

THESIS

STALLED LABOR:

HOME BIRTH PARENTS, GENDER, AND RITUAL IN THE US

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ABSTRACT

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Pregnancy and birth are not purely biological, but fraught in every human culture with a great deal of meaning. Home birth, though unusual in the US, offers an opportunity to examine the cultural beliefs of those that choose it. Through a series of semi-structured ethnographic interviews with homebirth mothers, partners, and midwives, I find that these parents hope to transform the culture of birth to empower women, include men more fully, and give babies a gentler welcome into the world. This thesis draws on feminist and symbolic anthropological theories to examine midwife-attended pregnancy and birth at home as a rite of passage in which the parents both enact and are socialized into their new roles as parents. The mothers learn that a healthy birth is a commodity to be earned or purchased, that society has few obligations to the individual, and that the body gives birth. Fathers receive the related, though not identical, messages that the family is (or should be) self-sufficient, that they are responsible, and that birth care is a business. Both mothers and fathers move in and out of conventionally-gendered activities and roles as they negotiate pregnancy and birth. In the context of ritual, this has the possibility of subverting or reinforcing gender norms. The parents must grapple with this as they raise their new children, and find themselves torn between the desire to foster individuality and coping with the consequences of their children's non-conformity. They

resolve this through denying their own role in socialization and attributing their children's gendered activities to individual choice. Though they challenge many ideas about gender as they attempt to change the culture of birth, I find that this labor is stalled: much work remains to be done to empower women and make men more central in birth.

For My Husband
John Michael Biasioli
May 17, 1977-November 23, 2008

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When I despaired of ever finishing my thesis – and there were many times I did – I took time to remind myself of how many steps had already been completed. It always made the steps ahead seem more manageable. As I look back now, I see not only how long the journey had been but how many people helped me along the way. I cannot list all those who made a difference, but I offer my thanks to them all.

The men and women in this thesis welcomed a nosy stranger into their homes to take up most of a day. They offered stories of the most important moments in their lives candidly to me. I hope they do not mind that I made anthropology out of them.

So many of my colleagues have become dear to me, and I am grateful for the challenging discussions and empathetic support we have shared.

My advisor, Lynn Kwiatkowski, saw me through many iterations of proposals and drafts. Her patient editing and keenly analytical mind helped shape this into a much more interesting and coherent work than I could have produced on my own, and her criticism was always tempered with kindness and encouragement.

I think that my parents have often found me baffling, but they have always listened to my wildest ideas and encouraged my most ambitious plans. It took their incredible patience and wisdom to help me grow into the person I am today. I am deeply grateful to them for seeing me not only through my thesis, but through the trying personal times that accompanied it. I cannot imagine how I would have made it without them.

It is hard for me to think of graduate school or thesis work without thinking of my husband, John. He is intertwined with this story from the beginning. He inspired me to begin and always believed I could finish. He sat through many conversations in which I animatedly described some new theory I learned or article I had read, and feigned interest every time. He was there the many times when I sat down in tears, convinced that I was a fraud and soon everyone would know it. His encouragement meant so much to me. I wish he had lived to see this completed.

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INTRODUCTION

The Garrahys' Story

Uma woke up at 7:45 on Saturday morning with a strong urge to move her bowels. Since their bedroom was in the basement, she had to run up the stairs to get to the bathroom. She laughs telling the story: “I was pretty quick for a big ol’ pregnant lady!” She got to the bathroom, and...nothing. She went back downstairs and got back into bed, only to have the same thing happen again a few minutes later. After another mad dash up the stairs, she realized she was in labor. She tried to eat some breakfast but promptly threw up. She paced through her contractions as her husband, Michael, called the midwife. The midwife thought at first that the labor would be long – it was a first baby, after all – but changed her mind once she heard the sounds Uma was making. She lived 45 minutes away and decided she should start driving. Meanwhile, Michael showered with Uma and washed and brushed her hair. She continued to walk around the house as her labor progressed, knowing she was surrounded by her husband and parents, but deeply focused within herself. Soon she felt the urge to squat by the bed, and her water broke. The midwife arrived and asked if she felt ready to push. She did, and the baby descended so quickly that the midwife instructed her to refrain from pushing for a few contractions so the tissues would have time to stretch. After two pushes, the baby crowned, and Uma reached down to feel her head as it emerged. Just three hours after labor started, her baby girl slid out onto the bed so fast no one caught her. She was a bit

blue, so the midwife held an oxygen tube under her nose. The baby pinked up quickly, and was soon nursing. The midwife, her assistant, family, and close friends who had gathered to attend the birth now withdrew to prepare breakfast and allow the new family time to bond. Uma and Michael exclaimed and kissed over every part of their daughter for over an hour before the midwives returned to examine the newborn under the watchful eyes of her mother and grandmothers. Uma tore badly enough that the midwife preferred not to stitch her, so a few hours after the birth Michael drove her to the hospital. The doctor stitched her up quickly and offered congratulations, while the baby slept in the car with her grandmother. Uma is now planning her second home birth.

For many people, the word *midwife* seems to come from antiquity. Its roots are indeed old, from Germanic words meaning ‘with woman,’ but the practice of midwifery is far from gone. Modern US midwives combine traditional and modern techniques to provide prenatal, birth, and postpartum care to women. The Garrahy’s story reflects this combination: they relied on traditional techniques for reducing pain – moving, taking a bath, vocalizing – as well as the modern suturing techniques of the hospital for coping with vaginal tearing. Their story also shows the way that home birth makes the family together, rather than the mother alone, the center of the birth process. I offer a series of stories throughout this introduction to give the reader a glimpse into the practice of homebirth among a group of parents in the US.

Significance of this Study

Birth has traditionally taken place in the home and been attended by family and midwives. It moved to the hospital in the US beginning in the early twentieth century as

hospitals became safer and doctors promoted the newest technologies. By mid-century virtually all births took place in hospitals (Wertz and Wertz 1989:135). In the 1970s, rates of home births rose briefly; a short period of academic interest in home birth followed (Bauwens and Anderson 1978; Anderson and Bauwens 1981; Peterson 1983). However, home birth rates subsequently declined, as did much of the academic interest in the topic. The 2000s seem to be a period of increased interest in home birth. A recent documentary (Epstein 2008) critiqued US birth management and featured home birth footage. A recent book (Block 2007) criticized US maternity care and devoted two chapters to home birth. The American College of Obstetricians and Gynecologists (2008) and the American Medical Association (2008) have both recently issued statements condemning home birth. This may indicate a resurgence of interest in home birth, and fresh cultural analysis is in order.

This thesis examines the ways that homebirth parents attempt to transform the culture of birth in the US. They hope to create a birth experience that is more empowering to women, inclusive of men, and gentler for babies. In particular, I examine the role of gender and other cultural beliefs in parents' grappling with the meaning of their births. Birth is always a culturally-significant time. To begin with, a new member is entering the society. Further, many people associated with this new member – parents certainly, but extended family, friends, and community members as well – will find their lives changed by the new arrival. All cultures mark birth. The baby must be accepted into the society, and the parents and other kin must accept their new roles and responsibilities. It is therefore fruitful to examine the activities and ideas around birth as a way to understand a culture. Many cultural values will be expressed through the customs for

birthing – those about gender in particular, but also other key beliefs. Birth is significant cross-culturally because it involves the crossing of body boundaries and the culturally-specific beliefs about such crossings. Most such activities, such as eating, sex, and excretion, are surrounded by rules and taboos. Birth is a particularly significant case of this, which makes it a useful way to look at ideas about the body. Last, birth often has ritual overtones. Many authors have examined birth in terms of ritual, including modern US hospital birth, but there is no research analyzing home birth in such a way.

Specifically, birth is a rite of passage, in which a non-parent is transformed into a parent. In short, many features of birth make it a significant event and a fruitful one from which to view a culture's beliefs: it creates a new human, changes the lives of many others, involves the crossing of body boundaries, and has many ritual overtones. I use the anthropological concept of the rite of passage to study the beliefs expressed through home birth, particularly those about gender. I also find that homebirth parents receive and enact messages about being self-sufficient and treating birth care as a consumer item – common US values – as they move through pregnancy care, birth, and the immediate post-partum period.

Homebirth parents' perspectives provide a valuable lens through which to examine gender in the US because: home birth has often been interpreted as an act involving resisting gender norms; whether at the home or the hospital, new parents confront gender in ways that force them to grapple with their own beliefs; and they are often (and in my sample) white, educated, and middle-class – that is, those who are expected to enact the preferred expressions of gender in this culture. A number of authors have described the ways that conventional hospital birth supports or enforces

conventional ideas about gender. Likewise, other authors have found that homebirth mothers are less likely to hold normative ideas about gender or to act in conventionally gendered ways during birth. Since many of these studies involved only a small subset of homebirth parents, this is an area that bears more study; homebirth mothers might provide a unique view of gender non-conformity. In addition, there has been little research focusing on men and birth. This work has typically found that men's roles in birth are in accordance with the traits expected of men in this culture. However, there is no research on the role of men in modern US home birth. I find that they, like their hospital-birth counterparts, will act in conventionally masculine ways, but that home birth does not support hegemonic masculinity in the same way that hospital birth does and often leads them into non-normative roles.

While homebirth parents provide a particularly valuable view of gender, it seems likely that all new parents are an important source of knowledge about gender because they begin to confront it in brand-new ways during pregnancy and child-rearing. They may find themselves pressured to find out the sex of the child as early in pregnancy as possible. As they buy baby things and decorate a room, they often find few gender-neutral options. After the child is born, they must decide how to dress him or her, and how to instill desired behaviors. All of these things bring gender norms – or violations of them – into a new light. At the same time, parents may find themselves in roles they did not anticipate. Staying home, going back to work, changing diapers, providing food, and other parenting duties have gendered implications that new parents must face. All of these reasons make parents in general, and homebirth parents in particular, an important lens with which to examine gender in the modern US.

The homebirth parents in this study were exclusively European-descended, educated, and middle-class. This is similar to the demographic profile of homebirth parents found in other large-scale studies of the US and North America, which found that homebirth parents were disproportionately likely to have these characteristics (Johnson and Daviss 2005; National Center for Health Statistics 2007). This demographic group provides an interesting perspective because they are people with a higher-than-average level of power and choice in the culture. In particular, the more-valued forms of femininity and masculinity in US culture are typically those associated with just this group of people. They can therefore be expected to both be enacting the preferred behaviors for their sex and to have fewer sanctions associated with their breaking the norms.

Birth foregrounds gender and other cultural values. Because home birth may be on the increase, because the people who practice home birth are perceived as non-normative, and because they can be expected to have a great deal of power to both enact and to change gender norms, an analysis of homebirth that examines the role of gender, cultural conceptions of the body, and the practice as a rite of passage, is, I believe, timely.

The Carters' Story

Nicole woke up around midnight having contractions. She tried to follow her midwife's advice – to sleep if her labor started in the middle of the night – but laying down did not feel comfortable. She woke her husband, Tom, and walked around the house. She had meant to make a cast of her belly but hadn't had time to do so. Since this was clearly the last chance, she and Tom got out the plaster and made the cast in the

kitchen, laughing at themselves, and pausing so Nicole could lean on the stove during contractions. After they finished the cast, Tom drew a bath for Nicole. They'd been told that it would either slow or speed the contractions, and it sped them up. Nicole labored and relaxed in the tub until the midwife and her apprentice arrived at six in the morning. She had already dilated to 8 centimeters! Everyone anticipated a quick birth, but the day wore into the afternoon and labor continued. Nicole's best friend joined the vigil. Tom stimulated her nipples to promote the production of oxytocin, the hormone that regulates labor. The midwife checked the baby's heartbeat every 15 minutes. Though the labor continued into the evening and then the night, both mother and baby were fine and the midwife saw no cause for alarm. Nicole walked around the house and up and down the stairs to help the baby descend and the pelvis to open up. Tom eased her back with hot compresses and pressure. Everyone kept up their strength with snacks, and the midwives made sure Nicole stayed hydrated with sports drinks. Around two the next morning, Nicole squatted by her bed to push her daughter out into the world. The baby's hand was cupped over her ear, the cause of the long labor, but was healthy and pink. She was immediately placed on her mother's chest, and was soon nursing.

The Carter's story illustrates many of the ways that home birth is different from hospital birth. For example, the parents are alone for much of the labor process, without nurses and other hospital staff moving in and out frequently. Nicole was instead attended by her midwives and a few people close to her, and these people stayed near her for long periods of time. She was encouraged to eat, drink, move around, and to deliver in the position that felt best to her, instead of being encouraged to stay in bed and deliver on her back. Nicole's labor was very long, and would quite likely have ended in a cesarean

section (c-section) if she had been at the hospital. Most hospitals' policies state that women must deliver within 24 hours, because the rate of infection increases at this time. Since Nicole did not receive hourly vaginal checks from multiple individuals, her risk of infection remained low. These simple differences can make a big difference for mothers and babies. In particular, it meant that Nicole avoided the dangerous surgery and long recovery that a c-section involves, and her ability to nurse and bond with her baby were not hampered.

Region

The Front Range Urban Corridor is the most densely populated part of Colorado. Nestled between the foothills of the Rocky Mountains to the west and the Great Plains to the east, it stretches along Interstate Highway 25 from Pueblo in the south to Fort Collins in the north. This research spanned the northern half of the corridor, a triangular region formed by Denver in the south, Fort Collins in the north, Boulder to the west, and including a number of small towns in between. The foothills buffer the region from the worst of the mountain weather, so winters are fairly mild, snowfall moderate to low, and summers warm. Politically, Colorado is considered a "purple state," sometimes voting Republican and sometimes Democratic. Its support in presidential elections has gone to Bill Clinton, Bob Dole, George W. Bush, and Barack Obama. Denver, Fort Collins, and Boulder, however, lean Democratic. The state's economic base rests on the mining and energy industries, agriculture, the federal government, and technology.

Denver is the capitol and largest city of the state with a population of 600,000. Its economy is largely shaped by its geography. Because it is centrally located in the US but

distant from other major metropolitan centers, it is the home of many government offices, a popular location for conventions, and a major hub for shipping and storage. Its airport is one of the largest in the country; two major airlines are based there. Its proximity to the mineral-rich mountains makes mining and energy major industries. Its central location and high elevation make it an ideal North American location for satellite-based communications. Additionally, Denver is home to many colleges and universities, nationally-recognized museums, and the second-largest performing arts center in the country. Easy access to the mountains and a yearly average temperature of 50 degrees Fahrenheit make outdoor sports popular. Major ski resorts, such as Winter Park, Breckenridge, Vail, and Keystone, are only a few hours away via Interstate 70.

Boulder lies twenty-five miles northwest of Denver and has a population of 95,000 people. Unlike Denver and Ft. Collins, which are fairly flat, Boulder is nestled into the foothills and therefore quite hilly. Biking, hiking, and other outdoor sports are very popular. There is a weekly cruiser bike ride that attracts as many as 500 people during the summer months. Boulder is the home of the University of Colorado, the largest university in the state; its students, faculty, and staff make up nearly half the city's residents. After the university, the city's major employers are mostly technology companies, including Sun Microsystems and IBM, and scientific endeavors, such as the National Center for Atmospheric Research. The city nevertheless has a "hippie" reputation, and is the home of the Naropa Institute, a Buddhist-inspired university, and Celestial Seasonings, an herbal tea producer. There are two film festivals, a music festival, and a Shakespeare festival each year.

Fort Collins is located some sixty miles to the north of Denver and has a population of about 130,000. It is the home of Colorado State University, with its wide lawns and historic buildings. The university is the city's largest employer, followed by Hewlett-Packard (a computer company), the local health system, and the local school district. There are thriving music- and beer-oriented scenes in the city. There are three local breweries, New Belgium, Odell's, and Ft. Collins, as well as several brewpubs and a branch of Anheuser-Busch brewing in the city. A variety of inexpensive eateries cater to students and other residents. The city prides itself on being bike-friendly, and one can often see more bikes on the road than cars. As in the rest of the region, outdoor and especially winter sports are quite popular.

Between these three cities lie a scattering of small towns, including Longmont and Lafayette. These are primarily commuter towns, with people driving into Boulder or Denver to work. Several of my participants lived in these communities and employed midwives from Boulder.

The Fredericksons' Story

The summer was hot, and it was uncomfortable to be so pregnant during the hottest part of the year. September came and Cecilia got bigger. Her due date came and went, and at five days overdue her fear of labor had long since been overcome by her desire to not be pregnant anymore. It was about ten o'clock in the evening when Cecilia started to have some cramping. Mindful of her midwife's advice to sleep through as much of early labor as she could, she stayed in bed. Throughout the night, she'd wake briefly and look at the clock whenever she had a contraction, about every twenty minutes.

By five in the morning, the contractions were ten minutes apart, and she woke her husband, Kevin, to tell him she was in labor. They were excited, laughed and talked between contractions, made breakfast, and called work. Since their midwife lived in Boulder, about thirty minutes away, and Cecilia had an early acupuncture appointment, Kevin drove them into Boulder. The acupuncture soothed Cecilia's aching back and nascent cold symptoms, and the midwife assured her that all was well. She encouraged Cecilia to eat and to take a walk, and promised to call at three. The parents-to-be bought sandwiches and took them to a park, but Cecilia wasn't able to eat much. Her labor was intensifying. They drove back home. It was exactly noon when they walked in the door, and the contractions were becoming ever more intense. Cecilia began to pace around the house. Her howling unnerved her husband but seemed to make her pain more endurable. She called a close friend who had promised to attend her as she gave birth, but Anita was on a hay ride with her children. She promised to get there as soon as possible. Cecilia assured her that there was no rush, that she'd probably be in labor all day, and in her mind she began to doubt that she could get through this ordeal. She called her midwife at one-thirty and asked her to come. Kevin began filling the birthing tub. Cecilia got in and out of it, changed positions, did what she could to curb her discomfort. The midwife arrived and massaged her back, which helped a lot. Cecilia lost track of time, listened to music, and walked to the rhythm of her labor. Her water broke. It contained meconium, the baby's first bowel movement. The midwife needed to monitor closely, as a baby can aspirate the feces and choke. The midwife's assistant arrived, along with Anita, and they paced with Cecilia, who was soon so tired that she lay down in bed. She began to push a little, just trying to see how it would feel. Her midwife noticed. "Are you just doing that,

or do you really have to?" she asked. "I don't know," Cecilia replied, "It just feels sort of right." The midwife checked her, and she was fully dilated. She pushed for an hour but made little progress. The baby's head was not in the right position. Instead of being crown-down, it was acynclitic, or tilted to one side. The midwife instructed Cecilia to stop pushing so that it could have time to straighten out. Not pushing was even more painful than pushing – more like not breathing – but Cecilia endured it for an hour. To encourage her, the midwives sang to her about birth, and the strength of women, and how she could draw strength from the earth. Finally, Cecilia said that she needed to push again. The midwife assured her that probably meant the baby's head had turned, and she resumed her efforts. It was still hard, but she could feel the baby moving down, though very slowly. The midwife encouraged her to move around, walk up and down the stairs, and change positions frequently to allow her pelvis to open up and the baby to work its way down. Finally, kneeling by a trunk and leaning over it to ease her back, Cecilia gave up. "I can't do this anymore," she said. "Something is wrong. I should go to the hospital." The midwife simply said, "Okay." She knew they didn't need to go to the hospital, but she also knew that Cecilia needed to have her fears acknowledged. She urged her to instead sit on the toilet for a time, where she could labor alone, and in the labor tub, where she and her husband could have some privacy. It must have been what was needed, because all of a sudden Cecilia could feel the baby move down. She reached down and felt the head approach with each push. She got out of the tub and onto her bed. The midwife suspected dystocia, a stuck shoulder, and knew that an all-fours position was the best way to manage this complication. (In the hospital, a c-section is considered the only remedy for dystocia.) The baby's head emerged but the midwife's concern proved well-

founded; the baby's shoulder was stuck. Her assistant moved Cecilia's leg forward so that she was in a runner's lunge, Cecilia pushed harder than ever, and the baby was born safely. The placenta emerged only minutes later, and Cecilia began to hemorrhage. Her midwife knew several remedies for this, ranging from pressure on the abdomen to herbal remedies to an injection of synthetic hormone, and she chose this last based on the volume of the hemorrhage. Though the blood loss made her recovery longer, Cecilia and her baby were fine. Her second child was born at home two years later after a considerably shorter and easier labor.

Many people assume that it is only the simplest, least complicated births that can take place at home. The Carters' story illustrates that complications can be handled competently by a trained midwife. For example, the all-fours position for delivering a baby with a stuck shoulder (shoulder dystocia) is called the Gaskin Technique for the famous midwife Ina May Gaskin. This technique has a much lower rate of poor outcomes than the Zavanelli Technique, sometimes used in hospitals, which involves pushing the baby back into the uterus and conducting an emergency c-section. Of course, midwives are also trained to recognize those complications that cannot be handled outside the hospital (such as the placenta coming out ahead of the baby, a potentially deadly complication called *placenta previa*) and to transport when necessary.

Homebirth Parents, Gender, and Ritual in the US

The beliefs and activities surrounding pregnancy, labor, birth, and early postpartum care have often been analyzed as rites of passage, which include ritual behaviors that convey the values of the culture. This analysis has been applied to many

non-Western cultures. More recently, it has been used as a way of understanding the experiences of both men and women in US hospital birth. Though home birth has been examined for the religious meaning that US parents bring to it, it has not been analyzed as a rite of passage. Birth has many of the features of a rite of passage – it follows a repetitive pattern, rises to a climax, and changes the social status of the people involved – making this a useful tool with which to examine it. Birth customs accentuate this ritual pattern of separation, liminality, and reintegration in different ways for men and women. This anthropological tool illuminates many of the cultural values, especially those about gender, that are symbolically encoded in home birth. I discuss the theory surrounding gender and ritual in anthropology in greater detail in chapter 2. The third chapter explores the history of birth in the US as well as the impact of gender and other cultural values on birth practices cross-culturally. Chapter 4 details the methods for data gathering and analysis.

In chapter 5, I illustrate the characteristics that make home birth a rite of passage and describe the transformative process for women and men. The rites express certain cultural values. For the women, these are: a healthy birth is a commodity to be purchased or earned, the society has few obligations to the individual, and the body gives birth. The men learn that birth care is a business, that fathers should be responsible, and that the family is a self-sufficient unit. I turn next to the role of gender in shaping the experiences of home birth. In chapter 6, I show the ways that both men and women move in and out of their usual gender roles throughout the rite of passage. Men initially approach their partners' pregnancies in conventionally-gendered ways, but often find themselves in unusual roles during the birth itself. Women follow a somewhat more complicated

pattern, both enacting and subverting conventional gender expectations during both pregnancy and birth. I use food and exercise as lenses through which to observe this. Because this occurs at such an emotionally-significant time, these role reversals contain a great deal of power. People may find themselves permanently changed, or they may feel relieved to slip back into the comfort of their usual roles. The gender lessons of birth are particularly significant to parents because they will soon be socializing the next generation of society members. I therefore examine their beliefs about teaching gender and about their children's gendered behaviors in chapter 7. I find that parents find themselves struggling with the concepts of gender as innate versus gender as learned, and resolve this tension by drawing the culturally-acceptable concepts of individualism and choice.

The struggle to reform childbirth has a long history in this country. In the late nineteenth century, women fought for the right to limit the size of their families and for access to anesthetic during childbirth. Later, they struggled to be allowed to remain “awake and aware” as they gave birth. Bringing men into the hospital maternity wards was a decades-long struggle. Homebirth parents, too, hope to change the culture of birth. They perceive many of the problems that academic researchers have found with modern hospital birthing practices: Birth is highly medicalized, often to the detriment of mothers' and babies' health. It is shaped by gender norms with which they may not agree, casting women as powerless and men as peripheral. Both parents find that their social and emotional needs are largely ignored. Minutes-old babies are whisked away to undergo medical procedures their parents may not understand or agree to. Homebirth parents believe that they can, through study and savvy consumerism, find a better experience of

childbirth – one in which mothers are empowered, fathers are central to the process, and babies receive a gentler welcome into the world. In chapter 8, I confront the question of whether they succeed in doing so, and find that there is no simple answer. These struggles for a new kind of childbirth do not take place in a vacuum. They take place in a culture that already has firm (though not immutable) ideas about men, women, babies, families, money, and power. Ideas about gender are strongly intertwined with these, so the work of changing the culture of birth must also challenge or accommodate gender norms. While they are seeking to make changes, homebirth parents and their midwives continue to exist in the web of beliefs and power that makes up their culture. This results in a complex and sometimes contradictory set of messages being conveyed. While they struggled to make a positive meaning from their experiences, I find that the labor of reforming birth remains stalled.

THEORETICAL UNDERPINNINGS

This analysis draws from several related theoretical traditions. The feminist critique of anthropology draws attention to the role of gender in observation and analysis. Recent theory addressing masculinity and femininity draws attention to the ways they are constructed and challenged. Symbolic anthropology, especially with its focus on the body, is an important approach to use to understand the way that gender impacts birth. Last, the anthropological concepts of ritual and rite of passage are useful for understanding how symbols, gender, and the body are conceptualized and used in modern US homebirth practices.

The Feminist Critique

In the 1970s, feminist anthropological analysis arose along with other social movements and in response to gaps in previous anthropological work. Much of this work had focused on men to the exclusion of women, assumed that women's experience in cultures was the same as men's, or discussed differences between men and women only in relation to kinship and childbearing (McGee and Warm's 2004a:473-5). Feminist anthropologists began reconsidering theories about human evolution, reinterpreting fossil records, and reexamining cultures to consider two things: the perspective and experiences of women as well as men and the way that the gender beliefs of anthropologists themselves affected their analysis. Gender, far from being confined to certain aspects of culture, or affecting only women, came to be seen as a pervasive force, shaping all

aspects of culture. Feminist analysis in anthropology today therefore considers the roles of both men and women through the lens of gender (McGee and Warms 2004:473-5; Visweswaran 1997). Dobris (2004:28) describes some of the key concepts of feminist analysis in the social sciences, saying that gender is a key way that societies are organized, that women's perspectives and experiences are often marginalized, and that identifying this marginalization can improve women's lives.

Fox and Murry (2000:1160) describe feminism in the realm of family research: "feminism assumes that men and women are of equal importance in social action, that structures and processes at work in the larger social arena have impact on relations in intimate environments and vice-versa, and that one's personal experience and sensibilities are not separate from the conduct of one's professional life." They go on to identify some characteristics of feminist research. The first is reflexivity, which entails reflecting on the ways that knowledge is produced, being critical of one's own status as an expert, and considering the relationships between the researcher and the researched. "Truth" is composed of fact and perspective, so those with more social power (i.e., those whose perspectives matter) are often the truth-makers. The next is the centrality of practice; feminist scholars often combine academic analysis with activism. Another key characteristic is a focus on process. Feminist scholars are aware of the process of constructing knowledge through research and may break the "scientific" model, moving back and forth among questions, literature, data collection, and analysis. The processes of gender dynamics are also considered in feminist research. For example, family research may explore the construction of gender as relational rather than an individual process (Blume and Blume 2003).

Gender: What and Whence?

The terms *sex* and *gender* are often used interchangeably in common usage, but the terms have distinct meanings in the literature of gender theory. Sex, in this usage, refers to biological maleness or femaleness (which are themselves culturally constructed). The US acknowledges only two sexes (male and female) and sex is traditionally assigned by visual inspection of the external genitals at birth. In ambiguous cases, internal sex organs, hormonal secretions, and/or genetics are used to place a person into one of these two categories. Gender, as distinct from sex, is a concept critical to feminist analysis. Gender refers to the trait, roles, and behaviors that are associated with each sex (Delphy 2003). Gender may be expressed through speech, dress, gestures, tasks, professions, interests, hairstyles, colors, personality traits, and so on. These behaviors vary across cultures and across time. For example, make-up is associated with men among the Wodaabe of Africa (Boesen 2008), but it is associated with women in the US. Likewise, high-heeled shoes were footwear for men at other times in Western history, but in the US they are now associated almost exclusively with women. While the cultural items assigned to the genders are essentially arbitrary, gender is typically seen and experienced as natural. These seemingly ‘obvious’ and ‘natural’ differences in men’s and women’s behaviors are variously attributed to biology, evolution, religion, history, myth, etc. Feminist analysis challenges this idea that gendered behaviors derive from any natural, essential, or pre-cultural source. De Beauvoir (1952:249) famously asserted, “One is not born a woman, but becomes one.” That is, she argued that a person is not born knowing the roles expected of men and women in that culture but must learn a gender role. This

process of socialization begins in infancy and goes on throughout life. People are subtly – or not-so-subtly – rewarded for ‘proper’ gender behavior and discouraged from ‘improper’ behavior.

Having defined gender as something learned rather than something essential, various theories arose about its dynamics. Fox and Murry (2000:1163-4) divide the perspectives into two groups: the gender roles perspective and gender as a social construct. The former derives from role theory and structural-functionalism. In this perspective, “gender is enacted or played out according to scripts that are carefully taught and repeatedly rehearsed until behavior governed by one’s gender role script becomes so natural as to be seen as an integral part of oneself” (Fox and Murry 2000:1163). In the latter perspective, gender embodies cultural meaning and is inextricably bound with other elements of identity, such as race and class. Rather than gender being second nature, “men and women not only vary in their degree of masculinity and femininity but also have to be constantly persuaded or reminded to be masculine and feminine” (Fox and Murry 2000:1164). The authors critique the gender role perspective, preferring to interpret gender as a social construct. I feel that their arguments proceed from a false dichotomy. Gender is complex, and a ‘both/and’ perspective is more useful. Further, their analysis disregards the role of the body in gender dynamics. Butler offers a more nuanced perspective. According to Butler, gender is constituted through acts of the body. These acts do not proceed from a pre-existing or natural gender but from culturally constructed beliefs: “gender is in no way a stable identity or locus of agency from which various acts proceed; rather, it is an identity tenuously constructed in time – an identity instituted through a stylized repetition of acts” (Butler 2003:415). Gender is not learned or achieved

once but enacted (or not) in everyday interactions. Expected behaviors are often easier but by no means taken for granted. That is, women and men make many choices each day about how to speak, walk, dress, and so on. Each of these is an opportunity to enact or subvert conventional ideas about gender. Of course, such opportunities do not exist in a cultural vacuum: “all femininity is a performance, but performing femininity is not a free choice” Wilkins (2004:338) observes. People may bend or break the rules of their gender, but they rarely do so without repercussion.

Masculinity and Femininity

While masculinity and femininity have been theorized in a variety of ways, in this thesis I draw on Butler’s (2003) ideas about gender as performance. That is, gender performances do not proceed in a natural or essential fashion from the biological body. Neither are they static or unitary. Multiple expressions of masculinity and femininity can co-exist within a culture; similarly, a single person may enact different forms of gender expression at different times and in different contexts. People may even enact the gender not associated with their biological sex. While certain gender expressions may come more easily or be more socially acceptable, men and women nevertheless create gender in their moment-to-moment interactions. They may choose among these expressions and even deploy gender strategically to legitimate actions, such as home birth.

Femininity and masculinity take different forms cross-culturally and intra-culturally. That is, the ways that men and women are expected to look and behave are not the same in every culture. Likewise, there are different forms of feminine and masculine behaviors associated with different sub-cultural groups, particularly racial/ethnic and

class groups. The most valued form of masculinity in a particular time and place is referred to as “hegemonic masculinity” (Dworkin 2001:335). Hegemonic masculinity is supported by social institutions such as churches and the media. Connell and Messerschmidt (2005) offer some valid critiques of the ways that the concept of hegemonic masculinity has been used, but nevertheless argue that it is a useful concept. In particular, they point out that “hegemonic masculinity may not be the commonest pattern in the everyday lives of boys and men” (Connell and Messerschmidt 2005:846) but works through exemplars and represents fantasies and desires as much as realities. They also emphasize that masculinity is created relationally, so masculinity is always referencing (real or imagined) femininity. The characteristics of hegemonic masculinity in the US have been described by many authors. David and Brannon (1976:12) colorfully sum it up in four tenets: no sissy stuff; be a big wheel; be a sturdy oak; and give ‘em hell. Ward (2005:496) lists mastery over one’s environment, interest in sports, competitiveness, independence, toughness, strength, suppressing emotions, and aggression and dominance in relationships. Anderson (2005:345) finds that homophobia and “defensive heterosexuality” are critical components of orthodox masculinity. The preferred form of femininity, “emphasized femininity” is associated with supportiveness, emotional work, enthusiasm, display, and heterosexual attractiveness (Gray 2003; Grindstaff and West 2006). Women have traditionally been defined as *other*, or as the foil to masculinity (Connell and Messerschmidt 2005:848; Kreps 2003). Indeed, masculinity is often defined negatively as that which is not feminine (Anderson 2005; David and Brannon 1976:12). It is common to insult a man by comparing him to a woman but few equivalent insults for women exist; both men and women are insulted by being called

women. Homophobia is intertwined with this. Gay men are denigrated, in part, because they are seen as feminine. Both Kane (2006) and Martin (2005) have found that gender nonconformity in male children is typically viewed as problematic only insofar as it is seen as a sign of homosexuality.

Concepts of “proper” masculinity and femininity are not separate from other power relations in a society. Because men have traditionally had more power and esteem, masculine traits tend to be more highly valued than feminine traits. Just as masculinity and femininity exist as unequal roles, different expressions of them are unequally valued. Hegemonic masculinity and emphasized femininity, the most valued forms, are associated with people who are white, middle-class, and heterosexual; i.e., with those who have the most social status. Other expressions of masculinity and femininity – those associated with racial/ethnic minority groups, the poor, gay men, and lesbians – are regarded as having less value or being less “real.” Black men are stereotypically associated with physical strength, athleticism, and large penis size, but these masculine traits are seen as threatening (Kendall 1999:264; Ward 2005:495). Gay men, as noted above, are denigrated for their presumed feminine characteristics. Interestingly, McInnes, Bradley, and Prestage (2009:651) found that gay men’s discourse about sex “sustains and values ways of doing masculinity as active and agentive, as aligned with the natural and primitive, wild and dangerous,” showing that they value hegemonic masculinity although they are seen as failing at it. Black women are often perceived as being too loud and as sexually promiscuous, therefore lacking proper femininity (Ward 2005). Lesbians are also often seen as failing at femininity because they are “too masculine;” mothering may be used to challenge this notion (Dalton and Bielby 2000). These less-valued gender

expressions show the interrelationship between social status and gender: those with higher status are perceived as “doing gender right,” and their enactment of “correct” gender roles in turn bolsters their status. Paradoxically, they may also have greater leeway to redefine gender roles: as high-status individuals, their gender non-conformity is seen as less problematic.

Of course, beliefs about what constitutes “correct” gendered behaviors in a culture are not uniform or static. Masculinity and femininity may be challenged and redefined, and multiple forms may co-exist within a culture. Wilkins (2004) finds that women in the “goth” subculture may challenge femininity by exaggerating it to the point of caricature, while simultaneously asserting their right to aggressively pursue sexual satisfaction. Anderson (2005) finds that some college-aged men challenge the homophobic aspects of masculinity by engaging in stereotypically gay behaviors (such as dancing with other men) and asserting that being perceived as gay is unimportant. Likewise, Connell and Messerschmidt (2005) also find that aspects of gay masculinity have become mainstream, as have aspects of African-American masculinity. The stereotypical “nerd” is an interesting example of a non-hegemonic but acceptable form of masculinity. The nerd is, in some ways, hypermasculine: he is smart, often makes a good salary, is not interested in appearance, and lacks “feminine” interest in relationships or social graces. The nerd is simultaneously seen as having feminine characteristics, though: he is physically small and weak, bad at sports, and inept in sexual relationships. Just as gender norms may vary and change in a culture, men and women may enact different forms of masculinity and femininity across their lifetimes and in different social situations. Gender is created relationally; it is “a configuration of practice organized in relation to the structure of

gender relations” (Connell and Messerschmidt 2005:843). It is also important to note that those enacting gender are not “cultural dopes;” they are often aware of the dynamics at play and may attempt to change them. “Children as well as adults have a capacity to deconstruct gender binaries and criticize hegemonic masculinity...they may actively attempt to modernize gender relations and to reshape masculinities as part of the deal” (Connell and Messerschmidt 2005:853). Indeed, I find that my informants were often aware of the gendered implications of their attempts to reform birth care in the US.

Feminist Perspectives on Childbirth

Beckett (2005) discusses the history of the feminist critique of birth and, in turn, offers a critique of contemporary feminist theorizing about birth. In the late nineteenth century, the first wave of birth activism fought for the right to limit and space births and for access to anesthetic during births. Though it was available for some time, many physicians believed that pain in birth was “Eve’s curse,” so that to administer anesthetic was to subvert God’s will. It took some time before it became acceptable, despite feminist and consumer demand. Ironically, total anesthetic became widespread and often used abusively in the first half of the twentieth century (as I detail in chapter 3), so the second wave of feminist birth activists then fought for the right to be “awake and aware” during birth. The third wave, which coincided with the social movements of the 1960s and 1970s, emphasizes the naturalness of birth and the right of women to make choices about its management. It critiques the highly medicalized nature of birth in the US.

Beckett goes on to analyze the ways that the current feminist discourse on birth is problematic and often paradoxical. The emphasis on the naturalness of birth, on the one

hand, is a way of contesting medical control of the process. It asserts that birth is a normal physiological process and that it does not require a high level of intervention. However, “the alternative birth movement’s veneration of the ‘the natural’ mistakenly seeks to overturn male domination by super-valuing the denigrated categories with which women have long been associated rather than by deconstructing and destabilizing hierarchical constructions” (Beckett 2005:258). That is, women have often been seen as “more natural” or closer to nature than men. Because the natural is devalued relative to technology and culture, this ideology supports women’s lower status. Beckett is arguing that trying to increase the value of “the natural” is not the proper tactic. Rather, feminists ought to critique the ranking of these concepts itself rather than simply upending the ranks. Further, she critiques the idea that technology is inherently patriarchal and the idea that midwives and “natural” birth are inherently feminist.

The valorizing of motherhood and of childbirth as a peak experience in women’s lives is also problematic. Women’s exclusion from the workplace, lower wages, and isolation in the domestic sphere have often been justified by their childrearing duties. Mothers often experience an odd status shift. While motherhood, as a concept, is revered, mothers themselves are not. They do low status domestic and emotional work, and are often symbolically equated with children themselves. Defining motherhood as the central component of women’s lives does not, in a patriarchal culture, elevate their status. Klassen (2001:4) finds this problematic as well: “Does this supreme valuing of women’s roles as birthers and nurturers define women solely as procreators and caretakers, or does it open up new realms of cultural and social power for women?” Likewise, it is difficult to interpret the “natural childbirth” movement’s emphasis on enduring pain from a

feminist perspective. Is it a form of “machisma,” allowing women a way to be viewed as strong and courageous, or is it another instance of devaluing women’s bodies and expecting mothers to be self-sacrificing? (Interestingly, the willingness to undergo a c-section can also be interpreted as a willingness to experience pain for one’s children, so the same ideology can function to support very different choices.)

Emphasizing choice in childbirth matters is also problematic for feminists: “this emphasis on choice does sit somewhat uneasily with the movement’s persuasive and quite damning critique of the medical management of childbirth” (Beckett 2005:257). If biomedical management of birth is both less safe and efficacious, as well as expressing and supporting the ideology of women’s lesser status (as has been argued convincingly), how should feminism interpret women “choosing” technological birth? Is this feminist simply because it is chosen by a woman, or does it imply a false consciousness? This becomes even more problematic when one considers what it means to have ‘true’ informed consent; there is evidence that doctors shape and withhold the information that they give to patients about various procedure (Beckett 2005:263; Wagner 2000). The role of race, gender, and other factors in constraining women’s choices also cannot be ignored (Klassen 2001:14).

Klassen (2001:16-37) also addresses the paradoxical role that childbirth can have in terms of women’s power. She studies the ways that women use a variety of religious and spiritual beliefs to assign meaning to their births. On the one hand, religion has often been a source of influence and status for women, especially minority women (Pena and Frehill 1998; Ward 2005). It has also been a way for them to challenge medical definitions of their bodies. On the other hand, those same religious traditions typically

uphold gender hierarchies, such as those between husbands and wives. Davis-Floyd (2003:187-240) finds a similar paradox among women who birth at the hospital. While she interprets the messages being sent by hospital rituals as emphasizing the power of technology and the institution, she also finds that not all women receive or interpret these messages in the same way. For example, a mother may redefine technology as a high-status convenience in her service rather than something controlling her birth. In either of these birth locations, women's seeming power or status can also be seen as an expression of traditional hierarchies. Nevertheless, this critique may serve simply to diminish women's subjective experience of empowerment.

Symbolic Anthropology and the Body

The symbolic, or interpretive, anthropology of the 1960s and 1970s was a theoretical model that grew out of a reevaluation of anthropology as a scientific endeavor (McGee and Warms 2004:524-6). Instead of focusing on observable phenomena, in the empirical style, it focused on the mental phenomena of culture. Culture, in this framework, is a set of symbols that exist in the minds of people and are expressed in a variety of ways – speech, actions, clothing, art, etc. These symbols convey meanings through non-literal associations. Symbolic anthropology drew on ideas from linguistics and literary criticism. Clifford Geertz and Victor Turner are two architects of this framework. Geertz saw symbols as transmitting meaning within a culture, and felt that an anthropologist could interpret them by trying to understand them from within their own cultural context. Turner, taking a different perspective, saw symbols as tools that maintained social order. He advocated observing ritual behaviors and considering both

emic and etic perspectives in interpreting them. The work of the symbolic anthropologist Mary Douglas (2004[1966]) is particularly relevant to this study. Douglas felt that symbols had shared characteristics cross-culturally, and that mundane items made the most potent symbols. For example, doors and crossroads cross-culturally have symbolic significance. The body, because it is shared by all humans, is the most important of these mundane symbols.

The body is understood differently across cultures and historical periods. Whether it is separate from the body, separate from the outside world, composed of separable parts or is holistic, etc., are beliefs related to culture. Likewise, the ways that anthropologists have theorized the body and its relationship to culture are multiple (Lock 1993). Here I do not treat the body as a pre-cultural object, something which exists *a priori*. The body, the way it is experienced, and the meanings given to it, are all products of culture. Indeed, the body itself has been seen as culturally constructed (McCallum 1996). I focus here on only a few of the ways that the body is used for meaning-making. It is used as a conceptual map, a metaphor, for society. An Indian myth explains that humans were created from a dismembered god, and that the various castes and duties thereof derive from his parts (Holdrege 1998). The god's head became the Brahmins, scholars and priests; his arms are Kshatriyas, royalty and warriors; his legs, Vaisyas, artisans and merchants; and his feet, Sudras, laborers. This creation myth reflects the metaphorical use of the body: the body is symbolically equated with society. The body is also used to express cultural values. Bodily activities from Maori tattooing to Chinese foot-binding to US American workouts are examples of the use of the body as a way to express identities and cultural values. The body is thus a symbol of society and acts out the values of that

society. Conceptions of the body are therefore interrelated to conceptions of society and the self.

Theorists such as Pierre Bourdieu (1990:66-79) and Thomas Csordas (2002:58-87) have demonstrated how cultural values are expressed via in the body. Csordas (2002:87) calls the body “the existential ground of culture.” Gender ideals and other cultural beliefs shape the way that men and women sit, stand, talk, walk, gesture, and so on. For example, women in the US typically hold their bodies in ways that take up less space, whereas men tend to take up more: women cross their legs and arms where men spread theirs. This is what Bourdieu called *habitus* (1990:66-79). People are aware of social ‘rules’ regarding bodily behavior on a semi-conscious level. “The social agent as a creative yet socially determined individual” (Scheuer 2003) chooses among a culturally-limited set of actions in a sort of “governed improvisation” (McAllister 2004). Similarly, Csordas found that ritual gestures seem ‘natural’ to those performing them, but he points out that these gestures make sense only within their own cultural context because they are produced by the “socially informed body” (Csordas 2002:72). Bourdieu (1990:71) says, “socialization instills a sense of the equivalences between physical space and social space.” The body acts not only as a metaphor for society but enacts the society’s values on the individual level. Thus, the body and the culture have an iterative relationship: the beliefs of the culture impact what the body does, and the body’s activities and significance reinforce the beliefs of the culture.

Body parts often have particular symbolic significance. In the modern US, for example, the heart is associated with emotion. A person suffering emotional pain might be described as having a “broken heart.” The “gut,” or internal lower abdomen, is

associated with intuition. People might describe themselves as having a “gut feeling” about a situation. Primary and secondary sexual characteristics often have a great deal of symbolism associated with them that does not necessarily follow from their literal functions. For example, I have observed that women’s breasts are highly sexualized, which does not relate to their function in feeding infants. Male genitals are associated with courage and strength; a courageous act is said to “take balls.” Female genitals, by contrast, are associated with weakness or cowardice; “pussy,” a slang term for the genitals, is used as an insult to convey these characteristics. Interestingly, to call a person by a slang term for a penis, such as “dick,” also conveys undesirable personality characteristics, though generally aggressive ones. A diminutive form, such as “weenie,” might be used to convey weakness. Some slang terms for female genitals, such as “cunt” and “twat,” may be used as generally offensive terms to describe a woman. All of these uses of genital slang are an expression of gendered values, not an extension of a biological reality; testicles, for example, are physically much more sensitive and delicate than a vagina. This shows the interrelationship between conceptions of the body and conceptions of the self as it relates to gender. In particular, it conveys cultural beliefs that men, and their body parts, are strong, courageous, and independent, while women and their body parts are weak, cowardly, and dependent. Other authors have similar findings. Slang terms for male genitals often evoke animals (“trouser snake,” “weasel”), monsters (“Cyclops”), foods (“sausage,” “meat”), tools (“screwdriver,” “jackhammer”), symbols of authority (“rod,” “staff”), or weapons (“sword,” “cum gun”) (Cameron 1992). Those for female genitals generally indicate space (“hole”), receptacles (“box,” “pussy” [which is derived from a word for pouch]), money (“money-maker,”), or animals (“beaver,”

“kitty”), and sometimes places of danger (“black hole,” “Bermuda triangle”) (Braun and Kitzinger 2001). Even non-sexual body parts – parts possessed by both sexes – often carried gendered connotations. Motschenbacher (2009), in an analysis of print ads, found that surface and aesthetic parts (e.g. skin, eyelashes, and hair) were gendered feminine while internal and functional parts (e.g. muscles, sinews, and knees) were gendered male.

As body parts carry particular significance, the crossing of body boundaries carries a great deal of significance cross-culturally. To put it crudely, when anything goes into or comes out of the body, there will be cultural rules about it (Douglas 2004[1966]). Blood, saliva, tears, semen, vaginal fluids, and excreta never have neutral meanings, although whether or not they are considered polluting (“disgusting,” in modern US parlance) will vary. Food and sex, since they involve something going into the body, will be similarly bound by cultural rules. Indeed, with whom one may share food and with whom one may share sex are important markers of identity and status in many cultures (Liechty 2005). Childbirth, therefore, has a great deal of symbolic significance: it involves the crossing of body boundaries and involves body fluids. This is another reason it is important to consider the body and its symbolism in analyzing birth customs.

Because bodies both symbolize and act out beliefs about cultural and individual identity, the ability to define and control the body carries a great deal of power. Biomedicine, in the Western world, exerts a great deal of this power. Foucault, in *The Birth of the Clinic* (1994 [1963]), demonstrated that medicine and the experience of the body are shaped by history and culture. He points out that the history of medicine is often presented as a linear, natural progression in which new medicines and technologies are constantly improving, with change coming from greater evidence and knowledge

(1994:54-63). However, he argues that medicine in fact changes along with political and economic ideologies and reflects those. “There is, therefore, a spontaneous and deeply rooted convergence between the requirements of political ideology and those of medical technology” (Foucault 1994:38). Modern biomedicine is thus related to the current political and economic paradigms. A number of authors have observed that biomedicine, by virtue of its ability to define what is normal and what is pathologic in pregnancy and birth, is a powerful institution which controls women’s bodies. It imposes various strictures on pregnant women’s behavior, such as prescribing their food intake, both when they are pregnant and when they are giving birth (Martin 2001:54-67; Abel and Browner 1998; Browner and Press 1997), has the power to stigmatize and punish those who fail to comply (Craven 2005:195-6; Kitzinger 1997), and tends to reinforce social norms such as gender, racial/ethnic, and class-based inequities (Martin 2003; Becker 2000:20; Lazarus 1997; Stephenson and Wagner 1993).

The body, then, is an important locus of beliefs about gender, society, and power. Pregnancy and birth, as activities that foreground the body, are fruitfully analyzed by keeping in mind the role of the body.

Rituals and Rites of Passage

Magic, as Malinowski classically defined it, is humankind’s attempts to alleviate fear and stress by creating a semblance of control over what is fundamentally uncontrollable (McGee and Warms 2004:170). When a Trobriand Islander goes through a careful repetition of actions and words before setting off on a sea voyage, he is he is responding to a stress-inducing but uncontrollable situation: the possibility of injury or

death at sea. Ritual is pervasive in human cultures, although it is not always recognized as such, and takes a dizzying array of forms. Rituals nevertheless share certain characteristics (Davis-Floyd 2003:8-17; Reed 2005:12-13). Ritual behavior has symbolic effects, rather than (or in addition to) practical effects. Symbols and symbolic behaviors are “loaded with cultural meaning” (Davis-Floyd 2003:9) above and beyond their literal meanings or purposes. A physician’s white lab coat both protects his clothes and establishes his status; a white coat, meaningless in itself, has come to mean “doctor” and to symbolically convey authority and competence. Rituals are derived from the beliefs of the culture and these symbols are used to communicate them. This communication is for an audience; this may be observers or other ritual participants. Ritual often occurs in a special place, or in an ordinary space that has been temporarily marked or set aside for ritual use. Churches are obvious examples; they are a space set apart from ordinary life. Likewise, ritual happens in a discrete time with a beginning, climax, and end. It often has rhythmic or repetitive elements within this time. This includes both repetitive sensory stimuli (such as drumbeats) and also repetition of a symbolic message in different forms. This use of repetition and climax within the ritual gives a ritual a sense of inevitability – it seems as if there is no other way for it to happen.

A Catholic mass is a clear example of a ritual. It takes place in special space, which may be shaped like a cross, and will certainly be decorated with crosses – which are literally sets of crossed lines but symbolically a reminder of Christ’s sacrifice. The clergy wear special garb and the participants wear clothes which are more formal than everyday wear and often designated “church clothes.” Repetitive prayers and body movements (sitting, standing, and kneeling) are enacted. There are sensory stimuli in the

form of music, chanting, and burning incense. The ritual rises to a climax with a taste of bread and wine, which have taken on symbolic meanings as the flesh and blood of the martyred god. After the ritual's completion, participants leave the church and return to their ordinary activities. Secular activities can be classed as rituals as well. Something as simple as meeting a new person in the US involves a short ritual of looking the other person in the eyes, shaking hands, exchanging names, inquiring about the other's well-being, and indicating pleasure at the meeting. Asking "how are you?" is rarely meant to elicit a true answer, but conveys the expected concern. Likewise, the eye contact and handshaking are loaded with cultural meaning; they convey openness and trust. A person's character may even be judged by the qualities of the handshake – in the US, a weak handshake is often thought to indicate a weak character. Thus, even this everyday ritual involves symbolic behaviors (handshaking, eye contact), multiple expressions of meaning (friendliness and trust), and repetitive sensory stimuli (the up-and-down of the handshake).

Ritual is a way of enacting magic and conveying cultural values (Gluckman 2004[1956]). "A ritual is a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is transformation" (Davis-Floyd 2003:6). Rituals arise from the values and beliefs of the society; these are strengthened as people participate in them, thus acknowledging their reality and importance (Davis-Floyd 2003:1). Rituals are therefore often controlled by the meaning-makers of a society, the people with the most cultural power. Paradoxically, rituals can also be used to challenge the social order (Davis-Floyd 2003:9; Myerhoff 1978:235). Their stylized and repetitive nature makes them appear to have a long history, so they rituals can have the effect of making new

ideas seem old. Ritual may be used by those with less cultural power, then, in order to effect – or attempt to effect – change.

Rites of passage are particular types of ritual that occur around changes in social status. Rites of passage often surround biological transitions, such as birth, puberty, and death, although they may occur at other times (de Vries 1981:1087). These changes are uncontrollable but also potentially disruptive; ritualizing them makes them appear to be under human control and serves to educate both the initiate and the wider community of the new rights and roles expected to accompany this transformation (Homans 1994:233). Rites of passage have a typical form (Davis-Floyd 1987:288-9; de Vries 1981:1089; Reed 2005: 13-16): separation, liminality, and reintegration. In the first phase, the initiate is separated from her usual status and isolated from usual society. She then enters a liminal phase in which she is “betwixt and between” (Turner 1967) states – having neither the characteristics of her former nor future role. During this liminal phase, the characteristics of the old self must be shed in some way and the characteristics of the new self acquired. Lastly, the initiate is reintegrated into society in her new status, typically with some fanfare. This ritual form serves the purpose of creating a receptive frame of mind in the initiate so that she will properly enact the new role. The ritual also alerts the rest of the community to treat the initiate in a way that fits the new role.

The creation of this liminal phase bears extra attention, because it is key to the transformation. Initiates must have their past identities stripped away and their cognitive states made a shambles so that they can be properly transformed into their future identities. There are three principal ways of accomplishing this (Davis-Floyd 2003:19). The first is *strange-making*. What was once familiar must be made strange, either through

taking away its traits or by juxtaposing it with the unknown. Sacred or secret items may be used. Occult writings may be invoked. Initiates must also become strange to themselves. Removal of clothing, wearing ritual clothing, and shaving of the head are some ways this may be accomplished. Sometimes all the initiates (if there is a group) are made homogenous in some way, such as through identical clothing. The second technique for inducing liminality is *hazing*. This may include fear, pain, hunger, or other altered states of mind. Many rites of passage, for example, include fasting, dance or other physical activity performed to exhaustion, mutilation of the body, drug use, repetitive sensory stimuli, and other ways of inducing stress in the initiate. In the US, the details of the birth process are rarely discussed openly; people often simply say, “She had the baby.” This mystery contributes to both strange-making and hazing. The last of these techniques of liminality, and the one most important to this analysis, is *symbolic inversion*. Aspects of the belief system to be instantiated are first turned upside down. Something first becomes its opposite before it becomes its true self. Among Huichol Indians, peyote pilgrims literally say ‘yes’ instead of ‘no’ and offer a foot, not a hand, in greeting (Myerhoff 1978:227) Gluckmann (2004[1956]) identified this first as “the license in ritual” and offered the British naval tradition of officers serving enlisted men on Christmas as an example. Myerhoff (1978:232) calls this *ritual reversal* and explains its purpose: “perhaps the most important and common function of rituals of this nature... is the capacity of reversals to invoke continuity through emphasis on opposition.” By experiencing an “opposite” in a time of stress, people feel comfortable when they then return to “normal.” As everything previously known has been stripped away and turned upside down, and the muddled mind is looking for something to hold onto, the meaning

offered by the ritual is seductive. People eagerly take it on to avoid the chaos that seems to be the only alternative.

At this point, rites of passage may seem like exotic and possibly frightening events. Indeed, they may be, but they may take more mundane forms as well. In the US, graduation ceremonies are an example of a rite of passage. Graduates are separated from their friends and family, sitting in a group in the center of the ceremony while their loved ones watch from a ring around them. This is when they enter the liminal phase. The initiates are dressed identically in a robe and hat that are used for no other purpose. Various dignitaries instruct them in their new roles and responsibilities. (A cynic might say that the boredom accompanying most of these speeches is a type of hazing.) At the climax of the ritual, the initiates' names are read, they are ceremoniously handed decorated sheets of paper, and move their hats' tassels from one side to the other. All of these activities have symbolic effects, not real ones – it is the years of study that confer the degree, not the paper or the tassel, but the ceremony of the “cap and gown” symbolize graduation nevertheless. Finally, the graduates file out to the sound of applause. As they greet and celebrate with their friends and relatives, they are reintegrated into society in their new statuses.

Pregnancy and birth have many aspects of a rite of passage in and of themselves; Douglas would call them natural symbols (2004[1966]). A woman is separated from her past identity when she discovers she is pregnant and her body begins to change shape. When she gives birth, she changes status from non-parent to parent, or from a parent of one child to a parent of two children, etc. Likewise, the fetus changes status to that of baby, from non-person to person. The contractions are repetitive and rhythmic and rise to

a natural climax. The pain provides a natural hazing. As the body does this seemingly without her volition, the woman becomes strange to herself. Given these “natural” ritual elements, it is therefore not surprising that cultural trappings will be used to give meaning to this highly fraught experience, to attempt to control it, to make it seem like something that arises from the society. Indeed, rituals around pregnancy and birth abound cross-culturally. Among the Kam of Guizhou, China, peanuts and rice are grown in gender-segregated fields, but a man and woman expecting their first child work in the “opposite” field (Lin 2007); this is an example of symbolic inversion. In Israel, women unbind their hair and open all interiors doors (even cupboards) in their homes while they are in labor; this symbolically facilitates the opening of the cervix (Sered 1993). In the US, men are reintegrated into society as fathers when they give out cigars to friends and colleagues after the birth of a child.

A few authors have interpreted US pregnancy and birth customs in terms of ritual transforming the parents. Frisbie (1977) describes the hospital and baby as pure, the father as polluted, and the mother liminal between these states; she is reintegrated as she regains control of her bodily functions and moves home. Small (1999) describes the tradition of the baby shower as a rite of passage: the pregnant mother is isolated from the planning stages, is subjected to various embarrassments during the party, and reintegrated as her new self via the giving of baby gifts and advice. Davis-Floyd (2003[1992]) describes pregnancy as a rite of passage in which the woman is separated from her former self when she learns she is pregnant and becomes strange to herself as other people begin to treat her differently. However, she notes that there is a lack of codified reintegration and speculates that post-partum depression may be related to this lack (Davis-Floyd

2003:41). She also elucidates the way that birth is a rite within a rite. She shows that standard medical procedures used for birth in US hospitals have little benefit and, indeed, are often detrimental to the birth process. Since they are nevertheless surprisingly widespread and homogenous, she interprets them as having symbolic, rather than practical, effect: socializing new parents into the roles expected of them by society. Klassen does not discuss ritual in the anthropological sense, but does describe the ways that homebirth women “have viewed childbirth as a bodily process capable of purveying religious messages and effecting religious transformation” (2001:24) in a variety of religious traditions. Reed (2005) discusses the activities of men during pregnancy and birth as rituals which make a man not only a father, but a father of the specifically modern US American type. I will discuss their analyses in more detail in chapter five.

Summary

Feminist scholars have critiqued the masculine bias in social science, showing that women’s perspectives and experience differ from men’s, ought to be studied, and exist in unequal power relations. The concept of gender is a tool for examining men’s and women’s seemingly natural differences as cultural constructions. Gender is a set of practices that is enacted in social relations. Though it is learned, gender is typically seen as natural and rooted in the physical differences between men and women. In particular, women’s traditionally subordinate role has often been justified by physical traits or reproductive necessities. Because pregnancy and birth highlight these physical differences, gender is especially relevant to the study of these experiences. It is an

experience that is highly shaped by gender ideologies and, in turn, has a capacity to shape them.

Symbolic anthropology sees culture as constituted and expressed through symbols. The body is a particularly potent symbol. It is used both as a mental map – a metaphor – of society, which shapes the individual identities of the members of the society. Body parts, products, and boundaries are accorded powerful symbolism. Within their specific cultures, people use their bodies to act out these ideas about society and identity. The body, then, exists as a physicality, as a symbol, and as an expression of cultural values. Pregnancy and birth, because they are significant activities of the body and because they produce new members of the society, are thus strongly shaped by cultural values.

As the body is used cross-culturally as a symbol, pregnancy and birth are analyzed cross-culturally as rites of passage. The concepts of ritual and rite of passage are therefore useful analytic tools for understanding them. I bring these concepts together because I wish to observe the ways that pregnancy, birth, gender, and other cultural values are intertwined. The parents who have chosen home birth are simultaneously shaped by their culture's ideologies and agents who may try to remake their meanings. In particular, they are making statements about their identities as men and women. Understanding their perspective both sheds light on the cultural values of their society and on the ways that people with social status can challenge norms. I find that homebirth parents create ritual from their experiences, and use this ritual to convey many important messages which encapsulate US American beliefs, especially those about gender. Before

I address this, however, I wish to place home birth within its historical and cultural background.

BACKGROUND AND LITERATURE REVIEW

Culture, Pregnancy, and Birth

Rituals, the dramatization of magic, are humanity's attempts to alleviate anxiety, control nature, and make potentially destabilizing changes appear to be under the control of society. Birth is a fear-inducing process which is uncontrollable and results in changes in social status for all involved: the child, mother, father, and other kin and kith. Customs about birth are ritual behaviors; ritual behaviors convey social values. Birth customs are related to cultural beliefs, particularly those about gender and the body, but also to the economy's structure and needs, and to historical forces. These cultural values shape the place of birth and its management. I wish to first give some examples of this relating to both home and hospital birth in non-US places. I will then discuss the role of history, gender, and economics in more detail as it applies to hospital and home births in the US.

Among the African Ju/'Hoansi in the 1980s, hunting prowess was believed to demonstrate men's bravery and strength. For women, unassisted birth is the analogous source of prestige and spiritual energy, so women leave their homes to birth alone in the bush (Biesele 1997). A woman's prestige is enhanced if she gives birth silently and if she completes the process all on her own, including cutting the cord and walking back to the village with her infant (though some women consider it acceptable to have help with these latter two). This conveys the cultural values of strength, discipline, and courage in the face of death.

In Jamaica, birth was moved to the hospital as part of a “modernization” project in the 1950s and 1960s (Sargent and Bascope 1997). By the 1980s, lay midwives became all but extinct, replaced by government-trained nurse midwives. They are seen as having greater knowledge than traditional midwives and hospitals are believed to be the safest place to give birth. Unfortunately, the funding required for Western-style highly medicalized childbirth is often lacking. Women may go to the hospital only to encounter attendants who treat them roughly, if at all – the majority deliver in hospital rooms unattended. This, ironically, is probably less safe than traditional home birth, but that knowledge has been lost. This is an example of an ideology – that modernity is best – shaping birth choices. It also shows the power of symbolism. The hospital is *symbolically* safe and modern, though not literally so.

Among some rural Mayans in Yucatan, Mexico, doctor-attended hospital birth is not an option due to both the remoteness of the region and the cost of such care, so in the early 1990s women were attended by informally-trained midwives (Sargent and Bascope 1997). These women become midwives based on their family’s status in the community, their personality traits, and their experience with birth. First-time mothers will be given a great deal of advice about labor; interventions such as cervical stretching and fundal pressure (pressing on the top of the uterus) are common. However, mothers giving birth to subsequent children are assumed to know how to do it, so they are supported and reassured but rarely advised. For all mothers, birth is considered a dangerous time, so shorter deliveries are preferred. These characteristics of birth in this region show the effects of economic factors and beliefs about birth in shaping the birth experience.

In Greece, birth was medicalized rapidly (though somewhat unevenly) after World War II. Ultrasound, in particular, became a key part of prenatal care. Though it was framed in terms of risk assessment and pregnancy dating, ultrasounds were in fact performed more often than needed, usually three to five times per pregnancy. Georges (1997) observed the ritual overtones of the procedure, which was performed in a dim room to hushed voices. She also notes the economic incentive: obstetricians working for the National Health Service receive fairly low salaries. However, it was traditional in the country for midwives to be given gifts in addition to their fees, and this tradition carried over to OBs; they therefore have an incentive to make patients happy. Since women enjoyed the process of “putting the baby on television,” (Georges 1997:96) doctors were willing to offer it in hopes of receiving a gratuity. This shows how history and economics give a seemingly purely medical procedure additional meanings.

In Japan, a historically patrilocal culture, women traditionally returned to their natal homes to give birth. Although in the 1990s birth takes place in the hospital, women still return to their home towns to give birth. During their pregnancies, they are given a health book by the government health service; all the medical records for that pregnancy will be recorded in this book. Rather than being kept by her provider, the woman herself keeps the book and brings it to each prenatal visit. This foregrounds her responsibility for a healthy pregnancy and reflects values of familial responsibility (Fiedler 1997).

What these examples all demonstrate is that birth customs exist in a tangle of history, political power, economics, media influence, and gender ideals. While women still have options within these constraints, they do not make purely free choices. Let us next examine the role of these forces in shaping US birth customs.

Home to Hospital (and Back Again?)

A number of authors (Ehrenreich and English 1973; Wertz and Wertz 1987; Duffin 1999) have documented the history of birth in the home and the hospital in the US. Unless otherwise noted, I draw on these authors for the following history.

Most US births were attended by formally or informally trained midwives until the mid-eighteenth century. People in the US often enjoyed better nutrition and less crowding and squalor than those in Europe, and this contributed to better birth outcomes. In the eighteenth century, physicians and “man-midwives,” as they were called, began attending births. As the US did not yet have its own medical schools, they were usually trained in Europe and especially France, and the paradigm of birth as a mechanical process was imported from there. The doctors and man-midwives were criticized by midwives and others as perverse, inept, or overly inclined to intervene in birth. They in turn characterized midwives as superstitious, dirty, unskilled, and even drunken. A lively professional turf war ensued, conducted via pamphlets, medical textbooks, and public lectures. By the late eighteenth and early nineteenth centuries, most births were still attended by midwives at home, but doctors were increasingly in demand for difficult births. Maternity care at this time varied by social class and national origin. The middle and upper classes were attended at home by midwives and, increasingly, doctors. Recent migrants often preferred to employ midwives who spoke their languages and understood their customs. The poor were more likely to go to hospitals, which employed both midwives and doctors. Hospitals were at this time charitable institutions; they were neither clean nor well-equipped, so childbed fever and other infections were a significant danger.

The nineteenth century saw the professionalization of medical training. Medical schools opened in the US, so aspiring doctors did not have to go abroad to study. This meant that there were more doctors, and they needed clients. Because births occur regularly and generally proceed well on their own, doctors could “prove” themselves by attending a birth and hope to gain a loyal client. Doctors began promoting themselves as having more knowledge and skill, especially of new technological advances such as forceps and anesthetic, than midwives. At the same time, midwives resisted professionalizing, preferring their traditional apprenticeships, in part because the training was expensive and often taught by men. The newly-formed American Medical Association (AMA) and the Victorian belief in women’s delicacy and mental inferiority pushed women out of medical professions. Doctor-attended birth became a fashionable form of conspicuous consumption, although for the middle and upper classes this still took place in the home. The urban poor went to hospitals, while the rural poor, immigrants, and black women, who were less desirable as clients, continued to be attended by informally-trained “granny” midwives. Antisepsis techniques improved toward the end of the century, due to the work of Semmelweiss, Pasteur, and others, and antibiotics were developed. The first successful cesarean section in the US took place in Boston in 1894. (Previously, c-sections were only performed if the mother was moribund but the baby still alive, because techniques that allowed the mother to survive the operation were not yet known.) Hospitals began to be seen not as septic charitable institutions but as clean, safe places offering the newest technology to help respectable women to give birth. Midwifery in the US declined seriously during this century.

It was not until the twentieth century that a significant percentage of births took place in a hospital. In 1900, less than 5% of births were at hospitals; this rose to 50% of US births by 1939 and nearly 100% by 1970. Rural women and poor women continued to be more likely to give birth at home since hospitals were often distant or financially inaccessible. Birth was increasingly medicalized during this period. By 1910, the concept of prenatal care was growing as tests for pre-eclampsia¹ and syphilis became available. The use of synthetic hormones to speed labor increased, as did the use of episiotomy² and forceps. Women campaigned for access to pain relief, including the now-infamous scopolamine, also known as “twilight sleep.” This drug, which was widely used from the 1920s to the 1950s, does not dull pain but does erase the memory of it. It also reduces inhibitions, so women would scream, bite, hit, and kick as they labored in a strange place with little memory of what was going on. Doctors and nurses felt justified in tying down, gagging, and even striking these out-of-control women; family members who might have protested such treatment were barred from maternity wards. Scopolamine did not always completely erase women’s memories, which by mid-century led to protests against such abuses. Medical treatment of birth, including the exclusion of fathers, twilight sleep, total anesthetic, routine use of enemas, and pubic shaving, was critiqued in the 1960s and 1970s by feminist scholars and members of alternative birth movements, resulting in some reforms. The number of home births increased due to these and other countercultural movements in the 1970s to as many as 2% nationwide and 10% in some US counties (Bauwens and Anderson 1978; Anderson and Bauwens 1981).

¹ Pre-eclampsia is a condition that can lead to convulsions, cerebral hemorrhage, and other serious complications.

² Episiotomy is cutting into the vaginal wall, usually through the perineum, to facilitate birth.

The home birth rate can be difficult to ascertain because birth certificate and other official data may be incomplete or misleading. Where attending home births is illegal, midwives are understandably wary about documenting the place of birth. They may not fill out a birth certificate, or they may indicate that the birth accidentally took place outside the hospital rather than being a planned home birth. Some parents who choose home birth reject other institutional practices, such as documenting the birth. These factors would tend to underestimate the number of home births. On the other hand, birth certificate data may not distinguish between planned home births and unplanned out-of-hospital births (which may or may not take place in the home and are often unattended), which would tend to inflate the numbers. Home birth rates are estimated at 0.6% of US births (National Center for Health Statistics 2007a; Murphy and Fullerton 1998) to as much as 1% (Rooks 1997). By comparison, about 0.2% of Australian and 2% of UK births take place at home (Australian Institute for Health and Welfare 2004; Shaw and Kitzinger 2005:2374). Nearly one-third of Dutch births are in the home (Poorter 2005:31; Rooks 1989:410-414).

The turf war between midwives and doctors – and the social debate that accompanies it – is far from over. A recent documentary called *The Business of Being Born (BOBB)* (Epstein 2008) critiqued US birth management as over-medicalized and profit-driven. It included footage of women giving birth in their homes, including the talk-show host Ricki Lake. The American College of Obstetricians and Gynecologists (ACOG) recently (2008) issued an official opinion on home birth. It included the statement “Childbirth decisions should not be dictated or influenced by what's fashionable, trendy, or the latest cause célèbre,” which some interpret as a response to

BOBB. The AMA has recently (2008) echoed ACOG's recommendations that all births take place in hospitals or hospital-affiliated birth centers and called for legislation to support it. While the language of the statement was not explicit, many homebirth activists fear this will mean criminalizing homebirth parents, such as by charging them with child abuse. (Currently, even where homebirth midwifery is prohibited, it is the midwives, not the parents, who face legal repercussions.) The AMA statement may also be in response to *BOBB*, because an early version included a specific reference to Ricki Lake which was later removed (Associated Press 2008; AMA 2008). A flurry of news reports and internet commentary followed. This may make homebirth more prominent in the national consciousness. This is an exciting time for anthropological analysis of this topic.

Men's Role in Pregnancy and Birth in the US

In many human cultures, men are excluded from or peripheral to birth (Olenja and Kimani 1998). In the US, this has traditionally been the case, as Wertz and Wertz (1989) document in *Lying-In: A History of Childbirth in America*. During the colonial period, the father's role was to notify and assemble the women of the community, including a midwife if one were available, when his wife went into labor. These women would then attend the laboring woman. The father often took care of chores, looked after the older children, or physically supported his wife as she labored, though rarely while she birthed. If community women were not available (due to remoteness, weather, or other factors) a man might attend his wife while she gave birth.

Births continued to be attended primarily by women until the mid-eighteenth century, when doctors from the US began training abroad and bringing their new skills

back. Forceps and anesthetic gave doctors something to offer that midwives could not, and male attendants – both doctors and fathers – became gradually more acceptable. Duffin (1999:250-251) attributes this, in part, to the discovery of the sperm. Reed (2005:80-81) offers several reasons for men's inclusion in doctor-attended home birth. First, doctors attending birthing women were often suspected of having prurient motives, so the father was needed to act as a chaperone. Second, as the labor force became more mobile, the traditional female kith and kin were not available. Third, and related to this, the rise of the nuclear family led to more companionate marriages, in which women depended on their husbands for emotional support. Last, decreasing birth rates meant that parents were more emotionally invested in each of their children. Although the doctor and his tools became more acceptable in the birthing chamber, the father, not the doctor, held authority over what medical procedures would take place (Leavitt 2009:23-7)

In the twentieth century, when the majority of births moved into the hospital, men were once again excluded from birth. Leavitt (2009) chronicles the evolving roles of men in hospital birth in *Make Room for Daddy: The Journey from Waiting Room to Birthing Room*. In the 1930s through 1950s, men were expected merely to transport their wives to the hospital and have the means to pay for her care. They were confined to waiting rooms, which were often physically distant from the labor and delivery rooms, where they would smoke, pace, read, and write in the journals that were left in the room for that purpose. Ironically, they gained a gendered support space while women had lost theirs. In the 1950s, the cultural emphasis on domesticity, emotionally closer marriages, and natural childbirth led to dissatisfaction with this separation. There was some institutional resistance to this, on a variety of grounds (Cassidy 2006:198-207): men were sources of

contagion. They were a threat to institutional efficiency. They had a perverse interest in seeing their wives in labor. They would no longer be sexually attracted to their wives after seeing them give birth. They were sadists who enjoyed their wives' pain, or masochists wallowing in guilt and shame over it. Reed (2005:77) argues that these are ostensible grounds and that fathers were excluded because they challenged the hospitals' definitions of birth and its power structures. A woman with a husband nearby is a social person, not a biological object, and therefore must be treated differently by hospital staff. Likewise, a second man in the room could legitimately challenge a doctor's authority in a way that nurses and laboring women could not. Despite this resistance, men began gradually to move into the labor and delivery rooms. This was facilitated by two doctors, Dr. Bradley, who advocated "husband-coached" childbirth, and Dr. Lamaze, who taught psychoprophylaxis for pain. Hospitals began to give in to consumer demand, but, as much as possible, hospitals made fathers conform to the existing belief system and hierarchy, requiring them to wash up and wear scrubs, and enlisted them as allies in obtaining women's compliance. Beginning with those who could afford private rooms, men began to accompany their wives in the labor rooms, where they provided emotional and physical support. However, they continued to be excluded from delivery rooms until the 1970s. Eventually, husbands, though not unmarried fathers, began to be allowed in the delivery room itself. This varied a great deal regionally and, as usual, those in the middle and upper classes were more likely to have their wishes accommodated. Men of color were also less likely to be allowed to stay with their wives. In the 1980s and beyond, men's access to birth expanded to include unmarried fathers, men of color, and

cesarean births. Some doctors even began allowing fathers to catch the baby as it emerged.

In *Birthing Fathers: The Transformation of Men in American Rites of Birth*, Reed (2005) analyzes the roles of middle-class US men in pregnancy and birth through a series of interviews in the early 2000s. He finds that during their partners' pregnancies, especially first pregnancies, men respond in a variety of ways. They may experience increased appetite or food cravings, or curb their drinking or smoking (or attempt to). They may prepare the nursery, assemble the crib, tune up the car, or landscape the house. Some work more, organize the family finances, make a will, or purchase life insurance. Expectant fathers may experience somatic disturbances, such as heartburn, nausea, backache, or labor pains. They may feel uncomfortable having sex with their pregnant partners. Reed (2005:32-74) interprets this as a type of *couvade*, male ritual behaviors during their partners' pregnancies and births. *Couvade* serves to keep men involved beyond the moment of conception and to establish them, socially, as fathers. As ritual behaviors, they arise from cultural values and have symbolic effects. For example, tuning the car, managing the finances, and assembling a crib make sense in the context of men's gender role; as Reed (2005:59-60) says, "a man exerts control where he can and exercises the skills and talents he has."

The rhetoric and roles that surrounded men's movement from the waiting room to the birthing room drew heavily on gendered expectations, on conceptions of the ideal family, and on consumer ideals (Leavitt 2009; Reed 2005). While there is a certain role reversal in a man providing emotional support while a woman labors, men were nevertheless cast in masculine roles. They were called "coaches," for example, which

draws on the masculine world of sports. They were expected to both protect and control their wives; doctors saw them as an ally in obtaining women's compliance. The importance of their participating in birth to strengthen their commitment to being fathers and breadwinners was stressed as a way to make changes more palatable. This role of breadwinner and protector meant also that men were expected to purchase for their partners the best care they could afford. US birth customs changed quite a bit during this period, but not all proposed reforms were accepted. As Leavitt (2009: 287) says, "The reforms that succeeded were those that promoted women's roles as mothers, fathers' roles as breadwinners, and physicians' roles as childbirth experts...childbirth reform reinforced physicians' authority and family gender hierarchies."

The recent history of men and birth in the US has been to allow them greater access to the event and greater closeness to their partners. Home birth takes this a step farther; the fathers are highly involved and their involvement is not mediated by a hospital (although a midwife may do this to a certain extent). There is not, to my knowledge, any previous research analyzing the role of US men in home birth, but many of the same forces shaping their changing roles in hospital birth influence their role in home birth. Indeed, I found that gender shapes my male participants' behavior during their partners' pregnancies and births. While I do not address politic-economic or other social factors in detail in this study, it is a fruitful area for future analysis. Ideas about the family, such as the ideals of self-sufficiency and antipathy toward state intervention, likely shape their roles. The increasingly small and geographically isolated nuclear family probably facilitates closer emotional bonds between men and women, making birth a time they feel they should share. Family life is increasingly privatized; recreation that

might once have taken place in a public park now takes place in a private backyard. Birth may be following a similar pattern, with families rejecting the public institution in favor of the private home.

Cultural Analysis of US Hospital Birth

Reed (2005:23-28) and Keller (2007) summarized the traditions of Western medicine and discuss the way that they shape beliefs about birth. Empiricism, a worldview developed in the Enlightenment, sees the body as an object of observation to be understood as a biological organism; biomedicine is the outgrowth of this belief system. Biomedicine is the dominant model for understanding the body, health, and illness in the modern Western world. A key concept of this model is *body-mind dualism*, first described by Descartes. The mind and the body are conceived of as separate; the mind is the seat of agency and the body a vehicle for it, an object. Keller (2007:4) described the mind, in this framework, as inhabiting a body “rather than being co-extensive with one.” Working in this framework, biomedicine treats the body, not the mind, and the body is seen as separate from its cultural milieu. That is, the body is believed to operate irrespective of the mind. The concept of *universalism* asserts that the body has an ideal form from which bodies deviate to greater or lesser degrees. This ideal form is a male body; female bodies have usually been seen as an “inferior deviation,” (Keller 2007:66) and more so when they are pregnant. The goal of biomedicine is to return the body to this ideal state, or bring it as close as possible. *Essentialism* is the belief that all illnesses come from a specific, locatable part of the body and that one can fix the illness by fixing the part. Essentialism also posits that men and women are

inherently different, and that these differences are rooted in their biology. The *individualism* of Western medicine means that each body is treated as an individual, separate from its social context. In sum, Western biomedicine sees the body in a radically reductive way: it is a pre-cultural, bounded object composed of separable parts. The application of these Western ideologies to birth means that a woman's social status and mental state are considered irrelevant to the birth process. It is the body, and specifically the uterus, which is in the altered pregnant state; the woman need give it no conscious thought for pregnancy or birth to proceed. Medicine's goal is to return her to her normal (or nearly-normal) state of non-pregnancy. In this framework, her mental or emotional discomfort – indeed, whether she is conscious or not – is irrelevant. In fact, the fetus has even been seen as operating independently within the woman and making its own entrance into the world without her help (Keller 2007:121). Reed (2005:27) summarizes it this way: “pregnancy and birth in biomedical terms are an abnormal biological condition, rather than a normal social process.”

Other authors have discussed the ways that specifically US ideologies shape hospital birth practices. Martin (2001) discusses the ways that industrialization, particularly Fordist factory production, has shaped US Americans' conceptions of their bodies. She argues that metaphors of mechanization (among others) are used to understand the female reproductive system. Menstruation, for example, is described negatively as a failure in production, since no baby will result. In contrast, sperm production is described in positive terms, since it is constant and the output astounding. When this industrial model is applied to birth, births are expected to be standardized. The hospital acts as a factory, “producing” babies in a uniform and timely way. This is

expressed by giving all women the same prenatal tests and labor monitoring, regardless of medical indication, and expecting all women to deliver within a certain time period. In this model, women are workers, doctors are managers, babies are products – and others are irrelevant. Martin (1994) has also discussed the “flexible body,” an ideal dictated by the needs of the post-Fordist market. As employers demand that employees change functions and jobs frequently and flexibly, employees expect their very bodies to be flexible as well. She notes that stretching exercises, rather than those focused on strength or endurance, became more popular as this ideology arose. While Martin does not apply concepts of the post-Fordist economy specifically to birth, it is likely that this ideology is now impacting conceptions of birth. In particular, the idea of small-batch, customized production seems to fit the model of home birth. Neoliberal ideals emphasize individual choice and market-based solutions; the concepts of “shopping around” for a practitioner that suits one’s tastes fits this model. In summary, Martin argues that the economic structure, especially the needs of employers, shape that way that people experience their bodies and the types of bodies and bodily practices that are considered desirable. These ideologies then shape the management and experience of birth.

Davis-Floyd (2003) extends this argument, showing that culture not only shapes birth management but that hospital rituals of birth socialize men and women into their “proper” roles. For example, requiring women to lay prone and push only when told to do so emphasizes their weakness and dependence. The tradition of the doctor “delivering” the baby, assessing it, and then presenting it to the mother creates the impression that the baby was produced by society, not the mother, and is under its supervision. She argues that a number of core US values are conveyed during birth, such as: women’s bodies are

defective machines; technology gives safety; a baby is society's product; and institutions know best. I discuss her argument in greater detail in chapter five.

Frisbie (1977) gave a tongue-in-cheek description of "A Female's View of Pregnancy and Birth in Nacirema." Nacirema, as everyone who took an introductory cultural anthropology class knows, is 'American' spelled backwards, and the articles about it take a light-hearted look at the US through the anthropological lens. Frisbie argues that women are expected to be joyous about motherhood but often feel ambivalent, which is not supposed to be expressed. She observes that pregnant women are expected to tire easily, to become increasingly emotionally unstable, and to purchase things. This fits the US beliefs that women are weak, emotional, and like to shop; it also supports the consumer ideology of the country, in which purchases represent identities and consumption drives the economy. She observes that laboring women are expected to not scream, cry, ask for food or water, or otherwise upset others while they labor. They are expected to cooperate with the nurses and doctors and to speed or slow their labors to meet the institution's needs. These latter two fit the ideology that institutions and businesses have primary importance in the US. The former conform to gender norms, in which women subjugate their own needs and comfort to those of others.

Reed (2005) also sees hospital birth as reinforcing gender norms. Since women are seen as emotional, irrational, and animal-like in birth, men must take the opposite role and be rational, calm, and civil. He also sees changes in birth customs reflecting changes in family structure. When men were expected to be emotionally distant patriarchs, they were isolated in a waiting room while their wives labored. With the rise of the

companionate marriage and the more hands-on father, men are expected to be by their partners' sides during the birth process.

Dobris, in her 2004 analysis of the hugely popular *What to Expect* series of books about pregnancy, birth, and parenting, finds some contradictory themes in modern US American discourse on birth. Women are both encouraged to worry and to not worry. They are told “you can do it,” along with “he can help.” They are simultaneously taught that biomedicine has all the answers and that they can rely on their instincts. This shows how seemingly contradictory messages can support the same choice about birth location. She also finds that the books paint all mothers as white, heterosexual, married, well-insured, and career-oriented, showing that these traits are the valued ones, the ones to which everyone should aspire.

All these authors demonstrate that cultural values, including gender, economics, and history, shape the way a seemingly purely natural process is managed in US hospitals.

Cultural Analysis of US Home Birth

Few authors have examined the interaction of US cultural values, economics, and history as they impact home birth, and most (though not all) stress its non-normative aspects. Davis-Floyd (2003:154-86) argues this strongly. In her framework, the dominant paradigm of birth – what she calls the technocratic model – sees birth as a medical event in need of technological management. In contrast, she asserts that homebirth parents believe in what she calls a wholistic model of birth, seeing it as a normal physiological process that women can handle well on their own. She sees this viewpoint as aberrant,

saying that “such a choice almost always entails a willingness to reject the core values of American society” (2003:206).

Bauwens and Anderson (1978) described the rise in home birth’s popularity in the 1970s as a reaction to the stress and cognitive dissonance of hospital birth. They emphasize that homebirth parents and hospital staff have very different conceptions of birth. They say, “there is a basic dissonance and lack of consensus between the consumer who chooses out-of-hospital birth and the health professions concerning their value system, their individual roles, and those services that are viewed as essential by each” (Bauwens and Anderson 1978:57). They found that many women experience the jargon, restricted movement, and “state of dependency” created by the hospital as stressful. Among the homebirth mothers they interviewed, they found that they chose home birth so they could have a more personal atmosphere, because they had a previous negative experience with a hospital birth that they wanted to avoid for subsequent births, or (ironically) because they had a positive hospital experience that made them feel they could handle the experience at home. The home birth parents in my sample did not support this model. Only one had hospital births before birthing her third at home. The others chose home birth for their first births, and most (though not all) successfully birthed their first babies at home.

In a later paper (Anderson and Bauwens 1981), the same authors find other reasons why women choose home birth: lack of access to a hospital, religious belief, to avoid the use of technology, to have more control over the birth, and to have a more family-centered experience. This more closely matches the reasoning in the parents in my study. Anderson and Bauwens give three cases studies: one couple who rejects the over-

medicalization of birth, one who chooses home birth as a reflection of their progressive ('hippie') values, and another who chooses it as an expression of their fundamentalist religious beliefs. This demonstrates that home birth can carry many meanings, and that a variety of belief systems – even seemingly contradictory ones – can lead to desire for home birth. Nevertheless, the authors continue to stress home birth's ideological opposition to mainstream beliefs about birth, saying that "birth in the home has conflicted both ideologically and legally with scientific medicine in the United States" (Anderson and Bauwens 1981:290).

Martin (2003) finds that women who give birth at home are less likely to enact conventional femininity. For example, they are less likely to see themselves via the doctor's gaze, to be "nice," or to facilitate conversation while in labor. Carter (2009) also found that homebirth women unapologetically break some gender norms in birth.

All of these authors see conventional US cultural beliefs about pregnancy and birth as incompatible with home birth. Other authors have not made this claim as strongly, though few show that US values can support home birth. McClain found that women who give birth at home tend to have non-kin in their social networks who have done the same; this reflects the priority of personal relationships within the feminine gender role. In a small study of (four) lesbian couples, Lewin (1998) found that two chose to birth at home. Lesbians are often interpreted as violating both gender norms and patriarchal power structures. However, Lewin interprets their valorizing of marriage and motherhood as accommodating more than resisting gendered and patriarchal norms. Likewise, Carter (2009) finds that homebirth women see their violations of gender norms

(for example, vocalizing their pain) as serving the feminine ideal of good mothering (because it allows them to avoid medical pain management).

Klassen (2001) describes the various ways that women use ideas about the “natural” and religious beliefs to assign meanings to home birth. Women have long been associated more closely with nature than are men (Ortner 1972). As Klassen points out (2001:13), what is considered “natural” is in fact highly culturally constructed, making the desire for “natural” home birth an expression, not a rejection, of US beliefs. The emphasis on religion, though she does not examine it in this way, also reflects US beliefs and gender norms. Among industrialized countries, the US is the most religious. More people profess a belief in God and attend church than in more secular Europe. Compared to US men, US women express higher levels of religiosity, are more harshly judged for criticizing religion, and are seen as responsible for their children’s religious training (Walter and Davie 1998). Religion as a justification for home birth supports the interpretation of it as an expression, not rejection, of normative values about gender and religiosity.

Craven (2005:195-196) found that homebirth parents draw on conventional US American values to support their decisions: “those of self-reliance, independence, and pragmatism around their health-care decisions.” However, she also found that the medical officials attempting to legislate against it countered with arguments that women are not competent to make such decisions, that birth is a medical event, and that home birth is a reckless and possibly negligent choice. This shows not only that home birth can have many meanings, but that people attempting to assign it meaning may select from among “acceptable” or common values to bolster their positions. It also demonstrates

how institutional forces – especially biomedicine – assert their right to define birth and women’s roles and rights within it.

Summary

The management of birth is shaped by many cultural factors. The history, economics, and political structure of the society all play a part. In particular, beliefs about gender and the family will shape the customs of birth. A number of authors have demonstrated the relationship between US culture and hospital birth, but fewer have addressed home birth. Those that have tend to interpret it as resisting conventional norms. However, home birth may draw from acceptable and widespread beliefs as well. There has been little recent work on home birth, and none that considers the perspectives of men, so new anthropological analysis is timely. I explore the role of gender and other cultural ideologies in shaping home birth, considering the roles of both women and men. I next describe the methods by which I explored these issues.

METHODS

Data for this study was collected primarily through formal, semi-structured interviews with twenty-six homebirth parents, as well as three key informants, who were midwives. Additional information was gathered through key documents such as books, magazines, and movies, and through participant observation. Themes were identified using both deductive and inductive approaches. These themes were then analyzed qualitatively using grounded theory methods.

Recruitment

Participants who had either had a home birth within two years (i.e. at least one child born at home was less than two years old) or were planning a home birth (i.e. were pregnant) were recruited. Recruitment was via reverse-snowball technique. I contacted homebirth professionals and parents with whom I had previous contact and gave them information about the study. They passed this information on to people they thought might be interested in participating. Potential informants then contacted me via phone or email to arrange an interview. This technique allowed me to identify homebirth parents without accessing medical records or other protected information. It also provided greater privacy for informants because they were contacted by people they knew rather than by a stranger. One participant posted information about the study on a Yahoo discussion group, and this elicited additional informants. However, the use of these recruitment techniques may have skewed the sample to those who were particularly vocal or active in

the homebirth community. It also meant that participants had many similarities. For example, there are two midwife pairs who handle most of the homebirths in Fort Collins. These two pairs appeal to different types of people, as one is composed of two older, Christian-identified, nurses-turned-midwives and the other of two younger, secular, non-nurse midwives. Because the latter pair was more active in recruiting for me, I spoke to more of their clients. This recruitment technique may also have meant that I spoke more to people who were motivated by ideology rather than economic concerns, since these people are more likely to be eager to discuss their choice and to have the leisure time to do so.

Setting

Informants lived in various cities in the northern half of the Front Range Urban Corridor in Colorado, including Fort Collins, the Denver metro region, Lafayette, Longmont, and Boulder; these regions are described in chapter one. Homebirth parents were offered the option of being interviewed in their homes, an on-campus office, or another setting of their choice. Most elected to be interviewed in their homes; one man was interviewed at his office and one woman was interviewed on campus. This lent a certain privacy and intimacy to the interviews. At informants' homes, we usually talked over kitchen tables or on couches. We often ate or drank during interviews, and I had the chance to observe parents' interactions with their infants and young children, including diaper-changing and breast-feeding.

Three of the homebirth midwives serving Ft. Collins and the surrounding area were interviewed. Each worked from her own home; they conduct prenatal exams (and

some well-woman exams) in cozy rooms located in their finished garages or basements. As with parents, we spoke in an informal, intimate setting, such as in the living room or at the kitchen table.

Informant Characteristics

A total of twenty-six home birth parents were interviewed. Fourteen of these were mothers, eleven were male partners, and one was a female partner. That is, I interviewed twelve couples as well as two mothers whose partners were not interviewed due to scheduling conflicts. Thirteen of the women gave birth at home successfully at least once; one woman went to the hospital to give birth after a lengthy labor at home. All informants were of European descent and twenty-five of the twenty-six were raised in the US (the other was raised in South Africa but had lived in the States for a number of years). Their annual household incomes ranged from \$8,000 to \$250,000, with a median of \$80,000 and an average of \$87,700. This places many of them well above the US and Colorado average incomes of \$67,626 and \$68,483, respectively (US Census 2008a). Many were professionals in some type of alternative medicine: two were chiropractors, two were naturopathic doctors³, three were massages therapists, two were Bradley-method childbirth instructors, one sold “natural” toothpastes and other hygiene supplies, and three of the women combined doula work⁴ with other paid employment. One was a nurse and another was a nursing student. This may not be coincidental; Lazarus

³ Naturopathic doctors are trained at accredited North American schools. They emphasize holistic, non-invasive treatments, such as counseling, nutrition, homeopathy, botanical treatments, massage, and acupuncture. Naturopaths are not legally recognized as health care providers in the state of Colorado, although they are in some states.

⁴ The term doula comes from the Greek word for a woman servant. Doulas support women physically and emotionally through labor, birth, and postpartum.

(1997:143) found that health professionals were more likely to choose midwives. The remainder of my sample had

non-health-related professions, including scientific research, sales, real estate investment,

<i>Educational Attainment by Sex of Informant</i>		
	Men	Women
High School or GED	0	0
Some College or Associate's	6	4
Bachelor's of Arts or Science	3	6
Advanced or Professional	2	5

administrative work, teaching, engineering, and woodworking. All had at least some post-secondary education; see the figure at right for a breakdown of educational attainment by sex. This compares with 61% of the US population with post-secondary education (US Census 2008b). The majority of the couples I interviewed were heterosexual and all of these were married. I also interviewed one lesbian couple. I have included their perspectives, but I do not feel that a single couple can represent the experience of lesbian parenting, so I have not addressed sexuality directly in this analysis.

This sample is not representative of the general US or Colorado population; most of my informants had higher-than-average income and education levels and none were racial or ethnic minorities. It seems to be representative of homebirth parents. Previous small-scale studies (Craven 2005:197; Hartley and Gasbarro 2002; Davis-Floyd, Pigg, and Cominsky 2001; Klassen 2001: 16-17; Rooks 1997:55-6; McClain 1987:147-8) have found that better-educated and non-minority people are more likely to have home births. Some have found that middle- and upper-class women are more likely to choose home birth, but others found that home birth parents come from all economic classes. Lesbians may be somewhat more likely to choose home birth, since their partners may be barred from staying with them in the hospital and because hospital staff may be homophobic

(Lewin 1998). Two large-scale studies of homebirth women in the US and North America have found that they are more likely to be middle-class, educated, married, and to have had a previous birth. I summarize the demographic profile of homebirth mothers compared to all US births in the chart below. Since homebirth midwifery is significantly less expensive than hospital-based care, it seems likely that some working-class people would choose it for this reason. However, they may be less likely to be interested in discussing this or they may not have time in which to participate in a lengthy interview. Also, since Colorado Medicaid will not cover homebirth midwifery care, those who want it but cannot afford to pay out of pocket will have to use conventional care; this was the case for a previous birth of one of the couples I interviewed.

This research is unusual in including the perspectives of the male and female partners of the homebirth mothers. I am not aware of any other research on home birth that does so. Indeed, US fathers' roles in birth have been little explored, although Reed (2005) and Leavitt (2009) offer insightful analyses of men's perspectives' on pregnancy and (hospital) birth. Including fathers in my sample was fruitful not only for this unique perspective. Fathers and partners are likely to be influential in decision to birth at home. They offer a way of exploring the gendered aspects of home birth. They also provide a second perspective on the birth process, and may remember things that mothers forget or overlook when they are (quite reasonably) distracted. Seeing the interactions of the couples and the ways that they managed childcare for the interview period also added insight.

<i>Selected Demographic Characteristics of Home and All US Births</i>			
Characteristic	5000 North American Women Planning Home Births (Johnson & Daviss 2005) (%)	All US Home Births (National Vital Statistics Reports, 2006 Data) (%)	All US Births (National Vital Statistics Reports, 2006 Data) (%)
<i>Age of Mother</i>			

≤19	2.4	2.2	10.4
20-24	17.2	11.6	25.3
25-29	28.7	19.3	27.7
30-34	26.3	17.4	22.3
35-39	17.9	10.6	11.7
≥40	6.0	3.6	2.6
<i>Parity</i>			
0	31.2	13.5	39.8
1	23.9	17.1	31.8
≥2	44.6	34.1	28.5
<i>Mother's Formal Education</i>			
High School or Less	39.2	(Not available)	52.4
Any College	23.2		21.6
College Graduate	21.3		22.7
Postgraduate	12.7		6.0
<i>Mother's Ethnicity</i>			
White	89.4	51.6	54.1
Hispanic	4.0	5.2	24.4
African-American	1.3	4.9	14.5
Other	2.6	3.3	7.5
<i>Socioeconomic Status</i>			
Low	23.2	(Not available)	19.0
Middle	59.9		44.0
Upper	12.3		21.0
Note: Italicized numbers are 2000 data.			

The three midwives that I interviewed were all of European descent and were raised in the United States. Their ages ranged from mid-forties to mid-sixties. They charge each woman \$3000 for care; this included prenatal exams, birth care, and three post-natal exams, as well as on-call assistance throughout pregnancy and lactation. This

seems to be the going rate for midwives in this region, although less experienced midwives may charge less. They typically stagger their client load so that no more than three women are due to give birth in the same month; this places their incomes at \$24,000-\$36,000 yearly. However, they all expressed a willingness to offer their services on a 'sliding scale' and to accept part of their fees in trade. Two of these midwives were conventionally-trained labor-and-delivery nurses before becoming midwives; one was an electrical engineer before she changed careers. All three are certified professional midwives (CPMs). This certification is overseen by the North American Registry of Midwives (NARM). In order to be certified, prospective midwives must pass exams and complete an apprenticeship. They must be observed as they complete a prescribed number of prenatal exams and births. To remain certified, they complete continuing education and submit it to NARM. This is not the only certifying agency for midwives in the US. Certified midwives (CMs) are another class of midwives; the internal and external politics involved in creating each designation are discussed in several chapters in *Mainstreaming Midwives: The Politics of Change* (Davis-Floyd and Johnson 2006). States which allow homebirth midwifery typically have their own exams and regulations, which vary state to state. After completing her state's exam, a midwife may append licensed midwife (LM) or registered midwife (RM), depending on the state, to her name. Colorado licenses homebirth midwives but has some of the stricter regulations on their scope of practice. They are legally allowed to carry oxygen, but not to write prescriptions, start IV lines, administer saline, give Pitocin injections, or stitch tears, as midwives in some states are (Erickson and Colo 2006). In practice, it appears that many

may in fact do these things, risking legal repercussions, if they feel it is in the best interest of their patients and within their skills.

Each informant has been assigned a pseudonym. Although not all of the couples shared a last name, I have given them the same last name here (including the lesbian couple). I realize that the tradition of a woman changing her name has its roots in patriarchal traditions and that this choice may be offensive to some. I have done it here simply for convenience and to ease the readers' comprehension.

Interviews

Each homebirth parent participated in a formal semi-structured interview lasting from one to three hours. The questions covered their initial exposure to home birth; influential people, books, or movies; reactions from friends, family, and strangers; experiences during pregnancy, labor, and birth; the actual and ideal place of home birth in the US health care system; and reactions to the AMA condemnation of home birth. My informants were generally eager to talk about their experiences with someone who was open to home birth and interested in every nitty-gritty detail. Many laughed and cried during their interviews. Most were wonderfully candid, sharing with me details of sex during pregnancy, conflicts with family, mental and spiritual upsets, and (in many cases) a nearly push-by-push account of their births. I heard about the vaginal "ring of fire," inadvertent bowel movements, and midwives who will suck mucous from a baby's lung by mouth rather than interfere with breastfeeding reflexes by using a bulb syringe. Many people showed me items related to their births: birth plans, scrapbooks, pictures, video, a

belly cast, and even a placenta print – pressing it on a sheet of paper produces a tree-like outline.

Midwives participated in a formal semi-structured interview lasting one to two hours. The questions covered many of the same topics listed above, as well as career path, the state’s regulation of midwifery, and impressions of their clients’ characteristics. They were very forthcoming about most topics, including illegal and unregulated activities, but were hesitant to discuss other midwives’ practices.

Other Data Gathering

In addition to formal interviews, I lived in the north-central region of Colorado and I attempted to immerse myself in the culture of my informants. If several mentioned a book or movie and I wasn’t already familiar with it, I would read or watch it. *Ina May’s Guide to Childbirth* (book) and *The Business of Being Born* (documentary) were frequently mentioned. Several mentioned that they read *Mothering* magazine, so I read the issues that dealt with home birth and looked at the products of its main advertisers. I also read *Get Born*, a local magazine with personal essays, letters, and poems about the “imperfect” side of motherhood, because a number of the contributors were home birth parents or birth professionals. I attended a birth fair, where I looked at birth-related merchandise and teaching tools, met with local birth professionals (midwives and doulas), and ate a great deal of chocolate, which is apparently endemic to the birth world. I attended a locally-produced showing of a play called *Birth*, which explored a variety of women’s experiences in giving birth, both at home and in the hospital.

Analysis

Each interview was recorded with the informant's verbal permission and then transcribed into Microsoft Word using digital audio software to slow the speed. Extraneous or irrelevant material (such as discussions of the weather or other off-topic conversation) was excluded and punctuation was added, but otherwise they were transcribed word-for-word. These transcripts were then uploaded into QSR NVivo 8 for coding. This program allows the researcher to highlight words and phrases and tag them as examples of key concepts or themes. A number of deductive codes were developed from the literature search; inductive codes were added as potentially fruitful themes emerged. For example, the category 'father mediates public and private realms' was derived from Reed's (2005) analysis. The category 'lighting' was added after several participants mentioned it; categories for 'sound' and 'other sensory' were later added. The two sets of coding themes are listed in alphabetical order in Appendix A. After each of the transcribed interviews had been coded, the program was used to extract all of the data relevant to each topic.

Analysis proceeded in an iterative fashion, moving from literature to data to interpretation to literature to interpretation to data in cycles. This process is quite similar to that of grounded theory methods (LaRossa 2005). The coding concepts were 'played with' in a variety of ways. They were written out on index cards and scattered across the living room, piled and re-piled. Flow charts and idea trees were drawn, crumpled, re-drawn. Concepts were written, discarded, re-written. In the end, what is hopefully a coherent 'story' emerged. I have made every effort to accurately capture my informants' perspectives, discarding arguments and interpretations if further examination of the data

showed them to be inaccurate or incomplete. Nevertheless, such an analysis is largely interpretive. No doubt another researcher would have found different points important; indeed, many interesting ideas were not pursued in the interest of having a (more or less) coherent argument in a (more or less) reasonable amount of space. However, I do not think that another researcher, given access to the full transcripts, would find that I have misrepresented my informants' experiences or cherry-picked their quotes to support a predetermined interpretation. Rather than provide a definitive interpretation of home birth, I hope to capture some of the richness of ideas embedded in the discourse of it.

Limitations

This research has several limitations. First, my sample size is limited and concentrated in a small geographic region. There may very well be regional differences in beliefs about this subject. Many of my informants were not native to Colorado, so this may have helped to provide a broader perspective. Second, as discussed above, this sample can all be considered white, well-educated, suburban, and middle class. While some had low incomes, this was related to having a family with one adult who was a full-time student; one father was pursuing an engineering degree and another a nursing degree, so it is likely that they will make middle-class salaries in the future. Since Martin (2001) found that working-class US women had different conceptions of their reproductive systems than similar middle-class women, it is possible that my informants' views were shaped by their class position. Further research involving working-class informants would shed light on this.

Characteristics of the researcher can influence what is found in the research. I shared many characteristics with my informants, such as being white, married at the time, and well-educated. This may have facilitated their feeling at ease with me and therefore speaking more freely. Likewise, the fact that I have no children and, in the case of the interviews with men, was of the opposite sex, may have made it more difficult for my informants to speak openly with me. As Klassen (2001:9) points out, a research interview is in itself a performance of gender. Informants are likely to choose from discourses that are suitable for their gender and to mine, and that shaped our conversations.

Awareness that I was a researcher and was audio-recording could not be avoided; my interview questions and recorder were always visible. Several of the men, in particular, made comments indicating that they thought the questions I asked were not the “real” questions. They seemed to think that they should not have prior knowledge of what would be asked (by studiously avoiding listening to my interviews with their partners) and that my questions had hidden meanings (by making comments about answering what they thought I was “really” asking). I answered questions freely about myself and my research process to mitigate some of these factors. Just as my characteristics influence my informants’ perceptions of me, theirs impact my perception of them and presumably color my behavior and responses. Certainly I was somewhat intimidated in the spacious and well-furnished homes of the more affluent families. Likewise, my primarily secular and feminist orientation made me somewhat uncomfortable with explanations based in religion and separate spheres. Because of these conscious and unconscious levels of comfort, I was better able to develop a rapport with some than others. A different researcher might therefore have received somewhat different responses.

Because of all of these factors, it is impossible to say how much my informants' discourse reflects their "true" feelings and how much is a reflection of our respective perceptions of each other, of their race, class, and gender, and of the discourses that are available to us in our historically-specific culture. This hardly invalidates this type of research. On the contrary, it simply shows the dazzling diversity of human interactions and sheds light on a limited, but worthwhile, piece of the human experience.

Summary

My data consist of interviews with twenty-six homebirth parents and three homebirth midwives from the northern half of the Front Range Urban Corridor, as well as participant-observation of this cultural niche. These interviews were transcribed and coded using inductive and deductive codes. This qualitative data was analyzed using the methods of grounded theory, moving between literature, theory, data, and analysis in an iterative fashion. In the following chapters, I discuss my interpretation of the information gathered through these interviews. I begin by demonstrating that home birth is a rite of passage that in which homebirth parents learn and enact values of the culture in which it takes place.

HOME BIRTH AS AN AMERICAN RIGHT OF PASSAGE

Imitation is the sincerest form of flattery, so I have chosen to reprise the title of Robbie Davis-Floyd's (1992 and 2003) brilliant and seminal work, *Birth as an American Rite of Passage*. I am by no means the first author to analyze birth practices in terms of ritual. Ayres (1967) interpreted the cross-cultural frequency of food and sex taboos in pregnancy as a form of magic. Olenja and Kimani (1998) described birthing women as liminal and argued that the roles of men and women in birth and postpartum care illuminate African cultural beliefs about gender. Rouhier-Willoughby (2003) described the way that religious birth traditions have been merged with modern biomedical birthing in Russia. Sered (1993) observed a similar phenomenon in Israel. Ehrenreich and English (1973) discussed the association of midwives and witches in Western culture.

There has been less work, however, on the ritual aspects of modern Western birth practices. Homans (1994) interpreted British (native-born and immigrant) women's experiences as a rite of passage. Small (1999) described the baby shower as a rite of passage. Davis-Floyd interpreted standard medical procedures for birth as having ritual importance. Likewise, Reed (2005) wrote about "the transformation of men in American rites of birth," the subtitle of his book. However, there has been no analysis of home birth from this perspective that I am aware of. Ina May Gaskin (2002 [1975]), perhaps the single most influential midwife in the US, called her midwifery manual *Spiritual Midwifery* and draws on a variety of religious and spiritual traditions to describe the meaning and power of birth. Klassen (2001a; 2001b) discusses the role of religion in

making meaning of home birth. However, neither discusses ritual in the anthropological sense. I wish therefore to summarize the works of Davis-Floyd and Reed before showing that home birth, along with hospital birth, is a rite of passage in which the initiates both enact and are socialized into US values.

As discussed in chapter two, rituals, and especially rites of passage, serve several important purposes. They convey a sense of control over a seemingly uncontrollable event, make changes in status seem to be under the direction of society, and reflect cultural values. The homebirth parents who participated in this study made their decisions about pregnancy and birth within the framework of their cultural and subcultural values. That is, the actions of pregnancy and birth have an iterative relationship with these values: parents both enact and are socialized into US values as they make the ritual journey of midwife-attended pregnancy, homebirth, and postpartum care to parenthood.

Women as Initiates

Modern US hospital and home birth follow the patterns of a rite of passage. The initiate goes through the steps of separation, liminality, and reintegration as her status changes from non-mother to mother. I will first go into detail about interpretation of hospital birth and then continue with my own analysis of the ritual aspects of home birth.

Ritual Features of Hospital Birth

Davis-Floyd (2003:73-153) has elucidated the ways in which hospital birth has the characteristics of a rite of passage and the messages conveyed by each ritual aspect. Rites of passage convey multiple messages and each message will usually be repeated

multiple times throughout the rite. Davis-Floyd finds that the key messages conveyed in hospital birth are: women's bodies are defective machines, women are impure and childlike, technology is paramount, and the baby is the product of society.

To begin the ritual, the laboring mother and her partner leave their typical social space to enter the ceremonial space, the hospital. As she enters, the woman is placed in a wheelchair. Since she is likely capable of walking – as she just walked into the hospital – this is usually not necessary. It is intended to convey her helplessness and dependence on the hospital. Her partner will typically be separated from her at this time and given the task of completing paperwork. She will then be given her ritual garb, a hospital gown that allows easy access to her back and genitals. By separating her from her partner and her individual clothing, the hospital makes her identical with other laboring women. She is literally stripped of her individual identity along with her clothes. Her partner will later be allowed to return, also in different clothing. In both cases, clothing is part of the process of strange-making; the parents-to-be do not quite recognize themselves. The woman will be placed into a bed, strengthening the message that she is weak and dependent. It forces her to (literally and figuratively) look up to hospital staff; it (literally and figuratively) lowers her status. Next, an IV will be inserted into the mother's arm. This is like an umbilical cord, making her dependent on the institution and equating her with an infant. One or more monitors will be attached to her abdomen; their printouts will begin recording the strength of her contractions and the baby's heartbeat. This makes her body a cyborg – a human-machine hybrid. It serves to define her body as machine-like and broken, requiring additional machinery to function properly. It also creates an illusion that the machines control the contractions and keep the baby's heart beating. As

her labor progresses, there will be frequent “checks” to determine how much the cervix has effaced (thinned) and dilated (opened). This is done by reaching deeply into the vagina and will be performed by one or more nurses as well as the doctor. Allowing strangers to reach repeatedly into a normally private area is part of the symbolic inversion of the rite of passage.

A laboring woman’s pain will be both increased and decreased by the hospital’s medications. Nearly all women will be given Pitocin, a synthetic hormone that increases the frequency, duration, and intensity of contractions. This serves two ritual purposes. First, it acts as a form of hazing. Second, it establishes the hospital’s routines and timetables as more important than the normal rhythms of birth. It continues the message that the woman’s body is a defective machine that requires augmentation to progress according to the timetable. Most women will also receive analgesia or anesthetic in some form; the epidural is the most common of these. This also establishes the body as machine-like; machines do not feel pain. It sends the message that a woman cannot endure the pain of labor without the help of the hospital, emphasizing her weakness and cowardice. When the laboring woman’s cervix reaches ten centimeters in dilation, the time for the second, or pushing, stage of labor has arrived. This is true despite the fact that not all babies’ skulls are the same size, not all cervixes are the same size, and that not all women will feel the urge to push at this time. Again, the hospital’s definitions and schedules are more important than her bodily experience. She will be moved from the labor room to the delivery room, symbolically moving from the outer temple into the *sanctum sanctorum*. She will be placed in the lithotomy position: on her back, feet in stirrups, bottom pushed forward. This continues the ritual inversion begun with the

“checks.” The doctor, in the role of head priest, will be ritually purified (“scrubbed”), suitably draped in sterile clothing, and enter rather dramatically. Rather than coming to her head, the doctor will be placed at her bottom, symbolically the opposite end of her body. The woman will not be allowed to push until the doctor completes the appropriate preparations and assumes the ritual location between her legs. She will then be exhorted to push when the machines indicate she should do so and for a standardized length of time unrelated to her own urges. Again, this establishes that she cannot birth her baby without the help of society, via its representatives, the hospital staff. When the baby emerges, the doctor will show it to her and announce the sex. It will likely be handed to its mother for a brief “bonding” period.

The baby will typically be taken from its parents (after the bonding period) for a number of hours. It will be quickly cleaned and assessed. This establishes the mother’s body as dirty; the hospital must remove the stain of her fluids from its product as quickly as possible. The assessment of its color, breathing, reflexes, etc. establishes society’s right to evaluate both the child and the mother and require them to meet its standards. The baby will be given eye drops as a prophylactic for gonorrhea-induced blindness and a vitamin K shot to prevent clotting problems. The tests and interventions establish the mother as unable to produce a perfect baby without institutional assistance. It also marks the baby as something to be graded and supplemented by society. After cleaning and assessment, the baby will be wrapped in a blanket. These are often pink or blue to indicate the baby’s sex, beginning a lifelong gendering process. The baby will then be placed in a plastic box to be monitored by nursing staff. Many family members will have their first view of the member this way. The mother, meanwhile, will then have her

placenta extracted, if it does not emerge quickly on its own, and her vagina stitched up. She is moved out of the inner sanctum into a recovery room. The doctor departs and nursing attention declines. The process of reintegration begins at this point. The new parents will greet visitors and make phone calls to announce the baby's birth – and announce their new status. They will be reunited with their baby, be allowed to change back into their own clothes, and return to their homes.

Davis-Floyd (2003:152) interprets the procedures of hospital birth as ritual that conveys certain key messages: “the necessity for cultural control of natural processes, the untrustworthiness of nature and the associated weakness and inferiority of the female body, the validity of patriarchy, the superiority of science and technology, and the importance of institutions and machines.” The stages of the ritual are clearly visible here: separation, liminality, and reintegration. Strange-making, hazing, and symbolic inversion are used to induce the liminal state. The hospital, as a separate location with unique protocols and social relationships, facilitates this ritual. It might seem that home birth would therefore lack the characteristics of ritual. However, I do not find this is true. I next wish to elucidate the ritual characteristics of home birth as practiced by my female participants, with particular attention to the key messages of home birth: a safe and satisfying birth experience is a commodity to be earned or purchased, society has few obligations to the individual, and bodies give birth.

Separation

Separation begins when a woman first discovers she is pregnant: from that moment, she will never be the same person. Most of my informants found out in what has become the usual way for US women. They notice that their menstrual period is late, purchase a home pregnancy test, and find out easily and early in the privacy of their own homes. This is relatively new in US history. When pregnancy tests were unknown and menstrual periods less regular (due to nutrition, illness, and lactation) women relied on their subjective physical experience. Swollen breasts, nausea, a swelling waistline, and “quickening,” or the first feeling of movement at 15-20 weeks’ gestation, were the only ways of knowing that one was pregnant. That is, the ability to ascertain a pregnancy lay within the woman herself. With the advent of reliable pregnancy tests, women could find out earlier in their pregnancies. This was accompanied by a change in the experience of such knowledge. Now it came from an outside source, one which carried the authority of science and the impersonality of the lab. A woman now needed technology and an interpreter to know she was pregnant; she might even receive such news over the phone. Rather than an internal source, she relied on society – represented by doctors and technicians – to determine that she was pregnant. As pregnancy tests became cheaper and more reliable, they came to be sold over the counter. For as little as a few dollars, a woman can now find out that she is pregnant within days of a missed period. She still relies on technology, but she herself is the interpreter. Her partner may hover over the plastic wand with her, waiting to see if they have conceived. This reflects the message that society has few obligations to the individual: she, and perhaps her partner, are on their own as they begin their ritual journey toward parenthood.

Nearly all of my informants – at least one in each couple – had considered home birth before becoming pregnant. Parents first do a great deal of research on the relative safety of home versus hospital birth, which they emphasized to me quite strongly.

[A professor who had had a home birth] pointed me in the direction of some of the research. He said, “It sounds very strange, but just look into it. Do your own research; look into your own stuff, and then come to your own conclusions.” (Nick Garrahy)

People do more research when they buy a mini-van. And I think a lot of people do more research just about a vacation than they do about the birth of their child. They feel like somebody else knows what to do, so they don’t need to do the research. (Ursula Campbell)

Note how this last quote implicitly compares a birth to a consumer item like a car or vacation. Having done their research, the parents concluded that a homebirth is both safer and more comfortable (for women with low-risk pregnancies) than a hospital birth.

Having come to this conclusion and learned that they were pregnant, my informants began the process of selecting a midwife. This was always described as “interviewing” midwives. This language is interesting because it uses the language of commerce.

“*Interview* your doctors, *interview* your midwives. Make sure you have a connection with them. Make sure that they have a philosophical view that is similar to yours, or that is respectful of yours,” said Uma Garrahy. This reflects both society’s dearth of obligations and the notion of the preferred birth experience as a purchased commodity. In fact, homebirth mothers sometimes explicitly described themselves as consumers:

So many people are so afraid to ask questions that send off the red flags like, “So, what are your cesarean rates? What is your episiotomy rate? How many women in your practice have had an epidural? Can I talk to one of the women who had an un-medicated birth?” We should be going into this as consumers and saying “I’d like a referral, please, to someone that had had the experience that I want.” (Ursula Campbell)

Homebirth parents “meet” with their midwives every month in the first two trimesters and gradually more often in the third trimester. The responsibility of each

mother for her own healthy pregnancy and birth was emphasized at each visit with the midwife. There, the mothers-to-be weighed themselves. They tested their own urine and compared the results to a chart. Rather than the midwife (or doctor) completing these actions, the mother did them herself and reported them to the midwife for charting. The midwife would spend a great deal of time talking to each client about her diet, exercise, and rest, which was experienced as empowering by many participants. However, if, as in Davis-Floyd's interpretation, the healthcare provider is the representative of society, this foregrounds society's minimal participation in the pregnancy. The mother, once again, has little outside help. She is expected to "earn" her healthy pregnancy and birth through her own individual actions.

Separation is further expressed by the changed consumption habits that my informants undertook in pregnancy. All eschewed alcohol, which, for some, also meant missing out on social interactions with friends or family; this marked their status as changed. Diet is an almost overwhelming concern for pregnant women in the US, and my informants were certainly no exception. Changed eating habits reflect a changed identity. (I address other symbolic aspects of food in the next chapter.) I heard over and over that eating unprocessed, organic food was important, and especially so in pregnancy:

Nutrition was my big thing...I did stay way away from any and almost all processed foods. That was my big thing that I was thinking about through his pregnancy, was what I was putting into my body. I avoided pretty much all white sugar and flour and hydrogenated oils and just any dyes. I mean, really, any kind of, most, packaged foods. (Bailey Anderson)

She had organic fruits, vegetables, and hormone-free meats. All the stuff she normally goes for anyways, but to a more strict sense. When we'd go out to a party or go to someone else's house, and she knew that this person didn't really purchase good-quality foods, she would actually forgo eating and then wait to get home. She'd say, "I'd rather starve than eat that stuff right now." (Hank Baron)

I totally go for 100% organic stuff. Here I am, building a baby; I don't want to be introducing all these pesticides and herbicides. I'm really picky and choosy about my produce and organic options. (Nicole Carter)

It is not a coincidence that these foods are more expensive. Processed foods, which are less healthy, are heavily subsidized in many cases and tend to be quite cheap. Fresh produce, locally-produced foods, and organic items are much more expensive. Two of the families I interviewed were members of raw milk cooperatives. Though many consider it more healthful, it is illegal to sell unpasteurized milk, so this is a bit of a legal dodge. This shows the lengths to which they were willing to go for “pure” foods. That my participants put so much emphasis on it conveys that a healthy pregnancy is a commodity to be purchased with money and earned with knowledge and discipline.

As their bodies swell, the mothers-to-be begin to be perceived as such by outsiders. They find that they are treated differently. The message that bodies, not women, give birth begins in pregnancy and is aided by midwives and even strangers. For example, quite a few mothers found that strangers were more likely to hold doors or offer to carry heavy objects.

I get looked at a lot. That is something that I had never experienced before, but people notice you. I don't know if all pregnant women experience that, but it's just you get people that will look at your belly, not your face, and that's just different. That's just a different experience. I feel – I'm totally okay with it now – but for a little while when I started showing it was clear that I was pregnant. That was like – I was a little kind of bothered by, you know...Or when people talking to me, not just people just walking by but even in conversation, you see people's eyes look at your abdomen and not your face. (Kieran Masters)

One of the things [our midwife] said to us over and over was, “Your body knows how to do this. Don't worry, your body knows what it's doing.” I really saw that played out, watching [Lisa] go through the pregnancy...it was an amazing thing to me to see a life growing and to see how [Lisa's] body and she handled that, and still functioned normally, for the most part. (Erin Harkness)

The face, of course, is associated with the personality, the self. Looking at the abdomen reinforces that a pregnant body is a body first and foremost. Kieran's simultaneous discomfort and minimization of this experience is evident in her verbal fumbling – “I was a little kind of bothered.” She goes on to assure me that she's “totally okay with it now,”

to indicate that she has accepted this message. This outside emphasis of a homebirth message also shows that these messages are not non-normative but expressive of wider trends. In the second quote, note that Erin said, “[Lisa’s] body and she.” This separates the two and gives credit to the body, not the person.

Separation intensifies when labor begins. Many of the homebirth mothers in this study left their homes early in labor: to shop for food or baby things, to go for a walk, to go out for a meal, for an acupuncture appointment, to visit the midwife. By leaving and then returning in labor, they make a journey; the home then becomes a symbolically different space. Other women cleaned up the home while in early labor. Some preparations were made: if a tub was used, it needed to be set up and filled. If the mother planned to birth in her bed, the bed would be prepared with a plastic under-sheet. All of these had the same effect of transforming an ordinary space into a private, ritual space. Other children, if any, were sent elsewhere in the home or to another home. If the woman was working at the time, a call to work was made. This separated the laboring woman from her usual social interactions.

Liminality

The midwives (they always come in pairs, a lead and an assistant) did not go to a woman’s house early in her labor. Most women called their midwives once labor was well-established, but they would often wait if it was very late or very early, out of deference to the midwife’s sleep schedule. This establishes the parents, rather than the midwife, as having the primary responsibility for the birth. The midwife would then assess the status of labor over the telephone by talking to either the mother or her partner.

When the midwives enter the home, the liminality techniques of strange-making and ritual inversion begin: whereas the mother usually visited the midwife in her home, the midwife now visits the mother in hers. Once they arrive, they reassess the stage of labor and sometimes offer the father a short break. Internal checks are rarely performed by midwives; to my knowledge, electronic monitors are never used. They instead rely primarily on a laboring woman's body language and vocalizations to judge the labor's progress. That is, the body is foregrounded as the birther, not the mind of the mother or the technology attached to her.

Midwives offer emotional and sometimes physical support to both parents, but often they are simply in the background. When I interviewed one midwife about the skills a midwife needs, she included knitting – so that she would have something to do in the long hours of labor. If labor is slow, fast, or especially painful, the midwife will suggest techniques to speed, slow, or alleviate. Lying down and refraining from pushing can slow a labor; walking, squatting, going up and down stairs, certain postures, and nipple stimulation can speed it. Rather than analgesia, counterpressure on the lower back, massage, a bath or shower, walking, moaning, etc., will be employed to manage pain. The minimal use of technology makes a home birth quite different from a hospital birth. This has several symbolic meanings. On the one hand, it does not convey the message that a woman's body is broken and needs technical assistance. On the contrary, it foregrounds the ability of the body to give birth. However, this emphasis on the body seems to leave out the woman in the body. This was the way that my informants described the knowledge of birth: it is something the *body* knows how to do if it is not dissuaded by the mind.

I believe like that my body was built and meant to do this and that's why I'm really excited

about seeing my body do this incredible physical feat that it was meant to do. (Kieran Masters)

Your *body* is built to do this thing, just like pooping, or growing hair, or your heart beating. Your body is built to do it...If you don't over-think it, your body will tell you what to do. (Michelle Davidson)

Note that in this last quote, the mind is seen as a detriment to the birth. The mind is separate from the body and the body knows how to birth. It is also an example of symbolic inversion: the body begins to direct experience, rather than the mind. Nature takes precedence over culture.

As the ritual continues, the midwife and her assistant take the role of shaman and acolyte: they direct and observe the actions of the initiates. The techniques of hazing, strange-making, and symbolic inversion invoke the liminal status of the laboring mother and to convey the key messages of the birth. Hazing is readily available in labor via the rhythmic and increasing pain of contractions. Other repetitive stimuli were also employed. Counterpressure, pacing, and walking up and down stairs, which is often not allowed in the hospital, are examples. Many used vocalization to cope with the pain; this created a repetitive sound. (One might think that this would be true of all births, but women laboring in hospitals are typically expected to be silent, or to at least pant quietly, so as to avoid disturbing others [Martin 2003]). The birthing mothers were encouraged to make low-pitched, rather than high-pitched, sounds, and to open up their throats. One father told me, "We learned [in our childbirth class] that open mouth means open cervix." Gaskin also asserts this in *Ina May's Guide to Childbirth* (2003:170), indicating that this is a widespread belief. It is a symbolic inversion: it makes the top like the bottom. It also emphasizes the idea that the body births, because it focuses on body parts and their interchangeability, rather than the mind.

Strange-making is similarly accomplished by both natural and cultural features of home birth. As her labor continues seemingly without her volition, the mother's very body seems foreign. The lights in the house are often dimmed and candles sometimes lit, adding to the effect of making an ordinary place extraordinary. Of course, a large birth tub in the middle of the house – one midwife repurposed a horse watering trough – also makes the familiar seem foreign.

Many women gradually remove clothing as their labors progress.

I tend to be pretty modest. Like, my mom's never seen me naked. In labor, I just don't care... I would never think to walk around naked in front of other people, with my butt in the air or something, but you just don't care. (Cecilia Frederickson)

I was completely naked at that point, which I didn't intend to be, but at one point I got out of the tub and barely made it to the bed and then never put any clothes on after that. (Bailey Anderson)

I was naked, and I was naked from then on. Now, I'm like, wow, I should have put at least a bathing suit top on or something. I was a little embarrassed afterwards. (Dana Richards)

This is so common that one midwife joked that she had no need to conduct cervical checks – she could tell the phase of labor simply by a woman's state of (un)dress! To walk around naked, especially in front of people besides her partner, makes a woman feel like someone else. It is another symbolic inversion, in which one does the opposite of an ordinary action. It also emphasizes the body as birthing. We are accustomed to seeing people clothed; it fades into the background. Since nudity is unusual, it makes the body stand out. A clothed person is a social person, with identity and status. A naked person is a body.

Labor continues to intensify until the cervix is completely open, which allows the baby moves lower into the pelvis. This leaves some space in the uterus, which must contract until it is once again snug around the baby in order to push it out. While for

some women this is a time to relax in the lesser intensity, for many this period (called transition) is the hardest part of labor, a dark night of the soul. It seems that she has endured all she can, and yet the hardest part is yet to come. Many despair at this time, thinking that they made the wrong decision having the baby at home. Others simply say that they cannot do it.

In the Bradley class, they talk about transition. We knew right when she was in that because she said, [in a pitiful voice] “I don’t think I can do this,” and she said, “I don’t think I made the right decision on having a home birth.” (Quentin Nelson)

I remember leaning over [an end table] and saying, “I can’t do this anymore. Something isn’t right. Maybe I should go to the hospital.” My midwife was standing behind the kitchen sink and she said, “O-kay.” Kind of like, “You need to say that, but it isn’t true.” She was making herself dinner. (Cecilia Frederickson)

I got really tired, and it was probably around five in the afternoon or six, and I turned to Beth, and I said – and I was completely serious – I said, “I need to take a nap. I need to go lay down for just thirty minutes. I need you to make it stop for thirty minutes and then I’ll be okay.” She said, “You just need to rest in between your contractions.” I was so – I felt all these emotions. I felt anger, and I felt betrayed. Looking back, it’s like, oh my god, this is ridiculous. Of course she can’t make it stop. It’s not like there’s a pause button. But, in my mind, she had been taking care of me for nine months, and here she was not taking care of me. That’s how I thought of it. (Erin Harkness)

At this point, the midwife, as shaman, seems to be in control of the ritual. When she does not stop it, or allow the woman the societal support of the hospital, it seems like abandonment. The intensity of transition makes this message especially poignant. The midwife emphasizes to the mother that, at this hardest time in her labor, she is largely on her own. The hospital – the large institution – is not there for her. The sole representative of outside society, the midwife, seems to be doing little.

The midwife may suggest a location or position for the birth itself, especially if there is a complication, but it is usually chosen by the mother herself. As the time to push the baby out approached, most women went to a special place, usually either the bedroom or a birth tub. Both represent a move deeper into the ritual space and have strong symbolism. The bedroom is the most intimate room in the house; it is a space usually

reserved for immediate family members only. It emphasizes the privatized nature of home birth. Allowing the midwives in strengthens the symbolic inversion begun when they entered the home. It also has sexual connotations and was often the place where the child was conceived, lending a sense of inevitability or of coming full circle; this sense of inevitability is a key part of rituals' ability to convey values. This intimacy also reinforces the bodily nature of the birth.

A birthing tub also has a great deal of significance. Water is associated with mystery and with new beginnings. Dunking in water, for example, is a very common US Christian ritual in which the initiate becomes "born again." The birthing tub, then, can be seen as a symbolic womb from which both the mother and child will emerge. The tub also separates the mother physically from the rest of the birthing team; they may be nearby, but she must complete this task alone. During the pushing phase, a woman again learns that it is her body, not herself, that has the capacity to give birth.

AB: You talked about having to surrender in your birth. What did you have to surrender to?

CF: Just not trying...just letting the power of my body and its natural process do what it had to do. (Cecilia Frederickson)

We just let the body do her thing. (Henry Campbell)

These quotes emphasize that the body can do its "thing" without the women's volition. On the contrary – "surrendering" to it made the labor go better for Cecilia. While this is in opposition to the hospital-birth message that the body is defective, it nevertheless reinforces the idea that women do not know how to birth, that it is something their bodies do on their own.

When the baby is born, it is "caught" by the midwife, the father, or the mother herself. This language is used by midwives and homebirth parents to highlight the fact

that the mother, not the attendants, delivers the baby; the attendants simply catch it for her. The sex is not announced immediately because this is considered the mother's prerogative. The baby is brought immediately to the mother's chest or breast, if there are no breathing difficulties. If there are, the midwife will resolve them and then give the child to the mother. All of these immediate actions around the birth emphasize the mother's responsibility for the child. The baby's older siblings, if any, are often brought into the room at or immediately after the birth. The placenta is allowed to emerge naturally; steps to reduce bleeding will be taken if necessary. In the hospital a placenta must emerge within a defined time (which varies from a few minutes to an hour) or the cord will be pulled to hurry it along. In home births, midwives will wait up to a few hours for it to appear. Until it does, the baby is still literally attached to its mother, stressing the bodily connection. Even after the placenta is born, it is often left attached to the baby at least until it stops pulsing and often for several hours. The baby usually nurses during this time, giving him or her a new bodily connection to the mother. Delaying cutting the cord and nursing early is explained in terms of nutrition, but cutting the cord has strong symbolic ramifications as well. Once it is cut, the child is on its own. Because earlier parts of the ritual have emphasized that society has few obligations to the individual, this feels even more momentous.

Reintegration

Reintegration is accomplished in a variety of ways. Getting out of the birthing tub may be the first step in this. The midwives will then withdraw for a time – as much as an hour – to allow the new family time together.

It was just awesome. [We] just kind of scooped everything up and got [Ursula] up and on the bed.

She kind of started, we were a family, we kind of focused on [our newborn son] and mom and baby and [our daughter] and we were all in the bed. (Henry Campbell)

Immediately after [the birth] we held her, and they moved us over to the bed pretty quickly. We laid down and they covered us up, me and [my daughter] and [my husband, Hank] was right there. We laid there for a little bit until the placenta was delivered. They kind of got us situated – got her and me pretty well covered up in blankets and towels. They really didn't wipe her off too much, just kept her dry, dried her off a little bit, but didn't wipe her off too much. She stayed attached to her cord with the placenta and they wrapped that all up. Then they put the three of us in bed, and everybody that was there left the room, everyone. In the room was our two cats, and our dog, and [Hank] and I. It was for about two hours that it was just us. (Marsha Baron)

Right after the birth, everybody just kind of left us alone. I don't think we even cut the cord right away. We just held the baby and...just kind of hung out, just enjoyed the moment for a while. (Nick Garrahy)

This contrasts strongly with a hospital birth, in which the infant is often whisked away after a brief bonding period for several hours or more. Davis-Floyd interprets this as sending the message that the child belongs to society foremost. In home birth ritual, the new family is left alone for a time as soon as possible. This reinforces the message that the society will have few obligations to either the child or the parents. As parents return from the intensity of the liminality of birth, they see that they are (literally as well as figuratively) on their own.

When they return, the midwives do conduct a series of exams on the baby but administer no interventions. The midwife may also stitch minor tears, but tearing is less common in home birth. Since the midwives withdraw quickly after the birth, their reappearance begins symbolically bringing the mother back into society. Family members and friends, who may be waiting in another part of the home or waiting for a phone call, enter the room to greet the woman as a mother for the first time. Many midwives give the new mothers a bath after the birth. This is filled with herbs thought to promote healing and serves to physically and symbolically clean the mother from the birth and move her back to her usual state. The midwives also typically prepare a meal

for the new mother. While women laboring at home (as opposed to women laboring in hospitals) are encouraged to eat and drink, this is nevertheless their first “proper” meal since labor began. That is, food in labor is eaten a few bites at a time and is conceived in functional terms: it is fuel for the labor. This meal, however, is served on a plate, may be eaten sitting up, and is intended to gratify taste as well as restoring the body. It serves as a symbol of returning to one’s usual self and also relates to the ‘bodies birth’ message.

Some of the midwives sing a special song to welcome the baby before leaving the home. The midwives typically leave just a few hours after the birth, leaving the new family on its own again. The midwife returns to the patient’s home the next day to check up. In fact, the first few postpartum exams will take place in the mother’s home. However, the mother is required to go to the midwife’s office for her final check-up. This re-rights the inversion of having the midwives in the home for the birth. It completes the symbolic reintegration: the woman must now leave her home, with her new baby; the midwife will “officially” declare that she has completed her transition into motherhood.

Men as Initiates

Men, along with their partners, also experience both home and hospital birth as a rite of passage. Reed discusses hospital birth, which conveys that birth is biological, that men are peripheral, and that their subjective experiences unimportant. I find that home birth conveys different messages. I detail both below.

Ritual Features of Hospital Birth

Both Davis-Floyd (2003) and Reed (2005) address men in the rites of passage of birth. Davis-Floyd notes the fact that men are typically separated from their partners for a time after their initial entry into the hospital. In order to accompany their partners in the labor and delivery rooms, they must change into different clothing, an act of identity-stripping and homogenizing. Here, her analysis of men's roles ends. However, drawing on her ideas, I suggest these other ritual aspects of their actions. In the labor room, they act as "coaches," helping their wives to breathe rhythmically, to focus on some object or picture, or massaging them. This makes them symbolically part of the process. It is a social acknowledgement of their paternity. During the birth, partners, in contrast to doctors, stand by the woman's head. This is a sort of symbolic inversion: he was at the "opposite" end of his partner during the conception. Later, he may make phone calls or greet visitors, reintegrating him and acknowledging his new status.

Reed (2005) goes into more detail about the role of men in US American rites of birth. He likens the birth process to a play in several acts. The ritual aspects transform the man's relationship to himself, his partner, his child, and his society. Men's separation begins more gradually than a woman's. The first knowledge seems a bit unreal. As her body swells, movement begins, and other physical evidence appears, it becomes more real. Reed found that because men have less subjective experience of pregnancy, they are more invested in objective evidence, such as sonogram images and test results. The men in his sample were also more interested than their partners in knowing the sex of the fetus – not because they had a preference, but because they wished to begin imagining the child.

The onset of labor begins a man's separation from his former self in earnest. Once he hears that labor has begun, he knows that his life, himself, and his relationship with his partner will never be the same – and yet he does not know what the future holds. He has entered the liminal state. Among the men Reed interviewed, the first stages of labor are a time of (relatively) relaxed intimacy with his partner. Some men lit candles, drew a bath, or went on walks with their partners. They feel emotionally connected to their partners and to the process. When they enter the hospital, however, the father-to-be finds himself in a new role. He is temporarily separated from his partner and asked to fill out paperwork. Reed interprets this as having ritual significance since many of the parents had pre-registered at the hospital. By asking a man about his health insurance, the hospital is judging his ability to provide and care for his partner and thereby defining a father as a breadwinner and protector. As they settle into the labor room, a nurse will appear to conduct a cervical check and announce the stage of dilation. Labor typically slows for a time with the bustle and anxiety of getting into the hospital. Men feel that they have put their wives in the care and control of the hospital, so that they are no longer so responsible. They may take this time to get a bite to eat, situate other children, or take care of other errands. When he returns, his partner will be in a different place emotionally and he must re-establish his place in the birth. This is often as an intermediary between the hospital staff and his wife. He provides emotional support, talking quietly, reassuring, massaging. Nurses will enter periodically to perform cervical checks and update the parents on the stage of labor. As labor intensifies, so does men's anxiety. They feel they can do little to control the situation or to comfort their partners. Her pain feels like his failure as a protector. He begins to feel more peripheral to the process as nurses and

protocols take over. If his wife receives pain medication, he may feel even more distant as she becomes groggy or simply no longer needs his support.

As the time for delivery arrives, the father must make a connection with the doctor; this rapport or lack of it will define his place for the rest of the birth. He will usually take his place by the laboring mother's head, although he may go to the foot of the bed to watch the baby emerge. The birth itself is the emotional high point of the ritual, and men often find themselves simultaneously laughing and crying with the strength of their emotions. They may be offered the option of cutting the cord, which many of the men Reed interviewed found intimidating and anticlimactic. The father may be allowed to hold his new child while the hospital staff stitches and cleans the mother; most find themselves entranced. The baby will be weighed, measured, cleaned, and taken to the nursery. Tension subsides. The father will later make phone calls or go to the waiting room to announce the birth, which begins his reintegration process.

Reed finds that the US rites of birth fail fathers in some key ways. First, by defining birth as purely biological, rather than social or spiritual, they make the father peripheral. His biological contribution ended at conception. This marginalizes both women's and men's subjective experiences. Second, men enter a power structure that is often hostile to their participation. They often find themselves in conflict with hospital staff or in the position of persuading his partner to follow their dictates. This interferes with his connection with her. Last, the rituals of birth do not socialize him into the roles now expected of an US American father but those of a bygone era: the patriarch, the breadwinner, the protector, the stoic. While fathers now have much more intimate

connections with their children, hospital birth rituals rarely foster this. He suggests that men need this ritual support in order to facilitate their transition into fatherhood.

I turn now to the ritual experiences of homebirth fathers. I find that the key messages for homebirth fathers are: the family is a self-sufficient unit, birth care is a business, and husbands should be responsible.

Separation

Men's separation from their former selves is more subtle and gradual than women's during pregnancy. Men do not experience the physical changes of pregnancy, and before their partners become visibly pregnant, it can seem a bit unreal. As the pregnancy continues, their changing role becomes more imminent.

There's moments, like when you start being able to feel the baby move – that's pretty cool – but outside of that, it's pretty hard to identify or even to empathize with what's going on. (Nick Garrahy)

It was really neat to watch our little baby grow. It started small and then it got bigger and bigger. She could feel it, and then she had – has – she had a bond with him before I was able to...relate – not necessarily relate – communicate – not communicate, either – but sense his presence, maybe. Just in terms of when I got to feel him kick, and then she lets me feel him kick, and then there would be nights when she would be asleep but I'd feel – all of a sudden her belly would be like [indicates] and I'd say, "Did he just hiccup?" and she'd be like, "Yeah." It's just neat to know that the little baby's in there with the hiccups and be able to feel them. As he got bigger, and you could feel him kick, and you get to kind of know his schedule. That was even neater. It's – you can start to envision that there is a baby in there. (Daryn Bernstein)

This gradual realization is accompanied by a slow change in how they are treated by others. Most men told me that they were treated the same before and after announcing the pregnancy. Nevertheless, as they spread the news, they find that there is a subtle shift in their social status. Non-fathers often tease the father-to-be about his loss of freedom. They may inquire if he plans to give up dangerous or expensive hobbies. In other words, the 'be responsible' message begins. Indeed, some of the men I talked to did begin

modifying their behavior during their partners' pregnancies. They spent some time reflecting on their new roles. They began to be responsible – giving up hobbies that were hazardous or absorbed resources that could be better spent, putting the finances in order, and taking a mental deep breath in preparation for shouldering new responsibilities.

Daryn Bernstein reflected on this:

I have a car that I'm building in the garage...in our hobby you always see [classified ads that say], "Baby on the way; have to sell Jeep," because they feel that they can't have a Jeep and have a baby, or they need the money— so when she [a friend] found out, she was like, "Are you going to sell your stuff?"... You know, as soon as she became pregnant, the fact that you're going to be a dad soon is imminent. I was like, okay, does that mean I have to change? Do I have to dress different, or have to carry a ball with me everywhere I go? It was – It wasn't – You start to change how you think, and maybe a little, or you start to – When you go out, it's not just you and her. There's a baby with us in-utero now, but in however many months from now, we're going to be taking a baby with us, so maybe I'll drive a little less like a screwball.

Friends who are fathers are typically congratulatory and convey a 'welcome to the club' attitude. In this sense, a man becomes an initiate: his friends treat him differently because they begin to see him as a different person. While non-parent friends begin moving him out of their circle, parent friends begin sharing with him some of the seemingly esoteric knowledge of parenthood.

Many of the men I spoke to accompanied their wives in interviewing midwives and at prenatal visits. Though his biological contribution to the pregnancy has ended, his social contribution continues. Attending midwife's visits and birthing classes is a way of acknowledging his paternity and his responsibility – both for his partner and his child.

The midwife helps to place him in this role.

We knew there was a baby inside of her, so we were still going to take care of [Ursula's] body. We're going to focus on the health of the baby and give it the best possible chance. (Henry Campbell)

[Our midwife] was concerned: "Are you getting enough exercise? Are you getting enough sleep?" She looked at me: "You need to make sure that she eats well. You need to make sure she's getting enough sleep. You need to do your part to help her wind down from work after she gets home from work." It wasn't all on [Tina]. It was on us as a family to make sure that she had what she needed

to grow the healthiest baby that she could. (Daryn Bernstein)

Daryn has clearly integrated this key message: “It was on us as a family.” That is, the family must take care of itself, and the husband must take responsibility.

For most of the couples I interviewed, it was the mother who first suggested a home birth. There were some exceptions to this: Sam Anderson was born at home himself and Landon Richards had been at home for the births of two of his siblings, so each of these men suggested a home birth to their wives. Most partners, however, were new to the idea and initially resistant. In describing their changes in perception of home and hospital birth, I was struck by the prevalence of financial and marketing language; the emphasis below is mine.

Everything becomes driven by this sort of fear of something going wrong. OB/GYNs and a lot of the medical profession have certainly bought it into themselves and they are happy to sell you on it. (Ulysses Davidson)

They put themselves at the mercy of a professional. Most of the time that’s a doctor. They take that person’s word as gold. (Tom Carter)

I think I was already that kind of person to begin with. It’s not like [Bailey] had to come up and convince me to have a home birth, or advertise it to me, or anything like that. (Sam Anderson)

The other thing that kind of sells it is when you start to listen to other people’s birth stories and the things that have happened to them in the hospital, and you start to say, well, maybe that’s because they went to the hospital. So, you start to sell yourself on it. (Daryn Bernstein)

We went to classes, went to meetings with our midwife every single week. (Hank Baron)

I just went to one or two face-to-face interviews with them. (Nick Garrahy)

The biggest preparation is our meetings with our midwife. (Neil Dean)

This language implicitly indicates that the speaker sees birth care as a business. Several informants made this explicit.

They started to make this birthing thing in the hospital into this huge, big commercial event. It’s mind-boggling. It’s huge business. We paid [our midwife] \$3,000 to have prenatal visits, a birth, and post-natal check-ups for six months. I think your insurance, even if you had a vaginal birth, probably pays the hospital – I don’t know how much; you probably do – but it’s got to be 30 grand. And a cesarean section can probably be 50 or 60 grand. I don’t know, but I know it’s a ton of

money. I have insurance, and I choose not to use it, because it just seems dumb to me... Why wouldn't you want people to take on their accord, pay 3,000 bucks, or have the insurance company pay 3,000 bucks on our behalf, to have a birth at home with no complications? Why would they prefer to spend 15,000 on a normal vaginal birth in a hospital? It makes no sense to me. Then they act like our birth doesn't exist. It's totally backwards; it makes no sense. If I were talking to a politician, or an insurance company, I would say exactly that. I would say, you are incentivizing people to use a system that costs you as an insurance company a ton of money, and in turn all of our costs go up. (Tom Carter)

Both this implicit and explicit use of the language of money demonstrates that birth is seen as a business. This is probably influenced, to some extent, by the fact that the documentary *The Business of Being Born* had come out recently and that most of my participants had seen it. However, this does not belie but strengthens the point. The documentary was produced and sold and watched, meaning that it struck a chord with quite a few people.

Note also that Tom, in the quote above, made a point of saying, "I have insurance, and I choose not to use it [for the birth]." This expresses the belief that the family is self-sufficient. Other fathers said similar things, although not all agreed.

AB: Did y'all have to pay out of pocket?

HB: Yeah, it was out of pocket. But we believed in it so much, I'd do it again in a heartbeat. (Hank Baron)

[Health insurance] shouldn't cover [home birth]. Truly, if people want to pay their midwife, it should be out of pocket; that's fine. Because then they are asking two things; they are saying pay for my thing, then also pay if I get hurt. It doesn't make sense to me. I – we were very happy to pay out of pocket for our midwife. We did that. (Henry Campbell)

Again, the belief that the family is (or should be) self-sufficient and the idea that birth is a business are expressed even as the couple first decides to have a home birth. The class position of my informants also plays into this. For many families, paying \$3,000 out of pocket is simply out of the question. Since Colorado Medicaid will not cover home birth, this puts it out of reach of many lower-income families. In fact, one family in this study

had a hospital birth with their first daughter for this very reason, and the choice to spend the money to have a home birth for their second was a serious one.

A man's separation from his former self begins in earnest when his wife goes into labor. If he is at work, he will be called away. This is a dramatic gesture: work is presumed to be defining in a man's life, so to leave abruptly separates him from his usual social milieu. It may also echo the idea that birth is business – it is so important that other business can be left behind. One man's wife went into labor as he was leaving for a football game. She insisted that he go, saying that it would be a long time, so he went. Though he was physically present, he told me later that he didn't see any of the game; all he did was text his wife and think about her. In this way, he was already separated from his usual way of being in the world. If a father is at home, he will likely be woken up. All of these sudden changes in routine – to be home during the day or awake in the middle of the night – announce that the ritual has begun. He knows his life will never be the same and he must begin his new role. He is often the one to complete the final preparations, setting up the birth tub or putting the plastic sheets on the bed. He may call the midwife. Whereas his wife had the primary communication with her before, he must now make that connection; this begins his ritual inversion. As Reed found with hospital-birth fathers, he takes the role of mediating the public and private spheres. Nick Garrahy describes his responsibilities in his wife's early labor:

The labor was very fast. Mostly, once we realized [Uma] was in labor, she just walked around, just paced in the house. I watched her pace, and timed contractions, and I put the plastic covering on the bed. She wanted to take a bath, so I drew the water for her, and I called the midwife at various intervals. [Uma] during the birth process didn't have to deal with the logistics of the midwives. I was calling her, "Hey, this is where she's at."

The family is on its own, and the father must take the responsibility of managing the birth.

Liminality

While his experience is not the same as his partner's, labor is nevertheless an intensive time for a man. The men I interviewed were intimately involved during the labor process. After the initial chores of setting up the birthing space were done, they felt at a loss for what to do. They look on helplessly at their wives' pacing and crying out. Watching the one he loves most in the world in pain generates a crisis for many men. It is his role to protect her, and he cannot. She is in pain, and he can offer little but the comfort of his presence. He may be worried about her safety and that of the baby. As the hours wear on, he experiences adrenaline exhaustion.

One of the biggest things that – when you're in the thick of it, it's like – it was scary. It was really scary, because you don't know how long it's going to last, you know? ...She was in big pain, and I just sat there, and kind of...I was like, oh, gosh, let this happen. Please let this happen. Please give us a healthy baby. Just...I was just hoping that everything would be all right, because I didn't – You're right in the thick of it. You know it's going to be over here pretty quick, but you don't know if everything's going to be all right. (Quentin Nelson)

These sights, sounds, and feelings generate the emotional intensity of the liminal state. In this intensity, messages seem especially strong; the man becomes receptive to ideas and roles.

In contrast to a hospital birth, in which the staff will direct the action, most midwives stay in the background and allow the couple to birth together. Some specifically recommend time alone together for the couple. This conveys the message that the family must be self-sufficient. The partner moves in closer, both physically and emotionally, to the birth.

We were very together the whole time. I mean, physically together – holding her hands, or kneeling in front of her when she was kneeled down. Very present with each other – talking to her a lot throughout the whole, trying to be as encouraging as possible, trying to be there with her as much as possible, knowing that I couldn't totally go to the same place where she was, obviously, but being there as much as I could with her, both physically and mentally, emotionally. (Neil Dean)

Consistently across all three births, I really didn't have – the only role I had was to be there for [Saba] both emotionally and physically, just to be there, to hold her hand, to wipe her brow, to help her in and out of the tub, to do whatever. I know that, just knowing her as long as I have, that there are times when she relies on me to be her rock, to...really hold her up at times. Whether it was a hard time during transition, or a hard push, or a hard cramp, or a hard contraction, just to be there and... Whether it was someone else giving a cold rag – She may ask for it, and I may want to go get it, but I know that I had to continue to be there, and I had to hand that off to somebody else. Anybody can go get a cold rag, but she needed me to continue to be there, to be by her side. I can't point to any specific role, but it was just whatever she needed, I did. (Edward Young)

I just sat there and tried to be there for her. We were all outside the hot tub; she was the only one in it. She was grabbing my shirt, ripping it, and at one point I went to go put another shirt on and she wouldn't let me. She wouldn't let me leave. (Quentin Nelson)

In fact, all of the men I spoke to were intimately involved in their children's birth. They left other chores to the midwives, as Edward described above, and focused on their wives as labor progressed.

As the moment of birth arrived, the partner's role remained central. As in the quote above, he was often physically supporting his wife. If she was in a tub, he was usually right next to her, looking into her eyes, breathing with her, holding her. Many men caught the baby as it emerged.

[Uma] and I did most of the birthing without our midwife. Our midwife showed up and twenty minutes later the baby was born. (Nick Garrahy)

During the labor – the final day of labor – really, the final night and day of labor, I was by [Bailey] the entire time... Every single time she went into a contraction, I felt like I was, not contracting, but tense, and fisted up. I was holding her hand; I was right with her the whole time. Really, that whole time I felt like I was going through my own childbirth, my own pain, obviously with not the same pain, but with a lot of physical exertion. Definitely when she was pushing I was definitely pushing along with her. She was gripping her hand so hard that... my hand was bleeding after it was done. We were in a weird position when she finally was towards the end of pushing. By that, I mean another thirty or forty-five minutes left. I had her leg up – I had one leg up like this and was pulling that up. I think either [the midwife or her assistant] was holding the other leg up. I had my hand behind her back, and I was also pushing with every muscle in my body every time she was pushing. I was physically exhausted by the time she was done. I'm not trying to say that I was anywhere near as exhausted as she was, but I was dead after she was done. (Sam Anderson)

I caught the baby, which was really, really cool. I don't know *any* of my friends who can say they actually caught the baby coming out. I brought her right up and put her right up to mom's chest. It

was...it was just an amazing experience. I don't have anything to compare it [to]. (Hank Baron)

We see that the family unit is made the center of the process; the midwives, especially for experienced mothers, are often fairly hands-off. Even for first-time mothers, the midwives do not displace the partner but nearly always keep him central. This emphasizes both the family's self-sufficiency and the father's responsibility. The one exception to this was the Richards. The baby was born with the cord wrapped around it several times, so they understood why the midwife caught it instead of Landon, as they planned. However, the midwife cut the cord as well. They were so dissatisfied with her that they told me they plan to have their future children unattended. This reinforces the idea that birth care is a business transaction: if you are not satisfied with the service, you do not return.

The time after the birth was very intimate for the fathers. Many held their newborn children as their wives cleaned up or rested. One story was particularly touching. Quentin told me the story of his first two children's births in the hospital rather succinctly and with little emotion. Telling me about the time after the birth of his third, however:

So, after the birth, this is where it just becomes magical. I mean, I can't even explain it to people. I can't even fathom that I got to go through it, but it was – So, [Vera] sat there in the hot tub, after having the baby, and we brought the kids down to meet the baby. [Our older son] was screaming, "I'm so happy the baby came out!" Then, at one point he looked at [Vera] and said, "It came out of your butt?" [I laugh.] We were all just sitting around. We were all outside the hot tub around the edge so we could touch the baby and kiss it and see it. The sun had just gone down, so we had natural lighting, and the baby looked perfect. It didn't look red and splotchy the way newborns do under fluorescent lights. It looked like it came out just normal. It was just amazing. About thirty or forty-five minutes after [Vera] just holding the baby, the midwife delivered the placenta, – in the hot tub – put it in a bowl, and set it on the side of the hot tub, still attached to the baby. We said, "Well, [Vera], do you want to go upstairs?" and she said okay. So, I took the baby and the placenta in the bowl – I mean, this is weird, yeah – upstairs. [Vera] came upstairs. She lay down in the bed. The placenta was still hooked up and the baby was there nursing. The baby had already nursed in the hot tub. We were just all standing around, holding the baby, and just...being a family. It was awesome. At 10 o'clock I went and read the boys a book and put them to bed. In 15 minutes I had them to bed while the midwives were doing their measurements and their – they had a hundred question test, or something, and they were doing that. I came back in, and about 11 o'clock the midwives went home, so it was just me and [Vera]. [Vera] said, "I want to go to sleep," so I took the baby and went out and sat back there on the porch. [I] just sat there and rocked it for an hour and a half. It was just

me and the little girl. She was two hours old and it was nobody else, just me and her. It was just magical.

He could not quite cover up his tears as he told me this story. This magic, created by the physical stimuli and emotional intensity of the birth, fostered an experience Quentin will never forget. When the midwives leave soon after the birth, he learns that he and his family are a self-sufficient unit; when he carries his minutes-old child and her placenta upstairs and rocks her to sleep alone, he learns that he must be responsible for this little group.

Reintegration

To a certain extent, a homebirth father is reintegrated along with his partner. The midwives reenter after their brief withdrawal. If he has other children, they will meet their new sibling. Friends and family come to visit. He may make phone calls. One man even took the herbal bath in place of his wife – she fainted briefly when she stood up, so the midwives thought it was best that she just lie down.

However, a homebirth father's reintegration period is also different than the mother's. Immediately after the birth, his wife is exhausted and there is a tiny, needy new member of his family; he feels obligated to care for both. From the ritual locus of the birth tub, bedroom, and home, fathers begin moving gradually back outward. Most men took some time off work and tended to their family members' needs.

[Marsha] and [daughter] didn't leave the master bedroom upstairs for the first two weeks. Every single thing that they wanted, I would run downstairs and get – water, more food, whatever – or it was brought up to us. It was really cool. You don't get that in a hospital. (Hank Baron)

They typically returned to work before their wives, though. This is an obvious reintegration: they re-enter their usual social spaces with some fanfare to accompany their return. It is traditional to offer congratulations to a new father and for the father to give out cigars and display pictures of the baby. Whereas his wife's reintegration takes place at the midwife's office, his takes place at his own workplace. The business of birthing completed, he now returns to his usual business.

Summary

Other authors' (Davis-Floyd 2003; Reed 2005) focus on the ways that the trappings and social structures of the hospital are used to create a rite of passage from birth would seem to imply that home birth does not have such ritual overtones. However, though they differ, the activities that surround a hospital birth follow the same ritual pattern of separation, liminality, and reintegration. This is true for both the mother and her partner, although the two follow somewhat different routes. Like all rituals, the rites of home birth rely on ritual inversion and other techniques to create a heightened emotional state. Messages about the society's values are conveyed multiple times through symbolic means. For men, these messages are that men should be responsible, that birth care is a business, and that the family is a self-sufficient group. Women's messages are similar: that a healthy birth is a commodity, that the body (not the mind) gives birth, and that society has little responsibility for the individual. These messages about birth derive from wider cultural beliefs about the family, the body, health, and especially gender. Because pregnancy and birth throw the difference between the sexes into heightened relief, beliefs about gender are critically important to the management of birth. I therefore

turn next to the role of gender in shaping my male and female informants' experiences in pregnancy and birth.

SLIPPING IN AND OUT OF GENDER

Rites of passage are a time when participants both act out and are socialized into the beliefs and actions of their new roles. In the previous chapter, I discuss a variety of messages conveyed by both women's and men's roles in the home birth ritual. These messages relate to US cultural values. In this chapter, I address specifically the role of gender in home birth rituals. As I discussed in chapter two, rituals are paradoxical because they may either reinforce or subvert conventional beliefs. In home birth, I find that homebirth parents move in and out of their typical gender roles at different times in the process. This may represent a true subversion or simply a symbolic inversion.

Masculinity and Home Birth

Masculinity refers to the gender role expected of men (though not all men enact it, and some women do). It varies with both time and place. I discussed some of the items, behaviors, and realms that are typically associated with men in chapter two. Birth can be considered a feminine terrain; it has traditionally (though not in recent US history) been a space inhabited and controlled by women. Home birth is an especially feminine terrain in part because the domestic sphere is more strongly associated with femininity than the technology-laden "temple of science" (Declercq et al. 2001:12) that is the modern hospital. Further, the father is likely to be the only man present; nearly all midwives are women (Smith 2008). The literature finds that US men entering feminized spaces usually react in one of two ways (Anderson 2005:338). The first is to attempt to redefine the

space by showing that it is incorrectly gendered as feminine. The second is to find or create a masculine niche and to perform orthodox masculinity in this niche. For example, in a series of interviews with heterosexual male collegiate cheerleaders, Anderson (2005) found that men would sometimes assert that cheerleading was originally a man's sport and that women entered it later, which drew on the first strategy. Others would stress the athleticism and strength necessary to perform many tricks, in particular to lift teammates above their heads. Categorizing lifts as masculine drew on the second strategy. I found that my male informants also drew primarily on this second strategy in pregnancy, looking for a way to perform normative masculinity in a feminine realm. However, the liminal period of the birth itself led them into unexpected role reversals.

“I went right into the technician thing”: Looking for a Masculine Niche

Men have often been considered peripheral to pregnancy and birth, both in the US and abroad (Olenja and Kimani 1998). Their physical involvement ends at conception; only culture keeps them involved thereafter (Reed 2005:47). Some of my informants echoed this peripheral feeling:

AB: What did y'all do to prepare for the births?

EY: I just showed up. (Edward Young)

AB: Have other men asked you about it, like prospective fathers?

HC: A few. Guys are guys and they tend to, unless you get into the right situation, they blow it off. It's not really guy talk. It's not normal to – we talk about guy things. (Henry Campbell)

I think it's pretty hard for men to identify with the baby and with the pregnancy process. It's like, what's going on? Somebody said that women become mothers when they fall pregnant and men don't become fathers until the baby is born. I think that's pretty accurate, especially with the first child. (Nick Garrahy)

I think a man probably takes a back seat for most of it. I mean, he's – the forefront is on his wife and her pregnancy. You're kind of trying to help her, make her feel better. Then when the baby comes it's like she's in love with this baby and you're, again, kind of back seat because all of her time is spent taking care of the baby. (Quentin Nelson)

Perhaps in response to this sense of being on the edge of the experience, many men began searching for a masculine role in their partners' pregnancies and births – a way to be involved through the aforementioned “guy things.” Mechanics, construction, and technology, as masculine realms, were often outlets for the homebirth fathers' energy during this time, which Reed found among hospital-birth fathers as well. Preparing the home, making financial preparations, and being a provider and protector were common themes. For example, a number took on major home improvement or remodeling projects:

I put the fireplace in, not toward the end of her pregnancy, but I got that project buttoned up. I knew I needed to have that one handled. (Daryn Bernstein)

There was a little construction project that I needed to – I had to blow out a wall and put the tub in our bedroom so we could open it up a little bit. Tore out a closet and made a different kind of the configuration of the room. We tried to get that done essentially for the event, so we could have some space, so everyone could fit. We were going to have a midwife, and her attendant or assistant, and somebody here to watch [daughter], so there was going to be a lot of activity, a lot of people, in a very small room, so we just blew it open. Kind of the guy thing to do; that's my nesting, I guess. (Henry Campbell)

Last weekend I spent the whole weekend painting and building furniture. There's a nice list of home projects with this one, but that's okay.

AB: What other projects are you doing?

NG: Let's see. I have to re-drywall the garage, re-organize all that, and there are some other things, too. I'm sure I'll be told before. The bedroom was probably the biggest one: changing the color on the walls, and we bought a bunch of new bedroom furniture I had to set up. (Nick Garrahy)

Several mentioned financial concerns, since a man is traditionally expected to be the sole or primary breadwinner in the family:

It's stressful from a provider's standpoint, in terms of, I've got to make sure I can pay these bills and I can always take care of him, because as a provider, you're going to take care of him and do whatever you can, or have to do, to put food on the plate, and make sure they do good in school. You know, there's a whole world of issues that open up. (Daryn Bernstein)

We were making okay money. It's not like we're rolling in dough or anything like that, but I went automatically to the financial aspect of raising a child, like, how are we going to afford this? (Hank Baron)

I think I had a – and still do – this growing concern for me to make things work, because now I have a baby, you know? For me to make things work, the money thing, and the business. (Landon Richards)

Taking care of their partners was also a concern, which accords with the protector role that is normative for men in the US and fits within the ‘be responsible’ message of home birth.

He was actually really frightened when we were talking about the bleeding, which I didn’t realize at the time, how worried he was. (Bailey Anderson)

I was rubbing her and touching her and getting her to stay calm, so she didn’t panic. (Landon Richards)

Only one other couple was in our class, and they were going to have a home birth. It was their first child. They kept asking if I had any advice, and I just said, “Get ready, because it’s a crazy experience. Your wife is going to be in pain, screaming, and there is nothing you can do. It’s a helpless feeling. (Quentin Nelson)

This accords with many of Reed’s findings about men’s responses to their partners’ pregnancies. However, homebirth fathers were left out of another common fathers’ chore, tuning up the car, since it would (presumably) not be needed for the trip to the hospital. Likewise, they did not have the option, as hospital-birth fathers do, of watching the monitors during their partners’ labors – an action which allows them to remain in the masculine realms of technology and measurement. Many homebirth fathers seemed grateful for the chore of setting up the birthing tub:

I was like, okay, be the support guy. What do we need? We’ve got the tub – I don’t know if she told you, but we got a tub – so we started filling up the tub and getting it warm, and knowing where the towels were, and knowing what the midwife expects you to have on hand. (Daryn Bernstein)

We had to get this birth tub, fill it with water, run a hose, put tarps and blankets down, put in the tub. There’s certain things – you have to put pillows in the bottom, then a tarp, then a sheet, and then another tarp. There’s the correct steps and procedures that you have to do to make sure that it works. (Edward Young)

Reed found that men often acted as an intermediary between the public and private spheres, and the men in this project often took on the task of updating the midwife on their wives’ progress in early labor. Likewise, timing contractions fits into a masculine role and also fits a cultural norm about what a father, in his role as “birth coach,” is

supposed to do. I noticed in my interviews that the men were often very concerned about telling me the story of the birth in a way that was very accurate, especially in terms of timing and measurements. This fits the masculine norm of being rational and analytical.

You go to your birth class, and you talk about positions that you go through contractions in, and how to make the contractions not as bad, and they have this chart that shows... This phase of labor takes this long, and this phase of labor takes this long, and this phase of labor takes this long. Being an engineer, I added all the averages and did some math, so it was about fourteen hours or so that this can last. (Daryn Bernstein)

It was maybe at 11:30 at night, November fifth... About five o'clock or so, the intensity really came through... That was about, I don't know, an hour and fifteen minutes [she spent sitting] on the birthing chair. (Hank Baron)

If I get some of the details on this wrong, [Bailey] knows it a whole lot better than I do. I kind of feel weird telling the birth story, 'cause I was so out of it. I mean, she was out of it too, but she remembers a little bit of the timing a little bit more. So, I might get some details wrong. (Sam Anderson)

“I went to the mental game”: Moving into a Feminine Role

Because the activities above fit into the conventionally masculine “technician thing” – as the quote below calls it – they were an easy and comfortable thing to do.

However, once these chores were done, the father could find himself at loose ends:

This time it completely threw me off [that] she ended up wanting to get into the tub, and to progress in the tub, so my role was – I went right into the technician thing. Okay, how do I get water into the tub? So my role was getting the tub the right temperature, and I was controlling all this, and she got into the tub. I figured that was part of my role as a supporter. I was going to be there. All of a sudden she was in the tub I had nothing to do. I couldn't do counter-pressure; I couldn't massage her; I couldn't do anything. I found myself like wow, ok, verbally. So I went to the mental game, is essentially what happened, so I supported her emotionally. I talked when I needed to talk, and I stopped when I needed to, that kind of thing. For the whole rest of the time, I was there for her that way. And it was bizarre to me because I'm a guy. I can't fix things; I've got to push on things. It was challenging. (Henry Campbell)

Note that he still uses the language of sports: “mental game.” Because verbal and emotional skills are presumed to be feminine, these are “challenging” realms for men. Other home birth men found themselves moving from masculine realms in which they were comfortable into more feminine realms such as talking, serving, and comforting:

“Do you need something to drink? Can I get you something? Do you need a towel? Am I doing okay?” I was rubbing her and touching her and getting her to stay calm, so she didn’t panic. That’s all I did. I’m trying to get her everything she needed. (Landon Richards)

She had this serious agony and self-pity and intense pain look in her eyes, and I’m just trying to...ground her. We’re just sort of gripping each other and she’s trying to push this thing out of her that won’t come. (Ulysses Davidson)

The only role I had was to be there for [Saba] both emotionally and physically, just to be there, to hold her hand, to wipe her brow, to help her in and out of the tub, to do whatever. I know that, just knowing her as long as I have, that there are times when she relies on me to be her rock, to...really hold her up at times. (Edward Young)

I talked when I needed to, or asked quietly when she needed something, and then just became this support role, inadvertently, and it was just kind of neat. Every time she was having [a contraction], she was looking right in my eyes. Just supportive words and encouragement and it was awesome and she came around. (Henry Campbell)

Another way that home birth took the men from their conventional roles was that it drew them in closer to their partners, to the birth, and to their children. Since focus on interpersonal relationships is considered feminine, this may be unfamiliar territory.

I think probably with a hospital birth you’d feel even more peripheral...I think in that I felt very involved. (Nick Garrahy)

I can’t imagine *not* having been less connected with the birth [if it were at a hospital]. There is no connection with the birth when you’re not there, or when you’re up by the head and there’s a big sheet there and the guy’s doing the thing. (Ulysses Davidson)

We became stronger as a couple because I was able to support [Ursula]. (Henry Campbell)

[Dana] held the baby for a few minutes and then they wanted to deliver the placenta, so after several minutes we cut the cord and I stayed with the baby in the room, with him on my chest... I just let him lay on my chest and I was talking to him. I was saying things to him to get my mind to anchor to him being my child. Telling him much I loved him, and telling him he’s here now, and kind of making the whole experience concrete in my mind. I was just talking to him soft and looking at him. (Landon Richards)

Many found that they enjoyed this closeness and reveled in their ability to care for and comfort their wives. They also found that the home birth gave them access to their newborn children in unexpected ways.

How has it changed *me*? I mean, I don't know if it's changed me so much as to show me that supporting, just being, not having to fix things, but being...supportive and staying away from it can actually be more powerful than having to fix it and having to do. If that makes sense? (Henry Campbell)

Typically the mom is to take a bath with the baby. [Nicole] had fainted, actually, right after [daughter] was – after she nursed and everything. People came back in the room, and we stood [Nicole] up to get her in the bath, and she fainted. I think she was just physically just totally exhausted. So, I took a bath with [daughter], which was really fun. (Tom Carter)

Some of the men expressed some mixed feelings about the gender role-reversals they experience around the home births, but most seemed to enjoy the new roles in which they found themselves. As other authors have noted, hospital birth tends to reinforce gender norms, whereas (for men) home birth does not. Interestingly, some informants told me about friends and acquaintances who rejected a home birth, and their comments seem to reflect this understanding:

I know that one couple we just had in this class that was exactly like me. I was no, the woman was yes. They compromised; they actually had the baby in the hospital and had a wonderful experience. The guy was a complete advocate; that was going to be his role. He was good with that. He didn't want to be the emotional support; he wanted to be the guard, and that worked so well for them. They had a great experience. (Henry Campbell)

I talked to one guy a while back who said his wife wanted a home birth but he didn't want to because he didn't want to clean up the mess. (Nicole Carter)

This is actually what I hear from a lot of women [who decide against a home birth]: “I didn't want to have clean up after. I didn't want to have to give birth and then have my husband be cleaning up the mess.” (Ursula Campbell)

This woman, she is the one that has said that she loves hospital births because they wait on you hand and foot for two days. Because her husband isn't someone that...he works even more than I do, with very regimented hours, and I don't really think that he would cater to everything that she wanted. (Hank Baron)

We have two women who were in the last series [of childbirth classes] that we had and their husbands, actually one of their husbands said, “I put my foot down; she's not going to have a baby at home. It's not safe.” (Ursula Campbell)

In other words, the reasons they rejected home birth had to do with masculinity – specifically with the belief that performing feminine actions undermines it. Home birth

meant doing women's work, such as cleaning up or waiting on his wife, or a perceived failure to protect his wife.

Home birth, it seems, is a feminine territory; men may attempt to approach it in orthodox gendered ways, but often find themselves in unusual gender territory. Their actions and perceptions in this unfamiliar arena shed light on US masculinity. If a key tenet of masculinity is "no sissy stuff" – avoiding acting like a woman – are these men who find themselves in the conventionally feminine roles of talking, serving, comforting, and caring for children gender transgressors, or are they enacting a new form of masculinity? The literature offers a few possible answers.

These gender reversals may indicate that, in some ways, home birth challenges some ideas about gender roles. It seems that people who are less concerned with gender roles may be more drawn to home birth. However, as I have discussed, my informants tended to approach pregnancy and birth in conventionally gendered ways. Gender role violations tended to occur in the liminal period of birth. From a ritual perspective, this can be interpreted as "the license in ritual," (Gluckman 2004[1956]) in which typical roles are reversed on rare occasions. For example, as noted earlier, in the British military it is traditional for officers to serve enlisted men on Christmas Day. Gluckman interprets this as strengthening the typical roles, rather than undermining them. "These rites of reversal obviously include a protest against the established order. Yet they are intended to preserve and even to strengthen the established order" (Gluckman 2004[1956]:202). In the same way, we can see the temporary and rare gender reversals of birth as demonstrating the inherent "rightness" of such norms because they happen only in dramatic circumstances and because they are uncomfortable. Thus, the reversals feel

“weird” and the typical roles feel “right.” In this way, the gender role reversals of home birth would support conventional masculinity.

Kane (2006) examined US parents’ responses to gender nonconformity in children. While boys’ playing with “icons of femininity” (Kane 2006:159), such as Barbie dolls, nail polish, or frilly dresses, were sources of anxiety for parents, boys’ engaging behaviors related to domesticity and nurturing, such as playing with dolls or kitchen toys, were condoned or even celebrated. It may be that these particular behaviors have become gender-neutral and that enacting them is not, therefore, a violation of normative masculinity. Kane also found that many mothers were concerned that their sons act in a “properly” masculine manner not because they themselves valued it, but because they perceived it as something their male partners valued. This casts masculinity as a performance for other men. Since other men are rarely present in home birth, perhaps men are exempted during this time.

Masculinity in US, as discussed in chapter two, has homophobia as one of its features. However, this seems to be declining (Anderson 2005; Connell and Messerschmidt 2005), leading one to wonder: what would masculinity look like without it? Anderson (2005), in the previously-mentioned study of male cheerleaders, found that two types of masculinity were enacted, which he called orthodox and inclusive masculinity. The former included “defensive heterosexuality,” (Anderson 2005:345) – frequent overt heterosexual signals, such as talk about sexual conquests. The latter type lacked this homophobia. The men enacting what he called “inclusive masculinity” engaged in ‘feminine’ and ‘gay’ behaviors freely. They talked about emotions, went to a gay bar, and even danced in an erotic manner with each other. When asked about it, they

simply said they did not care if people thought they were gay because there is nothing wrong with being gay. Anderson suggested this might represent a new masculinity that will develop as homophobia wanes in the country. Likewise, Connell and Messerschmidt (2005) found that aspects of gay masculinity had become mainstreamed. I did not ask my informants about their views on homosexuality, but it is possible that they are participating in this new masculinity. It is also possible that, since their heterosexuality is firmly established by the fact of a female partner giving birth, birth becomes an area in which men are freer to engage in more “feminine” behaviors. This presents an interesting area between Anderson’s orthodox and inclusive masculinities as homophobia may not eschewed but merely pushed temporarily aside.

All of these explanations offer intriguing possibilities: is home birth a time that reinforces masculinity, temporarily escapes its enforcement, or actively subverts it? I would like to suggest that a bit of both is occurring. Men in the rites of home birth experience some of the license in ritual: they are in a liminal state, their heterosexuality is well-established, and they are not performing masculinity for other men. However, it seems that some of the men enjoyed their “feminine” time and incorporated it into their roles outside. Most felt that their relationships with both their partners and their children were strengthened. They also reflected on the time of the birth and felt that parenthood changed them as men. It seems that the power of birth ritual does indeed allow them to temporarily leave the bonds of masculinity. In the next chapter, I explore the question of whether this ‘sticks’ by looking at homebirth parents’ gender socialization of their children. First, however, I turn to the role of gender in women’s experience of home birth.

Femininity and Home Birth

Femininity, as discussed in chapter two, refers to the expected behaviors of women. In the US, this includes traits such as weakness, emotionality, religiosity, nurturing, concern with personal appearance, and focus on interpersonal relationships. It also includes a set of bodily practices, such as ways of sitting, walking, dressing, and grooming. In the US, motherhood is highly feminine (Lewin 1998). Women are expected to want children and to be willing to make sacrifices for their children. Pregnancy and motherhood emphasizes women's femaleness and femininity. Mothers, then, are in many senses conforming to the values of their society. Davis-Floyd (2003) found that hospital birth socializes and reinforces many beliefs about women, as detailed in the previous chapter. Though she addresses home birth only briefly (2003:199-206), she implies that to choose home birth involves a rejection of normative gender roles. I find that this is, in some senses, true, but the story is more complex. I use food and exercise as lenses to explore this. Like their partners, homebirth women move in and out of conventional gender roles in the ritual of pregnancy and birth.

Eating Gender; Eating Magic: The Foods of Home Birth

Human beings face what Michael Pollan (2006) calls "the omnivore's dilemma": they can eat an almost limitless number of foods; and a variety of different diets, even radically different ones, can sustain a healthy life. People in the modern US are no longer constrained to the food resources that can be extracted from their immediate or even regional environments; fresh and processed foods are shipped in from every corner of the

globe. The dilemma lies in selection. Many authors (e.g. Back 1976; Liechty 2005) discuss how food – what is eaten and what is not, what is considered good and bad to eat – is a key marker of identity. It may signify class, caste, nationality, gender, and many other ideas. Food becomes especially important for pregnant and birthing women, in part, for this reason. The women are changing identities – from their pre-maternal state to pregnancy to motherhood – and a brand-new member of the society, the baby, is created. Food is one of the ways of expressing these identities. In fact, “you are what you eat” is a common saying. In the US, food consumption choices are usually couched in terms of nutrition science. Nevertheless, food carries a great deal more meaning. After all, there are many foods that are “healthy” (and the foods believed to be healthy change often). Foods are selected not only because they meet the scientific criteria of the moment but because they feel “right” symbolically. I find that certain foods are seen as suitable for pregnancy and others for labor, that these have symbolic meanings, and that they are related to gender.

For modern US women, to be properly feminine involves disciplining the body in a variety of ways, especially diet. Women are expected to diet nearly constantly throughout their lives to achieve and maintain – or at least strive for – the idealized slim physique that became popular in the 1960s (Ayres 1967; Quandt 1996:285-286). They are expected to take up little physical space as a symbol that they will take up little cultural space (Dworkin and Wachs 2004). Women are typically expected to eat food that is lesser in both quantity and quality than that of men (Quandt 1996:276). In particular, bread and vegetables are associated with women, while meat and fat are associated with men. Not coincidentally, these latter two foods are both calorie-dense and high-status.

This is in part because they are more costly and in part because they are associated with larger body size (which is more acceptable for men than for women). Meat is especially associated with men in the US, because it connotes blood, hunting, and muscularity.

Women are expected to monitor their food intake as closely as ever during pregnancy, but expectations change somewhat. This is not unique to the US; food proscriptions and prescriptions abound for pregnant women cross-culturally (Ayres 1967:111). For example, rural Nepalese consider pregnancy a “hot” state, so women are discouraged from eating “hot” foods such as chile and lime but encouraged to eat “cool” foods like fruit and yogurt (Christian et al. 2006). In Cameroon, hyena and snake meats are taboo for pregnant women; in Togo, raw tomato (Cusack 2003:288). Since the food US women eat in pregnancy is perceived as being for the baby rather than for herself, the implications of taking “too much” or eating the “wrong” foods are not the same (Ayres 1967:114). Women are allowed, and even expected, to consume more food and to consume different foods than when not pregnant. The foods they mentioned most often in this study were symbolically associated with status, maternity, and newness. Protein foods, especially meat and eggs, were prominent:

I knew that I had to eat more protein so that I didn't have things go wrong later in my pregnancy. (Dana Richards)

We had a checklist of what did you eat today. Proteins – you only ate four proteins, and you were supposed to get six proteins. Leafy green vegetables – you're low on leafy green vegetables. Oh, you need to eat more iron, and a good way to get iron is red meat, you know, because iron contributes to red blood cell count, which helps the nutrient transfer between you and the baby. (Daryn Bernstein)

[Saba] is very good with her diet, and very diligent with proteins. (Edward Young)

I actually increased my protein because I didn't eat as much protein before I got pregnant and that's also really important, so [I was] conscious of that. (Kieran Masters)

I follow the [Dr.] Brewer's diet, which is what we teach in the Bradley method. It's a diet that helps – a diet that brings the likelihood of pre-eclampsia and toxemia down to zero percent. If you go over 74 grams of protein a day, so included in that is two eggs everyday, which is really hard to

eat, but I forced myself to eat. I love eggs but when I was pregnant it was really hard. So, two eggs a day, lots of dairy products...shakes, chocolate shakes were always really good, being pregnant. Generally a lot of fruits, a lot of vegetables, and 80-100 grams of protein a day. (Ursula Campbell)

Meat's been pretty hard for me to eat, although I generally enjoy meat. I'm not a vegetarian; don't worry about that. I would say probably a lot of fruits and vegetables have tasted good to me, things that are not cooked. I really try to get my protein, dairy, like milk, cheese, yogurt, cottage cheese, that kind of stuff, just because I'm having a hard time with meat. I tried a protein shake, but I don't like the taste of them. (Uma Garrahy)

I've never been a big meat eater but, especially in the beginning, and this time too, I've been craving more meat, which I'm sure is just a protein thing. I would never eat it, but the smell of fried foods, like fried chicken and stuff, smells really good to me, but I could never bring myself to actually eat that. I'm not even sure if I'd like the taste, but that kind of stuff smells good – just a lot more, kind of fatty, salty, protein things, which is not normally my big craving or my big tasting. (Bailey Anderson)

Because protein foods, especially meat, are high-status foods in the US (as they traditionally have been in the Western world), to be allowed to eat more of them is an indication of esteem. Eggs are both a protein food and a symbol of fertility. Since maternity – at least among middle-class white women – is “a highly valued route to femininity” (Dworkin and Wachs 2004:611), it is not surprising that pregnancy is a time when women are encouraged to eat more of such foods. Note that several women (Dana, Kieran, Ursula, and Uma) talk about eating protein foods – meats, eggs, and specially-formulated shakes – even when they are unappealing, because these foods are considered important. Bailey said she has been enjoying meat and high-fat foods, but makes a point to say that this is unusual for her. These both indicate that women's eating protein and fat foods are not for the woman but for the baby. They are clearly presented as a detour from what is considered appropriate for them to eat when they are not pregnant.

Dairy products were also considered very important. Again, this was typically couched in nutritional terms, but we can assume that dairy carries other important connotations. Dairy products are considered quite nutritious. It also has maternal meanings; milk is, literally, food for babies. Consider these quotes:

This pregnancy, I probably was craving cheese more, and dairy products, and sometimes just fats, whatever kind of fat. The last month or so I've really been trying to drink more milk, and that has a lot of fat in it, so I haven't craved cheese quite as much. I think that's kind of what my body wants. (Laurie Dean)

I've been really conscious of having dairy because I just can't drink straight milk and calcium is really, really important. I go through a tub of yogurt every four days or something, you know those big tubs, and cottage cheese. So I'm really interested in my dairy, my calcium. (Kieran Masters)

Again, note that foods are discussed in terms of their nutritional components – calcium and fat. Nevertheless, foods may be “good for you” in more than one way. Back (1976:28) points out that classification of foods as good or bad “may later be rationalized by scientific findings,” but that their symbolic value remains. Pregnancy is a time when women are expected to eat in a way that is optimally “healthy” as currently defined. It is also a time when they are expected to increase their consumption of certain foods, especially meat and dairy, which have gender significance. Meat conveys strength and status; dairy connotes maternity. Since maternity is valued in the US, the extra provision of these foods signifies a woman's increased status as well as their newly-maternal statuses.

Other foods that were mentioned commonly were fruits, especially citrus fruits, and leafy greens. These carry less symbolic cultural weight than meat and milk, but are nevertheless interesting. Both are associated with freshness and newness. It makes sense, both nutritionally and symbolically, that these are considered “good” foods for women in the process of making new people.

Food choices make a slight turn from pregnancy to labor. Again, the stated rationale for the foods was that they were “healthy” as currently defined. For example, sports drinks are advertised as hydrating the body better than plain water. However, these foods have symbolic meanings as well. While foods associated with status, maternity,

and newness are suitable for pregnancy, I found that foods associated with childhood, sport, and maternity were consumed during labor. Those associated with childhood included graham crackers, lemonade, Fruit Roll-ups, mashed potatoes, bananas, and peanut butter. Those associated with sport included specially-formulated sports beverages, such as Recharge and Gatorade, and protein shakes. Those associated with maternity included dairy products, such as milk and yogurt, fruit, and eggs, which were commonly eaten after the birth. Meat, mentioned so prominently as a food for pregnancy, was conspicuously absent.

AB: What did y'all eat while she was in labor?

HC: I remember when the midwife got here she had an electrolyte drink, a Pedialite-ish type of Recharge, Power Bar, or Powerade, type of stuff. (Henry Campbell)

We got crackers, and grapes, and cheeses, and apples [to eat during labor]. (Erin Harkness)

I was trying to keep eating and drinking and stuff – the raspberry tea with honey, and the Recharge drinks, and stuff. Peanut butter sandwiches and apples and stuff. (Bailey Anderson)

What did I personally eat [during labor]? I think peanut butter and celery; I think I had some rice cakes, oatmeal, eggs. Continually drinking water or anything with electrolytes – Recharge or anything like that. (Saba Young)

I ate graham crackers with sun-butter; it's like peanut butter but made with sunflower seeds. (Lisa Harkness)

My husband brought me graham crackers and a banana, and it was better than any birthday meal I've ever had. (Vera Nelson)

These foods can also be seen as a form of sympathetic magic. Magic, as Malinowski classically defined it, is an attempt to control the uncontrollable in order to ameliorate anxiety (McGee and Warms 2004:154; Ayres 1967:111). Sympathetic magic operates on the principle that like attracts like. To produce a child, one consumes foods associated with maternity and fertility (milk, eggs, fruit) and childhood (peanut butter, graham crackers); to ensure the child's vigor, one consumes beverages associated with sport.

Humans eat a seemingly limitless number of foods. However, the foods that are considered “good” to eat make a much shorter list. US Americans tend to explain their food choices in terms of science. While the foods they eat are nutritionally good to eat, they must also be good in a number of other ways. Food is a key marker of identity, including gender identity. For women transitioning from their pre-pregnant identity to their pregnant identity to their maternal identity, food as a marker of identity takes on highlighted meaning. This was clearly the case with my participants. Most of these discussions of food were precipitated by the questions, “Was there anything you avoided during your pregnancy? Anything you made an effort to do?” While this question was intentionally vague, it was almost always answered in terms of food. The foods of pregnancy and of labor differed somewhat. During pregnancy, fresh fruit and vegetables, meat, eggs, and dairy were mentioned most often. The emphasis on “fresh” vegetables may be symbolically related to the fact that a new person is being produced. Eggs and dairy are associated with fertility and maternity. Meat is a masculine and high-status food. “Allowing” women to eat it in greater quantity during pregnancy is something of a role reversal – they eat something typically associated with men. However, the women were careful to assure me that this consumption was for their babies, not for themselves. In this sense, they were fulfilling the expected gender role of doing what was best for others rather than themselves. This change in eating patterns – eating “masculine” foods for “feminine” reasons – is an interesting move in and out of gendered norms. During labor, meat becomes conspicuously absent. Foods associated with fertility and maternity remain; foods associated with sport and childhood are added. In all of these ways,

homebirth mothers eat gender and magic during their pregnancies and births.

“It’s really like a marathon, you know”: Home Birth as Athletic Event

Food proscriptions and prescriptions were mentioned prominently by all my participants. Physical activities were mentioned nearly as often. Although sport has traditionally been associated with men, physical activity has become increasingly acceptable for women (Brace-Govan 2004:503; Dworkin 2001). Unlike eating, physical activity during pregnancy is optional, but no participant neglected to mention it. As with food, there is any number of ways of moving the body; in the modern US, there is a dizzying array of gyms, teams, classes, books, and other forms of individual and group “fitness” opportunities from which to choose. The particular activity selected is a statement of one’s identity and values – an attempt to shape the body both for pragmatic and symbolic reasons. I find that the homebirth women in this sample engage in exercise that has a specifically gendered character during their pregnancies, but that exercise has different meanings during labor.

Like monitoring food consumption, fitness is another way that modern US women are expected to discipline their bodies in a Sisyphean attempt to achieve and maintain the idealized body shape. The ideal varies somewhat from decade to decade but typically emphasizes slimness. Dworkin (2001:341) describes the current “ideal” physical form this way: “slender is no longer adequate, while toned, firm, curvy, and muscled (but not too much) is.” Also like food consumption, these body-disciplining requirements are not lessened during pregnancy. Indeed, “fitness discourse now prescribes fit femininity as being highly compatible with motherhood” (Dworkin and Wachs 2004:616). Women are

expected work a “third shift” to “train for birth” and to “get their bodies back,” or regain their pre-partum shape, soon after giving birth (Dworkin and Wachs 2004).

I found that both men and women among the homebirth parents interviewed used the language of sport to describe labor and birth.

This is our environment; this is home turf, home-court advantage almost. (Henry Campbell)

It’s hard; it’s hard work. It’s kind of like running a marathon. (Tina Bernstein)

I was pretty athletic in high school. I was like, it’s just like pushing your muscles to the max. That’s what it feels like. That’s not painful. That’s putting stress on your muscles; that’s challenging your muscles. (Uma Garrahy)

I liken childbirth frequently to a marathon... It was a physical challenge; it was not just a way to have the baby but a way to experience, a full experience of life. It’s like the epitome of that. (Ursula Campbell)

It was very powerful. I don’t think running a marathon or winning the Tour de France would ever be as amazing as giving birth to a baby – at home. (Cecilia Frederickson)

Dworkin and Wachs (2004) found that training for birth was a common theme in *Shape Fit Pregnancy* magazine. I found this as well. In fact, the women and men I interviewed not only stressed the physical training they did to prepare for the birth; one even compared it explicitly to training.

It’s really like a marathon, you know, one of the hardest physical things you’ll do in your life. I wanted to be ready. (Tina Bernstein)

As far as activities, she was very active with staying active – swimming, walking, things like that, to continue to be active with all the pregnancies. (Edward Young)

I worked out a lot. I knew it was important to, you know, be fit, so that would help my birth, my labor...I worked out my back. I worked out with weights. I worked out my back and stuff like that that would keep me strong, you know, [to] prepare me for my birth – squats, stuff like that. (Dana Richards)

Physically, just the way that you take care of yourself in pregnancy and keeping yourself healthy are all preparing yourself for labor. Labor is called ‘labor’ for a reason, because it is hard; it is work that your body does. I don’t want to go into it not feeling strong. I want to feel strong, like my body can do it. (Laurie Dean)

I’m an athlete, so training is, you know, you have a procedure to follow, this is what you do, take care of yourself. She had to get her exercise, she had to eat right; it was her training. (Henry Campbell)

This emphasis on physical activity does not lie outside the realm of what is considered acceptably feminine for US women, although not all types or aspects of fitness are considered feminine. Women's magazines in the US promote sport as an avenue to fitness, beauty, pleasure, and sociability. This contrasts with men's magazines, which emphasize competition, power, and performance in sport (Dworkin and Messner 2002:350). Correspondingly, the exercises my participants considered suitable and unsuitable during pregnancy had a specifically gendered character:

Maybe some activities that I would usually deem to safe for my body, I don't deem to be safe for the baby and I. [Nick] did indoor sky-diving. I thought, oh, that would be so fun, but not while you're pregnant. There's some things like that: jet-skiing, or snow-skiing, or whatever. Those are activities I would normally do, but probably not [while pregnant]. (Uma Garrahy)

I tended to be pretty active in my pregnancies, lifting things, but also I biked throughout all three so far... I've never felt like my balance was changed at all. If I did, I wouldn't ride. I'm not riding intensely or going mountain bike riding, but I ride for transportation... Even though I'm exercising, high-impact sorts of things that would be dangerous or competitive sort of sport I haven't – well, I haven't even had a desire to do those things when I'm pregnant. (Laurie Dean)

I did a lot of the recumbent bike when I would work out. The elliptical, which I usually do, I would get going too fast, and I would start getting cramps, and I'd be like, ooh, this is too much. Too much strain; I don't want to do that. (Dana Richards)

I started out in really good shape because we had just gotten done with a hike and the Appalachian Trail, and been on the beach, and just out playing, and having some fun exercise stuff. (Bailey Anderson)

I swam once a week and I did yoga once a week. (Tina Bernstein)

I did Bikram yoga, in the hot. People gave me advice about that all the time, but I just kept doing what I was doing. I was like, I've done yoga five to eight times a week for five years, so [laughs] I think I'll be okay. I wouldn't recommend starting, but I was fine. I did yoga five times a week up until two days before she was born. (Marsha Baron)

I am committed to going to prenatal yoga. I think that's absolutely wonderful. I had a yoga practice before being pregnant, as well. It really helps during pregnancy. (Nicole Carter)

The first three quotes illustrate activities not deemed suitable for pregnancy: those that are high-impact, those that involve high speeds or danger, and those that are competitive. I do not deny that there may be medical reasons for discouraging women from avoiding these activities. However, these are also activities that would be

considered unfeminine: to be daring and competitive are masculine traits. To see oneself as vulnerable, on the other hand, is appropriately feminine. Hiking, swimming, and “fun exercise stuff” also lack this masculine edge. On the contrary, cardiovascular exercise (as opposed to weight training) is seen as enhancing femininity (Dworkin 2001:340) Yoga, of course, was the exercise mentioned most often. This is a physical activity that fits neatly with the expectations of modern US femininity. It is a quiet and slow exercise that emphasizes flexibility, grace, and control rather than strength. Strength, being a masculine trait, is less desirable for women. In fact, physically powerful women experience a variety of negative reactions, as Brace-Govan (2004) found in her study of female weightlifters. Flexibility, on the other hand, is regarded positively. Martin (1994:xvii) has argued that “one of our new taken-for-granted virtues for persons and their bodies has come to be ‘flexibility’.” This is a desired trait for both sexes in the contemporary US, but especially so for women (McDowell 1991). The issue of control is especially interesting from a gender perspective. Yoga requires slow, controlled movements and breathing. Pregnancy and especially birth are often seen as out-of-control states (Davis-Floyd and Davis 1997:316; Dworkin and Wachs 2004:611; Martin 2003:54). The purpose of much of the hospital routines and staff was to keep a woman in this state under control (Martin 2003:60); as recently as the 1950s, women were routinely blindfolded, tied down, or given complete anesthesia to accomplish this end (Davis-Floyd and Sargent 1997:10; Wertz and Wertz 1989:136). Leavitt (2009:120-155) has suggested that Lamaze and other “natural childbirth” reforms were accepted into hospitals because it transferred the responsibility from the staff to the fathers and birthing women to keep themselves under control via breathing and other techniques. Home birth may take this an

extra step, requiring women to control themselves without the strictures of the hospital. Yoga, at any rate, is regarded in the US as a highly feminine type of exercise and shows that the women in this sample were enacting this conventional femininity as they prepared for birth.

At this point in the pregnancy process, women's exercise has remained firmly in cisgendered territory. They eschew exercises that are too "masculine," such as competitive, dangerous, and high-impact pursuits, and focus on appropriately "feminine" pursuits such as walking, biking, and yoga. It is during birth that exercise takes on a different character. The homebirth women not only exercised to prepare for birth; they often did exercises during birth to facilitate the process:

The baby needed to come down for a bit; he was really high. I did the stairs, like two stairs at a time, trying to rotate my pelvis. I did that, did some stuff on the coffee table, just some lunges. (Saba Young)

So we did a lot of walking, doing the duck walk thing, where you're kind of doing side lunges, to kind of get the baby, take wide steps, and kind of squat down a little bit, a lot of squatting and kind of hanging on [Sam]. (Bailey Anderson)

I was in and out of the bathtub, changing positions, walking around the house, walking up and down the stairs, trying to create more room in the pelvis and help the baby move down. (Nicole Carter)

I can remember with [oldest son], [Saba] walked around the block, actually went on a walk. Things had slowed down and she, to kind of...I don't want to say pick things up again, but she walked around the block to shake things up a little bit more. With [youngest son], especially, she walked the stairs, came down here, got on her birth ball, and did some things. (Edward Young)

This is a striking difference from a hospital birth. Although women are allowed to move about somewhat more than in the past – such as by walking or using a large inflated "birth ball" to adopt different poses – movement is much more restricted in the hospital (Block 2007:1-43; Davis-Floyd and Sargent 1997:11). The many tubes and wires to which a woman is typically attached (Block 2007:113) contribute to this – it is difficult to move while hooked up to an IV and monitors, and doing so may interfere with their

accuracy – but so does the culture of the hospital. As discussed in the previous chapter, women giving birth in hospitals typically lie down for most of labor and give birth in the lithotomy position. These positions make women literally and symbolically passive and dependent on hospital staff to tell them what to do. To suggest that women move about actively in birth, as homebirth midwives do, is a radical departure. This emphasis on women's activity in pregnancy and birth conflicts with the typical messages US culture conveys during birth discussed in the last chapter (Davis-Floyd 2003:73-153). It has not only physiological effects but psychological effects. It foregrounds a woman's agency, rather than her passivity, in birth, thus moving her away from a conventionally feminine role.

Summary

The ways that women move in and out of birth are somewhat more complex than those of their male partners. While the men approached their partners' pregnancies in conventionally gendered ways and did not engage in more "feminine" activities until the crucible of birth, women moved in and out of cisgendered roles throughout pregnancy and birth. In the case of food, women eat more high-status and "masculine" foods during pregnancy, but return to "feminine" and childlike foods during birth. In contrast, their exercise routines in pregnancy are quite feminine, while their physical movement during birth challenges beliefs about women's passivity in birth. This is similar to Carter's (2009) findings that homebirth women in the US both break and follow some gender "rules" as they give birth. Both men and women in this group had opportunities to challenge what it means to be a man or a woman in this culture through their actions in

birth. What remains to be seen is whether these reversals remain a part of the new identity, or whether they are symbolic inversions which temporarily subvert but ultimately reinforce normative cultural beliefs about gender. I believe that the parents' discussions of their children's gendered activities, and their responses and beliefs about these activities, suggest the answer to this question. It is to this topic that I turn next.

HOMEBIRTH PARENTS AND THE NATURE-NURTURE DIVIDE

Home birth, like hospital birth, is a rite of passage. (I include pregnancy and the immediate postpartum period as part of this ritual.) It places initiates in a highly receptive state in which the roles and ideals they find themselves enacting can be transformative. I have illustrated the messages of home birth, with especial attention to the ways that the gendered messages are mixed. Both men and women find themselves moving in and out of their usual gender roles as they move through pregnancy, labor, and birth. These gender role reversals have a great deal of power: they can either create a new way of doing gender for the initiates, or they can serve to reinforce conventional roles. The purpose of a rite of passage is to create a person who will properly enact the expectations of the new status. Parents need to be properly socialized for their own sakes but also for their children: they will soon be teaching gender roles to the next generation. It is useful to examine the ways that homebirth parents talk about their children's gendered behavior and what they identify as the source of such behavior; this sheds light on whether gender roles are subverted or reinforced in home birth.

It is easily observable that the sexes behave differently in the US; they are differentiated by hairstyle, clothing, *habitus*, activity, profession, parenting duties, etc., as described elsewhere. This leads to the question: why is this? In other words, where do such differences originate? This question, and its various answers, has been referred to succinctly as "nature vs. nurture" (Galton 1874:277) That is, gendered behaviors can be explained in terms of natural causes such as biology, evolution, hormones, design, etc., or

in terms of learning, reward, and punishment. My informants were aware of this debate and seemed to embrace both sides of the nature-nurture divide; many cited both socialization and inborn impulses as sources of gendered traits. They fumbled as they tried to reconcile beliefs they could see were incompatible, and tended to lean toward the “nature” end of the spectrum – to see gender roles as innate – but with reservations. In particular, parents did not want to see themselves as enforcing gender “rules” for their children. Nevertheless, they wanted their children to engage in the “correct” behaviors for their gender. To resolve this tension, they drew on concepts that are highly acceptable to US Americans: individuality and choice. The argument seems to be: “Of course it’s okay for boys to play with dolls, or for girls to play with trucks, but my kid(s) just don’t like to.” Each child can then be seen as individually choosing behaviors that just “happen” to match what is expected and each parent can be absolved of socializing gender norms. I unpack these beliefs more below.

Some informants talked about gendered behaviors as learned.

You hear so many debates about nature versus nurture that I’m kind of curious to see what, if we have a boy, to see what the differences will be versus “this is how I parent, so this is how my girls are,” versus, “you parent that way so this how your boy is.” (Laurie Dean)

I think the way that we, maybe stereotype, like obviously colors, and clothing, and maybe the way that you talk to them, would be a little bit different, you know? You might be a little bit tougher on boys than you are on girls. Right now, I don’t feel like it’s too different, because I would treat him the same way. But once they get a little bit older and start understanding words, it would be...I don’t know [laughing]. It’s like when we were shopping, when they were shopping for clothes and stuff, it was really hard to find gender-neutral clothes for people who don’t find out [the sex of the child before it was born]. (Tina Bernstein)

Where it starts is, “Oh, a little girl!” Let’s dress her in all pink and all frills – that’s the way I was raised. I think they are more catered to, and “You are so delicate!” (Dana Richards)

Despite the fact that a few acknowledged culture as a source of gendered behavior, my informants leaned more toward the “nature” end of the nature-nurture debate on gender. While they acknowledged that upbringing and expectations shaped

behavior, they still saw some traits as essentially gendered. These differences were typically attributed to a physical origin, although some cited religious or spiritual sources for gender differences. Hormones, in particular, are seen as the essence of masculinity and femininity, so differences were often attributed to them.

In general, men's masculine energy is just different. It's more of go out and conquer, I don't care about the details, I need to take things on, from a huge-picture standpoint. That's sort of a caveman mentality from a hundred thousand years ago. Women are more-detailed oriented nurturers. They take care of the kids, the husband, the house. Again, I'm being general. You asked about the differences; I think they're totally different. (Tom Carter)

Some of it I think is just in your genetics, if you're female, to be drawn more to make-up, or cleaning, but not always, of course. (Nicole Carter)

When I see all these boys wanting to climb the jungle gym, and jump off, doing these insane leaps of death, that's testosterone. If I see a girl doing that, it's like, "Wow, what a bold, tough kid." It's not like, "Is that really a boy?" It's just a girl who's not acting like all the other girls in the playground. I think there is a certain amount of nature. (Ulysses Davidson)

I definitely think there's fundamental differences. ...I think a lot of it is core neurology. If you look at the *in utero* experience and the testosterone actually burning the two halves of the brain apart a little bit, there's a reason why that happens. I think we were built to be different. (Nick Garrahy)

Our physiological make-up, I think, is developed differently. (Neil Dean)

I do feel like men and women are different, they're wired differently in how they nurture and the ways that they interact with other people. (Cecilia Frederickson)

It's an underlying belief about the body, about how we were created, and why we were created. I think probably a very, very strong sense about...my *feminine* body, my feminine identity, who I was as a woman. (Uma Garrahy)

I would say there is certainly a feminine and masculine energy in everyone. I look around in different cultures and, by and large, women exhibit these feminine tendencies, nurturing. They are both very powerful, nurturing, and looking at the whole rather than the particulars. (Ulysses Davidson)

In other words, although upbringing is thought to have some effect, they gave much more weight to essentialist explanations of gender differences. To bolster the belief that gender norms are natural, many told me stories about children acting in conventionally gendered ways:

[Son] has been, ever since he was four or five months old, really, really interested and intrigued in wheels and things that go round. [He has] kind of an analytical look on his face and stuff. You

know, he's got some dolls and he's got plenty of animals that he likes to play with, but his favorite thing, really, is kind of cars and trucks and things that go. I think it sounds like it surprises lots of parents to see that the little-boy preferences are really coming out of the little boy and little-girl preferences are really coming out of the little girl. (Bailey Anderson)

Certainly, because we have boys, we have more prevalence of wrestling, and guns, and knives, and swords, and stuff, but that's just boys will be boys. I wouldn't say we tolerate more of it, but we accept and we deal with it, based on just their natures. (Edward Young)

We have a little kitchen set in there that [my daughters] love to cook with. They play with their dolls. [My older daughter] can play for hours – [my younger daughter] too – and make a nest on the floor, talking, making this, or making that. “This is my baby, this is what I'm doing, and this is where I'm going.” (Laurie Dean)

My daughter – it was so funny – was playing with some boys and found this squirt bottle. She was squirting it and saying, “this is make-up,” and putting it on. The boys were like, “What? What are you doing?” Those differences are really kind of funny to see. It's really amazing how early that happens. (Nicole Carter)

[My daughter] right now just jabbars all the time – talk, talk, talk, talk. I think boys talk typically later and have better fine and gross motor skills than girls. I think there are some of those differences. But the things that I find most different is their choice in how they play and interact. (Nick Garrahy)

The frequent use of children's gendered behavior to support the existence of “natural” gender traits demonstrates my informants' belief that at least some of these behavioral are inherent. The assumption here is that children are pre-cultural. If children exhibit a trait, the reasoning goes, it must be inborn, not socialized. This ignores the fact that anecdotal data suffers from selection bias: parents may be ignoring, or failing to mention, the times when their children act in the “wrong” way. In fact, informants almost never identified their own children as acting in ways that violated gender norms, although they would sometimes give examples of other children who did:

I think there is an aggressive – just the way that they play – boys tend to be more...physical in their play, in the sense of being...pushier with their bodies, almost more physical with their bodies in an aggressive sense. Then, I can think of girls, too, that I know that are very aggressive. My girls are not. (Laurie Dean)

Interestingly, most of the people I talked to did not find out the child's sex before the birth, and some cited this desire to avoid gender-stereotyped clothing and toys are part of

the reason for this: “If you know it’s a boy or a girl, then you start to build stereotypes – not stereotypes, but personality,” Daryn Bernstein said. Despite this, my informants were quite willing to attribute their children’s behavior to their sex. They could do this because they were quite sure that they did not treat their boys differently from their girls.

I don’t think that I treated him any different because he was a boy. I know that some people are a little rougher with boys and that kind of thing. He slept with us until about a month ago, so he was almost two and half, and nursed for about the same time, for over two years, and I wore him all the time. I think as far as that goes, that will be no different for a girl, for me, for the first few years. (Bailey Anderson)

If we had a girl, I can’t...I don’t think I would change my...my discipline, my example, my behavior either way. We’ve had nieces and nephews and we’ve have friends come over who have girls. We’ve had them spend the night, had sleepovers. It’s our leadership and our example and our discipline that we set down is gender-neutral. (Edward Young)

AB: You have a little girl. Do you think raising a little boy would be different?

HB: No, I think it would be right around the same steps. I can’t really identify anything that we would change as far as our process, at all. (Hank Baron)

Truly, watching [daughter] grow up, and how easy it was, a girl; now she’s four and half and how easy it is; she’s an incredible kid and she’s a smart kid and she feeds off our energy. I think [son] is going to grow up the same way. (Henry Campbell)

We’ve always felt like rather we have a boy or we have a girl, it’s the same for us. (Neil Dean)

These denials of socializing gender make sense because the notion of gender being socialized is somewhat problematic in the US context. First of all, US Americans place a great deal of emphasis on individuality and agency. To think that social factors, such as gender norms, largely shape their personalities conflicts with this underlying ideal. To aggressively socialize gender would be seen as impeding a child’s individuality, which Euro-American parents, especially those in the middle and upper classes, are hesitant to do (Hill, Bush, and Roosa 2003:191). Nevertheless, despite some acceptance of the idea of gender being culturally constructed, and some acceptance of the idea that alternative gender expressions should therefore be acceptable, behaviors that violate gender norms cause discomfort. Parents do not want see themselves as teaching gender, but also do not

want to see their children acting in non-normative ways. Many informants expressed this tension by vacillating between nature and nurture explanations, as can be seen above – the same people make one argument, only to make the other a moment later. Some acknowledged this tension:

The little boys seem to be much more aggressive with things, with toys, or with playing. [Daughter] seems to be much calmer. I mean, she's still a fireball [laughing] but in a different way. (Nicole Carter)

I think emotionally, we're definitely different in how we handle our emotions, but I think it's also how you're raised. I think boys are taught to not show emotion as much. It's not acceptable to cry and you need to be tough, whereas for girls it's okay to cry. We have different interests, a lot of the times, like girls are into cooking and maybe the stereotype for cleaning and being housewives. I don't know where I'm going [laughing]. I think you have – there's definitely differences because we're obviously two totally separate beings, physically, and we have different hormones. (Tina Bernstein)

I'm not saying either that you're all or none. I'm not saying that a woman can't be more analytical or whatever the case is. But, I would say we were created that way. (Uma Garrahy)

You know, there's always the big nature versus nurture question, and I definitely think there's a combination of both of it. I'm not going to try to figure it all out. That's the anthropologists trying to figure it out for years, trying to figure out where things fit in. I do think there's a significant amount of nature in it. It's just how we're born. Especially, I think, when you see such a difference in really young children – I think it's easier when they're older to say it's more the nurture that plays a role in it. I think even at a very, very young age, the nurture maybe plays more of a role than we think. That's pretty vague! But I do think there are significant differences in the nature of boys and girls. (Neil Dean)

To resolve this tension, they were able to draw on ideas that are very popular in US society: uniqueness and choice. My participants were generally quick to say all children were individuals and should be themselves regardless of gender norms. This resolved the tension neatly, as children could be seen as freely “choosing” behaviors that just happened to match what was expected of their gender. These informants summed it up neatly:

When I say, yeah, women and men are fundamentally different, I think everybody's fundamentally different. (Ulysses Davidson)

I think there are individual variations, for sure, but I do think there are inherent differences. (Neil Dean)

It's hard to generalize though. There are exceptions to everything. (Sam Anderson)

Their personalities are going to be all different. I don't know if that's necessarily based on sex. (Uma Garrahy)

Summary

Parents are forced to confront gender in brand-new ways as they begin making childrearing choices. While children are seen as being pre-cultural, or acting “naturally,” that is, without socialized norms, there is in fact evidence (cf. Kane 2006:151) that gender socialization begins in the earliest days of life. The informants in this study were aware of this, as their choice not to learn their baby's sex in advance and their frustration with the dearth of non-gendered baby clothes showed. They were nevertheless uncomfortable with it. First of all, to enforce gendered behaviors is seen as violating a child's rights to be an individual, which is a highly prized ideal in the US. Second, awareness of the social origin of gendered behavior has not yet translated into a full acceptance of non-normative behaviors. This accords with Kane's (2006:172) finding that parents would both point out “natural” differences between boys and girls and hold themselves responsible for gender “failures,” particularly in boys. It also fits with Martin's (2005) findings that parenting books widely acknowledge the social shaping of gender, but find gender nonconformity problematic, especially for its association with homosexuality. Homebirth parents find themselves in a bind: they do not want to enforce gender traits, but they do not want their children to fail to perform them, either. To resolve this, the homebirth parents in this study cite examples of their children exhibiting

“correct” behaviors for their gender, deny treating children differently based on their genders, and conclude that their children exhibit these behaviors due to some combination of biology and choice. The “nature vs. nurture” tension is resolved with highly-acceptable concept of individualism.

STALLED LABOR

Many of the men and women I spoke to chose a homebirth, in part, because they believed it would be empowering. They intuited, at some level, what Davis-Floyd and Reed articulated about hospital birth: that it emphasizes women's weakness and dependence, their inability to give birth on their own. It marginalizes men and their experiences. They felt that, in a hospital, they would give up their power to make decisions about their births and the sense that they had given birth themselves. Just as Davis-Floyd found, they thought that the doctor and the hospital would produce a baby, not the parents. Many comments demonstrated this understanding of hospital birth.

You know, they just sort of go in and say, "Well, he's a doctor, or she's a doctor, and he tells me what to do. That's the nature of this relationship. I don't really have a say." (Uma Garrahy)

I think the general opinion in this country is that whatever the doctor says is best. Doctor knows best; I'll do what he says. We don't really question that, you know. (Sam Anderson)

This is my job and not somebody else's job. They've done such a good job of convincing us that it *is* their job, so much that we've paid them insane amounts of money to do it. (Michelle Davidson)

Birth in a hospital is really based on this idea, this overwhelming notion, that you can't do it on your own. You've got to have all these highly trained people with highly advanced technology and equipment to get that baby out of there safe. (Ulysses Davidson)

I think that part of going to a hospital is that other people are doing it for you. They are the safety net that makes you have a safe birth, and they're monitoring you, and the doctor delivers your baby. Well, *I* delivered my baby. *I* gave birth to my baby. Nobody delivered my baby for me. I feel like being at home that was where the power was – with me, I did it all. I had a support team, but that was all. At the hospital, it's like you're on their turf and they're running the show. I don't think I would have felt empowered by it. (Cecilia Frederickson)

In addition to taking away their sense of accomplishment, both the women and their partners thought that a hospital birth would place them in conflict with hospital staff.

That's all the different things that you'd have to *battle* going into the hospital. (Hank Baron)

I liked that I didn't have anybody telling me what I needed to do. I think that really would have

sent me over the edge if I had been at a hospital. I really would have wanted to tell them to just fuck off and leave me alone. (Dana Richards)

AB: How do you think your experience would have been different if you had gone to a hospital?
HC: For me, I mean I would have become more of the defensive role. I mean, 100% advocate. I would have had to be the defensive one for the family, for her wishes, for her... They have their protocols, and they have to... You know, if there is a shift change, if you've established rapport with any particular nurse, you're going to have to do it again. I would have been – the biggest disadvantage, I would not have been able to do what I did with [Ursula] this last time and I would have missed that. We would have been in a completely different role that I would *not* have enjoyed. (Henry Campbell)

I would feel very angry and afraid in a hospital. Right off the bat, I would feel defensive. I don't know how you can birth feeling that way. I think other women feel safe in the hospital; I wouldn't. I would be constantly like, "What are you doing to me? What are you doing to my baby? Don't take them out of my sight. Don't do that. I didn't want you to do that." I'd be so hyper-vigilant. (Michelle Davidson)

I think I was able to relax and enjoy the birthing process because I wasn't having to defend our choice to not have the types of interventions. I think in the hospital I would have spent time bucking up against the physician. (Nick Garrahy)

Mothers believed that they would have a great deal of difficulty having the low-intervention birth that they wanted in a hospital setting, and this belief is well-founded. This desire conflicts directly with the hospital protocols in which doctors have primary decision-making power and interventions are used routinely. Such assertiveness also conflicts with their expected gender role. Martin (2003) found that women birthing in the hospital made extraordinary efforts to avoid being rude to their doctors, making eye contact, considering their emotions, and facilitating polite conversation even through contractions. The hugely popular pregnancy manual *What to Expect When You're Expecting* encourages women to make a birth plan detailing their wishes, but not to expect it to be taken seriously. It cautions against "thrusting" the birth plan into a nurse's face and suggests that laboring women "offer it in a pleasant, non-threatening way," perhaps with "a small basket of goodies" (Murkoff et al. 2002:276). Patients have the right to make choices about their own medical care and parents have the right to make such choices for their children, so it is pretty appalling to suggest that one would need to

bake cookies for the hospital staff merely to have one's decisions respected. It certainly reinforces the idea that women are childlike and irrational in birth and therefore cannot expect that their wishes be accommodated. The mothers I spoke to are likely correct that they would have experienced conflict at the hospital.

Their partners also wished to avoid conflict at the hospital. As Reed observed, placing men in a role of mediating between the public and the private worlds draws on older ideas about men's gender and their role in the family. It puts him in the role of distant patriarch rather than domestic companion. It paints them as rational, as needing to take charge of their wives, and ignores their emotional experience in birth. By contrast, home birth allows men to be closer to the process, and by extension closer to their partners and children. That the men prized this shows in their comments in the last chapter. Likewise, many women's comments showed that they found the experience of giving birth at home empowering.

It's a very intense time for a woman anyway, and giving birth...it's very intense in terms of how you perceive yourself as a person, as a woman, and as a person about your accomplishments, about what you can do, about how strong you are and...I was at home. I did it. I didn't have drugs. I didn't have people messing with me. It was me having my babies. (Michelle Davidson)

In part, these parents chose to birth at home because they believed a situation in which they could have the power to make decisions and be together in birth was desirable and empowering. These perceptions are likely correct. Although some women had very long or difficult births (and most likely would have had c-sections if they had gone to a hospital) it certainly appears that home birth provides an amazing experience for both mothers and their partners. At every interview, I found myself smiling uncontrollably, and often near tears, as people told me their births. They were clearly powerful. I do not wish to belittle my participants' experiences or to attribute them to a false consciousness.

Nevertheless, the labor of changing birth's meaning and making it into a more empowering experience for all involved seems to be stalled in some important ways.

The message that society has few obligations to the individual and that the family is (or should be) a self-sufficient unit was a key message of home birth. This message was perceived as empowering by many participants because it made them feel self-reliant and independent from institutional interference.

I think it's important to make a connection between homebirth and...owning your own body. I think that is a big component to the decision to *not* sign over your body to somebody else, and to trusting that you can do it. If you own your own body, that includes your reproductive organs, and birth canal. I can make this happen...that is tied to having a lot of confidence in yourself, and not even just ego-wise, but tied in the confidence with nature that I am a woman; I'm going to have a baby like so many women before me have. This isn't whether I'm good enough. I'm already a woman; I've got all the parts. I need to be strong; I can be strong. (Michelle Davidson)

I think homebirth is tied very much into a really strong sense of self-reliance and self-validation, self-sovereignty and authority. I don't need someone else's help to get through my life. (Ulysses Davidson)

I really felt like we were a family the whole time. It happened the way we wanted it to happen. Her experience, [my daughter's] experience, was better for her because of it. (Erin Harkness)

We're just bringing the kid in slow but sure. Put the music on, put the candles on, and tried to create an atmosphere, just like [Ursula] wanted. It's a quiet atmosphere and even with three people, [a friend], the birth attendant, the assistant, and the midwife, it was like they weren't here. It was quiet. They were totally respectful. They came in, they respected that, they stayed back, they laid on the bed. I think the midwife fell asleep for a little while. I was just there for [Ursula]. (Henry Campbell)

I was more comfortable with the midwife there, with this one. But the next birth I think we're going to do unassisted...We just kind of did this on our own. (Landon Richards)

This sense that the family is a self-sustaining unit that can operate free from institutional assistance is a powerful myth in the US (Coontz 2000b). People from the US take a great deal of pride in self-reliance, so it is not surprising that homebirth parents draw on this as a source of esteem. However, this seemingly empowering message belies a stark reality. The US has one of the lowest percentages of GDP spent on social welfare in the developed world (OECD 2010). It lacks universal maternity care, paid maternity leave,

and subsidized childcare. The family really *is* on its own. The new parents hear this message loud and clear during birth. Interestingly, this message pervades other aspects of their lives; many were avid do-it-yourselfers. The Youngs finished their own basement. The Davidsons brew their own beer and Ulysses founded a local home-brewing club. Many participants gardened, made their own baby food, and baked their own bread. Even their commitment to extended breastfeeding can be seen as an indication of this self-reliant mindset. Co-sleeping (in which babies and young children sleep in the same bed as their parents), another common practice among homebirthers, also expresses this sense of insular nuclear family life. The fact that they not only accept but laud this situation shows how strongly it has been accepted. The positive interpretation my informants give to family independence does not change the reality that the US has a poor social safety net compared to other developed nations. It also shows the privilege of their class status: they can take pride in being self-reliant because they are relatively well-off; for poorer citizens, this sense of pride is less accessible. Similarly, the belief that families should be self-sufficient paints those who need help as failures while ignoring the complexity of such situations.

An unexpected and striking finding was that very few of the parents vaccinated their children. Even those who did had thought it over carefully and seemed to feel that they needed to justify the decision to me. To not vaccinate one's children very strongly conveys that the family is a unit which protects its own but has few reciprocal responsibilities with the larger society. Vaccinations protect not just the individual; much of their importance comes from "herd immunity." That is, making vaccinations widespread helps to protect everyone by making diseases less common and sometimes

virtually unheard-of – as in the cases of smallpox and polio. While the evidence that vaccinations can contribute to autism is weak at best, it is something that concerns many parents and has received a great deal of media attention (Immunization Safety Review Committee 2004). It is true that any vaccine can have negative side effects at an individual level. These are outweighed, on the epidemiological scale, by their positive impacts. Choosing not to vaccinate prioritizes the individual over the group; this seems to be a natural outgrowth of the beliefs that the family is an autonomous unit and that the society has few obligations to the individual. Once again, we find that a seemingly positive message has negative ramifications, putting children and the larger group at risk for infectious disease.

The messages that the family is a self-sufficient unit and that the society has few obligations to the individual are key messages conveyed in home birth. It is clear that the homebirth parents accept these messages and in fact enact them in other facets of their lives, especially childrearing decisions, such as breastfeeding, co-sleeping, and vaccinations. While this message may be more empowering than those of hospital birth, and may fit better with the political and economic realities of the modern US, it is a message that has mixed benefits at best. This sense of pride in not accepting institutional help obscures the many privileges that white middle-class US Americans enjoy and makes them less likely to support measures to strengthen the US's ragged social safety net. In this way, a seemingly empowering situation glosses a stark economic reality. Policies that genuinely make families more secure (if not more independent) such as improved birth care, maternity and paternity leave, universal health care, and subsidized

childcare get lost in the desire to be “self-sufficient.” It appears that this way of reforming birth does not go as far as it could in empowering women, men, and families in birth.

The messages that a healthy birth can be earned or purchased and that fathers should be responsible are other key messages of home birth. Again, the feeling that one can have a great deal of control over the outcome of a pregnancy through diet, exercise, and informed consumption of health care may be perceived as empowering. My participants emphasized over and over that what they liked about home birth was that they had to take responsibility for their pregnancy and birth (as shown in chapter five). The logical flipside of this, of course, is to feel that going to a hospital to birth abdicates this responsibility.

I think so many people who are in the care of a doctor don't feel that responsibility because the hospital is there; all the stuff is there if they need it. I was sure I wasn't going to need it [hospital technology] but it wasn't going to be there if I did need it right there. I think just having that...self-reliance and responsibility was really important to me. (Bailey Anderson)

That's one of the problems with having a birth in a hospital. These women and sometimes fathers are in such a suggestive state that the doctor can say *anything*, and they're like, “Yeah, absolutely, let's get that done, yeah.” They become puppets, almost. They stop thinking for themselves. (Hank Baron)

There is, at some level, a belief that people who have bad experiences during hospital birth are responsible for the bad experience: they were inadequately prepared or lacked the strength of character to stand up for what they wanted.

[My sister-in-law] wanted to have a natural birth [but] she didn't do any preparation. She thought seeing births in her [medical] training, and reading about it, was all that she needed to know. She ended up going to the hospital earlier than she planned, getting an epidural, getting an episiotomy. (Bailey Anderson)

I hear from a lot of people that they had an emergency c-section, and when they tell you the story you know what happened. They got steamrolled into a c-section because...their baby was too big, or whatever crock story you hear over and over again. You have to say, “Wow, that must have been really hard,” instead of saying, “Wow, your doctor really pulled the wool over your eyes.” (Cecilia Frederickson)

I've seen so many women who know us and know our situation, and want to have a natural birth in the hospital. I don't think they quite have the feeling that they want to be at home. It scares them a

bit, which is fine. They go to their doctor and say, “I want to have a natural birth.” The doctor at first is amenable to them. Then as they get closer to the birth – it happens every time – the doctor starts to go, “You’re getting a little big,” or, “The baby’s not quite big enough,” or – every time they convince these poor people that if they don’t intervene in some way that baby won’t make it... I get so frustrated with people who go through the medical, the hospital, experience. (Tom Carter)

I’m like, “Are you serious? You’re going [to the hospital to give birth]?” The emotional stress that she was put through! At the end of her pregnancy they were saying that she was going to be early, and she ended up being a week late. They were saying that she needed to deliver the baby and induce, and that the baby was going to be huge, and that on the ultrasound the baby was measuring nine pounds. When the baby was born, she was 7 pounds, one ounce. The whole time, I was like, that’s what you get for going into conventional medicine. (Marsha Baron)

Homebirth parents see themselves as taking control of their births through their knowledge and their consumption choices. Likewise, they see people with poor experiences in the hospital as to blame for these experiences. If one believes one can purchase or earn a healthy pregnancy, then the belief that parents, whether at home or hospital, are at fault if anything goes wrong follows logically. This places the weight of responsibility on their shoulders even in the cases of unavoidable negative outcomes and negative outcomes that are related to larger-scale phenomena, such as poverty, dangerous workplaces, and lack of access to nutritious food and quality prenatal care. Though a few of the mothers interviewed were transported to the hospital, none of the families I interviewed had significant maternal or neonatal problems. This is mostly, I imagine, due to the rareness of such outcomes. Poor outcomes are even rarer among people who are well-educated and well-off financially, which describes this group. However, it may also indicate that people with poor outcomes did not choose to contact me for an interview. If a problem is, in their minds, their own fault, they are unlikely to want to advertise it.

The messages that one can purchase and earn a healthy pregnancy, that birth is a business, and that one can have responsibility and control over one’s birth experiences were experienced as positive. However, this positive interpretation concealed the more

negative faces of such messages. First of all, it allows parents to be “blamed” for poor outcomes. Second, it ignores sources of poor outcomes that exist above the personal level – institutional, economic, and other large-scale forces that impact health. Ignoring such forces and blaming the individual places an unnecessary burden on parents and inhibits reforms. This suggests that while home birth perhaps offers more compelling messages than hospital birth, the work of making birth more empowering is not yet finished. The ideas that are conveyed about gender during home birth follow a similar pattern.

The homebirth fathers I spoke to approached their partners’ pregnancy from a conventionally masculine perspective. They took on home improvement projects, looked after the family finances, and reorganized their free time. They attempted to continue in this vein when their wives went into labor, timing contractions, mediating communication with the midwife, and taking care of the technical chores, such as setting up the birth tub. In the liminal time of labor and birth, though, they found themselves increasingly taking on feminine roles. They talked to their wives, held them, comforted them, waited on them. They sometimes caught their babies as they emerged. They were a part of the intimate time after the birth, and sometimes took care of their hours-old children while their wives rested. This closeness seems to have “stuck” after the birth. Co-sleeping was very common. Most of the fathers seemed very involved in their children’s lives; their comments to me indicated that they were familiar with their feeding, changing, and sleeping habits. (This did vary by family.) Some parents rearranged their work schedules so that one or the other parent was with the child at all times. Others had a stay-at-home parent, however, and this parent was inevitably the mother. I noticed that when the whole family was home during our interviews, the baby

joined us while I interviewed his or her mother, but not while I interviewed the father. Although I did not address the division of childcare duties directly, it appears that mothers continue to have the primary responsibility. This is not uncommon; wives in the US typically take on more domestic work, including childcare duties, than their husbands (Bianchi et al. 2000). Both Leavitt (2009) and Reed (2005) noted that the arguments in favor of allowing men to be with their partners who were birthing in the hospital centered on making them more committed fathers and breadwinners. However, Reed and others have also noted that men typically feel peripheral to the birth experience. Homebirth takes the next step in bringing men closer to the birth and to their families. While the fathers I spoke to seemed very committed to childcare, it does not appear that an even division of responsibility has occurred. In this sense, reforming birth and family life to fully integrate men is not complete.

One of the key messages expressed by homebirth was that the body births. Davis-Floyd found that hospital birth makes the female body seem like a defective machine needing outside assistance to correctly produce a baby. To emphasize that the female body can give birth without technical assistance undermines this idea and makes strides toward a more woman-friendly birthing paradigm. Nevertheless, the homebirth emphasis remains on the female *body* rather than *mind* or the *self*. Because the mind and the body are seen as separate but unequal in the Western world, this emphasis on the body's ability to give birth, while somewhat empowering, also serves to reify the equating of women with the body and the body as having lower status than the mind. It supports the traditional notion that "female is to male as nature is to culture" (Ortner 1972); that is, that a woman *is* a body. The homebirthing body may not be seen as broken, as is the body

birthing in the hospital, but it is still just a body. A truly positive message, it seems to me, would emphasize not just the body's ability to birth, but also the woman's ability to endure fear, pain, and fatigue, and to give birth. Beckett (2005) also addressed this when discussing the feminist critique of biomedical birth management. While valuing motherhood is a significant step forward for women, it is a mixed blessing when it is packaged with essentialist notions about women. Rather than praising women for being "natural" birthers and nurturers, perhaps they should be praised for doing something so difficult and all-consuming without such "natural" advantages.

Home birth offers other mixed messages about women's roles; the topics of food and exercise were prominent themes that demonstrated this. The emphasis on exercise in pregnancy offered women a source of strength and power. It shows that sport, traditionally a masculine realm, has become not just acceptable for women but for pregnant women, who are in a state of emphasized femininity. This strength carried over into their labors and deliveries. The homebirth mothers moved about throughout their births. This contrasts strongly with hospital birth, in which women are largely expected to lie passively. In addition to the physiological advantages of movement, it emphasizes the agency of the women throughout the birth. Although this is somewhat diluted by the emphasis on feminine types of exercise (e.g. walking and yoga) and by the continued emphasis on the body, encouraging women to be active in labor nevertheless conveys what I consider a genuinely empowering message for women because it foregrounds their agency in giving birth and encourages them to feel strong.

The messages conveyed through food consumption were not so heartening, however. Women were allowed and even expected to break their usual food consumption

patterns in pregnancy. In particular, meat and fat became much more acceptable. Because these are masculine, high-status foods, this can be seen in terms of increased status. Allowing women increased access to status for maternity is problematic, however. Motherhood, though superficially valorized, in fact brings increased expectations of femininity. Mothers are expected to be nurturing and self-sacrificing, traits which are not otherwise highly valued. By giving them “better” foods, our culture is giving women a token reward. This is an example of what Kandiyoti (1988) might call an exchange in the “patriarchal bargain:” acquiescing to the demands of patriarchy in order to receive the benefits of doing so. Furthermore, this is a temporary allowance. In labor, meat becomes conspicuously absent. In its place, foods associated with children appear. Just as a hospital birth, with the IV line as an umbilicus, makes women into infants, this choice of food in home birth makes women symbolically like children. Through emphasizing women’s bodily and childlike attributes, home birth, in some ways, reinforces conventional ideas about women. While the messages are not so negative as those of hospital birth, this use of birth to challenge normative ideas about femininity is perhaps a stalled labor.

Homebirth parents moved in and out of their conventional gender roles throughout the rite of passage of pregnancy, labor, and birth. Because rituals have a great deal of power both to reinforce or to subvert cultural values, this slipping in and out of gender represents a challenge in interpretation. It may be a symbolic inversion, in which the ritual temporarily turns things into their opposites, only to re-right them later. It may also be a genuine subversion of gender. That homebirth parents identified their children’s gendered behavior as freely chosen, rather than socialized, and that they identified

inherent sources of gendered behaviors, suggests that the moving in and out of gender that they experience in pregnancy and birth is an example of a ritual reversal, not a true subversion. However, that they vacillated on the “nature vs. nurture” question suggests that this issue is more complex. Further, they seemed to genuinely believe that home birth was empowering for women and brought men closer to their families, which would indicate a true change from the conventional roles enforced by hospital birth.

So now we go, as woman [sic], we go into a doctor's office and we're kind of like, “We're at your mercy.” Not that I have a problem with male or female doctors, but in a lot of cases it's male doctors who are imposing their views, their ways of doing things, which is not based on instinct, it doesn't honor or respect any of that, in a society that doesn't honor and respect that. You kind of go in there and go, “You're responsible. I'm not. Do what you want.” How un-empowering is that? How non-feminist is that? I can't think of a more way to say, “I'm not valuable. What I bring to the table is not valuable. Having children, bearing children, the miracle of that, is not honored, is not valuable, not respected.” You're a guy, and this is sort of a male model of care for woman, I think, in a lot of ways, the way it's approached and the philosophy. (Uma Garrahy)

My real education actually came, and it sounds goofy probably coming from a guy, but truly, when [Ursula] had natural childbirth in the best possible homebirth situation we could have...Typically she has always been a very empowered lady; she just has that way about her. When she had the natural childbirth, when she had it her way, truly as it would have been at home, but it was at a hospital childbirth center, her empowerment – you could see it, you could feel it. It was there. It went from here to here [gestures]. She was on top of herself; she was on top of whatever she wanted to do. Right then I was like, wow, what a gift to a woman, to *empower* them. I was like, that's kind of cool. I guess that's kind of goofy, but I got it [during the first birth]. It was right then [snaps] that it became clear. I was like, look at her, and I was proud, and I was, like, wow, that's neat. So when she said, “Hey, I want to start teaching this,” I'm like, “Let's do it,” because...to see her empower other women, or couples –What we really found throughout these classes is that it's not about what the partners get; it's more about the couples coming together and working together. What I saw, if that was me and if [Ursula] did that with me, we became stronger as a couple because I was able to support [Ursula] That's what we do in our classes. (Henry Campbell)

They are arguing for an essentialist understanding of women – one in which they are natural nurturers – but also saying that taking responsibility for one's pregnancy and birth can be empowering. While she fumbles a bit in articulating it, Uma has hit upon many of the problems of feminism and motherhood: can we valorize motherhood without ignoring women's other activities? Can we prize ‘natural’ birth without reifying the idea of women as natural, with all the second-class status this implies? Can we assign traits as

‘naturally’ masculine or feminine without devaluing one or the other – is it possible to be separate but equal? These complexities, though often not articulated by homebirth parents, are clearly at play in homebirth and the messages that they and their midwives convey and enact. It is this complexity that leads me to suggest that using the rites of home birth as a way to valorize women or maternity or to remake men’s role in the family is a “stalled labor”: it is not wholly effective in producing what participants may intend for it to produce. While important steps have been taken, more work remains to be done.

I wish to end with what several parents and midwives told me, in one form or another. No matter how long or hard the labor is, the baby is eventually born. I hope that the labor of making birth a time that is fulfilling and empowering to all involved, though lengthy and difficult, will have such a happy ending as well.

CONCLUDING REMARKS

In this thesis, I have used the tools of gender analysis, symbolic anthropology, and the concept of a rite of passage to explore the ways that a sample of white, middle-class US parents make meaning from their choice to give birth at home. They intuit many of the problems with hospital birth that academic researchers have identified. The highly medicalized nature of modern US hospital birth foregrounds the technology, not the mother, minimizing her contribution. Hospital policies make men peripheral to the process of birth and make them mediate between hospital and mother – placing them in a position of enforcing hospital policies they may not agree with while ignoring their social and emotional needs. Likewise, a hospital birth means that a baby is taken from its mother early and often to undergo testing and procedures that the parents may not understand or agree to. Hospital birth routines reinforce conventional gender roles that many parents feel uncomfortable with. Confronted with these issues, the parents I interviewed decided to opt out – to give birth at home instead. They hoped that by doing so, they could change the meaning of birth and perhaps begin to change the culture of birth in the US. Rather than making women passive, they hope to empower them. Rather than make men peripheral, they hope to make them integral. Rather than treating the baby as a product of society, they hope to keep it knit tightly within the family. However, the culture of birth is strongly tied to other cultural beliefs, especially those about gender, so homebirth parents must confront these issues. I find that they sometimes challenge and sometimes accommodate such roles as they attempt to re-make the experience of birth.

The culturally-specific activities that surround pregnancy and birth – both in the US and abroad – have often been interpreted in terms of the anthropological concept of a rite of passage. This rite separates initiates from their former identities, plunges them into the chaos of the liminal period, and reintegrates them in their new roles. It does so by marshalling culturally-significant symbols to repetitively convey key messages. These messages reflect those of the larger group. In chapter 5, I show that, like hospital birth practices, home birth practices can be interpreted as rites of passage. Parents simultaneously enact and are socialized into beliefs and roles about their new status as parents. Through the liminality techniques of hazing, strange-making, and ritual inversion, mothers receive the message that a healthy birth is a commodity to be earned or purchased, that society has few obligations to the individual or the family, and that bodies give birth. Their partners' ritual experience is somewhat different though they receive the related messages that birth care is a business, the family is a self-sufficient unit, and that fathers should be responsible. While these messages were perceived by my respondents as positive and empowering, they are problematic in some ways. In chapter 8, I discuss the way that such beliefs place all responsibility for birth outcomes with the individual and the family, while ignoring macro-level forces that impact health.

Along with other cultural beliefs, gender is a major force in shaping the experience of home birth. While gender has been theorized in a variety of ways, I have treated gender as performative and flexible; that is, seeing “correctly” gendered actions easier to perform though the choice to do otherwise exists. In chapter 6, I show that both the mothers and their partners slip in and out of their conventional gender roles over the ritual course of pregnancy, birth, and postpartum care. This is particularly interesting

from the perspective of rites of passage, because ritual inversion – temporarily making things into their opposite – is a common technique. It can serve to undermine the belief in question by making it seem ridiculous, or to strengthen belief by highlighting how it feels right. The men approach pregnancy and labor in conventional gendered ways, focusing on financial and technical issues. However, they find themselves in the unusual position of performing emotional and domestic work in the crucible of labor and birth: they massage their wives, comfort them, talk to them, wait on them. That is, they move from masculine “technician thing” to the feminine “mental game.” The women follow a more complex route of moving into and out of feminine behaviors. They eat more “masculine” foods in pregnancy, including meat and fat, but couch it in the properly feminine role of taking care of their yet-unborn children. They engage in exercise in pregnancy and labor, but make sure that it is suitably feminine in nature – non-competitive, non-aggressive, and stressing personal control. In labor, they continue to be active but their food choices become more feminine and indeed childlike. Much as Davis-Floyd interpreted hospitals as infantilizing women (for example, by shaving their pubic hair), home birth women are infantilized as they eat foods such as milk, graham crackers, bananas, and peanut butter – foods associated with children in our culture.

Throughout the pregnancy and birth process, then, both homebirth mothers and their partners subvert or accommodate gendered expectations for their behavior at emotionally-significant times. Such performance of “opposite” gendered actions in ritual has the power to either subvert or to reinforce conventional beliefs. In order to further explore this issue of whether homebirth parents’ beliefs and practices about gender have been transformed through the rite of birth, I turn in chapter 7 to parents’ beliefs about

their children's gendered behaviors. More complexity arises here. Parents vacillate on the "nature vs. nurture" debate but ultimately lean toward essentialist explanations of gendered behaviors. They acknowledge that gendered behaviors are learned but point to their children's early activities as evidence that they are innate. They find themselves in a difficult situation as they simultaneously wish for their children to express their own individuality and for them not to engage in "improper" behaviors for their gender. They intuit, correctly, that seeing gender as learned does not mean that there are no social repercussions for performing it incorrectly. They want their children to avoid these repercussions but also feel uncomfortable with the idea of stifling their choices through socialization. To resolve this tension, the parents deny that they socialize gender. They assume that young children's behavior is pre-social, ignoring evidence that socialization begins almost immediately. They can then attribute their children's "correctly" gendered activities to individuality and choice and absolve themselves of socializing gender. This resolves the dilemma neatly by drawing on a trait – individuality – that is highly valued in their culture. It is somewhat problematic from a feminist perspective, however, since it relies on essentialist ideas about men's and women's expected behaviors.

In chapter 8, I address the question of whether home birth, as it was practiced by my informants, truly accomplishes what they hope it will: creating a birth experience that is empowering to women, welcoming of men, and kinder to babies. While they interpret the messages of birth, including those about gender and the body, in a positive manner, I find that reforming birth remains a stalled labor. Messages that place emphasis on individual- and family-level choices are repeated many times throughout the ritual. Parents are told that the society has few obligations to them, that they should be self-

sufficient, that they are responsible for their own birth, and that they must be savvy consumers of birth care. This ignores the larger systemic forces that shape birth and the fact that people with less social power than those in my sample will not have the “choice” to opt out of them. Likewise, I find that the work of incorporating men into the domestic sphere is not complete: while they are involved parents, the mothers continue to have primary childrearing responsibility. Empowering women through birth – especially by emphasis on the “natural” and bodily aspects of it – is problematic. Likewise, parents’ refusal to acknowledge the strong role of themselves in shaping their children’s ideas about the acceptable behaviors of their gender makes it more likely that essentialist ideas will persist.

While parents hope that they can challenge the culture of birth, especially its messages about the roles of men and women, this labor remains stalled. Other authors have identified ways that sexuality and reproduction are problematic realms in which to challenge gender norms. For example, Wilkins (2004), in her work on US “goth” subculture, examined the ways that goth women challenge gendered sexual expectations: by exaggerating femininity to caricature; by asserting the right to dress provocatively without being harassed; and by appropriating some masculine behaviors, such as by being sexually aggressive and openly having multiple sexual partners. However, they were not wholly successful in creating the gender-egalitarian space they hoped for. For example, women’s dress and appearance was judged more harshly than men’s; women were objectified in goth culture in much the same way as in the larger culture. The goth women also couched their sexual relationships in terms of love, which continues to position relationships and romance as central to women’s lives. Further, their sexual

availability often meant that men had greater sexual access, that women shared the “work” of establishing sexual relationships, and that men continued to be seen as sexual consumers. As the author concludes, “centering gender change on sexuality only partially challenges interpersonal inequalities between men and women” (Wilkins 2004:347). In a similar fashion, authors such as Beckett (2005), Klassen (2001a), and Lewin (1998) have found that women (including lesbians) challenging gender norms through childbirth and mothering is problematic because they continue to seat women’s identities in conventional realms. Martin (2005) found that while parents are increasingly tolerant of gender non-conformity, they find it problematic when it suggests homosexuality. Similarly, I find that homebirth parents both challenge and accept cultural beliefs about gender as they negotiate pregnancy, home birth, and parenting. My study and these others all suggest that the realm of sexuality is a sort of “final frontier” in changing gender norms.

Despite these critiques, I think that the stalled labor of changing gender norms by changing the culture of birth is worthwhile. It offers men and women a partial, if not complete, opportunity to change their roles in birth and open up the possibility of changing them elsewhere. I hope that the availability and work of home birth continues.

Future Directions

I have emphasized the similarity, rather than diversity, of informants’ perspectives. This is largely because they are a small and relatively homogenous group. All were European-descended and middle-class or aspiring to be so. They were more educated than the average. Only one couple was lesbian. There seemed to be some

diversity of political opinion – and earlier authors have found that homebirthers fall on all parts of the political spectrum – but I did not address this issue directly in my interviews. A larger and more diverse sample would offer the opportunity to parse out differences in perspectives based on gender, racial or ethnic identity, socioeconomic status, sexual orientation, and political affiliation. For example, Dillaway and Brubaker (2006) found that African-American teens were not concerned with maintaining femininity in hospital childbirth, so a study of African-American women giving birth at home could shed additional light on this issue. This study contributes to the literature that attempts to parse out the various ways that gender is constructed and enacted – especially as this is done via the body. A more diverse sample of homebirth parents would add to this. In particular, more study of the role of men in home birth is needed.

A future analysis of US home birth from a political-economic perspective also offers intriguing possibilities. These homebirth parents' concerns about food and vaccinations often centered on purity, locality, and on conceptions of the immune system and the flexible body, which Martin (2000; 1994) identified as a new paradigm for understanding the body. Since the attacks on the World Trade Center and Pentagon on September 11, 2001, a great deal of national discourse has centered on immigration and the defense of national boundaries. Homebirth parents' concerns about dangers in institutional settings and emphasis on organic foods may parallel such concerns. The relationship between home birth and these trends are ripe for analysis. Similarly, both Davis-Floyd (2003) and Martin (2001) observed the similarities between hospital birth and factory production. This relates to the fact that hospital birth became widespread in the early twentieth century, when this country had a Fordist economic structure. If home

birth as it is practiced by these informants becomes more common, it will do so in a post-Fordist, neoliberal economic climate. It is easy to see home birth as an expression of small-batch, unregulated production. Taking these or other theoretical perspectives, home birth will continue to be a unique opportunity for understanding modern US values about the body, gender, and other cultural realms.

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APPENDIX A: CODES

Deductive Codes

- Antipathy toward state interference in family
- Biomedical studies as evidence
- Birth as natural
- Body as a communication center
- Choice / options
- Desire for control over birth
- Domestic sphere proper for women
- Economic factors
- Father as mediator between public / private sphere
- Fear of homophobia / perception of hospital staff as homophobic
- Fear of racism / perception of hospital staff as racist
- Feeling like a real woman
- Female as emotional and bodily
- Female body-disciplining (esp. by self)
- Home birth as better for infant
- Home birth as better for mother
- Individual choice / rights
- Lack of access for non-economic reasons
- Male as rational and mental
- Metaphors for birth
- Negative hospital experiences
- No “rival” men; sexual monogamy; modesty
- Patient as consumer
- Pragmatism about health care decisions
- Religious beliefs
- Safety
- Self-sufficiency of family unit
- Transgressive / countercultural is appealing

- Uniqueness of each birth
- Women naturally know how to birth

Inductive Codes

- Abdicate responsibility
- Artificial
- Being “nice” or accommodating
- Biomedicine goes too far
- Birth is athletic
- Birth is beautiful
- Birth is dangerous or risky
- Birth is safe
- Birth is misrepresented in the media
- Birth proceeds well on its own
- Birth as metaphor for other activities
- Birthing at home requires strength / bravery
- Body as complex system
- Body as machine
- Body-mind dualism
- Business relationship with midwife
- Business / market language
- Comfort
- Concern about accuracy (dates / times) in telling birth story
- Cutting
- Discipline
- Doctors manipulate patients
- Don’t want strangers around; want personal relationship with attendants
- Emotion
- Fear or threat of c-section
- Flexible body
- Friends / family had home birth before

- Gender roles
- Going to hospital abdicates responsibility
- Had witnessed a birth
- Hormones
- Hospital provides safety
- Hospital is for emergencies
- Hospital as place of conflict
- Hospital as risky
- Hospital interferes with natural process
- Ignorance
- Immune system talk
- Intimacy
- Intuition
- Lighting and other visual / auditory stimuli
- Many women before me have done this
- Market forces negatively affect care
- Maternal imperative
- Maternal self-sacrifice
- Medical studies/terms authoritative
- Medication
- Meritocracy
- Men's role in birth
- Men as emotional support
- Men's opinions about birth not valued
- Midwives have unique knowledge
- Mind can control body
- Misconceptions about birth
- Natural vs. Artificial
- Neoliberal economics
- Nutrition
- Patients' rights
- Post-911 worldview
- Post-Fordism
- Pride
- Privacy
- Reductive approach to the body
- Seen a home birth before
- Statistics
- Stress / stimulation
- Sympathetic magic
- Take responsibility for health
- Technology gives safety
- Tradition
- Training for birth; birth as athletic event
- Use medical language and definitions of pregnancy and risk; don't challenge biomedical
- Vulnerability
- Writing affirmations as a form of magic; power of mind to influence outcome

APPENDIX B: INTERVIEW GUIDE FOR HOMEBIRTH PARENTS

I am interested in understanding how women and their partners decide to have their children at home. I am especially interested in how this is related to what you think and believe about gender, pregnancy, birth, your background, and your sexual orientation. Our interview will last from 2-4 hours, and it will involve my asking you questions about home birth.

You have the right to:

- Not participate in the research.
- Refuse to answer any question.
- Stop participating in the research at any time.

Your privacy will be protected by:

- Your real name will only be on one research document; pseudonym elsewhere.
- Research documents are in password-protected computers or locked offices.
- Research assistants do not see your real name and are instructed about confidentiality.

Do you have any questions for me about our interview at this time?

May I tape this interview for later transcription?

How did you first learn about home birth?

- What was your initial reaction to the idea?
- Books, movies, newspapers, friends, family?
- Did you know anyone who had given birth at home? Did you attend?
- Why did you decide to have a home birth?
- What was your partner's initial reaction?
- Have you had previous experiences with health care system that were positive / negative?
- What was most influential in making this decision? (Books, movies, etc)
- Do you believe women naturally know how to birth or not? Where does this knowledge come from?

When you explain this choice to others, what do you say?

- Do you explain it differently to different people?
- How do people react when they hear about this? How do you respond to them?
- Was there anyone who was particularly supportive or opposed?

Is there anything that would make you decide not to birth at home?

- If your partner disagreed, how would you feel?

How did you choose your midwife?

What were your experiences during your / your partner's pregnancy?

- How did you know you were pregnant?
- How did you feel about your / your partner's body?
- How did others treat you / react to your pregnancy?
- What advice did you get from family / friends?

Did you seek or avoid any foods / experiences / emotions / people?
 Did your pregnancy change the way you felt about yourself as a woman / man?
 If you/your partner had a hospital birth, please tell me about your/your partner's hospital birth(s).
 What did you do to prepare?
 How did it proceed?
 What did you like / dislike?
 Would you change anything about it?
 Please tell me about your home birth(s).
 How did you prepare?
 Mentally?
 Physically?
 Did you purchase anything?
 Did you prepare a space?
 What were you thinking / feeling as the time for the birth approached?
 How did it proceed?
 What did your partner do?
 What did you do during the labor and immediately after the birth?
 What did you like / dislike about your homebirth experience?
 How do you think your birth would have been different if it were at a hospital?
 How have your births changed who you are as a person?
 Has it changed the way you feel as a man / woman?
 Did hospital birth make you feel different than home birth?
 Do you think that your children who were born in the hospital differ from those born at home?
 Do you recommend home birth to others?
 What do you tell them?
 What kind of people do you think are drawn to home birth?
 Do you do any other unusual parenting practices?
 (Cosleeping, extended breastfeeding, cloth diapering, vaccinations, circumcision, etc)
 Do you think little boys and little girls are fundamentally different?
 How / why are they different?
 What about men and women?
 Where do you think that home birth should fit into US health care?
 Do you think home birth should be more common?
 Are there people who shouldn't have home births?
 What do you think about ACOG and AMA statements?
 Is there anything else you would like to tell me about homebirth?