ALL THAT "SANCTI-MOMMY BULLSHIT": UNRAVELING THE CULTURAL COMPLEXITIES OF "NATURAL" CHILDBIRTH

by

Catherine Faye Sturtevant

A thesis submitted in partial fulfillment of the requirements
for graduation with Honors in Anthropology

Whitman College
2013

Certificate of Approval

This is to certify that the accompanying thesis by Catherine Faye Sturtevant has been accepted in partial fulfillment of the requirements for graduation with Honors in Anthropology.

_____

Jason C. Pribilsky

Whitman College
May 8, 2013

Table of Contents

I. Introduction

By simply reviewing American childbirth statistics, it is evident that the American birthing culture assumes a dual-system of childbirth experiences; those births that are "natural" and those that are "medical". As will be examined in this thesis, a birth's location, attendant, and use of medical technology are primary indicators used by society to determine the "natural-ness" of a birth.

The 2010 birth statistics on the Center for Disease Control website reflect America's emphasis on the importance of these factors by providing easily accessible information on birth location, birth attendants, and frequency of medical interventions. To name a few, in 2010, 98.8% of all U.S. births occurred in a hospital, 7.6% of hospital births were attended by a certified nurse midwife, and less than 1% of U.S. births occurred in a home (Martin et al. 2012: 9). Most striking, however, are the U.S. cesarean section rate which in 2010 was 32.8% (Martin et al. 2012: 9) compared to 17.4% in Japan, from 2008 data (Gibbons et al. 2010: 18). Numerically, and at first glance, it seems that many American births are medicalized. Many of these births occur at a hospital, with a doctor, and sometimes require surgical intervention, three characteristics that are popularly associated with a "medical" birth. Still, there are other births which occur at a hospital with a midwife and have no medical interventions, so are these births considered "natural" (midwife-attended and no pain medications) or "medical" (hospital setting)? Can we even confidently categorize births in this way?

My research among expectant mothers, new mothers, and birth practitioners in Walla Walla, Washington has suggested that we cannot, with any accuracy, organize lived birth experiences into the overly simplistic categories of "natural" and "medical".

Even though popular and academic literature suggests that there is a dichotomy of "natural" and "medical" births (Ratcliffe 2002: 44), reality suggests that each birth is a unique experience of blending the various components of "natural" and "medical" categories to fit the needs of the individual mother and child. To limit the full complexity of these childbirths by forcing them into the categorical boxes of "natural" and "medical" births is wildly inaccurate and disrespectful to the mother's experience. After a semester of library research, I, like many inexperienced young researchers, fell prey to the convenience of the "natural" vs. "medical" childbirth dichotomy. As I headed into the community to speak with women about their birth experiences and opinions on midwifery care, I subconsciously began slotting their stories into "natural" and "medical" birth categories. If not for a short question at the bottom of my interview notes, "What does 'natural birth' mean to you?" I may have forever remained naïve to my inaccurate interpretations of these women's experiences. Thankfully, early on in my research, one informant, Danielle, confronted my narrow-mindedness by "[refusing] to put a definition on natural childbirth" (Danielle, new and expectant mother).

After this interview, I began to reflect on the framework used by modern, American birthing culture to understand childbirth and the care options available for women. I was curious about the different ways women did, or did not, define "natural" birth and how our general, cultural discourse on birth encouraged the use of this controversial term. In this thesis I present the various definitions of "natural" childbirth used by Walla Walla women and unravel how this terminology disempowers new mothers by isolating them from their own births and the births of other mothers in their community.

The Research Setting

All of my research was conducted among women who either lived in or came to Walla Walla, Washington, for their pre-natal care and childbirths. The rural city of Walla Walla is just over 12 square miles, with an approximate population of 30,000, and is located in the south-eastern quadrant of Washington State, only 15 minutes from the Washington-Oregon border. The population is over 80% white with a significant Hispanic population, 22% (a total over 100% is a result of the census participant's ability to list themselves as more than one race). 23% of the population is below the poverty level (Walla Walla QuickFacts). Supported by strong agriculture and tourism industries, Walla Walla is also home to the Washington State Penitentiary and three colleges. Along with the rest of eastern Washington, Walla Walla is generally considered to be politically conservative; however the seasonal population of college students does bring a liberal flavor to the city.

The majority of women in my study lamented the dearth of women's health care options available in Walla Walla. There are two religiously-affiliated hospitals in the city, Walla Walla General Hospital and Providence St. Mary Medical Center. Walla Walla General Hospital's Birth Center includes three MDs and one CNM (Certified Nurse Midwife) on their staff. Providence St. Mary's collaborates with the Walla Walla Women's Clinic and includes three MDs, two DOs (Doctor of Osteopathy), and two NPs on their staff. Walla Walla also has one private midwife who recently opened her homebirth practice in the summer of 2012. There are additional health clinics in Walla Walla, but these were not the primary services used by my participants.

Many Walla Walla women searched outside of Walla Walla for their childbirth care options. There are multiple out-of-town midwives that Walla Walla women have hired to do homebirths. Additionally, some women in my study traveled to Kennewick, Spokane, or Seattle, WA, for more specialized medical care such as NICU's, amniocentesis tests, and VBACs (Vaginal Birth After Cesarean). There are no free-standing birth centers in Walla Walla, so the women in my study were limited to hospital births or homebirths if they wanted to have their baby in the city. As I will discuss later in my thesis, the limited options for childbirth care in Walla Walla may influence the ways women defined "natural" childbirth in my study.

Methods

From January through March, 2013, I conducted 23 in-depth, structured interviews with expectant mothers, new mothers, and childbirth practitioners in the greater Walla Walla region. I consider my study blind to demographic factors such as race, class, or mother's age because I did not control for or collect this information from my participants. However, I did limit my study to mothers who were either currently pregnant and/or had given birth in the last three years. I chose do limit my study in this way because medical technology is rapidly developing and I wanted my research to reflect current understandings of childbirth. Changes in birth technologies could have a dramatic effect on the birth experiences of my participants, so I wanted to limit my study to women with more recent births. For women who had more than one birth/pregnancy within this three-year timeframe I asked questions about both of their births. If the mother had one birth/pregnancy within the three-year window and another outside of it, I clarified that for my study I was only interested in the most recent birth or current

pregnancy. However, I did encourage the woman to reflect on how this earlier birth may have influenced the decisions she made for the second one.

Research participants were recruited through a variety of personal contacts and family services in the Walla Walla area. From my thesis adviser's personal contacts I connected with an obstetrician and a registered lactation nurse at Providence St. Mary Medical Center. Through indirect personal contacts I connected with two midwives in Walla Walla; one has her own private practice, the other works at Walla Walla General Hospital. With the help of these four childbirth practitioners I distributed recruitment letters to new and expectant mothers in Walla Walla (a copy of this letter may be found in Appendix B). When possible I also interviewed these practitioners. Additional participants were recruited through the Whitman College faculty and staff e-mail listserv, a flyer at a local childcare center, and networking through personal contacts. Copies of these additional recruitment e-mails and advertisements are also included in Appendix B. These opportunistic interviews were completely confidential and voluntary. If a participant saw one of my recruitment letters and was interested in participating in my study she was encouraged to contact me directly via e-mail or telephone. I did not financially compensate my informants for their participation in my research. Before starting an interview, every participant completed a consent form acknowledging their understanding that the study was confidential, voluntary, and no compensation was provided in exchange for their participation.

Each interview lasted from 31 to 120 minutes depending on the amount of detail the participant chose to share and the conciseness of their responses. The mean duration of interviews was 70 minutes, specific interview lengths can be found in Appendix A.

Every interview was recorded and then analyzed for thematic content, which included transcribing pertinent portions of the interviews. All interviews were conducted in English with fluent English speakers, except for Sandra's. Sandra is a recent immigrant and her husband occasionally helped with translation during our interview. Interviews were conducted at a location of the participant's choosing. Most commonly, interviews were conducted at their homes, but I also met participants at their offices or coffee shops. One interview was conducted over the phone because the participant had moved away from Walla Walla shortly after her daughter's birth. Interviews included a series of open-ended questions about the mother's (or practitioner's) experiences with childbirth, their expectations for care providers, their relationship with the maternal community, and their reactions to the term "natural" childbirth (lists of specific interview questions can be found in Appendix C). In addition to these specific questions I asked a variety of follow-up questions on each topic to tease out the participant's exact meaning of certain words or to clarify ambiguous details. I also regularly restated the participant's responses which allowed them to elaborate on their responses themselves.

I began every interview by reminding my participant that I was a student conducting research for a senior thesis project and that I had never been pregnant before, so they were truly the experts in the conversation. I opened with this statement in order to empower the mother in her knowledge and offset the possible influence of the researcher-informant power dynamic. Whenever I had the opportunity, I tried to strengthen rapport with a participant by accepting a dinner invitation or casually discussing unrelated, participant-prompted topics during the interview. In their interviews, some participants chose to mention sensitive personal information that

colored their birth experiences, such as their sexual identity, medical history, or experiences with sexual assault. When these topics arose I reacted sympathetically to their experiences and acknowledged its significance in their childbirth, but I did not question them further about these possibly sensitive subjects. However, I think my participants' comfort mentioning these experiences during their interviews reflects my study's relaxed and safe atmosphere.

Limitations

Although I tried to use a variety of methods to recruit research participants, the majority of my participants came from two sources; my contact with a registered lactation nurse (33% of participants) and the Whitman College faculty and staff listserv (33% of participants). Since my study did not control for race, class, or age I do not think this limitation is catastrophic to the reliability of my data. However, there are a few general characteristics of these populations that I would like to discuss. Participants who were recruited through the lactation nurse at Providence St. Mary's were part of a new mother's support group that focuses primarily on breastfeeding. Very vaguely, a mother's choice to breastfeed is associated with a more "natural" outlook on birthing and parenting. Since a large portion of my participants came from this source, my study may be skewed in favor of women who give higher value to more "natural" childrearing methods. Additionally, the heavy participation from members of the Whitman faculty and staff may have skewed my study in favor of working mothers with higher levels of education. These women may have been more comfortable and familiar navigating medical resources when learning about their childbirth options. As a result, a woman recruited from the Whitman faculty and staff listserv could be considered a more

informed participant than a woman recruited from other sources. Furthermore, all of these women worked throughout their pregnancies and returned to work at the end of their maternity leave. This professional lifestyle may have influenced their selection of health care providers in favor of hospital care because it stereotypically requires less personal preparation time than a homebirth.

I mention the vague, stereotypical associations with these two majority groups of women in my study in order to be transparent in my research. I do not, however, consider these superficial associations in my analysis because I believe they are one-dimensional in light of the complex decision-making process that childbirth demands. This over-simplification and categorization of a mother's childbirth experience is the exact subject that I will dissect throughout the remainder of my thesis.

II. Defining "Natural" Childbirth

> *I have a really good example of a gal. First baby, kind of older parents. That, of course, wanted a natural birth and were determined to make sure that happened. But things just didn't go the way they planned, or the way I planned. She was exhausted and had lost quite a bit of sleep by the time she went into labor and so she wasn't able to handle her pain. If you're exhausted you can't cope with pain, it's just a bad equation. Then, if that's what's going on, your labor stops. You stop dilating, your contractions space out, and your body knows it needs rest so it shuts down labor. And so that happened with her…She was to the point that she was hysterical. She was upset because she knew she was losing her natural birth opportunity and she was upset because she was in so much pain, she just couldn't cope. So I said, "You know what, at this point we want to prevent a C-section, so let's go ahead and do an epidural and see what happens." And I was so pleasantly surprised. She fell asleep after the epidural. Slept hard and she woke up completely dilated and shortly after that she had the urge to push. I always turn the epidural off when they're ready to push…so I turned it off for her. And she just decided "Well since it's off I want it out." She pulled the line out and she wanted everything off. So we took her IV off…epidural came out, the medication wore off very quickly. I like a dangled position a lot for pushing, so she was in that position. She was totally naked and we were on the floor and she would push, push, push. And then she'd stand up and she'd smile and she'd walk around and then she'd feel another contraction come so she would squat back down and she would push. And I remember thinking "Wow this is a homebirth-like experience in the hospital" you know? And she had friends there and everybody was relaxed, a lot of long hair and beards, you know, and it was just. You know the nurses weren't real happy but they got into it after a while. And she delivered her baby…I told her, "you know what, you had a natural birth, you really, really did. You didn't have an epidural when you gave birth, you didn't have any medication, you didn't have an IV going, nothing. You had a natural birth. Maybe not your labor, but you had a natural birth." And I was just flying on a kite at that point, I was just so happy. And so you know, even in a not optimal situation it can turn out to be a really good situation.* – Elena, certified nurse midwife

I heard the above story within my first few days of interviewing pregnant women, new mothers, and childbirth practitioners in Walla Walla. At this point in my research I had become very comfortable with the natural birth vs. biomedical birth dichotomy that is emphasized in the anthropology of birth literature. So I was surprised by Elena's recollection of a client who used medical technology to achieve a natural birth which threw my previous understanding of "natural" childbirth to the wind. Her story echoes

some of the popular images of "natural" childbirth that I had discovered in my reading and from speaking with other participants. The "long hair and beards" of hippies, a squatting position, and a clear rejection of medical technology are all common themes in "natural" childbirth. However, this woman also used an epidural which classically falls outside the realm of "natural." Elena's story of a birth that was simultaneously "natural" and "biomedical," did not fit neatly into the classic categories presented by the literature. This left me unsure of my personal definition of "natural" childbirth. I knew "natural" childbirth would be a keyword in my research so I wanted to be clear in my definition, however when I asked Elena if she had a definition for "natural" childbirth, she responded, "a natural birth, there is no firm definition, no concrete definition of it. It can mean many different things."

For a term that lacks a standard definition, "natural" childbirth is used incredibly frequently in daily American life. Every mother that I spoke with was familiar with the term and had a variety of opinions on the subject. When I asked mothers about the connotations, definitions, or images that they associated with the term "natural childbirth" I received a wide variety of responses, from "I refuse to put a definition on natural childbirth" (Danielle, new and expectant mother) to "yes, natural childbirth, is there another way that we would advocate for?" (Pam, new mother). Often, when responding to my questions, women would put their personal definitions of "natural" birth within the context of what they perceived as the cultural definition of "natural" childbirth. Typically, women used this comparison to either justify their own personal definitions or express how they differed from the norm, thus acknowledging the complexities of

defining the term. As a result, my research yielded a wide variety of definitions for "natural" childbirth.

Using George Lakoff's theory of clustering cognitive models, which I will discuss further in the next section, I organized this set of definitions into three broad models. The first model defines "natural" birth as homebirth, the second defines an unmedicated, vaginal birth as "natural" birth, and the third believes that the term "natural" childbirth is superfluous because all births are "natural". However there is also a fourth model, the platonic form of Natural Childbirth, which women from all three cognitive models expressed when defining "natural" childbirth. This platonic model often included a brief story of a woman who gives birth alone in a natural environment. Through the lens of the platonic form of Natural Childbirth as an idealized definition of "natural" birth, I explore how this cognitive model cluster complicates our cultural definition and usage of the term "natural" childbirth. I conclude this chapter by clarifying the terminology I will use for the remainder of my thesis.

Clusters and Cognitive Models: Creating a Framework to Interpret the Definitions of "Natural" Childbirth

In his 1987 article, *Cognitive Models and Prototype Theory*, George Lakoff presents his theory of cognitive models to explain how multiple, correct definitions of one term may exist. We may apply Lakoff's theory of cognitive models to the term "natural" birth as he applies it to the term "mother" in his article. He first describes cognitive models as "idealized," meaning that "they may be defined relative to idealized circumstances rather than the circumstances as they are known to exist" (Lakoff 1999: 393). As I will argue in the next section, the platonic form of Natural Childbirth is an idealized cognitive model because it exists outside of the geography and time of modern

American culture. In order to navigate the idealized nature of some cognitive models, "some categories are characterized by *clusters* of cognitive models" (Lakoff 1999: 394). "Natural" childbirth is a term based on such an "experiential cluster" (Lakoff 1999: 395) and is composed of three cognitive models:

1. Homebirth model: "natural" birth is at home without medical intervention.
2. Unmedicated model: "natural" birth does not use medical interventions, may be at home or a hospital.
3. Inclusive model: all births are "natural" births; the term "natural" birth is obsolete.

Breaking a term down into the individual cognitive models that inform its definition is often necessary with complex cultural terms such as "mother" or "natural" childbirth because a single definition may not fully incorporate its multiple facets. Using the framework of idealized models, experiential clusters, and cognitive models, I will further explore the nuances included in the definition of "natural" birth among women in Walla Walla.

Squatting Down and Catching It Yourself: Natural Childbirth as an Idealized Cognitive Model

> *I've read stories where a woman, however many hundreds of years ago, was pregnant, leans over as she's in birth, puts her back up against a wall and gives birth to her baby and catches it herself. It wasn't painful for her. She didn't scream or yell or anything like that, she just needed to do, you know, needed to get the baby out or whatever. It's like, I wonder now how many kids she'd had before, you know?* – Lauren, new mother

> *The platonic form of natural childbirth would be like totally unassisted, right? Like the stories you hear of the women squatting on the floor in their cabin, and like pop a baby out.* – Julia, expectant mother

Many of the women I interviewed described a model of "natural" birth that was the "most natural" form of birth, or the platonic form of "natural" birth. This model of "natural" birth was constructed of fictional stories that women thought most exemplified a "natural" childbirth. These stories of Natural Childbirth[1] shared four common themes including: 1) isolation, 2) a squatting position, 3) a natural environment, and 4) a temporal/geographical distance from the modern, American birthing culture. Additionally, there was general agreement among women that Natural Childbirth is impractical and unattainable in modern American culture. In this section I outline the common ideas associated with Natural Childbirth and how they create an ideal "natural" birth experience that is rarely pursued in current American culture.

Isolation was a common theme among my participants who referred to the idealized cognitive model of a Natural Birth. In addition to the two quotations above, which both clearly articulate a sense of isolation with the phrases "totally unassisted" (Julia) and "catches it herself" (Lauren), the following women expressed the theme of isolation in their descriptions of Natural Birth:

Squatting in your, you know, bedroom by yourself. – Olivia, new mother

So I guess a completely natural birth would be just you. – Genevieve, new mother

This isolation means a separation from family, birth attendants, and the greater community during birth. Additionally, Natural Childbirth is isolating because a woman must reach internally for her power to labor and give birth to her child. Julia describes her anticipation for the experience of finding her internal power and connecting her body and spirit in new ways:

[1] I will refer to the concept of the platonic form for "natural" birth through capitalization and no quotation marks.

> *There's like a way that you strip away…You can't just give birth…without getting to this other place like psychologically or in your spirit or something…And I think I do sort of hope for that, to see something in myself that I didn't know was there before, or to connect my body and spirit…in a way that hasn't been connected or I hadn't realized was possible before.*

Olivia also comments on her definition of Natural Birth with: "like that is just amazing, you know". Pam reflects on the strength of women who have Natural Births, surmising that "women used to be much more strongly banded together and in charge of their reproductive passage". Collectively, my participants described that the physical and emotional isolation created by (and for) women in Natural Childbirth forced these women to find their inner birthing strength. Many of my participants seemed to be in awe of these women who tapped into their biological ability to labor and birth alone.

The squatting position and a natural setting are two more themes that were commonly associated with a Natural Birth. Julia's description of "the women squatting on the floor in their cabin" supports this characterization, along with the examples:

> *I think the most natural childbirth that I can think of is like, have you read* When the Spirit Catches You and You Fall Down*? You know that beginning part where she's like squatting and giving birth to her like fifth child, in the room with people there, and the kids don't even wake up until they hear the baby crying.* – Olivia, new mother

> *It means to me, natural childbirth is a woman squatting over a river and giving the birth and washing the baby off and going on her day, you know?* – Pam, new mother

The images of a cabin, a river, and the hut in *When the Spirit Catches You and You Fall Down* are characterized by these participants as a more natural environment than the American home or hospital, the setting of all of my participants' births. Additionally, the squatting position that they describe is considered a more biologically efficient birth position, taking advantage of gravity to move the baby down the birth canal. As Joyce

Roberts discusses, when left to find their own birthing position "some patients instinctively assume either a hands-and-knees or a squatting position at this time," which suggests that this instinctual position is more biologically effective (Warsh 2010: 149). The squatting position directly opposes the traditional hospital setting of a bed with stirrups that is the standard position for delivery in most American hospitals (Martin 1987: 161). Roberts suggests that the birthing position where women lie on their backs is more comfortable for doctors and observers, and she critiques biomedical birth for adopting a birthing standard that focuses on the needs of the practitioners rather than the patient (Warsh 2010: 150). The women in my study who described Natural Childbirth placed this type of birth as clearly rejecting and in opposition to the medicalization of birth through hospital technologies and procedures.

Traditionally people go to a hospital when they are ill. They expect to see a doctor who may use medical technology to supply a diagnosis and prescribe a treatment. Even though pregnancy is not a pathology, hospitals use this same procedure when approaching birth. Some of the most common medical procedures experienced by birthing mothers are; 1) pain medications, 2) vaginal extraction assistance such as episiotomies or vacuum suction, and 3) cesarean sections. All three of these technological interventions developed in the twentieth century as the hospital became the standard setting for birth (Rooks 1997). Even though, on the grand timeline of human existence, birthing in a hospital is a rather new characteristic of childbirth, the association of doctors or "male-midwives" with birthing tools arose 300 years earlier with the invention of the forceps (DeVries 1996). Many have marked the development of forceps technology as the "fatal blow to the female midwives" (Roush 1979: 34) because this

innovation was the first to delineate childbirth as belonging to the realm of men and medicine. For some, the forceps marks the beginning of the end of Natural Childbirth, a historical development further discussed in Appendix D.

The fourth characteristic of Natural Childbirth found in my study supports the historical claim that Natural Birth belongs in an earlier period. The temporal or geographical distancing of Natural Childbirth from modern, American birth is highlighted in these responses:

> *I've read stories where a woman, however many hundreds of years ago, was pregnant, leans over as she's in birth, puts her back up against a wall and gives birth to her baby and catches it herself.* – Lauren, new mother

> *"Kind of like, back in the pioneer days, when women only could deliver vaginally, without medication, and if they didn't I guess they would die, you know?* – Beth, new mother

> *Squatting in your, you know, bedroom by yourself…but it's not super practical here.* – Olivia, new mother

These women all agreed that theoretically Natural Childbirth is attainable, especially in other times and places, but that in the modern American birthing culture it is rare, if not impossible. In addition to the feeling of impossibility associated with Natural Birth there seems to be very little desire among women to have a Natural Birth even if these stories inspire them.

> *Like the stories you hear of the women squatting on the floor in their cabin, and like pop a baby out. And I'm not having that and I don't want it.* – Julia, expectant mother

> *Gives birth to her baby and catches it herself…I love the idea about it. Am I glad that I live in a society that can offer me options for pain management? Yes.* – Lauren, new mother

Women have created a distance between themselves and Natural Childbirth by classifying it as uncommon in mainstream birthing practices and undesirable for their

own births. However, this platonic form of "natural" childbirth inspires their own births as they try to approximate this platonic form. The idealized definition of "natural" childbirth informs women's decisions about their birth plan but rarely is Natural Childbirth the primary goal[2].

Hippies, Hospitals, and Hormones: Homebirth as "Natural" Birth

> *I think natural childbirth would probably be completely at home, no medication, no medical intervention. That's probably more what a natural childbirth would be…some people think of natural, like, some people look at it bad, like that's how hippies, or you know, would look at childbirth. But yeah I would say, probably having no technical intervention at all is what I would classify as a natural childbirth.* – Nancy, new mother

> *I don't think being in a hospital bed strapped up to monitors and all that stuff is natural even if you're not on drugs*. – Julia, expectant mother

> *The atmosphere of being in a hospital is enough to shut down the normal hormonal cascade that makes labor happen because of fear. You know women, people generally, have a fear of hospitals, some more than others. And even though they know that they want to be there, they know they have to be there. They might act like they're okay with it, but women have told me that deep-down they were scared to death. And epinephrine is your fight-or-flight hormone, and when it's expressed it shuts down oxytocin. And oxytocin is your ejection hormone. That's what makes the contractions happen and helps you push the baby out. And so, looking back during those years, I just felt like "wow" a lot of the interventions and C-sections that happened, I bet you anything, they wouldn't have happened if they were at a home birth, because they were scared.* – Elena, certified nurse midwife

The homebirth model in the experiential cluster of "natural" childbirth believes that a "natural" childbirth has no medical or technological interventions, including a hospital setting. Therefore for women in Walla Walla this definition of "natural" birth becomes a homebirth because there are no alternative birth centers in the city. In other

[2] Although it is rare, some women in the United States pursue an unassisted homebirth, a birth experience which highly resembles Natural Childbirth. In my study, one woman, Pam had an unassisted homebirth. Since her experience was so close to a Natural Birth, she had very different reactions as opposed to some of the other women. When considering Natural Birth Pam says, "I know that's possible" while some other women doubt its practicality and have no desire to pursue this type of birth.

studies, free-standing alternative birth centers have been proposed as desirable blends between holistic homebirth and technological hospital birth. For example, while Robbie Davis-Floyd is critical of hospital-based birthing centers because the home-like décor distracts from the fact that "the birthing center is still hospital territory," she does believe that "a very viable mediation of the technocratic/holistic, hospital/home opposition is provided by free-standing alternative birth centers" (Davis-Floyd 2003: 185-186). Although most women in my study were aware that free-standing birth centers existed, the lack access to this care in Walla Walla left them with two options: the home or the hospital. Therefore, while other studies discuss an out-of-hospital birth as a "natural" birth, in Walla Walla the only option for out-of-hospital birth is in the home.

I dwell on the limited options for out-of-hospital births in Walla Walla because this is the defining factor between the homebirth model and the unmedicated model, which will be discussed in the next section. Just as a square is a type of rectangle, but a rectangle need not be a square, the homebirth model is encompassed by the unmedicated model but an unmedicated birth is not necessarily a homebirth. Both the homebirth model and the unmedicated model define a "natural" birth as a vaginal delivery without any medical interventions. However, the proponents of the homebirth model include the hospital setting as a medical intervention, while the unmedicated model allows "natural" childbirth to occur in a hospital or a home. The homebirth model includes the hospital setting as a medical intervention because, as Elena described earlier, the hospital atmosphere has strong associations with fear and pathologies. Hormonally, as Elena explains, a hospital setting is enough to upset the biologically normal cascade that drives birth. Additionally, however, the culture of the hospitals and the medical field in general,

has values that, some argue, contradict with "natural" birth. For example, modern obstetrics is based on the belief that "during pregnancy and birth, the unusual demands placed on the female body-machine render it constantly at risk of serious malfunction or total breakdown" (Davis-Floyd 2003: 53). Even if no medications or interventions are actually used, the proponents of the homebirth model believe that this overarching ideology of birth is enough to place the hospital atmosphere outside of a "natural" childbirth.

Instead of using pain medications or anesthesia, homebirth and unmedicated births use alternative pain management techniques such as breathing exercises, massage, or water therapy. Charlotte describes how her neighbors prepared to manage their births in this way:

> *Well, I guess I think of, we had neighbors who had their whole childbirth planned…they had a midwife who was coming to the house…they had an actual birthing pool in their living room…it was a natural birth in the pool…I guess that's what people usually mean.*

Since the homebirth model and unmedicated model clearly overlap in many aspects, such as pain management techniques, I want to be very explicit that Walla Walla homebirth models are classified as a "natural" birth because a hospital setting is considered medical intervention and the home is the only out-of-hospital option available to women there. If a free-standing alternative birth center were opened in the city, this cognitive model may change accordingly.

Robbie Davis-Floyd's concept of the technocratic model exists in stark contrast to the homebirth model of "natural" childbirth as defined above. The technocratic model is based primarily on the metaphor of human as machine and that the male body is the better machine because of its consistency, predictability, straight lines, and steadfastness

against the pulls of nature (Davis-Floyd 2003: 52). This model emphasizes the "defectiveness and dangers" (Davis-Floyd 2003: 53) inherent to the female body and the need of male hospital procedures to control birth. The technocratic metaphor of the hospital as a factory is common, suggesting that women are cogs in a machine to be monitored and controlled rather than active leaders in their births (Davis-Floyd 2003). Davis-Floyd's research quotes a physician who explains that "there was a set, established routine for doing things, and the laboring woman was someone you worked around, rather than with" (Davis-Floyd 2003: 55). Women in my study were wary of the disconnect between the woman, her birth, and the birth attendant, which is a common theme in the technocratic model. Accordingly, a large component of the homebirth model addresses the direct involvement and leadership of the mother in the birth.

> *So people talk about having natural childbirth in a hospital, which I think is sort of a contradiction, because of a whole lot of things…Just all these ways that the rituals of hospitals take women out of what it actually means to be in their body or owners of it, which I would say is a more natural way to be.* – Julia, expectant mother

Julia discusses her concern of having women "taken out of their bodies" in a hospital setting. She mentions the rituals of hospitals, as I discussed above, with the technocratic model and the medical view of a woman's body as a machine to be fixed. Many women, such as Julia, are aware of the technocratic model of birth, even if they do not specifically refer to it. In reaction to the body-as-machine model for birth, the homebirth model of "natural" childbirth proposes a new method for birth:

> *My body gets to determine how the birth happens. So the pain that it produces and the ways I choose to respond to that pain are things that I get to decide. How long it takes. And even like, when I choose to push or, just all of that stuff. Instead of being affected by medications or influenced by medical professionals or whoever.* – Julia, expectant mother

The desire to have a body-driven birth experience without the influence of hospital procedures is a common theme for proponents of the homebirth model as being a "natural" childbirth. Emily Martin, a feminist anthropologist, suggests a "dance" as an alternative, empowering birth metaphor that encourages the woman's active involvement in her birth: "the mind and body, when aligned, dance in rhythm and unity, surrendering willingly to the new life coming forth" (Martin 1987: 158). As part of her analysis of birthing metaphors in *The Woman in the Body*, Martin also argues that the birthing dance "could well be taken as higher, more essentially human, more essentially cultural forms of consciousness and activity. Here perhaps are whole human beings, all their parts interrelated, engaged in what may be the only form of truly unalienated labor now available to us" (Martin 1987: 164). Martin works to empower women, like Julia, who want to allow their bodies to guide their birth processes without the alienation created by medical professionals or hospital procedures. By focusing on the biological beauty of homebirth rather than the flaws of hospital birth, Martin reframes our cultural understanding of the woman's role in birth. Consciously or not, the proponents of the homebirth model in my study have been influenced by Emily Martin's ideas and promote them by suggesting that a "natural" birth occurs outside of a hospital (so in Walla Walla, in the home) and is driven by the instinctual urges experienced by the woman herself.

"Just Pushing Through": Avoiding Pain Medication in an Unmedicated, "Natural" Birth

> *Natural birth can be anywhere over there* [referring to a continuum between homebirth and C-section*] where you're even in a hospital and as long as people aren't enforcing any changes on your labor, then that, to me, is still natural…letting you labor how you wish without medicine or interventions, to me, is still a natural birth. Epidural, not natural. Even taking the edge off with a little bit of Stadol, or something, not natural. You know even an IV with fluids, I*

> *don't think of as natural anymore, in my little view of the world.* – Whitney, registered lactation nurse
>
> *Natural childbirth to me can be at home or in a hospital, but it is you and your doctor and you having the baby and that's about it. I don't, I see no drugs or no other sort of interventions.* – Hannah, new mother
>
> *For some women it's not natural childbirth unless you have no IV, no nothing, nothing hooked up to you, absolutely nothing and that's what natural childbirth is. For me it's mostly the issue of pain management and what I was going to do to manage that without medication… I guess I mean unmedicated, not hooked up to anything, yelling and screaming, probably outside the hospital I guess. Not necessarily, I guess I would think of a natural birth in the hospital. Not a lot of medical intervention, no like suction or forceps or all of the other things that might become necessary when a baby is stuck. Just pushing through.* – Katie, new mother

The unmedicated model overlaps with the homebirth model in a variety of ways; both groups argue that "natural" birth is vaginal, unmedicated, and driven by the needs of the woman and the baby. However, the unmedicated model drifts from the homebirth model when discussing acceptable locations for a "natural" birth. As discussed previously, the homebirth model adamantly separates a "natural" birth from a hospital while the unmedicated model welcomes hospital birth into their "natural" birth model. This is because the crux of the unmedicated model's definition of "natural" childbirth is the presence or absence of pharmaceutical drugs as pain management techniques during labor and birth. With this definition, the location remains ambiguous. In my study, the unmedicated model was the model most commonly described by my participants. Eleven of my 23 participants defined "natural" childbirth as unmedicated. Of those eleven, six clearly stated that "natural" birth could be in a hospital, while the other five responses remained ambiguous about the location of a "natural" birth. This distribution of responses in favor of the unmedicated model is unsurprising. Other studies on the

anthropology of birth, such as Robbie Davis-Floyd's have found similar results that most women define "natural" birth as unmedicated.

Robbie Davis-Floyd attributes the popularity of the unmedicated model to Grantly Dick-Read's book *Children without Fear: The Principles and Practices of Natural Childbirth*. She argues that this work introduced the term "natural childbirth" and defined it as an "unmedicated and uninterfered-with labor and birth" (Davis-Floyd 2003: 162). Davis-Floyd attributes the responses that she received from women that "natural" childbirth is unmedicated birth to the influence of Dick-Read's 1944 book. Davis-Floyd discusses the definition of "natural" childbirth among her participants:

> *For most mothers, only analgesia/anesthesia or its absence seems to be the defining factor in whether a birth is "natural" or not; for many, even light analgesia during labor does not deprive them of the right to say they had "natural childbirth," as long as they were able to feel much of their labor and to push by themselves* (Davis-Floyd 2003: 162).

The emphasis on being "aware and awake" (Davis-Floyd 2003: 162) is critical to the women in Davis-Floyd's study. While my participants were more adamant about having no pain medication in a "natural" birth, regardless of the strength and dosage, both studies do suggest that among American mothers the unmedicated model may be the most common definition of "natural" childbirth.

When boiled down, the unmedicated model believes that a "natural" birth is a vaginal birth that could be completed outside of the hospital setting without technological intervention, yet it is accepted for women to choose a hospital setting. The women who opt to give birth in a hospital setting generally perceive this as a preventative measure. This is a reaction to the cultural belief that birth is unpredictable, has the potential to

become an emergency, and that obstetricians are the best equipped to manage these emergencies.

> *And for me I wanted to be able to give birth in a hospital the first time that I ever gave birth because if anything did go wrong I wanted the support staff of the hospital to be able to be there to help me or my baby.* – Lauren, new mother

> *If I could have gone through most of it at home and then have gone to the hospital once I was really close to having the baby. Just to have everyone there in that "in case" situation. But yeah, if I could do it without an epidural or without really any interventions, like an episiotomy or anything, that would have been like, yeah, my ideal situation.* – Zoey, new mother

Having medical staff and their technologies readily available during childbirth provided women with a sense of security, especially when considering their first birth. This is likely an impact of our culture's pervading assumption that if you are ill or in pain, you belong in the hospital.

> *When I was like a teenager and in my twenties I had had some episodes of severe menstrual cramps…I was in so much pain and I remember at the time feeling like kind of scared how much pain I was in and feeling like "I wish I was at the hospital, cause could something go wrong here?" You know? So I think from that I was like, when I'm in extreme pain I don't want to be at home. I want to be somewhere where if something is going wrong I can be whisked into the operating room for a C-section, not that that's ideal by any means, but I wanted to know that I had that, you know, that that was right there.* – Tami, new mother

For these women who were sensitive to the risks associated with childbirth, but still wanted the perceived benefits of "natural" birth, such as early infant-mother bonding and a less traumatic birth experience, an unmedicated birth in the hospital was an effective compromise. Among the women who advocate for unmedicated birth, either in the home or hospital, as the definition of "natural" childbirth, there remains an understanding that "it is possible in a hospital…but it's harder, you know" (Whitney, registered lactation nurse).

For women who defined "natural" birth by the unmedicated model there was a lot of discussion about how giving birth felt. Experiencing the whole range of emotions and physical obstacles brought on by being "awake and aware" in childbirth was very important for many of the mothers I interviewed. However, there were discrepancies among mothers about whether they classified these experiences as painful.

> *And I think that I just felt like my body was created to do that and…so I know that natural could mean just a vaginal delivery and for me I really just wanted to experience everything without medication and deliver vaginally.* – Beth, new mother

> *I guess I mean unmedicated, not hooked up to anything, yelling and screaming.* – Katie, new mother

> *You deliver a baby, without, essentially without any medical intervention. So drug-free birth. That means nothing that speeds it up, nothing that keeps you from feeling pain.* – Victoria, new mother

> *I think that for me, you know, the whole idea of a natural birth and not having any drugs involved was kind of this magical, or fairytale idea that it shouldn't be that painful.* – Lauren, new mother

Beth remains neutral about the pain included in the childbirth and expresses her desire to fulfill her biological role as a birther and not allow medication to dull that experience. However, by comparing Lauren's expectations for birthing pains with Katie and Victoria's, it is evident that there is no consensus among Walla Walla women about the intensity of pain in labor and birth. Katie and Victoria's descriptions both create negative images of unmedicated birth as painful experiences, while Lauren contradicts these descriptions with her comparison of birth to a fairytale. Since foregoing the use of pain medication as the primary criterion for a "natural" childbirth, women who adhere to the unmedicated model often spoke of their experiences with pain and pain management

techniques. The cultural significance of physically challenging births will be further explored in Chapter 2.

"It's *All* Natural": The Refusal to Distinguish Some Births as "Natural"

> *I don't think there is a natural childbirth. No I don't think there is any such thing as a natural childbirth…I hate, I actually take, I actually get a little ruffled at the term natural childbirth…I think it's something that we as a society need to get away from, saying that it's a natural childbirth. You can have one with little intervention, you can have a vaginal unassisted childbirth, or you can have a surgical one. To say something's natural, there is nothing unnatural about my son being born. It was surgical, but nothing unnatural.* – Irene, new mother

> *But, really, once you're in the midst of it, it's natural, whether you, you know, don't have medication, whether you have the epidural, whether you have something else, whether you have to have the C-section. The baby came out of you, so yes… my thought is that, once you have the baby here, it came out of your body, so that makes it natural, and the important thing is that you now have this little bundle. So even if it didn't go according, to your, you know, the way you had envisioned it, it's still a completely legitimate way to have a baby.* – Rebecca, new mother

The inclusive model of "natural" birth is rooted in the discomfort some women feel using the term "natural" childbirth. They argue that the term "natural" birth suggests that some births are "unnatural" which is offensive. As will be discussed in depth in Chapter 2, "natural" childbirth carries many judgmental connotations. Tami describes her reaction to this judgment:

> *I think what surprised me in my pregnancy was feeling like I was being judged by some people for having the baby in the hospital. That surprised me and made me upset for a few reasons. You know, first of all it's my choice and I don't feel like anyone should be judging that but also because, there are so many different variables that go into play when making a decision like that and for some people that is the best decision, for others it's not. But I think to also imply that somehow that childbirth experience is less natural than having it at home, I just don't think that's the case.* – Tami, new mother

Participants like Tami who believed in the inclusive model of "natural" childbirth often cited stories of exclusion or judgment based on their birthing method. They did not

suggest an alternative, less judgmental term for "natural" childbirth but instead desired that the category was expanded to include all births, because by their definition all births are "natural".

If our birthing culture considered all births to be "natural" through the inclusive model, the term would become redundant and obsolete. Rendering the term unnecessary is the primary goal of the proponents of the inclusive model because this would also forgo the judgmental attitudes that plague the maternal community in Walla Walla. Shifting our framework from categorizing childbirth to accepting multiple birth experiences would create more maternal support which Julia promotes because "every mother, or parents, like you know, you get to the birth of your child and you just have to do it, whatever that means". Proponents of the inclusive model argue that limiting the judgmental attitudes surrounding childbirth would reestablish the goal of childbirth as producing a healthy baby rather than navigating social pressures to fit into a certain frame.

The inclusive model emphasizes that the mother's creation of the baby and the baby's passage out of the mother's body makes any birth a "natural" birth. Rebecca introduces this idea with: "once you have the baby here, it came out of your body, so that makes it natural". Her opinions are echoed by Tami:

> *You know the baby is being born, that's natural no matter what…I do think that there is, I do believe in the term "medicalization of birth" I believe that that does happen, but I don't think that that childbirth is necessarily any less natural than any others.*

Unlike Rebecca, Tami does not completely remove categorical value from different birthing experiences, but she does explicitly remove the cultural value from the term "natural" birth by saying "that's natural no matter what". Together Rebecca and Tami highlight that the process of having a baby is biologically normal and therefore "natural,"

regardless of the birthing method. Among my participants, the inclusive model was the least common response. However, a much larger contingent of women expressed discomfort with the term "natural" childbirth. This tension will be explored in Chapter Two.

For those women who dislike the term "natural" childbirth and purposely avoid using it, their reactions to my use of the term were strongly negative.

> *No I don't think there is any such thing as a natural childbirth…I hate, I actually take, I actually get a little ruffled at the term natural childbirth.* – Irene, new mother
>
> *I prickle a little bit to it.* – Tami, new mother
>
> *That's kind of where you get your fire and brimstone ladies. I refuse to put a definition on natural childbirth.* – Danielle, new and expectant mother

Often the conversation became short and stinted after I mentioned "natural" childbirth. The term is evidently a very sensitive subject for many women, and this discomfort transcends the woman's personal experience with childbirth. Irene had a medically necessary C-section, Tami had a medicated, vaginal birth, and Danielle had a homebirth. Evidently uneasiness with the term "natural" birth is not limited only to those women who feel they exist outside of other mother's definitions of "natural," a sentiment common among mothers with surgical births. Even though many mothers mentioned that the term "natural" childbirth fostered judgment and pressure among women, very few mothers argued for a complete dismissal of the category. The inclusive model "purists," however, were adamant that the negative effects of this term were highly problematic and called for a discussion of the term's exclusivity which will be covered in the next chapter.

So What Is "Natural" Anyway?: Creating a New Framework to Discuss "Natural" Childbirth

As I have presented in this chapter, the term "natural" childbirth is defined by an experiential cluster including three cognitive models; 1) the homebirth model, 2) the unmedicated model, and 3) the inclusive model. In addition there is the idealized definition of "natural" childbirth, Natural Childbirth. Due to the complexity of the term "natural" childbirth I would like to clarify the terminology I will use for the remainder of my thesis. When possible I will use the explicit terms of homebirth, unmedicated birth, vaginal birth, surgical birth, and Natural Childbirth to be clear in my descriptions of birth experiences. However, when I use the term "natural" childbirth with quotation marks included, I am including all of the nuances and debates intrinsic to "natural" birth that have been teased out in this chapter. Purposefully understanding the layered complexity of the term "natural" childbirth is necessary in order to fully grasp the tense and complex atmosphere of the birthing culture in Walla Walla. The competition and isolation felt among Walla Walla mothers, created by the valuation of "natural" childbirth experiences above other experiences, will be explored in the next chapter.

III. The (Dis)-Empowering Effects of Language and Isolation

> *I think every woman probably feels pressure to deliver, to go through natural childbirth. Whether or not they choose it, most probably at least know that that would be the choice that would be most celebrated by other people. Even though it's not at all uncommon not to make that choice, I still think that there is some pressure there …* [natural childbirth] *is the thing that's valued, and the other stuff, if not blatantly devalued, at least it's not something that's good to do. It's accepted because everyone knows that it's common but it certainly isn't the thing that people are going to cheer for you.* – Victoria, new mother

As Victoria described above, "natural"[3] childbirth is valued and celebrated in American culture. In the previous chapter, I introduced the many variations and complexities included in the term "natural" childbirth. Despite the frequency of its use, the term "natural" childbirth lacks a clear, uncontested definition. For mothers who desire a "natural" childbirth, the discrepancies outlined in Chapter I may create confusion about what their birth experience will look like. Additionally, if an expectant mother shares this desire with birth practitioners or friends, there may be miscommunications about what that experience entails. However, more important than the ambiguity of "natural" childbirth is the value and preference that it receives over other birth experiences. For the women in my study, the effects of the cultural value of "natural" childbirth included feeling pressure to complete a "natural" birth and, for mothers with surgical births, experiencing physical and social isolation post-partum. In this chapter I will discuss the characteristics of a "natural" birth that give it greater value than other

[3] As discussed in Chapter 2, the term "natural" childbirth is highly problematic. The definition of "natural" childbirth in the Walla Walla maternal community is very controversial and unclear. Although I use the term "natural" childbirth throughout this chapter, because it was the language used by my informants, I have purposefully surrounded it with quotation marks in order to indicate that I use the term with full knowledge of and fully encompassing the variety of definitions that were discussed in Chapter 2. Despite my informants' varying definitions of "natural" childbirth, many of them used the term to describe the type of birth that is most highly valued in their community. However, as will be discussed in this chapter, it is difficult to achieve an experience that is so variable among individuals. As a result, we must consider that a woman's interpretation of whether she achieved a "natural" childbirth depends on her definition of this idealized birth experience.

American birth experiences. Then I explore the competitive language and metaphors used to describe the pressure women feel from themselves or from their communities to have a "natural" childbirth. Lastly, I will also consider the isolation from their bodies and their communities felt by mothers with emergency or medically-necessary cesarean sections.

Nature and Nurture: Explanations for the Valuing of "Natural" Childbirth

Birth as biologically normal. One of the primary reasons cited by women in my study about why they preferred "natural" birth was that birth is a biologically normal process. Women emphasized that their bodies, just like those of other female animals, are built to have babies. Not only is birth biologically commonplace but all other species of animals complete it without medical assistance. Quinn, a new mother, found comfort in this philosophy:

> *The general philosophy that, you know, animals give birth and they don't have drugs or things like that, you know. Just the idea that we as humans, our bodies, we as women particularly, our bodies are made to give birth.* – Quinn, new mother

Trusting in the biological normalcy of birth and female anatomy was a recurring theme among my participants. Some women connected this philosophy to a spiritual source:

> *God designed my body to have babies and healthy babies…I just so strongly believed in the capability of my body and my mind.* – Beth, new mother

Like Quinn, Beth also found comfort in trusting that her body was created to reproduce and give birth. However, rather than reflecting on the normalcy of birth that she sees in nature, Beth trusts in her faith that a higher power has designed her to be a mother. The belief that the woman's body should be able to give birth, because birth is a biologically normal process, drives much of society's tendency to value "natural" births over other

experiences. Since there is a pervading belief that female bodies can birth, those women who do not complete this "natural" birth may see their bodies as malfunctioning. In this way the biological normalcy of birth, while it empowers some women, can also lead to the idea that women who do not complete a "natural" birth took an alternative, or less desirable, route to give birth.

Expectant mothers also found comfort and strength in the instinctual nature of childbirth. Many women believed that because their bodies were designed to give birth, the birth would happen regardless of their involvement or outlook. Cecilia Van Hollen also discusses this idea in the context of birthing in South India. She refers to Descartes' theory of mind-body duality to examine the American assumption that childbirth could be painless because of the "view of a woman's body during birth as a machine that would function automatically regardless of the woman's subjective experience" (Van Hollen 2003: 51). Although the women in my study did not refer to their bodies as machines and actually wanted to find a connection between their mind, body, and soul (as discussed in Chapter One), there is a conviction that "your body does it whether you like it or not" (Quinn, new mother). Pam, also a new mother, made a particularly striking comparison of her trust in birthing to her trust in walking:

> *There was just zero doubting and I just knew that I could do it. If this is how the body's built and this is what the woman's body is designed for. Like, do I question that I can walk, you know? I don't, so like I just, it just wasn't an issue.* – Pam, new mother

Pam's confidence in her body's biological ability to give birth is an extreme metaphor for the normalcy of birth, but many mothers have similar sentiments. One mother, Irene, even discussed how her faith in childbirth allowed her to "worry more about 'after baby' than 'having baby.'" Women's acceptance of birth as a biologically normal process

relieves some of the anxiety associated with childbirth. However this normalcy also creates a pressure for the individual's body to be strong enough for "natural" birth (as will be discussed in the next section) and creates a space for failure or abnormality if uncontrollable, unexpected circumstances cause deviation from the original "natural" birth plan.

Infant health. When asked about "natural" childbirth, many mothers spoke of their belief that it was a healthier option for the baby and herself. While some mothers cited specific benefits, such as early opportunities for breastfeeding and mother-infant bonding and the risks of medical interventions, others left their responses broad and generic:

> *[CS: What does it mean to have a natural or "birth by nature" in your opinion?] Well I think what I know that it's good for you, for me and the baby that it's more, from what I know, that it's more healthy and more safely for the baby. And when they grow up and the way they developing, kind of thing, you know.* – Sandra, new mother

Even if women are not giving specific reasons that "natural" birth is healthier for the baby, they still acknowledge the cultural pressure that "natural" birth is the best option, which Victoria spoke of in her introductory quotation.

Another consideration of women who favor "natural" birth, for medical reasons, is the risk factors associated with pain medications.

> *I thought it was healthier for [the baby] and healthier for me. The less interventions you have the less risk you have of having something go wrong cause with epidurals there's a whole set of risk factors that can happen. With any pain medication there's a set of risk factors and there's an impact on the baby and so if I could avoid that I wanted to.* – Nancy, new mother

"Natural" birthing books and media have heavily advertised the risks of medicated births and this information has deeply influenced American birthing culture. Women in my

study were very aware that epidurals "can really slow down the childbirth" (Zoey, new mother) which would require additional induction medications, such as Pitocin, to speed the labor back up again. A resource promoting "natural" childbirth that women commonly referred to was Ricki Lake's documentary *The Business of Being Born*. In this film a midwife explains how the slowing effects of an epidural require induction with Pitocin, which intensifies contractions causing greater pain. The increased contractions may put a baby into distress from lessened blood and oxygen supply, which leads to an emergency C-section (Lake and Epstein 2008: 13:52-14:48). One mother in the film also comments that "it seemed to me that once they started an intervention they all just kind of, it's like a domino effect" (Lake and Epstein 2008: 13:40). Messages such as this one are commonplace in pregnancy and birthing literature. So as women begin to learn more about the birthing process and all the options available to them they receive significant amounts of information discouraging medical births. Even if they are not consciously repeating these explanations, women are sensitive to the cultural preference given to "natural" births.

Early opportunities to bond and breastfeed. For women who were more specific about their reasons that "natural" birth was preferable, early opportunities for breastfeeding and infant-mother bonding were often cited as deciding factors for a mother to pursue a "natural" birth. Often this was because medical interventions, such as epidurals and Pitocin (discussed above), increased the risks of needing a cesarean section. Women knew that having a C-section would significantly limit their opportunities for early bonding and breastfeeding because the surgical procedures that it requires did not

create much space for early mother-child bonding time. Victoria describes how C-section procedures do not support these early bonding opportunities:

> *When you have a C-section, there's still, like I said, surgery to be done, so they take the baby away. They basically show you the baby but you can't, unlike when you have a regular delivery, you can't just hold the baby then, you can't nurse the baby right away. You can't do all these things that doctors and others and the pediatric community tell you you are supposed to be doing to bond with your child. And that caused me a lot of stress, both times actually, because the rhetoric sort of makes you feel like this is what you have to do, this is what you must do. And it made me feel like I can't do this and because of that, my bond with my child is going to be destroyed. He's not getting this feel-mama's-skin right after he's born kind of thing. That's in a lot of the literature, that that's what you want to do so that your child feels you and feels safe. So I'm thinking my baby is traumatized, he doesn't know me, he doesn't see me, and he's just whisked off somewhere…I'm not doing what I'm supposed to be doing, it's not even my choice, I just can't do it because I'm in surgery and they won't let me have the baby.* – Victoria, new mother

Victoria emphasizes how her limited options for early bonding caused her great stress during her C-section. She refers to the medical literature as creating an impossible situation for her, where she wanted to breastfeed and bond with her child but the surgical procedures of a cesarean section barred her ability to do this[4]. One birth book that many women interested in an unmedicated birth read is *Natural Hospital Birth* by Cynthia Gabriel. Gabriel explains that "this first hour is the ideal time to begin breastfeeding" because the baby tries to "actively root for the mother's breast and open their mouths with quiet insistence" (Gabriel 2011: 206). Additionally, she mentions that "although many babies are ready to suck right away, some are more interested in smelling, licking, tasting and just being close to the mother's breast. By licking you, the baby starts to ingest bacteria that are beneficial for her intestines" (Gabriel 2011: 207). Gabriel also reminds new mothers "that your baby's first experience at the breast should be pleasant, not goal-oriented. Enjoy watching and holding your newborn as you begin this new step

[4] The isolating effects of this experience will be further discussed in a later section.

of your relationship" (Gabriel 2011: 207). As Victoria described above, it is difficult to follow this advice when hospital procedures limit the mother's autonomy, ultimately creating pressure and stress for her.

Cesarean sections are not the only hospital procedures that limit early opportunities for infant-mother bonding. Elena, a midwife, explains how some common hospital procedures can create difficulties in early bonding and why this opportunity is so crucial:

> *So she's waiting and waiting and waiting and by the time she gets her baby, they've gotten their shot, their Vitamin K injection, they've have erythromycin eye ointment put in their eyes, they're wrapped up in a burrito blanket, they're handed to the mom, the baby is laying sideways. There is all this barrier between the baby and the mom, with all these blankets. And the baby can't see the mom because there's all this goo in their eyes. And it's really important for them, for survival, to start memorizing the frame of mom's face…that memorization is their way of making sure that they can survive, that they can always find their mom. So they can't do that when they have goo in their eyes.* – Elena, certified nurse midwife

As Elena describes it, the material separation between the mother and the newborn is an unnecessary procedure. In her own practice she lays the infant on the mother's chest and wraps mom and baby up together. Additionally, Elena waits an hour before giving the baby their vitamin K injection and their eye ointment so the mother and child can have uninterrupted bonding and breastfeeding time. For women who promote homebirth as a "natural" birth, these procedures are a clear example of how a hospital or medical setting conflicts with the primary needs of the infant and the mother. "Natural" birth promotes and encourages these early bonding and breastfeeding opportunities, which is why many mothers understand "natural" birth to be the better childbirth option.

In this section I have discussed three common explanations that mothers and practitioners refer to as the benefits of "natural" childbirth; 1) the biological normalcy of

birth, 2) avoiding risks associated with pain medications, and 3) the early opportunities for bonding and breastfeeding. These reasons for favoring "natural" childbirth are the ones presented explicitly by my informants; however for the remainder of this chapter I will analyze how the competitive language of birth experiences and isolation influence the American birthing culture's perceptions of "natural" birth as the ideal birth experience.

The Mother's Marathon: The Competitive Side of Childbirth

As I completed interviews with women in Walla Walla I was very surprised by my informant's unprompted application of sports-related metaphors or language in their descriptions of "natural" birth. Usually these references were used when discussing the appropriateness of pain medications:

> *No one is going to give you a trophy at the end of this for not getting an epidural. Get the epidural.* – Tami, new mother
>
> *Really at the end of the day, they're not going to give you a medal for doing it without drugs so you might as well be as comfortable as you can be.* – Lauren, new mother
>
> *If we start categorizing births and making some better, it's not like you get points for how you give birth.* – Maureen, new and expectant mother
>
> *Nobody is going to win in like those pain Olympics, you know?* – Irene, new mother

These four references to trophies, medals, points, and the Olympics suggest that women see some connection between birth and competition, even if they do not consciously believe that some women receive awards based on their birth experiences. By even applying sports language to the realm of childbirth, two categories which are traditionally unrelated, these women are suggesting that competition exists in maternal

culture even if they do not promote it. In this section I discuss the competition of childbirth in American birthing culture through the lenses of pain and female empowerment.

Pain as power. Perceptions of pain in American culture are generally negative. Pain is something to be avoided and treated, which is the primary role of the hospital and medicine (Davis-Floyd 2003: 102). In pregnancy, the fear of pain was connected to the possibility of death in labor and delivery. Today, however, the death rate is so low that only the fear of pain endures (Brodsky 2008: 178). With her body-as-machine, technocratic birth metaphor, Davis-Floyd suggests that "perhaps we devalue pain so much because it, like birth, reminds us of our human weakness…machines don't feel pain, so if we are going to be like them, neither should we" (Davis-Floyd 2003: 102). Fear or negative interpretations of pain is not, however, a cultural universal. In her work among the Tamil women in South India, Cecilia Van Hollen reinterprets labor pains as desirable. Among the Tamil, the administration of oxytocin to induce labor, without the use of an epidural for pain medication, is a service that laboring mothers insist on. In her article *Invoking Vali*, Van Hollen draws parallels between the double meaning of *vali* (pain/ache and strength/force/power) and the valuing of intensified labor pains (Van Hollen 2003: 57). By enduring greater pains, Tamil women are stronger and improve their social status through childbirth. This is explained through the concept of *sakti*, "the activating principle of life" (Van Hollen 2003: 58).

> *Because sakti was associated with a woman's ability to suffer nobly the pain of birth, that pain was an important ingredient in women's self-conception of the powers of motherhood. Many women told me that it was because of their sakti that they could withstand the intensified pain of oxytocin-induced labor. Their ability to withstand this increased pain was a sign that they indeed had sakti.*

> *Furthermore, some women went so far as to say that oxytocin-induced pain* increased *their sakti* (Van Hollen 2003: 58).

By withstanding the pains of childbirth, Tamil women gain greater standing, respect, and power in their community. While in America there is still an overarching assumption that pain is bad and undesirable, the reactions "natural" births receive from the community may suggest otherwise.

Birth as a personal challenge. Some mothers framed childbirth as a competition with themselves, to see if their body is strong enough to endure "natural" childbirth. The image of a marathon runner was often used to express this idea:

> *So it's more of like, to see if I could do it….just to challenge myself, I guess, a little bit… just to see if I could do it, see what it's like. I've heard people just have this exhilaration, this high, this kind of like, why do people run marathons or half-marathons? You know, just to see if they can do it, a little bit.* – Zoey, new mother

> *I've done other things before like running a marathon or competing in a triathlon, and not that I'm competitive because I'm not fast, I just did it to finish, but I think it's sort of that same feeling like "Wow I really" you know "had to dig deep to find the resolve to do this and I did it" and that feels amazing. I feel stronger as a person because of it.* – Maureen, new and expectant mother

Just as marathon runners train for their race by increasing their exercise routines, pregnant women train for their births by taking birth classes to learn pain management techniques, mentally preparing themselves to cope with an intense situation, and researching about the biological changes that their bodies will experience. The personal challenge that childbirth presents, and the opportunity to be empowered by it, is a huge draw for mothers.

> *I think to some degree I'm a little bit looking, not looking forward to the pain, but a little bit looking forward to it. It's like knowing you can do it, kind of. Like "I did that," that kind of satisfaction of being like "no, I did it, I went through that."* – Julia, expectant mother

> *Like I wanted to be tough enough, you know? ... I kind of wanted to do it for myself.* – Irene, new mother

This desire to experience and endure intense pain for personal pride is a theme that runs parallel with the work of Cecilia Van Hollen among the Tamil women in South India, as discussed previously. By proving their own capabilities to themselves, Tamil and American mothers are empowered by their birth experiences. They then apply this empowerment to their parenting and general interactions with their communities. Furthermore, the strength of these women is praised and acknowledged by community members. The positive feedback women receive from their peers, in addition to their own pride in completing a "natural" childbirth, draws many women to this birth experience.

Positive reinforcement. Women who have a "natural" birth receive positive reinforcement from their communities which may encourage expectant mothers to pursue a "natural" birth.

> *You'll notice when you hear someone say that they did it all without drugs and people go "Oh my god, that's amazing, you're so amazing, you're tough, you're strong." You know, and I think that seeps in, I think that is common that people get sort of heralded as these heroes when they do it naturally.* – Victoria, new mother

This celebration of the woman's strength in the public sphere reflects and fortifies her personal pride. The combination of internal satisfaction and external validation may leave the mother with a "superwoman" sensation as referenced in many pregnancy books: "Many women tell 'superwoman' stories about their quick returns to work, shopping, exercising, and other activities after delivery" (Gabriel 2011: 204). Childbirth may leave some mothers feeling like they can do anything. This empowerment is one of the many

perceived benefits of "natural" childbirth and will be explored later on with the mothers who lacked this confidence and empowerment after cesarean births.

Detaching and Devaluing: The Isolating Effects of Cesarean Births

Most of the literature, and many of the women in my study, understand childbirth as a spectrum with "natural" birth on one side and surgical birth on the other. In the two previous sections I discussed how the characteristics commonly associated with "natural" childbirth are seen as benefits of "natural" childbirth. Some of these benefits were 1) respecting the biological normalcy of birth, 2) accessing early opportunities for bonding and breastfeeding, 3) personal satisfaction and empowerment by persevering through pain, and 4) validation through community encouragement. For the remainder of this chapter I will examine the flip side of "natural" birth, or the isolation felt by women who have cesarean births. To clarify, my study only involved women whose cesarean sections were medically necessary, not elected for personal convenience. Common conditions in my study that required a C-section were breeched babies, placenta previa (placenta is exposed before the baby), and a history of C-section deliveries. Cesarean birth mothers, who are considered by their community to be outside of the "natural" birth category, receive many cultural messages about the legitimacy and value of their births from other mothers. Isolation is a primary symptom of this exclusion from "natural" birth, beginning with the physical isolation inherent to a C-section surgery and compounded by the post-partum social isolation from the maternal community.

Physical isolation during surgery. It is important for mothers and the general community to remember that a cesarean section is a major abdominal surgery. As a result there are many medical procedures that are involved in this experience which may

communicate feelings of isolation to the mother. The use of anesthesia acts as a physical block between the mother's brain and her sensations of birth. Although I did not have any mothers express their desire to feel more of their surgeries, many expressed that the disconnect from their own bodies was bizarre:

> *There were smells and sounds that made me aware that I was cut open, I could tell that I was even though I couldn't feel, and that was weird, that was kind of scary.* – Victoria, new mother

Furthermore, the curtain that separates a mother's head from her belly during surgery is another common medical procedure that separates the mother from the birth.

> *They put a screen here and you couldn't look down and see anything. There's something right on your chin.* – Victoria, new mother

As has been mentioned previously, birth is usually understood as a very active and demanding process for women. Surgery is the opposite of that experience; mothers in my study described C-sections as isolating, weird, and vulnerable. By being disconnected from the birth, some mothers, such as Irene, felt helpless:

> *There's a sense of helplessness when you're having a C-section, when you're fully open on a table with your arms out wide. I want that feeling of reaching down and grabbing my baby immediately after the birth and holding it in my arms. I want that and I didn't have that the first time. Not that I don't feel wonderfully connected to my son and I love him, but I want that feeling of that special, immediate closeness.* – Irene, new mother

Here Irene discussed how her physical position on the operating table exacerbated her feelings of helplessness because the surgical procedures of a cesarean section would not allow her the opportunity to bond with her son right away. Zoey relates this experience to being like a "piece of meat":

> *I wasn't really crazy about that whole experience. Because you're pretty much like completely naked, on this table, you know, you feel like a piece of meat kind of, you know what I mean? And all these people are just standing around looking at you…for a while there you feel really exposed.* – Zoey, new mother

Physical experiences of isolation in cesarean births such as anesthesia, curtained divisions, and vulnerable positions are all hospital procedures that promote the metaphor of woman-as-machine or woman-as-birthing-vessel.

As I introduced in Chapter One, Robbie Davis-Floyd's concept of the technocratic model acts as a counterpoint for many of the beliefs associated with "natural" birth. One aspect of the technocratic model is the division between the woman's mind and her body. As discussed by some of the participants in Davis-Floyd's 1994 study, cesarean sections emphasize the mother's role as a vessel for the fetus rather than a participating and reacting agent in the pregnancy and birth (Davis-Floyd 1994: 1131). This "technocratic body" philosophy which keeps the mother as a separate entity from the baby, if not in conflict with the baby[5], is clearly reflected in the atmosphere of surgical birth. Katie was surprised by this climate after having a very positive relationship with her obstetrician throughout her pregnancy.

> *[My obstetrician] didn't care about me that day; truly it was all about my belly. The nurse was there to take care of me, my doctor was there to take care of the belly, and the pediatrician was there to take care of what was inside the belly. It was a very clear division.* – Katie, new mother

Unlike the women in Davis-Floyd's study, all of the women in mine expressed discomfort at the idea of separating their mind or body from their unborn child or the birthing experience. As a result, a C-section was never suggested as a preferred birthing method because of the physical isolation from the birth experience.

[5] One participant from Davis-Floyd's study describes the baby as "a demon to me. There's another being in your body that has to get out and it's looking for a way to get out. And all of a sudden, it's like the center of control left my brain and went to this, this thing in my body…I had to do whatever this other being said was going to happen. And it was my body that it was happening to" (Davis-Floyd 1944: 1131).

Physical isolation after surgery. Once the baby is born there are still hospital procedures that keep the mother separate from her family. After a brief period where she sees the newborn, the mother is stitched back up as her child is sent to the warmer and to receive their injections. Then the baby and the partner are sent to the nursery while the mother is sent to recovery. A woman feeling isolated in the recovery room was a common theme among my participants who had cesarean sections.

> *So I'm basically laying there, numb from the waist down, waiting to regain feeling, with nobody…I felt this intense sense of loneliness. I just wanted to see my baby. I had to lay there for about an hour on my own. I didn't get a chance to be with my son right after he was born, or my husband. I didn't get any of that.* – Irene, new mother

Here we see that even outside of the operating room, hospital procedures create an isolating environment for mothers. As Victoria questions in her interview:

> *Why isn't it just standard procedure to bring the baby down to the mom [in recovery]?* – Victoria, new mother

Avoiding the surgical and post-surgical isolation is one reason Walla Walla mothers prefer "natural" births because, as discussed earlier, there is no space for early bonding and breastfeeding in a cesarean setting.

Feelings of failure. After a cesarean, many mothers reported feeling failure, weakness, disappointment, or cheated by their birth experience.

> *I think that sometimes surgical birth can make women feel like they lost control and they're not the strong powerful mother they had hoped, that kind of thing…If you are expecting that your body can do something and then it doesn't succeed, they may have that sense of failure. Sort of that they weren't able to give birth to their baby…surgery is that kind of experience, because you lay there, and they hand you a baby and you're totally disconnected.* – Whitney, registered lactation nurse

> *I know a friend of mine who has three kids and she had two intervention-free, drug-free births, um, natural, and then she had to have a C-section because of a breech baby and she said she felt like, and everybody was trying to comfort her*

> *and be like "You know, you shouldn't feel bad you have a healthy baby and that's the goal" but she said she felt like "it stole her moment" you know?* – Maureen, new and expectant mother

> *After I had my first C-section I was upset about it and when my husband would say things like "You did such a great job." Like I didn't do anything. I recovered from a surgery and he would always try to correct that thinking but at first I was pretty down on it. It's not easy, so I wouldn't say it's the easy-way-out because actually it's a lot harder to recover from that than it is a regular birth but yeah, I think I felt like I had cheated somehow, I did it the easy way. It's like the equivalent of somebody losing 200 pounds having had gastric bypass surgery. It's that kind of, you know, discounting of it, "Well yeah you lost all this weight but you had surgery to do it, you didn't do it the real way, you didn't do it the hard way." So a woman who gives birth without drugs, she did it the real way and all the other ways are shortcuts or cheats.* – Victoria, new mother

These emotions of disappointment and cheating are not surprising. Instead, they are a product of the competitive language associated with "natural" childbirth. Sports metaphors suggest that there are winners and losers so feelings of loss are expected for a mother who hopes for a "natural" birth and finds herself on the operating table for an emergency C-section. Additionally the positive reinforcement and affirmation of her strength that "natural" birthers receive from the community suggests to cesarean birthers that they are weak. Clearly the language we use to discuss childbirth is highly problematic if mothers are being slotted into winners and losers. As Rebecca highlights, it is important for the American birthing culture to alter their frame of mind:

> *Think about the outcome, don't think about that you failed, you know? So, I just don't like the idea of women having this idea that they failed at childbirth. Come on!* – Rebecca, new mother

Even though, as many mothers expressed earlier, women do not technically receive medals for their birth experience, the cultural mindset that birth is a mother's personal challenge can leave space for failure and disappointment.

Social isolation after surgery. Even after leaving the hospital, a cesarean section mother continues to experience isolation from her community. Most commonly among my participants this isolation stems from the lost opportunity to experience the physical demands of labor and vaginal delivery. As Katie discussed in her interview, there is a popular assumption that mothers have labored, however this is not always the case.

> *I've never had labor, I've had contractions but they were pretty mild. But I've never had labor. I don't know what labor is like. And I feel weird about that…I have a baby, I should know what labor feels like and I don't. [CS: Why does that seem weird to you?] Because that's a motherly experience, mothers should know what birthing a baby feels like and when I think about birthing I think about a vaginal delivery…I think you look at someone with a child and you, for whatever reason, assume that they've had a certain experience.* – Katie, new mother

The false assumption that all mothers have experienced labor makes it difficult for women with cesarean births to connect with their fellow mothers. Victoria explains the isolation that she feels from the inner circle of the "mother's club" because she did not experience a vaginal birth:

> *I was scared to death of it and I never wanted to push a baby out of my body…I was terrified of it. And so in some ways it feels very strange to me to be like "I wish I had done it." But I think there is some lingering sense that there is an experience there, an experience that people in the "club" have that I didn't have so it's different. So I'm in the "club" but I'm, I'm not in the center of it, I'm a little on the fringe of it because I don't know what that feels like.* – Victoria, new mother

Both Katie and Victoria's descriptions pinpoint their isolation as their personal reactions to their own confusion about how to relate to their peer mothers. Unfortunately, however, cesarean birthers have also shared that other community members are an additional source of this exclusion.

The external pressure to cope with the judgmental attitudes of community members is an additional challenge for cesarean section mothers. When mothers share

their stories of cesarean births, many peers do not know how to react because of the complex blend of celebration and disappointment felt by the mother herself. In general, American culture is confused about how to appropriately respond to cesarean births because it places the cultural values of personal perseverance and medical expertise in conflict. Unfortunately, as a result, some cesarean birthers receive hurtful comments from their community which exacerbates their feelings of isolation.

> *It's afterwards you get the comment. I've been told that "Well you don't know, you never really had to give birth"…It's a very weird sancti-mommy bullshit that goes through these minds, it's divisive and it's disgusting. I've been told I didn't actually give birth to my son and that's probably one of the most hurtful things that you could say to a woman.* – Irene, new mother

Just as the mother needs to resolve her own cultural confusion about the common relationship between labor and birth, so too does the general community. Regardless of the speaker's intention, Irene and many other mothers have felt isolation and have been hurt by our culture's limiting and vague definition of "natural" childbirth.

Coming into Conflict: Reflecting on the Role of Competitive Language as Simultaneously Valuing Personal Endurance and Medical Technology in Birth

The application of competitive language to childbirth is an unusual pairing that both gives value to "natural" childbirth and fosters negative feelings of failure among cesarean mothers, thus devaluing their birth experiences. The overly simplistic association of "natural" births as good and cesarean births as bad in American birthing culture is at best inaccurate for the actual experiences of women in Walla Walla, and at worst it encourages negative emotions, which can have long-term consequences, as will be discussed in this thesis' conclusion. Framing birth with competitive language also puts our cultural values of personal strength and medical knowledge into conflict. This can be a difficult contradiction for new mothers and their communities to navigate

because our instinct to avoid pain does not support our high value of those women who self-select to endure the pains of "natural" childbirth. Consequently many mothers receive mixed reviews about their birth story, which as I address in the conclusion, is incredibly important for them to share with their community.

IV. Conclusion: Sharing Birth Stories and Caring for Other Mothers

Embracing maternity is an important transition period for new mothers regardless of their birth experience. Adapting to their new social role as mothers, integrating into the network of mothers in their community, and processing their birth experiences are three components of motherhood that some scholars have referred to as the integration period of birth as a rite of passage (Davis-Floyd 2003). In my research, women emphasized the importance of this period, especially the support they found by connecting with other mothers in the Walla Walla community. Unless they had an existing community of mothers from work or personal connections, many mothers discussed how the tradition of sharing birth stories helped them to connect with fellow mothers. Yet, for mothers with cesarean births the feelings of failure and judgment often associated with this birth experience, as presented in Chapter Two, may discourage them from sharing their story. By not sharing her story and having her experiences validated by the maternal community, a mother may have increased difficulty processing her birth. To conclude my thesis I examine the maternal community's role in the postpartum period and how the term "natural" childbirth creates transitional challenges for a new mother. Lastly, I call for a cultural reconsideration of the ambiguous term "natural" childbirth and the hierarchical framework that American culture uses to interpret childbirth.

"The Mommy Club": Connecting with Other Mothers through Birth Stories

Many women discussed the unique opportunity to connect with a community of mothers through sharing birth stories. They described this experience as a bonding ritual among mothers that transcends other political or religious factors that may otherwise divide these women.

> *If you don't have anything else in common with another woman, if they have kids that's something you have in common. So that's really a cool thing.* – Quinn, new mother

> *It's one of the really major differences between women and men. And how women who might like have all sorts of different opinions about things in life can relate to each other.* – Olivia, new mother

> *Although it isn't unique for women to have babies, it is really intense and it changes everything and it's really personal… I think it very much is a bonding thing because…when someone shares something of theirs that is really personal it tends to inspire some reciprocation of that because it does feel in some ways…it's a very intimate thing to share with somebody else.* – Victoria, new mother

The tradition of sharing birth stories creates an avenue for mothers to be welcomed into American motherhood where they may connect with women who relate to their challenges. The majority of the mothers in my study recognized and valued this maternal community in Walla Walla. They found camaraderie, support, and acceptance from this diverse group of women tied together by their maternal status. In addition to the social support that mothers receive from other mothers in the first few years of their child's life, participants in my study discussed that connecting and sharing a birth story with peers in the early phases of motherhood is critical to process the birth experience.

> *It's very important…There is a need for women, even if your birth is normal or ideal, there is that need to decompress. But then when it's traumatic…for whatever reason just different than what the mom hoped or planned, you know, it takes some, it can take a year to get over it…I do try to address that every time [for a new mom with a newborn] I try to ask "How did the birth go?" "How are you feeling about the birth?" Because if things went really well they can be on top of the world, they can have this euphoria that lasts for weeks and that's great. And if it didn't go well, especially if they had hopes of a natural birth and then didn't, they seem to have this, it's like a gouge in their self-esteem, and so I like to give them an opportunity to talk about it and amongst themselves…It's important for women to process the birth, good or bad, whatever their experience was.* – Whitney, registered lactation nurse

In the above excerpt from Whitney's interview, she discusses how important it is for women to discuss their birth experiences with other mothers in her new mothers

support group. With the variety of experiences that women may have, and the frequency with which these experiences do not align with a mother's expectations, Whitney addresses the need for women to process these differences by speaking with other mothers. The validation that women receive from speaking with peer mothers and relating to another's birth story is more than a bonding ritual; it legitimizes the new mother's birth and her motherhood by reassuring the mother that her experience was "within the realm of ordinary" (Nelson 2006: 11). Relating with the maternal community in this way encourages a new mother to develop her parenting confidence by learning from and being affirmed by fellow mothers. Usually even women with "traumatic" birth stories can benefit from this community of mothers; however, in the event that this relationship is not fostered successfully some mothers may feel isolated from this community, as discussed in Chapter Two. I have found in my study that categorizing some births as "natural" excludes many women from the maternal community. Among the women I interviewed who had cesarean births, feeling uncomfortable or discouraged from sharing their birth stories with this maternal community was a recurring theme.

Unintended Side Effects: Judgmental Attitudes Perpetuating Postpartum Complications

While there are characteristics of "natural" birth that encourage mothers who have a "natural" birth to share their birth experiences, such as anticipating celebration from the community and personal pride, there are assumptions about cesarean births that discourage mothers from sharing their stories with their peers. Most often in my study, cesarean birthers hesitation to share their birth story originated from their anxiety of possible criticism or a belittling of their own story as boring or uninteresting.

> *And it can feel, especially if there were any difficulties or hiccups in [the birth], it can feel like a very vulnerable story to tell.* – Victoria, new mother

> *[Birth] is like this unknown, you know, you don't know when it's going to happen, how it's going to happen. And think that's the part that gives you that story that's really kind of fun, and my story is kind of boring. Like "oh, I had a C-section."* – Zoey, new mother

Unlike "natural" birth stories which, as Zoey suggests are "really kind of fun" to tell, sharing cesarean birth stories can create additional anxiety for a mother, as discussed in Chapter Two. The possibility of criticism or devaluation from peer mothers, such as that experienced by Irene in the previous chapter, deters many mothers from sharing their stories. However, if these mothers are not sharing their stories with their community they miss the opportunity to have their stories validated by peer mothers. Therefore it is vital that maternal communities are acknowledging the isolating effects that the term "natural" childbirth may have on mothers with medicated or surgical births.

When mothers enter motherhood without sharing their birth stories or processing their birth experiences, there can be negative effects. Postpartum depression is common among mothers and varies in severity, but in Western countries about 10-15% of all mothers suffer from postpartum depression (Warsh 2010: 141). For some mothers, postpartum depression (PPD) occurs after a mother's euphoria from the birth has "faded and dispersed, [so] they plummeted to an all-time low. For others, 'PPD' is primarily a result of their perception of their birth experience as negative; when this is the case, the depression will usually be deeper and longer-lasting, as it forms part of an important grieving process during which the woman must attempt to work through and reinterpret her birth experience in order to make some structural sense out of it" (Davis-Floyd 2003: 41).

Since a cesarean birth is more likely to be interpreted as "negative" by the community, it is particularly important that these mothers have the opportunity to share their births in a safe environment. In some of the worst-case scenarios, if women do not share and process their birth stories there can be serious, long-lasting side effects:

> *Women have such traumatic experiences in birth…[and] they aren't able to put closure on it because a lot of times they don't understand what happened. All they knew is that they were miserable and all the after effects of that experience. Post-partum depression and, you know, addictions or worse. Or unhappy parenting and child abuse, child neglect.* – Elena, certified nurse midwife

In her interview, Maureen summarized all of these ideas and tied them back to the importance of developing a mother's confidence:

> *You take your birth story into motherhood and if it felt out of control then maybe it's harder to get a grip on things, I mean not that it is, but you know that there is something about feeling empowered by your birth process that helps you maybe feel more capable or something as a mom, and I don't think it necessarily works that way for everybody but I think it is important to feel confident…I think a lot of moms that I know that were disappointed by their experiences, not that it made them weaker moms in any way, shape, or form, but it was just something that lingered with them. It felt like an unresolved issue rather than just being able to kind of embrace the maternal in the whole motherhood experience.* – Maureen, new mother

By leaving some birth experiences unresolved because of the judgment that cesarean birthers receive from other mothers, this may limit their involvement in the maternal community and possibly stunt their development of parenting confidence. Unintentionally the American system to categorize births fosters negative experiences between mothers and disempowers mothers whose births did not go according to plan.

A New Focus: Moving Beyond the "Natural" vs. Medical Dichotomy

The terminology that we use to describe different birth experiences has a wide array of consequences that are not consciously acknowledged in daily life. The ambiguity of the term "natural" childbirth, while an empowering classification for

women who achieve it, is isolating for those mothers whose circumstances drive their birth experience in a different direction. Unfortunately, these effects can have unintended, long-term consequences. The American tendency to categorize births as "natural" or medical is first inaccurate in terms of the actual experiences of women and second, hurtful for some new mothers because of the cultural value given to "natural" births. In order to remedy this exclusion in American culture, a discussion to reframe childbirth is necessary to release ourselves from the judgmental term "natural" childbirth, which implies that births outside of this category are unnatural. However, until another system has been established, it is crucial that the wider community becomes more sensitive to the negative effects of this terminology and is more explicit in their personal definitions of the term "natural" childbirth. As women in my study stressed, the most important part of childbirth is creating a healthy baby. Therefore, rather than dividing the Mommy Club into "natural" and "unnatural" births, our cultural focus must shift to guiding all women into motherhood empowered and bursting with confidence as they transition into their new social roles as mothers.

V. Appendix A: List of Participants

Participant Pseudonym	Description	Date Interviewed	Length of Interview
Ally	New mother	January 21, 2013	46 minutes
Beth	New mother	February 3, 2013	61 minutes
Charlotte	New mother	February 4, 2013	34 minutes
Danielle	New and expectant mother	February 5, 2013	31 minutes
Elena	Certified Nurse Midwife	February 5, 2013	92 minutes
Faye	New mother	February 6. 2013	56 minutes
Genevieve	New mother	February 8, 2013	49 minutes
Hannah	New mother	February 9, 2013	62 minutes
Irene	New mother	February 10, 2013	65 minutes
Julia	Expectant mother	February 11, 2013	56 minutes
Katie	New mother	February 12, 2013	120 minutes
Lauren	New mother	February 13, 2013	94 minutes
Maureen	New and expectant mother	February 15, 2013	116 minutes
Nancy	New mother	February 16, 2013	63 minutes
Olivia	New mother	February 16, 2013	70 minutes
Pam	New mother	February 17, 2013	70 minutes
Quinn	New mother	February 18, 2013	67 minutes
Rebecca	New mother	February 21, 2013	75 minutes
Sandra	New mother	February 28, 2013	48 minutes
Tami	New mother	March 2, 2013	101 minutes
Victoria	New mother	March 2, 2013	113 minutes
Whitney	Registered Lactation Nurse	March 7, 2013	70 minutes
Zoey	New mother	March 8, 2013	50 minutes

VI. Appendix B: Recruitment Methods

Letter Distributed via Birth Practitioner Contacts

January 15, 2013

Dear Client,

Hi, my name is Cate Sturtevant and I am a student at Whitman College. I am writing an anthropology thesis (year-long research project) on how women make decisions about childbirth. Initially, I became interested in this project when studying abroad in Senegal and learning about their cultural birth practices. This year, I look forward to exploring the culture of birth and motherhood in Eastern Washington.

I am interviewing new mothers (women who have given birth within the last three years) and expectant mothers about how they planned for their deliveries. These will be voluntary, confidential interviews. They will last about an hour and will be scheduled for your convenience. These interviews are only being used for my thesis and your personal information will be kept confidential. The majority of these interviews will be held from January 2013 to March 2013.

If you are interested in participating, please contact me with any further questions or to schedule an interview time. Thank you so much for your consideration.

Sincerely,

Catherine (Cate) Sturtevant
425-283-8911
sturtecf@whitman.edu

E-mail to Whitman College Faculty and Staff

Dear Whitman Community,

My name is Cate Sturtevant and I am a senior anthropology major. I am writing my thesis on cultural aspects of childbirth and women's experience of pregnancy in Walla Walla. I originally became interested in this topic when studying abroad in Senegal and learning about the variety of childbirth options that are available to women there. Through my research in Walla Walla I hope to learn more about issues of autonomy, empowerment, and social solidarity that may shape women's experiences during the transition to motherhood.

Currently, I am interviewing new mothers (women who have given birth within the last three years) and expectant mothers about how they planned for their births. Interviews are voluntary and confidential and will last approximately one hour. Interviews will be scheduled at the convenience of participants. Information gathered in the interviews will only be used for the purpose of my thesis in anthropology and all names and any information that might help identify interviewees will be removed in the writing process. This research has been granted approval by the Whitman College Institutional Review Board (IRB).

The majority of these interviews will be held between now and March 2013. If you are interested in participating, or know someone who might be interested, please contact me by email (sturtecf@whitman.edu) or phone (425-283-8911). If you have additional questions about anthropology thesis research, please contact my adviser, Associate Professor of Anthropology Jason Pribilsky (pribiljc@whitman.edu). I really appreciate your consideration and support.

Thanks!

Cate Sturtevant

Flyer Advertisement at Local Day Care Center

Are you a new* or expectant mother?

Hi Kids Place Moms!

My name is Cate Sturtevant, I am a student at Whitman College, and I am writing my senior thesis on the culture of childbirth in Walla Walla. I am a housemate of Jane Smith, a Kids Place aide.

I am currently interviewing women about their childbirth preparations and experiences. These interviews are voluntary and confidential. Each interview will last about an hour and will be scheduled for your convenience.

If you are interested in participating please contact me with any further questions or to schedule an interview time. Thank you so much for your consideration!

Sincerely,
Cate Sturtevant
425-283-8911, sturtecf@whitman.edu

*Women who have given birth in the last three years.

Cate Sturtevant
425-283-8911
sturtecf@whitman.edu

Cate Sturtevant
425-283-8911
sturtecf@whitman.edu

Cate Sturtevant
425-283-8911
sturtecf@whitman.edu

Cate Sturtevant
425-283-8911
sturtecf@whitman.edu

Cate Sturtevant
425-283-8911
sturtecf@whitman.edu

Cate Sturtevant
425-283-8911
sturtecf@whitman.edu

Cate Sturtevant
425-283-8911
sturtecf@whitman.edu

VII. Appendix C: Interview Questions

For pregnant women and new mothers
Second draft: January 30, 2013

1. Could you give me a brief overview of your pregnancy and birth from the beginning? Think back to when you first discovered that you were pregnant and walk me through your process until the baby was born. What were some of the decisions that you had to make? How did you feel throughout your experience?
    a. What was your birth plan and how did it differ from your actual experience? Did the person you give birth with (doctor, midwife, family member) follow/refer to this plan as much as possible?
    b. Understanding of natal care options before pregnancy – midwives?
    c. Preparation and Resources (personal research, meetings with birth attendant, etc?)
    d. Reactions from family/friends/community to your pregnancy and birth plan

2. In a make-believe, ideal world where you could have anything you wanted regardless of practicality, what would be the best birth experience, for you? What comes to mind?

3. So far, how has your experience of childbirth and motherhood influenced your personal values? How has this experience changed your life or your outlook on life?
    Examples:
    a. Increased self-confidence?
    b. Appreciation for family or community?
    c. Greater understanding of and appreciation for the human body?

4. How was your relationship with your birth attendant? What were your expectations for them and how did they meet these?
    a. Education/Prep
    b. Addressing concerns

5. What does "natural birth" mean to you? What are some images, words, or ideas that come to mind when I use this term?
    a. Drugs/Technology?
    b. Location?
    c. Birth Attendants?
    d. Finding inner strength?

6. Is there anyone else you would recommend for my study or resources that I should consult?

7. May I contact you for a follow-up interview?

For birth practitioners
First draft: February 4, 2013

1. Could you please give me a brief overview of your job? What do you do? What services do you provide for your clients? What role do you play in pregnancy and childbirth?
    a. Preparation/Pregnancy
    b. Delivery/Birth
    c. Pre-natal/Post-natal care? Family planning? Women's health services?

2. I've never been to a birth. Could you describe to me what happens at a birth? Once you arrive at the home/hospital/clinic, what happens?

3. Why do you think women choose your services? Why are women seeking out midwives/obstetricians/doulas/etc?
    a. Is there a high demand for these services in Walla Walla? Why (not)?

4. How do you incorporate medical technology into your practice? In your opinion, what role does technology play in birth?

5. How would you define "natural childbirth"? What about "biomedical birth"? How do these two childbirth options work in tandem and/or conflict?

6. May I contact you for a follow-up interview?

VIII. Appendix D: The Legacy of the American Midwife: Her Retreat and Resurgence

I wrote this chapter on midwife history as an assignment for Anthropology Senior Seminar in Fall 2012, with the original intention to include it in my final thesis. However, as my research progressed in the spring semester it became clear that the topics discussed in this chapter were no longer productive to my discussion of "natural" childbirth. I have opted to include the chapter as an appendix because I believe that this research colored my understandings of midwifery care and its relationship with the medical profession. This appendix remains as a source of additional information for readers interested in the history of the American midwife, but is not intended as a contributing argument in my thesis.

Even though midwifery has a long, universal history, the practices of the modern American midwife are highly misunderstood. In less than 200 years, biomedical births have become the standard delivery method, forcing midwives out of practice and casting natural births as an anomaly. In doing so, childbirth, which women are biologically designed to perform, is interpreted as a pathology requiring hospitalization, monitoring, and medical intervention. In resistance to the medicalization of childbirth, midwives have professionalized by adhering to certification programs and allowing regulations by state governments. Despite their adaptations to mainstream medicine, midwives are still underutilized in American health care, attending 10% of births in Washington state per year (MAWS History, WA Fact Sheet). So how did American society stray so far from trusting our natural, biological processes? Over the last century, medicine has grown to become the unquestionable authority on health care in the United States. This was powered by their monopoly on medical technologies and their ability to centralize their profession. Once the physician's authority was established they promoted the discrediting and stigmatization of midwives, which pressured midwives to take their practices underground and out of the mainstream health care system. Today, midwifery has returned to many states, thanks to revitalized legislation and active national

midwifery organizations. In this chapter I will discuss the historical origins of the midwife stereotypes and her classification as an "alternative" birth option. Then I will introduce the types of midwives in the United States and their supporting organizations. Finally, I will review the Washington state laws that govern midwifery practices to establish an understanding of midwife regulations in my research community.

History of Midwifery in the United States

Midwifery was not always the "alternative" childbirth option that it is today. Historically, the midwife "has existed for as long as women have been giving birth" (McCool and McCool 1989: 326). Traditionally, her role was to assist the natural process of birth and support the mother who gave birth kneeling or sitting (Banks 1991: 1). Midwives promoted births where female relations played an active role in the birth by providing comfort and aid, keeping the focus of the birth "women-centered" (McCool and McCool 1989: 327) and classified the process as "woman's business" (DeVries 1996: 21). This form of birth was the norm among American colonists and other 17th century women. Additionally, for early American colonists, the midwife played a unique role as "the sole source of health care" in the community because few university-educated physicians were among the rebellious American colonists (McCool and McCool 1989: 327). As a result of their broader responsibilities, colonial midwives were highly respected and utilized in their communities (Rooks 1997: 18).

In contrast with the traditional birth practices of the colonists, today childbirth is dominated by the biomedical model, characterized by a hospital setting, obstetrician attendance, and medical interventions. For example, in 2005 a third of all births in the United States were by cesarean section (Lake and Epstein 2008). How did our cultures'

mainstream childbirth practices shift so dramatically from natural to biomedical births? A study of American midwife history illuminates that the rise of medical authority and the discrediting of midwives was the result of the technological innovations, professionalization of medicine, and stigmatization against poor women during the 20th century.

Technological innovations. One of the first technological innovations that shifted the authority of childbirth from the midwives to the physicians was the invention of the forceps. Starting in the 1700's, barber-surgeons, exclusively male professionals, were called upon to assist in complicated deliveries. Their involvement in the lying-in chamber was largely reactive and their exclusive right to surgical instruments, due to their guild membership, kept their roles distinctive from the midwife's. Men's door into childbirth was through their monopoly on technology, seen first with the involvement of the barber-surgeons and then with the development of the forceps (DeVries 1996: 24). When the forceps were invented, women were drawn to them because they promised shortened labors (DeVries 1996: 24). Even though women were demanding forceps intervention in their deliveries, midwives did not adopt them to their practices. This may have been because 1) the laws of the barber-surgeon's guilds restricted the use of forceps to those professionals with guild membership, 2) men refused to sell forceps technology to women, or 3) the physical strength required to wield early models of forceps may have been too much for most midwives (Wertz and Wertz 1977: 39). Whatever the reason that the midwives did not adopt forceps, mothers interested in forceps technology had to look beyond the traditional midwife for this service.

The introduction of the forceps, created a space for male participation in childbirth, so that "modesty and tradition eventually gave way to medical science" (DeVries 1996: 21). Childbirth as "woman's business" was lost to the demand for easier births aided by medical technology. Traditionally, men were restricted from the lying-in chambers where the exposition of the woman's body was only appropriate in the presence of other women or her husband. The inclusion of barber-surgeons, men without a familial relationship to the mother, in the birthing room reflects a social shift in priorities. The opportunity to scientifically improve birth outcomes was so revolutionary and appealing that the former priorities for female solidarity and modesty were displaced. The development of the forceps was the first birth technology that was widely accepted and incorporated into childbirth which led to Roush's suggestion that the forceps were the "fatal blow to the female midwives" (1979: 34). Ultimately the adoption of forceps intervention to childbirth opened the flood-gates for additional medical interventions that would explode in the 20th century as physicians settled into their role as the childbirth authority.

The next significant technological innovation for childbirth was twilight sleep in 1914. This anesthetic drug was a combination of morphine, for pain relief, and scopolamine, so women had no memory of the birth (Rooks 1997: 22-23). A technology that could relieve women of the burden of childbirth was attractive to the early feminists of this period. In the early 1900s it was still widely believed that the pain of childbirth was woman's punishment for Eve's disobedience in the Garden of Eden. The scientific advancement of twilight sleep gave women the power for painless childbirths, releasing them from their biblical oppression (Lake and Epstein 2008). Upper-class women, the

mothers who could afford a hospital birth with twilight sleep, established "twilight sleep societies" to support the novel technology (Rooks 1997: 23). The promotion of twilight sleep by upper-class women further advanced the authority of physicians in childbirth. As upper-class women self-selected doctors as their primary birth attendants the midwife became stigmatized as the cheap option for lower-class women who could not afford physician care (Rooks 1997: 23). The male physicians' exclusive access to the technological innovations that appealed to women allowed them to establish themselves as the childbirth specialists of the wealthy, which set the ideal standard for all American women.

The early 20th century was characterized by high maternal mortality rates, peaking at "600 to 700 deaths per 100,000 births" (Rooks 1997: 31). Historically, midwives were the scapegoat for these disturbing rates, but research has shown that they are more likely a reflection of the weak sterilization in hospitals. In 1913 "nearly half of [maternal] deaths were from 'childbed fever'" (Meigs 1985), a common term for puerperal fever which is a "postpartum infection of the mother's uterus and other pelvic organs, often due to infectious agents transmitted to the mother on the hands of the person who assisted the delivery" (Rooks 1997: 23). Even though it seemed that midwives, who worked in homes without any regulation, were likely culprits of unsanitary practices, "puerperal fever was especially common among women whose babies were delivered in hospitals, an environment in which physicians often examined many patients in sequence without washing their hands" (Rooks 1997: 23-24). Infection was so common from these unsanitary conditions that most of the technological improvements to childbirth were

cancelled out by the exposure to infection (Wertz 1983: 14). Despite the technology available at the hospital, this environment was highly dangerous for deliveries.

However, in the 1930s the introduction of "sulfa drugs, antibiotics, blood transfusions, and drugs to treat pregnancy-induced hypertensions" gave hospitals the technology to counteract the risks of hospital birth (Rooks 1997: 459). The medical interventions developed by doctors, such as the forceps and twilight sleep, which drew women to hospital births, unknowingly exposed them to greater complications with their pregnancies resulting in higher mortality rates. The invention of antibiotics and other drugs to combat infection caused "the number of infection-related maternal deaths [to fall] from 3,719 in 1937 to 392 in 1954", from Maine's 1991 study (Rooks 1997: 31). As Walsh suggests, now that physicians had the necessary interventions to treat hospital-borne infections, public acceptance of physicians and hospitals increased (Rooks 1997: 1997: 22). The medical innovations which attracted 20th century women to the hospitals actually weakened their health during pregnancy, a phenomenon which reflects the absolute authority of physicians. Then, when doctors developed a treatment for these pregnancy complications, which they had helped to create, the general population hailed them as miracle-workers rather than skeptically challenging their practices. Doctors and the medical profession had placed themselves in a position of authority in American healthcare, thanks to their seemingly miraculous technologies and their centralized professional organizations which will be discussed in the following section.

Professionalization of medicine. Beyond controlling medical technologies, physicians established their authority in the American health care system by creating an organizing professional body. The American Medical Association (AMA) was founded

in 1847 with the goals of "scientific advancement, standards for medical education, launching a program of medical ethics, [and] improved public health" (The Founding of AMA). By centralizing their power in a professional organization, physicians were able to participate in politics and legislature. Physicians defined their scope of practice with state legislatures, legally carving out their areas of expertise. However many of these definitions were extremely broad, for example according to the North Carolina Statue of 1983, "any person…who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person" (Safriet 1992: 441). Legal definitions, such as this one, left very little room for any specialist except a physician to work in health care. Effectively doctors established themselves as the sole medical professionals in American health care (Safriet 1992: 441). With unified professional goals and the political savvy to lobby their positions in government, physicians expanded their authority to encompass every aspect of public health care and education. During this same period midwives did not mobilize to involve their profession in the political stadium, as physicians had. As a result, they were ill-prepared to fight against the "midwife debate" of the early 1900s (Rooks 1997: 459).

The "Midwife Debate"

The "midwife debate" of 1910 to 1935 was sparked by two reports that critiqued the safety of obstetrics (Rooks 1997: 24). In 1910, the Flexner report assessed that American medical education, especially in obstetrics, was very low-quality (Rooks 1997: 24). Then in 1912, the Children's Bureau conducted research comparing US infant mortality rates to those of major European countries, revealing that American rates were

significantly higher (Rooks 1997: 451). These two critiques of obstetrics sparked a physician-led campaign to blame the midwives for America's poor standing in maternal and infant health. Supported by the strength and support of the medical profession, who were actively looking for a way to explain their shortcomings, publications by Dr. J. Whitridge Williams and Dr. Joseph DeLee led the charge against midwives.

In 1912, Dr. Williams' article in the *Journal of the American Medical Association* confronted Flexner's ugly accusations about American medical schools. Williams conducted his own survey, confirming that current obstetric training was insufficient, especially when considering the availability of clinical observations (Williams 1912). For example, out of 43 obstetric schools "only nine [had] anything like adequate clinical material for the instruction of their students" (Williams 1912: 89). With approximately half of American births being attended by midwives, these births were seen by obstetrics instructors as lost opportunities for obstetrician training (Rooks 1997: 24). Dr. Williams concluded his article with a series of recommendations calling for an urgent reform that could "be accomplished more speedily by radical improvement in medical education than by attempting the almost impossible task of improving midwives" (Williams 1912: 100). He suggested replacing midwives with obstetric charities, where low-class women could receive discounted obstetric care from students, and focusing the field's efforts on improving obstetric education in a profession that was already unified (Williams 1912: 100). By characterizing midwifery reform as an unreasonable solution to obstetric ineffectiveness, Dr. Williams limited the discussion of maternal health reform to the role that the medical field could play as a universal and reliable provider.

Dr. Joseph DeLee's 1915 publication continued Dr. William's devaluing of midwives by attacking them from two angles. First, Dr. DeLee argued that childbirth was a dangerous condition which required the skills of a highly trained doctor (Litoff 1986: 84). Even though childbirth was natural it often damaged both mothers and babies, as seen by the high rates of infant and maternal mortality exposed in the Children's Bureau report (DeLee 1915: 104). Therefore he believed that "if child-bearing is destructive, it is pathogenic, and if it is pathogenic, it is pathologic" and pathology belongs in the field of medicine and hospital treatments (DeLee 1915: 104). The American Medical Association had defined their practice as the experts for pathology, so by defining childbirth as pathologic, DeLee convinced the public that childbirth was the responsibility of physicians. However, according to DeLee, the continued practices of midwives were "a drag on the progress on the science and art of obstetrics" (DeLee 1915: 102). His second argument against midwives was that the frequency of "untrained" women working in medicine barred the obstetrician from receiving the esteem and honor that his practice deserved (Litoff 1986: 84). DeLee blamed the limited progress of the American obstetricians on the continued existence of midwives in women's health. By scape-goating the midwife as the "bad guy" of health care and using medicine's widespread influence to convince the public that childbirth needed obstetrics, DeLee and Williams powered a social movement against midwives that simultaneously placed professional value on physicians.

As the professional rivalry between physicians and midwives escalated into the mid-twentieth century, midwives were discredited based on their identities as women and members of the working class. Traditionally women had been excluded from science

because of their social roles as mothers and the sexist prejudices against their intelligence. According to Wertz, the economic prosperity of the 1920s emphasized these divides by creating the social ideal among the growing middle class that women "were supposed to be wives, mothers, and 'ladies' and were not expected to work for pay" (Rooks 1997: 23). However, lower-class women continued to work out of necessity and the working-class midwives continued their practices. As a result, midwives were socially stereotyped as low-class women with minimal training whose only clients were women who could not afford a doctor (Rooks 1997: 23). Physicians took advantage of the social stigmatization against midwives by critiquing the intelligences and capabilities of midwives based on the cultural prejudices against groups they identified with, namely women, immigrants, black people, and poor people (Rooks 1997: 24). Social campaigns to limit midwifery were very effective when the justification was coming from the medical body which had already established its authority through scientific invention and professional associations.

Without professional organizations to promote solidarity, the midwives were ill-equipped to combat the professional campaign against them. At the most basic level, the midwives were so isolated from each other that a centralized association was never fully considered. The traditional midwife's practice did not incorporate a professional component, rather it was defined by the needs of the community (Borst 1989: 47). Unlike physicians, who decided early on that centralized authority was necessary to monitor the standards of their practices, midwives never "agreed on the necessity of organization or any other professional apparatus" (Borst 1989: 47). Furthermore, even if midwives decided that professional organization was a worthy goal, as a population they did not have the education to develop a legal association. The few midwives who did

have formal training were immigrants who completed their training abroad and were not fluent in English (Rooks 1997: 24). Thus the midwives lacked the necessary academic skills and professional community to discredit the physician's attacks against them, so the negative stereotypes of their practice became part of mainstream medical beliefs.

The stigmatization of midwives continues into the present day. There is a lot of misunderstanding about the qualifications of midwives and their practices. Choosing a physician-attended, hospital-based, biomedical birth has become the norm for American women. However, despite the attacks against them in the 20th century, the midwives began a revival in the late 1900s. The professionalization of midwifery, approximately 100 years after a similar movement in medicine, was vital for midwives to begin their return to mainstream births.

Different Types of Midwives

Unlike physicians, whose professionalization worked in tandem with their centralization, midwives remain divided based on the variety of certifications available. Many Americans are deterred from considering midwives because of the confusing technicalities of the modern midwives professional standing. The professionalization of midwives and the accompanying organizations will be discussed in the following section but first we must clarify the distinction between certified nurse-midwives and direct-entry midwives.

Today, in the United States, the most common type of midwife is the certified nurse-midwife who practices legally in every state (Our Credentials) and has official approval from the AMA (DeVries 1996: 93). The overwhelming majority of CNMs work in hospitals as seen in the ACNM's 1991, 1993, and 1994 surveys where over 90%

of CNMs identified hospitals as the site of birth (Walsh and Boggess 1996: 230). All certified nurse-midwives begin their careers as nurses and then continue on to complete an additional one to two years of training in obstetrics (DeVries 1996: 17). Due to their early involvement in medical settings it is unsurprising that the majority of CNM practices continue in hospitals. Working in a hospital has many benefits, including the ease of consulting, collaborating, or referring patients to a physician when appropriate (Rooks 1997: 8). According to their certification requirements, a CNM is capable and qualified to provide complete care to uncomplicated maternity patients but they are legally obligated to refer complicated cases to obstetricians (DeVries 1996: 91). By locating in hospitals, CNMs improve their relationships with physicians and remove the liability hassle of referrals, because of their employer-employee relationship with the hospital (Rooks and Schmidt 1980). Thanks to the accessibility of midwives in the dominant medical setting, CNM service has become more common among women of all socio-economic status' (Rooks 1997: 461). By blending midwifery with medicine CNMs have been vital to dispelling the stereotypes of midwifery as a free-spirited, unreliable form of healthcare. A brief history of the certified-nurse midwives further highlights their unique path to forge a middle ground between doctors and midwives.

Since the migration of childbirth from the home to the hospital, nurses were crucial in providing care during all stages of birth. Doctors were becoming increasingly busier, serving multiple patients at once. In 1914, the American physician, Fred Taussig proposed training nurse-midwives to attend normal births because deliveries were drawing general physicians away from their other patients (Taussig 1986: 228). At the time there were not enough specially trained obstetricians to cover all the births so nurses

seemed ideal candidates to cover the shortage because they already had sufficient experience in hospital routines (Taussig 1986: 229). Taussig even suspected that the general physician would "look forward with relief to the time when the properly trained nurse can undertake this irksome [childbirth] work for him" (Taussig 1986: 229). Ultimately Taussig's recommendations were adopted with the development of nurse-midwife education programs. Since CNMs were originally established to cover the shortage of qualified physicians, it is unsurprising that they became a stigmatized alternative for women who could not afford doctors, who remained the first choice of care (Rooks 1997: 23). This pattern was not fought by the physicians because they regarded the poor and minority populations as undesirable clientele, and were happy to leave their care to midwives (DeVries 1996: 27). While physicians were conquering lay midwife practices all over the country with the "midwife debate", they simultaneously supported CNM programs working in the ghettoes and among the poor (DeVries 1996: 27). With the support of physicians, certified nurse-midwives created a professional niche for themselves. Their historical cooperation with medicine led to their acceptance into hospitals, unlike their non-CNM peers who entered midwifery without nursing degrees and have continuously fought suppression by the medical field.

In the United States there are multiple methods to becoming a licensed midwife[6]. The federal government places the responsibility of midwife certification on state

[6] There is a debate among midwives, physicians, and lawmakers about the distinction between "lay" and "direct-entry" midwives. According to Myers-Ciecko, when direct-entry midwifery schools began to appear in the United States "there was an effort to limit the direct-entry term to midwives, other than CNMs, who had completed a structured educational program that meets the requirements for licensure" (Rooks 1997: 9). Opposing this movement are many people who believe "any effort to distinguish between direct-entry midwives and lay midwives is not acceptable" and use both terms interchangeably (Rooks 1997: 9). This terminology debate is really a reflection on varying perspectives about the degree of training, provided by non-nursing midwifery schools. Although many sources use the "direct-entry" or "lay" midwife

governments so there is great variation between state standards (Rooks 1997: 10). Additionally there are private, national organizations which provide midwife certification programs that states may adopt. The Midwives Alliance of North America (MANA) and the American College of Nurse-Midwives (ACNM), both will be discussed in detail later, have each developed a certification process for midwifery licensure. In 1987, MANA inspired the development of the North American Registry of Midwives (NARM) (Myers-Ciecko 1999: 385). By passing the NARM certification written exam, skills assessment, and verifying that they have sufficient experience, midwives receive credentials as a certified professional midwife (CPM) (Entry-Level Applicants). The ACNM also provides a similar examination through the American Midwifery Certification Board (AMCB) for both CNMs and direct-entry midwives. Without a prior nursing degree, midwives can be certified through the AMCB as a certified midwife (CM). These two forms of accreditation, the CPM and the CM have similar requirements for certification; the distinguishing factor is whether they are inspired from the MANA or ACNM core competencies.

Despite available opportunities to achieve certification, some midwives choose to continue their practices, usually illegally, as unlicensed midwives. Typically unlicensed midwives serve women of a specific subculture, such as a religious community, or live in rural areas where access to health care in limited (Myers et al. 1990: 728). A Washington state study in 1990 confirms this tendency. Mothers reported that they "chose unlicensed midwives because they had religious beliefs in common, or because they were the only providers available who would attend a home birth" (Myers et al 1990: 726). In order to

terminology, I will refer to non-CNM midwives through the terms "licensed" and "unlicensed" midwives in hopes to create consistency and clarity in my argument.

address this legal conflict of personal choice and monitoring midwife licensure, some states allow unlicensed midwives to practice with the stipulation that they do not advertise of charge for their services (Rooks 1997: 232). The legal standing of unlicensed midwives is poorly defined and they are becoming increasingly invisible in the broader forum of childbirth care, as CNM and licensed midwife care gains support.

In contrast with the certified-nurse midwife who developed in a medical setting and maintained respectful relationships with physicians, licensed and unlicensed midwives were born out of conflict with the medical profession as part of an antiauthoritarian, antibureaucratic counter-culture (Rooks 1997: 460). This 1960s grassroots movement was established by women who distrusted the overmedicalization of birth and sought home birth with personalized care. So they turned to their fellow women for support and alternative birth services (Myers-Ciecko 1999: 384). Unlike the certified nurse-midwives who were trained in mainstream medicine, licensed and unlicensed non-CNM midwives were "young, middle-class college students and graduates with the nerve and verve to buck the medical paradigm" (Rooks 1997: 460). Predictably, they received a lot of backlash from the medical profession who were distrustful of their qualifications and threatened by their practice. However, a benefit of the non-CNM midwives' practice was that they took on fewer patients and therefore had more time to dedicate to their clients throughout pregnancy and birth (DeVries 1996: 101). Unsurprisingly the environments in which midwives choose to work are reflective of the nature of their practice. According to a study by Foley and Faircloth in Florida, "LMs work primarily in home or birth center settings while CNMs work primarily in hospital settings" (Foley and Faircloth 2003: 182). Even though CNMs and non-CNM

midwives grew with different histories to serve different communities, today they are increasingly more inclusive and work toward similar goals. The two largest midwife associations, MANA and ACNM exemplify these modern relationships.

Private Midwifery Organizations

Founded in 1955, the American College of Nurse-Midwives is the primary organizing body for certified nurse-midwives and "works to establish midwifery as the standard of care for women" (About ACNM). Representing CNMs and CMs, the ACNM is the "oldest woman's health care organization in the United States" (About ACNM). At the heart of their philosophy, ACNM midwives strive to "affirm the power and strength of women and the importance of their health in the well-being of families, communities and nations" (Our Philosophy of Care). In addition to their role in the movement to empower women, the ACNM is a major body of midwife accreditation in the USA. They sponsored the formation of the American Midwifery Certification Board (AMCB) the national certification process for both CNMs and CMs (Certification). Although ACNM lists "inclusiveness" as one of its core values by "[embracing] those prepared dually in nursing and midwifery *and* those prepared directly in midwifery" (About ACNM, emphasis added) ACNM has historically been characterized by its "exclusivity and rigid eligibility requirements" (Rooks 1997: 242). Subsequently, this selectivity led to the establishment of another midwifery organization, the Midwives Alliance of North America (MANA).

In reaction to ACNM's exclusivity and focus as professionals "setting the standard for midwifery excellence" (About ACNM), the Midwives Alliance of North America was created "to provide a nurturing forum for support and cooperation among

midwives" (What is MANA?). It was founded in 1982 after the American College of Obstetrics and Gynecologists expressed their difficulties communicating with non-CNM midwives when ACNM was the only national midwifery organization. At the time only CNMs, not CMs, were represented by the ACNM (Rooks 1997: 241). From its inception, MANA emphasized awareness about "the diversity of educational backgrounds and practice styles within the profession" making it a popular association for both licensed and unlicensed midwives (What is MANA?). Although they cater primarily to different membership bases MANA's organizing structure and documents are modeled from the ACNMs (Rooks 1997: 242). Consequently, MANA's historical progression mirrors ACNM's. In 1985 it adopted standards of practice, in 1987 it created a written exam of basic midwifery knowledge, in 1989 it established its core competencies, and in 1991 it issued a statement of values and ethics (Myers-Ciecko 1999: 385). Comparable to ACNMs relationship with the AMCB, MANA supported the establishment of the North American Registry of Midwifery (NARM) which grants the title of Certified Professional Midwife (CPM) with a competency-based certification process (What is MANA?). Despite their divergent philosophies on the definition of a "professional midwife" MANA and ACNM both aim to "ensure midwifery care for all mothers and their babies throughout North America" (What is MANA?).

Washington State Midwifery History and Current Standing

Keeping in mind the history of midwives and their legal standing in the United States, we will now focus on midwives practicing in Washington State. Since my research was conducted among women in Eastern Washington we must review the specific laws governing their practices. Additionally I will analyze the accessibility of

licensed midwives to Washington women when insurance and other financial obstacles are considered.

Legality of practice and certification. As mentioned previously, the laws controlling midwifery practice and accreditation vary greatly between states. Since the beginning of biomedical birth's takeover of women's health, Washington State has had a "strong history of supporting the development of the direct-entry midwifery profession as well as choice and access to care for childbearing women" (Myers-Ciecko 1999: 387). Unlike most states whose laws limited midwife practices by creating specific consultation requirements, Washington focused on developing independent midwife education programs (MAWS History). In addition to Washington's unique emphasis on education, it is one of the few states that license direct-entry midwives (Myers et al 1990: 726). Washington is home to the first direct-entry midwifery school and the Midwives Association of Washington State (MAWS) which was founded in 1983 (MAWS History 2011).

The first legislation regulating lay midwifery in Washington State was the 1917 Midwifery Act requiring two years of schooling for licensure (MAWS History). The 1981 Midwifery Act reevaluated the original 1917 act to establish standards for direct-entry midwifery practices (Myers et al 1990: 726). This revised act increased the education requirement to three years, listed specific curriculum requirements (such as life sciences, nutrition, and epidemiology), increased the number of required birth experiences to 100, and established a list of drugs and equipment that midwives could incorporate into their practices (MAWS History). This law also included a challenge mechanism so that unlicensed midwives can take the licensing examinations without the

required coursework if they have sufficient documented experience (Myers et al 1990: 726). The act also allowed for unlicensed midwives to practice if they offer their services free of charge (Myers et al 1990: 726). Originally this provision was established to allow midwifery practices that were traditional to certain religious communities (Rooks 1997: 235). Aligning with its liberal political leanings, Washington State has been supportive of midwifery as an alternative to biomedical birth, in comparison to some of its peers.

Washington State is also exceptional because it distinguishes licensed midwives from certified nurse-midwives in its laws. Washington legislation places direct-entry midwives in a separate category from CNMs so that all health insurers must include both types of licensed midwives in their lists of health care professionals available to subscribers (Rooks 1997: 461). This has helped create a demand for and greater awareness about the birthing options in Washington. The 1994 State Health Personnel Resource Plan recognized licensed midwives as primary care providers for maternity care (MAWS History). Then in 2000, the government passed legislation allowing women to choose an LM as a health care provider without first visiting a primary care doctor (MAWS History). All three of these measures in Washington legislation have helped to assure that women have the freedom to choose midwives as their primary care providers and have established systems that allow them to access these services without the approval of the dominant medical system.

The establishment of direct-entry midwifery education programs in Washington has a long, progressive history in the context of the United States. The Fremont Women's Clinic Birth Collective in Seattle started as a group of young women who began attending home births with the support of several young physicians (Myers-Ciecko

1999: 384-385). Then in 1978, a time when other independent midwifery schools were being launched, the Fremont Collective founded the Seattle Midwifery School (Myers-Ciecko 1999: 385). Then in 1984, another midwifery program for naturopathic students and physicians was created at Bastyr Naturopathic College (MAWS History). In 2010, Bastyr University and the Seattle Midwifery School merged to become the first direct-entry midwifery program to offer a masters degree (MAWS History). Washington's official acceptance of licensed midwifery, in addition to its support of certified nurse-midwives, has allowed the state to create a social space and harness legal support for midwifery. However, midwives in Washington still face many challenges such as securing malpractice insurance and hospital privileges, two requirements for legal practice.

Midwives as an accessible option. Securing health insurance for the patient and malpractice insurance for the practitioner are major hurdles for midwives all over the United States. In Washington State, recent laws have assured mothers that their midwifery payments will be covered by their health care plan. Improvements to the Medicaid program in favor of midwifery have been particularly groundbreaking for midwifery practices in Washington. As early as the 1980s, Washington Medicaid recognized LMs as qualified providers however they only provided reimbursements for prenatal and postpartum care (MAWS History). Furthermore, at this time, Medicaid did not recognize homebirths or birth in unlicensed facilities, but with the birth-center licensing law in 1986, Medicaid programs approved reimbursements for birth-center births (MAWS History). Finally in 1999, a pilot project was started to research the incorporation of homebirth reimbursement into Medicaid (MAWS History). Ultimately,

this project produced positive results so that homebirth reimbursement was fully implemented (MAWS History). Beyond securing payment plans for patients who choose midwifery care, in 1993, Washington "legislation was passed to create a Joint Underwriting Association (JUA) that required all liability carriers in the state to participate in underwriting professional liability insurance for LM, CNMs and licensed birth centers" (MAWS History). By legally supporting midwives with malpractice insurance, the state has made physician-midwife transfer relationships easier by providing insurance to midwives, which has historically limited midwives access to reliable hospital referrals.

Formal communications between midwives, physicians, and state officials are frequent in Washington State and have helped to create a more effective system of care for all mothers. The 1981 law requires that "every licensed midwife shall develop a written plan for consultation with other health care providers, emergency transfer, transport of an infant to…neonatal intensive care, and transport of a woman to an appropriate obstetrical department" (Washington State 1981). As a result, midwives are limited to practice only where physicians are available for consultation and hospitals are available for transfer. For example, in a 1988 study, CNMs expressed that their primary reason for not working in rural settings was that physicians were not available to work with them (Rooks 1997: 219). In order to facilitate these relationships, since 1995, the Midwives' Association of Washington State, Washington State Medical Association, and Washington Obstetrical Society have met regularly to develop mutually acceptable procedures for consultation and referral (MAWS History). In 2004, after an unsuccessful attempt in 1995, the Midwives' Association of Washington State wrote the "Planned Out-

Of-Hospital Birth Transport Guidelines" which were approved by the Statewide Perinatal Advisory Committee, the Midwives' Association of Washington State, and the Physician-Licensed Midwife Work Group" (MAWS History). In Washington State, midwives have achieved a certain level of professional autonomy thanks to the legal systems that support their insurance coverage and encourage strong working relationships with hospitals. However, midwife-attended births still remain low, indicating that stronger cultural factors are limiting the acceptance of midwives, not just the legal system.

Conclusion

Generally midwifery statistics are very inconsistent because of the variety of midwife certifications, inaccurate recordings of information on birth certificates, and the continued illegal practices among unlicensed midwives. Generating perfectly accurate numbers for the frequency of midwife-attended births are nearly impossible, but all statistics show a low-frequency of births attended by midwives with very little growth. Unlike most European and Asian nations where "midwives attend over 70% of births", less than 8% of American births are attended by midwives, and these numbers include all forms of midwifery (Lake and Epstein 2008). Today, CNMs are more likely to care for women who are of low socioeconomic status, young, non-white race/ethnicity, unmarried, low education, third trimester entry to prenatal care, and using Medicaid insurance coverage, the same role they have played historically (Bussey et al 2007: 445). From 1995 to 2004, "CNMs attended approximately 10% of all singleton spontaneous vaginal births" (Bussey et al 2007: 445). On the other hand, the populations served by non-CNM midwives are divided depending on geographic location licensed midwives are more likely to serve married professionals in urban areas, whereas unlicensed midwives are

likely to work in rural counties (Myers et al 1990: 727). In Washington, a state with dense urban centers and rural areas, "there are now approximately 110 licensed midwives…and in 2009 they attended 2,130 births (2.5% of all births in the state)" (MAWS History). As of 2008 there were also 258 CNMs in Washington State and in 2007 they attended the births of 8,134 babies, or 9.1% of Washington's births (WA Fact Sheet). Despite the legal and professional advances of the last century, midwives remain the minority attendant in American childbirth. If their legal standing is no longer limiting their practices, what cultural limitations are restricting the midwives practice in the United States?

Through our analysis of American midwife history and our review of the current position of midwives, we discover that the modern stereotype of midwives as outdated, incompetent, and low-quality are unfounded. As the medical profession grew and established itself as the ultimate health authority, they blamed midwives for the high maternal mortality rates that resulted from the physician's premature introduction of technology to childbirth. With the help of upper- and middle-class women, who were attracted to the freedom of painless and quick births that these new technologies offered, midwives became the birth attendant of the lower-class and they fell out of style. Today's stereotype of midwives as unqualified birth attendants is a reflection of historical prejudices and not of the modern reality of their practices. Without persistent promotion of midwifery as a viable option for expectant mothers, there will continue to be rampant misunderstandings about their practices, a misconception which midwives continue to rebuke in their modern practices.

IX. Bibliography

American College of Nurse-Midwives. "About ACNM." Accessed November 19, 2012. http://www.midwife.org/About-ACNM.

American College of Nurse-Midwives. "Certification." Accessed November 19, 2012. http://www.midwife.org/Certification.

American College of Nurse-Midwives. "Our Credentials." Accessed November 19, 2012. http://www.midwife.org/Our-Credentials.

American College of Nurse-Midwives. "Our Philosophy of Care." Accessed November 19, 2012. http://www.midwife.org/Our-Philosophy-of-Care.

American Medical Association. "The Founding of AMA" Accessed November 19, 2012. http://www.ama-assn.org/ama/pub/about-ama/our-history/the-founding-of-ama.page?.

Banks, Amanda Carson
1991 Birth Chairs, Midwives, and Medicine. Jackson: University Press of Mississippi.

Borst, Charlotte G.
1989 Wisconsin's Midwives as Working Women: Immigrant Midwives and the Limits of a Traditional Occupation, 1870-1920. Journal of American Ethnic History 8(2):24-59.

Brodsky, Phyllis L.
2008 The Control of Childbirth. Jefferson: McFarland and Company, Inc.

Bussey, Carie G., Janice F. Bell, and Mona T. Lydon-Rochelle
2007 Certified Nurse-Midwife Attended Births: Trends in Washington State, 1995-2004. Journal of Midwifery and Women's Health 52(5):444-450.

Davis-Floyd, Robbie E.
1994 The Technocratic Body: American Childbirth as Cultural Expression. Social Science and Medicine 38(8):1125-1140.

Davis-Floyd, Robbie E.
2003 Birth as an American Rite of Passage. Berkeley: University of California Press.

Declercq, Eugene R.
1992 The Transformation of American Midwifery: 1975 to 1988. American Journal of Public Health 82(5):680-684.

DeLee, Joseph B.

1915 Progress Towards Ideal Obstetrics. *In* The American Midwife Debate: A sourcebook on its modern origins. Judy Barrett Litoff, eds. Pp. 102-109. New York: Greenwood Press.

DeVries, Raymond G.
1996 Making Midwives Legal. Columbus: Ohio State University Press.

Foley, Lara and Christopher A. Faircloth
2003 Medicine as discursive resource: legitimation in the work narratives of midwives. Sociology of Health & Illness 25(2):165-184.

Gabriel, Cynthia
2011 Natural Hospital Birth: The Best of Both Worlds. Boston: The Harvard Common Press.

Gibbons, Luz, Jose M. Belizan, Jeremy A. Lauer, Ana P. Betran, Mario Merialdi, and Fernando Althabe
2010 The Global Numbers and Costs of Additionally Needed and Unnecessary Cesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage. World Health Report 30: 1-31.

Lake, Ricki and Abby Epstein
2008 The Business of Being Born. 84 min. New Line Home Entertainment. Burbank.

Lakoff, George
1999 Cognitive Models and Prototype Theory *In* Concepts: Core Readings. Eric Margolis and Stephen Laurence, eds. Pp. 391-421. Cambridge: Bradford Books.

Litoff, Judy Barrett, ed.
1986 The American Midwife Debate: A sourcebook on its modern origins. New York: Greenwood Press.

Martin, Emily
1987 The Woman in the Body. Boston: Beacon Press.

Martin, Joyce A., Brady E. Hamilton, Stephanie J. Ventura, Michelle J.K. Osterman, Elizabeth C. Wilson, and T.J. Matthews
2012 Births: Final Data for 2010. National Vital Statistics Reports 61 (1):1-71.

McCool, William F. and Sandi J. McCool
1989 Feminism and Nurse-Midwifery: Historical Overview and Current Issues. Journal of Nurse-Midwifery 34(6):323-334.

Meigs, G.L.
1985 A survey of the problems of childbirth, 1911-16. American Journal of Public Health 75: 546.

Midwives Alliance of North America. “What is MANA?” Accessed November 19, 2012. http://mana.org/about.html.

Midwives’ Association of Washington State. “MAWS History.” Accessed November 19, 2012. http://www.washingtonmidwives.org/about-maws/maws-history.html

Myers, Susan J., Patricia A. St. Clair, Stephen S. Gloyd, Philip Salzberg, and Joanne Myers-Ciecko
1990 Unlicensed Midwifery Practices in Washington State. American Journal of Public Health 80(6):726-728.

Myers-Ciecko, Jo Anne
1999 Evolution and Current Status of Direct-Entry Midwifery Education, Regulation, and Practice in the United States, with examples from Washington State. Journal of Nurse-Midwifery 44(4):384-393.

Nelson, Fiona
2006 Birth Stories: Narrative Constructions of Transitions to Motherhood. Paper presented at Annual Meeting of the American Sociological Association, Montreal.

North American Registry of Midwives. “Entry-Level Applicants.” Accessed November 19, 2012. http://narm.org/entry-level-applicants/.

Ratcliffe, Krista
2002 Bearing Witness to Birth: A Literary Perspective. *In* Who’s Having This Baby?: Perspectives on Birthing. Pp. 43-86. East Lansing: Michigan State University Press.

Rooks, Judith Pence
1997 Midwifery and Childbirth in America. Philadelphia: Temple University Press.

Rooks, Judith, and Marilyn Schmidt
1980 Hospital privileges: Experience of the certified nurse-midwife. Clinical Psychologist 33(4):10-11.

Roush, Robert E.
1979 The development of midwifery – Male and Female, Yesterday and Today. Journal of Nurse-Midwifery 24(3):27-37.

Safriet, Barbara J.
1992 Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing. Yale Journal on Regulation 9(2):417-488.

Taussig, Fred J.

1914 The Nurse Midwife. *In* The American Midwife Debate: A sourcebook on its modern origins. Judy Barrett Litoff, eds. Pp. 227-231. New York: Greenwood Press.

United States Census Bureau. "State and County QuickFacts: Walla Walla, Washington." Accessed April 15, 2013. http://quickfacts.census.gov/qfd/states/53/5375775.html.

Van Hollen, Cecilia
2003 Invoking *Vali*: Painful Technologies of Modern Birth in South India. Medical Anthropology Quarterly 17(1):49-77.

Walsh, Linda V., and John H. Boggess
1996 Findings of the American College of Nurse-Midwives Annual Membership Surveys, 1993 and 1994. Journal of Nurse-Midwifery 41(3):230-235.

Warsh, Cheryl Krasnick
2010 Prescribed Norms: Women and Health in Canada and the United States since 1800. North York: University of Toronto Press.

Washington State Fact Sheet. "Certified Nurse-Midwives in Washington." Aug. 2008. Accessed December 11, 2012.

Washington State Revised Code 18.50.108 (http://apps.leg.wa.gov/rcw/default.aspx?cite=18.50.108).

Wertz, D.C.
1983 What birth has done for doctors: A historical view. Women and Health 8(1):7-24.

Wertz, Richard W., and Dorothy C. Wertz
1977 Lying-In: A History of Childbirth in America. New York: Free Press.

Williams, Whitridge J.
1912 Medical Education and the Midwife Problem in the United States. *In* The American Midwife Debate: A sourcebook on its modern origins. Judy Barrett Litoff, eds. Pp. 86-101. New York: Greenwood Press.