wind through a labyrinth of hallways and arrive at the nursing station in labor and delivery. Deirdre asks for the charge nurse. She introduces herself,

> Deirdre: Hi. I'm Deirdre Allen-Harris, certified professional midwife. We spoke on the phone.
>
> Charge nurse: Yes. You are going to be in room 58.

The charge nurse escorts us down the hall. She says to Deirdre, "I'm Amanda. I think I met you the last time you were here. Do you have any paperwork for her?"

Already, I can see that there will be no disarticulation during this transfer (Davis-Floyd 2003b). This hospital has received home-to-hospital transports before and while home birth is controversial in Minnesota, the state's direct-entry midwifery legislation is quite progressive and the culture is less combative than in other states. The charge nurse does not seem overly friendly or welcoming, but she is certainly not hostile. By asking Deirdre for any paperwork she has on Jolene, she is indicating at least partial accommodation of the midwifery knowledge system.

The charge nurse, of course, is not the only care provider with whom Jolene, Adam, Deirdre, and Kathryn must articulate. Deirdre asks,

> Deirdre: Are you going to be her nurse?
>
> Amanda: No. Helen will be your nurse. She just took someone down for a c-section. She'll be up in a minute.

While we wait for Helen, Jolene continues to have contractions. She is standing and leaning on a table with instruments. The instruments are all wrapped up and the entire table is draped in blue paper. In my fieldnotes I wrote, "She has no regard for the

sanctity of the sterile table. I'm too well socialized from my time working in hospitals. I'd never touch it."

During our postpartum interview, I asked Jolene to tell me about those early moments at the hospital. She said,

> Jolene: And we got to the room and I really started to freak out. I kind of stayed close to the doorway and was leaning on some cabinet or something like that … Some rolling cabinet.
>
> Rachael: It was covered in blue paper. It had all the instruments on it for the delivery. I just remembered thinking – "Oh, my gosh! I can't believe she's leaning on that." It's the sacred medical ….
>
> Jolene: Sterile – right?
>
> Rachael: Yeah, sterile instruments …
>
> Jolene: Well, I didn't even know what it was. I kind of remember thinking, "What is this thing that I'm on?" I remember it rolled and that there was blue. And you guys were over there by the bed – where I was supposed to be – and I just stayed. It was like between the room and the doorway. It was like this little hallway.

Anthropologists have long identified childbirth as a time of transition marked by liminality (Van Gennep 1960; Turner 1969; Davis-Floyd 2003a; Cheyney 2011). Jolene is standing – literally – in a liminal space. She pauses before she crosses the threshold into the foreign land with its foreign language and customs. She tries to hold onto her world, her belief system, her *home*. She sees Deirdre, Kathryn, and me standing over by the hospital bed where she is "supposed to be," but she is not ready to go there. She knows that she will have to go eventually, but not yet. She said later that she knew that "once [she] stepped into the hospital, [she] was giving up control."

A few minutes later, Helen enters. She has lots of questions.

> Helen: Because you're not a patient here, you don't have a chart. Sometimes we can just pull up the electronic chart from your doctor, but ...

Adam: (starting to get angry) Can you ask the midwife as much as possible?

Helen: Okay. Usually the patient answers. So, just listen and make sure the answers are right. They probably are. I didn't mean that they weren't.

Here we see the fault lines of fractured articulation appearing. Home-to-hospital transfer is scary for birthing women and their family members. They fear for the health and safety of mother and baby. They also fear encountering stigma-related discrimination. Adam expects that he and Jolene will be labeled as irresponsible "risk parents" and, in Helen's comments, he sees his expectations being met. Additionally, Deirdre is not recognized as a fully legitimate care provider – as someone who has the authority to transmit information about Jolene's medical history or current status.

If the articulations between Jolene's home birth team and the nurses are fractured, the articulations with the first physician who cares for them are quite smooth. Shortly after one o'clock in the morning, Dr. Patterson (Jolene's family practice doctor) arrives. She asks Deirdre for an update. Deirdre and Dr. Patterson know each other. They are on a first name basis and are very cordial.

When the Dr. Patterson enters the room, Helen is preparing to start an IV. She pauses,

Helen to Dr. Patterson: Would you like to check her before I put in the IV?

Dr. Patterson looks at Deirdre.

Deirdre: I think the IV will be a really good thing right now.

Dr. Patterson: Yes, if she's been barfing. Let's do that first.

Helen clearly defers to Dr. Patterson, but Dr. Patterson – acknowledging Deirdre's expertise and knowledge of Jolene's status – defer to Deirdre's judgment.

After Helen gets the IV started, Dr. Patterson does a cervical exam. She says she can feel an anterior lip. That means that Jolene is almost fully dilated – only a small "lip" remains. Dr. Patterson wants to break Jolene's bag of water. Adam looks at Deirdre. Making eye contact with her through the IV pole he asks,

Adam: What do you think?

Deirdre: I think it's a very good idea.

Helen to Dr. Patterson: Do you want to listen to heart tones right after you rupture?

Dr. Patterson: Yes, thank you.

Deirdre: Okay. Jolene, let's put your bottom down here ...

Deirdre helps Jolene into a good position on the hospital bed. Adam asks Dr. Patterson to explain the procedure. Dr. Patterson explains that it is not painful. "It is just like a cervical check and I'm going to use a little hook …" Dr. Patterson puts two fingers into Jolene's vagina then slides the hook up along her fingers and ruptures the amniotic sac.

This pattern of "mutual accommodation" (Jordan 1993) and cooperation continues until Deirdre and Dr. Patterson quietly agree that a c-section is probably necessary. At that point, they jointly decide to bring in an obstetrician. Dr. Patterson leaves the room to consult with the obstetrician on-call.

Deirdre moves from a clinical role to an emotional support role.

Jolene: (distraught) Oh, Deirdre.

Deirdre: I know, Jolene.

Jolene: I don't think I can do this.

Deirdre: (in a stern voice) Don't you give up yet. You've come too far.

Deirdre does a cervical check.

Jolene: (looking at Deirdre) I don't like that face.

Deirdre climbs up onto the bed with Jolene. She doesn't say anything. She sits behind Jolene and wraps her arms around her. "Lean back on me," she says. They rock.

Dr. Patterson reenters the room with Dr. Bilinski, the obstetrician. Dr. Bilinski introduces herself and goes to the bed to do an internal check of fetal position. Jolene is fully dilated and has been pushing, but the baby is not moving down. Dr. Bilinski does an internal exam and feels the baby's head. She asks Jolene to push while she assesses fetal position.

> Dr. Bilinski to Jolene: That's the stuff … Can I get a monitor? My way of doing medicine is to do fetal monitoring. I need a good strip to assess how the baby is doing before, during, and after contractions.

Helen gets the fetal monitor hooked up to Jolene's abdomen. A "strip" (print out of the fetal heart rate over time) starts coming out of a machine. Dr. Bilinski studies the strip for a moment. She says the baby's heart rate looks fine. She tries to manually rotate the baby's head into a tucked position.

Dr. Bilinski's comment about "my way of doing medicine" reopens the fracture. The smooth articulation that was present for a short time while Dr. Patterson was managing the labor is now gone, but the fracture is manageable. All the care providers are on the same page regarding what needs to be done and cooperation remains the overarching theme.

> Dr. Bilinski: Honestly, I don't think pushing more is going to get this baby out.
> Jolene: Are you saying c-section?
>
> Dr. Bilinski: I am suggesting that.

Jolene: (sounding a bit panicky) Can you give me an epidural?

Jolene is hoping that with epidural anesthesia she could rest and the baby could have more time to move and change position.

Dr. Bilinski: I don't think that is a good idea. There is no risk as the baby looks fine on the monitor, but there is also no real benefit. There is no sign that the baby can turn into a better position. You've tried everything. Also, the way out – your cervix and vagina – is getting very swollen.

Jolene: Deirdre, what is your professional opinion?

Deirdre talks about how Jolene has tried a lot of movement, about how much swelling she's experiencing, about her exhaustion.

Deirdre: I think it's time to be done.

Dr. Bilinski: You've really tried hard.

Jolene: I think we've got to do it.

Deirdre: Do you want a few minutes to talk?

Jolene: Yes.

Dr. Patterson, Dr. Bilinski, and Helen leave the room. Deirdre, Kathryn, and I stay with Adam and Jolene.

Miller (2010) and Cheyney (2011) both find that transfer situations are difficult not just for birthing women and midwives, but also for hospital staff who worry about many things including encountering a noncompliant patient. That is, they worry that a patient will not agree to the procedures and interventions they deem necessary to keep the mom and baby safe. Cheyney (2011), however, suggests that what looks like noncompliance from the vantage point of hospital staff, may – at least in part – be the result of clashing models of patient-provider interaction and informed consent. She points out, "the decision to transport amounts to a tacit acknowledgment of the need for

interventions available only in the hospital" (p. 110). Patients may ask lots of questions about the physician's advised course of action and medical rationale, but, she writes, "this behavior does not mean they intend to decline a procedure" (p. 110). Rather, it may more accurately reflect the fact that they have "internalized a model of care that involves detailed discussion of options, a focus on informed consent, and valuing of client input" (p. 110).

To Cheyney's analysis, I add that women who transfer from home-to-hospital ask questions and take considerable time to think through options, not because they plan to say "no," but because it takes time to integrate – or at least try to integrate – the procedures and interventions they know they need into their preexisting worldview. They believe that birth is a normal, natural, physiological event that occurs most safely and easily when it is undisturbed. Attempts to integrate their new reality take time and are accompanied by significant "cognitive distress" (Davis-Floyd 2003a:229).

Jolene's story illustrates what could be seen by nurses and physicians as non-compliance – both when Adam asks Dr. Patterson to explain the artificial rupture of membranes and when Jolene requests time to talk before consenting to a c-section. Jolene knows that she will almost certainly say "yes" to both, but she needs time to build bridges between her current embodied experience and her prior cognitive framework.

In Lisa's case, when the doctor recommended a c-section, Lisa's midwife said, "Now is the time to ask questions, Lisa." The doctors left the room to give Lisa and her support people time to talk. Lisa recalls, "We didn't spend that much time discussing at that point. Even though I was shocked and sad to be at this point, I didn't resist much."

After a short conversation, Deirdre sends me to the nursing station.

Charge nurse: Can I help you?

Rachael: I'm looking for Dr. Patterson and Dr. Bilinski.

The two doctors – sitting at a table talking – turn and face me.

Rachael: She's ready to consent to a c-section.

The articulations between Jolene's home- and hospital-based care providers ranged from fractured to smooth. While it is true that smooth articulations can improve physical safety for women and infants and contribute to a more positive birth experience (Davis-Floyd 2003b; Johnson and Davis-Floyd 2006), they do not eliminate trauma.

Like Jolene, my transport experience was characterized by both fractured and smooth articulations. The charge nurse was relatively supportive of home birth and my midwife knew her personally. Our first[50] labor and delivery nurse had given birth to some of her own children at home. Both the charge nurse and our first "L and D" nurse contributed significantly to the smoothness of the transfer, but even this degree of mutual accommodation could not prevent the traumatic disruption of values and beliefs that is part and parcel of home-to-hospital transport in the U.S. context.

Phase 6: The Birth – Oscillating between Disappointment and Joy

As Helen prepares Jolene's body for surgery, Deirdre says, "Jolene, I need you to move your head away from being disappointed toward getting ready to welcome this baby. This is joyful. And she has worked as hard as you have." A few minutes later, Helen rolls

[50] I had numerous nurses during my hospital stay – two during labor and many during the postpartum period. Only the first nurse assigned to me was clearly "pro" home birth.

Jolene's bed out of the labor and delivery room and onto an elevator to go downstairs to the operating suites. Another nurse comes in and hands Adam the surgical clothes he needs to wear in the operating room. He puts the clothes on over his street clothes and follows the nurse down to the OR.

Jolene's surgery has complications. The surgical incision tears through her uterus, her cervix, and into her vagina and she suffers greater than normal blood loss. Dr. Bilinski later reports to Deirdre that Jolene's tissues were "friable" and – as a result of the tear – she will likely never be able to give birth vaginally.

When Jolene returns to the room, Deirdre explains what has happened. Jolene says, "Just one thing after another." She is trying not to cry. She wants to be happy about the baby. This is just too much right now. Adam opens his computer and puts on some music. He plays the song he and Jolene chose to be "the first song." We all listen.

Phase 7: Postpartum Processing

Lisa went back and forth between seeing her birth as traumatic and not traumatic. During our postpartum interview, she said, "I think there's a birth euphoria. In the first week or so, it was great. Like, 'Oh, it was wonderful and it doesn't matter that it was a c-section.' I felt a sense of accomplishment. Like, 'Wow, we did it!' I was proud of myself, you know. And then about a week later, it set in. Like, 'Ah! Oh my God, maybe we did fail in some way and we didn't do it the normal way and I missed out on these things and if I never have another kid, I don't know if I'll ever … I'll never get to feel these certain things. So, there was some of that too." Around that time, Lisa's midwife said to me,

"Lisa is rethinking her entire birth. I want to have a heart to heart, talk her down from her tree."

Jolene, on the other hand, identified her experience as traumatic – without question. During our postpartum interview, I ask her to tell me about all of her "processing."

> Rachael: I feel like, because it wound up as a c-section, people have really encouraged you to process, process, process. Like this is a requirement.
>
> Jolene: Yes. [laugh] That's very true.
>
> Rachael: And how do you feel about processing – do you feel like it's something you have to do in order to heal or is it just too much?
>
> Jolene: Yes, I do have to do it in order to heal. [Pause] I need to. Actually, I just went to a psychologist that Deirdre referred me to – for birth trauma – earlier today. And that was good. I'm glad that I'm going to do that. I recognize how detrimental it can be when you don't, when you avoid that. But … as it is when you process anything that's difficult, some days you just don't feel like doing it, you know? You just can't feel all of that, all the time. You just can't. Or else you'll just fall apart.
>
> Rachael: That reminds me of something you said when you came back upstairs after the c-section. I think Adam told you about the uterine tear and you were like, "I can't deal with that right now. I just want to be happy. I just want to enjoy my baby."
>
> Jolene: Yeah. And I needed him to be happy, too. That's part of the recovery. It was definitely hard to see Adam so upset about it. To see him cry like that. So, it's not just me.

Indeed it is almost never just the birthing woman who experiences trauma. Her support people are often traumatized as well. They experience both the *primary trauma* of having their own values and beliefs disrupted and the *secondary* or *vicarious trauma* that results from exposure to the pain and suffering of others (McCann and Pearlman 1990; White 2007; Leinweber and Rowe 2010, Halifax 2011a and 2011b).

Support People: Primary, Secondary, and Vicarious Trauma

Soon after Jolene gave birth, her husband, Adam, posted the following to their blog,

> So let's see:
> - Train Wreck: Check
> - Failed Farm Adventure: Check
> - Move From Paradise To Cold Ass Town: Check
> - Crappy Apartment: Check
> - Corporate Job That Contradicts Beliefs: Check
> - Failed Home Birth: Check
> - C-Section: Check
> - Massive Tear During C-Section Ruining The Goods: Check
> - Swollen Cyst: Check
> - Massive Amounts Of Drugs: Check
> - Massive Amounts Of Hospital Bills: Check
> - More Debt: Check
> - Life Totally Opposite Of Our Goals: Check

Adam's statement about having a "life totally opposite of our goals" perfectly articulates the theory of trauma as a fractured connection between one's beliefs and values and his or her lived experience. When the misalignment is related to something so foundational – and controversial – as childbirth, the traumatic stress may even be magnified.

In addition to Adam, Jolene's midwife also experienced the birth as traumatic. During our interview, Jolene said,

> It has helped me to just watch Deirdre work through it a little bit. I know she's still working through it, but at first she was – it was hard to see her getting so upset and I think she felt like she failed us or failed herself, you know. I didn't feel that way, but I can't really tell her that she can't feel that way. She had her own experience.

Years after the birth, Deirdre still thinks about Jolene and Adam. She wonders what she could have done differently and she feels partly responsible for their trauma. She recalls that the birth challenged her assumptions and changed her practice. She remembers the pain she felt not just as a caregiver, but, simply, as a human being bearing

witness to the suffering of others. These are common responses by midwives to witnessing traumatic birth (Rice and Warland 2013).

The relationships midwives develop with their clients are marked by a "high degree of mutuality and reciprocity, which might even go beyond empathy" (Leinweber and Rowe 2010:82; Fleming 1998; Kennedy et al. 2004). Such "empathic identification" heightens the risk of traumatic stress for midwives (Wilson and Thomas 2004).

Jolene's birth no longer traps Deirdre in active trauma. She now interprets the experience as an opportunity to learn and grow. Women and their partners can also experience birth trauma as transformative and the literature is starting to reflect this. Instead of discussing recovery from trauma as a "return to the person you were before" (Ayers et al. 2008), a new concept of post-traumatic growth is emerging (Joseph and Linley 2008; Sawyer and Ayers 2009; Thomson and Downe 2013). Here, trauma is conceptualized as part of the range of human experience and both resilience and emotional growth are emphasized.

Retraumatization

Unfortunately, the trauma does not end with the birth. Because of the obstetrical complications usually involved in a home-to-hospital transport, women often need to seek treatment for ongoing medical problems. As I described in chapter 2, I saw a gynecologist for bladder issues after a difficult birth. I was shamed, I was told that I was lucky that my son wasn't sicker than he was – my son was a perfectly healthy 8½ pound baby – and, ultimately, I was not helped, medically. I also sought diagnosis and treatment

of chronic abdominal and pelvic pain. It was implied that my pain was the direct result of having "attemped" a home birth and, as such, was my own fault. During these medical visits, I was routinely restigmatized and retraumatized.

Improving Home-to-Hospital Transport in the U.S.

One of the most important things that can be done to improve the both the physical and the emotional/psychological safety of home birth is to improve the transfer process such that smooth articulations become the norm. Around the world, but especially in places where home birth midwifery and biomedicine operate in separate silos and represent different belief systems, the creation of structures for interaction is essential. Such structures include laws, working groups, interdisciplinary educational programs, and standard transport protocols (Downe, Finlayson and Fleming 2010; Cheyney 2011; Avery, Montgomery, and Brandl-Salutz 2012, and Vedam et al. 2012).

In the absence of these kinds of structures, birthing women are forced to depend on "relations that develop over time in micro level interactions" in which particular care providers, at particular times "are able to transcend the philosophical and ideological boundaries that divide home and hospital" (Miller 2010:10). These "fragile, easily ruptured" webs of articulation lead to uncertainty and fear (Johnson and Davis-Floyd 2006:502). This is not a sustainable model and it is not in the best interest of birthing women, infants, or care providers.

Davis-Floyd (2003b) points to the Netherlands as a place where stable nexuses of collaboration offer certainty and predictability for women and providers in cases of

transfer. She describes the situation in the Netherlands as one of "seamless articulation" between home and hospital in which the health care system "fully support[s] birth in all settings, creating ease of choice and continuity of care across what in other countries can only be seen as the home/hospital divide" (p. 1929). I agree that the Dutch system has the most integrated home/hospital system in the world and that it offers a useful model for midwife-physician interaction, but, as I have demonstrated in previous chapters, to call the articulation "seamless" and home birth "fully supported" is an overstatement. Below, I describe some additional challenges in the Dutch system.

DISENTANGLING TRANSFER AND TRAUMA IN THE NETHERLANDS

In 2008, approximately 36 percent of pregnant women in the Netherlands were referred from the first to the second line during pregnancy (Wiegers and De Borst 2013). Of those women still in the first line at the onset of labor, 31 percent experienced a transfer to the second line during labor. Women who begin labor in the first line can choose home or hospital birth. Historically, women in this position have preferred to birth at home (Wiegers et al. 1998c). Therefore, transfer from the first to the second line during labor generally means transfer from home-to-hospital. As in North America, most transfers are preventative and primiparous women are significantly more likely than multiparous women to be transferred (Amelink-Verburg et al. 2008; Amelink-Verburg, Rijnders, and Buitendijk 2009).

The Dutch transfer or "referral" system seems to be increasingly problematic for birthing women. In the 1990s, research suggested that referral from the first to the second

line had little influence on women's experience of childbirth (Wiegers 1998; Wiegers, Van der Zee, and Keirse 1998b). More recent studies, however, reveal that transfers of care now contribute significantly to negative recall of the birth experience (Christiaens, Gouwy, and Bracke 2007; Rijnders et al. 2008). The rate of transfer in the Netherlands is higher than in other high-income countries, it is increasing, and it is contributing to women's dissatisfaction with the birth process (Amelink-Verburg, Rijnders, and Buitendijk 2009; Christiaens, Gouwy, and Bracke 2007; and Rijnders et al. 2008).

While transfers of care seem to be linked to dissatisfaction, they are not as intimately intertwined with trauma as they are in the U.S. In my Netherlands sample, two women transferred from the first to the second line at the end of pregnancy, three during labor, and two immediately postpartum. None of the women showed signs of trauma and they all expressed relative satisfaction with the process.[51]

Experiences of First-to-Second Line Referral

For example, about her transfer at the end of pregnancy due to high blood pressure and preeclampsia, Sophie said,

> It all happened very quickly and I thought, "No problem." Things weren't good anymore and the baby needed to come out. So, I didn't find it terrible. I agreed. *Prima* … I never imagined it, but when I look back I have a good feeling about it.

Astrid transferred to the hospital during labor due to decelerations in the fetal heart rate. Her baby was delivered by c-section and while the gynecologist later questioned whether the c-section had been necessary, Astrid felt that it was the right thing

[51] The fact that the women in my study expressed satisfaction with the transfer process does not necessarily contradict the finding that when compared to women who do not experience a transfer, those who do are less satisfied with their birth experience.

to do. She had hoped for a normal birth at home, but the transfer and c-section did not upset her. She was not philosophically tied to home birth.

Margo and Sabine were both interested in birthing in the hospital from the start, but remained under the care of their community midwives until meconium-stained amniotic fluid in Margo's case and a desire for pain medication in Sabine's led to transfers to the second line. Both women were overwhelmingly satisfied with their experience. During our post-birth interview, Sabine, for instance, said, "I found it very good. Great people. Super care." When I asked whether she would do anything different with a second child, she replied, "I would do it exactly the same."

Mieke transferred to the hospital after giving birth to repair a third degree perineal laceration. According to my fieldnotes, Charlotte puts her headlamp on to examine Mieke's tear. She asks the *kraamversorgende* in training (the *stagaire*) to open some gauze packets for her. "Six, please," she says. Significant tear, but it does not go through the anal sphincter. That's good. Charlotte prepares to suture at home. Needle ready, syringe for lidocaine … Then she changes her mind. "No," she says. "While it is not a 4th degree tear, it should still be sutured in the hospital by a gynecologist."

Mieke is upset. She says she feels *verdrietig* (sad). She cries a little bit. Charlotte says, "It is alright to cry. This is very unfortunate, but the birth went very well. You can be proud of that, of the work you did. And the baby is doing well." Charlotte then calls for an ambulance to transport Mieke – non-emergency. She also calls the labor and delivery unit at the hospital to let them know she is sending a patient in for suturing.

The experienced *kraamverzorgende* and the *stagaire* clean the bathroom (where Mieke gave birth), help Mieke into some clothes, and get the baby into a car seat. They give Mieke's husband, Jan, instructions about what to bring to the hospital – an overnight bag, hospital pass, *zwangerschapskaart* (pregnancy-related medical record), and camera. The experienced *kraamverzorgende* says to Jan, "Do me a favor. Go eat something." She then helps Mieke walk downstairs and get as comfortable as possible on the single bed she rented from the *thuiszorgwinkel* (home health store). We wait for the ambulance to arrive.

When the ambulance personnel arrive, they shake Mieke's and Jan's hands. "Congratulations!" The experienced *kraamverzorgende* helps Mieke to the gurney waiting outside the front door. The *stagaire* helps Jan install the car seat – he and the baby will follow by car. We say goodbye.

Charlotte packs up her bags. She has just been called by another woman in labor. Her contractions are three minutes apart, lasting one minute each. Charlotte looks at me, "This is an example of a time when you just couldn't do without *kraamverzorgenden*. They were excellent."

During our post-birth interview, I asked Meike about the transfer. She said,

> When we arrived at the hospital, they were waiting for me. Ready. It was a quiet night on the labor and delivery ward. I was their only patient. It was great. I went from the stretcher to the bed and they started immediately.

When I asked her if the experience was traumatic, she replied,

> I think my husband experienced that all as more difficult and traumatic than I did. He was very sweet. He gave me my cell phone to take in the ambulance and said, "You can always call me …" Very loving.

About whether she would do things differently with a second child,

> No. Everything went really well. I guess with a second, there are things that you don't need to do – you don't have to read so much or take so many courses … I think I might do something instead of the pregnancy gym (prenatal course) – like yoga or swimming.

Like Mieke, Imke transferred to the hospital immediately postpartum for repair of a perineal laceration. Imke's, however, was a fourth degree tear or *totaal rupture*. She was physiologically stable after birth and she initiated breastfeeding while we waited for the ambulance to arrive. Imke went in the ambulance, her husband and infant went in their car, and Charlotte and I followed in Charlotte's car.

According to my fieldnotes, Charlotte leads the way to the maternity ward and walks directly to the nursing station. They point us to Imke's room. Imke's husband, Hindrik, is right behind us with the baby in the car seat. We walk to the room. Charlotte knocks on the door and we enter. The second line midwife says to Hindrik, "Don't be frightened. She has lost a lot of blood – 1000 milliliters in the ambulance and then another 800 milliliters after she arrived."

There are four women in white hospital uniforms in the room. One of the nurses is putting in a catheter. It is terribly painful. Imke is almost screaming. Hindrik sets the baby (still in the car seat) down on a counter and goes immediately to his wife.

An older man in his 50s – grey hair, tall, slim – walks into the room. He is the gynecologist. He goes to Imke's side and gets a report from the second line midwife. He then tells Imke about the plan. They will move to the *operatiekamer* (operating room) for suturing of a *totaal ruptuur* under general anesthesia. They will also check to make sure there is no retained placenta as that may be the cause of the bleeding.

The gynecologist asks Charlotte, "Did she receive Pitocin at home?" Charlotte replies, "No. The uterus was well contracted with little blood loss. Strong *naweeën* (after

pains). It was not indicated at that time." They decide to give Pitocin now in an IV line. The gynecologist has his hand on Imke's uterus. "Uterus is contracting nicely," he says. "Seems to have gotten boggy in the ambulance." Charlotte gives some additional information to a nurse who is charting and the gynecologist talks with Imke some more. He says, "You need to keep your head."

Charlotte receives a call on her cell phone. Another woman is in labor. She says to me, "Strong, intense contractions. We need to go to her. Nothing more we can do here. Imke is in good hands." We say goodbye to Imke, Hindrik, and the medical staff.

During our post-birth interview, Imke and I sat in her living room and I asked how she felt about the transfer to the hospital. She said,

> It was so nice to give birth at home – in this room. It was bothersome to have to transfer to the hospital after that. I was looking forward to a relaxing, nice time at home. Having people come visit. But it didn't go that way.

From my perspective, Imke seemed quiet panicked when we arrived at the hospital. I asked her to tell me what it was like for her.

> The entire team was ready for me. Lots of people doing stuff, asking questions. Very intense. But, you don't think about it at the time. You just have to do it. It is what is happening. You just deal with it. IV, getting taken to the operating room, stitched under anesthesia, a blood transfusion.

Imke arrived at the hospital around 10:30 or 11am and was not out of the recovery room until close to 3:30pm. About the passage of time, she said, "You can think of that as a long time or just half a day. I didn't experience it as hugely traumatic." Regarding future births, she said, "I prefer to give birth at home, but if it can't be, it can't be."

In addition to the structures of *samenwerking* (interprofessional collaboration) that contribute to smooth transfers of care in the Netherlands, I argue that – unlike in the

U.S. – home and hospital birth in the Netherlands do not occupy separate cultural domains. There is a significant overlap of both knowledge and values between the two systems. In fact, they are not two systems at all. They are two lines, or levels, of care within the same system. This helps to prevent the traumatic disruption of beliefs and values associated with home-to-hospital transport in the U.S.

If birth trauma does not seem to be closely associated with home-to-hospital transport in the Netherlands, then when do we see trauma?[52] There are likely many answers to this question. My fieldwork, however, allows me to describe one particular situation in which birth trauma arises – among non-Dutch women with primary socialization in societies in which highly medicalized birth is the norm.

Birth Trauma among Non-Dutch Participants in the Netherlands

There were two non-Dutch women in my study. Both were from countries – Israel and Sweden – where home birth is stigmatized and technocratic birth is the norm (Jordan 1993; Nelson and Popenoe 2001; Ivry 2010). Both found themselves pregnant and not quite sure what to make of the Dutch system. They wanted to birth in the hospital and they wanted pain medication. They wanted care that was consistent with their expectations for medical management and monitoring during labor and birth. These women did not get what they expected. Or rather, they *did* get what they expected from the Dutch system – a system that could not provide them with the experience they wanted, perhaps even needed.

[52] I do not mean to suggest that no one who transfers from home-to-hospital experiences birth trauma. Rather, that transport in the Netherlands is not, by definition, traumatic.

Adina: This Nightmare Called Delivery

Adina is Israeli and her husband, Niels, is French. They have two children – both born in the Netherlands. Both births took place in the hospital, by choice – the first with epidural pain relief, the second without. Adina's second birth was particularly traumatic – not because of the pain per se, but rather, I argue, because of a disruption of beliefs and values. Adina was not a formal participant in this study. She was my neighbor and friend. She shared the following experience in an e-mail.

> I know you like delivery stories, so I will tell you mine:
>
> My water broke at 3:45pm and contractions started at the same time. The midwife came and I was debating if to do it the Dutch way (i.e., deliver at home). As contractions got stronger, I decided to go to hospital and get an epidural. When we arrived to the hospital, contractions were stronger, very frequent (every 2 minutes or so) and I was 3-4 centimeters dilated. In the hospital they told me the anesthetic is busy with a surgery and won't be available for the next hour. Since the delivery is going fast, they have no time to give me epidural. Instead, they gave me 250mg morphine which did not relief my pain at all. I got completely freaked out there. You have no idea what a scene I made them. I didn't know how to deal with that. I was begging them to give me something. It was really painful and I just refused to accept the fact I will be delivering naturally. Anyway, I had no choice. Gabriella was born at 7:56pm. Three VERY PAINFUL push contractions and she was out.
>
> Just when I thought this nightmare called delivery is over, we were up to a surprise. The placenta did not come out. I tried pushing but nothing. They were waiting for an hour to see if the placenta will come out naturally. In the meantime I lost 2.5 litter of blood. Then they decided to operate and take the placenta out manually. It is a very simple operation – only 10 minutes under full anesthetic, but we were still worrying and stressed. So this is the delivery story.

When I read Adina's story, what is clear to me is that she felt stuck in a system that was incompatible with her worldview. For Adina, childbirth is a normal part of the female life cycle, but it is also a medical event that is best managed in a hospital with the aid of pharmaceutical pain relief. In the Dutch system, she was able to request a hospital birth

without medical indication (which she appreciated), but she was not able to secure the pain medication she saw as an essential component of humane and civilized treatment.

Upon arriving at the hospital, Adina was faced with organizational realities of Dutch maternity care. In the Netherlands, the use of epidural analgesia during labor is relatively rare. Demand is growing, but in 2009 the epidural rate was only about 10 percent (Wassen et al. 2011; Christiaens, Nieuwenhuijze, and De Vries 2013). Compare that to 50 percent in Israel (Weiniger et al. 2010) and 76 percent in the U.S. (Declercq et al. 2006). As a result, anesthesiologists are not nearly as ubiquitous on labor and delivery wards in the Netherlands as they are in many other countries and I am not surprised that personnel constraints, in part,[53] made it impossible for her to receive the pain relief she felt necessary.

Davis-Floyd (2003a) describes how women adapt to the technocratic model of childbirth. If they already have a technocratic approach, they will adapt "with cognitive ease" whereas if they enter the hospital with a more natural view "conceptual fusion" with the technocratic model will take place "with cognitive distress" (p. 239). In Adina's case, the question is not one of adapting to a technocratic model, but rather of adapting to a model that is not technocratic enough. Adina was socialized in a culture in which medicalized childbirth and epidural anesthesia during labor are the norm. When she is unable to obtain what she sees as appropriate care, she becomes distressed and this distress overwhelms her ability to cope.

[53] Adina also noted that the birth was progressing quickly and hospital staff told her that there was not time for her to receive an epidural.

Some might assume that the operative removal of the placenta would be more traumatic than the unmedicated vaginal birth of a healthy child, but Adina's experience tells us otherwise. She experienced both elements of her birth – the "natural" and the "medicalized" – as traumatic, but in reading her e-mail message it seems that the "very simple operation – only 10 minutes under full anesthetic" to remove the placenta was less challenging to her worldview than the unmedicated birth which she described as "this nightmare called delivery." Making assumptions about which obstetrical procedures are likely to cause trauma fails to recognize that trauma depends largely on the degree to which (1) the actual birth experience corresponds with already held beliefs and (2) the woman feels a sense of cultural alignment between her preexisting worldview and the maternity care system in which she finds herself.

Gerda: I Hope Quickly To Forget It

Gerda is Swedish and her partner is Dutch. They are both professional horse riders. When we met, Gerda was 30 years old, had been living in the Netherlands for 11 years, and was pregnant with her first child. She had a normal pregnancy, but was seeking a planned induction because her partner was competing in the world finals of a horse riding competition and was scheduled to be out of the country for at least one week around her due date.

When Gerda first described the situation to one of her midwives, I was surprised that the midwife was so quick to suggest induction. I was equally surprised when Gerda so thoroughly embraced the idea. I had assumed that she had a "natural" orientation to

pregnancy and birth. As I got to know her, I learned that she did indeed describe childbirth as a natural process. But, like for Adina, a belief in the naturalness of birth did not preclude an understanding of birth as a medical event.

During our prenatal interview, I asked Gerda about her decision regarding place of birth. She had been breeding horses for years and likened human birth to the foaling she had seen. Nonetheless, she wanted to birth in the hospital. She even considered requesting a cesarean section. She said,

> Gerda: I have decided to birth in the hospital, but it is written in the books that you can change your mind – up until the last minute you can change your mind. It will have to come fast for me to give birth at home. I don't think I will change. In Sweden, I don't think anyone births at home.
>
> Rachael: Almost no one. It is a big difference (compared to the Netherlands).
>
> Gerda: In Sweden you can, I believe, also choose between a normal birth or a c-section. I have a friend in Denmark, there you can definitely choose. She asked me, "What are you going to choose?" But I don't think such a choice is possible in the Netherlands.
>
> Rachael: Do you have a preference?
>
> Gerda: My mother had two c-sections. Her pelvis was too small. They didn't discover that in time when I was born. That almost went completely wrong. She was very, very worried about me. Therefore, I thought hard about it, but … better the normal way. There are fewer complications. It is natural. It heals better. Like with horses. I have never been to another birth, except by horses. It will be a little bit the same, I think.

She repeated this comparison to foaling throughout the interview and continued to describe childbirth as natural. When I asked whether she took one of the prenatal education classes offered in the community, she said,

> I've heard about them, but I don't have any interest in courses. It seems so strange to follow a class. It is a natural process. I have been so frequently present at the birth of a horse. I have a bit of an idea about how it goes.

And when I asked about her plans for breastfeeding, she replied,

> Gerda: I have decided to breastfeed for the first month, then see how it is to combine. If I travel a lot, it will be onerous. I can't get my breast out at a competition – with all the people around me. I will see how easy it is. If it works, perhaps I'll do it longer. I have the idea that it is most important in the beginning. That is the same with horses. The first 48 hours. The first feedings.
>
> Rachael: The colostrum.
>
> Gerda: It is very important. I have the idea that we are a little bit the same ...

After our pre-birth interview, I continued to attend Gerda's prenatal appointments at the midwifery clinic as well as her obstetric consultations (regarding induction) at the hospital. As the date for the induction approached, I worried. I worried that the induction would lead to an instrumental delivery or a c-section. I worried that surgical interventions would be traumatic for her. What did not occur to me at the time is that the trauma would be caused not so much by excessive intervention as by a paucity of intervention.

On the first day of the induction, Gerda called the hospital labor and delivery unit to see if there was a room available for her. There was. She arrived at the hospital around 7am. The induction began with the insertion of a prostaglandin gel to "ripen" her cervix. We waited.

A cervical exam mid-day showed no change. Her cervix was still long, hard, and closed, but she was having contractions and back pain. The second line midwife overseeing her care consulted with a gynecologist. They decided not to apply more gel. Around 4pm, she was officially admitted to the hospital. I went home shortly thereafter.

The next day, I receive a text message saying, "Hi, I just want to let you know that I have gone home and they are going to wait on the induction. *Groetjes* (greetings), Gerda." A few days later, she sent another message, "I think it's going to work this time."

I rode my bike to the hospital. When I entered the room, Gerda was lying in bed with an epidural catheter in her back. She was wearing a blue hospital gown and was covered with blankets. The lights were low, the shades drawn. The room was warm and quiet. Her partner, Eddy, was sitting at a small table reading. I walked over to Gerda and put my hand on her leg.

> Rachael: Can you feel your legs?
>
> Gerda: My thighs, no. But my calves and feet, yes. The midwife thinks I can start pushing in about 30 minutes.

I was surprised to discover that Gerda was so far along. Half an hour later, a male *verloskundigen* (midwife) came in to do cervical check. A *basisarts in opleiding* (general practice resident) – also male – entered with him. There were handshakes all around. The two men then helped Gerda out of her gauze underpants and the midwife did a cervical exam. He told her to push with the next contraction. He instructed, "Pull your legs back – use your arms. Chin to chest. A deep breath and push. Another deep breath … push. A third … push." After three pushes, Gerda lay back down. Her face and chest were red from holding her breath and from exertion.

Over the course of the next hour, the midwife, the resident, and a *tweedelijns kraamverzorgende* (second line maternity care aide) coached Gerda with pushing – giving her positive affirmations. The maternity care aide said, "*Hartstikke mooi* (brilliant, beautiful). *Fantastisch* (fantastic)." The midwife said, "*Goed zo* (well done). *Heel goed* (very good). *Knap hoor* (clever hear)."

The room felt calm and still. Gerda gazed off at the television between contractions until the maternity care aide turned it off. I worried, at this point, that she

was dissociating from her body, from the experience – a sign of possible trauma (Kennedy and MacDonald 2002; Simkin and Klaus 2004).

During the pushing stage, Gerda developed a fever. The midwife explained,

> The fever may be caused by the epidural or by an infection and we can't know which. So, I'm going to give you an antibiotic. There isn't much use in administering the antibiotic intravenously because it is for the baby and the baby will be born before IV antibiotics can work. So, I'm going to give you something rectally. We'll wait and see whether the baby has a fever. If so, then the pediatrician will come and the baby may have to go to the pediatric department for observation.

About 40 minutes into pushing, the midwife left the room. He returned with an ultrasound machine. As he scanned Gerda's abdomen, he pointed to a monitor, "Here is the back …the neck." At exactly one hour of pushing he said, "There has been one hour of pushing. With the next contraction, I am going to inject some *verdoving* (local anesthetic) and make a *knip* (episiotomy)." He was matter-of-fact. There was no discussion. I felt caught off guard. I did not expect the transition from normal hospital delivery to surgical delivery to happen so abruptly.

With the next contraction, the midwife instructed the maternity care aide to apply firm fundal pressure (i.e. push hard at the top of the uterus to try to force the baby to move down). I felt a mounting tension in the room. This was no longer a straight-forward delivery.

Moments later, a young female *gynaecoloog in opleiding* (gynecology resident) entered the room. She had been called upon to use the ventouse or vacuum. The staff gynecologist came to oversee the procedure, but stayed quietly out of the way. The resident explained what she was going to do – "put gel on a vacuum cup, insert it, and use it to help the baby come out." The midwife added that he was going to push on Gerda's

belly with the next contraction. “Don’t be afraid about what you feel,” he told her. “Just push like you’ve been doing.”

Within ten minutes of the ventouse being applied, the baby was born. The gynecology resident placed the baby on Gerda’s chest, clamped the umbilical cord, and asked Eddy if he wanted to cut the cord. The placenta was delivered and a *kinderarts* (pediatrician) arrived to examine the baby. A pediatrician does not examine all babies. She was called in to consult on this case both because the ventouse was being used and because infection was suspected. Following her examination, the pediatrician said to Gerda,

> I know this is not how you hoped it would be, but the baby was breathing very quickly when I examined him and that, along with the fact that you had a fever, leads us to believe that he has an infection. So, we need to take him to the unit and start him on an *infus* (IV) of antibiotics.

The midwife completed his work – repairing Gerda’s perineum and removing the epidural catheter from her back – and left the room. Then, the maternity care aide moved in to do her job. “Shall we wash and clean you now?” she asked.

After she was bathed, Gerda asked me to bring her toiletry bag to her. She pulled out a brush and brushed her hair vigorously with sharp, quick strokes. She searched for perfume and sprayed herself a few times. It seemed brisk, harsh – like she was trying to brush off, cover up, or in some way cleanse herself of the experience.

After the birth, I went to the staff lounge to make myself a cup of tea. The midwife was watching the news and eating lasagna. We talked about the birth. I asked him to tell me more about what was going on during pushing. Why did he only allow one hour? Why didn’t he get Gerda into a different position? Why did he cut an episiotomy?

Why was the vacuum necessary? It was useful to hear about his decision-making process. As I came to understand during my time in the Netherlands, Dutch midwives (and the protocols within which they operate) have a much lower threshold and tolerance for abnormality than do U.S. direct-entry midwives.

Two days after the birth, I visited Gerda in the hospital. I sat down on her bed and asked her how she was feeling. She said, "It was terrible. I hope to quickly forget it. Next time I'm choosing a c-section." I felt sad as I left her room. Her words echoed in my head.

Marlies, the first line midwife who visited Gerda at home during the postpartum period, also noticed that she seemed traumatized. As we drove away from Gerda's house one day, Marlies said,

> I sense that she had a bad birth experience. She will need to talk about it at some time. Often that comes out in the *kraamperiode* (postpartum period), but if not … some other time. She hasn't brought it up so far. So, I will let it lie for now.

I talked to Gerda about the experience again during our postpartum interview. Her report was mixed.

> Rachael: I remember that the day after the birth you said, "That was terrible."
>
> Gerda: Yes. I found it dreadful. Awful ... When he came out, I thought that I was going to split open.

Later in the conversation she said, "Next time, I want a c-section. This, I dare not do again. Perhaps I'll change my mind, but I think not."

About her care providers she said, "There were so many people involved. Each time someone new came. Annoying. It seemed like the entire hospital staff was in my

room. I had hoped for a female midwife, but it was a man – two even." But she also expressed satisfaction with the hospital staff,

> The hospital was super comfortable, like being in a motel. The midwife at the hospital was also very caring. Everyone was very helpful. I could get an epidural. It is well-known that that is difficult in the Netherlands. I had expected that to be more difficult, but the midwife himself said that I must have an epidural.

When I suggested that she was not really given an option regarding the episiotomy, she replied, "I understood that it was really necessary. It also heals better. To split open is also not good ... A *knip* (episiotomy) seems better – a straight line is more easily sutured."

Many elements of Gerda's birth could be implicated in the development of birth trauma (e.g., a lack of female care providers, fear for the baby's health, and surgical intervention). It is likely that all these played a role – to some extent. I want to point out, however, that the parts of the birth that Gerda seemed most satisfied with were the medical interventions. She said, for example, that she thought an episiotomy was better than a perineal tear and she was happy and relieved when the midwife agreed that she should receive an epidural. She feared having a belief system that she saw as *ouderwets* (old-fashioned) imposed on her. She did not want to be forced to give birth unmedicated or at home. She wanted to have access to what she believed was appropriate care. She said many times, "I want to be able to choose." And next time, she may choose a c-section.

BIRTH TRAUMA: CORRESPONDENCE OF BELIEF AND EXPERIENCE

This part of the dissertation developed out of the experiences of four women in the study – two in the U.S. and two in the Netherlands – as well as my own. When I ask myself, "What makes these experiences traumatic?," I find two related, but distinct, disconnects. First, there is a structural disconnect – a lack of congruence between how we thought birth should be accomplished and what was possible in the locations in which we found ourselves. By "location" I mean the physical location (e.g., home or hospital), but also the cultural space and cognitive realm of possibility. Related, but distinct, there is an embodied disconnect – an incompatibility between how we envision the physical process of birth and what actually happens to and within our bodies. It is not the specific content of our beliefs or the objective obstetrical circumstances that matter most, but rather the degree of overlap between our preexisting worldviews, the belief systems that reign in the environments in which we ultimately give birth, and the content of our actual births.

Davis-Floyd (2003a) puts forth a similar theory. She writes that during pregnancy and birth, most women "feel a very real need for social acknowledgement and cultural alignment to give meaning and order to this often chaotic and bewildering experience" (p. 66). Cultural alignment is the sense that one's beliefs and actions are consistent with those most valued in society. I demonstrated in Part I of this dissertation that women planning home births in the U.S. experience a misalignment between their beliefs and those of dominant society. Similarly, the non-Dutch women who participated in the Netherlands portion of the study experienced cultural misalignment as they planned for non-medically indicated hospital births.

Further, Davis-Floyd (2003a) argues that when there exists a "conceptual conflict" between the belief system a woman espouses and the belief system imposed on her during birth, this conflict becomes "the basis of a profound alienation" (p.240). I find that there is a compounding of alienation that begins during pregnancy and continues through the birth. The women I write about in this chapter experience alienation first during pregnancy as a result of cultural misalignment and later during the birth due to structural and embodied disconnects. I do not argue that these fractures are the sole cause of birth trauma. They are, however, important sources to consider – especially among the populations examined in this study (i.e., U.S. women who experience home-to-hospital transport and non-Dutch women who desire medicalized childbirth.

CHAPTER 9
EPILOGUE

On the morning of Saturday, November 29th, 2008, I caught a bus to a shopping center in Eindhoven, The Netherlands. I was meeting a colleague for tea. On my way home, I stopped at an Etos drugstore and bought a *zwangerschapstest* (pregnancy test). I waited until Sunday morning to take the test. The result confirmed what I already knew – I was pregnant.

My husband, who had been in the Netherlands just a few weeks prior, was currently visiting his family in Canada. On this particular Sunday morning, he was scheduled to fly from Calgary to Winnipeg and then drive from Winnipeg back to Minneapolis. Because of the time difference, I would not be able to reach him until the evening. So, I took out my calendar and calculated my due date. Questions flooded my mind: Would I be able to finish my fieldwork? How late in pregnancy could I fly internationally? Did my health insurance cover maternity care? I busied myself by taking a walk, calling my insurance company, and looking up guidelines for air travel during pregnancy.

I had been giving lectures on home birth to undergraduate students and community groups in the U.S. for years. After every presentation, someone inevitably would ask, "What would you do? Would you give birth at home?" I usually answered, "Intellectually, I support home birth 100 percent, but I was raised in the U.S. and I am not immune to the cultural messages we have all received. To be honest, I don't know what I

would do." But once I was pregnant, the answer came easily. I wanted to give birth at home. I could not imagine it any other way.

The next question was, "Who will I ask to be my midwife?" Immediately, I started thinking about all the midwives I knew in Minnesota. For years I had thought that if I ever had the chance to give birth in the Netherlands – "where," as my history of medicine professor once said, "every civilized woman should be so lucky as to give birth" – I would take the opportunity without hesitation. But here I was – I lived in the Netherlands, I spoke Dutch, I worked with wonderful midwives every day – and, yet, I sat making plans to call a midwife in Minnesota.

When I finally reached Aaron on his cell phone, I asked, "Are you driving? Can you pull over?" He had just stopped at a gas station in North Dakota. He parked so that we could talk. "I have some news," I began ... He was very excited. I was filled with ambivalence.

Aaron is a college art instructor and while I was living in the Netherlands, he was working in Minnesota. We talked about the possibility of him flying to the Netherlands after he was done teaching in May. I was due in August and we could spend the summer together, have the baby, and then – with any luck – fly back to Minnesota in time for him to start the fall semester. "Wouldn't it be great if our baby was a Dutch citizen?," we thought. But we only half-heartedly considered this option. As tempting as it was, we wanted to be home – in *our* home – when the baby came.

Further, I had seen Dutch maternity care in action and I did not think it was for me. I knew that my prenatal appointments would be short and mostly clinical and that my

midwife – whoever she might be – would not have time to spend hours upon hours with me in labor. She would also be limited to a specific set of protocols regarding how long I could labor with ruptured membranes, for instance, or how long I could push before transferring to the second line. I knew that the range of normal (e.g., regarding the duration of first and second stage labor) had been shrinking in recent decades and that the rate of referrals from the first to the second line was quite high – especially for first time moms (Pasveer and Akrich 2001; Amelink-Verburg, Rijnders, and Buitendijk 2009). I was already imagining a transfer to the second line and I did not like the prospect.

Perhaps if I had grown up in the Netherlands, Dutch-style midwifery would work for me (though it is starting to work less and less even for Dutch women), but I was born and raised in the U.S. and I inhabited an American body. While I had held alternative – even radical – views about women's health since I was a teenager and had been working as a doula and a home birth researcher for years, I knew that my pregnant "bodymind" still required significant re-education. I needed hour-long prenatal appointments to discuss my fears and sense of alienation. I needed practices and rituals to teach me how to listen to, hear, and trust my body. I needed a midwife who could stay with me – continuously – for three days, if that is what it took. I needed a midwifery rooted in a discourse of empowerment, transformation, and resistance. In short, if I was to birth at home, I needed *American*-style midwifery.

So, it was decided. I would come home for a few weeks over Christmas and New Year's and Aaron and I would schedule our first prenatal appointment for when I was home. Then, Aaron would come back to the Netherlands over his spring break in March

and I would fly home after I finished my fieldwork in May or June. I knew that in planning a home birth in the U.S. I was voluntarily signing up for discrimination by mainstream health care providers, lack of social support from family members and friends, and significant cultural misalignment, but I did it anyway. Thus began my home birth journey and my efforts to cope with the consequences of my decision.

Individual versus Societal Responsibility for Positive Birth Outcomes

Our first appointment with our midwife, Rose, was in January 2009 when I was ten or eleven weeks pregnant. Rose came to our house; we talked, filled out health history forms, set up a payment schedule,[54] and signed an "Agreement of Informed Choice, Consent, and Disclosure." The agreement detailed, among other things, Rose's education and experience, the legal status of direct-entry midwifery in Minnesota, our responsibilities as parents, and the possibility of death or injury. The form we signed included a statement which read,

> We realize that there are risks associated with birth, including the risk of death or disability of either mother or child. We understand that a situation may arise, which requires emergency medical care and that it may not be possible to transport the mother and/or baby to the hospital in time to benefit from such care. We fully accept the outcome and consequences of our decision to have a licensed traditional midwife attend us during pregnancy and at our birth. We realize that our licensed traditional midwife is not licensed to practice medicine. We are not seeking a licensed physician or certified nurse midwife as the primary caregiver for this pregnancy, and we understand that our licensed traditional midwife shall inform us of any observed signs or symptoms of disease, which may require evaluation, care, or treatment by a medical practitioner. We agree that we are totally responsible for obtaining qualified medical assistance for the care of any disease or pathological condition.

[54] Services associated with home birth were not covered by our U.S. insurance plan and, even if they had been, Rose was not a licensed midwife and most insurance companies only offer reimbursement for services provided by a licensed caregiver.

Minnesota state law requires that this "notice" be included in the informed consent documents issued by licensed direct-entry midwives. Rose's documents clarified that she was not licensed nor was she seeking licensure, but that, nonetheless, she agreed that "you, the parents, take full responsibility." "This is your choice," the forms went on, "without support from the medical community." These weighty statements gave me pause.

A few days later, I returned to Europe. Over the next few months, I would think back on the consent form that Aaron and I signed during our first midwifery appointment. Why were we "totally" responsible in the U.S., but not in the Netherlands? Why couldn't we have the experience of shared responsibility in the production of a safe birth outcome? No one in the U.S. ever signs such a form when she registers with a physician and plans a hospital birth – during which death or disability of mother or child is, of course, also a possibility.[55] In the U.S., childbirth-related death or injury that takes place during planned home birth is constructed as the responsibility of the parents or, more accurately, of the mother – the result of her informed choice. Death or injury that takes place during planned hospital birth is a tragedy – everything possible having been done to prevent it.[56]

The idea that a woman could be solely responsible for the outcome of her (home) birth is almost unthinkable in the Netherlands where all births are constructed as societal accomplishments bearing societal responsibility. Safe birth – often narrowly defined as

[55] I know this first-hand. A few months after the birth of my son, I attended a funeral for a friend who died of complications from an amniotic fluid embolism during a planned hospital birth.

[56] Of course, care providers are demonized as well. In the home setting, midwives are depicted as unintelligent, irresponsible, and unskilled. Issues surrounding professional liability insurance for obstetrician-gynecologists and the changes they make to their practice out of fear of litigation highlight the issue from the perspective of the hospital-based provider (Klagholz and Strunk 2012).

birth which results in both a living mother and a living child – is understood to be the result of strong educational and health care systems, safe transportation and food supplies, environmental protection, and many other population-level factors. Of course, this is also true in the U.S., but it is not framed that way.

This is related, at least in part, to what Schalet (2011) identifies as different cultural logics operating in the two countries. U.S. culture, Schalet argues, is dominated by an *adversarial individualism* based on the ideal of complete self-reliance. Within this model, freedom and autonomy require a severing of bonds and a lack of dependency on others. Dutch culture, on the other hand, embraces an *interdependent individualism* in which autonomy is attained "in concert with ongoing relationships" and interconnection is a primary goal (p. 206). Schalet notes that both models have benefits and trade-offs, but she urges Americans to try on the Dutch model in recognition of the fact that all human beings need strong social bonds at both the interpersonal and societal levels. With respect to childbirth in the U.S., the choice to birth in the hospital and the rituals of medicalized birth tend to cement the woman-society bond and strengthen the sense of dependency – though not *inter*dependency (Davis-Floyd 2003a). Home birth, by contrast, follows the more adversarial path and demands that women sever ties – certainly at the societal level, but often at the interpersonal level as well.

Technology: Low and High, Embodied and Disembodied

At that same prenatal appointment in January 2009, I had a profound experience that informed my decision to forgo medical screening and imaging during pregnancy. After

sitting together at the dining room table for some time, Rose asked if we would like to hear the baby. She said, "You can't hear the heartbeat with a fetoscope[57] until 17 to 20 weeks, but we can probably hear it with my Doppler[58] today. Would you like to try?" I looked at Aaron and thought, "this may be his only chance to hear it until March." I turned to Rose, "I think we'd like to try."

We moved to the couch in our living room. I lay down on my back and unbuttoned my jeans. Rose put gel on the Doppler and then placed the monitor on my abdomen. We heard the placenta - whoosh, whoosh. We heard one of my arteries – a strong boom, boom, boom. Rose moved the Doppler around. She was not finding the fast fetal heart. Moving the Doppler … moving the Doppler. Aaron got up and went to the kitchen for something. I stared getting nervous. "Is it dead?" I thought. Completely forgetting that we had heard the placenta, I worried, "Did I ask Rose here for nothing? Maybe I'm not pregnant. Maybe I misread the pregnancy test?"

Aaron came back into the room. Rose said, "We'll find it." "Oh, that's okay if we can't find it today," I replied trying to sound nonchalant. "Okay, let you daddy hear your heartbeat," said Rose. After what felt like forever, we heard it – a fast thump, thump, thump, thump, thump, thump. "Thank God," I thought. "I *am* pregnant."

The experience was unsettling and, a few days later, I thought, "this is exactly what the literature says about how these technologies disembody the woman's experience and undermine what she knows to be true." I had felt nauseous for almost two months,

[57] A fetoscope, also called a fetal stethoscope or Pinard horn, is a relatively low-tech way to listen to the fetal heart and the placenta. Only the person using the instrument can hear the heart tones.
[58] A fetal Doppler uses ultrasound technology and speakers to produce an audible representation of the fetal heartbeat that can be heard by everyone in the room.

my breasts were sore, I was incredibly tired, and the list went on. Yet, in the span of two to three minutes, all of those bodily signs had been undermined. In the face of this medical technology, my embodied knowledge lost its standing. What was worse, it was not that my knowledge was not authoritative as far as my midwife or my husband was concerned. They did not question the pregnancy. The problem was that the technology caused *me* to question what *I* knew.

After that, I had to seriously consider the week twenty *structureel echo* or fetal morphology ultrasound that was standard procedure in the Netherlands. I had figured that I would just do it. Plus, that would be in March when Aaron was visiting. It would be perfect. Wouldn't it?

It took me weeks to decide. The likelihood of finding anything definitive that would change my plan to birth at home was extremely low, but the likelihood of undermining my confidence was high. Thinking through the decision, I discovered that I was not afraid of learning that about a fetal anomaly – that, I knew we could handle. What scared me was the blame – the fear that if I did not have the ultrasound and we found out at the birth that there was a problem, people would blame me. They would think, "You could have known. You *should* have known. If you weren't so pig-headed, so ideological, you could have done things differently." When I shared this with Aaron he said, "That's not a good reason to do it." He was right. So, when he came to the Netherlands in March, we had an appointment with my midwife, Charlotte, and we listened to the fetal heart with the Doppler, but we did not have the anomaly scan.

It was Aaron's support and that of my midwives – both Rose in Minnesota and Charlotte in the Netherlands – that allowed me to decline the ultrasound and other screening tests during pregnancy. Women need that kind of support – from family members, from friends, from caregivers, and, ideally, from society. They need people and maternity care models that hold open the cultural space to resist unwanted technological intrusion into pregnancy and birth.

Pasveer and Akrich (2001) put forth a novel hypothesis regarding the declining home birth rate in the Netherlands, a hypothesis that deeply informed my understanding of the dangers of relying on information produced by disembodying technologies. They identify two prenatal pathways. The first "consists of visits to a series of caregivers, of examinations by a variety of people and apparatuses residing in different and rather unconnected places, and of a number of dossiers that contain crucial information about the pregnancy but that are not 'owned' by the pregnant woman" (p. 238). The second involves "visits to a midwife, examinations within her practice, and a dossier that is carried around by the woman herself." In the U.S., only the first trajectory exists in the mainstream health care system. In the Netherlands, however, the two trajectories have operated side-by-side – until very recently.

Examining the website for the group practice I followed in the Netherlands illustrates how midwifery care is increasingly coming to resemble the first type of prenatal trajectory. In a section of the website titled *echoscopie* (ultrasound), the midwives describe their relationship with a local diagnostic center. They refer women to the center for four ultrasounds during pregnancy: one around eight weeks to determine

whether the pregnancy is intact, a second around twelve weeks to calculate a more precise due date, a third around twenty weeks to assess the structural development of the fetus, and a fourth around 36 weeks to determine the position of the fetus – the purpose of which is primarily to prevent surprise breech deliveries at home. In addition to these ultrasounds, the practice also regularly refers women to the center for first and second trimester tests that screen for chromosomal abnormalities. It is not difficult to see why Pasveer and Akrich argue that obstetrical trajectories that train women, their bodies, and their midwives to rely on externally-produced information are losing their desire and ability to birth at home in the absence of these kinds of "markers."

I was familiar with the work of Pasveer and Akrich many years before I became pregnant and after my first experience with Doppler monitoring I embraced their analysis even more thoroughly. They write that

> the increasing excorporation of the pregnancy, combined with the enlargement of the circuit within which knowledge of a specific pregnancy travels, and with the differences in kind between markers that can travel without a body and markers that cannot, will produce a woman-and-a-body that are increasingly unprepared, quite literally, to be able to be surprised by the event of home birth in which they must get along without this circuit of excorporated information about their bodies. (P. 238)

I knew that if I was going to develop the set of competencies necessary to birth at home – competencies that do not just come "naturally" – I was going to have to do everything in my power to keep my pregnancy embodied (i.e., to keep the knowledge about it *inside* my body).

A Vision of the Future of Childbirth in the U.S. and the Netherlands

I usually ended my post-birth interviews with some version of the following question: If you could redesign maternity care, what would you like to see? Participants in both the U.S. and the Netherlands were typically satisfied with the particular care they received and had few suggestions for improvement. I found this frustrating, but I suppose it should not have come as a surprise – as De Vries and colleagues (2001b) write, women's "knowledge of 'appropriate care' at birth is shaped almost entirely by the existing maternity system; if you ask women what kind of care they prefer, it is *no* surprise to learn they favor the type of care they are offered" (p. 244). Because of my academic training, my fieldwork, and my personal experience of being pregnant in two societies, I have access to multiple models of "appropriate care" and now it is my turn to try to provide an answer to the question I posed to so many others.

I will start with the Netherlands. There are many things that Dutch maternity care gets right. The distinction between midwives as experts in physiological birth and gynecologists as specialists in treating pathology is useful. Now, if only they can maintain their understanding of birth as fundamentally physiological instead of potentially pathological until proven otherwise. Obstetric cooperation networks, the Dutch obstetrics manual and indications list, and the system of professional in-home postpartum care are also outstanding accomplishments of the Dutch system.

Where I see the system failing is in the realm of relationship and on-going support during labor. Dutch women have historically been quite independent during labor, but cultural and structural changes have eroded their confidence – if not their ability. Medical

monitoring, pharmaceutical pain relief, and "relocated" home births are currently being offered as ways to deal with a new orientation to pain and a heightened sense of fear and uncertainty. I propose, however, that an alternative way to deal with pain, fear, and uncertainty is with a deeper relationship between woman and midwife – more time together prenatally and the assurance of the midwife's continuous presence from an earlier stage of labor than is currently possible. To this end, I argue that top priorities of policy makers and midwifery organizations should include (1) decreasing the full-time caseload for midwives, (2) incentivizing solo, duo, and, possibly, small (up to three midwives) group practices while looking for ways to make these arrangements sustainable, and (3) explicitly training midwives in how to provide emotional support during labor and offering remuneration for this work.

As far as U.S. maternity care is concerned, there are three things I am sure of. First, direct-entry midwifery should be decriminalized in all 50 states and the District of Columbia. There is room for continued discussion about whether or how it should be regulated, but the criminalization of direct-entry midwifery is unwarranted and unethical. Further, interprofessional working groups should be established to help midwives and physicians build rapport, respect, and agreement around how to work together both during pregnancy and in the case of birth center- or home-to-hospital transport.

Second, midwives should be the primary care providers for most pregnant women. In the U.S. there are many types of midwives – nurse-midwives, direct-entry midwives, those who are certified, and those who are not. By "midwives," I mean all these types. Like regulation, the question of how midwives should be trained and

credentialed is contentious. Currently, I lean toward the idea that there should be one midwife credential in the U.S., that it should be direct-entry (instead of requiring nursing training), and that it should be based on competency thereby allowing for multiple educational pathways. This would require significant collaboration and negotiation between the American College of Nurse-Midwives and the Midwives Alliance of North America. These two groups have a difficult past, but a recent joint conference gives me hope that such cooperation could be possible.

In any case, when a woman takes a home pregnancy test, I want her first call to be to a midwife. This means training far fewer obstetrician-gynecologists and far more midwives. Currently, there are 42,855 obstetrician-gynecologists in the U.S. and only 14,555 midwives – this includes 13,071 certified nurse-midwives, 84 certified midwives, and 1400 certified professional midwives (North American Registry of Midwives et al. 2008; American Congress of Obstetricians and Gynecologists 2011; American College of Nurse-Midwives 2013). The benefits of midwife-led care in the U.S. and around the world are well documented (for the most recent examples see Johantgen et al. 2012 and Sandall et al. 2013) and should be the norm.

Finally, U.S. home birth midwives, in part because they are locked out of the mainstream health care system, have developed a low-tech, high-touch, embodied obstetrical trajectory that trains women to read, interpret, and trust their bodies. Additionally, they offer a relationship-rich pathway with long prenatal appointments, deep interpersonal bonds, and continuous reassuring presence during labor. We need to protect and expand this trajectory as well as this model of continuity of care(r).

Jordan (1997) suggests that the modern world is not likely to go back to simpler technologies. Therefore, she tries to imagine how information obtained in high-tech ways could be coupled and reconnected with women's embodied knowledge. She asks,

> What if machine outputs and test results were to be made available and comprehensible to the woman and her nonspecialist attendants? What if labor rooms built in the possibility of transforming papered walls into large interactive information displays that could show, in graphic and comparative form, what is known about the state of the labor on the basis of physical examinations, monitor outputs, and test results? What if such displays were routinely used for generating conversations between the woman, the medical staff, and the woman's attendants …? (P. 73)

I am horrified by this image of the future. De Vries (2004) writes that "the door to the medicalization of birth … now seems impossible to close" (p. 242). I agree, but I think we at least have to try.

I am not naïve about the politics, the economics, or the culture of birth, but I join with so many others who have been fighting this battle for decades and I imagine an alternative future that does not involve large interactive displays, but rather intimate, dimly lit bathrooms in which women labor forehead to forehead with their partners, their midwives sitting quietly on the floor. As has been true for thousands of years, what women confront in birth is pain, fear, and uncertainty. Medical management and high-tech monitoring are human beings' most recent attempts to cope with these realities, but these methods are lacking. They have dangerous iatrogenic effects and they alienate us from ourselves and each other. We do not necessarily need to transform or transcend our relationship to the birth process. We can continue to see birth as painful and scary, but we need a different way of coping – a way that is grounded in human bodies and human connection.

I started this project by asking how it feels to give birth at home in the U.S. and the Netherlands. The research process taught me about stigma, coping, collaboration, the enactment of natural birth discourse, the organization of home birth when its outcomes are seen as a societal responsibility, and the experience of trauma. I thought I was going to the Netherlands to learn about a system that would provide a "credible challenge" (De Vries 2004:20) to the American way of birth and model for reform. In part, that is what I found, but I also discovered that an excellent model for the future of birth already exists in the U.S. I will continue to promote a low-tech, relationship-rich, embodied midwifery and to look both at home and abroad for ways to expand our collective view of what is good and appropriate care during pregnancy and birth.

BIBLIOGRAPHY

Aalten, Anna. 2004. "'The Moment When it All Comes Together:' Embodied Experiences in Ballet." *European Journal of Women's Studies* 11(3): 263-76.

Aetna. 2012. "Clinical Policy Bulletin: Home Births." Hartford, CT: Aetna Inc. Retrieved July 23, 2013 (http://www.aetna.com/cpb/medical/data/300_399/0329.html).

Akrich, Madeleine and Bernike Pasveer. 2004, "Embodiment and Disembodiment in Childbirth Narratives." *Body and Society* 10(2-3):63-84.

Allen, Sarah. 1998. "A Qualitative Analysis of the Process, Mediating Variables, and Impact of Traumatic Childbirth." *Journal of Reproductive and Infant Psychology* 16(2-3):107-131.

Amelink-Verburg, M.P., M. E. B. Rijnders, and S. E. Buitendijk. 2009. "A Trend Analysis in Referrals During Pregnancy and Labour in Dutch Midwifery Care 1988-2004." *BJOG: An International Journal of Obstetrics and Gynaecology* 116(7):923-32.

Amelink-Verburg, M. P., S. P. Verloove-Vanhorick, R. M. A. Hakkenberg, I. M. E. Veldhuijzen, J. Bennebroek Gravenhorst, and S. E. Buitendijk. 2008. "Evaluation of 280,000 Cases in Dutch Midwifery Practices: A Descriptive Study." *BJOG: An International Journal of Obstetrics & Gynaecology* 115(5):570–578.

American College of Nurse-Midwives. 2013. "Fact Sheet: Essential Facts about Midwives." Silver Spring, MD: American College of Nurse-Midwives.

American College of Obstetricians and Gynecologists. 2008. "ACOG Statement on Home Births." Washington, DC: ACOG.

American College of Obstetricians and Gynecologists. 2011. "Planned Home Birth – Committee Opinion No. 476." *Obstetrics and Gynecology* 117:425-8.

American Congress of Obstetricians and Gynecologists. 2011. "2011 Women's Health Stats and Facts." Washington, DC: American Congress of Obstetricians and Gynecologists.

American Gynecological Society. 1920. "Transactions of the American Gynecological Society, Volume 45." Philadelphia, PA: Wm. J. Dornan.

American Journal of Obstetrics and Gynecology. 2011. "Editors' Comments." *American Journal of Obstetrics and Gynecology* 204(4):e20.

American Medical Association. 2008. “Resolution 205: Home Deliveries.” Chicago: AMA.

American Psychiatric Association. 1980. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, DC: APA.

American Psychiatric Association, 2000. *Diagnosis and Statistical Manual of Mental Disorders IV-TR*. Washington, DC: APA.

Andersen, Louise B., Lisa B. Melvaer, Poul Videbech, Ronald F. Lamont, and Jan S. Joergensen. 2012. “Risk Factors for Developing Post-traumatic Stress Disorder Following Childbirth: A Systematic Review.” *Acta Obstetricia et Gynecologica Scandinavica* 91(11):1261-72.

Arms, Suzanne. 1998. *Giving Birth: Challenges and Choices*. DVD. Bayfield, CO: Birthing the Future.

Armstrong, Elizabeth M. 2003. *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder*. Baltimore, MD: Johns Hopkins University Press.

Arney, William Ray. 1982. *Power and the Profession of Obstetrics.* Chicago: University of Chicago Press.

Aune, Kristin. 2009. “Feminist Ethnography.” Pp. 309-12 in *Encyclopedia of Gender and Society* edited by Jodi O’Brien. Thousand Oaks, CA: Sage.

Avery, Melissa D., Owen Montgomery, and Emily Brandl-Salutz. 2012. “Essential Components of Successful Collaborative Maternity Care Models: The ACOG-ACNM Project.” *Obstetrics and Gynecology Clinics of North America* 39(3):423-34.

Ayers, Susan. 2007. “Thoughts and Emotions during Traumatic Birth: A Qualitative Study.” *Birth* 34(3):253–263.

Ayers, Susan, Andrew Eagle, and Helen Waring. 2006. “The Effects of Childbirth-related Post-traumatic Stress Disorder on Women and Their Relationships: A Qualitative Study.” *Psychology, Health and Medicine* 11(4):389-398.

Ayers, Susan, Stephen Joseph, Kirstie McKenzie-McHarg, Pauline Slade, and Klaas Wijma. 2008. “Post-traumatic Stress Disorder following Childbirth: Current Issues and Recommendations for Future Research.” *Journal of Psychosomatic Obstetrics and Gynecology* 29(4):240-50.

Ayers, Susan, Kirstie McKenzie-McHarg, and Andrew Eagle. 2007. "Cognitive Behaviour Therapy for Postnatal Post-traumatic Stress Disorder: Case Studies." *Journal of Psychosomatic Obstetrics and Gynecology* 28(3):177-84.

Ayers, Susan and Alan Pickering. 2001. "Do Women Get Posttraumatic Stress Disorder as a Result of Childbirth? A Prospective Study of Incidence." *Birth* 28(2):111-118.

Ayers, Susan and A. D. Pickering. 2005. "Women's Expectations and Experience of Birth." *Psychology and Health* 20(1):79-92.

Bais, Joke M. J., and Maria Pel. 2006. "The Basis of the Dutch Obstetric System: Risk Selection." *European Clinics in Obstetrics and Gynaecology* 2(4):209-12.

Baker, Jeannine Parvati. 2001. *Prenatal Yoga and Natural Childbirth*. 3rd edition. Monroe, UT: Freestone.

Ballard, C. G., A. K. Stanley, and I. F. Brockington. 1995. "Post-traumatic Stress Disorder (PTSD) after Childbirth." *British Journal of Psychiatry* 166:525-528.

Bastos, Maria Helena, Debra Bick, Catherine J. Rowan, Rhonda Small, Kirstie McKenzie-McHarg. 2009. "Debriefing for the Prevention of Psychological Trauma in Women following Childbirth (Protocol)." *Cochrane Database of Systematic Reviews*, Issue 2, Article No. CD007194.

Beck, Cheryl Tatano. 2004a. "Birth Trauma: In the Eye of the Beholder." *Nursing Research* 53(1):28-35.

Beck, Cheryl Tatano. 2004b. "Post-traumatic Stress Disorder due to Childbirth." *Nursing Research* 53(4):216-224.

Beck, Cheryl Tatano. 2006. "The Anniversary of Birth Trauma: Failure to Rescue." *Nursing Research* 55(6):381-390.

Beck, Cheryl Tatano, Robert K. Gable, Carol Sakala, and Eugene R. Declercq. 2011. "Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey." *Birth* 38(3):216-227.

Beck, Cheryl Tatano and Sue Watson. 2008. "Impact of Birth Trauma on Breastfeeding: A Tale of Two Pathways." *Nursing Research* 57(4):228–236.

Borst, Charlotte G. 1995. *Catching Babies: The Professionalization of Childbirth, 1870-1920.* Cambridge, MA: Harvard University Press.

Bradley, Robert A. 1965. *Husband-Coached Childbirth.* New York: Harper and Row.

Bradley, Robert A. 2008. *Husband-Coached Childbirth.* 5th ed. New York: Bantam.

Brazile, Monica. Forthcoming. "Natural Labor: Representations of Race, Gender and the Primitive Birthing Body." In *Challenging the Maternal Notion: Essays on an (Un)traditional Instinct,* edited by Alina M. Luna.

Buckley, Sarah. 2003. "Undisturbed Birth: Nature's Blueprint for Ease and Ecstasy." *Journal of Prenatal and Perinatal Psychology and Health* 17(4):261-88.

Buckley, Sarah. 2009. *Gentle Birth, Gentle Mothering*. Berkeley, CA: Celestial Arts.

Buckley, Sarah. 2010. "Sexuality in Labour and Birth: An Intimate Perspective." Pp. 213-34 in *Essential Midwifery Practice: Intrapartum Care*, edited by Denis Walsh and Soo Downe. Oxford: Wiley-Blackwell.

Buss, Fran Leeper. 2000. *La Partera: Story of a Midwife.* New ed. Ann Arbor, MI: University of Michigan Press.

Carver, Charles S. and Jennifer Connor-Smith. 2010. "Personality and Coping." *Annual Review of Psychology* 61:679-704.

Centraal Bureau voor de Statistiek. 1993. "Births by Obstetric Assistance and Place of Delivery, 1991." *Maandber Gezondheid* 12(2):19–31.

Centraal Bureau voor de Statistiek. 2013. "Bevalling, lengte en gewicht bij geboorte, borstvoeding." Den Haag/Heerlen, The Netherlands: CBS. Retrieved September 19, 2013 (http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=37302&D1=0-2&D2=a&VW=T).

Chervenak, Frank A., Laurence B. McCullough, Robert L. Brent, Malcolm I. Levene, and Birgit Arabin. 2013a. "Planned Home Birth: The Professional Responsibility Response." *American Journal of Obstetrics and Gynecology* 208(1):31-8.

Chervenak, Frank A., Laurence B. McCullough, Amos Grünebaum, Birgit Arabin, Malcolm I. Levene, and Robert L. Brent. 2013b. "Planned Home Birth in the United States and Professionalism: A Critical Assessment." *Journal of Clinical Ethics* 24(3):184-91.

Cheyney, Melissa. 2008. "Homebirth as Systems-Challenging Praxis: Knowledge, Power and Intimacy in the Birthplace." Qualitative Health Research 18(2): 254-67.

Cheyney, Melissa. 2011. *Born at Home: Cultural and Political Dimensions of Maternity Care in the United States.* Belmont, CA: Wadsworth.

Christiaens, Wendy, Anneleen Gouwy, and Piet Bracke. 2007. "Does a Referral from Home to Hospital Affect Satisfaction with Childbirth? A Cross-National Comparison." *BMC Health Services Research* 7:109.

Clarke, Adele E., Janet K. Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer R. Fishman. 2003. "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine." *American Sociological Review* 68:161-94.

College voor Zorgverzekeringen. 2003. "Verloskundig Vademecum: Eindrapport van de Commissie Verloskunde van het College voor Zorgverzerkeringen" [Dutch Obstetrics Manual: Final Report of the Obstetrics Commission of the College for Health Insurance]. Diemen, Nederland: CVZ.

Compas, Bruce E. Jennifer K. Connor-Smith, Heidi Saltzman, Alexandria Harding Thomsen, and Martha E. Wadsworth. 2001. "Coping with Stress during Childhood and Adolescence: Problems, Progress, and Potential in Theory and Research." *Psychological Bulletin* 127(1):87-127.

Conrad, Peter. 1975. "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior." *Social Problems* 23:12-21.

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18:209-32.

Conrad, Peter. 2005. "The Shifting Engines of Medicalization." *Journal of Health and Social Behavior* 46(1):3-14.

Conrad, Peter. 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders.* Baltimore, MD: Johns Hopkins University Press.

Conrad, Peter and Joseph W. Schneider. 1992. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia, PA: Temple University Press.

Corrigan, Patrick W., Fred E. Markowitz, Amy C. Watson. 2004. "Structural Levels of Mental Illness Stigma and Discrimination." *Schizophrenia Bulletin* 30:481-91.

Craven, Christa. 2010. *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement.* Philadelphia, PA: Temple University Press.

Davey, Mary-Ann and Margaret M. Flood. 2011. "Perinatal Mortality and Planned Home Birth." *American Journal of Obstetrics and Gynecology* 204(4):e18.

Davis, Elizabeth. 1981. *A Guide to Midwifery: Heart and Hands*. Santa Fe, NM: John Muir Press.

Davis, Elizabeth. 2004. *Heart and Hands: A Midwife's Guide to Pregnancy and Birth.* New York: Celestial Arts.

Davis, Elizabeth and Debra Pascali-Bonaro. 2010. *Orgasmic Birth: Your Guide to a Safe, Satisfying, and Pleasurable Birth Experience*. New York: Rodale.

Davis-Floyd, Robbie. 2001. "The Technocratic, Humanistic, and Holistic Paradigms of Childbirth." *International Journal of Gynecology and Obstetrics* 75:S5-S23.

Davis-Floyd, Robbie E. 2003a. *Birth as an American Rite of Passage*. 2nd ed. Berkeley, CA: University of California Press.

Davis-Floyd, Robbie. 2003b. "Home Birth Emergencies in the U.S. and Mexico: The Trouble with Transport." *Social Science and Medicine* 26:1911-31.

Davis-Floyd, Robbie. 2006. "ACNM and MANA: Divergent Histories and Convergent Trends." Pp. 29-80 in *Mainstreaming Midwives: The Politics of Change*, edited by Robbie Davis-Floyd and Christine Barbara Johnson. New York: Routledge.

Davis-Floyd, Robbie. 2011. "Preface." Pp. ix-xi in *Born at Home: Cultural and Political Dimensions of Maternity Care in the United States*, by Melissa Cheyney. Belmont, CA: Wadsworth.

Davis-Floyd, Robbie E., Lesley Barclay, Betty-Anne Daviss, and Jan Tritten. 2009. "Conclusion." Pp. 441-56 in *Birth Models that Work*, edited by Robbie E. Davis-Floyd, Lesley Barclay, Betty-Anne Daviss, and Jan Tritten. Berkeley, CA: University of California Press.

Davis-Floyd, Robbie E. and Carolyn F. Sargent. eds. 1997. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives.* Berkeley, CA: University of California Press.

De Bony, Jacqueline. 2004. "How to Reach Consensus from a Diversity of Viewpoints: The Dutch Decision Process as a Case Study." Paper presented at the Annual Meeting of the Academy of International Business Education, Stockholm, Sweden.

De Bony, Jacqueline. 2005. "Dutch Decision as Rooted in Dutch Culture: An Ethnologic Study of the Dutch Decision Process." Paper presented at the Annual Meeting of the European Group for Organizational Studies, Berlin, Germany.

De Jonge, Ank, Ruth Baron, Myrte Westerneng, Jos Twisk, and Eileen K. Hutton. 2013. "Perinatal Mortality Rate in the Netherlands Compared to Other European Countries: A Secondary Analysis of Euro-PERISTAT Data." *Midwifery* 29(8):1011-8.

De Vries, Raymond G. 1985. *Regulating Birth: Midwives, Medicine, and the Law.* Philadelphia, PA: Temple University Press.

De Vries, Raymond G. 1996. *Making Midwives Legal: Childbirth, Medicine, and the Law*. 2nd ed. Columbus, OH: Ohio State University Press.

De Vries, Raymond. 2004. *A Pleasing Birth: Midwives and Maternity Care in the Netherlands.* Philadelphia, PA: Temple University Press.

De Vries, Raymond, Cecilia Benoit, Edwin R. van Teijlingen, and Sirpa Wrede. 2001a. *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*. New York: Routledge.

De Vries, Raymond, Helga B. Salvesen, Therese A. Wiegers, and A. Susan Williams. 2001b. "What (and Why) Do Women Want?" Pp. 243-66 in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe* edited by Raymond De Vries, Cecilia Benoit, Edwin van Teijlingen, and Sirpa Wrede. New York: Routledge.

De Vries, Raymond and Simone E. Buitendijk. 2012. "Science, Safety and Place of Birth – Lessons from the Netherlands." *European Obstetrics and Gynaecology* 7(Suppl. 1):13-7.

De Vries, Raymond and Marianne Nieuwenhuize. 2011. "Commotie over babysterfte" [Commotion over Perinatal Mortality]. *Medisch Contact* 66(18):1126-30.

De Vries, Raymond, Therese A. Wiegers, Beatrijs Smulders, and Edwin van Teijlingen. 2009. "The Dutch Obstetrical System: Vanguard of the Future in Maternity Care." Pp. 31-53 in *Birth Models that Work*, edited by Robbie D. Davis-Floyd, Lesley Barclay, Betty-Anne Daviss, and Jan Tritten. Berkeley, CA: University of California Press.

Declercq, Eugene R., Carol Sakala, Maureen P. Corry, and Sandra Applebaum. 2006. "Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences." New York: Childbirth Connection.

Declercq, Eugene R., Carol Sakala, Maureen P. Corry, Sandra Applebaum, and Ariel Herrlich. 2013. *Listening to Mothers III: Pregnancy and Birth.* New York: Childbirth Connection.

DeLee, Joseph B. 1913. *The Principles and Practice of Obstetrics*. Philadelphia, PA: W. B. Saunders Company.

DeLee, Joseph B. 1920. "The Prophylactic Forceps Operation." *American Journal of Obstetrics and Gynecology* 1(1):34-44.

Dick-Read, Grantly. 1933. *Natural Childbirth*. London: Heinemann Medical Books.

Dick-Read, Grantly. 1972. *Childbirth without Fear: The Original Approach to Natural Childbirth*. 4th ed. New York: Harper and Row.

Doula.nl. 2013. "Welcome to the Dutch Doula-Website!" Retrieved September 13, 2013 (http://www.doula.nl/english.htm).

Downe, Soo. 2010. "Debates about Knowledge and Intrapartum Care." Pp. 13-29 in *Essential Midwifery Practice: Intrapartum Care*, edited by Denis Walsh and Soo Downe. Oxford: Wiley-Blackwell.

Downe, Soo, Kenny Finlayson, and Anita Fleming. 2010. "Creating a Collaborative Culture in Maternity Care." *Journal of Midwifery and Women's Health* 55(3):250-4.

Downe, Soo and Christine McCourt. 2008. "From Being to Becoming: Reconstructing Childbirth Knowledges." Pp. 3-28 in *Normal Birth: Evidence and Debate*, edited by Soo Downe. Oxford: Elsevier.

Effting, Maud. 2010. "550 dode baby's per jaar minder is haalbaar." *Volkskrant*, July 3. Retrieved October 24, 2013 (http://www.volkskrant.nl/vk/nl/2672/Wetenschap-Gezondheid/archief/article/detail/1010191/2010/07/03/550-dode-baby-s-per-jaar-minder-is-haalbaar.dhtml).

Elmir, Rakime, Virginia Schmied, Lesley Wilkes, and Debra Jackson. 2010. "Women's Perceptions and Experiences of a Traumatic Birth: A Meta-Ethnography." *Journal of Advanced Nursing* 66(10):2142-53.

England, Pam and Rob Horowitz. 1998. *Birthing From Within: An Extra-Ordinary Guide to Childbirth Preparation*. Albuquerque, NM: Partera Press.

EURO-PERISTAT Project, with SCPE, EUROCAT, and EURONEOSTAT. 2008. "European Perinatal Health Report." Retrieved November 14, 2012 (http://www.europeristat.com/).

Fineberg, Annette E. 2013. "One Obstetrician's Look at a Polarizing Birth Arena." *Journal of Clinical Ethics* 24(3):283-4.

Fiske, Susan T. 1998. "Stereotyping, Prejudice, and Discrimination." Pp.357-411 in *The Handbook of Social Psychology*, Vol. II, 4th ed., edited by Daniel T. Gilbert, Susan T. Fiske, and Garner Lindzey. Boston: McGraw Hill.

Fleming, Valerie E. M. 1998. "Women-with-midwives-with-women: A Model of Interdependence." *Midwifery* 14(3):137–143.

Fontein, J. A. C. A. Yvonne. 2010. "The Comparison of Birth Outcomes and Birth Experiences of Low-Risk Women in Different Sized Midwifery Practices in the Netherlands." *Women and Birth* 23(3):103-10.

Foucault, Michel. 1985. *History of Sexuality*, Vol. 1. 1st Vintage Books ed. New York: Vintage.

Foucault, Michel. 1995. *Discipline and Punish*. 2nd Vintage Books ed. New York: Vintage.

Fraser, Gertrude Jacinta. 1998. *African American Midwifery in the South: Dialogues of Birth, Race, and Memory*. Cambridge, MA: Harvard University Press.

Freeze, Rixa Ann Spencer. 2008. "Born Free: Unassisted Childbirth in North America." Ph.D. dissertation, Department of American Studies, University of Iowa, Des Moines.

Freidson, Eliot. 1970a. *Professional Dominance: The Social Structure of Medical Care.* Chicago: Aldine Publishing Company.

Freidson, Eliot. 1970b. *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York: Dodd, Mead and Company.

Frye, Anne. 2004. *Holistic Midwifery: A Comprehensive Textbook for Midwives in Home Birth Practice*. Vol. 2, *Care of the Mother and Baby from the Onset of Labor through the First Hours after Birth*. Portland, OR: Labrys Press.

Frye, Anne. 2010. *Holistic Midwifery: A Comprehensive Textbook for Midwives in Home Birth Practice*. Vol. 1, *Care During Pregnancy.* Revised ed. Portland, OR: Labrys Press.

Gamble, Jenny, Debra Creedy, Wendy Moyle, Joan Webster, Margaret McAllister, and Paul Dickson. 2005. "Effectiveness of a Counseling Intervention after a Traumatic Childbirth: A Randomized Controlled Trial." *Birth* 32(1):11-9.

Gamble, Jenny and Debra K. Creedy. 2009. "A Counselling Model for Postpartum Women after Distressing Birth Experiences." *Midwifery* 25(2):e21-e30.

Garthus-Niegel, Susan, Tilmann von Soest, Margarete E. Vollrath, and Malin Eberhard-Gran. 2013. "The Impact of Subjective Birth Experiences on Post-traumatic Stress Symptoms: A Longitudinal Study." *Archives of Women's Mental Health* 16(1):1-10.

Gaskin, Ina May. 1990. *Spiritual Midwifery*. 3rd ed. Summertown, TN: The Book Publishing Company.

Gaskin, Ina May. 2003. *Ina May's Guide to Childbirth*. New York: Bantam.

Gaskin, Ina May. 2011. *Birth Matters: A Midwife's Manifesta*. New York: Seven Stories Press.

Gleick, James. 1987. *Chaos: The Amazing Science of the Unpredictable.* New York: Viking Penguin.

Goer, Henci. 1995. *Obstetric Myths versus Research Realities: A Guide to the Medical Literature.* Westport, CT: Bergin and Garvey.

Goffman, Erving. 1959. *The Presentation of Self in Everyday Life.* New York: Doubleday.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster.

Green, Josephine M., Vanessa A. Coupland, and Jenny V. Kitzinger. 1990. "Expectations, Experiences, and Psychological Outcomes of Childbirth: A Prospective Study of 825 Women." *Birth* 17(1):15-24.

Green, Kyle. 2011. "It Hurts So It Is Real: Sensing the Seduction of Mixed Martial Arts." *Social and Cultural Geography* 12(4):377-96.

Griesemer, Lynn M. 1998. *Unassisted Homebirth: An Act of Love.* Charleston, SC: Terra.

Grosz, Elizabeth A. 1994. *Volatile Bodies: Toward a Corporeal Feminism*. Bloomington, IN: Indiana University Press.

Gyte, Gillian M. L., Miranda J. Dodwell, and Alison J. Macfarlane. 2011. "Home Birth Metaanalysis: Does it Meet AJOG's Reporting Requirements?" *American Journal of Obstetrics and Gynecology* 204(4):e15.

Halifax, Joan. 2011a. “Inside Compassion: Edge States, Contemplative Interventions, Neuroscience.” Presentation at the Library of Congress, May 12, Washington, DC. Retrieved January 28, 2013 (http://www.loc.gov/today/cyberlc/feature_wdesc.php?rec=5225).

Halifax, Joan. 2011b. “The Precious Necessity of Compassion.” *Journal of Pain and Symptom Management* 41(1):146-53.

Hauck, Yvonne, Jennifer Fenwick, Jill Downie, and Janice Butt. 2007. “The Influence of Childbirth Expectations on Western Australian Women’s Perceptions of their Birth Experience.” *Midwifery* 23(3):235-47.

Hayden, Erika Check. 2011. “Home-birth Study Investigated: Criticism Led Journal to Re-examine Controversial Paper that Found Higher Death Rate in Babies Born at Home.” *Scientific American*, March 18. Retrieved July 31, 2012 (http://www.scientificamerican.com/article.cfm?id=home-birth-study-investigated).

Heatley, Michelle and Sue Kruske. 2011. “Defining Collaboration in Australian Maternity Care.” *Women and Birth* 24(2):53-7.

Herschderfer, K.C., K. C. A. Sneeuw, and S. E. Buitendijk. 2002. “Kraamzorg in Nederland: een landelijk onderzoek: eindrapportage inventarisatie- en evaluatieonderzoek” [Maternity Care Assistance in the Netherlands: A National Investigation: Final Report of Inventory and Evaluation Study]. Leiden, The Netherlands: TNO-PG.

Hingstman, Lammert. 1994. “Primary Care Obstetrics and Perinatal Health in the Netherlands.” *Journal of Nurse-Midwifery* 39(6):379-86.

Hingstman, Lammert and Raymond J. Kenens. 2010. *Cijfers uit de Registratie van Verloskundigen: Peiling 2010* [Figures from the Registration of Midwives: 2010]. Utrecht, the Netherlands: NIVEL.

Hinshaw, Stephen P. and Andrea Stier. 2008. “Stigma as Related to Mental Disorders.” *Annual Review of Clinical Psychology* 4:367-93.

Hodnett, Ellen D. 2002. “Pain and Women’s Satisfaction with the Experience of Childbirth: A Systematic Review.” *American Journal of Obstetrics and Gynecology* 186(5):S160-72.

Holloway, Kris. 2007. *Monique and the Mango Rains: Two Years with a Midwife in Mali*. Long Grove, IL: Waveland.

Holmes, Linda Janet. 1986. "African American Midwives in the South." Pp. 273-291 in *The American Way of Birth* edited by P. S. Eakins. Philadelphia, PA: Temple University Press.

Hutton, Eileen. 2011. "Keeping Women at the Centre of Care." Amsterdam: Vrije Universiteit. Retrieved October 4, 2012 (http://www.verloskunde-academie.nl/template/avag/binaryresource/pdf/Tekst%20oratie%20Keeping%20women%20at%20the%20centre%20of%20care%20Feb%2017%202011.pdf).

Ivry, Tsipy. 2010. *Embodying Culture: Pregnancy in Japan and Israel.* Newbrunswick, NJ: Rutgers University Press.

Jacoby, Ann. 1994. "Felt versus Enacted Stigma: A Concept Revisited: Evidence from a Study of People with Epilepsy in Remission." *Social Science and Medicine* 38(2):269-74.

Jasen, Patricia. 1997. "Race, Culture, and the Colonization of Childbirth in Northern Canada." *Social History of Medicine* 10(3)383-400.

Johantgen, Meg, Lily Fountain, George Zangaro, Robin Newhouse, Julie Stanik-Hutt, and Kathleen White. 2012. "Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008." *Women's Health Issues* 22(1):e73-e81.

Johnson, Christine and Robbie Davis-Floyd. 2006. "Home to Hospital Transport: Fractured Articulations or Magical Mandorlas?" Pp. 469-506 in *Mainstreaming Midwives: The Politics of Change,* edited by Robbie Davis-Floyd and Christine Barbara Johnson. New York: Routledge.

Johnson, Kenneth C. and Betty-Anne Daviss. 2005. "Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America." *British Medical Journal* 330:1416-1419.

Johnson, Kenneth C. and Betty-Anne Daviss. 2011. "International Data Demonstrate Home Birth Safety." *American Journal of Obstetrics and Gynecology* 204(4):e16-7.

Jones, Carl. 1988. *Mind over Labor: A Breakthrough Guide to Giving Birth*. New York: Penguin.

Jordan, Brigitte. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States.* 4th ed. Prospect Heights, IL: Waveland Press.

Jordan, Brigitte. 1997. "Authoritative Knowledge and Its Construction." Pp. 55-79 in *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* edited by Robbie E. Davis-Floyd and Carolyn F. Sargent.

Joseph, Stephen and P. Alex Linley, eds. 2008. *Trauma, Recovery, and Growth: Positive Psychological Perspectives on Posttraumatic Stress.* Hoboken, NJ: Wiley.

Jutel, Annemarie. 2009. "Sociology of Diagnosis: A Preliminary Review." *Sociology of Health and Illness* 31(2):278-99.

Karmel, Marjorie. 1959. *Thank You, Dr. Lamaze: A Woman's Experiences in Painless Childbirth.* New York: Harper and Row.

Kennedy, Holly Powell and Emily L. MacDonald. 2002. "'Altered Consciousness' During Childbirth: Potential Clues to Post Traumatic Stress Disorder?" *Journal of Midwifery and Women's Health* 47(5):380-2.

Kennedy, Holly Powell, Maureen T. Shannon, Usa Chuahorm, and M. Kathryn Kravetz. 2004. "The Landscape of Caring for Women: A Narrative Study of Midwifery Practice." *Journal of Midwifery and Women's Health* 49(1):14-23.

Kernick, David. 2002. "The Demise of Linearity in Managing Health Services: A Call for Post Normal Health Care." *Journal of Health Services Research and Policy* 7(2):121-4.

Khazan, Olga. 2011. "At-home Birth Has Pros and Cons." *Los Angeles Times,* July 8. Retrieved June 27, 2012 (http://articles.latimes.com/2011/jul/11/health/la-he-home-births-20110711).

Kirby, Russell S. and Jordana Frost. 2011. "Maternal and Newborn Outcomes in Planned Home Birth vs. Planned Hospital Birth: A Metaanalysis." *American Journal of Obstetrics and Gynecology* 204(4):e16.

Kitzinger, Sheila. 1992. "Birth and Violence against Women: Generating Hypotheses from Women's Accounts of Unhappiness after Childbirth." Pp. 63-80 in *Women's Health Matters*, edited by Helen Roberts. New York: Routledge.

Klagholz, Jeffrey and Albert L. Strunk. 2012. "Overview of the 2012 ACOG Survey on Professional Liability." Washington, DC: American Congress of Obstetricians and Gynecologists.

Klassen, Pamela E. 2001. "Sacred Maternities and Postbiomedical Bodies: Religion and Nature in Contemporary Home Birth." *Signs: Journal of Women in Culture and Society* 26(3):775-809.

Klaus, Marshall H., John H. Kennell, and Phyllis H. Klaus. 1993. "Mothering the Mother: How a Doula Can Help You Have a Shorter, Easier, and Healthier Birth." Cambridge, MA: Perseus Books.

Kleiner, Sibyl. 2009. "Thinking with the Mind, Syncing with the Body: Ballet as Symbolic and Nonsymbolic Interaction." *Symbolic Interaction* 32(3):236-59.

Kleinman, Arthur, Wen-Zhi Wang, Shi-Chuo Li, Xue-Ming Cheng, Xiu-Ying Dai, Kun-Tun Li, and Joan Kleinman. 1995. "The Social Course of Epilepsy: Chronic Illness as Social Experience in Interior China." *Social Science and Medicine* 40(10):1319-30.

Koninklijke Nederlandse Organisatie van Verloskundigen. 2012. "Verloskundige Samenverskinsverbanden" [Obstetric Cooperation Networks]. Utrecht, The Netherlands: KNOV. Retrieved October 26, 2012 (http://www.knov.nl/voor-anderen/samenwerking-in-de-verloskunde/verloskundige-samenwerkingsverbanden/).

Koninklijke Nederlandse Organisatie van Verloskundigen and Nederlandse Vereniging voor Obstetrie en Gynaecologie. 2007. "Gezamenlijk standpunt KNOV en NVOG inzake zogenaamde 'Verlengde arm' constructie" [KNOV and NVOG Joint Position on So-called 'Extented Arm' Construction]. Retrieved July 23, 2013 (http://www.knov.nl/docs/uploads/Verloskundig_vademecum_Gezamenlijk_standpunt_KNOV_en_NVOG_inzake_verlengde_arm.pdf).

Konner, Melvin and Marjorie Shostak. 1987. "Timing and management of Birth among the !Kung: Biocultural Interaction in Reproductive Adaptation." *Cultural Anthropology* 2(1):11-28.

Kooiker, Sjoerd en Lianne van der Wijst. 2003. *Europeans and Their Medicines: A Cultural Approach to the Utilization of Pharmaceuticals.* Dongen, The Netherlands: Social and Cultural Planning Office.

Kukla, Rebecca. 2010. "The Ethics and Cultural Politics of Reproductive Risk Warnings: A Case Study of California's Proposition 65." *Health, Risk, and Society* 12(4):323-34.

Kulick, Rachael B. 2006. "Occupational Professionalization." Pp. 563-566 in *Encyclopedia of Career Development* edited by Jeffrey H. Greenhaus and Gerard A. Callanan. Thousand Oaks, CA: Sage.

Kulick, Rachael B. 2009a. "Planned Parenthood Federation of America." In *Encyclopedia of Gender and Society* edited by Jodi O'Brien. Thousand Oaks, CA: Sage.

Kulick, Rachael B. 2009b. “Women’s Health Movements.” In *Encyclopedia of Gender and Society* edited by Jodi O'Brien. Thousand Oaks, CA: Sage.

Kulick, Rachael B. and Raymond de Vries. 2008. “Midwifery.” Pp. 219-226 in *Oxford Encyclopedia of Women in World History* edited by Bonnie G. Smith. New York: Oxford University Press.

Kuznia, Allison. 2013. “Midwife: A Look into the World of Homebirth Midwifery.” DVD. Minneapolis, MN.

Lake, Ricki and Abby Epstein. 2008. *The Business of Being Born*. DVD. Burbank, CA: New Line Home Entertainment.

Lamaze, Fernand. 1984. *Painless Childbirth: The Lamaze Method*. 1st Contemporary trade paperback edition. Chicago: Contemporary Books.

Lancet. 2010. “Editorial: Home Birth – Proceed with Caution.” *Lancet* 376:303.

Lawrence, Hal C., Joshua A. Copel, Dan F.O’Keeffe, William C. Bradford, Pamela K. Scarrow, Holly Powell Kennedy, William Grobman, Christina Johnson, Kathleen Rice Simpson, Audrey Lyndon, Karri Wade, Karren Peddicord, Debra Bingham, and Carl R. Olden. 2012. “Quality Patient Care in Labor and Delivery: A Call to Action.” *American Journal of Obstetrics and Gynecology* 207(3):147-8.

Lay, Mary M. 2000. *The Rhetoric of Midwifery: Gender, Knowledge, and Power*. New Brunswick, NJ: Rutgers University Press.

Lay, Mary M. and Kerry Dixon. 2006. “Minnesota Direct-Entry Midwives: Achieving Legislative Success through Focusing on Families, Safety, and Women’s Rights.” Pp. 261-288 in *Mainstreaming Midwives: The Politics of Change* edited by Robbie Davis-Floyd and Christine Barbara Johnson. New York: Routledge.

Lazarus, Richard S. and Susan Folkman. 1984. *Stress, Appraisal, and Coping*. New York: Springer.

Leavitt, Judith Walzer. 1986. *Brought to Bed: Childbearing in America 1750 to 1950.* New York: Oxford University Press.

Leavitt, Judith Walzer. 2009. *Make Room for Daddy: The Journey from the Waiting Room to the Delivery Room*. Chapel Hill, NC: University of North Carolina Press.

Leder, Drew. 1990. *The Absent Body*. Chicago: University of Chicago Press.

Leinweber, Julia and Heather J. Rowe. 2010. “The Costs of ‘Being with the Woman’: Secondary Traumatic Stress in Midwifery.” *Midwifery* 26(1):76-87.

Lewis, Jacqueline. 1998. “Learning to Strip: The Socialization Experiences of Exotic Dancers.” *Canadian Journal of Human Sexualtiy* 7(1):51-66.

Light, Donald W. 2000. “The Medical Profession and Organizational Change: From Professional Dominance to Countervailing Power.” Pp. 201-216 in *Handbook of Medical Sociology*, edited by C. E. Bird, P. Conrad and A. M. Fremont. Upper Saddle River, NJ: Prentice-Hall.

Light, Donald W. 2005. “Countervailing Power: The Changing Character of the Medical Profession in the United States.” Pp. 215-224 in *The Sociology of Health and Illness: Critical Perspectives*, edited by P. Conrad. New York: Worth.

Link, Bruce G. and Jo C. Phelan. 2001. “Conceptualizing Stigma.” *Annual Review of Sociology* 27:363-85.

Link, Bruce G., Lawrence Hsin Yang, Jo C. Phelan, and Pamela Y. Collins. 2004. “Measuring Mental Illness Stigma.” *Schizophrenia Bulletin* 30(3):511-41.

Litoff, Judy Barrett. 1978. *American Midwives: 1860 to the Present.* Westport, CT: Greenwood Press.

Litoff, Judy Barrett. 1986. *The American Midwife Debate: A Sourcebook on Its Modern Origins.* New York: Greenwood Press.

Logan, Onnie Lee and Katherine Clark. 1989. *Motherwit: An Alabama Midwife’s Story*. New York: Dutton.

Loller, Travis. 2008. “Pioneering Midwife Crusades for Natural Birth.” *USA Today*, February 2. Retrieved May 18, 2012 (http://www.usatoday.com/news/health/2008-02-23-childbirth_N.htm).

Lupton, Deborah. 2012. “‘Precious Cargo:’ Foetal Subjects, Risk, and Reproductive Citizenship.” *Critical Public Health* 22(3):329-40.

Maarse, H. and R. T. Meulen. 2006. “Consumer Choice in Dutch Health Insurance after Reform.” *Health Care Analysis* 14(1):37-49.

Maassen, Marloes S., Marijke J. C. Hendrix, Helena C. Van Vugt, Sabastiaan Veersema, Frans Smits, and Jan G. Nijhuis. 2008. “Operative Deliveries in Low-Risk Pregnancies in The Netherlands: Primary versus Secondary Care.” *Birth* 35(4): 277–282.

MacDorman, Marian F, Eugene Declercq, and T. J. Mathews. 2011. "United States Home Births Increase 20 Percent from 2004 to 2008." *Birth* 38(3):185-90.

MacDorman, Marian, Eugene Declercq, and Fay Menacker. 2011. "Trends and Characteristics of Home Births in the United States by Race and Ethnicity, 1990-2006." *Birth* 38(1):17-23.

MacDorman, Marian F., T.J. Mathews, and Eugene Declercq. 2012a. "Data Table for Figure 3. Percentage of Home Births by State, 2004 and 2009." *NCHS Data Brief* 84. Hyattsville, MD: National Center for Health Statistics. Retrieved October 18, 2013 (http://www.cdc.gov/nchs/data/databriefs/db84_tables.pdf).

MacDorman, Marian F., T.J. Mathews, and Eugene Declercq. 2012b. "Home Births in the United States, 1990-2009." *NCHS Data Brief* 84. Hyattsville, MD: National Center for Health Statistics.

MacEnulty, Pat. 2012. "Oh Baby: Ina May Gaskin on the Medicalization of Birth." *The Sun Magazine* 433. Retrieved May 29, 2012 (http://www.thesunmagazine.org/issues/433/oh_baby).

Major, Brenda and Laurie T. O'Brien. 2005. "The Social Psychology of Stigma." *Annual Review of Psychology* 56:393-421.

Marland, Hilary. 1993. "The *burgerlijke* Midwife: The *stadsvroedvrouw* of Eighteenth-Century Holland." Pp. 192-213 in *The Art of Midwifery: Early Modern Midwives in Europe* edited by Hilary Marland. New York: Routledge.

Martin, Emily. 2001. *The Woman in the Body: A Cultural Analysis of Reproduction*. Revised ed. Boston: Beacon Press.

Martin, Joyce, Brady E. Hamilton, Stephanie J. Ventura, Michelle J. K. Osterman, and T. J. Mathews. 2013. "Births: Final Data for 2011." *National Vital Statistics Reports* 62(1). Hyattsville, MD: National Center for Health Statistics.

Martin, Karin A. 2003. "Giving Birth Like a Girl." *Gender and Society* 17(1):54-72.

May, Vanessa. 2008. "On Being a 'Good' Mother: The Moral Presentation of Self in Written Life Stories." *Sociology* 42(3):470-86.

McCann, Lisa and Laurie Anne Pearlman. 1990. "Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims." *Journal of Traumatic Stress* 3(1): 131–49.

McCoy, Shannon K. and Brenda Major. 2003. "Group Identification Moderates Emotional Responses to Perceived Prejudice." *Personality and Social Psychology Bulletin* 29(8):1005-1017.

McGann, PJ and David J. Hutson, eds. 2011. *Advances in Medical Sociology*. Vol. 12, *Sociology of Diagnosis.* Bingley, UK: Emerald.

McKinlay, John B. and Lisa D. Marceau. 2002. "The End of the Golden Age of Doctoring." *International Journal of Health Services* 32(2):379-416.

McKinlay, John B. and John D. Stoeckle. 1988. "Corporatization and the Social Transformation of Doctoring." *International Journal of Health Services* 18(2): 191–205.

McNaughton, Darlene. 2011. "From the Womb to the Tomb: Obesity and Maternal Responsibility." *Critical Public Health* 21(2):179-90.

Menage, Janet. 1993. "Post-traumatic Stress Disorder in Women Who Have Undergone Obstetric and/or Gynaecological Procedures: A Consecutive Series of 30 Cases of PTSD." *Journal of Reproductive and Infant Psychology* 11(4):221-8.

Merry, Uri. 1995. *Coping with Uncertainty: Insights from the New Science of Chaos, Self-Organization and Complexity*. Westport, CT: Praeger.

Michal, Carl A., Patricia A. Janssen, Saraswathi Vedam, Eileen K. Hutton, and Ank de Jonge. 2011. "Planned Home vs Hospital Birth: A Meta-Analysis Gone Wrong." *Medscape News Today*, April 1. Retrieved January 8, 2012 (http://www.medscape.com/viewarticle/739987).

Midwives Alliance of North America. 2011. "Direct-Entry Midwifery State-by-State Legal Status." Retrieved January 7, 2012 (http://mana.org/statechart.html).

Miller, Amy Christine. 2010. "Experiences with Hospital Transport for Planned Home Births." Ph.D. dissertation, Department of Sociology, University of Oregon, Eugene.

Miller, Carol T. and Cheryl R. Kaiser. 2001. "A Theoretical Perspective on Coping with Stigma." *Journal of Social Issues* 57(1):73-92.

Mitford, Jessica. 1992. *The American Way of Birth.* New York: Dutton.

Mol, Annemarie. 2008. *The Logic of Care: Health and the Problem of Patient Choice.* New York: Routledge.

Moloney, Sharon. 2006. “The Spirituality of Childbirth.” *Birth Issues* 15(2):41-6.

Moran, Marilyn A. 1981. *Birth and the Dialogue of Love.* Leawood, KS: New Nativity Press.

Moran, Marilyn A. 1997. *Pleasurable Husband/Wife Childbirth: The Real Consummation of Married Love*. Leawood, KS: New Nativity Press.

Morgan, Laurie Annis. 2003. *The Power of Pleaseurable Childbirth.* Lincoln, NE: Writers Club Press.

Moscucci, Ornella. 2003. “Holistic Obstetrics: The Origins of ‘Natural Childbirth’ in Britain.” *Postgraduate Medical Journal* 79:168-73.

Moyzakitis Wendy. 2004. “Exploring Women’s Descriptions of Distress and/or Trauma in Childbirth from a Feminist Perspective.” *Evidence Based Midwifery* 2:8-14.

Murphy, Samantha. 2012. “Reclaiming a Moral Identity: Stillbirth, Stigma, and ‘Moral Mothers.’” *Midwifery* 28(4):476-80.

National Institute for Occupational Safety and Health. 2010. “NIOSH Hazard Review: Occupational Hazards in Home Healthcare.” Atlanta, GA: Centers for Disease Control and Prevention. Retrieved June 4, 2013 (http://www.cdc.gov/niosh/docs/2010-125/pdfs/2010-125.pdf).

National Institute of Mental Health. 2012. “Post-traumatic Stress Disorder among Adults.” Bethesda, MD: NIMH. Retrieved December 14, 2012 (http://www.nimh.nih.gov/statistics/pdf/NCS-R_data-PTSD.pdf).

Nelson, Margaret K. and Rebecca Popenoe. 2001. “Looking Within: Race, Class, and Birth.” Pp. 87-111 in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and* Europe, edited by Raymond de Vries, Cecilia Benoit, Edwin van Teijlingen, and Sirpa Wrede. New York: Routledge.

Nicholls, Karen and Susan Ayers. 2007. “Childbirth-related Post-traumatic Stress Disorder in Couples: A Qualitative Study.” *British Journal of Health Psychology* 12(4):491-509.

North American Registry of Midwives, Midwifery Education Accreditation Council, National Association of Certified Professional Midwives, and Midwives Alliance of North America. 2008. “Issue Brief: Certified Professional Midwives in the United States.” Lilburn, GA: North American Registry of Midwives.

Oaks, Laury. 2000. “Smoke-filled Wombs and Fragile Fetuses: The Social Politics of Fetal Representation.” *Signs: Journal of Women in Culture and Society* 26(1):63-108.

Odent, Michel. 1984. *Birth Reborn.* New York: Pantheon Books.

Odent, Michel. 2005. Testimonial. Retrieved February 23, 2012 (http://www.sarahbuckley.com/).

Odent, Michel. 2009. *The Functions of the Orgasms: The Highways to Transcendence.* London: Pinter and Martin.

Olde, Eelco, Onno van der Hart, Rolf Kleber, Maarten van Son. 2006. “Posttraumatic Stress Following Childbirth: A Review.” *Clinical Psychology Review* 26:1-16.

Park, Madison. 2010. “Home Births: No Drugs, No Doctors, Lots of Controversy.” *CNN*, August 9. Retrieved June 27, 2012 (http://www.cnn.com/2010/HEALTH/08/09/home.births.debate/index.html).

Pascali-Bonaro, Debra. 2008. *Orgasmic Birth: The Best-Kept Secret*. DVD. Westlake Village, CA: Seedsman Group**.**

Pasveer, Bernike and Madeleine Akrich. 2001. “Obstetrical Trajectories: On Training Women/Bodies for (Home) Birth.” Pp. 229-242 in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and* Europe, edited by Raymond de Vries, Cecilia Benoit, Edwin van Teijlingen, and Sirpa Wrede. New York: Routledge.

Pescosolido, Bernice A. 2014. “Stigma, Pedjudice, and Discrimination and Health Disparities.” *Annual Review of Sociology* 40.

Pescosolido, Bernice A., Steven A. Tuch, and Jack K. Martin. 2001. “The Profession of Medicine and the Public: Examining Americans’ Changing Confidence in Physician Authority from the Beginning of the ‘Health Care Crisis’ to the Era of Health Care Reform.” *Journal of Health and Social Behavior* 42(1):1-16.

Phelan, Jo C., Bruce G. Link, Ann Stueve, and Bernice Pescosolido. 2000. “Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and is it to be Feared?” *Journal of Health and Social Behavior* 41:188-207.

Pinel, Elizabeth C. 1999. “Stigma Consciousness: The Psychological Legacy of Social Stereotypes.” *Journal of Personality and Social Psychology* 76(1):114–128.

Pols, Hans. 2011. “Trouble in Paradise.” *O&G Magazine* 13(4):16-9.

Pope, Thaddeus Mason and Deborah Fisch. 2013. “Legal Briefing: Home Birth and Midwifery.” *Journal of Clinical Ethics* 24(3):293-308.

Radcliffe, Polly. 2009. “Drug Use and Motherhood: Strategies for Managing Identity.” *Drugs and Alcohol Today* 9(3):17-21.

Radcliffe, Polly. 2011. “Substance-Misusing Women: Stigma in the Maternity Setting.” *British Journal of Midwifery* 19(8): 497-504.

Rice, Hannah and Jane Warland. 2013. “Bearing Witness: Midwives Experiences of Witnessing Traumatic Birth.” *Midwifery* 29(9):1056-63.

Richland, Shea. 2008. “Birth Rape: Another Midwife’s Story.” *Midwifery Today* 85:42-3.

Right Livelihood Award Foundation. 2011. “Ina May Gaskin (USA).” Stockholm, Sweden: Right Livelihood Award Foundation. Retrieved May 29, 2012 (http://www.rightlivelihood.org/inamay_gaskin.html).

Rijnders, Marlies, Helen Baston, Yvonne Schönbeck, Karin van der Pal, Marianne Prins, Josephine Green, and Simone Buitendijk. 2008. “Perinatal Factors Related to Negative or Positive Recall of Birth Experiences in Women 3 Years Postpartum in the Netherlands.” *Birth* 35(2):107-16.

Ritzer, George. 1983. “The ‘McDonaldization’ of Society.” *Journal of American Culture* 6(1):100-7.

Rooks, Judith. 1997. *Midwifery and Childbirth in America*. Philadelphia, PA: Temple University Press.

Rosenthal, Sara M. 2006. “Socioethical Issues in Hospital Birth: Troubling Tales from a Canadian Sample.” *Sociological Perspective* 49(3):369-90.

Rothman, Barbara Katz. 1982. “Awake and Aware or False Consciousness? The Cooptation of Childbirth Reform in the United States.” Pp. 150-80 in *Childbirth: Alternatives to Medical Control*, edited by Shelly Romalis. Austin, TX: University of Texas Press.

Rothman, Barbara Katz. 1991. *In Labor: Women and Power in the Birthplace*. New York: Norton.

Rothman, Barbara Katz. 1993. “Going Dutch: Lessons for Americans.” Pp. 201-211 in *Successful Home Birth and Midwifery: The Dutch Model*, edited by Eva Abraham-Van der Mark. Westport, CT: Bergin and Garvey.

Sandall, Jane, Susan Bewley, and Mary Newburn. 2011. "'Home Birth triples the neonatal death rate': Public communication of Bad Science?" *American Journal of Obstetrics and Gynecology* 204(4):e17-8.

Sanders, Marianne. 2004. "Midwifery in the Netherlands: A Prospect for Future Development in Europe." *International Midwifery*, July 1. Retrieved November 6, 2012 (http://www.highbeam.com/doc/1G1-122580819.html).

Sandall, Jane, Hora Soltani, Simon Gates, Andrew Shennan, and Declan Devane. 2013. "Midwife-let Continuity Models versus Other Models of Care for Childbearing Women." *Cochrane Database of Systematic Reviews* 8, article number CD004667.

Sandström, Marianne, Britt Wiberg, Marianne Wikman, Anna-Klara Willman, and Ulf Högberg. 2008. "A Pilot Study of Eye Movement Desensitisation and Reprocessing Treatment (EMDR) for Post-traumatic Stress after Childbirth." *Midwifery* 24(1):62-73.

Sargent, Carolyn Fishel. 1989. *Maternity, Medicine, and Power: Reproductive Decisions in Urban Benin.* Berkeley, CA: University of California Press.

Sawyer, Alexandra and Susan Ayers. 2009. "Post-traumatic Growth in Women after Childbirth." *Psychology and Health* 24(4):457-471.

Saxell, Lee, Susan Harris, and Lehe Elarar. 2009. "The Collaboration for Maternal and Newborn Health: Interprofessional Maternity Care Education for Medical, Midwifery, and Nursing Students." *Journal of Midwifery & Women's Health* 54(4):314-20.

Sayce, Liz. 1998. "Stigma, Discrimination and Social Exclusion: What's in a Word?" *Journal of Mental Health* 7(4):331-43.

Scambler, Graham. 2007. "Sex Work Stigma: Opportunist Migrants in London." *Sociology* 41(6): 1079-96.

Scambler, Graham and Anthony Hopkins. 1986. "Being Epileptic: Coming to Terms with Stigma." *Sociology of Health and Illness* 8(1):26-43.

Scambler, Graham and Frederique Paoli. 2008. "Health Work, Female Sex Workers and HIV/AIDS: Global and Local Dimensions of Stigma and Deviance as Barriers to Effective Interventions." *Social Science and Medicine* 66(8):1848-62.

Schalet, Amy T. 2011. *Not Under My Roof: Parents, Teens, and the Culture of Sex.* Chicago, IL: University of Chicago Press.

Schmid, Verena and Soo Downe. 2010. "Midwifery Skills for Normalising Unusual Labours." Pp. 159-90 in *Essential Midwifery Practice: Intrapartum Care*, edited by Denis Walsh and Soo Downe. Oxford: Wiley-Blackwell.

Schneider, Joseph W. 1988. "Disability as Moral Experience: Epilepsy and Self in Routine Relationships." *Journal of Social Issues* 14(1):63-78.

Shanley, Laura. 1994. *Unassisted Childbirth*. Westport, CT: Bergin and Garvey.

Shetter, William. 2002. *The Netherlands in Perspective: The Dutch Way of Organizing a Society and Its Setting.* 2nd ed. Utrecht, The Netherlands: Nederlands Centrum Buitenlanders.

Suzuki, Shunryo. 1970. *Zen Mind, Beginner's Mind.* New York: Weatherhill.

Simkin, Penny and Phyllis Klaus. 2004. *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women.* Seattle, WA: Classic Day Publishing.

Slade, Pauline. 2006. "Towards a Conceptual Framework for Understanding Post-traumatic Stress Symptoms following Childbirth and Implications for Further Research." *Journal of Psychosomatic Obstetrics and Gynecology* 27(2):99-105.

Slade, P., S. A. MacPherson, A. Hume, and M. Maresh. 1993. "Expectations, Experiences and Satisfaction with Labour." *British Journal of Clinical Psychology* 32(4):469-483.

Smith, Benjamin Richard. 2007. "Body, Mind and Spirit? Towards an Analysis of the Practice of Yoga." *Body Society* 13(2):25-46.

Smith, Margaret Charles and Linda Janet Holmes. 1996. *Listen to Me Good: The Life Story of an Alabama Midwife.* Columbus, OH: Ohio State University Press.

Stein, Rob. 2012. "Home Births Grow More Popular in U.S." All Things Considered, National Public Radio, January 26. Retrieved June 27, 2012 (http://www.npr.org/blogs/health/2012/01/26/145880448/home-births-grow-more-popular-in-u-s).

Stramrood, Claire A.I., Janneke van der Velde, Bennard Doornbos, K. Marieke Paarlberg, Willibrord C.M. Weijmar Schultz, Maria G. van Pampus. 2012. "The Patient Observer: Eye-Movement Desensitization and Reprocessing for the Treatment of Posttraumatic Stress following Childbirth." *Birth* 39(1):70-6.

Sullivan, Deborah and Rose Weitz. 1988. *Labor Pains: Modern Midwives and Home Birth.* New Haven, CT: Yale University Press.

Szasz, Thomas. 1970. *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement.* New York: Harper and Row.

Thoits, Peggy. 1995. "Stress, Coping, and Social Support Processes: Where Are We? What Next?" *Journal of Health and Social Behavior* (Extra Issue):53-79.

Thomson, Gill and Soo Downe. 2008. "Widening the Trauma Discourse: The Link Between Childbirth and Experiences of Abuse." *Journal of Psychosomatic Obstetrics and Gynecology* 29(4), 268–273.

Thomson, Gill and Soo Downe. 2013. "A Hero's Tale of Childbirth." *Midwifery* 29(7):765-71.

Treffers, Pieter E. 1993. "Selection as the Basis of Obstetric Care in the Netherlands." Pp. 97-114 in *Successful Home Birth and Midwifery: The Dutch Model*, edited by Eva Abraham-Van der Mark. Westport, CT: Bergin and Garvey.

Trevathan, Wenda R. 1987. *Human Birth: An Evolutionary Perspective*. Hawthorne, NY: Aldine de Gruyter.

Trevathan, Wenda R. 1996. "The Evolution of Bipedalism and Assisted Birth." *Medial Anthropology Quarterly* 10(2):287-90.

Turner, Victor. 1969. *The Ritual Process: Structure and Anti-Structure.* Chicago: Aldine Publishing Company.

Tuteur, Amy. 2011a. "The Myths of Natural Childbirth." *Time*, October 12. Retrieved June 27, 2012 (http://ideas.time.com/2011/10/12/the-myths-of-natural-childbirth/).

Tuteur, Amy. 2011b. "The Skeptical OB Blog." Retrieved October 12, 2011 (http://www.skepticalob.com/).

Tuteur, Amy. 2011c. "What Ricki Lake Doesn't Tell You About Homebirth." *Time*, November 7. Retrieved June 27, 2012 (http://ideas.time.com/2011/11/07/what-ricki-lake-doesnt-tell-you-about-homebirth/).

United Nations Economic Commission for Europe. 2012. "Mean Age of Women at Birth of First Child by Country and Year." UNECE Statistical Division Database. Retrieved October 25, 2013 (http://w3.unece.org/pxweb/dialog/varval.asp?ma=04_GEFHAge1stChild_r&path

=../database/STAT/30-GE/02-Families_households/&lang=1&ti=Mean+age+of+women+at+birth+of+first+child).

U.S. Agency for Healthcare Research and Quality. 2010. *HCUPnet: Healthcare Cost and Utilization Project*. Rockville, MD: AHRQ. Retrieved October 3, 2012 (http://hcupnet.ahrq.gov).

Van Gennep, Arnold. 1960. *The Rites of Passage*. Chicago: University of Chicago Press.

Van Lieburg, M. J. van and Hilary Marland. 1989. "Midwife Regulation, Education, and Practice in the Netherlands during the Nineteenth Century." *Medical History* 33(3):296-317.

Van Teijlingen, Edwin R. 1990. "The Profession of Maternity Home Care Assistant and Its Significance for the Dutch Midwifery Profession." *International Journal of Nursing Studies* 27(4):355-66.

Van Teijlingen, Edwin. 2004. "Maternity Home Care Assistants in the Netherlands." Pp. 163-72 in *Midwifery and the Medicalization of Childbirth: Comparative Perspectives*, edited by Edwin van Teijlingen, George Lowis, Peter McCaffery, and Maureen Porter. Hauppauge, NY: Nova Science Publishers.

Vedam, Saraswathi, Laura Schummers, Kathrin Still, Judy Rogers, Michael C. Klein, Nichole Fairbrother, Safik Dharamsi, Robert Liston, Gua Khee Chong, and Janusz Kaczorowski. 2012. "The Canadian Birth Place Study: Describing Maternity Practice and Providers' Exposure to Home Birth." *Midwifery* 28(5):600-8.

Viisainen, Kirsi. 2000. "The Moral Dangers of Home Birth: Parents' Perceptions of Risks in Home Birth in Finland." *Sociology of Health and Illness* 22(6):792-814.

Wacquant, Loïc. 2006. *Body & Soul: Notebooks of an Apprentice Boxer*. New York: Oxford University Press.

Waldman, Richard, Holly Powell Kennedy, and Susan Kendig. 2012. "Collaboration in Maternity Care: Possibilities and Challenges." *Obstetrics and Gynecology Clinics of North America* 39(3):435-44.

Walsh, Denis and Soo Downe, eds. 2010. *Essential Midwifery Practice: Intrapartum Care*. Oxford: Wiley-Blackwell.

Wax, Joseph R., F. Lee Lucas, Maryanne Lamont, Michael G. Pinette, Angelina Cartin, and Jacquelyn Blackstone. 2010. "Maternal and Newborn Outcomes in Planned Home Birth vs Planned Hospital Births: A Metaanalysis." *American Journal of Obstetrics and Gynecology* 203(3):243.e1-8.

Wax, Joseph R., Michael G. Pinetter, and F. Lee Lucas. 2011a. "Reply." American Journal of Obstetrics and Gynecology 204(4):e18-20.

Wax, Joseph R., Michael G. Pinetter, and F. Lee Lucas. 2011b. "Reply to Zohar and De Vries." American Journal of Obstetrics and Gynecology 204(4):e14-5.

Weiniger, C. F., S. Ivri, A. Ioscovich, L. Grimberg, S. Evron, and Y. Ginosar. 2010. "Obstetric Anesthesia Units in Israel: A National Questionnaire-Based Survey." *International Journal of Obstetric Anesthesia* 19(4):410-6.

Wendland, Claire L. 2013. "Exceptional Deliveries: Home Births as Ethical Anomalies in American Obstetrics." *Journal of Clinical Ethics* 24(3):253-65.

Wertz, Richard W. and Dorothy C. Wertz. 1989. *Lying-In: A History of Childbirth in America*. Expanded ed. New Haven, CT: Yale University Press.

Wessel, Helen. 1963. *Natural Childbirth and the Christian Family*. New York: Harper and Row.

White, Gillian. 2007. "You Cope by Breaking Down in Private: Fathers and PTSD following Childbirth." *British Journal of Midwifery* 15(1):39-45.

Wiegers, Therese A. 1998. "Home or Hospital Birth: A Prospective Study of Midwifery Care in the Netherlands." *European Journal of Obstetrics and Gynecology and Reproductive Biology* 79:139-41.

Wiegers, Therese A. 2006. "Adjusting to Motherhood: Maternity Care Assistance During the Postpartum Period: How to Help New Mothers Cope." *Journal of Neonatal Nursing* 12(5):163-71.

Wiegers, Therese A. 2007. "Workload of Primary-Care Midwives." *Midwifery* 23(4):425-32.

Wiegers, Therese A. 2009. "The Quality of Maternity Care Services as Experienced by Women in the Netherlands." *BMC Pregnancy and Childbirth* 9(18).

Wiegers, Therese A. and Julia de Borst. 2013. "Organisation of Emergency Transfer in Maternity Care in the Netherlands." *Midwifery* 29(8):973-80.

Wiegers, Therese A. and Chantal W. P. M. Hukkelhoven. 2010. "The Role of Hospital Midwives in the Netherlands." *BMC Pregnancy and Childbirth* 10(80).

Wiegers, Therese A., Jouke van der Zee, and Marc J. N. C. Keirse. 1998a. "Maternity Care in The Netherlands: The Changing Home Birth Rate." *Birth* 24(3):190-7.

Wiegers, Therese A., Jouke van der Zee, and Marc J. N. C. Keirse. 1998b. "Transfer from Home to Hospital: What Is Its Effect on the Experience of Childbirth?" *Birth* 25(1):19-24.

Wiegers, Therese A., Jouke van der Zee, Jan J. Kerssens, and Marc J. N. C. Keirse. 1998c. "Home Birth or Short-Stay Hospital Birth in a Low Risk Population in the Netherlands." *Social Science and Medicine* 46(11):1505-11.

Wijma, Klaas, Johan Söderquist, and Barbro Wijma. 1997. "Posttraumatic Stress Disorder after Childbirth: A Cross Sectional Study." *Journal of Anxiety Disorders* 11(6):587-97.

Wilson, John P. and Rhiannon Brywnn Thomas. 2004. *Empathy in the Treatment of Trauma and PTSD*. New York: Brunner-Routledge.

Winchester, Daniel. 2008. "Embodying the Faith: Religious Practice and the Making of a Muslim Moral Habitus." *Social Forces* 86 (4):1753-80.

World Bank. 2013. "Population Density (people per sq. km of land area)." Washington, DC: World Bank Group. Retrieved April 18, 2013 (http://data.worldbank.org/indicator/EN.POP.DNST).

Wrede, Sirpa. 1997. "The Notion of Risk in Finnish Prenatal Care: Managing Risk Mothers and Risk Pregnancies." Pp. 133-80 in *Images of Women's Health: The Social Construction of Gendered Health*, edited by Elianne Riska. Åbo, Finland: Institute of Women's Studies at Åbo Akademi University.

Yang, Lawrence Hsin and Arthur Kleinman. 2008. "'Face' and the Embodiment of Stigma in China: The Cases of Schizophrenia and AIDS." *Social Science and Medicine* 67(3):398-708.

Yang, Lawrence Hsin, Arthur Kleinman, Bruce G. Link, Jo C. Phelan, Sing Lee, and Byron Good. 2007. "Culture and Stigma: Adding Moral Experience to Stigma Theory." *Social Science and Medicine* 64(7):1524-35.

Zadoroznyj, Maria. 1999. "Social Class, Social Selves, and Social Control in Childbirth." *Sociology of Health and Illness* 21(3):267-89.

Zohar, Noam and Raymond De Vries. 2011. "Study Validity Questioned." *American Journal of Obstetrics and Gynecology* 204(4):e14.

Zola, Irving Kenneth. 1972. "Medicine as an Institution of Social Control." *Sociological Review* 20(4):487-504.